



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: 2022



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.

This publication has been produced by the:

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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. Public reporting is a key theme of WA Health's Sustainable Health Review, which recommends public reporting of several key measures including patient and carer reported experience and outcomes (Recommendation 4), WA's environmental footprint (Recommendation 5), outpatient wait times (Recommendation 11), and clinical variation (Recommendation 16). In this vein, WA Health produces an annual report on patient safety within WA health services which provides the public with transparent information on clinical incidents, complaints, and coroner's cases.

This 2021–22 report outlines the state of patient safety in Western Australia during the second year 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. The system impacts included a shift of approach to living with COVID-19, pause for elective surgery, reducing administrative burden where possible, monitoring of incidents related to vaccines and administration of anti-viral medications.

Despite these challenges, many metrics of patient safety and quality demonstrate that our system continues to perform at high levels. For example, in line with many other states and territories, hospital acquired complication rates (HACs) in WA decreased by 34 per cent from 2014–15 to 2020–21. The vast majority of HACs, including pressure injuries, medication complications, delirium, falls and hospital acquired infections, have seen downward trends over this time period.

Many WA sites also excel in particular clinical areas. For example, the Australian and New Zealand Hip Fracture Registry 2022 annual report identifies several WA hospitals as achieving excellence in their care for one or more of the clinical care standards outlined with the Hip Fracture Clinical Care Standard, which outlines best practice care for patients receiving treatment for osteoporotic hip fracture. WA also reported the highest proportion of patients receiving pre-operative cognitive

assessment, receipt of nerve blocks both before and in operating theatre, and has the second shortest emergency department length of stay and average time to surgery of any Australian state.

However, despite these reassuring metrics, all hospitals and health services have areas that require improvement. Just like other safety critical industries such as aviation and the nuclear industry, healthcare services must have systems to continuously monitor and improve the services they provide. 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.

All clinical incidents occurring in WA Health 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 would like to acknowledge the work of the Patient Safety Surveillance Unit within the Department of Health, who have compiled this report on my behalf and support patient safety efforts across WA Health. I am proud to present to you this 11th 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. This 2022 report has shown us the continued importance of medication safety which was highlighted internationally during the year by the World Health Organisation.

## **Jodie South**

A/Assistant Director General  
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# Overview

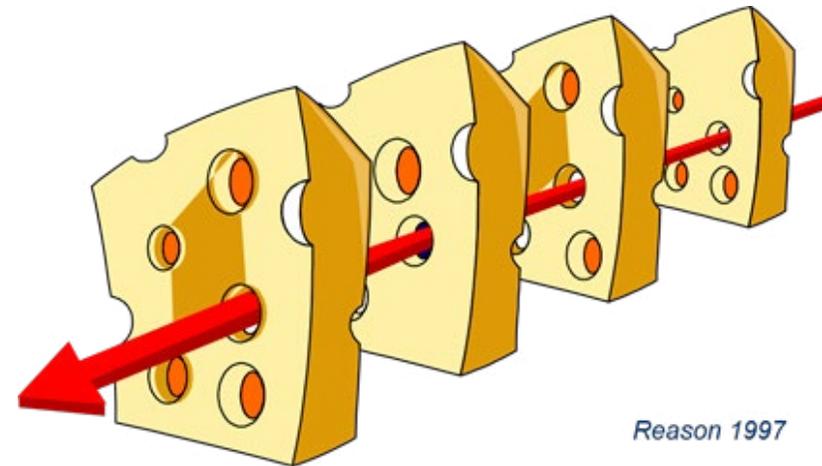
# What is Patient Safety?

Patient safety is considered "... a framework of organised activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce its impact when it does occur".<sup>1</sup> Whilst all health care contains a degree of risk, patient safety is concerned with reducing this to an acceptable minimum. Patient safety processes within health services help to identify areas where opportunities for improvement in the delivery of health care may exist to prevent avoidable harm.

Much of patient safety best practice and process adopts a systems thinking approach. A systems approach recognises that human error will always arise, but that rather than taking an individual 'name, blame and shame' approach, it is through emphasis on the system and its defences in place that patient safety events can be prevented from occurring.

This systems approach to patient safety is most popularly explained via Dr James Reason's 'swiss cheese model'.<sup>2</sup> The slices of cheese represent defensive patient safety strategies in place, for example some strategies may be focused on improving communication, changing the physical work environment or scheduling of staff. As systems can be imperfect, the holes in the cheese represent situations where the defences in place have not provided the intended control. By layering multiple defences there is a greater likelihood that the next layer of defence will prevent a patient safety event from occurring when one hole appears. However, when multiple holes in the swiss cheese line up and none of the intended defences work, a patient safety event may occur.

Investigation of patient safety events focuses on identifying these 'holes' that may have contributed to the event occurring, recognising that in isolation these contributory factors may not cause harm.



Reason 1997

Once contributory factors are identified, system solutions are implemented to continue 'plugging' these holes within the swiss cheese. This cycle where issues are identified, analysed, solved and monitored is a core aspect of continuous quality improvement and an integral component of high-quality health care.

A strong patient safety reporting culture in organisations may translate into an increase in patient safety events reported but with decreased patient harm. These events, called near miss or low harm events are opportunities for continuous learning and quality improvement that support the WA health system in its commitment to providing safe, high-quality, person-centred care.

Patient safety systems, including clinical incident, consumer feedback, and mortality review processes, form part of the clinical governance structures in the WA health system. An emphasis on learning and quality improvement is achieved through the development, implementation, and evaluation of recommendations made following the investigation of patient safety events.

The outcomes of WA health system patients involved in patient safety events are explored throughout this report.

<sup>1</sup> World Health Organization. (2021). Patient safety: [About us](#)

<sup>2</sup> Reason, J. (2000). Human error: models and management. *BMJ*, 320, 768-770

## Clinical Governance

Effective clinical governance processes must work in harmony with other systems within the health service such as financial, risk and other frameworks such as occupational safety and health.

One of the key components of good clinical governance is its patient safety and quality improvement systems. They must be integrated with other governance processes within the organisation to actively manage patient safety and quality.

The PSSU have recently updated the clinical governance and patient safety webpage<sup>3</sup> which helps stakeholders to navigate the WA health system's clinical governance responsibilities and mechanisms surrounding patient safety. It outlines the Department of Health's Clinical Governance framework as well as mandatory policy frameworks which have the most direct relationship to patient safety. The Department of Health as a system manager continues to strengthen these areas of clinical governance through their safety and quality programs.

More recently, the 2021 independent inquiry into Perth Children's Hospital<sup>4</sup> has prompted review within organisations as it has highlighted 30 recommendations, some which are actions in relation to strengthening clinical governance mechanisms. These included recommendations 7, 8 and 9:

7. The hospital's RCA policy and procedures include guidance that is issued to both RCA team members and interviewees that clearly outlines their roles, responsibilities, the confidentiality extended to the RCA process, together with how the RCA findings will be used.
8. A consumer-friendly document should explain the purpose and format of the RCA process and clarify how the patient and their family may be involved in the RCA process, the opportunity to be interviewed and when and in what form they will receive the report.
9. The WA Department of Health supports the implementation of the recommendations of the draft Clinical Excellence Division Review of the Guidance for Procedures Associated with Notification of Reportable Conduct to provide a clearer more cohesive policy framework for managing complaints and concerns about clinicians.

<sup>3</sup> [Clinical governance and patient safety \(health.wa.gov.au\)](https://health.wa.gov.au)

<sup>4</sup> [Independent Inquiry into Perth Children's Hospital](#)

The ACSQHC developed the [National Model Clinical Governance Framework](#). This framework recognises and ensures there are robust systems in place within health services to maintain and improve the safety and quality of health care. There are five components:

1. Governance, leadership and culture
2. Patient safety and quality improvement systems
3. Clinical performance and effectiveness
4. Safe environment for the delivery of care
5. Partnering with consumers.

## Corporate governance



# About this Report

This comprehensive patient safety report for 2021/22 is the 11<sup>th</sup> WA health system report of this kind and integrates statewide clinical incident (including sentinel events), mortality review, and complaint data. Supplementary data tables have been included at the end of the report to provide additional information where relevant.

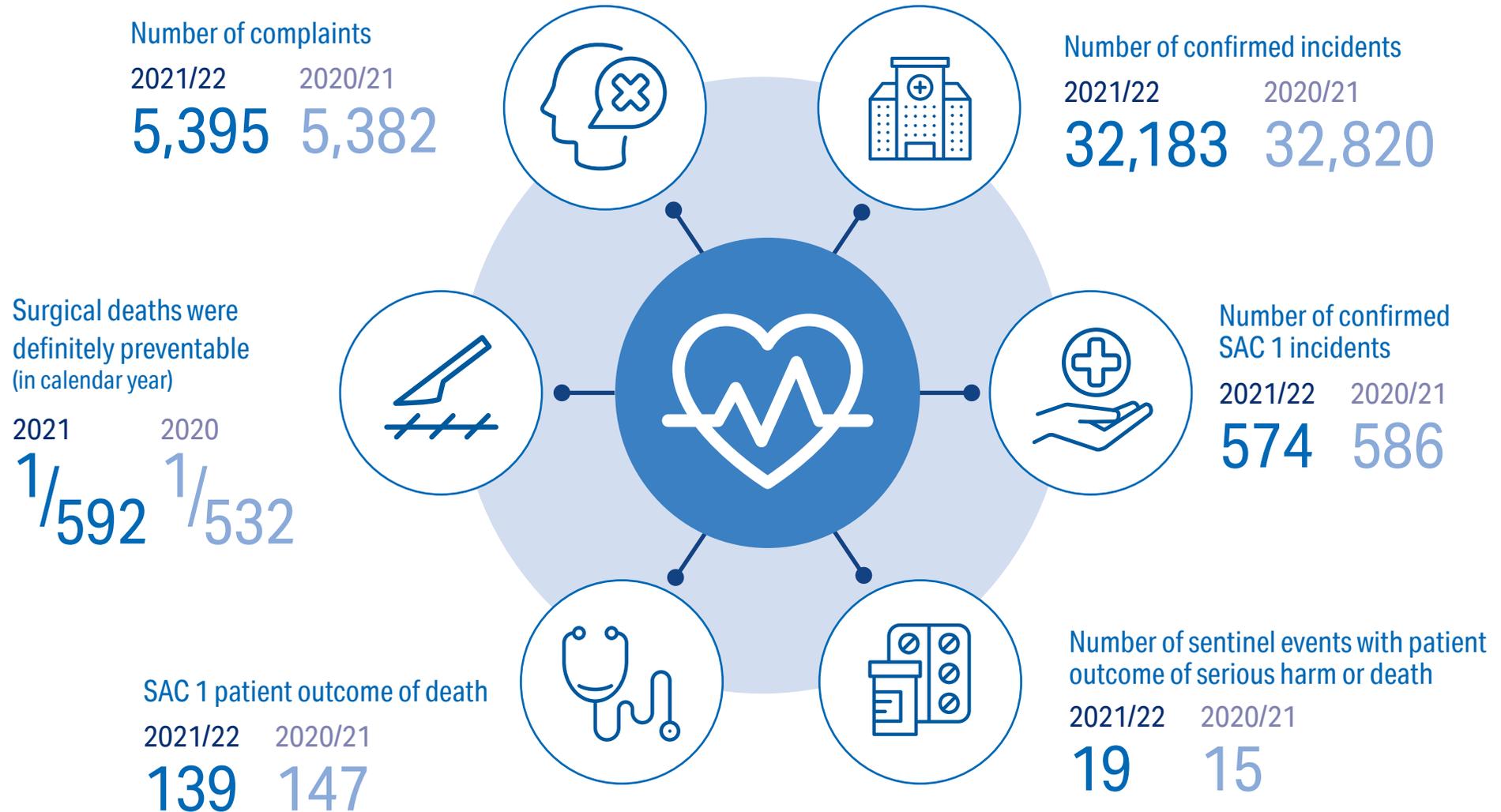
## Quality improvement and research

Quality improvement activities are designed to bring about immediate improvements in health care. Research activities are designed to increase knowledge, which may translate to changes in practice. Although the two are linked and will inform each other, caution should be exercised when interpreting the data in this report as much of the data has been generated through quality improvement activities rather than research and may therefore lack suitability for statistical analysis.<sup>5</sup>

<sup>5</sup> For further information about the differences between quality improvement and research data see [this IHI page](#).



# Executive summary infographic



Comparison is based on data published in the 2021 report

# Executive Summary

In 2021/22, there were 33,641 clinical incidents notified across the WA health system of which 32,183 had been allocated a confirmed Severity Assessment Code (SAC) rating at the time of data extraction. Consistent with previous years, most clinical incidents were confirmed as SAC 3 (n=28,841; 85.7%) and most confirmed incidents reported a patient outcome of no harm or minor harm (n=29,853; 92.8%).

During this period the WA health system provided 636,877 episodes of care (amounting to 1,964,975 bed days) to inpatients at public hospitals and contracted health entities. Confirmed inpatient clinical incidents (n=25,753) were associated with 1.5% of public hospital bed days and accounted for 4.9% of public hospital separations. The involvement of patients across the different demographic measures (e.g. age, gender, and Aboriginal and Torres Strait Islander persons) in clinical incidents continued to show a direct relationship to public hospital activity.

Reporting of clinical incident data against the second edition of the Australian Commission on Safety and Quality in Health Care's (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards showed that clinical incidents associated with comprehensive care (n=11,267; 35.0% of confirmed incidents) and medication safety (n=8,263; 25.7% of confirmed incidents) were the most frequently reported categories that related to the NSQHS Standards.

It was found that 8.5% (n=120) of confirmed incidents related to recognising and responding to acute clinical deterioration, and 5.4% (n=96) of confirmed incidents related to preventing and controlling infections, reported patient outcomes of serious harm or death, showing the risk these types of incidents pose to patients in the WA health system.

There were 574 SAC 1 clinical incidents confirmed in 2021/22 by WA health service providers, private licensed healthcare facilities, and other contracted non-government organisations, of which 26 were categorised as sentinel events and 548 were 'Other SAC 1' incidents.

A further 122 events were notified as possible SAC 1 incidents and declassified following investigation as it was found that health care did not contribute to the event.

The rate of inpatient SAC 1 incidents in WA hospitals continues to remain low and was calculated at 1.5 incidents per 10,000 bed days or 4.6 incidents per 10,000 separations. Inpatient SAC 1 incidents accounted for 1.0% (n=246) of all confirmed inpatient incidents in WA's public hospitals in 2021/22.

The WA health system's *Clinical Incident Management Policy* encourages the notification and investigation of near miss events, i.e. those that resulted in no harm to the patient. In 2021/22, 10.6% (n=61) of confirmed SAC 1 clinical incidents reported a patient outcome of minor harm or no harm.

The most frequently reported categories of SAC 1 clinical incidents in 2021/22 were infection control breaches (n=124; 22.6% of 'Other SAC 1' incidents), complications of inpatient falls (n=105; 19.2%) and hospital/service process issues (n=74; 13.5%). A patient outcome of death was reported in 139 SAC 1 clinical incidents. The most common category reporting this outcome was the unexpected death of a mental health client (n=48). Twelve SAC 1 clinical incidents reported fetal death.

The 2021/22 reporting period is the fourth year to report data aligned with the second version of the ACSQHC sentinel event categories. Twenty-six sentinel events or near miss sentinel events were reported in 2021/22, representing 4.5% of all confirmed SAC 1 incidents. The most frequently reported sentinel event in WA in 2021/22 was medication error resulting in serious harm or death (n=16) which included 2 patients with an outcome of death, 12 patient outcomes of serious harm, and 2 near miss sentinel events with a patient outcome of no harm. Surgery or other invasive procedure performed on the wrong site and the unintended retention of a foreign object in a patient after surgery or other invasive procedure each reported a patient outcome of serious harm in 2 cases.

The Independent Health and Aged Care Pricing Authority (IHACPA) national approach to pricing and funding for safety and quality in Australian public hospitals continued in 2021/22, with funding penalties for episodes of care that include a sentinel event with a realised patient outcome of serious harm or death. Eleven of the 26 sentinel events reported in WA in this period met the national criteria for reporting to the IHACPA.

The most frequently identified contributory factor in SAC 1 clinical incidents in 2021/22 continues to be communication (n=69.9%; n=330), with communication between staff and issues related to documentation being the most common type. Issues associated with policies, procedures and guidelines were identified as contributory in 66.5% of SAC 1 clinical incidents (n=314). These are areas where the WA health system can continue to focus attention and deliver sustainable improvements in the quality and safety of the care it delivers.

Consumer feedback continues to be a valuable source of information to organisations to identify opportunities for improvement. A total of 19,520 consumer feedback items were reported across the WA health system in 2021/22. There were 8,595 compliments (44.0%) received about the WA public health system in this period, with the remainder of feedback received being complaints (n=5,395; 27.6%) and contacts and concerns (n=5,530; 28.3%).

The Coronial Liaison Unit continues to work with the Office of the State Coroner to share the lessons learnt from coronial inquests to improve patient care. The Coronial Review Committee considered 25 coronial inquest findings, with 13 inquest deaths discussed in 2021/22. This included 7 inquests in which 14 health-related recommendations were made, and 6 inquest findings where no recommendations were made. As of August 2022, two of the 14 health-related recommendations had been completed or closed. Members of the Coronial Review Committee consider current systems and processes and identify quality improvement opportunities.

All deaths in WA that occur under the care of a surgeon are notified to the WA Audit of Surgical Mortality (WAASM) and in 2021, 592 deaths met the WAASM inclusion criteria. For cases that had completed the audit process by 6 April 2022, the WAASM identified four adverse events that caused death in 2021, of which one was considered definitely preventable.

The continued strain on the health workforce as the system moved to living with COVID-19 is noted throughout this report. While total numbers of patient safety events are largely unchanged there is an increase in workforce related contributory factor themes in many of the cases reviewed.





Confirmed incidents  
by patient outcome

**62.3%**  
no harm

**1.6%**  
serious harm or death



**16.6%**  
of patients involved in  
confirmed incidents were  
mental health patients



**80%**  
of confirmed incidents  
occurred during a patient's  
stay in a public hospital

# Clinical incidents

# Clinical Incident Management: Overview

The WA public health system uses the Datix Clinical Incident Management System (CIMS) for the notification, investigation and analysis of all clinical incidents that relate to public health services in WA, and evaluation of the actions that are taken in response to these incidents.

It is mandatory for all SAC 1 clinical incidents related to public health services, as well as all private licensed health care facilities<sup>6</sup> and contracted non-government organisations (NGOs) to be notified to the Department of Health and suitably investigated.

While public health services manage SAC 2 and SAC 3 incidents in the Datix CIMS, private licensed health care facilities and contracted NGOs manage SAC 2 and SAC 3 incidents locally, meaning these incidents are not reported into the Datix CIMS and are not included in this report.

During 2021/22, there were 33,641 clinical incidents notified, which represents a small decrease from the previous reporting period. The SAC rating for 32,183 of these incidents had been confirmed at the time of this report.

Of the confirmed clinical incidents, 25,753 occurred during a public hospital stay, with the remainder reported by emergency departments, outpatient departments, community health care providers, private licensed healthcare facilities (including contracted health entities) and other contracted NGOs.

Over this period there were 636,877 separations, with inpatients accumulating a total of 1,964,975 bed days, from public hospitals and for patients receiving publicly funded services at three contracted health entities (CHEs), being Peel Health Campus, Joondalup Health Campus and St John of God Midland Public Hospital.

Confirmed inpatient clinical incidents were associated with 4.9% of public hospital separations. Of the 25,753 confirmed incidents related to public hospital inpatients, 246 were classified as SAC 1 incidents. A further 48 SAC 1 incidents were confirmed relating to public inpatients at CHEs.

Clinical incidents in WA are prioritised using a Severity Assessment Code (SAC).

SAC 1 clinical incidents are those that did or could have led to a patient outcome of serious harm or death.

SAC 2 incidents did or could have led to moderate harm to a patient, and SAC 3 incidents did or could have led to minor or no harm.

The WA health system devotes more resources to the investigation of SAC 1 clinical incidents as these pose the highest risk of harm to patients.

The rate of inpatient clinical incidents<sup>7</sup> observed between July 2021 and June 2022 was calculated at:

- 4.6 SAC 1 clinical incidents per 10,000 separations
- 42 SAC 2 clinical incidents per 10,000 separations
- 440 SAC 3 clinical incidents per 10,000 separations.

Confirmed inpatient clinical incidents were associated with 1.5% of public hospital bed days at health service providers. Findings showed that there were:

- 1.5 SAC 1 clinical incidents per 10,000 bed days
- 13 SAC 2 clinical incidents per 10,000 bed days
- 139 SAC 3 clinical incidents per 10,000 bed days.

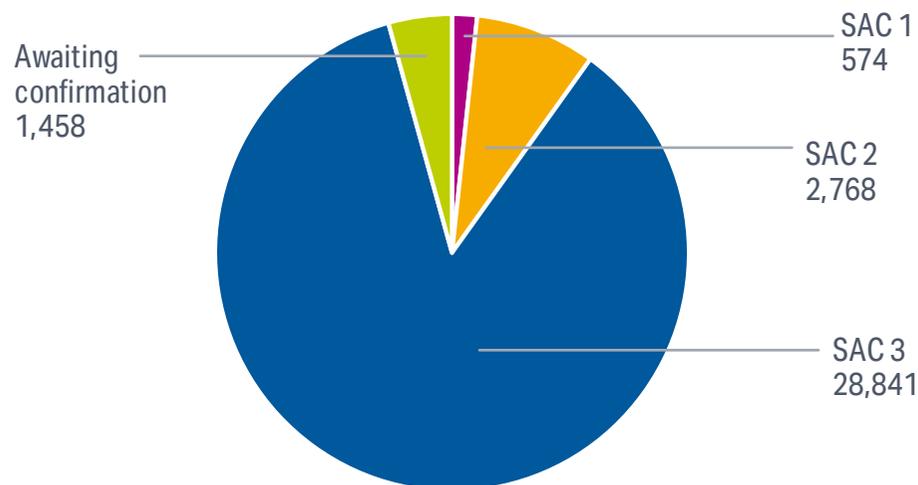
The rates of inpatient clinical incidents in 2021/22 are slightly lower than those seen in 2020/21 due to the small decrease in the number of confirmed incidents and a small increase in activity in the WA public health system during this period.

<sup>6</sup> [About licensing of private healthcare facilities](#)

<sup>7</sup> The rates of SAC 1 incidents include public inpatient incidents and separations/bed days at public hospitals and the three CHEs. All other rates relate to inpatient activity in WA's public hospitals only.

Clinical incidents were most frequently confirmed as SAC 3 in 2021/22 (85.7% of incidents notified). Severity Assessment Code 2 clinical incidents accounted for 8.2% of incidents notified in this period, followed by SAC 1 clinical incidents (1.7%). At the time of this report, 4.3% of clinical incidents were awaiting confirmation of the SAC rating (see Figure 1).

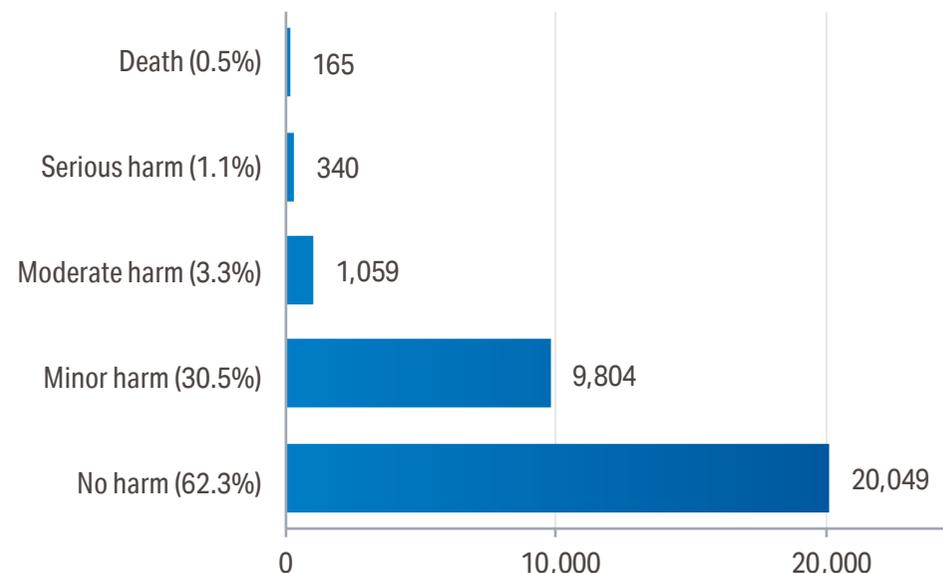
Figure 1: Clinical Incidents by SAC Rating for 2021/22



**Note:** The number of SAC 1 clinical incidents includes incidents from health service providers (including public hospitals), private hospitals (including CHEs) and contracted NGOs in accordance with their license and/or contract with the WA health system.

Most clinical incidents confirmed during 2021/22 reported a patient outcome of no harm (62.3%) or minor harm (30.5%; see Figure 2). There were 505 clinical incidents that reported a patient outcome of serious harm or death, representing 1.6% of confirmed incidents in this period.

Figure 2: Confirmed Clinical Incidents by Patient Outcome for 2021/22



**Note:** Patient outcome missing data n=766 (2.4%)

The proportion of patient outcomes reported in confirmed incidents across the WA health system in 2021/22 is similar to that seen in previous years.

Review of information for patients involved in confirmed clinical incidents in 2021/22 showed an almost equal distribution between male and female patients where this information was recorded (males accounted for 50.3% of patients involved and females 49.7%). However, between the ages of 15-34 years, 63.4% of patients involved in confirmed incidents were female.

When grouped by patient age, a direct relationship was observed between the frequency of patients involved in confirmed inpatient incidents in public hospitals and inpatient activity over this period. Patients aged 75 years and above appear a little more likely to be involved in clinical incidents in WA's public hospitals.

In 2021/22, Aboriginal and Torres Strait Islander persons accounted for 10.5% of patients involved in confirmed clinical incidents where this information was recorded in incident records. Within public hospitals, Aboriginal and Torres Strait Islander persons accounted for 9.6% of patients involved in confirmed incidents and 9.9% of inpatient activity (bed days) along with 12.1% of hospital separations.

It was noted that Aboriginal and Torres Strait Islander persons stayed in hospital on average for a shorter duration- 2.58 days vs 3.25 days for other patients. Aboriginal and Torres Strait Islander persons were proportionally represented in clinical incidents.

In 2021/22, 16.6% of patients involved in confirmed clinical incidents were identified as voluntary, involuntary, or referred mental health patients under the *Mental Health Act 2014*. Review of this data within confirmed SAC categories showed marked differences, with 17.5% of patients involved in confirmed SAC 1 incidents and 49.4% of patients involved in confirmed SAC 2 incidents identified as mental health patients. The higher proportion of mental health patients involved in SAC 2 incidents is consistent with previous years findings.

Incidents related to six categories in the second edition of the ACSQHC's NSQHS Standards accounted for 82.5% of all confirmed clinical incidents during 2021/22. The total number of confirmed incidents related to each of these Standards was similar to that observed in the previous year, with a small decrease in the number of incidents related to Communicating for Safety noted (see Table 1).

Incidents related to Comprehensive Care and Medication Safety continue to be the types of incidents most frequently reported that align with the NSQHS Standards.

Incidents related to Recognising and Responding to Acute Deterioration are most likely to lead to patient outcomes of serious harm or death.

**Table 1: Confirmed Clinical Incidents for NSQHS Clinical Standards (2nd edition) for 2021/22**

NSQHS Standard Categories 2nd ed	(n)	(%)
Preventing and Controlling Infections	1,767	5.5
Medication Safety	8,263	25.7
Comprehensive Care	11,267	35.0
Communicating for Safety	4,133	12.8
Blood Management	166	0.5
Recognising and Responding to Acute Deterioration	1,411	4.4

**Note:** A clinical incident may relate to multiple NSQHS Standards

Figure 3 overleaf shows patient outcomes for confirmed clinical incidents associated with these NSQHS Standard categories over the period from 2019/20 to 2021/22. The harm associated with incidents related to most of these NSQHS Standard categories has remained relatively stable over this time.

While the total number of confirmed incidents related to the Standards of communicating for safety and recognising and responding to acute deterioration has decreased in 2021/22 this is due mainly to lower numbers of incidents that reported outcomes of minor harm or no harm.

An increasing number of confirmed incidents resulting in serious harm can be seen for the Standards related to medication safety and comprehensive care over this period. Incidents related to recognising and responding to acute physical or mental health deterioration and preventing and controlling infections continue to be more likely to lead to patient outcomes of serious harm or death.

Figure 3: Confirmed Clinical Incidents for NSQHS Clinical Standards (2nd edition) by Patient Outcome for 2019/20 to 2021/22



**Notes:**

- Data is presented using a logarithmic axis to enhance visibility of low frequencies and enable comparison across NSQHS Standards. A clinical incident may relate to multiple NSQHS Standards. Patient outcome missing data: Preventing and Controlling Infections (n=38); Medication Safety (n=190); Comprehensive Care (n=242), Communicating for Safety (n=111); Blood Management (n=12); Recognising and Responding to Acute Deterioration (n=48). Most missing patient outcome data relates to the 2021/22 period.
- Data included in Figure 3 – Comprehensive Care was corrected in July 2023 due to an administrative error in the original version.



# SAC 1

# Clinical Incidents

 **26** Sentinel events. 16 of 26 were medication sentinel events

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 Patient outcome

<b>139</b>	<b>315</b>	<b>39</b>
death	serious harm	no harm

---

 **19.2%** of SAC 1 related to mental health

# SAC 1 Clinical Incidents

The reporting and investigation of Severity Assessment Code (SAC) 1 clinical incidents is mandatory for WA public health services. Private licensed health care facilities and contracted non-government organisations (NGOs) are required to report SAC 1 clinical incidents in accordance with their licence or contract with the WA health system.

The *Clinical Incident Management Policy* allows for the declassification of a SAC 1 clinical incident.<sup>8</sup> Declassification may be approved by the PSSU following a thorough investigation, if it is identified that no health care factors contributed to the incident. Declassification requests are reviewed by two PSSU senior clinicians with extensive experience in safety and quality in health care. Declassification means that the event is no longer considered to be a clinical incident.

In 2021/22, 574 SAC 1 clinical incidents were confirmed by WA Health Service Providers (including public hospitals), private licensed health care facilities (including contracted health entities), and contracted NGOs. There were a further 122 events investigated that were approved for declassification. The investigation of 102 SAC 1 clinical incidents notified during 2021/22 remained ongoing as at 8 July 2022. Of the 574 confirmed SAC 1 clinical incidents, 99 (17.2%) related to private licensed health services and contracted non-government organisations.

Of the 574 confirmed SAC 1 clinical incidents, 26 (4.5%) were categorised as sentinel events with the remainder classified as 'Other SAC 1 Incidents' (n=548; 95.5%).

Table 2 shows the frequency of confirmed SAC 1 clinical incidents over the 5-year period from July 2017 to June 2022. The total 2021/22 figures are consistent with the reporting of SAC 1 clinical incidents prior to the COVID-19 pandemic onset in 2020 however an upward trend in the reporting of sentinel events, including near miss sentinel events, is noted.

The *Clinical Incident Management Policy* mandates that SAC 1 clinical incidents are notified to the Patient Safety Surveillance Unit and details the requirements for the investigation and evaluation of implemented recommendations.

Table 2: Confirmed SAC 1 Clinical Incidents by Sentinel Event and Other SAC 1 Clinical Incident Types for 2017/18 to 2021/22

SAC 1 Category	2017/18	2018/19	2019/20	2020/21	2021/22
Sentinel Events	12	17	14	20	26
Other SAC 1 Incidents	551	555	488	533	548
<b>Total</b>	<b>563</b>	<b>572</b>	<b>502</b>	<b>553</b>	<b>574</b>

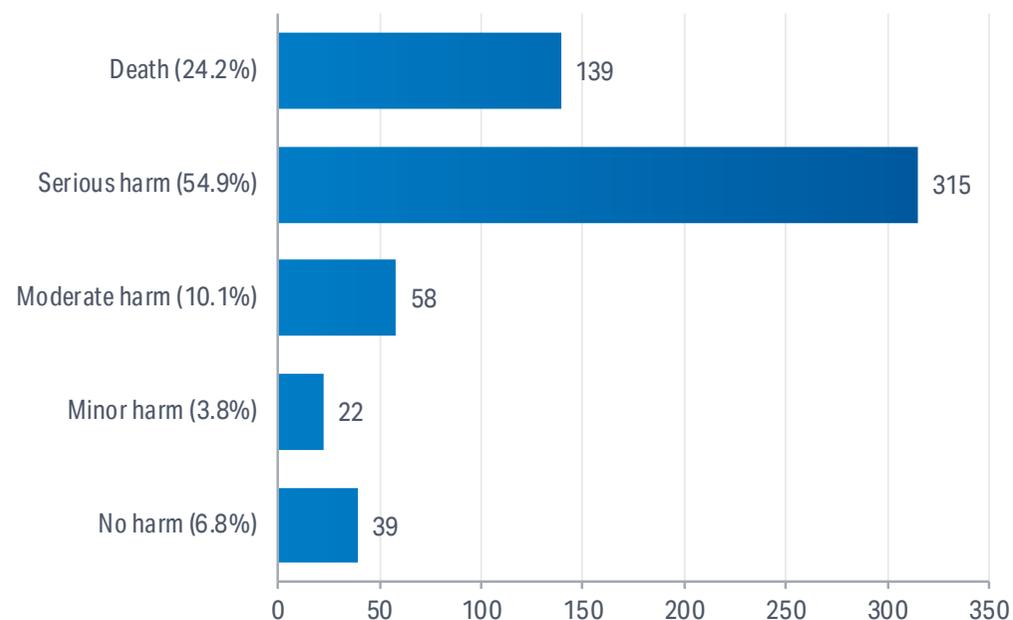
There were 139 SAC 1 clinical incidents with a patient outcome of death notified during 2021/22 and a further 315 SAC 1 clinical incidents with a patient outcome of serious harm notified. Figure 4 details all recorded patient outcomes associated with SAC 1 clinical incidents during 2021/22.

SAC 1 clinical incidents related to private patients include events notified by licensed private hospitals and contracted non-government organisations.

In April 2018, the licensing of all healthcare providers was expanded to include the requirements of the *Clinical Incident Management Policy*.

8 MP0122/19 [Clinical Incident Management Policy](#)

Figure 4: Confirmed SAC 1 Clinical Incidents by Patient Outcome for 2021/22



**Note:** The patient outcome of one SAC 1 clinical incident was unknown at time of data extraction for this report

The proportion of patient outcomes reported in confirmed SAC 1 clinical incidents in 2021/22 is similar to that seen in previous years.

A review of confirmed clinical incidents during 2021/22 identified that a further 51 incidents with a patient outcome of death or serious harm were confirmed as SAC 2 or SAC 3. The Supplement section: [Table 14](#) details the number of confirmed SAC 2 and SAC 3 clinical incidents with patient outcomes of death or serious harm for the period 2017/18 to 2021/22.

The *Clinical Incident Management Policy* defines SAC 1, SAC 2 and SAC 3 events using patient harm (or potential harm) as a key criterion. The above observation recalls the need to ensure appropriate classification (and therefore, follow-up and actions to reduce the risk of further harm).

The *Clinical Incident Management Policy* requires that health service providers facilitate an appropriate level of open disclosure to the patient, their family and carers as soon as practicable, in accordance with the Australian Open Disclosure Framework.<sup>9</sup> The elements of open disclosure may include an expression of regret, a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. During 2021/22, the open disclosure process was initiated for 77.4% (n=434) of confirmed SAC 1 clinical incidents.<sup>10</sup> This rate of open disclosure is consistent with previous years.

A near miss describes a clinical incident that may have, but did not cause harm, either by chance or through timely intervention.

Investigation of near miss SAC 1 clinical incidents provide opportunities for quality improvement to be identified and implemented with the goal of prevention of future patient harm.

