OREGON STATE HOSPITAL

POLICY ATTACHMENT POLICY: 1.003 ATTACHMENT D: Sentinel Event Examples **Director of Quality Management** POINT PERSON: DATE: NOVEMBER 3, Interim Superintendent APPROVED: 2025 Minor/technical revision of SELECT ONE: New policy attachment existing policy attachment Reaffirmation of existing Major revision of existing policy attachment policy attachment

Events that are more likely to occur in a behavioral healthcare inpatient hospital setting:

- Suicide of any patient receiving care, treatment, and services or who was discharged within 7 days;
- Homicide, sexual abuse/assault, physical assault (leading to death, permanent harm, or severe harm) of any patient receiving care, onsite at the organization;
- A fall resulting in any of the following for a patient:
 - Any fracture;
 - Surgery, casting, or traction;
 - Required care for a neurological (i.e., skull fracture, subdural or intracranial hemorrhage) or internal (i.e., liver laceration) injury;
 - A patient with coagulopathy who receives blood products as a result of the fall;
 - o Death
- An elopement (unauthorized leave) resulting in a related death (suicide or homicide), or major loss of function or severe temporary harm to the patient;
- Homicide, sexual abuse/assault, physical assault (leading to death, permanent harm, or severe harm) of a health care personnel, onsite at the organization or while providing care/supervision to patients, regardless of location;
- An abduction of a patient;
- An unanticipated death, including any that results from seclusion or restraint use.

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According to the Joint Commission (TJC) Sentinel Event Policy July 2023, in cases in which the health care organization is uncertain whether an event meets TJC's definition of a sentinel event, the event will be presumed to be a patient safety event, requiring comprehensive analysis. TJC requests that this analysis be shared with their Office of Quality and Patient Safety (OQPS).