Safer Care Victoria

March 2022

Supporting patient safety: learning from sentinel events

Executive summary 2020-21

OFFICIAL

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Foreword

The coronavirus (COVID-19) pandemic continues to test our health system's capacity. I am proud of the Victorian community for striving to learn and improve from adverse events. Even when our healthcare system faces extraordinary challenges, our health services and clinicians continue to put patient safety first. This annual report details the sentinel events notified to us in 2020-21, their review findings and the actions to implement recommended improvements.

Between July 2020 and June 2021, **168** sentinel events were notified to us. These are incidents where serious harm or death occurred and where a safety issue was raised. This is a drop from last year's 186 notifications. We have also seen fewer notifications of Victorian Health Incident Management System (VHIMS) incidents recording severe patient harm or loss of life – the highest incident severity rating (ISR 1).

As Safer Care Victoria (SCV) shifted to remote working, we connected with quality and safety leaders in new and dynamic ways to provide one-on-one support through virtual meetings using Microsoft Teams. Our patient safety review training was resumed after a brief pause, and 331 health professionals and 14 consumer representatives attended training from metropolitan, regional and rural health services across Victoria.

In 2022, we have a new sentinel event reporting system – the **sentinel events portal**. This portal securely stores all sentinel event documentation in one location and will strengthen how we report sentinel events annually. We are excited to continue key sentinel event projects in the coming financial year, including:

- sentinel events monthly drop-in sessions to enable health services across the state to engage with the program and their peer groups virtually
- supporting consumer representative recruitment across regional and rural services and connecting peer groups to share resources and expertise
- more adverse event review methodology workshops for health services and consumer representatives – including root cause analysis (RCA) and AcciMap training.

Learning never stops. Not for SCV nor for the Victorian healthcare system. We look forward to working in partnership with all of those who are dedicated to continually improving the quality and safety of health care that is the right of every Victorian.

Professor Mike Roberts
Chief Executive Officer

How to use this report

This report informs the Victorian community about the most serious adverse patient safety events in health services that were notified as sentinel events in 2020-21.

Sentinel events are broadly defined as wholly preventable adverse patient safety events that result in serious harm or death to individuals. All Victorian health services are required to report adverse patient safety events in accordance with the Australian Commission on Safety and Quality in Healthcare (ACSQHC) national sentinel event category list. In addition to the revised national sentinel event category list, all Victorian health services are required to adhere to category 11: All other adverse patient safety events resulting in serious harm or death.

We support health services to undertake reviews of sentinel events. These reviews help identify the factors that contributed to an adverse event and the actions required to prevent them occurring in the future.

You can find further information in relation to sentinel event reviews at our sentinel events webpage.

We hope to provide a report that is accessible to consumers and health services alike. This year we have presented the sentinel event data in a new way – in addition to the full version of the report highlighting the key sentinel event themes and messages for health services to consider, we have published a consumer summary version of the report. We continue to present what we are notified about, what has contributed to these events occurring, and what we have learned. We unpack the work being done to prevent patient harm and provide examples from some Victorian health services that are leading the way in improving patient safety.

To maximise learning and improvement opportunities, we focus on three main themes based on recent royal commissions, and the pandemic:

- mental health
- residential aged care
- COVID-19 and its impacts on pre-admissions and emergency departments.

This report uses medical terms and phrases which may be unfamiliar; definitions can be found in the Terminology guide attached to this report.

Summary of findings[1]

Sentinel event notifications

Between July 2020 and June 2021, **168** sentinel events were notified to us. These are incidents where serious harm or death occurred and where a safety issue was raised. This is a drop from last year's 186 notifications.

Of the **168** sentinel event notifications during 2020-21:

- 11 per cent (19) related to mental health sentinel events
- 8 per cent (14) related to residential aged care
- 13 per cent (22) related to COVID-19.

Review findings

We use RCA as our method of reviewing events to find out what happened, why it happened, and what can be done to improve. Of the 168 reviews undertaken during 2020-21, there were:

- 520 sentinel event review findings
- 498 lessons learned from these events
- 1041 recommendations developed.

Review panels

Sentinel event review panels require at least one consumer representative. Clinicians involved in the sentinel event cannot be on the review panel itself; this would introduce potential bias in the review process. Instead, clinical perspectives and expertise are represented by clinician members of the review team who were not involved in the sentinel event. Similarly, patients and their families cannot be review team members because of the potential for them to bring their own biases; however, the panel should invite them to share their story as part of the review process.

