SCV
Safer Care
Victoria

4 October 2019

Incident response overview

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Consumers as Partners Branch

VICTORIA
State
Government

Overview

1. Sentinel event definition and new categories
2. Overview of the sentinel event program
3. New patient safety adverse event policy
4. Draft patient safety adverse event framework
5. Lens for learning - systems thinking
6. Incident review process overview
7. Incident analysis methodologies
8. The role of the Board in sentinel events

Revised national definition of sentinel event

‘a particular type of serious incident that is wholly preventable and has caused serious harm to, or death of, a patient.’

Serious harm :

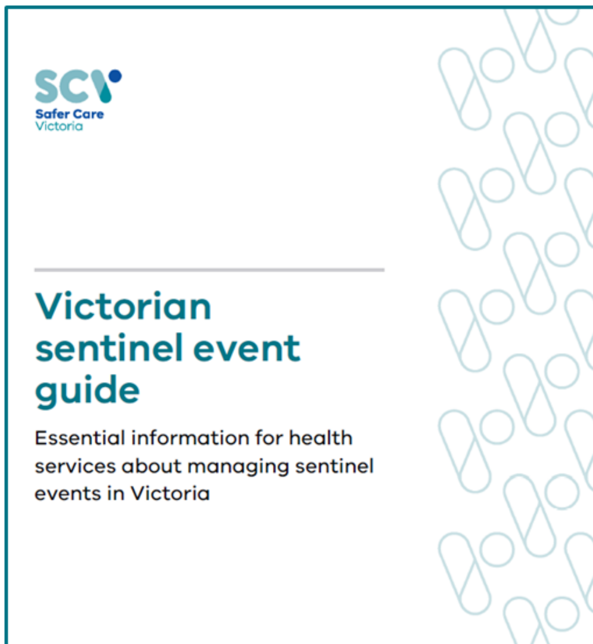
- required life-saving surgical or medical intervention, or
- shortened life expectancy, or
- experienced permanent or long-term physical harm, or
- experienced permanent or long-term loss of function.

. . . adopt a consumer-focused approach

Revised sentinel event categories

Revised Australian sentinel events list (version 2) (2017)	Original Australian sentinel events list (2002)
1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function [Split into three]
2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death	2. Suicide of a patient in an inpatient unit
3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death	3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death	4. Intravascular gas embolism resulting in death or neurological damage [Removed]
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death	5. Haemolytic blood transfusion reaction resulting from ABO incompatibility
6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
7. Medication error resulting in serious harm or death	7. Maternal death associated with pregnancy, birth and the puerperium [Removed]
8. Use of physical or mechanical restraint resulting in serious harm or death [New]	8. Infant discharged to the wrong family
9. Discharge or release of an infant or child to an unauthorised person	9. Other catastrophic: incident severity rating 1 (ISR 1)
10. Use of an incorrectly positioned oro or naso-gastric tube resulting in serious harm or death [New]	
11. All other adverse patient safety events resulting in serious harm or death	

