Pricing and funding for safety and quality: Sentinel events

Background

In 2017, all Australian governments signed the Addendum to the National Health Reform Agreement and committed to improve Australian health outcomes through safety and quality reforms. This is supported by the collaborative work program between the Independent Health and Aged Care Pricing Authority (IHACPA) and the Australian Commission on Safety and Quality in Health Care (the Commission) to incorporate safety and quality measures into the pricing and funding of public hospital services across three key areas:

Sentinel events

Hospital acquired complications

Avoidable hospital readmissions

Definition

- Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient.
- They are the most serious incidents reported through each jurisdiction's incident reporting system.

Overview

- In 2002, Australian Health Ministers agreed on the first version of the Australian Sentinel Events List. The Commission is responsible for managing, reviewing and updating the Australian Sentinel Events List and associated criteria.
- The Australian Sentinel Events List and specifications are available on the Commission's website.
- Version 2.0 of the Australian Sentinel Events List is outlined in **Table 1**.

Table 1

Australian Sentinel Events List Version 2.0

Sentinel events	
1	Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
2	Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
3	Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
4	Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
5	Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
6	Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
7	Medication error resulting in serious harm or death
8	Use of physical or mechanical restraint resulting in serious harm or death
9	Discharge or release of an infant or child to an unauthorised person
10	Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death

Development of the funding approach

The approach to pricing and funding for sentinel events is driven by their very low prevalence.

IHACPA commenced development of a funding approach for sentinel events in 2015 to ensure public accountability and transparency, and to drive national improvements in patient safety.

How is the funding approach applied?

In July 2017, IHACPA introduced a funding approach for sentinel events whereby no funding is provided if an episode of care includes a sentinel event.

This approach is applied to all relevant episodes of care (being admitted and other episodes) in all hospitals, whether funded on an activity basis or a block-funded basis.

Case study

The following clinical example demonstrates the application of the sentinel events funding adjustment to an individual episode of care.

Initial admission

A 70-year-old male patient was admitted to hospital for a nephrectomy of a chronically diseased right kidney. The patient was assigned to the Diagnosis Related Group L09B (Other Interventions for Kidney and Urinary Tract Disorders, Interm Complexity) and the hospital received a 2.2073 national weighted activity unit.

Adverse event

Following the surgery it was discovered that the operating urologist had viewed the patient's X-ray incorrectly, resulting in the removal of the working left kidney. Function was not able to be restored to the chronically diseased right kidney and the patient had to be placed on dialysis. Within five weeks of the initial surgery the patient developed septicaemia and died.

Application of the funding adjustment

The Australian Sentinel Events List defines 'Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death' as a sentinel event. As the patient died due to surgery being performed on the wrong site, the episode of care was assigned a zero national weighted activity unit, meaning the hospital received no funding for the episode of care.

Further information

Visit ihacpa.gov.au/safety-and-quality to learn more about the Independent Health and Aged Care Pricing Authority. Get in touch with us via the details below.

(02) 8215 1100 enquiries.ihacpa@ihacpa.gov.au www.ihacpa.gov.au

Find us online to connect with us.

Independent Health and Aged Care Pricing Authority

@IHACPA