Government of **Western Australia**
Department of **Health**

Your safety in our hands in hospital

An integrated approach to Patient Safety Surveillance by WA Health Service Providers, hospitals and the community: 2023

The Department of Health, Western Australia acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. We acknowledge the wisdom of Aboriginal Elders past and present and pay respect to Aboriginal communities of today.

The term Aboriginal and Torres Strait Islander is mostly used throughout this report due to the way the data is collected.

Aboriginal people should be aware that this publication may contain images or names of deceased persons in photographs or printed material.

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Acknowledgements

The PSSU thanks and acknowledges the contribution of all clinical and administrative staff who have devoted their time and effort to notify, report, investigate and evaluate clinical incidents and consumer feedback with the goal to improve health care delivery. We also acknowledge the patients and their families who have experienced unintended harm while receiving care in our health system. By reporting, investigating, implementing change and sharing the lessons learnt, we aim to reduce error and improve patients' safety.

Foreword

Globally, the public reporting of information about the performance of hospitals and health services is an important tool used by governments to support transparency and consumer choice. To this end, the Department of Health produces an annual report on patient safety within WA health services which provides transparent information on mortality review, clinical incidents and consumer feedback including complaints.

This 2022/23 report outlines the state of patient safety in Western Australia (WA) as we continue to recover from the impacts of the COVID-19 pandemic. The strain of delivering essential health care services to the community during the preparation and wide community spread of COVID-19 after the borders opened in March 2022, had and continues to have health service staff working under very challenging circumstances. Despite these challenges, healthcare services have systems to continuously monitor and improve the services they provide.

The World Health Organisation has selected the World Patient Safety 2023 theme to be **Engaging patients for patient safety**. This recognises the central role patients, their family and care givers play in advancing safe care and this remains a key priority area for WA.

High reliability organisations are organisations that work in situations that have the potential for large scale risk and harm, and this concept provides a gold standard for us to aspire to. Such organisations routinely review incidents and contributing factors when things go wrong, and also aim to take the learnings from these incidents and apply them to continuously improve care provided to patients.

I would like to commend our hard-working staff who continue to deliver excellent standards of care. This report identifies that while our services are busier than ever, that clinical incident reporting rates remain high but with no commensurate increase in avoidable harm – a sign of a positive safety culture.

All clinical incidents occurring in WA health system facilities are routinely reviewed to assess the reasons why, the systems factors that may have contributed, and to develop and implement recommendations for improvements. It is essential that lessons learnt are shared across healthcare services and also with the general public in the spirit of openness and transparency.

I am proud to present to you this 12th edition of the Western Australian Patient Safety series 'Your Safety in Our Hands', which continues to promote and illustrate the importance of transparent, public patient safety reporting. To assist the public the 12th edition has become more streamlined with critical data valued by health researchers now presented in a standalone technical supplement.

Dr D J Russell-Weisz PSM
Director General

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Episodes of inpatient care

2022/23
658,859

2021/22
636,877

Number of confirmed incidents

2022/23
35,957

2021/22
32,183

Number of complaints

2022/23
4,883

2021/22
5,395

Number of confirmed SAC 1 incidents

2022/23
585

2021/22
574

SAC 1 patient outcome of death

2022/23
114

2021/22
139

Number of sentinel events with patient outcome of serious harm or death

2022/23
23

2021/22
19

Comparison based on data published in 2022 report

Executive summary

In 2022/23, there were 37,641 clinical incidents notified across the WA health system of which 35,957 had a confirmed Severity Assessment Code (SAC) rating at the time data was extracted for this report. Consistent with previous years, more than 86 per cent of clinical incidents were confirmed as SAC 3 and more than 92 per cent of confirmed incidents reported the patient outcome as no harm or minor harm.

During this period the WA health system provided 658,859 episodes of inpatient care (amounting to more than 2 million bed days) from public hospitals and contracted health entities (CHEs). Confirmed inpatient clinical incidents were associated with 1.7 per cent of public hospital bed days.

There were 585 SAC 1 clinical incidents confirmed in 2022/23 by WA health service providers, private licensed healthcare facilities, and contracted non-government organisations, of which 30 were categorised as sentinel events, and 555 were categorised as 'Other SAC 1' incidents. An additional 132 events were investigated as possible SAC 1 incidents and declassified once it was determined that health care did not contribute to the event.

The rate of inpatient SAC 1 incidents in WA hospitals continues to remain low, with one SAC 1 incident confirmed for every 7,120 bed days across public hospitals and CHEs. Less than 1 per cent of clinical incidents in public hospitals were confirmed as SAC 1 incidents.

The Western Australian Clinical Incident Management Policy encourages the investigation of near miss events (incidents that had the potential for harm but resulted in no harm to the patient). In 2022/23, 5.8 per cent (34) of confirmed SAC 1 clinical incidents reported a patient outcome of no harm.

The most frequently reported categories of SAC 1 clinical incidents in 2022/23 were infection control breaches (141) and complications of patient falls (107). A patient outcome of death was reported in 114 SAC 1 clinical incidents and was most reported in association with the unexpected death of a mental health client (43).

Thirty sentinel events (including near miss sentinel events) were reported in 2022/23, representing 5.1 per cent of all confirmed SAC 1 incidents. The most frequently reported sentinel event in WA in 2022/23 was medication error resulting in serious harm or death (12), all of which included an associated patient outcome of serious harm. Fourteen sentinel events resulted from surgeries performed on the wrong site, using the wrong procedure, or from the unintended retention of foreign objects; with a reported patient outcome of serious harm in 7 of these cases.

The 2 most frequently reported categories related to the second edition of the Australian Commission on Safety and Quality in Health Care's (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards were comprehensive care (12,528; 34.8 per cent of confirmed incidents) and medication safety (9,521; 26.5 per cent of confirmed incidents).

Patient outcomes of serious harm or death were reported in 8.3 per cent (121) of confirmed incidents related to recognising and responding to acute clinical deterioration, and 6.0 per cent (104) of confirmed incidents related to preventing and controlling infections, demonstrating the risk incidents of this nature pose to the WA health system.

Consumer feedback provides the WA health system with important information about areas of risk or opportunities for improvement . A total of 19,814 consumer feedback items were reported across the system in 2022/23. There were 8,734 (44 per cent) compliments received with the remainder of feedback being between complaints (4,883; 25 per cent) and contacts and concerns (6,197; 31 per cent).

The Coronial Liaison Unit (CLU) continues to examine health-related inquest findings to improve care across the system, with the Coronial Review Committee (CRC) reviewing 10 inquested deaths over 2022/23 with 15 recommendations from the coroner.

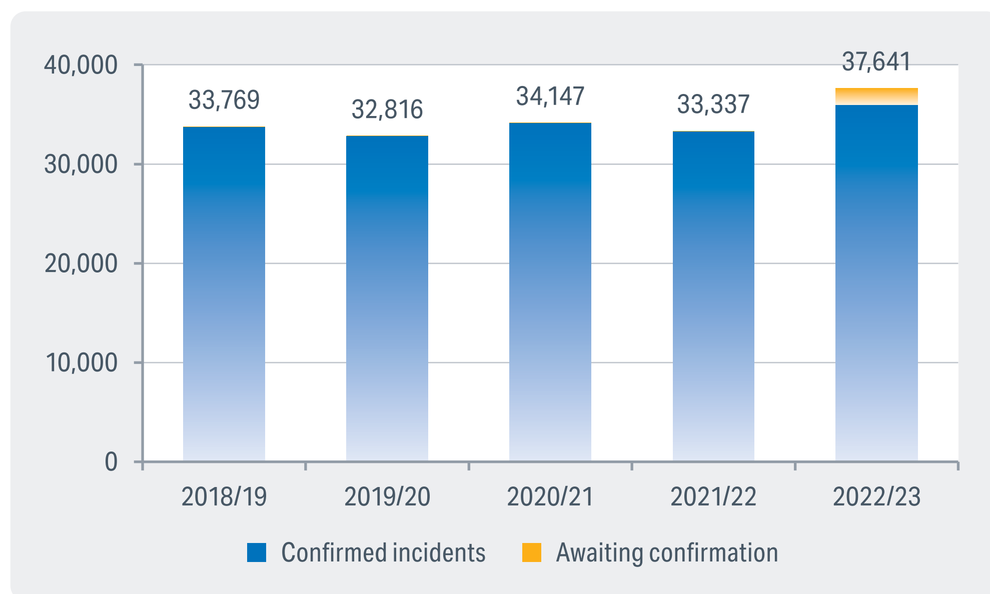
All deaths in WA that occur under the care of a surgeon are notified to the WA Audit of Surgical Mortality (WAASM) and in 2022, 590 deaths met the WAASM inclusion criteria. For cases that had completed the audit process by 17 April 2023, the WAASM considered none to be definitely preventable.

Clinical incident management: overview

At 31 December 2022, the Australian Bureau of Statistics reported more than 2.8 million people living in WA and from July 2022 to June 2023 more than 270,000 people received inpatient care in WA's public hospitals. There were 658,859 episodes of inpatient care (separations) delivered from WA's public hospitals and the 3 main contracted health entities (CHEs) over this period.

During 2022/23, there were 37,641 clinical incidents notified, and the Severity Assessment Code (SAC) rating for 35,957 of these incidents had been confirmed at the time of this report. A small increase in the total number of clinical incidents notified was seen compared to recent years.

Figure 1: Total clinical incidents notified from 2018/19 to 2022/23



More than 86 per cent of clinical incidents notified in 2022/23 were confirmed at the lowest rating of SAC 3, with 1.6 per cent of incidents confirmed as SAC 1.

