



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: 2020



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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.

The PSSU also thanks the Child and Adolescent Health Service (CAHS) and the South Metropolitan Health Service (SMHS) for providing some of the images used in this report.

Foreword

It is well-recognised that patient safety is fundamental to the delivery of high-quality patient-centred health care, and that health workers are more likely to make errors, which can lead to patient harm, when placed in stressful work environments.

Globally, 2020 has seen the COVID-19 pandemic add enormous challenges and risks to health workers and health systems. While Western Australia has fared relatively well during this time, the impacts on our health system and its staff have been significant and the road to recovery will be long. Health workers are members of the broader community and their concerns extend well beyond the risk of contracting COVID-19 in the workplace and the availability of personal protective equipment (PPE).

In recognition of health workers' dedication and hard work during the COVID-19 pandemic, the World Health Organization themed the second World Patient Safety Day, held on 17 September 2020, "Health Worker Safety: A Priority for Patient Safety".¹ World Patient Safety Day 2020 sought to raise awareness about the importance of health worker safety and its link to patient safety, engage stakeholders and adopt strategies to improve the safety of health workers and patients, and implement urgent and sustainable actions by all stakeholders which recognise and invest in the safety of health workers as a priority for patient safety.

The WA health system has long encouraged the adoption of organisation-wide approaches that foster a 'no blame' reporting culture to minimise the impact on health workers and facilitate learning and improvement when adverse events occur in health care. Now, more than ever, it is vital that the WA health system continues to support its workforce, and that health workers continue to support each other, to promote physical and mental wellbeing and deliver the safest and most effective care possible.

The Institute for Healthcare Improvement (IHI) uses the term "psychological PPE" to describe the individual and system-level actions owned by unit and team leaders that provide protection and support for staff's mental health that can be deployed both before providing care and after a shift has ended.² Strategies for leaders to promote mental health and wellbeing in their teams include limiting staff members time on site/shift; designing clear roles and leadership; training managers to be aware of risk factors and monitor for any signs of distress; making peer support services available to all staff; and fostering peer support using a "buddy system".

Key suggestions for health workers to promote their own mental health and wellbeing include creating space between work and home life; avoiding media coverage about COVID-19; receiving mental health support both during and after the crisis; facilitating opportunities to show gratitude; and reframing negative experiences as positive.

This ninth report in the Western Australian Patient Safety series provides an integrated review of patient safety across the WA health system with the aim to give an indication of the types of challenges affecting patient safety, and to support improvement in the quality of health care. Patient safety data in this report has been aligned to the second edition of the National Safety and Quality Health Service Standards, which took effect in WA from January 2019.

¹ Further information about World Patient Safety Day 2020 is available on the World Health Organization website: <https://www.who.int/campaigns/world-patient-safety-day/2020>

² Further information about psychological PPE is available at: <http://www.ihi.org/resources/Pages/Tools/psychological-PPE-promote-health-care-workforce-mental-health-and-well-being.aspx> and <http://www.ihi.org/communities/blogs/why-is-psychological-ppe-important-for-the-health-care-workforce>

High levels of clinical incident reporting coupled with a low or decreasing level of harm to patients is regarded as an indicator of a strong patient safety culture within a healthcare system. For the first time in recent years, there has been a decrease in the number of clinical incidents reported in the WA health system, while harm to patients has continued to remain low.

This should not be regarded as suggesting a decline in the WA health system's commitment to the safety and quality of the care it delivers. Rather, it more likely reflects of the impact of COVID-19, which has seen a decline in overall activity in the WA health system and an increased focus on preparation for the potential effects of the pandemic.

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Common Acronyms

ACORN	Australian College of Perioperative Nurses (formerly Australasian Conference of Operating Room Nurses)
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers' Advisory Council
ANZASM	Australian and New Zealand Audit of Surgical Mortality
ATSI	Aboriginal and Torres Strait Islander (persons)
CFM	Consumer Feedback Module
CHE	Contracted Health Entity
CIM	Clinical Incident Management
CIMS	Clinical Incident Management System
CLU	Coronial Liaison Unit
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CPR	Cardiopulmonary resuscitation
CTG	Cardiotocography
CVA	Cerebrovascular accident
DVT	Deep vein thrombosis
ECG	Electrocardiogram
ED	Emergency Department
GP	General Practitioner
HaDSCO	Health and Disability Services Complaints Office
HAI	Healthcare-associated infection
HDU	High dependency unit
HiTH	Hospital in The Home
HMDC	Hospital Morbidity Data Collection
HSP	Health Service Provider
ICT	Information and communications technology
ICU	Intensive care unit
IHI	Institute for Healthcare Improvement
IHPA	Independent Hospital Pricing Authority
INR	International Normalised Ratio
NaCS	Notifications and Clinical Summaries
NGO	Non-government organisation
NHMRC	National Health and Medical Research Council
NHRA	National Health Reform Agreement
NSQHS	National Safety and Quality Health Service (Standards)
PAS	Patient administration system
PEHS	Patient Evaluation of Health Services (Survey)
PPE	Personal protective equipment
PSSU	Patient Safety Surveillance Unit
QI	Quality improvement
RACS	Royal Australasian College of Surgeons
ROD	Review of Death
ROGS	Report on Government Services
SABSI	<i>Staphylococcus aureus</i> bloodstream infection
SAC	Severity Assessment Code
WAASM	Western Australian Audit of Surgical Mortality
VF	Ventricular fibrillation
VTE	Venous thromboembolism
WHO	World Health Organization



Perth Children's Hospital - image courtesy CAHS

Executive Summary

This report provides the WA public with information and data on how the WA health system manages and resolves clinical incidents, consumer feedback and coronial recommendations resulting from health care delivery, as well as its mortality review processes, in accordance with policy requirements.

In 2019/20, there were 33,143 clinical incidents notified across the WA health system of which 31,720 had been confirmed at the time of writing this report. Most clinical incidents reported in 2019/20 were classified as Severity Assessment Code (SAC) 3 (n=28,420; 85.7%) and most confirmed incidents resulted in no harm or minor harm to the patient (n=29,778; 93.9%). During this period the WA health system provided 610,956 episodes of care (amounting to 1,807,369 bed days) to inpatients at public hospitals and Contracted Health Entities (CHEs). Confirmed inpatient clinical incidents (n=25,749) were associated with 1.7% of public hospital bed days and accounted for 5.2% of public hospital separations.

A decrease of 3.3% in the total number of clinical incidents notified across the WA health system was observed from 2018/19 (n=34,272) to 2019/20 (n=33,143). This corresponded with a 1.8% decline in inpatient activity (measured as patient bed days in Health Service Providers (HSPs) and CHEs) over this period. The number of clinical incidents notified by WA's public hospitals in 2019/20 showed a distinct relationship to public hospital activity when viewed through the lenses of patient age, gender, and Aboriginal and Torres Strait Islander (ATSI) status. It is possible the reduction in the number of incidents notified in 2019/20 may reflect to some extent the impact of COVID-19, through both the decline in overall activity in the WA health system and an increased focus of health service organisations on preparation for the potential effects of the pandemic.

Reporting of clinical incident data against the Australian Commission on Safety and Quality in Health Care's (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards has been aligned to the second edition of the NSQHS Standards³ that took effect from January 2019. In 2019/20, clinical incidents associated with comprehensive care (n=11,705; 34.9% of confirmed incidents) and medication safety (n=7,806; 24.6% of confirmed incidents) were the most frequently reported categories that related to the second edition NSQHS Standards.

There were 519 SAC 1 clinical incidents confirmed in 2019/20 by WA's HSPs, private licensed healthcare facilities, and other contracted non-government organisations, of which 12 were sentinel events and 507 were 'Other SAC 1' incidents. A further 151 events were notified as possible SAC 1 incidents and declassified 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 4.5 incidents per 10,000 separations.⁴ Inpatient SAC 1 incidents accounted for 0.9% (n=221) of all confirmed inpatient incidents in WA's public hospitals in 2019/20.

The WA health system's Clinical Incident Management (CIM) Policy encourages the notification and investigation of near miss events (those that resulted in no harm to the patient). In 2019/20,

³ Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney: ACSQHC; 2017. Available at <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition>

⁴ The numerator for the SAC 1 clinical incident rate includes inpatient incidents at HSPs and involving public patients treated at CHEs and excludes SAC 1 incidents that have not been confirmed, or were notified by community health care providers, private licensed health care facilities and contracted non-government organisations. The denominator includes either separation or bed day data from WA public hospitals' inpatient activity including public patients treated at CHEs.

8.7% (n=45) of confirmed SAC 1 clinical incidents reported a patient outcome of no harm, and a further 5.2% (n=27) reported a patient outcome of minor harm.

The most frequently reported categories of SAC 1 clinical incidents in 2019/20 were infection control breaches (n=104; 20.5% of 'Other SAC 1' incidents), complications of inpatient falls (n=82; 16.2%) and unexpected deaths of mental health clients (n=52; 10.3%).

Ten revised sentinel event categories were endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in December 2017 and commenced use in WA in July 2018. Twelve sentinel events were reported in 2019/20, representing 2.3% of all confirmed SAC 1 incidents. The most frequently reported sentinel event categories in WA in 2019/20 were medication error resulting in serious harm or death, unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death, and suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward (n=3 for each category).

The Independent Hospital Pricing Authority's (IHPA) national approach to pricing and funding for safety and quality in Australian public hospitals continued in 2019/20, with a third year of funding penalties for episodes of care that include a sentinel event. In 2019/20, the basis for sentinel event penalties moved to the 10 revised sentinel events categories, and five of the 12 sentinel events reported in WA in this period met the national criteria for reporting to the IHPA.

The most frequently identified contributory factors in SAC 1 clinical incidents in 2019/20 continue to be issues with communication which were identified in 69.3% (n=294) of SAC 1 incidents investigated, and policies, procedures and guidelines which were identified in 64.2% (n=272). These are areas where the WA health system can focus attention and deliver sustainable improvements in the quality and safety of the care it delivers. Patient factors, which are often beyond the control of hospitals and clinicians, were identified in 62.0% (n=263) of SAC 1 incidents investigated during this period.

Consumer feedback provides the WA health system with information about its service that may help identify opportunities for improvement in the safety and quality of health care as well as consumers' overall experience. A total of 18,780 consumer feedback items⁵ were reported across the WA health system in 2019/20, of which 54.4% (n=10,220) were compliments, 24.2% (n=4,543) were contacts, and 21.4% (n=4,017) were complaints. The 4,017 complaints identified 7,215 separate complaint issues, and the four most frequently identified complaint categories were quality of clinical care, communication, access, and rights, respect and dignity. These four categories accounted for 86.4% of complaint issues in 2019/20.

The Coronial Liaison Unit (CLU) continues to work with the Office of the State Coroner to share the lessons learnt from coronial inquests to improve patient care. Seventeen inquest findings were released in 2019/20 that resulted in nine health-related recommendations, all of which related to mental health care. As of August 2020, four of these nine mental health-related recommendations had been completed or closed.

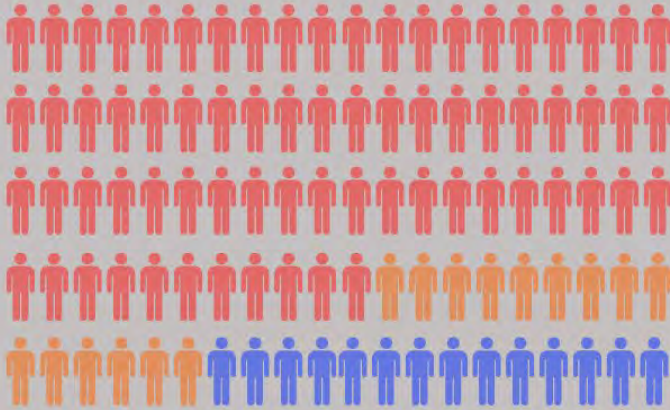
All deaths in WA that occur under the care of a surgeon are notified to the WA Audit of Surgical Mortality (WAASM) and in 2019, 541 deaths met the WAASM inclusion criteria. For cases that had completed the audit process by 31 March 2020, the WAASM identified three adverse events that caused death in 2019, of which one was considered definitely preventable.

⁵ It is mandatory for all complaints received by WA HSPs to be entered in Datix CFM, and all complaints relating to public patients at CHEs (Joondalup Health Campus, Peel Health Campus and St John of God Midland) to be reported to PSSU. Recording of compliments and contacts in Datix CFM is optional.

TOTAL SAC 1 INCIDENTS

519

INCLUDING 12 SENTINEL EVENTS



71%

serious harm
or death

14%

minor harm
or no harm



31,720

CLINICAL INCIDENTS CONFIRMED

62.3%

of clinical incidents reported a
patient outcome of NO HARM

CONSUMER FEEDBACK RECEIVED

MENTAL HEALTH

431

COMPLAINTS

10,220 COMPLIMENTS

4,543 CONTACTS

4,017 COMPLAINTS



17

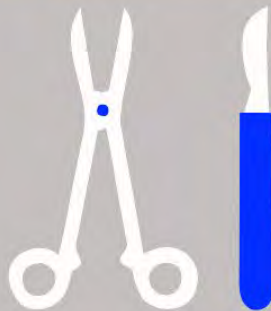
 health-related
coronial inquests
shared patient
safety lessons

THE WAASM REVIEWED

541

DEATHS UNDER THE CARE
OF A SURGEON

3 adverse events that
caused death were
identified



1 event was
considered to be
definitely preventable

94.7%

of patient deaths in hospital
were reviewed within 4 months



Review of death processes
identified 12 possible SAC 1
clinical incidents

About this Report

This comprehensive patient safety report for 2019/20 is the ninth WA health system report of this kind, and integrates data from the following sources:

- Datix Clinical Incident Management System (CIMS) (online)
- Hospital Morbidity Data Collection (HMDC)
- Review of Death (ROD)
- Western Australian Audit of Surgical Mortality (WAASM)
- Coronial review process
- Datix Consumer Feedback Module (CFM) (online) database and other complaints management systems (used by CHEs)
- PathWest Laboratory Information System (ULTRA)
- Patient Evaluation of Health Services (PEHS) survey.

Data for 2019/20 are presented with the following caveats:

- Datix CIMS is a dynamic online electronic clinical incident management system and contains a full 12 months of financial year data.
- There is a time lag in Datix CIMS for the confirmation of SAC which will cause figures to change over time.
- Datix CFM is a dynamic online electronic complaint management system and contains a full 12 months of financial year data.
- The Coronial data includes a full 12 months of financial year data.
- The ROD data reflects the 2019 calendar year.
- The WAASM data are captured by calendar year and covers the period from 1 January 2010 to 31 December 2019.
- The PEHS includes a full 12 months of financial year data.⁶

Information regarding the context and processes for ensuring safety and quality in the WA health system is presented in the clinical governance section of this report, which has a relationship to Standard 1 of the NSQHS Standards (Clinical Governance Standard).

Care should be taken when comparing data from previous editions of this report as the data summarised here are taken from dynamic systems and both data definitions and numbers may vary over time. Caution should also 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.⁷

Clinical incident rates only include inpatient data as the numerator over inpatient separation or bed day data as the denominator where meaningful comparison exists, as this provides a more accurate rate of clinical incidents. Inpatient separation and bed day data is obtained from the Hospital Morbidity Data Collection, which captures inpatient activity and discharge data related to WA's public hospitals and CHEs. Data in the HMDC is entered by clinical coders, based on the information recorded by clinicians in each patient's medical record.

Demographic data related to clinical incidents (patient age, gender and ATSI status) are sourced from the WA health system's Patient Administration System (PAS) via a link to the Datix CIMS. During 2019/20, the link between the Datix CIMS and the PAS was enhanced to include

⁶ The PEHS survey cohort includes acute admitted patients aged 16-74 years who had an inpatient stay of 0-34 days, with no psychiatric care days, no interpreter service required, and who were discharged home.

⁷ For further information about the differences between quality improvement and research data see: <http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Moses-ResearchVsQI.aspx>

patients' ATSI status, allowing this data to be included in this report for the first time. For further information about the Datix CIMS data presented in this in this report, including demographic data, refer to the interpretability section of the Data Quality Statement for this Report.

Declassification of a SAC 1 clinical incident that has been reported to the Patient Safety Surveillance Unit (PSSU) may occur following a thorough investigation, if it is identified that no health care causative 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.

From 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 (see Appendix One: SAC 1 Clinical Incident Notification List). The changes to the sentinel events from this date included the addition, removal and redefining of sentinel event categories. Sentinel event data for 2018/19 and 2019/20 are reported under these revised categories, while data prior to July 2018 were reported in line with the previous categories that were in use in WA at the time of notification into the Datix CIMS. Sentinel event data for 2018/19 and 2019/20 are not directly comparable to that for prior years contained in previous editions of this report.

The second edition of the National Safety and Quality Health Service (NSQHS) Standards was implemented in the WA health system from January 2019 and this report is the first time that clinical incident data aligned to the second edition NSQHS Standards has been published.⁸ The data presented focuses on the six clinical Standards in the second edition: preventing and controlling healthcare-associated infections, medication safety, comprehensive care, communicating for safety, blood management and recognising and responding to acute deterioration. Patient stories have been included for some of the NSQHS Standards to help share the lessons learnt from these incidents. The 2019/20 clinical incident data related to the NSQHS Standards in this report are not directly comparable to that for the first edition of the NSQHS Standards contained in previous editions of this report.

Consumer feedback is a key component of Standard 2 of the NSQHS Standards (Partnering with Consumers Standard) and data regarding consumer feedback and complaints received by the WA health system during 2019/20 can be found in the consumer feedback review section. Consumer feedback provides health care providers with an indication of current areas of concern to consumers and thereby highlights potential areas for service improvements. Although not all consumer feedback items and resultant improvements will directly relate to the quality of clinical care provided, any improvements which lead to increased consumer satisfaction are equally valuable. Data related to the top four complaint categories in 2019/20 are included in this report and complemented by data from the annual Patient Evaluation of Health Services (PEHS) survey administered by the Department's Health Survey Unit.

From 2019/20, data regarding Hospital-Acquired Complications (HACs)⁹ are no longer included in this report. Data regarding selected HACs are published in the Health Service Performance Report (HSPR) available to authorised staff within the WA public health system. The HACs included in the HSPR are pressure injury, falls resulting in fracture or intracranial injury, healthcare-associated infection, venous thromboembolism, and medication complications.

⁸ The proprietary three-tiered Datix CIMS clinical incident classification (CCS2) was reviewed by the State Datix Committee in 2019, with codes relevant to the NSQHS (2nd ed) Standards agreed. NSQHS (2nd ed) Standards data are not comparable to previous editions of this report. The list of Datix CIMS CCS2 codes linked to each NSQHS (2nd ed) Standard is available to staff in the WA health system at: <https://wahealthdept.sharepoint.com/sites/hss-customer-ict-hosp-admin/SitePages/cims.aspx>

⁹ For further information about the HACs refer to the ACSQHC website: <https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications>

Clinical Governance

Clinical Governance is everyone’s business and good clinical governance is vital to maintaining and improving the safety and quality of health care for patients. The ACSQHC defines clinical governance as “the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, governing body, executive, workforce, patients, consumers and other stakeholders to ensure good clinical outcomes”.

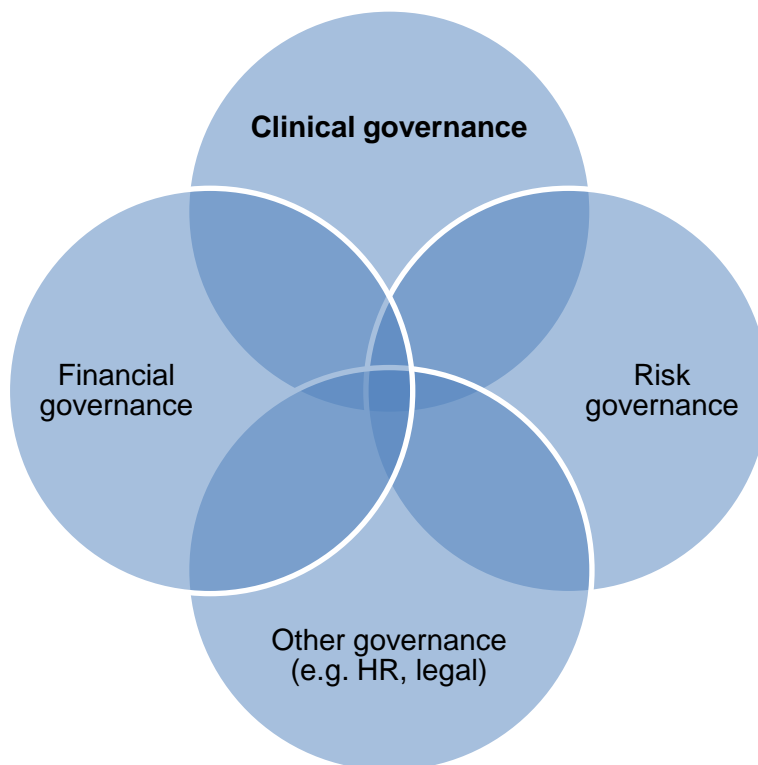
The importance of strong clinical governance in health service organisations is highlighted in Standard 1 of the second edition of the NSQHS Standards. This Clinical Governance Standard, against which the WA health system has been assessed since January 2019, has a strong focus on risk, monitoring, quality improvement, training and performance management.¹⁰

In support of the delivery of safe and high-quality care for patients and consumers, the ACSQHC has developed the National Model Clinical Governance Framework¹¹ based on the NSQHS Standards, in particular the Clinical Governance and Partnering with Consumers Standards. This framework recognises that clinical governance is an integrated element of corporate governance (see Figure 1), and identifies the following five essential components:

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

Figure 1: Elements of Corporate Governance

(Adapted from the National Model Clinical Governance Framework)



¹⁰ ACSQHC NSQHS Standards (2nd edition) Clinical Governance Standard available at: <https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard>

¹¹ ACSQHC National Model Clinical Governance Framework available at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-model-clinical-governance-framework>

The Clinical Governance Standard is explicit in recognising the importance of leadership and culture in establishing effective clinical governance systems, and includes actions relating to the role of leaders in safety and quality, Aboriginal health, e-health, credentialing of clinicians, variation in clinical practice and health outcomes, and the safety of the environment in which health services are provided. This Standard also requires health service organisations to establish and maintain a clinical governance framework and use the processes within the framework to drive improvements in safety and quality.

The commencement of the *Health Services Act* in July 2016 introduced a new governance model for the WA health system, with the Director General established as the System Manager and HSPs established as independent governing bodies for their sections of the health system. Effective governance of the WA health system therefore requires clear direction from its leaders, strong policy and strategic decisions, robust oversight and monitoring of organisational performance and transparent accountability for HSPs. In October 2019, the Department of Health released an updated *Clinical Governance Framework*¹² which outlines clinical governance roles and responsibilities along with core mechanisms for their implementation.

The WA health system is committed to delivering safe and high-quality care, achieved through the provision of health care that is efficient, evidence based, governed by sound clinical practice, and focused on preventing and reducing the impact of clinical incidents. The second edition of the NSQHS Standards recognises the importance of risk management as an essential component of good clinical governance and requires health service organisations to have systems and processes in place to identify, document, and manage risks to the organisation, including those identified via the analysis of clinical incidents and complaints. The *WA Health Clinical Risk Management Guidelines*¹³ provide information regarding processes for judging risks, understanding the factors that lead to them, learning lessons from incidents and putting systems in place to prevent recurrence. WA's public health system uses the Enterprise Risk Management System (ERMS) to capture and manage risks, including clinical risks.

While prevention via effective risk management is always the best strategy, it is important to report, investigate and address clinical incidents when they occur. The investigation of clinical incidents enables strategies to be put into place and evaluated to improve the safety of health care delivery and prevent other patients being harmed. The management of clinical incidents in the WA health system is governed by the *Clinical Incident Management Policy*.¹⁴

To enhance the clinical incident management process, Severity Assessment Codes are used in WA to guide incident analysis, action and escalation (see Figure 2 overleaf). Clinical incidents are categorised according to the harm that did or could occur to the patient from the delivery of health care rather than the patient's underlying condition or illness.

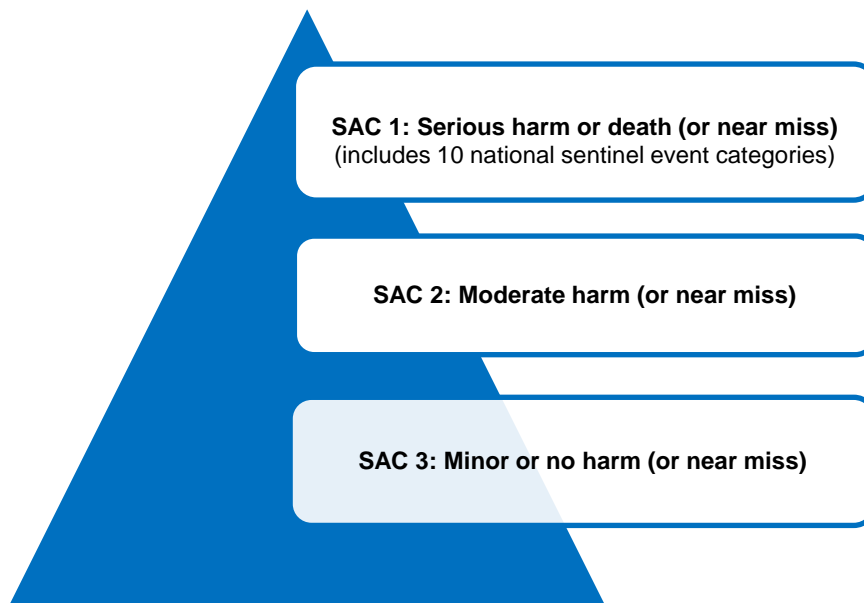
- **SAC 1** rating refers to clinical incidents that have, or could have (near miss), caused serious harm or death attributed to health care provision (or lack thereof) and includes 10 nationally endorsed sentinel event categories
- **SAC 2** rating refers to clinical incidents that have, or could have (near miss), caused moderate harm attributed to health care provision (or lack thereof)
- **SAC 3** rating refers to clinical incidents that have, or could have (near miss), caused minor or no harm attributed to health care provision (or lack thereof).

¹² The Clinical Governance Framework is available at: https://ww2.health.wa.gov.au/Articles/N_R/Patient-Safety-Surveillance

¹³ The WA Health Clinical Risk Management Guidelines are available at: https://ww2.health.wa.gov.au/Articles/A_E/Clinical-risk-management

¹⁴ The Clinical Incident Management Policy, Guideline and Toolkit are available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Clinical-Incident-Management-Policy>

Figure 2: Clinical Incidents by SAC Category



When a clinical incident is identified, immediate action is taken to provide care to the patient involved. Once this has occurred, an online clinical incident form is completed via the Datix CIMS to notify senior staff and enable an appropriate investigation to take place. The clinical incident is then assigned a SAC rating that guides the type of investigation method used. Incidents with a patient outcome of serious harm or death (SAC 1) require a detailed and rigorous investigation to be undertaken. In December 2019, new fields were added to the Datix CIMS to allow staff to identify SAC 1 incidents that are the realisation of known risks recorded in the ERMS. It is hoped this will strengthen the link between incident and risk management in WA's public health system and lead to more proactive management of clinical risk.

Analysis of the clinical incident is then undertaken which leads to the implementation of recommendations intended to prevent the clinical incident from recurring and/or reducing the harm that may occur to patients. Furthermore, all recommendations must be evaluated to ensure that the quality improvement strategies are effective in making health care safer.

Clinical incident data is then used at local and state-wide levels to review trends and identify areas where practice improvements can be achieved. Complementing this annual report is the internal release of the Patient Safety Dashboards and the quarterly Check-Up Reports, which are one-page poster reports that focus on specific state-wide clinical incident trends. These resources are available to staff in WA's public health system via the PSSU's intranet pages.¹⁵

Considerable resources have been invested to improve patient safety in the WA health system. Resources to guide clinical incident management in WA include the CIM Policy, Guideline and Toolkit, which are updated to keep abreast with state and national changes. The PSSU also continues to work collaboratively with HSPs to enhance the Datix CIMS on an ongoing basis to ensure alignment with local and national approaches to clinical incident management.

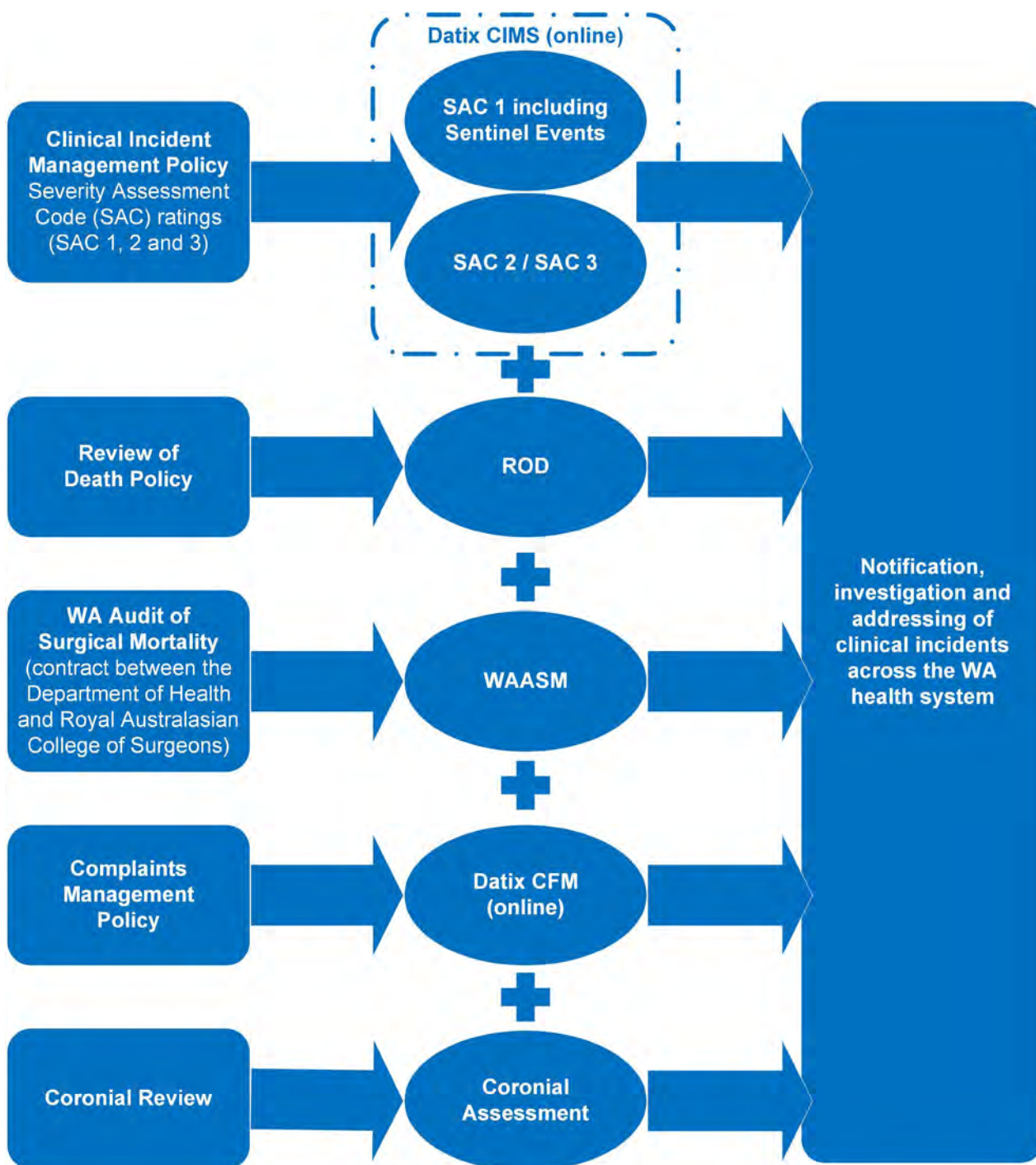
Additional strategies to strengthen clinical governance processes include the *Review of Death Policy* and the WA Audit of Surgical Mortality. The purpose of ROD and WAASM is to

¹⁵ The PSSU's intranet pages can be accessed by staff in the WA public health system at: <https://doh-healthpoint.hdwa.health.wa.gov.au/directory/Clinical%20Services%20and%20Research/Patient%20Safety%20Clinical%20Quality/PSSU/Pages/About%20Us.aspx>

systematically review patient deaths to identify opportunities for improvement in care delivery and those deaths that may have been preventable so that lessons can be learnt. Collectively, SAC 1 incident management, ROD and WAASM ensure that clinical incidents resulting in a patient's death are captured, notified and investigated.

All health-related findings from coronial inquests are reviewed and assessed, with recommendations considered by HSPs and implemented where appropriate. Consumer feedback is also an important part of clinical governance and incident management as it informs the provision of patient centred care. Figure 3 shows the relationship of these processes to clinical incident management.

Figure 3: Clinical Incident Management Processes





Clinical Incident Management: Overall Notifications

The WA public health system uses the Datix CIMS for the notification, investigation, analysis and evaluation of practice improvements for clinical incidents that occur within all public hospitals in Western Australia. Severity Assessment Code 1 is used to identify clinical incidents with a patient outcome of serious harm or death (or near miss). It is mandatory for all hospitals/HSPs, as well as all private licensed health care facilities and contracted non-government organisations (NGOs), to notify and investigate SAC 1 clinical incidents.¹⁶ Severity Assessment Code 2 incidents (those with a patient outcome of moderate harm or near miss) and SAC 3 incidents (minor or no harm or near miss) occurring at private licensed health care facilities and contracted NGOs, which are managed locally and not reported into the Datix CIMS, are not included in this report.

Between 1 July 2019 and 30 June 2020 there were 610,956 separations, with inpatients accumulating a total of 1,807,369 bed days, from public hospitals and public patients attending a Contracted Health Entity. During 2019/20, the CHEs were Peel Health Campus, Joondalup Health Campus and St John of God Midland.

During 2019/20, there were 33,143 clinical incidents notified of which 31,720 clinical incidents were confirmed at the time of this report. Of these confirmed incidents, 25,749 occurred during a public hospital stay, with the remainder of clinical incidents reported by emergency departments, outpatient departments, community health care providers, private licensed healthcare facilities (including CHEs) and other contracted NGOs.

Confirmed inpatient clinical incidents were associated with 5.2% (n=25,749) of public hospital separations from HSPs. The rate¹⁷ of inpatient clinical incidents observed between July 2019 and June 2020 was calculated at:

- 4.5 SAC 1 clinical incidents per 10,000 separations¹⁸
- 44 SAC 2 clinical incidents per 10,000 separations
- 471 SAC 3 clinical incidents per 10,000 separations.

Confirmed inpatient clinical incidents were associated with 1.7% (n=25,749) of public hospital bed days at HSPs. Findings showed that there were:

- 1.5 SAC 1 clinical incidents per 10,000 bed days¹⁹
- 14 SAC 2 clinical incidents per 10,000 bed days
- 154 SAC 3 clinical incidents per 10,000 bed days.

Clinical incidents were most frequently confirmed as SAC 3 incidents in 2019/20 (n=28,420; 85.7%). The next most frequently reported category was SAC 2 clinical incidents (n=2,781; 8.4%), followed by SAC 1 clinical incidents (n=519; 1.6%; see Figure 4 overleaf).

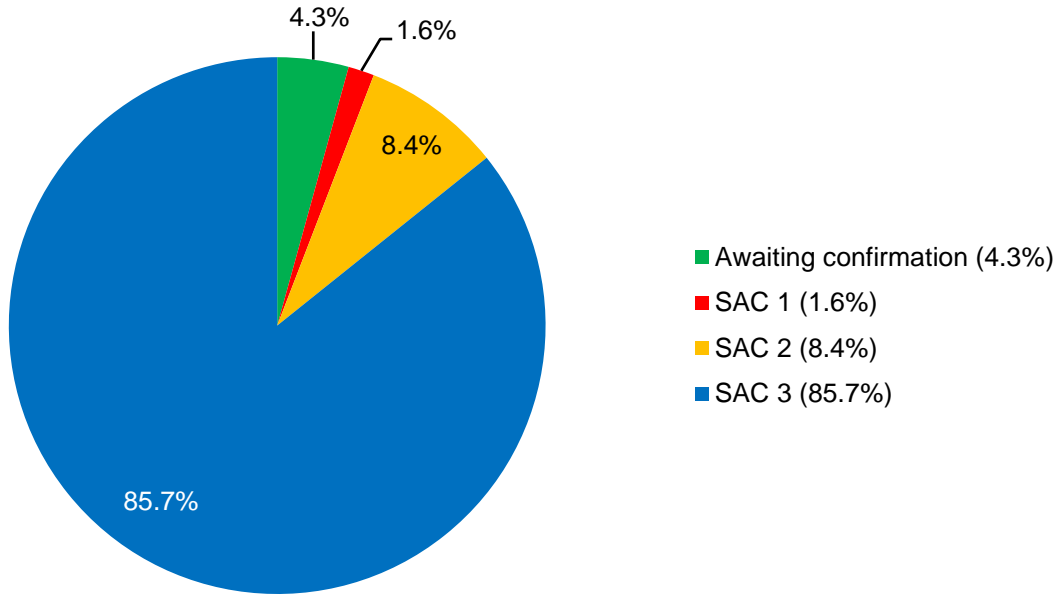
¹⁶ Further information on the licensing of private healthcare facilities can be found at: http://ww2.health.wa.gov.au/Articles/A_E/About-licensing-of-private-healthcare-facilities

¹⁷ The numerator for the SAC clinical incident rate excludes incidents where the SAC has not been confirmed, or that were notified by emergency or outpatient departments, community health care providers or private licensed health care facilities (including CHEs) and contracted non-government organisations, while the denominator only includes either separation or bed day data from WA public hospitals' inpatient activity

¹⁸ The numerator for the SAC 1 incident rate includes incidents involving public patients treated at CHEs, and the denominator includes public patient separations from CHEs.

¹⁹ The numerator for the SAC 1 incident rate includes incidents involving public patients treated at CHEs, and the denominator includes public bed days data at CHEs.

Figure 4: Percentage of Clinical Incidents by SAC Category for 2019/20

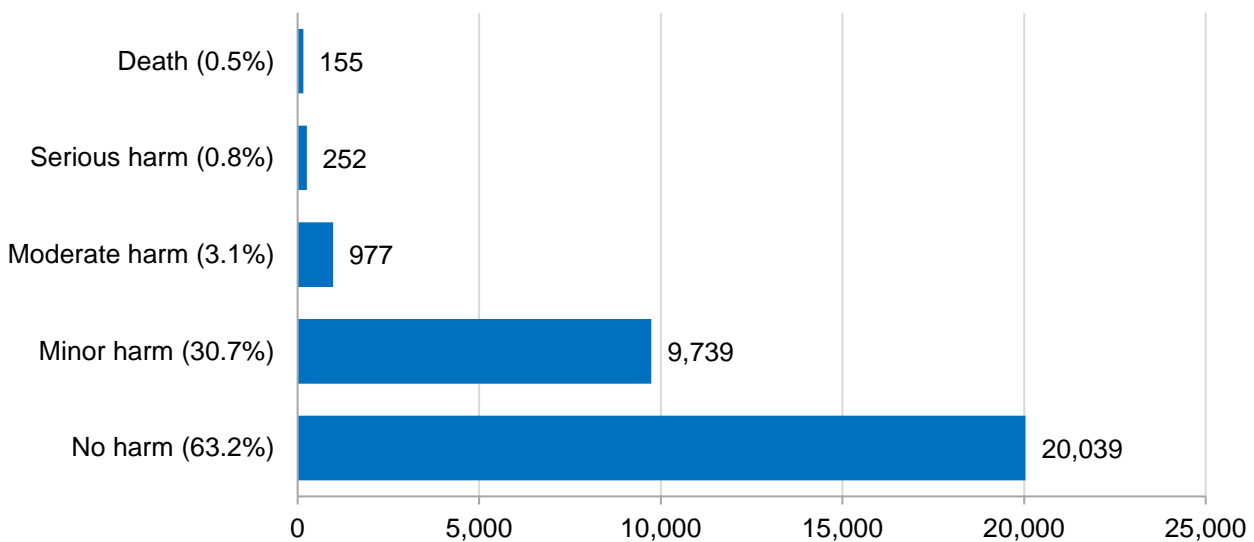


Note: SAC 1 clinical incidents include clinical incidents from HSPs (including public hospitals), private hospitals (including CHEs) and contracted NGOs in accordance with their license or contract with the WA health system. As of 4 July 2020, there were 1,423 clinical incidents that had yet to have a SAC rating confirmed.

In 2019/20, 17.5% (n=5,550) of confirmed clinical incidents related to patients identified as voluntary, involuntary, or referred mental health patients under the *Mental Health Act 2014* (MHA). Further review showed that 23.9% (n=124) of confirmed SAC 1 incidents and 44.4% (n=1,236) of confirmed SAC 2 incidents related to mental health patients.

Figure 5 shows the patient outcome reported for confirmed clinical incidents during 2019/20. The outcome of incidents was most often reported as no harm to the patient (n=20,039; 63.2%), followed by minor harm (n=9,739; 30.7%). A patient outcome of serious harm or death was reported in 1.3% (n=407) of confirmed clinical incidents during this period.

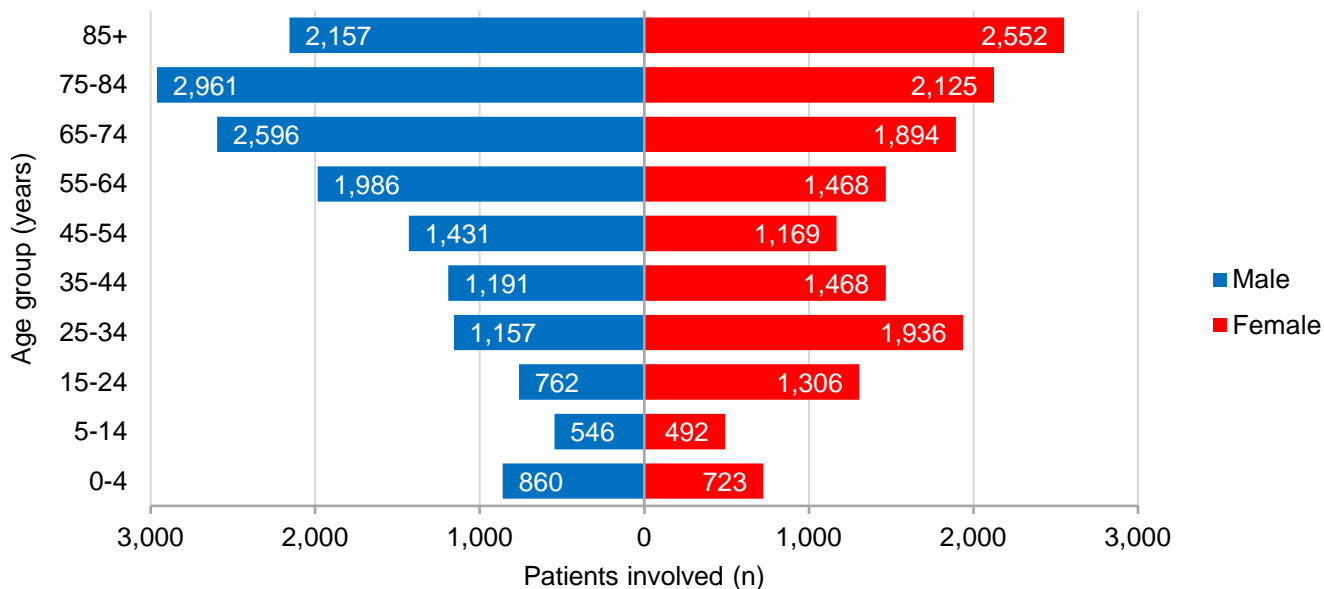
Figure 5: Frequency and Percentage of Confirmed Clinical Incidents by Patient Outcome for 2019/20



Note: Patient outcome missing data n=558; 1.8%

Males accounted for 50.8% (n=15,758) of patients involved in confirmed clinical incidents in 2019/20, with females making up 49.2% (n=15,237; missing gender n=1,583). Patient ages ranged from 0-107 years with a median of 62 years. Figure 6 shows that in patients aged 15-44 years, and 85 years and over, females were more often involved in clinical incidents than males.

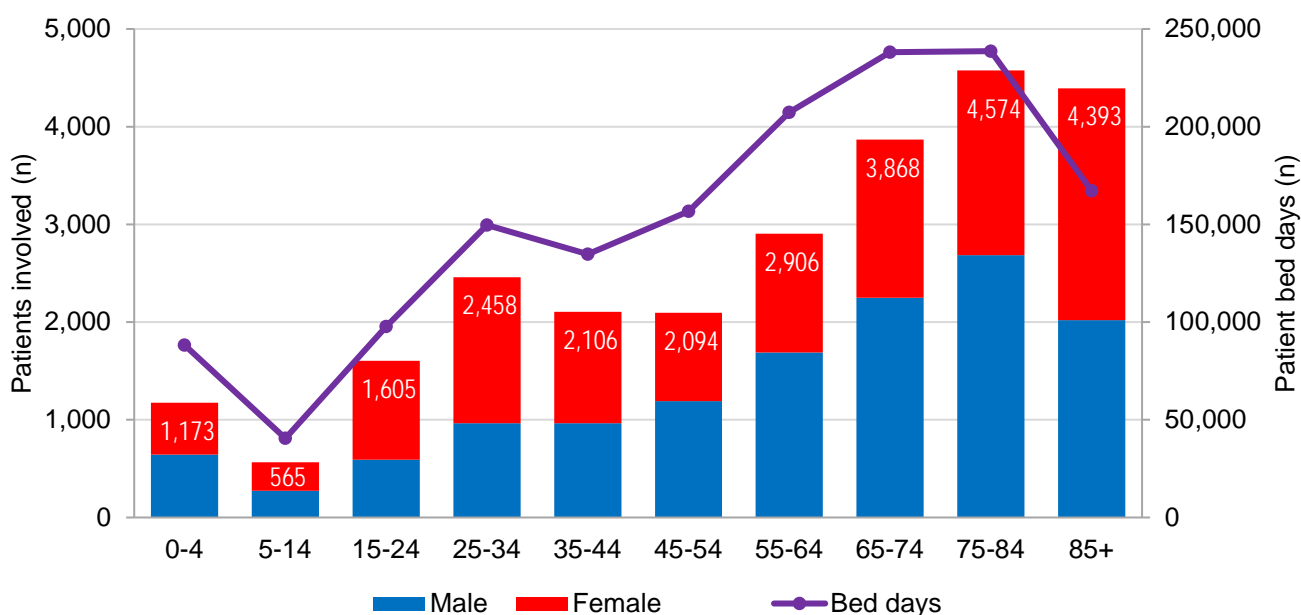
Figure 6: Frequency of Patients Involved in Confirmed Clinical Incidents by Age Group and Gender for 2019/20



Note: Patient age and/or gender missing data n=1,798; a clinical incident may affect multiple patients

Figure 7 shows the frequency of patients involved in confirmed inpatient clinical incidents in HSPs by age group and gender compared to HSPs' inpatient activity measured in bed days. A relationship can be seen between the frequency of patients involved in confirmed inpatient incidents in HSPs and inpatient activity in the public hospital system in 2019/20.

