

# Clinical Incident Management Policy

## Using the Advanced Incident Management System (AIMS)

# Incident Management Policy

The Advanced Incident Management System (AIMS)



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## Foreword

The Western Australian community enjoys an excellent standard of health care. Despite this, there is a need to constantly adapt and improve health care delivery to meet the current and future challenges such as the high demand for health services, advances in technology, a changing workforce and an ageing population. The more complex the health care provided to individuals the more room there is for system and human error.

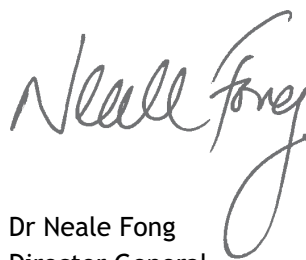
The Western Australian Council for Safety and Quality in Healthcare, in association with the Department of Health's Office of Safety and Quality in Healthcare and local clinicians, has developed the *Strategic Plan for Safety and Quality in Health Care in Western Australia 2003/04 to 2007/08* in order to meet these challenges.

This policy document replaces the 'Incident Reporting and Management Policy - Information Series No. 4'. The policy incorporates recent strategic developments in health care such as the move toward more open communication with patients and their nominated support person. Recent changes to the qualified privilege protection afforded to the Advanced Incident Management System (AIMS), formerly the Australian Incident Monitoring System, are also outlined.

The document also incorporates information generated from an extensive evaluation of the Clinical Incident Reporting and Management Program carried out by the Office of Safety and Quality in Healthcare, Department of Health (WA) in 2005.

As safety and quality in health care is an area of rapid change, future updates of this policy will be made available on the Office of Safety and Quality in Healthcare website ([www.safetyandquality.health.wa.gov.au](http://www.safetyandquality.health.wa.gov.au)).

We encourage all health service staff within WA Health to read this policy and embrace the culture of change as we strive for an improved, open and accountable health care system.



Dr Neale Fong  
Director General  
Department of Health

## 1. Introduction

*The Strategic Plan for Safety and Quality in Healthcare in Western Australia 2003/04 to 2007/08*, sets the agenda for continuous improvement of health care delivery across the State. It is built around four important interlinked strategic areas of clinical governance: consumer focused health care, clinical practice improvement, risk management and system improvement and accountability. Central to risk management is the reporting, monitoring and management of clinical incidents to the Advanced Incident Management System (AIMS).

AIMS is in place across all WA government area health services and covers the reporting, investigation, analysis and monitoring of clinical incidents that occur as a result of the provision of health care. The main objective of AIMS is to improve health care delivery. The reporting of clinical incidents enables hospital and health service staff to commence an investigation to identify contributing factors and system errors that may have caused or contributed to the incident. Preventative measures can then be put in place to minimise the risk from similar events occurring in the future. Trended data can also be used to signal system errors that are, not obviously visible in individual cases.

This document is designed for hospital and health service staff across WA Health to provide guidance on reporting, investigating analysis and monitoring of clinical incidents through the AIMS process. Staff should be aware that a single clinical incident can give rise to many reporting requirements and information on the relationship of clinical incidents to some of these other reporting requirements is investigating analysis and monitoring of clinical incidents included in Section 8 of this policy.

## Scope of policy

Whilst reporting to AIMS is voluntary, the Australian Health Ministers mandated in 2004 that all public hospitals will have an incident reporting system in place by January 2005. This policy provides direction for WA hospitals and health services to comply with this mandate. Area Health Services will implement systems and processes that comply with the guidelines set out in this policy in order to provide a consistent approach to reporting, investigation, analysis and monitoring of clinical incidents to AIMS.

This policy applies to WA Government metropolitan and rural health services and their staff including contract staff and unpaid staff (e.g. volunteers).

## Updates of policy

This policy may be updated from time to time. To access the latest version please go to the policies and publications page on the Office of Safety and Quality in Healthcare website:

<http://www.safetyandquality.health.wa.gov.au>

## Definition of a clinical incident

A clinical incident is an event or circumstance resulting from health care which could have, or did lead to unintended harm to a person, loss or damage, and/or a complaint.<sup>1</sup> In the context of this document, a 'person' includes a patient, client or visitor. Clinical incidents include:

- near misses - incidents that may have, but did not cause harm; and
- adverse events - an incident in which harm resulted to a person. Harm includes death, disease, injury, suffering and/or disability.<sup>1</sup>

1. Australian Council for Safety and Quality in Health Care

## Clinical incidents that fall within the scope of this policy

One clinical incident can give rise to many reporting requirements. Some of these are outlined in Section 8 of this document. For the purposes of reporting to AIMS, staff should consider reporting clinical incidents that meet the definition of an incident. Examples of clinical incidents reportable to AIMS include (but are not limited to):

- medication errors (e.g. wrong medication, omission, overdose);
- patient falls;
- intended self harm or suicidal behaviour;
- therapeutic equipment failure;
- environmental hazards;
- contaminated food;
- problems with blood products;
- documentation errors;
- delayed diagnosis;
- surgical operation complications;
- hospital acquired infection;
- incidents when a patient expresses concern with their treatment; and
- inappropriate treatment/s.

