Safer Care Victoria

February 2024

# Victorian sentinel event guide (Version 2)

Essential information for health services about managing sentinel events in Victoria.

OFFICIAL

To receive this publication in an accessible format phone 1300 543 916, using the National Relay Service 13 36 77 if required, or email **Safer Care Victoria** <info@safercare.vic.gov.au>

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.



**ISBN 978-1-76131-236-6 (pdf/online/MS word)**

Available at the Safer Care Victoria website <https://www.safercare.vic.gov.au>

VICTORIA State Government

# Acknowledgment 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 and present. 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.

Our appreciation extends to the clinical and non-clinical workforces that support people with lived experience.

# Contents

# Purpose of this guide

The Victorian Sentinel Event Guide (SE Guide) has been prepared to help health services in Victoria fulfil their obligations when managing and notifying sentinel events. This guide aligns to our Adverse Patient Safety Event policy and supports the implementation of actions 1.11 and 1.12 of the National Safety and Quality Health Service (NSQHS) standards <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance/clinical-governance-standard> from the Australian Commission on Safety and Quality in Health Care (ACSQHC).

Victorian health services must notify and review sentinel events that meet the criteria for the Australian sentinel event (ASE) categories and those that fall under the Victorian-only category 11.

This guide contains descriptions, examples, and case studies to support health services to identify sentinel events. It provides an overview of what is required when reviewing these events. The case studies in this guide are for illustrative purposes only and reflect learnings from the Victorian sentinel event program. They do not represent actual events, nor are they an exhaustive list of examples.

Health services are reminded that sentinel events are a subset of serious adverse patient safety events (SAPSE). While all sentinel events will meet the criteria of a SAPSE, not all SAPSE will be sentinel events. Please refer to Statutory Duty of Candour (SDC) < https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour> resources for further details. These also provide detail regarding SAPSE review protections.

When adverse events occur but do not meet sentinel event criteria, health services must still undertake appropriate review and action in line with the Adverse Patient Safety Events policy <https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events>.

This guide serves as an adjunct to information included in the Australian sentinel event list (version 2) (ASE) <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-sentinel-events-list-version-2-specifications> and should be considered as supplementary to the ASE resources, not as a substitute.

We oversee the sentinel event program in Victoria. For further support and advice on determining whether an adverse patient safety event meets sentinel event criteria, please contact the sentinel event program by emailing sentinel.events@safercare.vic.gov.au or by calling 1300 543 916.

Please refer to the glossary for key terminology used throughout this guide.

## How did we do?

Please provide your feedback via our quick online survey

# What is a sentinel event?

In Victoria, a sentinel event is “an unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury [category 11 only] to a patient as a result of system and process deficiencies at the health service entity”[1].

This sentinel event definition uses injury as the descriptive term without defining it. The Australian Sentinel Event criteria definition references patient harm. SAPSE are also referred to in terms of harm. For the purposes of this guide, the term harm is used in reference to sentinel events. Harm may be considered interchangeable with injury for the purposes of this guide.

**Serious harm** is considered to have occurred when, as a result of a serious adverse patient safety event, a patient has:

- required life-saving surgical or medical intervention, or
- a 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, advanced life support measures such as intubation or emergency surgery. For advice on whether an event fulfils the notification criteria of a sentinel event, please call the sentinel event program team on 1300 543 916.

When determining whether serious harm has occurred, health service staff should adopt a consumer-focused approach, including considering the psychological and lifestyle impacts of the event.

Health services must notify any harm that occurred in the preceding 2 years, which fulfils sentinel events criteria.

## Sentinel events related to psychological harm

Psychological harm may result from an adverse patient safety event. Psychological harm is described as harm that causes or is likely to cause mental or emotional trauma, behavioural changes, loss of enjoyment in life or psychological symptoms that require psychological or psychiatric care.

A sentinel event resulting from psychological (serious) harm is considered to have occurred when, as a result of the adverse event, the patient has experienced or is likely to experience **permanent or long-term loss** of function or distress. This may include **ongoing, recurring, or situational** loss of function or distress.

Refer to the case study section for examples of sentinel events related to psychological harm.

[1] Regulation 3A, Health Services (Quality and Safety) Regulations 2020

# Which sentinel events are notifiable in Victoria?

The Australian Sentinel Event list and Victorian-only category 11 sentinel event classifications are below. Health services are encouraged to take a proactive and consumer focused approach to notifying sentinel events.

## Australian Sentinel Event List (Version 2)

1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death.
2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death.
3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death.
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death.
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death.
6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward.
7. Medication error resulting in serious harm or death.
8. Use of physical or mechanical restraint resulting in serious harm or death.
9. Discharge or release of an infant or child to an unauthorised person.
10. Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death.

*The ASE list is available online at Australian Commission on Safety and Quality in Health Care <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident-management-and-sentinel-events>.

## Victorian category 11

Category 11 sentinel events include all adverse patient safety events resulting in serious harm or death that are not included in the 10 national categories. The addition of category 11 in Victoria serves to expand on the national list, creating a more robust and comprehensive mechanism for reviewing adverse patient safety events.

Sentinel events that fall within the Victorian category 11 are outlined below. These examples, also referred to as sub-categories, are:

- intended as a guide only.
- used for the purposes of theming and analysis.

Health services are reminded that the review of a sentinel event should maintain a comprehensive focus, ensuring all relevant variables are considered, regardless of the subcategory under which the sentinel event has been notified.

It is recognised that sentinel events may align to more than one of the Victorian subcategories. Health services are encouraged to consider the most applicable subcategory when making a sentinel event notification.

## Category 11 sentinel event sub-categories

All other adverse patient safety events resulting in serious harm or death:

- clinical process or procedure
- falls
- deteriorating patients
- self-harm
- communication of clinical information
- medical device or equipment
- nutrition
- resource or organisational management
- healthcare associated infection
- patient accidents.

This guide provides descriptions and case studies for each of these category 11 events.

## What is the difference between categories 1-10 and category 11?

ACSQHC defines sentinel events as a subset of adverse patient safety events that are wholly preventable and result in serious harm to or death of a patient. Events fulfilling the ASE categories are deemed wholly preventable in the context of there being barriers available to prevent the event occurrence. Examples of preventive barriers include the National Safety and Quality Health Service standards (NSQHS), policy documents or clinical protocols providing safety guidance, safety recommendations or both, on how the event could be prevented.

The current ASE list (version 2) commenced 1 July 2019. Health services across Australia are mandated to report and review these sentinel events to ensure public accountability, transparency and drive national improvements in patient safety.

In addition to categories 1-10, Victoria includes a category 11 - *All other adverse patient safety events resulting in serious harm or death*. Unlike the ASE criteria, **wholly preventable** is not a necessary determinant for category 11 sentinel events.

## Definitions side-by-side

| Category 1 – 10 (ASE) | Category 11 (Victorian Only) |
|---|---|
| "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." | All other serious adverse patient safety events resulting in *serious harm or death* that are not included in the 10 national categories. |

Each year, Australian sentinel events (those notified under categories 1-10) are reported to the Independent Hospital and Aged Care Pricing Authority (IHACPA). Australian sentinel event numbers are reported annually by the Australian Government Productivity Commission <https://www.pc.gov.au/ongoing/report-on-government-services>. We monitor and report annually on all category 1- 11 events in the Safer Care Victoria sentinel event annual report <https://www.safercare.vic.gov.au/reports-and-publications/sentinel-events-annual-report-2021-22>.

## Which health services are required to notify sentinel events in Victoria?

All public and private health services, as well as the services under their governance*, are required to notify sentinel events to us. These include:

- public health services
- public hospitals
- multi-purpose services
- denominational hospitals
- Ambulance Victoria
- Victorian Institute of Forensic Mental Health (Forensicare)
- bush nursing centres (publicly funded)
- private hospitals
- day procedure centres
- non-emergency patient transport (NEPT) services
- first aid services.

Examples of services managed within the governance* structures of the above health services may include, but are not limited to, Hospital in the Home (HITH), residential aged care services, and community health services.

