



Sentinel Events

Annual Report 2023–2024



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Acknowledgements

ACKNOWLEDGEMENT OF COUNTRY

Safer Care Victoria acknowledges the strength, power and resilience of Aboriginal people as members of the world's oldest living culture. We recognise Aboriginal people as Australia's First People and honour the richness and diversity of all Traditional Owners across Victoria.

We respect the lore, customs and languages practised by Aboriginal people in Victoria, and their deep spiritual and cultural connections to land and water. We are committed to a future based on equality, truth and justice, and recognise the ongoing systemic injustices facing Aboriginal people. Victoria's treaty and truth-telling processes offer a chance to address these wrongs, empowering Aboriginal people to make decisions for their communities.

We pay our deepest respects to ancestors, Elders and leaders, past and present, whose strength and fortitude have paved the way for future generations.

ACKNOWLEDGEMENT OF LIVED EXPERIENCE

Safer Care Victoria acknowledges the 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.

CONTENT WARNING

The content in this report may be distressing because it references death and serious harm in patients of all ages, death and harm as a result of suicide, self-harm and mental health challenges.

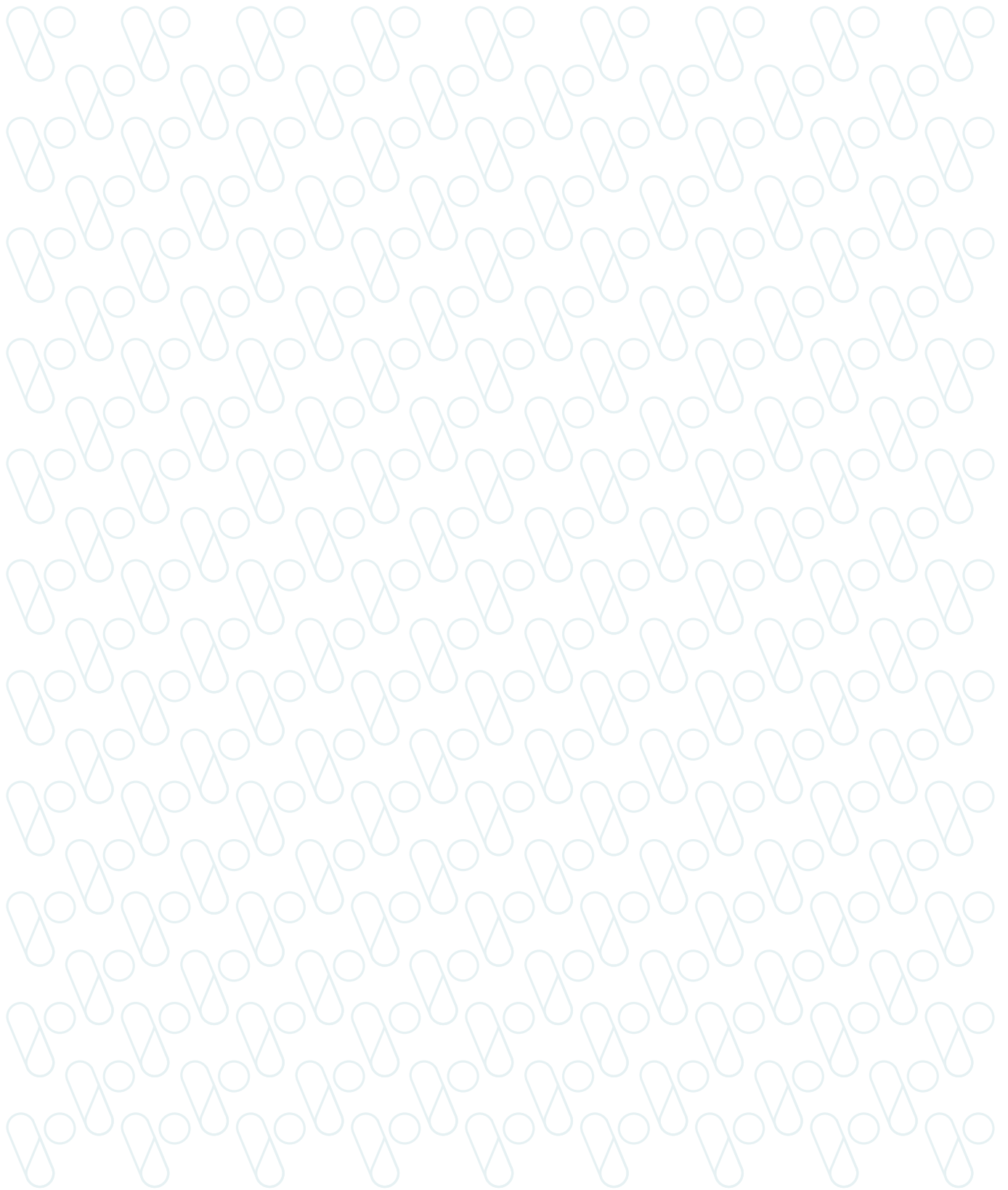
ACKNOWLEDGMENT OF TERMINOLOGY

Due to the diversity of programs and specialties covered by the Sentinel Event Program we acknowledge different terms routinely used in these areas to refer to a 'patient' or 'consumer'. This includes terms such as 'client', 'person' and 'people with lived experience of specific areas of ill health'.

The terms 'family', 'carer(s)' and 'supporters' may also be used interchangeably. We acknowledge the diversity of the networks that patients/consumers affected by sentinel events have surrounding them.

THANK YOU

Safer Care Victoria's Sentinel Events team prepared this report. The team thanks Victorian health services and consumers for continuing to share and improve our health sector. Thank you to the agencies and individuals involved in sharing their learnings and system improvements in detail.



Contents

Acknowledgements	3
Acknowledgement of Country	3
Acknowledgement of lived experience	3
Content warning	3
Acknowledgment of terminology	3
Thank you	3
Foreword	7
Introduction	8
Feedback and future reports	9
What is a sentinel event?	10
Which events are notifiable in Victoria?	11
The sentinel events process	12
2023–2024 at a glance	14
Sentinel events reporting	15
Sentinel event notification rates	15
What does the sentinel event notification rate tell us?	17
Services notifying events	17
Review panel composition	19
Key sentinel event themes 2023–2024	22
Sentinel events and priority populations	22
Sentinel events related to a clinical process or procedure: colonoscopy	25
Sentinel events related to mental health	28

Engaging with impacted patients, families and carers	35
Healthcare Complaints Analysis Tool	36
Open disclosure	39
Statutory duty of candour	40
Recommendations from sentinel event reviews	43
Developing recommendations	43
Writing recommendations	43
Recommendation strength	43
Cluster reviews	46
Identifying clusters of events	46
Strengthening just culture	49
Further reading and resources	53
Glossary	55
Data supplement	57
Sentinel events reporting by category and subcategory	57
Age of affected patient	60
Top admitting specialities	61
Sentinel event peer group and location	62
Time to notify sentinel events	64
Time to review sentinel events	65
Appendix 1: Guide to strength of recommendations	66

Foreword

Safer Care Victoria promotes a safer healthcare system for all Victorians. While most health care in Victoria leads to good outcomes, there are times when things go wrong and patients and consumers are harmed as a result. These events have a devastating impact on patients, their families and carers, and the healthcare staff involved. As a healthcare system, we need to be honest when harm occurs, and we have a shared responsibility to learn from these events.

Safer Care Victoria partners with health services to monitor and improve the quality and safety of care delivered across our health system, with the goal of improving our understanding of events that result in patient harm. We continue to support health services to empower, support and truly listen to affected patients, and their loved ones. They can provide valuable insights into these events and help inform solutions to prevent future occurrences.

We are committed to continuous improvement and collaboration for a safer healthcare future in Victoria. Learning from sentinel event reviews is key to continuous improvement and achieving the aim of harm reduction and improving patient safety. This report shares important data and insights from across the state to help health services understand and improve their systems of care.

This information includes harm events, analysis of key themes and advice and recommendations for health services. It also includes links to a range of resources and examples of improvement activities underway across the sector.

This year's report shows continued improvement in:

- the makeup of review panels
- family engagement and better family contribution to reviews
- open disclosure and statutory duty of candour processes.

Every member of the health service team, including clinicians, administrative and support staff, plays an essential role in providing safe care. Health service staff partner with government agencies whose role it is to monitor systems and promote best practice adverse event management to ensure system improvement and change. Together, we will continue to learn from serious patient harm and strive for outstanding health care for all Victorians.



Louise McKinlay
Chief Executive Officer
Safer Care Victoria

Introduction

This report summarises trends that Safer Care Victoria (SCV) has identified through the sentinel event notification process during the 2023–24 financial year. Its purpose is to inform opportunities for enhancing the safety of Victorian health care. We want health services to understand the contributing factors leading to patient/consumer harm and provide them with the information and resources to reduce the risk of recurrence.

This year's report includes:





- a 5-year overview of mental health-related sentinel event data and corresponding improvement work
- a 3-year overview of sentinel events related to clinical process/procedures under the theme of colonoscopy, linking to SCV's recent *Promoting best practice colonoscopy – recommendations* report
- a thematic review of sentinel events involving patients from diverse backgrounds, with a focus on patients with First Nations heritage and the importance of cultural safety.

We have also included sections highlighting:

- the importance of consumer representation on review panels
- how health services can strengthen 'just culture' and support staff involved in sentinel events
- how recommendations can be strengthened when similar adverse events occur in a system
- statutory duty of candour (SDC) and some early statewide data and health service learnings.

This report discusses real events, encompassing lessons learnt and improvements currently being implemented at both the service and system levels. Sharing these insights offers valuable opportunities for health services to learn and enhance their practices.

We want this report to be accessible and relevant to consumers and health services. To make this easier, you can find:

-  actions that health services may wish to take in response to the information provided
-  actions that consumers may wish to take
-  links to further resources and a resources list at the end of the report, to help drive awareness of our Sentinel Events Program
-  areas of significant health service improvement
- a glossary at the end of the report.

Throughout this report, names and clinical details have been changed to protect patient and staff privacy. The data presented is primarily descriptive. Data has been rounded to the nearest percentage and, where infographics show multiple categories, only 80% of variables may be represented for easier interpretation.

FEEDBACK AND FUTURE REPORTS

How did we do?

When you have finished reading this report, we would value your feedback. Please complete our online survey <<https://forms.office.com/Pages/ResponsePage.aspx?id=H2DgwKwPnESciKEExOufKAmpZ6TvOktMue3x0-8llpdUQlhFNDdSNIROMzBZOEpiWTJHTjRRRjdZOS4u>> or use the **QR code** below to access it.



Do you have a consumer or health service story to share?

If you would like to be involved in the development of future reports and share your story, please provide your contact details at the end of the survey or email SCV <sentinel.events@safercare.vic.gov.au>.

WHAT IS A SENTINEL EVENT?

Sentinel events are unexpected and adverse events that occur infrequently in a health service entity that result in the death of, or serious physical or psychological harm, to a patient because of system or process deficiencies.

Serious harm is considered to have occurred when the patient has:

- needed a life-saving surgical or medical intervention
- a shortened life expectancy
- experienced permanent or long-term physical harm
- experienced permanent or long-term loss of function.

Life-saving surgical and medical treatments can include advanced life support measures such as intubation or emergency surgery.

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.

Case example: Sentinel event

A 22-year-old patient developed prolonged psychological harm following a complication involving general anaesthesia. The patient needed general anaesthesia for a laparotomy (abdominal surgery). In the recovery unit after the procedure, the patient became agitated and then highly distressed. They reported feeling awake but unable to move during the procedure, 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 couldn't return to work or previous sporting activities.

Should this be notified as a sentinel event? Yes. The patient suffered prolonged psychological harm resulting in long-term or permanent loss of function as a complication of a clinical procedure.

WHICH EVENTS ARE NOTIFIABLE IN VICTORIA?

Victorian health services must notify and review sentinel events that meet the criteria for both the Australian sentinel event categories (1–10) set out by the Australian Commission on Safety and Quality in Health Care and those that fall under the Victorian-only category 11: All other adverse patient safety events resulting in serious harm or death.

The Commission defines sentinel events as a subset of adverse patient safety events that are preventable and result in serious harm to, or the death of, a patient. For details on national categories, visit the [Incident management and sentinel events](https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident) <<https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident>>.

Category 11 was established in Victoria to capture all other adverse events that result in serious harm. This aligns us with other states that report events of this nature. This inclusion ensures we have greater visibility of risks that lie within our system and provides a statewide learning opportunity. Category 11 does not require the event be ‘wholly preventable’ for it to be notified.



RESOURCE:

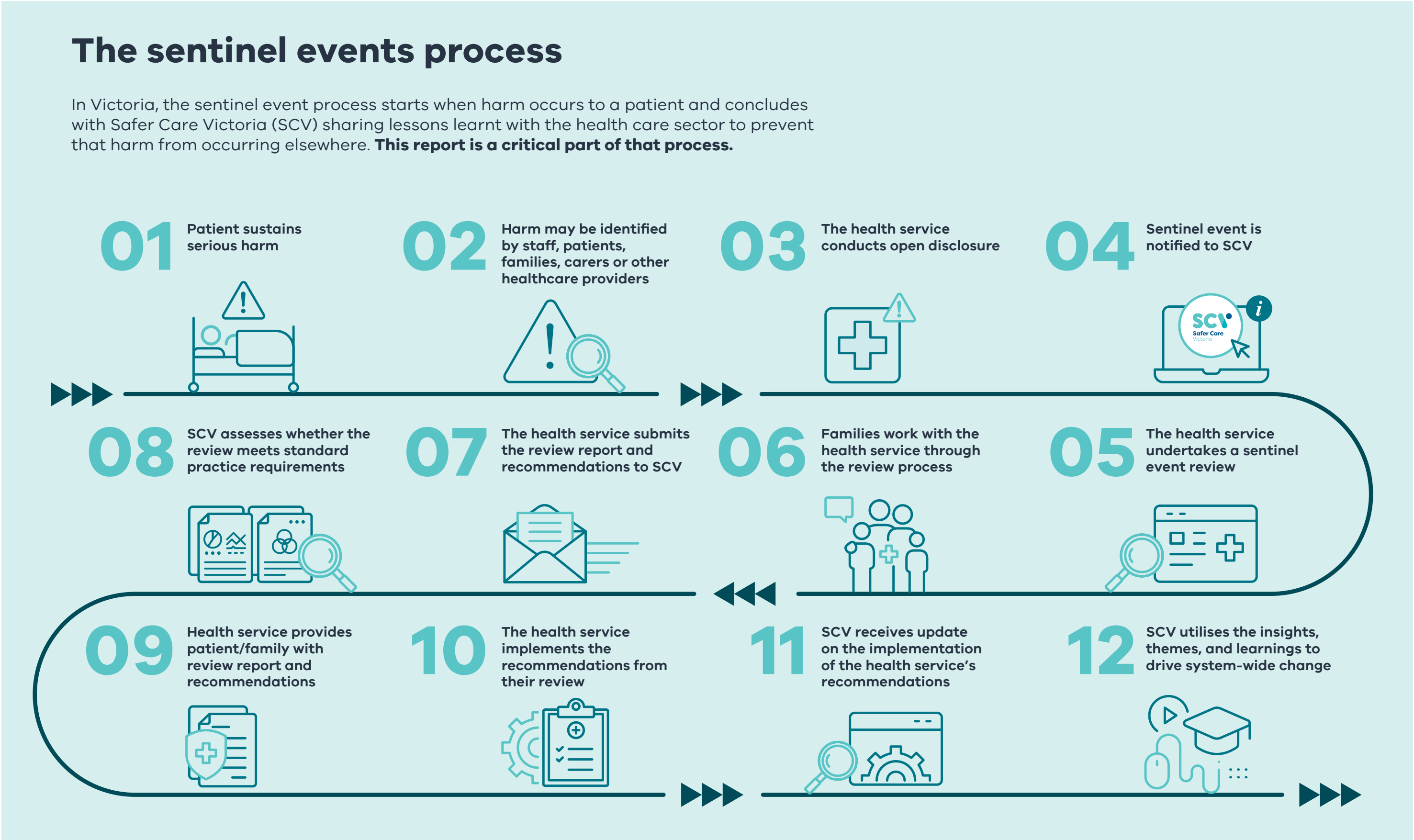
Victorian sentinel events guide

The [Victorian sentinel events guide](https://www.safercare.vic.gov.au/best-practice-improvement/publications/sentinel-events-guide) <<https://www.safercare.vic.gov.au/best-practice-improvement/publications/sentinel-events-guide>> has essential information for health services about identifying and managing sentinel events.