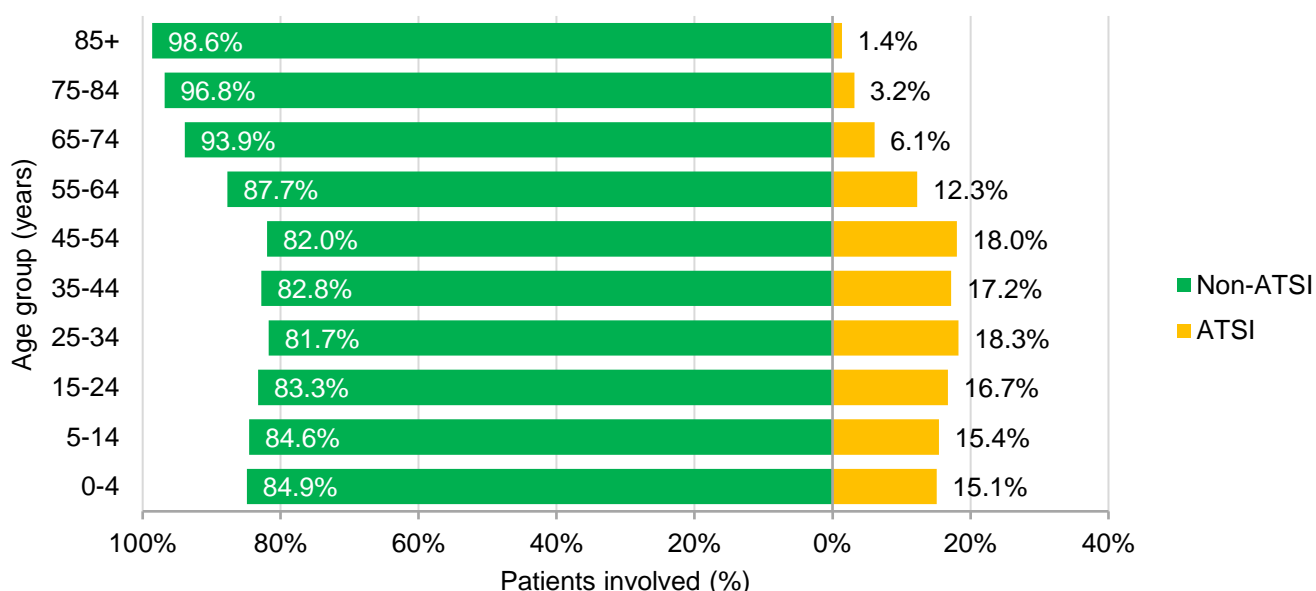
Figure 7: Frequency of Patients Involved in Confirmed Inpatient Clinical Incidents in HSPs by Age Group/Gender and Inpatient Activity for 2019/20



Note: Patient age and/or gender missing data n=499; a clinical incident may affect multiple patients

Aboriginal and Torres Strait Islander persons accounted for 10.3% (n=3,131; missing ATSI status n=2,150) of patients involved in confirmed clinical incidents in 2019/20. Figure 8 shows the proportion of patients involved in confirmed incidents by their ATSI status within each age group, with the highest proportion of ATSI patients involved found in the 25-34 years age group (18.3%). Further review showed that ATSI persons accounted for 9.7% of patients involved in confirmed inpatient incidents in HSPs (n=2,476; missing ATSI status n=735) and 9.9% of public hospital inpatient activity (n=151,001 bed days) in 2019/20.

Figure 8: Percentage of Patients Involved in Confirmed Clinical Incidents by Age Group and ATSI Status for 2019/20



Note: Patient age and/or ATSI status missing data n=2,177; a clinical incident may affect multiple patients

The five most frequently reported SAC 1 clinical incident categories, representing 65.1% (n=338) of all confirmed SAC 1 incidents in 2019/20, are presented in Table 1. Infection control breaches were the most frequently reported SAC 1 incident category (n=104; 20.0%), followed by complications of a fall in a health service (n=82; 15.8%).

Table 1: Frequency and Percentage of the Top Five Confirmed SAC 1 Clinical Incident Categories for 2019/20

SAC 1 Category	(n)	(%)
Infection control breach	104	20.0
Complications of a fall in a health service	82	15.8
The unexpected death of a mental health client	52	10.0
Hospital/Service process issues	51	9.8
Any other incident resulting in serious harm or death or near miss*	49	9.4
Total	338	65.1

*In 2019/20, examples of incidents notified in this SAC 1 category included attempted self-harm or suicide, missed or delayed diagnoses, failed or delayed treatments, failed or delayed patient transfers, delayed escalation of care, incorrectly performed treatments/procedures, complications of treatments/procedures, complications of falls outside of health services, equipment failure, failure to provide appropriate antibiotic cover and unexpected patient deaths.

The SAC 1 clinical incident category most often involving mental health patients was the unexpected death of a mental health client, which accounted for 10.0% (n=52) of all confirmed SAC 1 clinical incidents in 2019/20 (see Table 2). The next most frequently reported SAC 1 incident category involving mental health patients was clinical deterioration resulting in serious harm, or death or serious harm to staff, other patients or other persons (n=34; 6.6% of confirmed SAC 1 incidents). Of these 34 incidents, 16 reported the patient outcome as serious harm and three reported the patient outcome as death.

Table 2: Frequency and Percentage of Confirmed SAC 1 Clinical Incident Categories Related to Mental Health Care for 2019/20

SAC 1 Category	(n)	%
The unexpected death of a mental health client	52	10.0
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	34	6.6
Missing or absent without leave of any high-risk mental health patient/consumer	10	1.9
Patient missing or absent without leave with adverse outcome*	5	1.0
Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	3	0.6
Total	104	20.0

*Data for this category includes incidents notified for patients classified as Involuntary, Voluntary, or Referred Mental Health Patients.

The five most frequently reported Datix CIMS Tier One incident types represented 74.5% (n=23,242) of all confirmed SAC 2 and SAC 3 incidents reported during 2019/20 (see Table 3). Incidents related to medication/biologics/fluids (n=7,794; 25.0%) and patient accidents/falls (n=7,089; 22.7%) were the most frequently confirmed SAC 2 and SAC 3 incidents over this period.

Table 3: Frequency and Percentage of the Top Five Tier One Incident Types for Confirmed SAC 2 and SAC 3 Clinical Incidents for 2019/20

Tier One Incident Type (SAC 2/3 Incidents)	(n)	(%)
Medication/Biologics/Fluids	7,794	25.0
Patient Accidents/Falls	7,089	22.7
Behaviour	3,549	11.4
Documentation	2,610	8.4
Pressure Injuries*	2,200	7.1
Total	23,242	74.5

Remaining incident types included: administrative processes; blood/plasma products; diagnostic processes/procedures; exposure to environmental hazards; health care associated infections; medical devices/equipment; medical gases/oxygen; nutrition; personal property/data/information; and therapeutic processes/procedures.

*This Tier One category is named Pressure Ulcers in Datix CIMS.

Data presented in Table 4 are based on the top five Tier One incident categories, of which the top five Tier Three incident types accounted for 19.7% (n=6,157) of all confirmed SAC 2 and SAC 3 clinical incidents.

Findings show that preventative and therapeutic interventions for pressure injuries that were provided but not effective was the most frequently reported Tier Three incident type (n=1,573). This represented 71.5% of all SAC 2 and SAC 3 incidents in the Pressure Injuries Tier One category. Ambiguous, incomplete or incorrect documentation was reported in 1,451 confirmed SAC 2 and SAC 3 clinical incidents during 2019/20, which represented 55.6% of incidents in the Documentation Tier One category.

Table 4: Frequency and Percentage of the Top Five Tier Three Incident Types for Confirmed SAC 2 and SAC 3 Clinical Incidents for 2019/20

Tier Three Incident Type (SAC 2 and SAC 3 Incidents)	(n)	(%)
Pressure Injuries: Preventive/therapeutic Interventions provided but not effective*	1,573	5.0
Documentation: Ambiguous, incorrect or incomplete	1,451	4.7
Medication/Biologics/Fluids: Failure to administer medication	1,250	4.0
Patient Accidents/Falls: Activity at time of fall unknown or patient found on floor/elsewhere	969	3.1
Behaviour: Inappropriate or aggressive physical behaviour	914	2.9
Total	6,157	19.7

*This Tier One category is named Pressure Ulcers in Datix CIMS.

Data on six categories in the second edition of the ACSQHC's NSQHS Standards accounted for 81.1% (n=25,721) of all confirmed clinical incidents during 2019/20. Results show that incidents related to the Comprehensive Care Standard (n=11,075; 34.9% of confirmed incidents) and Medication Safety Standard (n=7,806; 24.6% of confirmed incidents) were the most frequently reported incidents associated with the NSQHS Standards (see Table 5).

Table 5: Frequency and Percentage of Confirmed Clinical Incidents for Six NSQHS Second Edition Standards for 2019/20

NSQHS Second Edition Standards	(n)	(%)
Standard 3: Preventing and Controlling Healthcare-Associated Infections	1,395	4.4
Standard 4: Medication Safety	7,806	24.6
Standard 5: Comprehensive Care	11,075	34.9
Standard 6: Communicating for Safety	4,415	13.9
Standard 7: Blood Management	160	0.5
Standard 8: Recognising and Responding to Acute Deterioration	1,444	4.6

Note: A clinical incident may relate to multiple NSQHS Standards

SAC 1 Clinical Incidents

The reporting and investigation of SAC 1 clinical incidents is mandatory for WA public health services. Private licensed health care facilities and contracted non-government organisations are required to report SAC 1 clinical incidents in accordance with their license or contract with the WA health system. The 2019/20 reporting period is the sixth full period in which Health Service Providers have reported SAC 1 clinical incidents via the web-based Datix CIMS.

In 2019/20, 519 SAC 1 clinical incidents were confirmed by WA’s HSPs (including public hospitals), private licensed health care facilities (including CHEs), and contracted NGOs. There were a further 151 events investigated that were approved for declassification. The investigation of 95 SAC 1 clinical incidents notified during 2019/20 remained ongoing at 30 June 2020.

Of the 519 confirmed SAC 1 clinical incidents, 12 (2.3%) were identified as sentinel events with the remainder captured as ‘Other SAC 1 Incidents’ (n=507; 97.7%; see Figure 9).

Figure 9: Percentage of Confirmed SAC 1 Clinical Incidents by Type for 2019/20

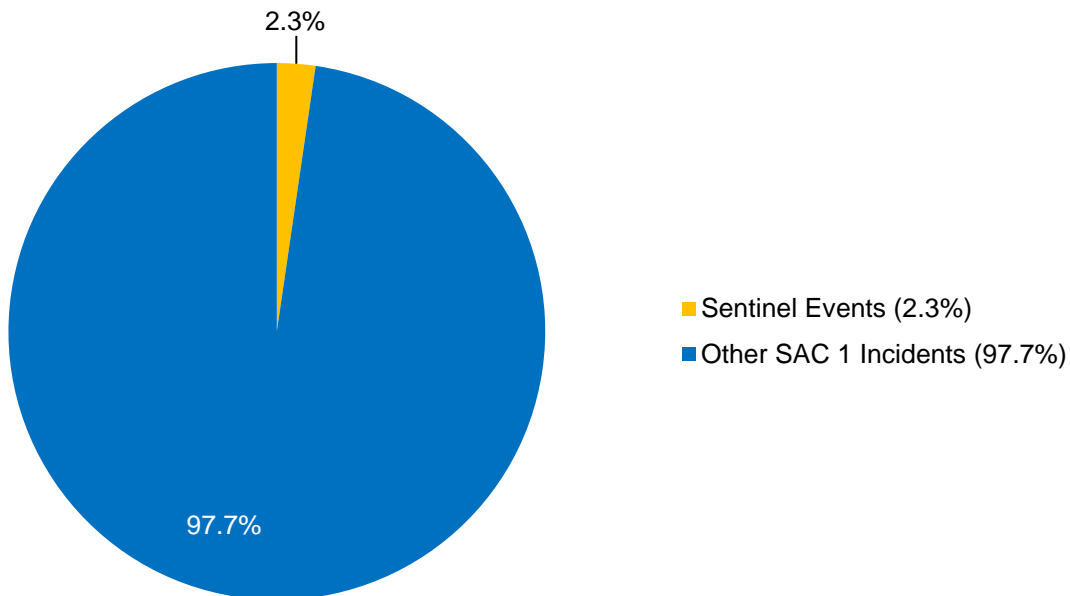


Table 6 shows the frequency of confirmed SAC 1 clinical incidents over the five-year period from July 2015 to June 2020. While there was a relatively consistent increase in the reporting of confirmed SAC 1 clinical incidents over previous years, 2019/20 figures indicate a decrease in SAC 1 reporting over the last year.

Table 6: Frequency of Confirmed SAC 1 Clinical Incidents by National Sentinel Event and Other SAC 1 Clinical Incident Types for 2015/16 to 2019/20

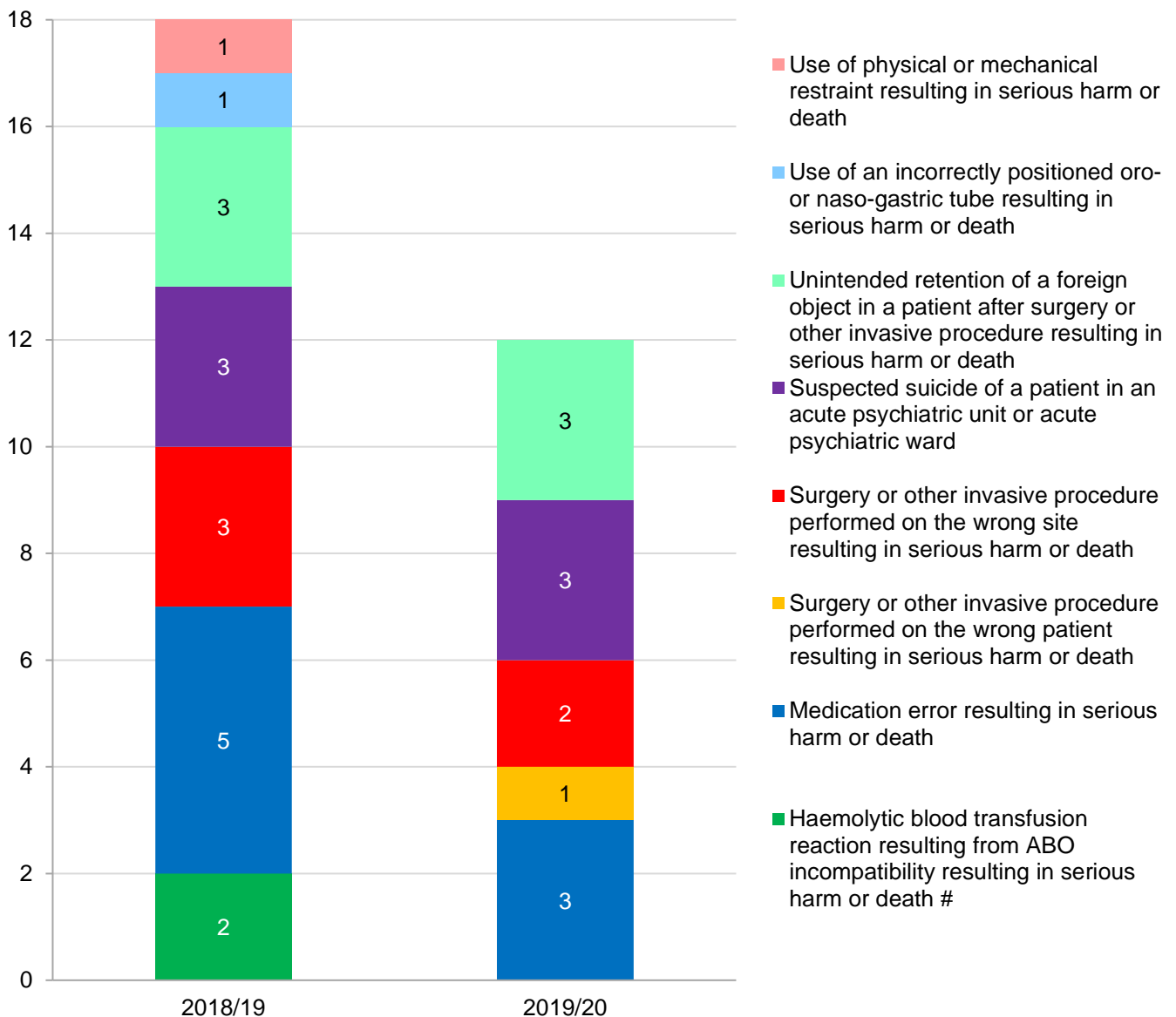
SAC 1 Categories	2015/16	2016/17	2017/18	2018/19	2019/20
Sentinel Events	14	13	12	18	12
Other SAC 1 Incidents	407	468	553	556	507
Total	421	481	565	574	519

Sentinel Event Notifications

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.²⁰ 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 the CIM Policy from 1 July 2018. The CIM Policy continues to support the reporting of near miss sentinel events in WA.

Figure 10 identifies sentinel events notified under the revised categories in WA in 2018/19 and 2019/20. For data relating to historical sentinel events notified prior to July 2018, refer to previous editions of the *Your Safety in our Hands in Hospital*²¹ report (sentinel event data prior to July 2018 reflects the categories that were in use in WA at the time the events were notified).

Figure 10: Frequency of WA Sentinel Events by Category for 2018/19 to 2019/20



Both sentinel events notified in this category in 2018/19 were near misses with the patient outcome reported as no harm.

²⁰ Further information about the Australian sentinel events list version 2 is available at: <https://www.safetyandquality.gov.au/our-work/indicators/australian-sentinel-events-list>

²¹ Previous editions available at: <https://ww2.health.wa.gov.au/Reports-and-publications/Your-safety-in-our-hands-in-hospital>

The most frequently reported sentinel events in 2019/20 were medication errors resulting in serious harm or death of a patient (n=3), suspected suicides of patients in an acute psychiatric units or acute psychiatric wards (n=3) and unintended retention of foreign objects in patients after surgery or other invasive procedure resulting in serious harm or death (n=3). Table 7 shows the patient outcomes reported for sentinel event categories in WA 2019/20.

Table 7: Frequency of WA Sentinel Events by Category and Patient Outcome for 2019/20

Sentinel Event Category	Death	Serious harm	Moderate harm	Minor harm
Medication error resulting in serious harm or death	1	1	1	-
Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death	-	-	1	-
Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	-	-	1	1
Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	3	-	-	-
Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death	-	3	-	-
Total	4	4	3	1

In addition to the reporting of sentinel events within this report, sentinel event notifications made by WA's public hospitals are included in the Australian Government Productivity Commission's annual Report on Government Services (ROGS).²² Commencing on 1 July 2017, sentinel events meeting national criteria are also reported to the IHPA in accordance with the Addendum to the National Health Reform Agreement (NHRA).

Of the 12 sentinel events reported in WA in 2019/20, five met the national criteria for reporting to the IHPA (two suspected suicides of patients in acute psychiatric units or acute psychiatric wards; one medication error resulting in serious harm or death; one unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death; and one surgery or other invasive procedure performed on the wrong site resulting in serious harm or death).

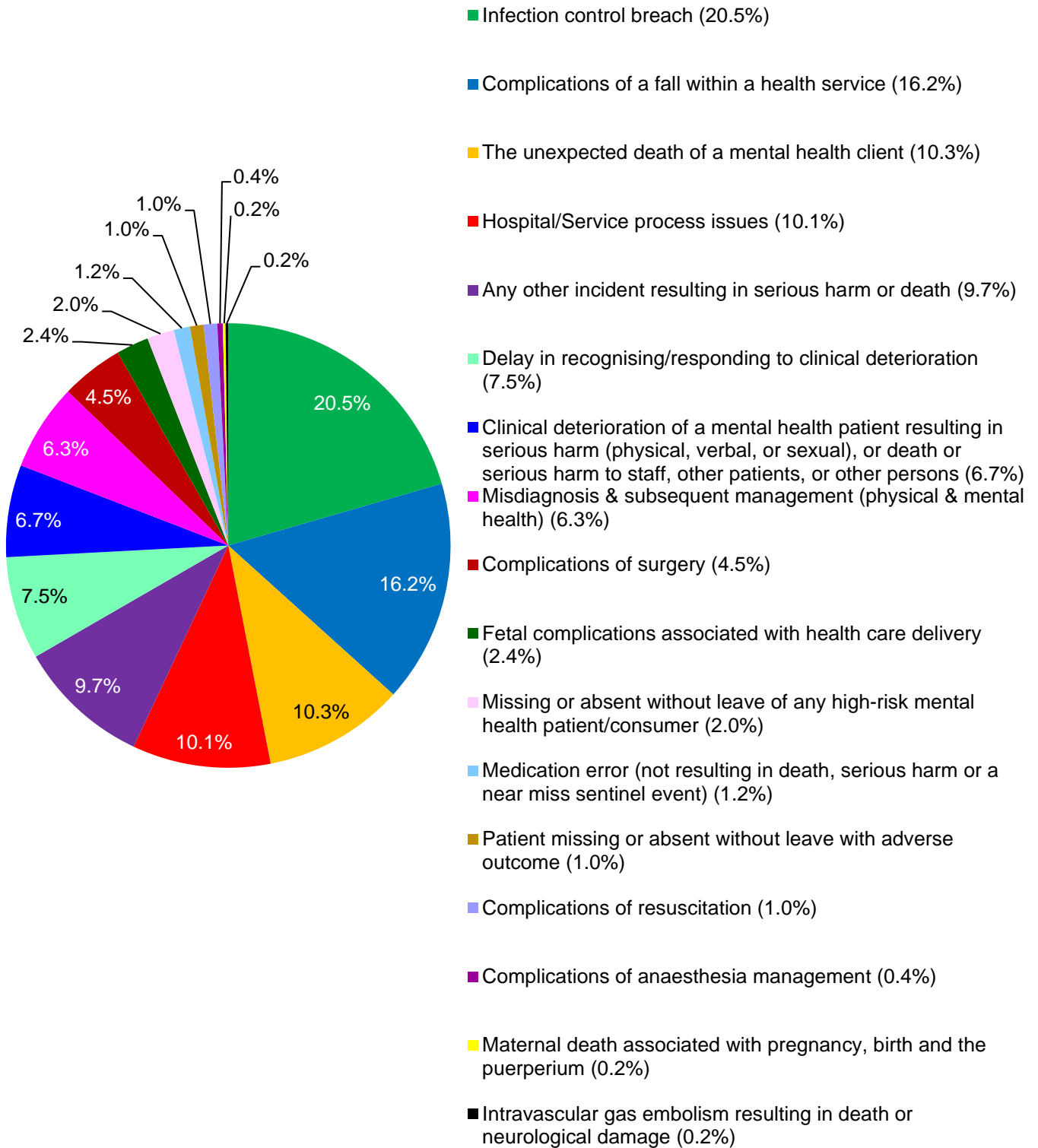
Because of the high risk of serious harm from these incidents, the PSSU continues to advocate for the reporting of near miss sentinel events, even though these do not meet the national reporting criteria. It is also important to note that sentinel events occurring at private health services involving private patients do not meet the national reporting criteria.

²² The Productivity Commission's annual Report on Government Services is available at: <https://www.pc.gov.au/research/ongoing/report-on-government-services>

Other Confirmed SAC 1 Clinical Incidents

In 2019/20, there were 507 SAC 1 clinical incidents other than sentinel events confirmed (see Figure 11). Infection control breaches (n=104; 20.5%) and complications of a fall within a health service (n=82; 16.2%) were the most frequently reported categories of Other SAC 1 incidents.

Figure 11: Percentage of Other Confirmed SAC 1 Clinical Incidents by Category for 2019/20



After seeing an increase in the reporting of Other SAC 1 clinical incidents from 407 incidents in 2015/16 to 556 incidents in 2018/19, there has been a decrease in the last year with 507 Other

SAC 1 clinical incidents confirmed for 2019/20 (see Table 8). Over the five-year period from July 2015 to June 2020, the categories of SAC 1 incidents most often reported were infection control breaches, complications of a fall within a health service, and hospital/service process issues.

Table 8: Frequency of Confirmed SAC 1 Clinical Incidents Other than Sentinel Events for 2015/16 to 2019/20

SAC 1 Categories	2015/16	2016/17	2017/18	2018/19	2019/20
Infection control breach	37	55	74	123	104
Complications of a fall within a health service ^a	53	68	72	68	82
The unexpected death of a mental health client	38	24	40	28	52
Hospital/Service process issues ^b	57	59	81	65	51
Any other incident resulting in serious harm or death	31	45	61	69	49
Delay in recognising/responding to physical clinical deterioration ^c	34	38	41	68	38
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 ^d	12	19	28	23	34
Misdiagnosis and subsequent management (physical and mental health)	18	31	28	28	32
Complications of surgery	25	16	29	17	23
Fetal complications associated with health care delivery	16	17	14	20	12
Missing or absent without leave of any high-risk mental health patient/consumer	59	58	43	32	10
Medication error (not resulting in death, serious harm or a near miss sentinel event) ^e	14	29	30	N/A	6
Patient missing or absent without leave with adverse outcome	2	3	4	3	5
Complications of resuscitation	8	2	4	7	5
Complications of anaesthesia management	3	4	4	4	2
Maternal death (associated with pregnancy, birth and the puerperium) ^f	-	-	-	-	1
Intravascular gas embolism resulting in death or neurological damage ^f	-	-	-	-	1
Total	407	468	553	556	507

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 first included 2015/16 with data for 2015/16 representing incidents notified from September 2015 to June 2016. 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 Dec 2019 to June 2020.

^f Category redefined as Other SAC 1 Incident from 1 July 2018. Incidents prior to 2018/19 were categorised as sentinel events.

Harm Associated with SAC 1 Clinical Incidents

Of the 519 SAC 1 clinical incidents confirmed in 2019/20, 142 (27.4%) reported a patient outcome of death and 226 incidents (43.5%) reported a patient outcome of serious harm. A further 45 incidents (8.7%) that reported no harm to the patient were confirmed as SAC 1, demonstrating the strong culture that exists regarding patient safety in WA.

Of the 142 incidents reporting the death of the patient, 54 (38.0%) related to voluntary, involuntary and referred mental health patients under the *Mental Health Act 2014*. Thirty-two (14.2%) of the 226 incidents reporting a patient outcome of serious harm also related to mental health patients. Figure 12 provides a summary of the patient outcome recorded for confirmed SAC 1 clinical incidents during 2019/20. It is important to note that the patient outcome may not be a direct result of the clinical incident itself.

Figure 12: Frequency and Percentage of Confirmed SAC 1 Clinical Incidents by Patient Outcome for 2019/20

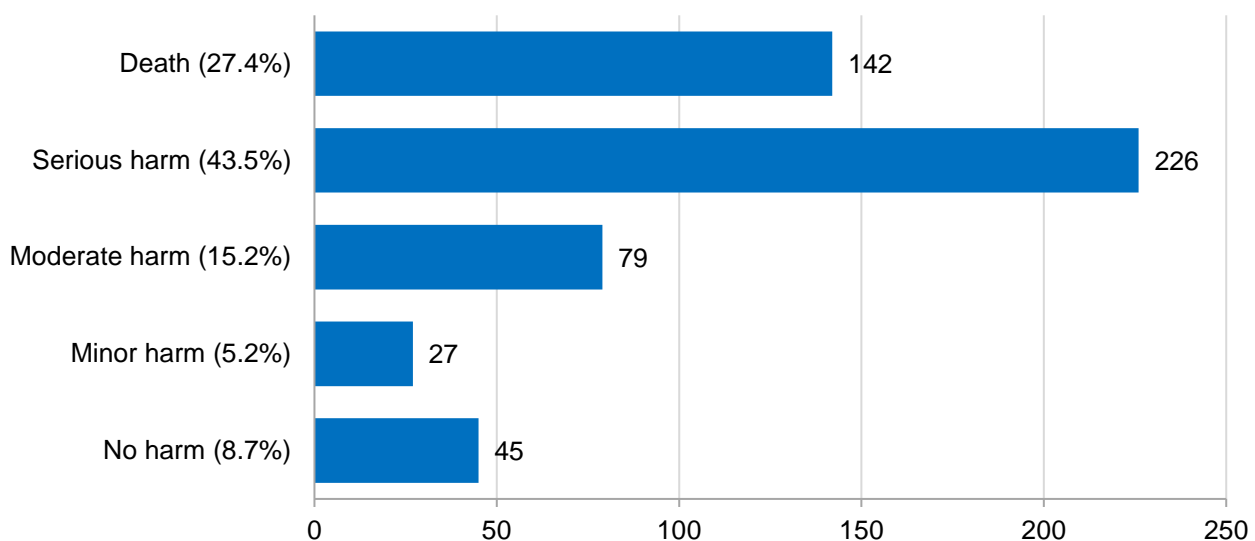


Table 9 provides the frequency by patient outcome for the five SAC 1 incident categories most often associated with a patient outcome of serious harm or death.

Table 9: Frequency of the Top Five Confirmed SAC 1 Clinical Incident Categories by Patient Outcome of Serious Harm or Death for 2019/20

SAC 1 Category	Death	Serious harm
Complications of a fall within a health service	11	58
Infection control breach	6	57
The unexpected death of a mental health client	52	-
Delay in recognising/responding to physical clinical deterioration	19	14
Hospital/service process issues	16	16
Total	104	145

In 2019/20, there were also 12 confirmed SAC 1 clinical incidents categorised as ‘misdiagnosis and subsequent management (physical and mental health)’; 10 incidents categorised as ‘other incident resulting in serious harm or death’; and four incidents categorised as ‘complications of surgery’ that described a patient outcome of death.

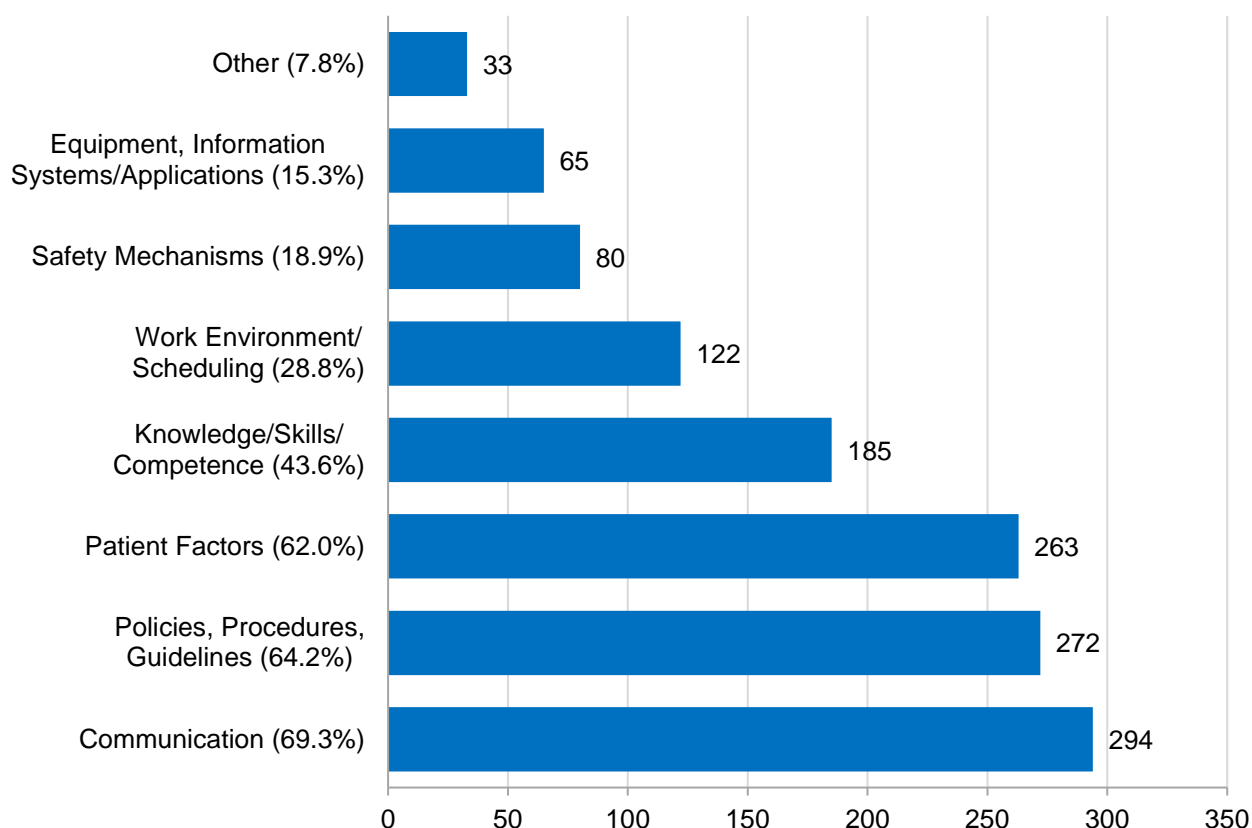
Of the 45 Other SAC 1 incidents that reported a patient outcome of no harm; 11 were related to hospital/service process issues; seven were categorised as missing/AWOL high risk mental health patients/clients; and five were related to medication errors (not resulting in death, serious harm or a near miss sentinel event). Eight Other SAC 1 incidents that reported no harm occurred to the patient were categorised as ‘other’ incidents with varying descriptions.

SAC 1 Contributory Factors

Figure 13 shows the contributory factors identified following the investigation of 424 SAC 1 clinical incidents (including sentinel events) by HSPs, private licensed health care facilities and contracted NGOs (representing 81.7% of all confirmed SAC 1 incidents reported in 2019/20). At the time of this report, 95 SAC 1 clinical incident investigations were still being progressed by the respective health service organisations.

The most frequently identified contributory factors in 2019/20 related to communication issues (n=294; 69.3%) and issues concerning policies, procedures and guidelines (n=272; 64.2%).

Figure 13: Frequency and Percentage of Contributory Factors for Closed SAC 1 Clinical Incidents for 2019/20



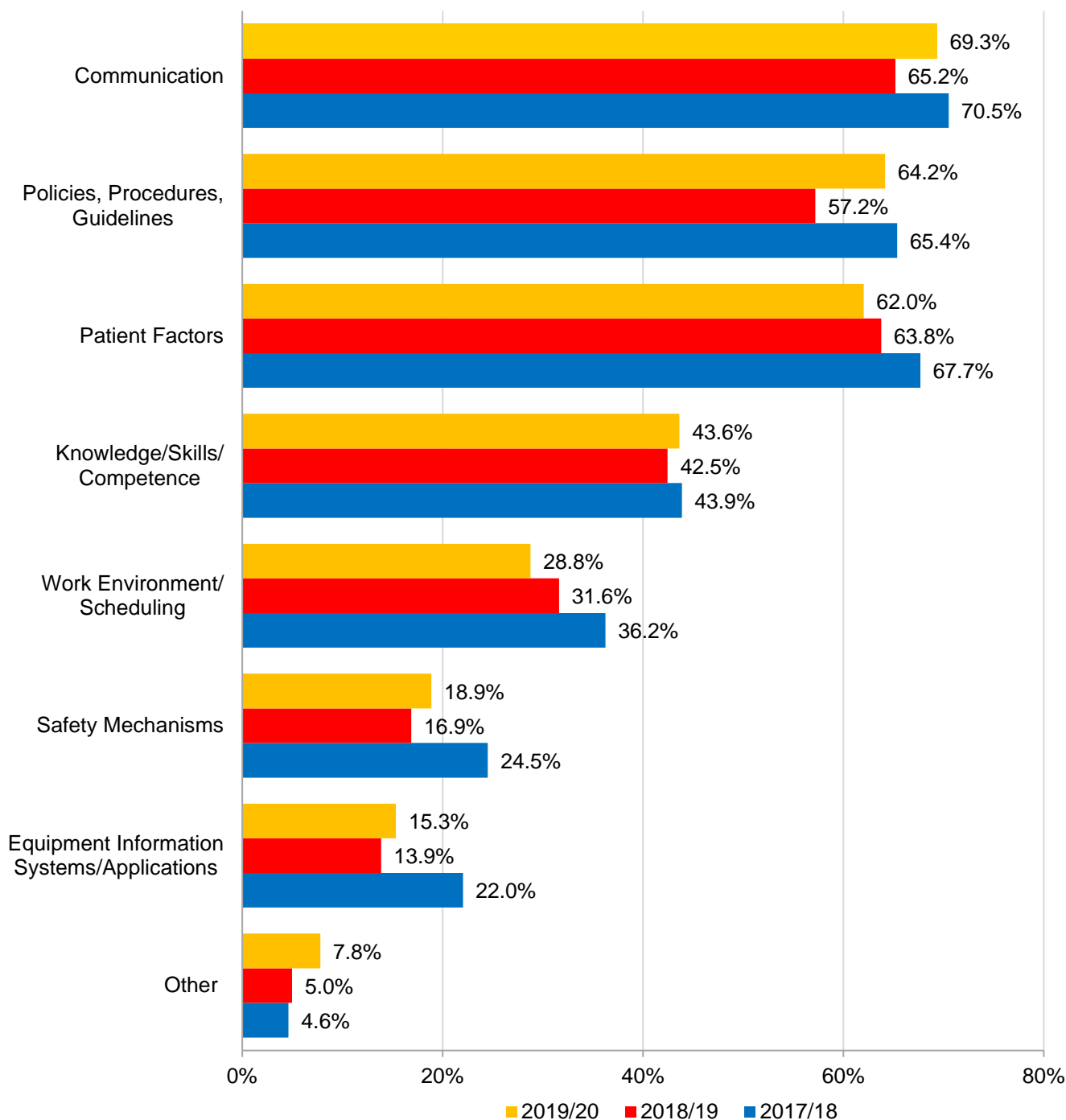
Note: A clinical incident investigation may identify multiple contributory factors

A significant number of the 294 closed SAC 1 clinical incidents that reported communication issues identified communication issues between staff (n=186; 63.3%), and issues related to documentation were identified in 58.2% (n=171).

Of the 272 closed SAC 1 clinical incidents that reported contributory factors related to policies, procedures and guidelines, 50.7% (n=138) identified concerns with the application of policies, procedures or guidelines, and 27.2% (n=74) identified an absence of relevant policies, procedures or guidelines.

Contributory factors identified in 2019/20 were compared with those identified in the two previous reporting periods (see Figure 14). The most frequently reported contributory factors over the last three years related to communication issues, patient factors, and issues with policies, procedures and guidelines.

Figure 14: Percentage of Contributory Factors for Closed SAC 1 Clinical Incidents for 2017/18 to 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

Sentinel Events Recommendations

Of the 12 sentinel events notified in this period, all investigation reports had been received at the time of writing this report, and all investigation reports submitted provided recommendations. Contributory factors identified through the investigation of selected sentinel events in 2019/20 are described in Table 10. The main themes revolved around enhancing communication between staff, improving documentation, and strengthening the compliance to, and application of, policies and procedures to assist in improving patient safety.

Table 10: Sentinel Events Identified Contributory Factors and Actions for 2019/20

Identified Issues	Health Service Providers Improvement Initiatives
Medication error resulting in serious harm or death	
<p>The prescription and discharge planning was not completed on the anticoagulant medication chart, which contributed to a failure to identify the missing medication at discharge.</p>	<p>A Lessons Learned poster was to be developed to remind staff of the correct process and documentation regarding the discharge of patients prescribed warfarin.</p>
<p>The anticoagulant medication was not added to the NaCS when transferred from ICU, which contributed to it being omitted from the discharge medications.</p> <p>The NaCS did not include a specific prompt regarding warfarin, contributing to a failure to communicate International Normalised Ratio (INR) history and guidance for ongoing monitoring to the patient's GP.</p>	<p>Staff were instructed to ensure that all valve replacement patients transferring from ICU to the specified ward have warfarin entered into the Notifications and Clinical Summaries (NaCS).</p> <p>Enhancements were to be considered for the NaCS to enable documenting whether the patient was prescribed warfarin, which would trigger the provision of more targeted information to the patient's GP about the history and ongoing monitoring.</p>
<p>The correct medication formulation was not adequately communicated.</p>	<p>A Lessons Learned poster was to be developed and disseminated across all clinical areas reminding staff of effective communication strategies such as read-back, independent checking, seeking clarification for medications not commonly used, and seeking confirmation of understanding.</p>
<p>Medication administration policy was not followed.</p>	<p>This case was to be used during education sessions to demonstrate the need for independent checking when dealing with high-risk medications.</p>
<p>Patient prescribed and administered medication at a significantly higher dose than recommended.</p>	<p>A multi-disciplinary working party was to be established which would develop a quality action plan for governance of knowledge and process requirements for the service; with consideration given to guidelines for patient allocation, knowledge requirements, and safe medication management.</p> <p>A process was to be developed for community to inpatient nurse to nurse handover.</p>

Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death	
Failure to use a patient sticker or electronic-automated identification when completing the request form contributed to a failure to identify the incorrect patient was being treated.	A team time-out process for procedures undertaken on the specified ward was to be implemented.
Failure to follow the clinical handover policy contributed to a failure to identify the incorrect patient was being treated.	An alert was communicated to all doctors in training regarding patient identification requirements and clinical handover format and compliance.
Use of incorrect documentation and identification label, with a failure to complete a team time-out process, contributed to a failure to identify the incorrect patient was being treated.	Case was to be discussed at a clinical review meeting.
A failure to utilise the electronic process for requesting the test contributed to a failure to identify the incorrect patient was being treated.	Communication was forwarded from leadership to all staff to clarify the appropriate use of downtime documentation.
Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	
The midline incision with lateralisation was difficult to observe by the rest of the surgical team.	Leadership was to promote the appropriate performance of the surgical safety checklist with each surgical specialty group.
Misinterpretation of medical imaging contributed to surgery being performed at the incorrect vertebral level.	<p>Discussion at the surgical audit group to recommend that:</p> <ul style="list-style-type: none"> a) where there is concern with the intraoperative imaging regarding vertebral level, that a second opinion be sought b) consideration be given to post-procedure imaging being undertaken prior to discharge in the event of uncertainty of vertebral level. <p>Consideration was to be given to the purchase of the O-arm system to improve intraoperative imaging.</p>
Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	
Patient's personal property used as ligature.	An amendment was to be made to the clinical risk policy to include removal of possible ligature articles upon request from the patient's doctor through periods of identified risk.
Ligature point accessible to the patient.	A worksite risk assessment of the ligature point, undertaken by an external party, was to be considered for further actions in relation to possible treatment of the ligature point.
Roof of service was accessible via the wall of an outdoor patient area.	An environmental and architectural review of the area was to be undertaken to identify potential safety measures and improvements.

<p>The existing policy did not contain any specific information about the management of chronically suicidal patients.</p>	<p>The policy was to be reviewed to determine the feasibility of including specific care planning strategies for patients who are chronically suicidal.</p>
<p>The existing bathroom design in the specified unit is a possible ligature point.</p>	<p>A review was to be undertaken to develop and document alternative bathroom door designs, including a costing model and proposal for replacement in a staged minor works program. The findings of the investigation were shared across the broader HSP network.</p>
<p>Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death</p>	
<p>The relevant policy was not being completely followed in theatre and the relevant bundle was not being completed by anaesthetists working in operating theatres.</p>	<p>A verbal check process was to be implemented during insertion so that removal of the guide wire is confirmed by both the proceduralist and the assistant. Standardised documentation for all central catheter insertions in theatre, in the form of a sticker adhered to the patient's record, was to be introduced.</p>
<p>Central venous catheter (CVC) trolley setups are assembled with multiple different kits, making the workspace busy and cluttered and therefore increasing the risk of retained guidewires upon completion of the procedure.</p>	<p>The possibility of standardising CVC trolley setup for this procedure was to be reviewed.</p>
<p>Retained wire not identified at the time of the procedure.</p>	<p>The case was to be reviewed by the specified department's clinical review committee to emphasise the key high-risk elements of the procedure.</p>
<p>The ACORN standard and site's policy relating to surgical count was not adhered to.</p>	<p>A regular surgical count audit to review the correct number of counts per procedure was to commence and be completed on a six-monthly basis.</p>
<p>An abdominal pack was used as a 'FISH®' retractor intra-operatively which contributed to it being retained.</p>	<p>The expected standard of practice was outlined in the investigation report. Auditing was to commence which would measure compliance with the expectations.</p>
<p>Caregivers did not escalate patient safety concerns relating to the failures in the surgical count process.</p>	<p>A graded assertiveness (speak up for patient safety) program was to be implemented.</p>
<p>A disjointed procedure (the handing over of a procedure to another clinician part way through) led to a breakdown in communication and the unintended retention of a vaginal pack. An incomplete procedural count process led to a breakdown in communication and the unintended retention of a vaginal pack.</p>	<p>The directorate was to promote a more robust (zero tolerance) culture that promotes, when a procedure is occurring: the completion of a full procedure count; and, the completion and documentation of all procedural counts to be undertaken by all clinicians involved in the procedure prior to leaving the patient.</p>

Fetal Harm Focus

Following review of a cluster of incidents resulting in fetal harm, where issues related to the interpretation and/or escalation of non-reassuring cardiotocograph (CTG) traces were identified as contributory factors, the *Cardiotocography Monitoring Policy* was released in January 2018. Changes to the configuration of Datix CIMS were made to enable the collection of information relating to fetal harm and to better differentiate between maternal and fetal outcomes. To support these changes the PSSU developed the *Datix CIMS Business rules for incidents that involve fetal harm*²³ and instructions were added to the existing Datix CIMS user guides.²⁴

Table 11 provides the frequency of confirmed SAC 1 clinical incidents where fetal harm was reported. Eleven SAC 1 incidents reported fetal harm in 2019/20, representing 2.1% of confirmed SAC 1 clinical incidents in this period. Retrospective completion of the fetal harm fields was discretionary for incidents notified prior to 1 July 2017.

Table 11: Frequency of Confirmed SAC 1 Clinical Incidents Where Fetal Harm was Indicated for 2015/16 to 2019/20

SAC 1 Category	2015/16 ^a	2016/17 ^a	2017/18	2018/19	2019/20
Fetal complications associated with health care delivery	12	13	14	18	6
Delay in recognising/responding to physical clinical deterioration	2	2	2	8	1
Hospital/service process issues	1	3	4	1	-
Misdiagnosis and subsequent management (physical and mental health)	1	-	2	1	1
Any other incident resulting in serious harm or death	1	-	2	1	-
Infection control breach	1	1	-	-	-
Complications of surgery	2	-	-	-	-
Complications of resuscitation	-	-	-	-	2
Maternal death (associated with pregnancy, birth and the puerperium)	-	-	-	1	1
Total	20	19	24	30	11

^a Fetal harm fields in Datix CIMS were implemented in October 2017. Retrospective data entry prior to 1 July 2017 was discretionary and data for the 2015/16 and 2016/17 years may not be complete.

Of the 11 incidents identifying fetal harm in 2019/20, five incidents reported fetal death and three reported serious harm to the fetus. Three incidents reported that moderate harm occurred to the fetus. None of the incidents reporting a fetal outcome of death were multiple pregnancies.

In 2019/20, incidents where fetal harm was indicated most frequently involved pregnancies with a gestational age of 40 or more weeks (n=4; 36.4%), or 25-29 weeks (n=3; 27.3%).

²³ Datix CIMS Business Rules for Fetal Harm are available at:

https://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system

²⁴ Datix CIMS User Guides are available to staff in the WA health system at:

<https://wahealthdept.sharepoint.com/sites/hss-customer-ict-hosp-admin/SitePages/cims.aspx>

Key Messages and Information: SAC 1 Clinical Incidents

There were 519 confirmed SAC 1 clinical incidents notified in 2019/20, of which 12 were reported as sentinel events. Four sentinel events were associated with the death of the patient, including one involving a medication error and three suspected suicides of patients in acute psychiatric units or wards. Three sentinel events with a patient outcome of serious harm were reported following the retention of a foreign object after surgery, two of which required return to theatre to remove the foreign material.

There were 507 Other SAC 1 clinical incidents confirmed in 2019/20, which is a decline from the 556 incidents confirmed in the previous year and goes against the upward trend seen between 2015/16 and 2018/19. This reduction in the number of confirmed SAC 1 incidents for 2019/20 is consistent with the observed decrease in reporting of clinical incidents more generally, which may be reflective of the WA health system's focus on preparing for, and responding to, the COVID-19 pandemic.

The three most commonly reported SAC 1 categories for 2019/20 were infection control breaches, complications of a fall in a health service and unexpected deaths of mental health clients. Six SAC 1 incidents reported as infection control breaches described a patient outcome of death, and 57 reported the patient outcome as serious harm.

