2021-22 Sentinel Events Annual Report

Safer Care Victoria

Contents page

Acknowledgement of Country

Our office is based on the land of the Traditional Owners, the Wurundjeri people of the Kulin Nation. We acknowledge and pay respect to their history, culture, and Elders past, present, and emerging.

We acknowledge Aboriginal people as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely.

We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches us.

We embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice.

For this land always was, and always will be, Aboriginal Land.

Acknowledgement of lived experience

Safer Care Victoria respectfully acknowledges consumers, families, carers, friends and loved ones who have experienced, or have been affected by, sentinel events. We are deeply sorry for their distress and grief. We bear witness to their stories in the sincere hope of improving care for others.

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VICTORIA State Government

Foreword

Since its foundation in 2017, SCV has worked in partnership to improve the safety of the Victorian healthcare system. We have achieved this by working with health services to drive a culture of continuous learning and improvement across the sector.

Being honest about when harm occurs is vital to developing and maintaining a patient safety culture and our annual sentinel event report highlights key opportunities for improvement. This year's report contains a high-level summary of harm events, analysis of four key themes, links to a wide range of resources, and a set of clear actions that we can take together to improve the safety of our health care system.

Across the 12-month period of this report we document a 43% increase in notified sentinel events which continues the year-on-year upward trend we've seen since SCV took ownership of the program. While the factors underpinning these increases are complex, we believe this trend demonstrates a growing culture of transparency and an increasing willingness to learn from patient harm.

In 2021-22 we also saw an increase in sentinel events related to patient deterioration, particularly in children and young people. This report details the work we are leading in response to this increase and outlines the actions we are taking in partnership with other organisations, consumers and clinical teams.

Every sentinel event is a tragedy that deeply impacts families and carers, and also the hard-working clinicians who have dedicated their lives to helping people and providing high quality care. We are committed to learning from every sentinel event, to honour those impacted, and to ensure that it does not happen again.

For the Victorian community, the efforts made to learn and improve from sentinel events remain largely unseen. This report makes sentinel events more visible, yet it is a relatively small part of a very large safety system.

Safer Care Victoria is working in partnership to put in place safety improvements across every service provided by the Victorian healthcare system. The breadth of this work ranges from the delivery of innovation and improvement programs through to safety monitoring and intervention. We work in collaboratively at every level of the health care system, from ward to boardroom, from training frontline health care workers, to influencing policy changes and driving largescale transformation projects.

It is a privilege to lead an organisation that places partnership with consumers, clinicians, and other health care agencies at the heart of everything we do.

All Victorians have the right to expect and receive consistently safe and high-quality healthcare.

Together we will deliver exactly that.

Professor Mike Roberts
Chief Executive Officer
Safer Care Victoria

How to use this report

This report provides an overview of the trends that we have identified through the sentinel event notification process across 2021-2022. It contains a high-level summary of key insights from real events, including lessons learned and system-wide improvements that are being actioned.

We want this report to be equally accessible and relevant to consumers and health services and have included learnings for each audience upfront. We have also included a terminology guide in the appendix which provides definitions to medical terms and phrases.

To help drive awareness of our sentinel event program and its role in guiding the safety of our healthcare system, we have included a visual roadmap of the sentinel event process as well as links to further resources.

This year's report contains four main themes emerging from sentinel event reporting:

- Increased notification of sentinel events
- Engagement with patients, families and carers
- Delays in recognising or responding to deteriorating patients
- Monitoring of recommendations

In the thematic analysis of patient deterioration we have included details of our work to improve the care of acutely unwell children and young people. This includes the launch of a consumer-led project that will provide a model for the implementation of a state-wide family escalation process. We have included a case study from Monash health as an example of Victorian health services leading the way in preventing patient harm.

The purpose of this report is to drive improvement in the safety of Victorian healthcare. We want health services to understand the factors that are leading to patient harm and provide them with the tools and solutions to reduce the risk of recurrence. We want to empower consumers with the information they need to achieve the best possible health care outcomes.

We each have a part to play in creating a safer health care system for all Victorians.

What is a sentinel event?