This resource includes:

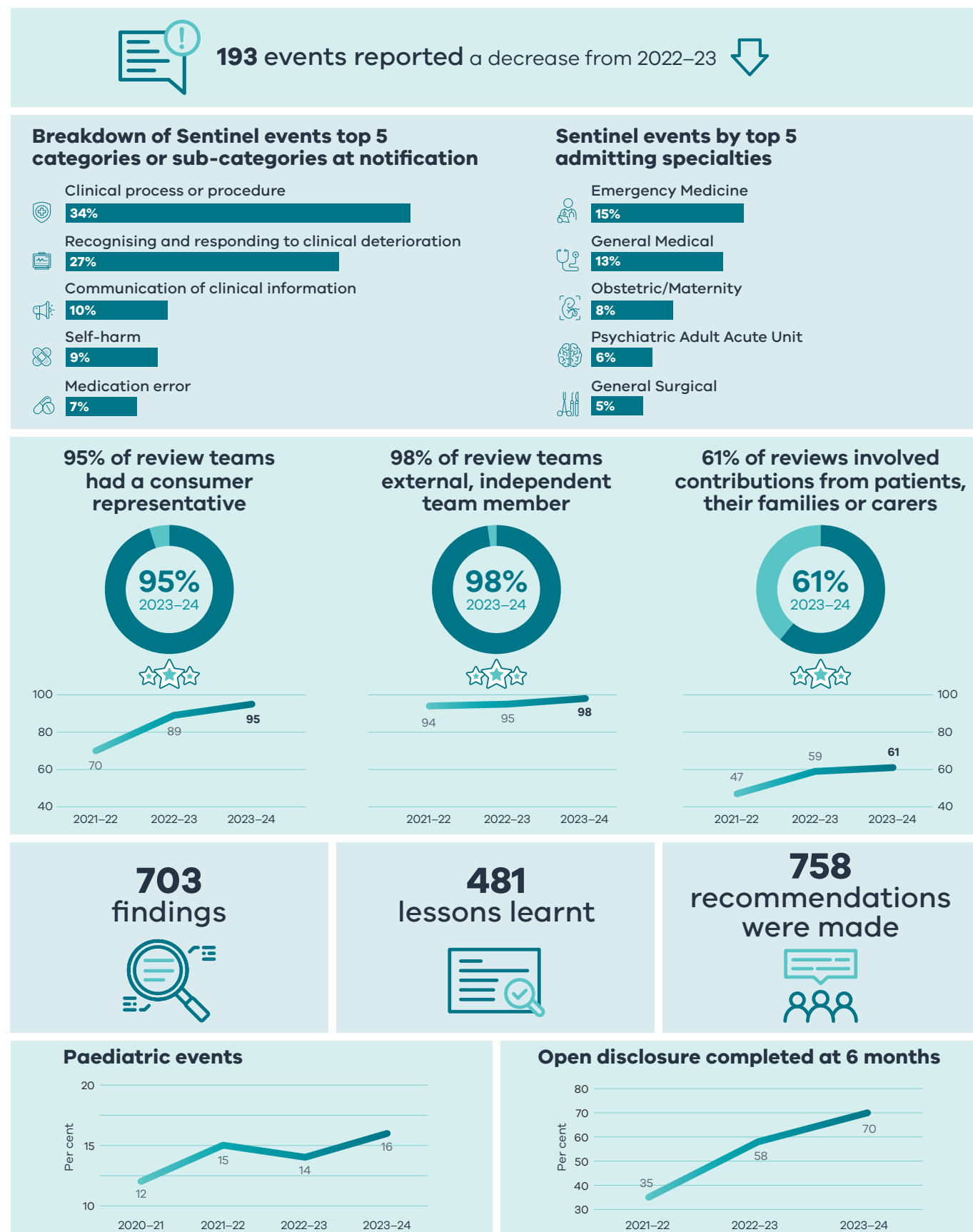
- guidance for notifiable sentinel events, including information relating to psychological harm and life-saving care
- guidance on the Victoria-only category 11, including case studies and examples.

Figure 1. The sentinel events process in Victoria



2023–2024 at a glance

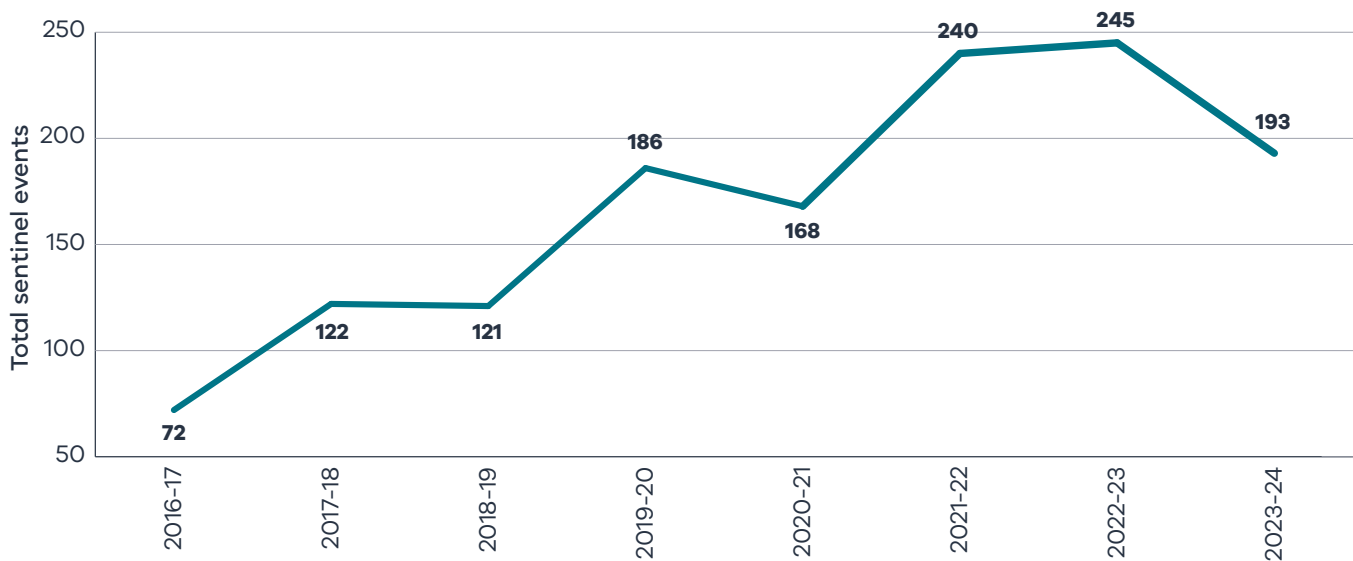
Figure 2. An overview of 2023–2024 sentinel events



Sentinel events reporting

The 2023–24 financial year saw a decline in sentinel event notifications (Figure 3). There are likely to be several complex reasons why this has happened.

Figure 3: Number of sentinel events notified across Victoria, 1 July 2017 to 30 June 2024



*On 1 July 2017, SCV took ownership of the Sentinel Event Program from the Department of Health.

For reporting purposes, we identified health services within tertiary, major and non-metropolitan hospital peer groups. We looked at notification rates across health service peer groups and noted the most significant reductions in the ‘major’ peer group and in the non-metropolitan services.

SENTINEL EVENT NOTIFICATION RATES

Identifying and reviewing sentinel events reflects a positive health service safety culture and contributes meaningfully to quality and safety improvements. SCV can use adverse event notifications to better understand a health service’s reporting culture. The incidence of sentinel events can vary within and between health services based on factors such as total service activity and the complexity of the health care delivered.

Reviewing the number of sentinel events alone only tells us about part of what is occurring in a service. It can be misleading due to the variability in the size and functions of our health services. A more accurate comparison considers the complexity and volume of clinical care provided by a health service. Health services providing more complex and higher volumes of care would be expected to manage higher clinical risk and have a concurrent higher risk of sentinel events.

SCV continues to work with services that are not engaged with the Sentinel Events Program. This includes health services yet to notify a sentinel event and those that have not reported an event for a long time.

National Weighted Activity Units (NWAUs) are used to understand and compare the cost and complexity of different healthcare services and activities. The unit 'weights' activities like surgeries, hospital stays and outpatient visits based on how complex or resource-demanding they are. For example, a major surgery might have a higher NWAU because it requires more resources (for example, staff and equipment) compared with a routine outpatient visit.



ADVICE FOR HEALTH SERVICES

Consider the clinical governance processes at your health service and the pathways you have between work areas to escalate or refer possible adverse events.

ADVICE FOR HEALTH SERVICES

There are several ways to identify sentinel events. We encourage health services to diversify and strengthen their processes to consider multiple information sources. Below are some of the many ways events can be identified in addition to incident management systems.

- consumer feedback – we recommend that Consumer Experience and Quality and Safety teams work together to ensure clinical adverse events can be identified from consumer feedback and reported in a timely manner. As an example of this, SCV sees around 6 complaints each year via the Minster for Health that are later recognised as sentinel events.
- morbidity and mortality reviews – SCV has developed a framework and toolkit to assist health services with a systems based, just culture approach to Morbidity and Mortality reviews SCV Resource <<https://www.safercare.vic.gov.au/publications/morbidity-and-mortality-meetings-framework-and-toolkit>>
- reports from the Coroners Court of Victoria and the Office of Chief Psychiatrist
- other health services – what do you do to let other services know if you become aware of harm to a patient they have cared for?

Considering sentinel event notification rates (based on NWAU) allows us to compare health services and peers over time. Changes in sentinel event notification rates may suggest changes in reporting culture, particularly in the context of other safety and quality risks.

While this measure enables us to compare, it doesn't account for other influencing factors such as safety culture, clinical governance processes and workload or workforce factors.

Key considerations

- We have seen a statewide reduction in relative sentinel events notification rates compared with the preceding 2 financial years (0.15 in 2023–24 compared with 0.23 in 2022–23 and 0.21 in 2021–22).
- Most notable reductions were for local (0.34 in 2023–24 compared with 0.61 in 2022–23), regional (0.10 in 2023–24 compared with 0.25 in 2022–23) and major (0.11 in 2023–24 compared with 0.21 in 2022–23) health services.

WHAT DOES THE SENTINEL EVENT NOTIFICATION RATE TELL US?

The reduction in sentinel event notification rates does not appear to be solely related to changes in health service activity or complexity. For example, the major peer group saw a 43% reduction in total sentinel events. Three individual services notified more than 50% fewer events compared with last year.

Action for SCV

SCV will continue to work with individual health services to better understand their reporting culture, barriers and trends.

SERVICES NOTIFYING EVENTS

Private health service notifications increased by 43% in 2023–24 (Figure 4, Table 1). This reflects significant improvements in health service onboarding to the sentinel event portal and work done between the Private Hospitals Unit within the Department of health and health services.

Figure 4: Number of sentinel events notified by public and private health services, 1 July 2017 to 30 June 2024

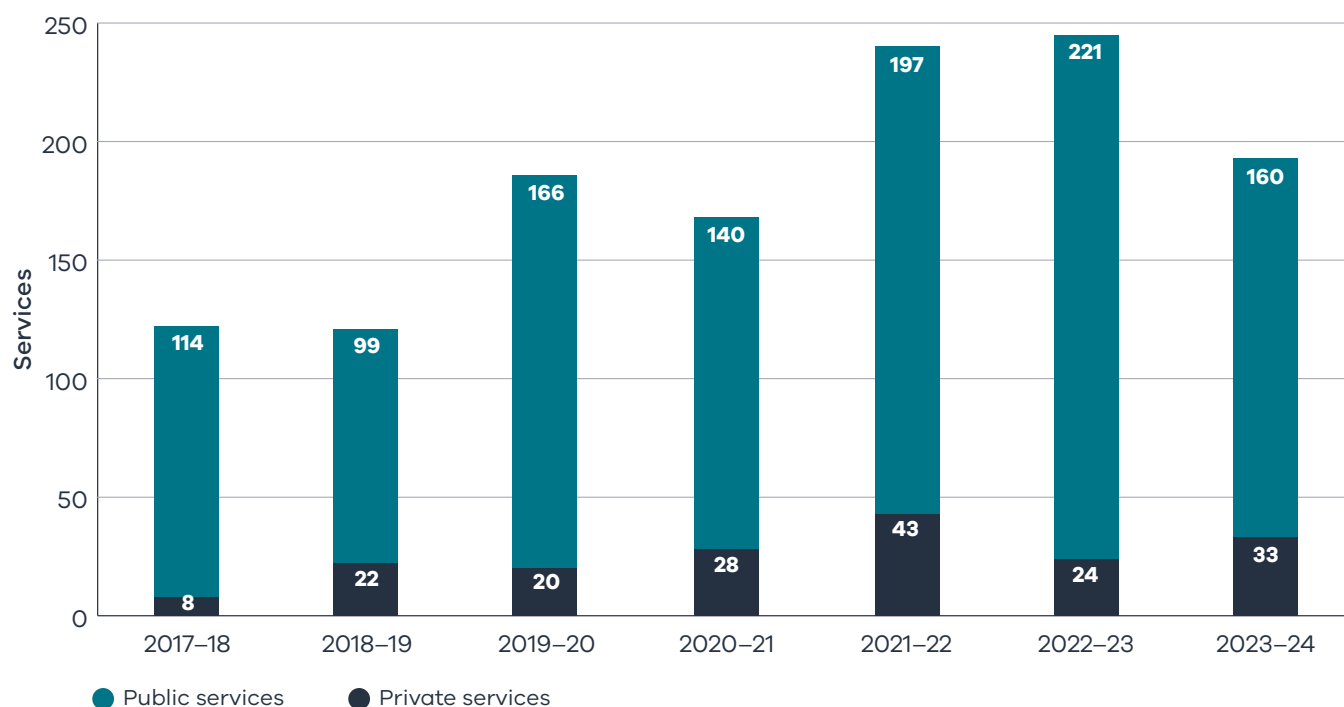


Table 1. Health services notifying sentinel events, 2021-22 to 2023-24

Health services notifications	2021-22	2022-23	2023-24
Number of sentinel events	240	245	193
Number of health services notifying events	64	54	51
Number of public services notifying sentinel events (total public services = 77)	44	39	32
Number of private hospitals notifying sentinel events (total private health services = 78)	20	15	19
Number of day procedure centres notifying events (total day procedure centres = 96)	0	0	0

ADVICE FOR HEALTH SERVICES

If you are working in quality and safety at a health service, you can learn more about your reporting requirements by visiting the Notify and review a sentinel event webpage <<https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events>>. If you need help ensuring you are onboarded to the sentinel events reporting portal or would like more information, email the Sentinel Events Program <sentinel.events@safercare.vic.gov.au>.

Review panel composition

SCV continues to recognise areas of improvement that we consistently see across the statewide data, noting year-on-year improvements in review panel composition (Figure 5, Table 2). This suggests health services are improving how they capture the consumer voice as well as ensuring they include relevant subject matter expertise.

Figure 5: Review panel membership, 2021–22 to 2023–24

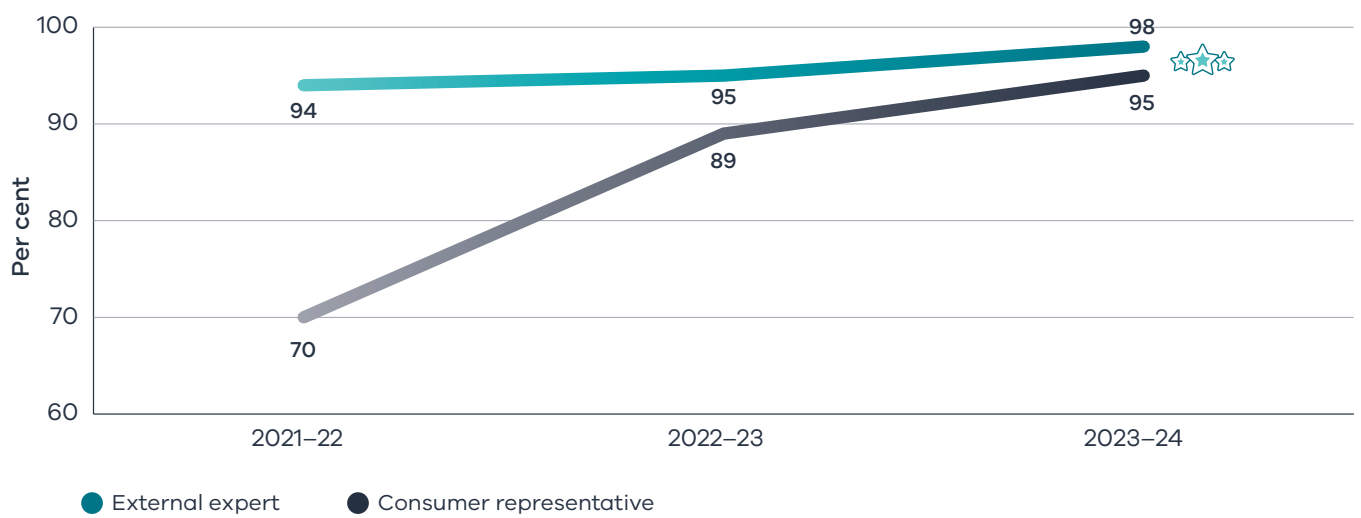


Table 2. Review panel membership, 2021–22 to 2023–24

Member type	2021–22 (%)	2022–23 (%)	2023–24 (%)
Consumer representative	70	89	95
External expert	94	95	98

Case study: Northeast Health Wangaratta



Lois, SAPSE review panel consumer representative, and Sara Gartside, Clinical Risk and Improvement Coordinator

In recent years, Northeast Health Wangaratta (NHW) has experienced challenges in engaging and supporting consumer representatives for serious adverse patient event reviews. SCV understands this is a common theme in regional and smaller communities.

The NHW team has partnered with other local health services to find ways to work together to ensure consumer representation is prioritised in reviews. Sara Gartside shared:

'This is why we are working within our Northeast Health Partnership and our consumers to strengthen these relationships. This means that our reviews are more robust and can lead to stronger recommendations when we have consumers with appropriate lived experience and sentinel event panel experience, and who understand review methodology. We are transparent about remuneration and truly value the time and dedication our consumer representatives give us, to try make things better for our patients and their families, to minimise the risk of these events occurring again.'

