Sentinel events

Since 2004, some serious events/incidents have been designated as Sentinel events by all Health Ministers across Australia (Appendix 2). These must be reported by all health services and are SAC1.

The National list of Sentinel Events was revised in 2018, and is:

- Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
- Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
- Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
- Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
- Medication error resulting in serious harm or death
- Use of physical or mechanical restraint resulting in serious harm or death (NEW)
- Discharge or release of an infant or child to an unauthorised person
- Use of an incorrectly positioned oro- or nasogastric tube resulting in serious harm or death (NEW)

As of 1 July 2019 this list will be adopted in SA Health. Please see Appendix 1 for full definitions and Appendix 2 for the previous Sentinel Events list.

Reporting into Safety Learning System (SLS)

The SLS has been amended to include appropriate classifications for all of these, and help text to guide staff. Appendix 1 includes the recommended classification for each Sentinel Event.

The notifier reports the incident within 24 hours or as soon as practicable, assigning a SAC1 rating if they or the manager suspects that it is a Sentinel Event.

The Incident Manager for the incident reviews the notifier’s information and contacts their Safety and Quality/Clinical Governance Units.

Note that some preliminary investigation may be required to confirm if the incident meets the definition of a sentinel event. After investigation, if it is found to not be a Sentinel event the incident can be re-classified.

The automatic SLS email generated from reporting the incident will alert senior staff, Safety and Quality/Clinical Governance of the incident.
Within 24 hours or sooner, the Safety and Quality/Clinical Governance/Risk Manager must:

- Confirm the incident is a sentinel event assigning it a mandatory SAC 1 and selecting the appropriate Sentinel Event definition from the dropdown list on the Structured Review Tab (formerly known as the SAC 1 and SAC 2 Investigation Panel) of the incident.
- Complete a Clinical Information Briefing (CIB) for the CE of SA Health and upload into SLS as a Level 1 secure document.
- Email HealthSentinelEvents@sa.gov.au, to advise the DHW Safety and Quality Unit that a Sentinel Event has occurred. Advice can be provided about further notifications and the correct conduct of appropriate investigations.

**Investigation**

These incidents frequently require ‘formal’ investigation and analysis by a Root Cause Analysis (RCA) or Part 7 review. These reviews are authorised by the designated authority in Local Health Network’s (LHN), Statewide Services or SA Ambulance Service (SAAS). Recommendations arising from any RCA are described in Reports 1 and 2. These are uploaded into the documents tab as a Level 1 secure documents.

**Open Disclosure**

Ensure that Level One Open Disclosure is conducted and noted in SLS. This includes advising the consumer/family if they have any concerns to lodge a complaint via the Consumer Liaison Officer.

Link any consumer feedback to the patient incident using the Linked records function.

**Additional reporting that may be required**

Use the Linked records function in the SLS to connect additional reporting and investigations for that incident (see below).

**Coroners Notification:**

- If the Sentinel Event meets the definition of a Coroners reportable death (Coroner’s Act 2003) the following must occur:
  - The Medical Officer reports the death to the Coroner’s office.
  - Safety and Quality /Clinical Governance / Risk Manager enter the coronial notification into the SLS Notifications module and assist in managing any subsequent coronial processes.

**Professional Indemnity Notification - Notifications Module (formerly known as Medical Malpractice)**

A report to other third party, for example AHPRA, NDIS, and/or Commonwealth Aged Care.

**Further information is available:**

- Safety Learning system (SLS) Guide - [How to Report a patient incident](#)
- Safety Learning system (SLS) Guide - [How to Manage a patient incident](#)
- Root Cause Analysis
- Coronial Notifications
- Coronial process and the Coroners Act 2003
- Part 7 Committees

For more information
APPENDIX 1.

For most classifications there will be a pop up alert or additional information to remind the notifier and the manager in the case of serious harm or death that the incident is a SAC1 and to contact their Clinical Risk Manager or Safety and Quality.