<sup>9</sup> [ACSQHC - The Australian Open Disclosure Framework](#)

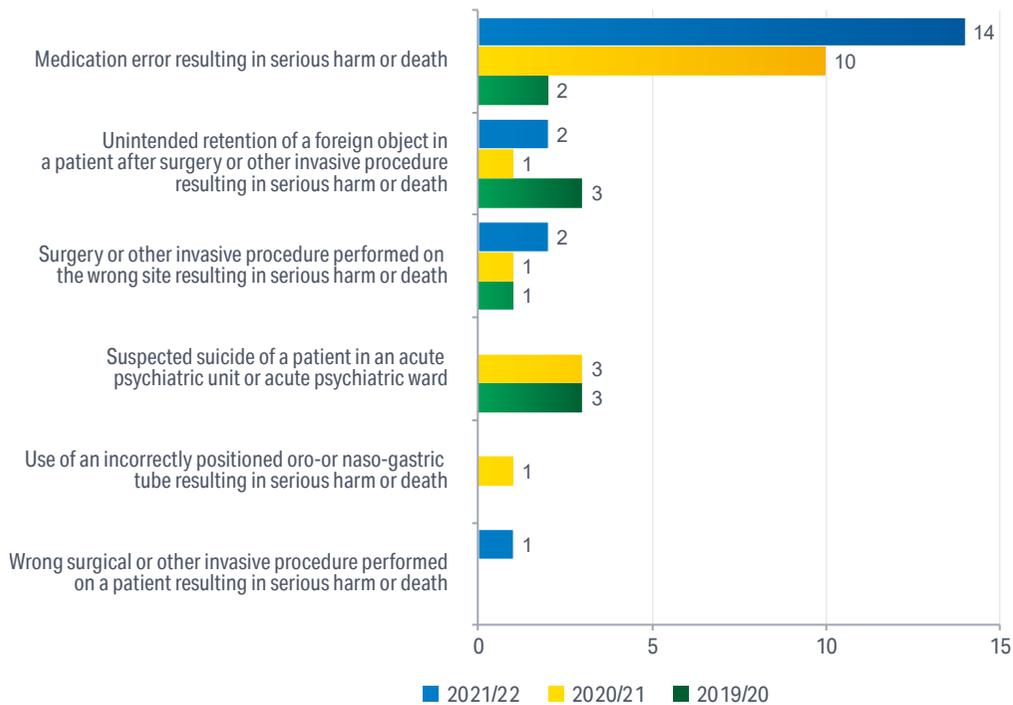
<sup>10</sup> The denominator for the percentage of confirmed SAC 1 clinical incidents where open disclosure has been initiated (n=561) excludes incidents where it was reported that open disclosure had not been initiated because the event was a near miss, or the incident did not cause harm and open disclosure may cause distress

## Sentinel Events – Overview

In WA, reporting of sentinel events is mandated by the *Clinical Incident Management Policy*.<sup>11</sup> The ACSQHC describes 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.<sup>12</sup> Version 2 of the Australian sentinel events list (see Appendix One: SAC 1 Clinical Incident Notification List), which includes 10 sentinel event categories, was implemented in WA from 1 July 2018.

Figure 5 presents sentinel events notified in WA for the 3 years ending 2021/22 with a patient outcome of death or serious harm. The Supplement section [Table 15](#) tabulates all notified sentinel events and near miss sentinel events for the period 2018/19 to 2021/22.

Figure 5: WA Sentinel Events by Category for 2019/20 to 2021/22 with a patient outcome of serious harm or death



11 [MP 0122/19 Clinical Incident Management Policy](#)  
 12 [Australian sentinel events list version 2](#)

The ACSQHC defines serious harm as: As a result of the incident the patient requires life-saving surgical/medical intervention, or has shortened life expectancy, or has experienced permanent or long-term physical harm or loss of function.

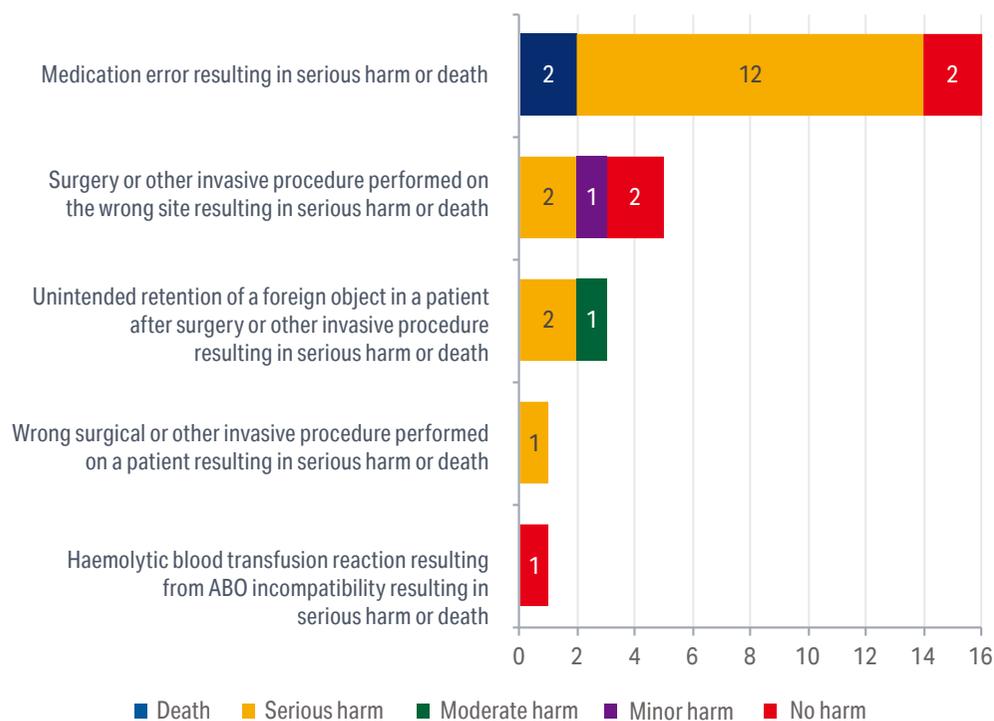
Medication errors continue to be the most frequently reported sentinel event category in WA.



For the 2021/22 period, 2 sentinel events reported a patient outcome of death, of which both were categorised as medication errors. During this same period, 12 patients suffered serious harm following a medication error sentinel event; this included 2 patients receiving private healthcare. Two patients suffered serious harm from surgery or other invasive procedure performed on the wrong site and a further two patients suffered serious harm arising from the unintended retention of a foreign object after surgery or other invasive procedure. During 2021/22, 5 near miss sentinel events with no patient harm were reported and investigated.

Figure 6 shows the patient outcomes reported for sentinel event categories in WA during 2021/22.

Figure 6: WA Sentinel Events by Category and Patient Outcome for 2021/22



The reporting of sentinel events in WA as mandated by the *Clinical Incident Management Policy* is broader than the ACSQHC definition with a more extensive description of serious harm that includes factors such as length of stay and escalation of care, as well the reporting of near miss sentinel events.

The ACSQHC definition of serious harm is used for national reporting such as to RoGS and IHACPA.

In addition to the reporting of sentinel events within this report, sentinel event notifications made by WA public hospitals that meet the ACSQHC definition are included in the Australian Government Productivity Commission's annual Report on Government Services (RoGS).<sup>13</sup> Commencing on 1 July 2017, sentinel events meeting the ACSQHC definition are also reported to the Independent Health and Aged Care Pricing Authority (IHACPA; formerly the Independent Hospital Pricing Authority (IHPA)) in accordance with the Addendum to the National Health Reform Agreement.<sup>14</sup>

Of the 26 sentinel events and near miss sentinel events reported in WA in 2021/22, 11 sentinel events occurred in public hospitals and met the criteria for notification to the IHACPA. All 11 sentinel events were medication errors resulting in serious harm or death. It is important to note that sentinel events occurring at private hospitals do not meet the requirement for notification to the IHACPA or for inclusion in the RoGS.

The IHACPA's national approach to pricing and funding for safety and quality in Australian public hospitals continued in 2021/22 with funding penalties for episodes of care that include a sentinel event with a realised patient outcome of serious harm or death.

13 The Productivity Commission's Annual [Report on Government Services](#)

14 [The Independent Health and Aged Care Pricing Authority](#)

## Sentinel Events – Medication Error recommendations

Medication errors continue to be the most reported type of sentinel event in WA, reflecting the high risk that can be associated with medication management. Sixteen medication error sentinel events, including near miss sentinel events, were reported during 2021/22. More than half of these incidents (n=9) were associated with medication administration errors. The two sentinel events that resulted in a patient outcome of death were associated with prescribing errors including a duplicate prescription of an anticoagulant and the prescription of an incorrect dose of a chemotherapy medication. The investigations into all 16 medication error sentinel events in 2021/22 have been completed and a total of 40 recommendations were made by health service providers to improve medication safety.

To address these recommendations, health service provider initiatives supporting the 6 rights of safe medication administration were further enhanced and these quality improvements aligned with WA Health resources.<sup>15</sup> Additionally, health services continued to promote their speaking up for safety programs and supported mechanisms for staff to improve clinical handover and escalation to more senior clinicians when warranted.

### Prescribing errors

Local policies and supporting documentation were reviewed and updated to align with best practice for prescribing analgesia, including oral opioids, and telephone ordering practices of high-risk medications. Health service providers developed simulation-based training programs and included a thrombolysis scenario. A lesson learned poster and accompanying case study presentation was developed to promote the risks associated with withholding medication, such as prophylactic anticoagulation medication.

## Dosing errors

A number of initiatives were proposed by health service providers to review and enhance policies in response to dosing errors. These included a review of the threshold required to activate a medical emergency response for a hypoglycaemic episode and the development of local policies requiring a comparison of documented patient weight with the actual patient weight to ensure prescription of the correct dosage. Alignment of local policies with national standards included the *National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines*.<sup>16</sup> Targeted education and training programs, including simulation-based training, were developed by health services and included medication safety topics related to the treatment of hyperkalaemia, and intravenous insulin infusion monitoring.

Recommendations were made by health service providers to address issues identified with equipment and ICT support that form part of the medication administration process. This included a change to the IV administration set with port-less option for inotrope infusions, the removal or relocation of high-strength doses of high-risk medications and the procurement or enhancement of medication support software.

### Medication allergy errors

Four sentinel events reported serious harm associated with contraindication due to a history of allergy. Recommendations were developed by health service providers to minimise the risk of recurrence. These included the release of Medication Patient Safety Alerts, targeted education programs and training which focussed on both non-medicinal allergy recognition and management, as well as associated safety initiatives to support the prescribing and administration of more common medications, or over-the-counter medications, such as lidocaine and chlorhexidine.

In December 2021, the PSSU released a Check-up report focussing on lessons learned arising from allergy-related sentinel events.

<sup>15</sup> [WA Health - Medication Safety Resources](#)

<sup>16</sup> [ACSQHC - National Standard for User-applied Labelling of Injectable Medicines Fluids and Lines](#)

The WA Health mandatory policies provide a standard of care for medication safety best practice and include useful guidance and resources for health service providers to assist in reducing clinical incidents associated with medications. These include:

*WA Medication Chart Policy 0078/18* which mandates the implementation of a suite of standardised medication charts for prescribing and administration of medications for inpatient care. The use of standardised medication charts leads to improved consistency and safety of documentation for prescribing and administering medication.

*WA Medication Review Policy 0104/19* which provides the minimum requirements for the review of a patient's medications on presentation to hospital, during hospitalisation and prior to transition back into the community or transfer to other health care facilities. The objective of this policy is to reduce the risk of preventable medication-related adverse events and improve patient safety.

*WA High Risk Medication Policy 0131/20* which mandates the minimum requirements for the safe management of high risk medications across Health Service Providers. While all medications carry risk of adverse events if prescribed, administered or dispensed inappropriately, high risk medications are those that have an increased risk of causing significant patient harm or death if they are misused or used in error. The objective of this policy is to improve patient safety by requiring the implementation of risk reduction strategies and best practice standards for prescribing, dispensing or administering high risk medications.

The *Guidelines for Managing Specific High Risk Medications Relevant to the Organisation*, a supporting document of the *High Risk Medication Policy*, provides high risk medication risk mitigation strategies, which guide the review of clinical incidents to support systemwide change initiatives.

The Department of Health also provide a number of medication safety resources that can be used to raise awareness and promote safe practices with targeted themes.



## Sentinel Events – Surgical recommendations

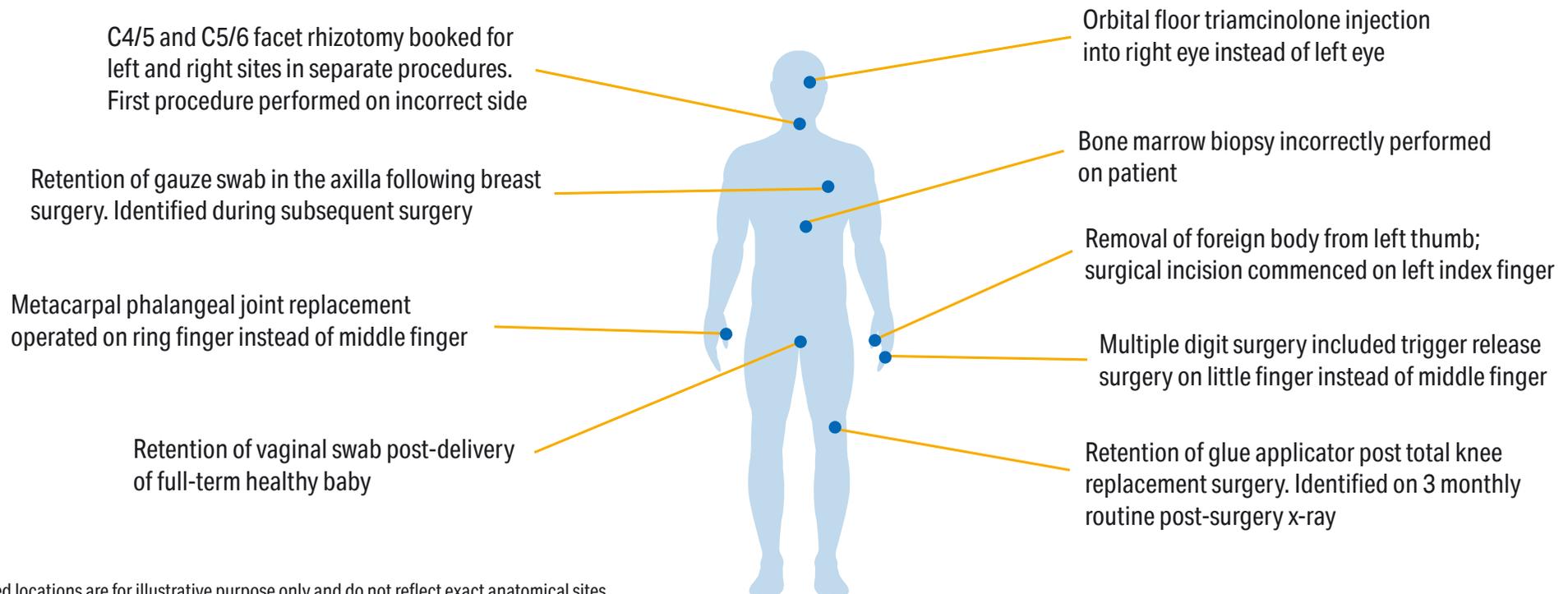
Nine sentinel events (including near miss sentinel events) involving surgery were notified during 2021/22. At the date of data extraction for this report, investigations had been completed for 6 of these events while 3 were still under investigation. Health service providers proposed a total of 13 recommendations in response to the 6 completed investigations.

In response to the wrong site and wrong procedure incidents, recommendations made by health service providers sought to improve health care provision with a focus on improving processes associated with pre-surgical and intra-surgical team time-outs. These included measures to support staff engagement and participation in team time-outs as well as promoting staff empowerment by provision of a graded assertiveness program.

An additional intra-operative team time-out was implemented where multiple operation sites required surgery. This time-out was to be completed prior to each procedure. Education sessions were proposed to support the implementation of these initiatives. Team time-out audits were scheduled to assess the effectiveness of these initiatives.

Several recommendations were made by health service providers in response to the retention of foreign objects. These included updating and standardising local surgical count forms, assessing the appropriateness and availability of required surgical equipment as well as optimising the physical location of items within the operating theatre. Education for all relevant staff and updates to orientation guides were proposed to follow process updates.

Figure 7: Anatomical sites affected by surgical sentinel events



Marked locations are for illustrative purpose only and do not reflect exact anatomical sites

## Other Confirmed SAC 1 Clinical Incidents

In 2021/22, there were 548 SAC 1 clinical incidents other than sentinel events confirmed. Figure 8 presents the percentage of confirmed SAC 1 clinical incidents (non-sentinel events) by category. This data is further tabulated and compared with the data since 2017/18 and is presented in Supplement [Table 16](#).

The *Clinical Incident Management Guideline*<sup>17</sup> provides a non-exhaustive list of SAC 1 clinical incident categories for non-sentinel events. Health services are encouraged to review this list of 17 incident types and select the most appropriate category for each SAC 1 incident. Infection control breaches (n=124; 22.6%) and complications of a fall in a health service (n=105; 19.2%) remain the 2 most frequently reported types of SAC 1 clinical incidents. During 2021/22, only 11 (2.0%) SAC 1 incidents were not categorised according to this list; this number having reduced from 61 (11.1%) SAC 1 incidents during 2017/18. This increase in appropriate categorisation supports data analysis and incident review associated with recurring themes.

During 2021/22, there were 435 SAC 1 clinical incidents (excluding sentinel events) that reported a patient outcome of serious harm or death, of which 48 (11.0%) related to private licensed health services and contracted non-government organisations. The percentage that related to private patients is comparable to the 10.0% (n=41) of the 409 reported during 2020/21.

While an infection control breach was greater than 10 times more likely to be associated with a patient outcome of serious harm (n=86) than death (n=8) and a complication of a fall in a health service was more than 8 times more likely to be associated with a patient outcome of serious harm (n=79) than death (n=9), a delay in recognising/responding to physical clinical deterioration was more likely to have a patient outcome of death (n=20) than a patient outcome of serious harm (n=19). SAC 1 clinical incidents associated with hospital/service process issues were almost as likely to have a patient outcome of death (n=26) as a patient outcome of serious harm (n=31).

In March 2022, the PSSU released a Check up report discussing SAC 1 clinical incidents related to diagnostic error, particularly those involving incorrect diagnostic conclusions.

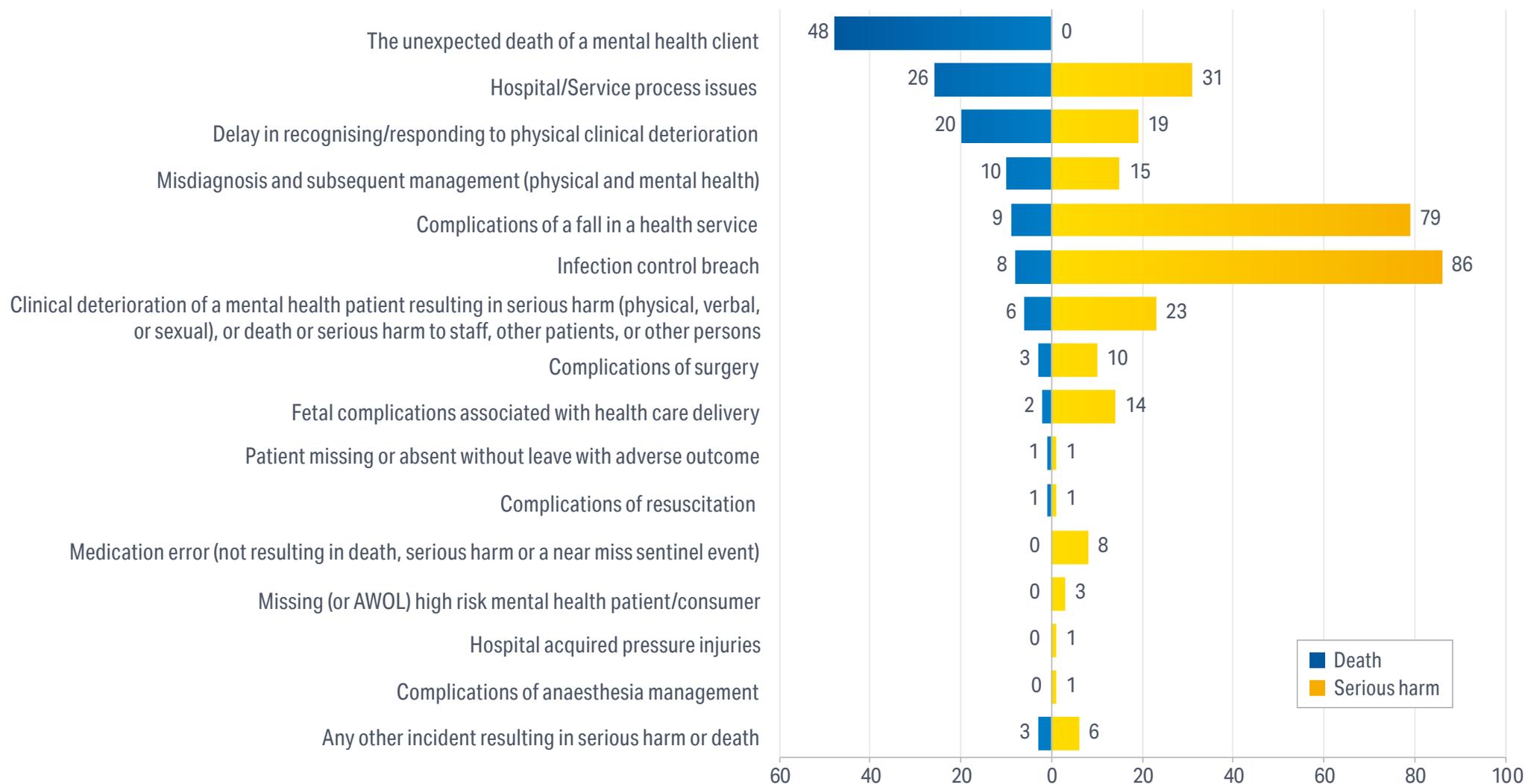
Figure 8: Confirmed SAC 1 Clinical Incidents by Category (non-Sentinel Events) for 2021/22



<sup>#</sup>This category includes Missing (or AWOL) high risk mental health patient/consumer, Patient missing or absent without leave with adverse outcome, Hospital acquired pressure injuries, Complications of anaesthesia management, Complications of resuscitation or any other incident resulting in serious harm or death.

17 [Clinical Incident Management Guideline](#)

Figure 9: Confirmed SAC 1 Clinical Incident Categories (excluding Sentinel Events) by Patient Outcome of Death and Serious Harm for 2021/22



## SAC 1 Contributory Factors

At the time of data extraction for this report, 472 confirmed SAC 1 clinical incidents (including sentinel events) had been investigated by Health Service Providers, private licensed health care facilities and contracted NGOs. This represented 82.2% of all confirmed SAC 1 incidents in 2021/22.

Figure 10: Contributory Factors for Closed SAC 1 Clinical Incidents for 2021/22



**Note:** A clinical incident investigation may identify multiple contributory factors

Of the 99 confirmed SAC 1 clinical incidents related to private patients, 77 investigations were complete with 207 recommendations developed to improve provision of health care.

Under the requirements of the *Clinical Incident Management Policy*, it is expected that the health service provider will develop recommendation(s) to address contributory factors identified during a SAC 1 clinical incident investigation. During 2021/22, 1,256 recommendations were developed in response to the completed SAC 1 investigations.

The most frequently identified contributory factors (Figure 10) again related to communication errors (n=330; 69.9%) and issues concerning policies, procedures and guidelines (n=314; 66.5%).

A majority of the 330 closed SAC 1 clinical incidents that reported communication issues identified communication issues between staff (n=185; 56.1%) and issues related to documentation (n=170; 51.5%). Of the 314 closed SAC 1 clinical incidents that reported contributory factors related to policies, procedures and guidelines 48.4% (n=152) identified concerns with the application of policies, procedures or guidelines, and 33.7% (n=106) identified an absence of relevant policies, procedures or guidelines. Over 70% of the 194 closed SAC 1 clinical incidents that reported issues associated with staff knowledge, skills and competency found deficiencies with staff training (n=136).

The frequency of the types of contributory factors identified in SAC 1 clinical incident investigations in 2021/22 is consistent with the data from preceding years. The data for the period 2019/20 to 2021/22 is presented in Supplement [Table 17](#). These contributory factors are explored in more detail against each of the NSQHS Standards sections of this report.

Patient factors have decreased as a contributory factor from 61.5% last year to 54.7% in 2021/22 suggesting an increased focus on identification of health system factors.

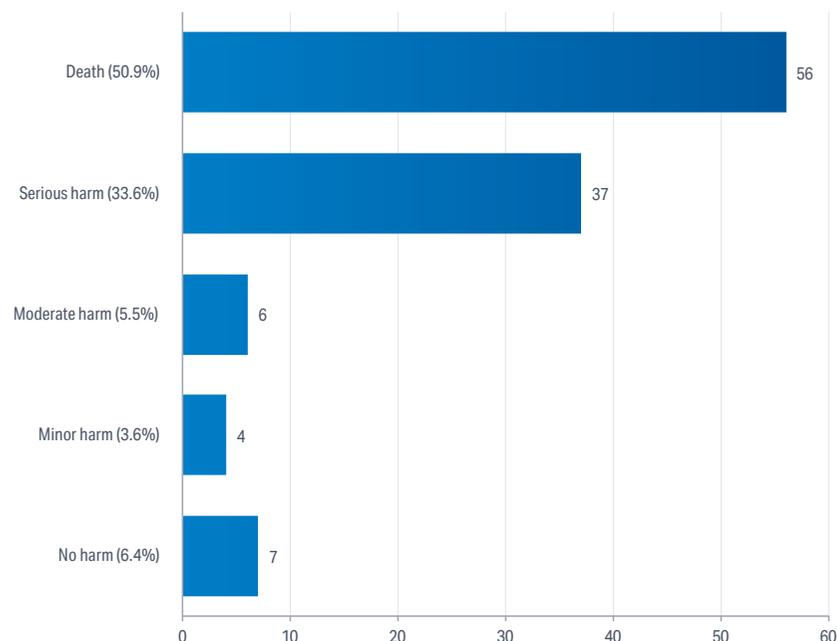
## SAC 1 Clinical Incidents – Mental Health patients

Mental health patients include voluntary, involuntary and referred mental health patients under the *Mental Health Act 2014* and may involve patients in both the inpatient and community settings.

In 2021/22, 110 SAC 1 clinical incidents involving mental health patients were confirmed. There were a further 36 events investigated that were approved for declassification. The investigation of 23 SAC 1 mental health clinical incidents notified during 2021/22 remained ongoing as at 30 June 2022. There were no sentinel events reported in 2021/22 involving mental health patients.

Of the total 139 SAC 1 clinical incidents with a patient outcome of death during 2021, 56 deaths involved mental health patients. Figure 11 details all patient outcomes associated with SAC 1 clinical incidents involving mental health patients.

Figure 11: Confirmed SAC 1 Clinical Incidents involving Mental Health Patients by Patient Outcome for 2021/22



The SAC 1 clinical incident category most often involving mental health patients in 2021/22 continues to be the unexpected death of a mental health client (n=48). The next most frequently reported SAC 1 category involving mental health patients was clinical deterioration of a mental health patient resulting in serious harm (physical, verbal, or sexual) or death or serious harm to staff, other patients, or other persons (n=36). Of these 36 incidents, 6 reported a patient outcome of death and a further 23 reported a patient outcome of serious harm. Supplement [Table 18](#) details all mental health care patient outcomes associated with the different SAC 1 category types.

The data presented in this table is consistent with the previous 2020/21 data presented in the 2021 edition of this report.

A majority of the mental health patient deaths involved voluntary mental health patients (n=39; 69.6%) and occurred in the community (n=52; 92.8%). Involuntary mental health patients suffered harm in 15 SAC 1 clinical incidents, with serious harm (n=11) the most common patient outcome.

Over 70% of the 87 mental health SAC 1 clinical incidents that had a completed investigation identified communication issues (n=62). Issues associated with policies, procedures and guidelines (n=56) were the next most frequently identified contributing factor.

Key communication issues included communication between staff, between staff and patients/family/carers, documentation and patient assessment.

Staff training and education, as well as the absence, application and implementation of policies, procedures and guidelines were common contributing factors.



In 2021/22, a small number of SAC 1 mental health clinical incidents involved 2 or more mental health clients. These incidents reported a patient outcome of serious harm and were associated with sexual harm suffered by the patient/s. Recommendations developed in response to these SAC 1 clinical incidents included an alignment with the Chief Psychiatrist's Sexual Safety Guidelines, development and delivery of an education package to increase staff knowledge and awareness of sexual risk management and a review of the physical layout of the ward.<sup>18</sup>

It is recognised that the mental health patient journey is often complex and may involve multiple mental health care settings including hospital inpatient services, emergency departments, community treatment services and community support services. The complexity of the integration of these services and the patient's transition between services increases the risk of patient harm.

In June 2022, the Patient Safety Surveillance Unit, in collaboration with the Office of the Chief Psychiatrist, published the *Guidance for SAC 1 Mental Health Clinical Incident Investigations*.<sup>19</sup> This guidance document serves to assist mental health clinical review teams and investigation panels when undertaking SAC 1 clinical incident investigations and provides an additional resource to complement the *Clinical Incident Management Guideline*, *Clinical Incident Management Toolkit* and other supporting resources.

<sup>18</sup> [Chief Psychiatrist's Sexual Safety Guidelines](#)

<sup>19</sup> [Guidance for SAC 1 Mental Health Clinical Incident Investigations](#)

## SAC 1 Clinical Incidents – Fetal Harm

During 2021/22, 18 confirmed SAC 1 clinical incidents reported fetal harm, representing 3.1% of all confirmed SAC 1 clinical incidents in this period. There were no sentinel events that reported fetal harm during 2021/22. Supplement [Table 19](#) details the frequency of SAC 1 categories where fetal harm was reported for the period 2017/18 to 2021/22.<sup>20</sup> Fetal complications associated with health care delivery (n=14) was this year again the most frequent SAC 1 category.

Of the 18 SAC 1 clinical incidents reporting fetal harm in 2021/22, 12 incidents (66.7%) reported fetal death and 4 incidents reported serious fetal harm. Greater than two thirds (n=13; 72.2%) of fetal harm associated with SAC 1 clinical incidents related to term pregnancies with a gestational age between 37<sup>0</sup> weeks and 41<sup>6</sup> weeks.<sup>21</sup> The majority of the SAC 1 clinical incidents related to term pregnancies reported fetal death (n=8). There was one SAC 1 clinical incident that was associated with a twin pregnancy at 23<sup>5</sup> weeks that reported fetal death/s.

The revised version of the *Cardiotocography (CTG) Monitoring Policy* was released in June 2021.<sup>22</sup> This policy mandates the minimum requirements for the monitoring and interpretation of CTG to help identify signs of suspected fetal distress and initiate appropriate clinical management. The number of confirmed SAC 1 clinical incidents reporting fetal harm in 2021/22 is consistent with that reported during the previous year.



<sup>20</sup> Fetal harm fields in Datix CIMS were implemented in October 2017 and remain non-mandatory.

<sup>21</sup> Term pregnancy is defined as 37<sup>0</sup> to 41<sup>6</sup> weeks gestation ([Pregnancy Care Guidelines - Part J: Clinical Assessments in Late Pregnancy](#))

<sup>22</sup> [Cardiotocography Monitoring Policy](#)

## Key Messages and Information: SAC 1 Clinical Incidents

During 2021/22, the WA health system reported 574 SAC 1 clinical incidents including 26 sentinel events, or near miss sentinel events. The frequency of medication error sentinel events has continued to increase this year, in addition to increased reporting of surgical sentinel events. Although the total number of confirmed SAC 1 clinical incidents is consistent with that reported in the pre-COVID year of 2018/19, the increase in the reporting of sentinel events with high levels of patient harm as a subset of the total number of SAC 1 clinical incidents highlights an area of focus for the WA health system. The PSSU strongly advocates for health services to review local trends and act upon identified risks to minimise the occurrence of these severe events.

The *Clinical Incident Management Policy* defines SAC 1 clinical incidents as including those that caused serious harm or death. During 2021/22, 51 clinical incidents with a patient outcome of serious harm or death were confirmed as SAC 2 or SAC 3. The frequency of inappropriate categorisation associated with this higher level of patient harm is more than four times greater than the 11 SAC 2 or SAC 3 clinical incidents reporting a patient outcome of death or serious harm in 2018/19. Inappropriate categorisation of the SAC rating of clinical incidents is inconsistent with the requirements of the *Clinical Incident Management Policy*.

Noting the higher risk to patient harm, the investigation of SAC 1 clinical incidents requires a more robust and rigorous methodology than those required for SAC 2 or SAC 3 clinical incidents. The increased trend in recent years of clinical incidents with a patient outcome of death or serious harm that have not been confirmed as SAC 1 requires further exploration by PSSU to understand system and local factors.

Identification of contributory factors is a critical component of the clinical incident investigation process. During 2021/22, the investigation into 472 SAC 1 clinical incidents was completed with similar contributory factors identified as in previous years. These investigations developed 1,256 recommendations to improve the provision of health care. It is recognised that some system-wide contributory factors 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.<sup>23</sup>

It is noted that some SAC 1 clinical incidents may involve patient journeys that transition across two or more health services, or require clinical escalation or collaboration across different services. It is widely recognised that there is increased risk of patient harm associated with clinical handover and the transition of care. The PSSU strongly advocates for health services to undertake a collaborative multi-site investigation to fully explore all potential contributory factors in these complex SAC 1 clinical incidents to assist the development of robust recommendations as part of ongoing efforts to minimise the risk of future harm to patients.<sup>24</sup>

During 2021/22 the PSSU published two new guidance documents to assist health services progress SAC 1 investigations - *SAC 1 Clinical Incident Investigations – Roles and Responsibilities* and *Guidance for SAC 1 Mental Health Clinical Incident Investigations*.<sup>25 26</sup>

<sup>23</sup> [Clinical Risk Management](#)

<sup>24</sup> [Guideline for the Investigation of Multi-Site Clinical Incidents](#)

<sup>25</sup> [SAC 1 Clinical Incident Investigations - Roles and responsibilities](#)

<sup>26</sup> [Guidance for SAC 1 Mental Health Clinical Incident Investigations](#)



NSQHS STANDARDS

- Icon 1: Patient safety (orange circle with a gear and a person)
- Icon 2: Infection control (green circle with a pill)
- Icon 3: Patient participation (purple circle with a person and a speech bubble)
- Icon 4: Patient care (green circle with a hand holding a document)
- Icon 5: Patient safety (red circle with a drop)
- Icon 6: Patient care (purple circle with a heart rate monitor)

# NSQHS Standards



# Preventing and Controlling Infections Clinical Incidents

The infection prevention and control actions of this NSQHS Standard focus on a range of important activities to protect both patients and health care workers, while the Datix CIMS incident classification specifically captures incidents related to infection control that affect patients.

The intention of the Preventing and Controlling Infections Standard is to reduce the risk to patients, consumers and health care workers from acquiring preventable infections, effectively manage infections if they occur, limit resistance to antimicrobial medications, promote appropriate prescribing and use of antimicrobials via antimicrobial stewardship, and promote appropriate and sustainable use of infection prevention and control resources.<sup>27</sup>

The revision of the Preventing and Controlling Infections Standard in 2021 broadened its scope to make explicit the need to protect both patients and staff from infectious diseases, and includes any infection that may be transmitted within a healthcare environment, regardless of where it or originated or was acquired. This includes potential environmental sources of infection such as water and air-conditioning systems, which may harbour the bacterium that causes Legionnaires' disease, a severe form of pneumonia.

A key action of the revised Standard is the need for health service organisations to establish multidisciplinary teams to identify and manage risks associated with infections using the 'hierarchy of controls' in conjunction with infection prevention and control systems.

Effective risk management systems, including those for infection prevention and control, require hazards to be identified and risks to patients, consumers and staff controlled as far as is reasonably practicable. The hierarchy of controls is a model used in occupational health and safety risk management that ranks controls from most to least reliable, and when used in conjunction with infection prevention and control systems can be used to develop more effective infection prevention and control programs.

The hierarchy of controls referred to in this Standard is like the hierarchy of intervention effectiveness for recommendations made in response to clinical incidents referred to in the [Clinical Incident Management Guideline](#).

Controls and actions that focus on people rather than systems are generally less reliable and less effective.

The most reliable controls are those that eliminate the risk of infection entirely (for example, conducting outpatient appointments via telemedicine rather than face-to-face), however these may not be suitable for all clinical settings or patients. The next most reliable controls are those that substitute the hazard with a safer alternative, isolate people from hazards (e.g. using protective barriers/screens) and reduce risk via engineering solutions (e.g. improved ventilation).

Less reliable controls are those that use administrative processes to reduce exposure to infections (e.g. asking patients and staff not to attend health care facilities if unwell) and personal protective equipment (PPE). A common feature of these less reliable controls is a dependence on humans to 'do the right thing' and they are rarely effective measures without significant education and ongoing monitoring and auditing of compliance.

Importantly, as not all clinical environments and activities have the same risks or will lend themselves to the ideal controls to prevent transmission, infection prevention and control programs must be tailored to the local context and risk.

