# Errata — Report on Government Services 2010

The following amendment was made to the 2010 Report since it was released in January 2010.

## Chapter and attachment 10 — Public hospitals

Data provided for NSW have been revised. Sentinel events for 'Procedures involving the wrong patient or body part resulting in death or major permanent loss of function' reduced by 14 for 2007-08 and by 6 for 2006-07. Sentinel events for 'Retained instruments or other material after surgery requiring re-operation or further surgical procedure' reduced by 5 for 2007-08. Sentinel events for 'Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs' reduced by 11 for 2007-08 and increased by 1 for 2006-07.

The revisions affect the following:

- table 10.16 on page 10.70 'Nationally agreed core sentinel events, 2007-08'
- attachment table 10A.81 'Nationally agreed core sentinel events (number)'.

The revised chapter table and attachment table are reproduced below.

*Amended table 10.16*

Table 10.16 **Nationally agreed core sentinel events, 2007-08 (number)**[a]

| *Sentinel event* | *NSW* | *Vic* | *Qld* | *WA*[b] | *SA* | *Tas* | *ACT* | *NT* | *Aust* |
|---|---|---|---|---|---|---|---|---|---|
| 1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.[c, d] | 4 | 1 | 8 | 1 | 1 | – | – | – | 15 |
| 2. Suicide of an admitted patient | 5 | 7 | 5 | 9 | 5 | 1 | – | – | 32 |
| 3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure | 14 | 11 | – | 3 | 3 | 1 | np | – | 32 |
| 4. Intravascular gas embolism resulting in death or neurological damage | – | – | – | – | 1 | – | – | – | 1 |
| 5. Haemolytic blood transfusion reaction resulting from ABO incompatibility | – | 2 | – | 2 | – | – | – | – | 4 |
| 6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs | 6 | 2 | 5 | 4 | – | 1 | – | – | 18 |
| 7. Maternal death or serious morbidity associated with labour or delivery | – | 6 | 1 | 5 | 2 | – | – | 1 | 15 |
| 8. Infant discharged to the wrong family | – | – | – | 2 | – | – | – | – | 2 |
| **Total** | **29** | **29** | **19** | **26** | **12** | **3** | **np** | **1** | **119** |

**a** Sentinel event definitions can vary across jurisdictions. **b** Includes public and private hospitals. **c** The definition of sentinel event 1 has been revised for the 2010 Report to include only those events that result in death or major permanent loss of function. In previous reports less serious events had been included by some jurisdictions for this event. **d** Data reported for this event in the 2010 Report are not comparable with the data reported in previous Reports. – Nil or rounded to zero. **np** Not published.

*Source*: State and Territory governments (unpublished); table 10A.81.

## Table 10A.81 **Nationally agreed core sentinel events (number) (a)**

| | *NSW* | *Vic* | *Qld* | *WA* (b) | *SA* | *Tas* | *ACT* | *NT* | *Total* (c) |
|---|---|---|---|---|---|---|---|---|---|
| 2006-07 | | | | | | | | | |
| Procedures involving the wrong patient or body part | 3 | 20 | 4 | 6 | – | 1 | np | – | 34 |
| Suicide of a patient in an in-patient unit | 10 | 11 | 2 | 3 | 3 | – | np | – | 29 |
| Retained instruments or other material after surgery requiring re-operation or further surgical procedure | 9 | 8 | 3 | 2 | 3 | – | np | – | 25 |
| Intravascular gas embolism resulting in death or neurological damage | – | – | – | – | – | – | np | – | – |
| Haemolytic blood transfusion reaction resulting from ABO incompatibility | – | 1 | – | – | – | – | np | 1 | 2 |
| Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs | 4 | 3 | 6 | 2 | – | – | np | – | 15 |
| Maternal death or serious morbidity associated with labour or delivery | 1 | 2 | 4 | 2 | 1 | – | np | 1 | 11 |
| Infant discharged to the wrong family | – | – | – | – | – | – | np | – | – |
| **Total** | **27** | **45** | **19** | **15** | **7** | **1** | **–** | **2** | **116** |
| 2007-08 | | | | | | | | | |
| Procedures involving the wrong patient or body part resulting in death or major permanent loss of function (d). | 4 | 1 | 8 | 1 | 1 | – | – | – | 15 |
| Suicide of a patient in an in-patient unit | 5 | 7 | 5 | 9 | 5 | 1 | – | – | 32 |
| Retained instruments or other material after surgery requiring re-operation or further surgical procedure | 14 | 11 | – | 3 | 3 | 1 | np | – | 32 |
| Intravascular gas embolism resulting in death or neurological damage | – | – | – | – | 1 | – | – | – | 1 |
| Haemolytic blood transfusion reaction resulting from ABO incompatibility | – | 2 | – | 2 | – | – | – | – | 4 |
| Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs | 6 | 2 | 5 | 4 | – | 1 | – | – | 18 |
| Maternal death or serious morbidity associated with labour or delivery | – | 6 | 1 | 5 | 2 | – | – | 1 | 15 |
| Infant discharged to the wrong family | – | – | – | 2 | – | – | – | – | 2 |
| **Total** | **29** | **29** | **19** | **26** | **12** | **3** | **np** | **1** | **119** |

(a) Sentinel events definitions can vary across jurisdictions.

(b) Includes public and private hospitals.

(c) Includes totals for those jurisdictions providing data only.

## Table 10A.81 **Nationally agreed core sentinel events (number) (a)**

| | *NSW* | *Vic* | *Qld* | *WA* (b) | *SA* | *Tas* | *ACT* | *NT* | *Total* (c) |
|---|---|---|---|---|---|---|---|---|---|

(d) The definition of sentinel event 1 has been revised for the 2010 Report to include only those events that result in death or major permanent loss of function. In previous reports less serious events had been included by some jurisdictions for this event. As a result, data reported for this event in the 2010 Report will not be comparable with the data reported in previous reports.

– Nil or rounded to zero. **np** Not published.

*Source*: State and Territory governments (unpublished).