There were 49 incidents reported under the category 'any other incident resulting in serious harm or death'. The types of incidents reported under this category varied and included missed diagnoses, delays in treatment, and harm associated with mental health deterioration not consistent with defined incident categories. There was significant patient harm associated with incidents categorised under 'any other incident resulting in serious harm or death', with 10 of these incidents reporting a patient outcome of death and 21 reporting a patient outcome of serious harm in 2019/20.

Of the 519 confirmed SAC 1 clinical incidents notified in 2019/20, 45 were identified as resulting in no harm to the patient and it is pleasing to see that the WA health system has acted to thoroughly investigate these near miss incidents. Of concern, there were 13 clinical incidents in 2019/20 that reported a patient outcome of death which were confirmed as SAC 2 or SAC 3 incidents. Changes to the *Clinical Incident Management Policy* made in late-2019 now require all events with a patient outcome of death to be notified and investigated as a SAC 1 clinical incident if there is any possibility that the event was preventable.

The *Clinical Incident Management Policy* also requires health service organisations to facilitate an appropriate level of open disclosure as soon as practicable following a clinical incident. Open disclosure is the open discussion of incidents that result in harm to a patient while receiving health care with the patient, their family, carers, and other support persons.¹⁴ At the time the data contained in this report was extracted from the Datix CIMS, the open disclosure process had been initiated for 74.6% (n=379) of confirmed SAC 1 clinical incidents.²⁵

In addition to the 519 confirmed SAC 1 incidents, 151 events were approved for declassification following investigation as no health care factors were found to have contributed. It is worth noting that the *Clinical Incident Management Guideline*¹⁴ provides a definition for contributory factors which is broader than causation: "*circumstances, actions or influences which are thought*

²⁵ The denominator for the percentage of confirmed SAC 1 incidents where open disclosure has been initiated (n=508) 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.

to have played a part in the origin or development of a clinical incident or to increase the risk of a clinical incident⁸. Where there is uncertainty about whether an event is a SAC 1 clinical incident, the PSSU advocates for a risk mitigation approach to clinical incident investigation and recognises the value of investigating these events to identify areas for improvement to prevent harm to patients.

Communication issues continue to be frequently identified as contributory to SAC 1 clinical incidents, with 69.3% of closed incidents in 2019/20 reporting communication issues. This is the fourth consecutive year in which communication issues have been the most frequently reported contributory factor. In SAC 1 incidents where communication-based factors were identified, 63.3% found communication issues between staff, and 58.2% found issues related to documentation.

In October 2017, fetal harm fields were added to the Datix CIMS which allowed the differentiation of maternal and fetal outcomes. For the 2019/20 period there were 11 SAC 1 clinical incidents where fetal harm was reported, with six of these incidents categorised as 'fetal complications associated with health care delivery'. The PSSU continues to monitor these incidents, particularly those where the interpretation and/or escalation of CTG traces may have contributed to poor neonatal outcomes.

The importance of evaluating the effectiveness of recommendations in addressing contributing factors, and spreading successes across other appropriate services, comes to the fore when reviewing the most frequently reported types of SAC 1 incidents and contributing factors. Similar patterns to previous years have been observed in 2019/20. Sites are encouraged to identify which commonly used strategies may not be producing the best outcome in terms of preventing further harm to patients, and search for alternatives that better address the root of the problem.



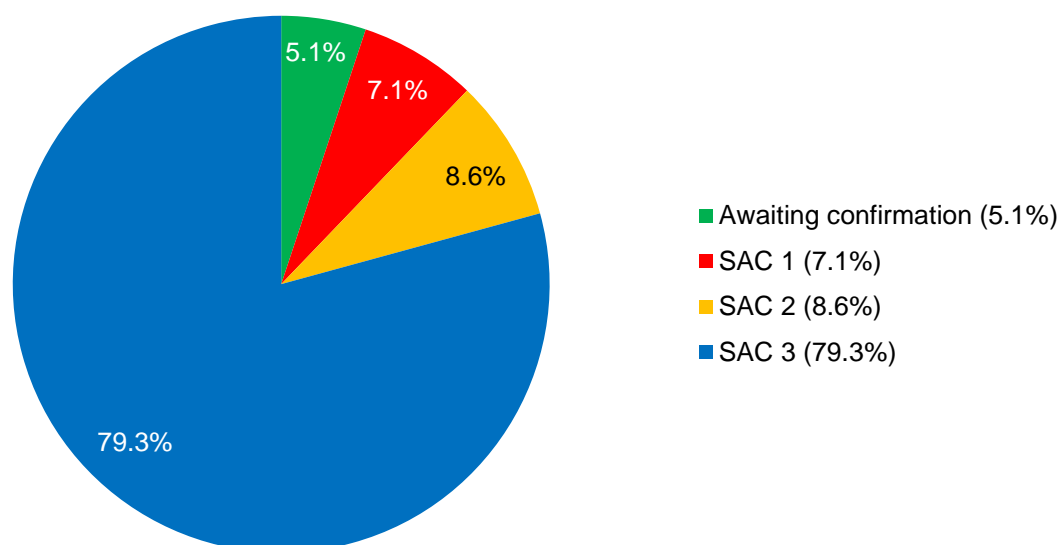
Standard 3: Preventing and Controlling Healthcare-Associated Infections Clinical Incidents

Healthcare-associated infections (HAIs) are infections that result from the provision of health care. There is evidence to suggest a considerable number of HAIs are preventable adverse events rather than inevitable complications of care. Standard 3 of the second edition of the NSQHS Standards refers to preventing and controlling HAIs, and the intention is to reduce the risk of patients acquiring HAIs, effectively manage infections if they occur, and limit the development of antimicrobial resistance through prudent use of antimicrobials as part of antimicrobial stewardship.³

Infection prevention and control aims to improve patient safety by minimising the risk of transmission of infectious agents to the patient and reducing the development of resistant organisms. Strategies to prevent HAIs are multi-factorial and include the adoption of evidence-informed guidelines for managing patients with indwelling devices or undergoing procedural interventions, maintaining high standards of environmental and equipment hygiene, strict adherence to cleaning, disinfection and sterilisation procedures of reusable medical devices, and safe and appropriate prescribing of antimicrobial agents. The application of standard and transmission-based precautions for all patients at all times, including high-level compliance with hand hygiene, to reduce the transmission of infections is of vital importance in preventing HAIs.

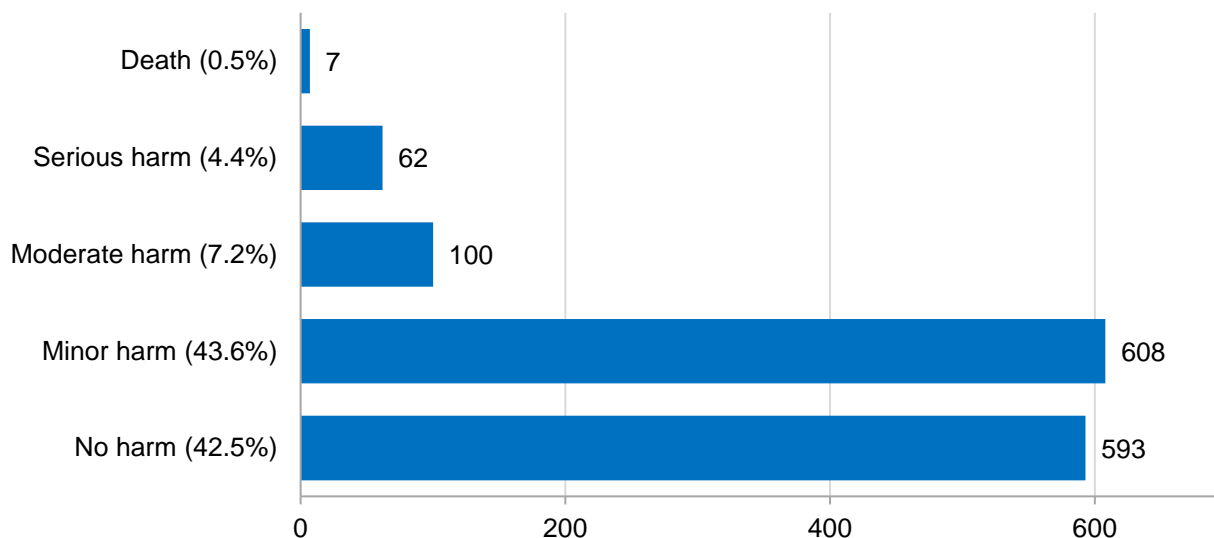
Clinical incidents related to healthcare-associated infections are identified in the Datix CIMS using the Tier One category “Infection Control Incident (Healthcare Associated Infection)”. In 2019/20, there were 1,470 infection control clinical incidents notified, of which 1,395 incidents were confirmed and 75 incidents were awaiting confirmation of the SAC rating at the time of this report. Infection control incidents accounted for 4.4% of all clinical incidents notified in this period. Most infection control clinical incidents were confirmed as SAC 3 incidents (n=1,165; 79.3%); followed by SAC 2 (n=126; 8.6%) and SAC 1 (n=104; 7.1%; see Figure 15).

Figure 15: Percentage of Infection Control Clinical Incidents by SAC Rating for 2019/20



The majority of confirmed infection control clinical incidents reported the outcome as minor harm (n=608; 43.6%) or no harm (n=593; 42.5%) to the patient. Seven confirmed infection control incidents during 2019/20 reported a patient outcome of death (see Figure 16).

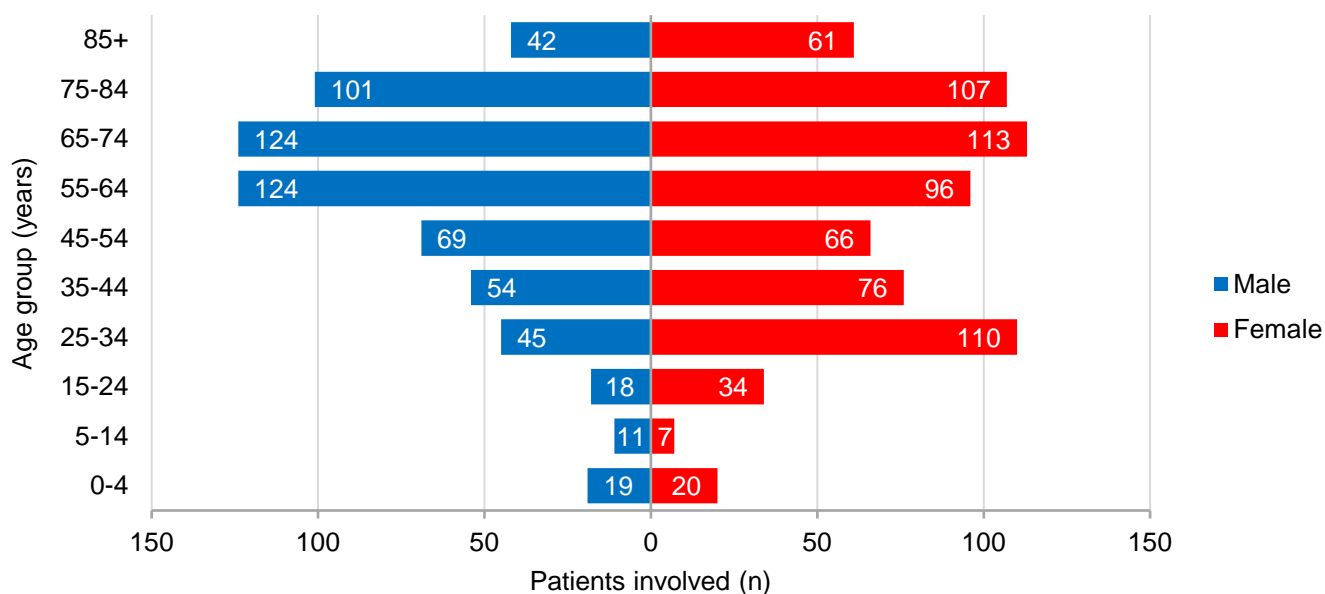
Figure 16: Frequency and Percentage of Confirmed Infection Control Clinical Incidents by Patient Outcome for 2019/20



Note: Patient outcome missing data n=25; 1.8%

Females accounted for 52.7% (n=702) of patients involved in confirmed infection control clinical incidents, with males making up 47.3% (n=630; missing gender n=69). Patient ages ranged from 0-100 years with a median age of 60 years. Figure 17 shows the distribution of patients involved in confirmed infection control clinical incidents by age group and gender.

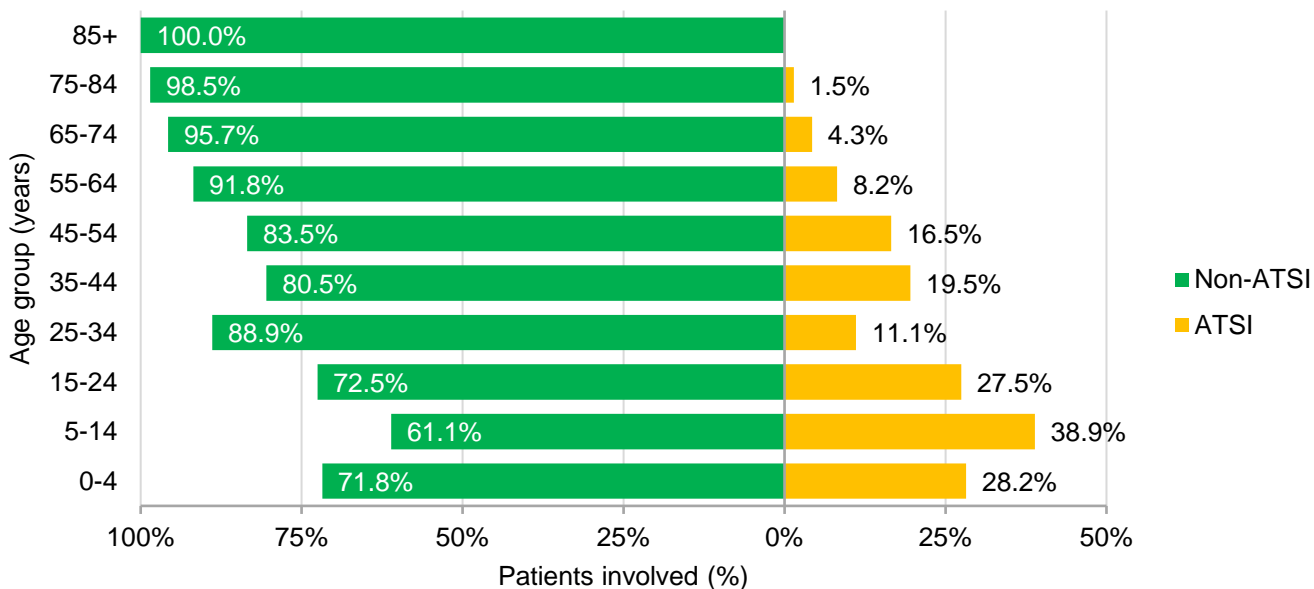
Figure 17: Frequency of Patients Involved in Confirmed Infection Control Clinical Incidents by Age Group and Gender for 2019/20



Note: Patient age and/or gender missing data n=104; a clinical incident may affect multiple patients

ATSI persons accounted for 9.9% (n=127; missing ATSI status n=116) of patients involved in confirmed infection control clinical incidents in 2019/20. While the number of patients aged 0-24 years involved in infection control incidents was relatively small (n=108), 29.6% (n=32) of them were ATSI persons (see Figure 18).

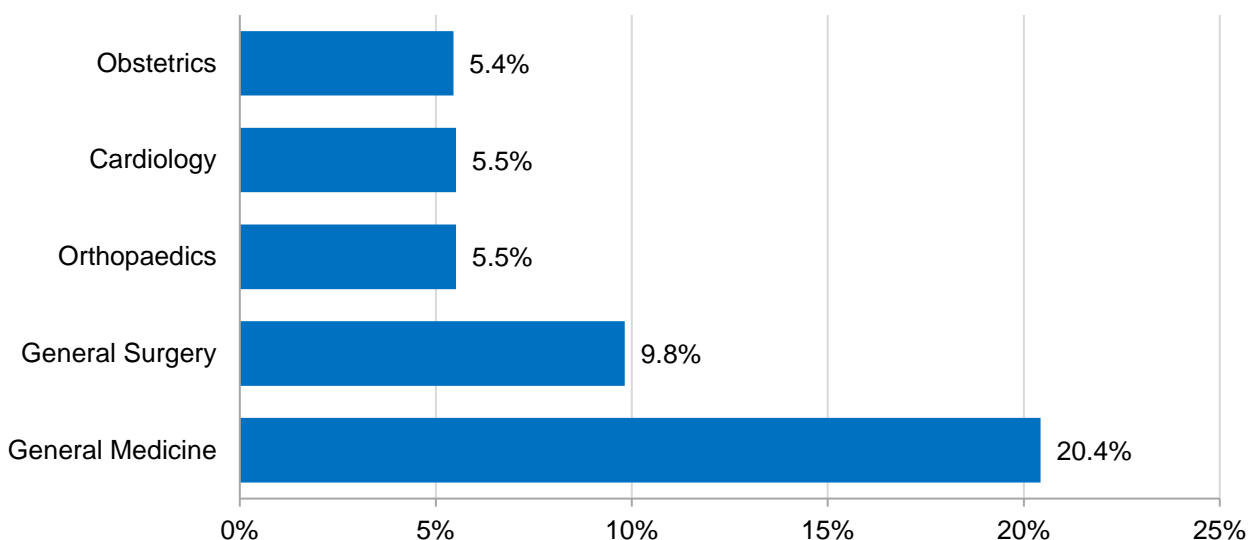
Figure 18: Percentage of Patients Involved in Confirmed Infection Control Clinical Incidents by Age Group and ATSI Status for 2019/20



Note: Patient age and/or ATSI status missing data n=117; a clinical incident may affect multiple patients

The treating specialties that most frequently reported infection control clinical incidents are shown in Figure 19. These five specialties accounted for 46.7% (n=652) of all confirmed incidents related to this NSQHS Standard in 2019/20. The General Medicine specialty reported the highest number of infection control clinical incidents (n=285; 20.4%).

Figure 19: Percentage of Confirmed Infection Control Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=242; 17.3%

The five most frequent Tier Three incident categories accounted for 93.6% (n=1,306) of confirmed infection control clinical incidents in 2019/20 (see Table 12). Most infection control incidents were categorised as contamination due to hospital processes (other than sterilisation) (n=621; 44.5%) or processes/protocols for infection prevention and control not being followed or adhered to (n=402; 28.8%).

Table 12: Frequency and Percentage of Top Five Tier Three Confirmed Infection Control Clinical Incident Categories for 2019/20

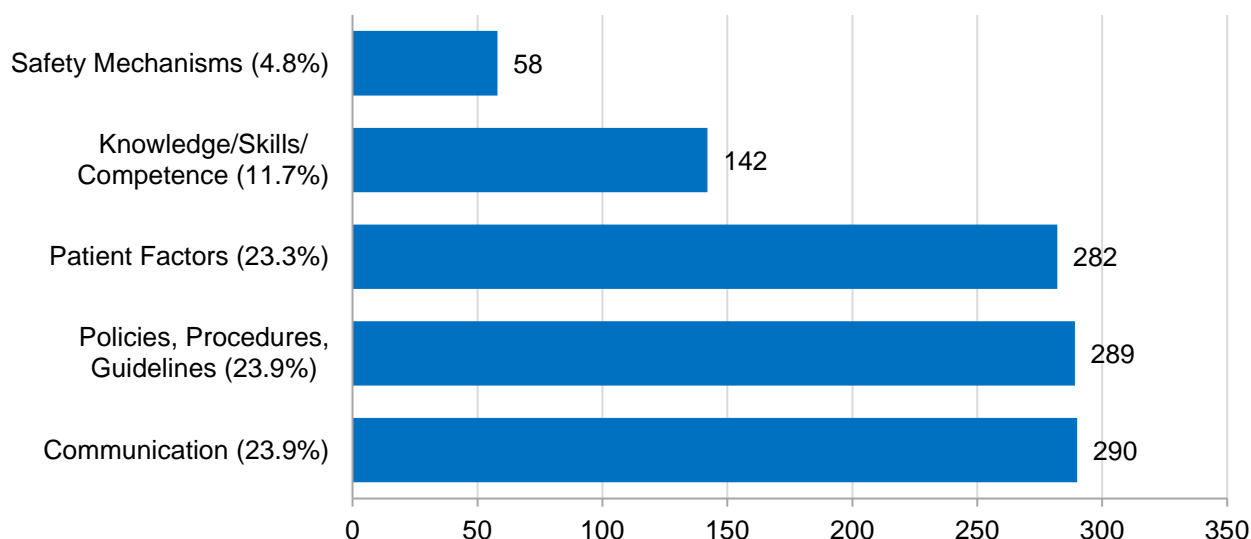
Tier Three Infection Control Categories	(n)	(%)
Contamination due to hospital processes (other than sterilisation)*	621	44.5
Processes/protocols established but not followed/adhered†	402	28.8
Breach in sterile techniques*	170	12.2
Delayed diagnosis	60	4.3
Processes/protocols not established†	53	3.8
Total	1,306	93.6

* Incidents for these Tier Three categories relate to infections associated with devices, products, medications and fluids.

† Incidents for these Tier Three categories relate to processes/procedures for antibiotic prophylaxis, environmental cleaning and hygiene, hand-hygiene, isolation and handling of body fluids/tissues, isolation of infected and immunocompromised patients, performance of clinical procedures, safe injection/sharps disposal, and sterilisation.

The most common contributory factors identified in the investigation of infection control clinical incidents in 2019/20 were issues with communication, cited in 23.9% (n=290) of closed incidents, and policies, procedures and guidelines, also cited in 23.9% (n=289; see Figure 20).

Figure 20: Frequency and Percentage of the Top Five Contributory Factors for Closed Infection Control Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

Communication issues most frequently related to problems with communication between staff (n=169; 58.3% of incidents where communication factors were identified) and documentation (n=168; 57.9%). Where issues regarding policies, procedures and guidelines were identified these most frequently related to problems with their application (n=170; 58.8% of incidents where policies, procedures and guidelines factors were identified).

Key Messages and Information: Preventing and Controlling Healthcare-Associated Infections Clinical Incidents

Healthcare-associated infections, particularly bloodstream infections, pose a significant threat to patient safety, and it is recognised that many are preventable. HAI surveillance continues to be a key component of Standard 3 in the second edition of the NSQHS Standards²⁶, and the WA health system has a long-standing program of healthcare infection surveillance.

While vital to the provision of modern health care, the infection control risk associated with invasive medical devices (such as catheters for intravascular access and urinary catheters) is well known. In 2019/20, more than half of all confirmed incidents (n=798; 57.2%), seventy percent of SAC 1 incidents (n=73; 70.2%) and four of the seven deaths related to confirmed infection control clinical incidents were associated with a device, product, medication or fluid. Most of these incidents were attributed to contamination due to hospital processes other than sterilisation (n=621) or a breach in sterile techniques (n=170). The remaining seven of these incidents were classified as contamination due to manufacturing problems.

Key concepts for minimising the risk of infection related to the use of invasive medical devices can be found in the National Health and Medical Research Council's *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.²⁷ These measures should be implemented as part of comprehensive approach to infection prevention and control that includes other established strategies, including hand hygiene, aseptic technique and antimicrobial stewardship.

Review of the infection control clinical incidents that reported a patient outcome of death in 2019/20 found that all involved vulnerable at-risk patients, including two preterm infants. In the first of these incidents the investigation identified that the risk of infection may have been minimised if the treating team had used an umbilical catheter rather than a peripheral venous catheter that had been replaced on multiple occasions.

Findings from the investigation of the second incident included that more attention could have been given to incubator temperatures when considering signs of sepsis in the baby. Both investigations led to updated clinical guidelines that incorporated the lessons learnt from the review of these cases.

²⁶ ACSQHC NSQHS Standards (2nd ed) Standard 3: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/preventing-and-controlling-healthcare-associated-infection-standard>

²⁷ NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019) are available at: <https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019>



Standard 4: Medication Safety Clinical Incidents

Medications (medicines) are the most frequent form of treatment used in health care and as such tend to be more frequently involved in clinical incidents than other forms of treatment. While the appropriate use of medications can provide substantial benefits to patients, when errors occur the adverse effects can be severe. There are many factors that may contribute to medication-related clinical incidents, including issues at the points of prescribing, dispensing and administration, such as incorrect medications, incorrect doses, and incorrect timing of administration (including omission of medication doses).

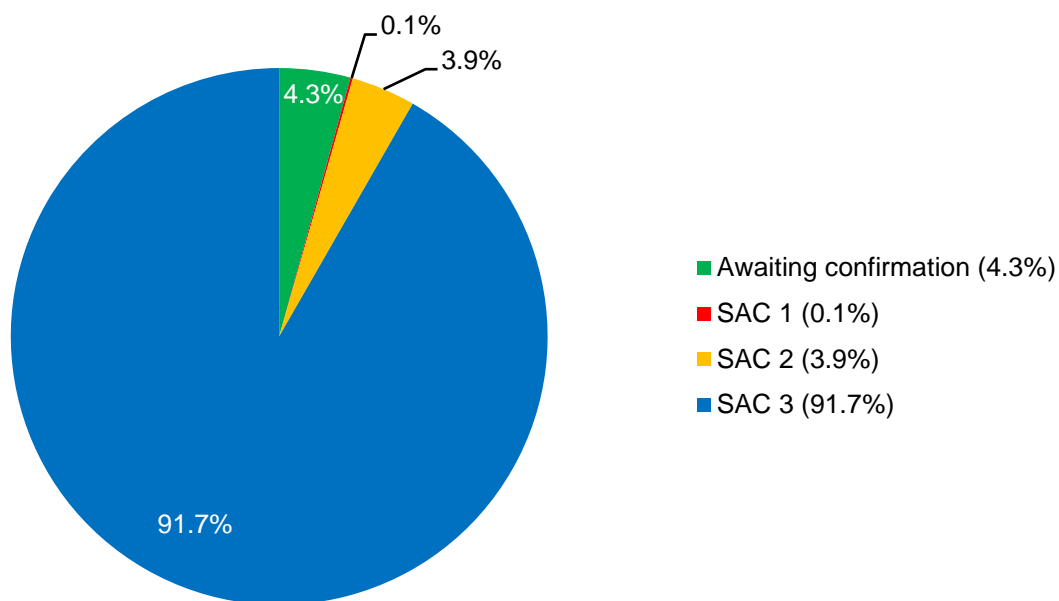
Standard 4 of the second edition of the NSQHS Standards refers to medication safety. The intention of this Standard is to ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use, and that consumers are informed about medicines and understand their individual medicine needs and risks.³

Standardising and systemising processes can improve medication safety by preventing medication incidents. Other recognised solutions for reducing common causes of medication incidents include: improving governance and quality measures relating to medication safety, improving clinician-workforce communication and clinical handover, improving clinician-patient communication and partnership, using technology to support information recording and transfer, and providing better access to patient information and clinical decision support.³

Medication-related clinical incidents are captured under the Tier One category in Datix CIMS that includes medications, biologics and fluids. During 2019/20, there were 8,155 medication incidents notified of which 7,806 were confirmed and the remainder (n=349) were awaiting SAC confirmation at the time of this report. Medication-related clinical incidents represented 24.6% of all clinical incidents notified in this period.

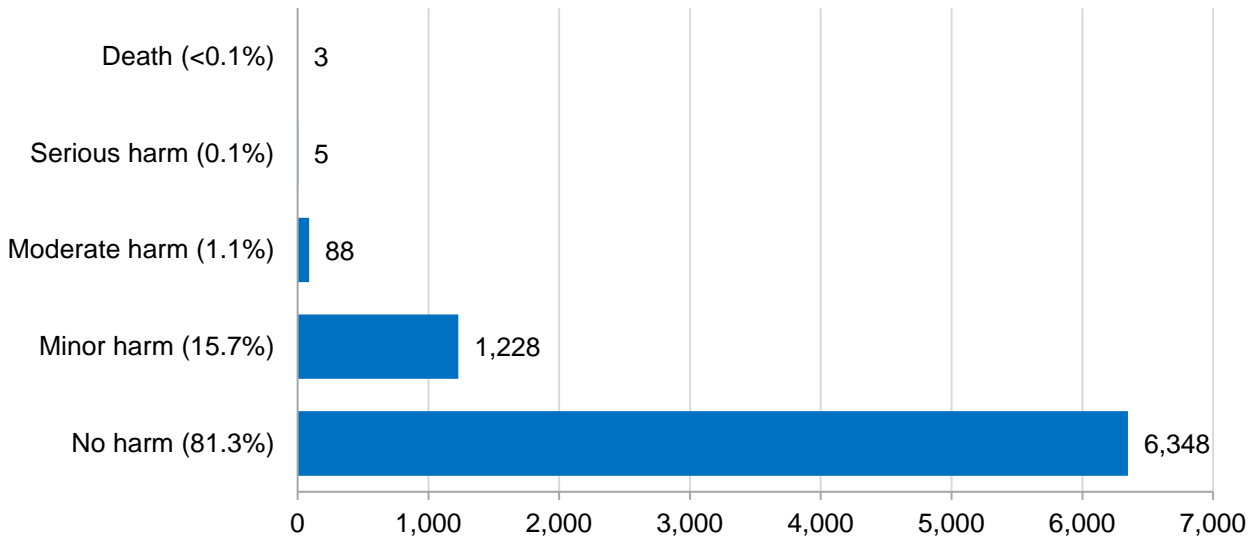
Most medication-related incidents were confirmed as SAC 3 clinical incidents (n=7,479; 91.7%). There were 12 medication-related clinical incidents confirmed as SAC 1, accounting for 0.1% of medication incidents in 2019/20 (see Figure 21).

Figure 21: Percentage of Medication Clinical Incidents by SAC Rating for 2019/20



During 2019/20, 81.3% (n=6,348) of confirmed medication-related clinical incidents reported no harm to the patient, and 15.7% (n=1,228) reported a patient outcome of minor harm (see Figure 22). One-third (n=4) of the 12 confirmed SAC 1 medication incidents were near misses reporting no harm to the patient, however only one of the three incidents reporting a patient outcome of death was confirmed as SAC 1. The remaining SAC 1 incidents reported patient outcomes of serious harm (n=3), moderate harm (n=3) and minor harm (n=1).

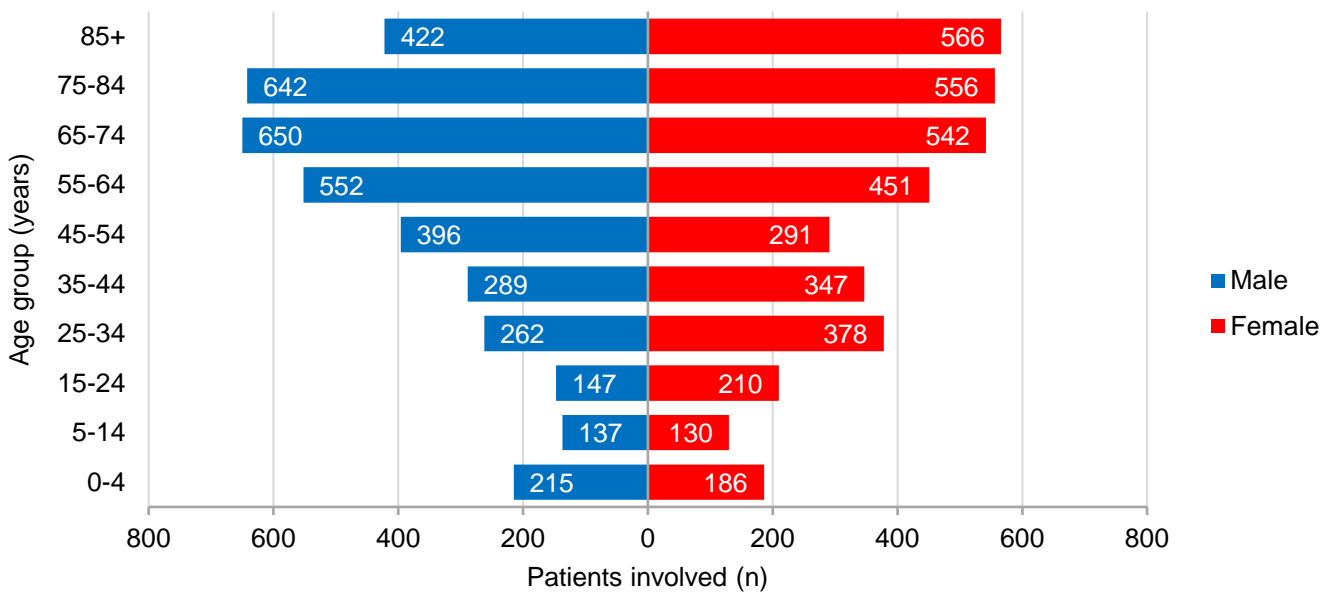
Figure 22: Frequency and Percentage of Confirmed Medication Clinical Incidents by Patient Outcome for 2019/20



Note: Patient outcome missing data n=134; 1.7%

Males accounted for 50.4% (n=3,724) of patients involved in confirmed medication-related clinical incidents, with females making up 49.6% (n=3,667; missing gender n=465). Ages ranged from 0-104 years with a median age of 62 years. Figure 23 shows the distribution of patients involved in confirmed medication-related clinical incidents by age group and gender.

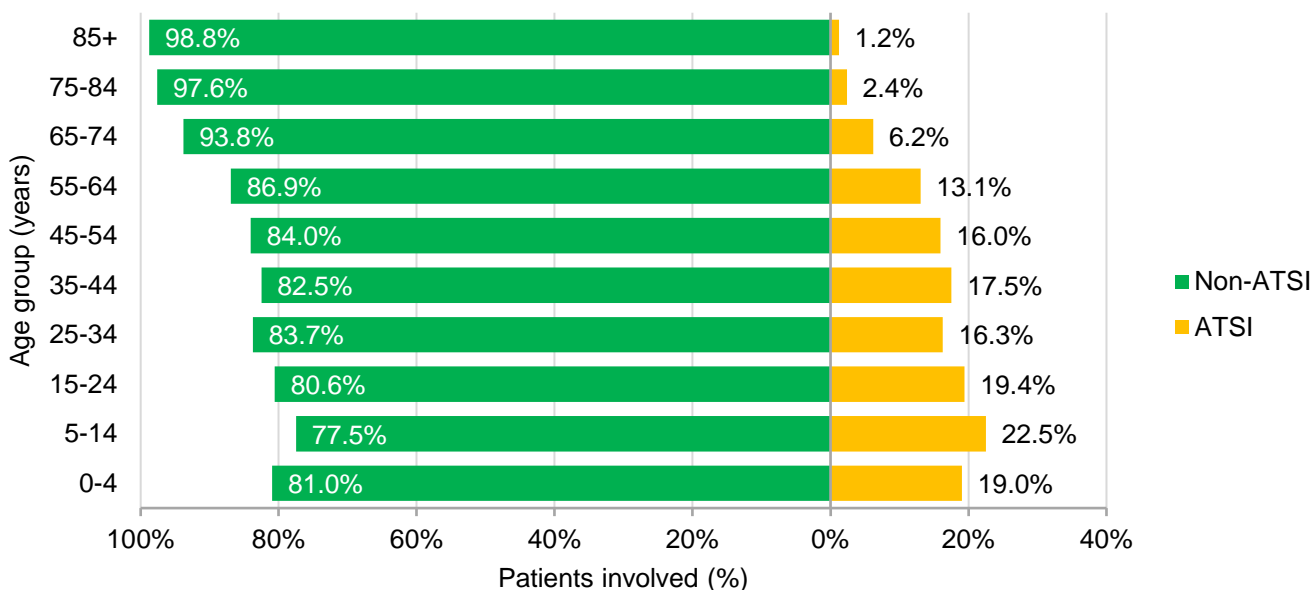
Figure 23: Frequency of Patients Involved in Confirmed Medication Clinical Incidents by Age Group and Gender for 2019/20



Note: Patient age and/or gender missing data n=487; a clinical incident may affect multiple patients

ATSI persons accounted for 10.6% (n=772; missing ATSI status n=568) of patients involved in confirmed medication clinical incidents in 2019/20. The highest proportion of ATSI patients involved was seen in the 5-14 years age group (22.5%; see Figure 24).

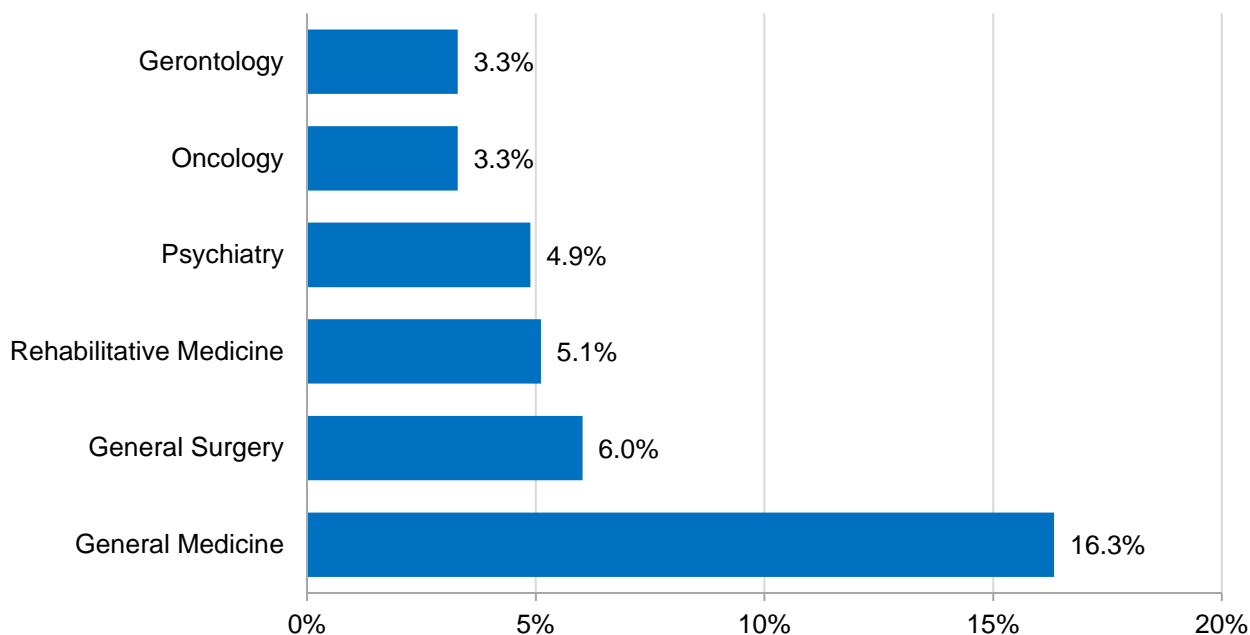
Figure 24: Percentage of Patients Involved in Confirmed Medication Clinical Incidents by Age Group and ATSI Status for 2019/20



Note: Patient age and/or ATSI status missing data n=577; a clinical incident may affect multiple patients

Six specialties accounted for 38.9% (n=3,039) of confirmed medication-related clinical incidents in 2019/20. The General Medicine specialty reported the greatest number of medication incidents (n=1,275; 16.3%) followed by General Surgery (n=470; 6.0%; see Figure 25).

Figure 25: Percentage of Confirmed Medication Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=2,064; 26.4%

In 2019/20, the five most frequent Tier Three medication clinical incident categories accounted for 44.0% of confirmed medication-related clinical incidents (see Table 13). Findings show that medication-related clinical incidents were most frequently categorised as a failure to administer medication (n=1,250; 16.0%), followed by prescribing, dispensing or administering an incorrect medication dose (n=869; 11.1%).

Table 13: Frequency and Percentage of Top Five Tier Three Confirmed Medication Clinical Incident Categories for 2019/20

Tier Three Medication Categories	(n)	(%)
Failure to administer medication*	1,250	16.0
Incorrect medication dose†	869	11.1
Incorrect medication/fluid†	553	7.1
Extravasation	399	5.1
Dose of medication omitted*	365	4.7
Total	3,436	44.0

* Failure to administer occurs when the clinician is aware that a medication is due at a certain time, but the medication cannot be administered (e.g. the patient is not present on the ward or there is a problem with an infusion pump). Omission of a medication dose relates to an oversight by staff resulting in the dose not being administered (e.g. the clinician was busy, didn't check the medication chart adequately, forgot to administer the medication or there was inadequate clinical handover of the patient).

† Incidents for these Tier Three categories relate to prescribing processes, dispensing processes and administration of medication to the patient.

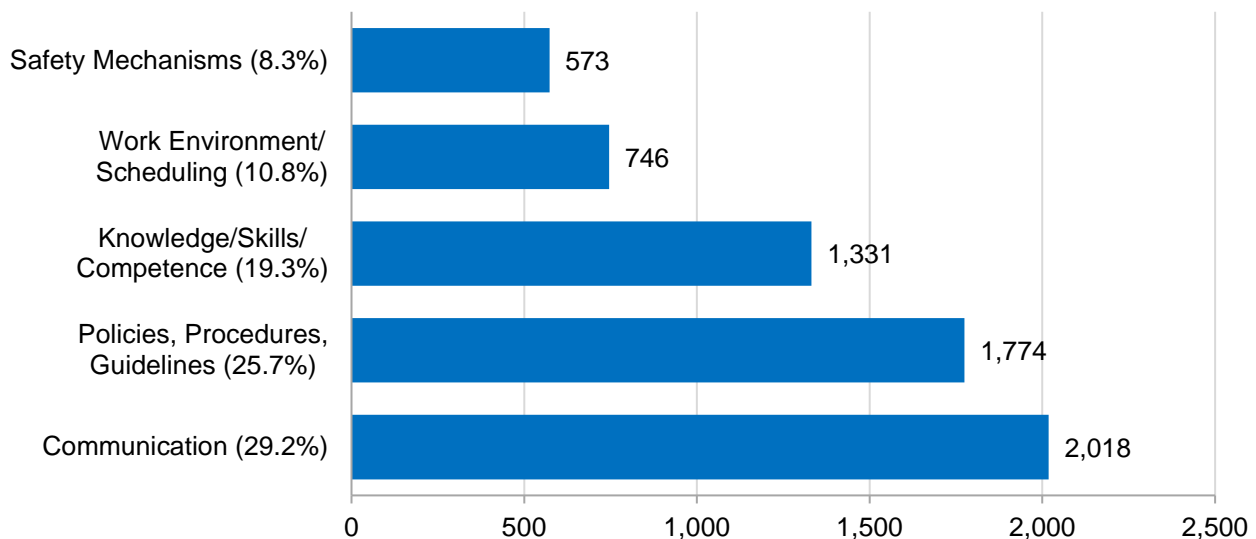
The 10 most frequent categories of medication involved in clinical incidents in 2019/20 accounted for 58.1% (n=4,535) of confirmed medication-related clinical incidents. Opioid analgesics (n=978; 12.5%) were the most frequent category of medication involved, accounting for one in every eight confirmed medication clinical incidents, followed by antibacterials (n=808; 10.4%), insulins (n=476; 6.1%) and anticoagulants (n=475; 6.1%; see Table 14).

Table 14: Frequency and Percentage of Top Ten Categories of Medications Involved in Confirmed Clinical Incidents 2019/20

Top Ten Medication Categories	(n)	(%)
Opioid analgesics (opioid based pain relievers)	978	12.5
Antibacterials (antibiotics)	808	10.4
Insulins (medications used for diabetes)	476	6.1
Anticoagulants (blood thinning medications)	475	6.1
Antipsychotics (medications for major psychiatric disorders)	454	5.8
Antihypertensives (medications for high blood pressure)	346	4.4
Non-opioid analgesics (non-opioid pain relievers)	298	3.8
Medications for anxiety and sleep disorders	266	3.4
Antiepileptics (medications for epilepsy)	252	3.2
Antidepressants (medications for depression)	182	2.3
Total	4,535	58.1

Communication issues were the most commonly identified contributory factors in medication-related clinical incidents investigated in 2019/20 (n=2,018; 29.2%; see Figure 26), followed by issues with policies, procedures and guidelines (n=1,774; 25.7%). Communication issues most frequently related to problems with communication between staff (n=1,121; 55.6% of medication incidents where communication factors were identified) and documentation (n=1,102; 54.6%). Issues regarding policies, procedures and guidelines most frequently related to problems with their application (n=1,047; 59.0% of medication incidents where policies, procedures and guidelines factors were identified) and their implementation (n=620; 34.9%).

Figure 26: Frequency and Percentage of the Top Five Contributory Factors for Closed Medication Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors



Key Messages and Information: Medication Safety Clinical Incidents

In 2019/20, medication-related clinical incidents continued to be one of the most frequently reported types of incident across the WA health system, representing nearly one-quarter of all clinical incidents notified. More than 80% of all confirmed medication-related clinical incidents, and one-third of the medication incidents categorised as SAC 1, resulted in no harm to the patient, demonstrating the strong culture that exists regarding medication safety in WA.

The most common category of medication-related clinical incident was a failure to administer medication, and omitted dose of medication was also in the top five most frequent medication incident categories in 2019/20. Collectively, 20.7% of confirmed medication-related clinical incidents involved the patient not receiving medication that they were supposed to, which has the potential to result in ineffective treatment and/or relief of the patient's symptoms. A guidance document has been developed to assist staff in correctly classifying incidents that involve a medication in the Datix CIMS.²⁸

The categories of medications involved in these incidents continues to follow the pattern seen in previous years, with four high-risk medications (opioid analgesics, antibacterials, insulins and anticoagulants) most often reported to be involved in confirmed medication-related clinical incidents. These four categories of medication accounted for 35.1% of confirmed medication-related clinical incidents in 2019/20. The second edition of the NSQHS Standards continues to recognise the danger that high-risk medications can pose to patients.²⁹ The updated *High Risk Medication Policy*³⁰ took effect in the WA health system in February 2020 and establishes the minimum requirements for the safe management of high risk medications across HSPs.

In 2019/20, all three confirmed medication incidents that reported a patient outcome of death involved high risk medications. One of these incidents involved an opioid analgesic and was reported and investigated as a sentinel event. The other two incidents, which both involved anticoagulant medications, were confirmed and investigated as a SAC 2 and a SAC 3 incident. Changes to the *Clinical Incident Management Policy* made in late-2019 now require all incidents where the patient outcome was death to be notified and investigated as SAC 1 clinical incidents.

In March 2017, the World Health Organization launched its third Global Patient Safety Challenge: *Medication Without Harm*³¹ with the aim of reducing severe avoidable medication-related harm. In April 2020, the ACSQHC published Australia's response to the Challenge, with the goal to reduce medication errors, adverse drug events and medication-related hospital admissions by 50% by 2025.³² Australia's target areas are monitoring and responding to inappropriate polypharmacy, reducing harm from high-risk medicines (with a focus on insulin, opioid analgesics, anticoagulants and antipsychotics), improving medication safety at transitions of care, particularly improving clinical handover when patients transfer between hospitals or are discharged to primary health care professionals (with a focus on a shared medicines list), and providing comprehensive medication information to consumers that is easy to understand.

²⁸ The Guidance document for incidents that involve a medication is available at:

https://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system

²⁹ ACSQHC NSQHS Standards (2nd ed) Medication Safety Standard available at:

<https://www.safetyandquality.gov.au/standards/nsqhs-standards/medication-safety-standard>

³⁰ The WA High Risk Medication Policy is available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/High-Risk-Medication-Policy>

³¹ WHO Global Patient Safety Challenge: Medication Without Harm: <https://www.who.int/patientsafety/medication-safety/en/>

³² Medication without harm – WHO Global Patient Safety Challenge: Australia's response is available at:

<https://www.safetyandquality.gov.au/our-work/medication-safety/who-global-patient-safety-challenge-medication-without-harm>

Standard 5: Comprehensive Care Clinical Incidents

Standard 5 of the second edition of the NSQHS Standards refers to comprehensive care and the intention is 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.³

The purpose of the Comprehensive Care Standard is to address the systemic issues that underlie many adverse events that occur in health care. These issues often include failures to provide continuous and collaborative care; of staff to communicate and work effectively as a health care team; and to work in partnership with patients, carers and families to adequately identify, assess and manage patients' clinical risks, and find out their preferences for care.