## Clinical incidents that do not fall within the scope of this policy

Clinical incidents that should not be reported to AIMS include (but are not limited to):

- Occupational Safety and Health (OSH) incidents that involve staff only (e.g. needlestick injuries);
- workplace aggression between staff (e.g. rudeness, bullying); or
- allegations or suspicions of:
  - physical altercation or sexual misconduct by staff or other individuals involving a patient or client;
  - non-compliance with a hospital or health service policy or practice concerning work safety;
  - suspected or alleged alcohol/substance use by a staff member/provider;
  - property theft or damage; or
  - incidents involving visitors unrelated to the provision of a health care service to a patient (e.g. spilling hot drink on self).

Please note that OSH or workplace aggression incidents (where no physical altercation is involved) resulting in harm to patients should be reported to AIMS.

The line manager or local AIMS coordinator can provide guidance where staff are unsure whether to report an incident or not.

## 2. Ensuring safety of a person involved in a clinical incident

Where a clinical incident occurs, the first priority is to ensure the subject of the incident is safe and that all necessary steps are taken to support and treat the person and prevent injury to that person and others.

A Medical Officer must be notified if a person suffers harm or injury as a result of a clinical incident.

Where the subject of the clinical incident is a patient, the hospital or health service member of staff ('the reporter') reporting the incident to AIMS must, before doing so, document the incident in the patient's medical record. Staff involved in providing clinical care to the patient must make a notation of the care provided in the usual way.

Where the subject of a clinical incident is a visitor, the reporter must document the incident as follows:

- Where a Medical Officer examines the visitor, a medical record should be generated for the visitor and the incident and care given documented in that medical record;
- Where the visitor has not been medically examined, the clinical incident should be recorded in the hospital or health service's corporate incident reporting system (e.g. an incident and accident register) following applicable local processes; or
- Where a visitor and patient are involved in the clinical incident the incident should be documented in the patient's medical record as well as the medical record generated for the visitor. Where no medical record is generated for the visitor, the clinical incident should be documented in the hospital or health service's corporate incident reporting system.

The recording of a clinical incident as outlined above should be a strictly factual account of the incident, the action taken immediately following the incident (including treatment administered or first aid given) and (where applicable) future treatment plan. Care must be taken to ensure that the clinically relevant information is recorded only in the medical record of the individual patient concerned.

The factual account of the clinical incident should not contain any commentary or expressions of opinion. Nor should it apportion blame to any individual involved in the clinical incident. Details of any investigation and analysis of the clinical incident conducted within AIMS should similarly be excluded from the medical record or other corporate reporting systems.

Information recorded in a medical record or separate corporate reporting system is not protected and may be accessible by means of the *Freedom of Information Act 1992* or be the subject of pre-action discovery (prior to the commencement of a civil action) or discovery (following the commencement of an action). Further, in the case of a death of a patient or visitor, such records may be accessible under the *Coroners Act 1996*.

### 3. Notification of clinical incidents to AIMS

Where hospital and health service staff witness or detect a clinical incident they are encouraged to report it to AIMS using the clinical incident form. A copy of this form can be found at Attachment 1. In cases where more than one individual witnessed or detected the incident, one person should be designated to report the incident to AIMS.

Patients, clients or visitors to hospitals and health services can also report incidents to AIMS. In order to maximise data quality, staff may need to help them complete the clinical incident form accurately.

The incident form allows for anonymous reporting. Anonymous reporters should be aware that they can not be informed about the outcome of their report.

If after a clinical incident (including those notified anonymously) has been notified to AIMS it becomes apparent that the clinical incident is one that should not properly be managed within AIMS (see section headed “Clinical incidents that fall within the scope of this policy”), staff should refer the matter to senior management and/or their Head of Department for a decision on withdrawing the incident from AIMS. If withdrawn, the incident should be referred to the hospital or health service’s Risk Manager, Clinical Director, senior management or other relevant staff member for future management through appropriate local processes.