NHW strives to engage consumers who have had a similar experience or have knowledge relevant to the adverse event being reviewed. This can sometimes present a challenge if the available consumers cannot bring the required lived experience voice to the panel, if they are unavailable or if there are other considerations that affect panel composition/suitability.

Lois has been a dedicated consumer representative at NHW for more than 7 years, when she began volunteering early in her

retirement to contribute to her local health service. Lois joined the service's community advisory committee and soon became involved in sentinel event reviews, supported by the NHW Quality and Safety team.

The role of a consumer representative is to:

- advocate for the patient to remain central to the review process
- challenge assumptions and identify gaps that may not be visible to clinical staff
- help address community expectations around public oversight and accountability
- be independent from the adverse event.

Lois completed adverse event review training and strongly recommends training for all consumer representatives. She finds her greatest contribution to panel reviews is her commonsense approach and logical problem-solving skills, often providing a unique perspective in discussions with experienced clinicians whose focus may be on clinical or process detail.

Lois feels empowered to share her thoughts thanks to NHW's 'just culture' approach. Just culture promotes thoughtful, open and inclusive reflection in a psychologically safe space. This culture is reinforced at the start of every meeting with a clear statement of purpose and values. The only challenge Lois has found is the frequent use of health sector acronyms.

The NHW Quality and Safety team supports consumer representatives like Lois by checking in before and after meetings to address any concerns. Lois feels valued and a part of the team. She is especially proud when her insights contribute to the review process and outcomes.

Lois acknowledges that reviews where more than one health service is involved can sometimes be intimidating due to the panel size and potential disagreements. However, she believes that clear communication and agreed terms of reference can resolve these issues.

ADVICE FOR HEALTH SERVICES

- Prepare a frequently used abbreviation resource or glossary for the panel.
- Ensure consumer panel members have a defined mentor/support person as well as the opportunity to engage with the employee assistance program process, if needed.
- Aim to understand any needs the consumer may have such as cultural support, accessibility support, orientation/access to IT platforms, parking and building access.
- Orientate consumers to their role on the panel to give them the confidence to find their voice.
- With agreement from the consumer panel members, network with neighbouring or larger health services to share consumer resources.
- Reach out to the SCV Sentinel Events team if you're having trouble finding consumer representatives, especially if seeking a consumer with lived/living experience.
- Develop a learning package using the SCV [online training modules](https://www.safercare.vic.gov.au/best-practice-improvement/online-training-modules) <<https://www.safercare.vic.gov.au/best-practice-improvement/online-training-modules>> and [guidance to support consumers in preparing for review panels](https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events#goto-tools-and-resources) <<https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events#goto-tools-and-resources>>.

RESOURCES:

- [How to engage a consumer representative](https://www.safercare.vic.gov.au/support-and-training/partnering-with-consumers/health-services/how-to-engage-a-consumer-representative) <<https://www.safercare.vic.gov.au/support-and-training/partnering-with-consumers/health-services/how-to-engage-a-consumer-representative>>
- [Consumer representatives on review teams](https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/involve-consumers-in-incident-reviews) <<https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/involve-consumers-in-incident-reviews>>
- [Guide to consumer remuneration](https://www.safercare.vic.gov.au/sites/default/files/2019-01/Remunerating%20consumers%20a%20guide%20for%20government.pdf) <<https://www.safercare.vic.gov.au/sites/default/files/2019-01/Remunerating%20consumers%20a%20guide%20for%20government.pdf>>

ADVICE FOR CONSUMERS

If you are interested in working with your local health service to improve the quality and safety of care, there are many ways to get involved. You could become a consumer representative and join the panels that review adverse events, or join a committee focused on improving safety or patient care.

Contact your local health service or visit the [Guides to consumer representatives on adverse event reviews webpage](https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews) <<https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews>>.

Key sentinel event themes 2023–2024

To maximise learning and improvement opportunities, this report focuses on key sentinel event themes that are frequently reported or provide key lessons.

This year's report contains sections relating to 3 themes:

- the diversity of impacted population groups, with a focus on closing the gap for First Nations people
- events related to clinical procedure or process, with a focus on events involving colonoscopy
- sentinel events related to self-harm and mental ill health, with a focus on supporting consumers at risk of harm from ligature in acute health settings.

By sharing these themes SCV hopes to enable focused system change.

SENTINEL EVENTS AND PRIORITY POPULATIONS

All Victorians have the right to experience optimal health and wellbeing. There are many initiatives dedicated to improving health equality and promoting access to high-quality health care.

Despite this, barriers to accessing services and differences in clinical outcomes remain. Negative impacts are particularly felt among some population groups. Such consumers may be less able to protect themselves against harm or exploitation and may therefore suffer adverse health outcomes. These population groups may be described as priority populations that may be considered underserved or marginalised in health as well as wider societal settings.

Population groups that may be underserved or marginalised in health services include those:

- with impaired intellectual or physical functioning
- who are of Aboriginal or Torres Strait Islander descent
- who do not speak English at home
- who are from a low socioeconomic background
- who are subject to modern slavery, which involves human exploitation and control such as forced labour, debt bondage, human trafficking and child labour
- with low levels of literacy or education
- who are younger (children and young people) or older
- who are experiencing mental health conditions
- who are homeless or at risk of homelessness
- who are incarcerated or exiting prison.

In 2023 an audit of 450 sentinel events investigated the impact of sentinel events on consumers with one or more of the above characteristics. The audit looked at how well health services considered these factors when completing the sentinel event review and making improvements.

THE AUDIT DEMONSTRATED:

51% of all sentinel events involved a consumer with at least one priority characteristic



34% of events involved consumers who had more than one priority characteristic*

*While it is recognised that some characteristics coexist (intersectionality), this suggests that consumers impacted by sentinel events commonly have complex medical and social backgrounds.



21% Only 21% of sentinel event reviews involving a consumer with a potential characteristic had an aligned expert health service or lived experience representative



46% The impacted consumer's characteristic was considered as a subject in just 46% of reviews



26% of sentinel event reviews relating to a consumer with a potential characteristic had a related finding



33% of sentinel event reviews relating to a consumer with a characteristic made an associated recommendation



ADVICE FOR HEALTH SERVICES

- Ensure sentinel event reviews have a [consumer-centred approach](https://www.safercare.vic.gov.au/sites/default/files/2022-12/Consumer%20involvement%20following%20a%20SAPSE_9-step%20guide.docx) <https://www.safercare.vic.gov.au/sites/default/files/2022-12/Consumer%20involvement%20following%20a%20SAPSE_9-step%20guide.docx>.
- Include appropriate representation on sentinel event review panels.
 - The external expert(s) should have expertise in the primary clinical area being reviewed.
 - The consumer representative should have similar experience or knowledge relevant to the event being reviewed (lived experience).
- Be sure to 'zoom out' during the review to consider the whole picture.
- Think broadly and take a consumer-centred approach when developing quality and safety recommendations.

Case study: Safe use of the Warrawee Room – enhancing care through community collaboration at Bairnsdale Regional Health Service

The Warrawee Room is a dedicated Aboriginal community room that offers a culturally safe place for patients, families and staff at Bairnsdale Regional Health Service. Feedback from the community following a sentinel event drove the health service to review the safety and use of the room.

The family detailed their safety concerns they had while waiting in the Warrawee Room with an unwell baby, whose condition was deteriorating. The family said they felt forgotten and neglected, citing lack of communication, long wait times and the delay in receiving treatment.

To address these concerns, an Aboriginal Health Unit staff member contacted the family, first by phone and then in a face-to-face meeting at the local Aboriginal health service. During these discussions, the family shared their concerns and outlined the changes they felt were necessary to ensure the safety and wellbeing of future patients using the Warrawee Room. The Aboriginal Health Unit staff documented these changes and communicated them back to the hospital for review.

A collaborative effort followed, involving numerous meetings with key stakeholders. The team included members from the Aboriginal Health Unit, the emergency department, Community Wellbeing & Aged Care, Clinical Care and Improvement and senior leadership such as the CEO and director of nursing. Together, they reviewed the concerns, proposed changes and finetuned solutions. The family's input remained central throughout, with regular consultations ensuring their concerns were addressed and incorporated into the revised process.

As a result of this collaborative approach, several documents were created. These includes guidelines for the safe use of the Warrawee Room, patient handouts with

instructions and a triage phone script for emergency staff. These documents were finalised and made available for distribution in November 2024.

One of the key learnings from this process was the critical role of consumer contribution. The family's direct involvement and their ongoing feedback ensured the changes were meaningful and effective. It was clear that open, ongoing communication with consumers was essential to creating real improvements. Furthermore, the collaboration across various hospital departments and community representatives showed the power of working together to create solutions that truly meet the needs of the people they serve.

To ensure the community hears about the new process, local Aboriginal Community Controlled Organisations will help disseminate this information. This initiative highlights how consumer feedback, when acted upon with care and dedication, can drive substantial improvements in healthcare practices, ensuring future experiences in the Warrawee Room are safer and more supportive for all.

Prepared by Narelle Bragg (Acting Aboriginal Health Unit Lead) and Renee Herbstreit (Clinical Care Improvement Co-ordinator)








SENTINEL EVENTS RELATED TO A CLINICAL PROCESS OR PROCEDURE: COLONOSCOPY

In 2023–24, 44% of all notifications related to the following 2 themes:

- clinical process and procedure
- communication of clinical information.

A recurring theme in these categories relates to patients undergoing or requiring a colonoscopy. We reviewed 14 sentinel events from the past 3 years concerning this type of care.

Top 5 findings and lessons learnt themes and sub-themes for colonoscopy-related events data

FINDINGS AND LEARNINGS THEME		SUB-THEMES
Procedures and guidelines	22% 	Missing critical information Not/insufficiently implemented Not available/written Not useful
Teamwork	16% 	General communication Lack of clarity re accountability between teams Written communication
Documentation, assessment and decision support	14% 	Fragmented record Incomplete documentation Lack of alerts Not available
Systems and processes	12% 	Missing critical information Not/insufficiently implemented Not available/written Not useful
Organisational and management	10% 	Insufficient access to services/ can't meet demand Safety culture and priorities

In July 2022, SCV received a sentinel event notification related to colonoscopy care that sparked a review and the recall of nearly 2,000 patients. The notification triggered a roundtable with experts and diverse stakeholders to address colonoscopy quality and equity in Victoria. Roundtable discussions, contributions and feedback provided by interjurisdictional colleagues and professional bodies informed 7 recommendations aimed at improving colonoscopy access and procedural practice.

Our review of these sentinel event cases revealed strong alignment between the identified themes, findings, and learnings and the following best practice recommendations made in the roundtable report:

- the timeliness of colonoscopy
- communicating results and appropriate surveillance after endoscopy
- consent for colonoscopy
- facility performance metrics.

The findings are documented in our *Promoting best practice colonoscopy – recommendations* report (Table 3).

Table 3: Top 6 recommendations from colonoscopy sentinel events reviews data

Learn more about how recommendations are rated in the [Appendix: Guide to strength of recommendations](#).

COLONOSCOPY RECOMMENDATIONS THEMES		STRENGTH*
Standardise Process	17%	Moderate 
Further Review and Develop Action Plan	15%	Weak 
Training	12%	Weak 
Simplify Process and Remove Unnecessary Steps	12%	Strong 
Share Outcomes/Education Reference	10%	Weak 
Software Enhancements	10%	Moderate 

RECOMMENDATIONS FROM SENTINEL EVENT REVIEWS



Colonoscopy events 2021–22 to 2023–24

41 recommendations

were developed to address the findings from **14** events

Weak



48%

Moderate



36%

Strong



16%

65% were written using **SMART** principles



37% of recommendations focused on training, education and further review, these are considered **weak actions**.

Weak recommendations may be needed when health services are developing or implementing stronger recommendations. Key to reducing the likelihood of an event happening again is developing recommendations which influence change at a system level.



ADVICE FOR HEALTH SERVICES

- Ensure robust and dedicated systems are in place to ensure patients are booked and receive their care within the recommended timeframe according to the surgery urgency categorisation.
- Ensure workflows for specimen reporting, follow-up and communication to the patient are designed with human factors principles.
- Ensure policy and procedures align with national and statewide colonoscopy care best practice recommendations.
- Follow guidance in the SCV *Promoting best practice colonoscopy – recommendations report* <<https://www.safercare.vic.gov.au/non-urgent-elective-surgery/promoting-best-practice-colonoscopy-recommendations-report>>. This will help strengthen the systemic actions of the health service.



NEW RESOURCE:

Implementing the recommendations in the colonoscopy report and subsequent action plan can be supported by using [quality improvement methodology](https://www.safercare.vic.gov.au/best-practice-improvement/quality-improvement/toolkit) <<https://www.safercare.vic.gov.au/best-practice-improvement/quality-improvement/toolkit>>.

SENTINEL EVENTS RELATED TO MENTAL HEALTH

The Royal Commission into mental health services in Victoria highlighted the requirement for improvements for system reform. The recommendations included the enhancement of safety and prevention of harm. Its recommendations focus on the importance of lived and living experience perspective, data approaches to identify risk factors and transparent reporting mechanisms. This aligned with the Mental Health and Wellbeing Act Principles of 2022 which emphasis person centred care, upholding human rights and promoting treating people with dignity and respect fostering a culture which is open and transparent.

Sentinel events involving a person who is experiencing mental ill health may be reported in 2 categories:

- the Australian sentinel event category 6 – suspected suicide of a consumer in an acute mental health unit or acute mental health ward
- the Victorian category 11 sub-category 4 – self-harm.

In the 2020–21 sentinel events annual report, we shared key insights for improving care related to mental health–related sentinel events.

This year, we are presenting a broader range of information, encompassing the past 5 years, to show trends that have informed our observations and learnings.

WHAT WE KNOW



9%

Mental health–related sentinel events average 9% of notified events

5

There are, on average, 5 events per year notified in Australian category 6



13

An average of 13 events per year are notified as Victorian only category 11 – self-harm

Most represented age group

30–64yrs



Increased reporting of events is occurring in or from emergency departments

Most patients in this category are **not** under a compulsory treatment order



Improvement in mental health–related sentinel event reviews

Improved lived and living experience representation on panels

We are pleased to be seeing better representation of lived and living experience of mental illness or psychological distress on sentinel events panels (Figure 6, Table 4). This reflects key recommendations from the Royal Commission into Victoria’s Mental Health System to expand the consumer and family-carer lived experience workforces.

This data is currently captured manually. SCV is upgrading the Sentinel Event portal to improve our ability to capture consumer representation.

Figure 6: Panel composition

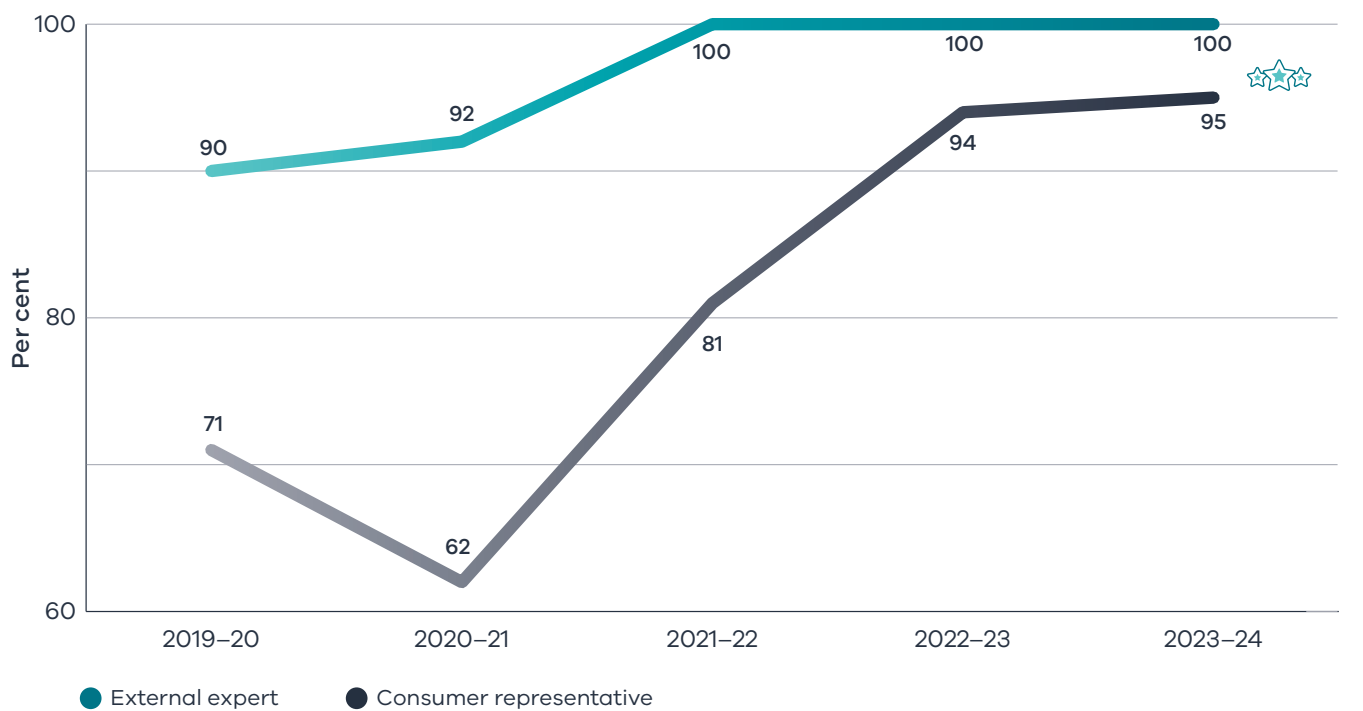


Table 4. Review panel membership, 2021–22 to 2023–24

Member type	2019–20 (%)	2020–21 (%)	2021–22 (%)	2022–23 (%)	2023–24 (%)
Consumer representative	71	62	81	94	95
External expert	90	92	100	100	100

External experts on panels

The mental health sector is consistently excelling at ensuring impartial subject matter expertise with an external expert engaged in sentinel event reviews. This reflects a collaborative culture of review and dedication to learn and improve across the sector.

