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Sentinel Events

Q. What is a sentinel event?

A. The Council defines sentinel events as “events in which death or serious harm to a patient has occurred”. They signal catastrophic system failure and have the potential to seriously undermine public confidence in the health care system.

Q. How often do sentinel events occur?

A. Sentinel events are a type of adverse event, or patient safety incident, that occur infrequently, but with alarming consequences. Victoria and New South Wales are currently the only States to publicly report their sentinel event data, with more States and Territories expected to follow. For the year 2003/04 Victoria reported the occurrence of a total of 30 sentinel events and New South Wales reported a total of 31 sentinel events.

Q. What is the Council doing about sentinel events in Australian health care?

A. The Council has worked closely with all jurisdictions to develop a national core set of sentinel events. It is also promoting a broad response to sentinel events which includes:

- agreement by Health Ministers that all States and Territories publicly report their sentinel event data by the end of 2005, that will be published in a National Sentinel Events Report;
- analysing trends at a national level to identify opportunities to improve patient safety;
- encouraging greater consistency in methodologies used to investigate and analyse sentinel events;
- disseminating information on lessons learnt and successful preventative actions; and
- facilitating change to prevent recurrence and reduce risks to patients.

In addition, the Council has facilitated a national training program in Root Cause Analysis (RCA) for health professionals across Australia called ‘*Effective Responses to Adverse Events*’. RCA is a type of investigation carried out to determine why errors occurred. This program aims to develop a core set of Australian trainers to lead in identifying system errors through RCA in their own jurisdictions.

Q. What do the agreed national list of core sentinel events consist of?

1. Procedures involving the wrong patient or body part
2. Suicide of a patient in an in-patient 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 or serious morbidity associated with labour or delivery
8. Infant discharged to the wrong family

Q. How can I find out about sentinel event figures in my state or territory?

A. To date, there are two states (Victoria and NSW) that are publicly publishing sentinel events data. By the end of 2005 all States and Territories will be required to publicly report their sentinel event data which will be published in a National Sentinel Events Report that the Council is coordinating. The report will bring greater transparency to this issue and will highlight patterns and trends to improve patient safety in Australian health care.