Sentinel events are unexpected and adverse incidents that occur infrequently in a health service entity and result in the death of, or serious physical or psychological harm to, a patient as a result of system and process deficiencies.

Serious harm is considered to have occurred when the patient has:

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

Life-saving surgical and medical treatments can include, but are not limited to, those requiring advanced life support measures such as intubation or emergency surgery.

For an adverse event to be notified as a sentinel event, it needs to meet clear criteria.

When an adverse patient safety event does not meet sentinel event criteria, the health service is still expected to conduct a comprehensive review. This review includes the opportunity for the patient, their family, or carers to contribute and then be informed of findings and actions to follow, just like a sentinel event review.

"Having a structure in place to notify of sentinel events provides an additional layer of governance to our findings and recommendations and supports our health services to make effective and sustainable improvements to the care we provide our patients. The sentinel event process also encourages early engagement with affected patients and their families which is vital to understanding what went wrong and how we can change what we do to deliver safe, high-quality care."

Katherine Frick
Deputy Director of Patient Safety
Barwon Health

"Families have critical knowledge when it comes to understanding how and why something might've gone wrong. We need to hear from them to make sure we're not missing out on important pieces of the puzzle."

Liat Watson
SCV academy member and consumer representative

The sentinel events process

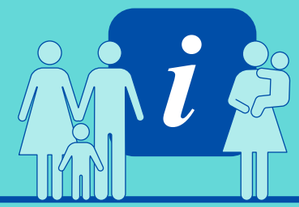
In Victoria, the sentinel event process starts when harm occurs to a patient and concludes with Safer Care Victoria (SCV) sharing lessons learned with the health care sector to prevent that harm from occurring elsewhere. **This report is a critical part of that process**.

01 **Patient sustains serious harm**

02 **Harm may be identified by staff, patients, families, carers or other healthcare providers**

03 **The health service conducts open disclosure**

04 **Sentinel event is notified to SCV**



05 **The health service undertakes a sentinel event review**

06 **Families work with the health service through the review process**

07 **The health service submits the review report and recommendations to SCV**

08 **SCV assesses whether the review meets standard practice requirements**

09 **The health service implements the recommendations from their review**

10 **SCV monitors the implementation of the health service's recommendations**

11 **SCV utilises the insights, themes, and learnings to drive system-wide change**

Actions to ensure safer care

We have compiled the following summary of the key takeaways, based on the reporting of sentinel events across the past year, to provide a clear set of actions to co-create a safer health care system for all Victorians.

Key actions for health services and leaders

- ***Ensure effective healthcare governance***
  Ensure you have integrated systems, processes, leadership and culture that support the provision of safe, effective, accountable and person-centred healthcare.
- ***Cultivate a transparent reporting culture***
  Foster a culture of continuous improvement and communicate transparently with staff involved in adverse events. Assure patients, families, staff and the community that adverse events are reviewed and acted on.
- ***Build capability through safety education and training***
  Deliver education and training to strengthen capability in sentinel event review processes and build awareness of the importance of transparent reporting in driving safety improvements.

Key actions for clinicians and managers

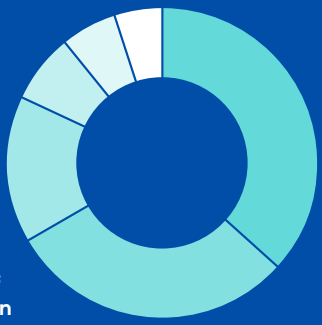
- ***Listen and respond to patients, families, and carers***
  Involving impacted consumers in sentinel event reviews can provide valuable insights and a fuller understanding of contributing factors, leading to more accurate and robust findings, and stronger system improvements.
- ***Form clinical networks that facilitate expertise and availability***
  Clinical networks connect people, coordinate, and develop clinical services and provide a better way to engage with and care for patients and consumers
- ***Form standardised guidelines and procedures***
  To ensure care provision is consistent with clinical best practice and improve outcomes for patients and staff.