In 2022/23, more than 80 per cent of confirmed clinical incidents occurred during a public hospital stay. There were 237 SAC 1 incidents related to public hospital inpatients, and a further 50 SAC 1 incidents were confirmed relating to public inpatients at the 3 main CHEs. Confirmed inpatient clinical incidents were associated with 5.3 per cent of public hospital separations or 1.7 per cent of public hospital bed days.

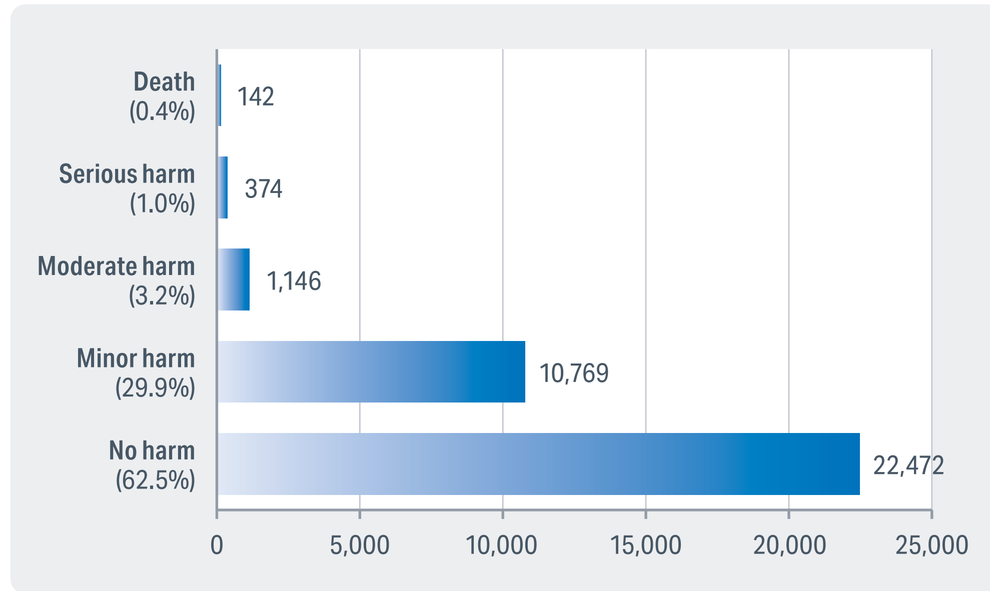
Findings showed that there were:

- 1.4 SAC 1 clinical incidents per 10,000 bed days
- 13.5 SAC 2 clinical incidents per 10,000 bed days
- 152 SAC 3 clinical incidents per 10,000 bed days.

The overall rate of inpatient clinical incidents in 2022/23 is slightly higher than that seen in 2021/22, due mostly to an increase in the number of SAC 3 incidents confirmed in this period. The rates of inpatient SAC 1 and SAC 2 incidents are comparable to the previous year.

More than 92 per cent of clinical incidents confirmed during 2022/23 reported a patient outcome of no harm or minor harm. There were 516 clinical incidents that reported a patient outcome of serious harm or death, representing 1.4 per cent of confirmed incidents in this period. The proportion of patient outcomes reported in confirmed incidents is similar to that seen in previous years.

Figure 2: Confirmed clinical incidents by patient outcome for 2022/23



Note: Patient outcome missing data n=1,054 (2.9%)

SAC 1 clinical incidents

SAC 1 clinical incidents are incidents that have, or could have (near miss), caused serious harm or death; and which are attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness. The reporting and investigation of SAC 1 clinical incidents is a requirement for WA public health services, private licensed health care facilities and contracted non-government organisations (NGOs).

In 2022/23, 585 SAC 1 clinical incidents were confirmed by WA health services and reported to the Department of Health. There were a further 132 events investigated that were approved for declassification. Declassification may be granted for a SAC 1 clinical incident if the investigation determines that no health care factors contributed to the patient harm. Declassified events are no longer considered to be clinical incidents. At the date of data extraction for this report the investigations for 136 SAC 1 clinical incidents during 2022/23 remain ongoing.

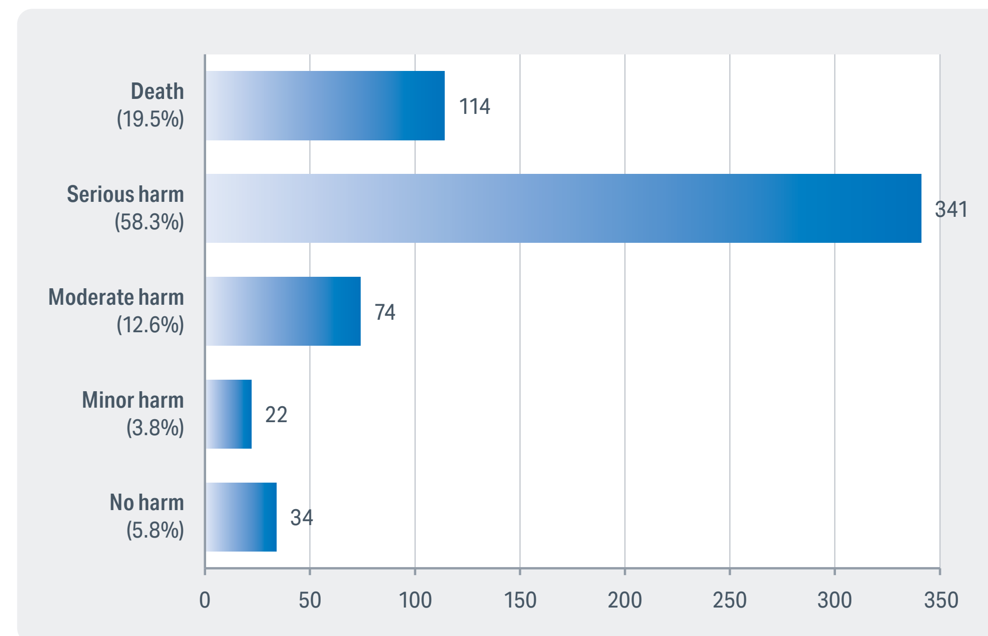
Of the 585 confirmed SAC 1 clinical incidents, 5.1 per cent were categorised as sentinel events, or near miss sentinel events, while the remaining incidents were classified as 'Other SAC 1 Clinical Incidents.' This included 106 (18 per cent) confirmed SAC 1 clinical incidents related to patients receiving care as private patients from private licensed health services.

Table 1: Confirmed SAC 1 clinical incidents by sentinel event and other SAC 1 clinical incident types for 2018/19 to 2022/23

SAC 1 category	2018/19	2019/20	2020/21	2021/22	2022/23
Sentinel events	17	14	20	27	30
Other SAC 1 incidents	555	487	532	526	555
Total	**572**	**501**	**552**	**553**	**585**

The frequency of confirmed SAC 1 clinical incidents in 2022/23 is consistent with reporting data over the 5-year period from July 2018 to June 2023. An upward trend in the reporting of sentinel events is noted and explored further below.

Figure 3: Confirmed SAC 1 clinical incidents by patient outcome for 2022/23



A decrease in the confirmed SAC 1 clinical incidents with an associated patient outcome of death was noted, with 114 SAC 1s notified during 2022/23, equivalent to reporting data from the 2018/19 period. Three (2.6 per cent) of the incidents that reported death were categorised as sentinel events, this is consistent with previous years.

A further 341 confirmed SAC 1 clinical incidents were reported with a patient outcome of serious harm. Twenty (5.9 per cent) of the incidents with associated serious harm were categorised as sentinel events. Reporting of serious harm has increased when compared to previous years for both sentinel events and other SAC 1 clinical incidents.

Sentinel events – overview

The ACSQHC describe sentinel events as a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of a patient. Specifications for which clinical incidents meet the 10 national sentinel event categories are strictly defined. Sentinel event reporting in WA has broader definitions than those listed by ACSQHC, with a more extensive description of serious harm and the inclusion of near miss sentinel events.

Thirty sentinel events were reported in WA by health service providers during 2022/23, 4 of which are still currently under investigation at the time of this report. Of the 26 sentinel events and near miss sentinel events with investigations concluded, 16 involved public patients and met the ACSQHC definition of serious harm. The high risk of serious harm and the wholly preventable nature associated with these incidents highlight the importance of near-miss incident reporting. These near-miss incidents are investigated as opportunities for system improvement within WA.

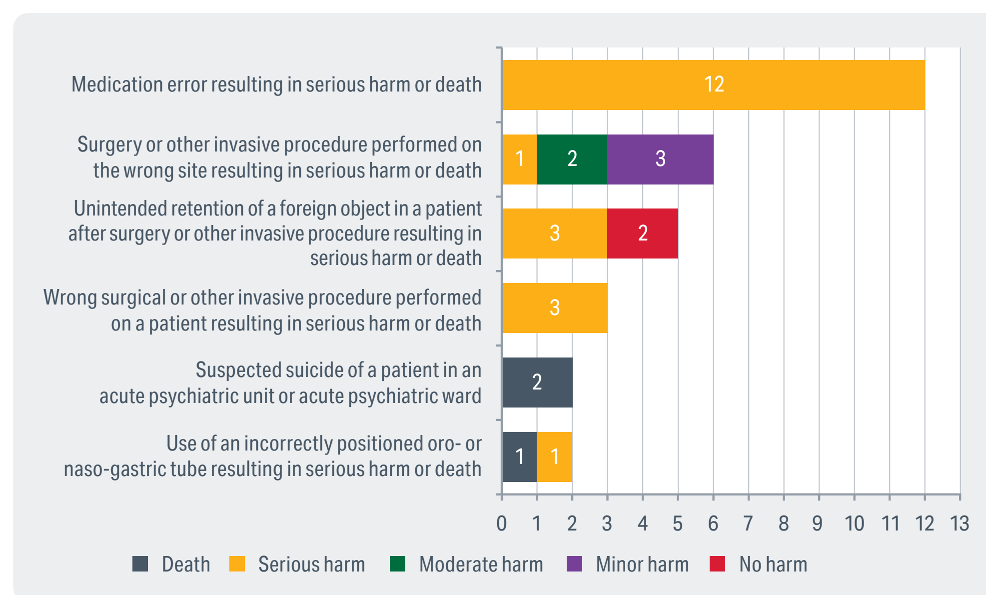
In 2022/23, 3 sentinel events resulted in death to patients. Two of these incidents were categorised as suspected suicides of a patient in an acute psychiatric unit or acute psychiatric ward. One death was associated with the use of an incorrectly positioned oro- or naso-gastric tube (Figure 4).