This improved collaboration is further noted through the increase in multiagency reviews.

Review methodology

Sentinel event reviews must follow a formal, structured, systems-focused methodology that includes a written report detailing all aspects of the review. SCV accepts various methodologies including RCA/RCA2, the London Protocol and AcciMap.

There has been a noticeable trend over the past 5 years towards using the London Protocol. Anecdotal evidence suggests a growing preference for this approach due to its suitability for complex events. SCV encourages organisations to adopt the methodology they find most effective and comfortable.

For more on review methodologies, refer to the [Adverse Patient Safety Event \(APSE\) guideline](https://www.safercare.vic.gov.au/sites/default/files/2023-07/Adverse%20Patient%20Safety%20Event%20guideline_Safer%20Care%20Victoria.pdf) <https://www.safercare.vic.gov.au/sites/default/files/2023-07/Adverse%20Patient%20Safety%20Event%20guideline_Safer%20Care%20Victoria.pdf>.

Multiagency reviews

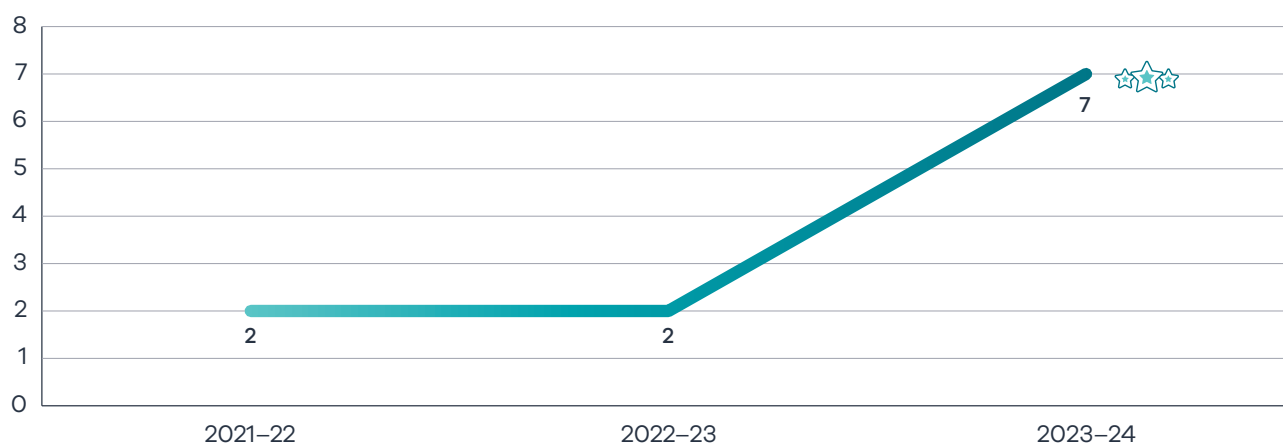
When a sentinel event involves 2 or more health services, the CEOs of those services may agree to appoint a multi-agency review panel. All services involved in the care of the patient are expected to participate in a multi-agency review of the adverse event.

Collaboration across health services can further strengthen the review process by:

- obtaining a more complete picture of the care delivered to the patient
- considering subject matter expertise from different health service perspectives
- applying systems improvements across multiple health services.

In the mental health sector, we have seen an increase in this type of collaboration in 2023–24.

Figure 7: Mental Health sector number of Multiagency Reviews



Engagement with impacted patients and families

Open disclosure is the open discussion of adverse events that result in harm to a patient while receiving health care with the patient, their family and carers.

The open disclosure process being commenced at notification of the sentinel event is a measure of clinical governance in adverse patient events. The mental health sector is meeting this expectation to a high level (Figure 8, Table 5).

Figure 8: Percentage of sentinel events commenced open disclosure process at notification of event to SCV, 2019–20 to 2023–24



Table 5. Percentage of sentinel events commenced open disclosure process at notification of event to SCV, 2019–20 to 2023–24

Member type	2019–20 (%)	2020–21 (%)	2021–22 (%)	2022–23 (%)	2023–24 (%)
OD commenced	86	100	88	88	97
Statewide performance result	89	91	83	79	85

Family contribution to reviews has also exceeded the statewide benchmark for the past 3 years, recognising the valuable insights family members or loved ones can provide to reviews (Figure 9, Table 6).

Figure 9: Family Contribution/Feedback provided in review process 2019–2020 to 2023–24

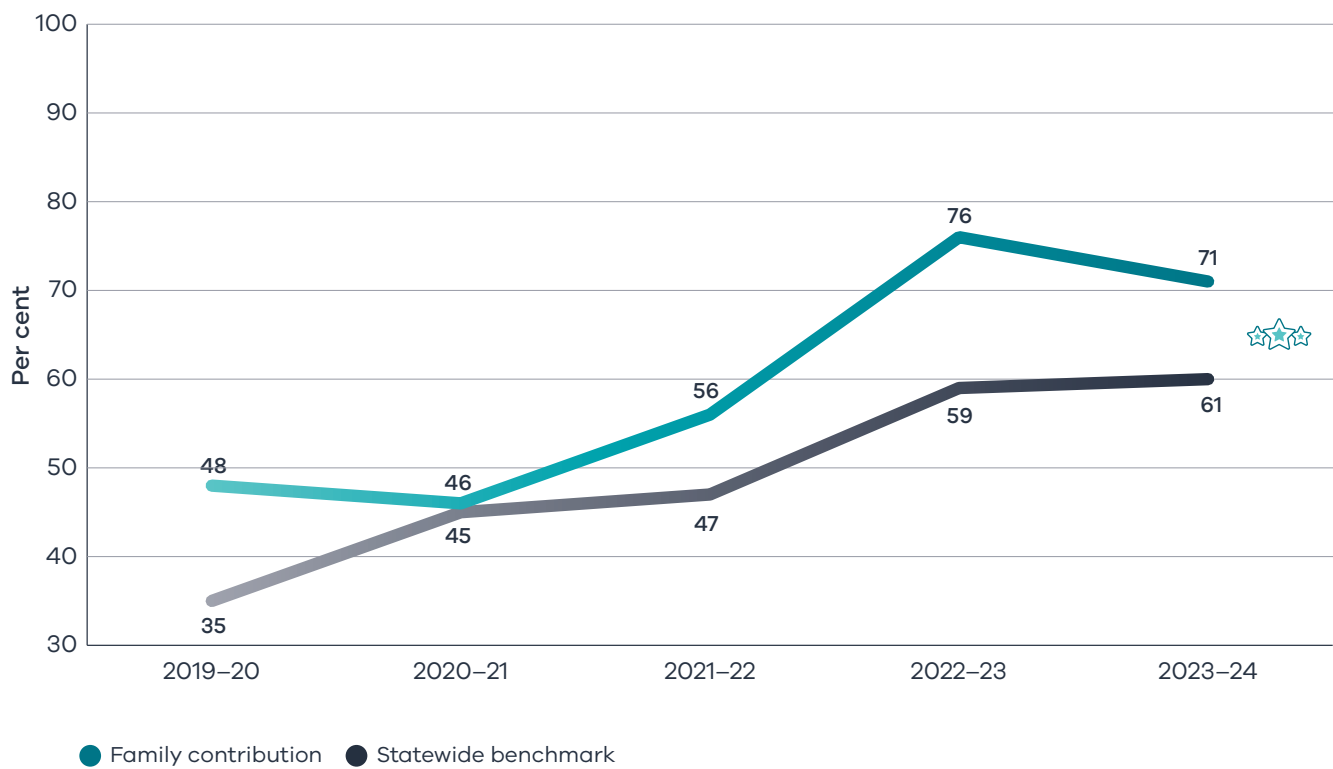


Table 6. Family Contribution/Feedback provided in review process 2019–2020 to 2023–24

Member type	2019–20 (%)	2020–21 (%)	2021–22 (%)	2022–23 (%)	2023–24 (%)
Family contribution	48	46	56	76	71
Statewide performance result	35	45	47	59	61

A focus on category 6 sentinel events

Improving safety for consumers at risk of harm of ligature

Over the past 5 years, SCV has received an average of 5 events per year notified under Australian sentinel event category 6. This category refers to suspected suicide of a patient in an acute mental health unit or acute mental health ward.

Despite safety being an organisational and clinical priority, there is no consensus on effective suicide prevention measures in these settings. Although suicide risk factors are well known at the collective level, predicting risk at the individual level remains low.¹

- *We see in the reported sentinel event data that risk assessments were completed in all cases, though none of the patients were considered a high risk at the time of their death.*

Hanging is reported to be the most common method of fatal and non-fatal deliberate self-harm behaviour in inpatient settings. Which international evidence suggests ligature use is a common form of deliberate self-harm in an inpatient settings. This is because other methods such as access to medication and sharps can be more effectively controlled.²

‘Ligature’ is anything that can be used to tie, bind or strangle such as a cord, rope, belt or fabric. It is often used in healthcare and safety contexts to describe materials or objects that could be used in self-harm or to harm others.

- *This is also reflected in the sentinel event data, with ligature the highest harm risk. It is reported to be the mode of suicide in all notified 2023–24 category 6 events.*

Importantly, minimising the risk of self-harm and suicide by ligature extends far beyond merely managing ligature risks.

- *We understand from our data that patient bedrooms and bathrooms, using door hinges or frames, is the most frequently reported location and environmental risk for harm events involving ligature.*

As well as removing as many ligature points as possible identified through auditing environments, the most effective means of preventing deliberate self-harm using a ligature are:

- ensuring timely and efficient responses to self-harm attempts
- therapeutic engagement.

In 2024, SCV’s Chief Mental Health Nurse commissioned an expert advisory working group to help develop key principles of ‘Improving safety of consumers at risk of harm of ligature’. The aim was to promote safety for consumers while admitted to inpatient and residential services.

1. Chammas, F., Januel, D., & Bouaziz, N. (2022). Inpatient suicide in psychiatric settings: Evaluation of current prevention measures. *Frontiers in Psychiatry*, 13, Article 997974. <https://doi.org/10.3389/fpsy.2022.997974>

2. Groves, S., Lascelles, K., & Hawton, K. (2024). Experiences of clinical staff who work with patients who selfharm by ligature: An exploratory survey of inpatient mental health service staff. *Journal of Psychiatric and Mental Health Nursing*, 31, 376–390. <https://doi.org/10.1111/jpm.12995>

This working group included:

- senior mental health nursing leaders from both SCV and the health sector
- lived experience colleagues
- mental health executive leaders from the public mental health and wellbeing sector.

The result is a new guidance document published in December 2024, co-designed and co-produced by the working group. The document aims to bring together best available evidence in the response to and management of ligature safety events while aligning with other clinical governance requirements such as National Safety and Quality Health Service Standards.

Key principles to consider for each organisation include the following:

- **Organisational and clinical governance**
 - Policy, procedures and processes including implementing ligature audit processes and schedules, responses to ligature events and workforce capability and readiness.
- **Engagement, therapeutic relationship and trauma-informed care**
 - Workforce training and education including immediate clinical response, trauma-informed care, therapeutic engagement and relationships and recognising deterioration and escalation.

- **Response to ligature incidents**

- Adverse event reporting and monitoring
 - recognising trends, notifiable deaths and new risks and learning from serious adverse events.

- **Consumer, workforce and visitor impact and follow-up support**

- Workforce support involving both formal and informal processes, clinical supervision, wellbeing supports, critical incident debriefing and psychological safety for leaders.

For more information, refer to [Improving safety for consumers at risk of harm of ligature](https://www.safercare.vic.gov.au/resources/clinical-guidance/mental-health/ligature) <<https://www.safercare.vic.gov.au/resources/clinical-guidance/mental-health/ligature>>.

Engaging with impacted patients, families and carers

When a sentinel event occurs, health services must invite the impacted patient, family or carer to provide feedback and raise any concerns or questions. Impacted consumers and their loved ones offer unique perspectives about the event circumstances, critical information and powerful insights to the review team.

Their involvement can be healing and restorative, offering potential improvements and solutions to reduce harm. Transparent engagement in the review process helps restore trust between health services and impacted consumers.

‘Being included [in the process] reduced my anger and frustration and showed the humanity of the health service.’

— Impacted consumer



RESOURCE:

SCV has developed guidance to health services on how to strengthen these processes in the *Consumer involvement following a serious adverse patient safety event: a 9-step guide for health services* <<https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/resources-for-involving-impacted-consumers>>.

We are seeing consistent improvements in health services reporting engagement and family contribution to sentinel event reviews. In 118 events of 193 (61%), the patient, family or carer contributed to review or were offered the opportunity to share their version of events, raise questions and express any concerns (Figure 10, Table 7).

Figure 10: Family contribution to reviews, 2021–20 to 2023–24

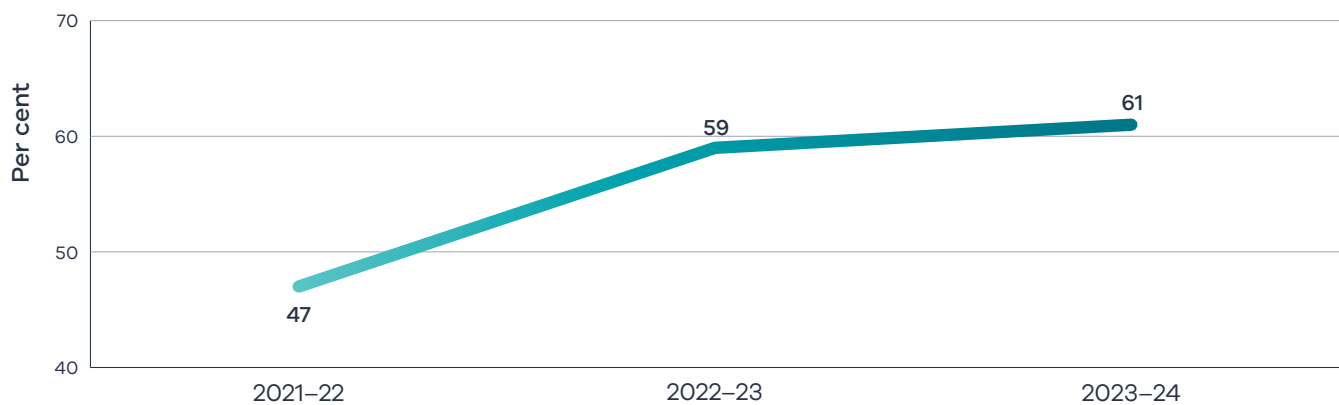


Table 7. Family contribution to reviews, 2021–20 to 2023–24

	2021–22 (%)	2022–23 (%)	2023–24 (%)
Family contribution	47	59	61

Impacted consumers and their families/carers may also choose not to contribute to the review. The key step is that families/carers are offered the opportunity to contribute, understanding that their decision might change as the process unfolds and with time. The consultation process must be adaptable to the unique circumstances of each event and flexible in how it is conducted to respond to the impacted consumer or loved one's needs.

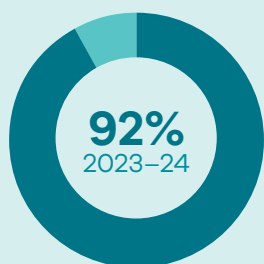
HEALTHCARE COMPLAINTS ANALYSIS TOOL

The sentinel events portal has embedded the [Healthcare Complaints Analysis Tool \(HCAT\)](https://healthcarecomplaintsanalysis.com) <<https://healthcarecomplaintsanalysis.com>> to capture the feedback consumers provide to sentinel event reviews. This evidence-based tool is used to code consumer feedback and helps us better understand the valuable feedback provided by patients and their loved ones.

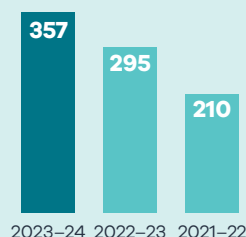
In 2023–24 we saw a significant increase in the number of feedback items from the patient/family contribution. We attribute this to improved health service engagement and improved reporting, and this increase aligns with the increase in completing an open disclosure.

In the 118 events where the patient or family contributed to the review, 109 (92%) events had this feedback incorporated into the review.

THE HEALTHCARE COMPLAINTS ANALYSIS TOOL (HCAT)



109 (92%) of the 118 sentinel events had documented patient, family or carer feedback into the review using the HCAT tool.

