The Joint Commission

Sentinel Event Data
2023 Annual Review

The Joint Commission Sentinel Event Policy is available online at
http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/

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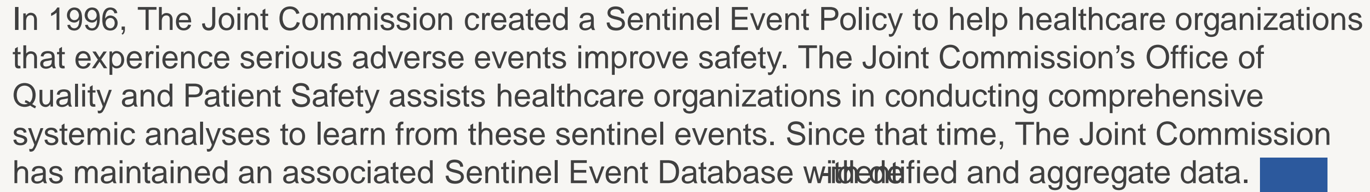
Overview


In 1996, The Joint Commission created a Sentinel Event Policy to help healthcare organizations that experience serious adverse events improve safety. The Joint Commission’s Office of Quality and Patient Safety assists healthcare organizations in conducting comprehensive systemic analyses to learn from these sentinel events. Since that time, The Joint Commission has maintained an associated Sentinel Event Database with de-identified and aggregate data.

The aggregate information, including causes and outcomes of sentinel events, is analyzed yearly to advance insight into causes of sentinel events and develop mitigating strategies to

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Sentinel Event Definition

The Joint Commission defines a sentinel event as 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:

- Death
- Permanent harm (regardless of severity of harm)
- Severe harm (regardless of duration of harm)

An event is also considered sentinel if it is one of the following:

- 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 health care organization's emergency department (ED)
- Unanticipated death of a full-term infant
- Homicide of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Homicide of a staff member, licensed practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Any intrapartum maternal death
- Severe maternal morbidity (leading to permanent harm or severe harm)
- Sexual abuse/assault of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization
- Sexual abuse/assault of a staff member, licensed practitioner, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Physical assault (leading to death, permanent harm, or severe harm) of any patient receiving care, treatment, and services while on site at the organization or while under the care or supervision of the organization

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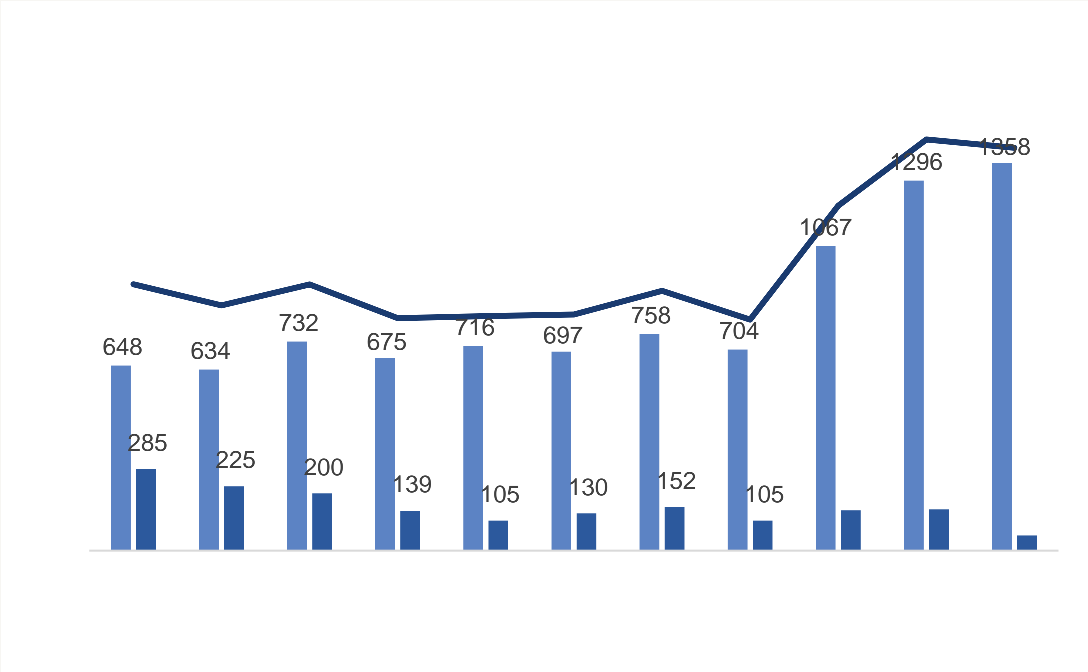