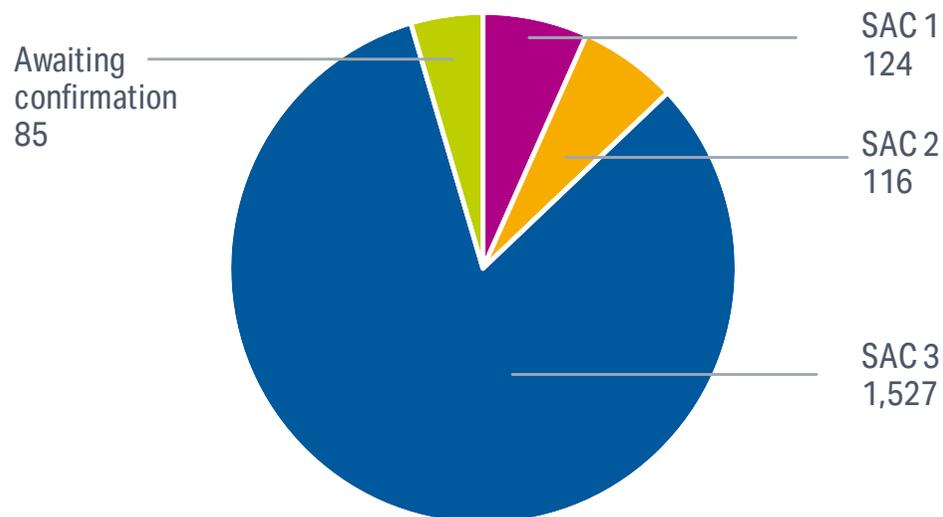
The standard and transmission-based precautions item of the revised Standard also include requirements for health workers to ensure consideration is given to patients' infectious status on transfer, and the risks to wellbeing of patients in isolation.

The need for clinicians to partner with patients and consumers to ensure they are actively involved in their own care and that their needs for information about infection prevention and control are met remains as important as ever.

<sup>27</sup> [NSQHS Standards \(2nd ed – version 2\) Preventing and Controlling Infections Standard](#)

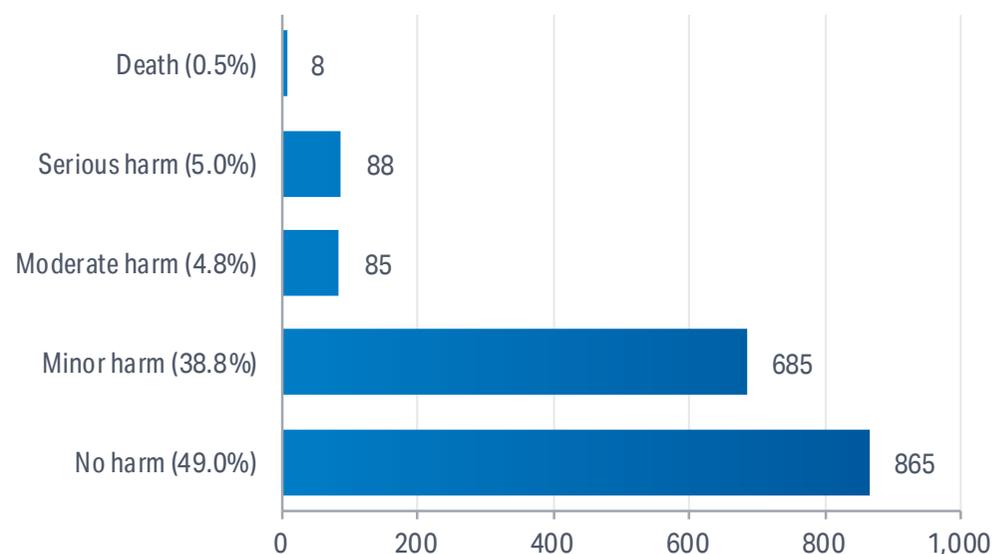
In 2021/22 there were 1,852 infection control incidents notified, of which 1,767 were confirmed at the time of this report, which is a small decrease from the previous year. Infection control incidents accounted for 5.5% of confirmed incidents in this period. Most infection control incidents were confirmed as SAC 3 incidents (82.5%) followed by SAC 1 (6.7%) and SAC 2 incidents (6.3%; see Figure 12).

Figure 12: Infection Control Clinical Incidents by SAC Rating for 2021/22



Nearly half of the confirmed infection control incidents in 2021/22 reported the patient outcome as no harm (see Figure 13). Eight confirmed incidents reported the patient outcome as death and a further 88 incidents reported the outcome as serious harm.

Figure 13: Confirmed Infection Control Incidents by Patient Outcome for 2021/22



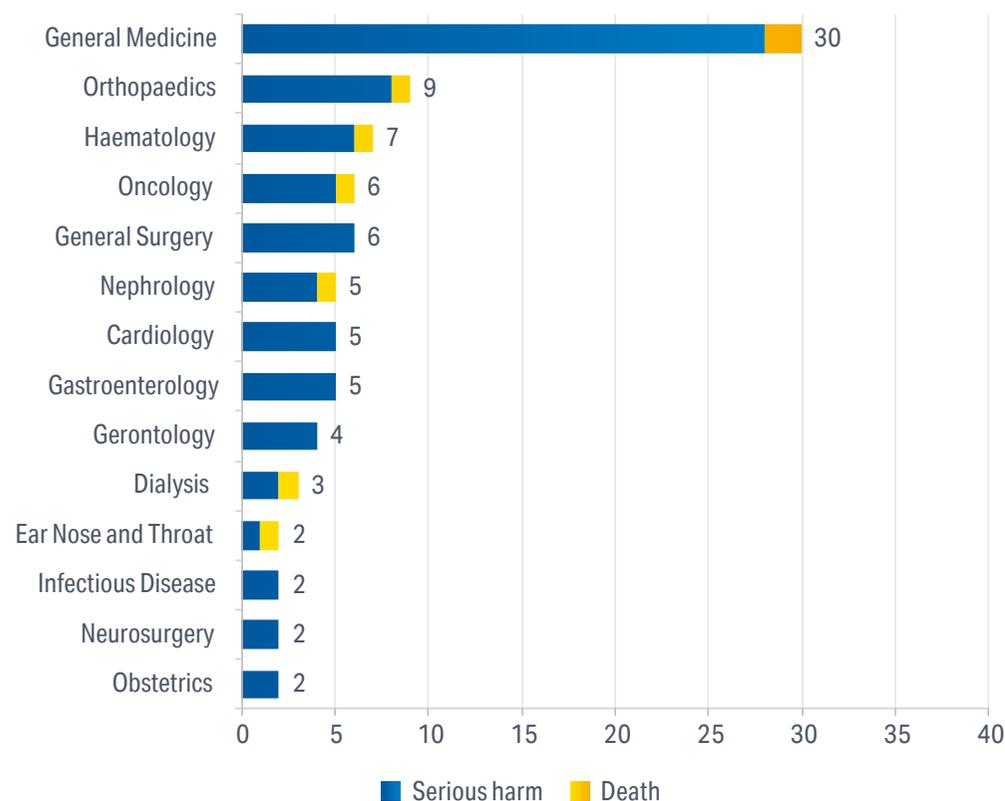
**Note:** Patient outcome missing data n=36 (2.0%)

Overall, there were slightly more female patients involved in confirmed infection control incidents than males, however a bias towards female patient involvement was noted in patients aged between 15 and 44 years. Males were observed to be more often involved in infection control incidents reporting the patient outcome as serious harm or death.

The percentage of Aboriginal and Torres Strait Islander persons involved in confirmed infection control incidents (11.6%) was similar to that seen for clinical incidents generally. Only 2.0% of patients involved in confirmed infection control incidents were mental health patients.

The specialties of General Medicine (n=476) and General Surgery (n=234) reported the highest number of confirmed infection control incidents during 2021/22. General Medicine also reported the highest number of infection control incidents describing a patient outcome of serious harm or death (n=30) followed by Orthopaedics (n=9; see Figure 14).

Figure 14: Confirmed Infection Control Incidents with Patient Outcomes of Serious Harm or Death by Treating Specialty for 2021/22



**Note:** A further eight specialties reported one incident with a patient outcome of serious harm. These were Cardiothoracic Surgery, Intensive Care Unit, Neonatology, Neurology, Pain Services, Rehabilitative Medicine, Spinal, and Urology.

In 2021/22, more than half of all confirmed infection control incidents, and 70 of the 96 incidents reporting a patient outcome of serious harm or death, were associated with the use or administration of devices, products, medications or fluids. The five most frequent infection control incident categories (based on the Datix CIMS Tier Two and Tier Three incident categories) are shown in Table 3.

Table 3: Most Frequent Confirmed Infection Control Incident Categories for 2021/22

Infection Control Incident Categories	(n)	(%)
Device/Product/Medication/Fluid Associated Infections – Contamination due to hospital processes (other than sterilisation)	734	41.5
Device/Product/Medication/Fluid associated infections - Breach in sterile techniques	246	13.9
Performance of Clinical Procedures – Processes/ protocols established but not followed/adhered to	236	13.4
Isolation Processes/Protocols for Infected Patients – Processes/protocols established but not followed/adhered to	191	10.8
Infection Diagnosis - Delayed diagnosis	58	3.3

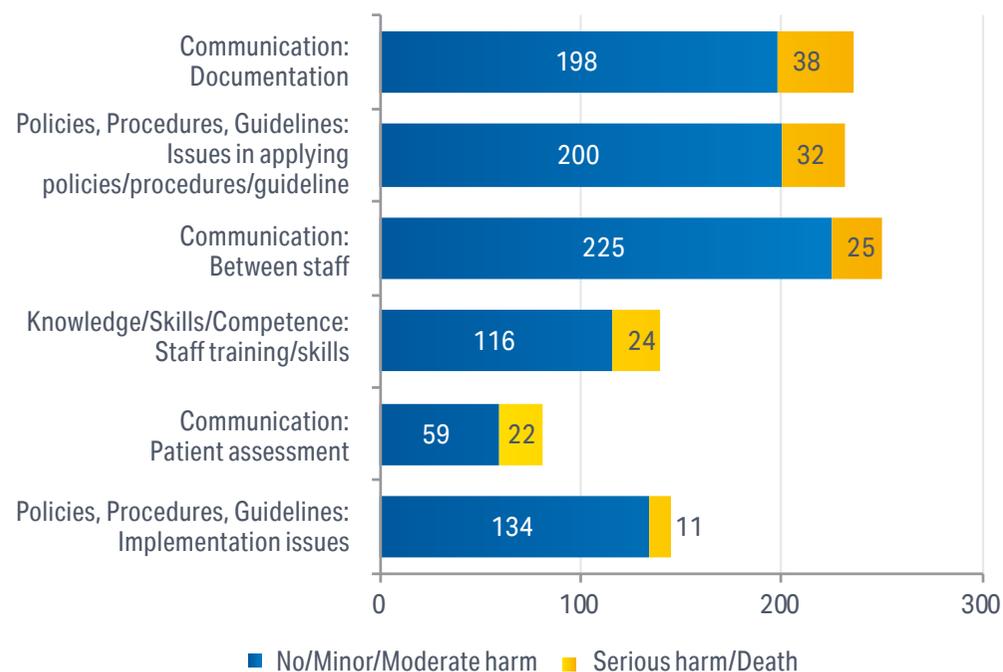
The proportion of infection control incidents associated with the use or administration of devices, products, medications or fluids is similar to that seen in previous years.

These types of infection control incidents are often associated with more severe patient outcomes due to the invasive nature of devices such as IV cannulae which can introduce infections directly into the bloodstream.

The investigation of 1,567 infection control clinical incidents had been completed at the time of this report, and 76 of these incidents reported the patient outcome as serious harm or death. The most frequently identified issues in these incidents related to communication and policies, procedures and guidelines.

While issues with communication between staff was the most frequently identified contributory factor (n=250), when looking at infection control incidents with outcomes of serious harm or death, problems with documentation (n=38) and issues in applying policies, procedures and guidelines (n=32) were more often found to have contributed (see Figure 15).

Figure 15: Most Frequent Contributory Factors for Closed Infection Control Clinical Incidents for 2021/22



**Note:** A clinical incident investigation may identify multiple contributory factors.

Review of the contributory factors in infection control incidents that reported patient outcomes of serious harm or death identified several themes, including:

- Poor peripheral intravenous cannula (PIVC) management including:
  - Lack of documentation about the insertion of a device
  - Delay in removal of a device
  - Placement of PIVC not optimal, including inappropriate siting at the anterior cubital fossa
  - Limited or no communication of insertion site management practices to the patient (in some cases the patient was also identified as having low health literacy)
- Poor aseptic technique and lack of aseptic technique training and auditing
- Poor knowledge of and compliance with Multi-resistant Organism policies<sup>28</sup>
- Incomplete preparation of the patient for a procedure.

The anterior cubital fossa is the triangular area located at the front of the elbow joint and is often used for insertion of peripheral intravenous lines.

The [Insertion and Management of Peripheral Intravenous Cannulae in Western Australian Healthcare Facilities](#) mandatory policy and the ACSQHC's [Management of Peripheral Intravenous Catheters Clinical Care Standard](#) provides guidance on the most appropriate sites for inserting peripheral lines.

Multi-resistant Organisms (MROs) are microorganisms that have become resistant to the medications usually used in their treatment.

<sup>28</sup> Advice on the management of specific MROs is contained in the WA health system's [Public Health Policy Framework](#)

## Key Messages and Information: Preventing and Controlling Infections Clinical Incidents

Infections resulting from the provision of health care, particularly healthcare-associated *Staphylococcus aureus* bloodstream infections (HA-SABIs), pose a significant threat to the safety of patients and are associated with significant morbidity and mortality. Undertaking surveillance of healthcare associated infections is an essential part of infection prevention and control programs and is a well-established process in the WA health system.<sup>29</sup>

Consistent with previous years, more than half of all infection control incidents reported in 2021/22, and nearly three quarters of the incidents describing the patient outcome as serious harm or death, were associated with the use or administration of devices, products, medications or fluids. While most of these incidents were categorised as contamination due to hospital processes (other than sterilisation), when viewed through the lens of patient outcomes of serious harm or death, the most frequent category was breach of sterile techniques (n=44).

An element of standard precautions is aseptic techniques, which are covered in Action 3.11 of the Preventing and Controlling Infections Standard. This action requires that health care organisations have processes for aseptic technique that:

- Identify the procedures in which aseptic technique applies
- Assess the competence of the workforce in performing aseptic technique
- Provide training to address gaps in competency
- Monitor compliance with the organisation's policies on aseptic technique.<sup>30</sup>

The actions for aseptic technique are directly linked to Action 3.12 which requires health care organisations to have processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.<sup>31</sup>



Aseptic techniques aim to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites. Aseptic techniques can be achieved in the typical ward setting by appropriately trained clinicians.

29 [MP 0108/19 Healthcare Associated Infection Surveillance Policy](#)

30 [NSQHS Standards \(2nd ed – version 2\) Preventing and Controlling Infections Standard - Action 3.11](#)

31 [NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#)



# Medication Safety Clinical Incidents

Medications (medicines) are the most frequent form of treatment used in health care and are more often involved in clinical incidents than other forms of treatment. While the appropriate use of medications provides great benefit to patients, when errors occur the adverse effects can be significant. Up to half of all medication clinical incidents globally are considered potentially avoidable.<sup>32</sup>

The intention of the Medication Safety Standard is to ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use, and that consumers are informed about medicines and understand their individual medicine needs and risks.

There are many factors that may contribute to medication-related clinical incidents, including issues at the points of prescribing, dispensing, and administration. When care transitions, for example when a patient is admitted to hospital, there is the potential for information about a patient’s current medications to be lost, which can in turn increase the chance of a medication-related clinical incident occurring.

Accordingly, an important aspect when commencing an episode of care for a patient is to ensure that their best possible medication history is recorded as early as possible, including information about allergies and previous adverse reactions, and made available to the clinicians who will be caring for them. This requires the active involvement of the patient and/or carers and is the first step in the process of medication reconciliation.

Medication reconciliation is a formal and structured process where clinicians review a patient’s current medication orders against their best possible medication history and the documented treatment plan and reconcile any discrepancies. It should occur early within the patient’s admission (ideally within 24 hours of presentation), at each time care transfers or medications are recharted, and on discharge.<sup>33</sup>

During 2021/22, there were 8,610 medication clinical incidents notified, of which 8,263 had been confirmed at the time of this report. Medication clinical incidents represented 25.7% of all confirmed incidents in this period.

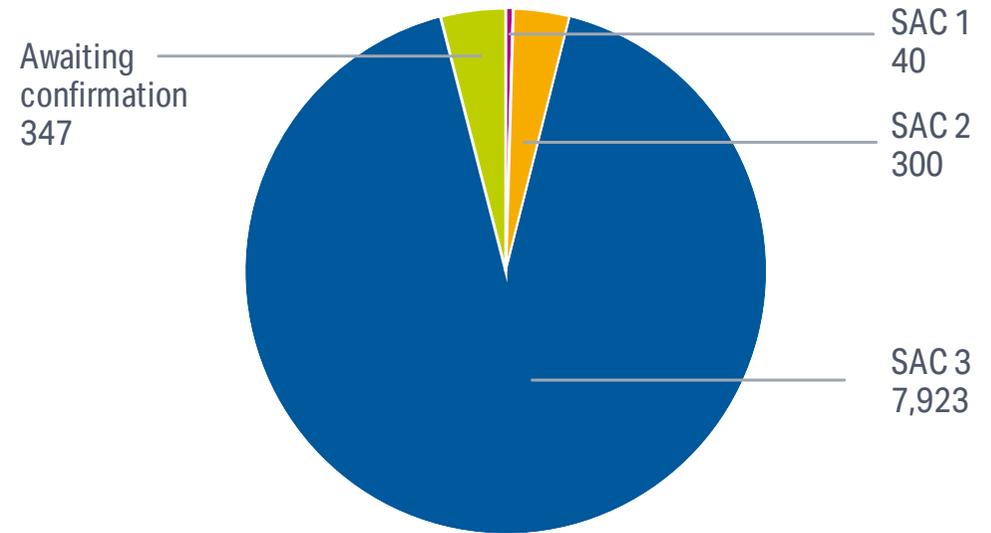
32 [NSQHS Standards \(2nd ed – version 2\) Medication Safety Standard](#)

33 [NSQHS Standards \(2nd ed – version 2\) Medication Safety Standard – Action 4.06](#)

Medication safety is highly dependent on communication between clinicians, and with patients throughout the medication management process, and has close links to the Communicating for Safety Standard.

Ninety-two percent of medication incidents notified were confirmed as SAC 3 incidents in 2021/22 (see Figure 16) and the number of medication incidents confirmed as SAC 1 (n=40) was similar to that seen in 2020/21.

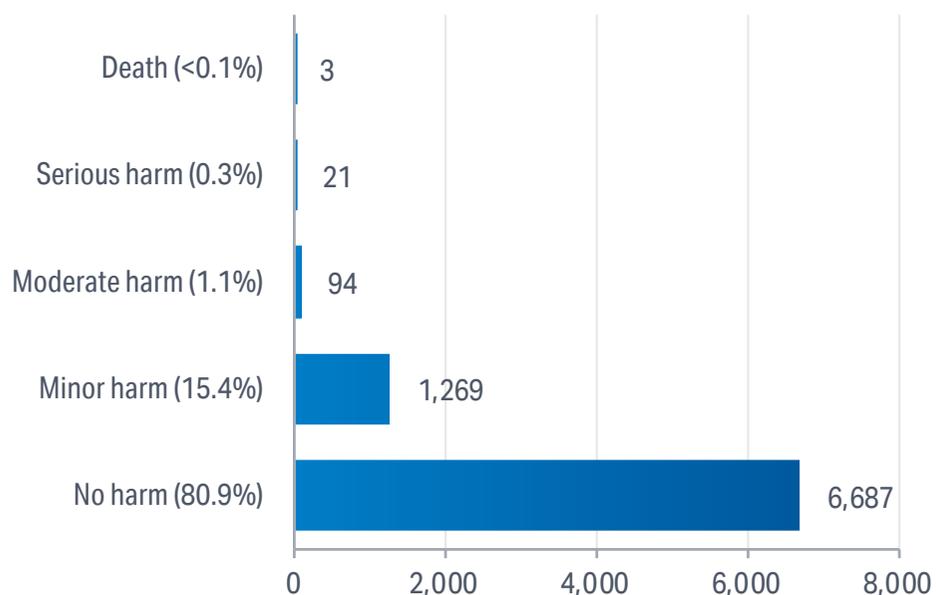
Figure 16: Medication Clinical Incidents by SAC Rating for 2021/22



Medication-related clinical incidents are captured under the Datix CIMS incident classification that includes medications, biologics and fluids. While the term “medication clinical incidents” is used in this section, the data includes clinical incidents involving biologics, fluids and medications. The number of medication clinical incidents notified has increased slightly from 2020/21.

More than eighty percent of confirmed medication incidents in 2021/22 reported the patient outcome as no harm, and a further 15.4% described the patient outcome as minor harm (see Figure 17). It is encouraging that forty percent of medication incidents confirmed as SAC 1 in this period reported lower levels of harm or were near misses, demonstrating the strong commitment to medication safety in the WA health system. However, it remains of concern that 24 incidents described the patient outcome as serious harm or death; a figure similar to that seen the previous year.

Figure 17: Confirmed Medication Clinical Incidents by Patient Outcome for 2021/22



**Note:** Patient outcome missing data n=189; 2.3%

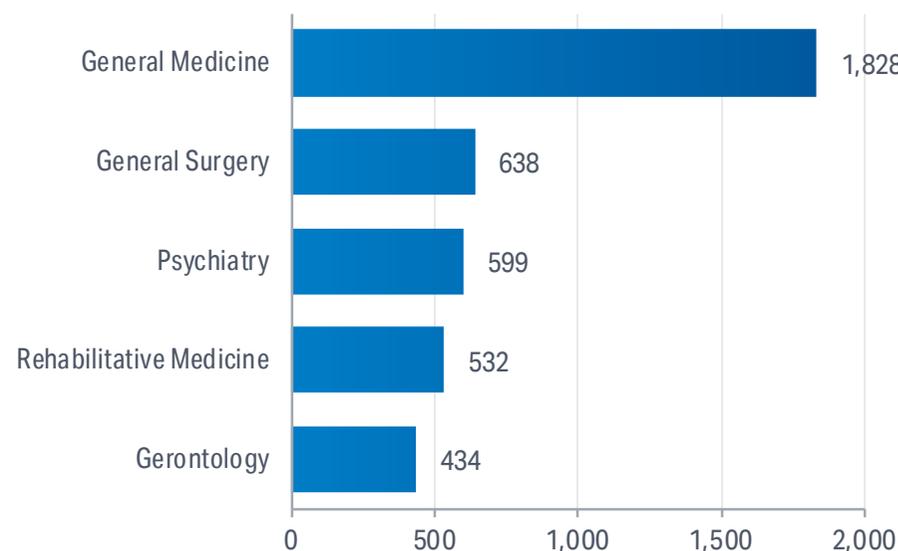
Overall, there were slightly more female patients involved in confirmed medication incidents than males, however a pronounced bias towards female patient involvement was noted in patients aged between 25 and 34 years. In 2021/22, nearly 70% of confirmed incidents reporting the patient outcome as serious harm or death involved female patients.

The percentage of Aboriginal and Torres Strait Islander persons involved in confirmed medication incidents (10.5%) was the same as that seen for clinical incidents

generally. The percentage of mental health patients involved in confirmed medication incidents (9.8%) was a little lower than that seen for clinical incidents overall.

The General Medicine specialty reported 22.1% of confirmed medication clinical incidents in 2021/22, followed by General Surgery (7.7%) and Psychiatry (7.2%; see Figure 18). The specialties that most often reported medication incidents with a patient outcome of serious harm or death were Emergency Medicine (n=5) and General Medicine (n=3).

Figure 18: Confirmed Medication Clinical Incidents by Most Frequent Treating Specialties for 2021/22



**Note:** Treating specialty unknown/missing data n=277; 3.4%

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=5,541; 67.1%). This was followed by incidents related to prescribing processes (n=1,290; 15.6%) and dispensing processes (n=688; 8.3%). Of the 24 incidents that reported a patient outcome of serious harm or death, 16 incidents were related to administration of medication and 8 related to medication prescribing.

In the Datix CIMS, the Tier Two incident categories for medication clinical incidents reflect the part of the medication process at which the incident occurred, while the Tier Three categories identify the nature of the incident or error.

Figure 19 shows the five most frequent types of medication clinical incident in each of the administration, prescribing and dispensing parts of the medication process. Incidents involving a failure to administer medication to a patient were most frequently reported and contributed to more than one-fifth of all confirmed medication incidents in 2021/22.

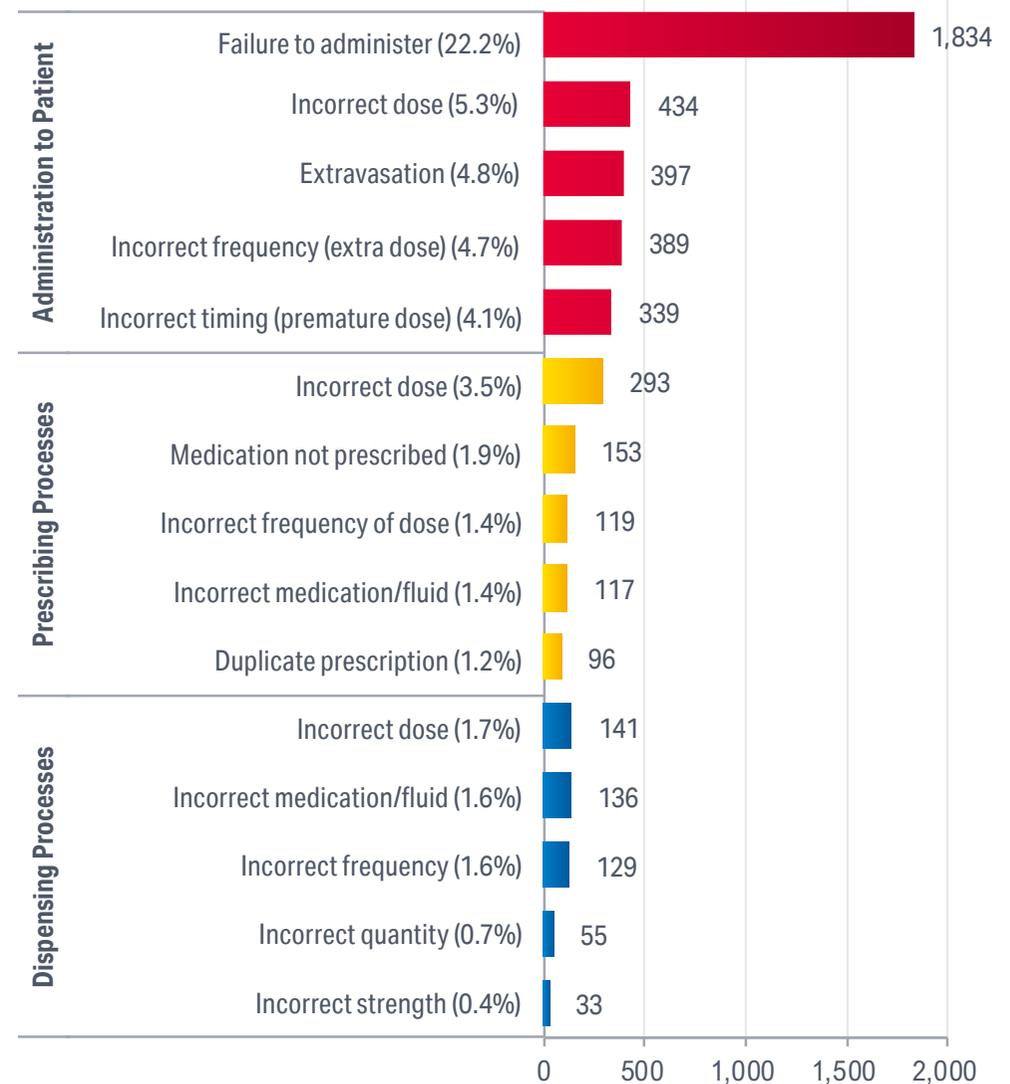
Within the prescribing and dispensing parts of the medication process confirmed incidents most frequently related to an incorrect medication dose. Including incidents involving the administration of an incorrect dose of medication to the patient, 10.5% (n=868) of all confirmed medication incidents related 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 (8 incidents, 5 of which related to administration and 3 to prescribing) and contraindication due to a history of allergy (4 incidents, 3 of which related to administration and 1 to prescribing).

Of these, incidents related to an incorrect dose most frequently involved insulins, with two related to administration issues and one to prescribing issues. Two of the four incidents related to administration of medication to which the patient was known to be allergic involved the local anaesthetic medication lidocaine (lignocaine).

Lidocaine is one of several medications that has recently undergone a name change as part of the Therapeutic Goods Association's (TGA) work to [update medication names](#) in Australia to align with international conventions. Clinicians should use extra care when handling medications they may not be fully familiar with.

Figure 19: Most Frequent Confirmed Medication Clinical Incident Categories for 2021/22



The 10 most frequent categories of medication involved in confirmed clinical incidents remains largely unchanged from previous years, with opioid analgesics, antibacterials, insulins and anticoagulants most often involved (see Table 4).

Antibacterial medications were most frequently associated with medication incidents that reported a patient outcome of serious harm or death (n=4), followed by anticoagulants, insulins, opioid analgesics and local anaesthetics (3 incidents each).

**Table 4: Most Frequent Categories of Medications Involved in Confirmed Clinical Incidents for 2021/22**

Medication Categories (Top 10)	(n)	(%)
Opioid analgesics (opioid based pain relievers)	1,001	12.1
Antibacterials (antibiotics)	836	10.1
Insulins (medications used for diabetes)	536	6.5
Anticoagulants (blood thinning medications)	530	6.4
Antipsychotics (medications for major psychiatric disorders)	381	4.6
Vaccines	334	4.0
Antihypertensives (medications for high blood pressure)	313	3.8
Non-opioid analgesics (non-opioid pain relievers)	304	3.7
Medications for anxiety and sleep disorders	218	2.6
Antiepileptics (medications for epilepsy)	216	2.6

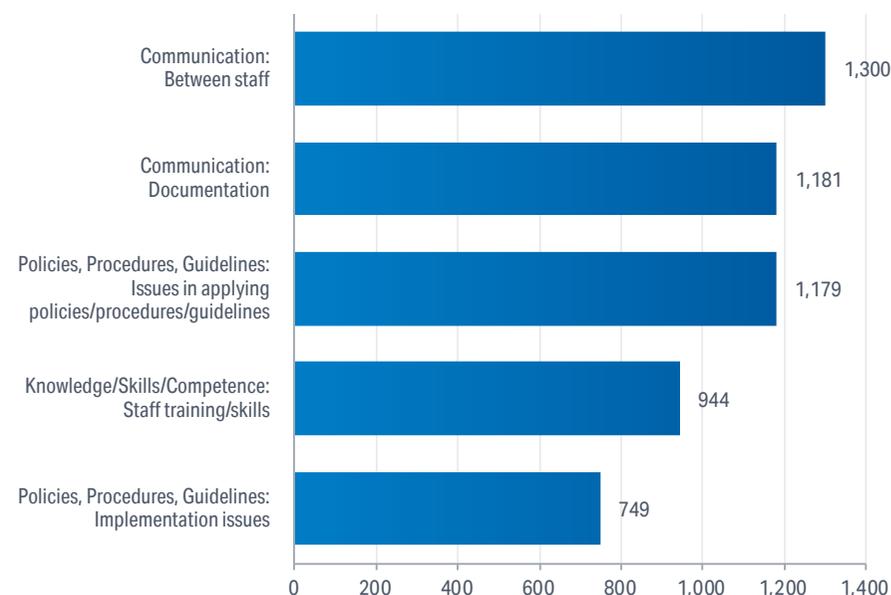
The key change in the medications involved in clinical incidents in 2021/22 is that vaccines feature in the top 10 medication categories for the first time. This is not surprising given the COVID-19 mass-vaccination program that was in progress. More than half of vaccine-related clinical incidents involved COVID-19 vaccines (n=193).

The number of incidents involving vaccines is very small compared to the number of doses administered and no confirmed vaccine-related clinical incidents over this period reported a patient outcome of serious harm or death.

The investigation of 7,360 medication incidents had been completed at the time of this report, and 22 of these incidents reported the patient outcome as serious harm or death. The most frequently identified issues in these incidents related to communication and policies, procedures and guidelines.

Issues with communication between staff and documentation were the contributory factors most frequently identified by the investigation of these incidents (see Figure 20). 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 2021/22.

**Figure 20: Most Frequent Contributory Factors for Closed Medication Clinical Incidents for 2021/22**



Note: A clinical incident investigation may identify multiple contributory factors.

Review of the contributory factors in medication incidents that reported patient outcomes of serious harm or death identified several themes, including:

- Inconsistencies in the naming and detailing of medication allergies and the resultant reactions in health care records, including medication charts
- Prescribing medications by brand name rather than active ingredient name
- The risk associated with administration of medications in smaller sites that have limited resources to respond to adverse reactions
- Incomplete handover of patient care within or between health care providers
- Implementation of new equipment and failure to provide adequate training for its use
- Breakdown in the process for independent double-checking of medication
- Inaccurate patient body weights used in the calculation of medication doses
- Unsafe storage of medications, with varying strengths of a medication stored close together.

## Key Messages and Information: Medication Safety Clinical Incidents

In 2021/22, medication incidents accounted for just over one-quarter of all confirmed clinical incidents across the WA health system. While there has been a small increase in the number of medication incidents compared to the previous year, this is not surprising given the mass vaccination program undertaken by the WA public health system in response to COVID-19.

The number of medication incidents reporting the patient outcome as serious harm or death in this period (n=24) was similar to the previous year and remains of concern. More than half of these incidents related to well-established high-risk medications such as antimicrobials, anticoagulants and insulins, and they were most often classified as involving an incorrect dose of medication.

The [High Risk Medication Policy](#) (MP0131/20) sets out the minimum requirements for the safe management of high risk medications in the WA public health system.

[Action 4.15](#) of the Medication Safety Standard also relates to high-risk medications.

Calculation errors in the dose of medications are easily made due to the number of variables involved, complicated by the ever-increasing number of strengths and formulations of medications that are available. Many medications require doses that are dependent on the patient's weight, body surface area and/or their kidney or liver function, and in such cases it is necessary to ensure that all the relevant information about the patient is collected, accurately documented and available to clinicians when needed to enable accurate dose calculation.

Where systems are used to assist with the calculation of doses it is vital that staff are adequately trained to use those systems, but also understand where any shortcomings may lie.

Similarly, where new medical devices such as 'smart' infusion pumps are implemented, the introduction of this new technology may bring both benefits and risks. Staff must be sufficiently trained to use these devices to enable them to administer medications correctly.

A 'smart' infusion pump is a computerised device to deliver medication that contains a medication library. Smart pumps are intended to help reduce dose-related medication errors.

Issues related to clinical incidents involving dosing errors, including the role that infusion pumps may play, are explored further in the PSSU's focus report *Medication dosing errors - Overdosing; Underdosing; Role of infusion pumps* released in June 2022.<sup>34</sup>

<sup>34</sup> The PSSU's focus reports are available to staff within the WA public health system



# Comprehensive Care Clinical Incidents

The Comprehensive Care Standard in the second edition of the NSQHS Standards intends to ensure that:

- Patients receive coordinated delivery of the total health care required or requested by the patient that is aligned with the patient's expressed goals of care and health care needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.
- Risks of harm for patients during health care are prevented and managed, with clinicians identifying patients at risk of specific harm during health care by applying relevant and robust screening and assessment processes.<sup>35</sup>

Essential to the delivery of comprehensive care to patients is the need for health care providers to develop and implement systems that support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment; provide care to patients in the setting that best meets their clinical needs; ensure timely referral of patients with specialist healthcare needs to relevant services; and at all times, identify the clinician with overall accountability for a patient's care.

Comprehensive care plans should be developed in partnership with patients, carers and families, and with input from all the clinicians involved in a patient's care. Standardised templates can assist clinicians in the goal-setting and comprehensive care planning process, particularly when patients have complex needs.<sup>36</sup>

To implement the Comprehensive Care Standard effectively, health care providers need to partner with patients in their own care and safely manage transitions of care (both within and between hospitals and other health care facilities).

There is a strong link between the delivery of comprehensive care and the Partnering with Consumers and Communicating for Safety Standards of the 2nd edition of the NSQHS Standards.

The Comprehensive Care Standard identifies six specific areas where targeted, best-practice strategies can be implemented to minimise the risk of harm to patients. These areas are:

- Pressure injuries
- Falls
- Poor nutrition and malnutrition
- Cognitive impairment
- Unpredictable behaviours
- Restrictive practices.