In addition, we include at least one external team member who is independent of the health service. This is vital to ensure sentinel event reviews are robust, fair and unbiased. An independent team member can bring relevant experience from the discipline(s) involved in the sentinel event, ideas about different ways of addressing situations, or management and quality and safety experience.

Of the sentinel event review teams, **47 per cent** had a consumer representative and **91 per cent** had an external independent team member.

[1] Based on the standards set by SCV since taking oversight of the sentinel event program in 2017. More information regarding requirements of health services can be found in the sentinel events guide located at www.bettersafercare.vic.gov.au/publications/sentinel-events-guide

Number of notifications

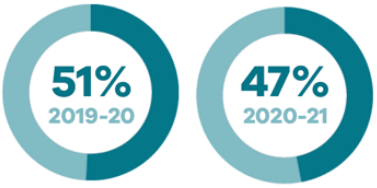
168

2019-20

9% decrease in 2020-21
compared to 2019-20

2020-21

Consumer representatives



47% of review teams
had a consumer representative compared to 51% in 2019-20

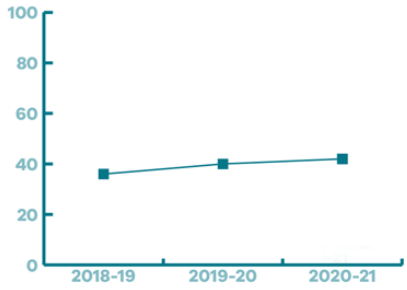
External independent team members

91% of review teams
had an external independent team member

This is a significant increase from 85% in 2019-20

18% of RCAS
included a consumer rep, external member and involved the affected consumer

RCA report part a and b: received within 30 days



42% of reports
were received within 30 days of notification

RCA report part c (recommendations)

73% of reports
were received on time

Reporting: requests for extensions

Decrease in the percentage
of health services requesting an extension on their RCA
from 57% to 54%

520
review findings identified

1041
recommendations developed

A family's perspective

> "The biggest hurt to our family has been inflicted by the clinicians and senior hospital staff we initially dealt with who we feel have not been honest with us, who sought to dissuade us from seeking answers around Eva's management, and who did not do what they had promised."

This quote is from a story about a sentinel event notified to SCV during 2020-21. Eva fell and broke her leg while on holiday in Queensland. Twelve days later, she died.

Eva's family have generously agreed to share what it was like as a family impacted by a sentinel event. Read their story in the full report, located at www.bettersafercare.vic.gov.au/publications/sentinel-events-annual-report-2020-21.

Affected patient/consumer involvement in reviews

> Patients are 'privileged witnesses of health care in the sense that they are at the centre of the treatment process, and, unlike individual clinical staff, they observe almost the whole process of care.'
>
> Vincent, C. and Davis, R. (2012) Patients and families as safety experts, *Canadian Medical Association Journal*, vol. 184, no.1, pp. 15-16

Eva's story is an important reminder that, after an adverse event has occurred, one of the most important stakeholders is the affected consumer.

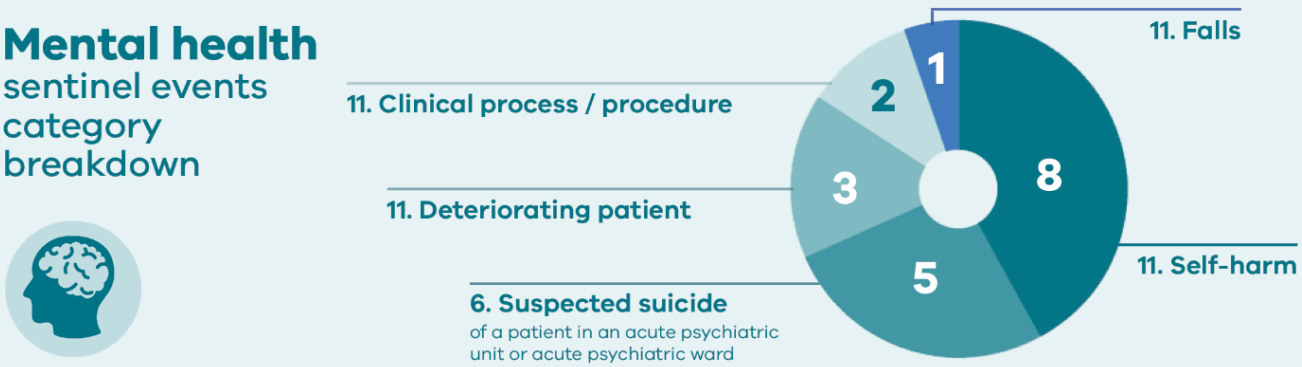
To improve the depth of findings and quality of recommendations from adverse event reviews, SCV is currently developing tools and resources to assist health services to routinely invite input from, and support involvement by, affected consumers in reviews into events that caused them harm.