Consistent with previous years, the most frequently reported sentinel events associated with serious harm to a patient are medication errors. Health services in 2022/23 reported 12 incidents that met the medication error sentinel event definition, this included 2 incidents involving patients receiving care as private patients from private licensed health services. There has been a reduction in both the number of medication error sentinel events reported and the severity of harm associated with the incidents when compared to the 17 reported incidents for 2021/22. In contrast with previous years no medication error incidents resulted in death to a patient in 2022/23.

Sentinel events related to surgical errors have increased from previous reporting years. For the category surgery or other invasive procedure performed on the wrong site, one patient suffered serious harm with 5 outcomes of lesser harm (minor or moderate harm) events reported. A further 3 patients suffered serious harm from the wrong surgical or other invasive procedure being performed.

Three incidents reported serious harm associated with the unintended retention of a foreign object in a patient after surgery, with a further 2 events having an outcome of no harm and being categorised as near-miss events.

Figure 4: WA sentinel events by category and patient outcome for 2022/23



The upward trend in the reporting of sentinel events compared to previous years is correlated with an increased reporting of sentinel events with a patient outcome of serious harm. The reporting of sentinel events associated with patient death is consistent with previous years, as is the reporting of near-miss sentinel events. While further analysis of local trends by health services is needed to determine the underlying factors contributing to sentinel event reporting, the targeted interventions aimed at enhancing patient safety for these events are outlined below.

Sentinel events – medication error recommendations

Medication errors remain the most reported category of sentinel event in WA. Twelve medication error sentinel events were reported during 2022/23. Six of these incidents were associated with medication administration errors, while 5 incidents resulted from errors in prescribing.

At the date of data extraction for this report 10 investigations have been completed for sentinel events involving medication errors, while 2 remain in progress. A total of 39 recommendations were developed by health services to address the factors that lead to the incidents occurring thereby improving medication safety.

The recommendations made in response to these events address a broad range of issues and centre on the following recurring themes:

- Medication safety and administration protocols and procedures
- Infrastructure, staffing and resources
- Safety mechanisms and procedural aids
- Training and education.

Prescribing errors

Five sentinel events reported serious harm associated with the prescription of medication and resulted from errors in the medication dose, medication type, or contraindication due to a history of allergy. Recommendations were developed by health service providers in response to these events to minimise the risk of recurrence.

Staff and resource management processes were reviewed to ensure after hours care was sufficient, including a review of rostering patterns to minimise fatigue risk among registrars and ensure patient transfers have adequate pharmacist review, as well as providing inventory management software access for after hours staff. Safety mechanisms were introduced to allow pharmacy staff to prompt diagnostic tests and to ensure prescribed medication for high-risk patients undergoes additional review prior to discharge.

Health service providers enhanced local patient resources with consideration of English as a second language, interpreter accessibility and the mandated use of patient/family/carer as a source of medication history.

Education for all relevant staff to ensure awareness and compliance with revised clinical standards and guidelines, as well as the consideration for the further development of simulation-based training and the use of case studies is ongoing.

Administration errors

Six sentinel events reported serious harm associated with the administration of medication to an incorrect patient, the administration of an incorrect dose or administration via an incorrect route in 2022/23. A number of initiatives were proposed by health service providers to review and enhance internal processes and policy in response to the administration errors.

These included a review of local medication administration policies to ensure alignment with the 6 rights of safe medication administration, the development of a standard protocol in line with ANZCA Local Anaesthetic Toxicity guidelines[1,2] and the incorporation of stronger identification checks to be included in inpatient medical record management and the re-labelling of medication charts.

Recommendations were made by health service providers to address issues identified with the preparation of drugs in medication rooms. These included the development of aid memoires and the replacement of measurement tools to assist in preparing correct medication concentrations.

Case studies to be delivered in an education and training format were developed by health services and delivered to relevant clinical staff. These included articulating the requirements of the 6 rights of safe medication administration, the administration of medications within palliative care units which included a medication safety focus centred on human factors, the Schedule 8 register requirements and care provision for patients with cognitive impairments.

1. ANZCA – Quick Reference Handbook Guidelines for crises in anaesthesia
2. ANZCA – Guideline for health practitioners administering local anaesthesia 2013

Sentinel events – surgical recommendations

Fourteen sentinel events (including near miss sentinel events) involving surgery were notified during 2022/23. Of the 14 sentinel events, 7 resulted in serious harm to the patients. Nine of these incidents resulted from surgery performed on the wrong site or through the wrong procedure, while 5 occurred from the unintended retention of foreign objects.

At the date of data extraction for this report, investigations had been completed for 12 of the clinical incidents while 2 remain in progress. A total of 29 recommendations were developed by health services to address the factors that lead to the incidents occurring thereby reducing patient harm attributable to surgical clinical incidents.

Recommendations made by health service providers in response to wrong site and wrong procedure sentinel events focused on improving local pre-surgical processes and enhancing associated documentation. This included the development of a specialist working group to implement formalised pre-surgical workflows and clinical processes, as well as developing standardised procedures and improved methods of communication for patient consent and procedural confirmation during time-outs and team huddles.

Amendments to local policy and documentation practices sought to reinforce the health service process updates, with an emphasis on aligning surgical and procedural safety checklists with contemporary practices and highlighting the importance of patient advocacy and patient participation during identification and consent checks.

Health service providers developed several recommendations in response to the retention of foreign objects. These included standardising local surgical techniques used for specific procedures, engaging the same practitioner for pre- and post-operative procedures wherever possible and incorporating diagnostic techniques post-procedure if there is a possibility of foreign object retention.

Education and training for all relevant staff, the inclusion of secondary observers and pre-surgical staff mentoring, visual prompts within electronic procedural checklists, as well as updates to existing guides and policy, were also proposed.

Other confirmed SAC 1 clinical incidents

In 2022/23, there were 555 SAC 1 clinical incidents other than sentinel events confirmed. Of the 555 SAC 1 clinical incidents reported, 111 were associated with a patient outcome of death and a further 321 associated with serious harm.

Infection control breaches and complications of a fall in a health service remain the 2 most frequently reported types of SAC 1 clinical incidents, with a total of 141 and 107 confirmed SAC 1s reported respectively. An infection control breach was over 30 times more likely to be associated with a patient outcome of serious harm (n = 98) than death (n=3). A complication of a fall in a health service was over 8 times more likely to be associated with a patient outcome of serious harm (n = 86) than death (n = 10).

It is noted that SAC 1 clinical incidents categorised as a delay in recognising or responding to physical clinical deterioration has a higher proportion of patient outcomes associated with death when compared to other SAC 1 types (21 of the 53 reported SAC 1 clinical incidents), highlighting the high risk in this category.

The dynamic nature of mental health patient journeys leads to an increased risk of patient harm in what is already a high-risk demographic. In 2022/23, 90 SAC 1 clinical incidents involving mental health patients were reported (including 3 sentinel events), 44 of these incidents were associated with a patient outcome of death and accounted for 38.6 per cent of the 114 SAC 1 related deaths reported in 2022/23 (inclusive of sentinel events).

The SAC 1 clinical incident category most often involving associated patient outcomes of death continues to be the unexpected death of a mental health client, with 43 incidents reported in 2022/23.

The second most frequently reported SAC 1 category involving mental health patients was clinical deterioration of a mental health patient resulting in serious harm to themselves or death or serious harm to staff, other patients, or other persons; 17 incidents were reported in this category, with 15 incidents associated with serious harm, a reduction from the 36 reported cases in 2021/22. It is acknowledged that the mental health patient journey can be complex and involve multiple healthcare settings.

SAC 1 contributory factors

The identification of the contributory factors of a clinical incident is a critical component of the SAC 1 clinical incident investigation process; a clinical incident investigation may identify multiple contributory factors for each incident.

The most frequently identified contributory factors in 2022/23 related to communication errors, which were present in 76.2 per cent of closed SAC 1 clinical incidents; and issues concerning policies, procedures, and guidelines, which were present in 62.4 per cent of closed SAC 1 clinical incidents. This is consistent with data from previous years.

The majority of the 342 closed SAC 1 clinical incidents which reported communication errors as contributory to the incident identified communication issues between staff (210 cases; 61.4 per cent) and issues related to documentation (192 cases; 56.1 per cent) as most prevalent.

Of the 280 closed SAC 1 clinical incidents that reported contributory factors related to policy, procedures, or guidelines, 138 (49.3 per cent) cases identified application of policy, procedure or guidelines as contributory. Ninety (32.1 per cent) cases identified an absence of relevant policies, procedures or guidelines as contributing to the incident.

Health service providers proposed a total of 82 recommendations to address the contributory factors identified through the completed investigation of the 26 sentinel events in 2022/23. A further 1,159 recommendations were developed for the 423 completed SAC 1 clinical incident investigations not categorised as sentinel events in 2022/23.

It is recognised that some contributory factors exist systemwide and may require actions beyond the immediate remit of the health service investigating the incident. The integration of clinical incident management and clinical risk management is a critical component of a robust clinical governance framework and allows for greater oversight and strategic focus in the development of solutions to these systemwide contributing factors, improving the safety and quality of health care for future patients.

