The Joint Commission

The Joint Commission

Sentinel Event Data 2024 Annual Review

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

Overview

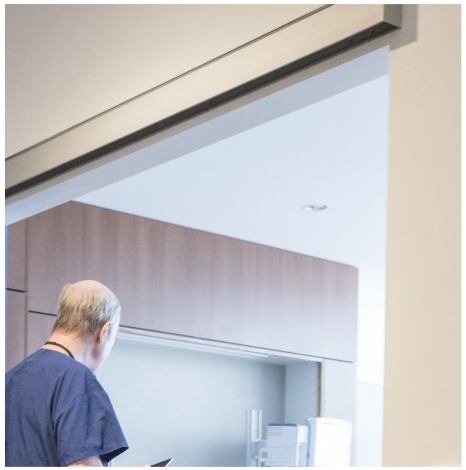
Sentinel events are serious adverse events that signal the need for immediate investigation and response by a healthcare organization to prevent future occurrences. In 1996, The Joint Commission established the Sentinel Event Policy to aid healthcare organizations in enhancing safety following serious adverse events, including conducting a thorough systemic analyses to learn from these events. Since then, The Joint Commission has maintained a Sentinel Event Database containing de-identified and aggregate data.

Each year, aggregate data on the causes and outcomes of sentinel events is analyzed to gain deeper insights into the conditions and contributors of the events, facilitating the development of preventive strategies within healthcare organizations.

From January 1 to December 31, 2024, The Joint Commission received 1,575 reports of sentinel events. Patient falls continued to be the most frequently reported sentinel event, accounting for 776 events (49%). The other leading categories included wrong surgery (n=127 events, 8%), delay in treatment (n=126 events, 8%), patient suicide/death by self-inflicted injurious behavior (n=122 events, 8%), unintended retention of foreign objects (n=119 events, 8%), and workplace violence-related events (e.g., assault/rape/sexual assault/homicide) (n=65 events, 4%). Together, these categories comprised 85% of reported sentinel events in 2024.

Of the reported sentinel events, 21% were associated with the outcome of death, 49% with severe harm, 21% with moderate harm, 5% with mild harm, 2% with psychological harm, and 2% with no harm. Among the events resulting in patient death, delay in treatment was the second leading category, following patient suicide/death by self-inflicted injurious behavior, with 60% of delays resulting in death.

As the reporting of 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.



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:

- Death caused by self-inflicted injurious behavior if any of the following apply:
  - ❑ While in a health care setting
  - ❑ Within 7 days of discharge from inpatient services
  - ❑ Within 7 days of discharge from emergency department (ED)
  - ❑ While receiving or within 7 days of discharge from the following behavioral health care services: Day Treatment/Partial Hospitalization Program (PHP)/ Intensive Outpatient Program (IOP), Residential, Group Home, and Transitional Supportive Living
- 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

- 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 comprises aggregate information from comprehensive systematic analyses, typically a root cause analysis, received by the Joint Commission Office of Quality and Patient Safety from January 1, 2024 through December 31, 2024.