Proper implementation of the Comprehensive Care Standard requires health care providers to partner with patients in their own care and safely manage transitions of care (both within and between health service organisations). As such, there is a strong link between the delivery of comprehensive care and Standard 2 (Partnering with Consumers) and Standard 6 (Communicating for Safety) of the second edition 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 and restrictive practices. While each of these may be seen as a discrete area of risk, it is important to recognise that for many patients a particular risk factor may make them more likely to suffer more than one of these adverse events, as demonstrated by the following case.

An elderly aboriginal woman with a history of dementia and wandering behaviour who also suffered from poor mobility was being cared for in a regional residential aged care facility. The woman had five minor falls prior to a further fall resulting in a fractured hip, which required an operation to repair. The clinical incident investigation noted a lack of multidisciplinary focused care for the woman. The investigation also noted that referral to a geriatrician via a Telehealth review for medication management may have prevented harm as the woman had been receiving sedation to assist her during periods of agitation. The review gave positive feedback to the care facility for initiating a specialist review by Dementia Support Australia, but unfortunately the dementia care plan had not been implemented by the facility at the time of the fall.

Clinical incidents related to comprehensive care are captured under various Tier One, Two and Three categories in the Datix CIMS.⁸ Data in this report is presented for all incidents related to comprehensive care as well incidents related to pressure injuries, falls, poor nutrition and malnutrition, unpredictable behaviours and restrictive practices. As cognitive impairment is not a clinical incident, identification of incidents related to cognitive impairment from the Datix CIMS Tier One, Two and Three categories is not possible. Consequently, data for clinical incidents related to cognitive impairment is only included in this report in relation to falls risk factors.

During 2019/20, there were 11,383 clinical incidents related to comprehensive care notified with 11,075 of these incidents confirmed at the time of this report and a further 308 incidents awaiting SAC confirmation. Incidents related to comprehensive care accounted for 34.3% of all clinical incidents notified in this period. Most clinical incidents related to comprehensive care were categorised as SAC 3 incidents (n=9,624; 84.5%; see Figure 27).

Figure 27: Percentage of Comprehensive Care Clinical Incidents by SAC Rating for 2019/20

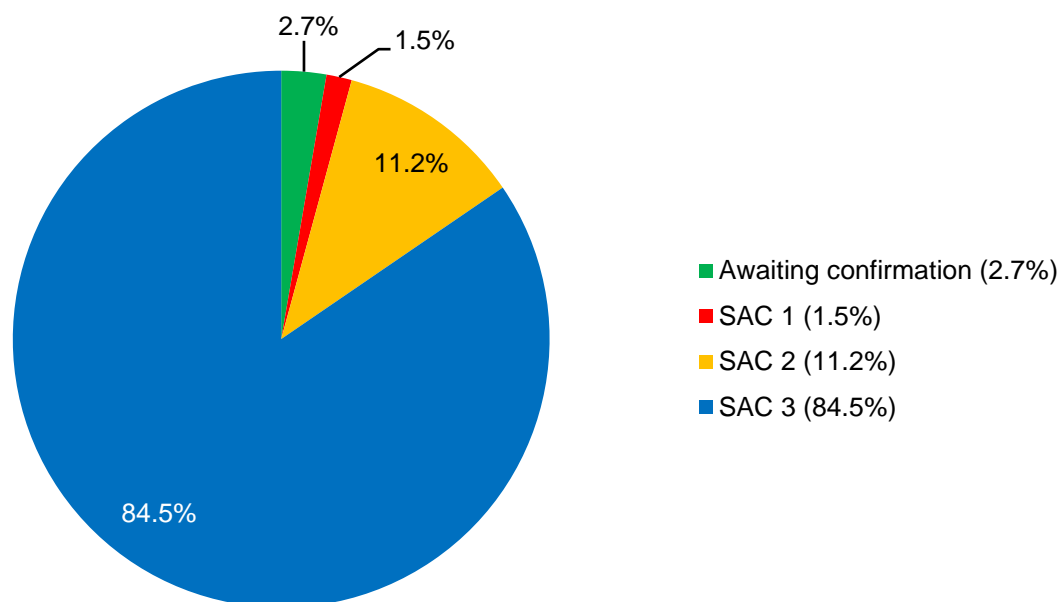


Table 15 shows patient falls were the most frequently reported sub-category of clinical incidents related to comprehensive care in 2019/20, accounting for 52.8% (n=5,852) of confirmed incidents associated with this NSQHS Standard. The next most frequently reported sub-categories were unpredictable behaviours (n=2,890) and pressure injuries (n=2,201). Falls and unpredictable behaviours accounted for all but one of the confirmed SAC 1 incidents related to comprehensive care in this period.

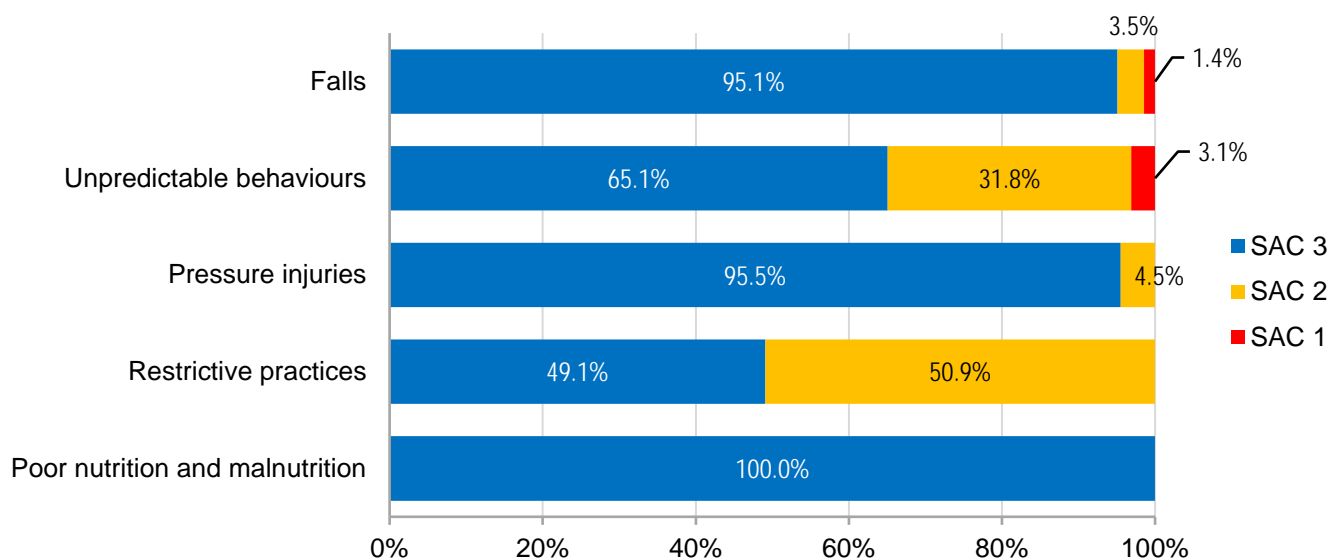
Table 15: Frequency of Confirmed Comprehensive Care Clinical Incidents by Sub-category and SAC Rating for 2019/20

Comprehensive Care Sub-categories	SAC 3	SAC 2	SAC 1	Total
Falls	5,565	204	83	5,852
Unpredictable behaviours	1,881	919	90	2,890
Pressure injuries	2,101	99	1	2,201
Restrictive practices	53	55	-	108
Poor nutrition and malnutrition	24	-	-	24
Total	9,624	1,277	174	11,075

Note: Incidents related to the cognitive impairment sub-category of comprehensive care are not captured in the Datix CIMS incident classification (CCS2) as cognitive impairment is not a clinical incident.

Figure 28 shows the proportion of confirmed clinical incidents for each comprehensive care sub-category by SAC rating. In the falls and pressure injuries sub-categories more than 95% of incidents were confirmed as SAC 3, as were all the incidents relating to poor nutrition and malnutrition. A higher proportion of SAC 2 incidents and lower proportion of SAC 3 incidents was observed in the unpredictable behaviours and restrictive practices sub-categories. Unpredictable behaviours reported the highest proportion of SAC 1 incidents (3.1%).

Figure 28: Percentage of Confirmed Comprehensive Care Clinical Incidents by Sub-category and SAC Rating for 2019/20



Note: Incidents related to the cognitive impairment sub-category of comprehensive care are not captured in the Datix CIMS incident classification (CCS2) as cognitive impairment is not a clinical incident.

In 2019/20, most confirmed clinical incidents related to comprehensive care reported no harm to the patient (n=5,666; 51.2%) and a further 43.2% (n=4,784) reported minor harm. Forty-six incidents described the patient outcome as death, representing 0.4% of confirmed incidents related to this NSQHS Standard (see Table 16). Apart from one case of pressure injury, clinical incidents related to falls (n=73) and unpredictable behaviours (n=57) accounted for all patient outcomes of serious harm and death. The most frequently reported patient outcome of pressure injury clinical incidents was minor harm (n=1,819; 82.6% of confirmed pressure injury incidents).

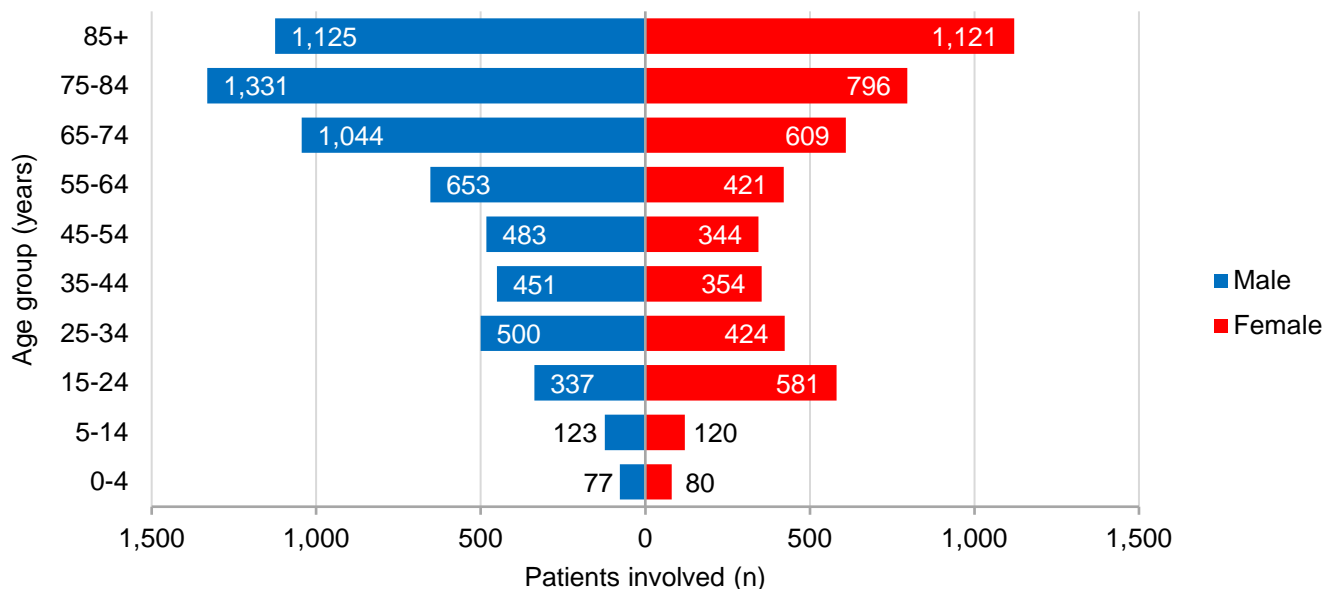
Table 16: Frequency of Confirmed Comprehensive Care Clinical Incidents by Sub-category and Patient Outcome for 2019/20

Comprehensive Care Sub-categories	No harm	Minor harm	Moderate harm	Serious harm	Death
Falls	3,455	2,118	137	61	12
Unpredictable behaviours	1,845	818	98	23	34
Pressure injuries	266	1,819	83	1	-
Restrictive practices	82	23	2	-	-
Poor nutrition and malnutrition	18	6	-	-	-
Total	5,666 (51.2%)	4,784 (43.2%)	320 (2.9%)	85 (0.8%)	46 (0.4%)

Notes: Patient outcome missing data n=174; 1.6%. Incidents related to the cognitive impairment sub-category of comprehensive care are not captured in the Datix CIMS as cognitive impairment is not a clinical incident.

Males accounted for 55.8% (n=6,164) of patients involved in confirmed comprehensive care clinical incidents in 2019/20, with females making up 44.2% (n=4,884; missing gender n=192). Patients involved in comprehensive care clinical incidents were aged 0-107 years with a median age of 68 years. The distribution of patients involved in confirmed comprehensive care clinical incidents by age group and gender is shown in Figure 29.

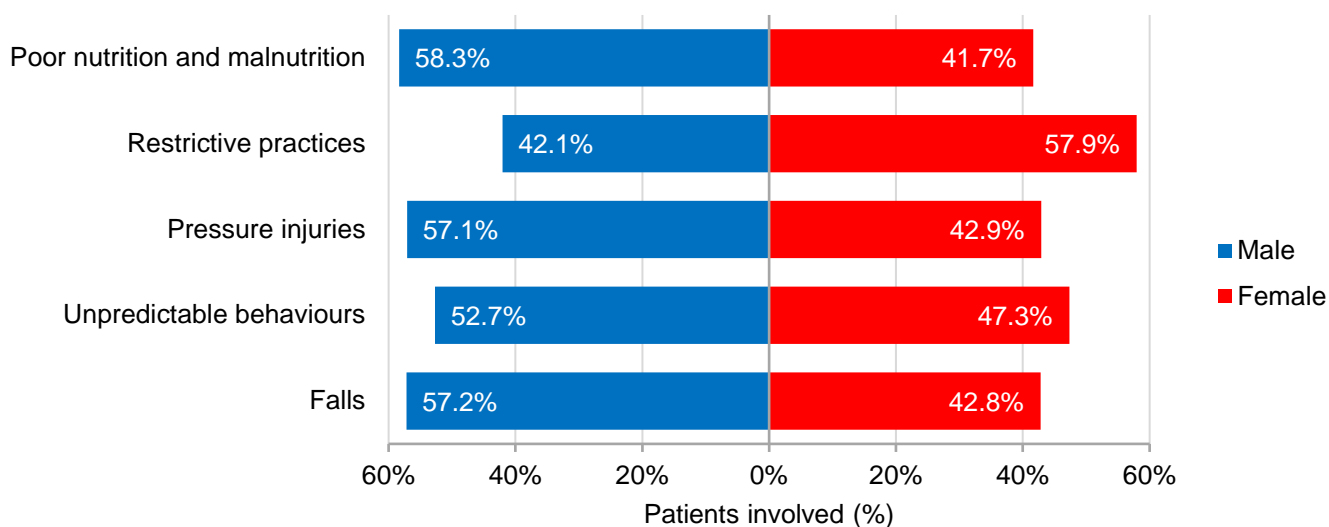
Figure 29: Frequency of Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Age Group and Gender for 2019/20



Note: Patient age and/or gender missing data n=266; a clinical incident may affect multiple patients

Females accounted for 57.9% (n=62) of confirmed incidents related to restrictive practices in 2019/20, while males represented the majority of patients involved in all other sub-categories of clinical incidents related to comprehensive care in this period (see Figure 30).

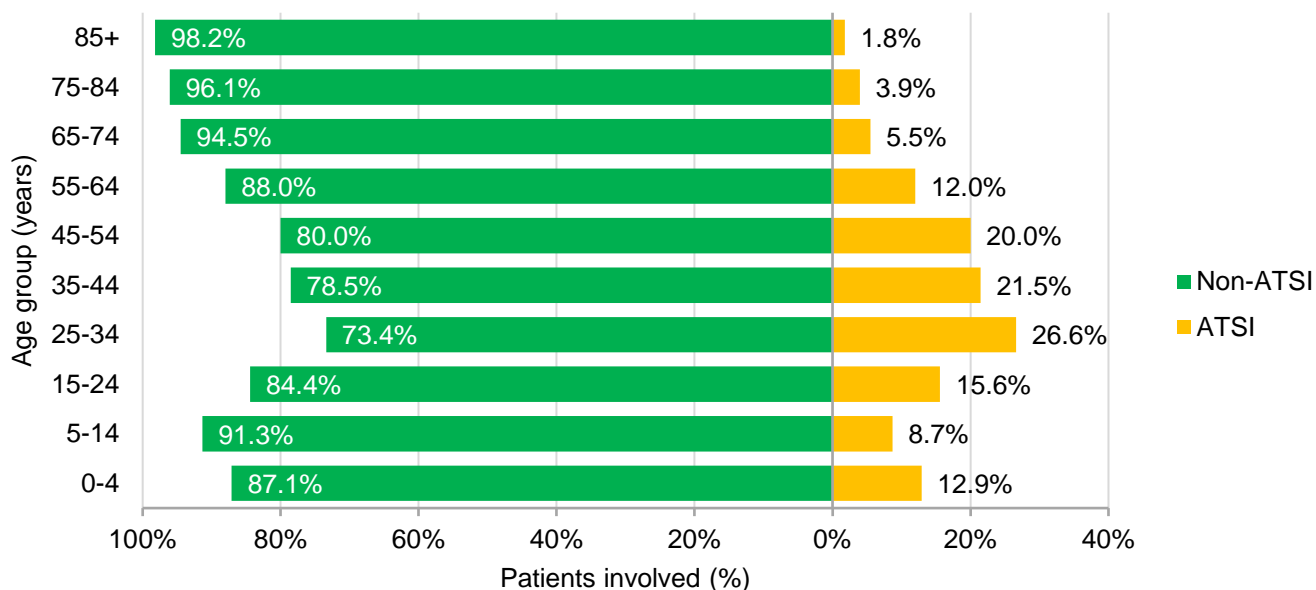
Figure 30: Percentage of Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Sub-category and Gender for 2019/20



Notes: Patient gender missing data n=192; a clinical incident may affect multiple patients. Incidents related to the cognitive impairment sub-category of comprehensive care are not captured in the Datix CIMS incident classification (CCS2) as cognitive impairment is not a clinical incident.

ATSI persons accounted for 10.1% (n=1,103; missing ATSI status n=372) of patients involved in confirmed comprehensive care clinical incidents in 2019/20. The highest proportion of ATSI patients involved was seen in the 25-34 years age group (26.6%; n=243; see Figure 31).

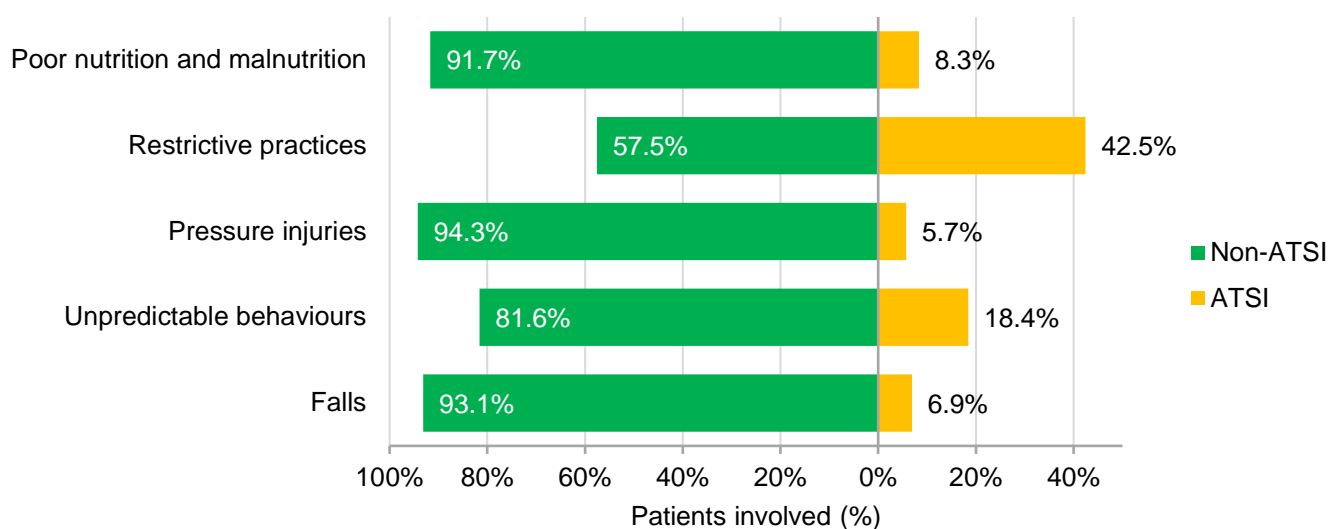
Figure 31: Percentage of Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Age Group and ATSI Status for 2019/20



Note: Patient age and/or ATSI status missing data n=379; a clinical incident may affect multiple patients

The proportion of ATSI patients involved in comprehensive care incident sub-categories is shown in Figure 32. In 2019/20, ATSI persons represented 42.5% (n=45) of patients involved in confirmed restrictive practices clinical incidents and 18.4% (n=544) of patients involved in confirmed unpredictable behaviours clinical incidents. Eighty percent (n=36) of ATSI persons involved in confirmed restrictive practices clinical incidents were female.

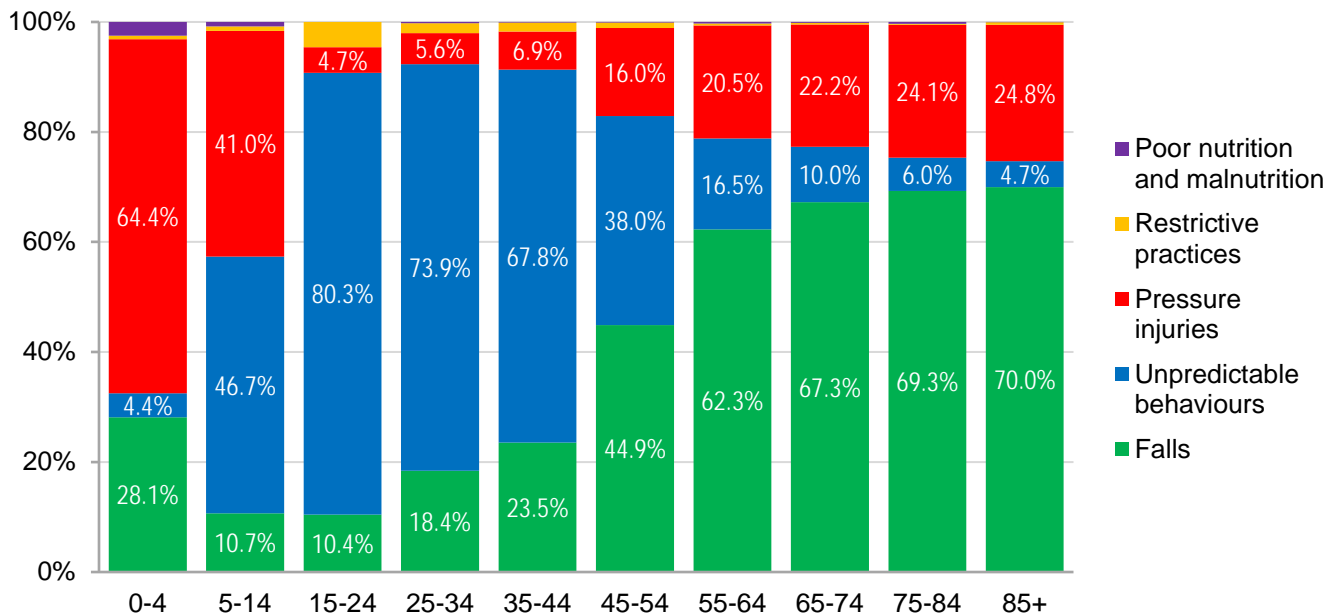
Figure 32: Percentage of Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Sub-category and ATSI Status for 2019/20



Notes: Patient ATSI status missing/unknown data n=372; a clinical incident may affect multiple patients. Incidents related to the cognitive impairment sub-category of comprehensive care are not captured in the Datix CIMS incident classification (CCS2) as cognitive impairment is not a clinical incident.

Figure 33 shows the proportion of patients involved in comprehensive care incident sub-categories within each age group during 2019/20. In patients aged 0-4 years nearly two-thirds of comprehensive care incidents related to pressure injuries. Unpredictable behaviours were the most frequently reported sub-category in patients aged 5-44 years, while falls were most commonly reported in patients aged 45 years and above. The median age of patients involved was 76 years for falls, 74 years for pressure injuries, 62 years for poor nutrition and malnutrition, 34 years for unpredictable behaviours, and 28 years for restrictive practices.

Figure 33: Percentage of Patients Involved in Confirmed Comprehensive Care Clinical Incidents by Age Group and Sub-category for 2019/20



Note: Patient age missing data n=231; a clinical incident may affect multiple patients. Incidents related to the cognitive impairment sub-category of comprehensive care are not captured in the Datix CIMS incident classification (CCS2) as cognitive impairment is not a clinical incident.



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. The Comprehensive Care Standard³ requires that:

- Health service organisations have systems 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.

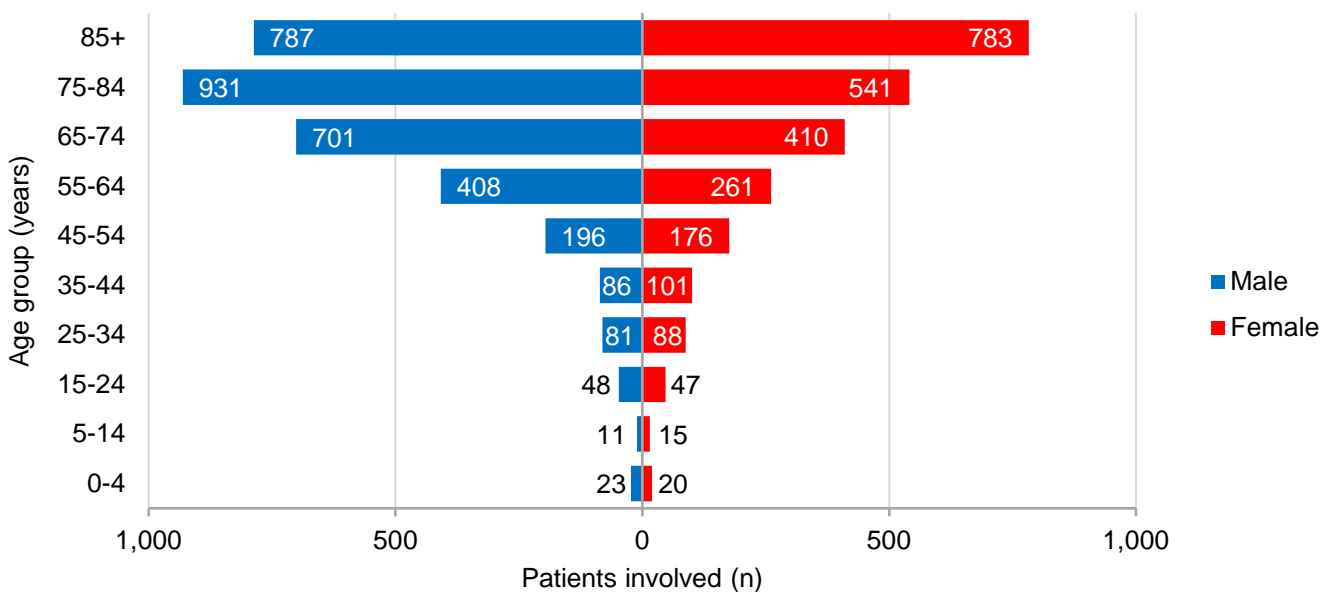
In the 2019/20 reporting period there were 6,001 falls clinical incidents notified with 5,852 falls incidents confirmed and a further 149 awaiting SAC confirmation at the time of this report. Falls incidents accounted for 18.1% of all clinical incidents reported in this period. More than two-thirds of falls clinical incidents (n=3,991; 68.2%) were categorised as “suspected slips/trips/falls” in the Datix CIMS as they were unwitnessed (see Table 17).

Table 17: Frequency and Percentage of Confirmed Falls Clinical Incidents by Tier Two Falls Categories for 2019/20

Tier Two Falls Category	(n)	(%)
Suspected slips/trips/falls (unwitnessed, includes faints)	3,991	68.2
Witnessed slips/trips/falls (includes faints)	1,861	31.8
Total	5,852	100.0

Males accounted for 57.2% (n=3,293) of patients involved in confirmed falls incidents, with females making up 42.8% (n=2,464; missing gender n=103). Ages ranged from 0-107 years. Figure 34 shows the distribution of patients involved in falls incidents by age group and gender.

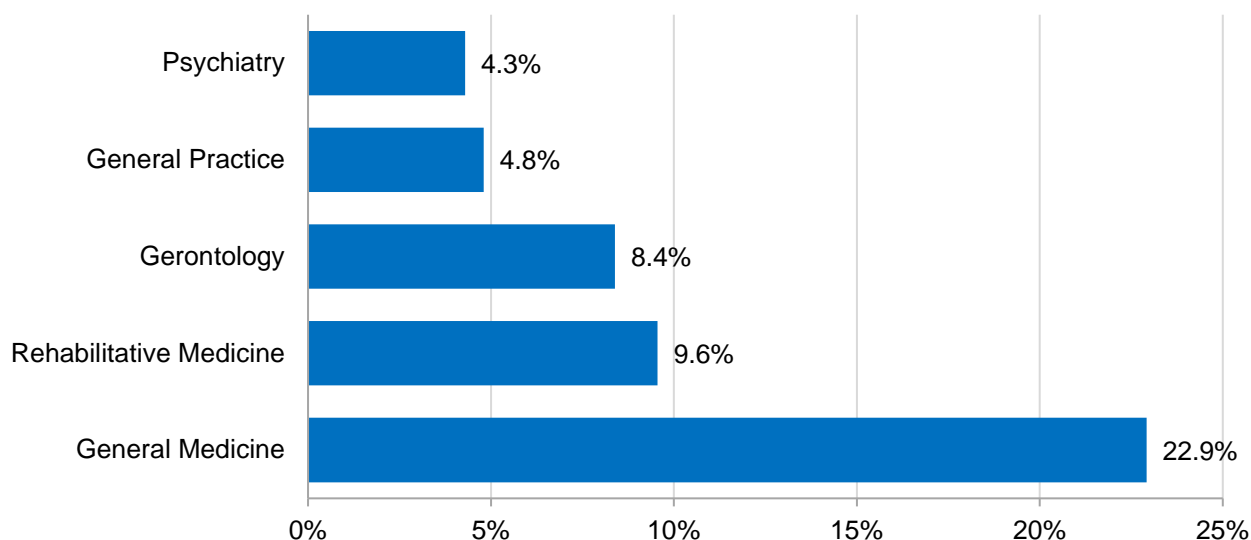
Figure 34: Frequency of Patients Involved in Confirmed Falls Clinical Incidents by Age Group and Gender for 2019/20



Note: Patient age and/or gender missing data n=146; a clinical incident may affect multiple patients

The top five treating specialties accounted for 49.9% (n=2,923) of confirmed falls incidents in 2019/20. The General Medicine specialty reported the highest frequency of falls incidents in this period (n=1,341; 22.9%), followed by Rehabilitative Medicine (n=559; 9.6%; see Figure 35).

Figure 35: Percentage of Confirmed Falls Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=1,147; 19.6%

When identifying the height from which the patient fell, 36.8% (n=2,153) of confirmed falls clinical incidents were classified as a low fall from a height of less than 0.5 metres, with a further 32.4% (n=1,896) of falls occurring from a standing position, and 12.3% (n=717) classified as medium falls from a height of 0.5-1 metre (missing/unknown fall height n=1,052; 18.0%).

The top five most frequent activities at the time of patient falls accounted for 70.9% (n=4,147) of confirmed falls incidents. At the time of the fall, 20.9% (n=1,223) of patients were walking, while a further 16.2% (n=950) of patients were attempting to sit or stand (see Table 18).

Table 18: Frequency and Percentage of Confirmed Falls Clinical Incidents by Top Five Activities at Time of Fall for 2019/20

Falls by Activity at Time of Fall	(n)	(%)
Walking	1,223	20.9
Attempting to sit/stand	950	16.2
Toileting or attempting to toilet	819	14.0
Getting in/out of bed	742	12.7
Bending/leaning/reaching over	413	7.1
Total	4,147	70.9

Note: Activity at time of fall missing data n=564; 9.6%

Places where falls incidents occurred most frequently in 2019/20 were at the bedside (n=2,020; 34.5%), in a ward setting (n=1,801; 30.8%) and in a bathroom (18.6%; n=1,090; see Table 19).

Table 19: Frequency and Percentage of Confirmed Falls Clinical Incidents by Top Five Places Where Fall Occurred for 2019/20

Place of Fall	(n)	(%)
Bed	2,020	34.5
Ward	1,801	30.8
Bathroom	1,090	18.6
Grounds	144	2.5
Dining Room	143	2.4
Total	5,198	88.8

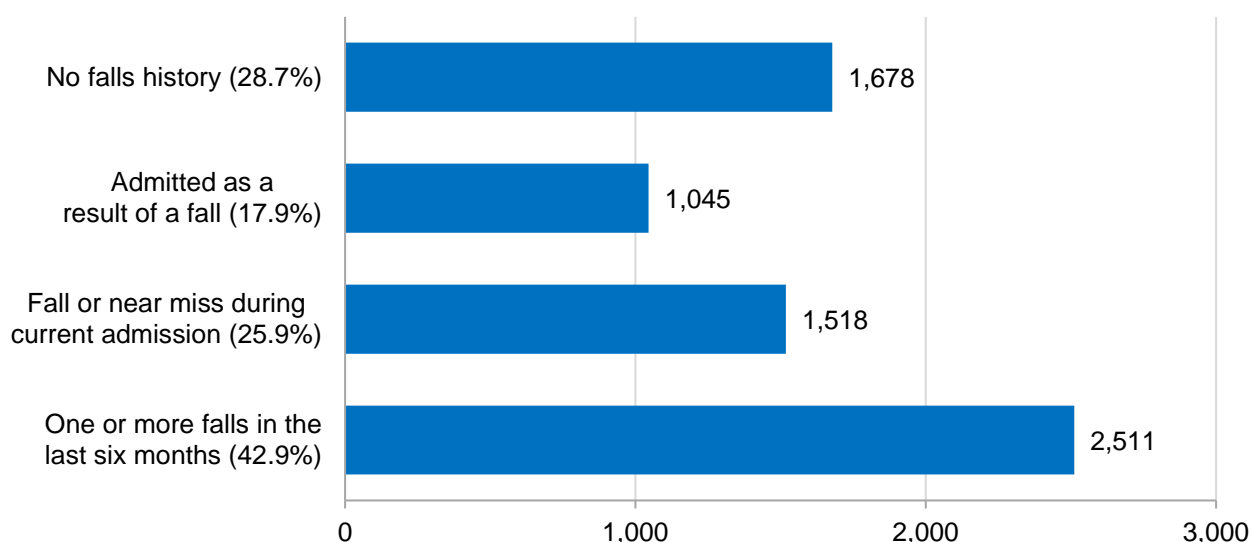
Note: Place of fall missing data n=366; 6.3%

Most falls incidents (n=3,908; 66.8%) were reported as having an unknown mechanism as to why the patient fell, which aligns with the data in Table 17 showing that 68.2% of falls were unwitnessed. Slipping on a usually wet or slippery floor, for example a bathroom (n=700; 12.0%) and tripping over an object (n=314; 5.4%) were the next most frequently identified mechanisms for falls (missing fall mechanism n=696; 11.9%).

Most patients who sustained a fall (92.9%; n=5,439) were reported to have a falls risk assessment in place, with 44.3% (n=2,594) of patients having had their most recent falls risk assessment completed within the last 24 hours, and 25.3% (n=1,483) within the last week.

It was reported that 28.7% (n=1,678) of patients who fell had no previous history of a fall, while 42.9% (n=2,511) of patients had experienced a fall within the last six months (see Figure 36).

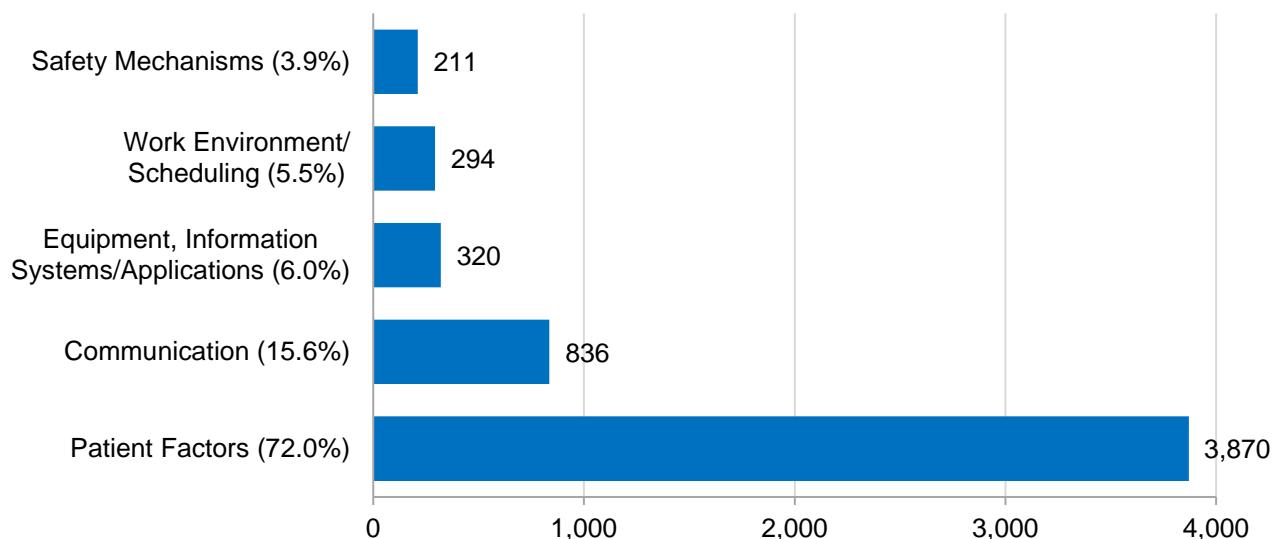
Figure 36: Frequency and Percentage of Confirmed Falls Clinical Incidents by Falls History Risk Factors for 2019/20



Note: Falls history risk factors missing data n=448; 7.7%. A patient involved in a falls clinical incident may have more than one falls history risk factor. The data in this figure may not be comparable to similar data presented in previous editions of this report due to refinement of the data analysis methodology.

Investigation of falls clinical incidents in 2019/20 identified that patient factors continue to be the most frequently identified contributor to falls, being cited in 72.0% (n=3,870) of closed falls clinical incidents (see Figure 37). Issues with communication were identified in 15.6% (n=836) of completed falls investigations, and in 76.2% of these incidents the investigation found problems with communication between staff and the patient, family members or carers (n=637).

Figure 37: Frequency and Percentage of Top Five Contributory Factors for Closed Falls Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

Review of the falls risk factors documented in clinical incidents where patient factors were identified as contributory showed that the most frequently identified risk factors were patients having poor balance (n=2,600; 67.2% of closed falls incidents where patient factors contributed) and patients taking more than five prescribed medications (n=1,891; 48.9%; see Table 20).

Table 20: Frequency and Percentage of Top Ten Falls Risk Factors for Closed Falls Clinical Incidents Where Patient Factors Contributed for 2019/20

Falls Risk Factors	(n)	(%)
Poor balance/unsteady	2,600	67.2
Taking more than five prescribed medications (polypharmacy)	1,891	48.9
Requires walking aid or similar (e.g. crutches, walking frame)	1,730	44.7
Requires assistance to mobilise	1,601	41.4
Dementia/cognitive impairment	1,492	38.6
Requires standby assistance	1,460	37.7
Difficulty communicating or following instructions	1,206	31.2
Weakness/generalised muscular weakness	1,192	30.8
Delirium, anxiety or agitation	1,080	27.9
Taking psychoactive medications (e.g. antidepressants or benzodiazepines)	790	20.4

Note: Falls risk factors missing data n=127; 3.3%. A patient involved in a falls clinical incident may have more than one falls risk factor.

Key Messages and Information: Falls Clinical Incidents

While most falls clinical incidents in 2019/20 had a patient outcome of no or minor harm, it is still of concern that systems were not in place or failed to prevent falls that resulted in the death of 12 patients in the WA health system. As a patient's condition can change rapidly, re-assessment is key when there has been a change in condition and/or treatment to ensure that each patient's individual risk factors are noted, and that their falls management plan is updated accordingly.

While patient factors can play a significant part in falls, good communication has a vital role in falls prevention. This includes communication between staff when assessing risks, developing care plans and delivering care, as well as communication between staff and the patient, their families and carers.

A comprehensive assessment should address the complexity of a patient's clinical presentation and their risks. Specific risks, such as falls risk, should not be considered in isolation, rather the factors which may contribute to a patient's risk of experiencing adverse events should be addressed. For instance, when cognitive impairment is identified as a risk factor for falls, the patient's impairment should be managed in accordance with best practice, and supplemented with specific and appropriate falls risk mitigation strategies, such as call bells and walking aids, as shown by the following case.

An elderly woman with a history of falls and previous left hip fracture was transferred to the Emergency Department with a fever and cough. The woman was noted to have delirium on a background of cognitive impairment and was admitted to hospital for treatment of her pneumonia. Three days into her admission the woman fell, hit her head and fractured her right hip. She underwent surgery and was later discharged. The investigation noted a delay in completing the Falls Risk Assessment and Management Plan (FRAMP), with the woman being cared for in a number of wards/units for a short period prior to her fall. Several strategies were implemented following the fall, including a referral to the Clinical Specialist Delirium & Dementia Nurse.

Further, when conducting a comprehensive risk assessment and developing a management plan, consideration should be given to the cognitive (e.g. delirium, cognitive impairment), medical (e.g. current medications) and physical factors (e.g. continence issues, mobility) that may contribute to a patient's risk of experiencing a fall. The risk management plan should be monitored for its effectiveness in achieving the goals of care, and should be reassessed and updated in accordance with the patient's changing needs.

Falls prevention and risk management should be a collaborative practice involving input from patients, families, carers, and multi-disciplinary teams. All involved should agree on the management plan and goals of care, and each episode of care should be considered in the context of the patient's continuum of care. As such, when planning discharge from hospital, appropriate referrals (e.g. occupational therapy, physiotherapy) should be made to maximise in-home safety post-discharge. Patients, families, and carers should also be educated on recognising falls risk factors and implementing falls prevention strategies. The importance of assessing the patient's home environment is demonstrated by the following case.

An elderly man was discharged from hospital to Hospital in The Home (HiTH) services following an admission related to increased anxiety and depression. The man was assessed as a falls risk due to his benzodiazepine use. On the fourth day at home the man fell. The investigation noted that the man had mobility assessments and a FRAMP, but that his home environment, which had steps into a sunken lounge, had not been adequately considered.

Pressure Injury Clinical Incidents

The National Pressure Injury Advisory Panel (NPIAP) defines pressure injuries as “localised damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.”³³

There are several stages of pressure injury development, defined³³ as:

- **Stage 1: Non-blanchable erythema of intact skin** “Intact skin with a localised area of non-blanchable erythema, which may appear differently in darkly pigmented skin.”
- **Stage 2: Partial-thickness skin loss with exposed dermis** “The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.”
- **Stage 3: Full-thickness skin loss** “Adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunnelling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.”
- **Stage 4: Full-thickness skin and tissue loss** “Exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunnelling often occur. Depth varies by anatomical location.”
- **Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss** “Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.”
- **Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration** “Intact or non-intact skin with localised area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister.”

The NPIAP has also published other definitions³³ relating to pressure injuries:

- **Medical Device Related Pressure Injury:** “Results from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.”
- **Mucosal Membrane Pressure Injury:** “Found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.”

The Comprehensive Care Standard³ requires that:

- Health service organisations have systems in place that are consistent with best-practice guidelines for pressure injury prevention and wound management
- Health service organisations use equipment, devices and products to prevent and effectively manage pressure injuries, and provide information about prevention to patients at risk of pressure injuries and their carers and families
- Clinicians conduct comprehensive skin inspections in line with best-practice time frames and frequency for patients at risk of developing or having pressure injuries.

³³ https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

Pressure injuries are largely considered avoidable and 65.1% (n=1,432) of confirmed pressure injury clinical incidents in 2019/20 related to pressure injuries that were not present at the time of admission of the patient (see Table 21).

Table 21: Frequency and Percentage of Confirmed Pressure Injury Clinical Incidents by Tier Two Categories for 2019/20

Pressure Injury Tier Two Category	(n)	(%)
Not present on admission	1,432	65.1
Present on admission	385	17.5
Unknown whether present on admission	384	17.4
Total	2,201	100.0

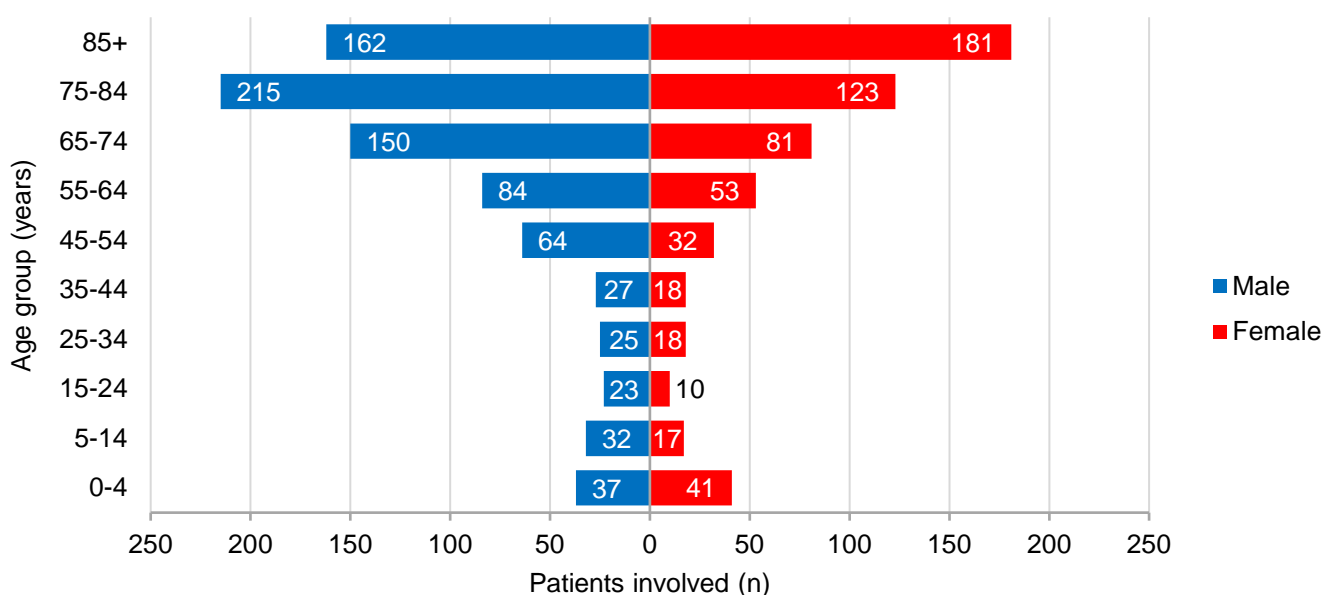
Pressure injuries that were present on admission (n=385; 17.5%) are regarded as clinical incidents where they were found to have deteriorated after admission, preventative/therapeutic interventions were not performed or were provided but not effective, or skin inspections and risk assessments were delayed or not performed.

Males accounted for 57.1% (n=1,228) of patients involved in confirmed pressure injury clinical incidents in 2019/20, with females making up 42.9% (n=924; missing gender n=50). Ages ranged from 0-104 years with a median age of 74 years.

Pressure Injuries Not Present on Admission

The gender distribution for clinical incidents related to pressure injuries that were not present on admission was like that seen for all confirmed pressure injury incidents. Males accounted for 58.9% (n=823) of patients involved in incidents where pressure injuries developed in hospital in 2019/20, with females making up 41.1% (n=575; missing gender n=34). Figure 38 shows the distribution of patients that developed pressure injuries in hospital by age group and gender.

