

FACT SHEET: Sentinel event

Do you know what to do in the case of a sentinel event?

During the course of your employment, you may be directly or indirectly involved in a sentinel event.

Examples of a sentinel event include:

- You are directly responsible for a patient's death, or serious harm; or
- You are a **witness** to events that then leads to a patient's death or serious harm.

Important steps - when you are 'involved' in a sentinel event

1. FOR YOUR EYES ONLY. Write down bullet points regarding the incident include only the **FACTS** pertaining to the event, for example:

- * dates
- * times
- * location
- * people
- * actions
- * medications
- * dosage amounts

This is **your own personal record**. Do not show this record to anyone prior to obtaining **LEGAL ADVICE**.
ENSURE YOU MARK EVERY PAGE WITH "NOTES FOR THE PURPOSE OF SEEKING LEGAL ADVICE".

2. Contact **NPAQ** as soon as possible on **1300 CODE PH**
AVAILABLE 24/7

One of our legal/support team will respond in business hours

These matters can be complicated and we will step you through what you need to do. If you advise by email we will still need to speak to you.

3. SECURE the following information **on site**. Do not remove from your place of employment.

- * Information given at handover about the patient ie. YOUR actual clinical handover sheet with or without already existing written notations.
- * Document the names of nurses on duty at the time of the incident and the positions held (Clinical Nurse, EN etc) and notate who was actually on the ward at the time as some staff members may have been on a break or in another area.
- * The names of any other people present i.e. relatives, visitors, allied health workers, wardspersons, cleaning staff, kitchen or catering staff.
- * The hospital/facility policy documents relating to the incident.
- * Names of doctors attending both during and after the incident.
- * Names of hospital/facility management attending both during and after the incident.

4. Your workplace Policy will require you to write in the patient's record and likely complete an incident report. Again, use Bullet Points and where possible only what was included in the finalised document from 1 above.

Under Section 8 [The Coroners Act 2003](#), any death that is **unnatural, or health care related or occurs in care** is a **reportable** death.

*NPAQ is committed to representing the professional needs of our members.
If you have an issue please contact your Branch Secretary or call 1300 CODE PH*