Key actions for patients, families, and carers

- ***Make your voice heard if you have concerns***
  Please contact the health service and raise your questions or concerns directly with them. If you are not satisfied with the health service response, you can also reach out to the Health Complaints Commissioner (HCC).
- ***Expect an apology if things go wrong and ask for Duty of Candour if not offered***
  Health services will offer a genuine apology to the patient and/or family or carer, Throughout the Duty of Candour process, consumers can expect
  - to be heard,
  - to be treated with respect,
  - to have the support needed,
  - to have open and honest communication from the health service
  - To have your questions answered
- ***Share your stories and expertise with your health service***
  Ask your local health service about opportunities to share your story including joining a committee or becoming a representative on a review panel

2021-2022 at a glance

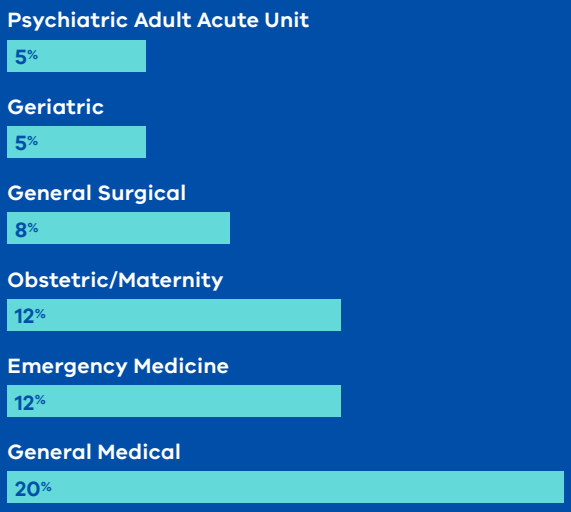
Breakdown of sentinel events by category*



- 31% Deteriorating patient
- 25% Clinical process or procedure
- 13% Falls
- 6% Medication
- 5% Communication of clinical information
- 4% Self-harm

*categories with a total of <4% have been excluded from this graph

Sentinel event clinical field breakdown*



*fields with a total of <5% have been excluded from this graph

240
sentinel events notified

43%
increase in reported sentinel events

88%
of review panels included consumer representation

767
findings

556
lessons learned

1149
recommendations

2021-2022 key themes

The sentinel event program generates insights and data that closely inform safety leadership and agenda. Across the past year four main themes emerged from sentinel event reporting. We have provided the following analysis to drive awareness of the underlying issues and support safety improvement.

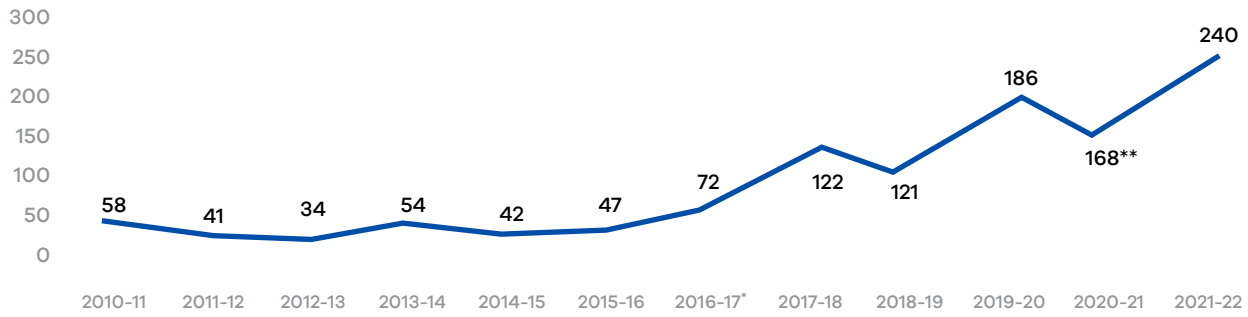
1. Increased notification of sentinel events

In 2021-22, sentinel event notifications to SCV increased by 43% from 168 in 2020-21 to 240 in 2021-22. This increase is consistent with the upward trend seen since 2017 when SCV was established and began oversight of the sentinel event program.

The upturn in sentinel event notifications is consistent with the improving recognition, notification and review of sentinel events. This demonstrates an ongoing, and increasing transparency from the health sector, illustrating that safety culture is evolving. This is further evidenced by an increase in the total number of health services notifying sentinel events, some for the first time in 2021-22.