Check our website for updates regarding when these resources will be available. You can also visit the ACSQHC website at www.safetyandquality.gov.au/our-work/clinical-governance/open-disclosure for their recently released resources.

Mental health sentinel events

Of the 168 sentinel events, **19** (**11 per cent**) were related to mental health. Notable themes emerging from these events related to deficits in appropriate patient-centred or culturally appropriate care, followed by issues around effective engagement with patients and families for their contribution to holistic care plans, including failure to respond when a patient's condition is worsening.

To help services improve the standard of their review analyses and recommendations, all mental health sentinel event reports are reviewed by a committee with representatives from the Office of the Chief Psychiatrist (OCP), SCV, and specialist mental health clinicians from across Victoria. These reviews intend to share lessons learned across the state, as well as give the service access to advice from specialist clinicians about how they have seen similar issues addressed and how to move towards best practice.



Key messages for health services to consider

Twenty-one per cent (4 of 19) of mental health sentinel event reviews found that suicide and self-harm occurred in patients who had been screened as a 'low risk'. This highlights the importance of staff not relying only on the risk assessment, but considering the whole clinical picture, including patient and family input, and identifying and responding to potential stressors. Considering these factors may have potentially led to better patient outcomes.

Insights from the OCP highlight the importance of aligning with best practice guidance issued by SCV, OCP and Chief Mental Health Nurse (CMHN). When health services undertake adverse event reviews with a diverse team, it is important to assess and manage risk factors in practice, as well as improve patient/family engagement in decision-making.

Sentinel events involving residents from aged care services

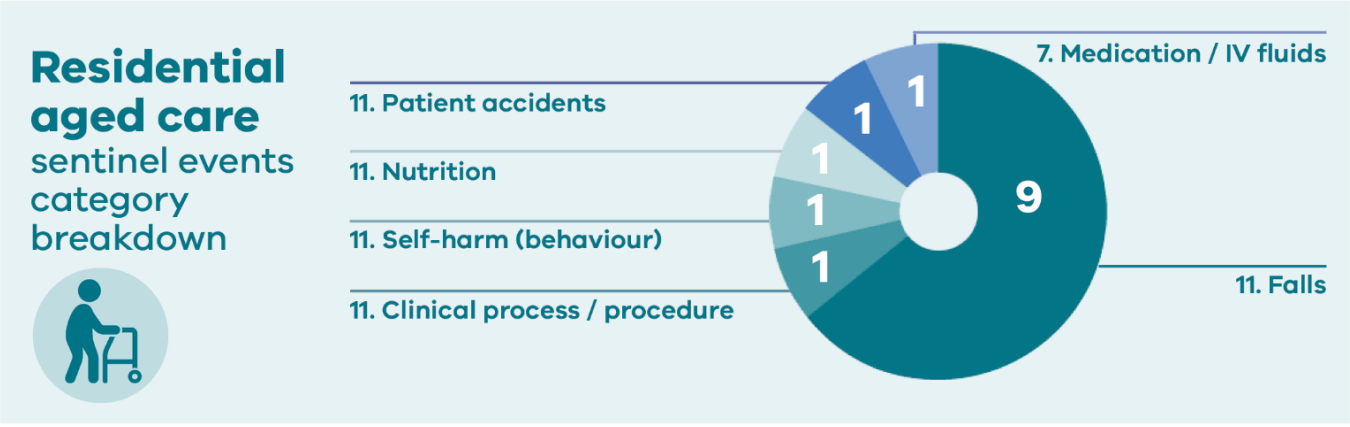
Of the 168 sentinel events, **14** (**eight per cent**) were related to residential aged care. All notified residential aged care sentinel events were from services in regional Victoria. Despite this outcome, it is worth noting that fewer residential aged care services fall under the governance of metropolitan health services.

Among residential aged care sentinel events notified to SCV during the year, the majority involved consumers over the age of 90 years, who fell and were seriously injured while walking and were then provided with palliative care.

There are several pieces of work being undertaken because of the Aged Care Royal Commission to improve outcomes for residential aged care consumers. Links between the Aged Care Royal Commission and sentinel events include:

- dignity of risk
- palliative care
- assessment.

You can find further information about these in the full version of the annual report.

