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| Sentinel Events |
| Non emergency patient transport |
| OFFICIAL |

# Reference

Non-Emergency Patient Transport Regulations 2016 Part 1, Regulation 5 ‘Sentinel event’ definition

Non-Emergency Patient Transport Regulations 2016 Division 3, Regulation 33

# Introduction

The term ‘sentinel event’ replaces the term ‘critical incident’ in the amended Non-Emergency Patient Transport Regulations 2016 (The regulations). The aim of capturing sentinel events is to improve patient safety and address systems improvement in the health sector. Reporting sentinel events as outlined in this document will bring the Non-Emergency Patient Transport (NEPT) sector in line with the rest of the health system.

# Sentinel Event definition

A sentinel event is an unexpected and adverse patient safety event that occurs infrequently in the provision of services by a NEPT service and results in the death of, or serious physical or psychological injury to, a patient as a result of system and process deficiencies of the non-emergency patient transport service.

# Reporting

## Who needs to report?

All services within the health system, including NEPT, are required to report all sentinel events.

## What to Report

In 2019, the Australian Commission on Safety and Quality in Healthcare (ACSQHC) published a national sentinel event category list, containing 10 sentinel event categories. In addition to the national categories, services within the Victorian health system are required to adhere to and report on category 11 ‘All other adverse patient safety events resulting in serious harm or death’. The sentinel event categories are available at the [Safer Care Victoria website](https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events/what-to-report) <https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events/what-to-report>

As a NEPT provider, if you are unsure if you need to report an adverse patient safety event, contact Safer Care Victoria via sentinel.events@safercare.vic.gov.au or 1300 543 916 for advice. Safer Care Victoria are available to discuss incidents to determine if they fall within a sentinel event category and also offer support with incident review.

## How to Report

Safer Care Victoria is Victoria’s healthcare quality and safety improvement specialist, providing support to providers within the health system for all concerns relating to patient safety.

The process of how to report sentinel events to SCV is the same for all services within the Victorian health system and is described in Table 1.

Table 1: Sentinel Event Reporting to Safer Care Victoria

| Reporting steps | Description |
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| Step 1: Access the SCV portal | Access the sentinel event portal on the SCV website. Note: If this is the first time reporting, you may need to complete an onboarding form and submit to SCV. |
| Step 2: Submit the Sentinel event | Notify SCV within three business days of the service becoming aware of the event via the portal. |
| Step 3: Conduct a Review | Review and analyse the sentinel event using root cause analysis (RCA) methodology |
| Step 4: Submit Review | Submit an RCA report (parts a and b) within 30 business days of the notification  |
| Step 5: Make Recommendations | Submit recommendations from the RCA (part c) within 50 business days of the notification  |
| Step 6: Implement Recommendations | Submit a recommendation monitoring report within 120 business days of the notification.  |

# Additional Information

Further information on how to report and conduct a review of sentinel events, including the use of a root cause analysis methodology can be found on the [Safer Care Victoria Website](https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events) < https://www.bettersafercare.vic.gov.au/notify-us/sentinel-events>.

Alternatively, email NEPT, First Aid and Investigations.

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