Since it was established in 2017, SCV has continued to develop close relationships with health services across the state, actively driving awareness of the importance of the notifying safety risks and issues. This has led to a greater transparency around recognising, reporting and acting on patient harm which, in turn, enables health services to implement changes that will prevent that harm from reccurring.

Sentinel event notifications – 1 July 2010 to 30 June 2022



* On 1 July 2017, SCV began oversight of the sentinel event program from the Department of Health

** There was a small reduction in notifications between 2019/20 (186) and 2020/21 (168) which has been associated with the impact of the COVID-19 pandemic.

We know from wider data sets around patient harm that sentinel events are likely to be under-reported. For this reason the year-on-year increase in sentinel event notifications is a welcome sign that health services across the state are increasingly dedicated to creating a safer healthcare system.

2. Engagement with patients, families and carers

In 2021-22, impacted patients, their families or carers contributed to 112 (47%) of sentinel event reviews. Research illustrates that these contributions are vital to the review process, providing invaluable insight and driving many of the subsequent findings and recommendations.

Of the 127 reports (53%) where the patient, family or carer did not contribute to the review, this was because they declined to participate, were satisfied with the outcome of care, or could not be contacted.

Open disclosure

Open disclosure is a core feature of the sentinel event review process and a vital first step in engaging patients, families, and carers. The elements of open disclosure are:

- an apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'
- a factual explanation of what happened
- an opportunity for the patient, their family and carers to relate their experience
- a discussion of the potential consequences of the adverse event
- an explanation of the steps being taken to manage the adverse event and prevent recurrence.

Over the past 12 months 37% of the sentinel events notified had completed open disclosure within 6 months. Of these:

93% reported that the patient, family, or career were satisfied with the review outcome

48% had provided the patient, family or carer with a summarised report of the sentinel event review

13% had provided the patient family or carer with a full copy of the report

This data illustrates an opportunity for improvement by health services in the provision of open disclosure and recognition of its importance led to the recent introduction of Statutory Duty of Candour legislation.

Statutory Duty of Candour

As of 30 November 2022, when a patient is seriously harmed or dies as a result of healthcare, the health service responsible must, by law:

- apologise to the affected consumer and/or their family, carer or significant others
- explain what went wrong
- describe what action will be taken, and what improvements will be put in place
- offer a copy of any report completed as part of a review of what happened.

This legal responsibility is called the 'Statutory Duty of Candour' (SDC) and there are key requirements and timelines health services must follow as outlined within the Victorian Duty of Candour Guidelines.

These changes will lead to greater transparency and closer engagement with patients, families, and carers - resulting in a safer healthcare system for all Victorians.

"I imagine a sentinel event would be one of the hardest things to face as a health worker, so for the hospital to include me in the review was brave, was acknowledging their transparency, their openness to discussion. It made a huge difference to me."

Joanie
lived-experience representative
and mum to Rachel

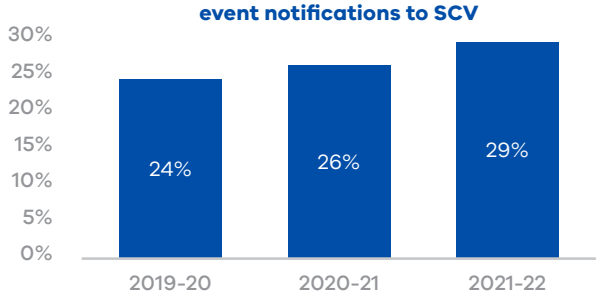
3. Recognising and responding to deterioration

Recognising deteriorating patients is a key focus for SCV and the health system. It supports timely intervention and appropriate medical care and avoids delays in treatment and risks of complications.