## When the cause of harm is unclear

A sentinel event notification is required within 3 business days of the health service becoming aware that the adverse event has occurred (see what is required of health services section below).

In some instances, it may not be immediately clear if a serious adverse patient safety event fulfils sentinel event criteria. Health services are expected to take a proactive and consumer-focused approach when determining if an event meets the criteria for notification. Our sentinel event program team can also provide guidance.

## Special considerations for sentinel events involving criminal review:

If a sentinel event is subject to review under the Victorian or Commonwealth criminal justice systems, and directly involves the health service conducting the review (e.g. where the event allegedly involves murder, manslaughter, or allegations of sexual or physical assault), the criminal process should take precedence.

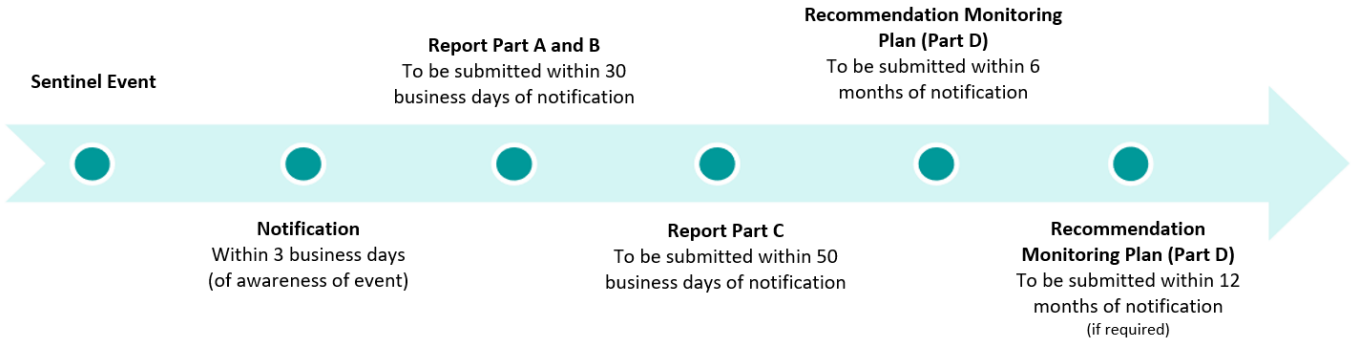
In this scenario, the sentinel event should be notified through the sentinel event portal, but the health service should consult with their legal counsel, and a sentinel event review should not be commenced (or continued) until the legal advice has been considered and the external criminal process has been completed. Australian Health Practitioner Registration Agency and Victoria Police may also need to be contacted.

## Additional notification requirements

In some circumstances, sentinel events may also require notification to other agencies (e.g. Coroner's Court of Victoria, Office of Chief Psychiatrist, Therapeutic Goods Administration).

Please refer to resources for further guidance.

# What is required of health services?




Under Victoria's sentinel event program, health services are required to:

- notify us within **3 business days*** of the service becoming aware of the event.
- review and analyse the sentinel event using an accepted review methodology.
- comply with the Statutory Duty of Candour <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour>
- submit a review report (Parts 'A' and 'B' of the report template) within **30 business days** of the notification (This may be extended to **55 business days**# in the case of a multiagency review)
- submit recommendations from the review (Part C) within **50 business days** (**75 business days**# for approved multiagency review) of the notification.
- submit a Recommendation Monitoring Plan (Part D) within **6 and 12 months** (if required) of the notification.

  - *Per regulations, NEPT/First Aid Service licence holders are only required to report to the Secretary immediately after the sentinel event's occurrence[2]
  - Private hospitals and day procedure centres are only required to notify (in writing) a sentinel event to the Secretary.[3] However, it is strongly recommended they still comply with the above requirements.
  - Bush Nursing and first aid services are exempt from requirements to comply with the statutory duty of candour.
  - For further details, refer to Adverse Patient Safety Event Policy <https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events>
  - #Refer to *Multiagency Reviews* section.

[2] Per Regulation 28 of the Non-Emergency Patient Transport and First Aid Services (First Aid Services) Regulations 2021.

[3] Per Regulation 46A of the Health Services (Health Service Establishments) Regulations 2013).

## The sentinel event portal

All sentinel event notifications and review documentation are submitted to us via the sentinel event portal <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/notify-and-review-a-sentinel-event>

Health services/staff can obtain access to the sentinel events portal by completing the onboarding form <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/notify-and-review-a-sentinel-event> and submitting to us via email sentinel.events@safercare.vic.gov.au.

Please note:

- the onboarding form must be accompanied by written approval from a relevant director or executive from the health service
- all onboarding requests are reviewed by the sentinel events team to ensure they meet the access requirements
- once approved, access should be granted within 24-48 hours

Learn how to use the sentinel event portal by watching our online training materials <https://vimeo.com/showcase/9172998>. Health services can also request individual training by contacting the sentinel event program.

## Minimum review and report standards

Health services are responsible for the quality of completed sentinel event reviews and reports. All submitted reports are screened by the sentinel event program to ensure they meet a minimum standard of quality and content that includes, but is not limited to:

- de-identification of health service/s, consumer/s, and sentinel event review panel member/s
- inclusion of an external subject matter expert and a consumer representative on the review panel
- all aspects of the report completed to an acceptable standard in alignment with the applied review methodology, such as root cause analysis (RCA2), London Protocol, or AcciMap
- identification of findings and lessons learnt
- appropriate recommendations to address the above

If reports do not meet these minimum standards, we may liaise with the health service. Health services may be guided by a member of the sentinel event program to ensure all issues are addressed.

Feedback will not routinely be provided for individual reports, unless specific concerns are identified. Health services are expected to ensure their staff have sufficient training and support to conduct a review that meets the minimum standards.

In select instances, health services may receive feedback regarding individual reports as part of the quality assurance process, such as the Department of Health Office or Chief Psychiatrist review of a sentinel event involving self-harm or suspected suicide.

To support services in building their review capability, we provide training in review methodology, review templates, and a minimum standard self-checking tool. The sentinel event program is also able to provide additional support to services who are new to sentinel event review or have limited capability. This is managed on a case-by-case basis.

Training and tools are available via our website <https://www.safercare.vic.gov.au/best-practice-improvement/online-training-modules>.

For support and guidance, please reach out to the sentinel event program at sentinel.events@safercare.vic.gov.au.

## Information sharing

Every sentinel event is an opportunity to learn and improve, for individual health services and across the healthcare system. Deidentified learnings from sentinel event reviews may inform Department of Health/SCV quality and safety priorities and improvements including projects, education, and be shared with external parties for the purpose of research.[4]

We share lessons learnt from sentinel events to the health sector and wider community through the sentinel events annual report < https://www.safercare.vic.gov.au/reports-and-publications/sentinel-events-annual-report-2021-22 >. Health services may circulate sentinel event learnings within their service so these reviews can contribute to systems and practices improvements.

## Review panel membership

A well-structured panel ensures the review is robust, unbiased, and thorough. Review panels should comprise a multidisciplinary team, including:

- person(s) with expertise in facilitation of the chosen review methodology. The sentinel event facilitator should have, at minimum, completed the Fundamentals of Adverse Patient Safety Event Review <https://www.safercare.vic.gov.au/e-learning/fundamentals> training (or equivalent)
- subject matter expertise in the main clinical area/s under review
- hands on experience with 'work as done' (e.g. clinical or operational requirements) in an area similar to where the event occurred
- executive sponsor or sponsors, though not necessarily a participant in the review panel, should oversee the review and aid implementation of recommendations.

[4] Note - Section 128U of the *Health Services Act 1988*, which relates to the confidentiality of SAPSE review documents and report, will apply if a SAPSE review is conducted about a sentinel event. This includes section 128U(6), which states that nothing in section 128U prevents a person to whom it applies from including de-identified information in any document and section 128U(7), which provides a definition of deidentified.

## Health services should also consider who ***not*** to include on the panel.

Inviting staff who were directly involved in the event creates a conflict of interest and the potential for bias. It may also exacerbate any psychological distress they may be experiencing following the event and is therefore not appropriate. For these reasons, and in alignment with SAPSE review requirements, staff who were involved in the event cannot be members of a review panel (but should participate through interview to inform the review process).

