ACCRÉDITATION SANS FRONTIÈRES

ASF Sentinel Event Policy

How ASF and its accredited organizations respond to serious patient safety events

Version 1 · 2026
Paris · Geneva · Tbilisi

ASF-SEP-001-v1 · Published Paris, 12 September 2026 · Next review 12 September 2029

Document Control

Document Title	ASF Sentinel Event Policy
Document Reference	ASF-SEP-001-v1
Version / Edition	Version 1
Status	Published
Date of Publication	12 September 2026
Place of Publication	Paris, France
Issuing Authority	ASF International Standards Council, Accréditation Sans Frontières
Language of Origin	English
Effective Date	12 September 2026
Next Scheduled Review	12 September 2029
Supersedes	None — first edition

Table of Contents

Foreword

Every other ASF document governs either becoming accredited or keeping standards current. None of them, until this one, addressed a question no accreditation body can honestly avoid: what happens when a serious, preventable harm occurs at an organization ASF has already accredited? This policy exists because that silence was itself a gap — not a neutral one, but one that left both ASF and its accredited organizations without a clear, accountable answer to a question that will eventually arise.

This policy is directly informed by Joint Commission's own Sentinel Event Policy, in continuous operation since 1996, and reflects the same foundational premise: how an organization responds to serious harm matters more, to accreditation status, than the fact that harm occurred at all.

> *No accreditation status, from any body, guarantees that serious harm will never occur at an accredited organization. What accreditation can and should guarantee is that when it does, there is a clear, honest, non-punitive process for learning from it — rather than an incentive to hide it.*

1. Purpose and Definitions

1.1 Purpose

This policy defines how ASF and its accredited organizations — across all seven ASF organizational standards — identify, report, investigate, and learn from serious patient safety events, and clarifies how such events relate to an organization's accreditation status. It applies to any organization holding current ASF accreditation, regardless of which of ASF's seven standards it was accredited against.

1.2 Sentinel Event, Defined

A sentinel event is a patient safety event — not primarily related to the natural course of a patient's illness or underlying condition — that reaches a patient and results in death, permanent harm, or severe temporary harm, consistent with Joint Commission's own definition [1–2]. The word “sentinel” signals exactly what it does in clinical or public health surveillance generally: an event serious enough that it warrants immediate, individual attention and investigation, not aggregation into routine statistics.

1.3 Related Terms

This policy distinguishes several related categories of event, consistent with standard patient safety terminology [3]:

- Adverse event — a patient safety event that results in harm to the patient, of any severity
- No-harm event — a patient safety event that reaches the patient but does not result in harm
- Close call (near miss) — a patient safety event that does not reach the patient
- Hazardous condition — a circumstance that increases the probability of an adverse event, such as inadequate staffing, even where no event has yet occurred

A sentinel event is a specific, serious subset of adverse events — not every adverse event is a sentinel event, but every sentinel event is an adverse event of the most serious kind. No-harm events, close calls, and hazardous conditions are not sentinel events, but organizations are encouraged to treat them as genuine opportunities to prevent a future sentinel event, not as non-events unworthy of attention.

2. Goals of This Policy

This policy has four goals, consistent with the same goals underlying Joint Commission's own Sentinel Event Policy [1–2]:

1. To improve patient, resident, or service-user care and prevent the recurrence of sentinel events — not to assign blame to individuals for systemic failures.
2. To focus an organization that has experienced a sentinel event on genuinely understanding the factors that contributed to it — including cultural conditions, latent weaknesses in systems, and active failures at the point of care — and on changing the organization's own culture, systems, and processes accordingly.
3. To increase general knowledge, across ASF's accredited network, about sentinel events, their contributing factors, and effective prevention strategies — the aggregate learning function described in Section 6.
4. To maintain the confidence of patients, families, staff, and the public that ASF accreditation reflects a genuine, ongoing commitment to safety — not merely a credential earned once and left unexamined.

> *Root cause analysis, done honestly, is uncomfortable. It asks an organization to examine its own culture and systems, not only the specific individual present when harm occurred. This policy is built around that discomfort being productive, not something to be managed away through a narrower, more convenient investigation.*

3. Reporting

3.1 What Is Expected

An accredited organization is expected to identify sentinel events occurring within its own operations and to self-report them to ASF within a defined period following identification. Self-reporting is not an admission of failure — it is the expected, professional response of an organization taking patient safety seriously, and this policy treats it as such.

A sentinel event may also come to ASF's attention through a report filed under the ASF Public Complaints & Feedback Policy, submitted by a patient, family member, or member of the public rather than the organization itself. Where a complaint filed under that policy meets the threshold defined in Section 1.2, it is handled under this policy from that point forward, following the same investigation and response process described in Section 4, regardless of who first identified it.

