

Current sentinel/never events on lists in Australia, US, UK and Canada

NOTE:

- the 'categories' do not necessarily reflect the categories used by the event programs
- the definitions should be read in association with the overall definition, which may include an outcome such as death or serious harm (e.g. UK)

Category*	AUSTRALIA (8 events)	UNITED STATES (JC) 2009 (15 events)	UNITED STATES (NQF) 2011 (29 Events)	UNITED KINGDOM (NHS) 2015 (14 Events)	CANADA (CIPS) 2015 (15 Events)
SURGICAL / OTHER PROCEDURES	Procedures involving the wrong patient or body part resulting in death or major permanent loss of function	Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is wrong (unintended) procedure	Surgery or other invasive procedure performed on the wrong site	Wrong site / wrong patient surgery	Wrong site / wrong patient / wrong procedure surgery
			Surgery or other invasive procedure performed on the wrong patient		
			Wrong surgical or other invasive procedure performed on a patient		
	Retained instruments or other material after surgery requiring re-operation or further surgical procedure	Unintended retention of a foreign object in a patient after an invasive procedure, including surgery	Unintended retention of a foreign object in a patient after surgery or other invasive procedure	Retained foreign object post-procedure	Unintended foreign object retained post procedure
				Wrong implant / prosthesis	Wrong tissue / biological implant / blood product
	Haemolytic blood transfusion reaction resulting from ABO incompatibility.	Haemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)	Patient death or serious injury associated with unsafe administration of blood products	Transfusion or transplantation of ABO-incompatible blood components or organs.	

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PRODUCT OR DEVICES			Intraoperative or immediately post-operative / post-procedure death in an ASA Class 1 patient		
			Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting		Patient death or harm resulting from improperly sterilised instruments or equipment provided by the health service
			Patient death or serious injury associated with the use or function of a device in patient care in which the device is used or functions other than intended.		
	Intravascular gas embolism resulting in death or neurological damage.		Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.	Air embolism REMOVED October 2014	
MEDICATION	Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.		Patient death or serious injury associated with a medication error (e.g. errors involving wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).		
				Mis-selection of a strong potassium containing solution.	Patient death or serious harm as a result of intravenous administration of a concentrated potassium

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					solution.
MEDICATION (Continued)				Wrong route of administration: i) Patient receives intravenous chemotherapy administered via the intrathecal route ii) Patient receives oral / enteral medication or feed / flush administered by any parenteral route. iii) Patient receives intravenous administration of a medicine intended to be administered via the epidural route.	Patient death or serious harm as a result of wrong-route administration of chemotherapy agents, such as vincristine administered intrathecally (injected into the spinal canal).
					Patient death or serious harm as a result of inadvertent injection of epinephrine intended for topical use.
					Patient death or serious harm as a result of overdose of hydromorphone by administration of a higher-concentration solution than intended
				Overdose of insulin due to abbreviations or incorrect device.	
				Overdose of methotrexate for non-cancer treatment.	

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MEDICATION (Continued)				Mis-selection of high strength midazolam during conscious sedation.	
					Patient death or serious harm as a result of neuromuscular blockade without sedation, airway control and ventilation capability.
					Patient death or serious harm due to a failure to inquire whether a patient has a known allergy to medication, or due to administration of a medication where a patient's allergy had been identified.
CARE MANAGEMENT		Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/decilitre)	.		Patient death or serious harm as a result of failure to identify and treat metabolic disturbances.
			Any Stage 3, Stage 4 and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting		Any stage III or stage IV pressure ulcer acquired after admission to hospital.
				Misplaced naso- or oro-gastric tubes	
			Artificial insemination with the wrong donor sperm or wrong egg		

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CARE MANAGEMENT (continued)			Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen		
			Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results		
		Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose			
	Maternal death associated with pregnancy, birth and the puerperium.	Any intrapartum (related to birth process) maternal death. Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in any of the following: permanent harm or severe temporary harm	Maternal death or serious injury associated with labour or delivery in a low-risk pregnancy while being cared for at a healthcare setting.	Maternal death due to post-partum haemorrhage after elective caesarean section REMOVED October 2014	
		Unanticipated death of a full-term infant	Death or serious injury of a neonate associated with labour or delivery in a low-risk pregnancy		

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MENTAL HEALTH	Suicide of a patient in an inpatient unit.	Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED).	Patient suicide, or attempted suicide, or self-harm that results in serious injury while being cared for in a healthcare setting.	Failure to install functional collapsible shower or curtain rails.	Patient suicide or attempted suicide that resulted in serious harm, in instances where suicide-prevention protocols were to be applied to patients under the highest level of observation.
ENVIRONMENT				Falls from poorly restricted window	
			Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting.	Chest or neck entrapment in bedrails	
		Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care	Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting.	Scalding of patients.	Patient death or serious harm due to an accidental burn
			Patient death or serious injury associated with an electric shock in the course of patient care process in a healthcare setting.		
			Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substance	Wrong gas administered REMOVED October 2014	Patient death or serious harm due to administration of the wrong inhalation or insufflation gas.

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			Death or serious injury of a patient or staff associated with the introduction of a metallic object in the MRI area		Patient death or serious harm due to uncontrolled movement of a ferromagnetic object in an MRI area
			Patient death or serious injury associated with a fall while being cared for in a healthcare setting		
PATIENT PROTECTION		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 temporary harm to the patient	Patient death or serious injury associated with patient elopement (disappearance)		Patient under the highest level of observation leaves a secured facility or ward without the knowledge of staff.
	Infant discharged to the wrong family.	Discharge of an infant to the wrong family	Discharge or release of a patient / resident of any age, who is unable to make decisions, to other than an authorized person.		Infant abducted, or discharged to the wrong person
					Patient death or serious harm as a result of transport of a frail patient, or patient with dementia, where protocols were not followed to ensure the patient was left in a safe environment.

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CRIMINAL			Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed care provider		
		Abduction of any patient receiving care, treatment, and services	Abduction of a patient / resident of any age		
			Sexual assault on a patient or staff member within or on the grounds of a healthcare setting.		
		Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital.	Death or significant injury of a patient or staff member resulting from a physical assault (i.e. Battery) that occurs within or on the grounds of a healthcare setting.		

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