## External expert representation

All sentinel event review panels must include at least one independent subject matter expert. These external experts:

- are independent clinicians not employed or engaged by the health service (this includes working at other sites under the same employer/organisation)[5]
- have expertise in the primary clinical area under review.

For assistance in sourcing an external expert or to register as an external expert, please visit our PEER Platform <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/review-and-response/peer> or reach out to the sentinel event program at sentinel.events@safercare.vic.gov.au. Health services can also contact the sentinel event program to be directed to clinical specialist advice to support sentinel event reviews.

## Consumer representation

All SAPSE review panels that relate to a sentinel event must include a consumer representative as per Regulations 3C(d) and 3D(b) of the *Health Services (Quality and Safety) Regulations 2020,* to ensure the protections associated with a SAPSE review apply and to meet the minimum standards for sentinel event review. The consumer representative's role is to provide a patient/consumer voice to the review. This representative should not have been directly impacted by the event being reviewed.

Health services are encouraged to engage a consumer who has had a similar experience or has knowledge relevant to the adverse event being reviewed. Appropriate consumer representatives include those:

- with lived experience as a consumer or carer for someone who has received/or is receiving healthcare
- from a cultural and linguistically diverse (CALD) background for adverse events impacting a CALD consumer
- with knowledge of the importance of and/or cultural safety experience for an adverse event involving a First Nations consumer.

In the instance of small rural or remote health services or sole operators who may find it difficult or inappropriate to identify a local consumer or external expert representative, we encourage linkage with other health services to develop a pool of appropriate representatives who can work across services.

Given the sensitive nature of sentinel event reviews, health services are encouraged to consider the wellbeing/psychological safety of review panel participants. This should include timely sharing of documentation, preparation for meeting/s with consumer representatives, establishing processes for debriefing, access to employee assistance program and/or vicarious trauma training.

Please refer to our guidance for involving consumers in adverse event reviews <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/involve-consumers-in-incident-reviews> for more information or contact the sentinel event program.

## Multiagency reviews

When a sentinel event occurs across more than one health service, all services involved in the patient care may be required to participate in a multiagency review of the event. This practice aligns with the expectations of SDC and ensures consistent messaging from all services involved to affected consumers.

All services have the responsibility to ensure a sentinel event notification is made. In most instances, we recommend the health service that provided the final period of care related to the adverse event take responsibility for notifying the event, initiating the review, and engaging with the other health services. This can be negotiated on a case-by-case basis. We can provide advice if required.

We recommend the notifying service inform all other listed agencies prior to or at the time the notification occurs, however this should not delay notification.

A successful multiagency sentinel event review has:

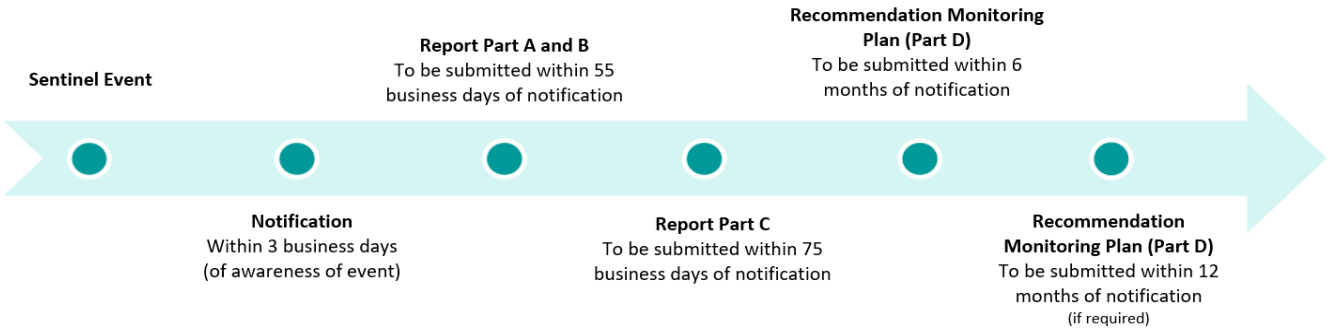
- agreement from all services regarding communication with the consumer or, where the consumer lacks capacity or has died, their immediate family, carer, next of kin or nominee per SDC requirements
- an experienced sentinel event review chair, facilitator, and terms of reference
- an agreed plan of approach for each of the required report submissions
- a ‘responsible person’ at each service who can act as that service’s key point of contact and direct aligned health service governance processes, e.g. review endorsement, coordinating recommendations and appropriate executive oversight.

We are currently developing further resources to support health services in completing multiagency reviews.

For any issues or questions regarding multiagency reviews, please contact the sentinel event program sentinel.events@safercare.vic.gov.au.

### Pre-approved extensions for multiagency reviews

In line with the SDC timeframes, we will grant an extension of 25 business days for an approved multiagency review. Such reviews must be discussed with us and completed in line with the requirements outlined above.




## Sentinel events that occur at other health services

Where a health service becomes aware of an actual or likely sentinel event that has occurred at another service, they are expected to alert the other health service and the sentinel event program.

Where a service is unsure of how to do this, they should reach out to the sentinel event program for assistance.

## Involving patients and families

In accordance with the SDC legislation[6] unless a patient opts out[7],health services must provide patients (or if the patient has died, their immediate families, carers or nominated persons) with an apology, and communicate openly and honestly following a SAPSE (which include sentinel events).

Per the Victorian Duty of Candour Guidelines (legislative instrument), health services must complete several actions to comply with SDC including, but not limited to:

- provide a written account of the event review to the patient and/or next of kin (NOK)/carer
- apologise to the patient (or their immediate family, NOK, carer or nominated person if the patient has died) for the harm suffered by the patient
- provide a description of the health service entity's response to the event
- outline the steps that the health service entity has taken to prevent re-occurrence of the event

Please visit the Statutory Duty of Candour webpage <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour> for more information.

[6] Within the *Health Services Act 1988*, *Mental Health and Wellbeing Act 2022*, and the *Ambulance Services Act 1986*.

[7] See the Victorian Duty of Candour Guidelines for more information.

## Performance issues

Sentinel event review methodology is not to be used for individual performance issues or disciplinary processes. Such issues are to be addressed by the relevant personnel in a performance management context, separate to the sentinel event review.

If a sentinel event involves performance issues, the review should consider the systems issues that may impact on or contribute to these performance issues. This could include how to identify and manage a person with performance issues or systems to support staff to speak up for safety.

# Subcategories of Victorian sentinel event category 11

The following section of this guide aims to help Victorian health services identify category 11 sentinel events. Sub-categorising these events is done for the purposes of theming and analysis. The case examples provided in this guideline are not intended to be an exhaustive list.

Sentinel events may align to more than one of the Victorian subcategories. Health services are encouraged to consider the most applicable subcategory when making a sentinel event notification.

## Subcategory 1 – Clinical process or procedure

### Description

This subcategory covers adverse events involving clinical procedures and processes resulting in serious harm or death. It includes any **delay, failure** or **complication** of a process or procedure related to clinical review, a test, investigation, or treatment resulting in serious harm or death of a patient.

If the sentinel event is associated with an administrative error, not a clinical process or procedure error, then it is to be attributed to subcategory 5 – *Communication of clinical information*.

### Examples

- any diagnosis or assessment not performed when indicated, or that was incomplete or inadequate, resulting in serious harm or death of a patient. e.g., delay completing scheduled observations contributing to delayed diagnosis and serious harm.
- any procedure, treatment or intervention not performed when required, or that was incomplete or inadequate, resulting in serious harm or death of a patient e.g., Incomplete excision of a melanoma (despite presurgical investigation/planning)
- any test or investigation not performed when required, performed for the wrong patient, or not acted upon, resulting in serious harm or death of a patient. e.g., Did not perform timely ECG in patient presenting with chest pain, leading to delayed diagnosis of myocardial infarction or electronic medical record (EMR) results attributed to incorrect patient.
- any mix-up of specimens or results, including incorrect labelling, resulting in serious harm or death of a patient e.g., lost specimen contributing to critical delayed diagnosis/treatment.