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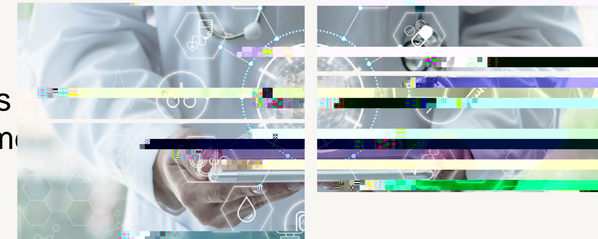
Sentinel events resulting in death were most associated with patient suicide (29%), delays in treatment (23%), and patient falls (10%). Events resulting in severe temporary harm were most associated with patient falls (67%).

Violencerelated sentinel events classified as assault/rape/sexual assault/homicide became one of the 5 most prevalent event types in 2023, increasing 77% from 2022.



Most reported sentinel events in 2023 occurred in the hospital settings (88%). Leading event types within this setting included falls (51%), unintended retention of foreign object (8%), wrong surgeries (8%), and assault/rape/sexual assault/homicide (7%). In the behavioral health setting, leading event types were patient suicide (23%), self-harm events (18%), assault/rape/sexual assault/homicide (18%), and delays in treatment (18%). Wrong surgeries (38%), delays in treatment (11%), op/post-operation complications (11%), and fire/burns (e.g., fire/burn from light source or bovie) (11%) were leading event types in the ambulatory care setting. Fire/burns (e.g., smoking while on oxygen) (40%) and patient falls (37%) were leading event types in the home care setting, and patient falls (50%) and delays in treatment (14%) were leading event types in the critical access hospital setting.

Top 10 Frequently Reviewed Sentinel Events, 2023

Consistent with 2022 reporting patterns, patient falls were the most prevalent sentinel event type reviewed in 2023 (n=672) an increase from 611 reviewed falls in 2022.

Top 10 Leading Reviewed Sentinel Event Types (CY2023)

Event Types	N	% of Tota
Fall	672	48%
Wrong site*	112	8%
Unintended retention of a foreign object	110	8%

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Patient Falls

Patient falls continue to be the leading sentinel event type reviewed since 2019. In 2023, there were 672 events classified as patient. Of these patient falls, 26 (4%) resulted in death, 56 (8%) in permanent harm, and 538 (80%) in severe harm to the patient. Leading injuries included fractures (hip/leg, shoulder/arm, rib) and head injury/bleed.

Consistent with 2022, patient falls while ambulating was the leading mechanism for falling followed by falling from bed and falling while toileting.

Reported contributors to falls included policies not being followed (e.g., fall risk assessment), lack of competency to recognize abnormal clinical signs or signals, inadequate staff-to-staff communication during handoffs or transitions of care, and lack of shared understanding or mental model regarding plan of care.

Wrong Surgery

Wrong surgeries include surgeries or invasive procedures that are performed at the wrong site or on the wrong patient, or that are the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of outcome. There were 112 sentinel events classified as wrong surgeries in 2023—a 26% increase from 2022.

Severe temporary harm (39%), unexpected additional care/extended stay (39%), and permanent harm to the patient (14%) were leading outcomes. Most wrong

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Leading factors associated with suicide included lack of shared understanding across team members, policies not being followed or adhered to, and lack of competency to recognize abnormal clinical signs or signals.

Conclusion

Reported sentinel events remained consistent with previous reporting patterns. Consistent with previous years, patient falls were the leading event type reviewed (48%).

Patient outcomes from reported sentinel events were death (18%), permanent

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