

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 prevent harm to individuals under their care.

Between January 1 and December 31, 2023, The Joint Commission received 1,411 reports of sentinel events; the majority—96% (1,358)—were voluntarily self-reported to The Joint Commission by an accredited or certified entity. Most reported sentinel events occurred in the hospital setting (88%).

As in previous years, patient falls was the most reported sentinel event (n=672, 48%) in 2023. The remaining leading categories were wrong surgery (n=112, 8%), unintended retention of foreign object (n=110, 8%), assault/rape/sexual assault/homicide (n=106, 8%), delay in treatment (n=81, 6%), and suicide (n=71, 5%). These categories represent 82% of all reported sentinel events in 2023.

The proportion of patient harm resulting from a sentinel event was comparable to previous years: 18% of reported sentinel events were associated with patient death, 8% with permanent harm or loss of function, 57% with severe temporary harm, and 12% with unexpected additional care/extended stay, such as additional treatments or procedures required following the event. Of events resulting in patient death, delay in treatment was the second most harmful event category following patient suicides with 69% of delays resulting in death.

As the reporting of most sentinel events to The Joint Commission is voluntary, no conclusions should be drawn about the actual relative frequency of events or trends in events over time.



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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



- Physical assault (leading to death, permanent harm, or severe harm) of a staff member, visitor, or vendor while on site at the organization or while providing care or supervision to patients
- Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of the outcome
- 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 harm to the patient
- Administration of blood or blood products having unintended ABO and non-ABO (Rh, Duffy, Kell, Lewis, and other clinically important blood groups) incompatibilities, hemolytic transfusion reactions, or transfusions resulting in death, permanent harm, or severe harm
- Unintended retention of a foreign object in a patient after an invasive procedure. including surgery
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized practice parameters were not followed
- Any delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure, or >25% above the planned radiotherapy dose

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- Fire, flame, or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the organization. To be considered a sentinel event, equipment must be in use at the time of the event; staff do not need to be present.
- Fall in a staffed-around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in any of the following:
  - Any fracture
  - Surgery, casting, or traction
  - Required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury
  - A patient with coagulopathy who receives blood products as a result of the fall
  - Death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

Methods

The sentinel event data represents aggregate data from comprehensive systematic analysis (typically a root cause analysis) received by the Joint Commission Office of Quality and Patient Safety from January 1, 2023 through December 31, 2023.

A Joint Commission patient safety specialist reviewed every comprehensive systematic analysis with the healthcare organization to discuss underlying causes and improvement strategies.

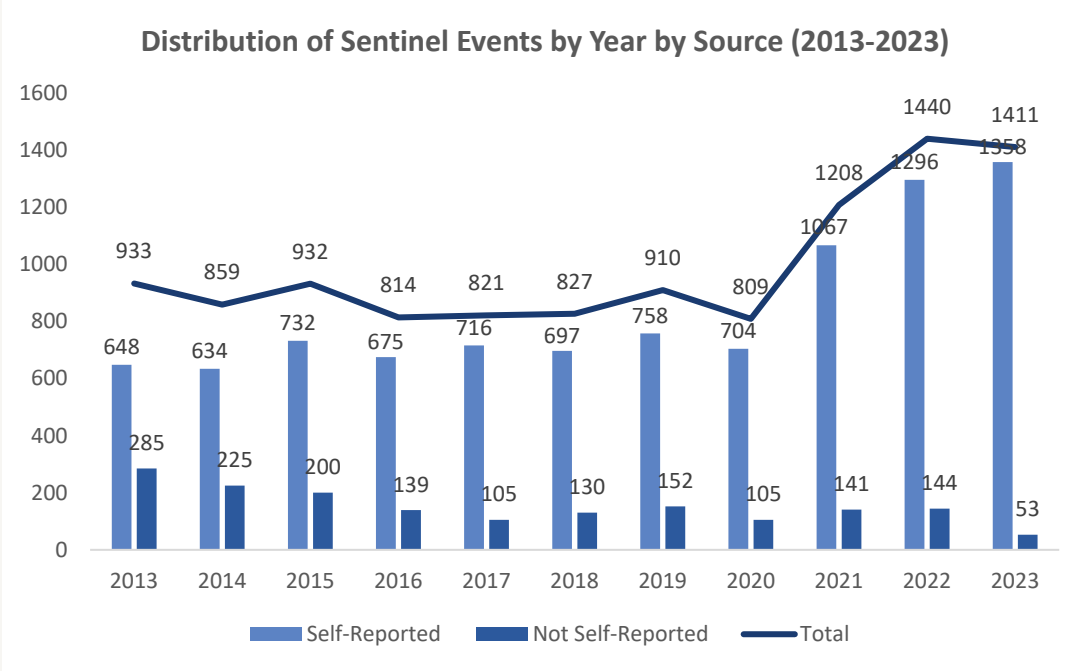
A patient safety specialist assigned an event type, event subtype, and event detail in accordance with the event classification taxonomy. These data, in addition to patient outcome and root causes attributed to the event, were de-identified and aggregated for analysis.