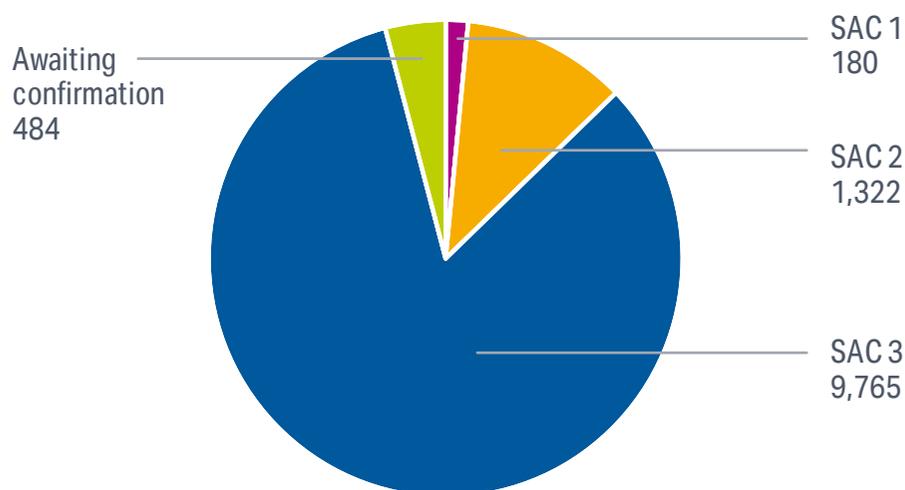
<sup>35</sup> [NSQHS Standards \(2nd ed – version 2\) Comprehensive Care Standard](#)

<sup>36</sup> [NSQHS Standards \(2nd ed – version 2\) Comprehensive Care Standard – Action 5.04](#)

During 2021/22, there were 11,751 clinical incidents related to comprehensive care notified with 11,267 of these incidents confirmed at the time of this report. This represents a very small increase in the number of incidents related to comprehensive care compared to 2020/21.

Incidents related to comprehensive care accounted for 35.0% of all confirmed clinical incidents in this period. Most clinical incidents related to comprehensive care were categorised as SAC 3 incidents (83.1%), with 11.3% confirmed as SAC 2, and 1.5% confirmed as SAC 1 (see Figure 21).

Figure 21: Comprehensive Care Clinical Incidents by SAC Rating for 2021/22



Consistent with previous years, falls continue to be the most frequently reported sub-category of clinical incidents related to comprehensive care, accounting for more than half of these incidents. The next most frequent sub-categories relate to unpredictable behaviours and pressure injuries (see Table 5).

An increased number of confirmed incidents related to restrictive practices was observed in 2021/22 compared to previous years, due mainly to an increase in incidents confirmed as SAC 2.

Table 5: Confirmed Comprehensive Care Clinical Incidents by SAC Rating and Sub-category for 2021/22

Comprehensive Care Sub-categories	SAC 1	SAC 2	SAC 3	Total
Falls	108	215	5,687	<b>6,010</b>
Unpredictable behaviours	70	893	1,663	<b>2,626</b>
Pressure Injuries	2	70	2,310	<b>2,382</b>
Restrictive practices	–	144	80	<b>224</b>
Poor nutrition and malnutrition	–	–	25	<b>25</b>
<b>Total</b>	<b>180</b>	<b>1,322</b>	<b>9,765</b>	<b>11,267</b>

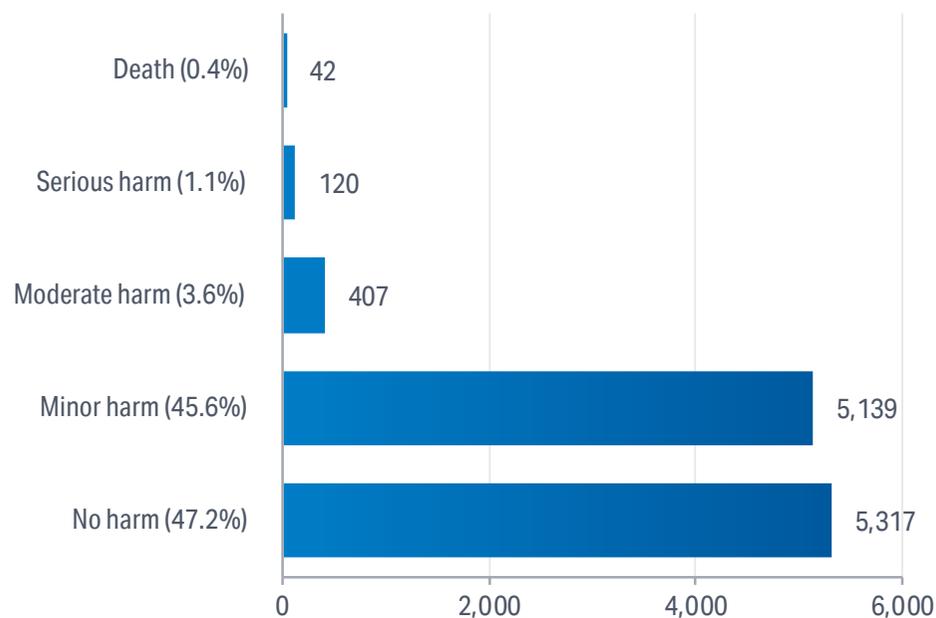
In 2021/22, the number of confirmed falls incidents increased, including an increase of 24% in the number of SAC 1 falls (up from 87 in 2020/21).

The number of confirmed incidents related to unpredictable behaviours decreased by about 6% in 2021/22, with lower numbers of incidents reported across all SAC ratings.

In 2021/22, more than 90% of confirmed clinical incidents related to comprehensive care reported a patient outcome of no harm or minor harm, while 162 incidents reported the patient outcome as serious harm or death (see Figure 22 overleaf).

Falls accounted for most of the confirmed incidents describing a patient outcome of serious harm or death (n=100), followed by unpredictable behaviours (n=58) and pressure injuries (n=4). For a full breakdown of confirmed incidents by comprehensive care sub-category and patient outcome see Supplement [Table 20](#).

Figure 22: Confirmed Comprehensive Care Clinical Incidents by Patient Outcome for 2021/22



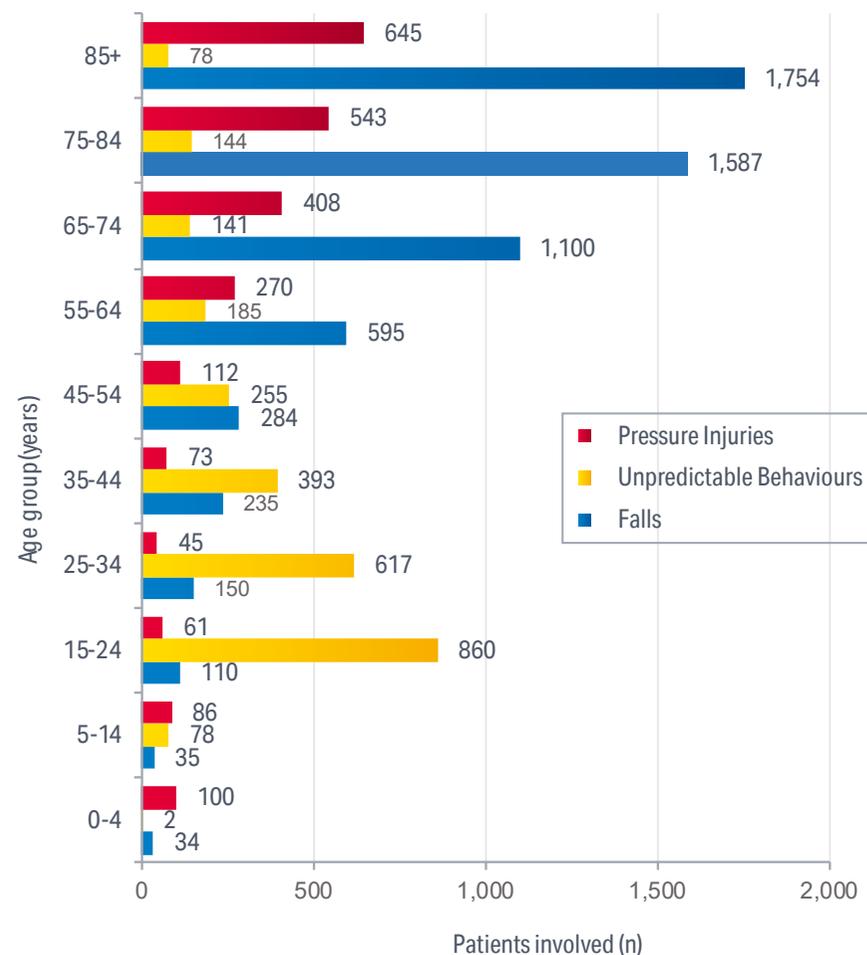
**Note:** Patient outcome missing data n=242; 2.1%

Figure 23 shows pressure injuries were the most common sub-category of incident related to comprehensive care in patients aged 0-14 years during 2021/22. Unpredictable behaviours were the most frequently reported sub-category in patients aged 15-44 years, while falls were the most common sub-category for patients aged 45 years and above.

It was observed that there were more male patients involved in comprehensive care clinical incidents (53.7%) compared to female patients (46.3%). However, as noted in the previous year, within the 15-24 years age group more than two-thirds of patients involved were female and the incidents these patients were involved in fell mostly in the sub-categories related to unpredictable behaviours and restrictive practices. Detailed demographic data can be found in Supplement Tables [21-23](#).

Aboriginal and Torres Strait Islander persons accounted for 9.4% of persons involved in confirmed comprehensive care clinical incidents and were most frequently involved in incidents related to unpredictable behaviours, representing 17.6% of patients involved.

Figure 23: Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Age Group and Sub-category for 2021/22



**Note:** Patient age unknown/missing data n=161; 1.4%. Due to low frequencies, data is not presented for the sub-categories related to restrictive practices and poor nutrition and malnutrition.

## Falls Clinical Incidents

While falls can occur at any age, the risk of falling and the harm that results from falls varies from patient-to-patient due to a range of factors such as balance, muscle strength, bone density, and the medicines the patient is taking.<sup>37</sup>

The actions in the Comprehensive Care Standard to prevent falls and harm from falls are:

- Health service organisations have systems in place that are consistent with best-practice guidelines for falls prevention, minimising harm from falls and post-fall management
- Health service organisations ensure equipment, devices and tools are available to promote safe mobility and manage the risk of falls
- Clinicians provide information about reducing falls risks and falls prevention strategies to patients at risk of falls and their carers and families.

Consistent with previous years, nearly two-thirds of the 6,010 confirmed falls clinical incidents in 2021/22 were categorised as suspected slips, trips or falls as they were unwitnessed (n=3,973; 66.1%). The remainder were categorised as witnessed slips, trips or falls.

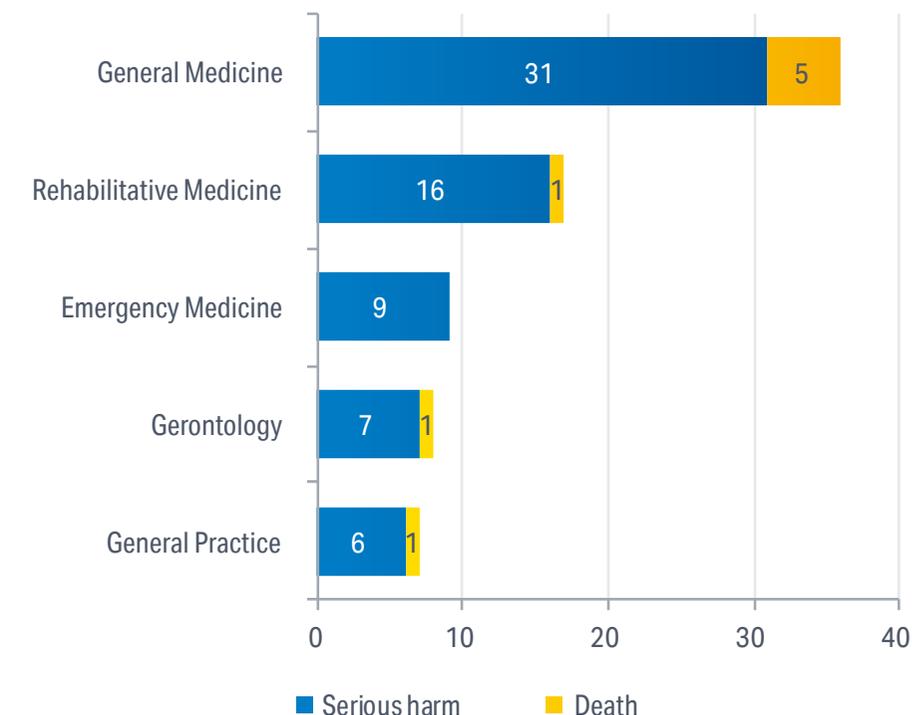
Most confirmed falls clinical incidents reported the patient outcome as no harm (n=3,313; 55.1%) or minor harm (n=2,291; 38.1%). There were 86 confirmed falls incidents that reported the patient outcome as serious harm and 14 incidents that reported an outcome of death.

Like 2020/21, the General Medicine specialty reported the highest frequency of falls incidents (n=1,868; 31.1%), followed by Rehabilitative Medicine (n=656; 10.9%) and Gerontology (n=630; 10.5%).

It is critical that health services have adequate appropriate equipment and strategies to promote safe patient mobility and manage falls risk.

These specialities, along with Emergency Medicine and General Practice most frequently reported falls incidents with patient outcomes of serious harm or death (see Figure 24).

Figure 24: Confirmed Falls Clinical Incidents Reporting Patient Outcomes of Serious Harm or Death by Most Frequent Treating Specialties for 2021/22



**Note:** There were six other treating specialties that each reported one falls incident with a patient outcome of death. These were General Surgery, Haematology, Infectious Disease, Oncology, Orthopaedics and Respiratory Medicine. The model of care in many WACHS centres is via Visiting Medical Practitioners who are General Practitioners.

37 [NSQHS Standards \(2nd ed – version 2\) Comprehensive Care Standard – Minimising patient harm](#)

Review of the characteristics of confirmed falls clinical incidents in 2021/22 found:

- The most common activity of the patient at the time of the fall was walking, followed by attempting to sit or stand, or toileting/attempting to toilet. Falls incidents associated with walking and toileting reported the most incidents with patient outcomes of serious harm or death.
- The most common places where falls incidents occurred were at the bedside, in a ward setting, and in a bathroom. These places also accounted for most falls incidents with patient outcomes of serious harm or death.
- Falls were most often noted to be from a low height (less than 0.5 metres) followed by falls from a standing position however, not surprisingly, falls from a standing position were associated with the most falls incidents with outcomes of serious harm or death.
- Most patients involved in falls incidents had a previous falls history that included at least one fall in the last six months, falls or near misses during their current admission, or had been admitted as a result of a fall; however, more than a quarter of patients who fell had no prior falls history.
- Five percent of falls incidents occurred in circumstances where a current falls risk assessment was not in place.

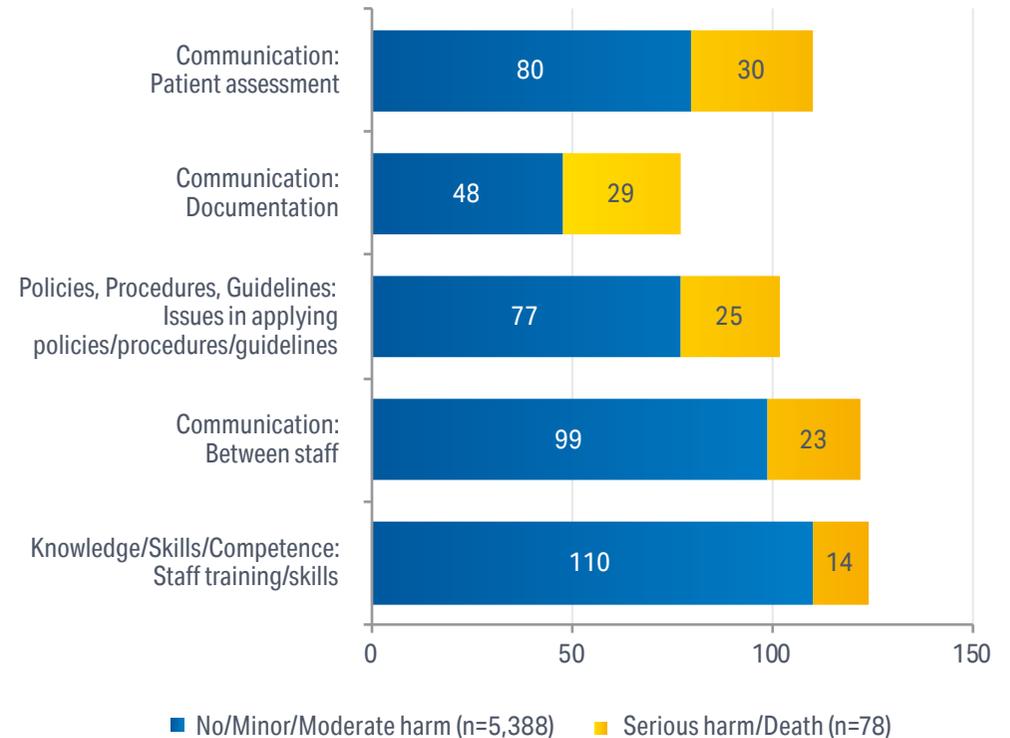
For more detailed information about the characteristics of falls incidents see Supplement Tables [24-27](#).

The investigation of 5,466 falls clinical incidents had been completed at the time of this report, and the most frequently identified issues in these incidents related to patient factors (n=4,186) and communication (n=1,000).

Seventy-eight of the completed investigations related to incidents that reported the patient outcome as serious harm or death. When the healthcare-related contributory factors in these incidents were reviewed more closely it was found that the most common concerns involved assessment of the patient, documentation and issues in applying policies, procedures and guidelines. Figure 25 shows the most common contributory factors in falls incidents with outcomes of serious harm or death compared to their frequency in less severe falls.

While issues regarding communication between staff and the patient, family and/or carer were found to be contributory in a large number of falls incidents associated with patient outcomes of no, minor or moderate harm (n=760), they were less frequently associated with outcomes of serious harm or death (n=8).

Figure 25: Most Frequent Healthcare-Related Contributory Factors for Closed Falls Clinical Incidents Reporting Patient Outcomes of Serious Harm or Death for 2021/22



**Note:** A clinical incident investigation may identify multiple contributory factors.

Review of the healthcare-related contributory factors in falls incidents that reported patient outcomes of 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
- Inadequate documentation of patient assessments and/or falls interventions
- Re-assessment of the patient not actioned in response to a change in their condition
- Insufficient handover of the patient's falls risk and/or interventions between hospitals/services, between the emergency department and the ward, and between staff
- Inadequate escalation of care after an inpatient fall
- Policies for assessment, documentation, handover and post-fall management of the patient not adhered to or incorrectly applied
- Lack of availability of falls prevention equipment/resources
- Lack of clarity regarding the safe levels of standby support from staff
- Babies falling due to lack of awareness from mother of the risk.

For details of the patient risk factors for falls most frequently identified during the investigation of falls incidents during 2021/22 see Supplement [Table 28](#).



## Unpredictable Behaviours Clinical Incidents

For the Comprehensive Care Standard, unpredictable patient behaviours include self-harm, suicide, aggression, and violence. People in health care settings may be more likely to exhibit unpredictable behaviours that may lead to harm.

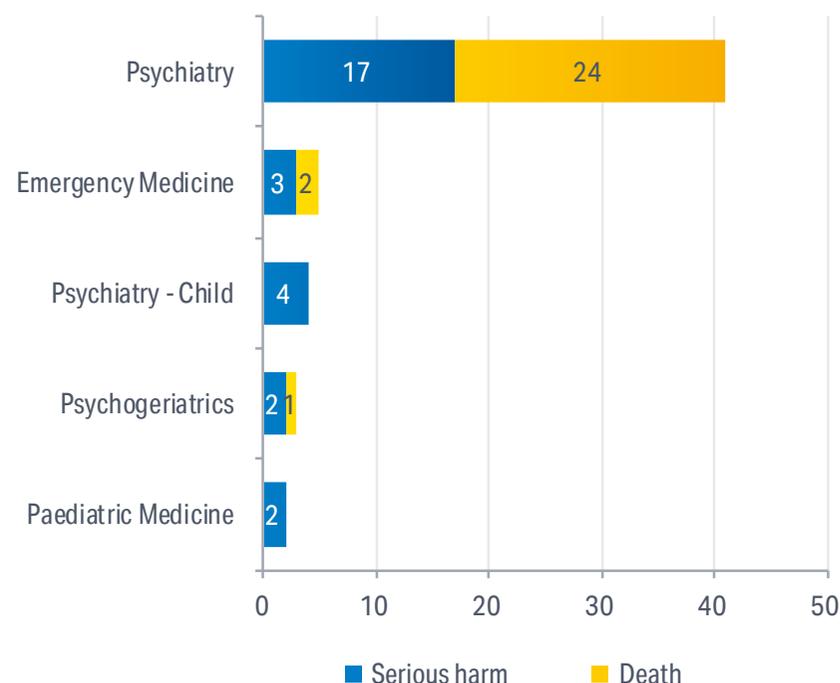
Health care providers need systems to identify situations where there is higher risk of harm from unpredictable behaviours, and strategies to prevent or reduce these risks. They also need systems to manage situations in which harm relating to unpredictable behaviour occurs, and it is important that these systems are designed to minimise further harm to patients and other persons.<sup>38</sup>

Most confirmed unpredictable behaviours clinical incidents in 2021/22 reported the patient outcome as no harm (n=1,528; 58.2%) or minor harm (n=857; 32.6%). There were 30 confirmed unpredictable behaviours incidents that reported the patient outcome as serious harm and 28 incidents that reported an outcome of death.

As expected, Psychiatry continues to be the treating specialty that most frequently reports clinical incidents related to unpredictable patient behaviours (n=1,774), and the greatest number of these incidents with patient outcomes of serious harm or death (n=41; see Figure 26).

Like 2021, General Medicine reported the second most confirmed incidents related to unpredictable behaviours (n=197), however the level of harm to patients was relatively low, with only one incident reporting a patient outcome of serious harm.

Figure 26: Confirmed Unpredictable Behaviours Clinical Incidents Reporting Patient Outcomes of Serious Harm or Death by Most Frequent Treating Specialties for 2021/22



**Note:** Three other specialties reported one incident with a patient outcome of serious harm (General Medicine and Orthopaedics) or death (Plastic Surgery)

In 2021/22, the classification of incidents related to unpredictable behaviours was similar to that seen during the previous year, and were most often reported as aggressive physical behaviour by a patient towards an object, structure or staff member (n=831) or self-harm attempts or gestures (n=509; see Supplement [Table 29](#)).

Unpredictable behaviours clinical incidents describing a patient outcome of serious harm most often related to suicide or self-harm attempts or gestures (n=22) and all incidents reporting the patient outcome as death were classified as completed suicides (n=28).

38 [NSQHS Standards \(2nd ed – version 2\) Comprehensive Care Standard – Minimising patient harm](#)

The investigation of 2,229 unpredictable behaviours clinical incidents had been completed at the time of this report, and the most frequently identified issues in these incidents related to patient factors (n=1,875) and the work environment or staff scheduling (n=362).

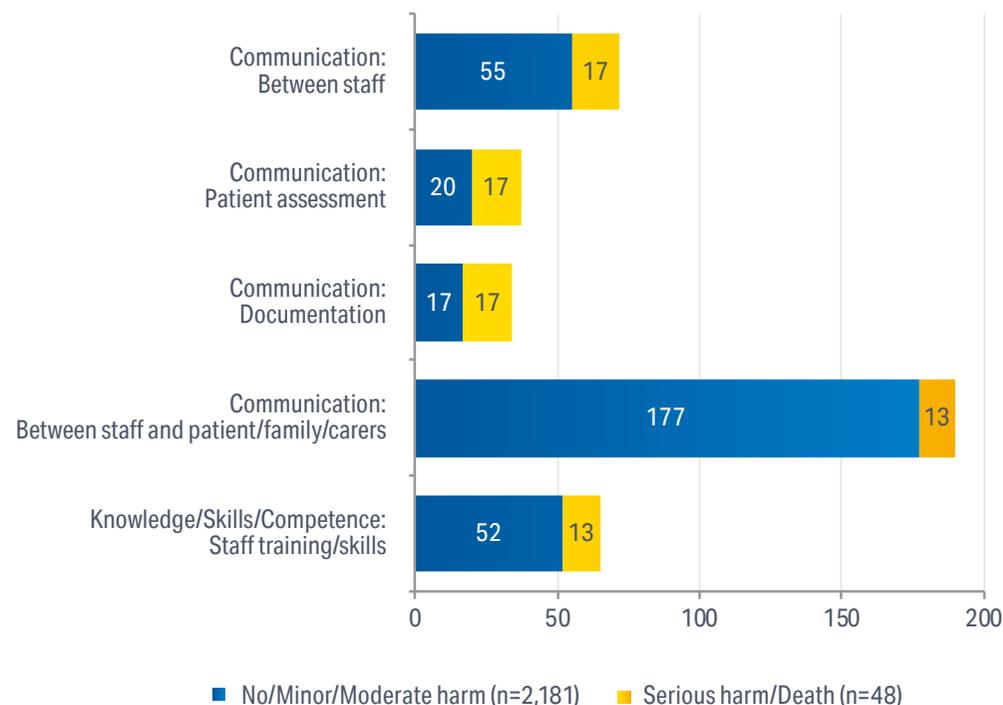
Forty-eight of the completed investigations related to incidents that reported the patient outcome as serious harm or death. Figure 27 shows the most common contributory factors in these incidents compared to their frequency in unpredictable behaviours incidents with less severe outcomes.

This demonstrates that issues with documentation, patient assessment or communication between staff are more likely to be associated with unpredictable behaviours incidents with patient outcomes of serious harm or death.

Issues regarding communication between staff and the patient, family and/or carer were found to be contributory in a large number of unpredictable behaviours incidents, however most of these were seen in incidents with patient outcomes of no, minor or moderate harm (n=177).

Similarly, issues with the suitability of the environment were identified in 239 investigations into unpredictable behaviours incidents in 2021/22, however only five of these events reported a patient outcome of serious harm or death.

Figure 27: Most Frequent Healthcare-Related Contributory Factors for Closed Unpredictable Behaviours Clinical Incidents Reporting Patient Outcomes of Serious Harm or Death for 2021/22



**Note:** A clinical incident investigation may identify multiple contributory factors.

Review of the healthcare-related contributory factors in unpredictable behaviours incidents that reported patient outcomes of serious harm or death identified several themes, including:

- Issues with assessment of the patient (for example mental state examination, risk assessment) including lack of assessment, or delayed or incomplete assessment
- Problems with escalation of care for patients whose mental state was deteriorating including a lack of clearly documented escalation pathways
- Incomplete handover between clinicians or teams providing care to the patient, including case managers, community mental health teams, multi-disciplinary teams, emergency departments, private clinicians, non-government organisations, police and security staff
- Ineffective discharge planning leading to failures to follow-up the patient in a timely manner
- Lack of involvement of family members and/or carers in developing care and safety management plans for the patient
- Local policies, procedures and guidelines not aligned to standards of best practice for mental health care, including the management of acute agitation
- Extended waiting times in Emergency Departments along with staff shortages
- Incomplete searches of patients and their belongings for potentially harmful objects
- Staff not aware of strategies to manage sexual risk, including protecting vulnerable patients from unwanted sexual behaviour by other patients.

In June 2022, the PSSU released a Check up report about clinical incidents related to predicting, preventing and managing unpredictable behaviours in patients.

## Pressure Injury Clinical Incidents

Pressure injuries are considered largely avoidable, and evidence-based strategies to prevent pressure injuries exist and should be used when screening identifies that a patient is at risk. Pressure injuries can occur in patients of any age, where risk factors such as immobility, lack of sensory perception, poor nutrition or hydration, poor skin integrity and reduced blood flow exist.

In 2021/22, 64.6% of confirmed pressure injury clinical incidents (n=1,539) were categorised as having not been present at the time of the patient's admission to a healthcare facility. A further 341 incidents (14.3%) related to existing pressure injuries that deteriorated following admission, and in 502 cases it was unknown whether the pressure injury was present at the time of admission or not.

Nearly seventy percent of confirmed pressure injury clinical incidents were classified as relating to preventative or therapeutic interventions being provided but not effective (n=1,660; 69.7%), and a further 18.4% (n=438) of pressure injury incidents were classified as preventative or therapeutic interventions not being performed (see Supplement [Table 30](#)). For pressure injuries not present at the time of admission, 77.8% were classified as relating to preventative or therapeutic interventions being provided but not effective (n=1,197).

More than three-quarters of confirmed pressure injury clinical incidents reported the patient outcome as minor harm (n=1,849; 77.6%). A further 386 incidents reported the patient outcome as no harm, and four pressure injury incidents described the patient outcome as serious harm.

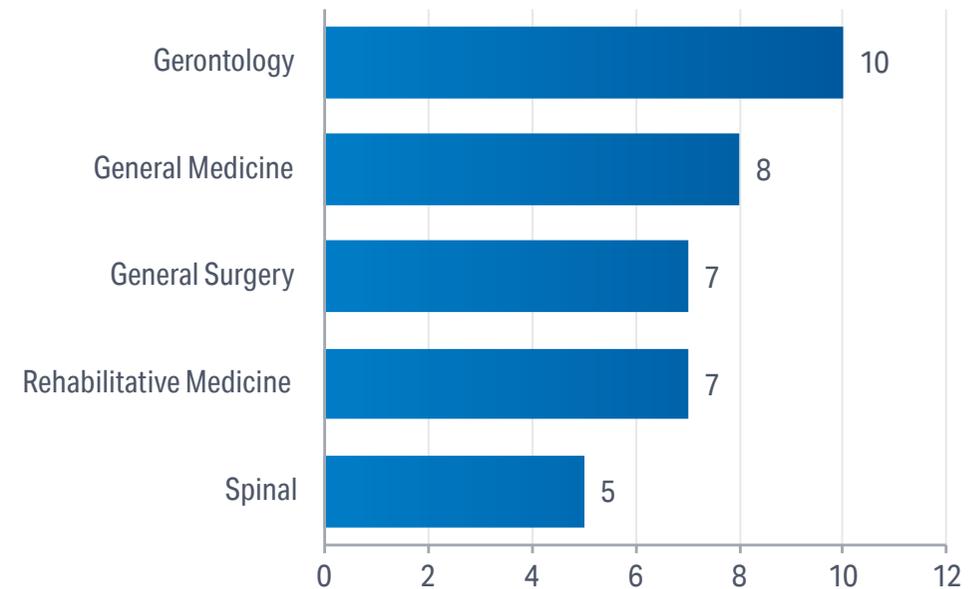
In this report more focus is placed on incidents related to pressure injuries that were not present at the time of admission as there are more opportunities for health care services to prevent these incidents occurring.

## Pressure Injuries Not Present on Admission

There was no great difference observed in the harm related to incidents for pressure injuries that were not present at the time of admission with 1,220 (79.3%) reporting a patient outcome of minor harm, 221 (14.4%) reporting no harm, and 63 incidents reporting the outcome as moderate or serious harm.

In 2021/22, the treating specialties that most frequently reported pressure injuries that developed after admission were General Medicine (n=325) and General Surgery (n=136). Figure 28 shows the treating specialties that most often reported these incidents associated with patient outcomes of moderate or serious harm.

Figure 28: Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission with Patient Outcomes of Moderate or Serious Harm by Most Frequent Treating Specialties for 2021/22



Pressure injuries are classified via a staging system, with Stage 1 being the least severe. For more information about the staging of pressure injuries refer to the National Pressure Injury Advisory Panel's [Pressure Injury Stages](#)

Review of the characteristics of confirmed clinical incidents related to pressure injuries that were not present on admission in 2021/22 found:

- Pressure injury incidents most frequently related to Stage 2 pressure injuries (n=746; 48.5%) or Stage 1 pressure injuries (n=500; 32.5%).
- Stage 3, Stage 4 and suspected deep tissue injuries were rarely classified as SAC 1 clinical incidents despite the significant impact these can have on patients.
- In most cases the patient had developed one pressure injury at the point the clinical incident was notified (n=971; 63.1%), however 23.6% (n=363) of patients had developed multiple pressure injuries, including five who had developed six or more.
- The most frequent locations that pressure injuries developed in hospital were the sacrum (n=399; 25.9%), and the heels, feet or ankles (n=299; 19.4%). Pressure injuries to the heels, feet or ankles were most often associated with a patient outcome of moderate or serious harm (n=22).

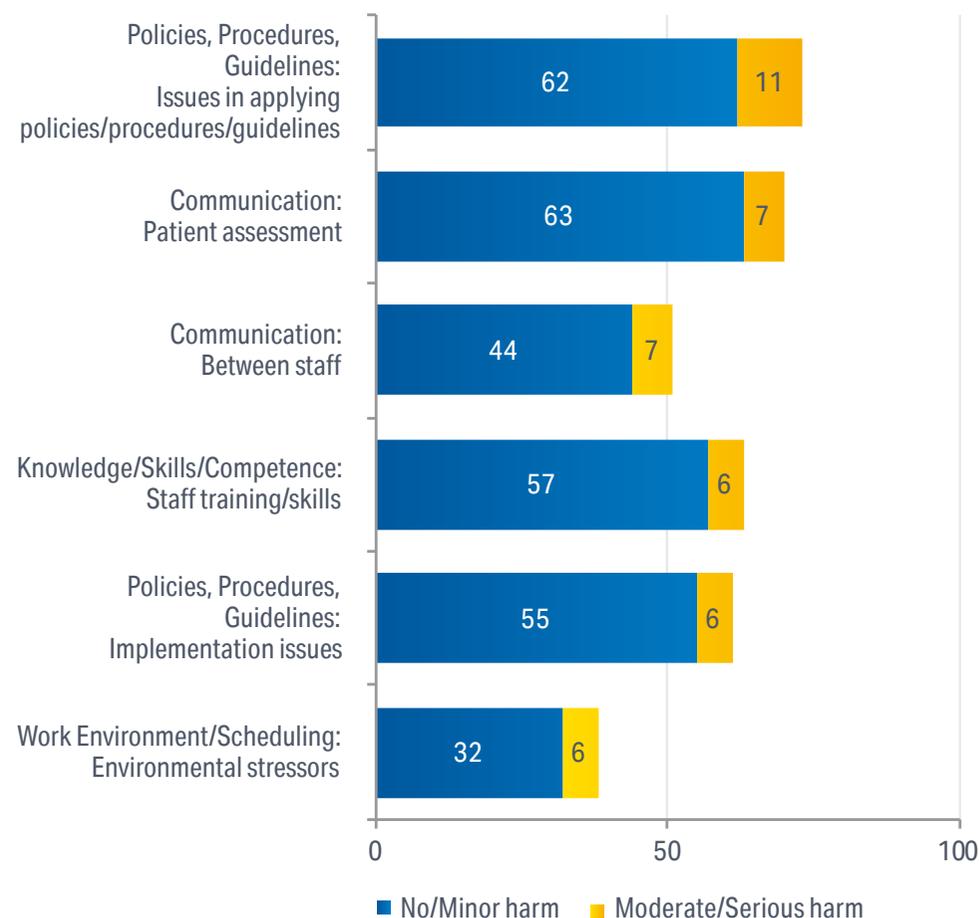
For more detailed information about the characteristics of these incidents see Supplement Tables [31-33](#).

The investigation of 1,405 clinical incidents related to pressure injuries not present on admission had been completed at the time of this report, and the most frequently identified issues in these incidents related to patient factors (n=949; 67.5%), communication (n=173; 12.3%) and equipment (n= 130; 9.3%).

Fifty-four of the completed investigations related to incidents that reported the patient outcome as moderate or serious harm. When the healthcare-related contributory factors in these incidents were reviewed more closely it was found that the most common concerns involved issues in applying policies, procedures and guidelines (n=11), assessment of the patient (n=7) and communication between staff (n=7).

Figure 29 shows the most common contributory factors in these incidents with outcomes of moderate or serious harm compared to their frequency in incidents reporting no harm or minor harm to the patient.

Figure 29: Most Frequent Healthcare-Related Contributory Factors for Closed Clinical Incidents Related to Pressure Injuries Not Present on Admission Reporting Patient Outcomes of Moderate or Serious Harm for 2021/22



**Note:** A clinical incident investigation may identify multiple contributory factors.

Review of the healthcare-related contributory factors in incidents related to Stage 3 or worse pressure injuries that reported patient outcomes of moderate or serious harm identified several themes, including:

- Delays in performing skin assessments or reassessment not done as often as needed
- Incomplete skin assessments
- Deficiencies with documentation of skin assessments and pressure injury risk management strategies
- Delayed implementation of pressure injury risk management strategies
- Pressure injuries that developed under a brace or cast
- Pressure injuries that developed in patients with reduced sensation, many of whom were diabetic
- Pressure injuries in bariatric patients where appropriate equipment was not available
- Pressure injuries that developed in patients who were medically unwell, including being cared for in an ICU
- Patients or their family declining pressure area care/devices, including in cases where the patient was receiving palliative care
- Staff shortages that limited pressure area care.