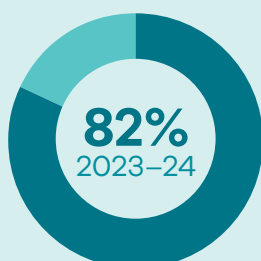


There were **357** feedback items documented in sentinel event reviews in 2023-24.

TOP FIVE HCAT ISSUES RAISED BY CONSUMERS

HCAT DOMAIN	CATEGORY	PERCENTAGE OF ISSUES RAISED
Clinical problems	Quality Clinical standards of healthcare staff behaviour	29%
Clinical problems	Safety Errors, incidents, and staff competencies	28%
Relationship problems	Communication Absent or incorrect communication from healthcare staff to patients	24%
Management problems	Institutional Processes Problems in bureaucracy, waiting times, and accessing care	7%
Relationship problems	Listening Family escalation of care	6%

RESPONDING TO FEEDBACK



In 82% of sentinel events where consumers had input, their feedback contributed to the recognition of critical events, finding or lessons learnt. This is an improvement from 70% in 2022-23.



TOP FIVE HCAT ISSUES LEADING TO A REVIEW FINDING OR LESSON LEARNT

HCAT DOMAIN	CATEGORY	PERCENTAGE OF TIMES ISSUES LED TO FINDING OR LESSON LEARNT
Relationship problems	Listening Healthcare staff disregard or do not acknowledge information from patients	86%
Management problems	Institutional Processes Problems in bureaucracy, waiting times, and accessing care	58%
Relationship problems	Respect and patient rights Disrespect or violations of patient rights by staff	56%
Management problems	Environment Problems Problems in the facilities, services, clinical equipment, staffing levels	55%
Clinical problems	Quality Clinical standards of healthcare staff behaviour	46%

ADVICE FOR HEALTH SERVICES

Prioritise capturing family contributions in reviews in all aspects of engagement and review processes. Ensure family contributions are clearly identified and addressed in the review report.

For more information about how SCV uses the HCAT to interpret consumer feedback, visit the [Thematic interrogation of patient complaints in the state of Victoria](https://www.safercare.vic.gov.au/best-practice-improvement/publications/thematic-interrogation-of-patient-complaints-in-the-state-of-victoria) webpage <<https://www.safercare.vic.gov.au/best-practice-improvement/publications/thematic-interrogation-of-patient-complaints-in-the-state-of-victoria>>.

OPEN DISCLOSURE

Open disclosure is the open and transparent discussion with a patient, their family and carers that takes place after an adverse event. Open disclosure data for sentinel events in 2023–24 shows continued and sustained improvement by health services. It reflects the embedding of the SDC into practice (Figure 11, Table 8).

Figure 11: Open disclosure indicators, 2021–22 to 2023–24

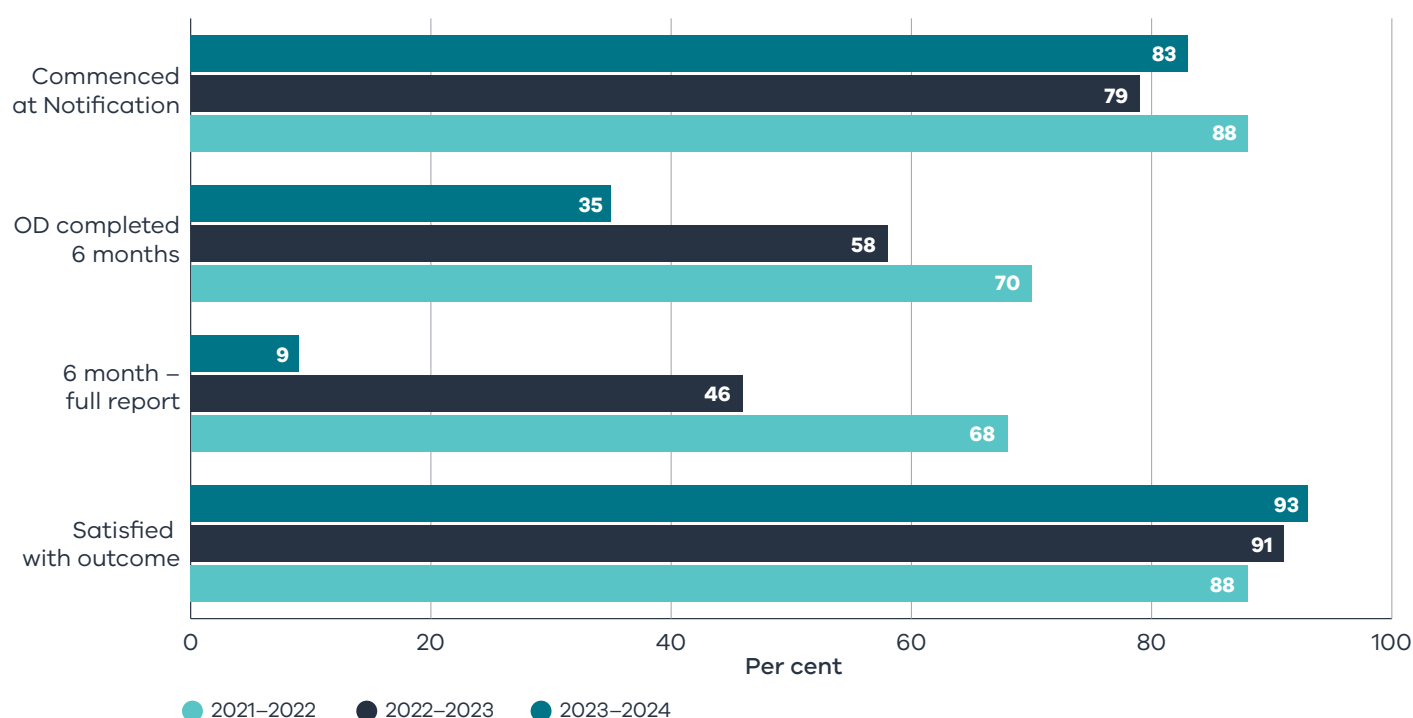


Table 8. Open disclosure indicators, 2021–22 to 2023–24

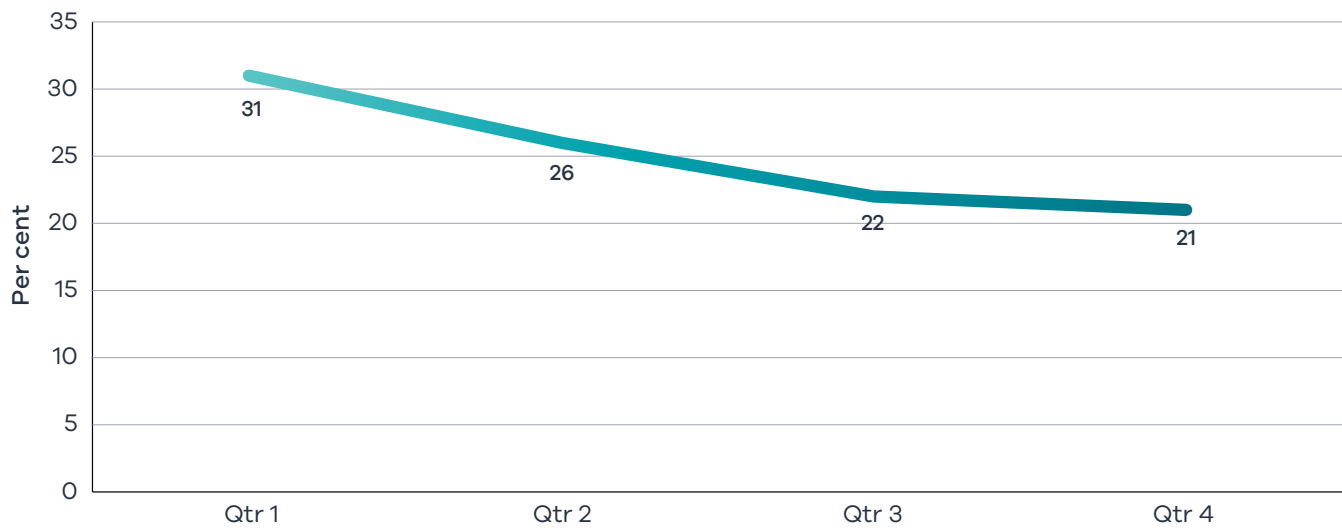
Open disclosure	2021–22 (%)	2022–23 (%)	2023–24 (%)
Commenced at notification	83	79	85
Completed at 6 months	35	58	70
Full report provided to consumer at 6 months	9	46	68
Consumer reported they were satisfied with the outcome of the review	93	91	88

STATUTORY DUTY OF CANDOUR

Starting from 30 November 2022, health services are legally required to take specific actions when a patient is harmed by a serious adverse patient safety event (SAPSE), including a sentinel event. This legal responsibility is called the SDC, and there are key requirements and timelines health services must follow. These are outlined in the *Victorian duty of candour guidelines*. Starting from July 2023, health services must report their compliance with SDC. SCV monitors this data to measure the uptake of SDC practices.

Impacted patients and families can choose to opt out of the SDC process because it may not be right for them. They can also choose to get involved at a later date. The early data trends are showing improving reporting compliance and reassuringly, with a reducing rate of impacted patients/families opting out of SDC (Figure 12). This tells us that as health services are continuing to embed processes and learn from these experiences, there is better engagement with impacted patients and families.

Figure 12: Percentage of consumers opting out of SDC process within 6 months, 2023–24



Case study: Evaluating SDC implementation at Western Health

Western Health has recently evaluated its implementation of SDC and has shared their experiences with us.

When we introduced the SDC at Western Health, our intention was to continue to promote transparency, trust and person-centred care, continuing to embed values-based behaviours and to foster a culture of learning, professionalism and trust-building between clinicians and patients.

These SDC requirements have been successfully integrated into the existing Western Health clinical incident management policies, procedures, guidelines and workflows to ensure patients and/or their next of kin or carers receive open and honest communication and are provided with a genuine apology, a clear explanation of what occurred and why it happened, and what steps are being taken to prevent similar adverse events in the future.

To ensure these requirements are embedded and sustained in our organisation, we redesigned the roles and responsibilities of our Best Care Coordinators. For each review, one of our Best Care Coordinators is allocated as the 'dedicated family contact'. Their role is to:

- serve as the main contact for the patient or next of kin throughout the SDC process
- build rapport and trust with the patient or next of kin, being available to respond to concerns or questions as needed
- complete all SDC meeting documentation
- facilitate communication within Western Health and with the patient or next of kin during incident reviews
- maintain fortnightly contact with the patient or next of kin via their preferred communication method, providing review updates.

We completed an evaluation activity 12 months after implementing SDC to understand feedback from patients and staff. We wanted to gauge their understanding and satisfaction with the SDC process and identify areas for improvement.

Patients who took part in the SDC process and chose to contribute to the evaluation were interviewed by the health service's dedicated family contact person. Nine patients took part.

Key findings

- 100% found the SDC consumer information helpful.
- 78% were satisfied with the support received.
- 44% found the process beneficial, noting it helped answer their questions and move on from the incident.

Feedback from those who found it less beneficial

- The process did not change the outcome.
- There was conflicting information between the patient and the organisation.
- The timing for contact was inappropriate.
- There were delays in receiving the review report.

Staff feedback was collected via an electronic survey, with 66 respondents. Notably, 45% of these respondents were managers, including directors, operations managers and nurse unit managers.

Case study: Evaluating SDC implementation at Western Health (continued)

Key findings from the staff survey were:

1. Awareness and training:

- 89% of staff are aware of the SDC legislation.
- 56% have completed SDC training.
- 82% are aware of the SDC process at Western Health.
- 42% have taken part in the process.

2. Confidence and information access:

- 44% feel confident or very confident in understanding the SDC process.
- 80% know where to find SDC information at Western Health.

3. Support during the process:

- 55% feel supported or very supported during the SDC process.
- 67% do not require additional support, while 33% do.

4. Additional support needs:

- 36% of those needing more support want additional training.
- 27% would like support available during the process.
- 9% need protected time to meet SDC process timeframes.

Since our evaluation, we have developed a safety capability framework to enhance skills in reviewing adverse events for staff and patients involved in SAPSE reviews. We are improving how meetings are planned to ensure there is protected non-clinical time and that reviews are completed in a timely way.

We have introduced a patient safety education program on our learning management system. The program features the SCV online packages for adverse event reviews, SDC and open disclosure. This program will be included as part of onboarding process at Western Health and mandatory for specific staff. We are

also exploring an SDC mentorship model for clinicians. This will not only provide peer support for our staff but continue to build a sustainable culture of support among our clinicians.

Based on feedback and to reflect Western Health's commitment to supporting patients throughout the SDC process, we've made the following changes:

- designed a dedicated and expedited procedure for the freedom-of-information process for patients and families who have experienced a SAPSE and waived fees for SDC-related requests
- provided taxi and parking vouchers for patients attending face-to-face SDC meetings.

We are also collaborating with patients through our Diversity, Equity and Inclusion Consumer Partnership Program to create an evaluation tool for ongoing collection of SDC experience information, helping us continually evaluate and improve our processes.

For more information about the SDC process at Western Health, [email the Best Care team](mailto:BestCare@wh.org.au) <BestCare@wh.org.au>.

Prepared by Belinda Bisignano, Best Care Operations Manager



For general information, visit the Statutory duty of candour and protections for SAPSE reviews webpage <<https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour>>.

Recommendations from sentinel event reviews

The following recommendations are the result of a review. They are designed to prevent or mitigate harm by identifying and addressing opportunities for improvement within systems. These actions aim to reduce the likelihood of similar adverse events recurring or to minimise harm if they do. In alignment with systems thinking and just culture, these recommendations should prioritise addressing systemic issues rather than focusing on individual faults.

DEVELOPING RECOMMENDATIONS

After each sentinel event review, the review panel develops recommendations and sets out an action plan for implementing these recommendations. These recommendations are developed to address findings and learnings from the review. They aim to reduce the risk of similar events recurring, ultimately improving the quality and safety of patient care.

WRITING RECOMMENDATIONS

Recommendations should be written and developed in line with SMART (specific, measurable, assignable, realistic, time-bound) principles.

RECOMMENDATION STRENGTH

Recommendations are classified according to the level of tangible impact that the actions outlined in the recommendation will have in the health service. Moderate and strong recommendations focus on changing the design of systems to better support human performance (Table 9).

For more information, refer to the [Appendix: Guide to strength of recommendations](#).

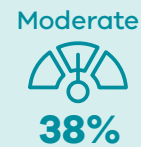
Table 9. Strength of recommendations from the review of sentinel events, 2021–22 to 2023–24

Strength	2021–22	2022–23	2023–24
Total recommendations	1,149	1,159	758
Weak	41%	48%	50%
Moderate	44%	40%	38%
Strong	15%	12%	12%
Rated SMART	61%	83%	85%

Note that the ‘total recommendations’ data is incomplete due to reporting timeframes. This will be reported in the 2024–25 annual report.

COUNT OF RECOMMENDATIONS

758 recommendations



85% were written using SMART principles

Up from 83% in 2022–23

S
Specific

M
Measurable

A
Achievable

R
Realistic

T
Timely

Progress of recommendations

Health services provide SCV with a recommendation monitoring report 6 months after notifying us of a sentinel event and again at 12 months, if required. This report describes the progress made against each recommendation and identifies any barriers to completion (Table 10).



SCV has been working to establish better processes for tracking the progress of recommendations. Health services can expect more communication from SCV around these metrics in 2025.

Table 10. Progress of recommendation implementation at 6 and 12 months, 2021–22 to 2023–24

Completion rate	2021–22	2022–23	2023–24
Complete at 6 months	38%	35%	49%
In progress at 6 months		60%	47%
Complete at 12 months	74%	70%	
In progress at 12 months		20%	
On hold at 6 months		3%	3%
On hold at 12 months	2%	2%	
Abandoned at 6 months		2%	1%
Abandoned at 12 months	4%	7%	
Average time to completion	186 days	178 days	

Note that some data fields are incomplete due to reporting timeframes. These will be reported in the 2024–25 annual report.

Table 11. Top 5 recommendation categories, 2023–24

RECOMMENDATIONS THEMES		STRENGTH*
Further Review and Develop Action Plan	17%	Weak 
Standardise Process	15%	Moderate 
Share Outcomes/Education Reference	14%	Weak 
New Procedure/Memorandum/Policy	12%	Weak 
Training	8%	Weak 

Cluster reviews

Cluster reviews are required when multiple (~3 or more) events of a similar nature result in actual harm or may result in harm to a patient. Cluster events can occur within or across health services and in various ways, for example:

- **one thing that went wrong and harmed a number of people (for example, broken equipment or IT system resulting in multiple patients experiencing or being exposed to harm)**
- **multiple occurrences of similar outcomes (harm) within one area or across different areas.**

IDENTIFYING CLUSTERS OF EVENTS

Health services must have processes to identify and manage clusters of events when they occur. If a health service notices a cluster of events resulting in actual or potential harm, they should notify SCV for advice on next steps.

When reviewing a cluster of events health services should reflect on, where able, previous reviews and resulting recommendations. This includes considering the effectiveness of these as part of the subsequent review. Services should also reflect on how they can improve processes to strengthen recommendations.

We are seeing increased recognition of these types of events across the sector. There is growing interest in reviewing these events as a whole. Monash Health identified a cluster of events across a number of years related to harm as a result of spinal cord compression.