Results

Sentinel Events Reviewed by Year, Source, and Setting

There were 1,411 sentinel events reported in 2023, consistent with reported volume in 2022. A majority (96%) of sentinel events reported in 2023 were voluntarily submitted by accredited healthcare organizations. The remaining 53 sentinel events were reported either by patients (or their families) or employees (current or former) of the organization.



Of reviewed sentinel events in 2023, 18% (n=248) resulted in patient death, 8% (n=107) in permanent harm or loss of function, 57% (n=807) in severe temporary harm, and 12% (n=167) in unexpected additional care/extended stay.

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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%).

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)

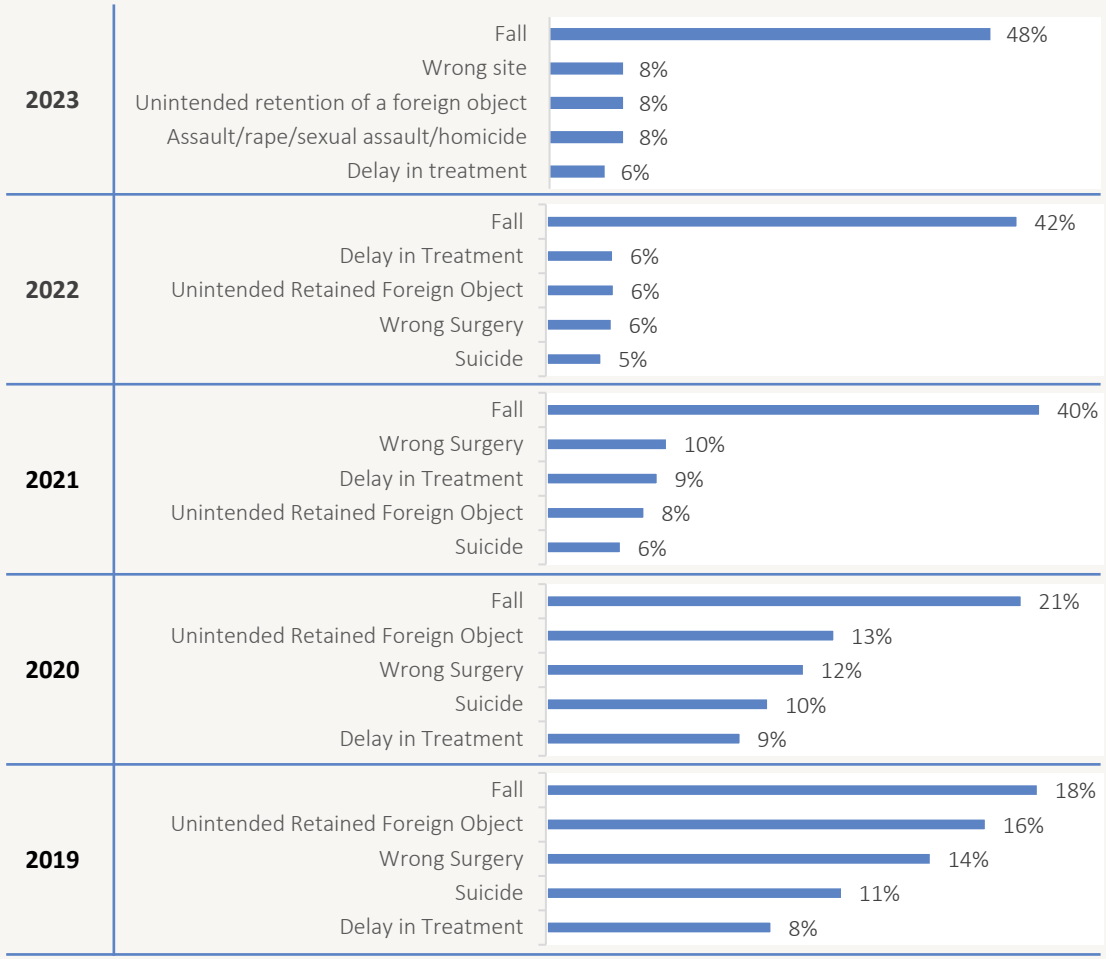
Event Types	N	% of Total
Fall	672	48%
Wrong site*	112	8%
Unintended retention of a foreign object	110	8%
Assault/rape/sexual assault/homicide	106	8%
Delay in treatment	81	6%
Suicide	71	5%
Fire/burns	58	4%
Medication management	34	2%
Perinatal event	26	2%
Self-harm	26	2%