3.2 Self-Reporting as a Sign of a Functioning Safety Culture

Consistent with Joint Commission's own framing [1–2], ASF treats timely, voluntary self-reporting as evidence that an organization's safety culture is genuinely functioning — not as evidence that the organization has failed. An organization that reports a sentinel event promptly and transparently is demonstrating exactly the culture ASF's standards are meant to build. An organization discovered to have concealed a sentinel event, by contrast, has demonstrated the opposite — regardless of how the event itself occurred.

> *This distinction is the single most important design choice in this policy. An accreditation system that punishes honest reporting more severely than it punishes concealment teaches organizations to conceal. This policy is built specifically to avoid that outcome.*

3.3 How to Report

Reports are submitted using the Sentinel Event Report Form (Annex A), directed to ASF's designated patient safety contact, and include a preliminary description of the event, immediate actions already taken to protect patients and prevent recurrence, and the organization's own initial assessment of contributing factors, where known at the time of reporting. A preliminary report need not be complete — timeliness matters more than completeness at this stage, since a full root cause analysis under Section 4 necessarily takes longer than an initial report should be delayed for.

4. Investigation and Response

4.1 Root Cause Analysis

Following a sentinel event report, the accredited organization conducts a root cause analysis — a structured investigation into the cultural, latent, and active factors that contributed to the event, not only the immediate, proximate cause [1–2]. A root cause analysis that identifies only the individual present at the point of harm, without examining the systems and conditions that made harm possible, has not actually completed a root cause analysis under this policy.

The organization submits its completed root cause analysis, using the Root Cause Analysis Template (Annex B), within a defined period following the event — proportionate to the event's complexity, and agreed with ASF's patient safety contact where a genuinely complex investigation requires more time than the default period allows.

4.2 Corrective Action Plan

The organization's root cause analysis is accompanied by a corrective action plan, using the Corrective Action Plan Template (Annex C), specifying the concrete changes the organization will make in response to the identified contributing factors, who is responsible for each change, and the timeline for implementation. A corrective action plan that restates existing policy, rather than describing genuine change, does not meet this requirement.

4.3 ASF's Role

ASF's designated patient safety contact reviews the root cause analysis and corrective action plan, and may request clarification or additional detail where either is genuinely insufficient. ASF's role in this process is to partner with the organization in strengthening its response, consistent with the goals in Section 2 — not primarily to adjudicate blame. Where ASF's review identifies a genuine, ongoing risk to patient safety not addressed by the organization's own corrective action plan, ASF may require specific additional action before the matter is considered resolved.

> *A root cause analysis submitted only because this policy requires one, without genuine organizational reflection behind it, protects nothing and prevents nothing. ASF's review exists specifically to distinguish a genuine response from a procedural one — not to add bureaucratic friction to an already difficult moment for the organization involved.*

5. Relationship to Accreditation Status

5.1 The Event Itself Does Not Jeopardize Accreditation

The occurrence of a sentinel event, by itself, does not affect an organization's accreditation status — consistent directly with Joint Commission's own explicit policy on this point [1–2]. Serious harm can occur at even a genuinely well-run, fully compliant organization; accreditation reflects an organization's systems and practices as verified, not a guarantee that no failure of any kind will ever occur within them.

5.2 Failure to Respond Honestly Does

What does affect accreditation status is an organization's response to a sentinel event — specifically, a willful failure to report a reportable event, a root cause analysis conducted in bad faith or designed to obscure rather than identify genuine contributing factors, or a corrective action plan not implemented as submitted. This is the specific, load-bearing principle of this entire policy: ASF does not accredit organizations because nothing ever goes wrong within them; ASF accredits organizations that respond to what goes wrong honestly, thoroughly, and without concealment.

> *This distinction has to be genuine, not merely stated, or the entire non-punitive framing in Section 3 collapses. An organization that self-reports honestly and conducts a genuine root cause analysis, even for a severe sentinel event, is treated entirely differently under this policy than an organization discovered to have concealed a comparable event — and that difference is exactly what Sections 3 and 4 are designed to produce.*

5.3 Where This Connects to the Accreditation Process Guide

Section 5.2 of the ASF Accreditation Process Guide references this policy directly, rather than duplicating it — an organization holding ASF accreditation is expected to already understand, before any sentinel event ever occurs, that honest response is what protects its accreditation status, not the absence of ever needing to respond.