Case study: Monash Health Cluster Review – spinal cord compression

In early 2024 the Patient Safety Review Team at Monash Health identified several adverse events involving delayed recognition or response to spinal cord compression. Trends in adverse events are identified by quality unit clinicians, who oversee all reported sentinel events. These are then confirmed via a review of the quality improvement database, which contains details of all adverse events with findings and lessons themed according to the London Protocol.³

Spinal cord compression is a time-critical condition requiring prompt recognition, magnetic resonance imaging (MRI) and surgical management to prevent long-term neurological complications.

Spinal cord compression can be caused by any condition that puts pressure on your spinal cord, these can include:

- bone issues – osteoarthritis, bone spurs, fractures, dislocation
- injury – falls, traumatic injury, haematomas
- tumours
- connective tissue changes.

Spinal cord compression is essentially a painless condition and should be suspected when patients present with:

- new/increasing numbness in the legs, inner thighs or back
- loss of bladder or bowel control
- weakness that spreads into one or both legs
- difficulty walking or getting out of bed/chair.

Monash Health decided to perform a cluster review of these cases, with the aims to:

- group findings and their contributing factors to identify common themes related to care management issues
- review recommendations previously developed and implemented to assess their effectiveness
- use this knowledge to develop high-impact recommendations to address gaps in care.

Over 4 and a half years there were 9 sentinel events where delayed recognition or response to spinal cord compression resulted in ongoing functional deficits for patients. Five cases were reviewed prospectively. Four of the 5 had been previously reviewed and reported to SVC. For the prospective reviews, one 'index' case was reviewed as per the usual processes. A panel including subject matter experts, an external clinician and a consumer representative met to identify care delivery problems and make findings about the contributors to these. The remaining 4 cases underwent desktop reviews by the subject matter experts, who then presented their findings back to the larger group. Reports and recommendations from the cases included retrospectively were reviewed.

Findings and contributing factors from all cases were then collated under 3 themes:

- delays in diagnosis
- delays to imaging after diagnosis suspected
- delays to surgical intervention after imaging.

3. Refer to: Taylor-Adams S, Vincent C (2004) Systems analysis of clinical incidents: the London protocol. *Clinical Risk*, 10(6):211–220.

Case study: Monash Health Cluster Review – spinal cord compression (continued)

Key findings

There were delays in diagnosis in all 9 cases. This was predominantly due to insufficient neurological examination by medical and nursing staff. Knowledge deficits were also noted, resulting in underappreciation of identified neurological signs (particularly limb weakness and urinary retention) and therefore delayed escalation.

Seven cases had a delay to imaging. This was primarily due to teams initially ordering the incorrect imaging modality (a computed tomography [CT] scan instead of an MRI) because processes to order MRI scans were unclear. Two cases experienced delays to surgery due to unclear transfer processes resulting in delayed inter-hospital transfers.

All recommendations from the cases reviewed retrospectively had been actioned, but similar cases continued to occur. This was because:

- previous recommendations were very specific, tailored to individual presentations
- though the recommended procedure to help clinicians manage patients with potential spinal cord compression had been written, it was highly detailed and complex and not implemented effectively into clinician workflows
- a number of recommendations were education-focused, and this is known to be a weak effector of change in a dynamic health system.

Summary

The process of reviewing these cases together allowed us to design a lower volume of higher-impact, system-focused recommendations to prevent similar cases happening in future. In a health system bound by economic restraints it is important that valuable resources are directed to be where they can be most effective.

ADVICE FOR HEALTH SERVICES

1. Consider how you can share the learnings from this cluster review with your local clinical teams. Ensure to involve medical, nursing and allied health staff who care for consumers with spinal pain and associated disorders.
2. Think about current processes and procedures related to:
 - completion and frequency of neurovascular and clinical observations
 - recognising and responding to neurovascular deterioration
 - timely access to appropriate imaging
 - timely access to surgery after imaging.
3. Neurological complications related to spinal conditions are commonly underappreciated and underreported. Consider ways that your health service can better identify, review and manage such adverse events.

Adverse patient safety events of this nature, where the identification of a clinical incident and permanent harm may not be appreciated until late in the patient's care journey, during rehabilitation or when/if the patient raises a concern.



Strengthening just culture

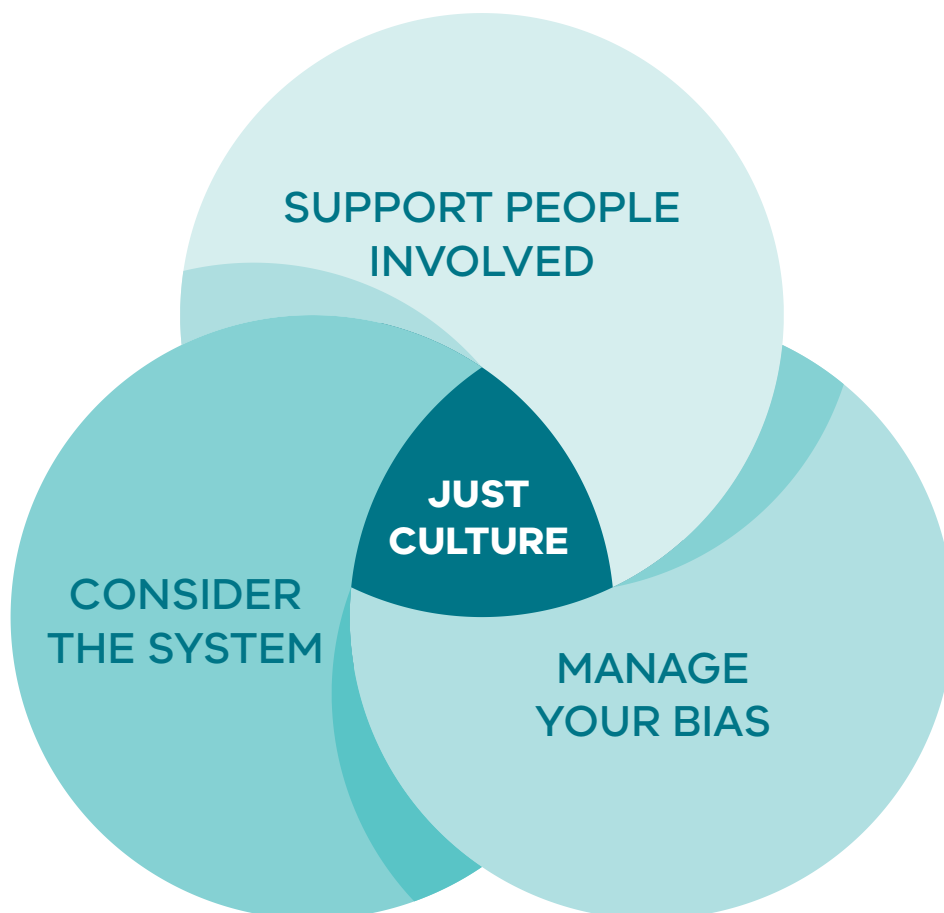
A 'just culture' applies systems-thinking principles to adverse patient safety events (Figure 13). A just culture is built on trust and shared accountability between individuals and the organisation responsible for designing and improving systems in the workplace.

Adopting this approach will help improve the quality of adverse event reviews and their outcomes. Working towards a just culture will foster an open and trusting environment where staff can freely discuss safety issues, including the

circumstances of how adverse events occurred. When staff trust that adverse event reviews aim to learn from what happened, finding a balance between individual and system accountability, they will be more willing to report incidents and take part openly in reviews.

For more information, [download a factsheet about just culture in adverse event reviews](https://www.safercare.vic.gov.au/sites/default/files/2022-08/Just-Culture-in-adverse-event-reviews-factsheet.pdf) <<https://www.safercare.vic.gov.au/sites/default/files/2022-08/Just-Culture-in-adverse-event-reviews-factsheet.pdf>>.

Figure 13: Just culture mindset – 3 key elements



Case study: Barwon Health – supporting frontline staff involved in adverse patient safety events

When an adverse patient safety event occurs, the immediate priority is the care and support of the affected patient and their families and carers. Respect, transparency and a heartfelt apology are fundamental elements of responding to an event.

While supporting patients and families after an adverse event must remain a priority, it is equally important to acknowledge the often-overlooked profound impact these events can have on frontline staff and those supporting them.

Healthcare workers typically enter their professions with the intention of providing the best care possible within a complex and high-pressure environment. But when things go wrong, the emotional toll on these workers can be immense. Frontline staff may face psychological, physical and behavioural issues such as anxiety, fear, shame, rumination, insomnia and reduced work performance, pushing them to engage in more conservative practice. Some healthcare workers leave the profession suffering from post-traumatic disorders and mental ill health.

Providing healthcare workers with respect, compassion and understanding after an adverse event is critical for their recovery and long-term wellbeing. Further research shows talking to a peer, someone who understands the workplace and context, may improve outcomes for healthcare workers affected by a critical event. Healthcare services may provide access to external formalised programs

to support staff after a critical event, but the affected staff members may choose not to engage in these activities.

Some past critical incident support processes caused harm in some settings despite an assumption of benefit. There is little data describing the efficacy of programs for mitigating stress after a critical incident.⁴

In recognition of this, Dr Belinda Carne and a group of senior colleagues have developed and formalised a peer support program in the Barwon Health emergency department. This came about after a critical incident in which the review preceded support for the healthcare workers involved.

This program has transformed how staff are supported after traumatic events. As the first program of its kind in an emergency department, it has fostered a culture of compassion and resilience, with trained team members reaching out promptly to offer empathetic peer support and encouragement.

Each craft group in the emergency department has a team of volunteer peer support providers plus a team leader who have undertaken an experiential training workshop. These groups run autonomous peer-to-peer programs – for example, nurses for nurses and administration staff for administration staff. Team members provide support in relation to a notified adverse patient safety event and, in the case of the doctors' program, are an adjunct to existing mentor and trainee support structures.

4. Refer to: Anderson GS, Di Nota PM, Groll D, et al. (2020) Peer support and crisis-focused psychological interventions designed to mitigate post-traumatic stress injuries among public safety and frontline healthcare personnel: a systematic review. *International Journal of Environmental Research and Public Health*, 17(20), 7645.

Case study: Barwon Health – supporting frontline staff involved in adverse patient safety events (continued)

This peer support program accepts referrals from peers, supervisors and self-referral. The impacted staff member is promptly allocated follow-up via text or a phone call with a no-pressure opt-out option. If the healthcare worker decides to engage, they can talk confidentially with a supportive and trained colleague.

In a recent evaluation of the peer support program, 100% of survey respondents praised its value. The program has become a beacon of positivity and teamwork, ensuring every clinician feels seen, supported and empowered in their challenging roles.⁵ The program has also achieved national recognition, winning the Australasian College of Emergency Medicine 2024 Wellbeing Award. Dr Carne is now supporting other departments at Barwon Health to train and implement their own peer support programs. Dr Carne hopes

to see these programs rolled out across the Victorian health system.

The implementation of such programs is a key step in building robust support structures for staff, ensuring they receive the care and attention they need to recover from the emotional toll of adverse events. By formalising these support mechanisms, healthcare organisations can foster a healthier, more resilient workforce, ultimately improving patient care and safety. Positive safety cultures are consistently associated with a range of positive patient outcomes including reduced rates of mortality, falls and hospital-acquired infections, and improved patient satisfaction.

For more information about implementing a peer support program at your health service, [email Dr Belinda Carne](mailto:Belinda.Carne@barwonhealth.org.au) <Belinda.Carne@barwonhealth.org.au>.



Pictured:

Emergency Department doctors involved in the peer support program: Megan Hamilton, Belinda Carne, Minnie Seward, Belinda Hibble, Chris McRae, Anoushka Perera.

5. Refer to Carne B, Furyk J (2024) Supporting clinicians post exposure to potentially traumatic events: emergency department peer support program evaluation. *Emergency Medicine Australasia*, <https://doi.org/10.1111/1742-6723.14518>.

Case study: Barwon Health – supporting frontline staff involved in adverse patient safety events (continued)



ADVICE FOR HEALTH SERVICES

Just culture in action: supporting staff involved in an adverse patient safety event

- 1. Check on staff:** Ensure all clinical and non-clinical staff involved are okay. Immediate emotional support is crucial following unexpected and tragic events.
- 2. Acknowledge hurt:** Recognise the pain and negative feelings staff may have after an unexpected event that may have been as a result of a potential or actual error.
- 3. Immediate response:** Ask staff what they need right away and provide it. This might include psychological support, compassion or reassurance about the review process.
- 4. Long-term support:** Develop a plan for ongoing support. Involve staff in the review process and system improvements, allowing them to contribute meaningfully.
- 5. Monitor recovery:** Create a recovery plan with input from staff, tailored to their specific needs. Ensure continuous support and follow-up.

Further reading and resources

SCV has resources and information available to support health services and consumers to improve safety culture and prevent patient harm.

Resources for health services and leaders:

- [Clinical governance framework](https://www.safercare.vic.gov.au/best-practice-improvement/publications/clinical-governance-framework)
<<https://www.safercare.vic.gov.au/best-practice-improvement/publications/clinical-governance-framework>>
- [Victorian safety culture guide](https://www.safercare.vic.gov.au/publications/victorian-safety-culture-guide)
<<https://www.safercare.vic.gov.au/publications/victorian-safety-culture-guide>>
- [Adverse patient safety events policy](https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events)
<<https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events>>
- [Adverse patient safety event guideline](https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events)
<<https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events>>
- [Falls Review Tool](https://www.safercare.vic.gov.au/best-practice-improvement/projects/older-people-and-palliative-care/falls-review-tool-pilot-project)
<<https://www.safercare.vic.gov.au/best-practice-improvement/projects/older-people-and-palliative-care/falls-review-tool-pilot-project>>
- [Partnering in healthcare framework](https://www.safercare.vic.gov.au/publications/partnering-in-healthcare)
<<https://www.safercare.vic.gov.au/publications/partnering-in-healthcare>>
- [ACSQHC incident management and sentinel events](https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident-management-and-sentinel-events)
<<https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident-management-and-sentinel-events>>
- [Managing adverse events](https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events)
<<https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events>>
- [Guides to consumer representatives on adverse event reviews](https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews)
<<https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews>>
- [Learning and education: fundamentals of adverse patient safety event review](https://www.safercare.vic.gov.au/e-learning/fundamentals)
<<https://www.safercare.vic.gov.au/e-learning/fundamentals>>
- [Learning and education: engaging with impacted consumers](https://www.safercare.vic.gov.au/e-learning/consumer)
<<https://www.safercare.vic.gov.au/e-learning/consumer>>
- [Morbidity and mortality framework and toolkit](https://www.safercare.vic.gov.au/publications/morbidity-and-mortality-meetings-framework-and-toolkit)
<<https://www.safercare.vic.gov.au/publications/morbidity-and-mortality-meetings-framework-and-toolkit>>
- [Quality improvement toolkit](https://www.safercare.vic.gov.au/best-practice-improvement/quality-improvement/toolkit)
<<https://www.safercare.vic.gov.au/best-practice-improvement/quality-improvement/toolkit>>
- [The Australian open disclosure framework](https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework#australian-open-disclosure-nbsp-framework)
<<https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework#australian-open-disclosure-nbsp-framework>>
- [Online training modules – SDC](https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour)
<<https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour>>
- [Learning and education: SDC](https://www.safercare.vic.gov.au/e-learning/duty-of-candour)
<<https://www.safercare.vic.gov.au/e-learning/duty-of-candour>>

- **About the sentinel events portal**
<<https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/about-the-sentinel-events-portal>>
- **Just culture resources**
<<https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/just-culture-training-and-resources>>
- **Thematic interrogation of patient complaints in Victoria**
<<https://www.safercare.vic.gov.au/best-practice-improvement/publications/thematic-interrogation-of-patient-complaints-in-the-state-of-victoria>>

Resources for patients, families and carers

- **What are adverse and sentinel events?**
<<https://www.safercare.vic.gov.au/consumer-resources/what-adverse-sentinel-events>>
- **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>>
- **Guides to consumer representatives on adverse event reviews**
<<https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews>>
- **Duty of candour resources for patients, families and their carers**
<<https://www.safercare.vic.gov.au/consumer-resources/duty-of-candour-resources-for-patients-families-and-their-carers>>

Glossary

Terminology	Definition
Adverse patient safety event/adverse event	An incident in which a person receiving health care is harmed. For more information on responding to an adverse event, visit Managing adverse events <https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events>
Australian Commission on Safety and Quality in Health Care	A Commonwealth Government entity for quality and safety in health care that sets the national sentinel event notification list. For more information, visit the commission's website <https://www.safetyandquality.gov.au>.
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
Cluster review	A review of multiple (3 or more) events of a similar nature that resulted in harm or may result in harm to a patient.
Critical event	Identified when reviewing an adverse event, it is the point at which a different action would have altered the subsequent sequence of events and the outcome of patient harm.
Harm	Physical or psychological damage or injury to a person. Examples of harm are disease, suffering, impairment (disability) and death.
Healthcare Complaints Analysis Tool	An evidence-based, standardised tool for systematically coding consumer voice and organising and analysing complaints information to reliably assess healthcare problems, their severity and the level of patient-reported harm. The HCAT can be used for service monitoring, organisational learning and research into complaints and is an early indicator for patient safety risks.
Healthcare consumer	A patient, their family or carer(s)
Human factors	Human factors refer to the environmental, organisational, human and job factors that influence human performance. The science of human factors applies theory, data, and methodologies to understand interactions among humans and the systems in which they work.
International Classification for Patient Safety	The international conceptual framework for classifying patient safety <https://www.who.int/publications/i/item/WHO-IER-PSP-10.2>. This is a framework developed by the World Health Organization to categorise 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.
Just culture	Just culture encourages balanced accountability between organisations and individuals and the application of systems-thinking principles to allow fair and just responses to adverse events.
Lessons learnt	The opportunities for improvement identified through the review process but that did not contribute to the adverse event.
Ligature	Anything, like a cord or other material, that could be used for hanging or strangulation (Source: Reducing harm from ligatures in mental health wards and wards for people with a learning disability <https://www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance>.)
Multi-agency review	A panel review of an adverse event that involves 2 or more health services. All services involved in the harm of the patient are expected to take part in the review panel.
Open disclosure	The open and transparent discussion of adverse events that result in harm to a patient while receiving health care. This takes place with the patient, their family and carers.