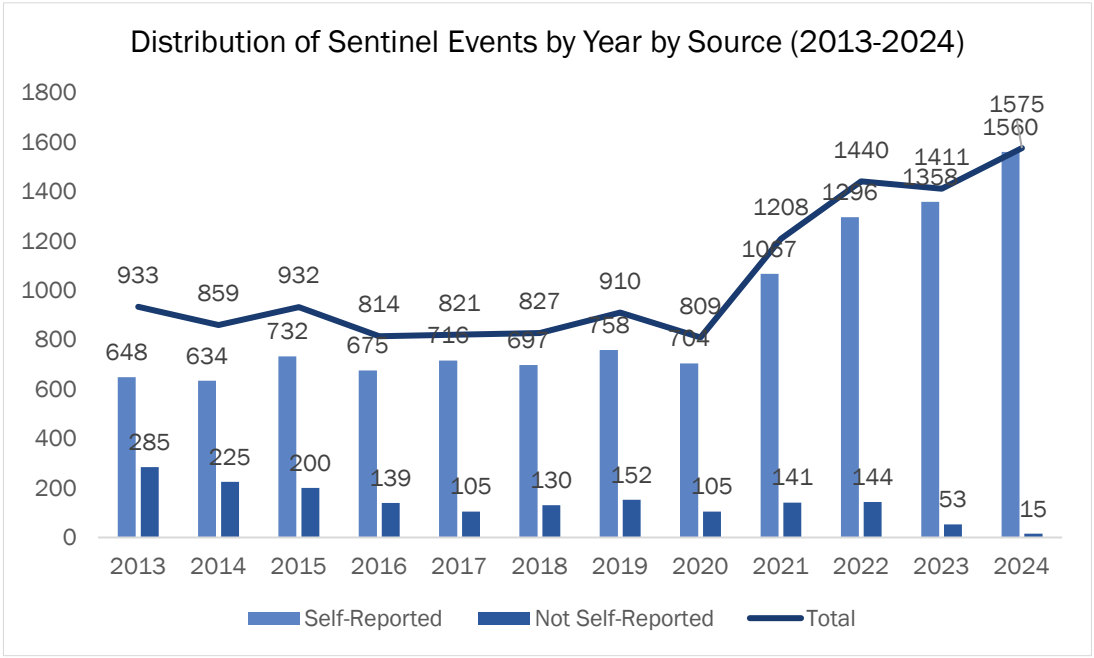
A Joint Commission patient safety specialist reviewed each comprehensive systematic analysis with the healthcare organization to discuss underlying causes and improvement strategies.

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

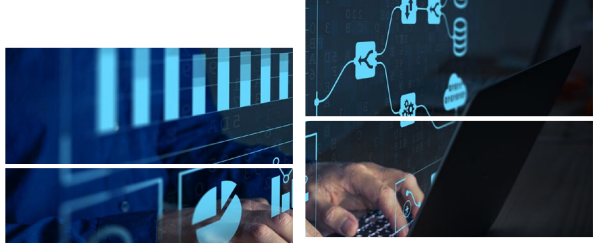
Sentinel Events Reviewed by Year and Setting

There were 1,575 sentinel events reported in 2024 – a 12% increase from 2023.



Reported outcomes from sentinel events in order of severity were:

- Death - 21% (n=332)
- Severe harm - 49% (n=772)
- Moderate harm 21% (n=328)
- Mild harm - 5% (n=84)
- Psychological harm - 2% (n=24), and
- No harm - 2% (n=35).



Of sentinel events resulting in severe harm, 67% (n=521) were temporary in duration, 23% (n=177) resulted in permanent harm, and 10% (n=74) had an unknown duration of harm.

Patient suicide/death from self-injurious behavior comprised 37% of all reported deaths in 2024 followed by delays in treatment (23%), patient falls (15%), perinatal events (4%), and clinical alarm response (e.g., failure to recognize/respond to abnormal telemetry rhythm (4%). Events resulting in severe harm were most associated with patient falls (65%).

Top 10 Frequently Reported Sentinel Events, 2024

Consistent with 2023 reporting patterns, patient falls were the most prevalent sentinel event type reported in 2024 (n=776) – a 15% increase from 2023.

Top 10 Leading Reported Sentinel Event Types (CY2024)

Event Types	N	% of Total
Fall	776	49%
Wrong surgery*	127	8%
Delay in Treatment	126	8%
Suicide/death by self-inflicted injurious behavior	122	8%
Unintended retention of a foreign object	119	8%
Assault/rape/sexual assault/homicide	65	4%
Fire/burns	45	3%
Severe maternal morbidity	32	2%
Medication management	29	2%
Self-harm	23	1%
Perinatal Event	22	1%

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

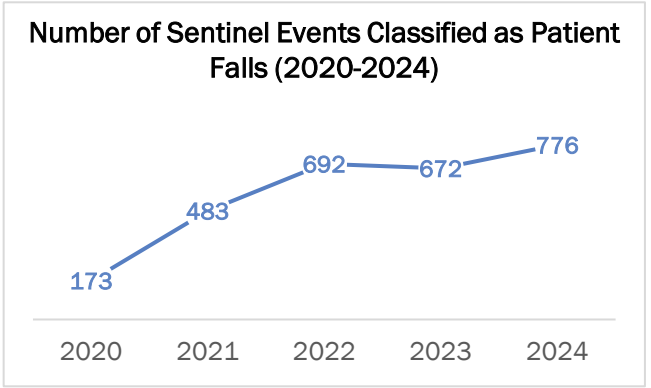
Leading event types associated with the medical hospital setting (n=1,345 sentinel events reported) included falls (53%), unintended retention of foreign object (8%), wrong surgeries (8%), and delay in treatment (7%). In the behavioral health setting (n=86), leading event types were suicide/death by self-inflicted injurious behavior (41%), falls (21%), and delays in treatment (19%). Leading event types within Psychiatric hospital settings (n=50) were falls (38%), suicide/death by self-inflicted injurious behavior (20%), and work-place violence-related events (assault/rape/sexual assault/homicide) (18%).