### Staff responsibilities

#### Reporter

The reporter is responsible for completing page 1 of the clinical incident form, (the notification). This page is not part of the declared quality assurance activity, and therefore information captured on this page is not protected (see Section 7 for further information). Information captured during notification of the incident to AIMS is purely factual.

### 4. Clinical incident investigation and analysis

Once a clinical incident has been notified to AIMS, the next stage is for the incident to be investigated and analysed. The investigation and analysis phase is used to establish the course of events and to identify the contributing factors. The goal of investigation and analysis is to improve health services through remedial action.

Hospitals and health services may also wish to investigate and analyse ‘near miss’ incidents, particularly those that could have had a catastrophic outcome (e.g. the incorrect limb marked for surgery but noted before the operation or a potentially fatal dose of medication drawn up but not given). Near miss incidents may signal serious breakdowns in health systems and can serve as ‘free lessons’ that may result in recommendations to prevent further incidents occurring at a later time.

### Staff responsibilities

#### Reporter

The reporter is responsible for completing page 2 of the clinical incident form. The information captured on this page comprises the first part of the investigation and analysis of the clinical incident, and is therefore protected (see Section 7 for further information).

To ensure clinical incidents can be coded accurately, reporters must record only their observations of the factual events on page 2 of the clinical incident form. Do not include suppositions. For example: a member of staff walks into a room and sees a patient lying on the floor. The reporter writes in the incident description box “Patient fell from chair. I walked in and saw patient lying on floor”. If there was no witness to the incident and the patient is not able to state what happened, the reporter does not know the patient fell from a chair. In this instance the reporter should write “I walked in and saw the patient lying on the floor - ?? fall”.



The following information should be reported on the incident form:

- a description of the actual or potential incident;
- a summary of possible factors contributing to the incident (subject, staff and systems);
- a description of any treatment or investigations ordered;
- an indication of what factors minimised the outcome;
- an indication of how the incident could have been prevented; and
- reporter details.

It is important that all relevant information is provided as the quality of the information reported has a direct impact on the ability of senior management to investigate and analyse clinical incidents, and prevent their recurrence. The quality of information also influences the usefulness of the trend reports available through the AIMS reporting software.

The following tips are useful when reporting clinical incidents that involve medication or behaviour:

- If a *medication* incident is being reported, it is important to include the name of the medication/s involved and specify the dosage that should have been given and the dosage in fact given. It is also useful to state the time period over which the incident occurred (e.g. Medication A was omitted over 2 days).
- Where a *behavioural* incident is reported it is important to differentiate between the aggressor and the victim. It may help to provide a description of their roles in the incident.

The information the reporter provides should not seek to apportion blame to any individual.

### Medical Officer

Where a Medical Officer was called to attend to a person who suffered harm or injury as a result of a clinical incident, the Medical Officer concerned should complete the section headed "Medical Practitioner's examination of subject" at the bottom of page 2 of the clinical incident form. Only factual and clinically relevant information should be provided.

### Senior Staff

The reporter's supervisor or senior staff member is responsible for conducting a risk assessment, undertaking further investigation and analysis of the clinical incident and documenting the appropriate remedial action to be taken. This information should be captured in the 'Senior staff evaluation' section on page 3 of the clinical incident form.

The investigation and analysis should be performed in a way that discourages the placing of blame on any of those involved in the incident. This can be best achieved by using a systematic process in which the following factors are considered:

- patient;
- communication;
- knowledge/skills/competence;
- work environment/scheduling;
- equipment;
- policies/procedures/guidelines; and
- safety mechanisms.

A standard for investigating high and extreme risk clinical incidents has been developed and is available at the Office of Safety and Quality in Healthcare website: <http://www.safetyandquality.health.wa.gov.au> Staff should consider applying the standard when investigating these types of clinical incidents.

When describing the remedial action avoid making general statements that refer to documents outside the incident reporting and management system (e.g. “as per patient notes”). Include a brief description to indicate what action was taken and why (e.g. ‘Falls risk was reviewed and care plan revised to include two hourly toileting’, ‘patient was provided with medication to relieve pain and was monitored’). The supervisor should also include comments on how the risk will be managed in order to prevent or reduce the likelihood and/or consequence of similar events in the future.

It is important that the supervisor or senior staff member regularly review and analyse local data to identify incident trends and patterns. This process can also provide information on whether particular strategies put in place to target incidents have been effective.

For more information on risk assessment please refer to the Clinical Risk Management Guidelines for the WA Health System, which is available at: <http://www.safetyandquality.health.wa.gov.au>

### Third Party

In this document, a ‘third party’ refers to an area (e.g. pharmacy, radiology, allied health, pain services, home visiting) at the local hospital or health service level other than the area responsible for conducting the investigation and analysis.

