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Australian sentinel events list (version 2)

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## Introduction

The Australian Commission on Safety and Quality in Health Care (the Commission) conducted a review of the Australian sentinel events list (version 2) (the Review) on behalf of the states, territories and the Commonwealth in 2017.

Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient. The purpose of sentinel event reporting is to ensure public accountability and transparency and drive national improvements in patient safety.

The Productivity Commission states that sentinel events ‘can indicate hospital system and process deficiencies that compromise quality and safety’ and are ‘an indicator of governments’ objective to deliver public hospital services that are safe and of high quality’.[1](#_ENREF_1) According to the Productivity Commission, sentinel events:

* Occur relatively infrequently and are independent of a patient’s condition
* Have the potential to seriously undermine public confidence in the healthcare system.

## Background

The Australian sentinel events list was agreed by Australian health ministers in 2002. In April 2004, Australian health ministers determined that public hospitals would report sentinel events to the relevant state or territory health department or an agreed third party and that all states and territories would contribute to a national report on the following eight events:

1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function[[1]](#footnote-1)
2. Suicide of a patient in an inpatient unit
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. Intravascular gas embolism resulting in death or neurological damage.
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
7. Maternal death associated with pregnancy, birth and the puerperium[[2]](#footnote-2)
8. Infant discharged to the wrong family.

The then Australian Council for Safety and Quality in Health Care (now the Commission) originally based the Australian sentinel events list on the United States (US) Joint Commission’s sentinel event list, which has evolved over time.[[3]](#footnote-3)

It was intended that public reporting against the sentinel events list would provide an opportunity to share learning about these events at the national level to prevent, or reduce the risk of, recurrence of the sentinel events. Public reporting against the sentinel events list was previously included in the Commission’s publication: *Windows into Safety and Quality in Health Care*[3](#_ENREF_3), which is no longer published. Since 2007, sentinel events have been reported in the Productivity Commission’s *Report on Government Services* (RoGS)[1](#_ENREF_1) as the total number of occurrences of each sentinel event by jurisdiction.

The Australian sentinel events list has not been comprehensively reviewed since its adoption by health ministers in 2002, with the exception of sentinel event 1:procedures involving the wrong patient or body part, which was redefined in 2009, and sentinel event 7: maternal death, which was redefined in 2014.

## Development of the Australian sentinel events list (version 2)

A Sentinel Events Review Steering Committee (SERSC) comprising a consumer representative and state, territory and Commonwealth patient safety experts was convened to guide the Review. The SERSC’s membership can be found at **Appendix A**. The SERSC developed a revised purpose, definition and criteria for inclusion of incidents on the Australian sentinel events list (version 2).

An environmental scan and literature review, comprising a background report and case studies was commissioned and used in the deliberations of the SERSC. These documents examined how sentinel events or ‘never events’ are used across Australia, the United Kingdom, the United States and Canada. The SERSC used the findings of the environmental scan and literature review and assessed each sentinel/never event in those international jurisdictions against the new purpose, definition and criteria to arrive at a draft revised Australian sentinel event list for consultation.

Consultation as part of the Review was undertaken in two stages. The first was targeted clinical consultation and the second was broader public consultation. Clinical advice was used to refine the list by ensuring each proposed sentinel event met the definition and criteria for the list as set out by the SERSC, and by ensuring that the individual sentinel event definitions were appropriate. The Commission then undertook public consultation on the draft revised sentinel events list and definitions between 9 June and 25 June 2017. Public consultation was undertaken via an online survey. A total of 800 healthcare professionals and members of the public participated in the public consultation survey, from every state and territory. The draft revised list of sentinel events was refined with each round of consultation.

### Purpose, definition and criteria

The purpose, definition and criteria for a revised Australian sentinel events list (version 2) were developed by the SERSC and were used to determine which incidents would be included in the list.

**Purpose**

The purpose of the Australian sentinel events list (version 2) is to ensure public accountability and transparency and drive national improvements in patient safety.

The intent of this document is to define sentinel events that are extremely serious, preventable, and of concern to both the public and health care providers for the purpose of public accountability. Sentinel events have the potential to seriously undermine public confidence in the healthcare system and are a subset of the most serious incidents reported through each jurisdiction’s incident reporting system. The intent is not to measure episodes that do not end in death or ongoing morbidity.

**Definition**

A sentinel event is a particular type of serious incident that is wholly preventable and has caused serious harm to, or death of, a patient.

All national sentinel events undergo a full review by the entity governing the organisation where the event occurred in consultation with experts and clinicians to make the final determination. This includes national sentinel events relating to the delivery of a medication, that causes death of a patient or resulted in shortened life expectancy, permanent or long term physical harm or loss of function.