Review of risk factors for pressure injuries that developed in hospital associated with incidents where patient factors were found to have contributed (n=949) showed:

- Nearly two-thirds of patients were identified as being bedfast or chairfast (n=618; 65.1%)
- Nearly two-thirds of patients were identified as having completely or very limited mobility (n=616; 64.9%)
- More than half of patients were identified as having very poor or probably inadequate nutrition (n=494; 52.1%)
- More than one-third of patients were identified as having completely or very limited sensory perception (n=328; 34.6%)
- Similar patterns were seen for these risk factors in pressure injury clinical incidents that reported patient outcomes of moderate or serious harm.



## Restrictive Practices Clinical Incidents

In 2021/22, most confirmed restrictive practices clinical incidents reported the patient outcome as minor harm (n=133; 59.4%) or no harm (n=75; 33.5%). Fifteen incidents reported the patient outcome as moderate harm.

The majority of confirmed restrictive practices incidents were classified as harm to the patient from restraint (n=180; 80.4%) followed by an incomplete or inadequate restraint procedure (n=40; 17.9%) and incorrect restraint procedure (n=4; 1.8%).

Given that nearly two-thirds of patients involved in confirmed restrictive practices clinical incidents in 2021/22 were involuntary, voluntary or referred mental health patients, it is not surprising that Psychiatry was the treating specialty that reported these incidents most often (n=74; 33.0%). The next most frequent specialties reporting restrictive practices incidents were Paediatric Medicine (n=61; 27.2%) and General Medicine (n=48; 21.4%). These three treating specialties also reported all fifteen of the restrictive practices incidents that described the patient outcome as moderate harm.

Investigation of 213 clinical incidents related to patient restraint had been completed at the time of this report. Patient factors were identified as contributory in more than three-quarters of these investigations (n=163; 76.5%) and issues related to the work environment and staff scheduling were found in nearly forty percent (n=85).

The most frequent healthcare-related contributory factor found in restrictive practices clinical incidents was issues around the suitability of the environment in which restraint was applied. This was identified in 77 of the incidents investigated, including four incidents with a patient outcome of moderate harm.

## Poor Nutrition and Malnutrition Clinical Incidents

In 2021/22, most confirmed incidents related to poor nutrition and malnutrition reported the patient outcome as no harm (n=15; 60.0%) or minor harm (n=9; 36.0%).

Most of these incidents related to food or meals from the kitchen (n=18; 72.0%) while seven incidents (28.0%) related to nutritional products from pharmacy.

Missed feeding was the most frequently reported category of incident related to nutrition (n=15; 60.0%), followed by delayed feeding and refusal of food/feeding (n=5; 20.0% each).

The treating specialties that most frequently reported incidents related to nutrition in 2021/22 were General Medicine (n=6; 24.0%) and Neonatology (n=4; 16.0%).

Twenty-four clinical incidents related to nutrition had been investigated at the time of this report, with communication issues (n=10; 41.7%) and patient factors (n=7; 29.2%) most frequently identified as contributory.

The healthcare-related contributory factors most often found to have contributed to clinical incidents related to nutrition were issues with communication between staff (n=7; 29.2%) and concerns related to staff training and skills (n=6; 25.0%).

## Key Messages and Information: Comprehensive Care Clinical Incidents

In 2021/22, comprehensive care continued to be the NSQHS Standard against which the most clinical incidents were reported. The total number of incidents reported across four of the five sub-categories related to comprehensive care is like that seen in previous years, with falls continuing to be the most frequently reported sub-category. An increase in incidents related to restrictive practices was seen in this period (albeit from a low base).

While the total number of clinical incidents related to comprehensive care has changed little in the past three years, there has been a gradual increase in the number of these incidents reporting patient outcomes of serious harm or death, from 131 confirmed incidents in 2019/20<sup>39</sup> to 162 this year. The rise in incidents reporting patient outcomes of serious harm or death is almost entirely associated with patient falls, showing the ongoing risk to patients in the WA health system.

Delivering comprehensive care requires an adequately resourced health system that supports its staff to provide the best care possible for every patient every time. This includes ensuring appropriate staffing levels are in place to enable care to be delivered consistently.

There is no doubt that the COVID-19 pandemic has had impacts on staffing throughout the WA health system and this may have affected the ability of staff to always provide optimal care. The fact that there has not been a marked increase in the number of incidents reported regarding comprehensive care this year is testament to the hard work and dedication of staff throughout the WA health system.

An important aspect of delivering comprehensive care is the care provided at the end of patients' lives. Actions in the Comprehensive Care Standard related to end-of-life care<sup>40</sup> include health care providers:

- having processes to identify patients who are at the end of life that are consistent with the [National Consensus Statement: Essential elements for safe and high-quality end-of-life care](#)
- providing end-of-life care having processes to provide clinicians with access to specialist palliative care advice
- having processes to ensure that current advance care plans can be received from patients, and are documented in the patient's healthcare record
- providing access to supervision and support for the workforce providing end-of-life care
- routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care.

In May 2021, the ACSQHC released a user guide for [Delivering and Supporting Comprehensive End-of-Life Care](#) which provides practical strategies that health care organisations and clinicians can use to meet the essential elements of safe and high-quality end-of-life care and the requirements of this NSQHS Standard.

<sup>39</sup> [Your safety in our hands in hospital \(2020\)](#)

<sup>40</sup> [NSQHS Standards \(2nd ed – version 2\) Comprehensive Care Standard – Delivering comprehensive care](#)

# Communicating for Safety Clinical Incidents

Communication is an important safety and quality issue in health care and the Communicating for Safety Standard of the second edition of the NSQHS Standards recognises the importance of effective communication and its role in supporting continuous, coordinated and safe patient care.

Recognising that communication is an integral part of patient care, the intention of this Standard is to ensure that systems and processes are in place at the key times when effective communication and documentation are critical to patient safety.

The criteria set out in the Communicating for Safety Standard include:

- Clinical governance and quality improvement to support effective communication
- Correct identification and procedure matching
- Communication at clinical handover
- Communication of critical information
- Documentation of information.<sup>41</sup>

Actions within the area of clinical governance and quality improvement to support effective communication include the strategies health care organisations should employ to ensure systems are in place for effective communication.

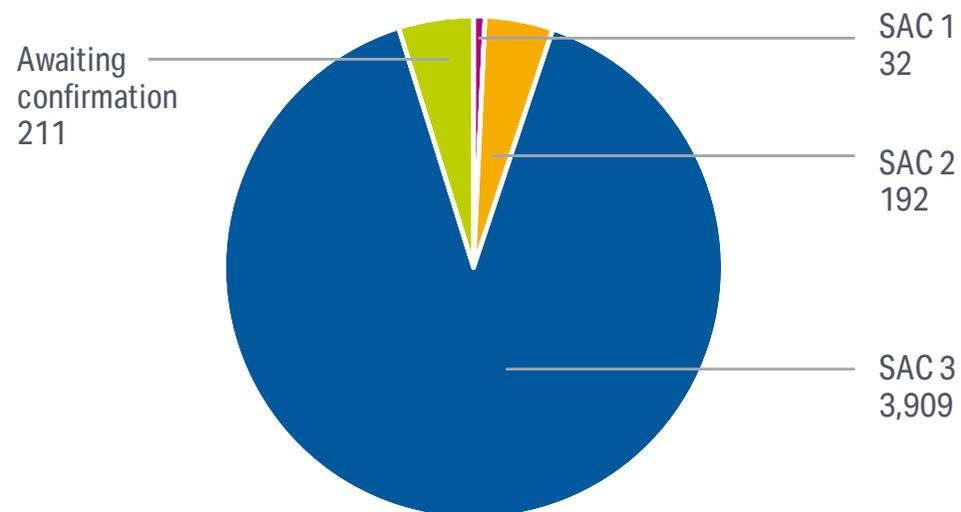
These include managing risks associated with clinical communication, identifying staff training needs, monitoring the effectiveness of clinical communication and processes and implementing improvement strategies when needed, actively involving patients in their own care and sharing decision-making, and ensuring effective communication at transitions of care and when critical information about a patient emerges or changes.

A proactive approach to effective communication requires organisations to identify the situations where safe communication is required; to review and map current communication processes considering patient flow and information sharing needs to identify gaps and areas for improvement; and support teamwork and communication.

In 2021/22, there were 4,344 clinical incidents related to communicating for safety notified with 4,133 of these incidents confirmed at the time of this report. This represents a decrease of approximately twelve percent in the number of incidents related to communicating for safety compared to 2020/21.

Incidents related to communicating for safety accounted for 12.8% of all confirmed clinical incidents in this period. Most of these incidents were categorised as SAC 3 incidents (90.0%), with 4.4% confirmed as SAC 2, and 0.7% confirmed as SAC 1 (see Figure 30).

Figure 30: Communicating for Safety Clinical Incidents by SAC Rating for 2021/22



41 [NSQHS Standards \(2nd ed – version 2\) Communicating for Safety Standard](#)

The most frequently reported sub-categories of confirmed clinical incidents related to communicating for safety in 2021/22 were documentation of information (n=1,578; 38.2%) and correct patient identification and procedure matching (n=1,203; 29.1%; see Table 6).

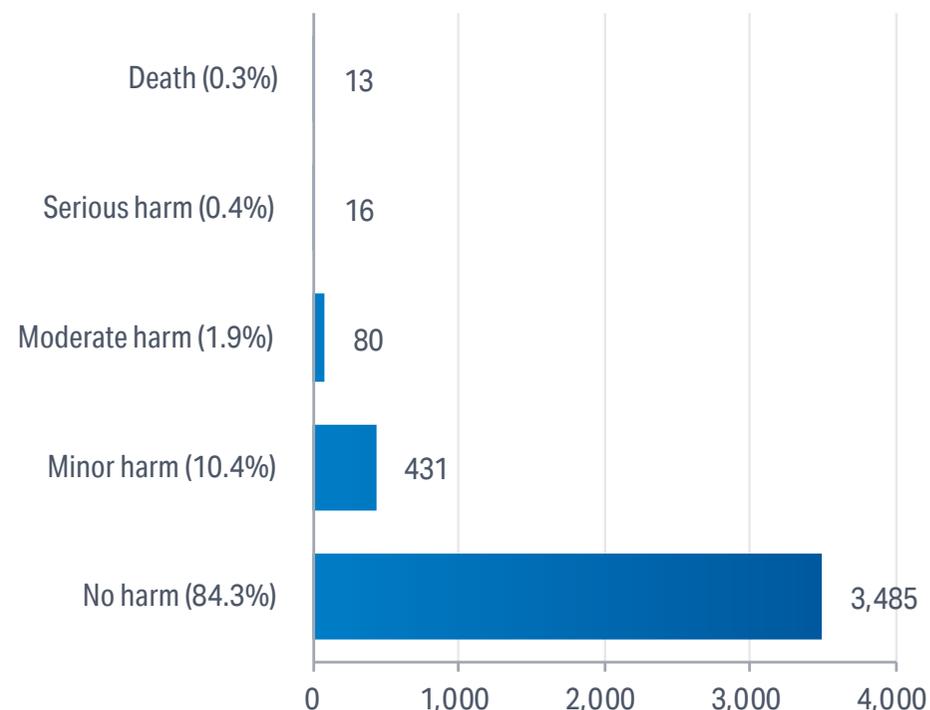
While the frequency of incidents related to most sub-categories was similar to 2020/21, there was a decrease of more than twenty-five percent in the total number of incidents related to correct identification and procedure matching in 2021/22, mainly attributable to a decline in the number of SAC 3 incidents confirmed for this sub-category.

**Table 6: Confirmed Communicating for Safety Clinical Incidents by SAC Rating and Sub-category for 2021/22**

Communicating for Safety Sub-categories	SAC 1	SAC 2	SAC 3	Total
Documentation of information	3	27	1,548	<b>1,578</b>
Correct identification and procedure matching	12	52	1,139	<b>1,203</b>
Communication at clinical handover	9	72	828	<b>909</b>
Communication of critical information	6	23	228	<b>257</b>
Other incidents related to communicating for safety	2	18	166	<b>186</b>
<b>Total</b>	<b>32</b>	<b>192</b>	<b>3,909</b>	<b>4,133</b>

Most confirmed incidents related to communicating for safety in 2021/22 reported the patient outcome as no harm, with 29 incidents describing the outcome for the patient as serious harm or death (see Figure 31).

**Figure 31: Confirmed Communicating for Safety Clinical Incidents by Patient Outcome for 2021/22**



**Note:** Patient outcome missing data n=108; 2.6%

Patient outcomes of serious harm or death were most often associated with the sub-categories related to communication at clinical handover (n=9), communication of critical information (n=8), and correct identification and procedure matching (n=7). For detailed information about the patient outcomes associated with each of the sub-categories related to this NSQHS Standard see Supplement [Table 34](#).

In 2021/22, females accounted for 52.8% of patients involved in confirmed clinical incidents related to communicating for safety. There was a pronounced bias toward female patient involvement (69.0%) in incidents related to the communication of critical information sub-category.

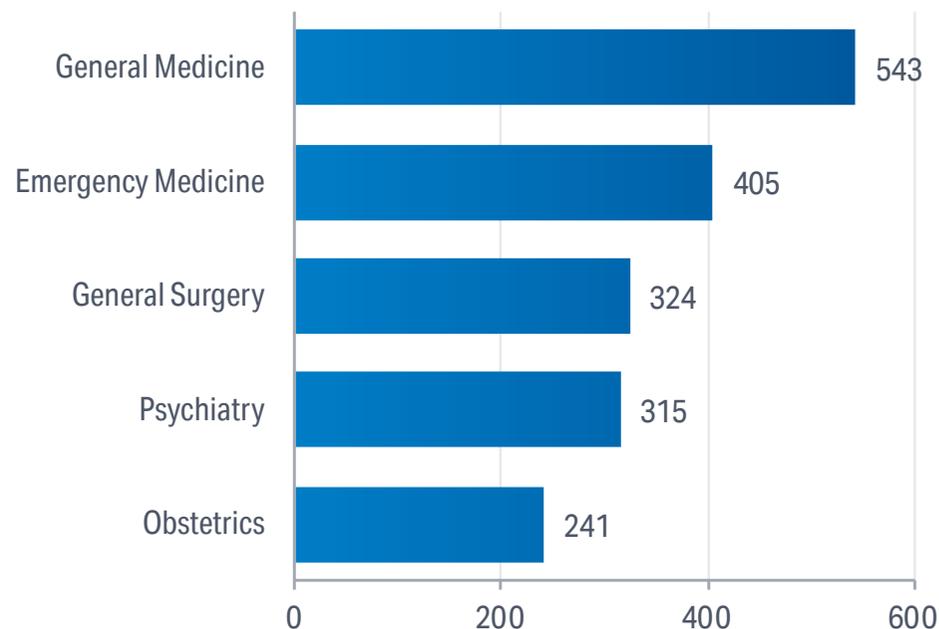
Aboriginal and Torres Strait Islander persons accounted for 12.2% of patients involved in confirmed communicating for safety clinical incidents, which is slightly higher than that seen for incidents in general. Review of patient outcomes showed that five of the 13 incidents reporting the patient outcome as death involved Aboriginal and Torres Strait Islander persons.

Incidents related to communicating for safety also appeared less likely to involve mental health patients, with 8.7% of patients involved in these incidents identified as voluntary, involuntary or referred patients under the *Mental Health Act 2014* compared to 16.6% of patients generally.

Figure 32 shows the treating specialties that most frequently reported incidents related to communicating for safety in 2021/22. General Medicine (n=543; 13.1%) and Emergency Medicine (n=405; 9.8%) reported the highest number of these incidents. However, when patient outcomes were considered, the treating specialties that most often reported communicating for safety incidents with outcomes of serious harm or death were Psychiatry (n=7) and General Medicine (n=3).

Effective communication processes will include transport services (for example, ambulance services) and consider the role that non-clinical staff such as ward, reception and administrative staff have in communicating with patients about tests, referrals and appointments.

Figure 32: Confirmed Communicating for Safety Clinical Incidents by Most Frequent Treating Specialties for 2021/22



**Note:** Treating specialty unknown/missing data n=259; 6.3%

In 2021/22, more than half of all confirmed incidents related to communicating for safety were associated with issues surrounding health care documentation (n=2,386; 57.7%), and a further 22.4% (n=926) were related to administrative process other than documentation.

However, when patient outcomes were reviewed, it was found that administrative process failures were far more likely to lead to patient outcomes of serious harm or death (n=16) than issues with documentation (n=5). Issues related to patient referral and follow-up were associated with eight of the administrative process incidents with outcomes of serious harm or death in this period.

Table 7 shows the most frequent Tier Three incident categories related to communicating for safety in the context of the Tier One category.

**Table 7: Most Frequent Tier Three Confirmed Communicating for Safety Clinical Incident Categories for 2021/22**

Tier Three Communicating for Safety Incident Categories	(n)	(%)
Ambiguous, incorrect or incomplete documentation	1,518	36.7
Documentation referred to incorrect patient	557	13.5
Handover/handoff between health care professionals insufficient, incorrect or incomplete	305	7.4
Documentation temporarily unavailable or delay in accessing	196	4.7
Medication prescribed or administered to incorrect patient	127	3.1

The most frequent contributory factors identified in the investigation of 3,594 incidents related to communicating for safety during 2021/22 are shown in Figure 33. Not surprisingly, issues with documentation and communication between staff were most often found in these incidents.

For completed investigations into communicating for safety incidents reporting the patient outcome as serious harm or death (n=24), the contributory factors most often identified were problems with communication between staff (n=11) and the absence or relevant policies, procedures and/or guidelines (n=8).

**Figure 33: Most Frequent Contributory Factors for Closed Communicating for Safety Clinical Incidents for 2021/22**



**Note:** A clinical incident investigation may identify multiple contributory factors.

Review of the contributory factors in incidents related to communicating for safety that reported patient outcomes of serious harm or death 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
- Fragmentation of health care information across multiple records systems and inconsistent use of those systems
- Diagnostic test results and/or follow-up plans not sufficiently documented or actioned
- Manual and hybrid communication processes, in some cases partly dependent on the patient, having potential for failure

- Variability in communication processes and use of systems between teams and individuals
- Roles and responsibilities of staff within communication processes not adequately defined.

## Key Messages and Information: Communicating for Safety Clinical Incidents

The importance of effectively communicating critical information and risks when they emerge or change are vital to ensuring safe patient care, however what constitutes critical information will depend on many factors related to both the patient and the clinical setting in which care is being delivered.

Types of critical information may include allergies and adverse drug reactions, changes to medications, new diagnostic test results (e.g. pathology, radiology and point-of-care tests), information that requires follow-up with another clinician or the patient, and changes to the patient's goals of care.<sup>42</sup>

Importantly, health care organisations need to have processes in place to identify the clinicians who are responsible for a patient's care and can make decisions about care at any given time, particularly when time-critical information emerges or changes.

However, communication in health care has never been limited to the flow of information between staff, and patient-centred care is a fundamental principle of the NSQHS Standards. Health care organisations also need to have communication processes in place for patients, carers and families to directly communicate critical information and risks about care to clinicians, and support patients and carers to understand these processes and use them appropriately.<sup>43</sup>

Aishwarya's CARE Call is the three-step process for patients, carers and family members in WA's public hospitals to use if they are worried, they, or a person they care for, are getting sicker in hospital. The third step includes a telephone number that can be called to speak to a dedicated senior staff member who will listen to their concerns and action these urgently.<sup>44</sup>

Aishwarya's CARE Call extended the existing escalation pathways available to patients, family members and carers in parts of the WA public health system to additional hospitals and clinical settings, such as emergency departments.



42 [NSQHS Standards \(2nd ed – version 2\) Communicating for Safety Standard – Action 6.09](#)

43 [NSQHS Standards \(2nd ed – version 2\) Communicating for Safety Standard – Action 6.10](#)

44 [Aishwarya's CARE Call](#)

# Blood Management Clinical Incidents

Treatment with blood and blood products can be lifesaving, however the administration of these products also carries inherent risks. These risks can be minimised by approaches 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.<sup>45</sup>

The Blood Management Standard has been refined over time to focus on the patient receiving blood and blood products (rather than on the blood and blood products themselves); effectively optimising and conserving a patient's own blood; ensuring the appropriate use of blood and blood products; and good stewardship to improve patient safety and reduce risk associated with the use of allogeneic blood and blood products.<sup>46</sup>

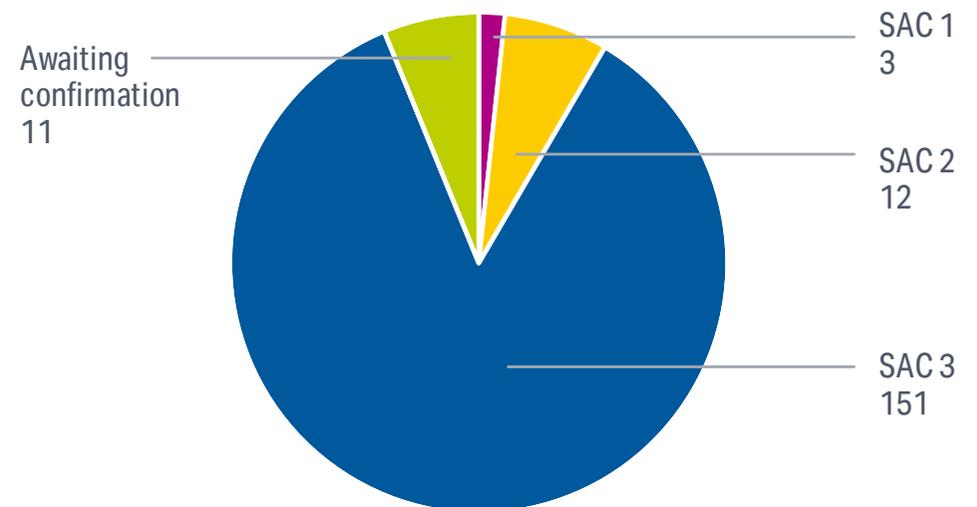
An allogenic transfusion uses blood or blood products sourced from another person. Where the donor and recipient are the same person this is called an autologous transfusion.

The scope of the Blood Management Standard includes fresh blood components (such as red blood cells and platelets), plasma derivatives (such as immunoglobulins) and recombinant products (such as coagulation factors).

In 2021/22, there were 177 blood management clinical incidents notified, with the SAC rating for 166 of these incidents confirmed at the time of this report. The number of blood management clinical incidents notified in this period was similar to previous years.

Blood management clinical incidents represented 0.5% of all confirmed clinical incidents during 2021/22 and were most frequently confirmed as SAC 3 incidents (n=151; 85.3%). Only three blood management incidents were confirmed as SAC 1 incidents (see Figure 34).

Figure 34: Blood Management Clinical Incidents by SAC Rating for 2021/22

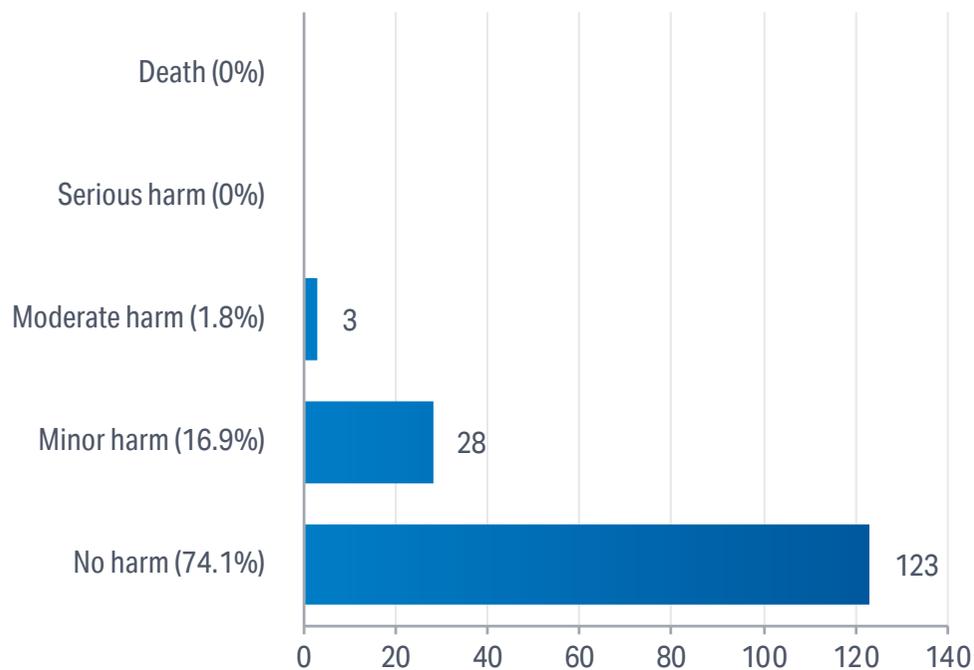


<sup>45</sup> [NSQHS Standards \(2nd ed – version 2\) Blood Management Standard](#)

<sup>46</sup> [Blood Management](#)

Most confirmed blood management clinical incidents reported the patient outcome as no harm (n=123; 74.1%; see Figure 35). No patient outcomes of serious harm or death were reported for blood management incidents in 2021/22.

Figure 35: Confirmed Blood Management Clinical Incidents by Patient Outcome for 2021/22



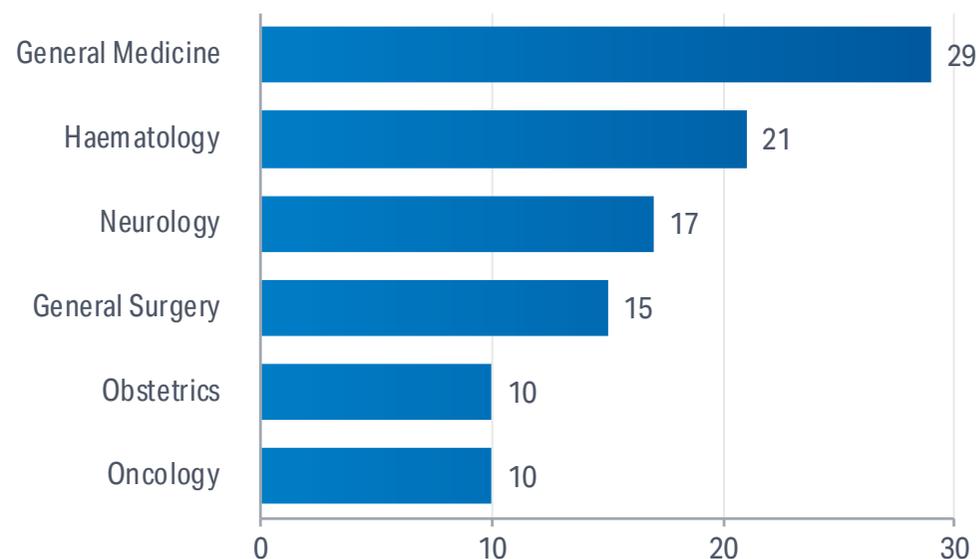
**Note:** Patient outcome missing data n=12; 7.2%

Blood Management is consistently the NSHQs Standard that sees the lowest number of clinical incidents and least harm to patients in the WA public health system.

More female patients (n=93; 58.9%) were involved in blood management clinical incidents in 2021/22 than males (n=65). Aboriginal and Torres Strait Islander persons accounted for 4.6% (n=7) of patients involved in these incidents.

The treating specialties that most frequently reported blood management clinical incidents in this period were consistent with the previous year and were General Medicine (n=29; 17.5%) and Haematology (n=21; 12.7%; see Figure 36). This may reflect the high use of transfusions in these specialties.

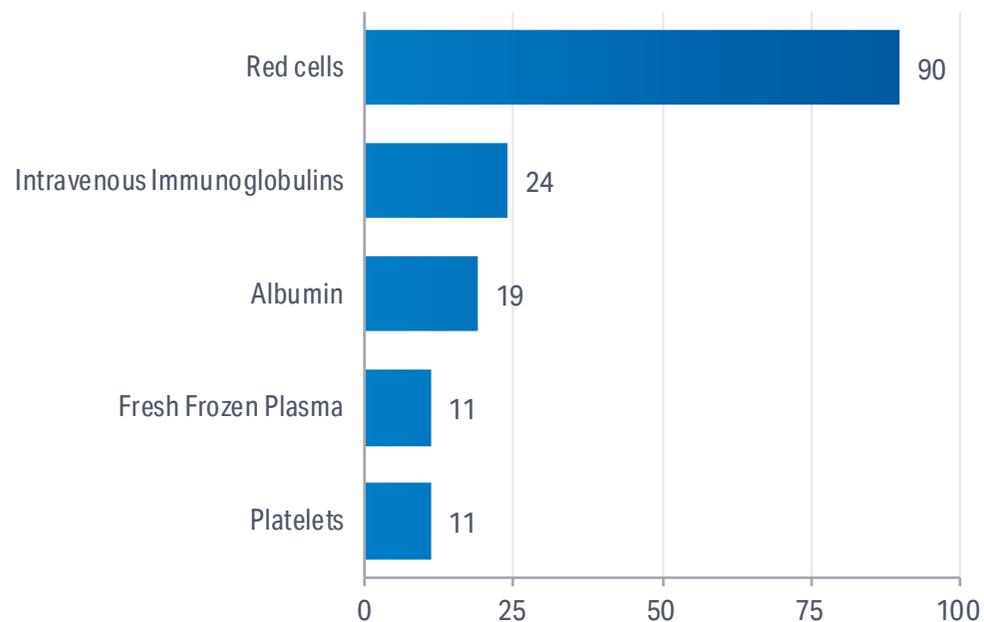
Figure 36: Confirmed Blood Management Clinical Incidents by Most Frequent Treating Specialties 2021/22



**Note:** Treating specialty unknown data n=2; 1.2%

In 2021/22, red cells continued to be the blood product most frequently involved in blood management clinical incidents (n=90; 54.2%; see Figure 37) however this is less than the previous year. The number of incidents involving intravenous immunoglobulins and albumin increased in this period compared to 2020/21.<sup>47</sup>

Figure 37: Most Frequent Product Types for Confirmed Blood Management Clinical Incidents for 2021/22



**Note:** A blood management clinical incident may involve more than one type of blood product

The three most frequently reported categories of blood management clinical incident in 2021/22 were the same as the previous year, although this year the category most often reported was blood products administered to the patient at an incorrect rate or frequency (n=23; 13.9%; see Table 8).

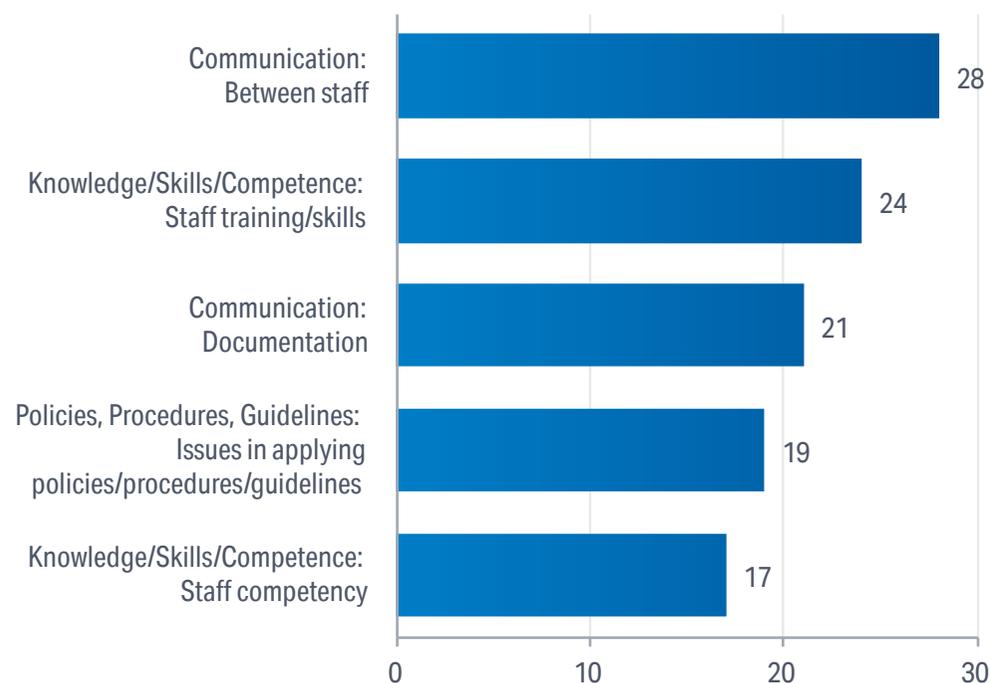
Table 8: Most Frequent Confirmed Blood Management Clinical Incident Categories for 2021/22

Blood Management Incident Categories	(n)	(%)
Incorrect rate/frequency of administration	23	13.9
Not given when indicated/administration delayed	17	10.2
Insufficient/incomplete monitoring of the patient during or after administration	15	9.0
Insufficient/incorrect preparation of product	9	5.4
Product ordered incorrectly	8	4.8

<sup>47</sup> [Your safety in our hands in hospital \(2021\)](#)

There were 139 blood management 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 the factors most often identified as contributory to blood management incidents in 2021/22 (see Figure 38).

**Figure 38: Most Frequent Contributory Factors for Closed Blood Management Clinical Incidents for 2021/22**



**Note:** A clinical incident investigation may identify multiple contributory factors.

Review of the contributory factors in blood management clinical incidents with patient outcomes of moderate or minor harm in 2021/22 identified several themes, including:

- Lack of staff familiarity with processes and procedures (including temporary staff), such as ordering procedures for blood products and premedication requirements for certain treatments
- Miscommunication between staff about blood product administration due to incomplete documentation
- Poor documentation and errors in infusion pump set up leading to transfusions exceeding permitted timeframes
- Incomplete two person checking of product and/or pump settings leading to avoidable wastage, delayed treatment and delays to subsequent procedures
- Workload acuity and staff shortages impacting staff performance
- Gaps in staffing preventing some procedures being done, for example ultrasound assisted PIVC insertion
- Lack of clarity in orders for blood products
- Delayed transfer of blood products from delivery point to patient leading to avoidable wastage
- Blood transfusions ordered for febrile patients that could not be given leading to avoidable wastage
- Wrong blood in tube incidents due to failures to complete three-point bedside identification checking and labelling of blood samples at the bedside.

## Key Messages and Information: Blood Management Clinical Incidents

The number of blood management clinical incidents reported across the WA public health system continued to be very low in 2021/22, with just 31 confirmed incidents reporting any harm occurring to the patient. Given the inherent risks associated with the use of blood and blood products, and the frequency with which they are required by patients, this demonstrates the high level of safety that exists for the systems and processes used in blood management.

The WA Haemovigilance program is an established part of the systems and processes that support blood management in WA and collects and assesses information about unexpected or undesirable effects resulting from the use of blood and blood products.<sup>48</sup>

The WA Haemovigilance program provides an important platform for identifying 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.

Importantly, haemovigilance and clinical incident management processes are complementary. Near miss clinical incidents and those that result in no harm to the patient may not fall within the scope of haemovigilance reporting, however it is important to review these events to identify potential areas where blood management systems can fail, and errors may occur.

In 2021/22, there were two "wrong blood in tube" clinical incidents that had the potential for serious harm to occur if the error had not been detected by the laboratory. In both cases the investigations found failures to complete three-point bedside checking of the patient's identification, and failures to label blood samples at the bedside which may have contributed to these events.

Fortunately, in both cases the laboratory identified discrepancies with the patients' previous blood results and requested new blood samples be taken. Wrong blood in tube clinical incidents are captured through clinical incident management systems to ensure appropriate investigation due to the potential for serious harm.



48 [Haemovigilance](#)



# Recognising and Responding to Acute Deterioration Clinical Incidents

Acute deterioration is defined in the second edition of the NSQHS Standards as physiological, psychological or cognitive changes that may indicate a worsening of the patient's health status, that may occur across hours or days. Serious events such as cardiac arrest and unexpected deaths of patients are often preceded by observable clinical changes, while other serious events such as suicide and aggression are also often preceded by observed or reported changes in a person's behaviour or mood that can indicate a deterioration in their mental state.<sup>49</sup>

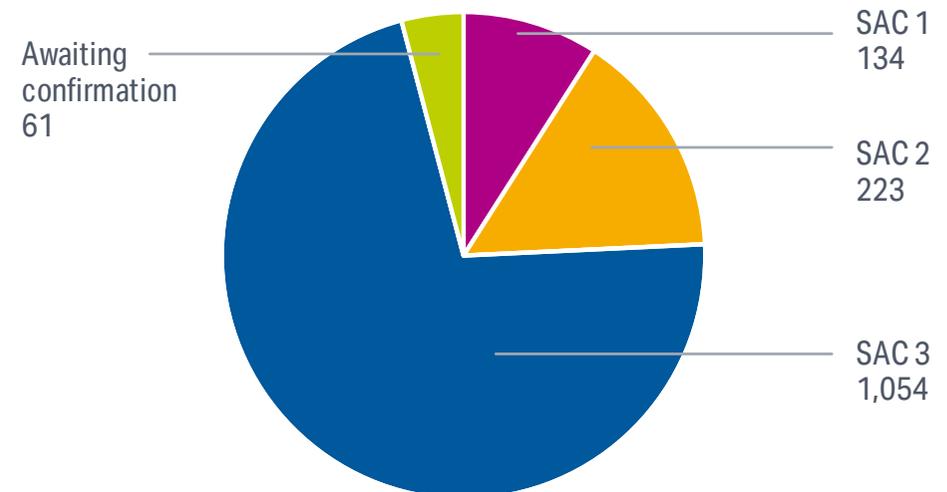
Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition is deteriorating. Health care organisations need to have systems in place to support staff in promptly identifying patients who are deteriorating and responding appropriately. These systems should be consistent with National Consensus Statements including [Essential elements for recognising and responding to acute physiological deterioration](#), [Essential elements for safe and high-quality end-of-life care](#), and [Essential elements for recognising and responding to deterioration in a person's mental state](#).