Wrong surgeries (38%), delay in treatment (14%), and fire/burns (e.g., from light source or bovie) (14%) were leading event types in the ambulatory care setting (n=37). Patient falls (56%) and delay in treatment (11%) were leading event types in the critical access hospital setting (n=27), and suicide/death by self-inflicted injurious behavior (35%), patient falls (31%), and fire/burns (e.g., smoking while on oxygen) (15%) were leading event types in the home care setting (n=26).

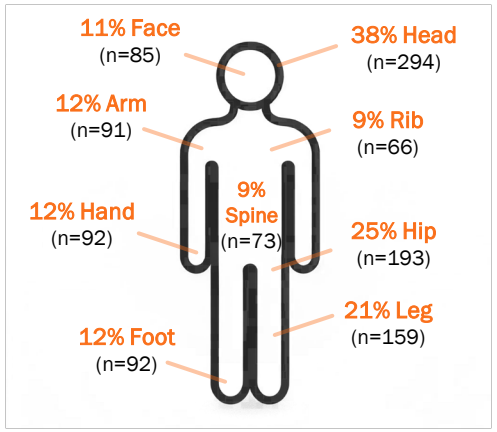
Of the top 10 reported sentinel events in 2024, patient falls, wrong surgery delay in treatment, suicide/death by self-inflicted injurious behavior, unintended retention of foreign objects, and workplace violence-related events comprised 85% of reported sentinel events.

Patient Falls

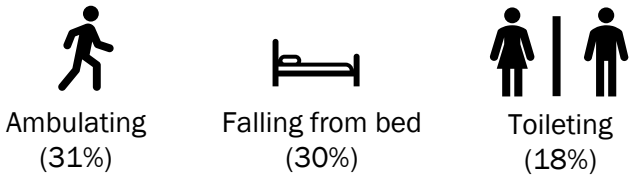
In 2024, patient falls remained the most frequently reported event with 776 events.



Of these, 51 falls (7%) resulted in patient death, 503 (65%) in severe harm, and 199 (26%) in moderate harm to the patient. Injuries to the head/brain (e.g., subdural hematoma or subarachnoid hemorrhage) were the leading fall-related harms (38%) followed by hip fractures (25%), and leg fracture (21%). Reported falls occurred most commonly among patients aged 70 and older (n=433, 56%) followed by adults aged 18-69 years (n=329, 42%).



Like reporting patterns in 2022 and 2023, patient falls while ambulating was the leading mechanism for falling (n=239, 31%) followed by falling from bed (n=231, 30%) and falling while toileting (n=137, 18%).



Similar to 2023, leading reported contributors to falls included challenges following policies (e.g., patient rounding, fall risk assessment) and establishing a shared understanding or mental model across the care team.

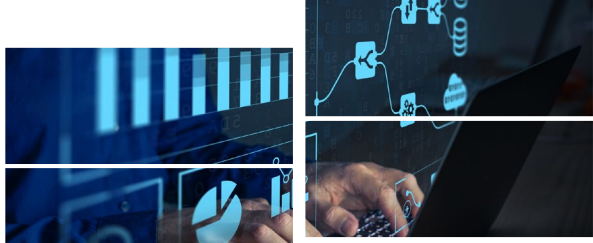
Falls Leading Contributors/Opportunities
(2024, n=7,774 total contributing factors identified)