For example, as a result of the medication error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, wrong route of administration, or known allergy, the patient dies, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Criteria**

An incident must also satisfy the following criteria in order to be classified as a sentinel event:

* The event should not have occurred where preventive barriers are available
* The event is easily recognised and clearly defined
* There is evidence the event has occurred in the past.

### Defining serious harm

Serious harm is indicated where as a result of the incident the patient:

* requires life-saving surgical or medical intervention, or
* has shortened life expectancy, or
* has experienced permanent or long-term physical harm, or
* has experienced permanent or long-term loss of function.

**Psychological harm**

Psychological harm is recognised as an important harm. In the context of the sentinel events list, psychological harm has not been included in the definition of serious harm given the inability to measure psychological harm in the way that physical harm can be measured.

### Preventive barriers

Sentinel events will be considered ‘wholly preventable’ in the context of preventive barriers being available to facilitate prevention.

Preventive barriers may include: the National Safety and Quality Health Service (NSQHS) Standards (second edition)4 such as NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations and NSQHS Standard 2: Partnering with Consumers;policy documents or clinical protocols; or documents providing safety guidance, safety recommendations or both on how the event can be prevented.

The preventive barriers listed in this paper are not exhaustive and represent only examples of barriers available at the national level. An increase in the number of occurrences of a particular sentinel event may be an indicator that preventive barriers need to be strengthened or better implemented.

### Summary of changes

A summary of the revised list compared to the original Australian list of sentinel events, determined by health ministers in 2002, is provided in Table 1.

Table : Comparison of 2017 sentinel events list and original 2002 sentinel events list

|  |  |
| --- | --- |
| Revised Australian sentinel events list (version 2) (2017) | Original Australian sentinel events list (2002) |
| 1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
 | 1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function

**[Split into three]** |
| 1. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
 | 1. Suicide of a patient in an inpatient unit
 |
| 1. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
 | 1. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
 |
| 1. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
 | 1. Intravascular gas embolism resulting in death or neurological damage

**[Removed]** |
| 1. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
 | 1. Haemolytic blood transfusion reaction resulting from ABO incompatibility
 |
| 1. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
 | 1. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
 |
| 1. Medication error resulting in serious harm or death
 | 1. Maternal death associated with pregnancy, birth and the puerperium

**[Removed]** |
| 1. Use of physical or mechanical restraint resulting in serious harm or death

**[New]** | 1. Infant discharged to the wrong family
 |
| 1. Discharge or release of an infant or child to an unauthorised person
 |  |
| 1. Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death **[New]**
 |

## Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death

|  |
| --- |
| Category: surgical or other procedures |

**Sentinel event**

Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death

**Inclusions/exclusions**

Nil

**Setting**

All hospitals

**Definitions**

Invasive procedure A medical procedure that enters the body, usually by cutting or puncturing the skin or by inserting a needle, tube, device or scope into the body.

Serious harm As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Examples of national preventive barriers**

* NSQHS Standards(2nd ed.)[4](#_ENREF_6)- Communicating for Safety Standard: Correct identification and procedure matching

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

## Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death

|  |
| --- |
| Category: surgical or other procedures |

**Sentinel event**

Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death

**Inclusions/exclusions**

Nil

**Setting**

All hospitals

**Definitions**

Invasive procedure A medical procedure that enters the body, usually by cutting or puncturing the skin or by inserting a needle, tube, device or scope into the body.

Serious harm As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Examples of national preventive barriers**

* NSQHS Standard (2nd ed.)4 – Communicating for Safety Standard: Correct identification and procedure matching

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

* Nationally agreed use of the WHO Surgical Safety Checklist5

<https://www.safetyandquality.gov.au/our-work/patient-identification/patient-procedure-matching-protocols/surgical-safety-checklist/>

## Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death

|  |
| --- |
| Category: surgical or other procedures |

**Sentinel event**

Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death

**Inclusions/exclusions**

Excluding surgeries or other invasive procedures resulting from incorrect diagnoses

Excluding surgeries or other invasive procedures altered to adjust for unexpected anatomical abnormalities

**Setting**

All hospitals

**Definitions**

Invasive procedure A medical procedure that enters the body, usually by cutting or puncturing the skin or by inserting a needle, tube, device or scope into the body.

Serious harm As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Examples of national preventive barriers**

* NSQHS Standard (2nd ed.)[4](#_ENREF_6) - Communicating for Safety Standard: Correct identification and procedure matching

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

* Nationally agreed use of the WHO Surgical Safety Checklist[5](#_ENREF_7)

<https://www.safetyandquality.gov.au/our-work/patient-identification/patient-procedure-matching-protocols/surgical-safety-checklist/>

## Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death

|  |
| --- |
| Category: surgical or other procedures |

**Sentinel event**

Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death

**Inclusions/exclusions**

Excluding where any relevant objects are found to be missing prior to the completion of the surgical intervention and may be within the patient, but where further action to locate and/or retrieve would be more damaging than retention, or impossible. This must be documented in the patient’s chart and the patient informed.