## Subcategory 2 – Falls

### Description

It is acknowledged that the classification of falls related sentinel events can be difficult, as these often impact patients already at, or nearing, end of life care.

The falls subcategory covers adverse events that **involve healthcare provision (or lack thereof),** which result in a fall and lead to serious harm or death.

Healthcare provision includes the systems in place, including but not limited to, decisions, actions, policies, and processes completed during the care of a patient.

We have created an evidence-informed Falls Review Tool <https://www.safercare.vic.gov.au/best-practice-improvement/improvement-projects/older-people-and-palliative-care/falls-review-tool-pilot-project>. This tool is system focused, intuitive and well suited to reviewing harm from falls. Health services are encouraged to utilise this tool when reviewing sentinel events resulting from falls.

### Examples

- a fall when falls risk assessment was not performed when required, was incomplete or inadequate, resulting in serious harm or death.
- a fall when falls risk prevention interventions were not performed when required, were incomplete or inadequate, resulting in serious harm or death.

## Subcategory 3 – Deteriorating patients

### Description

Observable changes in physiological and clinical signs often precede serious adverse events, such as cardiac arrest.

This subcategory covers adverse events involving a lack of, or delayed **recognition**, **escalation,** or **response** when there is clinical deterioration of a patient, directly resulting in serious harm or death.

It includes a failure to recognise or respond appropriately to physiological signs and symptoms or changes in behaviour or mood (mental state) that would indicate clinical deterioration where alternate management would have changed the outcome for the patient.

### Examples

- inadequate monitoring of physiological observations or recognition of critical changes in physiological observations, clinical signs or symptoms that could signal deterioration.
- non-recognition of clinical features or physiological measures indicative of cognitive deterioration resulting in serious harm or death
- lack of, or inadequate formal systems for responding to deterioration resulting in serious harm or death.
- lack of, or inadequate skills to manage patients who are deteriorating resulting in serious harm or death.
- failure to communicate clinical concerns, including during clinical handover, resulting in serious harm or death.
- mistakenly attributing physical or mental symptoms to an existing condition, such as dementia or a mental health condition resulting in serious harm or death.

## Subcategory 4 - Self harm

### Description

This subcategory refers to adverse events relating to self-harm that **involve healthcare provision (or lack thereof),** leading to serious harm or death.

Healthcare provision includes the systems in place, including but not limited to decisions, actions, policies, and processes completed during the care of a patient.

This subcategory covers intentional adverse self-harm events resulting in serious harm or death, not included in ASE category 6 – *suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward*.

Health services are encouraged to take a consumer-focused perspective when determining whether a self-harm event is notifiable as a sentinel event.

### Examples

- suspected suicide of a patient admitted to a health service to non-psychiatric wards i.e., acute, sub-acute or general rehabilitation services (or other services under the health service governance structure). This includes patients in the community receiving healthcare from staff employed by these health services – such as HITH and some prevention and recovery care (PARC) models of care.
- suspected suicide or serious self-harm of a consumer in the community where there is evidence of incomplete care from a health service, which has contributed to the adverse event. For example, failure to coordinate follow up or escalate care for a person who has reached out in situational crisis or incomplete or inaccurate emergency department mental health assessment and management.
- suspected suicide of a patient admitted to an acute psychiatric unit or acute psychiatric ward, on approved or unapproved leave.
- serious self-harm sustained by a patient in an acute psychiatric unit or acute psychiatric ward, emergency department or acute, subacute or rehabilitation service (or services under their governance).

In the instance of unintentional self-harm resulting in serious harm or death (such as secondary to cognitive deterioration or delusion), this should be notified as a sentinel event under the appropriate subcategory (e.g., ‘deteriorating patient’ or ‘patient accident’).

Instances of death where a person is a registered, or recently was, a mental health consumer may also require notification to the Office of the Chief Psychiatrist (OCP).

Please refer to reportable deaths <https://www.health.vic.gov.au/chief-psychiatrist/reportable-deaths-mental-health-and-wellbeing-act-2022> for more information.

## Subcategory 5 - Communication of clinical information

### Description

This subcategory addresses adverse events resulting in serious patient harm or death due to the miscommunication of clinical information.

### Examples

- incidents involving a process or problems with the administration or documentation of clinical information resulting in serious harm or death.
- any administrative process not performed when required, not completed, or inadequately completed, or involving a mix-up of patients, processes, or services resulting in serious harm or death.
- incidents involving missing or unavailable documents, delays in accessing a document, use of the wrong document or unclear, ambiguous, illegible, or incomplete information in a document resulting in serious harm or death.
- provision of incorrect patient information that directly results in serious harm or death.
- inability to provide information in a suitable format including culturally and linguistically diverse appropriate communication resulting in serious harm or death.

### Communication of clinical information sentinel events may involve:

- waitlist delays
- inter-hospital transfer delays
- delays to investigation or procedure secondary to administration error
- delays to referral
- clinical handover / transfer of care
- task allocation
- consent
- patient identification
- labels/stickers/identification bands/cards
- letters/e-mails/records of communication
- reports/results/images
- transcription errors
- electronic medical record errors

## Subcategory 6 - Medical device or equipment

### Description

This subcategory includes adverse events associated with medical **devices** or **equipment** resulting in serious harm or death.

### Examples

- product, medication, or device unavailable
- use of a product that is inappropriate for the task.
- use of an unclean or unsterile product
- malfunction of a product (e.g., ventilator, IV pump)
- dislodgement, faulty connection, or removal of a product

## Subcategory 7 – Nutrition

### Description

This subcategory includes adverse events associated with the provision of **nutrition** (oral, parenteral, hydration and enteral) and **food** to patients, resulting in serious harm or death.

### Examples

- delivery of food to the wrong patient
- delivery of the wrong nutrition
- delivery of the wrong food to patient with known allergies
- provision of the wrong quantity
- delivery at incorrect frequency
- incorrect consistency or incorrect storage
- patient not supervised according to requirement.
- incorrect level of assistance provided.

## Subcategory 8 - Resource or organisational management

### Description

This subcategory covers events where a **lack of resources**, or deficiencies in **organisational management**, contribute to errors resulting in serious harm or death. It also includes events relating to human resource management and workforce management and distribution.

### Examples

- workload mismanagement (e.g., inappropriate shift allocation, insufficient induction, or training)
- staff resourcing and accessibility (e.g., staffing ratio, language interpreter availability)
- bed availability or management (e.g., impacting transfer of critically unwell patient, theatre access)
- policy, procedure, or guideline availability and/or adequacy

## Subcategory 9 - Healthcare associated infection

### Description

Systems are in place to support and promote prevention and control of infections, improve antimicrobial stewardship, and support appropriate, safe and sustainable use of infection prevention and control resources.

This subcategory covers adverse events that involve **healthcare provision (or lack thereof)**, which result in a healthcare associated infection (HAI) and lead to serious harm or death. It includes **bloodstream**, **surgical site**, **intravascular devices,** or **urinary drain infections** as well as **viral illnesses**.

Healthcare provision refers to the systems in place, including but not limited to decisions, actions, policies, and processes completed during the care of a patient.

### Examples

- surgical site infections
- infections associated with peripheral or central intravascular devices.
- infections from urinary catheters
- viral illnesses
- communicable diseases

## Subcategory 10 - Patient accidents

### Description

This subcategory covers patients in care who are involved in accidents that result in serious harm or death. Such events could involve **blunt force trauma**, **penetration injury** and **thermal or chemical** injury.