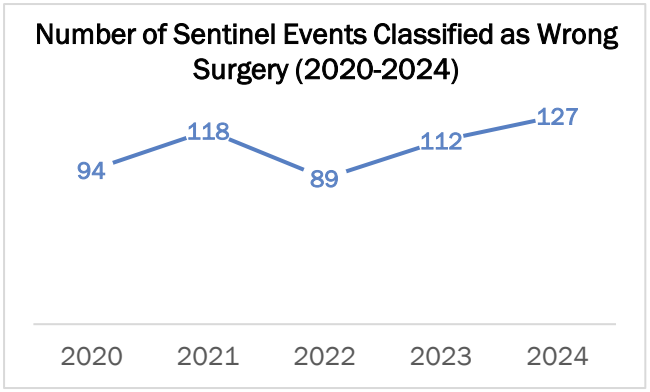
Falls risk mitigation policies and procedures were not followed or adhered to	10%
Lack of shared understanding or mental model across the care team	7%
No or inadequate patient education regarding fall risk	7%
Task fixation or preoccupation limiting situational awareness	6%
No or inadequate staff-to-staff communication during handoffs or transitions of care	6%
Insufficient provider competency to recognize abnormal clinical signs	6%
No or inadequate communication of critical information among staff	5%
Inadequate precautions in place for high fall risk patients	5%
Insufficient or incomplete staff training related to fall prevention	4%
Task saturation/multitasking increasing cognitive load	3%

Wrong Surgery

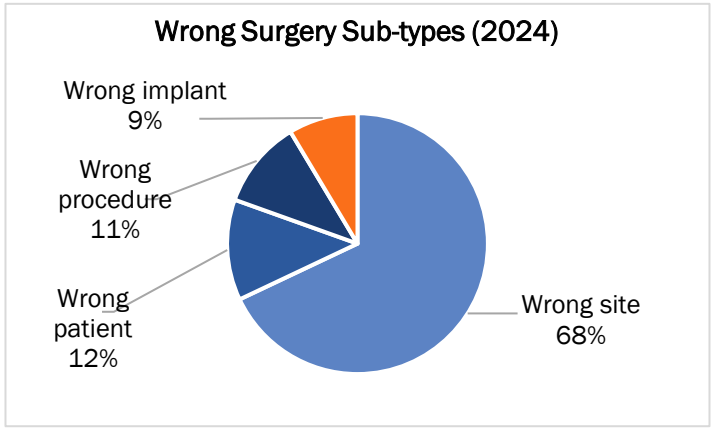
Wrong surgeries include surgeries or invasive procedures that are performed at the wrong site or on the wrong patient, or that are the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of outcome.

There were 127 sentinel events classified as wrong surgeries in 2024—a 13% increase from 2023.





Like 2023, most wrong surgeries occurred at the incorrect site (n=86, 68%) with 56% of these reported as incorrect laterality (wrong side) (n=48).



Nerve blocks or injections for pain management comprised 33% of laterality-related wrong site surgeries followed by urologic procedures such as ureteroscopy and stent placement (13%). Procedures on the incorrect tooth, such as wrong tooth extraction or restoration comprised 14% of wrong site surgeries. Spinal surgeries were associated with 7 of 9 sentinel event reports related to wrong level surgeries and placement of the wrong lens comprised 73% of wrong implants (n=8).

Of reported wrong surgery sentinel events, 51% resulted in severe harm that was temporary and 36% in severe harm that was permanent. No deaths were attributed to wrong surgery sentinel events.

Leading contributors to wrong surgeries included opportunities with performing thorough time-outs to confirm right patient and plan, communicating clearly, and establishing a shared understanding across team members.

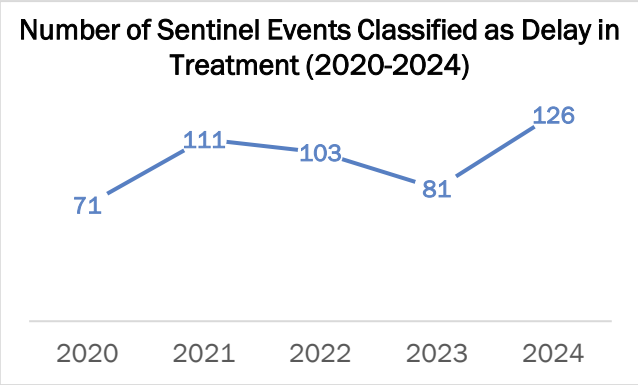
Wrong Surgery Leading Contributors/Opportunities (2024, n=1,520 total contributing factors identified)