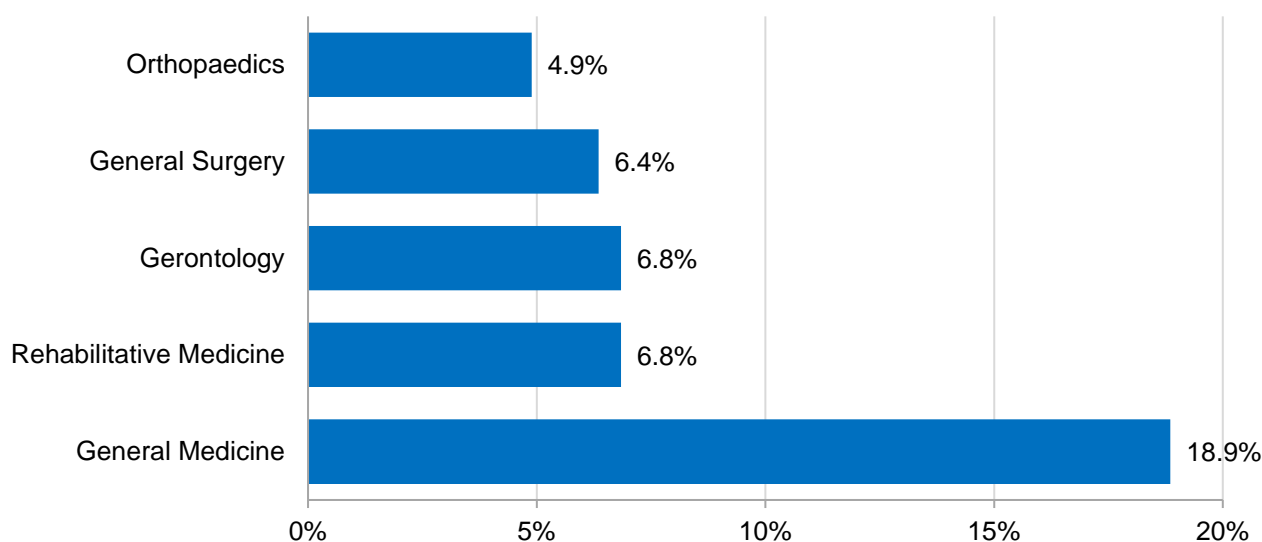
Figure 38: Frequency of Patients Involved in Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission by Age Group and Gender for 2019/20



Note: Patient age and/or gender missing data n=39; a clinical incident may affect multiple patients

The five treating specialties that most frequently reported clinical incidents related to pressure injuries that developed while in hospital accounted for 43.8% (n=627) of these incidents (see Figure 39). The General Medicine specialty reported the most incidents related to pressure injuries that were not present on admission (n=270; 18.9%) followed by Gerontology and Rehabilitative Medicine (n=98; 6.8% each).

Figure 39: Percentage of Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=232; 16.2%

In 2019/20, the five most frequently reported Tier Three pressure injury clinical incident categories accounted for 99.2% of confirmed incidents related to pressure injuries that developed after admission (see Table 22).

Clinical incidents related to pressure injuries not present on admission were most frequently reported as the preventative and/or therapeutic interventions provided to the patient lacking effectiveness (n=1,155; 80.7%). The next most frequently reported Tier Three category was preventative and/or therapeutic interventions not being performed (n=234; 16.3%).

Table 22: Frequency and Percentage of Top Five Tier Three Pressure Injury Clinical Incident Categories Related to Pressure Injuries Not Present on Admission for 2019/20

Tier Three Pressure Injury Categories	(n)	(%)
Preventive/therapeutic interventions provided but not effective	1,155	80.7
Preventive/therapeutic interventions not performed	234	16.3
Skin inspection never performed	12	0.8
Skin inspection not performed on admission	10	0.7
Skin inspection performed but not until after 24 hours of admission	10	0.7
Total	1,421	99.2

In 2019/20, most clinical incidents related to pressure injuries that developed while in hospital involved Stage 1 (n=485; 33.9%) or Stage 2 (n=682; 47.6%) pressure injuries (see Table 23). Recognition of the significant impact that Stage 3 and Stage 4 pressure injuries can have on patients continues to be limited, with only one of the 24 incidents related to Stage 3 and Stage 4 pressure injuries that developed while in hospital confirmed as SAC 1. Stage 3 and Stage 4 pressure injuries can increase the time patients spend in hospital, and WA's *Clinical Incident Management Guideline*¹⁴ recommends that incidents leading to an increased length of stay of seven or more days should be classified and investigated as SAC 1 incidents.

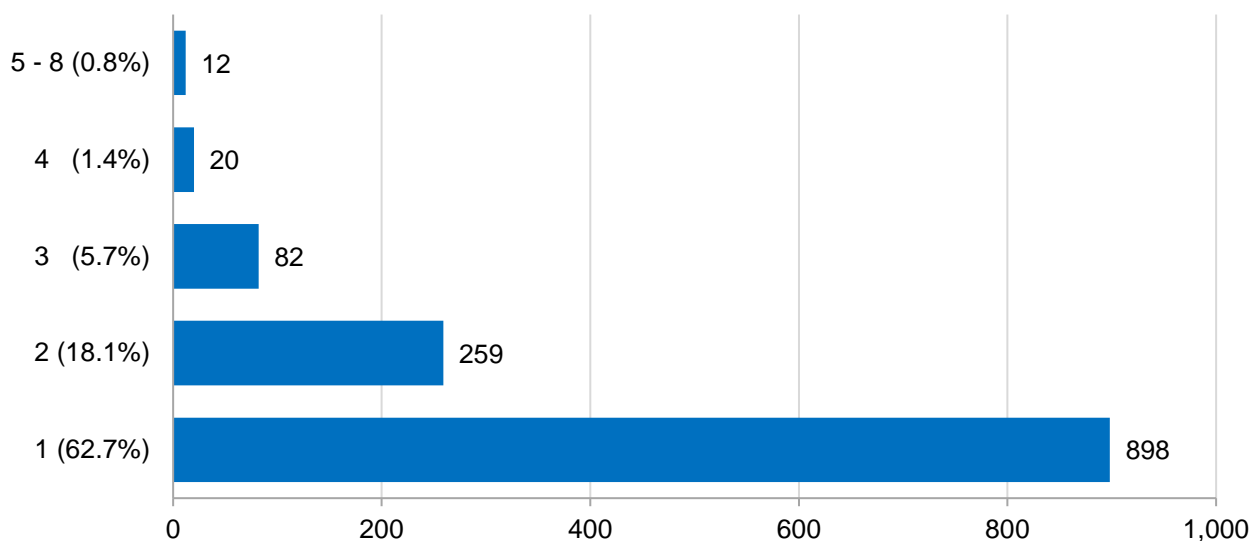
Table 23: Frequency of Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission by Stage and SAC Rating for 2019/20

Pressure Injury Category	SAC 3	SAC 2	SAC 1	Total
Stage 1 – non-blanchable erythema	482	3	-	485
Stage 2 – partial-thickness skin loss	664	18	-	682
Stage 3 – full-thickness skin loss	14	7	-	21
Stage 4 – full-thickness skin and tissue loss	2	-	1	3
Unstageable pressure injury	51	25	-	76
Suspected deep tissue pressure injury	75	8	-	83
Total	1,288	61	1	1,350

Mucosal membrane pressure injuries accounted for 2.9% (n=42) of confirmed pressure injury clinical incidents that occurred following admission, and the remainder (n=40; 2.8%) had not been staged at the time of this report.

Most patients had developed only one pressure injury in hospital when the clinical incident was notified (n=898; 62.7%), however 373 patients were identified as having multiple pressure injuries, with 12 of these patients reported as having five or more (see Figure 40).

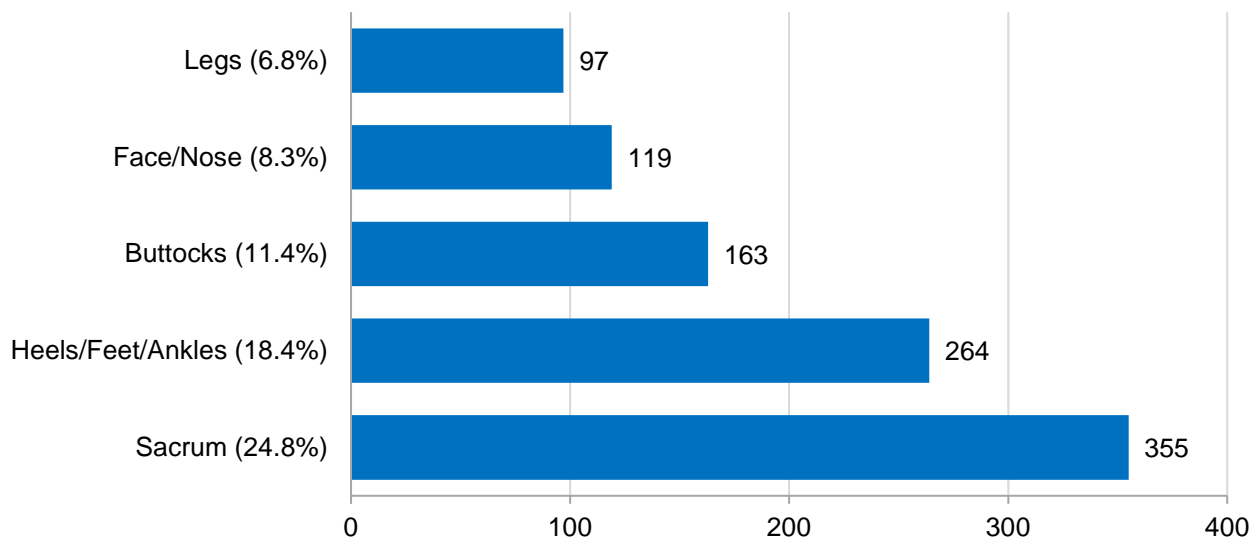
Figure 40: Frequency of Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission by Number of Pressure Injuries at the Time of Incident Notification for 2019/20



Note: Number of pressure injuries at time of incident notification missing/unknown data n=161; 11.2%

Figure 41 shows the anatomical locations where pressure injuries were most frequently reported to have developed in hospital for confirmed pressure injury clinical incidents. These five locations accounted for 69.7% (n=998) of pressure injury anatomical locations in 2019/20. Sacral pressure injuries were reported to have developed after admission in almost one-quarter of incidents (n=355; 24.8%), followed by pressure injuries to the heels, feet or ankles (n=264; 18.4%) and buttocks (n=163; 11.4%).

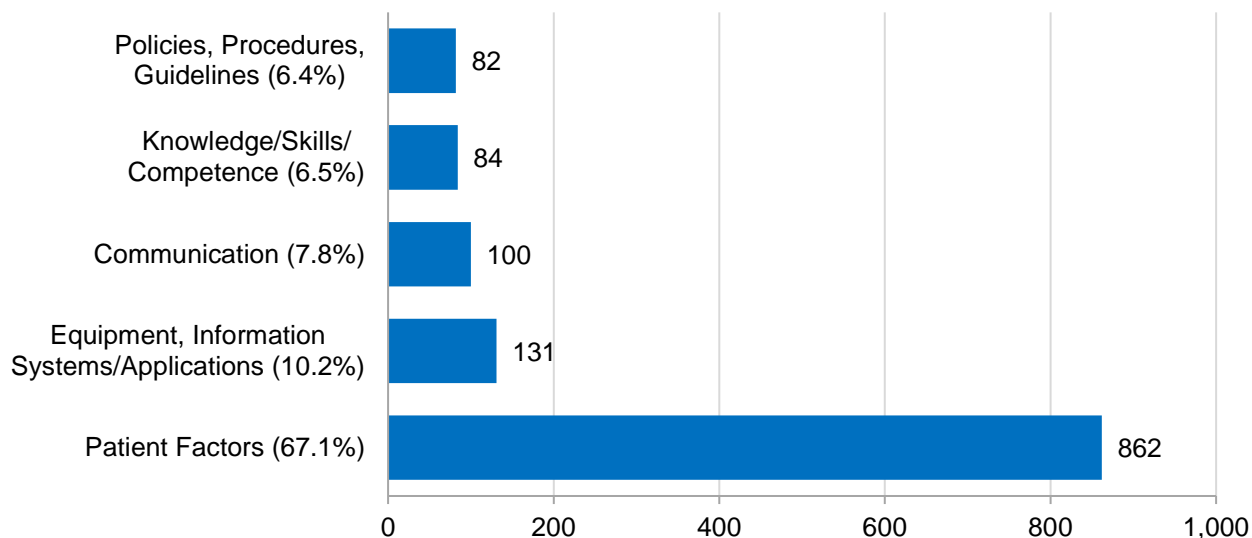
Figure 41: Frequency and Percentage of Top Five Anatomical Locations for Confirmed Clinical Incidents Related to Pressure Injuries Not Present on Admission for 2019/20



Note: Anatomical location of pressure injury missing data n=136; 9.5%

Patient factors were cited as contributory in 67.1% (n=862) of clinical incidents investigated that related to pressure injuries which developed in hospital (see Figure 42). The next most frequent contributory factor was issues related to equipment which were identified in 10.2% (n=131) of these incidents. Equipment issues were most frequently classified as relating to the appropriate use of equipment (n=43; 32.8% of closed incidents where equipment issues were identified).

Figure 42: Frequency and Percentage of Top Five Contributory Factors for Closed Incidents Related to Pressure Injuries Not Present on Admission for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

Key Messages and Information: Pressure Injury Clinical Incidents

Pressure injuries are recognised as having a significant impact on patients' quality of life by causing pain, disturbing sleep, increasing vulnerability to infection, and affecting mobility. Pressure injuries that develop while in hospital require additional treatment and can affect rehabilitation, which may prolong patients' stay in hospital and increase cost. A comprehensive and effective program of measures aimed at preventing patients from developing pressure injuries is a key component of patient-centred care.

In the context of the Comprehensive Care Standard, measures to minimise patient harm associated with pressure injuries include:

- Health service organisations providing services to patients at risk of pressure injuries should have systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
- Clinicians providing care to patients at risk of developing or with a pressure injury should conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
- Health service organisations providing services to patients at risk of pressure injuries should ensure that patients, carers and families are provided with information about preventing pressure injuries, and equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries.³

In 2019/20, one pressure injury clinical incident was confirmed as SAC 1. This case involved an elderly man with a history of hypertension, type 2 diabetes, ischaemic heart disease, congestive heart failure and chronic kidney disease, who was admitted to hospital with bilateral leg swelling and pain causing reduced mobility. On day 10 of his admission he was noted to have a sacral pressure injury which then deteriorated to Stage 4, exposing bone and causing osteomyelitis. The incident investigation noted a lack of multidisciplinary care with a culture of pressure injury care being a nursing role and not raised with the senior medical team. The investigation noted poor pain control may have also contributed to a reduction in the man's mobility. The review recommended increased multidisciplinary focus for patients identified by a new long stay hospital report.

The third edition of the *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline (2019)*³⁴ provides internationally-recognised evidence-based recommendations for the prevention and treatment of pressure injuries. The abridged Quick Reference Guide indicates that the strongest research evidence currently available relates to:

- Low patient mobility and activity being a risk for the development of pressure injuries
- Patients who have Stage 1 pressure injuries being at risk of developing Stage 2 pressure injuries or greater
- The impact of diabetes mellitus on the risk of developing pressure injuries
- The value of skin inspections for patients at risk of pressure injuries to identify the presence of erythema.

There is also strong evidence that supports organisational level development and implementation of structured programs for quality improvement related to pressure injury reduction, and professional level education in pressure injury prevention and treatment as part of a quality improvement plan to reduce pressure injuries.

³⁴ The Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline (2019) is available at: <http://www.internationalguideline.com/guideline>



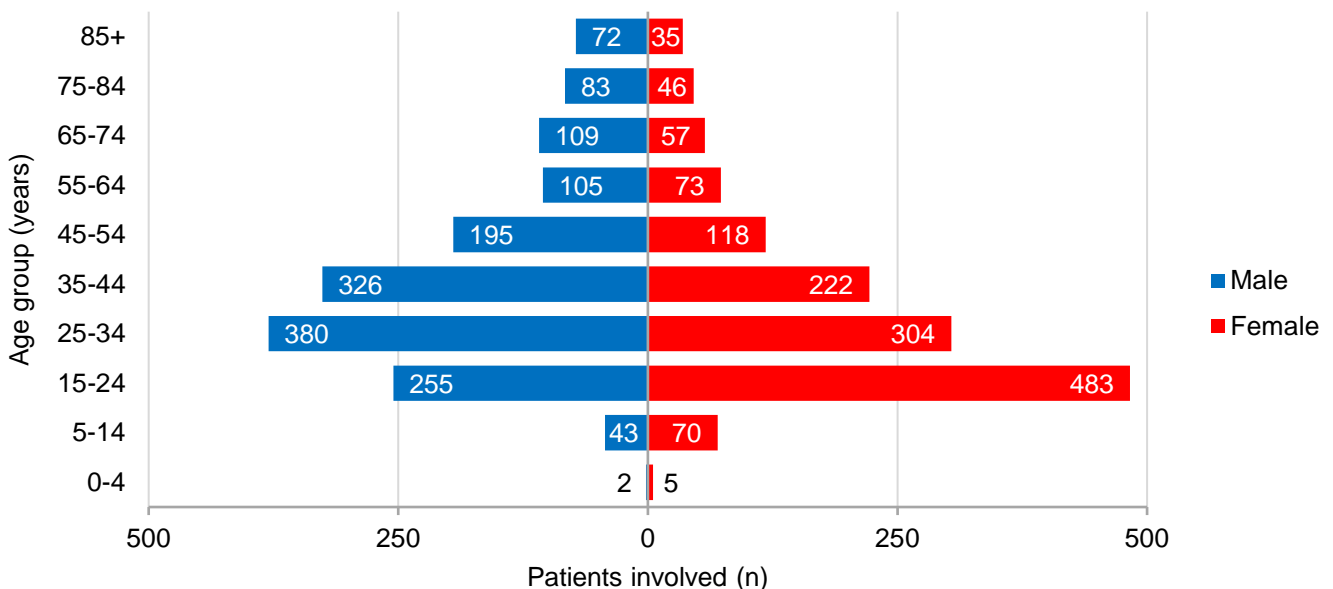
Unpredictable Behaviours Clinical Incidents

For the Comprehensive Care Standard, unpredictable patient behaviours include self-harm, suicide, aggression and violence. Health service organisations 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.³ The *Clinical Care of People With Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive Policy* and accompanying Principles and Best-Practice document guide WA’s providers of public mental health care to provide evidence-informed clinical care for consumers with mental health problems who are at risk of becoming violent or aggressive.³⁵

All members of the health workforce, including both clinical and non-clinical staff, need skills to identify risks and strategies to manage aggression and violence when it occurs. Health service organisations must have processes to support collaboration with patients, carers and families to identify patients at risk of becoming aggressive or violent, implement de-escalation strategies, and safely manage aggression to minimise harm to patients, carers, families and staff. Processes to manage persons who have thoughts of self-harm, or have harmed themselves, need to provide physical safety and support to deal with the psychological and other issues contributing to self-harm, as well as ensuring that follow-up services are arranged before the person leaves the health service, because of the known risks of self-harm after discharge.³

Males accounted for 52.7% (n=1,584) of patients involved in confirmed unpredictable behaviours clinical incidents in 2019/20, with females making up 47.3% (n=1,424; missing gender n=38). Patient ages ranged from 0-101 years. In the 15-24 years age group females represented 65.4% (n=483) of patients involved in these incidents (see Figure 43).

Figure 43: Frequency of Patients Involved in Confirmed Unpredictable Behaviours Clinical Incidents by Age Group and Gender for 2019/20



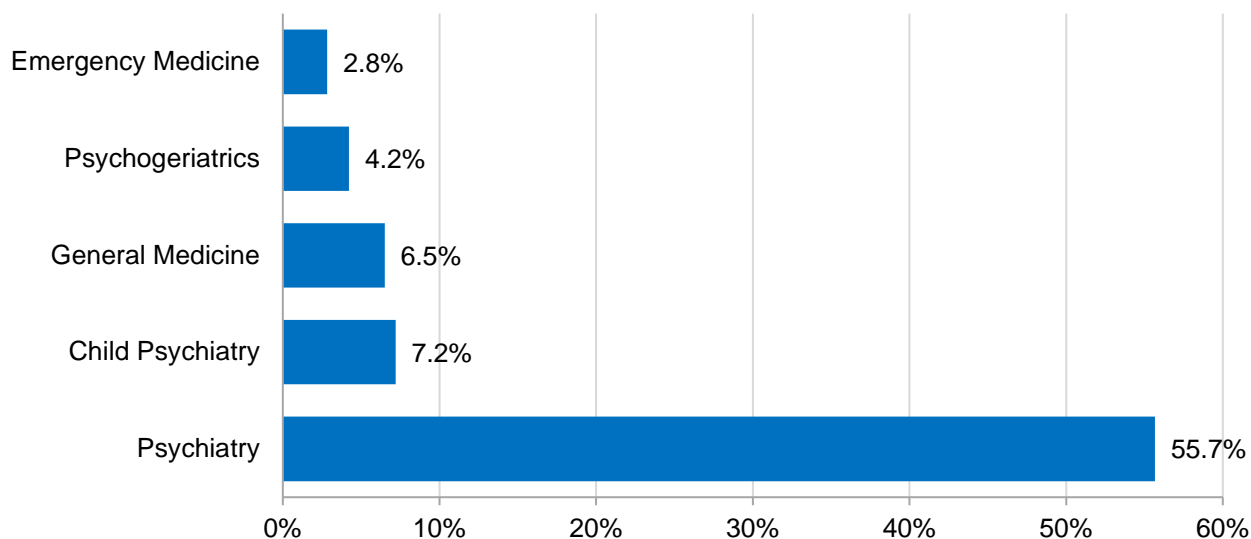
Note: Patient age and/or gender missing data n=63; a clinical incident may affect multiple patients

³⁵ This policy and the principles and best practice guide are available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Mental-Health/Mandatory-requirements/Clinical-Care-of-People-With-Mental-Health-Problems>

Further review of data for patients involved in confirmed unpredictable behaviours clinical incidents in 2019/20 showed that 43.7% (n=1,332) were involuntary mental health patients under the *Mental Health Act 2014*. A further 1,085 patients (35.6%) were voluntary mental patients and 128 (4.2%) were referred mental health patients under the MHA.

The top five treating specialties accounted for 76.4% (n=2,209) of confirmed unpredictable behaviours clinical incidents in 2019/20. Psychiatry reported the highest frequency of unpredictable behaviours incidents in this period (n=1,609; 55.7%), followed by Child Psychiatry (n=208; 7.2%; see Figure 44).

Figure 44: Percentage of Confirmed Unpredictable Behaviours Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=443; 15.3%

In 2019/20, the five most frequent Tier Three unpredictable behaviours clinical incident categories accounted for 77.5% of confirmed incidents related to unpredictable patient behaviours (see Table 24). Clinical incidents related to unpredictable behaviours were most frequently reported as inappropriate or aggressive physical behaviour towards an object, structure or staff member (n=915; 31.7%), and self-harm attempts or gestures (n=462; 16.0%).

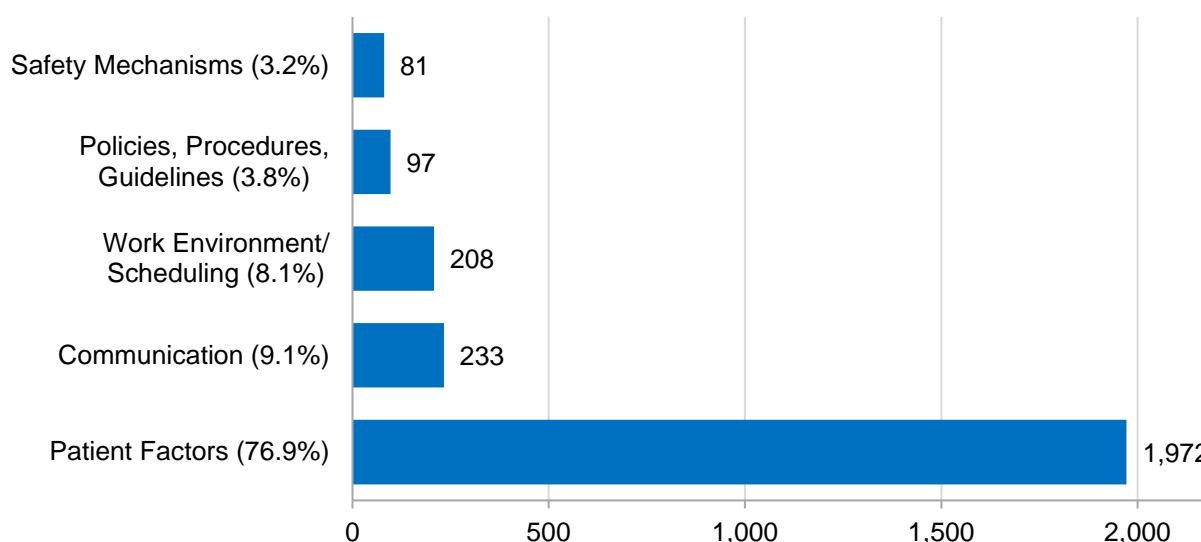
Table 24: Frequency and Percentage of Top Five Tier Three Unpredictable Behaviours Clinical Incident Categories for 2019/20

Tier Three Unpredictable Behaviours Categories	(n)	(%)
Inappropriate or aggressive physical behaviour towards an object, structure or staff member	915	31.7
Self-harm attempt or gesture	462	16.0
Absconded or left without informing staff	390	13.5
Inappropriate or aggressive physical behaviour towards another patient	303	10.5
Detained patient absconded or absent without leave*	169	5.8
Total	2,239	77.5

* 161 confirmed incidents in this Tier Three category related to involuntary mental health patients under the MHA.

Investigation of unpredictable behaviours clinical incidents in 2019/20 identified that patient factors were the most frequently identified contributory factor, being cited in 76.9% (n=1,972) of closed incidents (see Figure 45). Issues with communication were identified in 9.1% (n=233) of completed clinical incident investigations into unpredictable patient behaviours, and in 53.6% (n=125) of these incidents the investigation found problems with communication between staff and the patient, family members or carers. Work environment or scheduling factors were found to have contributed to 8.1% (n=208) of unpredictable behaviours incidents investigated in 2019/20, and these most often related to the suitability of the environment (n=96; 46.2%).

Figure 45: Frequency and Percentage of Top Five Contributory Factors for Closed Unpredictable Behaviours Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

Key Messages and Information: Unpredictable Behaviours Clinical Incidents

The ACSQHC has identified key tasks for the identification of patients at risk of attempting self-harm or suicide. These include:

- Implementing screening for thoughts of self-harm or suicide for people who present with self-harm, mental illness or acute emotional distress
- Setting up a tiered system for response according to the level of risk
- Ensuring that the environment is safe
- Maintaining a recovery-oriented approach throughout engagement.³⁶

Risks can never be completely eliminated, however evidence-based guidelines and clinical risk assessment documentation can assist in the treatment and support of consumers to mitigate possible harm and optimise patient outcomes. Staff in the WA health system are supported in responding to unpredictable patient behaviours through state-wide policies including the *State-wide Standardised Clinical Documentation for Mental Health Services Operational Directive* and the *Clinical Care of People Who May Be Suicidal Policy*.³⁷

³⁶ NSQHS (2nd ed) Standard 5; Action 5.31 available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-531>

³⁷ Department of Health Western Australia, (October 2020). The Mental Health Policy Framework available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Mental-Health>

The need to ensure a safe environment for patients at risk of attempting self-harm or suicide is highlighted by the following two incidents that were reported during 2019/20.

In the first incident, a woman was admitted to hospital as a voluntary patient with feelings of depression and suicidal thoughts. She had been under pressure with financial concerns. After a few days the woman requested and was given a razor for her personal hygiene use. Later, the woman pressed the call bell and was found in the shower with neck wounds. The investigation identified that the health service organisation needed a more standardised approach to monitoring patients at risk of self-harm after issuing them with potentially dangerous items.

In the second incident, a man was admitted to a treatment centre with an increase in suicidal thoughts following the break-up of his marriage and the loss of his job. The man was improving following a few weeks of medication management, improved sleep, group therapy and psychological counselling. Unfortunately, the man was found unresponsive having used personal property to hang himself from a door. The clinical incident was investigated as a sentinel event and the organisation amended its policy requiring the removal of possible ligature articles during periods of increased risk.

It is critical for health service organisations to ensure they have systems in place for frontline members of the workforce to gain access to specialist mental health expertise to assess and manage persons with suicidal thoughts. Health service organisations must also ensure adequate follow up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts. Key tasks for this include:

- Developing a collaborative post-discharge treatment plan involving the person, their carers and family, and key service providers before the person leaves the health service organisation
- Communicating this plan verbally and in writing to all people who have a role in implementing the plan
- Ensuring the plan is implemented.³⁸

The importance of ensuring that the plan is implemented is highlighted by the following case.

A man in his thirties suffered with chronic mental illness and was homeless. He presented to an Emergency Department stating that he was hearing voices and needed accommodation. The man was assessed as low risk and was referred to attend a mental health service on the following day for further assessment. The man did not attend his appointment and the referral was closed. The man was later found deceased and suicide was suspected. The investigation recommended the development of a standard operating procedure for patients who did not attend for care or who are difficult to engage, including for reasons such as personal, cultural and social circumstances.

A further critical component of the Comprehensive Care Standard is predicting, preventing and managing violence and aggression. This includes identifying environmental triggers for aggression, identifying aspects of organisational procedures that could cause stress and lead to aggression, and implementing strategies to lessen these.³⁹

³⁸ NSQHS (2nd ed) Standard 5; Action 5.32 available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-532>

³⁹ NSQHS (2nd ed) Standard 5; Action 5.33 available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-533>

Restrictive Practices Clinical Incidents

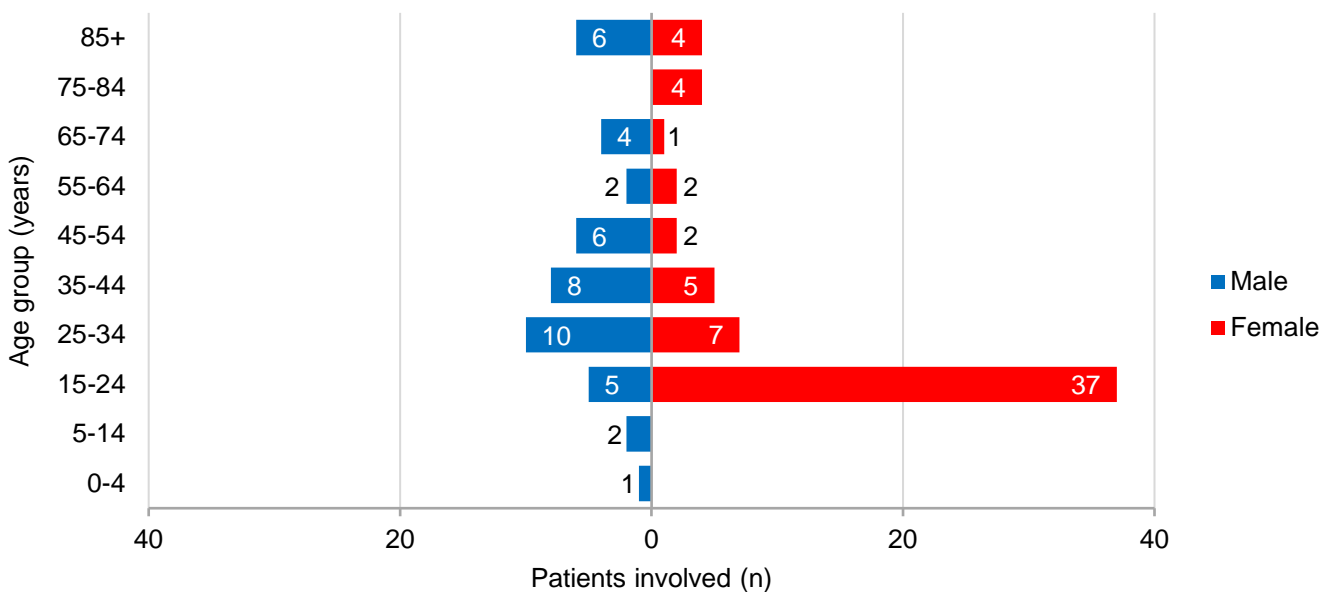
All health consumers, including those accessing mental health services, have the right to receive the least restrictive treatment appropriate, considering their preferences, the demands on carers, and the availability of support and safety of those involved. Mental health services must respect these rights to the extent that they do not impose serious risk to the consumer or others. Restrictive practices involve the use of interventions by service providers that have the effect of limiting the rights or freedom of movement of a person, with the primary purpose of protecting the person or others from harm. These include restraint (chemical, mechanical, physical or social), seclusion, and limiting free communication. There is often a link between unpredictable behaviours and the use of restrictive practices in health care settings.

Minimising and, where possible, eliminating the use of restrictive practices are key parts of national mental health policy and have been identified as clinical priorities in other health care settings. Identifying risks relating to unpredictable behaviours early and using tailored response strategies can reduce the use of restrictive practices. Restrictive practices must only be implemented by members of the workforce who have been trained in their safe use.³

While the restrictive practices area of the Comprehensive Care Standard focuses on minimising restraint and seclusion, it should be noted that the Datix CIMS incident classification captures incidents related to physical, mechanical and chemical restraint.

Females accounted for 57.9% (n=62) of patients involved in confirmed restrictive practices clinical incidents in 2019/20, with males making up 42.1% (n=45; missing gender n=1). Patient ages ranged from 0-93 years. More than one-third of patients (34.9%; n=37) involved in restrictive practices clinical incidents were females aged 15-24 years (see Figure 46).

Figure 46: Frequency of Patients Involved in Confirmed Restrictive Practices Clinical Incidents by Age Group and Gender for 2019/20

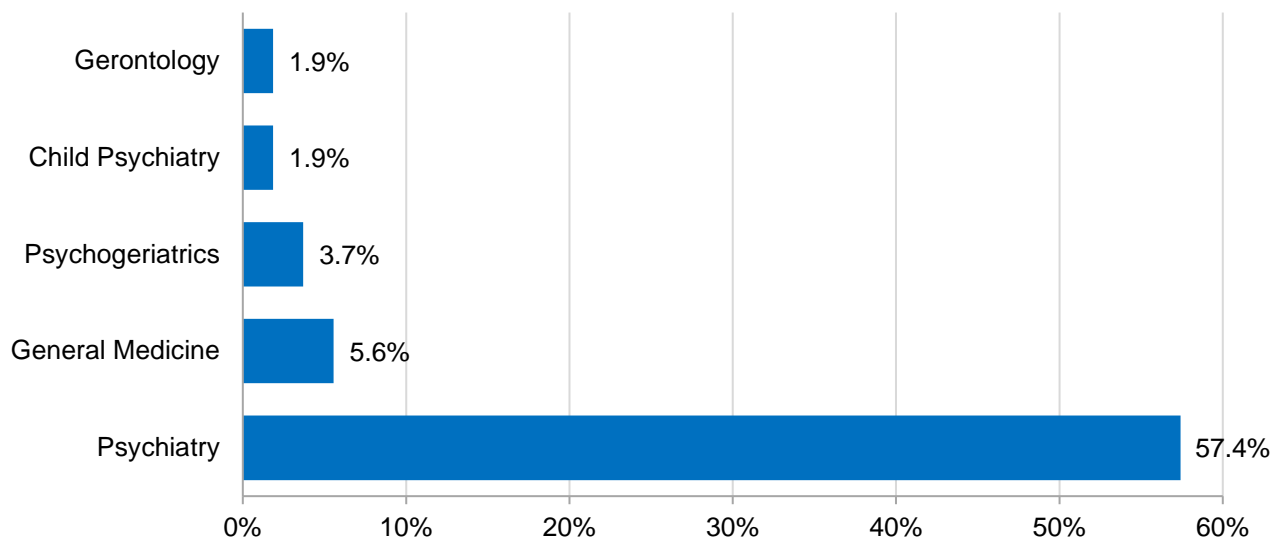


Note: Patient age and/or gender missing data n=2; a clinical incident may affect multiple patients

Further review of data for patients involved in confirmed restrictive practices clinical incidents in 2019/20 showed that 67.6% (n=73) were involuntary mental health patients under the *Mental Health Act 2014*. A further nine patients (8.3%) were voluntary mental patients and six (5.6%) were referred mental health patients under the MHA.

The top five treating specialties accounted for 70.4% (n=76) of confirmed restrictive practices clinical incidents in 2019/20. The Psychiatry specialty reported the highest frequency of restrictive practices incidents in this period (n=62; 57.4%), followed by the General Medicine specialty (n=6; 5.6%; see Figure 47).

Figure 47: Percentage of Confirmed Restrictive Practices Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=20; 18.5%

Clinical incidents related to restrictive practices were most frequently reported as the restraint procedure being incomplete or inadequate (n=81; 75.0%). The next most frequently reported Tier Three category was patient harm resulting from the restraint procedure (n=25; 23.1%; see Table 25).

Table 25: Frequency and Percentage of Tier Three Restrictive Practices Clinical Incident Categories for 2019/20

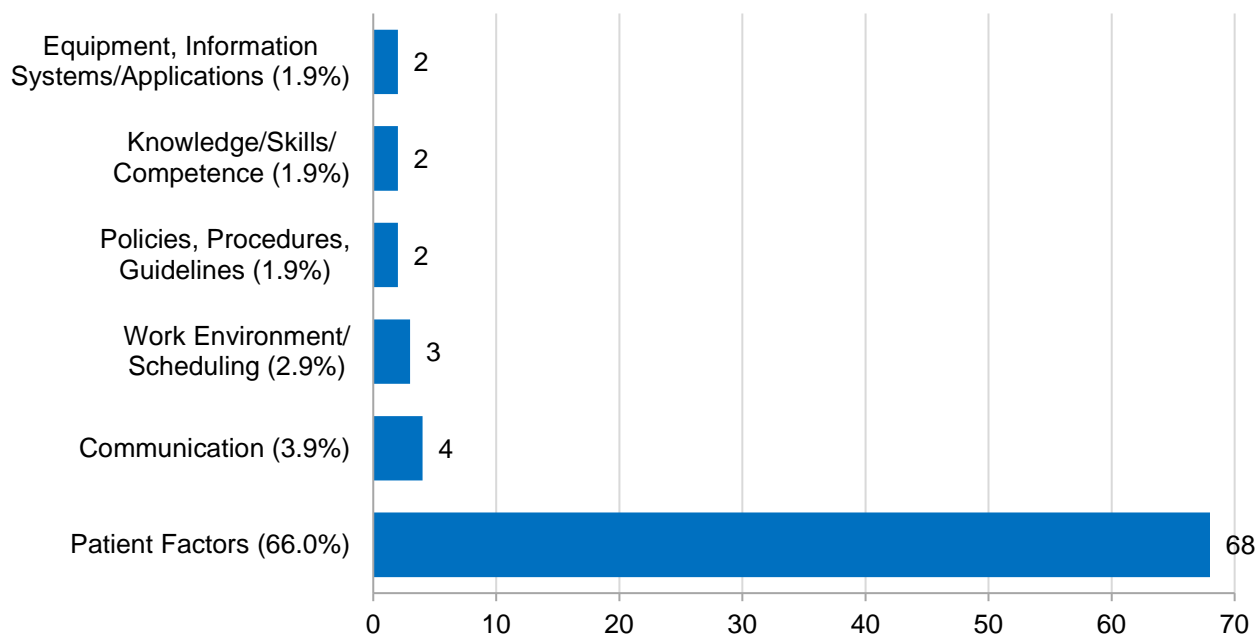
Tier Three Restrictive Practices Categories	(n)	(%)
Incomplete or inadequate restraint procedure*	81	75.0
Harm from restraint†	25	23.1
Incorrect restraint procedure*	2	1.9
Total	108	100.0

* Incidents for these Tier Three categories were reported under the Tier One categories “Behaviour” and “Therapeutic Processes/Procedures (except medications/fluids/blood/plasma products administration)” and the Tier Two category “Patient Restraint Processes”.

† Incidents for this Tier Three category were reported under the Tier One category “Behaviour” and the Tier Two category “Patient Restraint Processes”.

Investigation of restrictive practices clinical incidents in 2019/20 identified that patient factors were the most frequently identified contributory factor, being cited in 66.0% (n=68) of closed incidents (see Figure 48). Issues with communication were identified in 3.9% (n=4) of completed investigations into restrictive practices clinical incidents in this period.

Figure 48: Frequency and Percentage of Top Five Contributory Factors for Closed Restrictive Practices Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

Key Messages and Information: Restrictive Practices Clinical Incidents

The ACSQHC has identified key tasks related to restraint and seclusion in health service organisations. Key tasks related to restraint include:

- Understanding where and when restraint is used in the health service organisation
- Benchmarking the use of restraint
- Demonstrating implementation of strategies to reduce the use of restraint
- Ensuring that members of the workforce who perform restraint are trained to do so safely
- Monitoring and documenting appropriate observations during and after restraint
- When restraint has occurred, offering debriefing for the people involved, including patients, carers and members of the workforce.⁴⁰

Similarly, the key tasks relating to seclusion are:

- Implementing strategies to minimise the use of seclusion
- Ensuring that seclusion is only implemented by members of the workforce who have been trained to implement it safely
- Monitoring and documenting appropriate observations during and after seclusion
- Reviewing the use of seclusion within the health service organisation.⁴¹

The Chief Psychiatrist's *Standard for Seclusion and Bodily Restraint Reduction*⁴² serves to reduce seclusion and restraint events, time spent in seclusion, and trauma associated with

⁴⁰ NSQHS (2nd ed) Standard 5; Action 5.35 available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-535>

⁴¹ NSQHS (2nd ed) Standard 5; Action 5.36 available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-536>

⁴² Chief Psychiatrist of Western Australia (2015). Chief Psychiatrist's Standards for Clinical Care available at: https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/12/CP_Standards_2015.pdf

seclusion and restraint. Staff in the WA health system are trained in trauma informed care principles and use these principles in the assessment process and in situations when restraint is required. One example of a clinical incident involving restraint that was reported during 2019/20 is described below.

A young man with a history of mental illness was taken to a local rural hospital by police after being involved in a violent incident. The man was sedated and transferred to a metropolitan hospital Emergency Department. The treatment plan was to transfer the man to an authorised secure mental health service. The man was waitlisted for the secure bed and remained sedated on an as required basis. By the evening of the next day the man was becoming increasingly aggressive and later that night a decision was made to intubate him and transfer him to an Intensive Care Unit under increased sedation until the secure bed became available.

When the bed became available the man was woken and transferred with the use of four-point restraint. The man continued to require close supervision and medication management, with episodes of seclusion until he gradually improved and could be discharged back to the care of his GP and mental health services in the rural community. The investigation noted the complexity of caring for people who are at risk of harming themselves or others and the difficulty in accessing timely, secure mental health beds. The service planned to escalate these concerns to the Hospital Executive for their consideration.



Poor Nutrition and Malnutrition Clinical Incidents

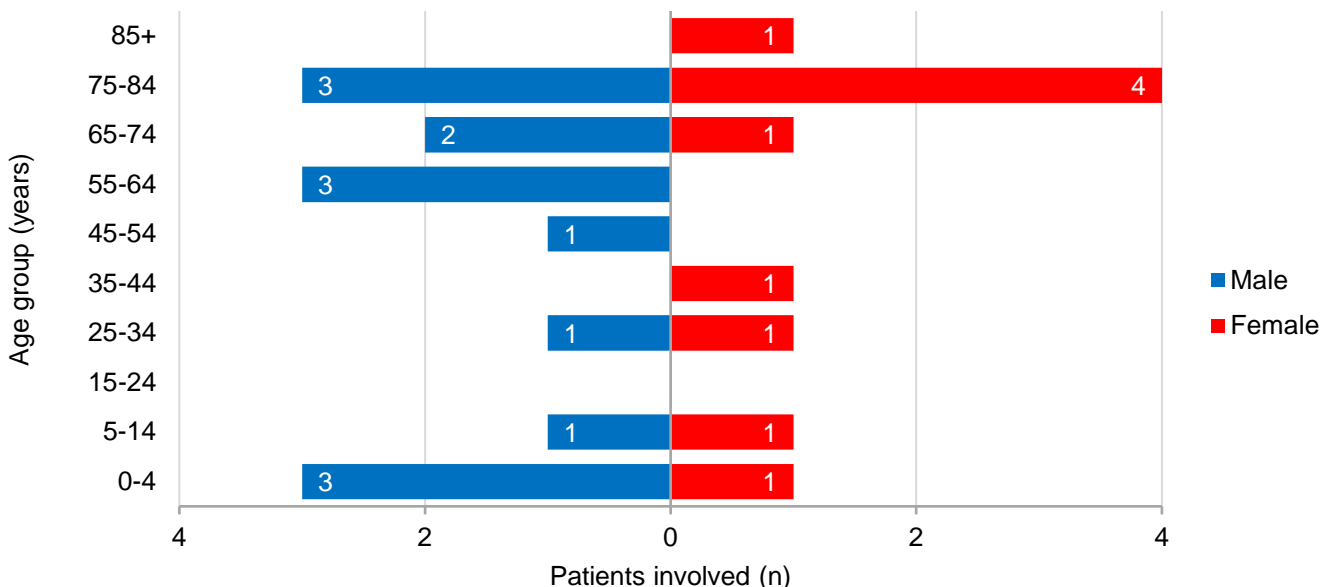
Food is part of the care that is provided to patients who are admitted to hospital. Malnutrition adversely affects patient outcomes, and nutrition needs to be considered as an integral part of the comprehensive care plan.⁴³ Patients with poor nutrition, including malnutrition, are at greater risk of pressure injuries and their pressure injuries are more severe. Malnourished patients are also at higher risk of developing healthcare-associated infections, have been observed to have longer stays in hospital and more unplanned readmissions, and have higher levels of mortality both in hospital and following discharge.

The Comprehensive Care Standard³ requires that:

- Health service organisations that admit patients overnight have systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice.
- The workforce uses the systems for preparation and distribution of food and fluids to:
 - Meet patients' nutritional needs and requirements
 - Monitor the nutritional care of patients at risk
 - Identify and provide access to nutritional support for patients who cannot meet their nutritional requirements with food alone
 - Support patients who require assistance with eating and drinking.

The Datix CIMS captures clinical incidents related to food and nutritional products, including incidents where these are delayed or not provided to the patient, or the patient refuses food or nutrition. High levels of patient refusal of food may suggest review of nutritional systems is required to improve their effectiveness and appropriateness. In 2019/20, males accounted for 58.3% (n=14) of patients involved in confirmed poor nutrition and malnutrition clinical incidents, with females making up 41.7% (n=10; see Figure 49). Patient ages ranged from 0-85 years.

