Sentinel Event Data Available for First Six Months of 2023

The Joint Commission's Sentinel Event Database includes de-identified data collected and analyzed from the review of sentinel events and comprehensive systematic analyses, such as root cause analysis, voluntarily submitted by health care organizations to The Joint Commission's Office of Quality and Patient Safety (OQPS). After each submitted sentinel event, patient safety specialists in OQPS help the organization conduct a credible and thorough analysis to identify causative factors and implement relevant system solutions to prevent harm to patients. Partnering with OQPS allows independent review of these reported events and sharing of insights from review of similar event types, as well as discussion of various improvement strategies that may have been successfully employed in other health care organizations.

In accordance with the Sentinel Event Policy and as required by Leadership (LD) Standard LD.03.09.01, accredited organizations must complete the following two actions:

1. Review all sentinel events, as defined by the Sentinel Event Policy detailed on E-dition® or in its counterpart, the *Comprehensive Accreditation Manual*.
2. Implement risk-reduction strategies to help prevent recurrence.

The Joint Commission received 720 sentinel event reports from January 1 through June 30, 2023. Reporting patterns in 2023 are similar to 2022, with a continued increase in reported sentinel events as compared to the prepandemic time frame. *See* Figure 1 on page 4 for the trend of reported sentinel events from 2010 through mid-year 2023.

Thus far, the most prevalent sentinel events reviewed in 2023 include the following:

- Falls (47%)
- Unintended retention of foreign object (9%)
- Assault/rape/sexual assault/homicide (8%)
- Wrong surgery* (8%)
- Suicide (5%)
- Delay in treatment (5%)

Similar to previous years, the majority of reported sentinel events occurred in a hospital (88%), with 18% associated with patient death, 63% severe temporary harm, and 7% permanent harm.

Reporting sentinel events to The Joint Commission is a voluntary process, and as such, epidemiological inferences are not reliable, and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

Visit The Joint Commission's Sentinel Event page for the comprehensive 2023 Sentinel Event Data Midyear Report. P

* The category "wrong surgery" includes wrong-site surgery, wrong procedure, wrong patient, and wrong implant.

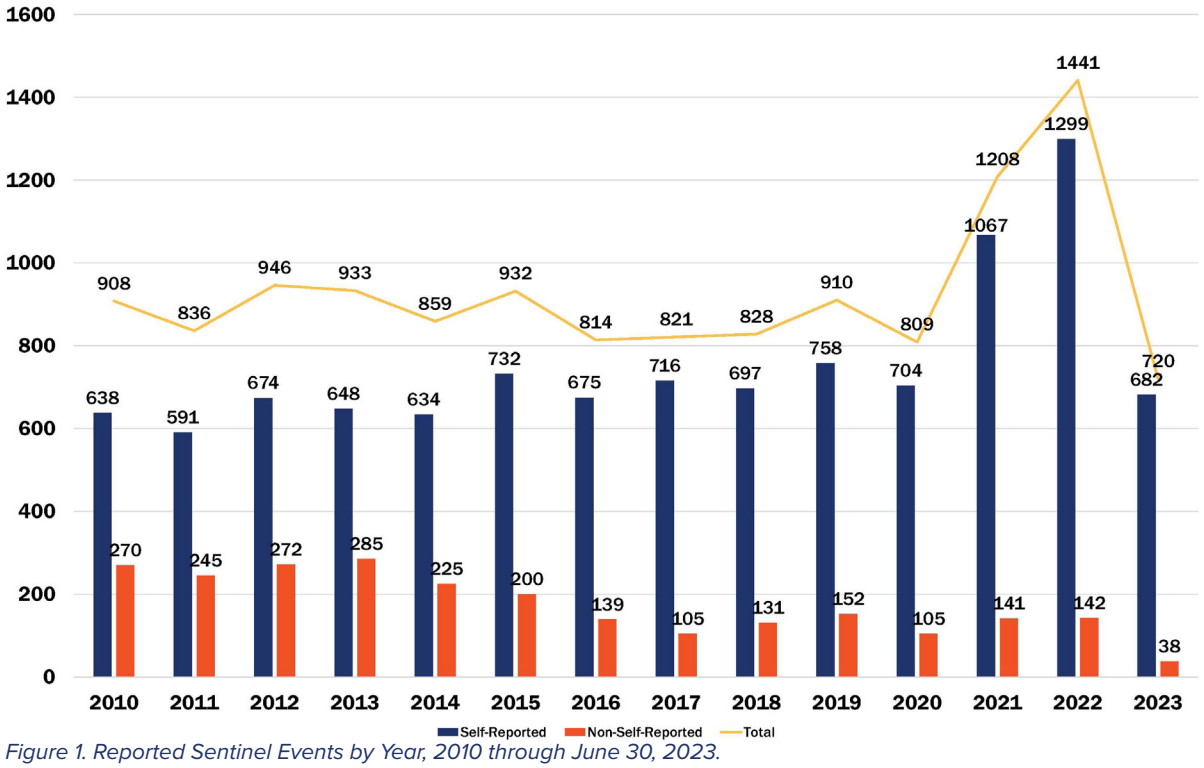

Figure 1. Reported Sentinel Events by Year, 2010 through June 30, 2023.