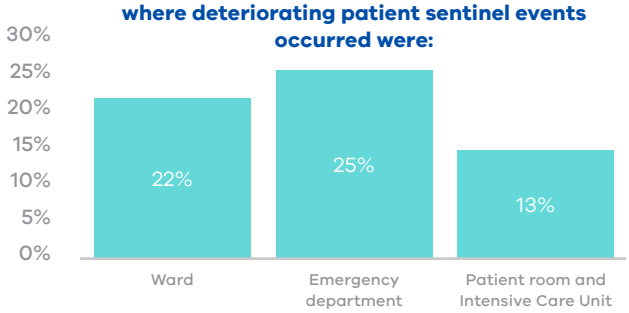
Since July 2019 when the sentinel event categories were revised, recognition and response to patients at risk of deterioration has increased and has consistently been one of the three most notified sentinel events categories.

In 2021-22, there were 72 (29% of the total) sentinel events related to delays in recognising and responding to patients at risk of deterioration. The patient at risk of deterioration subcategory made up 33% of all Category 11 sentinel event notifications.

Proportion of deteriorating patient sentinel event notifications to SCV



In 2021-22, the most frequent locations where deteriorating patient sentinel events occurred were:



SCV is partnering with Victorian health services to address this critical issue across three key action areas:

1. **Enhancing communication and escalation to senior staff**, embedding standardised tools (such as Identify, Situation, Background, Assessment and Recommendation [ISBAR] clinical handover) to ensure critical information is communicated effectively for deteriorating patients.

2. **Developing and utilising evidence-based care pathways**, to better recognise and respond to clinical deterioration. Toolkits to support health services have been developed including the Adult Sepsis (Whole Hospital) Pathway Toolkit and Sepsis for ED Toolkit.

3. **Defining 'exemplar' clinical engagement**, setting out essential elements for recognising and responding to acute physiological deterioration' and the National Safety and health service standards. SCV's Clinical Engagement in Recognition and Response Systems Framework presents four key domains and lists enablers to help health services achieve this, with practical information, and a self-assessment tool.

In 2021-22, deterioration was the most common risk factor leading to sentinel events in children and young people.

Deterioration and paediatrics

There are more than two hundred thousand presentations of acutely unwell children and young people in Victoria each year. Approximately two-thirds of these children and young people attend General Emergency Departments (ED) that do not have a Specialist Children's Emergency Service and most care is delivered to a high quality with clinicians, parents, carers, and patients working together to provide excellent outcomes.

However this is not always the case and where a patient has experienced harm, it is important that we understand what went wrong and prevent it from happening again. In 2021-22 38 paediatric sentinel events were notified. This represents an increase from 12% of total sentinel events in 2020-21 to 16% of total sentinel events in 2021-22.

In 2021-2022 the most frequent themes included recognition and response of deterioration (50%), clinical process or procedure (29%) and clinical communication (8%).

What is being done to reduce the risk?

In November 2022, SCV held a round table event focussed on improving the care of acutely unwell children and young people.

Over 110 clinicians, managers, and parents, shared their experiences and which supported the development of three priority recommendations to improve the safety of care for children and young people which are now being implemented:

RECOMMENDATION 1

Mandate clinician use of Victorian Children's Tool for Observation and Response (ViCTOR) wherever children and young people have vital signs recorded. This tool has been demonstrated to be key in recognising and responding to those at risk of deteriorating.

RECOMMENDATION 2

Implement a system of virtual paediatric emergency consultation, with appropriate infrastructure, training and quality assurance and video links to clinicians with paediatric expertise and retrieval services. This service will be particularly key to providing safe care for children in regional health services, providing expertise in management of acutely unwell children.

RECOMMENDATION 3

Implement a state-wide patient escalation process, empowering patients and carers to voice unresolved concerns and receive timely responses from their health service. All other states have such a service including Queensland's Ryan's Rule call service, has high satisfaction rates among consumers and has improved communication between clinicians, patients and carers.

CASE STUDY

Monash Health Paediatric Improvement Project: Proactive Assessment of Caregiver Concerns

Monash Health reviewed the process by which patients and their caregivers come forward with clinical concerns. The traditional Family Escalation of Care Procedure can be difficult for families from culturally and linguistically diverse (CALD) communities, those who are less familiar with the structure of the health service, and those who fear negative repercussions for speaking up.

Monash Health aimed to shift the responsibility to clinicians to proactively assess caregiver concerns about children and respond if these were identified.