*Wrong surgery includes wrong site, wrong procedure, wrong patient, and wrong implant.



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

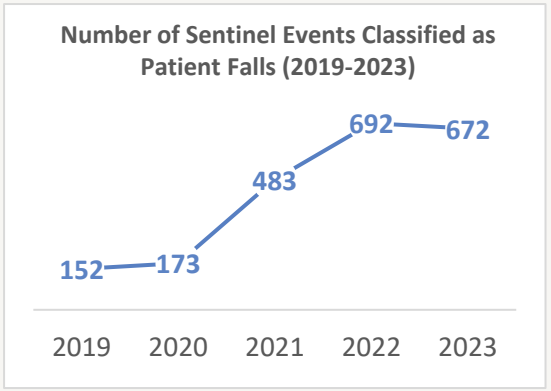
Leading Sentinel Events (2019 – 2023)



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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.

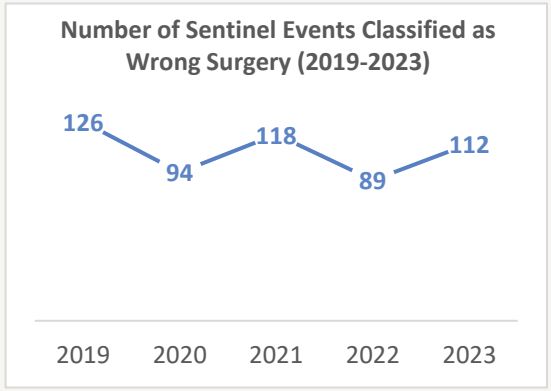


Reported contributors to falls included policies not being followed (e.g., fall risk assessment), lack of competency to recognize abnormal clinical signs or signals, inadequate staff-to-staff communication during handoffs or transitions of care, and lack of shared understanding or mental model regarding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

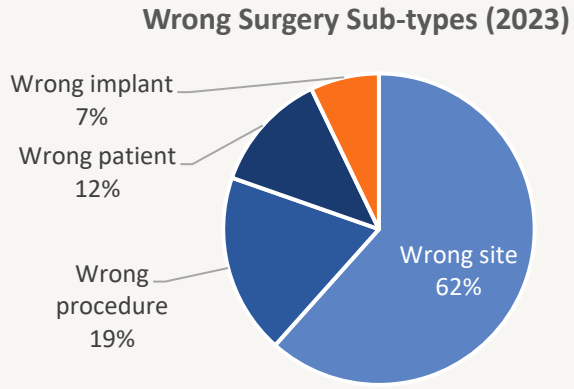


Wrong Surgery

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 surgery sentinel events (62%) were surgeries or invasive procedures performed at the wrong site.