Figure 49: Frequency of Patients Involved in Confirmed Poor Nutrition and Malnutrition Clinical Incidents by Age Group and Gender for 2019/20

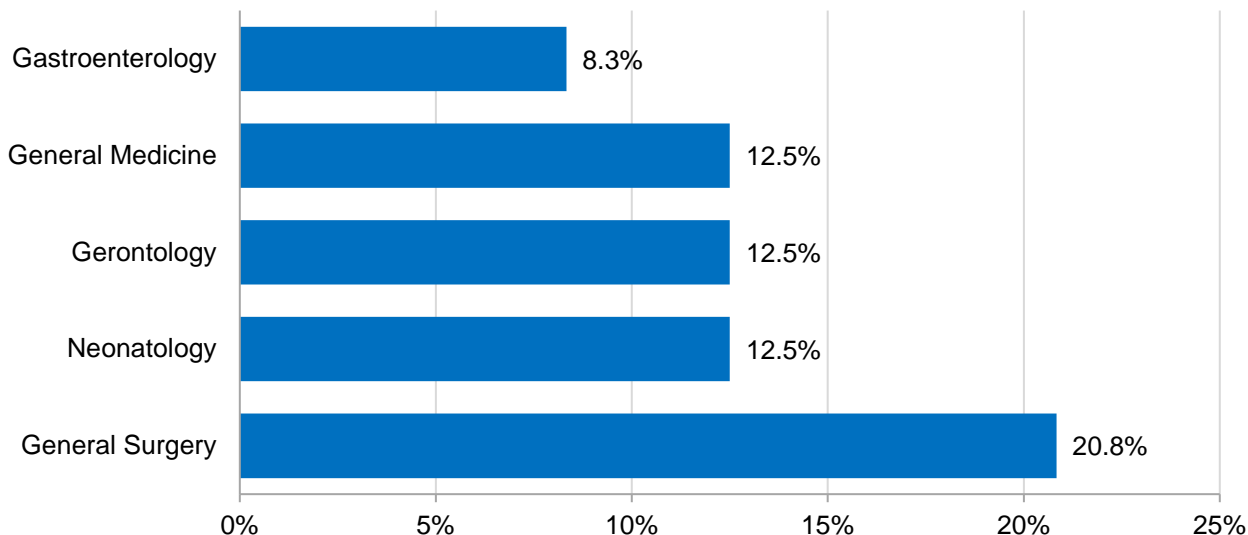


Note: A clinical incident may affect multiple patients

⁴³ NSQHS (2nd ed) Standard 5; Action 5.27 available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-527>

The top five treating specialties accounted for 66.7% (n=16) of confirmed clinical incidents related to poor nutrition and malnutrition in 2019/20. The General Surgery specialty reported the highest frequency of poor nutrition and malnutrition incidents in this period (n=5; 20.8%; see Figure 50), followed by General Medicine, Gerontology and Neonatology (n=3; 12.5% each).

Figure 50: Percentage of Confirmed Poor Nutrition and Malnutrition Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=2; 8.3%

Clinical incidents related to poor nutrition and malnutrition were most frequently reported as a delay in feeding the patient (n=11; 45.8%). The next most frequently reported Tier Three category was feeding of the patient being missed (n=9; 37.5%; see Table 26).

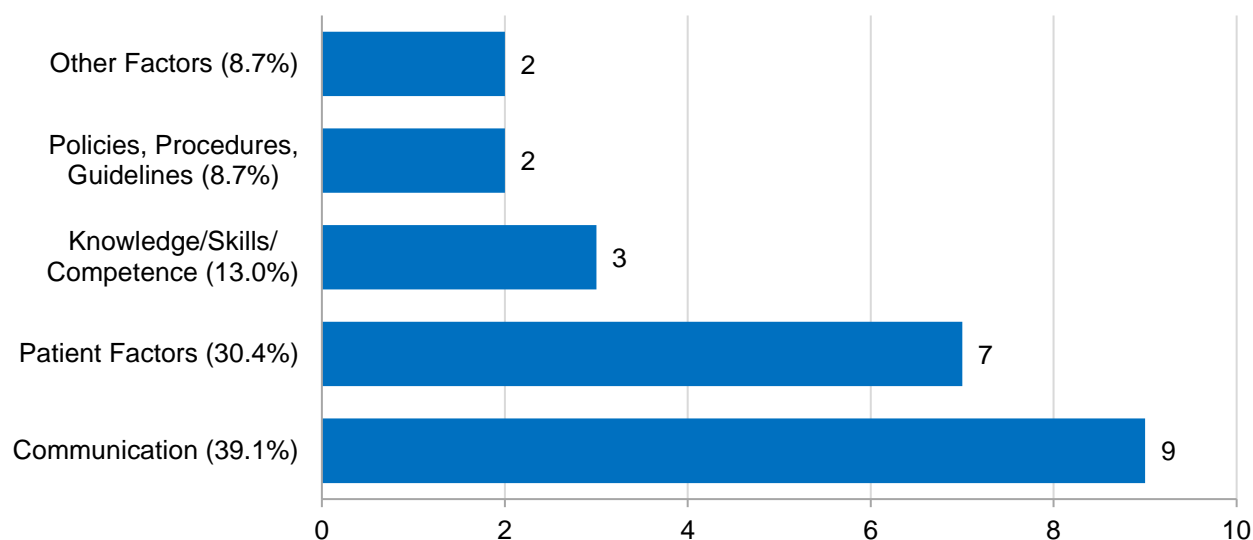
Table 26: Frequency and Percentage of Tier Three Poor Nutrition and Malnutrition Clinical Incident Categories for 2019/20

Tier Three Poor Nutrition and Malnutrition Categories	(n)	(%)
Feeding delayed	11	45.8
Feeding missed	9	37.5
Refusal of food/feeding	4	16.7
Total	24	100.0

Note: Incidents for these Tier Three categories were reported under the Tier One categories “Nutrition Food/Meals from Kitchen” and “Nutrition Pharmacy Products” and the Tier Two category “Administration to Patient”.

Investigation of clinical incidents related to poor nutrition and malnutrition in 2019/20 identified communication issues as the most frequent contributory factor, being cited in 39.1% (n=9) of closed incidents (see Figure 51). Issues with communication between staff members were found in seven of these nine incidents. Patient factors were identified as contributory in 30.4% (n=7) of incidents investigated that related to poor nutrition and malnutrition.

Figure 51: Frequency and Percentage of Top Five Contributory Factors for Closed Poor Nutrition and Malnutrition Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

Key Messages and Information: Poor Nutrition and Malnutrition Clinical Incidents

The key task related to nutrition in the Comprehensive Care Standard is for health service organisations to put in place processes for addressing patients' nutrition and hydration needs.⁴³

Health service organisations are required to ensure that processes for planning, preparing and distributing food, fluids and nutritional supplements are timely, safe and appropriate to the setting of care.

Processes for menu and meal planning should:

- Reflect the nutritional requirements appropriate to the age and life stage of patients receiving care
- Reflect the special dietary needs appropriate to consumers' requirements
- Consider psychosocial, cultural and religious needs
- Offer food and fluid choices that are appealing and that patients enjoy
- Consider flexible meal timing and service arrangements
- Be relevant to patients' length of stay, and to patients who are admitted frequently.

A nutrition risk assessment is a key part of the organisation's screening and assessment processes, and involves:

- Conducting screening on admission and weekly during an episode of care if care changes or if the patient's condition changes, or at routine review
- Considering nutrition risk such as malnutrition and dehydration, dysphagia, special dietary needs, food intolerance or allergy
- Documenting the results of nutrition risk screening and assessment.⁴⁴

⁴⁴ NSQHS (2nd ed) Standard 5; Action 5.28 available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard/minimising-patient-harm/action-528>



Standard 6: Communicating for Safety Clinical Incidents

Communication is a key safety and quality issue in health care and Standard 6 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.³ The Communicating for Safety Standard builds on the Patient Identification and Procedure Matching and Clinical Handover Standards from the first edition of the NSQHS Standards.

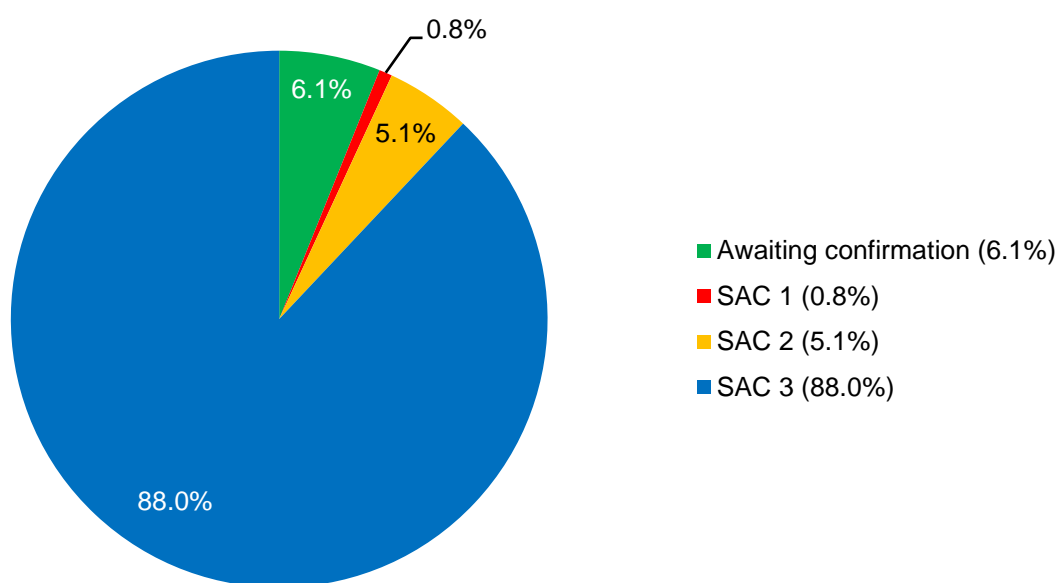
Key areas of communicating for safety include:

- 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.³

Communicating for safety clinical incidents are captured under Tier Three categories in the Datix CIMS⁸ and some data in this report has been presented for the key areas described above (excluding the clinical governance and quality improvement area). A small number of Tier Three categories in the Datix CIMS relating to administrative processes for access, admission and informed consent are relevant to communicating for safety but do not directly align to one of these key areas - these incidents are categorised as “Other incidents related to communicating for safety” in this report.

In 2019/20, 4,702 clinical incidents related to communicating for safety were notified of which 4,415 incidents were confirmed, with the remainder (n=287) awaiting SAC confirmation at the time of this report. Incidents related to communicating for safety accounted for 14.2% of all clinical incidents notified in this period and were most often categorised as SAC 3 (n=4,137; 88.0%; see Figure 52).

Figure 52: Percentage of Communicating for Safety Clinical Incidents by SAC Rating for 2019/20



The most frequently reported sub-category of clinical incidents related to communicating for safety was documentation of information which was reported in 36.0% (n=1,589) of confirmed communicating for safety incidents in 2019/20 (see Table 27). The next most frequently reported sub-categories were correct identification and procedure matching (n=1,431; 32.4%) and communication at clinical handover (n=1,021; 23.1%).

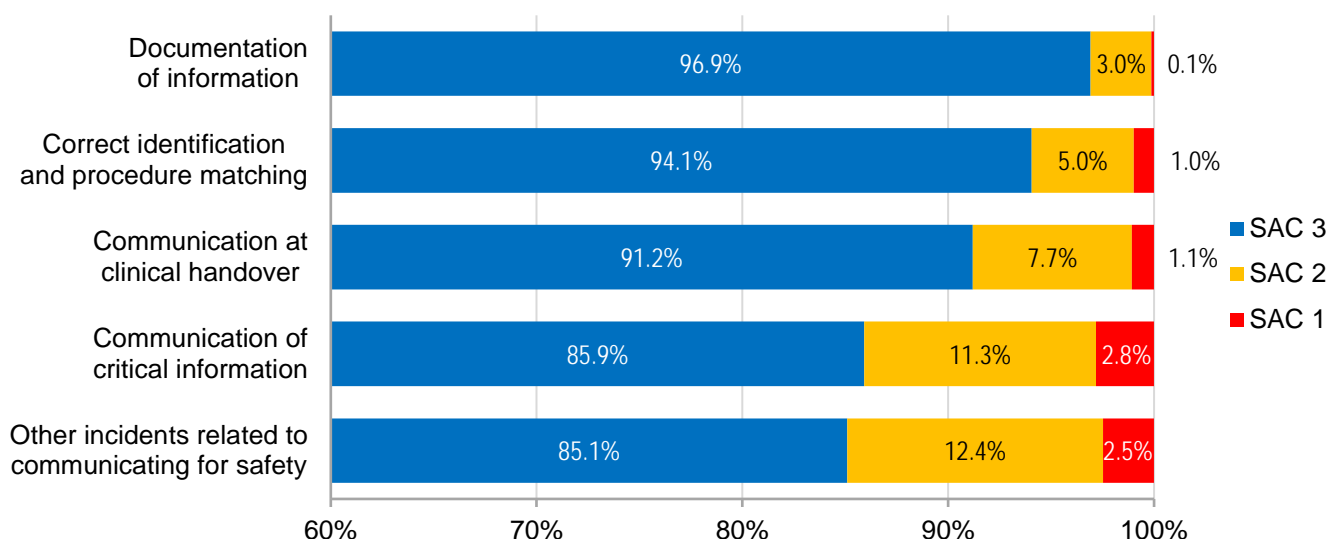
Table 27: Frequency of Confirmed Communicating for Safety Clinical Incidents by Sub-category and SAC Rating for 2019/20

Communicating for Safety Sub-categories	SAC 3	SAC 2	SAC 1	Total
Documentation of information	1,540	47	2	1,589
Correct identification and procedure matching	1,346	71	14	1,431
Communication at clinical handover	931	79	11	1,021
Communication of critical information	183	24	6	213
Other incidents related to communicating for safety	137	20	4	161
Total	4,137	241	37	4,415

Note: Other incidents related to communicating for safety includes administrative processes for access, admission and informed consent.

Figure 53 shows the proportion of confirmed clinical incidents for each communicating for safety sub-category by SAC rating. While the differences are relatively small, the proportion of incidents reported as SAC 1 and SAC 2 was higher in the communication of critical information and other incidents related to communicating for safety sub-categories than for communication at clinical handover, correct identification and procedure matching, and documentation of information.

Figure 53: Percentage of Confirmed Communicating for Safety Clinical Incidents by Sub-category and SAC Rating for 2019/20



Note: Other incidents related to communicating for safety includes administrative processes for access, admission and informed consent.

Table 28 shows the frequency of patient outcomes for confirmed incidents in the sub-categories related to communicating for safety. In 2019/20, most confirmed clinical incidents related to this NSQHS Standard reported the outcome as no harm to the patient (n=3,813; 86.4%), followed by minor harm (n=423; 9.6%). These were the most frequently reported patient outcomes for all sub-categories related to communicating for safety. The highest number of incidents describing a patient outcome of death related to communication of critical information (n=4), and the highest frequency of serious harm related to communication at clinical handover (n=8).

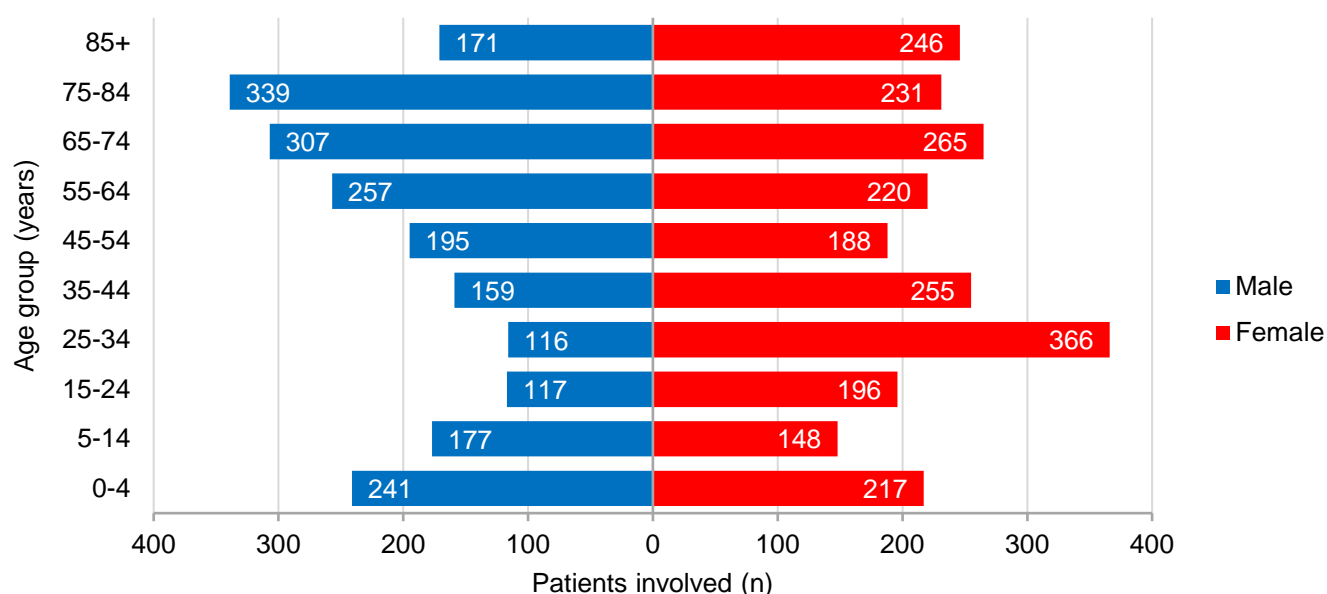
Table 28: Frequency of Confirmed Communicating for Safety Clinical Incidents by Sub-category and Patient Outcome for 2019/20

Communicating for Safety Sub-categories	No harm	Minor harm	Moderate harm	Serious harm	Death
Documentation of information	1,446	107	13	-	1
Correct identification and procedure matching	1,253	124	20	3	-
Communication at clinical handover	811	149	23	8	2
Communication of critical information	171	24	8	3	4
Other incidents related to communicating for safety	132	19	5	2	1
Total	3,813 (86.4%)	423 (9.6%)	69 (1.6%)	16 (0.4%)	8 (0.2%)

Note: Patient outcome missing data n=86; 1.9%. Other incidents related to communicating for safety includes administrative processes for access, admission and informed consent.

Females accounted for 52.9% (n=2,344) of patients involved in confirmed incidents related to communicating for safety in 2019/20, with males making up 47.1% (n=2,083; missing gender n=491). Patient ages ranged from 0-101 years with a median of 50 years. Figure 54 shows the distribution of patients involved in communicating for safety incidents by age group and gender.

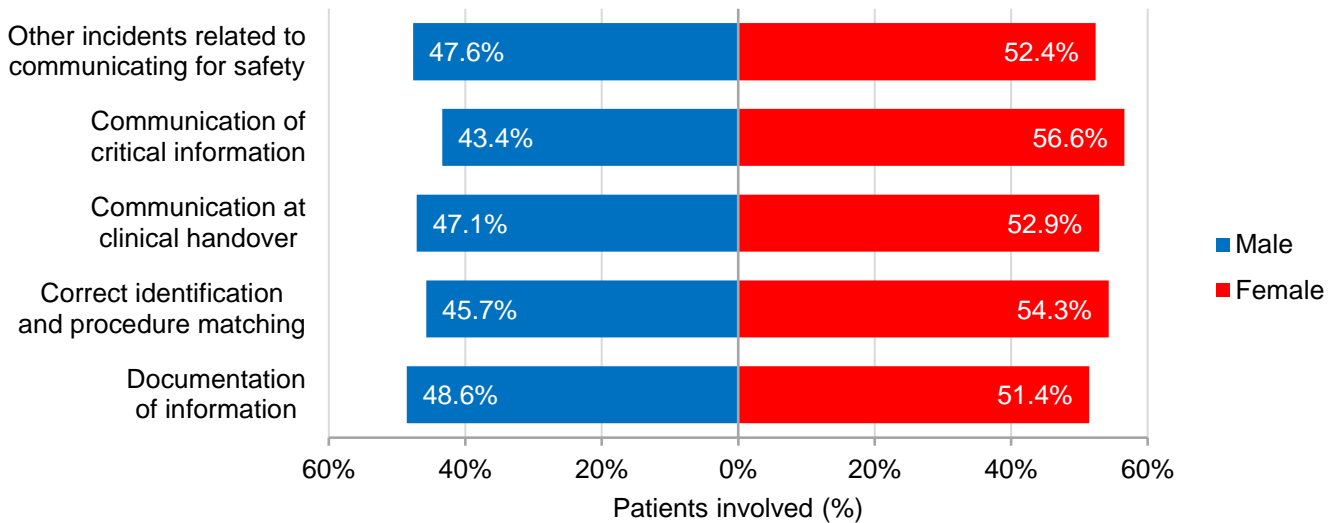
Figure 54: Frequency of Patients Involved in Confirmed Communicating for Safety Clinical Incidents by Age Group and Gender for 2019/20



Note: Patient age and/or gender missing data n=507; a clinical incident may affect multiple patients

In 2019/20, the proportion of females involved in each sub-category of incident related to communicating for safety was higher than the proportion of males, and ranged from 51.4% (documentation of information) to 56.6% (communication of critical information; see Figure 55).

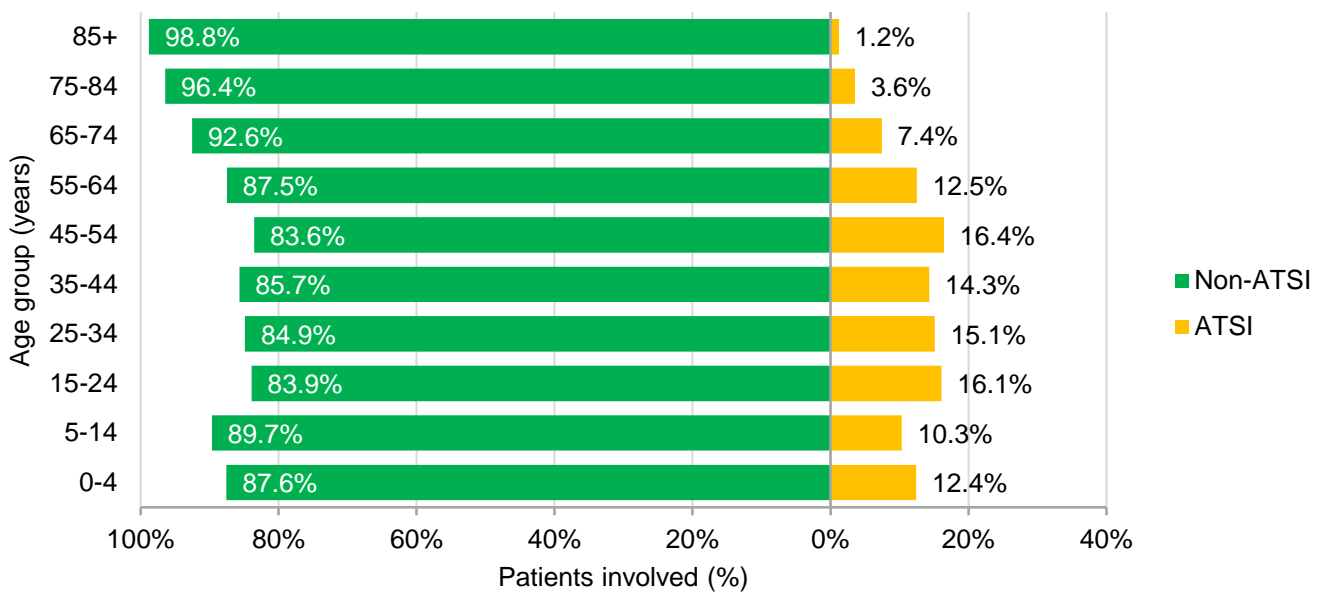
Figure 55: Percentage of Patients Involved in Confirmed Communicating for Safety Clinical Incidents by Sub-category and Gender for 2019/20



Note: Patient gender missing data n=491; a clinical incident may affect multiple patients

Figure 56 shows the proportion of patients involved in confirmed communicating for safety clinical incidents by their ATSI status within each age group. ATSI persons accounted for 10.6% (n=459; missing ATSI status n=568) of patients involved in these incidents in 2019/20. The proportion of ATSI patients involved in communicating for safety clinical incidents in each age group reflected that seen for all clinical incidents reported in this period (refer to Figure 8).

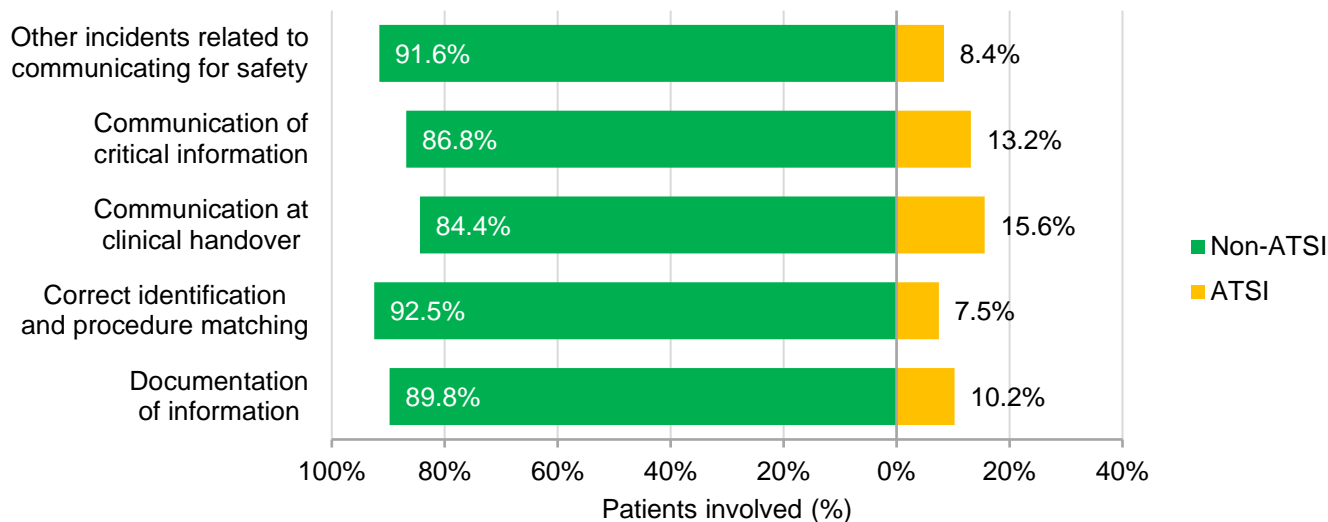
Figure 56: Percentage of Patients Involved in Confirmed Communicating for Safety Clinical Incidents by Age Group and ATSI Status for 2019/20



Note: Patient age and/or ATSI status missing data n=573; a clinical incident may affect multiple patients

Figure 57 shows the proportion of ATSI and non-ATSI patients involved in communicating for safety clinical incident sub-categories during 2019/20. The proportion of ATSI patients involved was highest in the communication at clinical handover (15.6%; n=146) and communication of critical information (13.2%; n=24) sub-categories of incidents related to this NSQHS Standard.

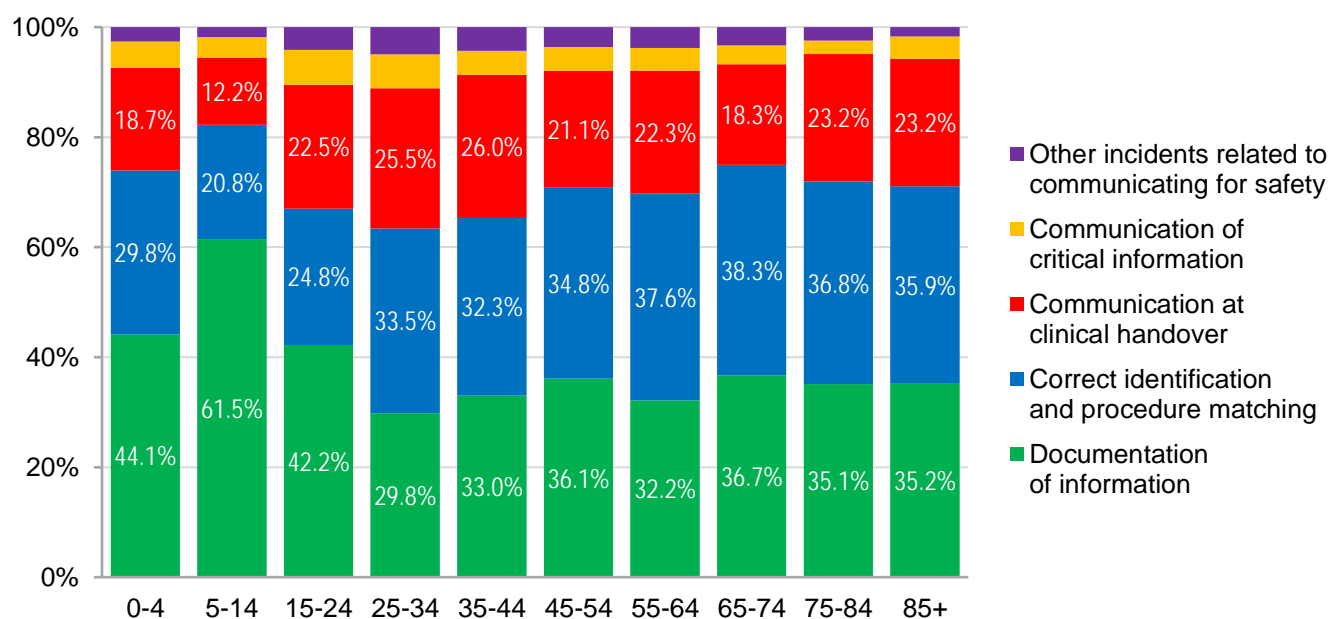
Figure 57: Percentage of Patients Involved in Confirmed Communicating for Safety Clinical Incidents by Sub-category and ATSI Status for 2019/20



Note: Patient ATSI status missing/unknown data n=568; a clinical incident may affect multiple patients

Figure 58 shows the proportion of patients involved in communicating for safety clinical incident sub-categories within each age group during 2019/20. In the 5-14 years age group, a higher proportion of incidents related to the documentation of information sub-category was observed.

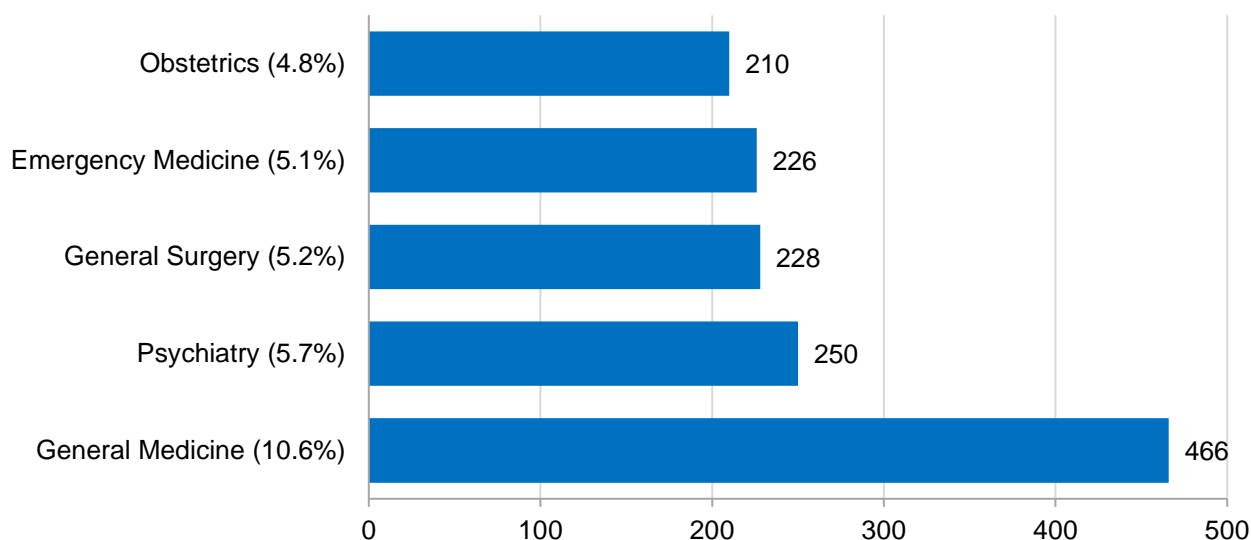
Figure 58: Percentage of Patients Involved in Confirmed Communicating for Safety Clinical Incidents by Age Group and Sub-category for 2019/20



Note: Patient age missing data n=485; a clinical incident may affect multiple patients

The five specialties that most frequently reported clinical incidents related to communicating for safety accounted for 31.3% (n=1,380) of these incidents in 2019/20 (see Figure 59). These incidents were most frequently reported by the General Medicine specialty (n=466; 10.6%), followed by Psychiatry (n=250; 5.7%). General Medicine reported the most incidents in each of the communicating for safety incident sub-categories, apart from other incidents related to communicating for safety, where Emergency Medicine reported the most (n=17).

Figure 59: Percentage of Confirmed Communicating for Safety Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=1,314; 29.8%

The five most frequently reported Tier Three categories accounted for 70.0% (n=3,089) of confirmed communicating for safety clinical incidents in 2019/20 (see Table 29). Ambiguous, incorrect or incomplete documentation was the most frequently reported Tier Three category (n=1,455; 33.0%), followed by incorrect patient, which was reported in 20.9% (n=922) of these incidents.

Table 29: Frequency and Percentage of Top Five Tier Three Confirmed Communicating for Safety Clinical Incident Categories for 2019/20

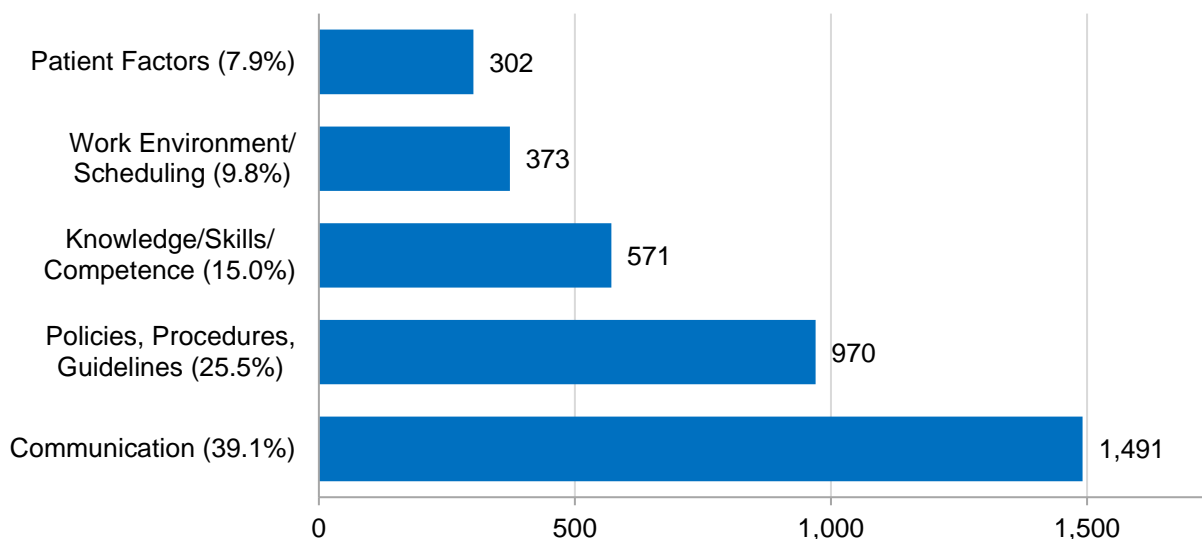
Tier Three Communicating for Safety Categories	(n)	(%)
Ambiguous, incorrect or incomplete documentation	1,458	33.0
Incorrect patient*	922	20.9
Handover/handoff between health care professionals insufficient, incorrect or incomplete	268	6.1
Documentation temporarily unavailable or delay in accessing	256	5.8
Discharge of patient insufficient or incomplete	188	4.3
Total	3,089	70.0

* Incidents in this Tier Three category include incorrect patient information in health care documentation/records, prescribing and administration of medication to the wrong patient, administration of blood products to the wrong patient, therapeutic and diagnostic procedures performed on the wrong patient, medical devices/equipment used on the wrong patient and nutrition/food given to the wrong patient.

Figure 60 shows the contributory factors most frequently identified in communicating for safety clinical incidents investigated during 2019/20. Communication issues were most frequently identified in communicating for safety clinical incidents (n=1,491; 39.1%), followed by issues with policies, procedures and guidelines which were cited in 25.5% (n=970) of these incidents.

Where communication factors were identified as contributory, issues with documentation were found in 55.8% (n=832) of incidents investigated, and issues with communication between staff were found in 54.8% (n=817). Where problems with policies, procedures and guidelines were identified these most frequently related to issues with their application (n=610; 62.9%).

Figure 60: Frequency and Percentage of Top Five Contributory Factors for Closed Communicating for Safety Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors



Key Messages and Information: Communicating for Safety Clinical Incidents

The Communicating for Safety Standard in the second edition of the NSQHS Standards recognises that ensuring correct identification of patients, patient and procedure matching, and documenting and communicating essential information in patient health care records are essential components of a safe and high-quality health system. The WA health system must ensure its staff are adequately skilled and supported to achieve this for every patient every time. The following case shows the need for critical information to be acted on in a timely manner.

A woman's daughter complained to a hospital regarding her mother's care. The investigation of the complaint resulted in a SAC 1 clinical incident investigation. The daughter complained that her mum had "fallen through the cracks" in the hospital's reporting system. Her mother had presented to the Emergency Department with shortness of breath and kidney impairment and went on to have treatment for her kidney problems. A chest X-ray performed at the time had been reported as showing an opacity that should be followed up via CT scan. The CT scan did not occur, and the woman later died of lung cancer. The hospital is considering options for improvement in systems related to medical imaging results acknowledgement.

The Communicating for Safety Standard also recognises that effective communication is needed throughout patients' care and identifies high-risk times, such as the points at which care transitions, when it is critical. Clinical handover is best facilitated using a structured process that ensures effective communication of relevant, accurate and up-to-date information about a patient's care to ensure patient safety.⁴⁵ The importance of effective handover is highlighted by the following case.

During 2019/20, a baby girl died in hospital following a viral illness. The investigation identified that there was no handover of the family from the metropolitan site where the child was born to the rural child health service. While the rural child health service visited the child, they were unaware that the family were active clients of the Department of Communities Child Protection service. While it was not considered that this contributed to the child's death, it was determined that improved communication could have assisted in ensuring that the family was supported. The health service recommended stronger links and handover between services supporting children and their families.

This reinforces the need for the WA health system to ensure structured approaches to clinical handover are used whenever patient care transitions, as detailed in the Department of Health's *Clinical Handover Policy*.⁴⁶ Where needed, the inclusion of other agencies or services that have a role in supporting patients and their families in the handover process may lead to better health outcomes. The Department of Health's *Guidelines for Protecting Children 2015*⁴⁷ (currently under review) and *Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby Is Identified as at Risk of Abuse and/or Neglect* outline the processes and requirements for staff in the WA health system for the ongoing case management of children and newborns when child abuse, neglect and/or protection concerns have been identified.

⁴⁵ NSQHS (2nd ed) Standard 6; Action 6.8 available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover/action-68>

⁴⁶ The Clinical Handover Policy is available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Clinical-Handover-Policy>

⁴⁷ The Guidelines for Protecting Children 2015 and the Bilateral Schedule are available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Services-Planning-and-Programs>

Standard 7: Blood Management Clinical Incidents

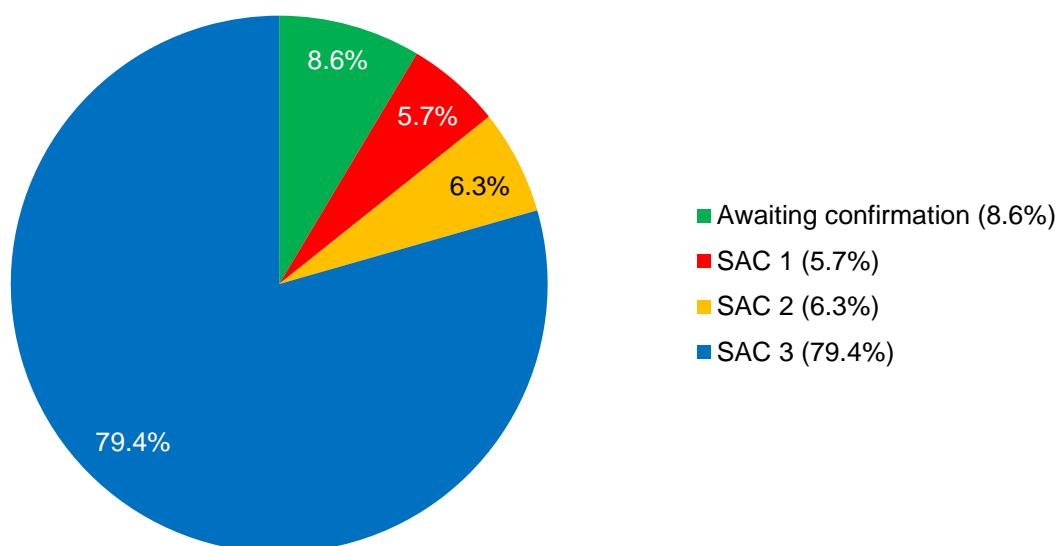
Treatment with blood and blood products can be lifesaving, however the administration of blood and blood products also carries inherent risks. Standard 7 of the second edition of the NSQHS Standards refers to systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The intention of this Standard is to identify risks, and put in place strategies, to ensure that a patient's own blood is optimised and conserved, and that any blood and blood products the patient receives are appropriate and safe.³

Patient blood management (PBM) views the patient's own blood as a unique and finite resource which should be conserved and managed appropriately. PBM takes an individualised approach to the management of a patient's blood and involves three key principles:

- Optimising a patient's own blood
- Minimising blood loss
- Optimising tolerance of anaemia.⁴⁸

Blood management clinical incidents are identified in the Datix CIMS using the Tier One category "Blood/Plasma Products". In 2019/20, there were 175 blood management clinical incidents notified with 160 clinical incidents confirmed, and the remaining 15 awaiting SAC confirmation at the time of this report. Blood management clinical incidents accounted for 0.5% of all clinical incidents notified in this period and were most frequently categorised as SAC 3 incidents (n=139; 79.4%), followed by SAC 2 (n=11; 6.3%), and SAC 1 (n=10; 5.7%; see Figure 61). Four blood management clinical incidents confirmed as SAC 1, and another four confirmed as SAC 2, related to delays in the delivery of blood products.

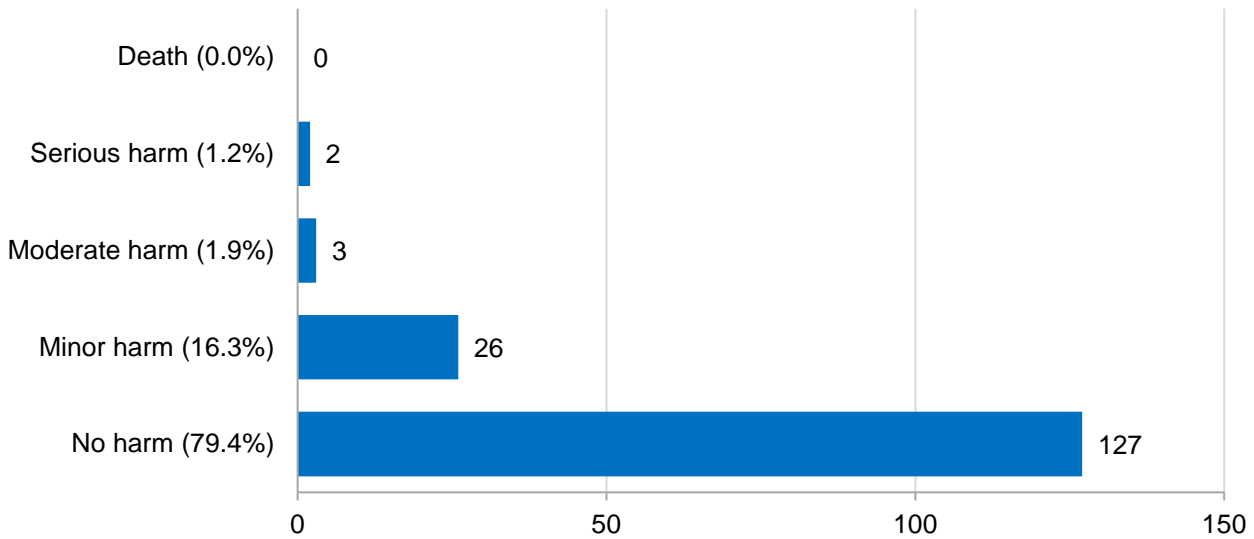
Figure 61: Percentage of Blood Management Clinical Incidents by SAC Rating for 2019/20



⁴⁸ Further information about Patient Blood Management is available at: https://ww2.health.wa.gov.au/Articles/A_E/Blood-management

Most confirmed blood management clinical incidents in 2019/20 reported no harm to the patient (n=127; 79.4%), with no incidents reporting a patient outcome of death and two incidents reporting an outcome of serious harm (see Figure 62).

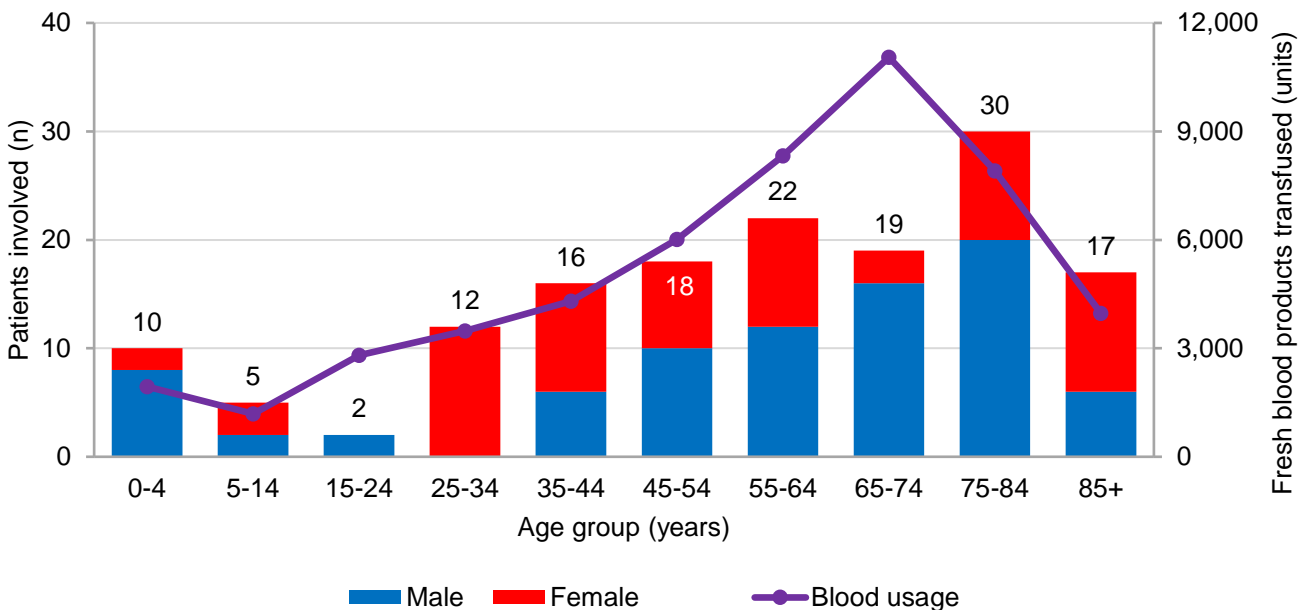
Figure 62: Frequency and Percentage of Confirmed Blood Management Clinical Incidents by Patient Outcome for 2019/20



Note: Patient outcome missing data n=2; 1.2%

Figure 63 shows the age and gender distribution of patients involved in confirmed blood management clinical incidents and the total units of fresh blood products transfused at WA’s public hospitals in these age groups during 2019/20. The distribution of patients involved in these incidents by age was similar to fresh blood product usage in this period, with relatively fewer patients aged 15-24 and 65-74 years involved in blood management clinical incidents.