Mechanisms should also exist whereby patients and their family members and carers are able to escalate care, for example if they have concerns that the patient is getting worse, not doing as well as expected, or not improving.

In 2021/22, there were 1,472 clinical incidents notified that related to recognising and responding to acute deterioration, and 1,411 of these incidents had been allocated a confirmed SAC rating at the time of this report. The total number of acute deterioration incidents notified in this period was a little lower than in 2020/21.

Incidents related to acute deterioration represented 4.4% of all confirmed incidents in 2021/22, and while most were confirmed as SAC 3 incidents, nearly one-quarter were confirmed as SAC 1 or SAC 2 (see Figure 39). Consistent with previous years, this NSQHS Standard has the highest proportion of incidents confirmed as SAC 1 (9.1%), equivalent to one in every 11 acute deterioration incidents in this period.

Figure 39: Acute Deterioration Clinical Incidents by SAC Rating for 2021/22

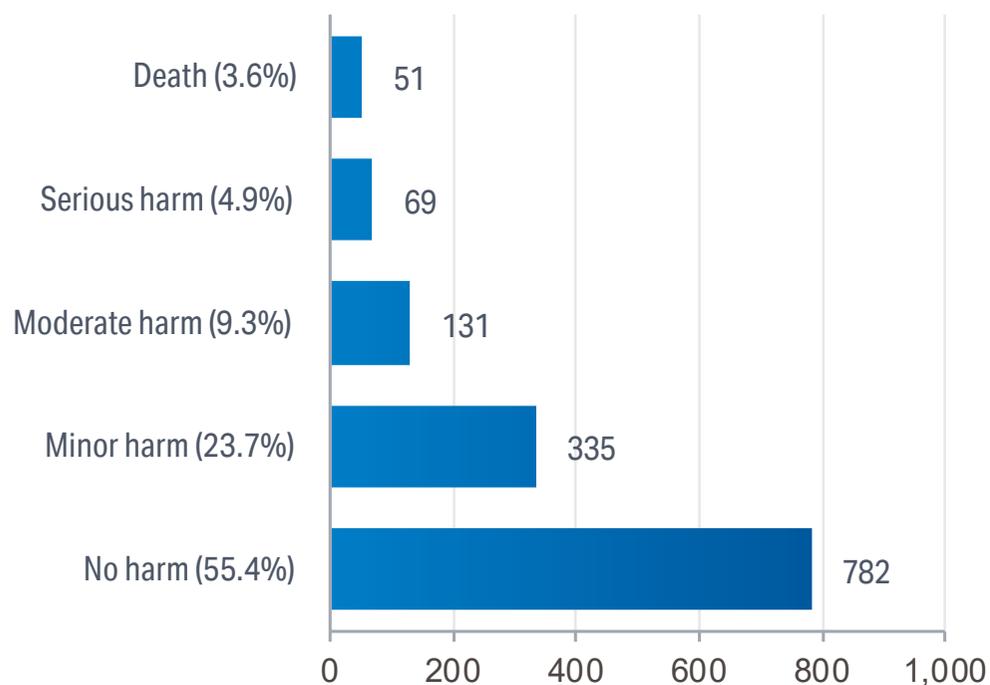


49 [NSQHS Standards \(2nd ed – version 2\) Recognising and Responding to Acute Deterioration Standard](#)

While the most frequently reported patient outcome in confirmed clinical incidents related to acute deterioration was no harm (see Figure 40), outcomes of death (n=51) and serious harm (n=69) have increased from the previous year.

These poor patient outcomes were reported in one in every 12 confirmed incidents related to recognising and responding to acute deterioration in 2021/22, demonstrating the high risk that incidents of this nature pose to patients.

**Figure 40: Confirmed Acute Deterioration Clinical Incidents by Patient Outcome for 2021/22**



**Note:** Patient outcome missing data n=43; 3.0%

The risk to patients associated with failures to recognise or respond to acute deterioration in cognition and mental state is highlighted by the number of poor patient outcomes seen in incidents related to the provision of mental health care.

Females accounted for 57.2% (n=799) of patients involved in confirmed acute deterioration clinical incidents in 2021/22. As seen in previous years, a distinct bias towards female patient involvement in these incidents was seen in the age group from 15-44 years, where more than three-quarters of patients involved were female. Almost half of the female patients in this age group were being treated by the Obstetrics speciality.

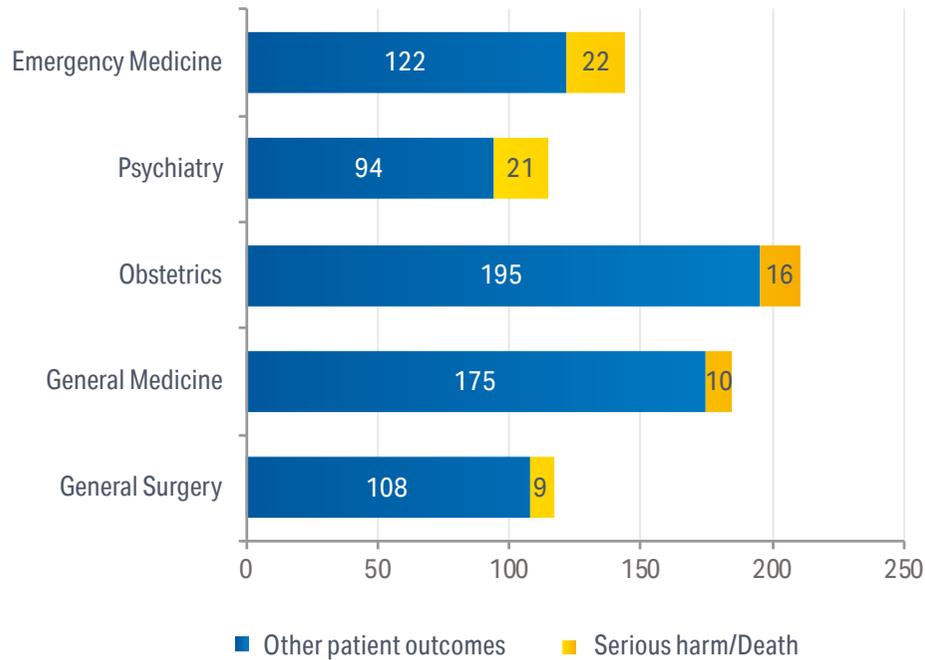
Aboriginal and Torres Strait Islander persons represented 13.3% of patients involved in acute deterioration clinical incidents in this period, which is slightly higher than the proportion involved in clinical incidents generally.

In 2021/22, 11.6% 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, a much higher proportion of clinical deterioration incidents that reported a patient outcome of serious harm or death involved mental health patients (28.3% of patients involved).

Figure 41 overleaf shows the five treating specialties that most frequently reported acute deterioration clinical incidents during 2021/22, separated into incidents describing patient outcomes of serious harm or death and those reporting less severe outcomes.

As seen in the previous year, Obstetrics reported the highest number of clinical incidents related to this NSQHS Standard (n=211), however Emergency Medicine and Psychiatry reported the most incidents with patient outcomes of serious harm or death.

Figure 41: Confirmed Acute Deterioration Clinical Incidents by Most Frequent Treating Specialties and Patient Outcome for 2021/22



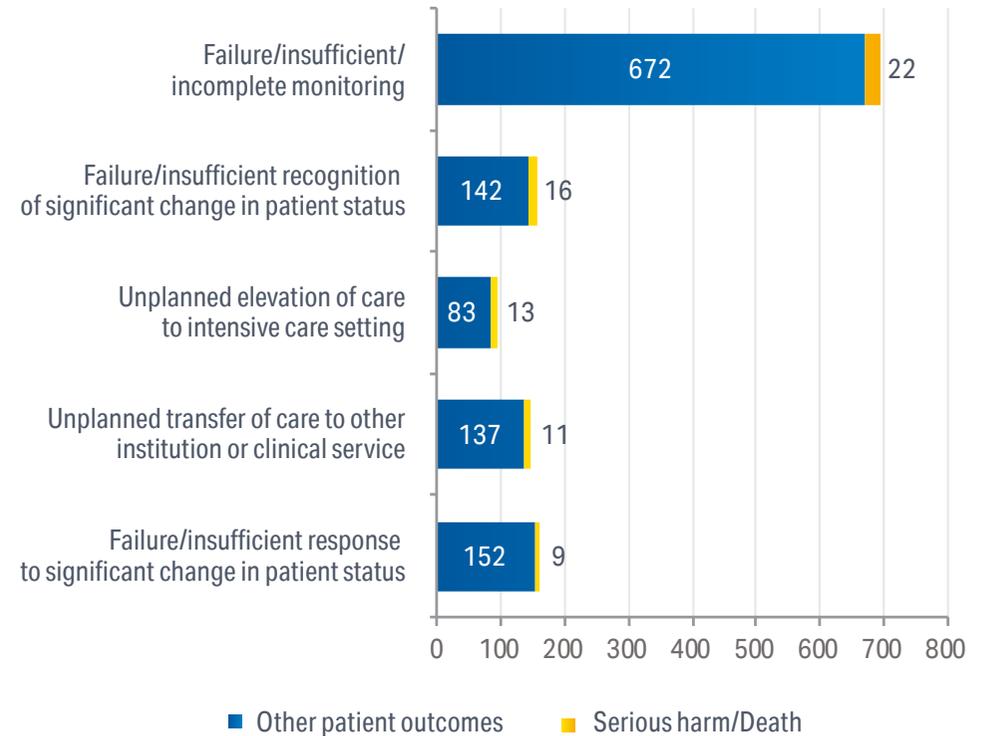
**Note:** Treating specialty unknown/missing data n=23; 1.6%. Other patient outcomes include No harm, Minor harm, Moderate harm and incidents where the patient outcome has not yet been confirmed.

The five most frequently reported Tier Three incident categories for confirmed acute deterioration incidents in 2021/22, separated into incidents describing patient outcomes of serious harm or death and those reporting less severe outcomes is shown in Figure 42.

Failure to monitor, or incomplete or insufficient monitoring of the patient was again seen as the most common type of incident related to this NSQHS standard and was also the type of incident most often associated with patient outcomes of serious harm or death.

However, incidents related to a lack of, or insufficient recognition of a significant change in the status of the patient were more than three times as likely to lead to a patient outcome of serious harm or death.

Figure 42: Most Frequent Confirmed Acute Deterioration Clinical Incident Categories by Patient Outcome for 2021/22

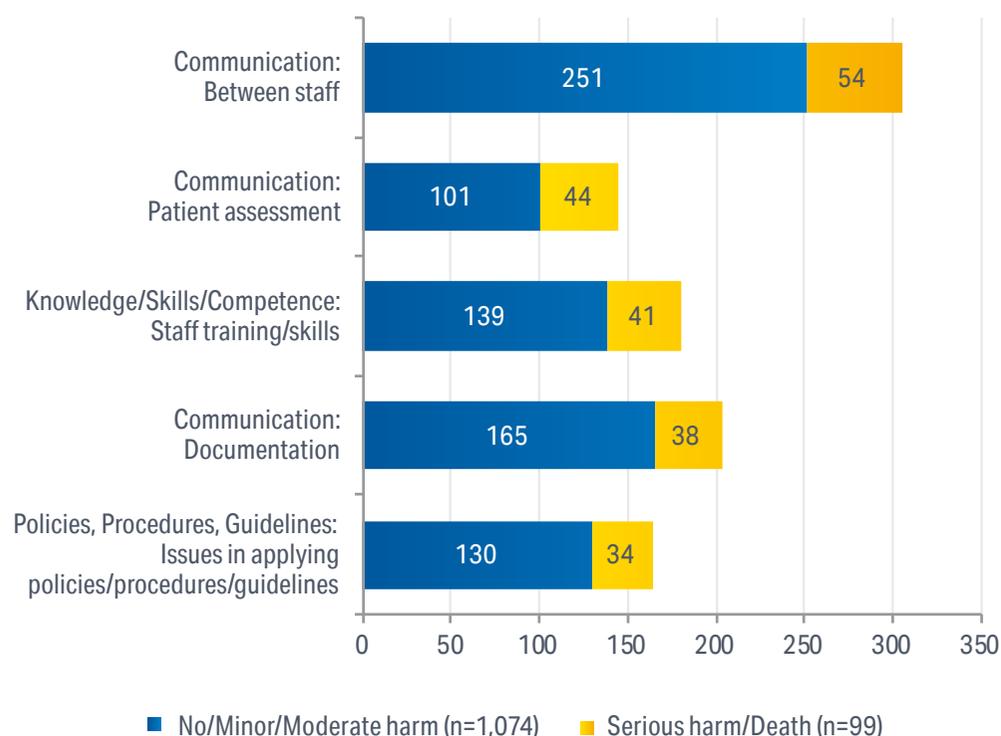


**Note:** Other patient outcomes includes No harm, Minor harm, Moderate harm and incidents where the patient outcome has not yet been confirmed.

The investigation of 1,173 acute clinical deterioration incidents had been completed at the time of this report, and 99 of the completed investigations were of incidents that reported a patient outcome of serious harm or death.

The most frequently identified contributory factors in acute clinical deterioration incidents reporting patient outcomes of serious harm or death in 2021/22 were issues with communication between staff and assessment of the patient (see Figure 43).

**Figure 43: Most Frequent Contributory Factors for Closed Acute Deterioration Incidents by Patient Outcome for 2021/22**



**Note:** A clinical incident investigation may identify multiple contributory factors.

Review of the contributory factors in incidents related to recognising and responding to acute clinical deterioration that reported patient outcomes of serious harm or death identified several themes, including:

- Delayed transfer of patients due to access blocks in both mental health and non-mental health settings
- Delayed or incompletely performed patient assessments (including mental state/risk assessments, pregnancy risk and physical health assessments)
- Lack of, incomplete or ineffective monitoring of patients including staff not being 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 transfer 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, including sepsis pathways, not established or not clear to staff
- Insufficient or ineffective communication between staff members and with patients, often involving temporary staff not aware of protocols
- Lack of inclusion of family/carers in assessment processes and care and discharge planning
- Lack of, or unclear procedure-specific policies or guidelines including multiple conflicting policies or guidelines
- Lack of senior staff support for junior staff after hours.

Staff workload was often identified as contributing to many of the factors listed above.

## Key Messages and Information: Recognising and Responding to Acute Deterioration Clinical Incidents

Incidents related to failures to recognise or respond to acute deterioration were more than 50% more likely to report patient outcomes of serious harm or death than incidents related to preventing and controlling infections, and almost six-times more likely than incidents related to comprehensive care.

Review of the clinical incidents related to failures to recognise and/or respond to acute deterioration continues to highlight the risk that this issue poses to patients in the WA health system. In 2021/22, one in every 12 confirmed incidents related to this NSQHS Standard reported the patient outcome as serious harm or death.

The Department of Health has drafted a revised [Recognising and Responding to Acute Deterioration Policy](#) which will take effect in January 2023 and enforces the clinical guidance in the Recognising and Responding to Acute Deterioration Standard throughout the WA public health system. The revised policy has been approved and released in advance to allow health service providers time to implement it effectively.

In 2021/22, the areas in which recognising and responding to acute deterioration clinical incidents most frequently described patient outcomes of serious harm or death included mental health care, obstetric care, surgical care, and the management of patients suffering sepsis, stroke or cardiac events such as heart attack.

In this period there were eight clinical incidents related to failures to recognise or respond to deteriorating sepsis patients that reported the patient outcome as death, and a further five incidents that reported a patient outcome of serious harm.

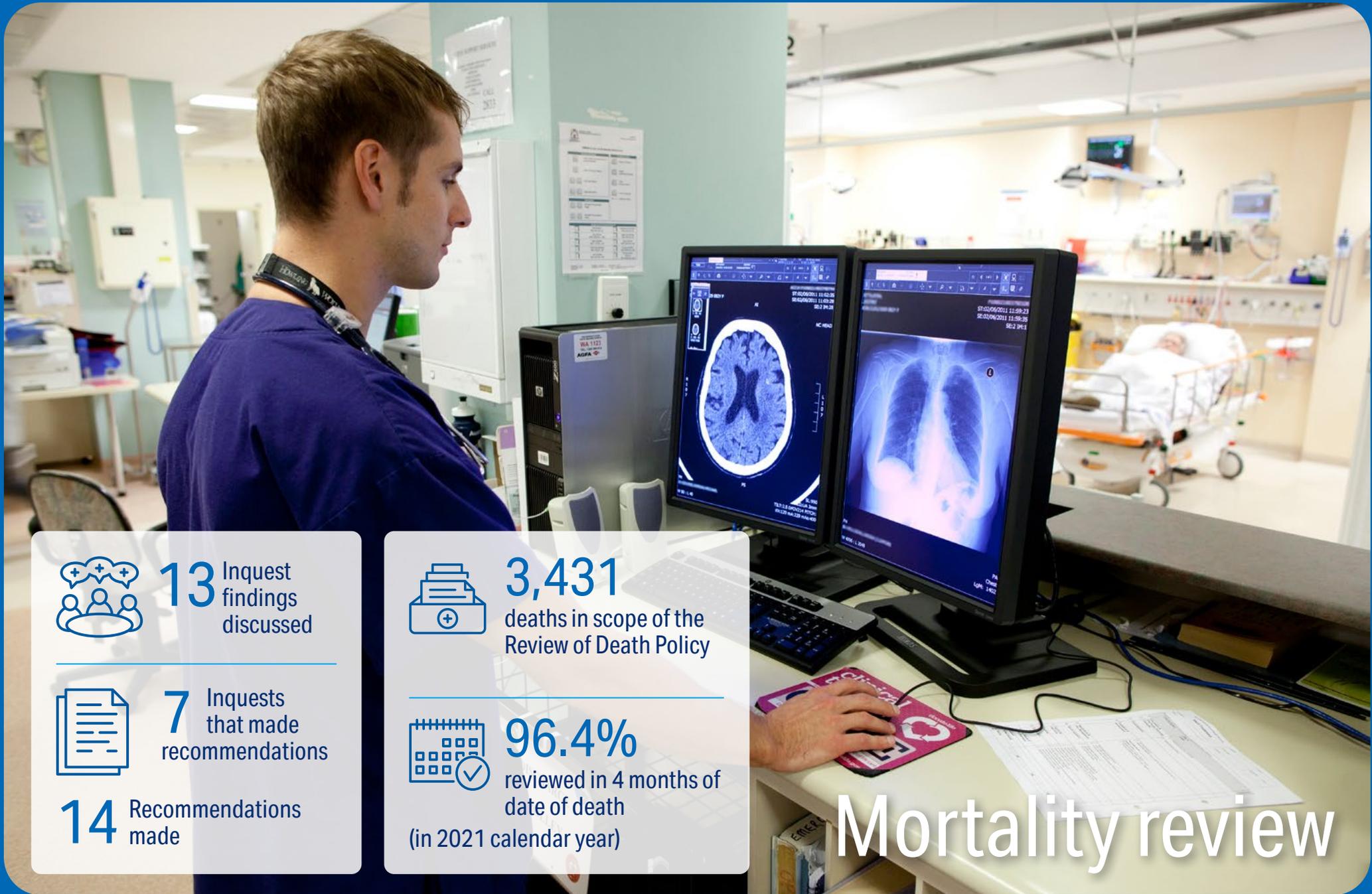
The ACSQHC released the [Sepsis Clinical Care Standard](#) in June 2022, which aims to help ensure sepsis is recognised early and patients receive coordinated, best-practice care so that the risk of death or ongoing morbidity is reduced. This includes timely recognition of sepsis, early and appropriate antimicrobial therapy and continuity of care from the acute setting through to discharge and survivorship. The Medicines and Technology Unit have convened the WA Sepsis Working Group with the aim to develop and oversee implementation of a program of activities to facilitate the delivery of appropriate care and reduction of unwarranted variation in sepsis care across WA Health based on guidance from the *Sepsis Clinical Care Standard (2022)* and the PSCQ Antimicrobial Stewardship Strategy 2020-2025.

Health care organisations should also have processes in place to enable clinicians to recognise acute deterioration in patients' mental state and take appropriate actions. This includes patients at risk of developing delirium. Monitoring a patient's mental state should utilise an individualised monitoring plan that includes their known early warning signs for deterioration. The possible causes of acute deterioration in mental state, including delirium, should be assessed when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported.<sup>50</sup>

Delirium is an acute change in mental status that is often triggered by acute illness, surgery, injuries or adverse effects of medicines. Despite being a serious condition that is associated with increased mortality, delirium has been poorly recognised in Australian hospitals and internationally. The ACSQHC released the updated [Delirium Clinical Care Standard](#) in September 2021, which aims to improve the prevention of delirium in patients at risk, and the early diagnosis and treatment of patients with delirium.

In September 2021, the PSSU released a Check up report discussing clinical incidents related to mental health deterioration.

50 [NSQHS Standards \(2nd ed – version 2\) Recognising and Responding to Acute Deterioration Standard – Action 8.05](#)



**13** Inquest findings discussed



**7** Inquests that made recommendations

**14** Recommendations made



**3,431** deaths in scope of the Review of Death Policy



**96.4%** reviewed in 4 months of date of death (in 2021 calendar year)

# Mortality review

# Coronial Review

The Coronial Liaison Unit (CLU) was established in 2005 to improve communication between the WA health system and the Office of the State Coroner. The Coronial Review Committee (CRC), established in 2014, operates closely with the CLU and exists to improve the governance and decision-making in relation to the implementation and response to coronial inquest findings and recommendations.

Table 9 provides a summary of the number of coronial inquest findings received by the CLU for the last three financial years. The CLU, in conjunction with the CRC, considered 25 coronial inquest findings that were published over 2021/22. Of these findings 13 were discussed with the CRC and 12 were for noting. Of the 13 inquests discussed by the CRC, 7 inquest cases directed recommendations to the WA health system, which represented 14 recommendations. There were 6 inquest cases that were discussed with the CRC where no recommendations were directed to the WA health system. These findings were considered by the CRC as there were patient safety issues or concerns raised for further investigation and action by the WA health system.

**Table 9: Overview of Coronial Liaison Unit activity for 2019/20 to 2021/22**

	2019/20	2020/21	2021/22
Total number of health-related coronial inquest findings received by CLU	17	27	25

Table 10 provides a summary of WA health system activity and response to coronial inquests and recommendations for the last 3 financial years. Recommendations are not considered completed until they have been implemented in all applicable services (ongoing recommendations may be partially implemented).

Closed recommendations are those that have been considered by the CLU and relevant stakeholders, and are either:

- not endorsed with reasonable justification;
- have not been implemented as existing systems/processes have been deemed to adequately manage the risk; or
- the changes are extensive (i.e. part of a large-scale project spanning a number of years) and are a long-term commitment of the WA health system.

**Table 10: Overview of coronial recommendations 2019/20 to 2021/22**

	2019/20	2020/21	2021/22
Total number of health-related recommendations (including mental health) <sup>a</sup>	9	8	14
Number of general health related recommendations	-	7	10
Number of general health related recommendations completed/closed <sup>b</sup>	-	7	2
Number of mental health related recommendations	9	1	4
Number of mental health related recommendations completed/closed <sup>b</sup>	9	1	0

a Health-related recommendations are those that are within the WA health system's jurisdiction to action (directed to the Department of Health, a health service provider, a hospital, or a contracted health entity; and/or are applicable to the services provided by the WA health system).

b Status as at most recent report to the State Coroner (August 2022). Completed actions are recorded in the year that the findings were released, rather than year of completion.

The following 13 synopses (for cases discussed at CRC) are provided for coronial inquests where the coroner's recommendations and/or findings have implications for the WA health system. The findings included are those that have been available to the CLU from 1 July 2021 to 30 June 2022 (the month and year that each of the findings were delivered are noted in brackets<sup>51</sup>). All Health Service Providers are encouraged to use these summaries to raise awareness of important messages to facilitate continuous quality improvement.<sup>52</sup>

## Cases for discussion

### Child AM (June 2021)

Child AM suffered from rapid weight gain as a baby and was frequently admitted to hospital for obesity related issues. When she was two years old Child AM's obesity was considered a significant risk to her life given her other conditions including severe asthma and obstructive sleep apnoea.

The deceased was almost four years old when she died unexpectedly after being found unresponsive at her foster carer's home. Resuscitation efforts were attempted by carers and paramedics, which continued at hospital, however attempts were unsuccessful.

The coroner found that Child AM died as a result of bronchopneumonia in an infant with obstructive sleep apnoea, and by manner of natural causes. Two recommendations were made by the coroner regarding healthy weight services in remote and regional areas; and, permanent establishment of a healthy weight service piloted 2015-2017.

### Mr W (June 2021)

Mr W was a 38-year-old man who, at the time of his disappearance, resided at a care facility under conditions related to a custody order under s21(a) of the *Criminal Law (Mentally Impaired Accused) Act* 1996. He had responded well to treatment and was granted Leave of Absence, however he failed to return on one occasion and was later discovered deceased in his vehicle in a remote WA area.

The coroner found that Mr W died as a result of carbon monoxide toxicity and by manner of suicide.

The coroner discussed the delays in notifying the police of his absence but concluded that there was a very real possibility he had already died by the time his absence was first noted.

The relevant standard operating procedure for the absence of Leave of Absence patients and the Absconders without Leave policy that were in existence at the time were reviewed by the coroner and found to be adequate.

The coroner did not make any recommendations.

### Mr R (July 2021)

Mr R was a 39-year-old man who died following an interaction with police. Police officers, who were attending the premises on a different matter, were approached by a member of the public with concerns about the deceased's (self-harming) behaviour. Police officers called for an ambulance and attempted to engage with the deceased, however he was tasered after suddenly advancing towards officers. He subsequently became unresponsive whilst being restrained and resuscitation efforts were unsuccessful.

The night prior to his death, Mr R attended the ED of a tertiary hospital on multiple occasions. Police accompanied the deceased on the first occasion, however he refused to engage with hospital staff and declined police assistance. It is unclear whether he spoke with anyone on later visits; in any event the deceased did not wait to be triaged on any subsequent occasion.

The coroner found that the cause of death was consistent with cardiac arrhythmia following violent exertion necessitating physical restraint in a man with methylamphetamine effect, known systemic hypertension and morbid obesity. The manner of death was found to be misadventure.

51 There may be some cases with release dates noted outside of the 2021-2022 financial year as there are delays from when the findings are delivered and when they are publicly released on the Office of State Coroner's website.

52 Full inquest findings can be accessed at the Office of the State Coroner's website.

### Mr M (August 2021)

Mr M, aged 40 years, deteriorated and died following emergency surgery to remove two knives lodged in his back. The coroner found that he died from penetrating wounds to the chest sustained as a result of unlawful homicide.

He was a random victim of a man who had a background of criminal convictions; as well as heavy alcohol, THC and methamphetamine use. The offender was experiencing drug-induced psychosis at the time of breaking into Mr M's apartment and attacking him. The offender had been released from police custody and dropped off at the address shortly before the attack.

The coroner explored the decision to release the offender rather than detain him under the *Criminal Investigation Act* or the *Protective Custody Act*; or to transport him to hospital for medical assessment under the *Mental Health Act*, however made no criticism of the decisions relating to his release.

The coroner made recommendations relating to the continued funding and expansion of the Mental Health Co-response model.

### Mr S (September 2021)

Mr S was 63 years old when he died from metastatic renal carcinoma by manner of natural causes. His healthcare for the last third of his life had been provided through the prison system.

Mr S had informed prison medical officers of a rectal mass on several occasions but by the time the mass was examined in hospital, further investigation revealed a poorly differentiated adenocarcinoma with widespread metastases. He rapidly developed liver failure and was deemed too unwell for treatment. He was palliated in hospital.

The coroner found that in Mr S's last two years, there were several missed opportunities to diagnose the cancer. These multiple missed opportunities for earlier identification of the cancer included: a reliance on a patient's self-diagnosis; not conducting per rectal examination or documenting discussion of risks involved in omitting such an examination; absence of annual health reviews or faecal occult blood tests; no monitoring of weight; and, no blood tests.

The coroner made two recommendations relating to the monitoring and tracking of referrals to health services for prisoners; and amendment of policy to prioritise annual reviews of vulnerable prisoners.

### Mr C (September 2021)

Mr C died aged 73 years as a result of disseminated malignancy (known advanced lung carcinoma and mouth carcinoma) in a man with comorbidities including chronic obstructive pulmonary disease. At the time of his death Mr C was a sentenced prisoner.

Due to a failure in communication between the two specialty clinics in the hospital, Mr C did not receive the most appropriate form of chemotherapy to maximise radiotherapy for his lung cancer, nor did he receive treatment following surgical removal of his oral cancer. When the errors in treatment were realised, the optimal window for post-operative radiotherapy for the oral cancer had lapsed, and the lung cancer had metastasised to his liver.

The coroner made two recommendations relating to actions to ensure the accuracy of notes from discussions at multidisciplinary meetings; and the appropriate and timely triage of referrals via the e-Referral system.

## Mr B (October 2021)

Mr B was a 38 year-old man with a long history of treatment resistant mental illness, variably diagnosed as schizophrenia and schizoaffective disorder. His illness was complicated by poor adherence to prescribed medication regimens and illicit drug use.

He was known to become aggressive when his mental health deteriorated, requiring admission to hospital where he would usually settle quickly with oral medication.

At the time of his death Mr B was an involuntary patient being treated in a high dependency unit of a regional hospital. There was no evidence that 15-minute overnight observations were carried out between midnight and 8:15am the next morning, when he was checked through a window and believed to be sleeping. He was found unresponsive at around 8:30am when nursing staff entered the room to complete observations and take blood samples. A MET call was put out; resuscitation attempts commenced but were unsuccessful.

The coroner found that Mr B's death was consistent with acute cardiac arrhythmia in a man with focal coronary atherosclerosis and morbid obesity. The history of chronic schizoaffective disorder was considered a significant contributing factor, given its association with an increased risk of sudden cardiac death. The coroner agreed with the GP who led the resuscitation, who was of the view that death was likely to have occurred before the last set of visual observations taken at 8:15am. The manner of death was found to be natural causes.

The coroner made one recommendation relating to funding for the redevelopment of the high dependency unit which would facilitate regular visual observations and furnished in a way to enable easy access for resuscitation purposes.

## Miss T (November 2021)

Miss T died at home aged 16 from acute abdominal obstruction secondary to adhesions associated with severe pelvic inflammatory disease.

Miss T sought medical care three times in the two weeks prior to her death. The first visit was to the hospital emergency department following an alleged assault. A bedside ultrasound was done in connection to abdominal pain but revealed no free fluid. She was discharged with analgesia. The second visit was to an Aboriginal medical service where she discussed several issues including the assault and new onset vaginal discharge. She was noted to have a BMI under 15 and leucocytes on urinalysis, with otherwise normal vital signs. She did not return the following day for further review as requested.

The third visit was via ambulance to the hospital emergency department after she had vomited through the night. With no other obvious signs of infection, a raised WCC was attributed to dehydration. When her pain settled, and she was able to retain fluids, she was discharged following further review with advice to see her GP if she had concerns. Early the following morning she started vomiting at home and an ambulance was called when she became unresponsive. Paramedics did not detect signs of life when they arrived, so resuscitation was not attempted.

Expert opinion was that death from overwhelming septic shock from gonorrhoea is rare, and small bowel obstruction complicating severe pelvic inflammatory disease is unusual. It appeared that she was not in shock during her presentation to the hospital, nor showed clear indication of definite sepsis. Admission to an inpatient ward or short stay observation unit would have allowed for further monitoring, repeat blood tests, and better opportunity to ascertain the cause of her pain, ketosis and raised WCC.

The coroner made two recommendations relating to funding to enable the creation of a short-stay unit at the regional emergency department; and the employment of Aboriginal Liaison Officers in the emergency department.

### Mr W (December 2021)

Mr W died aged 29 years from acquired methaemoglobinaemia in association with sodium nitrite toxicity. The coroner found the manner of death to be by suicide.

Mr W had been diagnosed with bipolar affective disorder. Following multiple inpatient admissions with deterioration related to nonadherence with medication regimens, he was made subject to a CTO.

There was no record of him expressing any self-harm or suicide ideation or making any attempts at any stage, and no evidence of recreational drug or alcohol use in the last few years of his life. He was reported by his family and health care team to be well with no risks identified.

He was found unresponsive in his room and an ambulance was called. Mr W had left a note stating that he'd ingested 25g of sodium nitrite in order to end his life. Resuscitation attempts by paramedics and hospital staff were unsuccessful.

The coroner made two recommendations relating to the regulation of sodium nitrate and raising awareness among sodium nitrite suppliers of its capacity to cause death in the context of suicide.

### Ms L (January 2022)

Ms L was last seen alive the day of absconding from the grounds of a metropolitan hospital. She was 50 years old at the time of her disappearance. Ms L had developed an eating disorder sometime in the last decade of her life, along with increasing depressive symptoms and alcohol consumption.

After injuring her arm and ankle during a suicide attempt, the deceased was admitted to a locked ward as an involuntary patient; deemed to have diminished insight and capacity due to chronic starvation; and at high risk of absconding, impulsivity and suicide. The treatment plan was to medically stabilise her, then to address her underlying psychological condition.

Whilst on escorted group therapy hospital grounds walk, Ms L unexpectedly leapt out of the wheelchair and sprinted away. Hospital security and the police were informed, and a search commenced. She was seen briefly at a nearby op shop, cold and in wet clothes. Staff gave her dry clothes and contacted the hospital. Ms L left before police arrived. There have been no confirmed sightings since.

The coroner made no recommendations, noting the changes and investment to improve services provided to patients presenting with eating disorders.

### Mr W (February 2022)

Mr W died, aged 20, when struck by a train after absconding from a regional mental health unit where he was an involuntary patient.

Mr W was impulsive and disinhibited, and frequently tried to harm himself. There were not enough nurses available to provide 1:1 nursing care as recommended, so security guards were employed to provide constant supervision. Mr W made multiple attempts to abscond; on one occasion he successfully scaled the fence of the courtyard and was found shortly afterwards, with one security guard claiming he had been found at the nearby railway line. That same evening, Mr W managed to escape again, and was struck by a train before he could be found.

The coroner found that Mr W died as a result of blunt force head and neck injuries. An open finding was made into the manner of death, as the coroner was not able to conclude that Mr W had been capable of forming the intention to take his own life.

Three recommendations were made relating to the height of the fencing around the MHU courtyard, the security of fencing surrounding the railway tracks, and resourcing to enable construction of a purpose-built mental health facility with appropriate staffing once established.

## Mr E (March 2022)

Mr E was born with Smith-Magenis syndrome: a chromosomal abnormality that results in a range of developmental delays and skeletal abnormalities. He was non-verbal; and had Crohn's disease and had previously experienced bowel obstruction from pseudo-volvulus. He lived in a group home, supported by two carers on morning and afternoon shifts, and one carer overnight.

An ambulance was called one evening when a carer noted he had rapid breathing and groaning, and he was transferred to hospital. No carer was available to accompany Mr E to hospital. A 'Transfer to hospital' file containing background information was provided but this didn't include information about the events of the evening or the carer's concerns.

No clear diagnosis was found, and he appeared to improve without intervention. The decision was made to discharge him home to a calmer environment, with the incorrect assumption that there would be a registered nurse at the group home to continue monitoring. Mr E continued to be unwell the following day. During a routine annual review in the afternoon, his gastroenterologist had concerns about a potential chest infection and organised transfer to the ED.

On arrival he was clearly very unwell. A portable chest x-ray demonstrated volvulus and 'right lower pneumonia'. Whilst in the radiology department awaiting CT scan, Mr E developed a ventricular tachyarrhythmia. Resuscitation attempts were unsuccessful.

The coroner found Mr E died, aged 31 years, as a result of complications in association with intestinal volvulus and by manner of natural causes.

The coroner made six recommendations, with recommendations five and six directed to the health service and related to policy for discharge summaries to provide detailed instructions; and consideration of a lower threshold for admission for non-verbal patients.

## Ms W (April 2022)

Ms W was a 26-year-old Noongar Yamatji woman, who had a turbulent upbringing after the death of her father in police custody when she was six. She presented to a hospital with concerns for her daughter, however left soon after. Her erratic behaviour prompted staff to contact the police requesting that she be brought back for review. She was brought in by a member of the public after Ms W approached them seeking help. Her child was medically cleared, and Ms W was kept overnight for further mental health review and social work input the next morning. Ms W was referred for involuntary admission to second hospital with a diagnosis of drug-induced psychosis, though she absconded from the Mental Health Observation Area (MHOA) when a staff member entered the unit.