Policies and procedures were not followed or adhered to	12%
Time-out was not performed or was incomplete	10%
Lack of shared understanding or mental model across the care team	10%
Task fixation or preoccupation limiting situational awareness	9%
Insufficient provider competency to recognize irregularities (e.g., anatomical)	3%
No or inadequate use of redundancy in processes	3%
No or inadequate communication of critical information among staff	3%
No or inadequate staff-to-staff communication during handoffs or transitions of care	3%
Task saturation/multitasking increasing cognitive load	3%
Incomplete information in electronic health record	2%

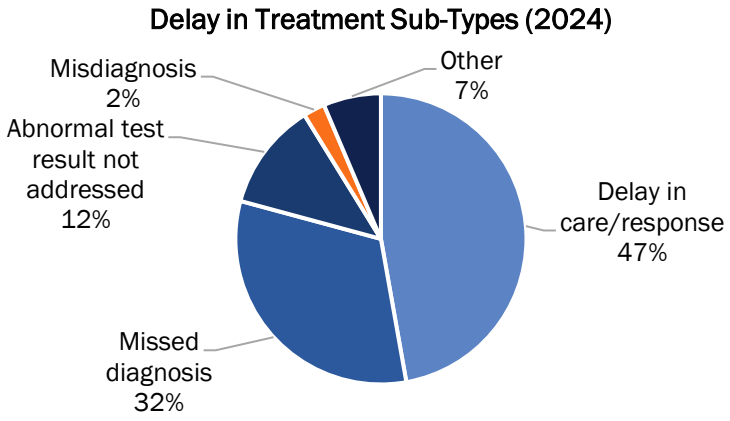
Delay in Treatment

Reporting of sentinel events classified as delay in treatment increased 56% from reporting in 2023.

Patient death was the leading outcome associated with delay in treatment (60%, n=76) followed by severe harm (32%, n=41) 44% of which resulted in permanent harm to the patient.



Of delay in treatment events in 2024, 47% (n=59) were associated with delays in care/response such as failure to recognize/respond to changes in patient condition, patient found unresponsive and delayed rapid response/code event. Ten reported sentinel events in this category were attributed to delayed recognition/notification/response to concerning cardiac rhythm.

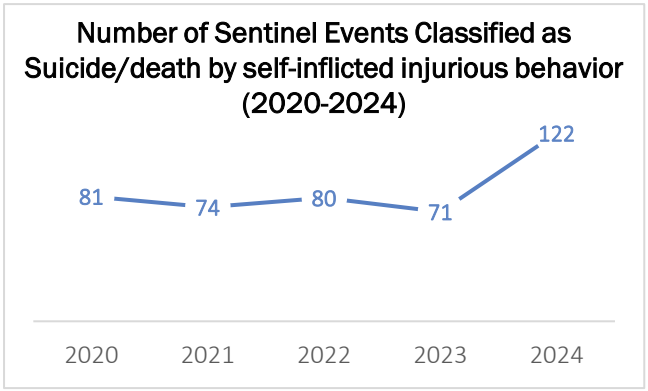


Reported contributors to delays in treatment included policies not being followed (e.g., monitoring, reassessment), staff lacking competency to recognize abnormal clinical signs or changes in condition, and insufficient shared understanding and awareness of patient condition, care plan, or risk factors across team members.

Delay in Treatment Leading Contributors/Opportunities (2024, n=1,565 total contributing factors identified)	
Policies and procedures were not followed or adhered to (e.g., monitoring, reassessment)	9%
Insufficient provider competency to recognize abnormal clinical signs	9%
Lack shared understanding or mental model across the care team	8%
No or inadequate communication of critical information among staff	7%
Vague or unclear roles and responsibilities among staff	4%
Insufficient or incomplete staff training	4%
Provider task fixation or preoccupation lending to lost situational awareness	3%
No or inadequate staff-to-staff communication during handoffs or transitions of care	3%
No or inadequate communication with external providers/transitions of care	3%
No or inadequate formal accountability structure	3%

Patient Suicide

The definition for patient suicide expanded in 2024 to include death caused by self-inflicted injurious behavior within 7 days (formerly 72 hours) from discharge from inpatient services or the emergency department , or while receiving or within 7 days of discharge from Day Treatment/Partial Hospitalization Program (PHP)/Intensive Outpatient Program (IOP), Residential, Group Home, and Transitional Supportive Living behavioral services.