### Examples

- suffocation secondary to bed entrapment
- drowning
- in theatre diathermy accident or burn or where there is an explosion or fire
- poisoning
- electrocution or radiation exposure

# Glossary

| Term | Meaning |
|---|---|
| AcciMap | AcciMap (Accident Mapping) is a retrospective accident analytical approach used for representing and analysing systemic failures (Rasmussen 1997)' |
| Adverse event | Adverse events are events that occurred while the patient was receiving care from a health service entity and result in unintended or unexpected harm. |
| Australian Commission on Safety and Quality in Health Care (ACSQHC) | Leads national improvements in safety and quality in healthcare. |
| Business days | Days falling between and including Monday and Friday. |
| Consumer representative | A health consumer who has taken up a role to provide advice on behalf of consumers with the overall aim of improving healthcare. |
| Electrocardiogram (ECG) | Measures electrical activity generated by the heart when it contracts. |
| External team member | A review team member who does not work within the health service (including visiting medical officers). |
| Healthcare associated infection (HAI) | Health complications caused by micro-organisms, such as bacteria and viruses, following medical treatment. |
| Serious adverse patient safety event (SAPSE) | Is an event that:<br>a) occurred while the patient was receiving care from a health service entity; and<br>b) in the reasonable opinion of a registered health practitioner, has resulted in, or is likely to result in, unintended or unexpected moderate or severe harm, or prolonged psychological harm being sustained by the patient.<br>Note – it includes an event that is identified following discharge from the health service entity.<br>This definition comes from section 3(1) of the *Health Services Act 1988* and Regulation 3B of the Health Services (Quality and Safety) Regulations 2020. |
| Sentinel event | An unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury to, a patient because of system and process deficiencies at the health service entity (per Regulation 3A of the Health Services (Quality and Safety) Regulations 2020). |
| Statutory duty of candour (SDC) | SDC is a legal obligation for Victorian health service entities to ensure patients (and, where relevant, their immediate family, carer, next-of-kin, or nominee) receive an apology and are communicated with openly and honestly when a serious adverse patient safety event (SAPSE) has occurred.<br>See section 128ZC of the *Health Services Act 1988* and the Victorian Statutory Duty of Candour Guidelines for more information. |

| | |
|---|---|
| International Classification of Patient Safety (ICPS) | A World Health Organization (WHO) approach to classifying patient safety information. |
| Independent Hospital Pricing Authority (IHPA) | The independent Commonwealth Government agency established as part of the national health reform agreement. |
| Intensive care unit (ICU) | A unit in a hospital where patients receive specialised critical care when they are extremely unwell. |
| London Protocol (LP) | London Protocol takes a systems approach to adverse patient safety event review. LP identifies problems that may have occurred during the care delivery process, and any contributory factors present at the time of the event. |
| Medical emergency team (MET) | A skilled clinical team that responds to patients with clinical deterioration. |
| Open disclosure | The open and transparent discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family, and carers. |
| Public sector residential aged care services (PSRACS) | Residential aged care beds funded by the Victorian Government. |
| Root cause analysis (RCA) | A method of problem solving used for identifying the root causes of an adverse outcome. |
| Safer Care Victoria (SCV) | The peak body for quality and safety in healthcare in Victoria. |
| Victorian Hospital Incident Management System (VHIMS) | An incident reporting system used in many Victorian health services to manage patient safety events. |
| Wholly preventable | Pertaining to ASE categories 1-10, sentinel events will be considered 'wholly preventable' in the context of preventive barriers being available to prevent the event from occurring (e.g., Quality Health Service [NSQHS] Standards, policy documents or clinical protocols, documents providing safety guidance, safety recommendations or both, on how the event can be prevented). |
| World Health Organisation (WHO) | Directs and coordinates international health within the United Nations system Incident severity rating (ISR).<br>The severity of impact to a patient when an incident occurs. ISR is measured on a scale of 1-4 (with 1 being most severe). |

# Resources

Sentinel events:

- Sentinel events portal <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/about-the-sentinel-events-portal>
- Lessons learnt from sentinel events <https://www.safercare.vic.gov.au/news/lessons-learned-from-paediatric-sentinel-events>

Training:

- Fundamentals | Safer Care Victoria <https://www.safercare.vic.gov.au/e-learning/fundamentals> - eLearning Adverse Patient Safety Event Review
- Consumer | Safer Care Victoria <https://www.safercare.vic.gov.au/e-learning/consumer> - eLearning Engaging with impacted consumers during the adverse event review process.
- Statutory Duty of Candour <https://www.safercare.vic.gov.au/e-learning/duty-of-candour> - eLearning modules for healthcare professionals and consumers
- Events and Training <https://www.safercare.vic.gov.au/news-events/events> - SCV training and workshops
- Adverse event review and response <https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events>

Adverse Patient Safety Event Review and Management:

- Adverse Patient Safety Event Policy <https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events>
- The Australian Open Disclosure Framework <https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework>
- Statutory Duty of Candour <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour>
- ACSQHC incident management and sentinel events <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident-management-and-sentinel-events>
- Partnering in Healthcare <https://www.safercare.vic.gov.au/publications/partnering-in-healthcare framework for engaging consumers>
- Consumers on adverse event review panels <https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews>

Resources for patients, families, and carers

- What are sentinel events? <https://www.safercare.vic.gov.au/consumer-resources/what-adverse-sentinel-events#:~:text=A%20sentinel%20event%20is%20when,their%20care%20had%20gone%20well> information for patients, families, and carers
- Statutory duty of candour <https://www.safercare.vic.gov.au/consumer-resources/duty-of-candour-resources-for-patients-families-and-their-carers>
- Resources for involving impacted consumers <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/resources-for-involving-impacted-consumers> including 'Rachel's Story'.

Additional Resources:

- Coroners Notifiable Deaths <https://www.coronerscourt.vic.gov.au/report-death-or-fire/reportable-deaths>
- Office of Chief Psychiatrist reportable deaths <https://www.health.vic.gov.au/sites/default/files/2023-09/ocp-reporting-directive-notification-of-reportable-deaths.pdf>
- VMIA <https://www.vmia.vic.gov.au/> Victorian Managed Insurance Authority
- TGA <https://www.tga.gov.au/resources/resource/guidance/reporting-adverse-events>
- WorkSafe <https://www.worksafe.vic.gov.au/report-incident-criteria-notifiable-incidents> Notifiable incidents
- Serious Incident Response Scheme (SIRS) <https://www.agedcarequality.gov.au/providers/serious-incident-response-scheme> Guidelines for residential aged care providers
- Australian Open Disclosure Framework <https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework>
- Freedom of Information <https://www.health.vic.gov.au/freedom-of-information> Department of Health

*We will continue to develop resources to support the SEP. Updates will be included in this list.

# Version control

| Version | Date | Changes made | Approved by |
|---|---|---|---|
| 1.0 | | This guideline has been published to support health services of Victoria in the notification and management of Sentinel Events – 2023. | Safer Care Victoria CEO |

