CJCP® Certified Joint Commission Professional™

Focus on the "Sentinel Events" Chapter

In January 2013, Joint Commission Resources (JCR) launched its credential for accreditation professionals—Certified Joint Commission Professional (CJCP®). Upcoming testing dates will occur in April, July, and later dates in 2015.

To help candidates prepare for the CJCP examination and understand what to expect, this column features sample questions similar to those that appear on the examination. The answer key on page 10 provides the context for the correct answer. All of the CJCP examination questions are multiple choice, offering three possible choices from which you should pick the BEST answer. Also, the examination does not have any true/false questions or include any answers that are "All of the above" or "None of the above." Please note the questions that follow are NOT actual examination questions; they are simply indicative of the types of questions a candidate may see on the exam. For more information on CJCP, or other products to help you prepare for the exam such as live events, workbooks, or online education learning modules, visit www.jcrinc.com /cjcp-certification/. You may also e-mail questions directly to cjcp@jcrinc.com.

About the 'Sentinel Events' Chapter

The "Sentinel Events" chapter houses the Sentinel Event Policy. The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious adverse events improve safety and learn from those sentinel events. Careful investigation and analysis of patient safety events, as well as evaluation of corrective actions, is essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how The Joint Commission partners with hospitals that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm.

A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm

The chapter also lists some specific types of patient safety events that are considered sentinel whether or not it results in patient harm, including abduction of a patient, fires in patient care areas, and other incidents. Such events are considered "sentinel" because they signal a need for immediate investigation and response. All sentinel events must be reviewed by the hospital and are subject to review by The Joint Commission.

Sample Questions

1 **Which of the following is NOT considered a sentinel event by The Joint Commission?**

a. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
b. Theft of patient property while the patient is receiving care, treatment, or services at the hospital, including in the emergency department
c. Severe neonatal hyperbilirubinemia (bilirubin > 30 milligrams/deciliter)

2 **A hospital that identifies a potential sentinel event is required to do which of the following?**

a. Report the sentinel event to Sentinel Event Unit of The Joint Commission's Office of Quality and Patient Safety
b. Conduct a thorough and credible comprehensive systematic analysis
c. Suspend operations in the clinical area in which the event occurred until an investigation is conducted

3 **In what circumstances can an occurrence of a sentinel event affect a hospital's accreditation status?**

a. When the sentinel event is found to be the result of noncompliance with Joint Commission standards
b. When the hospital fails to report the sentinel event to The Joint Commission
c. When the hospital fails to respond appropriately to the sentinel event

(See Answer Key on page 10.)

(continued from page 7)

Answer Key

1 **The correct answer is b.** Theft of patient property is not considered a sentinel event by The Joint Commission. In addition to the definition provided above, the following events are considered sentinel:

- Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital
- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
- Severe neonatal hyperbilirubinemia (bilirubin > 30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose > 1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose
- Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
- Any intrapartum (related to the birth process) maternal death or severe maternal morbidity

2 **The correct answer is b.** Appropriate response to a sentinel event includes the completion of a comprehensive systematic analysis for identifying the causal and contributory factors. Root cause analysis, which focuses on systems and processes, is the most common form of comprehensive systematic analysis used for identifying the factors that underlie a sentinel event. The product of the comprehensive systematic analysis is an action plan. The action plan identifies the strategies that the hospital intends to implement in order to reduce the risk of similar events occurring in the future. Reporting of sentinel events to The Joint Commission is voluntary. Each hospital is strongly encouraged, but not required, to report to The Joint Commission any patient safety event that meets the Joint Commission definition of sentinel event. The Joint Commission does not require or recommend suspension of operations in a clinical area that has experienced a sentinel event.

3 **The correct answer is c.** The fact that a hospital has experienced a sentinel event will not impact its accreditation decision. However, willful failure to respond appropriately to the sentinel event could have such an impact. For instance, if the hospital fails to submit a comprehensive systematic analysis within an additional 45 days following its due date, its accreditation decision may be impacted. In these instances, staff in the Sentinel Event Unit would recommend that the Accreditation Committee of the Joint Commission's Board of Commissioners change the hospital's accreditation status. TS