There were 122 sentinel events classified as suicide/death by self-inflicted injurious behavior in 2024. Of these, 75% (n=94) occurred either within 7 days of discharge or while receiving intensive behavioral health care services. Most 70% (n=64) occurred within 7 days of discharge from inpatient or ED services with 27% occurring the day of discharge, 48% within 1-3 days, and 25% within 4-7 days. Twenty-two reported suicide/death by self-inflicted harm events were associated with individuals enrolled in an IOP or PHP. Eight additional suicides occurred while receiving home hospice care.

Five reported suicides occurred within the emergency department setting and twenty-five within an inpatient setting. The patient bedroom (56%) and bathroom (32%) were leading inpatient locations in which suicide/death by self-inflicted injurious behavior occurred. Death by hanging/ligature was the leading means by which a patient died by suicide (36%) followed by asphyxiation (not by hanging) (24%).

Leading contributors and opportunities associated with reported suicide/death by self-inflicted injurious behavior were similar to patterns in 2023. A lack of shared understanding across team members was the leading identified factor in 2024 followed by issues with adhering to implemented policies.

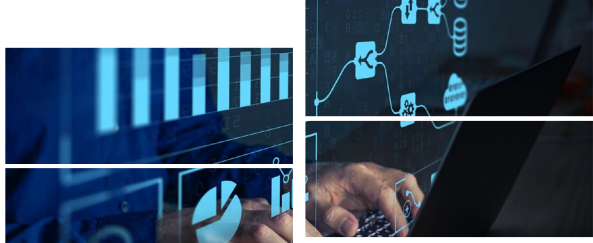
Though infrequent, there were reported suicides in which no causal or contributing factors could be identified, as well.

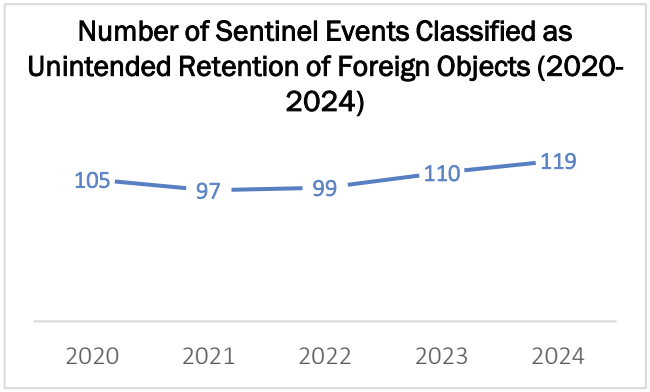
Suicide/death by self-inflicted injurious behavior
Leading Contributors/Opportunities
(2024, n=1,001 total contributing factors identified)

Lack shared understanding or mental model across the care team	9%
Policies and procedures were not followed or adhered to (e.g., suicide screening or assessment/reassessment)	7%
No or inadequate communication with external providers/transitions of care	6%
Insufficient or incomplete staff training	5%
Insufficient provider competency to recognize abnormal clinical signs	5%
Vague or unclear roles and responsibilities among staff	5%
No or inadequate communication of critical information among staff	4%
Inadequate precautions in place for high suicide/self-harm risk patients	4%
Policies or procedures not in place or available	3%
Task fixation or preoccupation limiting situational awareness	4%