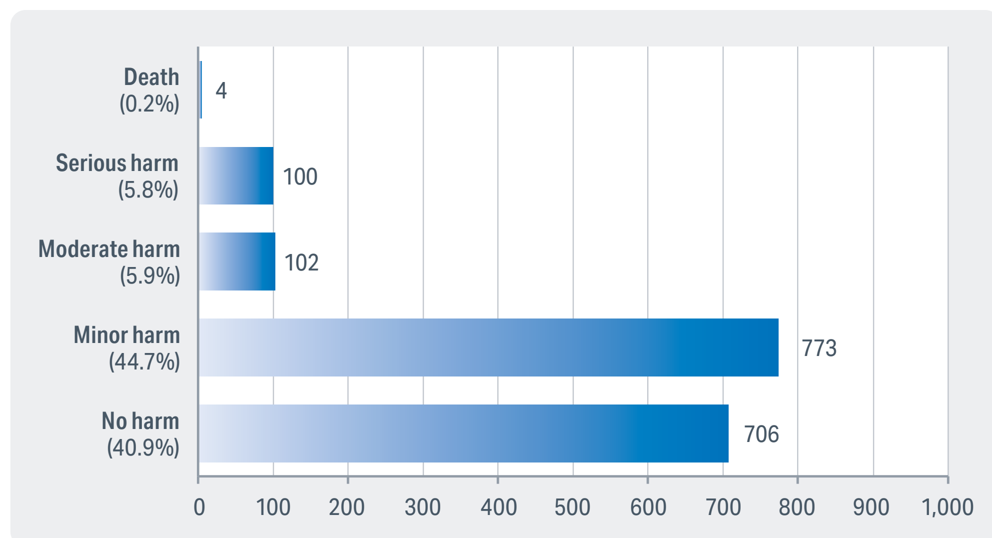
NSQHS Standards
NSQHS
STANDARDS

Preventing and controlling infections clinical incidents

The intent of the Preventing and Controlling Infections Standard is to reduce the risk to patients, consumers, and healthcare workers from acquiring preventable infections, and if they occur, to have measures in place to promote appropriate antibiotic prescribing, prevent further infection spread, and promote appropriate and sustainable use of infection prevention and control resources[3].

In 2022/23 there were 1,811 infection control incidents notified, of which 1,728 were confirmed at the time of this report, which is a slight reduction from the previous year. Infection control incidents accounted for 4.8 per cent of confirmed incidents in this period. Most infection control incidents were confirmed as SAC 3 incidents (82.7 per cent) followed by SAC 1 (8.1 per cent) and SAC 2 incidents (4.7 per cent). No harm was reported in 39.2 per cent of cases demonstrating the strong reporting culture in the WA health system. Four confirmed incidents reported the patient outcome as death and a further 100 incidents reported the outcome as serious harm.

Figure 5: Confirmed infection control incidents by patient outcome for 2022/23



Consistent with the previous year, the specialties of general medicine (n=486) and general surgery (n=229) reported the highest number of confirmed infection control incidents during 2022/23. General medicine also reported the highest number of infection control incidents describing a patient outcome of serious harm or death (n=30) followed by oncology (n=15).

In 2022/23, more than half of all confirmed infection control incidents, and 77 of the 104 incidents reporting a patient outcome of serious harm or death, were associated with the use or administration of devices, products, medications or fluids. The 5 most frequent infection control incident categories (based on the Datix CIMS Tier Two and Tier Three incident categories) are shown in Table 2.

Table 2: Most frequent confirmed infection control incident categories for 2022/23

Infection control incident categories	(n)	(%)
Device Product Medication Fluid Associated Infections – Contamination due to hospital process (other than sterilisation)	788	45.6
Device Product Medication Fluid Associated Infections – Breach in sterile techniques	271	15.7
Performance of Clinical Procedures (protocols/bundles/guidelines)	230	13.3
Isolation Processes/Protocols for Infected Patients	109	6.3
Infection Diagnosis – Delayed diagnosis	77	4.4

3. NSQHS Standards (2nd ed – version 2) Preventing and Controlling Infections Standard

The investigation of 1,488 infection control clinical incidents had been completed at the time of this report, and 86 of these incidents reported the patient outcome as serious harm or death. The most frequently identified issue in these incidents related to contamination and breach in sterile techniques.

Within the confirmed incidents, the most frequently identified contributing factor was communication problems with documentation (n=245). When examining infection control incidents with outcomes of serious harm or death, problems with documentation (n=46) and issues in applying policies, procedures, and guidelines (n=33) were the most frequently reported issues.

Review of the contributory factors in infection control clinical incidents with a patient outcome of serious harm or death in 2022/23 identified several themes consistent with previous reviews, including:

- Incomplete patient preparation for a procedure
- A lack of documentation of the insertion of a device
- The delay in the removal of a device
- Limited or no communication of insertion site management practices to the patient; in some cases, the patient was also identified as having unmet health literacy/cultural needs
- Cannula site not optimal including inappropriate siting at the Anterior Cubital Fossa
- Poor aseptic technique including temporary staff and in emergency settings
- Poor knowledge of and compliance with Multi Resistant Organism Policy.

Medication safety clinical incidents

The medication safety standard aims to ensure that clinicians safely prescribe, dispense, and administer appropriate medicines, monitor medicine use and that consumers are informed about medicines, understand their own medicine needs and risks, and monitor medicine use[4].

Medications (medicines) are the most frequent form of treatment used in health care and are therefore more commonly involved in clinical incidents compared to other treatment forms. Medication-related clinical incidents arise for a variety of reasons, including issues at the point of prescribing, dispensing and administration.

When used as intended, medications have many positive outcomes for patients, however when medication errors occur, the outcomes can be catastrophic. Australian estimates consider 50 per cent of medication errors to be potentially avoidable. During 2022/23, there were 9,948 medication clinical incidents notified, of which 9,521 had been confirmed at the time of this report. Medication clinical incidents represented 26.5 per cent of all confirmed incidents in this period.

Confirmed SAC 3 incidents comprised 92 per cent of total medication incidents in 2022/23 with approximately 80 per cent of confirmed medication incidents in 2022/23 reporting the patient outcome as no harm, and a further 16.1 per cent described the patient outcome as minor harm.

Confirmed SAC 1 (n=42) incidents were similar to figures seen in the previous period. It is encouraging that 47 per cent of medication incidents confirmed as SAC 1 in this period reported lower levels of harm or were near misses, demonstrating the ongoing strong commitment to medication safety in the WA health system. However, it remains of concern that 22 incidents described the patient outcome as serious harm or death; a similar result to that seen the previous year.

The general medicine specialty reported 21.7 per cent of confirmed medication clinical incidents in 2022/23, followed by general surgery (6.6 per cent) and psychiatry (6.1 per cent). The specialties that most often reported medication incidents with a patient outcome of serious harm or death were general medicine (n=12), emergency medicine (n=3), cardiology (n=3) and psychiatry (n=3).

Consistent with previous years, most confirmed medication clinical incidents were reported to have occurred at the point of administration of medication to the patient (n=6,492; 65.2 per cent) (see Figure 6). This was followed by incidents related to prescribing processes (n=1,566; 15.7 per cent) and dispensing processes (n=734; 7.4 per cent). Of the 28 incidents that reported a patient outcome of serious harm or death, 15 incidents were related to administration of medication and 11 related to medication prescribing.

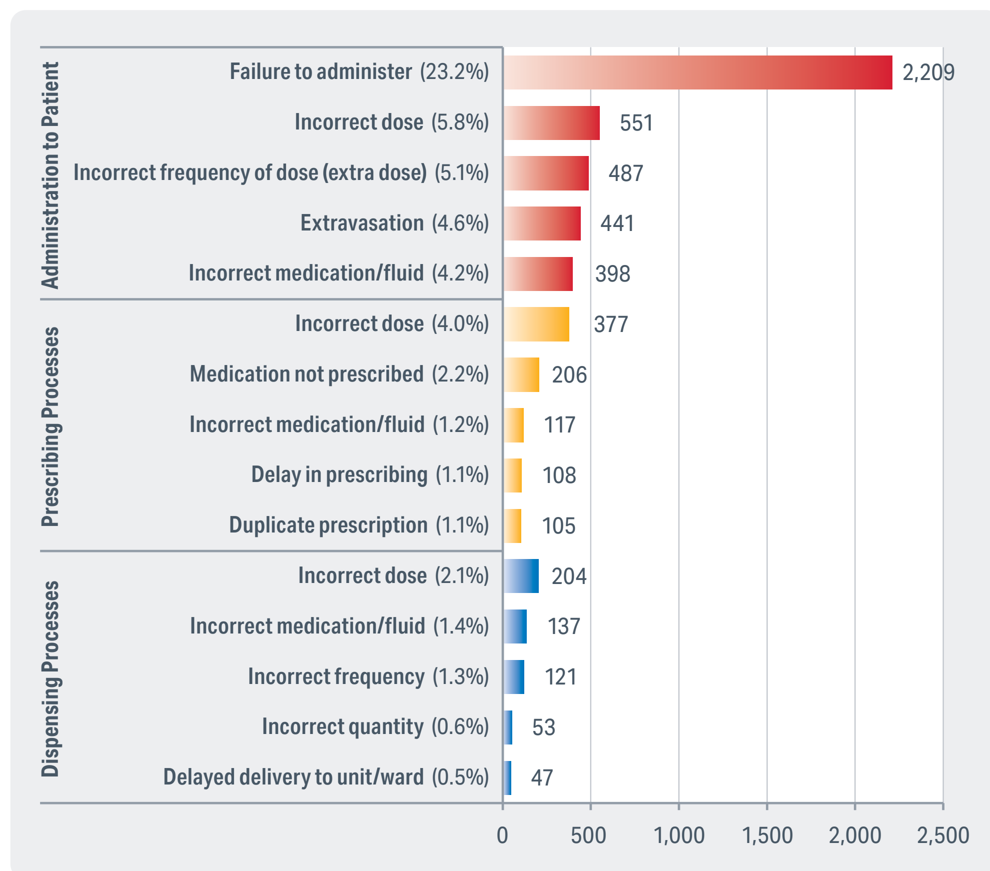
Figure 6 shows the 5 most frequent types of medication clinical incident in each of the administration, prescribing and dispensing parts of the medication process. Incidents involving failure to administer medication to a patient were the most frequently reported and contributed to 23.2 per cent of all confirmed medication incidents in 2022/23.