If a third party was either involved, or can provide additional expert information, the clinical incident form should be forwarded to the appropriate area (eg. pharmacy, infection control) for comment. On completion of the relevant section of the clinical incident form (‘Third party comments’ section on page 3 of the clinical incident form), the third party should forward the form to the Head of Department or Senior Staff Member.

### Head of Department

The Head of Department/Service Head or Director should:

- a) Complete the relevant section of the incident form (‘Department/Service Head or Director Comments’ section on page 3 of the clinical incident form) by commenting on the action taken or needed to prevent recurrence, resource implications and an indication of the incident outcome. It should be clear from these comments how the risk will be managed, who will be responsible for taking any necessary actions and in what time frame.
- b) Make a final judgement on the incident outcome level by checking the relevant box (‘Incident Outcomes’ section on page 3 of the clinical incident form) and ensure that relevant notifications have occurred.
- c) Sign the clinical incident form after they are satisfied that all necessary information is included on the form and relevant risk management has occurred.

## 5. Prevention of clinical incident recurrence

The identification of contributing factors must be documented and appropriate actions taken to enable improvements in patient safety. Where there is a high to extreme risk of patient injury in the future, the recommendations arising from the investigation and analysis of the clinical incident should be placed on the health service risk register. This information placed on the register must not identify, either expressly or by implication, a particular individual or individuals involved in the clinical incident.

Appropriate groups within the hospital and health service, such as the Clinical Governance Committee or Unit, can then monitor remedial action. For further information on risk management please refer to the Clinical Risk Management Guidelines for the WA Health System, which is available at: <http://www.safetyandquality.health.wa.gov.au>

Remedial action for non-serious clinical incidents should also be monitored and evaluated to determine its effectiveness in preventing the recurrence of similar events. If the volume of clinical incidents prevents this process occurring, such incidents should be prioritised according to risk to patients or visitors and other local criteria.

## 6. Feedback to staff and patients

Providing feedback to staff about clinical incidents reported to AIMS is a crucial step in the quality improvement process. Formal recognition that reporting clinical incidents results in visible or tangible system improvements supports and fosters a safety and quality culture.

Hospitals and health services should ensure that feedback is provided personally to the reporter, where possible, and feedback should be provided to staff more generally on the actions taken and lessons learned as a result of reporting incidents. De-identified information regarding clinical incident trends and patterns and improvements to patient safety can be disseminated and reinforced via a newsletter, staff meetings, group emails or the intranet.

Where possible, patients harmed by clinical incidents should be informed about what happened and whether an internal investigation will take place. Where a hospital or health service wishes to provide the recommendations of an investigation and analysis to the patient, the consent of the patient must be obtained prior to the disclosure of such information. The consent should be obtained in writing by means of a consent form that is signed by the patient and then witnessed. The consent form should be kept in a separate file relating to the open disclosure process. For further information on the open disclosure process and when and how to disclose, please refer to the Open Disclosure Policy soon to be available at: <http://www.safetyandquality.health.wa.gov.au> If the disclosure of recommendations will also directly or indirectly identify another individual(s) (such as a health professional) then the consent of that person must also be obtained in addition to the consent of the patient.

Hospitals and health services are advised to attach a general disclaimer to accompany the recommendations, and to refer any draft correspondence to patients for review by their medico-legal department to ensure that the disclaimer is appropriate to the circumstances of the case.

It should be noted that there will be restrictions regarding disclosure of information to individuals (including staff and the patient) if the clinical incident has been notified to AIMS but is then investigated and analysed by a registered quality improvement committee under the *Health Services (Quality Improvement) Act 1994*. For more information on restrictions regarding disclosure of information under the *Health Services (Quality Improvement) Act 1994* please refer to the Qualified Privilege guidelines which are available at:  
<http://www.safetyandquality.health.wa.gov.au>

## 7. Statutory protection of AIMS

The investigation and analysis of clinical incident reported to AIMS is a declared quality assurance activity under the *Commonwealth Health Insurance Act 1973* Part VC ('the Act'). Notification of the incident to AIMS is not part of the declared activity.

### Prohibition on making records and disclosing information

The effect of the declaration made under Part VC of the Act is that protection is afforded to all information that becomes known solely as a result of investigation and analysis of clinical incidents reported to AIMS by:

- Prohibiting either directly or indirectly the making of a record of that information except:
  - for the purposes of the investigation and analysis of the clinical incident; or
  - where the information does not identify, either expressly or by implication, any particular individuals (including the patient and staff).
- Prohibiting either directly or indirectly the disclosure of that information or documents created solely for the purpose of the activity to another person or a court except:
  - for the purposes of the investigation and analysis of the clinical incident;
  - where the information does not identify, either expressly or by implication, any particular individuals (including the patient and staff);
  - if each of the persons who would be directly or indirectly identified by the disclosure consents to that disclosure of the information; or
  - in accordance with the authority given by the Minister and for the purpose of enabling the Minister to decide whether to authorise the disclosure of the information under section 124Z of the Act.