Terminology	Definition
Peer group	Grouping of health services of comparable size or clinical capability to allow for accurate comparison for the purpose of data reporting
Reporting culture	An environment where individuals have the confidence and feel safe to report safety issues without fear of blame, and where they can trust their concerns will be acted on
Review finding	A summary statement that describes how a system issue or factor contributed to an adverse patient safety event
Safety culture	The individual and group values, attitudes and behaviours that determine the commitment to and practice of organisational safety
SAPSE	Serious adverse patient safety event
SCV	Safer Care Victoria
SDC	Statutory duty of candour: In Victoria, “statutory duty of candour” (SDC) is a legal obligation that requires healthcare providers to openly and honestly inform patients and their families when a serious adverse patient safety event (SAPSE) occurs, including providing an apology and explaining the details of what happened, as well as steps to prevent similar incidents from happening again
Sentinel event	The most serious adverse event in which a patient dies or is seriously harmed
SMART	This acronym stands for specific, measurable, achievable, realistic, time-bound. It refers to goals

Data supplement

Data in this report and data supplement has been compared with previous years, where possible. The number of years that can be included for comparison varies between indicators. This is due to changes to the reporting requirements for health services and the methods for collecting this data over time.

SENTINEL EVENTS REPORTING BY CATEGORY AND SUBCATEGORY

Table 12 shows sentinel events notifications by category.

Table 12. Sentinel event notification by category, 2021–22 to 2023–24

Australian sentinel event category	2021–2022	2022–2023	2023–2024
1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	1	3	3
2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death	0	0	0
3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death	2	1	0
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death	2	4	2
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death	1	0	0
6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	6	2	6
7. Medication error resulting in serious harm or death	16	22	13
8. Use of physical or mechanical restraint resulting in serious harm or death	0	0	0
9. Discharge or release of an infant or child to an unauthorised person	0	0	0
10. Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death	0	3	0
11. All other adverse patient safety events resulting in serious harm or death	212	210	169
Total	240	245	193

We use subcategories based on the World Health Organization's International Classification for Patient Safety (ICPS) for events notified under the Victorian-only category 11 (Table 13).

Table 13. Sentinel event notifications as a percentage of all Category 11 events 2021–22 and 2022–23

Subcategory	2020–2021 (%)	2022–23 (%)	2023–24 (%)
Clinical process or procedure	29	28	38
Recognising and responding to clinical deterioration	34	33	31
Communication of clinical information	6	6	11
Self-harm	5	7	10
Falls	15	9	3
Medical device or equipment	1	2	2
Healthcare-associated infection	4	9	1
Resource or organisational management	4	5	1
Patient accident	1	2	1
Nutrition	0	0	1

In 2023–24, we observed the following:

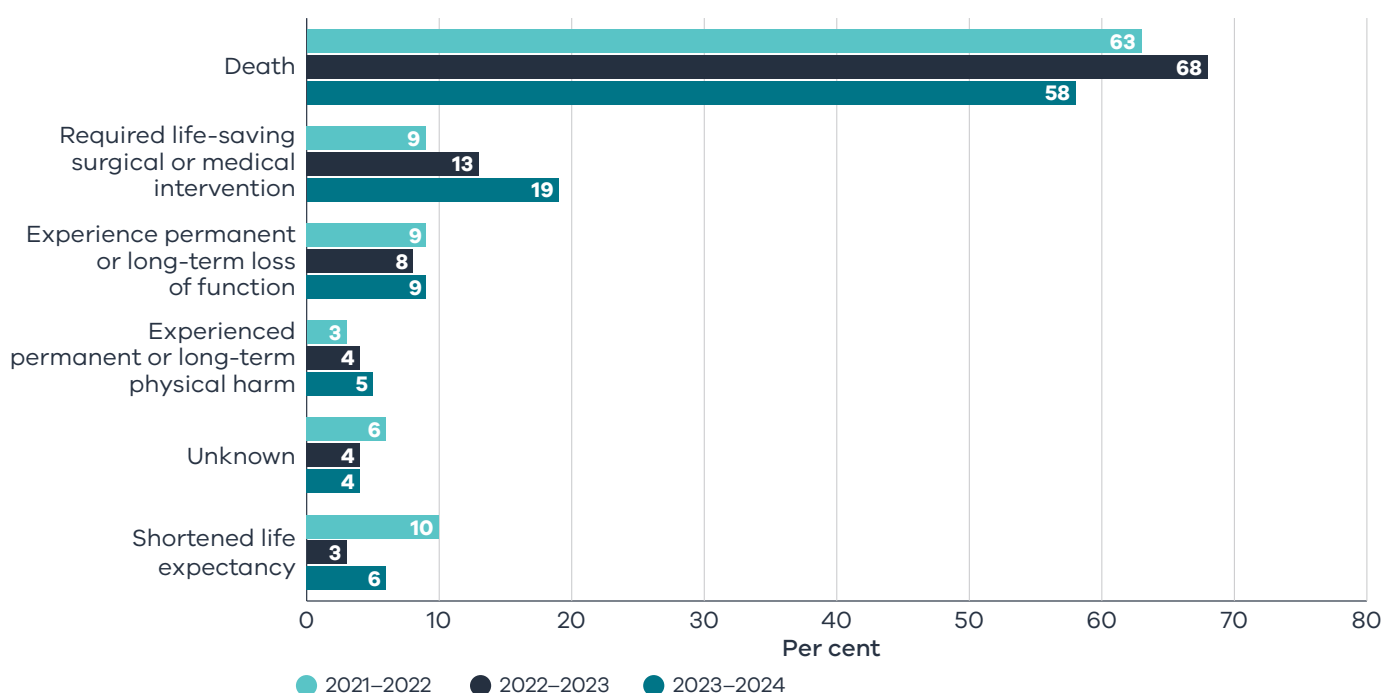
- Clinical process and procedure was the most common event category, as opposed to 'recognising and responding to clinical deterioration', which was the top category over the last 2 years.
- The notification of falls-related sentinel events was on hold for this reporting period until February 2024, hence the significant reduction in notifications.
- A reduction in healthcare-associated infections is noted.

Patient outcomes

Fifty-eight per cent of sentinel events reported in 2023–24 resulted in the patient's death (Figure 14).

Health services must indicate the degree of harm to the patient when they notify SCV about a sentinel event. The full degree of the impact of the event may not be known at the time of the notification and the patient outcome is not expected to be updated throughout the review.

Figure 14: Patient outcome by percentage of total sentinel events, 2021–22 to 2023–24



AGE OF AFFECTED PATIENT

The ages of patients affected by sentinel events are shown in Figures 15 and 16 and in Table 14.

Figure 15: Age (years) of adults affected by sentinel events by percentage of total sentinel events, 2021–22 to 2023–24

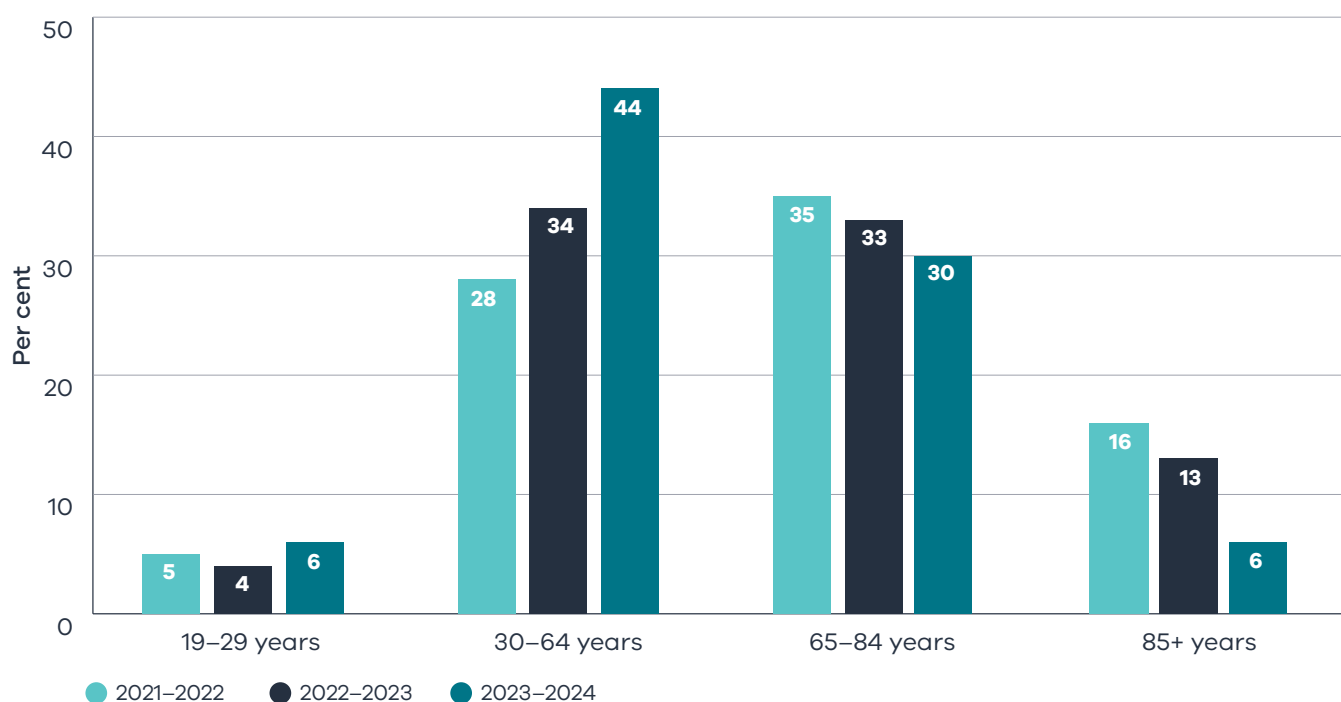


Figure 16: Age of babies, children and adolescents affected by sentinel events by percentage of total sentinel events, 2021–22 to 2023–24

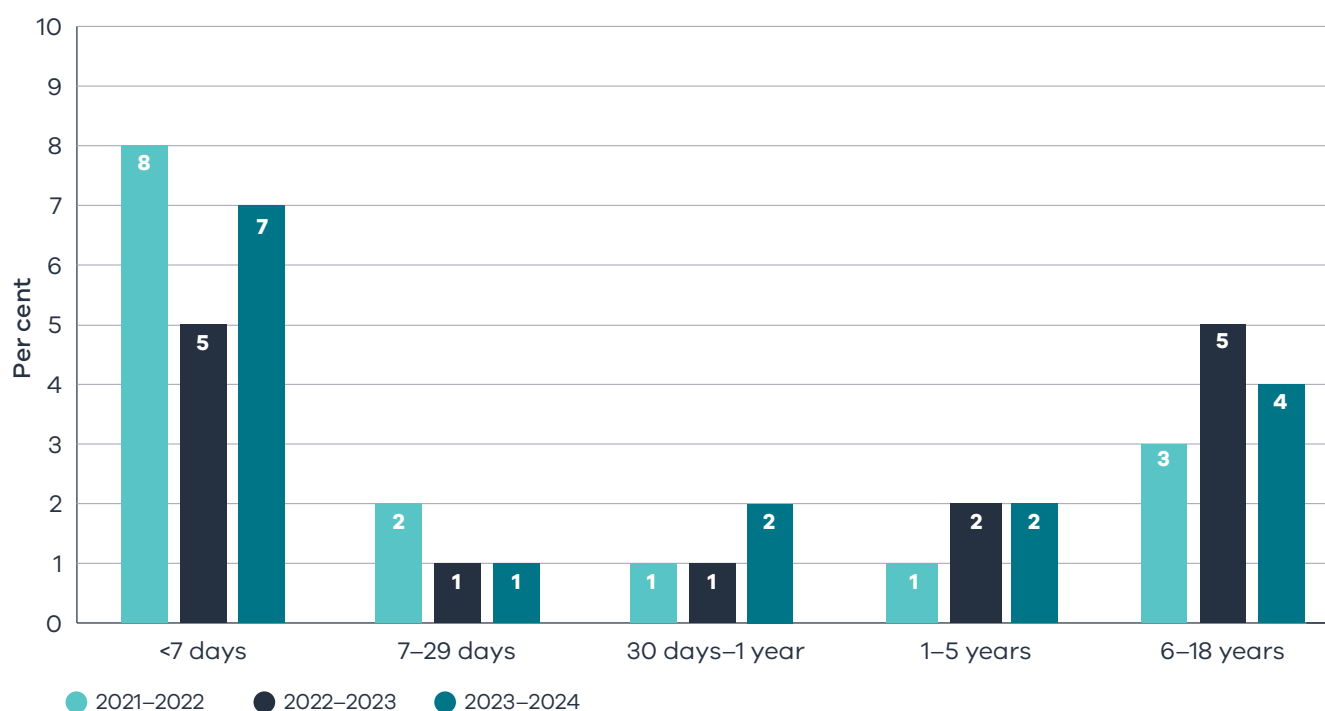


Table 14. Sentinel events affecting babies, children and adolescents by percentage of total sentinel events, 2021–22 to 2023–24

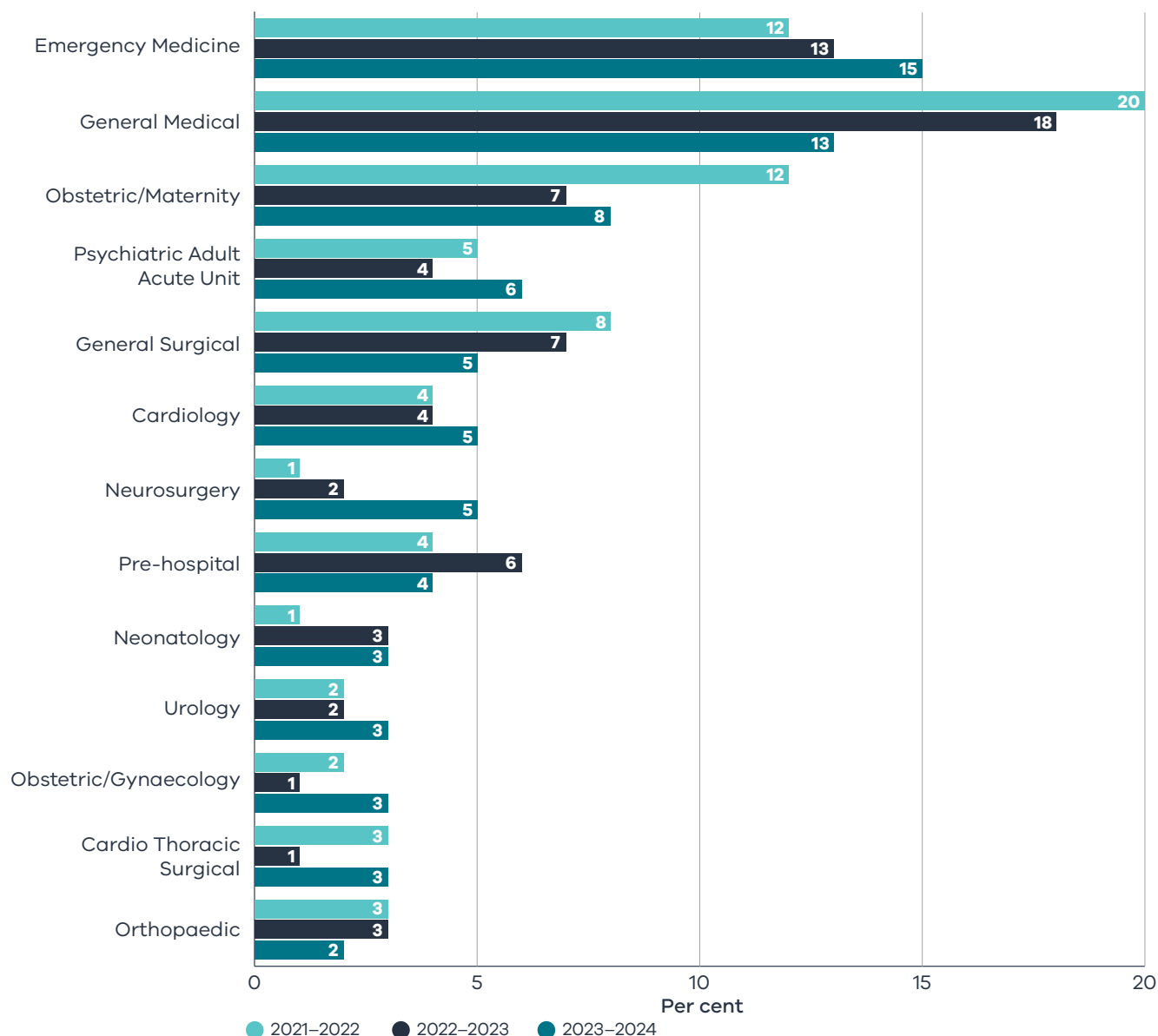
	2021–22 (%)	2022–23 (%)	2023–24 (%)
	15	14	16

TOP ADMITTING SPECIALITIES

Reporting health services must identify the speciality providing care to the patient when the sentinel event occurred.