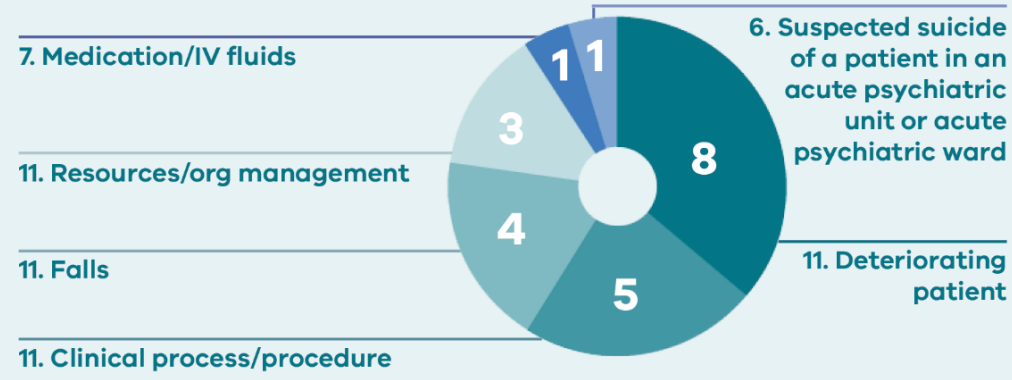


COVID and impacts on the health sector

Of the 168 sentinel events, **22** (**13 per cent**) were related to coronavirus (COVID-19). These events highlighted COVID-19-related impacts as a direct factor. Common findings during sentinel event reviews related to COVID-19 included the following key themes:

- **Visitor restrictions**
  - During much of the COVID-19 pandemic, visitor restrictions were in place across health services in Victoria. This meant support people, such as the patient's family or carer, were not there to assist with communicating the patient's condition to clinicians.
- **Communication**
  - Families contribute critical information that adds completeness to a patient health record. These conversations are as important as those held with members of the clinical team. These conversations and resulting actions must be included in the patient's progress notes to ensure members of the clinical team have access to all information that may inform clinical decision making.
- **New procedure/s delaying care**
  - Patients with suspected COVID-19 required isolation precautions, which may have delayed physical assessment, investigations and treatment.

COVID-19 sentinel events category breakdown



Key message for health services to consider

To reduce impacts on clinical decision-making, pandemic models of care should be reviewed through a lens of identifying safety gaps in COVID-19 workflows, especially during periods of demand surge. This includes the need to ensure the timely physical review of patients, particularly when they are re-presenting to a health service.

All other sentinel events

Of 168 sentinel events, **71 per cent** (**120**) were notified under the following categories:

- **Category 1**: Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death – 1 event
- **Category 4**: Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death – 2 events
- **Category 7**: Medication error resulting in serious harm or death – 15 events
- **Category 10**: Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death – 1 event
- **Category 11**: All other adverse patient safety events resulting in serious harm or death – 101 events
  - Clinical process or procedure – 41 events
  - Falls – 13 events
  - Deteriorating patient – 33 events
  - Medical device or equipment – 2 events
  - Nutrition – one event
  - Resource or organisational management – 3 events
  - Healthcare associated infection – 5 events
  - Patient accidents – 3 events

A small number of sentinel events were retrospectively notified to SCV following receipt of a complaint from the affected consumer or family member.

Building capability for improved review outcomes

A new way to report sentinel events in Victoria

In 2021 we launched a new sentinel event reporting system– the sentinel events portal.

This means all sentinel event documentation can now be stored securely in one location. Users have greater version control and can designate report access control within their organisation before submitting to SCV.

The portal better enables SCV to monitor trends, recognise potential statewide risks, inform new projects, and increase sharing and learning from events to the health sector. This richer, more meaningful data will also strengthen how we report sentinel events annually. We look forward to presenting this data to you in our next annual report.

For more information on the sentinel events portal, visit our sentinel events webpage.

Including the affected consumer/family member

A total of 45 per cent of sentinel event reports included input from the affected consumer or their family member. The consumer/s affected by the event (the patient, family or carer) should have the opportunity to contribute to the review process if they wish – for example, in an interview or in writing. Participation can be beneficial for the consumer who is able to share their perspective and can provide the review team with information about the event that they would not otherwise have known.

Sentinel event review training and resources

Due to the COVID-19 pandemic, incident review training was put on hold during 2020. However, this provided the opportunity to develop a new online training workshop – Fundamentals of adverse patient safety event review – which was successfully launched in February 2021. This workshop is targeted at health professionals and consumers and introduces human factors, systems thinking and safety culture in the context of adverse event reviews.