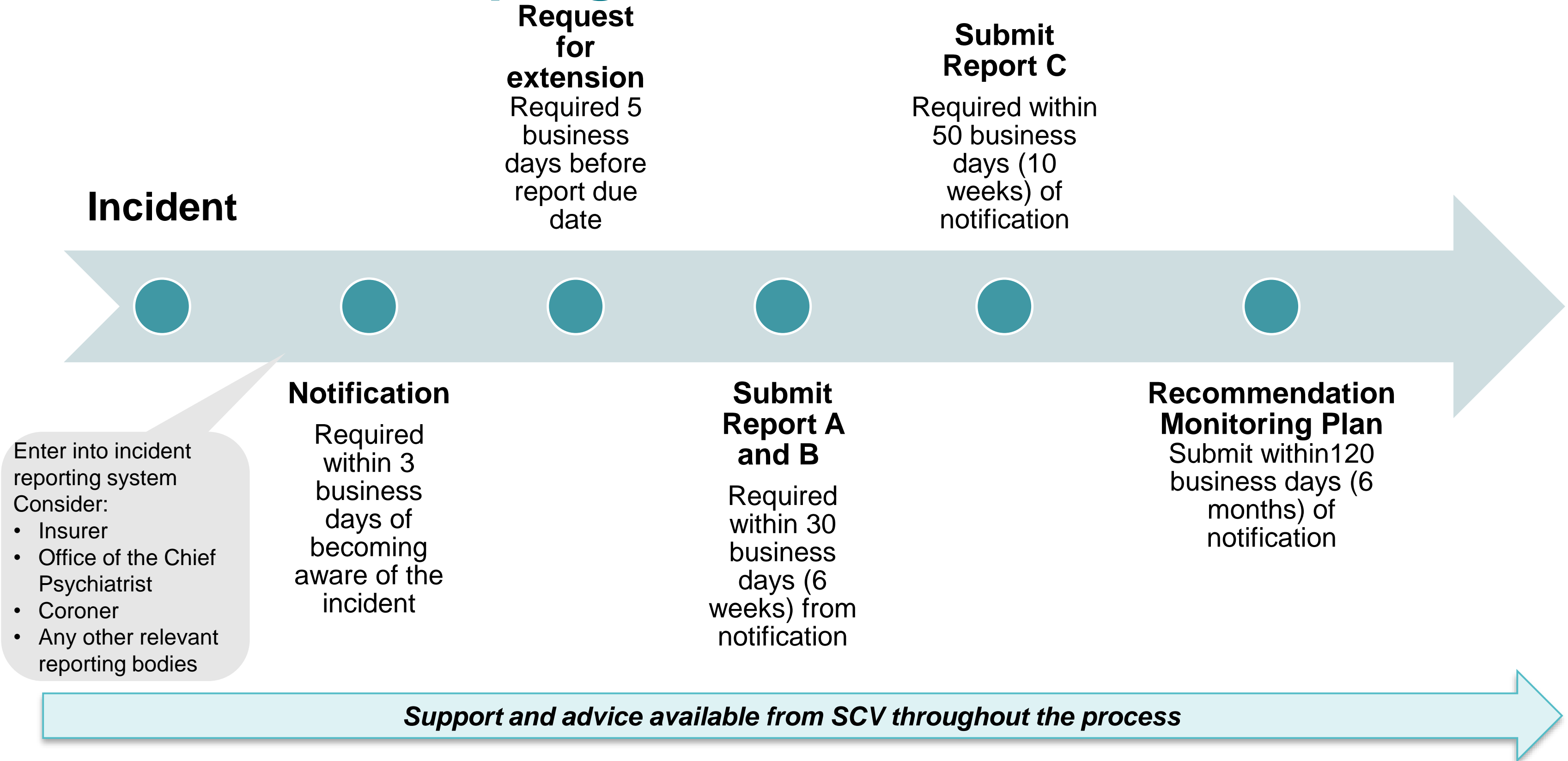
Category 11 (Victorian only) inclusions



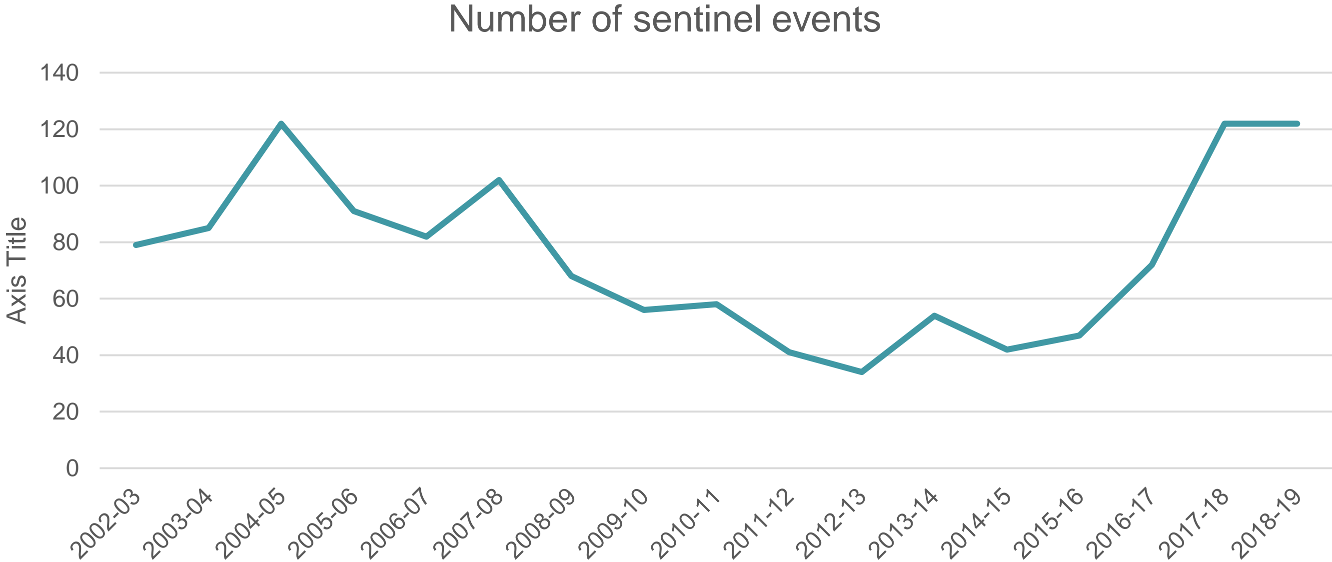
All adverse patient safety events resulting in serious harm or death (that are not included in the 10 national categories).

Guide available at: https://www.bettersafercare.vic.gov.au/sites/default/files/2019-06/Victorian%20sentinel%20events%20guide_0.pdf

