## 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 1 (s)1 1 Tw 12 r1ultHf r supetion ]


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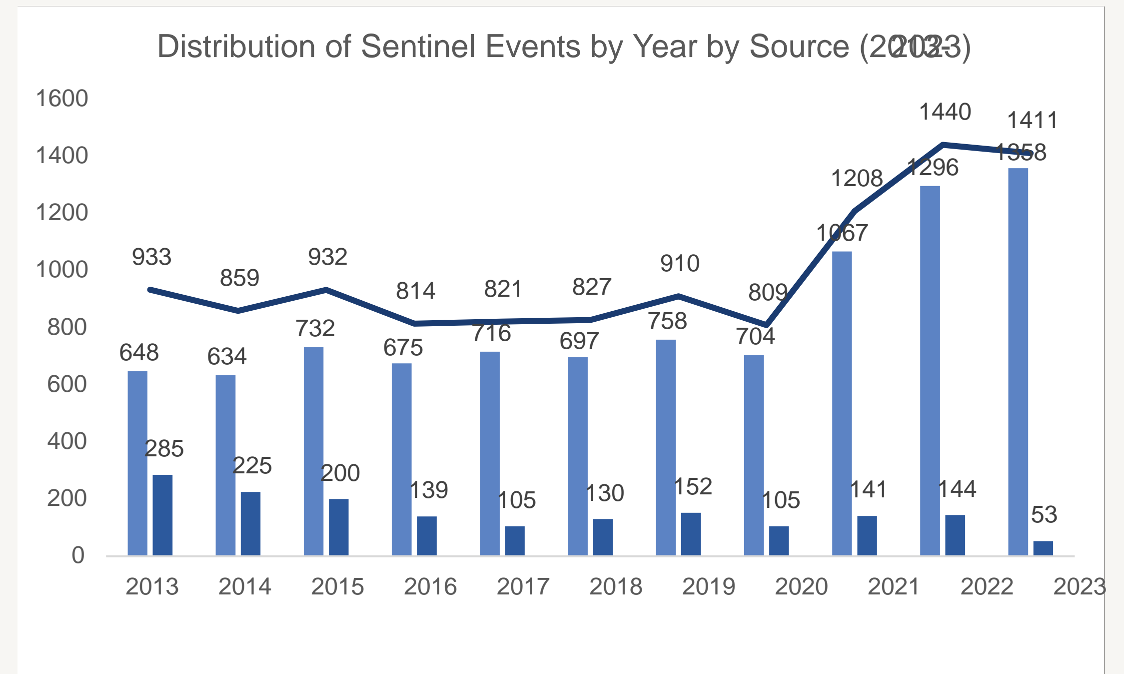



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Sentinel events resulting in death were most associated with patient suicide (29%), delays in treatment (23%), and patient falls (10%). Events resulting in severe temporary harm were most associated with patient falls (67%).

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


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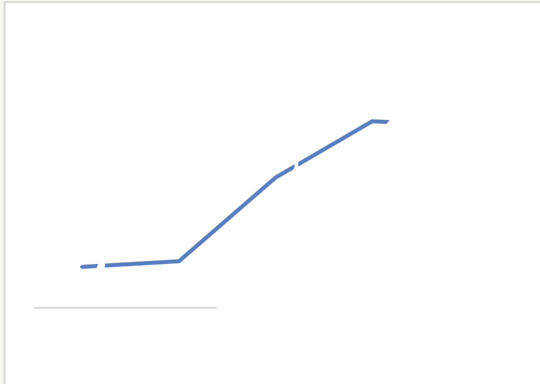
## Patient Falls

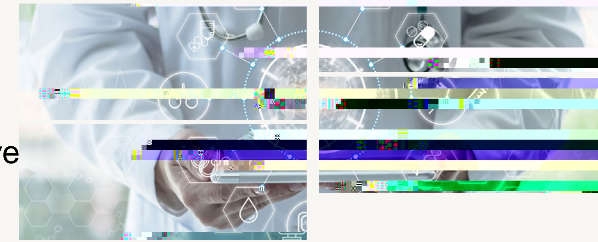
Patient falls continue to be the leading sentinel event type reviewed since 2019. In 2023, there were 672 events classified as patient. Of these patient falls, 26 (4%) resulted in death, 56 (8%) in permanent harm, and 538 (80%) in severe harm to the patient. Leading injuries included fractures (hip/leg,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


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## Delay in Treatment

Sentinel events classified as delay in treatment continued to decrease in 2023 as compared 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.


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