Between February and June 2021, 12 interactive workshops were delivered virtually to 345 health professionals and consumers, a significant increase from 280 participants in 2019-20. Approximately one third of participants (115) were from rural and regional health services, demonstrating the benefits of the online learning format in reaching a wider target audience.

Feedback from these workshops has been extremely positive, with the participants who completed the fundamentals training now eligible to enrol in the interactive, online methodology workshops launching in 2022. New training will include workshops in RCA^2 and AcciMap review methodology.

Terminology

ACSQHC	Australian Commission on Safety and Quality in Health Care	A commonwealth entity for quality and safety in healthcare that sets the national sentinel event notification list. Further reading is available at www.safetyandquality.gov.au
Adverse patient safety event/ adverse event	An incident in which a person receiving healthcare is harmed	For more information on responding to an adverse event, please refer to our adverse patient safety events policy.
Carer		A person who provides unpaid care and support to either a family member or friend who has a disability, mental illness, chronic condition, terminal illness or general frailty
Critical event		Identified when reviewing an adverse event, it is the point at which a different action would likely have altered the subsequent sequence of events, and the outcome of patient harm
CMHN	Chief Mental Health Nurse	The Chief Mental Health Nurse promotes recognition of the mental health nursing profession, provides education and training, and promotes best practice standards, workforce planning and development and professional leadership in Victoria.
Healthcare consumer		A patient, their family or carer(s)
ICPS	International Classification for Patient Safety	A framework developed by the World Health Organization (WHO) to enable categorisation of patient safety information using standardised sets of concepts with agreed definitions, preferred terms, and the relationships between them. The Victorian category 11 sentinel event subcategories are based on the ICPS classification for incident type.
ISR	Incident Severity Rating	A scale from one to four (one being most severe), of clinical incidents. Public hospitals categorise incidents by ISR when reporting them as part of the Victorian Health Incident Management System (VHIMS) dataset

Lesson learned		The opportunities for improvement identified through the review process but were not contributory to the adverse event.
OCP	Office of the Chief Psychiatrist	Led by a Chief Psychiatrist appointed by the Minister for Mental Health under the Mental Health Act, the OCP provides system-wide oversight of Victoria's public mental health services. The OCP promotes quality and safety in services provided to some of the state's most vulnerable people.
Review finding		A summary statement that describes how a system issue or factor contributed to an adverse patient safety event.
RCA	Root cause analysis	A root cause is the underlying cause of an event and, by extension, its outcome. Root cause analysis is a structured method of reviewing events to find out what happened, why it happened, and what can be done to improve
Recommendation strength		The level of tangible impact that the actions outlined in the recommendation will have within the health service. Health services tend to overestimate the strength of their recommendations. For example, policies and procedures alone are considered weak actions, because the working environment needs to enable staff to put the procedure into practice. When including recommendations regarding procedures, consider how they will be implemented, how you will ensure new staff are made aware of them, and if there is anything that can be put in place to ensure key points are followed (for example, a decision support tool or safety checklist). For further guidance, refer to our recommendation template.
SCV	Safer Care Victoria	The state's healthcare quality and safety improvement agency since 2017 whose role includes partnering with patients, clinicians and health service managers to support continuous improvements in healthcare.

SE	Sentinel event	The most serious adverse events, which result in a patient dying or being seriously harmed
Separations		The process where an admitted patient completes an episode of care – either by being discharged, dying, transferring to another hospital or changing type of care.
Systems thinking approach	.	An approach to examining healthcare safety that considers how factors at different levels of the healthcare system interact with each other, and how this impacts patient care. Systems factors go beyond the individual, and include team-based, environmental, management and external factors
VAHI	Victorian Agency for Health Information	VAHI was established in 2017 as part of the state government reforms to overhaul quality and safety across Victoria's healthcare system. The role of VAHI is to deliver trusted information to inform better decisions intended to improve the health and wellbeing of Victorians. This information is delivered through comprehensive quality and safety reporting to health services, government and the Victorian community.
VAED	Victorian Admitted Episodes Dataset	VAED provides a comprehensive dataset of the causes, effects and nature of illness, and the use of health services in Victoria. VAED supports health service planning, policy formulation, epidemiological research and public hospital funding. All Victorian public and private hospitals, including rehabilitation centres, extended care facilities and day procedure centres, report a minimum set of data for each admitted patient episode.
VHIMS	Victorian Health Incident Management System	A state-wide incident reporting system developed and managed by the Department of Health. The system captures clinical, occupational health and safety (OHS), and hazard incident data, as well as recording consumer compliment and complaint feedback.

Safer Care Victoria