Sentinel event program overview



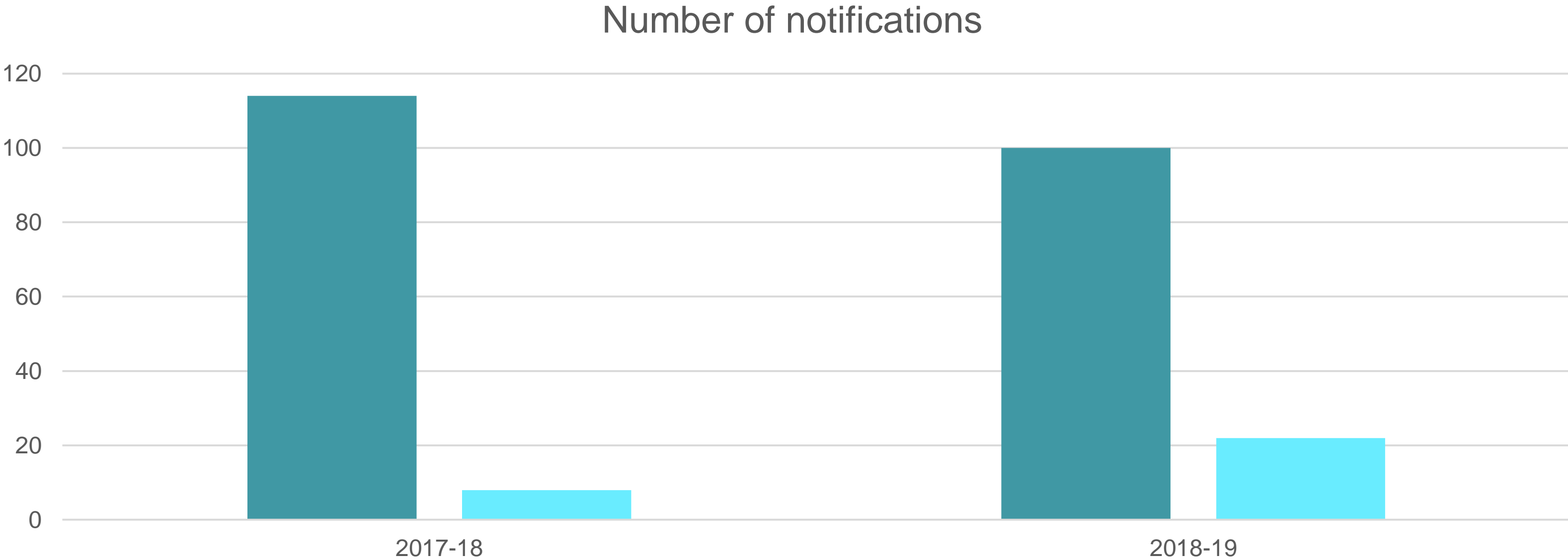
Number of sentinel events over time



Breakdown of categories over time

	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	2016-17	2017-18	2018-19
Wrong patient or body part	1	1	0	0	0	0	1	1	1
Suicide in an inpatient unit	9	8	9	8	4	7	7	7	5
Retained instrument or other material	5	7	6	6	6	7	7	12	10
Intravascular gas embolism	1	0	0	1	0	1	2	0	1
Haemolytic blood trans reaction	1	0	0	0	0	0	0	2	0
Medication error	2	4	1	3	7	1	3	2	5
Maternal death	2	0	1	3	2	0	3	0	0
Infant discharged to wrong family	0	0	0	0	0	0	0	0	0
Other catastrophic: ISR 1	37	21	17	33	23	31	49	98	100
Total	**58**	**41**	**34**	**54**	**42**	**47**	**72**	**122**	**122**

Public and Private SE notifications



Adverse Patient Safety Event Management Policy

- Available on SCV's website: https://www.bettersafercare.vic.gov.au/reports-and-publications/policy-adverse-patient-safety-events
- Replaces DHHS 2011 incident management policy and guide
- Policy statement not a procedure manual
- Supported by the Adverse Patient Safety Event Management Framework
- Informs management of both Sentinel and non Sentinel events
- Applicable health services broadened, simplified, more inclusive

Adverse Patient Safety Event Management Policy

July 2019

Adverse Patient Safety Event Management Framework

Sections of the Framework will be released in stages to allow consultation and health service uptake

August/September 2019

What is an Adverse Event?

- Why review?
- International Classification for Patient Safety by the World Health Organization (WHO
- VHIMS ISR 1-4
- Sentinel Events- Updated list and Victorian 11

Consumer Perspective

- The partnership between consumers and health care providers
- Adverse events within whole consumer experience of care
- Ensuring consumers are informed what happened.
- Including the consumer in the analysis process

October 2019

Open Disclosure

- What is Open Disclosure?
- When should Open Disclosure occur?
- Barriers to maintaining good verbal and written communication
- National Safety and Quality Health Service Standards
- Elements for successful Open Disclosure

October/November 2019

Adverse Event Management and Review Process

- Adverse Event management procedures.
- Sentinel Event Procedures.
- Notification and preparation of RCA report
- QA Checklist
- Internal review.
- SCV Internal.
- Peer platform.
- Multi-Health Service reviews

Analysis Methodologies

- Human factors
- Root Cause Analysis, RCA2

December/January 2019/2020

Preparation and Leadership

- Ensure leadership support.
- Cultivate safe, just, flexible, reporting and learning cultures.
- Understanding Legal requirements

Secondary trauma

- SCV training

Accimap

Outcomes and Improvement

- Using recommendations to drive improvement.
- Monitoring and measuring the effectiveness of actions.
- Sharing of learning

