AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

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Australian Sentinel Events List (version 2)

Specifications

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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* on behalf of the states, territories and Commonwealth in 2017. *The Australian Sentinel Events List (verison 2): Specifications* was subsequently adopted in January 2019. Further information about the process of review is available in the *Australian Sentinel Events List (version 2): Review summary*.

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

What is a sentinel event?

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

The intent of this document is to define sentinel events that are extremely serious, preventable and of concern to both the public and healthcare 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.

To be classified a sentinel event, a strict set of criteria need to be met:

- 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 wholly preventable

Sentinel events will be considered 'wholly preventable' in the context of preventive barriers being available to stop the event from occurring.

Preventive barriers may include:

- the National Safety and Quality Health Service (NSQHS) Standards[2] (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
- documents providing safety guidance, safety recommendations or both, on how the event can be prevented.

The preventive barriers listed here 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. Investigation and review of incidents will help to identify where this is the case.

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.

Sentinel event specifications

The specifications for the 10 national sentinel events were developed to provide clarity about what constitutes a sentinel event. This is intended to aid consistency in reporting.

1: 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

National Safety and Quality Health Service (NSQHS) Standards (second edition)[3] – Communicating for Safety Standard: Correct identification and procedure matching. Action 6.6 states that:

> The health service organisation:
>
> a) specifies the processes to correctly match patients to their care
>
> b) specifies what information should be documented about the process of correctly matching patients to their intended care.

https://www.nationalstandards.safetyandquality.gov.au/

2: 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 Standards (2nd ed.)[3] – Communicating for Safety Standard: Correct identification and procedure matching. Action 6.6 states that:

  The health service organisation:

  a) specifies the processes to correctly match patients to their care

  b) specifies what information should be documented about the process of correctly matching patients to their intended care.

  https://www.nationalstandards.safetyandquality.gov.au

- Nationally agreed use of the World Health Organization (WHO Surgical Safety Checklist.[4]
  https://www.safetyandquality.gov.au/our-work/patient-identification/patient-procedure-matching-protocols/surgical-safety-checklist/

3: 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, or
- 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 Standards (2nd ed.)[3] – Communicating for Safety Standard: Correct identification and procedure matching. Action 6.6 states that:

  The health service organisation:

  a) specifies the processes to correctly match patients to their care

  b) specifies what information should be documented about the process of correctly matching patients to their intended care.

  https://www.nationalstandards.safetyandquality.gov.au/

- Nationally agreed use of the WHO Surgical Safety Checklist.[4] https://www.safetyandquality.gov.au/our-work/patient-identification/patient-procedure-matching-protocols/surgical-safety-checklist/

4: 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.

Example of national preventive barriers

Nationally agreed use of the WHO Surgical Safety Checklist.[4]
https://www.safetyandquality.gov.au/our-work/patient-identification/patient-procedure-matching-protocols/surgical-safety-checklist/

5: 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.

Definition

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.)[3] – Blood Management Standard
  https://www.nationalstandards.safetyandquality.gov.au/
- National Blood Authority – Patient Blood Management Guidelines[5]
  https://www.blood.gov.au/pbm-guidelines
- BloodSafe – National e-learning program[6]
  https://bloodsafelearning.org.au/resource-centre/links-and-resources/state-and-territory-contacts/
- Australian Red Cross, Flippin' Blood (2012) resources for safe transfusion.[7]
  https://transfusion.com.au/node/2228

6: 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 (2nd ed.)[3] – Comprehensive Care Standard, Action 5.31 Predicting, preventing and managing self-harm and suicide https://www.nationalstandards.safetyandquality.gov.au/
- Australasian Health Facility Guidelines: Part B – Health Facility Briefing and Planning, 0134 – Adult Acute Mental Health Inpatient Unit (revision 6.0)[8] https://healthfacilityguidelines.com.au/hpu/adult-acute-mental-health-inpatient-unit-0
- Living is for Everyone (LIFE) Framework[9] 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)([10] 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

- National Practice Standards for the Mental Health Workforce (2013)[11] 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
- Department of Health. Reducing suicide and deliberate self-harm in mental health services[12] (2005) 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

7: Medication error resulting in serious harm or death

Category: medication

Sentinel event

Medication error resulting in serious harm or death.

Inclusions/exclusions

Nil.

Setting

All hospitals.

Definition

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.)[3] – Medication Safety Standard
  https://www.nationalstandards.safetyandquality.gov.au/

- Various medication safety initiatives led by the Commission:
  - medication charts
  - medication reconciliation
  - medication administration
  - medication safety and quality education and training
  - safer naming, labelling and packaging of medicines
  - electronic medication management.

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

8: 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: The restriction of an individual's freedom of movement by physical or mechanical means.[13]

Physical restraint: The bodily force that controls a person's freedom of movement.[13]

Mechanical restraint: A device that controls a person's freedom of movement.[13]

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 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.)[3] – Comprehensive Care Standard: Minimising restrictive practices: restraint. Action 5.35 states:

> Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:
>
> - minimise and, where possible, eliminate the use of restraint
> - govern the use of restraint in accordance with legislation
> - report use of restraint to the governing body.

https://www.nationalstandards.safetyandquality.gov.au/

9: 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: Any person under the age of 15.[14]

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.

Example of national preventive barriers

NSQHS Standards (2nd ed.)[3] – Communicating for Safety Standard. Action 6.5 states that:

> The health service organisation:
>
> a) defines approved identifiers for patients according to best-practice guidelines
>
> b) requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and whenever clinical handover, transfer or discharge documentation is generated.
>
> https://www.nationalstandards.safetyandquality.gov.au/

10: 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.

Definition

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[15]

http://connect.jbiconnectplus.org/ViewSourceFile.aspx?0=5384

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