Ms W was eventually found by police, and after several brief interactions, an ambulance was called to take her to hospital to treat wheezing and some self-inflicted neck abrasions. The police left her in the care of the paramedic staff, but she then suddenly ran out from the ambulance onto a busy road. When police returned to remove her from the road, she was placed into prone restraint and handcuffed. Shortly afterwards she became unresponsive. Resuscitation was commenced with return of circulation; however, she never regained consciousness and was subsequently palliated at a third hospital.

The cause of death was found to be hypoxic ischaemic encephalopathy and bronchopneumonia in a woman with methylamphetamine effect and exertion with restraint, with the manner of death being by way of accident.

The coroner made one recommendation regarding the provision of training to police officers in relation to the use of prone position.

# Review of Death

The purpose of the *Review of Death Policy*<sup>53</sup> is to ensure that Health Service Providers, contracted health entities, and private licensed health care facilities (participating entities) identify potentially preventable deaths, and opportunities for improvement in the delivery of health care, including the quality of end-of-life care.

Any preventable deaths identified via the review process are required to be notified as SAC 1 clinical incidents and investigated under the *Clinical Incident Management (CIM) Policy* (if this has not already occurred). The *Review of Death Policy* also has a relationship to the Western Australian Audit of Surgical Mortality (see Appendix Two: Interaction of the *Review of Death Policy* with CIM and WAASM Processes for a diagram showing this relationship).

The *Review of Death Guideline* supports the implementation of the *Review of Death Policy*. The *Review of Death Guideline* includes information to assist healthcare providers in the development of comprehensive review processes for the deaths of terminally ill and palliative care patients, and effective governance of independent review processes. Information regarding the statutory reporting requirements that may apply when a patient dies is also provided.

Data provided by participating entities showed there were 3,431 patient deaths that fell within the scope of the Review of Death Policy between 1 January and 30 June 2021<sup>54</sup>, and that 96.4% (n=3,308) of these deaths were reviewed within 4 months of the date of death (see Table 11). In monitoring compliance, variances are reviewed with participating entities to reinforce the importance of mortality review in clinical governance. Participating entities are also required to indicate whether SAC 1 clinical incidents are notified as an outcome of a mortality review process conducted under the *Review of Death Policy*. Between 1 January and 30 June 2021, hospitals reported 8 patient deaths were notified as SAC 1 clinical incidents following mortality review.

Table 11: Review of Death Indicators for 2020 – 2021

Indicator	2020 <sup>55</sup>	Jan – Jun 2021 <sup>56</sup>
Number of deaths in scope of <i>Review of Death Policy</i>	6,953	3,431
Number of deaths with a completed review within 4 months of the date of death	6,533	3,308
Percentage of deaths with a completed review within 4 months of the date of death	94.0%	96.4%
Number of SAC 1 clinical incidents notified as an outcome of mortality review process conducted under the <i>Review of Death Policy</i>	13	8

**Note:** Data includes health service providers, contracted health entities and private facilities that have a licence requirement to comply with the *Review of Death Policy*. Patient deaths that have been referred to the WAASM and/or notified as a SAC 1 clinical incident for investigation under the CIM Policy are not required to be reviewed under the Review of Death Policy and are excluded from this data.

53 [MP 0098/18 Review of Death Policy](#)

54 Review of Death Policy reporting requirements were suspended for the July-December 2021 period due to increased COVID-19 caseload across the system. Data from this period will be included in the 2023 report.

55 For deaths that occurred between 1/1/2020 and 31/12/2020.

56 For deaths that occurred between 1/1/2021 and 30/06/2021 (six months only).

# 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. The WAASM is managed by the Royal Australasian College of Surgeons (RACS) and funded by the Department of Health. The WAASM has been operating since 2002, with data reported by calendar year.

Participation in the WAASM fulfils mortality review obligations established by the *Review of Death Policy*.<sup>57</sup>

An overview of the WAASM process is shown in Figure 44. The WAASM is notified for all deaths that occur where the patient was under the care of a surgeon or under the care of a physician and underwent a surgical procedure. The surgeon is then notified and completes a form about the death.

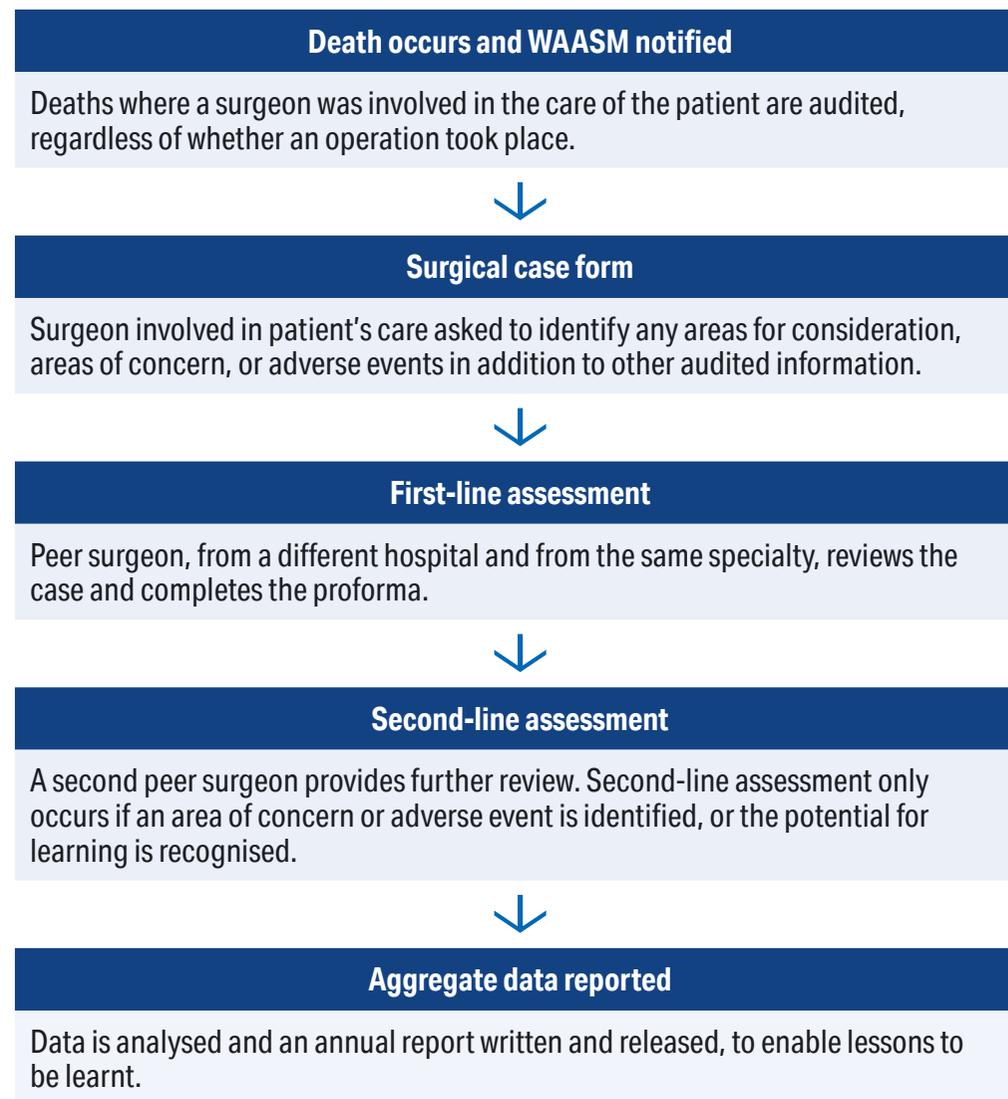
The case then undergoes first-line assessment, where the assessor is asked to identify any clinical management issues that are classified as:

- **area for consideration:** care could have been improved or been different, but there may be an area of debate
- **area of concern:** care should have been better
- **adverse event:** an unintended injury caused by medical management, which lead to prolonged hospitalisation or to temporary or permanent impairment or disability, or which contributes to or causes death.

The assessor can also request a second-line assessment if deemed appropriate.

Second-line assessment involves an in-depth review by a second peer surgeon using the patient's medical notes. The second-line assessor is asked to document further about the clinical management issues and prepare a short report to be sent to the surgeon for feedback.

Figure 44: WAASM process



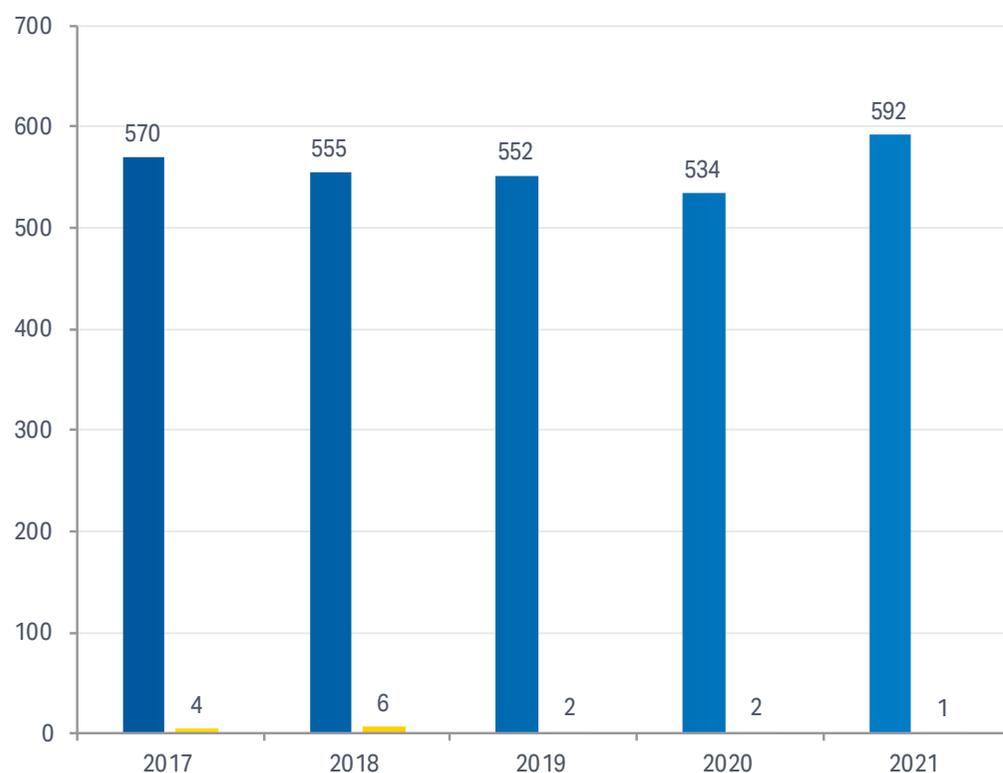
57 [MP 0098/18 Review of Death Policy](#)

The WAASM 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.

In 2021, 592 deaths across public and private hospitals met the WAASM criteria. There were 55 cases that were referred for second-line assessment, representing 12.8% of the 431 cases with a completed first-line assessment.

Over the 5-year period (2017-2021), definitely preventable surgical deaths represented less than 1% of surgical deaths (see Figure 45).

Figure 45: Total surgical deaths and deaths with definitely preventable adverse events



The WAASM assessors considered 40.9% (n=18) of the 44 adverse events identified from 2017 to 2021 to be definitely preventable. There were ten adverse events that caused death identified in 2020, of which two were considered definitely preventable, and four adverse events have been identified so far in 2021 of which one was considered definitely preventable; see Table 12.

Table 12: Total Adverse Events and Adverse Events Causing Death that were Considered Definitely Preventable between 2017-2021

	2017	2018	2019	2020	2021
Total surgical deaths <sup>a</sup>	570	555	552	534	592
Total adverse events identified <sup>b,c</sup>	10	15	5	10	4
Adverse events considered definitely preventable <sup>b,d</sup>	4	9	2	2	1

- a Total surgical deaths are those reported as meeting the WAASM inclusion criteria (as contained in the WAASM 2022, 2021, 2020 and 2019 Reports).
- b Data includes cases that were complete at 6 April 2022 and will be updated in future editions of this report.
- c Includes adverse events that were considered not preventable.
- d Multiple adverse events that caused death and were considered definitely preventable may have been recorded for a single surgical death.

In 2021, the 4 adverse events causing death that have been identified so far, are related to:

- diagnosis missed by surgeons
- inadvertent venous injury
- intraoperative bleeding during open surgery
- patient related factors.

A total of 44 adverse events were identified by the WAASM surgeon assessors during the 5-year period from 2017 to 2021. The most frequently reported adverse event type over this period was complications of surgery (n=9) as seen in Table 13.

**Table 13: Most Frequently Reported Adverse Event Types Causing Death between 2017 and 2021 (Including Events that were Considered Not Preventable)**

Adverse Event	(n)	(%)
Complication of surgery	9	20.4
Decisions relating to surgical treatment	8	18.2
Medical management/assessment issues	5	11.4
Other adverse events	22	50.0
<b>Total</b>	<b>44</b>	<b>100.0</b>

**Note:** Data includes cases that were complete at 6 April 2022. Only adverse events with frequencies  $\geq 5$  have been included. Adverse events have been grouped by the PSSU based on event descriptions provided by the surgeon assessors for the WAASM. Other adverse events include Bleeding associated with operation, Communication issues, Delay to treatment, Diagnosis issues, DVT/DVT prophylaxis, Gastrointestinal perforation, Infection (including septicaemia), Patient factors and Pulmonary embolus.

The [WAASM Annual Reports](#) provide de-identified information of data gathered through the audit process to identify trends.



Number of feedback items  
**19,520**



Number of compliments  
**8,595**



**33.2%**  
of complaint issues related to the quality of clinical care



**9.8%** (n=530)  
of complaint feedback was mental health related

# Consumer feedback

# Consumer Feedback Review

Encouraging consumers to provide feedback about their health care experience offers a source of valuable information to hospitals and health service organisations. Consumers can provide feedback and can be described in three categories:

- **Complaints** identify aspects of a service that are not meeting consumers' expectations and may relate to serious quality of care issues, indicating where services could be improved.
- **Compliments** identify areas where the health service is meeting or exceeding consumers' expectations and express the consumers' appreciation to staff.
- **Contacts and concerns** can include requests for information or assistance, or minor concerns regarding an aspect of service that are resolved at the point of first contact.

The NSQHS Partnering with Consumers Standard<sup>58</sup> necessitates that health care services encourage all consumers to report complaints and work with consumers to resolve these complaints, which are in turn used to inform quality improvement activities.

Culturally however, complaints remain challenging for staff, hospitals, and health service organisations to receive. Adopting a no-blame safety culture and embracing consumer feedback as a learning opportunity can improve patient care and reduce the potential for future harm.

Actively encouraging patients to use their voice, particularly under-represented groups, is indicative of a mature consumer feedback culture.

As part of ongoing work in this area, the National Principles for Child Safe Organisations (National Principles) were endorsed by the former Council of Australian Governments in February 2019. The PSSU in particular, has a strong focus and role with National Principle 6 (*Processes to respond to complaints and concerns are child focused*).

58 [NSQHS Partnering with Consumers Standard](#)

59 [Complaints system | Commissioner for Children and Young People WA \(ccyp.wa.gov.au\)](#)

In 2021, the Department of Health and Health Service Providers participated in the Commissioner for Children and Young People (CCYP) complaints monitoring process, which strongly focused on Principle 6. Results were released by the CCYP in the *Monitoring of complaints systems 2021 report*<sup>59</sup>, which has helped to inform further work for the Department in child friendly complaints systems.

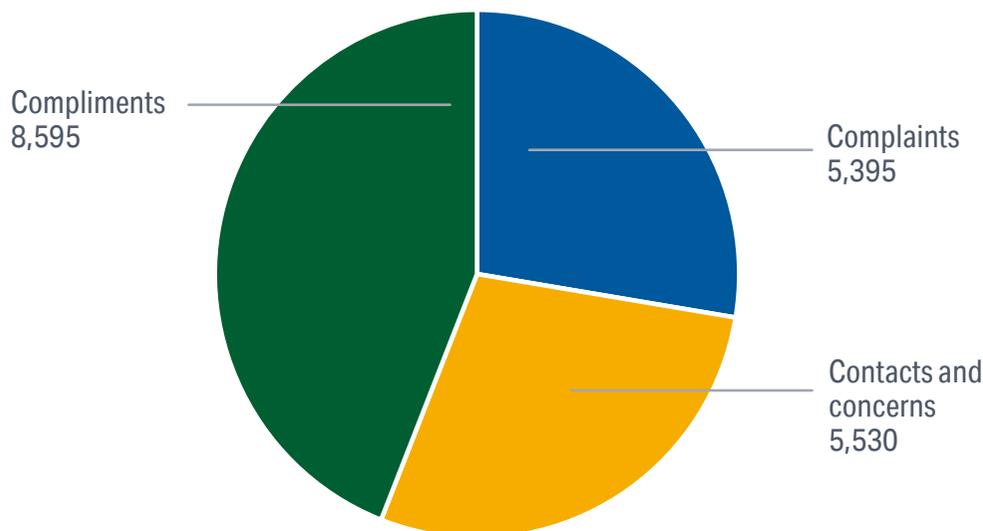
The Datix Consumer Feedback Module (CFM) continues to be the enterprise system used for complaint management in the WA public health system. The system provides a three-tier classification system for categorising complaint issues. Multiple issues can be recorded for each complaint which often cover various aspects of a consumers' health care experience. It also has the capacity to record consumer compliments, contacts, and concerns to provide a fuller picture of the consumer perspective.



## Consumer Feedback Overview

Consumers provided the WA health system with feedback on 19,520 occasions in 2021/22.<sup>60</sup> Just under half of all feedback received was positive in nature, with 8,595 compliments (44.0%) received about the WA public health system in this period (see Figure 46). The remainder of feedback received was equally split between complaints (n=5,395; 27.6%) and contacts and concerns (n=5,530; 28.3%).

Figure 46: Type of Consumer Feedback Received by the WA Health System for 2021/22



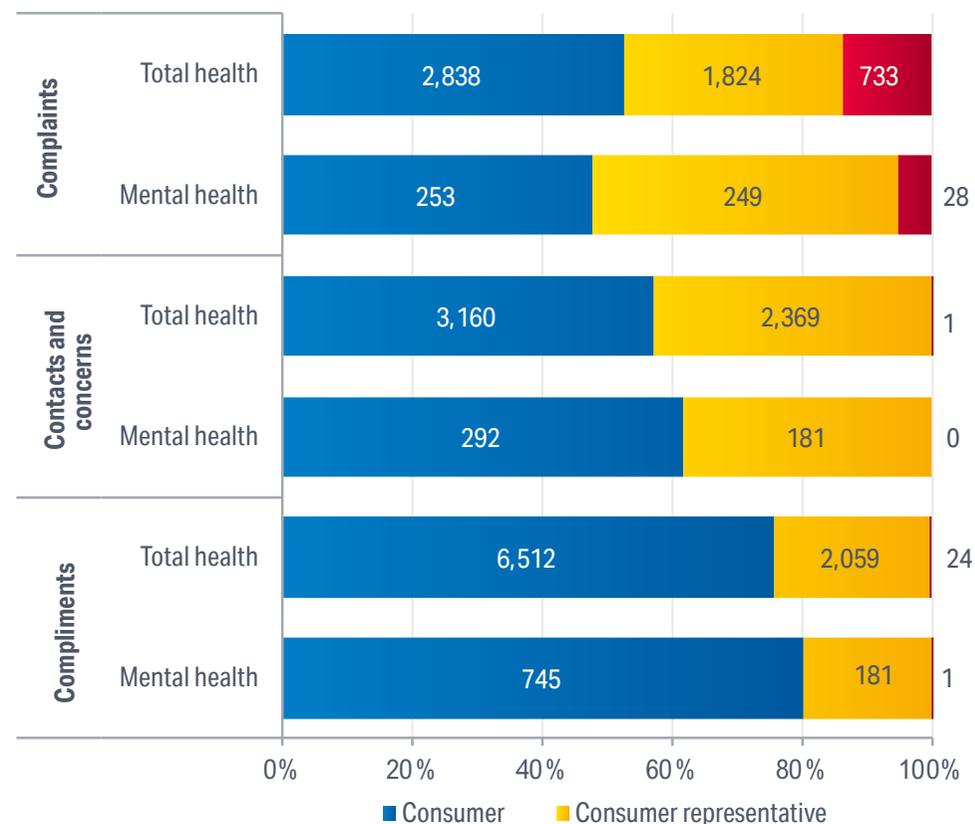
The majority of feedback was received directly from the consumer (n=12,510; 66.7%), with 33.3% (n=6,252) of feedback received from consumer representatives, including family, friends and carers.<sup>61</sup> A greater proportion of compliments were received directly from consumers (76.0%; n=6,512) compared to complaints (60.9% n=2,838; see Figure 47).

<sup>60</sup> It is mandatory for all complaints received by WA's public hospitals and health care providers to be entered in the Datix CFM, and for all complaints relating to public patients treated at Contracted Health Entities (Joondalup Health Campus, Peel Health Campus, and St John of God Midland) to be reported to the PSSU. Recording of compliments and contacts in the Datix CFM by WA's public hospitals and health care providers is encouraged but optional. Contracted Health Entities do not provide the PSSU with compliments and contacts data.

<sup>61</sup> Some data is not requested from Contracted Health Entities (Joondalup Health Campus, Peel Health Campus, and St John of God Midland) and represents the 'Unknown' component in Figure 47.

This was particularly true for consumers of mental health services where 80.5% of compliments were received directly from consumers, compared to just 50.4% of complaints.

Figure 47: Person Reporting by Type of Consumer Feedback Received for the WA Health System for 2021/22



**Note:** Mental health feedback is a subset of total health feedback.

## Complaints Overview

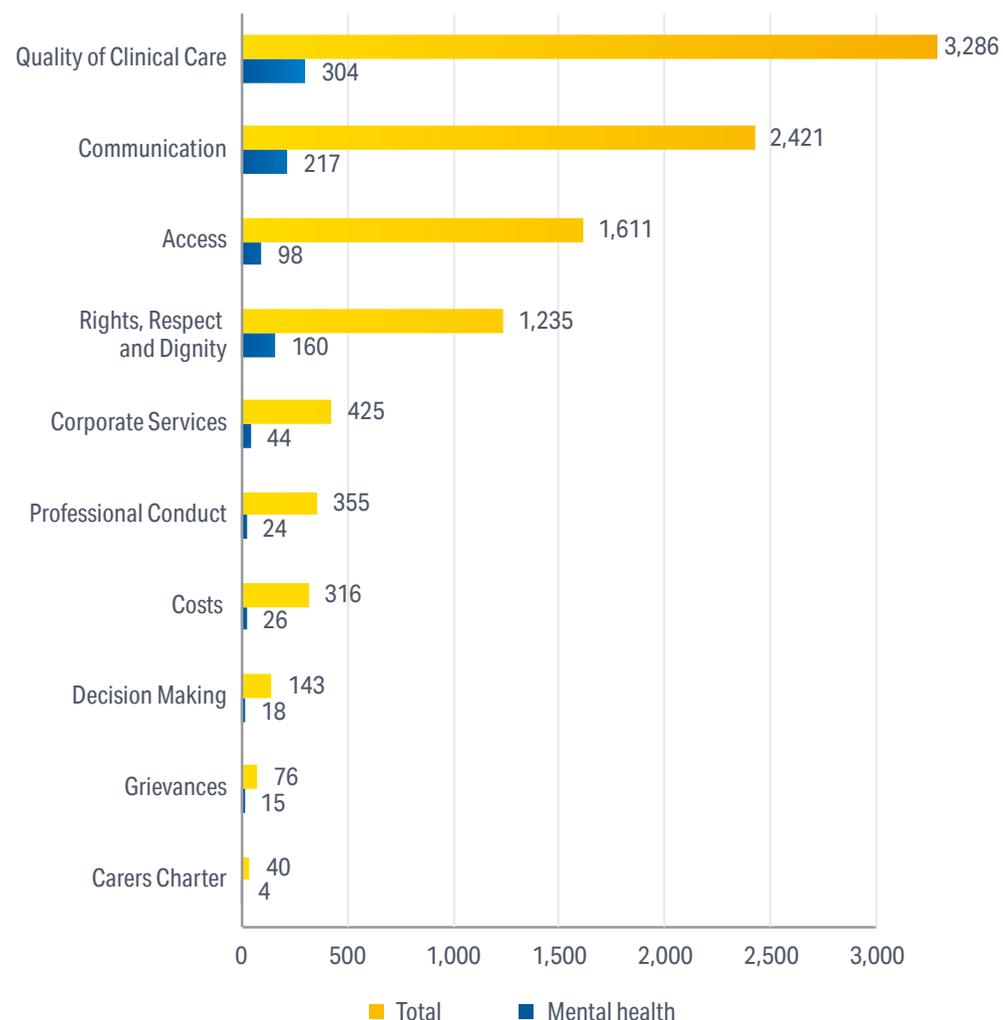
Every complaint received by the WA health system must have at least one issue identified. There are ten categories that issues are recorded against. The complaint issue categorisation used in the WA health system is further explained in the *Complaints Management Policy and Guideline*<sup>62</sup> and has three tiers of categories. Issue categorisation is based on the two-level category descriptions in the *Health and Disability Services (Complaints) Regulations 2010*<sup>63</sup>, with a further third level of categorisation available in the Datix CFM enabling analysis of specific trends in complaints.

In 2021/22, a total of 9,908 issues were identified in the 5,395 complaints received. The proportion of issues identified in each first-level category is shown in Figure 48. The top four broad complaint categories remain unchanged from previous years and accounted for 86.3% of all issues identified.

Complaint issues relating to mental health care generally followed a similar distribution of total health complaint issues. However, for mental health care there is a higher proportion of issues categorised within 'Rights, Respect and Dignity' (17.6% compared to 12.5% for total health complaints) and a lower proportion of 'Access' issues reported (10.8% compared to 16.3% for total health complaints).

For the purpose of this report the term mental health complaint describes those complaints received by health services providing specialised mental health care in community services or hospitals and is presented as a subset of total health complaints.

Figure 48: Issues Identified by Person Reporting the Feedback in Complaints Received by the WA Health System for 2021/22



62 [MP 0130/20 Complaints Management Policy, Pg4 and Complaints Management Guideline Pg28-35](#)

63 [WALW - Health and Disability Services \(Complaints\) Regulations 2010 - Home Page \(legislation.wa.gov.au\)](#)

## Complaints Demographics

The Datix CFM captures a range of demographic data which can be used to identify issues faced by the different vulnerable groups in the WA health system.<sup>64</sup> In late 2020, demographic data from the patient administration system was interfaced into Datix CFM, with the intent to improve the completeness of demographic data in Datix CFM without having to specifically ask consumers. Complete demographic data enables health service organisations to identify trends in issues relating to particular demographic groups. Services can then develop improvements specifically tailored to improve the health care experiences of vulnerable groups.

Of the people affected in the 4,664 complaints recorded in Datix CFM:

### Age

- 13.7% were under 18 years of age
- 56.7% were between 18 and 64 years of age
- 29.6% were 65 years or older.

### Gender

- 2,488 identified as female
- 1,647 identified as male
- 5 did not identify as male or female.

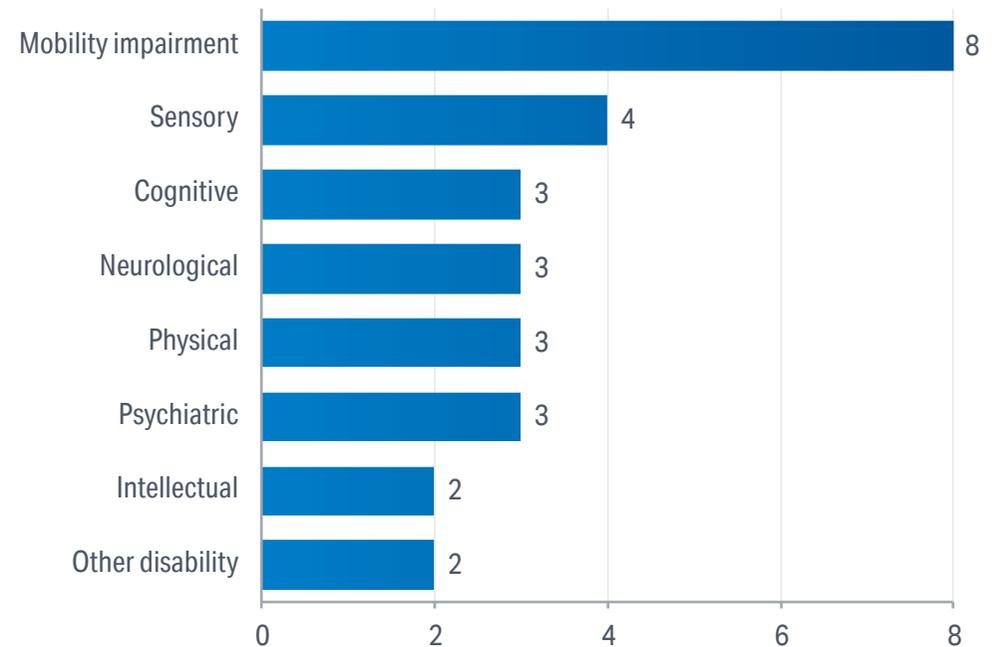
### Aboriginal and Torres Strait Islander

- 212 (6.2%) were Aboriginal and/or Torres Strait Islander persons.

### Disabilities identified

- 19 people identified at least one disability (see Figure 49).

Figure 49: Disabilities Identified by the Person Affected in Complaints in 2021/22



**Note:** A person affected by a complaint may identify multiple disabilities.

<sup>64</sup> As demographic data is not mandatory to report, the available data will not reflect a complete demographic profile and numbers will be small. It also does not include contracted health entities. Caution is required when interpreting demographic data.

## Complaints Resolution

At the conclusion of the complaint management process a resolution is recorded that reflects the measures taken by the service in response to the issues raised in the complaint. Each complaint should have at least one resolution recorded, with more than one resolution possible for each complaint. There may be further quality improvement activities that arise from a complaint that are not captured within the recorded resolution.

Of the complaints received during 2021/22, 4,389 had been closed at the time of reporting with at least one resolution recorded in 4,326 records.<sup>65</sup> The most frequent resolutions achieved (Figure 50) continue to be the provision of an apology (n=3,241, achieved in 74.9% of complaints with recorded resolutions), the registration of a concern (n=2,625, achieved in 60.7% of complaints with recorded resolutions), and the provision of an explanation (n=2,561, achieved in 59.2% of complaints with recorded resolutions).

Other outcomes include: Referral to another internal process (n=105), Referred to another organisation (n=53), Costs refunded or reduced (n=77), Agreement not reached (n=34), Complaint has been withdrawn (n=37), Change in policy effected (n=20), Compensation paid (n=17), Other outcomes not stated (n=184), and Unknown outcome (n=17).

Consumers have shared the importance of receiving a sincere apology targeted to their specific circumstances rather than a stock-standard apology that lacks caring and compassion.

Figure 50: Complaints Resolution Achieved in 2021/22



<sup>65</sup> Each closed complaint record should have at least one resolution recorded, with multiple resolutions possible in each complaint. Resolutions may not be entered if the complaint management process was not concluded at the time data was extracted from the Datix CFM. Resolution information is not received for complaints regarding public patients treated at Contracted Health Entities (Joondalup Health Campus, Peel Health Campus and St John of God Midland).

## Quality of Clinical Care Complaint Issues

The quality of clinical care is consistently the largest contributor to total complaint issues identified by consumers. In 2021/22, of the 9,908 issues recorded, 33.2% (n=3,286) of complaint issues related to the quality of clinical care. The representation of this category was similar for issues relating to mental health complaints (n=304, 33.4%).

The three most frequently reported quality of clinical care issues in 2021/22 were consistent with previous years and are shown in Supplement [Table 35](#). Issues of 'Inadequate treatment/therapy' were the most frequently reported at 10.2% of total complaint issues (n=1,006) and higher at 13.1% of mental health complaint issues (n=119). Inadequate assessment was the second most common quality of clinical care complaint issue at 7.1% of total complaint issues (n=701). This category reflected a similar proportion in mental health complaint issues at 6.0% (n=55). The third most common complaint issue was 'Discharge or transfer arrangements' at 4.3% of total complaint issues (n=426). Mental health complaints reflected greater concern regarding discharge or transfer arrangements, which were the second most common complaint issue in mental health complaints (n=61; 6.7%).

### Key Messages and Information: Quality of Clinical Care Complaint Issues

Quality of clinical care complaint issues identify situations where consumers felt their treatment or assessment was inadequate or where there were poor discharge arrangements as top concerns.

Inadequate assessment and treatment can include a wide range of issues, including circumstances where there are delays in treatment through to inexperience regarding a procedure and its complexity. Issues reported by consumers in this category can be potential early warning signs for situations that could lead to patient harm.

Hospitals and health services can capitalise on these issues and implement improvement strategies to mitigate the risks identified by consumers and improve the safety of services provided for all patients.

## Communication Complaint Issues

In 2021/22, there were 2,421 communication complaint issues reported, constituting 24.4% of total complaint issues. The top three communication complaint issues were the same across total health and mental health services, but the order of the complaint issues differed.

The most frequently reported communication complaint issue was 'Misinformation/failure in communication (not failure to consult)' with 826 issues identified (8.3% of total complaint issues; see Supplement [Table 36](#)). This issue was ranked second in mental health communication complaint issues (n=64; 7.0%).

For complaints in mental health services, the most common communication complaint issue was 'Failure to listen to consumer/representative/carer/family' (n=72; 7.9% of mental health complaint issues) which was ranked second for total communication complaint issues (n=659; 6.7%).

The issue category of 'Inappropriate verbal/non-verbal communication' was the third most common across all complaints (n=542; 5.5%) and in mental health communication complaint issues made up 4.2% (n=38).

### Key Messages and Information: Communication Complaint Issues

Issues with communication are a common theme in complaints and are often a contributory factor to the occurrence of clinical incidents. Communication is not a one-way flow of information from health professional to consumer but requires provision of information in a respectful manner and taking the time to ensure understanding by the consumer. Furthermore, a failure to listen and take into account the family who are an important part of a consumer's care when they are unwell and cannot optimally advocate for themselves can lead to poor outcomes.

Initiating quality improvement activities from consumer complaints that highlight where communication has failed, been inappropriate or inadequate can potentially avoid future harmful clinical incidents.

## Access Complaint Issues

Complaint issues surrounding access to services constituted 16.3% of total complaint issues (n=1,611) in 2021/22. [Table 37](#) in the Supplement shows the most commonly reported access issue was 'Delay in admission/treatment' (n=525; 5.3% of total issues), followed by 'Inadequate resources/lack of service' (n=417; 4.2%), and 'Waiting list delay' (n=383; 3.9%).

The most frequent issues in mental health services differed, with 'Inadequate resources/lack of service' being the most common complaint issues (n=39; 4.3% of total mental health complaint issues), followed equally by 'Refusal to provide services' (n=19; 2.1%), and 'Delay in admission/treatment' (n=19; 2.1%).

### Key Messages and Information: Access Complaint Issues

Open and clear communication is required to discuss consumer expectations of access to public health services. Clearly explaining reasons for delays to patients, including both delays on a waiting list and delays experienced once at a hospital or health service can aid to reduce potential anxiety, misunderstandings and ensure the patient remains engaged in their health care in order to achieve optimal outcomes.

Sometimes however the access issue becomes a concern as it can lead to a clinical incident, for example a lost referral or lack of case review within the recommended timeframe may mean the patient becomes unwell. Inadequate resourcing of staff during busy periods can also lead to lengthy waiting times for treatment and increase the risk that the patient deteriorates. These situations represent opportunities for changes to be implemented – sometimes a small change, such as a staffing roster where there is permanent on-call help, may relieve these issues before they become a clinical incident.

## Rights, Respect and Dignity Complaint Issues

In 2021/22, there were a total of 1,235 complaint issues lodged relating to the 'Rights, respect and dignity' category, accounting for 12.5% of total complaint issues received, but 17.6% (n=160) of mental health complaint issues.

The top three issue categories ([Table 38](#) in Supplement) continues to be the same as in previous years: 'Inconsiderate service/lack of courtesy' as 6.7% of total complaint issues (n=664) and 7.9% of total mental health issues (n=72); 'Absence of compassion' as 3.3% of total complaint issues (n=331) and 4.3% of total mental health issues (n=39); and 'Breach of confidentiality' identifying situations where information was provided to a third party without the consent of the consumer as 1.0% of total complaint issues (n=96) and 2.7% of total mental health issues (n=25).

### Key Messages and Information: Rights, Respect and Dignity Complaint Issues

Consumers deserve to be treated with politeness, kindness and respect during their care. When health consumers are faced with staff who have an unhelpful manner, it can lead to a breakdown of the therapeutic relationship between health care professionals and the consumer.