London Protocol

Cluster analysis

February 2019

Safety II

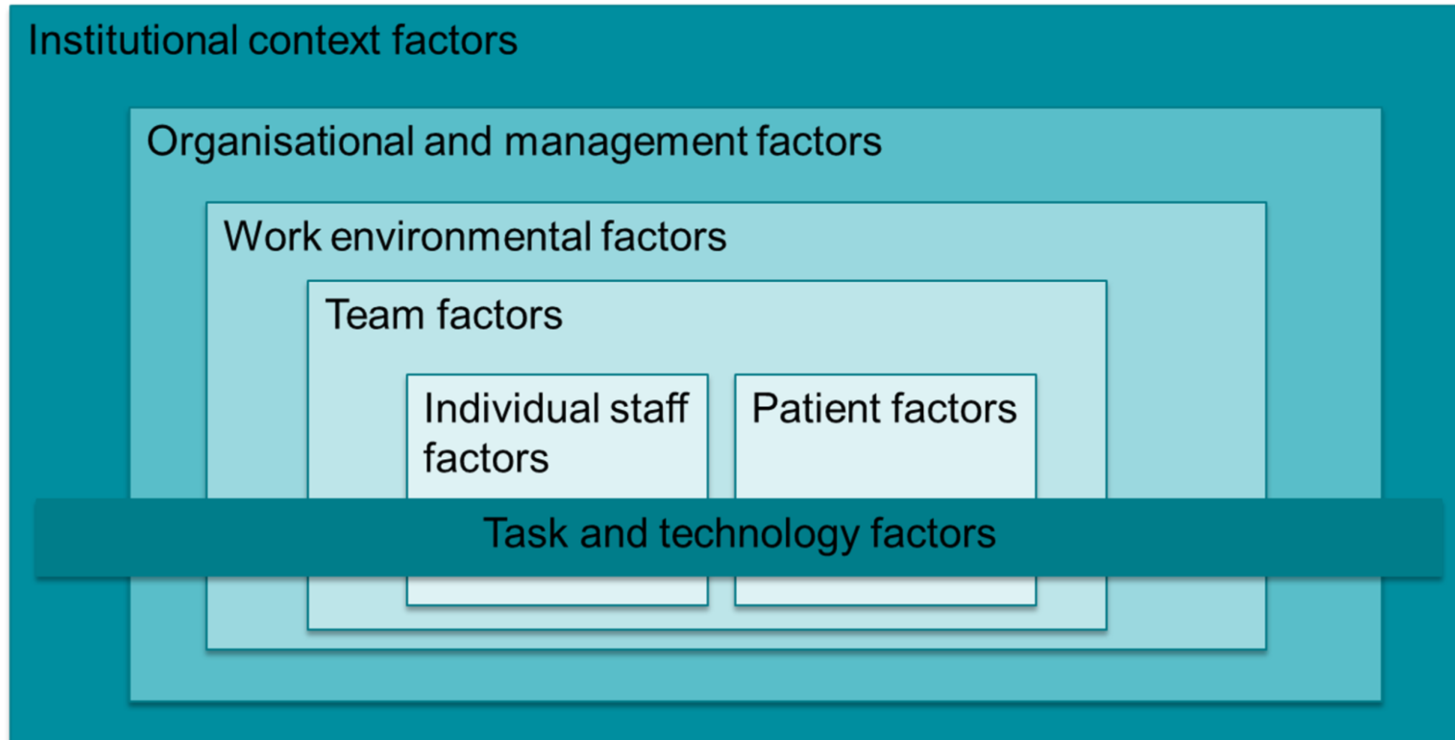
- Safety I and Safety II
- Resilience Engineering
- Resilience Potentials

Falls analysis

Mental Health Reviews

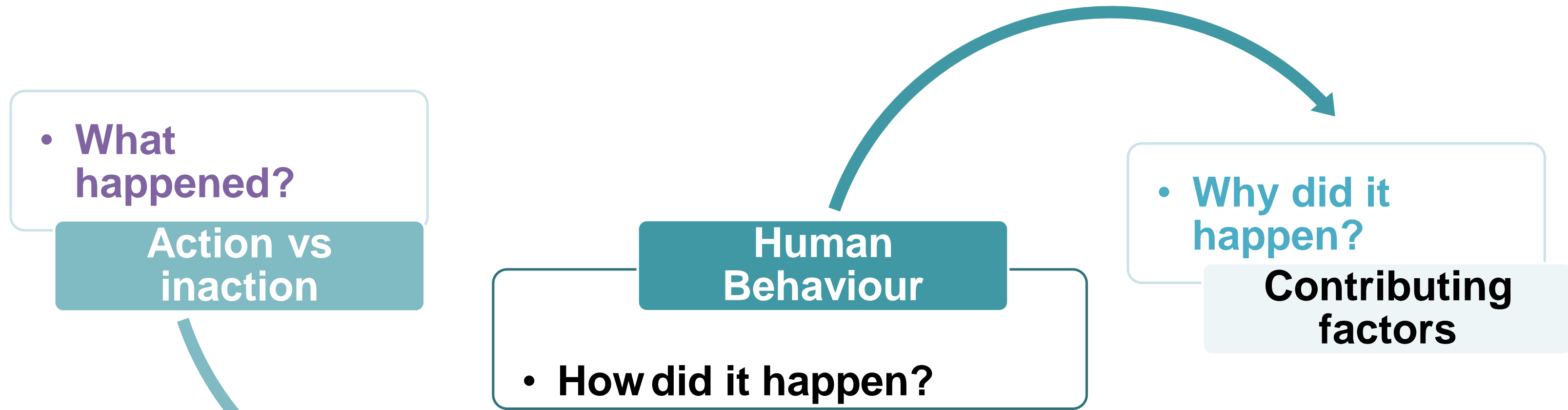
Guidelines, Tools, Templates and Training resources will be developed in conjunction with the sections of the Framework