As the notification of clinical incidents to AIMS is not a declared quality assurance activity, information captured during this phase of the AIMS process (information captured on page 1 of the clinical incident form) is not protected under Part VC of the Act. That means that documents generated during the notification of the clinical incident to AIMS may be accessible under the *Freedom of Information Act 1992*. They may also potentially be accessible through pre-action discovery (prior to the commencement of a civil action) or discovery (following the commencement of an action). Further, in the case of a death of a patient or visitor, such records may be accessible under the *Coroners Act 1996*.

Information captured during the investigation and analysis phase of the AIMS process (pages 2 to 4 inclusive of the clinical incident form) is protected under Part VC of the Act.

### **Authority by Minister for disclosure of protected information**

Section 124Z of the Act permits the Commonwealth Minister for Health to issue an authority for the disclosure of protected information for the purposes of law enforcement, a Royal Commission or for other prescribed purposes. An authority can only be issued where the information that became known solely as a result of the investigation and analysis of clinical incidents reported to AIMS relates to conduct that may have been a serious offence (namely, an offence punishable with imprisonment for a period of more than one year) or a law in force in any State or Territory.

### **Protection from civil liability**

Part VC of the Act also provides protection from civil proceedings (apart from those relating to the breach of rules of procedural fairness) to a person ('the relevant person'):

- who engages in any conduct in good faith in connection with the investigation and analysis of clinical incidents as part of the AIMS process;
- the relevant person's conduct adversely affects any right or interest of a person who provides health services;
- the relevant person engages in the conduct as a member of a committee for the purpose of making an assessment evaluation of the health services provided by that other person; and
- all or a majority of the committee members are health professionals belonging to the same health profession as the person who provided the health services.

## 8. Clinical Incidents and their Relationship to other Reporting Systems

It should be noted that one clinical incident (particularly very serious clinical incidents) can give rise to several reporting requirements. Hospital and health service staff should note there are statutory reporting requirements, mandated reporting requirements as per Department of Health policy as well as professional reporting obligations, some of which are outlined below.

### (i) Statutory requirements

- Maternal deaths must be reported to the Executive Director, Public Health (Section 336 A of *Health Act 1911*, please see Operational Circular 1453/01).
- Perinatal and infant deaths must be reported to the Executive Director, Public Health (Section 336 A of *Health Act 1911*, please see Operational Circular 1454/01).
- Deaths of persons under anaesthesia must be reported to the Executive Director, Public Health (Section 336 A of *Health Act 1911*, please see Operational Circular 1197/99).
- Reportable deaths which require notification to the Coroner (*Coroner's Act 1996*, please see Information Circular 0008/07).
- Certification of death (*Births, Deaths and Marriages Registration Act 1998*, please see Operational Circular 1652/03).

### (ii) Mandated requirements as per Department of Health policy

- Sentinel events must be reported to the Director, Office of Safety and Quality in Healthcare via the Senior Policy Officer at the Office of Safety and Quality in Healthcare (please see Sentinel Event

Policy available at: <http://www.safetyandquality.health.wa.gov.au>. Also see Operational Directive OD0002/06 and Terms and Conditions of Indemnity for Salaried Medical Officers and Terms and Conditions of Indemnity for Non-Salaried Medical Officers available at: <http://www.health.wa.gov.au/indemnity/indemnity/index.cfm>

- Serious adverse events (including deaths) that result in a medico-legal claim or have the potential to result in a medico-legal claim (please see Operational Circular 1850/04).
- Patient suicides and serious incidents that occur in mental health services throughout WA must be reported to the Chief Psychiatrist (*Mental Health Act 1996*, please see Operational Circular 2061/06).

### (iii) Professional obligations

- Deaths should be reported to hospital or health service Mortality Review Team, Clinical Governance Committee or similar.
- Communication with the patient and/or their family/carer. Where relevant this may include disclosure of the incident and consideration of organ donation.
- Deaths that occur while under the care of a surgeon are automatically reported to the WA Audit of Surgical Mortality (please see Terms and Conditions of Indemnity for Salaried Medical Officers and Terms and Conditions of Indemnity for Non-Salaried Medical Officers available at: <http://www.health.wa.gov.au/indemnity/indemnity/index.cfm>).