# Appendix – Sentinel event case examples

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| **Subcategory 1 – Clinical process or procedure** | | |
| Clinical procedure | Surgery, tracheostomy, resuscitation, difficult airway, delayed procedure | A 48-year-old patient suffered a severe hypoxic brain injury and died 2 days later.<br>The patient had a tracheostomy following extensive surgery for mouth cancer and experienced spontaneous severe breathing distress after the tracheostomy airway dislodged. A large neck haematoma and generalised swelling made re-positioning the airway difficult. There was a delay in staff accessing the emergency advanced airway and resuscitation equipment in-line with organisation policy. The delay in securing an appropriate airway contributed to a severe hypoxic brain injury and the patient subsequently died 2 days later.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The delay in securing an appropriate airway contributed to the hypoxic brain injury. The patient suffered serious harm that led to death resulting from a delayed procedure. |
| Clinical procedure | Psychological harm, anaesthetic awareness | A 22-year-old patient developed prolonged psychological harm following a complication involving general anaesthesia.<br>The patient required general anaesthesia for a laparotomy (abdominal surgery). Whilst in recovery following the procedure, the patient became agitated and then highly distressed. They reported intraoperative awareness, pain, and an extreme sense of powerlessness. The patient developed recurrent nightmares, a fear of dying and was subsequently diagnosed with post-traumatic stress disorder. They required long term psychological support and were not able to return to employment or previous sporting endeavours.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The patient suffered prolonged psychological harm resulting in long-term or permanent loss of function as a complication of a clinical procedure. |
| Clinical process | Pathology, sepsis, emergency department, differential diagnosis | A 76-year-old patient died following delayed diagnosis of sepsis.<br>The patient presented to an emergency department (ED) with a 2-day history of feeling unwell and difficulty passing urine. The patient also reported that his urine was a bit smelly. He had a temperature of 38.3C and was hypotensive (low blood pressure 90/55). The patient was given Panadol and admitted to a cubicle in the ED. Intravenous fluids were commenced and blood tests taken but the results were not checked. The patient was transferred to the ward. Later that night, he was found to be hypotensive, tachycardic and anuric (no urine output). He was transferred to ICU, however despite all treatment, the patient died the next day. |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | Upon review, the pathology taken in ED, showed a high white cell count and elevated lactate of 8. If these results had been reviewed and acted upon, sepsis pathway management would have been indicated.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The patient suffered serious harm that led to death following a missed assessment/diagnostic opportunity. |
| Clinical procedure | Psychological harm, delayed diagnosis | A 57-year-old patient developed prolonged psychological harm because of an emergency department interaction and delayed clinical diagnosis.<br>A male patient presented to an emergency department with chest pain, dizziness, and slurred speech. His medical history was noted to include poorly managed diabetes, smoking and alcohol consumption. The patient explained that he had not been drinking prior to presentation, however the admitting physician thought he appeared intoxicated and that he had associated symptoms. The patient was discharged with no further follow up.<br>He was reviewed the following day by his GP and further investigation showed he had suffered a myocardial infarction. The patient required admission and a surgical procedure.<br>He subsequently developed long term distress as a result of the emergency department interaction and delayed diagnosis and required ongoing support from a psychologist.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The patient sustained prolonged psychological harm because of an adverse healthcare interaction and delayed clinical diagnosis. |
| Clinical procedure | Mastectomy, prolonged psychological harm, anxiety, surgery | A 36-year-old patient sustained prolonged psychological harm because of an adverse patient safety event.<br>The patient required a surgical mastectomy following a diagnosis of breast cancer. The surgery was initially successful, however, several months later she developed pain in her chest. She became highly anxious, believing the cancer had recurred. Investigation demonstrated a small surgical swab had been retained following the procedure. Although the procedure to remove this was successful, the patient developed long-term anxiety related to the event. She found it highly distressing to return to health services for ongoing care and was unable to return to work due to associated depression.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The patient suffered prolonged psychological harm because of an adverse patient safety event.<br>Although this event involved the unintended retention of a foreign object following surgery, it did not result in serious (physical) harm, and therefore did not fulfil the *ASE category 4 criteria*. |
| Clinical process | Radiology, emergency | A 46-year-old sustained serious harm because of delayed diagnosis of a life limiting condition. |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | department, follow-up | The patient was admitted to ED following a car accident with acute abdominal pain. CT scans of his chest and abdomen showed a suspicious liver lesion. Radiology phoned the emergency medical team to highlight the finding and recommend further investigation. This recommendation was documented by the emergency medical officer who received the radiology call while the patient was being transferred to the ward for admission. The patient was discharged two days later when his pain had improved. The abnormal CT result was not reviewed again, and no further referral or investigations were ordered. The patient re-presented 6 months later with advanced and metastasised liver cancer.<br>**Should this be notified as a sentinel event?**<br>**Yes**. A clinical process failure led to delayed appropriate and urgent follow up likely contributing to serious harm.<br>If the medical team had made the surgery referral but the delay to clinical review was related to an administrative error, the sentinel event would be notified in *Subcategory 5 - Communication of clinical information*. |
| Clinical process | Anaphylaxis, surgery, medication error | A 32-year-old patient required cardiopulmonary resuscitation (CPR) and ICU admission following an anaphylactic reaction during surgery.<br>The patient required a laparotomy for management of ulcerative colitis. During the procedure, they were given Amoxil antibiotic prophylaxis. The patient became profoundly haemodynamically unstable and required CPR. The staff quickly recognised this as anaphylaxis and treated the patient promptly. The patient was stabilised and transferred to ICU for ongoing care.<br>The health service completed a review after the adverse event. All pre-operative screening and assessment had been completed appropriately and had not identified any known drug allergies. Anaphylaxis management was recognised and managed appropriately.<br>**Should this be notified as a sentinel event?**<br>**No.** Appropriate pre-operative screening and assessment took place and would not have reasonably been able to identify a new drug allergy. Recognition and response to patient deterioration was timely and appropriate.<br>If the patient's allergy had been known pre-operatively, and administration of the medication occurred resulting in anaphylaxis requiring lifesaving treatment, the event would be notifiable as a *Category 7 – Medication Error sentinel event*. |
| **Subcategory 2 – Falls** | | |
| | Residential aged care facility, cerebral bleed | An 88-year-old died as a direct result of a fall.<br>The resident fell in a public health service residential aged care facility, sustaining a head laceration and becoming confused. She was diagnosed with cerebral bleeding and after a family meeting, it was decided not to proceed with lifesaving surgical intervention. She was palliated and died 12 |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | hours after the fall. Review of her clinical record indicated her falls risk assessment was not completed in line with the organisation's procedure.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The patient suffered serious harm that led to death from a fall without an up-to-date falls risk assessment. |
| | Hip fracture, chronic co-morbidities, underlying medical condition, palliation | A 56-year-old patient with complex medical history died 3 weeks following an inpatient fall.<br>The patient was in declining health with a chronic and complex medical history and fell while ambulating to the toilet. They sustained a fractured hip, which required transfer to a larger health service for surgery. The patient's advanced care directive stated a wish for no surgical intervention. The patient was provided with comfort care and died 3 weeks later.<br>Review of the event noted that falls risk assessment was up-to-date and appropriate falls prevention strategies were in place. Although the patient was noted as a falls risk, decisions regarding his mobility had been made in line with his agreed 'dignity of risk'.<br>**Should this be notified as a sentinel event?**<br>**No.** Although the fall resulted in harm to the patient, a contemporary falls risk assessment had been completed and appropriate prevention strategies in place. The patient mobilised in line with agreed dignity of risk. |
| | Residential aged care facility, palliation | An 81-year-old died following surgical repair of a fractured hip.<br>An aged care facility resident with multiple complex co-morbidities was walking with a frame and 2 nurses (in line with an up-to-date falls risk assessment) when she unexpectedly fell. Following the fall, she complained of significant pain in the hip and was transferred to a tertiary service where a fracture was diagnosed. Treatment options were presented to the patient and their family. A decision was made to proceed to surgery for palliative pain management. The high surgical risks were explained, and the patient and family provided surgical consent. Post-operatively, the patient deteriorated, conservative efforts were made to stabilise the patient, but as identified pre-operatively and secondary to their co-morbidities, they continued to deteriorate and died in the days following the surgery.<br>**Should this be notified as a sentinel event?**<br>**No**. Although the fall resulted in serious harm and ultimately death, the resident's care was in-line with an appropriate falls risk management plan. |