Unintended Retention of a Foreign Object

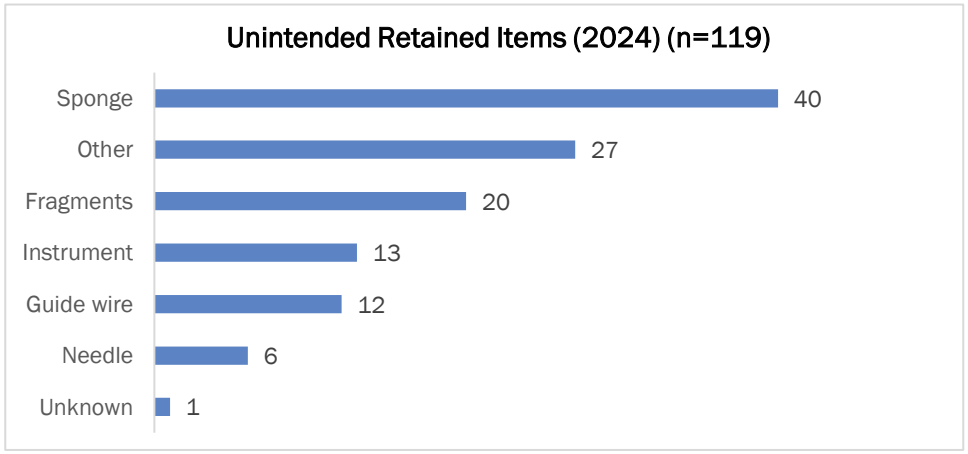
Reporting of unintended retention of a foreign object continued to increase in 2024 with 119 reported events. Outcomes associated with unintended retention of a foreign object included severe harm to the patient (43%), 80% of which resulted in temporary harm.





As in 2023, the leading unintentionally retained object were sponges (34%, n=40) of which 41% were attributed to the Obstetrics/Gynecology service line (11 sponges were left behind during labor/delivery and 5 retained sponges were associated with surgical procedures such as total hysterectomy).

Retained fragments of instruments or devices comprised 17% of retained objects (n=20). Examples include fragments of catheters, drill bits, suture devices, and ureter stents.



Twelve retained guide wires were reported with 50% associated with bedside central/ midline/or femoral line placements.

Retained retractors and clamps were leading examples of the 13 reported instruments left behind. There were 27 assorted other retained items reported such as dental retractor cords, mesh, asepto bulb irrigation syringe, syringe cap, wound dressing, shunt, stent, and pins or screws.

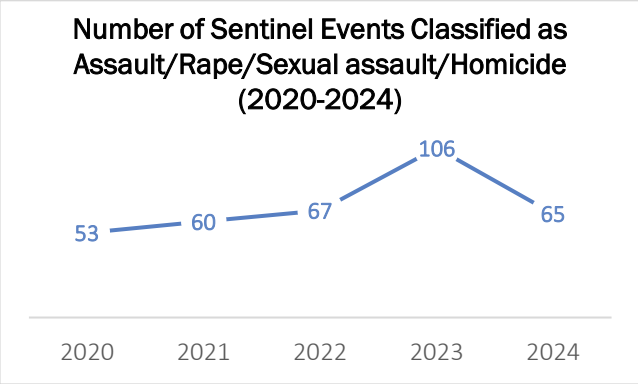
Consistent with previous years, opportunities related to retentions included consistent adherence to policies (e.g., count policy), establishing a shared understanding or mental model across team members, and engaging in clear team communication before, during, and after a shared team task.

Unintended Retained Foreign Object Leading Contributors/Opportunities (2024, n=1,472 total contributing factors identified)

Policies and procedures were not followed or adhered to	15%
Lack shared understanding or mental model across the care team	14%
No or inadequate team communication before, during or after a shared team task	6%
No or inadequate communication of critical information among staff	6%
Task fixation or preoccupation limiting situational awareness	5%
No or inadequate use of redundancy in processes	4%
Insufficient provider competency to recognize abnormal clinical signs	4%
Vague or unclear roles and responsibilities among staff	3%
Policies or procedures not up-to-date	2%
No or inadequate staff-to-staff communication during handoffs or transitions of care	2%

Assault/Rape/Sexual assault/Homicide

Violence-related sentinel events classified as physical assault, sexual assault including rape, or homicide was the 6th leading event type reported in 2024.

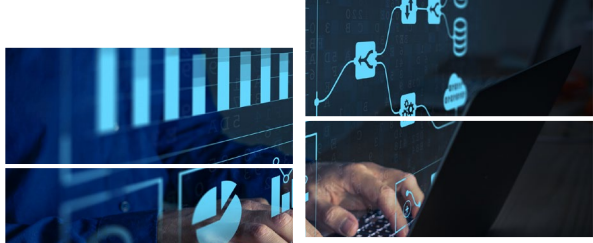


Of violence-related sentinel events, 51% (n=33) were associated with physical assaults 45% of which were patient-on-patient, 27% were patient-on-staff, 21% were staff-on-patient, and 6% visitor-on-patient. Reported assaults largely resulted in severe harm (55%) (e.g., head injury) and 12% resulted in death.