## 9. Security of the Incident Reporting and Management System

Hospitals and health services need to ensure the security access requirements to the incident reporting and management system conform to the AIMS2 Security Administration Policy<sup>2</sup>.

Due to the sensitive nature of the information collected during the investigation and analysis phase of AIMS, hospitals and health services are obliged to maintain confidentiality. In addition to complying with the *Health Insurance Act 1973: Part VC, Health Insurance Amendment Act 1992*, hospitals and health services are asked to observe the following “Code of Practice” when using AIMS:

- semi completed/completed clinical incident forms should not be available for public view and should be transported in a sealed envelope;
- clinical incident forms should be stored in a secure (locked) area within the hospital/ health service;
- hardcopy clinical incident forms may be destroyed after 12 months as the verbatim softcopy in the incident reporting and management system will constitute the record. Hospitals and health services may choose to keep hardcopy clinical incident forms in secure storage for a period of time determined by the hospital or health service;

- employees with access to the AIMS application must not disclose their access number and password to others;
- employees with access to the Data Manager Module of AIMS application must not disclose identified information from the system to any person not directly involved in the incident or its investigation and management; and
- employees not involved in the incident or its investigation and management should not request information from staff with access to the system.

<sup>2</sup> Available at the Office of Safety & Quality.



# Clinical Incident Form

## (AIMS)

**OFFICE USE ONLY**  
 INSERT AIMS CASE ID HERE

Date Entered

/ /

Ensure medical records are factual and up to date before completing this form

The investigation and analysis phase of the Advanced Incident Management System (AIMS) is a declared quality assurance activity under the *Health Insurance Act 1973 (Cth)*. The yellow shaded areas on this form denote the investigation and analysis phase.

### INCIDENT NOTIFICATION (to be completed by reporter)

Please refer to prompts in the blue shaded areas when completing this form

HEALTH SERVICE NAME

#### Subject details

Last Name:

First Name:

Record / Patient No.:

(or affix patient label here)

Date of Birth / Age:

Sex:

Ward / Unit:

#### Was the subject of the incident

☐ Patient☐ Visitor☐ Equipment

#### Mental Health Clients

☐ Involuntary☐ Voluntary☐ Unknown

Country of birth

ATSI ☐

#### Place of incident (Where did the incident occur?)

Ward or unit or place e.g. child health clinic, ward 7A, Radiology Dept, Day Centre.

Specific location e.g. subject's home, toilet, shower, theatre room 1, dining room, reception area, car park.

Date of incident:

/

/

Time of incident:

Current and relevant diagnosis / problems

Treating specialty e.g. General Surgery, Respiratory Medicine

Was a Medical Practitioner (treating Doctor) notified?

☐ Yes☐ No☐ N/A

Has the incident been documented in the medical record?

☐ Yes☐ No☐ N/A

Was the next of kin / guardian notified?

☐ Yes☐ No☐ N/A

Was the patient informed of the incident?

☐ Yes☐ No☐ N/A

#### Type of incident

☐ Fall☐ Medication☐ Behaviour☐ Property☐ Injury☐ Safety or Security☐ Nutrition☐ Blood or Gas☐ Documentation☐ Other

**Definition: An incident is any event or circumstance that could have or did cause unplanned harm, suffering, loss or damage. Types of incidents to report (examples):**

Hospital acquired infections

Documentation incomplete or inaccessible

Inappropriate restraint / seclusion

Wrong patient, body part or side

Equipment or therapeutic device problems

Delayed assessment or treatment

Absence of informed consent

Self harm

Verbal / physical aggression

#### WARNING

Section 124Y of the *Health Insurance Act 1973 (Cth)* prohibits a person from making a record of, or disclosing, information that became known solely as a result of a declared quality assurance activity except in circumstances specified in the legislation. It is an offence to release information contrary to section 124Y of the *Health Insurance Act 1973 (Cth)*. The information on this form should not be copied or disclosed without referring to the Clinical Incident Management Policy which is available at [www.health.wa.gov.au/safetyandquality/publications](http://www.health.wa.gov.au/safetyandquality/publications).

**DO NOT PUT THIS FORM INTO A MEDICAL RECORD**

Page 1



## Attachment 1 - AIMS Form continued

### INCIDENT INVESTIGATION AND ANALYSIS (to be completed by reporter)

#### Describe the actual or potential incident:

Please include the immediate response and outcome. For each pressure ulcer, please indicate the site, side, stage and whether present on admission (see back page for stage guidelines). For medication incidents please state all drugs involved. (Please attach an extra sheet of paper if needed).