Emergency Medicine and General Medical continue to be the top 2 admitting specialities for patients when sentinel events occur (Figure 17).

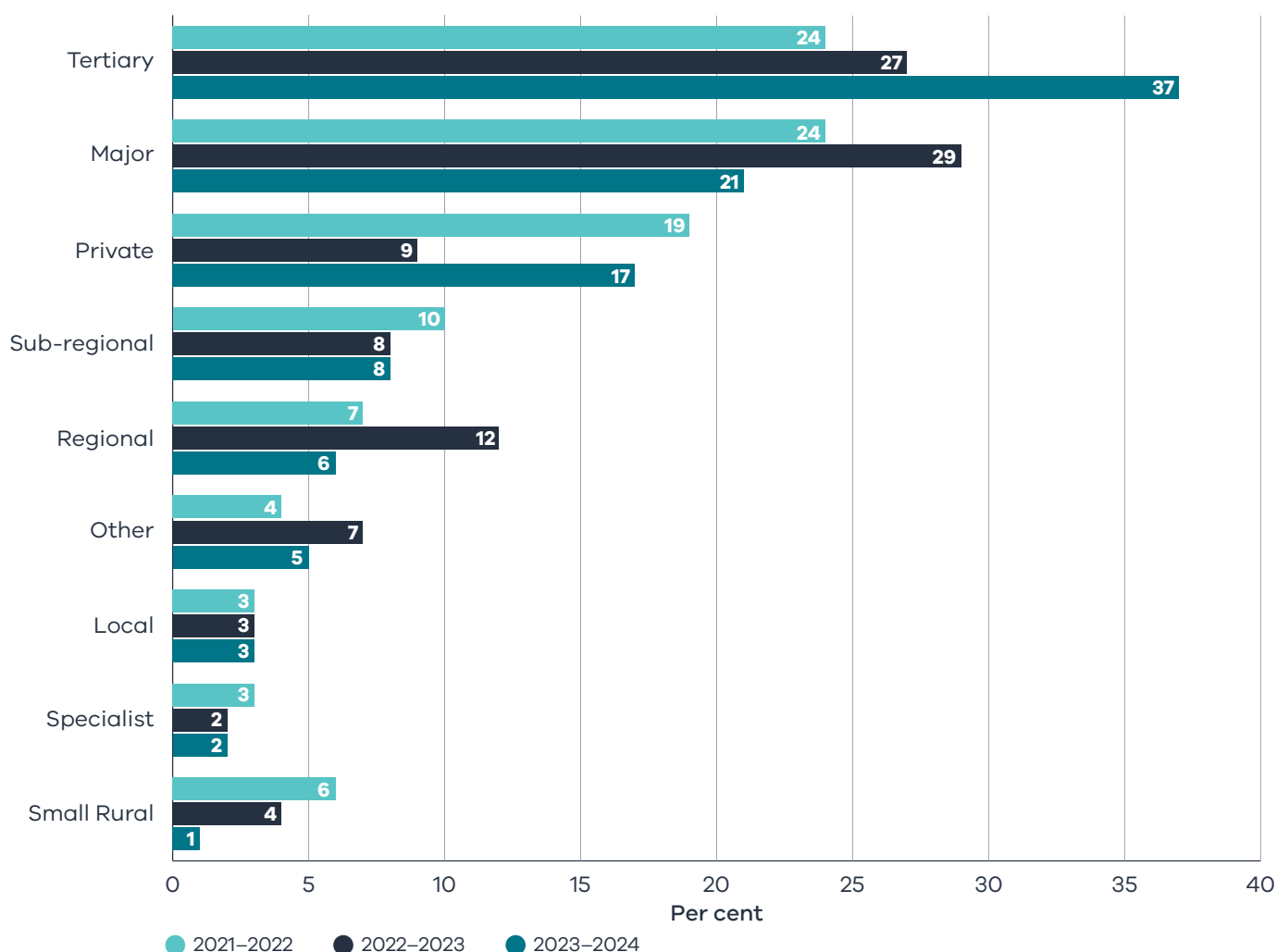
Figure 17: Sentinel events by top admitting specialty, 2021–22 to 2023–24



SENTINEL EVENT PEER GROUP AND LOCATION

Figure 18 shows that most sentinel events over the past 3 years occurred in tertiary hospitals, which is understandable given the numbers of patients they admit across Victoria.

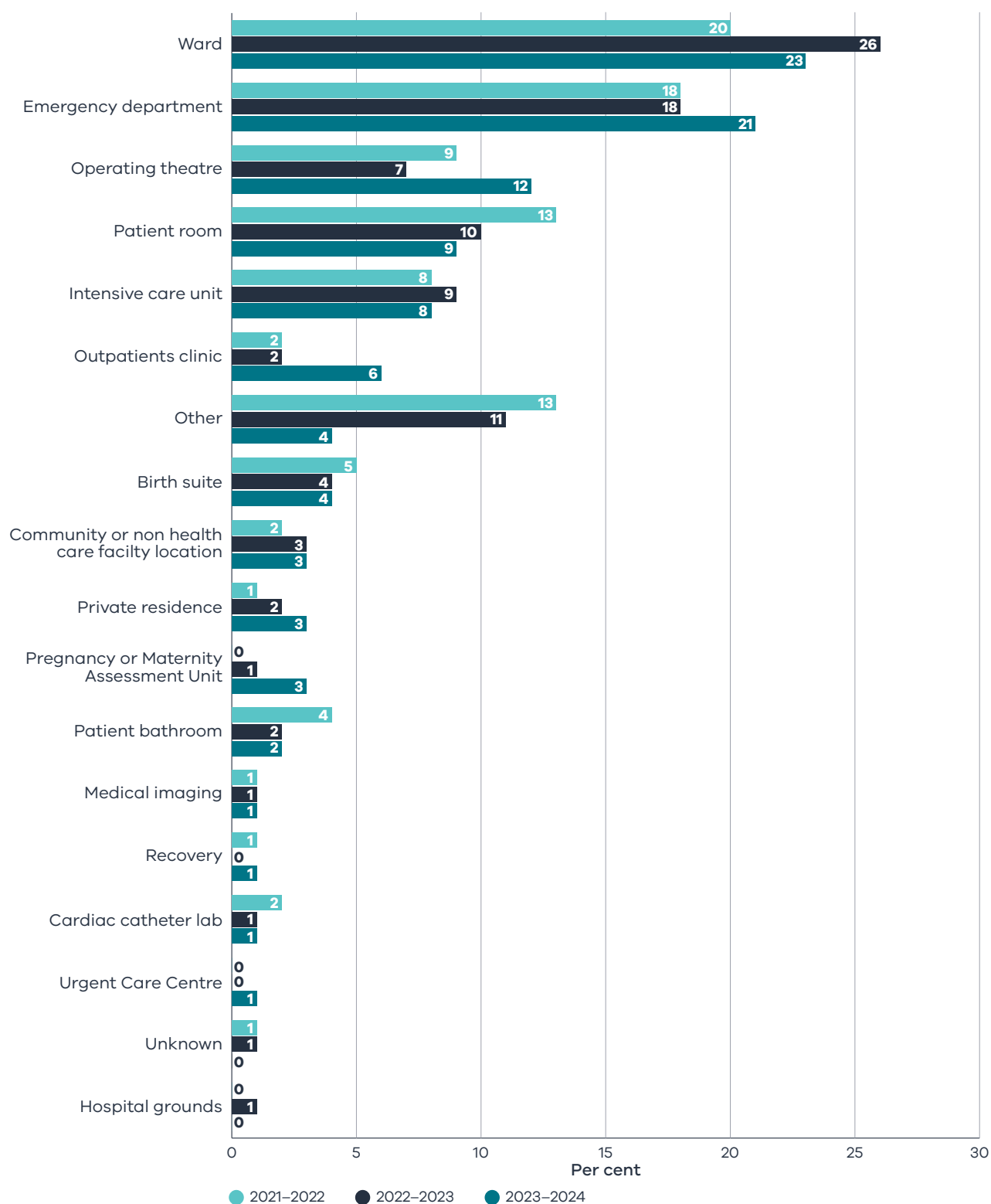
Figure 18: Percentage of sentinel events by health service peer group, 2021–22 to 2023–24



The location of sentinel events occurring in health services has remained steady across 3 years, reflecting areas where patients spend the most time receiving care (wards and patient

rooms) or where complex, high-risk situations unfold (emergency departments, operating theatres and intensive care units) (Figure 19).

Figure 19: Percentage of sentinel events by location in the health service, 2021–22 to 2023–24



TIME TO NOTIFY SENTINEL EVENTS

Health services must notify SCV of a sentinel event within 3 business days of becoming aware of the event.

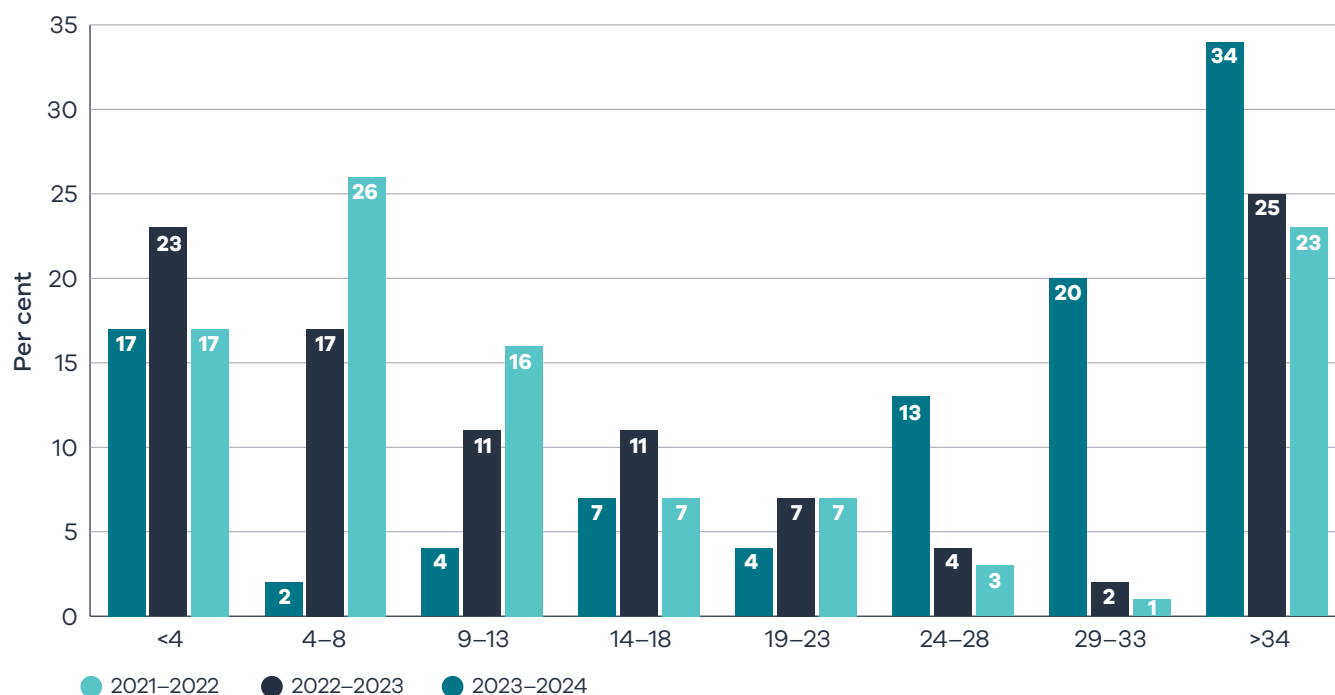
Table 15 and Figure 20 show that, for 2023–24:

- the average days to notify a sentinel event was 22.0 business days, reduced from 27.7 business days in 2022–23
- 17% of sentinel events were notified within 3 business days, down from 23% in 2022–23.

Table 15: Time to notify sentinel events, 2021–22 to 2023–24

	2021–22	2022–23	2023–24
Average days to notify	22.5 days	27.7 days	22 days
Percentage of events notified within 3 business days	17%	23%	17%

Figure 20: Number of business days to notify sentinel events, 2021–22 to 2023–24



TIME TO REVIEW SENTINEL EVENTS

This indicator measures the time taken from sentinel event notification to the submission of the recommendations formed by the health service's review of the event (part C of the sentinel event report).

The required timeframes for sentinel event report part C submission for a health service is:

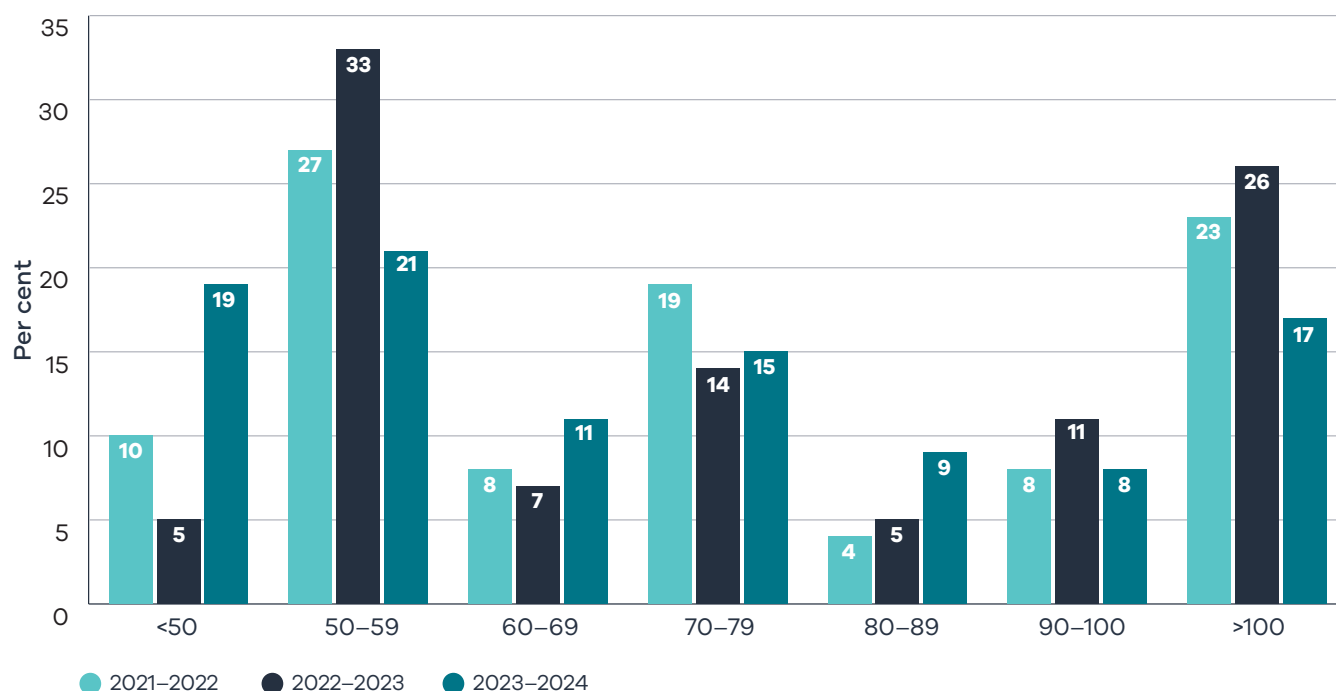
- 50 business days for a single agency review
- 75 business days for an approved multi-agency review.

Figure 21 shows that the average number of days to complete a review in 2023–24 were:

- for a single agency review, 76 business days, compared with 89 business days in 2022–23
- for a multi-agency review, 93 business days, compared with 105 business days in 2022–23.



We note improvements in both measures.


Figure 21: Number of business days to complete a sentinel event review, 2021–22 to 2023–24



Appendix 1: Guide to strength of recommendations

Table 16. Strength of recommendations

Recommendation strength	Recommendation category	Example
	Strong actions	Architectural/physical changes in surroundings
	Strong actions	New devices with usability testing
	Strong actions	Engineering control (forcing functions that force the user to complete the action)
	Strong actions	Simplify process and remove unnecessary steps
	Strong actions	Tangible involvement by leadership
	Moderate actions	Redundancy
	Moderate actions	Increase in staffing/decrease in workload
	Moderate actions	Software enhancements or modifications
	Moderate actions	Eliminate/reduce distractions
	Moderate actions	Education using simulation-based training with periodic refresher sessions/observations
	Moderate actions	Checklist/cognitive aids
	Moderate actions	Eliminate look- and sound-alikes
	Moderate actions	Standardised communication tools

Recommendation strength	Recommendation category	Example
	Weak actions	Double checks
	Weak actions	Warnings
	Weak actions	New procedure/memorandum/ policy
	Weak actions	Training