Lens for learning from sentinel events – systems thinking



Incident review process

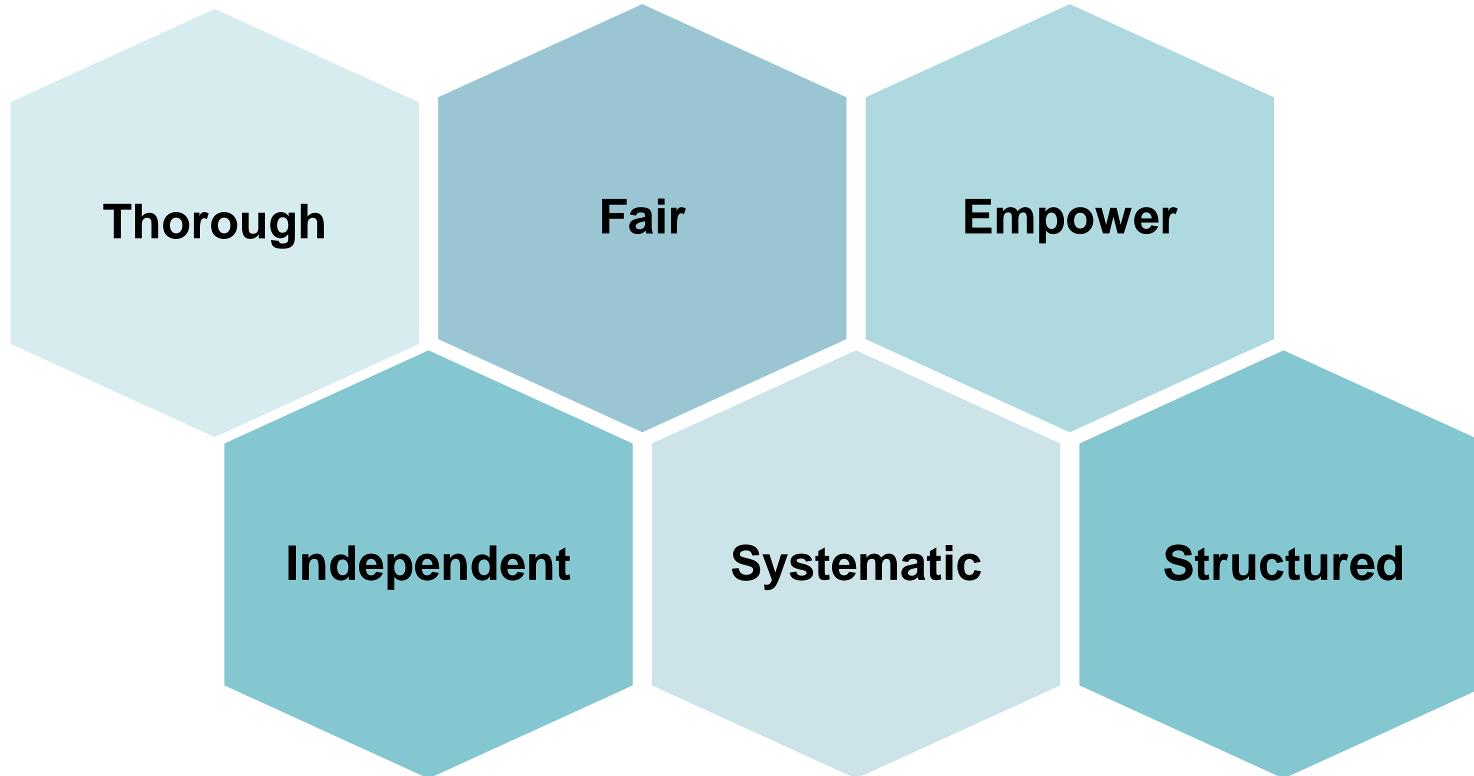
‘A structured method to identify factors that contributed to an adverse event’