Figure 63: Frequency of Patients Involved in Confirmed Blood Management Clinical Incidents by Age Group/Gender and Fresh Blood Products Transfused for 2019/20

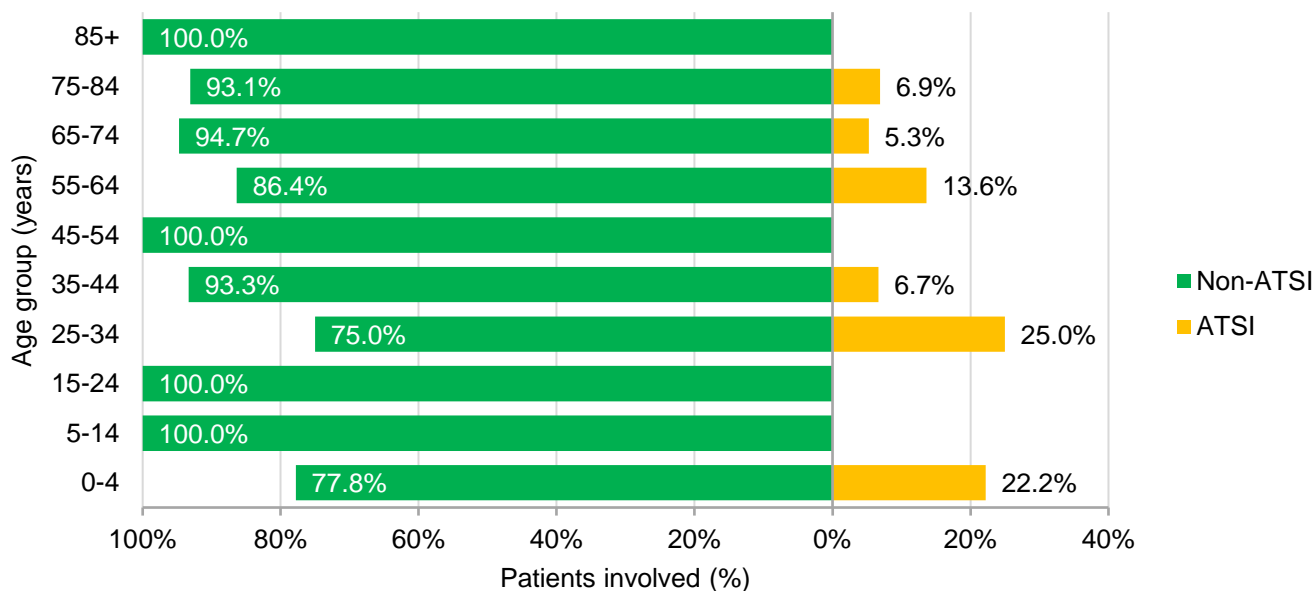


Notes: Patient age and/or gender missing data n=11; a clinical incident may affect multiple patients. Blood usage data was provided by PathWest from the ULTRA database. Fresh blood products are comprised of red cells, platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma.

Males accounted for 54.9% (n=84) of patients involved in confirmed blood management clinical incidents in 2019/20, with females making up 45.1% (n=69; missing gender n=9). The age of patients affected ranged from 0-96 years with a median age of 59 years.

ATSI persons accounted for 8.2% (n=12; missing ATSI status n=15) of patients involved in confirmed blood management clinical incidents in 2019/20 (see Figure 64).

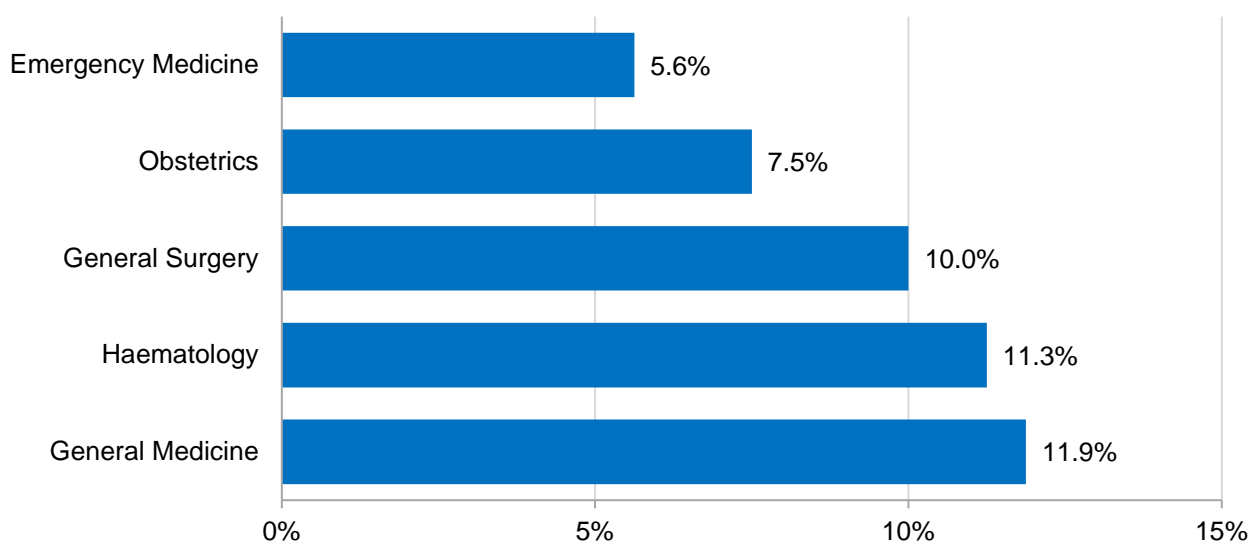
Figure 64: Percentage of Patients Involved in Confirmed Blood Management Clinical Incidents by Age Group and ATSI Status for 2019/20



Note: Patient age and/or ATSI status missing data n=15; a clinical incident may affect multiple patients

The top five treating specialties that reported blood management clinical incidents accounted for 46.3% (n=74) of confirmed incidents during 2019/20. The General Medicine specialty reported the highest number of blood management clinical incidents (n=19; 11.9%) followed by Haematology (n=18; 11.3%) and General Surgery (n=16; 10.0%; see Figure 65).

Figure 65: Percentage of Confirmed Blood Management Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=30; 18.8%

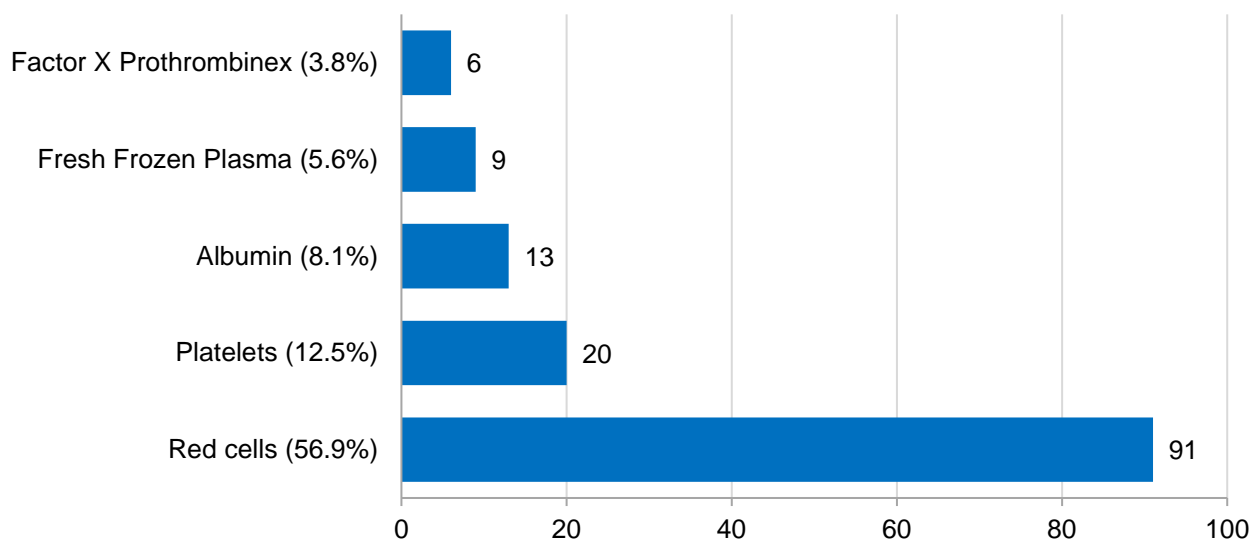
The five most frequent blood management clinical incident Tier Three categories accounted for 40.6% (n=65) of confirmed blood management clinical incidents in 2019/20 (see Table 30). Blood or blood products were administered at the incorrect rate or frequency in 11.9% (n=19) of confirmed blood management clinical incidents in this period, and a delay in the delivery of blood or blood products was reported in 8.8% (n=14) of confirmed incidents.

Table 30: Frequency and Percentage of Top Five Tier Three Confirmed Blood Management Clinical Incident Categories for 2019/20

Tier Three Blood Management Categories	(n)	(%)
Incorrect rate/frequency of administration	19	11.9
Product delivery to ward/unit delayed	14	8.8
Product contraindicated for patient	13	8.1
Not given when indicated/administration delayed	10	6.3
Insufficient/incomplete monitoring during administration	9	5.6
Total	65	40.6

The types of blood product most frequently associated with confirmed blood management clinical incidents in 2019/20 are shown in Figure 66. Red cells were involved in more than half of these incidents (n=91; 56.9%), and accounted for 63.9% of fresh blood products used in WA’s public hospitals during this period, while platelets were involved in 12.5% (n=20) of confirmed blood management incidents, and comprised 14.4% of fresh blood product usage.

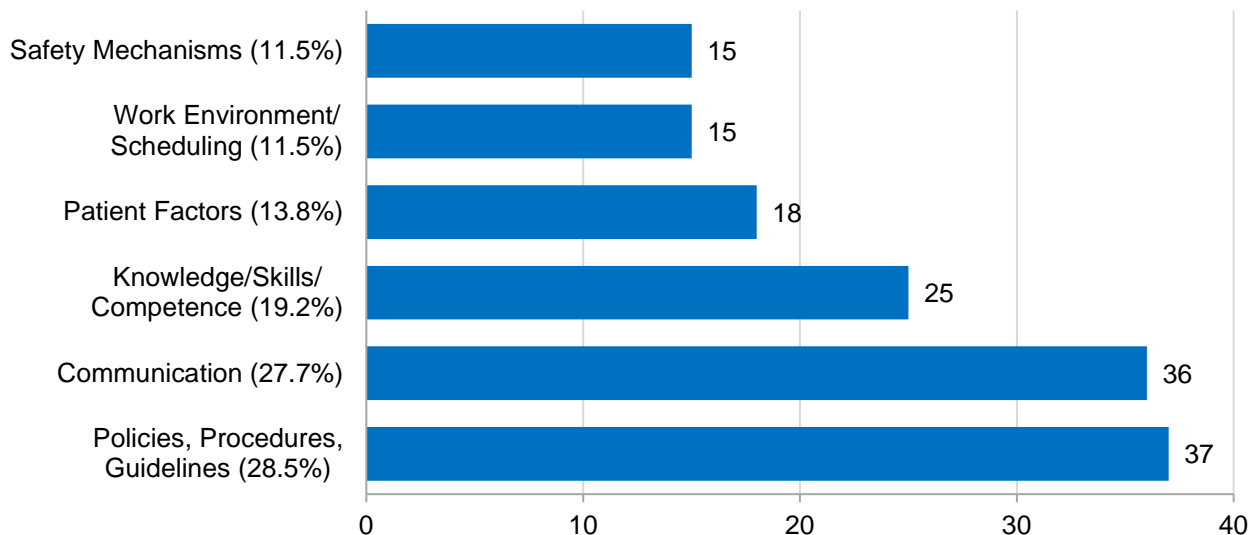
Figure 66: Frequency and Percentage of the Top Five Product Types for Confirmed Blood Management Clinical Incidents for 2019/20



Notes: A blood management clinical incident may relate to more than one type of product. The Datix CIMS allows the capture of other product types in addition to fresh blood products. Blood usage data was provided by PathWest from the ULTRA database. Fresh blood products are comprised of red cells, platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma.

The most common contributory factor identified in closed blood management clinical incidents in 2019/20 was issues with policies, procedures and guidelines (n=37; 28.5%; see Figure 67). The next most frequent contributory factor was communication issues which were identified in 27.7% (n=36) of blood management clinical incidents investigated.

Figure 67: Frequency and Percentage of the Top Five Contributory Factors for Closed Blood Management Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

Where contributory factors related to policies, procedures and guidelines were found, these were most often identified as issues with their application (n=20; 54.1%), or implementation issues (n=8; 21.6%). Where communication issues occurred, problems with communication between staff members was most often identified (n=28; 77.8%), followed by documentation issues (n=14; 38.9%).

Key Messages and Information: Blood Management Clinical Incidents

While the number of blood management clinical incidents reported in the WA health system continues to be relatively small, and the harm resulting from those incidents remains low, their significance should not be underestimated, nor the value in investigating them to determine what actions can be taken to avoid them in the future.

In 2019/20, the most frequently identified Tier Three category of blood management clinical incident related to incorrect rate or frequency of administration (n=19) and these included incidents where blood or blood products were administered faster or slower than intended.

The administration of blood and blood products to critically unwell patients can be both life-saving and time-critical. In 2019/20, two blood management clinical incidents reported a patient outcome of serious harm and both were associated with a delay in administration related to the time taken to deliver the blood products to the patient.

The first case involved a patient with an upper gastrointestinal bleed. The site reviewed the processes for Life Threatening Urgent Blood supply and made recommendations to improve the response time of these processes. The site also identified the value of simulation exercises to test and fine tune efficiencies related to the processes.

The second case related to a very preterm birth with maternal uterine rupture where blood was urgently requested for the baby, but supply was delayed. A faulty piece of equipment was found to have contributed to the delay in supplying the blood and was replaced. The review found that even if the delay had not occurred it was not likely that the baby would have survived. The National Blood Authority provides guidance to sites related to critical bleeding in its Patient Blood Management Guidelines available at: <https://www.blood.gov.au/pbm-module-1>.

In 2019/20, there were also three SAC 1 incidents related to wrong blood events where the patient received blood labelled for a different patient. These events have the potential to cause serious harm to patients through the transfusion of ABO incompatible blood. These incidents all related to collection/issue of blood from the Transfusion Laboratory, with bedside checks failing to identify the primary errors prior to transfusion. This emphasises the importance of robust bedside checking processes, as this is the final point to detect errors and omissions.



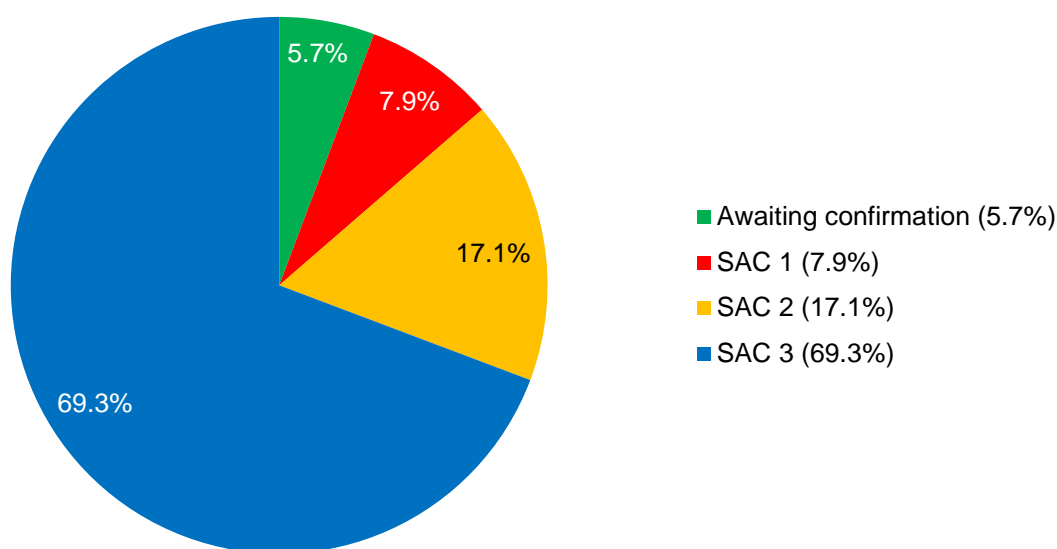
Standard 8: Recognising and Responding to Acute Deterioration Clinical Incidents

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. Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates in hospital.³ Appropriate action in response to acute deterioration may include rapid escalation of care, for example to a high dependency unit (HDU) or intensive care unit (ICU).

Standard 8 of the second edition of the NSQHS Standards relates to recognising and responding to clinical deterioration in acute health care and its intention is to ensure that a person's acute deterioration is recognised promptly, and appropriate action is taken. In the second edition of the NSQHS Standards acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.³

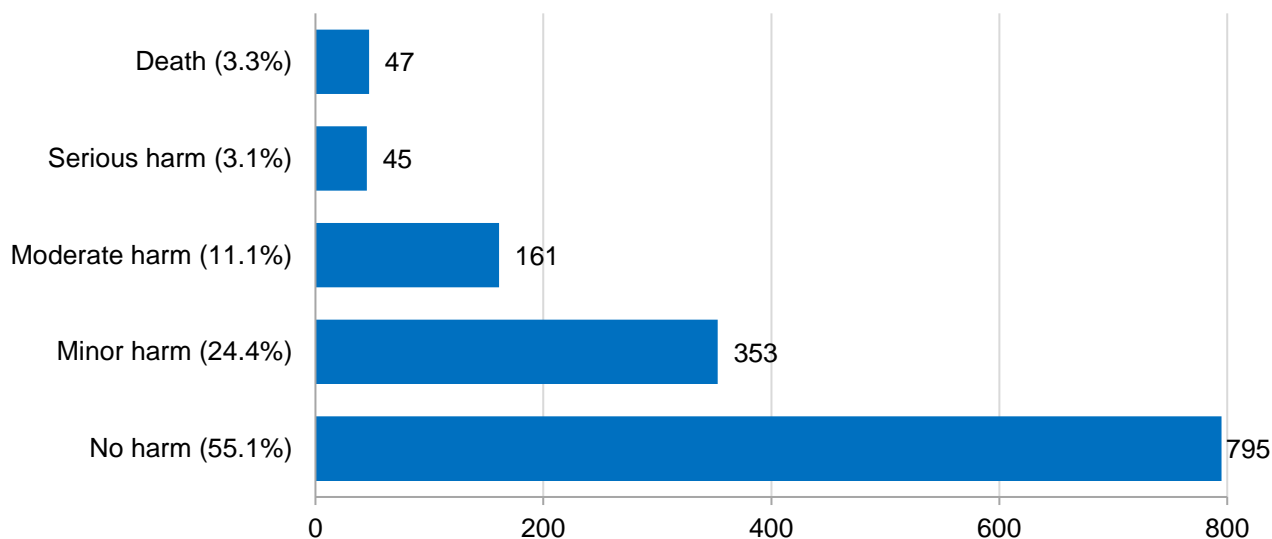
Acute clinical deterioration incidents are captured under several Tier Three categories in Datix CIMS⁸ as well as the SAC 1 categories of "Delay in recognising/responding to physical clinical deterioration" and "Clinical deterioration of a mental health patient resulting in serious harm (physical, verbal, or sexual), or death or serious harm to staff, other patients or other persons". In the 2019/20, there were 1,532 acute clinical deterioration clinical incidents notified with 1,444 incidents confirmed, and the remaining 88 awaiting SAC confirmation at the time of this report. Acute clinical deterioration incidents were most frequently categorised as SAC 3 (n=1,061; 69.3%), followed by SAC 2 (n=262; 17.1%) and SAC 1 (n=121; 7.9%; see Figure 68). Acute clinical deterioration incidents accounted for 4.6% of all clinical incidents notified in this period.

Figure 68: Percentage of Acute Clinical Deterioration Clinical Incidents by SAC Rating for 2019/20



Reviewing patient outcomes from confirmed acute clinical deterioration clinical incidents shows the most frequently reported outcome was no harm to the patient (n=795; 55.1%), followed by minor harm (n=353; 24.4%; see Figure 69). A patient outcome of death was described in 3.3% (n=47) of confirmed acute clinical deterioration incidents in 2019/20, highlighting the risk to patients posed by delays in recognising and/or responding to acute clinical deterioration.

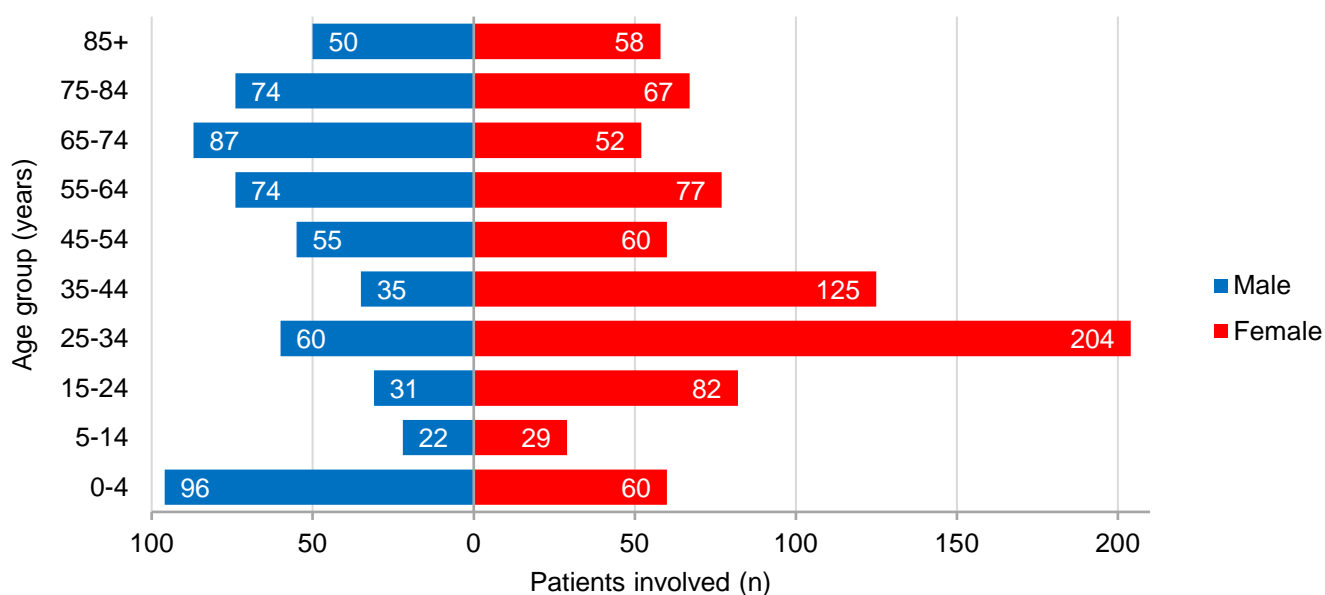
Figure 69: Frequency and Percentage of Confirmed Acute Clinical Deterioration Clinical Incidents by Patient Outcome for 2019/20



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

Females accounted for 58.2% (n=834) of patients involved in confirmed clinical deterioration incidents in 2019/20, with males making up 41.8% (n=599; missing gender n=31). Patients ranged in age from 0-104 years with a median age of 40 years. Clinical deterioration incidents occurred most often in patients aged 25-34 years (n=264) and 35-44 years (n=160), and more than three-quarters (n=329) of these patients were female (see Figure 70).

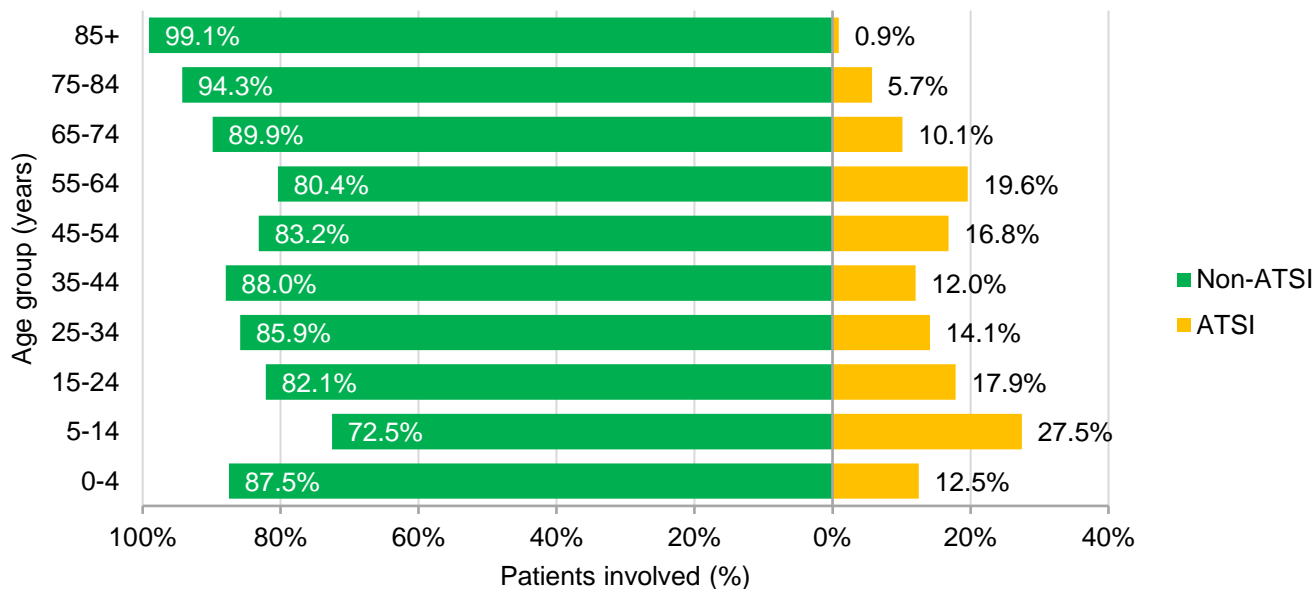
Figure 70: Frequency of Patients Involved in Confirmed Acute Clinical Deterioration Clinical Incidents by Age Group and Gender for 2019/20



Note: Patient age and/or gender missing data n=66; a clinical incident may affect multiple patients

ATSI persons accounted for 13.1% (n=181; missing ATSI status n=81) of patients involved in confirmed acute deterioration clinical incidents in 2019/20. Figure 71 shows the highest proportion of ATSI patients involved was in the 5-14 years age group (27.5%), followed by the 55-64 years age group (19.6%).

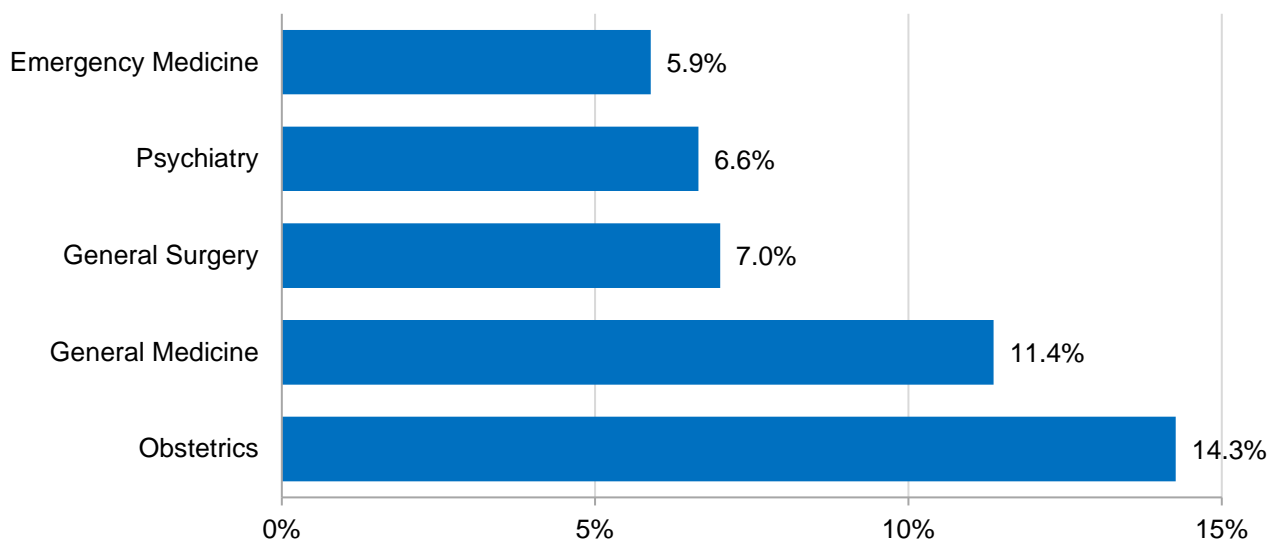
Figure 71: Percentage of Patients Involved in Confirmed Acute Clinical Deterioration Clinical Incidents by Age Group and ATSI Status for 2019/20



Note: Patient age and/or ATSI status missing data n=82; a clinical incident may affect multiple patients

The treating specialties that reported acute clinical deterioration incidents most frequently in 2019/20 are shown in Figure 72. These specialties accounted for 45.2% (n=652) of all confirmed acute clinical deterioration incidents reported in this period. The Obstetrics specialty reported the highest number of acute clinical deterioration incidents (n=206; 14.3%), followed by General Medicine (n=164; 11.4%), and General Surgery (n=101; 7.0%).

Figure 72: Percentage of Confirmed Acute Clinical Deterioration Clinical Incidents by Top Five Treating Specialties for 2019/20



Note: Treating specialty missing data n=291; 20.2%

The five most frequent acute clinical deterioration Tier Three incident categories accounted for 86.8% (n=1,253) of all confirmed acute clinical deterioration incidents in 2019/20 (see Table 31). Failure to monitor or incomplete or insufficient monitoring of the patient during or after treatments or procedures was the most frequent category of acute clinical deterioration incident reported, accounting for 45.8% (n=661) of confirmed incidents in this period.

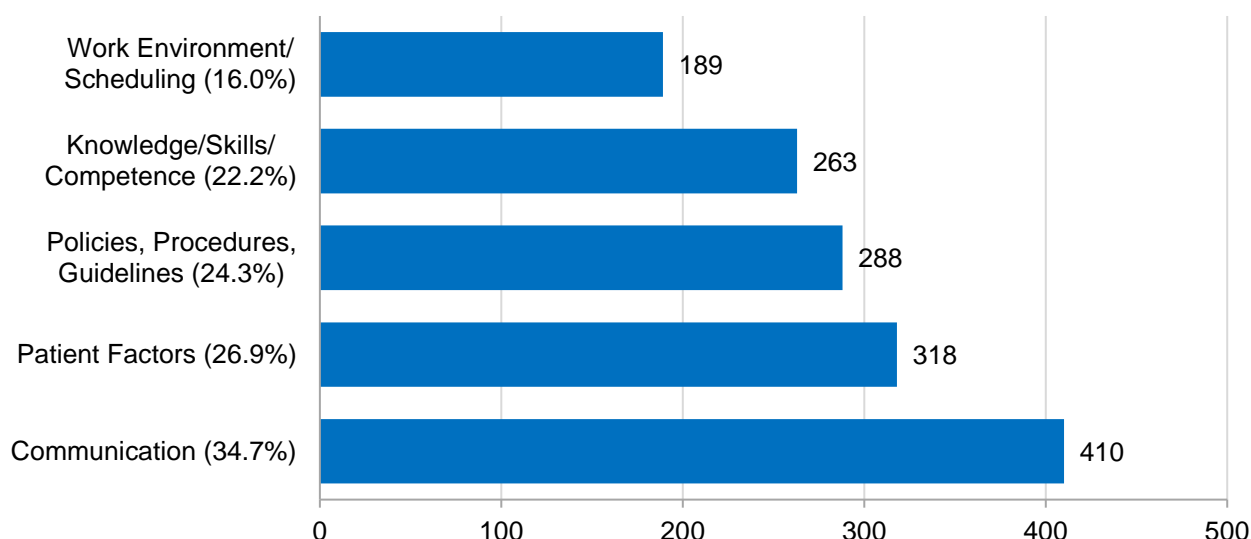
Table 31: Frequency and Percentage of Top Five Tier Three Confirmed Acute Clinical Deterioration Clinical Incident Categories for 2019/20

Tier Three Acute Clinical Deterioration Categories	(n)	(%)
Failure/insufficient/incomplete monitoring	661	45.8
Failure/insufficient recognition of significant change in patient status	174	12.0
Failure/insufficient response to significant change in patient status	171	11.8
Unplanned transfer of care to other institution or clinical service	164	11.4
Unplanned elevation of care to intensive care setting	83	5.7
Total	1,253	86.8

Communication issues were identified as a contributory factor in 34.7% (n=410) of closed acute clinical deterioration clinical incidents in 2019/20 (see Figure 73). Problems with communication between staff members were identified in 70.5% (n=289) of these incidents.

The next most frequently cited contributors to these incidents were patient factors, which were identified in 26.9% (n=318) of incidents investigated, and issues related to policies, procedures and guidelines, which were identified in 24.3% (n=288).

Figure 73: Frequency and Percentage of the Top Five Contributory Factors for Closed Acute Clinical Deterioration Clinical Incidents for 2019/20



Note: A clinical incident investigation may identify multiple contributory factors

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

Early recognition and a timely response when a patient's clinical condition worsens can minimise the subsequent need for higher-level and more stressful interventions to stabilise the patient. The Department of Health's *Recognising and Responding to Acute Deterioration Policy*⁴⁹ sets the minimum requirements, to be implemented by HSPs through the development of local evidence-based policies, to facilitate the early recognition and response to acute deterioration (including physiological and mental state deterioration) for all inpatients in WA's public health system.

The second edition of the NSQHS Standards recognises the importance of deterioration related to cognition and mental state, and there is an increased focus on partnering with consumers in decision making, which is especially applicable when a patient deteriorates. It is essential that the treating team is aware of the patient's and their family's plan and wishes for health care through tools such as Goals of Patient Care⁵⁰ and Advance Health Directives.⁵¹

The broadening of the second edition of the NSQHS Standards to include both mental and physical aspects of health in the Recognising and Responding to Acute Deterioration Standard has, as expected, resulted in an increase in the number of clinical incidents that relate to acute deterioration being identified in 2019/20 (n=1,532 compared to 869 incidents in 2018/19). It was also observed that this Standard contained the highest proportion of incidents confirmed as SAC 1 (7.9%) and the highest number of incidents that reported a patient outcome of death (n=47) in 2019/20, highlighting the risks to patients that exist when acute clinical deterioration is not recognised or responded to in an appropriate or timely manner.

The Obstetrics specialty continued to report the highest number of clinical incidents related to recognising and responding to acute deterioration in 2019/20. While there was a decrease in the proportion of acute deterioration incidents reported by this specialty (from 22.1% in 2018/19 to 14.3% in 2020), the number of incidents reported increased (from 188 incidents in 2018/19 to 206 incidents in 2019/20). Fortunately, most of these incidents reported that no harm or minor harm occurred to the patient (n=157; 76.2%).

This specialty area of the WA health system has resources to assist with recognising and responding to clinical deterioration in a timely manner, including clinical practice guidelines⁵² designed for both hospital and community settings, and the *Cardiotocography Monitoring Policy*.⁵³ This policy, which sets the state-wide minimum requirements to monitor and identify signs of fetal compromise, has seen a larger focus placed on identifying the clinical signs of fetal deterioration across WA's public health system, however more needs to be done to effectively implement this policy, as shown by the following case.

⁴⁹ The Recognising and Responding to Acute Deterioration Policy is available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Recognising-and-Responding-to-Acute-Deterioration-Policy>

⁵⁰ Further information about Goals of Patient Care is available at: https://ww2.health.wa.gov.au/Articles/F_I/Goals-of-patient-care

⁵¹ Further information about Advance Health Directives is available at: https://www.healthywa.health.wa.gov.au/Articles/A_E/Advance-Health-Directives-in-practice

⁵² King Edward Memorial Hospital Obstetrics & Gynaecology Acute deterioration (adult): Resuscitation and life support Clinical Practice Guidelines available at: <https://www.kemh.health.wa.gov.au/For-health-professionals/Clinical-guidelines/OG>

⁵³ The Cardiotocography Monitoring Policy is available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Cardiotocography-Monitoring-Policy>

A woman presented at 41 weeks and 1 day of pregnancy with no fetal heartbeat and fetal death in utero was confirmed. The woman had presented three days earlier and there were concerns over a non-reassuring CTG although a fetal heartbeat had been detected. A plan was made for the induction of labour, but the fetus died before the induction took place. The SAC 1 investigation recommended specialist training and the purchase of bedside ultrasound equipment to assist in the prevention of fetal harm.

Through review of the acute deterioration clinical incidents in 2019/20 that reported a patient outcome of death, five cases related to clinical deterioration associated with sepsis were identified. In June 2019, local clinicians participated in a High Value Health Care Workshop which identified sepsis as a priority area. This raised the need for WA health care providers to manage patients who present with sepsis via a sepsis pathway. Such a pathway would alert clinicians to the likelihood of sepsis and the need to escalate the patient's care to prevent deterioration and collapse. A WA Sepsis Working Group was established to share knowledge on approaches for improving sepsis diagnosis and management. The risk posed to patients by sepsis is shown by the following case.

A woman in her early-sixties was admitted to hospital with back pain. The woman's condition deteriorated very quickly, and despite escalation of her care to an HDU and then an ICU, she died three days after admission. The investigation found that the woman had a history of rheumatoid arthritis for which she was taking medication that suppressed her immune system. The immunosuppressive medication was not seen as a risk for sepsis and the woman was not assessed on a sepsis pathway. The hospital reviewed its escalation of care procedures and increased awareness of immunosuppression as a risk factor for sepsis amongst the staff.



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 CLU reviews health related findings from coronial inquests and allocates these to appropriate stakeholders for consideration and implementation of recommendations. This information drives quality improvement in health care which supports the provision of a high standard of health care. Health Service Providers and other stakeholders provide advice and comments on coronial findings and an account of actions taken to improve patient safety. This feedback is communicated to the State Coroner in a biannual progress report. The executive summaries of the biannual reports can be accessed online at: https://ww2.health.wa.gov.au/Articles/A_E/Coronial-Liaison-Unit.

Table 32 provides a summary of WA health system activity and response to coronial inquests and recommendations for the last three 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 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 32: Overview of Coronial Liaison Unit Activity for 2017/18 to 2019/20

	2017/18	2018/19	2019/20
Total number of health-related coronial inquest findings received by CLU	21	40	17
Total number of health-related recommendations (including mental health) ⁵⁴	7	30	9
Number of general health related recommendations	7	2	-
Number of general health related recommendations completed/closed ⁵⁵	7	2	-
Number of mental health related recommendations	-	28	9
Number of mental health related recommendations completed/closed ⁵⁵	-	28	4

The Coronial Review Committee (CRC) was established in January 2014. The CRC operates closely with the CLU and provides a mechanism for recommendations and/or coronial inquest findings to be considered in a collaborative manner with key stakeholders across the WA health system. The CRC exists to improve the governance and decision-making in relation to the state-wide implementation and response to coronial recommendations. The CRC members review and endorse the sharing of the WA health system's progress against coronial recommendations in the biannual progress report to the Coroner.

⁵⁴ 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).

⁵⁵ Status as at most recent report to the State Coroner (August 2020). Completed actions are recorded in the year that the findings were released, rather than year of completion.

The following synopses are provided for coronial inquests where the coroner's recommendations and/or findings have implications for the WA health system and where findings have been released from 1 July 2019 to 30 June 2020 (the month and year that each of the findings were released are noted in brackets). All HSPs are encouraged to use these summaries to raise awareness of important messages to facilitate continuous quality improvement. Full inquest findings can be accessed at the Office of the State Coroner's website: <https://www.coronerscourt.wa.gov.au/>.

Mr C (July 2019)

Mr C was a 45-year-old man who was diagnosed with, and treated for, smoking-related chronic obstructive pulmonary disease (COPD) while in prison. Years later, while still serving his sentence in prison, he was admitted to an Emergency Department for infective exacerbation of his chronic lung disease. He deteriorated and advised that he wanted palliation. A week later, he died with his family present after he received a release from prison under the royal prerogative of mercy earlier that day.

The Coroner found that Mr C died by way of natural causes from severe COPD and was satisfied that the treatment and care provided was reasonable and appropriate.

Ms N (July 2019)

Ms N was on remand in prison when she died by way of suicide. While in prison, she was referred for counselling sessions with a psychologist as well as psychiatric review. She made several self-harm attempts, mostly ingesting cleaning products.

The preferred option for management was to provide long term psychological therapy. Transfer to the State's only forensic mental health unit was considered but deemed not to be safe or of therapeutic value, as it is overcrowded, has high turnover, and is mostly filled with male patients who have psychotic disorders and a history of violence and sexual offences.

Sentencing was adjourned twice while she was in prison due to delays in finalising psychiatric assessment reports, and a few days after the second adjournment she completed suicide, leaving notes to family members finalising her affairs and saying goodbye. It was noted that court-ordered pre-sentence psychological and psychiatric reports are regarded as confidential, and thus not shared with prison clinicians who provide care and treatment.

The Coroner made two recommendations relating to improving the mental health resources at the prison. A third recommendation was made to allow medical and nursing staff who are treating remand and sentenced prisoners access to information which will assist them to provide a better level of care and treatment.

Mr F (July 2019)

Mr F was a 38-year-old man who was subject to a community treatment order (CTO) under the *Mental Health Act* and took his own life after a long history of mental illness.

In the week leading up to his death, Mr F and his mother presented to a regional hospital as his mental health had deteriorated. He was discharged home with follow up organised. During the week, members of his family reported their concerns about his mental health to the regional mental health service and other agencies. Mr F was reviewed by a doctor but did not meet the criteria for involuntary admission to the acute psychiatric unit (APU).

On the night of his death, Mr F had dinner with family and after returning home, sent a goodbye message to his brother. Worried, his mother and brother broke into his house with help from police and ambulance officers. They found him dead in his bedroom.

The Coroner found that the death occurred by way of suicide. The Coroner noted that since Mr F's death there have been improvements to the regional mental health service's record keeping systems. In addition, emergency action plans had been introduced and peer workers had been employed to support mental health consumers, their carers and families. The Coroner did not make any recommendations and considered that the supervision, treatment and care provided to the deceased in the period prior to his death were adequate.

Mr B (July 2019)

At the time of his death, Mr B was a 59-year-old sentenced prisoner. He had a medical history of diabetes, severe cardiac disease and chronic renal failure. Mr B was on the Department of Corrective Service's terminally ill register.

Shortly after Mr B was admitted to prison he suffered a cardiac arrest. His medication was adjusted but his condition deteriorated requiring ongoing treatment and investigations. During Mr B's two years in prison, he was taken to hospital approximately 40 times.

After complaining of being unwell for two days prior, the prison nurse and doctor reviewed Mr B and he was admitted to hospital for further assessment. He was transferred from the emergency department to the intensive care unit with acute-on-chronic renal failure requiring dialysis, possibly precipitated by recent contrast CT and compounded by taking nephrotoxic medications. Cardiogenic shock/low cardiac state was also diagnosed. Despite treatment, Mr B deteriorated and died.

The Coroner investigated the administration of contrast media and its contribution to his cardiac failure. While it was deemed to have contributed, the main factor was concluded to be the significant underlying heart disease and the death was found to have occurred by way of natural causes.

The Coroner was satisfied that the treatment and care in prison was timely and appropriate and noted changes in the hospital's procedures for patients receiving a CT scan to reduce the development of contrast-induced kidney injury. The Coroner made no recommendations.

Mr O (July 2019)

Mr O was subject to a CTO because he had little insight into his mental illness and lacked capacity to make sound treatment decisions.

Mr O had a long history with mental health services and was generally stable when compliant with his medications. He also had a number of risk factors for cardiovascular disease, but the terms of the CTO did not authorise mental health staff to compel him to undergo investigations into his cardiovascular health.

After receiving a call from Mr O's friend to say she had received no response when trying to visit him, Mr O's mother went to his home to find him lying on the floor. Ambulance officers confirmed he had died.

The Coroner concluded that Mr O's lifestyle choices played a significant role in his unexpected and premature death and found the deceased died of natural causes. The Coroner made no

recommendations and found the supervision, treatment and care that the deceased received from the mental health service while he was the subject of a CTO was of a very good standard.

Child KT (July 2019)

Child KT was a 7-year-old boy who was in the care of the Department of Child Protection and Family Services at the time of his death.

A few weeks after his birth, he was diagnosed with spastic quadriplegia, cerebral palsy and developmental delay. Due to his high care needs his mother found it difficult to care for him and manage her other children so he was placed into the care of the Department of Child Protection and Family Services. When he wasn't at the hospital, he lived with foster parents and they were assessed to have provided an excellent level of care for him.

Child KT suffered from chronic respiratory disease and was admitted several times to the paediatric ICU. After several acute respiratory events, a decision was made that he could not receive invasive surgery and would receive palliative care. After a period of good health, he was admitted to hospital and deteriorated over the next month before passing away in hospital.

The Coroner found that the supervision, treatment and care provided to Child KT was of a very high level and made no recommendations.

Mr C (August 2019)

Mr C was an involuntary inpatient at the time of his death. He died from multiple organ failure and pulmonary thromboemboli complicating generalised sepsis.

Mr C had an unconventional belief system and he was taken to hospital via ambulance after refusing medical treatment. At hospital he was assessed by a psychiatrist where it was found that he had a psychotic illness and was placed on an Inpatient Treatment Order.

As his medical condition worsened, Mr C was transferred to the acute medical unit and the ICU. He suffered a cardiac arrest and attempts to resuscitate him were unsuccessful.

The Coroner was satisfied with the supervision, treatment and care provided to Mr C and no recommendations were made.

Ms B (August 2019)

Ms B was a 44-year-old remand prisoner at the time of her death. She died in hospital from acute myocardial infarction due to a coronary thrombosis.

Ms B developed mild chest pains while eating dinner in prison and prison staff were alerted. Upon review in the prison medical centre, she suddenly felt severe chest pain and nurses suspected a heart attack, so an ambulance was arranged to transfer her to hospital.

Ms B had a ventricular fibrillation (VF) arrest while leaving the prison and ambulance officers were able to revive her. In hospital she went into VF arrest again several times and the angiography suite team borrowed a LUCAS mechanical chest compression device from the ambulance. This device allowed for continuous cardiopulmonary resuscitation (CPR) while x-rays were being performed. Despite attempts at clot extraction and stent placement, she did not survive.

While the Coroner's inquest focused on the care provided at the prison medical centre, the care Ms B received in hospital was also reviewed. As ongoing CPR was needed, the angiography

services borrowed a mechanical chest compression device as they did not have one of their own. In light of this, the Coroner urged relevant health services to consider purchasing mechanical chest compression devices for their respective angiography services.

All three WA public health services with angiography services have reported that their sites now have access to mechanical chest compression devices.

Mr C (August 2019)

Mr C was a 69-year-old man who died of chronic obstructive pulmonary disease and coronary artery atherosclerosis in a mental health unit while he was an involuntary patient.

Mr C had increasingly treatment-resistant bipolar affective disorder since early adulthood. He had limited insight into his illness and developed significantly disabling Parkinsonism as the result of long-term depot antipsychotic medications. He had a number of chronic co-morbidities and continued to smoke heavily throughout his life.

Mr C's last admission to a mental health unit lasted for several years. He was assessed as needing high-level care for physical frailty as well as psychiatric care. A trial of respite in an aged care facility was initially successful but attempts to care for him in the open unit were not successful as he refused medications, returned to his home in the community, and relapsed despite assertive community follow-up.

He was transferred back to the mental health unit where he later died after an episode of breathlessness, despite resuscitation efforts that were in line with agreed upon goals of care.

The Coroner was satisfied that the overall level of care provided was of very good standard, but that the deceased's social and emotional well-being were not optimal due to his long-term residence in an involuntary institutional setting instead of an appropriately configured and resourced facility providing supported accommodation. A recommendation was made relating to improving long term supported accommodation for mental health patients in the Kimberley.

Mr R (September 2019)

Mr R was a 16-year-old who died of a pulmonary embolism in hospital.

He was diagnosed with paediatric nephrotic syndrome when he was six years old. Mr R received medical treatment successfully throughout his frequent relapses over the years.

During a relapse period, Mr R was taken to hospital after becoming increasingly unwell. He was transferred to the ICU for treatment and was diagnosed with probable massive pulmonary embolus. He was given treatment, but his condition did not improve. Mr R went into cardiac arrest and was unable to be resuscitated.

The Coroner discussed the delay in diagnosis of the pulmonary embolism and highlighted the importance of doctors keeping an open mind and constantly re-evaluating their diagnosis of symptoms. Experts were consulted, and the Coroner concluded that the unusual complication of a massive pulmonary embolism in Mr R's case was extremely rare and unexpected. The Coroner made no adverse comments or findings.