<table>
<thead>
<tr>
<th>2018 Sentinel Event Definitions</th>
<th>Classification guide for reporting the incident within the Patient Incident Module of SLS (Levels 1, 2, and 3)</th>
</tr>
</thead>
</table>
| Surgery or other invasive procedure* performed on the wrong site resulting in serious harm** or death | 1. Treatment/procedure  
2. Connected with the management of operations/treatment  
3. Wrong body part /side/site |
| Surgery or other invasive procedure* performed on the wrong patient resulting in serious harm** or death | 1. Treatment/procedure  
2. Connected with the management of operations/treatment  
3. Patient incorrectly identified |
| Wrong Surgery or other invasive procedure* performed on a patient resulting in serious harm** or death | 1. Treatment/procedure  
2. Connected with the management of operations/treatment  
3. Treatment/procedure inappropriate/wrong |
| Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward***       | 1. Challenging Behaviour  
2. Self-harm  
3. Suicide (completed ) in inpatient facility, whether proven or suspected |
| Unintended retention of a foreign object in a patient after surgery or other invasive procedure* resulting in serious harm** or death | 1. Treatment, procedure  
2. Connected with the management of operations/treatment  
3. Retained needle/swab/instrument |
| Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm** or death | 1. Treatment, procedure  
2. Transfusion related incident/event  
3. Adverse reaction to blood product |
| Medication error resulting in serious harm** or death                                          | 1. Medication  
2. Select most relevant classification  
3. Select most relevant classification |
| Discharge or release of an infant or child to an unauthorised person                            | 1. Access, Appointment, Admission, Transfer, Discharge  
2. Discharge  
3. Discharge or release of an infant or child to an unauthorised person ( NEW) |
<table>
<thead>
<tr>
<th>a person who is the subject of a legal order preventing access to the infant or child.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of physical or mechanical restraint resulting in serious harm** or death</td>
</tr>
<tr>
<td>Physical restraint means the bodily force that controls a person’s freedom of movement</td>
</tr>
<tr>
<td>Mechanical restraint means a device that controls a person’s freedom of movement</td>
</tr>
<tr>
<td>1. Restraint /Seclusion</td>
</tr>
<tr>
<td>2. Physical restraint</td>
</tr>
<tr>
<td>3. Physical restraint</td>
</tr>
<tr>
<td>Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm** or death</td>
</tr>
<tr>
<td>1. Treatment, procedure</td>
</tr>
<tr>
<td>2. Upper digestive tract</td>
</tr>
<tr>
<td>3. Incorrect position of oro- or naso-gastric tube (NEW)</td>
</tr>
<tr>
<td>There are 2 additional questions that are proposed to appear if the level 3 classification is selected. They are:</td>
</tr>
<tr>
<td>• Was there delay / failure to order a check x-ray?</td>
</tr>
<tr>
<td>• Was there delay / failure to review results of the check xray?</td>
</tr>
</tbody>
</table>

**Invasive procedure**: A medical procedure that enters the body, usually by cutting or puncturing the skin or by inserting a needle, tube, device or scope into the body.

**Serious Harm**: As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long term physical harm or loss of function.

***Acute psychiatric unit or acute psychiatric ward**: A specialised unit or ward that is dedicated to the treatment and care of admitted patients with mental illness or mental disorder. This includes specialist psychiatric units or psychiatric wards within emergency departments where all three of the following criteria apply:

1. The psychiatric unit or psychiatric ward is specifically designed with fixtures and fittings that minimise the opportunity for patient suicide
2. The psychiatric unit or psychiatric ward is specifically designed to prevent any unauthorised ingress or egress
3. Observation protocols are applied within the psychiatric unit or psychiatric ward.

The Office for the Chief Psychiatrist can provide advice re SA Health units or wards.

**APPENDIX 2 – 2004 LIST OF SENTINEL EVENTS**

- Procedures involving the wrong patient or body part resulting in death or major permanent loss of function
- Suicide of a patient in an inpatient unit
- Retained instrument/s or other material after surgery requiring reoperation or further surgical procedure
- Intravascular gas embolism resulting in death or neurological damage
- Haemolytic blood transfusion reaction resulting from ABO incompatibility
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
- Maternal death associated with pregnancy, birth and the puerperium
- Discharge of an infant to the wrong family

For Official Use Only: I1_A1