#### Contributing factors:

Please include any factors contributing to the incident including: Staff factors e.g. fatigue, skill / knowledge deficit, failure to follow policy, communication problem. Subject factors e.g. mental, physical or medical condition, social support, aggression, inadequately medicated, overstimulated environment, failure to follow instructions. System factors e.g. access to services, lack of training / policy / facilities. Consider anything that occurred immediately before the incident.

#### Treatment / Investigations ordered:

E.g. X-Ray, Blood test, ECG, EEG, Dressings, New medications, Referral for review by another clinician

#### What factors minimised the outcome?

E.g. Early detection by monitor or alarm, Good assistance, Good plan or protocol, Good luck, Consultation or conciliation, de-escalation techniques, use of PRN medication.

#### How could the incident have been prevented?

E.g. Equipment check before use, better written or verbal communication, better rostering / work layout / teamwork.

#### Reporter's details (if you want to submit an anonymous report, leave the Name, Contact Number and Other person present fields blank)

Name:

Contact Number:

☐ Nurse / Midwife (Designation .....)

☐ Patient

☐ Other (Specify .....)

☐ Doctor (Designation .....)

☐ Visitor

☐ Allied Health Worker (Designation .....)

1. Other person present:

2. Other person present:

#### Medical practitioner's examination of subject:

Name:

Date: / /

Time:

**INCIDENT INVESTIGATION AND ANALYSIS (to be completed by Management)****Senior staff evaluation:**

To allow for full evaluation of the incident, please ensure that all results are available e.g. blood tests, X-rays etc.

Describe results of investigation and findings. Please do not repeat a description of the incident.

Name:

Signature:

Designation:

Date / Time:

Have you discussed your recommendations and actions with the reporter?

☐

Yes

☐

No

☐

N/A

Have the relevant authorities been notified, where appropriate?

☐

ADRAC

☐

TGA

☐

OSH

☐

Other (specify)

**Third party comments:**

Please forward this form to any relevant 3rd party area for comment e.g. Pharmacy, Radiology, Allied Health, Pain Services, Home Visiting etc.

Name:

Signature:

Designation:

Date / Time:

**Department / Service Head or Director comments:**

Comment on action taken or needed to prevent recurrence. Comment on resource implications. Please do not repeat the senior staff evaluation.

Did the incident result in an increase of costs or length of stay, or consume extra resources? Please specify:

Please complete the recommendations section on page 4.

**Incident Outcomes** (please tick the most appropriate box - see back page for Risk Assessment matrix if required)**POTENTIAL INCIDENT**

Dangerous state / potential for harm e.g. understaffed ICU, torn floor covering

**POTENTIAL INCIDENT**☐

Level 1

Intercepted prior to causing harm e.g. wrong drug drawn up but not given, drug allergy identified so drug not given / bedrails not in place

☐

Level 2

**ACTUAL INCIDENT**

No harm occurred, no change in condition or treatment e.g. harmless drug given to wrong patient

**ACTUAL INCIDENT**☐

Level 3

Review by doctor / extra observations or monitoring, minor harm not requiring treatment

☐

Level 4

Minor diagnostic interventions e.g. blood test / x-ray / urinalysis, minor treatment e.g. dressings / cold pack / analgesia, security or emergency services attendance, allied health review

☐

Level 5

Diagnostic investigations e.g. MRI / CT, surgical intervention, cancellation or postponement of treatment, transfer to another area not requiring increased length of stay, treatment with another drug

☐

Level 6

Increase in length of stay, hospital admission, readmission, transfer to ICU, CPR / resuscitation, secure ward management, seclusion, # NOF, morbidity which continued at discharge.

☐

Level 7

Permanent disability or death.

☐

Level 8

Specify the ward / department / area responsible for follow-up and investigation: (the incident will be included in that ward / department / area's reports)

Name:

Signature:

Designation:

Date / Time:

**Risk Assessment Matrix***Please circle / cross the most appropriate box*

LIKELIHOOD	CONSEQUENCE				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	Low 1	Low 2	Low 3	Moderate 4	Moderate 5
Unlikely (2)	Low 2	Low 4	Moderate 6	Moderate 8	High 10
Possible (3)	Low 3	Moderate 6	Moderate 9	High 12	High 15
Likely (4)	Low 4	Moderate 8	High 12	High 16	Extreme 20
Almost certain (5)	Moderate 5	High 10	High 15	Extreme 20	Extreme 25

**Sentinel Events**

Sentinel events are rare events that lead to catastrophic patient outcomes. For Western Australia, the list of reportable sentinel events is based on nationally endorsed categories and includes:

1. Procedures involving the wrong patient or body part.
2. Suicide of a patient in an inpatient unit (under the *Mental Health Act*, Mental Health services are required to report to the Chief Psychiatrist episodes of unexpected death).
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
4. Intravascular gas embolism resulting in death or neurological damage.
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility.
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
7. Maternal death or serious morbidity associated with labour or delivery.
8. Infant discharged to wrong family or infant abduction.
9. Other sentinel events as defined by the WA Sentinel Event Policy.