Find answers to these questions

Recommend actions to reduce the likelihood of recurrence or mitigate outcome

Principles of the incident review process



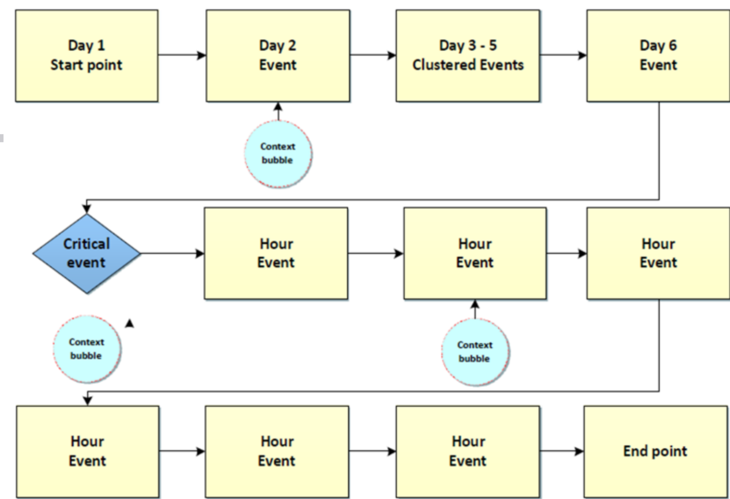
What is the incident review process not used for?

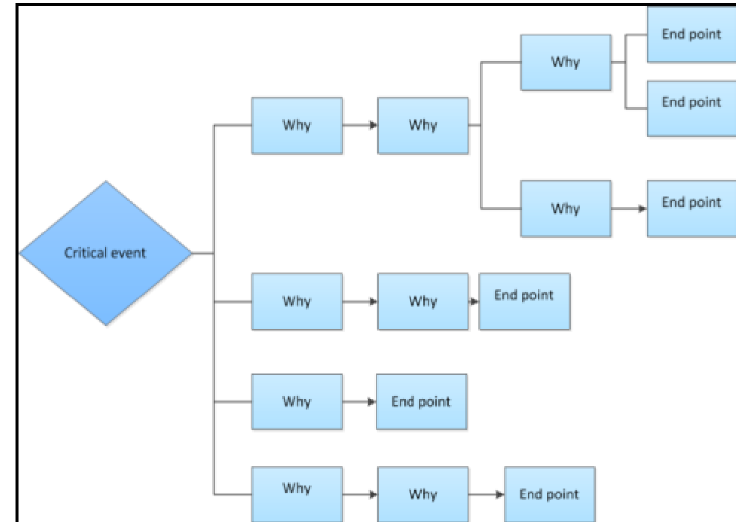
- X Attributing blame
- X Assessing professional competence of individual clinicians
- X Investigating allegations of a criminal offence
- X Reviewing patient care when the outcome is solely due to their underlying medical condition

Safety reviews and criminal or professional performance reviews are managed independently of the RCA process

Root cause analysis

- Linear method
- Visual timeline and critical event/s
- Critical events undergo cause and effect analysis (5 whys)
- End points of C&E analysis are the findings (root causes)
- Recommendations address findings