| | Fall, slipping, environmental | A 61-year-old patient sustained serious harm after slipping on a wet hospital floor.<br>A female patient was admitted to hospital for gynaecological surgery. The following morning, she slipped on water which had been spilt on the floor. The fall resulted in a severe spinal fracture. Despite a prolonged period of |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | rehabilitation, the patient was unable to return to independent living in her own home and required ongoing care in a residential care facility.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The fall resulted in serious harm to the patient (long term physical harm and loss of function) and meant she was unable to return to her previous independent living arrangement. |
| **Subcategory 3 – Deteriorating patients** | | |
| Recognition | Ambulance, recognition, deterioration | Death of a 45-year-old man associated with delayed clinical recognition and diagnosis.<br>The patient's family called an ambulance service after noticing his slurred speech, inability to move his left arm and incontinence. The patient had a history of heavy drinking and drug use. An ambulance attended, the patient was assessed and informed that transport to hospital may not be required. The patient and his family decided to stay at home. The next day, the patient was found unconscious in bed by his family and another ambulance was called. The patient suffered a respiratory arrest on the way to hospital and died.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm that led to death after a delay to recognise his clinical deterioration at the initial ambulance attendance |
| Recognition, escalation | Surgery, compartment syndrome, observations, deterioration | A 23-year-old man sustained serious harm and long-term loss of function from delayed recognition and escalation of clinical deterioration.<br>The man had lower limb orthopaedic surgery and commenced patient-controlled analgesia (PCA) for pain relief post-operatively. Despite appropriately using the analgesia, his leg pain significantly worsened overnight. Staff did not review his foot, perform neurovascular observations, or escalate concerns regarding poorly controlled pain. The following morning, he was diagnosed with compartment syndrome. He required extensive surgery and prolonged hospital admission. Persistent neurological impairment meant he was unable to return to usual employment or sports.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm because of delayed recognition and escalation of clinical deterioration. |
| Monitoring | Neurology, intracerebral haemorrhage, observation | A 36-year-old woman died from a catastrophic intracerebral bleed.<br>She presented to an emergency department with a moderate left sided headache. The patient was appropriately triaged, assessed and referred to a neurologist. While waiting for review she rapidly deteriorated and became unresponsive. A brain CT demonstrated a large, spontaneous intracerebral haemorrhage which was not deemed survivable. The patient was palliated, and she died soon after. Subsequent case review identified that a single set of neurovascular observations was not completed by nursing staff. |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | **Should this be notified as a sentinel event?**<br>**No.** The patient suffered a catastrophic medical event. Although there was a gap in care delivery, this was not deemed to have meaningfully contributed to the patient's death. |
| Escalation | Surgery, MET, dialysis, deterioration | A 67-year-old woman died after delayed recognition and escalation of clinical deterioration.<br>The woman returned to a hospital ward after a significant surgical procedure. Two hours later her blood pressure was noted to be decreasing and her heart rate increasing. These changes were attributed to the anaesthetic. Despite the patient's condition meeting Medical Emergency Team (MET) call criteria, no escalation was made. Six hours after returning to the ward the patient became unconscious and required urgent transfer to the Intensive Care Unit (ICU). She was placed on life support but suffered permanent kidney damage, which necessitated ongoing dialysis and later a kidney transplant.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious and permanent harm due to a delay to escalate deterioration of her clinical condition. |
| Escalation | HITH, community, vascular, delayed diagnosis, ischaemia | A 56-year-old female required limb amputation following delayed recognition of limb ischaemia.<br>The patient was discharged to hospital in the home (HITH) nursing care following a femoral popliteal bypass (vascular surgery) procedure. The patient described foot pain and numbness during the first HITH visit. The following day she reported worsening symptoms, however the attending staff did not escalate these. On the third day, a new staff member attended and noted the limb to be discoloured, cool and pulseless. The patient returned to hospital where she was diagnosed with critical limb ischaemia and subsequently required a limb amputation.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious and permanent harm due to delayed recognition and escalation of her deteriorating clinical condition. |
| Response | Maternity, newborn, antenatal, CTG, perinatal | Death of a newborn baby secondary to inadequate monitoring and delayed response to deterioration.<br>A woman who was 37 weeks pregnant presented in early labour with a history of decreased fetal movements in the 48 hours prior. A fetal heart rate monitor was applied and after 2 hours, the trace was interpreted as abnormal. At the time, the activity in the maternity unit was high, with many patients requiring care. The midwifery staff escalated the abnormal trace. The fetal heart rate monitoring continued, but there was a period of loss of contact, making the trace difficult to interpret. A fetal scalp electrode was applied for more accurate monitoring, but this took some time. Five hours after escalation of the abnormal trace there was a prolonged fetal bradycardia. An |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | emergency caesarean was performed, and the baby was born pale and not responsive. The baby could not be resuscitated and died.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered death due to a delay in the response to an escalation of concern regarding clinical deterioration. |
| **Subcategory 4 – Self harm** | | |
| Self-Harm | Palliation, self-harm | An 83-year-old consumer died on a medical ward from intentional self-harm.<br>The consumer had been diagnosed with advanced cancer. After a family meeting, the decision was made to provide palliative care. He was transferred to a palliative care ward. A few days after this decision, the consumer was found unconscious on the ward on the bathroom floor with a dressing gown belt around her neck. Resuscitation attempts were unsuccessful, and the patient died.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The consumer died by suicide on a medical ward of an acute health service. |
| Self-Harm | Voluntary admission, emergency department, community, self-harm | A 26-year-old woman died by self-harm after leaving emergency department against medical advice.<br>A consumer voluntarily presented to an emergency department with suicidal ideation. An emergency mental health clinician and a member of the psychiatry medical team reviewed her. A plan was made for a voluntary in-patient admission. Whilst in the emergency department, observations were completed infrequently, and increased agitation was unrecognised. Following an extended stay in the emergency department, the consumer left without telling staff and was found later that day deceased in the community because of self-harm.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient died by suicide in the community associated with unrecognised agitation secondary to incomplete clinical observation. |
| Self-Harm | Self-harm risk, mental health outreach, suicidal ideation, community death, unrecognised deterioration, escalation | A 38-year-old man died in the community by self-harm associated with failure to escalate deterioration.<br>The man was discharged from a health service after a week-long inpatient mental health admission where he was deemed to be moderate self-harm risk. Community care from the health service outreach team was arranged. The client rang the mental health outreach team 3 times on the day following his discharge from hospital to report worsening suicidal ideation. There was no escalation of care, and the client was found the following day deceased because of self-harm.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The client died by suicide in the community associated with unrecognised deterioration and failure to escalate. |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| Self-Harm | Emergency department, mental health assessment order, self-harm | Self-harm death of a 54-year-old who left an emergency department while admitted under the mental health act.<br>A consumer presented to the emergency department with an acute mental health illness, intoxicated and expressing a plan to self-harm. It was decided to apply a Mental Health Assessment Order and admit the consumer to an acute mental health bed. While waiting for the mental health bed, the consumer left the emergency department. Police notified the health service 24 hours later that the consumer had died after jumping from a height.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The consumer took his own life after leaving an emergency department while on a Mental Health Act order. |
| Self-Harm | Acute mental health in-patient, self-harm, serious harm | Serious self-harm sustained by a 19-year-old voluntary inpatient acute mental health consumer whilst on day leave.<br>A consumer was on approved day leave from an acute mental health inpatient unit and was found hanged and unresponsive. The consumer was revived by ambulance services and transferred to an intensive care unit. The patient sustained a permanent brain injury and required ongoing personal care.<br>**Should this be notified as a sentinel event?**<br>**Yes.** This adverse event resulted in serious harm of an acute mental health unit in-patient on day leave. |
| Deterioration, recognition | Emergency department, delirium, deterioration | Death of an 84-year-old associated with unrecognised deterioration.<br>An elderly patient presented to emergency department with acute delirium secondary to a urinary tract infection. Whilst in the emergency department, his confusion worsened, and he was scheduled for hourly neurological observations and 1:1 nursing. Despite the appropriate staffing, the observations were not completed. The patient left the emergency department while staff attended to a clinical emergency. He was struck by a car and died while wandering on a street nearby.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm while in the care of a health service, however the death was not a result of intentional self-harm. This event should be reported under *category 11 – Deteriorating patient*. |
| **Subcategory 5 – Clinical communication** | | |
