OREGON STATE HOSPITAL

POLICY ATTACHMENT

ATTACHMENT A:	Sentinel Event Examples	**POLICY: 2.012**
POINT PERSON:	Director of Quality Management	
APPROVED:	Superintendent	**DATE: FEBRUARY 16, 2024**
SELECT ONE:	(●) New policy attachment	( ) Minor/technical revision of existing policy attachment
	( ) Reaffirmation of existing policy attachment	( ) Major revision of existing 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;
  - 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.

According to the Joint Commission (TJC) Sentinel Event Policy July 2023, in cases in which the health care organization is uncertain 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 this analysis be shared with their Office of Quality and Patient Safety (OQPS).