Within the prescribing and dispensing parts of the medication process, confirmed incidents most frequently related to an incorrect medication dose. Including incidents involving the administration of an incorrect dose of medication to the patient, 11.9 per cent (n=1,132) of all confirmed medication incidents related to patients being prescribed, dispensed, or administered an incorrect dose.

For medication incidents reporting patient outcomes of serious harm or death, the most frequent incident categories were incorrect dose (11 incidents, 5 of which related to administration and 5 to prescribing) and contraindication due to a history of allergy (3 incidents, 1 each from prescribing, administration, and dispensing).

4. NSQHS Standards (2nd ed – version 2) Medication Safety Standard

Figure 6: Most frequent confirmed medication clinical incident categories for 2022/23



The 10 most frequent categories of medication involved in confirmed clinical incidents remains similar to previous years, with opioid analgesics, antibacterials, insulins and anticoagulants most often involved. Insulin medications were most frequently associated with medication incidents that reported a patient outcome of serious harm or death (n=4), followed by anticoagulants and drugs for bipolar disorder (3 incidents each).

Table 3: Most frequent categories of medications involved in confirmed clinical incidents for 2022/23

Medication categories (top 6)	(n)	(%)
Opioid analgesics (opioid based pain relievers)	1,202	12.6
Antibacterials (antibiotics)	926	9.7
Insulins (medications used for diabetes)	687	7.2
Anticoagulants (blood thinning medications)	630	6.6
Antihypertensives (medications for high blood pressure)	417	4.4
Antipsychotics (medications for major psychiatric disorders)	393	4.1

The investigation of 8,398 medication incidents had been completed at the time of this report, and 19 of these incidents reported the patient outcome as serious harm or death.

The most frequently identified contributory factor in these incidents related to communication amongst staff and documentation. These along with issues in applying policies, procedures and guidelines and concerns about staff training and skills were the contributory factors most often found in medication incidents with outcomes of serious harm or death in 2022/23.

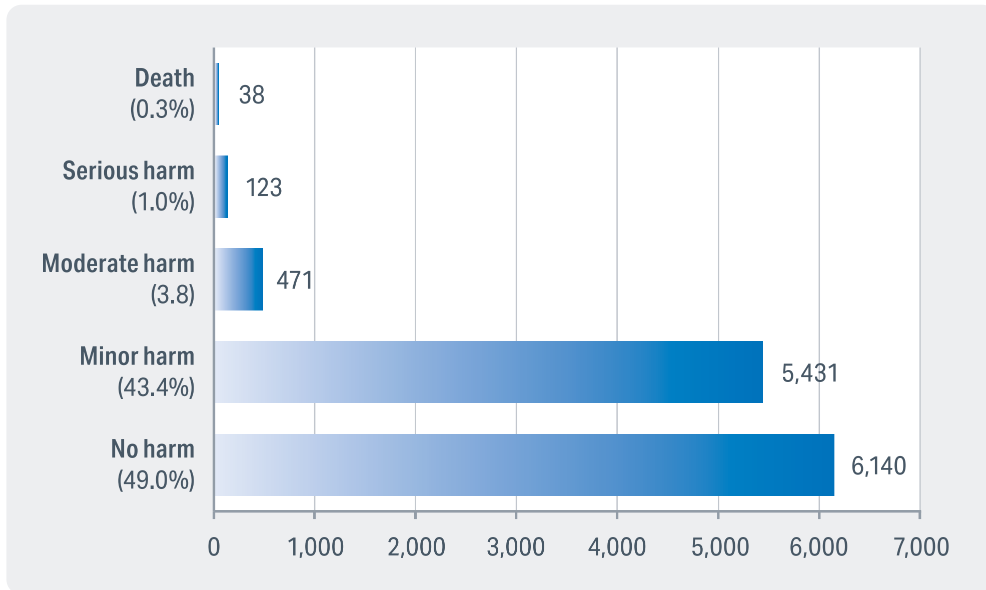
Some specific factors for these incidents included:

- Failure in medication reconciliation on discharge including from multiple medication charts
- The unavailability of appropriate insulin delivery equipment increased the risk of a medication error
- Failure of the 3-point patient identification check
- Breakdown in communication involving My Health Record documentation of medications
- Changes in radiology access preventing routine safety mechanism of check naso-gastric tube placement before administering medication
- Incorrect restocking of similar named medications
- Failure to document verbal medication order.

Comprehensive care clinical incidents

The Comprehensive Care Standard intends to ensure that patients receive coordinated delivery of the total health care required or requested by the patient. The provision of this care should be aligned with the patient's expressed goals of care and healthcare needs, consider the effect of the patient's health issues on their life and wellbeing, and be clinically appropriate. The standard aims to ensure that the risks of patient harm are prevented and managed, with clinicians identifying patients at risk of specific harm by applying robust and relevant screening and assessment processes.[5] The standard identifies 6 specific areas of patient care where targeted best-practice strategies can be implemented to minimise the risk of harm to patients. These include falls, unpredictable behaviours, pressure injuries, restrictive practices and poor nutrition or malnutrition.

Figure 7: Confirmed comprehensive care clinical incidents by patient outcome for 2022/23



Comprehensive care clinical incidents in 2022/23 accounted for more than one third of all clinical incidents in this period. There were 12,528 confirmed clinical incidents associated with this standard, across all categories of comprehensive care, which represents an increase of almost 10 per cent compared to 2021/22. This increase is largely attributed to an increase in reporting of near miss events with no reported patient harm. During 2022/23, more than 90 per cent of comprehensive care clinical incidents reported no patient harm or minor patient harm.

Table 4: Confirmed comprehensive care clinical incidents by SAC rating and sub-category for 2022/23

Comprehensive care sub-categories	SAC 1	SAC 2	SAC 3	Total
Falls	106	239	6,357	6,702
Unpredictable behaviours	52	1,106	1,705	2,863
Pressure Injuries	4	89	2,692	2,785
Restrictive practices	1	74	77	152
Poor nutrition and malnutrition	-	1	25	26
Total	**163**	**1,509**	**10,856**	**12,528**

In 2022/23, there were 163 comprehensive care clinical incidents that were categorised as SAC 1, which accounted for 1.3 per cent of all incidents associated with this standard. Consistent with previous years, falls continue to be the most commonly reported category across all severities of patient harm. While falls are associated with the highest number of patient outcomes of serious harm (n=94), unpredictable behaviour remained the most frequent category reporting a patient outcome of death (n=27).

5. NSQHS Standards (2nd ed – version 2) Comprehensive Care Standard

Similar to previous years, two thirds of all falls were categorised as unwitnessed and were most frequently associated with the patient walking or attempting to toilet or sit/stand. Common risk factors identified in falls incidents included poor balance and/or polypharmacy. Almost 10 per cent of falls clinical incidents reported that a current falls risk assessment was not in place at the time of the incident.

Unpredictable patient behaviours include self-harm, aggression and violence. In 2022/23, one third of all unpredictable behaviour clinical incidents were categorised as aggressive physical behaviour by a patient towards an object, structure or staff member. This included 2 patient outcomes of serious harm. In 2022/23, there were 53 patient outcomes of death or serious harm reported, the majority of which were categorised as suspected suicide or attempted suicide. Compared to 2021/22, there has been an increased over-representation of Aboriginal people involved in unpredictable behaviour clinical incidents, with more than 20 per cent of all persons involved in these types of clinical incidents identifying as such. This finding emphasises the importance of the use of de-escalation strategies.

Pressure injuries can occur in patients of any age and can be influenced by risk factors such as immobility, poor nutrition or hydration and poor skin integrity. In 2022/23, more than 90 per cent of all pressure injury clinical incidents reported no patient harm or minor patient harm with the majority categorised as a preventative or therapeutic intervention that was not effective. Almost half of all pressure injuries were recorded as Stage 2 (partial thickness skin loss) and the most frequent location was the sacrum. In 2022/23, there were 2 incidents with a patient outcome of serious harm reported where the pressure injury was not present on admission. The type and number of pressure injuries, as well as the associated patient harm, is consistent with previous years.

Communication issues between staff and patients, family or carers were identified as the most common contributing factor in falls clinical incidents, whereas environmental factors such as the suitability of the environment were more frequently identified in unpredictable behaviour incidents. Irrespective of the comprehensive care category, investigations into patient outcomes of serious harm or death were more likely to identify factors associated with documentation, patient assessment and communication between staff.

Review of the contributory factors in cases where the patient outcome was serious harm or death identified several themes, including:

- Assessment of the patient not performed, delayed or incomplete/insufficient, including assessment for delirium and/or cognitive state
- Re-assessment of the patient not actioned in response to a change in their condition
- Insufficient handover of the patient's risk and/or interventions between hospitals/ services/ nursing homes or between the emergency department and the ward, and between staff
- Care provided in a location not suitable for patients needs
- Lack of involvement of family members and/or guardians/carers in developing care and safety management plans for the patient.

Communicating for safety clinical incidents

Every day humans communicate with each other through various modes including verbal, non-verbal and written communication. Appropriate communication is critical to managing the delivery of safe patient care and is a key safety and quality issue amongst organisations.

