

Lessons learnt from three years of sentinel events reporting

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Objective:

The Victorian sentinel event program's primary aim is to build a culture of learning within health services to ensure a safer environment for patients by decreasing the occurrence of serious adverse events. The system promotes self-reporting of errors and encourages analysis of the underlying causes. The Department of Human Services (DHS) disseminates information learned from sentinel events and how they can be prevented. All information DHS receives is de-identified to preserve the privacy of patients, practitioners and the organisation. The program has now released three public reports on sentinel events.

A sentinel event is defined as "...relatively infrequent, clear-cut event that occurs independently of a patient's condition; commonly reflects hospital system and process deficiencies; and results in unnecessary outcomes for the patient."

Results:

Classification of event	Frequency		
	2002-03	2003-04	2004-05
Procedure involving the wrong patient or body part	16	14	24
Suicide in an inpatient unit	5	1	4
Retained instruments or other material after surgery requiring re-operation or further surgical procedure	9	8	5
Haemolytic blood transfusion reaction resulting from ABO incompatibility	0	1	1
Medication error leading to the death of patient reasonably believed to be due to the incorrect administration of drugs	0	4	1
Maternal death or serious morbidity associated with labour or delivery	4	2	9
Infant discharged to wrong family	0	0	0
Intravascular gas embolism resulting in death or neurological damage	0	0	0
Other catastrophic event	42	55	78
Total	79	85	122

Analyses of the contributing factors in sentinel events reported is conducted using a modified *Joint Commission on Accreditation of Health Care Organizations root cause analysis matrix*. Examples of factors that contributed to the occurrence of sentinel events include procedures/guidelines, communication, human resources, health information, equipment, and physical resources.

Conclusion:

Three years into this process, it is apparent that the pure numbers of sentinel events have no great relevance to the process, the strength of the sentinel event program, now into its fourth operational year, is a direct result of collaboration between the government, health services, clinicians and consumers striving to continually improve care delivery for patients.

As yet there is no evidence of a reduction in occurrence of sentinel events, however success is evident through the learning from the program and its wide acceptance across the sector.

The annual report provides a breakdown of the data analysis from the reporting and provides a range of case studies to promote shared learning. In addition, a monthly newsletter is distributed widely providing a case review.