| | Administration, delayed appointment | A 56-year-old woman died after delayed diagnosis of a terminal condition due to an administrative error.<br>The woman was referred to an outpatient department to investigate bleeding and a change in bowel habit. The referral was triaged and given a category 1 for an urgent colonoscopy to investigate symptoms (within 30 days). |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | However, no appointment was made due to an administrative error in processing the referral. Twelve months later she was diagnosed with advanced colon cancer. She died several weeks later.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm that resulted in death following an administrative delay that prevented timely care. |
| **Subcategory 6 - Medical device or equipment** | | |
| Medical device | Cardiac catheter laboratory, guide wire, procedure | A 48-year-old woman died following a complication associated with failure of surgical apparatus.<br>The woman had a percutaneous coronary intervention (PCI) for an acute myocardial infarction in a cardiac catheter laboratory. Upon retrieval of the guide wire used during PCI, the wire snapped and became lodged in the vessel. Before the patient could be transferred to a larger hospital for surgery to retrieve the guide wire, her condition deteriorated. She suffered cardiac arrest and died.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm that resulted in death following the malfunction of the guide wire. |
| Equipment | Ventilator, intensive care unit, alarm failure | A 24yr old female died because of ventilator malfunction.<br>The patient was transported on a ventilator from the intensive care unit to radiology. Whilst undergoing an MRI scan, the ventilator experienced a malfunction which caused a complete power failure. As the accompanying staff members were located outside the MRI room, they did not identify the ventilator failure until the monitoring started alarming and the patient was in cardiorespiratory arrest. The patient was unable to be resuscitated and died.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The patient suffered serious harm that resulted in death following the malfunction of a ventilator. |
| Equipment | Cardiac monitor, cardiac arrest | Death of a 76-year-old man associated with malfunctioning cardiac monitor.<br>The man was admitted to a coronary care ward for monitoring of cardiac function. The cardiac monitor failed to identify the patient going into ventricular tachycardia. He suffered a cardiac arrest and died.<br>**Should this be notified as a sentinel event?**<br>**Yes**. The patient suffered serious harm that resulted in death following the malfunction of a cardiac monitor. |
| **Subcategory 7 – Nutrition** | | |
| | Diet, speech therapy, aspiration | A 79-year-old resident died following eating the incorrect diet.<br>The man had been living in a public sector residential aged care facility for 2 years. In recent months, his ability to swallow had declined. After a speech |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | therapy assessment, the decision was made to start a vitamised and thickened fluid diet. Sometime after this assessment, a full diet was erroneously delivered to his room. The resident was assisted with feeding and, after eating a piece of roast meat, he started coughing, experienced facial colour changes and collapsed in the chair. The resident had a not-for-resuscitation order and advanced care directive in place, and no resuscitation measures were commenced.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm (choking) that led to death due to the provision of the incorrect meal. |
| | Swallowing assessment, thickened fluids | A 92-year-old woman died from aspiration pneumonia after a choking episode.<br>The woman had a swallowing assessment after being admitted to a health service with general decline. The assessment recommended a vitamised diet and thickened fluids, stating supervision was required for all meals.<br>During lunch, she began coughing on the vitamised vegetables. The supervising staff immediately removed her meal. Overnight she developed a fever and had an increased respiratory rate. The patient and family had an advanced care directive, and the patient wanted no further medical intervention. She died 3 days later from aspiration pneumonia.<br>**Should this be notified as a sentinel event?**<br>**No.** The patient had received a risk assessment and appropriate risk mitigation strategies were in place. |
| | Food allergy, anaphylaxis | A 6-year-old girl required lifesaving medical care following anaphylactic reaction to a known food allergy.<br>She was admitted for a minor surgical procedure. Despite an alert in her medical record and wearing a wrist band denoting an allergy to seafood, she was given a meal containing fish. The girl developed an anaphylactic reaction and required intubation and brief care in the intensive care unit. She made a full recovery.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm requiring lifesaving medical care because of anaphylaxis to a known allergen. |
| **Subcategory 8 – Resource or organisational management** | | |
| Organisation management | Post-surgery haemorrhage, surgical waiting list, organisation management | A 48-year-old woman died while waiting for surgery, which was delayed due to organisation demand.<br>The woman had undergone abdominal surgery in hospital. After the surgery, her condition deteriorated. She was assessed and a decision was made to return to surgery for further exploration of suspected internal bleeding. She |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | was placed on the waiting list for emergency surgery behind 3 other patients. While waiting for surgery, she suffered a cardiac arrest and died.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm (cardiac arrest) that led to her death due to a lack of availability of operating theatres. |
| Resource management | Stroke, hypertension, procedure, guideline | A 59-year-old man died after care that was not delivered in line with health service guidance.<br>The patient had a stroke while in hospital. It was decided to administer medication (thrombolytic) to treat the stroke and the thrombolysis guideline was followed. However, the thrombolysis guideline did not include advice on how to treat the patient's high blood pressure, which continued to increase. The patient's condition deteriorated further, resulting in a cardiac arrest and death. During a review of the case, the health service discovered the management of high blood pressure when administering thrombolytics was outlined in the stroke guideline, but a different guideline had been used which did not include this information.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm that led to death due to the failure to access the appropriate guidelines. |
| Organisation management | Colonoscopy, short staffed, wait-list, prioritisation, organisation management | A 52-year-old woman was diagnosed with advanced, terminal cancer after delayed investigation due to health service resource management.<br>The patient had been referred to a health service with bleeding from her bowel. Given her history, her referral was classified as urgent. Whilst awaiting the procedure, key health service employees resigned, and the health service was unable to offer colonoscopies. Alternate arrangements were not coordinated for patients waiting. The patient received her colonoscopy 8 months later and was found to have inoperable metastatic bowel cancer. The delay to colonoscopy was deemed to have likely impacted her prognosis.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm associated with delayed access to appropriate investigation due to health service resource management. |
| **Subcategory 9 – Healthcare associated infection** | | |
| HAI | Peripheral intravenous catheter, infection, healthcare associated infection, HAI | A 56-year-old man died after developing an intravenous catheter infection.<br>The man had a peripheral intravenous cannula inserted on admission to hospital. Seven days after the insertion the area around the cannula was painful, red, and inflamed. The cannula was removed, and the patient was discharged home with oral antibiotics and instructions to follow up with his general practitioner within 5-7 days. Two days after his discharge, the patient's partner was unable to wake him in the morning and called an |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | ambulance. Soon after arrival at the hospital emergency department he suffered a cardiac arrest and died.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient died because of an infection associated with the peripheral intravenous cannula inserted while he was in hospital. |
| HAI | Virus, varicella, healthcare associated infection, HAI | Death of a 67-year-old patient secondary to healthcare associated virus.<br>The patient was admitted to a medical ward. While on the ward, there was an outbreak of chicken pox. The outbreak was not controlled in line with expected health service protocol. The patient acquired chicken pox as a result of the uncontrolled outbreak and subsequently developed varicella pneumonia. Despite appropriate care, his condition worsened, and he subsequently died as a result.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient died because of a healthcare associated infection. |
| **Subcategory 10 – Patient accident** | | |
| | Rehabilitation, pressure injury care, suffocation | A 51-year-old patient died due to a health service accident.<br>The patient was admitted to a brain injury rehabilitation unit and was receiving pressure injury care every 4 hours. Pillows and rolled blankets were used to maintain patient's position. After several hours, the patient was found unconscious, trapped in the bedside rails. Resuscitation attempts were unsuccessful, and the patient died.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient died because of entrapment in the bedside rails. |
| | Acquired brain injury, hydrotherapy, drowning | A 13-year-old boy died due to a health service accident.<br>The boy had an acquired brain injury and was participating in a physiotherapy hydrotherapy class. The attending physiotherapist left the boy unsupervised to attend to an emergency at the opposite end of the pool. Upon returning, the boy was found submerged and unresponsive. Despite resuscitation attempts, the boy could not be revived, and he died.<br>**Should this be notified as a sentinel event?**<br>**Yes.** The patient suffered serious harm that resulted in death because of a patient accident (drowning). |
| | Operating theatre fire, burn | A 47-year-old woman sustained serious harm secondary to a theatre fire.<br>The patient presented for abdominal surgery. Alcohol preparation was used to clean and disinfect the surgical field. Theatre staff did not wait for the alcohol solution to dry before commencing the procedure. Diathermy (high-frequency electrical currents to produce heat and either make incisions or induce coagulation) was used in the surgical field, causing the alcohol solution to ignite. The patient sustained second-degree burns. |

| Theme | Keyword (descriptors) | Case study description |
|---|---|---|
| | | **Should this be notified as a sentinel event?**<br>**Yes.** The patient sustained serious and potentially permanent harm from an accidental surgical burn whilst in the care of a health service |

Safer Care Victoria