The Communicating for Safety Standard recognises the need to ensure effective, timely and purpose-driven communication and documentation within all aspects of healthcare. The objective is to support leaders of a health service organisation to set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations[6].

The standard recommends that clinical governance and quality improvement strategies are put in place within healthcare systems to support effective communication between staff and patients. This includes partnering with consumers, applying quality improvement systems, organisational processes to support effective communication and integrating clinical governance.

In 2022/23, there were 5,118 clinical incidents related to communicating for safety notified with 4,818 of these incidents confirmed at the time of this report. This represents an increase in reporting related to communication issues of approximately 11 per cent in the number of incidents related to communicating for safety compared to 2021/22. Incidents related to communicating for safety accounted for 12.8 per cent of all confirmed clinical incidents in this period. Most of these incidents were categorised as SAC 3 incidents (95.2 per cent), with 4.1 per cent confirmed as SAC 2, and 0.7 per cent confirmed as SAC 1.

While there has been an overall increase in reporting, more than 80 per cent of confirmed incidents relating to communicating for safety in 2022/23 reported the patient outcome as no harm, with 19 incidents describing the outcome for the patient as serious harm or death, which is a 35 per cent reduction in this category from 2021/22.

6. NSQHS Standards (2nd ed – version 2) Communicating for Safety Standard

Similar to reporting data from previous years, the most frequently reported sub-categories of confirmed clinical incidents related to communicating for safety in 2022/23 were documentation of information (n=1,961; 40.7 per cent) and correct patient identification and procedure matching (n=1,348; 28 per cent).

Table 5: Confirmed communicating for safety clinical incidents by SAC rating and sub-category for 2022/23

Communicating for safety sub-categories	SAC 1	SAC 2	SAC 3	Total
Documentation of information	1	32	1,928	1,961
Correct identification and procedure matching	20	58	1,270	1,348
Communication at clinical handover	2	59	962	1,023
Communication of critical information	7	39	247	293
Other incidents related to communicating for safety	2	12	179	193
Total	**32**	**200**	**4,586**	**4,818**

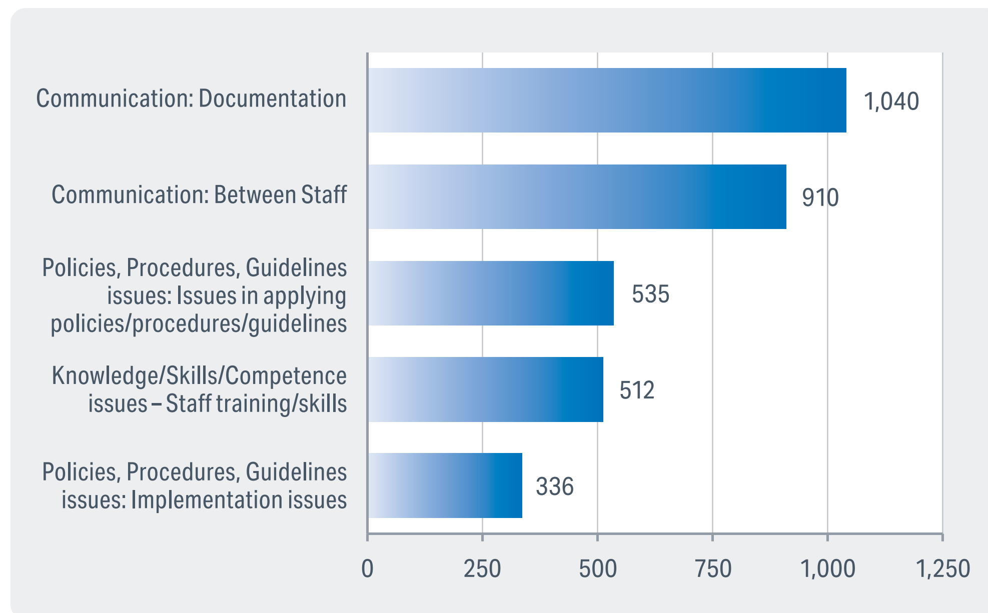
Patient outcomes of serious harm or death were most often associated with the sub-categories related to communication of critical information (n=10) and correct identification and procedure matching (n=5).

General medicine (n=839; 17.4 per cent) and emergency medicine (n=563; 11.7 per cent) reported the highest number of incidents related to communicating for safety. However, when considering patient outcomes of serious harm or death, the treating specialty that most often reported communicating for safety incidents was Emergency Medicine (n=3).

When patient outcomes were further studied, it was found that issues related to communication of critical information was far more likely to lead to patient outcomes of serious harm or death (n=10) than communication at handover (n=2). Of note, issues related to patient referral and follow-up were associated with 9 of the administrative process incidents with outcomes of serious harm or death in this period.

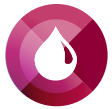
As demonstrated in Figure 8 the top 3 contributing factors related to this standard include communication issues from documentation (n=1,040), communication issues between staff (n=910), and issues in applying policies/procedures/guidelines (n=535).

Figure 8: Most frequent contributory factors for closed communicating for safety clinical incidents for 2022/23



Review of the contributory factors in communicating for safety clinical incidents with a patient outcome of serious harm or death in 2022/23 identified several themes, including:

- Deficiencies in communication within and between treating teams, including the patient's general practitioner
- Insufficient communication with the patient or their family/carers including incomplete consent to treatment
- Failure in patient identification/other checking procedures
- Diagnostic test results and/or follow-up plans not sufficiently/correctly documented or actioned
- Manual and hybrid communication processes, in some cases partly dependent on the patient, having potential for failure.



Blood management clinical incidents

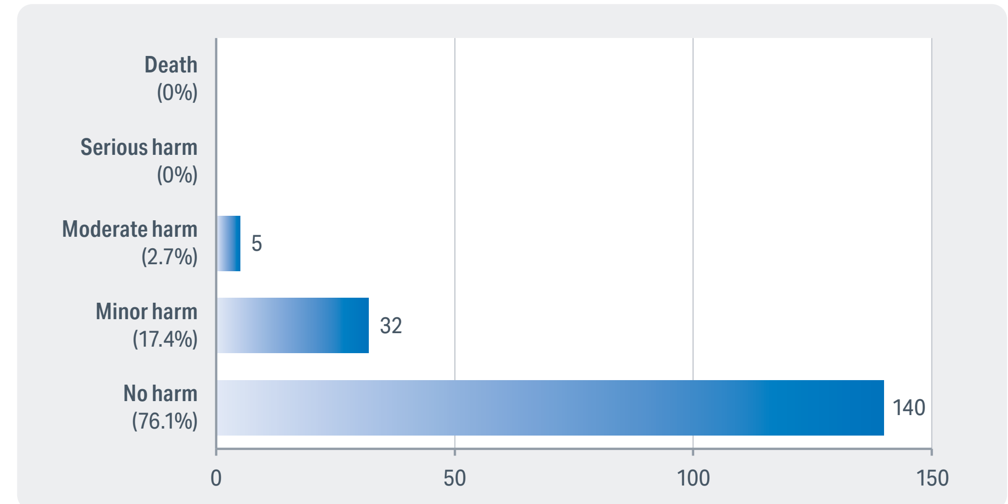
Treatment with blood and blood products can be lifesaving, however the administration of these products also carries inherent risks. Over a number of years, Western Australia has developed robust blood management processes that have ensured that the public health system continues to see low numbers of clinical incidents and low levels of patient harm.

The Blood Management Standard provides a framework to support safe and appropriate blood usage and is instrumental in creating a system where patient harm is minimised. The standard promotes strategies such as screening and testing of donors and donated blood; and ensuring that all treatment options, including their risks and benefits, are considered before deciding to transfuse. The scope of this standard includes fresh blood components (such as red blood cells and platelets), plasma derivatives (such as immunoglobulins) and recombinant products (such as coagulation factors).[7,8]

Blood management in Western Australia is supported by the WA Haemovigilance program which collects and assesses information about unexpected or undesirable effects resulting from the use of blood and blood products.[9] The WA Haemovigilance program also contributes to the identification of emerging trends in hazards related to blood transfusion. Haemovigilance data from WA's participating hospitals is reported to the National Blood Authority as part of a national reporting framework.

In 2022/23, there were 184 confirmed blood management clinical incidents, representing 0.5 per cent of all confirmed clinical incidents. More than 75 per cent of all blood management clinical incidents reported no patient harm and a further 17 per cent reported minor patient harm. During this period, there was one blood management clinical incident confirmed as SAC 1 which was reported as a near miss with no patient harm. During 2022/23, there were no reported patient outcomes of death or serious harm.

Figure 9: Confirmed blood management clinical incidents by patient outcome for 2022/23



The types of blood management clinical incidents in 2022/23 were similar to those in previous years. Red cells continued to be involved in around half of all blood management clinical incidents and the most frequent reported incident category remained the administration of blood products at an incorrect rate or frequency. There were 143 clinical incidents where the investigation had been completed at the time of this report. Issues with communication between staff, staff skills and/or training and documentation were again most often identified as contributory to blood management clinical incidents in 2022/23.

Review of the contributory factors in blood management clinical incidents with a patient outcome of moderate harm in 2022/23 identified several themes, including:

- Miscommunication between staff about blood product administration
- Incomplete assessment/documentation
- Delayed transfer of blood products from delivery point to patient leading to avoidable wastage.

7. NSQHS Standards (2nd ed – version 2) Blood Management Standard
8. Blood Management
9. Haemovigilance

Recognising and responding to acute deterioration clinical incidents

Rapid changes in a patient's physiological, psychological, or cognitive health status over a period of hours or days, may indicate they have suffered from acute deterioration. The NSQHS Recognising and Responding to Acute Deterioration Standard aims to ensure that early detection and intervention in response to changes in a patient's physical or mental state are made promptly to improve patient outcomes[10]. The warning signs of clinical deterioration are not always recognised or acted on appropriately, often due to organisational or workforce factors, therefore it is imperative that health service organisations recognise these factors and have systems in place to support staff to identify deterioration and respond accordingly. These systems should be consistent with National Consensus Statements.