The continued higher number of rights, respect and dignity issues identified by mental health consumers emphasises the particular challenges felt by consumers of mental health services in the WA health system. Encouraging feedback from vulnerable groups is vital to ensuring all consumers feel safe receiving care from the WA health system.



# Future focus

## Future Focus

The PSSU aims to provide an integrated approach to patient safety policy, systems and processes in the WA health system. The PSSU supports health services and organisations with expertise in a wide range of areas including clinical governance, data management, liaison between key stakeholders and strategic planning.

The considerable impact of COVID-19 in the WA community in the last year has meant in some instances a pause or limited progress on the actions and programs that were planned. It has been a demanding time for the WA health system staff and the ongoing commitment to the delivery of safe, high-quality care is most appreciated.

In the area of progressing a positive safety culture, the PSSU undertook a refresh of their internet resources. The new materials unpack for stakeholders the key components of safety culture. The PSSU will continue to promote a culture of reporting and learning from patient safety events. This will include ensuring that clinical incidents with serious, harmful outcomes are reviewed thoroughly as SAC 1 events.

The next area for intense focus is safety and quality capability and a project has commenced that is a component of the Sustainable Health Review Recommendation 23:

*Build a systemwide culture of courage, innovation and accountability that builds on the existing pride, compassion, and professionalism of staff to support collaboration for change.*

The imperative need for an electronic medical record (EMR) cannot be overstated. There have been calls for the introduction for a state-wide EMR from many sources, including the State Coroner as a result of coronial cases involving medication safety issues. Medication safety issues are at the forefront of preventable harm incidents and as with all complex problems, require a multi-faceted approach to addressing improvements. The PSSU's surveillance of the patient safety data illustrates just some of the rationale for the pressing need for an EMR to aid in the modernisation and innovation needed to tackle patient safety and quality concerns.





# Appendices

# Appendix One: SAC 1 Clinical Incident Notification List

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

\* Effective 1 July 2018, the CIM Policy was amended to incorporate the 10 revised sentinel event categories endorsed by the Australian Health Ministers' Advisory Council in December 2017. Sentinel event data in this report includes those events reported under these revised categories from 2018/19.

Severity Assessment Code 1 Categories (Other)
<p><b>SAC 1 includes clinical incidents which 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.</b></p> <p><b>Note: this list is NOT EXHAUSTIVE.</b></p>
<p>Medication error (not resulting in death, serious harm or a near miss sentinel event) may include:</p> <ul style="list-style-type: none"> <li>▪ The inappropriate administration of daily oral methotrexate.</li> <li>▪ The intravenous administration of epidural medication.</li> <li>▪ Wrong gas being administered.</li> </ul>
<p>Fetal complications associated with health care delivery:</p> <ul style="list-style-type: none"> <li>▪ Unrelated to congenital abnormality in an infant causing death, or serious and/or ongoing perinatal morbidity.</li> <li>▪ Complications not anticipated yet arose and were not managed in an appropriate/timely manner resulting in death or serious and/or ongoing morbidity.</li> <li>▪ Delivery at a site other than where labour commences which requires transfer to another facility for a higher level of care resulting in death or serious and/or ongoing morbidity.</li> </ul>
<p>Misdiagnosis and subsequent management (refers to physical and mental health)</p> <ul style="list-style-type: none"> <li>▪ Failure to monitor and respond to oxygen saturation.</li> </ul>
<p>Clinical deterioration of a mental health patient resulting in serious harm (physical, verbal, or sexual) or death to staff, other patients, or other persons</p>

## Severity Assessment Code 1 Categories (continued)

### Complications of resuscitation:

- Events in which staff experienced problems in managing an emergency situation or resuscitation resulting in death or serious and/or ongoing morbidity.
- Failed resuscitation where resuscitation guidelines could not be followed due to a deficiency of equipment, communication, or staffing resulting in death or serious and/or ongoing morbidity.

### Complications of anaesthetic management:

- Unintended intra-operative awareness.
- Anaesthetic events resulting in death or serious and/or ongoing morbidity.

### Complications of surgery:

- Intentional retention of foreign material for treatment which is found to have resulted in harm.
- Pulmonary embolism.
- Injury to major blood vessels.

### Complications of a fall within a health service

### Delay in recognising/responding to physical clinical deterioration

### Hospital acquired pressure injuries

### Hospital/Service process issues:

- Events in which hospital or other health service processes such as triaging, assessment, planning or delivery of care (e.g. miscommunication of test results, response to abnormal test results) contributed to death or serious and/or ongoing morbidity.
- Transport or transfer – events in which delays in transport or transfer contributed to death or serious and/or ongoing morbidity.
- Misidentification of patients.

## Severity Assessment Code 1 Categories (continued)

### Intravascular gas embolism resulting in death or neurological damage\*

### Infection control breach (e.g. IV cannula related bacteraemia infections)

The unexpected death of a mental health client (e.g. suspected suicide which occurs in a location other than an acute psychiatric unit or acute psychiatric ward, unnatural or violent death).

### Maternal death\*

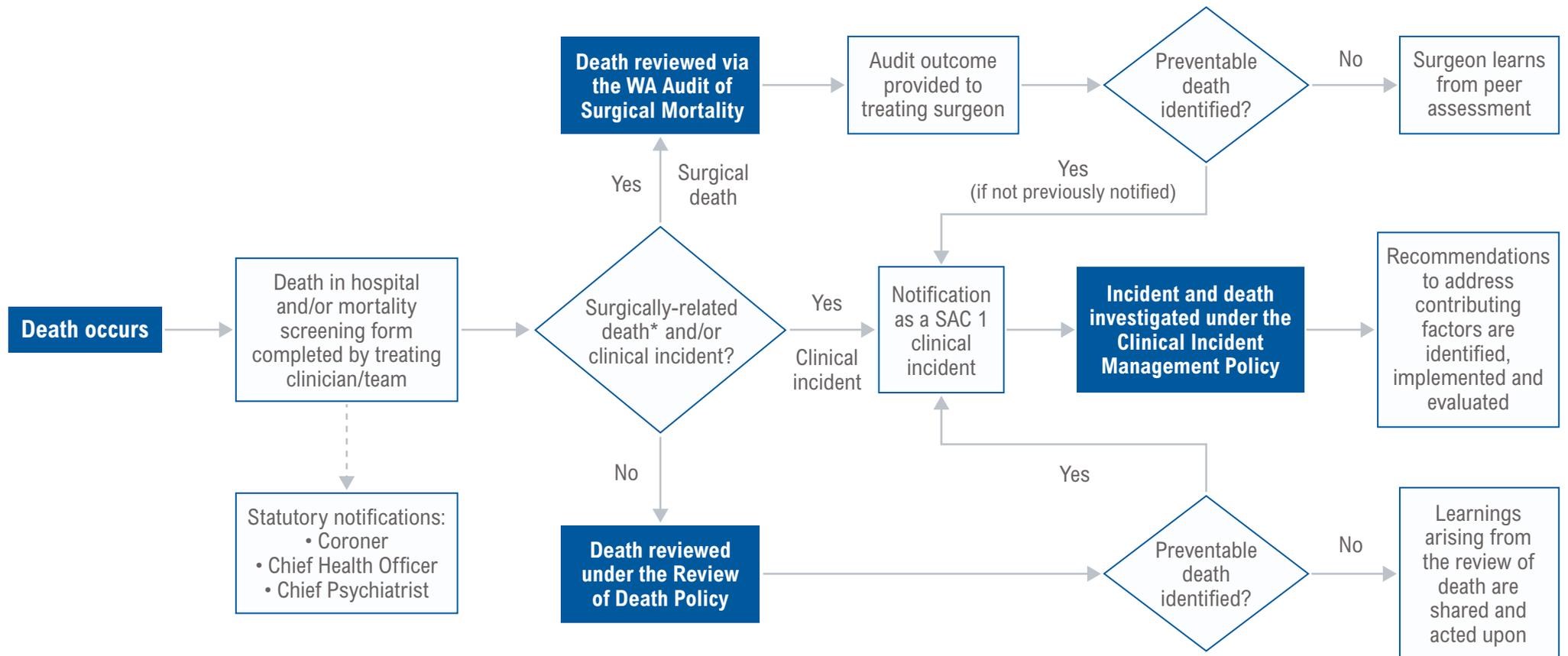
The death of a woman whilst pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

### Missing or absent without leave (AWOL) of any high-risk mental health patient/consumer

### Patient missing or absent without leave (AWOL) with adverse outcome

\* These categories were recognised as sentinel events prior to 1 July 2018.

# Appendix Two: Interaction of the Review of Death Policy with CIM and WAASM Processes



\* Surgically-related deaths include deaths under the care of a surgeon where a surgical procedure was performed, and where no procedure was undertaken unless a decision for terminal care had been made at the point of admission. A surgically-related death where a clinical incident is thought to have occurred must be concurrently investigated as a SAC 1 clinical incident while being reviewed via the WAASM. Non-operative terminal care cases are reviewed under the Review of Death Policy unless a clinical incident is suspected to have occurred.

# Data Quality Statement for this Report

## Quality Dimensions

### Institutional Environment

Clinical Incident data are obtained from across the WA health system. It is mandatory for all health service providers to report all clinical incidents in the Datix Clinical Incident Management System (CIMS). Severity Assessment Code (SAC) 1 clinical incidents are also received from all WA licensed private hospitals (including contracted health entities) and contracted non-government organisations (NGOs).

Consumer feedback data are obtained from WA Health Service Providers, including complaints from public patients treated by contracted health entities. It is mandatory for public hospitals and health services and contracted health entities to report complaints data in accordance with the Complaints Management Policy.

Demographic data related to clinical incidents and consumer feedback are sourced from the WA health system's Patient Administration System (PAS) via a link to the Datix CIMS and CFM.

Hospital separation and bed day data are extracted from the Hospital Morbidity Data Collection (HMDC) and are provided by Inpatient Data Collections. The HMDC captures inpatient activity and discharge data related to WA public hospitals and contracted health entities. Data in the HMDC is entered by clinical coders, based on the information recorded by clinicians in each patient's medical record.

The WAASM data are obtained from the Royal Australasian College of Surgeons.

Review of death data are obtained from WA public hospitals, WA licensed private hospitals (including contracted health entities) and contracted non-government organisations.

The PSSU undertakes all data analysis presented within this report unless otherwise stated.

## Relevance

The purpose of the clinical incident data is to report all state-wide clinical incidents notified within the 2021/22 period. SAC 1 clinical incidents include data from the WA health system, including hospitals and health services and data from licensed private hospitals (including contracted health entities) and contracted NGOs.

Clinical incident rate calculations include inpatient clinical incidents only (unless otherwise specified) with the denominator including separation/bed days data from WA health system hospitals' inpatient activity data. The web based Datix CIMS has improved rates analysis by providing more specific location information.

The purpose of the consumer feedback data is to report all complaints and other consumer feedback received by the WA public health system to the Datix Consumer Feedback Module (CFM), as well as complaints data reported to the PSSU by contracted health entities within the 2021/22 period. Complaints inform about patient centred care and are an integral component of clinical governance.

WAASM data includes deaths that occurred under the care of a surgeon, whether a procedure occurred or not. The WAASM follows a peer review model of audit and can identify areas of concern for the care of a surgical patient.

The purpose of the review of death data is to report the proportion of deaths in WA public hospitals, WA licensed private hospitals (including contracted health entities) and contracted non-government organisations reviewed within four months of the date of death.

## Timeliness

The Datix CIMS and CFM data was extracted on 8 July 2022 (including demographic data). Complaints data from contracted health entities was provided to the PSSU in July 2022.

The reference period for this data is 1 July 2021 to 30 June 2022. Due to data coding delays, there is a lag time regarding some Datix CIMS data such as confirmed SAC data. As such, data frequencies may change over time and prohibit comparison with previous reports. Notification to IHACPA was based on Datix CIMS data extracted on 5 September 2022. In some parts of this report clinical incident data has been presented for the five-year period 1 July 2017 to 30 June 2022.

HMDC data was extracted on 9 August 2022 and all HMDC data are preliminary. Standard exclusions have been applied as follows: separations for unqualified newborns, boarders, posthumous organ procurements, non-WA or non-inpatient facilities, aged care residents, and funding hospital (duplicate) cases. Mental health activity is not excluded.

WAASM data includes cases that had completed the review process by the census date of 6 April 2022. WAASM data includes cases where the death occurred over the period 1 January 2017 to 31 December 2021.

In accordance with the Review of Death Policy (MP 0098/18) review of death data is ordinarily provided to the PSSU twice per year (due 31 May and 30 November). All Health Service Providers were advised in April 2022 that reporting for the period 1 July 2021 to 31 December 2021 was suspended to support the health system's COVID-19 response. The reference period for this report is 1 January 2021 to 30 June 2021 with the last data collection due 30 November 2021.

Coronial inquest summaries include all health-related inquest findings released between 1 July 2021 and 30 June 2022 and discussed by the Coronial Review Committee. The status of coronial recommendations is current as at the most recent Progress Report for Health-Related Coronial Recommendations (August 2022).

## Accuracy

Data are entered into the Datix CIMS and CFM databases on a routine basis by WA Health Service Provider staff at each facility. Datix CIMS data are entered in real time by the notifier. All data entered undergo data validation processes both at a local and state-wide level. This is to ensure the data are clean and free from duplicates.

Data regarding clinical incidents related to 2nd edition NSQHS Standards are reported from the Datix CIMS via the proprietary three-tiered Common Classification System (CCS2). The CCS2 was reviewed in 2019, with codes relevant to 2nd edition NSQHS Standards agreed by the State Datix Committee. Details of the CCS2 codes relevant to each NSQHS Standard can be provided by the PSSU on request.

WAASM data are reported in accordance with that reported to the PSSU by the Royal Australasian College of Surgeons.

## Coherence

Datix CIMS and CFM data are dynamic and lag times exist for some CIMS and CFM variables. Due to ongoing updates to the Datix CIMS and CFM data over time values may change, which can prevent the comparison of data at different times. Care should be taken when comparing data from previous editions of this report as data definitions may vary over time.

The 2019/20 clinical incident data was the first year related to the 2nd edition NSQHS Standards. Data in this report are comparable to the 2019/20 and 2020/21 editions but are not directly comparable to previous editions of this report that related clinical incident data to the 1st edition of the NSQHS Standards.

## Accessibility

Datix CIMS and CFM data are only accessible to WA health system employees who have been granted permission to access the Datix CIMS and/or CFM. The PSSU does allow access to de-identified CIMS and CFM data by external parties whose research proposal has been approved by PSSU and who have obtained Department of Health ethics approval.

All requests for HMDC data require approval from Data Integrity Management.

The WAASM data is protected under the Commonwealth's *Health Insurance Act 1973*. The release of aggregate data is subject to the authorisation of the Royal Australasian College of Surgeons.

## Interpretability

Datix CIMS data presented in this report may include percentages. Numerators and denominators for all percentages exclude incidents with a workflow status of 'Inactive'. Unless otherwise stated, denominators for:

- Percentages of incidents notified are counts of incidents confirmed as SAC 1, SAC 2 and SAC 3 as well as incidents awaiting SAC confirmation
- Percentages of confirmed incidents are counts of incidents confirmed as SAC 1, SAC 2 and SAC 3
- Percentages of closed incidents are counts of incidents confirmed as SAC 1, SAC 2 and SAC 3 that have a workflow status of 'Closed'
- Percentages relating to demographic data (age group, gender and Aboriginal and Torres Strait Islander) are counts of patients involved in incidents confirmed as SAC 1, SAC 2 and SAC 3. Missing demographic data is excluded. A clinical incident may affect multiple patients.

Datix CFM data presented in this report may include percentages. Numerators and denominators for all percentages exclude records with a workflow status of 'Inactive'. Unless otherwise stated, denominators for:

- Percentages of closed complaint records are counts of complaints with a complete 'Date reply done'
- Percentages relating to demographic data are counts of person affected in a complaint. Missing demographic data is excluded. There may be multiple people affected in one complaint record.

Demographic data presented in this report relates to the individuals involved in patient safety events as follows:

- Clinical incidents notified as not involving a patient are excluded from demographic analysis throughout the report but included in other analyses
- Data is presented where there appears to be disproportionate representation of demographic groups
- As the percentages expressed for demographic data exclude records with missing data denominators will vary throughout the report
- Demographic data noted as not recorded may not be recorded in the record or may be recorded as unknown
- Data presented for Aboriginal and Torres Strait Islander people is obtained from Datix CIMS and CFM where people can identify as Aboriginal and not Torres Strait Islander, Torres Strait Islander but not Aboriginal, or Aboriginal and Torres Strait Islander. Due to low frequencies in some of these groups these figures have been aggregated throughout the report.

Any queries regarding the data found in this report can be directed to the Patient Safety Surveillance Unit, Department of Health.

# 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. Clinical incidents include:

- **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.<sup>66</sup>

**Clinical Incident Management (CIM)** - the process of effectively managing clinical incidents with a view to minimising preventable harm.<sup>70</sup>

**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.<sup>67</sup>

**Contracted health entity** - a non-government entity that provides health services under a contract or other agreement entered into with the Department CEO on behalf of the State, a health service provider or the Minister.<sup>68</sup>

**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.<sup>70</sup>

**Datix Clinical Incident Management System (CIMS)** - the approved WA health

state-wide 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 three 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.<sup>69</sup>

**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.<sup>70</sup>

**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.<sup>72</sup>

66 [MP 0122/19 Clinical Incident Management Policy](#)

67 [MP 0130/20 Complaints Management Policy](#)

68 [Health Services Act 2016](#)

69 [Datix Common Classification System Version 2](#)

**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 Appendix One: SAC 1 Clinical Incident Notification List).<sup>70</sup>

**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.<sup>70</sup>



# Supplement section

Table 14: Confirmed SAC 2 and SAC 3 Clinical Incidents with Patient Outcomes of Death or Serious Harm for 2017/18 to 2021/22

Confirmed SAC rating	2017/18	2018/19	2019/20	2020/21	2021/22
SAC 2	13	11	16	22	41
SAC 3	1	0	10	4	10
<b>Total</b>	<b>14</b>	<b>11</b>	<b>26</b>	<b>26</b>	<b>51</b>

Table 15: WA Sentinel Events (including near miss Sentinel Events) by Category for 2018/19 to 2021/22

Sentinel Event Category	2018/19	2019/20	2020/21	2021/22
Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	3	3	1	5
Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death	–	1	–	–
Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death	–	–	–	1
Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death	3	4	3	3
Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death	2	–	–	1
Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	2	3	3	–
Medication error resulting in serious harm or death	5	3	12	16
Use of physical or mechanical restraint resulting in serious harm or death.	1	–	–	–
Discharge or release of an infant or child to an unauthorised person.	–	–	–	–
Use of an incorrectly positioned oro-or naso-gastric tube resulting in serious harm or death	1	–	1	–
<b>Total</b>	<b>17</b>	<b>14</b>	<b>20</b>	<b>26</b>

Note: Version 2 of the Australian sentinel events list was implemented in WA from 1 July 2018.<sup>70</sup>

<sup>70</sup> [Australian sentinel events list version 2](#)

Table 16: Confirmed SAC 1 Clinical Incidents other than Sentinel Events for 2017/18 to 2021/22

SAC 1 Category	2017/18	2018/19	2019/20	2020/21	2021/22
Infection control breach	74	123	99	127	124
Complications of a fall in a health service <sup>a</sup>	72	68	74	85	105
Hospital/Service process issues <sup>b</sup>	81	65	55	63	74
The unexpected death of a mental health client	39	28	46	34	48
Delay in recognising/responding to physical clinical deterioration <sup>c</sup>	41	68	38	57	45
Clinical deterioration of a mental health patient resulting in serious harm (physical, verbal, or sexual), or death or serious harm to staff, other patients, or other persons <sup>d</sup>	28	23	31	30	36
Misdiagnosis & subsequent management (physical & mental health)	28	28	34	26	29
Medication error (not resulting in death, serious harm or a near miss sentinel event) <sup>e</sup>	30	N/A	8	29	23
Fetal complications associated with health care delivery	14	20	13	19	20
Complications of surgery	28	17	21	10	15
Any other incident resulting in serious harm or death	61	68	46	22	11
Missing (or AWOL) high risk mental health patient/consumer	43	32	9	14	9
Patient missing or absent without leave with adverse outcome	4	3	5	2	3
Complications of resuscitation	4	7	4	7	2

SAC 1 Category	2017/18	2018/19	2019/20	2020/21	2021/22
Complications of anaesthesia management	4	4	2	3	2
Hospital acquired pressure injuries <sup>f</sup>	-	-	-	2	2
Death while pregnant or within 42 days of pregnancy ending <sup>g</sup>	-	1	2	1	-
Intravascular gas embolism resulting in death or neurological damage	-	-	1	2	-
<b>Total</b>	<b>551</b>	<b>555</b>	<b>488</b>	<b>533</b>	<b>548</b>

Note: The Datix CIMS and SAC 1 databases are dynamic, with data changing over time as events are investigated retrospectively. The addition of new incident categories to these databases may have resulted in reclassification of events to different incident categories.

- a Category renamed in November 2019; previously named 'Complications of an inpatient fall'.
- b Hospital/Service process issues refers to hospital/health service processes such as referral, transport and transfer, triage, admission, assessment, planning (including discharge planning) or the delivery of care that contributed to a poorer than expected outcome. Category renamed in November 2019; previously named 'Hospital process issues'.
- c Category renamed in November 2019; previously named 'Delay in recognising/responding to clinical deterioration'.
- d Category renamed in May 2020; previously named 'Mental health clinical deterioration resulting in serious harm'.
- e Category 'Medication error not resulting in death' decommissioned in July 2018. 'Medication error (not resulting in death, serious harm or a near miss sentinel event) established December 2019. Data for 2019/20 relates to December 2019 to June 2020.
- f Category added 15 January 2020. Incidents prior to this date were categorised as "Any other incident resulting in serious harm or death".
- g Category redefined as Other SAC 1 Clinical Incident from 1 July 2018. Incidents prior to this date were categorised as sentinel events.

Table 17: Contributory Factors for Closed SAC 1 Clinical Incidents for 2019/20 to 2021/22

Type of Contributing Factor	2019/20		2020/21		2021/22	
	(n)	(%)	(n)	(%)	(n)	(%)
Communication	357	71.1	390	70.5	330	69.9
Policies, Procedures, Guidelines	327	65.1	337	60.9	314	66.5
Patient Factors	303	60.4	340	61.5	258	54.7
Knowledge/Skills/Competence	225	44.8	251	45.4	194	41.1
Work Environment/Scheduling	147	29.3	177	32.0	143	30.3
Safety Mechanisms	103	20.5	146	26.4	108	22.9
Equipment, Information/Applications	76	15.1	90	16.3	80	16.9
Other issues	36	7.2	34	6.1	18	3.8

**Note:** A clinical incident investigation may identify multiple contributory factors.

The denominator for each year is the total number of closed SAC 1 clinical incidents (2019/20 = 502; 2020/21 = 553; 2021/22 = 472).

Table 18: Confirmed SAC 1 Clinical Incident Categories related to Mental Health Care for 2021/22

SAC 1 Category	Death	Serious harm	Moderate harm, Minor harm or No harm
The unexpected death of a mental health client	48	–	–
Clinical deterioration of a mental health patient resulting in serious harm (physical, verbal, or sexual), or death or serious harm to staff, other patients, or other persons	6	23	7
Hospital/Service process issues	1	1	2
Patient missing or absent without leave with adverse outcome	1	1	–
Missing (or AWOL) high risk mental health patient/consumer	–	3	6
Complications of a fall in a health service	–	3	–
Infection control breach	–	3	–
Other incidents	–	2	1
Delay in recognising/responding to physical clinical deterioration	–	1	–
Medication error (not resulting in death, serious harm or a near miss sentinel event)	–	–	1
<b>Total</b>	<b>56</b>	<b>37</b>	<b>17</b>

Table 19: Confirmed SAC 1 Clinical Incidents where Fetal Harm was reported for 2017/18 to 2021/22

SAC 1 Category	2017/18	2018/19	2019/20	2020/21	2021/22
Fetal complications associated with health care delivery	14	18	7	10	14
Hospital/Service process issues	4	1	-	2	2
Misdiagnosis & subsequent management (physical & mental health)	2	1	1	2	1
Delay in recognising/responding to physical clinical deterioration	2	8	1	1	1
Sentinel Event - Medication error resulting in serious harm or death	-	-	-	1	-
Sentinel Event - Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death	-	-	-	1	-
Complications of resuscitation	-	-	1	-	-
Death while pregnant or within 42 days of pregnancy ending	-	1	1	-	-
Any other incident resulting in serious harm or death	2	1	-	-	-
<b>Total</b>	<b>24</b>	<b>30</b>	<b>11</b>	<b>17</b>	<b>18</b>

**Note:** Fetal harm fields in Datix CIMS were implemented in October 2017 and remain non-mandatory data fields. Inclusion in this data requires staff to have recorded that a fetus was harmed in this incident.

Table 20: Confirmed Comprehensive Care Clinical Incidents by Patient Outcome and Sub-category for 2021/22

Comprehensive Care Sub-categories	No harm	Minor harm	Moderate harm	Serious harm	Death
Falls	3,313	2,291	168	86	14
Unpredictable behaviours	1,528	857	132	30	28
Pressure Injuries	386	1,849	92	4	–
Restrictive practices	75	133	15	–	–
Poor nutrition and malnutrition	15	9	–	–	–
<b>Total</b>	<b>5,317</b>	<b>5,139</b>	<b>407</b>	<b>120</b>	<b>42</b>

**Note:** Patient outcome missing data n=242 (Falls n=138; Unpredictable behaviours n=51; Pressure injuries n=51; Restrictive practices n=1; Poor nutrition and malnutrition n=1)

Table 21: Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Gender and Sub-category for 2021/22

Comprehensive Care Sub-categories	Female	Male
Falls	2,588	3,322
Unpredictable behaviours	1,412	1,344
Pressure Injuries	1,042	1,300
Restrictive practices	155	67
Poor nutrition and malnutrition	13	10
<b>Total</b>	<b>5,210</b>	<b>6,043</b>

**Note:** Patient gender missing/unknown data n=138 (Falls n=85; Unpredictable behaviours n=11; Pressure injuries n=37; Restrictive practices n=3; Poor nutrition and malnutrition n=2)

Table 22: Aboriginal and Torres Strait Islander Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Sub-category for 2021/22

Comprehensive Care Sub-categories	Aboriginal and/or Torres Strait Islander patients	Other patients
Falls	399	5,362
Unpredictable behaviours	472	2,203
Pressure Injuries	133	2,170
Restrictive practices	22	198
Poor nutrition and malnutrition	2	20
<b>Total</b>	<b>1,028</b>	<b>9,953</b>

**Note:** Missing/unknown data n=410 (Falls n=234; Unpredictable behaviours n=92; Pressure injuries n=76; Restrictive practices n=5; Poor nutrition and malnutrition n=3)

Table 23: Mental Health Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Sub-category for 2021/22

Comprehensive Care Sub-categories	Mental Health patients	Non-Mental Health patients
Falls	628	5,356
Unpredictable behaviours	2,348	416
Pressure Injuries	37	2,340
Restrictive practices	145	79
Poor nutrition and malnutrition	3	22
<b>Total</b>	<b>3,161</b>	<b>8,213</b>

**Note:** Patient mental health status missing/unknown data n=17 (Falls n=11; Unpredictable behaviours n=3; Pressure injuries n=2; Restrictive practices n=1). Mental health patients include involuntary, referred and voluntary patients under the *Mental Health Act 2014*.

Table 24: Confirmed Falls Incidents by Most Frequent Activities at Time of Fall for 2021/22

Activity at Time of Fall	(n)	(%)
Walking	1,244	20.7
Attempting to sit/stand	914	15.2
Toileting or attempting to toilet	896	14.9
Getting in/out of bed	774	12.9
Bending/leaning/reaching over	441	7.3

**Note:** Activity at time of fall missing data n=544; 9.1%

Table 25: Confirmed Falls Incidents by Most Frequent Places Where Fall Occurred for 2021/22

Place of Fall	(n)	(%)
Bed	2,203	36.7
Ward	1,679	27.9
Bathroom	1,204	20.0
Dining Room	140	2.3
Grounds	127	2.1

**Note:** Place of fall missing data n=358; 6.0%

Table 26: Confirmed Falls Incidents by Height of Fall for 2021/22

Height of Fall	(n)	(%)
Low fall (less than 0.5 metres e.g. off low bed or chair)	2,189	36.4
Fall from standing position	1,938	32.2
Medium fall (0.5 - 1 metre e.g. off bed)	824	13.7
High fall (more than 1 metre e.g. over high bed rail)	39	0.6
Fall on or from stairs or escalators	8	0.1

**Note:** Height of fall missing/unknown data n=1,012; 16.8%

Table 27: Confirmed Falls Incidents by Falls History Risk Factors for 2021/22

Falls History Risk Factors	(n)	(%)
One or more falls in the last six months	2,647	44.0
Falls or near miss during current admission	1,547	25.7
Admitted as a result of a fall	1,150	19.1
No falls history	1,705	28.4

**Note:** Fall history missing data n=401; 6.7%. A patient may have more than one falls history risk factor.

Table 28: Most Frequent Risk Factors for Closed Falls Incidents Where Patient Factors Contributed for 2021/22

Patient Risk Factors for Falls	(n)	(%)
Poor balance/unsteady	2,865	68.4
Taking more than 5 prescribed medications (polypharmacy)	2,084	49.8
Requires walking aid or similar (e.g. crutches, walking frame)	1,923	45.9
Requires assistance to mobilise	1,797	42.9
Dementia/cognitive impairment	1,603	38.3
Requires standby assistance	1,582	37.8
Delirium, anxiety or agitation	1,333	31.8
Difficulty communicating or following instructions	1,273	30.4
Weakness/generalised muscular weakness	1,248	29.8
Taking psychoactive medications (e.g. antidepressants or benzodiazepines)	812	19.4

**Note:** Patient risk factors for falls missing data n=122; 2.9%. A patient involved in a falls clinical incident may have more than one falls risk factor.

Table 29: Most Frequent Tier Three Unpredictable Behaviours Clinical Incident Categories for 2021/22

Unpredictable Behaviours Sub-categories	(n)	(%)
Inappropriate or aggressive physical behaviour by a patient towards an object, structure or staff member	831	31.6
Self-harm attempt or gesture	509	19.4
Inappropriate or aggressive physical behaviour by a patient towards another patient	283	10.8
Patient absconded or left without informing staff	280	10.7
Detained patient absconded or absent without leave*	137	5.2

\* 129 confirmed incidents in this category related to involuntary mental health patients under the *Mental Health Act 2014*

Table 30: Tier Two and Tier Three Pressure Injury Clinical Incident Categories for 2021/22

Pressure Injury Incident Category	Not present on admission	Present on admission	Unknown if present on admission	Total
Preventive/therapeutic interventions provided but not effective	1,197	157	306	<b>1,660</b>
Preventive/therapeutic interventions not performed	267	70	101	<b>438</b>
Deterioration after admission*	N/A	73	N/A	<b>73</b>
Skin inspection not performed on admission	15	13	35	<b>63</b>
Skin inspection performed but not until after 24 hours of admission	22	12	19	<b>53</b>
Skin inspection never performed	11	8	14	<b>33</b>
Risk assessment not performed on admission	7	3	16	<b>26</b>
Risk assessment never performed	15	4	6	<b>25</b>
Risk assessment performed but not until after 24 hours of admission	5	1	5	<b>11</b>

\*This incident category relates only to pressure injuries that were known to be present at the time of admission.

Table 31: Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission by Stage and SAC Rating for 2021/22

Pressure Injury Stage	SAC 1	SAC 2	SAC 3	Total
Stage 1 - non-blanchable erythema	-	3	497	<b>500</b>
Stage 2 - partial thickness skin loss	-	14	732	<b>746</b>
Stage 3 - full thickness skin loss	-	4	27	<b>31</b>
Stage 4 - full thickness skin and tissue loss	-	1	2	<b>3</b>
Unstageable pressure injury	-	9	96	<b>105</b>
Suspected deep tissue injury	2	15	56	<b>73</b>
<b>Total</b>	<b>2</b>	<b>46</b>	<b>1,410</b>	<b>1,458</b>

**Note:** Stage of pressure injury unknown data n=37; 2.4%. Incidents related to mucosal pressure injuries n=44; 2.9%.

Table 32: Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission by Number of Pressure Injuries at Time of Incident Notification for 2021/22

Number of Pressure Injuries	(n)	(%)
1	971	63.1
2	272	17.7
3	56	3.6
4	23	1.5
5	7	0.5
6 or more	5	0.3

**Note:** Number of pressure injuries at time of incident notification not specified/missing data n=205; 13.3%.

Table 33: Anatomical Locations for Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission for 2021/22

Anatomical Location	(n)	(%)
Sacrum	399	25.9
Heels/Feet/Ankles	299	19.4
Buttocks	189	12.3
Face/Nose	156	10.1
Head/Neck	89	5.8
Legs	86	5.6
Arms/Hands	80	5.2
Abdomen/Back/Chest	54	3.5
Other locations	51	3.3
Genital/Urethra	18	1.2

**Note:** Anatomical location of pressure injury missing data n=118; 7.7%.

Table 34: Confirmed Communicating for Safety Clinical Incidents by Patient Outcome and Sub-category for 2021/22

Communicating for Safety Sub-categories	No harm	Minor harm	Moderate harm	Serious harm	Death
Documentation of information	1,399	125	10	2	1
Correct identification and procedure matching	1,001	141	23	5	2
Communication at clinical handover	728	110	37	4	5
Communication of critical information	207	29	5	5	3
Other incidents related to communicating for safety	150	26	5	-	2
<b>Total</b>	<b>3,485</b>	<b>431</b>	<b>80</b>	<b>16</b>	<b>13</b>

**Note:** Patient outcome missing data n=108 (Documentation of information n=41; Correct identification and procedure matching n=31; Communication at clinical handover n=25; Communication of critical information n=8; Other incidents related to communicating for safety n=3)

Table 35: Complaint Issues Relating to Quality of Clinical Care for 2021/22

Quality of clinical care issues	Mental Health	General Health	Total
Inadequate treatment/therapy	119	887	<b>1,006</b>
Inadequate assessment	55	646	<b>701</b>
Discharge or transfer arrangements	61	365	<b>426</b>
Pain issues	5	258	<b>263</b>
Poor coordination of treatment	17	229	<b>246</b>
Medication issues	19	179	<b>198</b>
Failure to provide safe environment	18	138	<b>156</b>
Inadequate infection control	2	77	<b>79</b>
Post-surgery complications	–	71	<b>71</b>
Post procedure complications	–	67	<b>67</b>
Refusal to refer or assist to obtain a second opinion	7	32	<b>39</b>
Patient's test results not followed up	1	33	<b>34</b>
<b>Total</b>	<b>304</b>	<b>2,982</b>	<b>3,286</b>

Table 36: Complaint Issues Relating to Communication for 2021/22

Communication issues	Mental Health	General Health	Total
Misinformation/failure in communication (not failure to consult)	64	762	<b>826</b>
Failure to listen to consumer/representative/carer/family	72	587	<b>659</b>
Inappropriate verbal/non-verbal communication	38	504	<b>542</b>
Inadequate information about services available	27	129	<b>156</b>
Inadequate medical information provided	8	143	<b>151</b>
Inadequate/inaccurate personal information in a medical record	8	59	<b>67</b>
Inadequate written communication	–	20	<b>20</b>
<b>Total</b>	<b>217</b>	<b>2,204</b>	<b>2,421</b>

Table 37: Complaint Issues Relating to Access for 2021/22

Access issues	Mental Health	General Health	Total
Delay in admission/treatment	19	506	<b>525</b>
Inadequate resources/lack of service	39	378	<b>417</b>
Waiting list delay	15	368	<b>383</b>
Refusal to provide services	19	102	<b>121</b>
Physical access/entry	3	80	<b>83</b>
Staff member or contractor unavailable	3	35	<b>38</b>
Parking issues	–	30	<b>30</b>
Failure to provide advice about transport options when necessary	–	14	<b>14</b>
<b>Total</b>	<b>98</b>	<b>1,513</b>	<b>1,611</b>

Table 38: Complaint Issues Relating to Rights, Respect and Dignity for 2021/22

Rights, respect and dignity issues	Mental Health	General Health	Total
Inconsiderate service/lack of courtesy	72	592	<b>664</b>
Absence of compassion	39	292	<b>331</b>
Breach of confidentiality	25	71	<b>96</b>
Failure to ensure privacy	9	57	<b>66</b>
Discrimination leading to less favourable health treatment	2	34	<b>36</b>
Consumer rights (Australian Charter of Healthcare Rights)	3	14	<b>17</b>
Failure to fulfil Mental Health legislation requirements	10	–	<b>10</b>
Translating and interpreting services problems	–	8	<b>8</b>
Certificate or report problem	–	5	<b>5</b>
Denying/restricting access to personal health records	–	2	<b>2</b>
<b>Total</b>	<b>160</b>	<b>1,075</b>	<b>1,235</b>



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