Sexual assaults including rape comprised 42% (n=27) of violence-related events with 59% occurring patient-on-patient, 30% patient-on-staff, 7% staff-on-patient. Homicide comprised 8% of reported violence-related events.

Thirty-eight percent (n=24) of violence-related sentinel events occurred while receiving medical services within the emergency department, on a medical floor, or in a critical care unit – 46% of which were patient-on-staff. Twenty-one reported violence-related sentinel events occurred in a psychiatric hospital and 11 within a hospital's behavioral health unit.

Reported contributing factors and opportunities regarding violence-related sentinel events included insufficient competency to identify or recognize escalating or at-risk behavior to proactively address, lack of shared understanding of patient condition or risk factors and ineffective communication of critical information among team members.



Assault/Sexual assault/Homicide Leading Contributors/Opportunities (2024, n=2,243 total contributing factors identified)	
Insufficient competency to recognize abnormal clinical signs, escalation	8%
Lack of shared understanding or mental model across the care team	8%
No or inadequate communication of critical information among staff	7%
Vague or unclear roles and responsibilities among staff	5%
Intentional unsafe act (instigating behaviors, failure to act)	4%
Insufficient or incomplete staff training (e.g., crisis prevention training)	4%
No or inadequate formal accountability structure	4%
Policies and procedures were not followed or adhered to	4%
No or inadequate staff-to-staff communication during handoffs or transitions of care	4%
Task fixation or preoccupation limiting situational awareness	3%

Conclusion

Reported sentinel events increased 12% from 2023 and reporting patterns remained consistent with previous years with most frequently reported event types: patient falls, wrong surgery delay in treatment, suicide/death by self-inflicted injurious behavior, unintended retention of foreign objects, and workplace violence-related events. Reporting increased in all leading categories this year, except for violence-related events, which saw a decrease from 2023.

The analysis of sentinel events underscores the critical need for healthcare organizations to establish and maintain a robust quality and safety program. These serious events reveal vulnerabilities in complex healthcare systems. A consistent approach that focuses on identifying and thoroughly investigating these events helps uncover systemic conditions that contribute to error. By using a systems-focused analysis, healthcare providers can move beyond individual blame to implement meaningful, evidence-based solutions that enhance patient safety. Establishing and sustaining these safeguards is essential to reducing future risks, fostering a culture of continuous improvement, and ensuring the highest standards of care.

Acknowledgement

The Joint Commission appreciates the healthcare organizations that have voluntarily reported sentinel events. Your transparency allows for the analysis and identification of recurring systemic factors that contribute to avoidable harm, and the communication of these factors to advance patient safety. Thank you for your commitment to safety and quality.

Resources

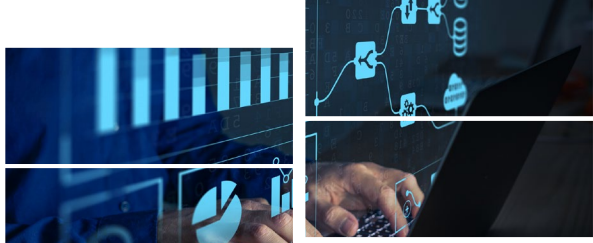
Important patient and quality improvement resources can be accessed from the following:

- ❑ Patient Safety Portal, The Joint Commission

  The Patient Safety Portal provides reference materials and other resources toward improving patient safety.

- ❑ Suicide Prevention Portal, The Joint Commission.

  The Suicide Prevention Portal is a resource for organizations seeking information on suicide risk reduction with recommendations from The Joint Commission Suicide Risk Reduction Expert Panel.



- ❑ Workforce Safety and Well-Being Resource Center, The Joint Commission.

  The Workforce Safety and Well-Being Resource Center provides health care leaders and staff accessible tools and strategies to enhance the safety and well-being of their workforce.

Other related Joint Commission publications are provided below:

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*

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

Updated surgical fire prevention for the 21st Century, *Sentinel Event 68.*