6. Aggregate Learning

6.1 A Confidential Sentinel Event Record

ASF maintains a confidential, de-identified record of sentinel events reported across its accredited network, consistent with the aggregate-learning function real comparable bodies maintain [1–2]. Individual organizations and patients are never identified in this record or in any analysis derived from it; the record exists to identify patterns — recurring contributing factors, settings, or practices — not to track any single organization's history for purposes beyond this policy's own goals.

6.2 Periodic Safety Alerts

Where the aggregate record identifies a genuine, emerging pattern warranting attention across ASF's accredited network — a specific contributing factor recurring across multiple, unrelated organizations — ASF issues a safety alert to all accredited organizations, describing the pattern and recommended preventive action, without identifying the specific organizations or events underlying it. These alerts are published as needed, not on the fixed three-year cycle governing full standards revision, since a genuine emerging safety pattern does not wait for a scheduled review to matter.

7. Confidentiality and Non-Punitive Culture

7.1 Confidentiality of Reports

Sentinel event reports, root cause analyses, and corrective action plans submitted under this policy are treated as confidential by ASF, accessible only to the designated patient safety contact and, where genuinely necessary for review, the standing Council — not published, and not disclosed to other accredited organizations or the public in identifiable form.

7.2 Protection for Good-Faith Reporting

An organization that reports a sentinel event in good faith, and responds to it consistent with Sections 3 and 4 of this policy, is not penalized under this policy for the event's occurrence, regardless of its severity. This protection does not extend to concealment, bad-faith investigation, or failure to implement a submitted corrective action plan — the distinction drawn throughout Section 5.

8. Surveyors' Role

8.1 Surveyors Do Not Investigate Sentinel Events During Routine Surveys

Surveyors conducting a routine accreditation or re-accreditation survey, under the ASF Accreditation Process Guide, are not instructed to search for or investigate sentinel events during that survey, consistent with Joint Commission's own explicit surveyor instruction on this point [1–2]. The processes are deliberately separate: a routine survey assesses ongoing compliance with a published standard, while this policy governs a specific, reported event through its own distinct process.

8.2 Where Sentinel Event Compliance Is Assessed

A routine survey does assess an organization's general compliance with sentinel-event-related requirements within the applicable ASF standard — for instance, whether a policy for identifying and responding to serious adverse events exists and is understood by staff — without investigating whether a specific past event was handled correctly. Evaluation of an organization's actual handling of a specific sentinel event is conducted exclusively through the process in Sections 3 and 4 of this policy.

References

[1] Joint Commission. Sentinel Event Policy and Procedures. Oakbrook Terrace (IL): The Joint Commission; 2026.

[2] Joint Commission. Sentinel Events. Oakbrook Terrace (IL): The Joint Commission; 2026.

[3] SASGOG. Sentinel Events — Common Sources of Improvement Work. 2026.

Annex A — Sentinel Event Report Form

Submitted by an accredited organization under Section 3.3, within the defined reporting period following identification of a sentinel event.

Organization name: _____

ASF standard accredited against: _____

Date of event: _____ Date of identification: _____

Date of this report: _____

Event Description

[Preliminary description of what occurred, the outcome, and how it was identified.]

Immediate Actions Taken

[Actions already taken to protect patients and prevent immediate recurrence.]

Initial Assessment of Contributing Factors (where known)

[Preliminary factors identified, if any, at the time of this report. A full root cause analysis follows under Annex B.]

Submitted by: _____ Role: _____

Annex B — Root Cause Analysis Template

Submitted under Section 4.1, within the period agreed following the initial report.

Sequence of Events

[A factual, chronological account of what happened, established through review of records and interviews.]

Contributing Factors

- Active failures (specific actions or decisions at the point of care)
- Latent conditions (underlying systems, staffing, equipment, or design factors)
- Cultural factors (organizational culture, communication patterns, reporting norms)

Root Cause(s) Identified

[The underlying cause or causes the analysis identifies as most directly responsible for the event, distinguished from proximate or superficial causes.]

Analysis conducted by: _____ Date completed: _____

Annex C — Corrective Action Plan Template

> *Submitted alongside Annex B, under Section 4.2.*

Corrective Actions

[For each root cause identified in Annex B: the specific action to be taken, who is responsible, and the implementation timeline.]

Monitoring for Effectiveness

[How the organization will verify that each corrective action was implemented and is genuinely effective, not only completed on paper.]

Plan submitted by: _____ Date: _____

Reviewed by ASF (patient safety contact): _____ Date: _____

This policy governs how ASF and every organization it accredits respond to the most serious patient safety events — not to avoid them entirely, which no accreditation system can guarantee, but to ensure that when they occur, the response strengthens the system rather than concealing its failure.

Index