**Setting**

All hospitals

**Definitions**

Unintended Incidents where any relevant objects retained in a patient after surgery or other invasive procedure were not intentionally retained. A foreign object may be intentionally left in the patient where further action to locate and/or retrieve the object would be more damaging than retention or impossible, for example where the patient is not yet clinically stable.

Invasive procedure A medical procedure that enters the body, usually by cutting or puncturing the skin or by inserting a needle, tube, device or scope into the body.

Serious harm As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Examples of national preventive barriers**

* Nationally agreed use of the WHO Surgical Safety Checklist[5](#_ENREF_7)

<https://www.safetyandquality.gov.au/our-work/patient-identification/patient-procedure-matching-protocols/surgical-safety-checklist/>

## Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death

|  |
| --- |
| Category: surgical or other procedures |

**Sentinel event**

Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death

**Inclusions/exclusions**

Excluding where ABO incompatible blood components are deliberately transfused in line with local protocols.

**Setting**

All hospitals

**Definitions**

Serious harm As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Examples of national preventive barriers**

* NSQHS Standards(2nd ed.)[4](#_ENREF_6)- Blood Management Standard

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

* National Blood Authority – Patient Blood Management Guidelines[7](#_ENREF_9)

<https://www.blood.gov.au/pbm-guidelines>

* BloodSafe – National e-learning program[8](#_ENREF_10)

<https://bloodsafelearning.org.au/resource-centre/links-and-resources/state-and-territory-contacts/>

* Australian Red Cross, Flippin’ Blood (2012) resources for safe transfusion[9](#_ENREF_11)

<http://resources.transfusion.com.au/cdm/ref/collection/p16691coll1/id/20>

## Suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward

|  |
| --- |
| Category: mental health |

**Sentinel event**

Suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward

**Inclusions/exclusions**

Excludes sub-acute care and rehabilitation

**Setting**

All hospitals

**Definitions**

Acute psychiatric unit or acute psychiatric ward

A specialised unit or ward that is dedicated to the treatment and care of admitted patients with mental illness or mental disorder. This includes specialist psychiatric units or psychiatric wards within emergency departments.

For the purposes of this sentinel event ‘acute psychiatric unit’ and ‘acute psychiatric ward’ refer to psychiatric units and wards where all three of the following criteria apply:

1. The psychiatric unit or psychiatric ward is specifically designed with fixtures and fittings that minimise the opportunity for patient suicide
2. The psychiatric unit or psychiatric ward is specifically designed to prevent any unauthorised ingress or egress
3. Observation protocols are applied within the psychiatric unit or psychiatric ward.

**Examples of national preventive barriers**

* NSQHS Standards[4](#_ENREF_6) Comprehensive Care Standard, minimising patient harm: Action 5.31 Predicting, preventing and managing self-harm and suicide <https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>
* Australasian Health Facility Guidelines: Part B – Health Facility Briefing and Planning, 0134 – Adult Acute Mental Health Inpatient Unit (revision 6.0)10

<https://healthfacilityguidelines.com.au/hpu/adult-acute-mental-health-inpatient-unit-0>

* Living is for Everyone (LIFE) Framework[1](#_ENREF_13)1 sets an overarching strategic policy framework for suicide prevention in Australia including a focus on managing risk within health services and shortly after discharge (Outcome 5.4)

<https://www.lifeinmindaustralia.com.au/>

* National Standards for Mental Health Services (2010)[1](#_ENREF_14)2 Standard 2: Safety. This incorporates requirements and guidance for assessing and managing risk of self-harm and suicide, including follow-up, assessment, environmental reviews and staff training

[http://www.health.gov.au/internet/main/publishing.nsf/Content/A26C43ABB710D134CA257BF000212022/$File/pub2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/A26C43ABB710D134CA257BF000212022/%24File/pub2.pdf)

* National Practice Standards for the Mental Health Workforce (2013)1[3](#_ENREF_15) reflects the above standards with reference to appropriate assessment of mental state and risks

[http://www.health.gov.au/internet/main/publishing.nsf/content/5D7909E82304E6D2CA257C430004E877/$File/wkstd13.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/5D7909E82304E6D2CA257C430004E877/%24File/wkstd13.pdf)

* Department of Health. Reducing suicide and deliberate self-harm in mental health services (2005)14

<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-safety-toc~mental-pubs-n-safety-3~mental-pubs-n-safety-3-sui>

