City Health
Day Hospitals

1.10.87 POLICY LIAISON WITH AUTHORITIES IN RELATION TO A SENTINEL EVENT

PURPOSE

The purpose of sentinel event reporting is to ensure public accountability and transparency and drive national improvements in patient safety.

APPLICABILITY

City Health Day Hospital & Procedure Centre Management

Reportable incident

For the purpose of the definition of ***reportable incident*** *in section 41 of the Act, Appendix D of the document entitled Ministry of Health Policy Directive PD2014_004 Incident Management Policy, as published in the Gazette on 24 January 2014, is adopted.*

DEFINITION

Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient.

The purpose of sentinel event reporting is to ensure public accountability and transparency and drive national improvements in patient safety,

Criteria

An incident must also satisfy the following criteria in order to be classified as a sentinel event:

- The event should not have occurred where preventive barriers are available
- The event is easily recognised and clearly defined
- There is evidence the event has occurred in the past.

Serious harm is indicated where as a result of the incident the patient:

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

Sentinel events will be considered 'wholly preventable' in the context of preventive barriers being available to facilitate prevention.

- Preventive barriers may include: The National Safety and Quality Health Service (NSQHS) Standards (second edition), policy documents or clinical protocols; or documents providing safety guidance, safety recommendations or both on how the event can be prevented.

EXAMPLES OF SENTINEL EVENTS:

- Delivery of a medication, that causes death of a patient or resulted in shortened life expectancy, permanent or long-term physical harm or loss of function
- As a result of the medication error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, wrong route of administration, or known allergy, the patient dies, or has shortened life expectancy, or has experienced permanent or long-term physical harm or loss of function

Sentinel events may include death or injury that occurs following the patient's discharge from City Health Day Hospitals or Procedure Centres.

SENTINEL EVENTS APPLICABLE TO CITY HEALTH

The Australian Commission on Safety and Quality in Health Care list the following Sentinel events relevant to Day Surgery Hospital:

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. Medication error resulting in serious harm or death
6. Use of physical or mechanical restraint resulting in serious harm or death
7. Discharge or release of an infant or child to an unauthorised person
8. Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death

PROCESS & RECORD KEEPING

In the occurrence of a sentinel event relating to a patient treated at City Health, the police, Department of Health and/or coroner may contact the hospital to obtain further information.

Only designated, trained spokespersons may communicate with these authorities on behalf of the organisation. Designated spokespersons include the Medical Director, General Manager and the Director of Nursing (DON). These people also have the authority to approve additional spokespersons, as required.

Any staff member who receive notification that information relating to a sentinel event is required, must immediately notify the Director of Nursing and must follow any instructions provided by the DON. This staff member must also ensure that an incident has been entered into RiskClear.

The Director of Nursing must:

1. Co-ordinate the provision of any information legitimately requested by the authorities
2. Contact the General Manager, Chief Executive Officer, and / or Chief Operating Officer

- NSW - If a reportable incident occurs in a private health facility in NSW, **the licensee** must notify the Secretary of that fact no later than 2 working days after the day of the incident.
- VIC - If a reportable incident occurs in Victoria, it is the duty of the MAC to report to Safer Care Victoria no later than 2 working days after the day of the incident.
- QLD - If a reportable incident occurs in a private health facility in QLD, **the licensee** must notify the Department of Health of that fact no later than 2 working days after the day of the incident.

- A **root cause analysis team** that is appointed must provide an incident report no later than 70 calendar days after the day of the incident.

NOTIFICATION TO PATIENT

Open Disclosure as early as possible after the event, the day hospital should share with the patient and/or their family or carer what is known about the event and what actions have been taken to immediately mitigate or remediate the harm to the patient. An expression of apology or regret can be extended at that time.

OTHER REPORTABLE EVENTS

An incident with *Major clinical consequences* which involves a day hospital patient:

- Suffering a major permanent loss of function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management;
- Suffering significant disfigurement as a result of the incident;

Corporate Incidents, such as:

- Fire, bomb or other threatening activities in the health facility
- Critical equipment breakdown or failure
- Serious threats affecting the facility's operation
- Complete loss of service i.e. power or water failure
- Criminal activity in or related to the workplace
- Non-accreditation of service provider

REFERENCES

1. https://www.safetyandquality.gov.au/our-work/indicators/australian-sentinel-events-list
2. https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_034.pdf Appendix D
3. Incident Management Policy PD2019_034 https://www.health.nsw.gov.au
4. ACSQHC TRIM: D18-36578 (2018): Australian sentinel events list (version 2)
5. Safer Care Victoria: https://www.dhhs.vic.gov.au/safer-care-victoria
6. Victorian Sentinel Event Guide: https://www.bettersafercare.vic.gov.au/sites/default/files/2019-06/Victorian%20sentinel%20events%20guide_0.pdf