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RESEARCH
ARTICLE

Monitoring Sentinel Events Using Routine Inpatient Data

T Jackson, C Moje, J Shepheard and A McMillan

Abstract

Objective: **To explore the extent to which routine inpatient diagnosis data correspond to the Australian nationally-mandated Sentinel Events (SE) data collection and Victoria's additional serious reportable events.**

Background: **Since 2005, state health authorities across Australia have required public hospitals to report on any instance of the eight nationally-agreed 'sentinel events'. The adoption of this list for national monitoring of 'events in which death or serious harm to a patient has occurred' was sponsored by the former Australian Council for Safety and Quality in Health Care. The State of Victoria has policies that support high quality coding of diagnoses in routine hospital data, but it is unclear whether this data source could be used by hospitals to validate voluntary reports and inform ongoing quality improvement efforts.**

Methods: **Code lists were developed by two Health Information Managers to identify ICD-10-AM codes that could be used to define each of the eight national indicators, and an additional 14 subcategories of 'other catastrophic events' reported only in Victoria in 2005. These were translated into computerised algorithms to select cases from the Victorian Admitted Episodes Database (VAED) or 2005/06 which matched the code sets for each of the 22 indicators. We used the 'C-prefix' (now incorporated into the national 'condition onset' flag) in Victorian data to identify hospital-acquired diagnoses, combining these with information on separation mode (specifically, death in hospital), and on admission type (maternity cases) to define some indicators.**

Results: **Seven indicators (one national and seven of the Victoria-specific SEs) could not be replicated using data available in the VAED, and several others could be replicated only partially. 'Serious harm' could not be identified other than by limiting analysis to deaths associated with (but not necessarily caused by) a SE. Coded records apparently under-reported cases of wrong patient/wrong surgery, suicide by an inpatient and maternal deaths, when compared with voluntary reports. Routine data, however, identified more incidents of retained instruments, gas embolism and medication errors.**

Discussion and Conclusions: **While Australian clinical coding standards are among the best in the world, routine patient abstract data may not be reliable for identifying all types of SEs. Voluntary reporting of adverse events is vulnerable to a different set of human and organisational factors that also impede full reporting. The code sets reported here identify some 'events' that may be less serious than those hospital staff are encouraged to report. This has the advantage of identifying 'near miss' events, but some may be**

false positives and would not warrant full root cause analysis. Hospital leadership may value the timeliness and low cost of using the routine data and this suggests its use as a second source of information on serious patient safety breaches.

Abbreviations: **QAHCS – Quality in Australian Health Care Study; RCA – Root Cause Analysis; SE – Sentinel Events; US – United States; VAED – Victorian Admitted Episodes Database; VSE – Victorian Sentinel Events.**

Key Words: **sentinel events, patient safety, adverse events, administrative data.**