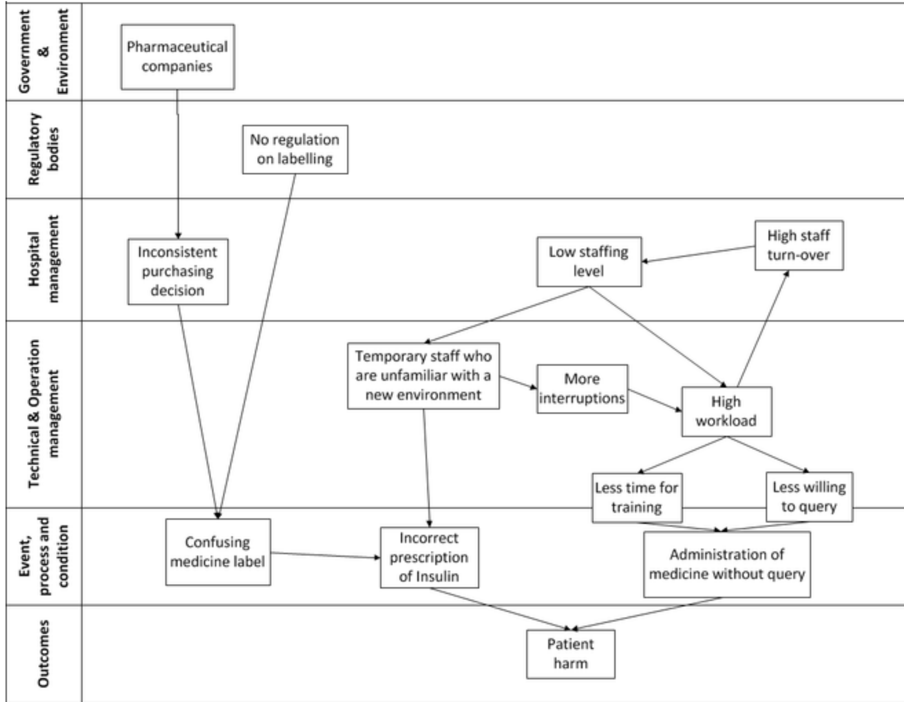


London Protocol

- Contributing factors framework method
- Visual or written timeline
- Identify 'Care Delivery Problems' (CDP's)
- CDP's undergo analysis of contributing factors
- Recommendations address contributing factors

FACTOR TYPES	CONTRIBUTORY INFLUENCING FACTOR
Patient Factors	Condition (complexity & seriousness) Language and communication Personality and social factors
Task and Technology Factors	Task design and clarity of structure Availability and use of protocols Availability and accuracy of test results Decision-making aids
Individual (staff) Factors	Knowledge and skills Competence Physical and mental health
Team Factors	Verbal communication Written communication Supervision and seeking help Team structure (congruence, consistency, leadership, etc)
Work Environmental Factors	Staffing levels and skills mix Workload and shift patterns Design, availability and maintenance of equipment Administrative and managerial support Environment Physical
Organisational & Management Factors	Financial resources & constraints Organisational structure Policy, standards and goals Safety culture and priorities
Institutional Context Factors	Economic and regulatory context National health service executive Links with external organisations

Accimap



- Systems method
- Supported by visual timeline
- Accimap represents the levels within a system
- Contributing factors are identified within each level
- Directions of influence are mapped (not causal)
- Recommendation address factors sensitive to improvement

The role of Boards and sentinel events means . .

Lead a 'just' organisational culture that drives consistently high-quality care and stay engaged, visible and accessible to staff

Ensure robust clinical governance structures that support and empower staff to provide high-quality care and are designed in collaboration with staff

Understand key risks and incidents and ensure controls and mitigation strategies are in place

Monitor and evaluate aspects of the care provided through regular and rigorous reviews of benchmarked performance data and information

Have the necessary skill set, composition, knowledge and training to actively lead and pursue quality and excellence in healthcare

- SE are seen as an opportunity to learn and improve
- Staff are thanked when they report a SE
- '*Name–shame–blame-re-train*' culture is actively discouraged
- Counting SE is avoided
- Training is undertaken to better understand review process and analysis methods
- Review (RCA) reports are read and understood without attempts to re-engineer them
- Review outcomes are endorsed, resourced and implementation is monitored

Support

- Visit our website - bettersafercare.vic.gov.au

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Incident Management Policy

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Closing thoughts . . .

We can't redesign humans

But we can redesign the systems in which humans work

(James Reason)

To err is human

To cover up is unforgivable

To fail to learn is inexcusable

Hope is not a strategy

(Sir Liam Donaldson; Adam Halligan)