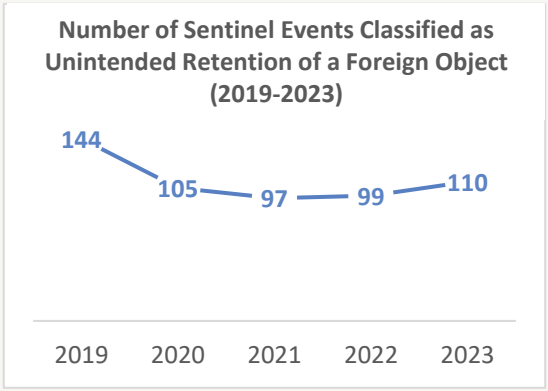


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Leading contributors to wrong surgeries included no or insufficient time-out procedures, preoccupation/task fixation limiting situational awareness, and no or inadequate shared understanding among team members.

Unintended Retention of a Foreign Object

Sentinel events classified as unintended retention of a foreign object increased 11% from 2022 with 110 reported events. Outcomes associated with unintended retention of a foreign object included severe harm to the patient (50%), unexpected additional care or extended stay (41%) or other/no harm (9%).



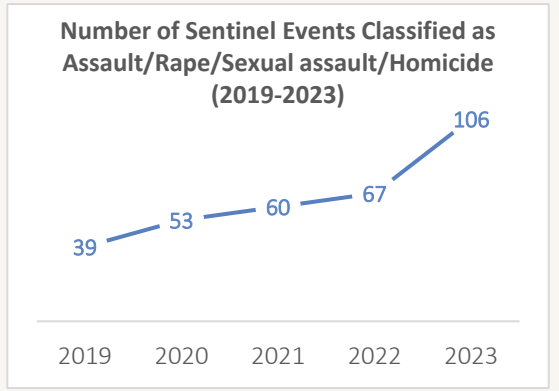
Leading objects left behind included sponges (35%), guide wires (10%), and fragments of instruments or devices (e.g., catheter fragment, foley balloon fragments) (8%). Other retained items included dental retractor cords, cottonoids, surgical specimens and, though infrequently reported, surgical scissors.

Consistent with previous years, contributors to retentions included policies not being followed (e.g., count policy), a lack of shared understanding or mental model, no or inadequate team communication before, during, or after a shared team task, and preoccupation or task fixation limiting situational awareness.



Assault/Rape/Sexual assault/Homicide

Violence-related sentinel events classified as physical assault, sexual assault including rape, or homicide have consistently increased over the last 5 years and became among the top 5 most prevalent sentinel event categories in 2023. This trend is consistent with an increase in workplace violence throughout healthcare organizations nation-wide.



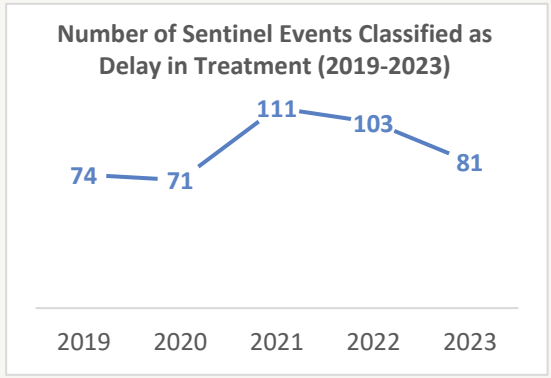
Of violence-related sentinel events, 52% were associated with physical assaults 55% of which were patient-on-patient, 22% were patient-on-staff, and 15%. Outcomes from assaults included permanent harm (7%), severe temporary harm (e.g., head injury) (78%), and psychological impact (9%). Sentinel events resulting in death—homicide—comprised 5% of reported violence-related events with 60% occurring from visitor-to-patient. Sexual assaults including rape comprised 43% of violence-related events with 50% occurring patient-on-patient, 28% staff-on-patient, and 13% patient-on-staff.

Contributors to violence-related sentinel events included lack of shared understanding or mental model, no or inadequate staff-to-staff of critical information, policies not being followed (e.g., 1:1 monitoring), and insufficient training.