**Staging of Pressure Ulcers (based on AMWA Clinical Practice Guidelines)**

Stage	Description
1.	Alterations of intact skin. May include changes in skin temperature, tissue consistency and/or sensation. Appears as a defined area of persistent redness in lightly pigmented skin and persistent red, blue or purple hues in darker skin tones.
2.	Partial thickness skin loss involving epidermis and/or dermis. Presents clinically as an abrasion, blister or shallow crater.
3.	Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. Presents clinically as a deep crater with or without undermining of adjacent tissue.
4.	Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures. Undermining and sinus tracts may also be associated.

**DO NOT PUT THIS FORM INTO A MEDICAL RECORD**

## Attachment 2

Level	Descriptor	Health Impacts (Patients, Staff, Public, Contractors etc)	Critical Services Interruption	Performance to Budget	Financial Loss Liability per Event Before Insurance	Organisational Objectives or Outcomes	Reputation and Image per Issue	KPI Variation	Non-Compliance
1	Insignificant	First aid or equivalent only.	No material disruption to dependent work.	Up to 1% temporarily over budget.	Less than \$5,000.	Little Impact.	Non-headline exposure. Not at fault. Settled quickly. No impact.	Less than 2%	Innocent procedural breach. Evidence of good faith by degree of care/diligence. Little impact.
2	Minor	Routine medical attention required. Temporary diminution of normal bodily/mental health or function. Max 2 weeks incapacity/time lost.	Short-term temporary suspension of work. Backlog cleared in day. No public impact.	More than 1% up to 2% temporarily over budget.	\$5,000 to less than \$100,000.	Inconvenient delays.	Non-headline exposure. Clear fault. Settled quickly by Departmental response. Negligible impact.	2% - <5%	Breach, objection/complaint lodged. Minor harm with investigation. Evidence of good faith arguable.
3	Moderate	Increased level of medical attention required. Prolonged diminution or loss of normal bodily/mental health or function. 2 weeks to 3 months incapacity/time lost.	Medium-term temporary suspension of work. Backlog requires extended work or overtime or additional resources to clear. Manageable impact.	More than 2% up to 5% temporarily over budget.	\$100,000 to less than \$3M.	Material delays. Marginal under achievement of target performance.	Repeated non-headline exposure. Slow resolution. Ministerial enquiry/briefing.	5% - <15%	Negligent breach. Lack of good faith evident. Performance review initiated. Material harm caused.
4	Major	Severe health crisis and/or injuries, Prolonged incapacity or absence beyond 3 months.	Prolonged suspension of work. Additional resources, budget, Management assistance required. Performance criteria compromised.	More than 5% to 10% temporarily over budget or material over-run not recoverable within the financial year.	\$3M to less than \$20M.	Significant delays. Performance significantly under target.	Headline profile. Repeated exposure. At fault or unresolved complexities impacting public or key groups. Ministerial involvement.	15% - 30%	Deliberate breach, or gross negligence. Significant harm. Formal investigation. Disciplinary action. Ministerial involvement.
5	Catastrophic	Multiple severe health crises/injuries or death, causally related to the risk being contemplated, of an individual.	Indeterminate prolonged suspension of work. Impact not manageable. Non-performance. Other providers appointed.	More than 10% temporarily over budget, or a significant over-run not recoverable within the financial year, or being unable to pay staff or finance critical services.	\$20M +	Non-achievement of objective / outcome. Total performance failure.	Maximum multiple high-level exposure. Ministerial censure. Direct intervention. Loss of credibility and public/key stakeholder support.	30% +	Serious and wilful breach. Criminal negligence or act. Litigation or prosecution with significant penalty. Dismissal. Ministerial censure.

## Attachment 3

### Consequences

Likelihood	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	Low 1	Low 2	Low 3	Moderate 4	Moderate 5
Unlikely (2)	Low 2	Low 4	Moderate 6	Moderate 8	High 10
Possible (3)	Low 3	Moderate 6	Moderate 9	High 12	High 15
Likely (4)	Low 4	Moderate 8	High 12	High 16	Extreme 20
Almost Certain (5)	Moderate 5	High 10	High 15	Extreme 20	Extreme 25

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## Delivering a Healthy WA