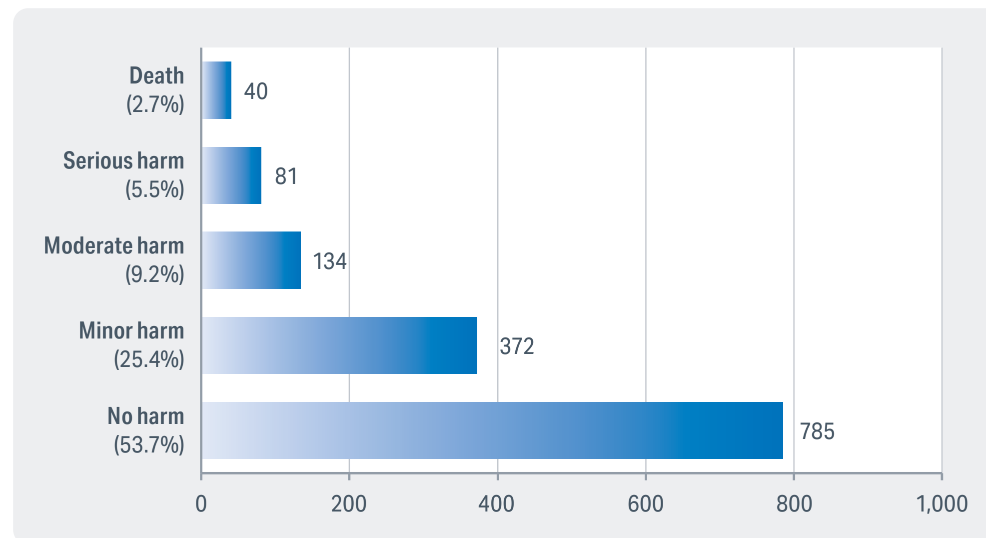
Detection of acute deterioration may be by way of frequent monitoring, including medical parameters and tracking changes in vital signs, or through other mechanisms such as communication with patients, their family members and carers who are able to escalate care, for example by voicing concerns that the patient's condition is getting worse, that they are not doing as well as expected, or not improving.

In 2022/23, there were 1,557 clinical incidents notified that related to recognising and responding to acute deterioration, and 1,462 of these incidents had been allocated a confirmed SAC rating at the time of this report.

Incidents related to acute deterioration represented 4.1 per cent of all confirmed incidents in 2022/23, and while the most were confirmed as SAC 3 incidents, nearly one-quarter were confirmed as SAC 1 or SAC 2. Consistent with previous years, this NSQHS Standard has the highest proportion of incidents confirmed as SAC 1 (8.3 per cent).

While the most frequently reported patient outcome in confirmed clinical incidents related to acute deterioration was no harm (Figure 10), outcomes of death (n=40) have reduced compared to the previous year (n=51). Similar to the previous year, patient outcomes of serious harm or death were reported in one in every 12 confirmed incidents related to recognising and responding to acute deterioration in 2022/23, demonstrating the detrimental effects that incidents of this nature pose to patients.

Figure 10: Confirmed acute deterioration clinical incidents by patient outcome for 2022/23



In 2022/23, 11.5 per cent of patients involved in acute deterioration clinical incidents were voluntary, involuntary or referred mental health patients under the *Mental Health Act 2014*, which is less than that seen for clinical incidents generally. However, compared to 2021/22 reporting data, 14.1 per cent of this patient population reported an outcome of serious harm or death, which is a reduction from the previous year.

General Medicine reported the highest number of clinical incidents related to this NSQHS Standard (n=239) however obstetrics and emergency medicine reported the most incidents with patient outcomes of serious harm or death.

Of the 29 obstetric clinical incidents with a patient outcome of serious harm or death 12 identified during investigation that some aspects of cardiotocography (CTG) monitoring contributed to the fetal outcomes including one death and 11 cases of serious harm.

10. NSQHS Standards (2nd ed – version 2) Recognising and Responding to Acute Deterioration Standard

In this period there were 3 clinical incidents related to failures to recognise or respond to deteriorating sepsis patients that reported the patient outcome of death and a further 2 patients that reported a patient outcome of serious harm. This represents a reduction from the 8 deaths and 5 serious harm cases in the previous period.

The most frequently identified contributory factors in acute clinical deterioration incidents reporting patient outcomes of serious harm or death in 2022/23 were issues with communication between staff and assessment of the patient. Details of contributing factors included:

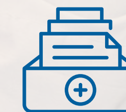
- Delayed care/transfer of patients due to access blocks in both mental health and non-mental health settings
- Delayed or incompletely performed patient assessments (both mental state/risk assessments, medication risk, pregnancy risk and physical health assessments)
- Lack of, incomplete or ineffective monitoring of patients including staff not familiar with monitoring equipment
- Patient assessments or observations not documented or incompletely documented
- Fragmentation of patients' information across multiple records/systems
- Lack of, or ineffective handover of patients' care between health service organisations, treating teams and individual clinicians including a lack of supervision of the transport of unwell patients
- Deteriorating patients not recognised as requiring escalation of care including patients cared for in smaller centres not equipped for resuscitation
- Policies and pathways for escalation of patients care not established or not clear to staff including sepsis pathways
- Insufficient or ineffective communication between staff members and also with patients often involving temporary staff not aware of protocols
- Lack of inclusion of family/carers in assessment processes, care and discharge planning
- Lack of senior staff support to junior staff after hours.

Mortality Review

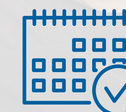
10 Inquest findings discussed

6 Inquests that made recommendations

15 Recommendations made



7,912 deaths in scope of the *Review of Death Policy*



94% reviewed in 4 months of date of death (in 2022 calendar year)

Mortality review

Coronial review

The Coronial Review Committee (CRC) operates closely with the Coronial Liaison Unit (CLU) and exists to improve the governance and decision-making in relation to the implementation and response to coronial inquest findings and recommendations. The Progress Report for Health-Related Coronial Recommendations, prepared by the CLU, includes information about the health system's response to recommendations and is submitted to the State Coroner on a biannual basis.[11]

The CLU, in conjunction with the CRC, considered 20 coronial inquest findings that were published by the Coroner's Court over 2022/23. Of these findings 10 were tabled for discussion by the CRC and another 10 were for noting. Of the 10 inquests discussed by the CRC, 6 inquest cases directed a total of 15 recommendations to the WA health system. Four of these recommendations have been completed or closed, and 11 recommendations remain ongoing.

Review of death

Requirements for the review of patient deaths (mortality review) in the WA health system are established by the *Review of Death Policy*.[12] In the 2022 calendar year there were nearly 8,000 patient deaths that fell within the scope of the Review of Death Policy, and 94 per cent of these were reviewed within 4 months of the patient's death. Four deaths were referred for further investigation as potential SAC 1 incidents following mortality review.

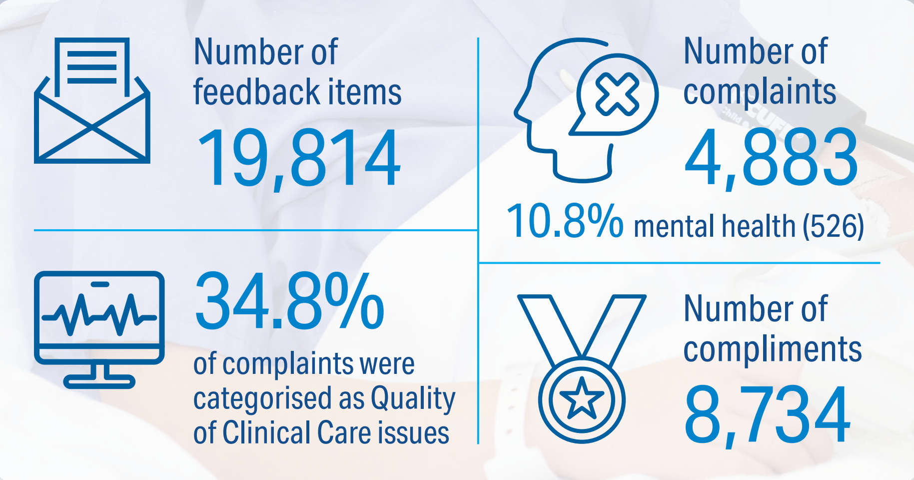
Western Australian Audit of Surgical Mortality

The Western Australian Audit of Surgical Mortality (WAASM) is a review of surgical deaths using a peer review methodology. It is designed to improve patient safety by providing direct feedback from surgeons to surgeons and by highlighting overall trends and system issues in surgical care.[13] The WAASM is managed by the Royal Australasian College of Surgeons (RACS) and funded by the Department of Health. Operating since 2002, the WAASM reports data each calendar year. Participation in the WAASM fulfils mortality review obligations established by the *Review of Death Policy*.

The WAASM Annual Report provides de-identified information of data gathered through the audit process and presents systemwide data including the total number of surgical deaths, adverse events identified and those considered definitely preventable or probably preventable.[14] In 2022, 590 deaths across public and private hospitals met the WAASM criteria and none were considered definitely preventable. WAASM continues to contribute cases to the Australian New Zealand Audit of Surgical Mortality Case Note Review Booklets to facilitate lesson sharing and education.[15]

11. Biannual Progress Report for Health-Related Coronial Recommendations
12. MP 0098/18 Review of Death Policy
13. Western Australian Audit of Surgical Mortality
14. WAASM Annual Report
15. Case Note Review Booklets

Consumer Feedback



Consumer feedback

Consumer feedback helps to monitor and improve services provided by health service organisations. Feedback is encouraged and is a key part of consumer health care rights[16]. In the WA health system feedback is described in 3 categories – complaints, compliments or contact/concern.