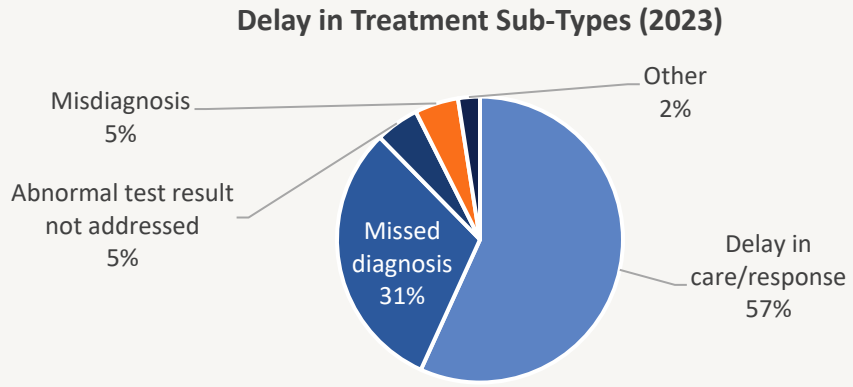
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Delay in Treatment

Sentinel events classified as delay in treatment continued to decrease in 2023 as compare to 2022 and 2021. Outcomes associated with delays in treatment largely resulted in death (69%) followed by severe harm (26%) and permanent harm (5%).



Of delay in treatment sentinel events in 2023, 57% were associated with delays in care/response to a decompensating condition and 31% were due to a missed diagnosis.

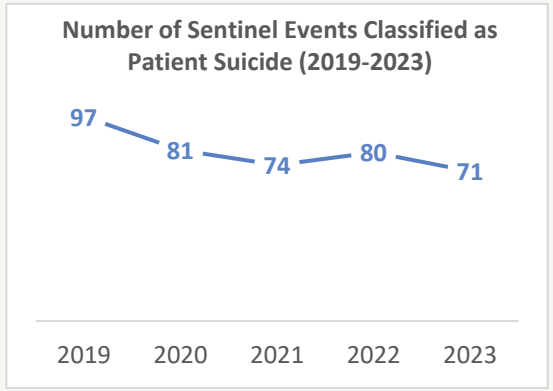




Reported contributors to delays in treatment included staff lacking competency to recognize abnormal clinical signs, policies not being followed (e.g., observation rounds), and no or inadequate staff-to-staff communication during handoffs or transitions of care.

Patient Suicide

There were 71 sentinel events classified as suicide in 2023—85% of which were adults 18-69 years of age and 13% aged 70 and older, and 79% of reported suicides were male gender. Of these, 70% occurred off site within 72 hours of discharge from an accredited healthcare organization, and 28% occurred in an inpatient setting.



In an inpatient setting, death by hanging/ligature was the leading means by which a patient died by suicide (60%) followed by laceration (10%) and jumping from height (10%). The bathroom and patient bedroom were leading locations in which death by hanging/ligature occurred with use of bed linen as common ligature and door as anchor. Death by gunshot, jumping from height, drug overdose, and hanging were leading means by which patients died by suicide within 72 hours of discharge. Of patients who were discharged, 43% were discharged with appointments for follow-up.

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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 harm (8%), severe harm (57%), and unexpected additional care/extended stay (12%).

As with previous years, failures in communication, teamwork and consistently following policies were leading causes for reported sentinel events.

Resources

Preventing falls and fall-related injuries in health care facilities, *Sentinel Event Alert 55*

Inadequate hand-off communication, *Sentinel Event Alert 58*

Advancing safety with closed-loop communication of test results *Quick Safety 52*

Preventing unintended retained foreign objects, *Sentinel Event Alert 51*

Utilizing validated tools for suicide risk screening, *Quick Safety 68*

Suicide Prevention Portal, The Joint Commission

Physical and verbal violence against health care workers, *Sentinel Event Alert 59*

Workplace Violence Portal, The Joint Commission

New and Revised Workplace Violence Prevention Requirements for all Joint Commission-accredited behavioral health care and human services (BHC) organizations, The Joint Commission



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