## Medication error resulting in serious harm or death

|  |
| --- |
| Category: medication |

**Sentinel events**

Medication error resulting in serious harm or death

**Inclusions/exclusions**

Nil

**Setting**

All hospitals

**Definitions**

Serious harm As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Examples of national preventive barriers**

* NSQHS Standards (2nd ed.)[4](#_ENREF_6) - Medication Safety Standard <https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>
* Various initiatives led by the Commission15:

<https://www.safetyandquality.gov.au/our-work/medication-safety/>

* Medication charts
* Medication reconciliation
* Medication administration
* Medication safety and quality education and training
* Safer naming, labelling and packaging of medicines
* Electronic medication management

## Use of physical or mechanical restraint resulting in serious harm or death

|  |
| --- |
| Category: care management  |

**Sentinel event**

Use of physical or mechanical restraint resulting in serious harm or death

**Inclusions/exclusions**

Nil

**Setting**

All hospitals

**Definitions**

Restraint Restraint is the restriction of an individual’s freedom of movement by physical or mechanical means16

Physical Physical restraint means the bodily force that controls a person’s freedom of movement[1](#_ENREF_18)6

Mechanical Mechanical restraint means a device that controls a person’s freedom of movement[16](#_ENREF_18)

Serious harm As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Explanatory notes**

In the event that a chemical restraint leads to the serious harm or death of a patient, it should be considered whether the event can be reported under sentinel event 8: Medication error resulting in serious harm or death.

**Examples of national preventive barriers**

* NSQHS Standards (2nd ed.)[4](#_ENREF_6) - Comprehensive Care Standard: Minimising restrictive practices: restraint

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

## Discharge or release of a child to an unauthorised person

|  |
| --- |
| Category: care management |

**Sentinel event**

Discharge or release of a child to an unauthorised person\*

\* This sentinel event will be counted regardless of whether serious harm or death has occurred.

**Inclusions/exclusions**

Nil

**Setting**

All hospitals

**Definitions**

Child A child is any person under the age of 15[1](#_ENREF_19)7

Unauthorised person A person who is not a parent or legal guardian of the infant or child, or is a person who is the subject of a legal order preventing access to the infant or child.

**Examples of national preventive barriers**

* NSQHS Standards (2nd ed.)[4](#_ENREF_6) – Communicating for Safety Standard

<https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf>

## Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death

|  |
| --- |
| Category: care management |

**Sentinel event**

Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death

**Inclusions/exclusions**

Nil

**Setting**

All hospitals

**Definitions**

Serious harm As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

**Example of national preventive barrier**

* Joanna Briggs Institute: Methods of determining the correct nasogastric tube placement after insertion in adults[18](#_ENREF_20)

<https://www.g-i-n.net/library/health-topics-collection/guidelines/jbi-au/methods-for-determining-the-correct-nasogastric-tube-placement-after-insertion-in-adults-14-1>

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## Appendix A

**Membership of the Sentinel Events Review Steering Committee (SERSC)**

|  |  |
| --- | --- |
| **Name** | **Title** |
| Michele McKinnon (Chair) | Executive Director, Quality, Information and Performance, Systems Performance and Service Delivery (SA) |
| Anthony Hobbs | Deputy Chief Medical Officer (CTH) |
| Cate Malone | Senior Manager, Patient Safety, Clinical Excellence Commission (NSW) |
| Jane Murkin | Deputy Director-General, Quality Governance and Risk (ACT) |
| Jennifer Nobbs (observer) | Executive Director, Activity Based Funding (IHPA) |
| Jodi Glading  | Deputy Principal Medical Advisor (TAS) |
| Tim van Bronswijk  | A/Assistant Director, Patient Safety Surveillance Unit (WA) |
| Jonathan Prescott | Manager, Clinical Safety and Monitoring, Safer Care Victoria (VIC) |
| Kirstine Sketcher-Baker | Executive Director, Patient Safety and Quality Improvement Service, Clinical Excellence Division (QLD) |
| Sarah Stephens | Assistant Director, Hospitals and Transport Programmes (DVA) |
| Sarah Watson | Director, Clinical Quality and Patient Safety (NT)  |
| Stephanie Newell | Consumer representative  |

1. Definition changed in June 2009 from ‘Procedures involving the wrong patient or body part’ to ‘Procedures involving the wrong patient or body part resulting in death or major permanent loss of function’. [↑](#footnote-ref-1)
2. Definition changed in November 2014 from ‘Maternal death or serious morbidity associated with labour and delivery’ to ‘Maternal death associated with pregnancy, birth and the puerperium’. [↑](#footnote-ref-2)
3. The Joint Commission is an ‘independent, not-for-profit organisation that accredits and certifies nearly 21,000 health care organisations and programs in the United States’.[2](#_ENREF_2)
  [↑](#footnote-ref-3)