With every set of clinical observations after triage – in the emergency department or on the ward – caregivers were asked "are you worried your child is getting worse?". If they responded yes, questions were asked to clarify if the concern was clinical, and if so, there was a process for clinically reviewing the patient.

Over the first 18 months of this improvement, it was found that:

- The addition of this question did not significantly burden on health service staff (only 1 in 25 caregivers indicated they were worried about their child getting worse)
- The children of "worried" caregivers were sicker. These children were more than twice as likely to be admitted into hospital, stayed twice as long when admitted, and 10% were admitted to the ICU.

Monash Health was one of six pilot sites participating in a SCV-led project which aimed to improve Family Escalation of Care processes for Paediatric Patients in Emergency Departments: Parental Recognition of the Deteriorating Child Quality Improvement Pilot Project - here.

4. Monitoring of recommendations

Following a sentinel event review, the review panel develops recommendations and sets out an action plan for implementation. These recommendations aim to reduce the risk of similar events recurring and improve quality and safety of patient care.

Health services provide SCV with a report 6 months after notifying a sentinel event, and again at 12 months if required. This report highlights the progress made against each of the recommendations and identifies any barriers or challenges to completing.

Of the 6-month monitoring reports SCV received across 2021-22:

- 34% of recommendations were completed at this six-month reporting mark,
- 62%, almost two-thirds, remained in progress.
- An average of 154 days were required to complete recommendations.
- A small portion of recommendations (2%) were placed on hold due to higher priorities or resource challenges within the reporting health services.
- Of the incomplete recommendations at 6 months, 76% were reported by health services as "not yet due".

This data highlights the importance of monitoring sentinel event review recommendations. SCV will work with the Department of Health to continue monitoring achievement of completed review recommendations through performance meetings held with each health service — both on a quarterly and annual basis.

Key actions for health services:

Sentinel event review recommendations are an important strategy for managing identified risks. Ensuring these recommendations are complete, and have the intended impact, contributes greatly to quality and safe healthcare

- **Health services must have robust systems (governance) and executive leadership** to oversee sentinel event recommendations and ensure timely completion
- **Implementing sentinel event recommendations requires commitment of staff time and resources.** Health services are encouraged to develop strategies to assist with prioritisation and resourcing. These strategies should be informed by an appropriate risk assessment
- **Recommendations addressing a high safety risk** (high risk of recurrence, with potential serious consequence) should be assigned more immediate resource and priority compared to lower safety risk actions.

What we're doing to support Safer Care

A safe health care system embraces a culture of continuous improvement. As Victoria's leading authority on healthcare quality and safety improvement, SCV has a wealth of resources and information available to support health care services and consumers to improve safety culture and prevent patient harm.

Resources for health services and leaders

- ***Consumer | Safer Care Victoria***
  eLearning - engaging with impacted consumers during the adverse event review process
- ***Fundamentals | Safer Care Victoria***
  eLearning - adverse patient safety event review
- ***Statutory duty of candour***
  eLearning - modules for healthcare professionals and consumers
- ***Lessons learnt from sentinel events*** - a deep dive into sentinel event themes
- ***Thematic interrogation of patient complaints in Victoria*** - an SCV-led research project
- ***The Australian Open Disclosure Framework*** - a nationally-recognised framework
- ***Adverse Patient Safety Events Policy***
- ***ACSQHC incident management and sentinel events***
- ***Partnering in healthcare*** - framework for engaging consumers
- ***Building your Health Community***- A guide for health service committee advisory committees
- ***Statutory duty of candour*** - training and resources
- ***Events and training*** - SCV training and workshops
- ***Adverse event review and response***
- ***Guides*** - for involving consumer representatives on adverse event reviews
- ***About the sentinel events portal*** - information for health services
- ***Capability development*** - SCV training for clinicians and consumers via events calendar
- ***100,00 Lives*** - current improvement projects

Resources for patients, families, and carers

- ***What are sentinel events?*** - information for patients, families and carers
- ***Statutory duty of candour*** - resources for consumers
- ***Resources for involving impacted consumers*** - including 'Rachel's Story'

HOW DID WE DO?

Please provide your feedback on this report via our **quick online survey**