Feedback – at a glance

In 2022/23, consumers provided feedback on 19,814 occasions, with 44 per cent of that feedback primarily positive and complimentary to the service. Most consumers have overall, a positive experience with public health services.

Complaints made up one-quarter of feedback received in 2022/23, with the remaining 31 per cent classified as contacts/concerns.

> *"I feel my concerns were completely understood and validated and I am forever thankful and appreciative of the support given. It has helped restore hope in a time where things were beginning to feel hopeless.*
>
> *I also feel a huge relief as I feel our voices were actually heard."*
>
> ***– Mother of a patient receiving care***

Mental health services accounted for 10 per cent of all feedback.

Most feedback was provided directly by the individual who received the care, with approximately 30 per cent of feedback reported on their behalf (such as by a parent or carer).

More than three-quarters of compliments were received directly from the consumer who received the care, compared to 53 per cent of complaints.

Complaints and compliments

In 2022/23, 4,883 complaints and 8,734 compliments were received. Both sources of feedback play an integral role in service improvement.

16. Australian Charter of Health Care Rights

Complaints provide a prompt to an organisation to review which services and their processes can be improved upon. They can act as an early warning flag to ensure issues do not develop into potentially riskier events. Compliments can assist in identifying what processes may be successful for the consumer and where appropriate replicated in other health services.

Complaints resolutions

When a complaint is made, the service responds to the consumer and aims to resolve their issues. Services will provide information back to the complainant about how they plan to improve the consumer experience at that service.

> *"She listened carefully to my concerns and took a very solution focused approach to helping me resolve my concerns. Her compassion and listening skills make her a great asset."*
>
> ***– Inpatient at hospital, mental health services***

The most common outcomes were having an apology provided (72 per cent), their concern was registered (64 per cent) and an explanation given (62 per cent).

A complaint resolution that indicated a clear, long term action was reported at lower frequency – a change in practice for example was only listed as a resolution 4 per cent of the time. While this is a start, long term quality improvement activities are also required to ensure that the same issue does not arise again.

Complaint issues

Every complaint received by the WA health system must have at least one issue identified. Knowing which issues are a concern for the consumer helps services to prioritise improvement where it is needed most to best serve the consumer experience.

Categories

There are 10 broad complaint categories that issues are recorded against, which are further divided into 2 more levels of detailed categories.

In 2022/23, a total of 9,251 issues were identified in the 4,883 complaints received.

The categories of issues which are most frequent include:

1. Quality of clinical care (e.g. inadequate treatment)
2. Communication (e.g. misinformation)
3. Access (e.g. delays)
4. Rights respect and dignity (e.g. inconsiderate services).

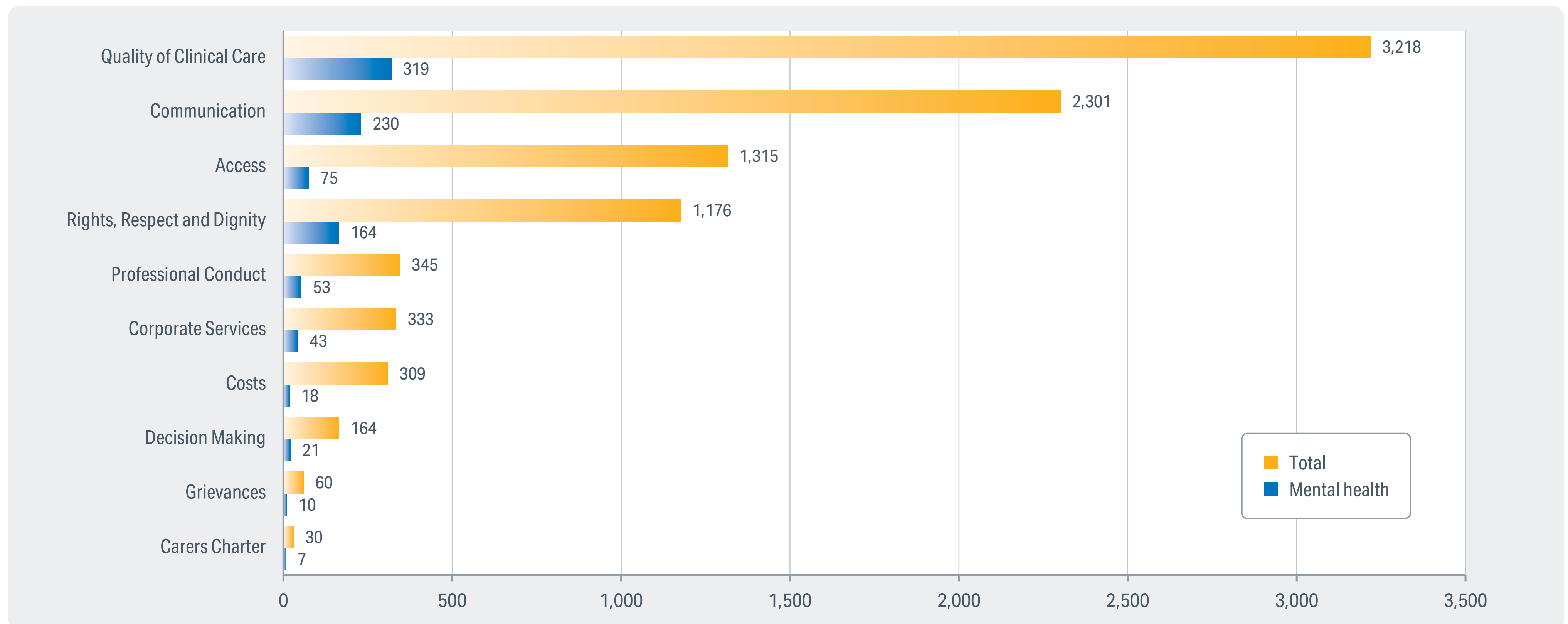
The top 4 complaint issues accounted for 86.5 per cent of all issues identified.

Mental health

Mental health complaints describe those complaints received by health services providing specialised mental health care in community services or hospitals. They are a subset of total health complaints.

Issues relating to mental health care generally followed a similar distribution of total health complaint issues. However within mental health complaints, issues related to rights, respect and dignity were a higher proportion compared to total complaints.

Figure 11: Issues identified in complaints received by the WA health system for 2022/23



Glossary

Adverse event – an injury or harm caused by medical management or complication thereof, instead of the patient's underlying disease. It results in an increase in the level of care and/or prolonged hospitalisation and/or disability at the time of discharge.

Clinical incident – an event or circumstance resulting from health care provision (or lack thereof) which could have or did lead to unintended or unnecessary physical or psychological harm to a patient.[17]

Clinical Incident Management (CIM) – the process of effectively managing clinical incidents with a view to minimising preventable harm.

Contact or concern – feedback from consumers/carers/representatives regarding any aspect of service where they state that they do not wish to lodge a formal complaint and the issue can be resolved without going through the formal complaint management process.[18]

Contracted health entity – a non-government entity that provides health services under a contract or other agreement entered into with the CEO, Department of Health on behalf of the State, a health service provider or the Minister.[19]

Contributory factor – a circumstance, action or influence which is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.[17]

Datix Clinical Incident Management System (CIMS) – the approved WA health statewide enterprise electronic online clinical incident management system, which has been used since February 2014 to capture and manage clinical incidents that occur within the WA health system.

Datix Common Classification System Version 2 (CCS2) – the proprietary classification system for clinical incidents used in the Datix CIMS. The Datix CCS2 consists of 3 tiers:

- **Tier One:** Broad domains of incidents that may result in adverse events
- **Tier Two:** Subdomains of process insufficiencies or failures within each Tier One domain
- **Tier Three:** Further, more detailed, subordinate categories of process insufficiencies or failures representing the finest level of granularity in classification.[20]

Declassification – is the process by which a clinical incident can be made inactive following the comprehensive and systematic investigation of a notified SAC 1 clinical incident which finds no contributory factors. The PSSU must approve declassifications for SAC 1 clinical incidents.[17]

Health service provider – a statutory body established to provide health services in a health service area established by the Minister. A health service area may be a part of the state, a public hospital, a public health service facility or a public health service.[19]

Near miss – an incident that may have, but did not cause harm, either by chance or through timely intervention.

Sentinel events – a subset of serious clinical incidents that have caused or could have caused serious harm or death of a patient. It refers to preventable occurrences involving physical or psychological injury, or risk thereof. There are 10 national sentinel event categories endorsed by Australian Health Ministers (for a list of the 10 sentinel event categories see www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-sentinel-events-list-version-2-specifications)

17. MP 0122/19 Clinical Incident Management Policy
18. MP 0130/20 Complaints Management Policy
19. *Health Services Act 2016* available at: www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13761_homepage.html
20. For further information about the Datix CCS2 see: https://healthmatrixcorp.com/MediaStorage/file/file_63.pdf

Separation – a patient is separated at the time the hospital records the cessation of treatment and/or care and/or accommodation of a patient. Separation is synonymous with discharge.

Severity Assessment Code (SAC) – is the assessment of actual or potential consequences associated with a clinical incident. The SAC rating (1, 2 or 3) is used to determine the appropriate level of analysis, action and escalation.

- **SAC 1** includes clinical incidents that have or could have (near miss) caused serious harm or death; and which are attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness. In WA, SAC 1 includes the 10 nationally endorsed sentinel event categories.
- **SAC 2** includes clinical incidents that have or could have (near miss) caused moderate harm; and which are attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.
- **SAC 3** includes clinical incidents that have or could have (near miss) caused minor or no harm; and which are attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.[17]

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