Mr S (September 2019)

Mr S was a 30-year-old man who died by way of suicide less than a fortnight after being discharged from a mental health unit.

Mr S had chronic major depression with anxiety and episodic interactions with mental health services. He was living with his supportive family. Stress over university exams and a relationship break-up resulted in an exacerbation of depression with increased attempts at self-harm. He was referred to hospital and voluntary admission to a mental health unit was agreed upon.

Unfortunately, the mental health unit that he had spent time in previously was full, and to avoid a prolonged stay in the emergency department, admission to a hospital in a different area was arranged.

During the 18-day admission, no family meeting was held despite his parents' requests for one, their daily presence on the ward, and extensive involvement in the deceased's care. It was documented that consent was given for collateral history to be obtained from family five days after admission. No rationale for not holding a family meeting was documented. Mr S was discharged home shortly after undergoing a change in medication. No formal follow-up in the community was arranged for him. Over a week later, he completed suicide at his home. Resuscitation attempts were unsuccessful.

The Coroner reviewed the care provided in hospital, in particular the lack of a documented safety plan, the absence of further risk assessment after an attempt at self-harm while on the ward, the absence of documentation around Mr S' alleged requests not to involve his family in his care, the inadequacy of discharge planning, and failure to arrange follow-up. The Coroner concluded that, when viewed globally, the care provided at the hospital was suboptimal.

The Coroner made six recommendations, of which five were directed to the health service and one to the Office of the Chief Psychiatrist. The recommendations focused on the discharge planning procedures and suggested amendments to relevant mental health policies to include requirements to ensure the discharge planning process includes information about follow-up appointments, contact details for support services, and the process for re-entry to health services if needed. The recommendations also included developing strategies to ensure staff were familiar with the relevant policies and examine the feasibility of establishing a post discharge follow-up team.

Mr M (December 2019)

Mr M was a 46-year-old man who died as a result of cardiac arrhythmia on the background of significant pre-existing heart disease. He was an involuntary patient at the time, suffering a relapse of bipolar affective disorder with psychotic features.

Mr M had a background of metabolic syndrome, including obesity, hypertension, type 2 diabetes and raised cholesterol. Medical examination and ECGs on admission and the day before his death revealed no obvious cardiac abnormalities.

He had previously threatened to burn down the ward if admitted as an involuntary patient due to not being allowed to smoke while on the locked ward. Despite being offered nicotine replacement therapy, he became agitated and aggressive to staff. Intramuscular clonazepam was administered without effect, then he was placed in seclusion for several hours.

When he agreed to take medications, he was allowed to return to his bedroom for the night. Half-hourly visual observations were conducted, and he was noted to settle and sleep. Mr M was seen snoring at 06:30 the next morning, but 15 minutes later when staff attempted to rouse him he was unresponsive. Resuscitation attempts were unsuccessful.

The Coroner made one recommendation for additional measures to be implemented for patients to have pulse oximetry in a psychiatric setting, where a patient is cooperative to its use. This would assist staff to monitor patients who have recently been agitated and then sedated. The Coroner found the medical care was of a generally high standard.

Mr W (February 2020)

Mr W was a 37-year-old man who died from valvular and ischaemic heart disease. He was a sentenced prisoner at the time of his death.

During his time in prison, he reported pains in his chest and was diagnosed with heart failure. He was transferred to hospital for review and treatment. Surgery was planned to address his serious heart condition and he was cared for in the prison infirmary while waiting for the surgery. Unfortunately, while in theatre for the surgery but before the procedure began, Mr W developed a life-threatening heart rhythm disturbance. He developed further complications while being treated and died during surgery.

The Coroner was satisfied that the hospital provided a high standard of care and the supervision, treatment and care while in custody was reasonable and made no recommendations.

Mr H (March 2020)

Mr H was a sentenced prisoner at the time of his death. He died of metastatic carcinoma of the lung.

During his time in prison, Mr H was diagnosed with COPD. His scheduled medical reviews were reduced significantly, and no follow-up was provided for years until he was taken to hospital when he experienced respiratory difficulties.

A chest scan showed a large tumour, and after further investigations he was diagnosed with lung cancer. Over the following months Mr H received palliative care and was admitted to a palliative care unit when it was apparent his death was imminent. He was kept comfortable and he passed away the next day.

The Coroner noted the internal review of Mr M's care in prison and was satisfied with the improvements to the prison health services that were reported by the Department of Justice. The increased prompt for medical reviews with an emphasis on preventative health was noted to be a good improvement.

Ms K (April 2020)

Ms K was a 67-year-old woman who was being held on remand in prison at the time of her death. She died of the combined effects of bronchopneumonia and acute liver failure.

Ms K had extensive chronic health issues and surgical history. Ms K was referred to a hepatology clinic in hospital after blood tests showed she had a low blood count that was possibly related to liver disease. Records show that an appointment was made for Ms K to see a liver specialist but there is no record that notification of that appointment was received by the prison. Unfortunately, medical staff at the prison did not follow up on the referral.

Ms K fell heavily in the doorway of her cell. She was taken to hospital, where she was found to have fractured the neck of her left femur, and this was surgically repaired. During her admission, Ms K was treated for a decline in her brain function caused by her severe liver disease (hepatic encephalopathy).

The palliative care team reviewed Ms K and she was not a suitable candidate for hospice care because of her variable mental state. Ms K received palliative care and remained largely unconscious over the next few weeks. Her condition continued to deteriorate until her death.

The Coroner found that Ms K's clinical care in hospital was of a high standard and was satisfied that the supervision, treatment and care that she received while she was in custody was adequate. One recommendation was made to the Department of Justice to ensure that referrals of prisoners to external agencies are appropriately actioned.

Mr C (April 2020)

Mr C was a 66-year-old man who was a sentenced prisoner when he died from bronchopneumonia.

Mr C's medical history included bowel polyps, prostate cancer and numerous cancerous skin lesions. Mr C had a Merkel cell carcinoma removed from his head years before his imprisonment. When the cancer returned during his time in prison, it was removed but he declined chemotherapy and radiotherapy despite being told the cancer could recur without it.

Years later, a lump on top of his head was reviewed by the prison nurse and doctor. Mr C declined further investigation when the prison medical staff suspected a recurrence of the cancer. His condition deteriorated, and he was placed on the terminally ill register in prison. When his condition worsened, he was placed into palliative care until his death.

The Coroner was satisfied with the standard of supervision, treatment and care provided while Mr C was in custody.

Mr B (April 2020)

Mr B was a 52-year-old man who died from ischaemic heart disease. He was a sentenced prisoner at the time of his death.

Mr B was transferred from a NSW prison to a WA prison. The medical history provided on transfer was not comprehensive, and he wasn't placed on his usual cholesterol lowering medication upon admission to prison in WA.

Upon review by a cardiologist, Mr B declined the treatment plan and suggested a change to his medication. He subsequently presented to the prison medical centre after feeling unwell and was taken to hospital. He went into cardiac arrest in hospital and was successfully defibrillated. He was sent to another hospital for urgent treatment but before that could be provided, he went into cardiac arrest. Despite concerted efforts he was unable to be resuscitated.

The Coroner was satisfied that the standard of supervision, treatment and care provided to Mr B while he was in custody was adequate and made no recommendations.

Review of Death

In January 2019, the updated *Review of Death Policy*⁵⁶ took effect in the WA health system. The ROD Policy revision considered local, national and international literature regarding approaches to delivering effective mortality reviews and included consultation with stakeholders across the WA health system.

The purpose of the updated ROD Policy is to ensure that public health care providers and private licensed health care facilities 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 Policy* (if this has not already occurred). The ROD 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).

To support the implementation of the updated ROD Policy, the PSSU also created the *Review of Death Guideline*. This includes information to assist health care 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 public health care providers and private licensed health care facilities showed there were 7,190 patient deaths that fell within the scope of the ROD Policy between 1 January and 31 December 2019, and that 94.7% (n=6,812) of these deaths were reviewed within four months of the date of death (see Table 33). This data represents the first reporting under the updated ROD Policy that commenced in January 2019.

Table 33: Review of Death Indicator for 2019

Indicator	Outcome
Percentage of deaths with a completed review within four months of the date of death (for deaths that occurred between 1/1/2019 and 31/12/2019)	94.7%

Note: Data includes public and private hospitals. 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 ROD Policy and are excluded from this data.

Public and private hospitals are also required to indicate whether SAC 1 clinical incidents are notified as an outcome of a mortality review process conducted under the ROD Policy. Between 1 January and 31 December 2019, hospitals reported 12 patient deaths were notified as SAC 1 clinical incidents following mortality review.⁵⁷

⁵⁶ The Review of Death Policy and supporting materials are available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Review-of-Death-Policy>

⁵⁷ The number of patient deaths notified as SAC 1 clinical incidents following mortality review is not comparable to previous editions of this report due to changes in the data collection methodology and reporting period.



Western Australian Audit of Surgical Mortality

The Western Australian Audit of Surgical Mortality⁵⁸ 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*. All deaths that occur in WA hospitals (including private hospitals) where the patient was under the care of a surgeon are notified to the WAASM and reviewed.

The RACS' Continuing Professional Development (CPD) Guide⁵⁹ mandates surgeons' participation in the Australian and New Zealand Audit of Surgical Mortality (ANZASM) "if a surgeon is in operative based practice and experiences a surgical death, and an audit of surgical mortality is available in the surgeon's hospital".⁶⁰ Non-participation jeopardises a surgeon's registration with the Medical Board of Australia.

Surgeons complete a form about the death and are asked to identify when there has been an area for consideration,⁶¹ an area of concern,⁶² or an adverse event. The case then undergoes first-line assessment, where it is de-identified and sent to a peer surgeon at a different hospital for review. Second-line assessment is the process whereby cases are reviewed by a second peer surgeon along with the patient's medical notes. Cases are only referred for second-line assessment if an area of concern or adverse event has been identified, or where there is the potential for lessons to be learnt (see Appendix Three: Western Australian Audit of Surgical Mortality Process for an overview of the WAASM process).

In 2019, 541 deaths across public and private hospitals met the WAASM criteria. Fifty-one cases were referred for second-line assessment, representing 13.5% of the 378 cases with a completed first-line assessment.

For the WAASM, an adverse event is defined as "an unintended injury caused by medical management rather than by the disease process, which is sufficiently serious to lead to prolonged hospitalisation or to temporary or permanent impairment or disability of the patient at the time of discharge, or which contributed to or causes death".

A total of 101 adverse events were identified by the WAASM surgeon assessors during the ten-year period from 2010 to 2019.⁶³ The most frequently reported adverse event types over this period were complications of surgery (n=22), delays to medical and surgical treatment (n=13), and decisions relating to surgical treatment (n=11; see Table 34 overleaf).

⁵⁸ Further information regarding the WAASM is available at:

<https://www.surgeons.org/research-audit/surgical-mortality-audits/regional-audits/waasm>

⁵⁹ The RACS' CPD Guide is available at: <https://www.surgeons.org/Fellows/continuing-professional-development>

⁶⁰ <https://www.surgeons.org/research-audit/surgical-mortality-audits/more-about-anzasm>

⁶¹ Area of consideration: The clinician believes an area of care could have been improved or been different

⁶² Area of concern: The clinician believes an area of care should have been better

⁶³ 2019 data includes cases for which the audit process was complete at 31 March 2020

Table 34: Most Frequently Reported Adverse Event Types Causing Death between 2010 and 2019 (Including Events that were Considered Not Preventable)

Adverse Event	2010 - 2019
Complication of surgery	22
Delay to treatment (medical and surgical)	13
Decisions relating to surgical treatment	11
Medical management/assessment issues	10
Bleeding associated with operation	7
Anastomotic leak	6
Injury caused by fall in hospital	6
Other adverse events	26
Total	101

Note: Data includes cases that were complete at 31 March 2020. Only adverse events with frequencies ≥ 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 allergy to blood/blood products, aspiration pneumonia, diagnosis issues, DVT/DVT prophylaxis, equipment/device issues, infections (including septicaemia), gastrointestinal perforation, liver failure, pulmonary embolism and patient factors.

The WAASM assessors considered 36.6% (n=37) of the 101 adverse events identified from 2010 to 2019 to be definitely preventable. Eleven adverse events that caused death were identified in 2018 (of which six were considered definitely preventable), and three have been identified in 2019 (of which one was considered definitely preventable; see Table 35).

Table 35: Frequency of Adverse Events, Adverse Events Causing Death that were Considered Definitely Preventable and Associated Deaths between 2010 and 2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total surgical deaths ^a	592	570	592	566	578	581	591	568	552	541
Total adverse events identified ^{b,c}	16	12	8	7	15	11	8	10	11	3
Adverse events considered definitely preventable ^{b,d}	4	7	4	1	6	2	2	4	6	1
Deaths associated with preventable adverse events ^b	3	7	2	1	4	2	2	4	5	1
Preventable deaths as percentage of surgical deaths	<1%	1.2%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%

^a Total surgical deaths are those reported as meeting the WAASM inclusion criteria (as contained in the WAASM 2020 and 2019 Reports).

^b Data includes cases that were complete at 31 March 2020 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 2019, the three adverse events causing death included one each that related to the decision to operate, over (excessive) anticoagulation and vascular injury to the colon during open surgery (see Table 36).

Table 36: Frequency of Adverse Events Causing Death between 2017 and 2019 (Including Events that were Considered Not Preventable)

Adverse Event	2017	2018	2019
Decision to operate	1	1	1
Adverse factors in management	1	1	-
Better to have done different operation or procedure	1	1	-
Allergy to blood or blood products	1	-	-
Care unsatisfactory (not otherwise specified)	-	1	-
Colonic complication of laparoscopic operation	1	-	-
CVA following open surgery	-	1	-
Delay to surgery (earlier operation desirable)	-	1	-
Delays (not otherwise specified)	-	1	-
Injury to heart during open surgery	1	-	-
Liver failure	-	1	-
Over anticoagulation	-	-	1
Patient-related factors	-	1	-
Perforation of duodenum during endoscopic operation	1	-	-
Pulmonary embolism	1	-	-
Surgeon too junior	1	-	-
Unsatisfactory medical management	-	1	-
Vascular injury to colon during open surgery	-	-	1
Wrong anaesthetic technique	1	-	-
Wrong operation performed	-	1	-
Total	10	11	3

Note: Data includes cases that were complete at 31 March 2020 and will be updated in future editions of this report. Multiple adverse events that caused death may have been recorded for a single surgical death.

The WA Audit of Surgical Mortality Annual Reports can be accessed online at: <https://www.surgeons.org/research-audit/surgical-mortality-audits/regional-audits/waasm/reports-publications>.

The ANZASM provides central oversight for each of the jurisdictional surgical audits, including the WAASM, and provides a national overview of audit data. The PSSU encourages all health practitioners to review the ANZASM case note review booklets for educational and professional development purposes. The ANZASM case note review booklets can be accessed online at: <https://www.surgeons.org/research-audit/surgical-mortality-audits/national-case-note-reviews>.



Image courtesy CAHS

Consumer Feedback Review

Feedback from health consumers offers direct information about how a health service organisation is meeting the needs of its consumers, and where services could be improved. Consumer feedback may be received as complaints, compliments or contacts. The National Safety and Quality Health Service Standards³ necessitate that 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.

Complaints identify aspects of a service that are not meeting consumers' expectations. Complaints may relate to corporate services and aspects of care that can make a health care experience more comfortable, or they can relate to serious quality of care issues. Attention should be given to improving these services through focused quality improvement initiatives. Compliments identify areas where the health service is meeting or exceeding consumers' expectations. While efforts should be made to maintain or improve services in these areas, it is important to share compliments with the staff involved to celebrate success and congratulate on a job well-done. Contacts can include requests for information or assistance, or informal complaints regarding a minor aspect of service that are resolved at the point of first contact.

The Datix Consumer Feedback Module is the enterprise system used for complaint management in the WA public health system. The Datix CFM also has the capacity to record consumer compliments and contacts, which although optional is encouraged. The Datix CFM provides a three-tier classification system for categorising issues raised in consumer complaints and contacts to enable analysis of data and trends. Multiple issues can be recorded for each feedback item, as consumers' feedback often covers several aspects of their care. It also has capacity for recording consumer demographic information to identify issues pertaining to specific consumer groups, and outcomes achieved from each complaint. Service improvement recommendations made following investigation of complaints and contacts are also recorded.

Public hospital and health service consumer feedback data presented in this report is extracted from the Datix CFM. Contracted Health Entities that provide health services to public patients do not utilise the Datix CFM but are required to report certain data on complaints relating to public episodes of care to the PSSU. This data has been included in this report where possible.

The revised *Complaints Management Policy*⁶⁴ for the WA health system came into effect on 3 February 2020. This Policy incorporated feedback from various stakeholders within and external to the WA health system, including representatives of consumer groups and advocacy groups. The importance of advocates in feedback management processes was a strong theme identified in the policy consultation and has been emphasised in the revised Policy.

In addition, the criticality of encouraging and capturing feedback from vulnerable consumer groups including children and young people, Aboriginal and Torres Strait Islander people, people of Culturally and Linguistically Diverse backgrounds, people experiencing mental health illness, people with disabilities, and LGBTIQ+ people was conveyed. The Policy was strengthened to promote recording and action on feedback received from these groups to improve their experiences in, and engagement with, the WA health system.

⁶⁴ The Complaints Management Policy is available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Complaints-Management-Policy>

Data from the Patient Evaluation of Health Services survey, managed by the Health Survey Unit at the Department of Health, has again been included in this report. The PEHS collects quantitative patient experience and satisfaction data from a sample of patients who have attended WA public hospitals and meet certain eligibility criteria. The PEHS captures feedback initiated by the WA health system, and therefore complements the data captured in the Datix CFM, which is initiated by the consumer or their representative. In 2019/20, the PEHS included interviews of 4,322 adult patients. Data from the PEHS is not included in the mental health complaints section of this report as the PEHS does not interview mental health patients. More information regarding the PEHS is available from the Senior Research Officer of the Health Survey Unit, Epidemiology Branch at PEHS@health.wa.gov.au.

Consumer Feedback Story

Rachel*, a young woman in her twenties, underwent an uncomplicated appendectomy and was discharged via the transit lounge the next day. Rachel's mother Barbara* sat with her in the transit lounge. Rachel was told she needed to urinate three times before she could leave the transit lounge. Rachel was drinking a lot of water but did not need to urinate.

Multiple bladder scans were done which showed her bladder was empty. Rachel was in pain but refused pain relief as she was concerned it would make her drowsy and she would not be able to continue drinking. Rachel was feeling pressured by staff to urinate and she was becoming very distressed when she couldn't. Barbara observed a nurse becoming annoyed with Rachel. Rachel was told if she didn't urinate soon she would have a catheter placed as the transit lounge would be closing.

A few hours after arriving in the transit lounge Rachel started to complain that her hands and feet were tingling and that there was pressure in her arms. Barbara reported to a doctor that Rachel's face was swelling, and she was having panic attacks which was out of character. The doctor did not examine Rachel but put the swelling down to a post-operative reaction and provided a prescription for anti-anxiety medication. Barbara voiced concerns about taking Rachel home as she was becoming confused and unstable on her feet. Despite this, Rachel was discharged home after a blood test.

Rachel started to vomit on the way home. Barbara rang the doctor who said that the sodium level in Rachel's blood was low and she should eat something salty. A while later, Barbara received a call from the doctor advising her to bring Rachel back to the hospital. Rachel had deteriorated so Barbara called an ambulance. When she arrived in the Emergency Department Rachel had a seizure and ended up spending three days in the Intensive Care Unit. Rachel was admitted with hyponatraemia.

Barbara placed a complaint with the hospital. Barbara complained that staff did not listen to her concerns about Rachel's condition. Barbara also complained that Rachel received inadequate treatment and inadequate assessment, including a lack of investigation of new symptoms.

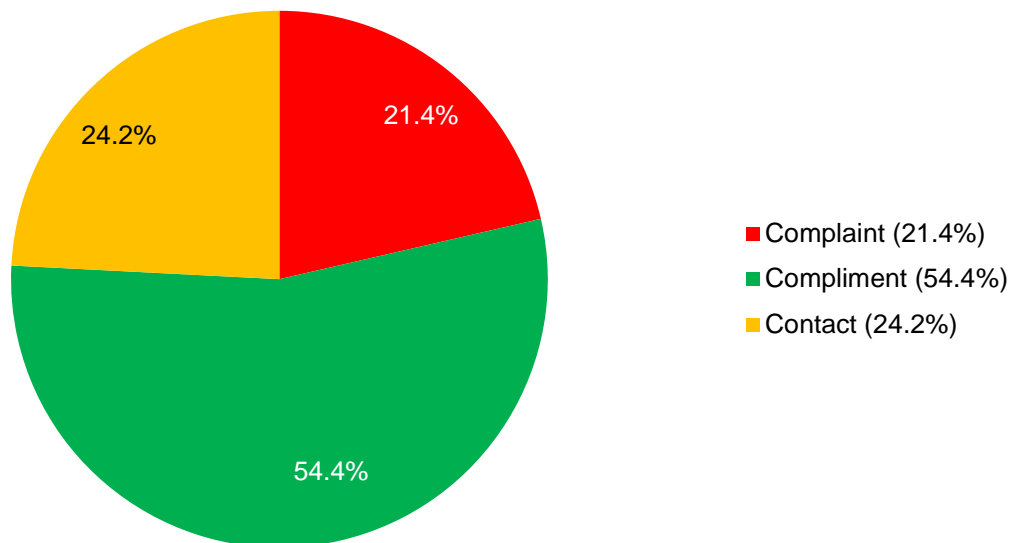
* All names have been changed to protect the privacy of individuals.

This complaint was investigated as a SAC 1 clinical incident and demonstrates how consumer feedback can identify serious patient safety risks. Complaints identifying issues about the quality of clinical care are particularly likely to identify opportunities for potential harm to consumers. Family and friends of patients and clients are well-placed to identify behaviours that are out of character, and their concerns should be listened to as they may identify serious clinical issues.

Consumer Feedback Overview

There were 18,780 occasions of feedback about the WA health system provided by consumers and their representatives in 2019/20.⁶⁵ Over half of feedback received was positive in nature, with 10,220 compliments (54.4%) received about the WA public health system in this period (see Figure 74). Complaints constituted 21.4% (n=4,017) of all consumer feedback received in 2019/20, identifying areas where the quality of care could be improved to better consumers' experience in the WA health system. The remainder of consumer feedback received (n=4,543; 24.2%) was recorded as contacts, which includes enquiries, suggestions, and minor issues.

Figure 74: Type of Consumer Feedback Received by the WA Health System for 2019/20



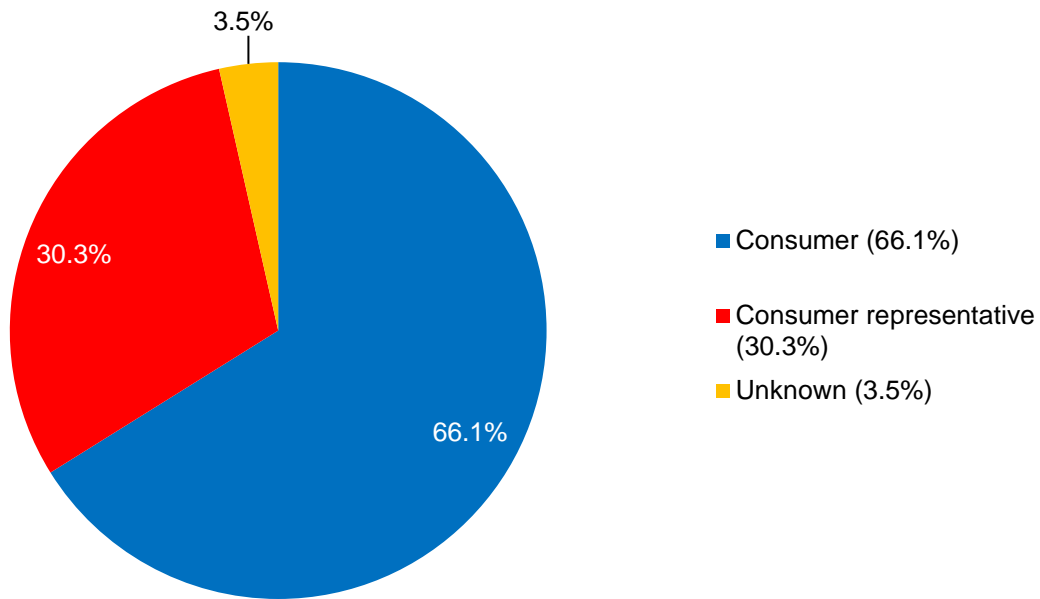
In 2019/20, the majority of feedback was received directly from the consumer (n=12,419; 66.1%), with 30.3% (n=5,696) of feedback received from consumer representatives (see Figure 75 overleaf).⁶⁶ Consumer representatives include family, friends and carers, all of whom have a right to offer valuable feedback to the WA health system. The *Australian Charter of Healthcare Rights*⁶⁷ highlights the importance of the consumer involving who they choose in their care planning and decision-making.

⁶⁵ 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 CHEs (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. CHEs do not provide the PSSU with compliments and contacts data.

⁶⁶ This data is not requested from CHEs (Joondalup Health Campus, Peel Health Campus, and St John of God Midland) and represents the 'Unknown' component in Figures 75 and 84.

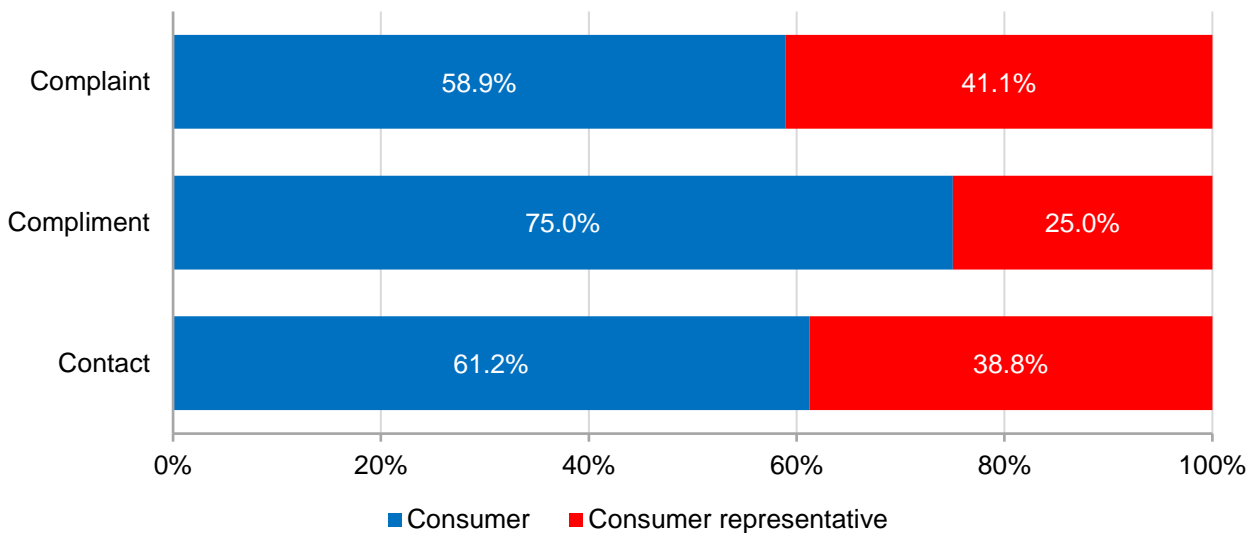
⁶⁷ The Australian Charter of Healthcare Rights (2nd ed) is available at: <https://www.safetyandquality.gov.au/australian-charter-healthcare-rights>

Figure 75: Person Reporting the Feedback Item to the WA Health System for 2019/20



While all types of feedback were more likely to be received from the consumer themselves rather than from their representative, three-quarters of positive feedback was received directly from the consumer (n=7,636; 75.0%; see Figure 76), showing that consumers are appreciative of the high quality and compassionate care normally received in the WA public health system. Less than two-thirds of complaints were received directly from the consumer (n=2,007; 58.9%), with a similar proportion of contacts received directly from the consumer (n=2,776; 61.2%).

Figure 76 Person Reporting by Type of Consumer Feedback Received for the WA Health System for 2019/20



Encouraging consumers to provide feedback about their health care experience offers a source of valuable information to hospitals and health service organisations. Informing consumers of the availability of feedback processes is the first step in obtaining this information. Knowledge of these processes appears widespread in the WA health system, with 82.0% of respondents to the 2019/20 PEHS stating they were aware that each hospital had a complaints service.

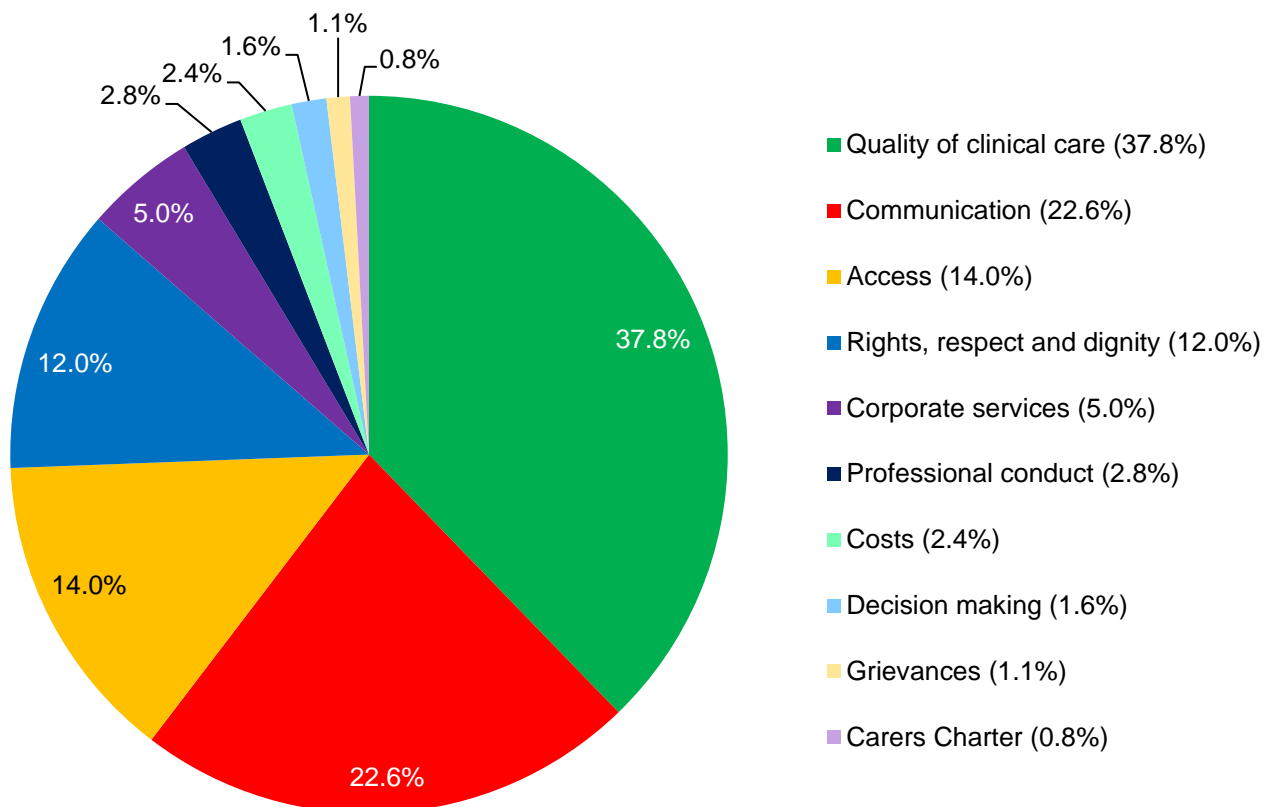
Complaints Overview

Issues raised in consumer complaints are classified in accordance with the two-level categorisation described in the *Health and Disability Services (Complaints) Regulations 2010*. A further third level of categorisation is compulsory in the Datix CFM, with the additional specificity enabling enhanced analysis of where to target service improvement activities to make the most difference to consumers.

The complaint issue categorisation used in the WA health system is explained in the *Complaints Management Policy*.⁶⁴ Every complaint received by the WA health system must have at least one issue identified and categorised, with multiple issues able to be identified in one or more categories. Issues are recorded as reported by the person providing the feedback to the hospital or health service organisation.

In 2019/20, a total of 7,215 issues were identified in the 4,017 complaints received. The proportion of issues identified in each first-level category in 2019/20 is shown in Figure 77. The top four broad complaint categories remain unchanged from previous years and accounted for 86.4% of all issues identified.

Figure 77: Issues Identified by Person Reporting the Feedback in Complaints Received by the WA Health System for 2019/20



Complaints Demographics

Obtaining complete demographic data can be challenging in complaint management. Asking questions that appear unrelated to complaint issues may make consumers feel that their response could impact the complaint process, or their or their loved ones ongoing health care. However, capturing this data when it is available 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. The revised *Complaints Management Policy* strengthens requirements around engaging with consumers from vulnerable groups and focuses on making complaint systems appropriate for the different consumers interacting with the WA health system on a daily basis, for instance by promoting the availability of advocacy groups and offering the opportunity to make a complaint anonymously. 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.⁶⁸

The age of the person affected was recorded for 2,697 complaints reported in 2019/20. Children or young people were affected in 13.3% of these complaints (n=360) while the elderly were affected in 32.2% (n=868). Nine complaints were received from young people aged 12-17 years, with two of these complaints received via advocacy groups. Children and young people experience significant unique barriers to using complaints systems and therefore additional strategies are required to make complaints systems accessible and responsive to their needs. Principle 6 of the *National Principles for Child Safe Organisations*⁶⁹ outlines requirements for establishing an effective complaint management system which is inclusive of children and young people and upholds their rights. An extensive *Complaint Handling Guide*⁷⁰ has been developed by the National Office for Child Safety to support implementation of this principle and maintenance of a child-safe complaint management system. The WA health system is currently working to implement the advice outlined in the *Complaint Handling Guide*, with initial steps including reference to Principle 6 in the *Complaints Management Policy*.

There were 79 instances where the person affected in a complaint identified at least one disability, with 15 people identifying more than one disability. The most frequently reported disability was psychiatric (n=34), followed by physical (n=20), and mobility impairment (n=17). Thirty-nine of these 79 people lodged the complaint on their own behalf, with the remainder lodged by consumer representatives. Complaints where the person affected identified at least one disability were more likely to identify issues related to rights, respect and dignity, with 21.7% of issues reported relating to this category in comparison to 12.0% across total complaints (see Figure 77). Providing person-centred care and treating individuals with consideration and compassion is fundamental to making health services accessible to and inclusive of all people, regardless of their abilities.

Where country of birth was recorded, the majority of people affected by complaints were born in Australia (n=114), followed by the United Kingdom (n=24), with country of birth recorded in 17 other complaints. A person's cultural background can influence their interaction with the health system and their likelihood to provide feedback. In the 2019/20 PEHS, only 43.8% of respondents said they were asked if they had any cultural or religious beliefs that might affect how they are treated while in hospital, suggesting there is room for significant improvement in

⁶⁸ As demographic data is not mandatory to report, the available data will not reflect a complete demographic profile and numbers will be small. Caution is required when interpreting demographic data.

⁶⁹ The National Principles for Child Safe Organisations are available at:

<https://pmc.gov.au/domestic-policy/national-office-child-safety>

⁷⁰ The National Office for Child Safety Complaint Handling Guide is available at:

<https://pmc.gov.au/resource-centre/domestic-policy/complaint-handling-guide-upholding-rights-children-and-young-people>

this area. A culturally-competent health system can lead to safer and more appropriate care and complaint resolution.

Across all complaints received, an interpreter was only reported as required in 14 instances. In the 2019/20 PEHS, 5.7% of respondents required assistance with the interview due to English not being their first language. This suggests that representation of people who do not speak English fluently in the complaint data is disproportionately low. The *WA Health System Language Services Policy*⁷¹ requires that interpreters are provided to all consumers who need assistance with English. Some people who prefer communicating in a language other than English may say they are happy to communicate in English as they don't want to feel like an inconvenience, or they may mean they are happy to communicate in English provided their family member helps them. It is important that staff and consumers are made aware of the role of interpreters and their services are used where appropriate in consumer feedback processes.

In complaints received in 2019/20 there were 64 people affected who identified as being Aboriginal or Torres Strait Islander, equating to 1.6% of people affected. This is a substantially lower figure than the 9.3% of respondents to the PEHS in 2019/20 who were Aboriginal or Torres Strait Islander. Feedback from Aboriginal and Torres Strait Islander health care consumers needs to be encouraged and reasons for lower rates of feedback explored, which may include a cultural tendency not to complain, an experience of racism, or lower levels of health literacy. Providing culturally-safe mechanisms to provide feedback are vital to capitalising on opportunities to improve health services to these consumers.

Complaints Resolution

The complaint management process aims to achieve an outcome for each complaint that is communicated to the consumer as a means of closing 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 with the recorded resolution.

At the time of this report, at least one resolution had been recorded for 3,053 of the complaints received during 2019/20.⁷² The WA health system provided 2,042 apologies to consumers who placed complaints about their own care or the care of a loved one, representing 66.9% of complaints where at least one resolution was recorded (see Figure 78 overleaf).

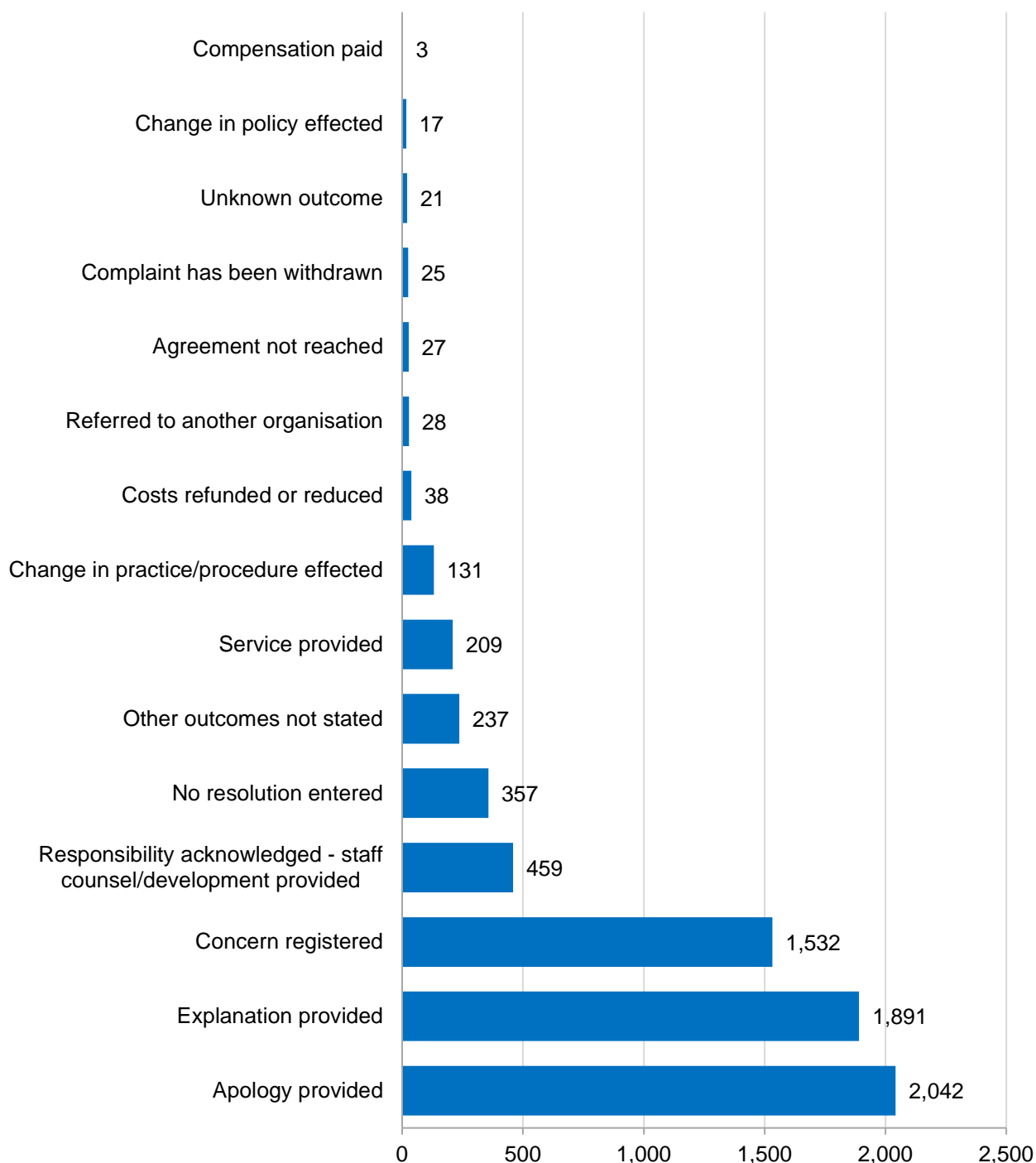
Communication is integral to consumer experience in the WA health system and often better communication may have prevented the situation occurring that caused the consumer to feel the need to place a complaint. The second most common resolution achieved in 2019/20 was 'Explanation provided' which was recorded as a resolution in 61.9% of complaints (n=1,891), followed by 'Concern registered' (n=1,532; 50.2%); evidence that communication between the service provider and the consumer in the complaint management process is also critical.

⁷¹ The WA Health System Language Services Policy is available at:

<https://ww2.health.wa.gov.au/-/media/Files/Corporate/Policy-Frameworks/Communications/Policy/WA-Health-System-Language-Services-Policy/MP51-WA-Health-System-Language-Services-Policy.pdf>

⁷² 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 CHEs (Joondalup Health Campus, Peel Health Campus and St John of God Midland).

Figure 78: Frequency of Complaints Resolution Achieved in 2019/20



The PEHS asks respondents to rate the way any complaints were dealt with by the hospital at which they placed a complaint. In 2019/20, the majority of respondents who made a complaint (81.5%) rated the complaints service as ‘excellent’, ‘good’, or ‘adequate’ (27.3%, 37.2%, and 17.0% respectively). However, 18.5% of respondents who made a complaint rated the complaints service at the hospital they attended as ‘poor’.

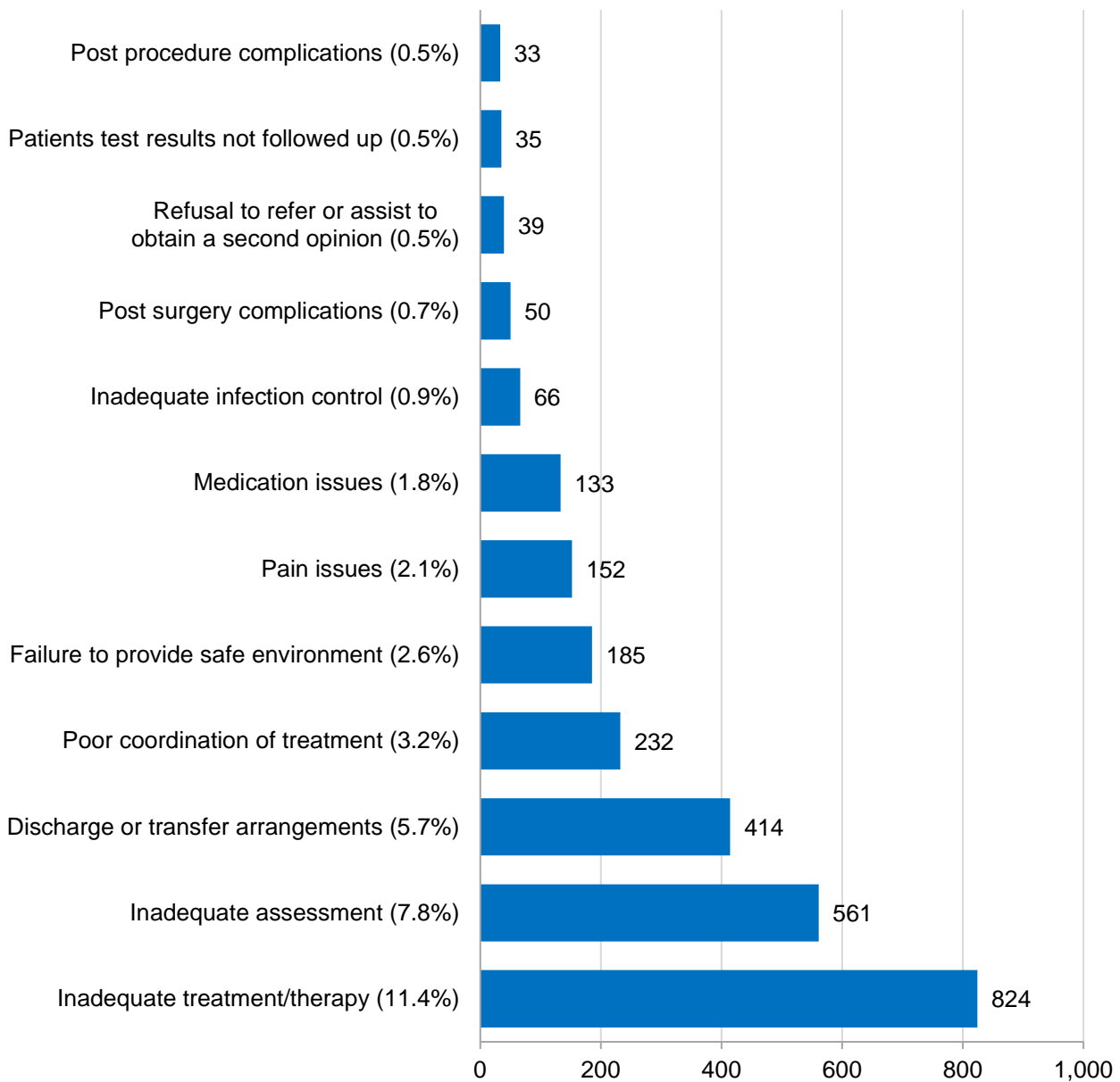
There were 76 grievance complaint issues identified in 2019/20, representing 1.1% of total complaint issues. These complaint issues highlight scenarios where the complainant was not satisfied with the complaint process. Quality improvement activities aimed at enhancing the complaint management process, to provide a better experience for consumers that is focused on their needs, is likely to provide greater satisfaction and more effective complaint resolution.

Quality of Clinical Care Complaint Issues

The largest contributor to total complaint issues were quality of clinical care complaint issues, which constituted 37.8% of all issues reported in 2019/20 (n=2,724; see Figure 77). Valuable insights into the safety of the care consumers receive can be drawn from these complaint issues, which due to their inherently clinical nature are most likely to align with the occurrence of clinical incidents. Actions stemming from these complaints may help to improve the safety of health services offered and reduce the potential for health care to cause harm to consumers.

The three most frequently reported quality of clinical care issues in 2019/20 were consistent with previous years and are shown in Figure 79. The most common was 'Inadequate treatment/therapy' (n=824; 11.4% of total complaint issues) which identified issues where the standard of performance of a treatment or procedure was inadequate, where treatment was delayed, or where there was a failure in duty of care.

Figure 79: Frequency and Percentage of Complaint Issues Relating to Quality of Clinical Care for 2019/20



The second most frequently reported issue of 'Inadequate assessment' (n=561; 7.8% of total complaint issues) involved situations where a condition or injury was overlooked or incorrectly identified, or there were inadequate levels of investigation and diagnosis of reported symptoms. Issues surrounding 'Discharge or transfer arrangements' (n=414; 5.7% of total issues) relate to reports of inadequate discharge planning and premature or otherwise inappropriate discharge.

The PEHS explores the consumer's perspective of the quality of care received. Overall, 87.9% of respondents felt that their hospital stay was worthwhile in achieving the results they expected. In 2019/20, 83.7% of respondents reported 'always' and 8.8% reported 'usually' having confidence in their doctors. Similarly, 85.9% of respondents reported 'always' having confidence in nursing staff and 8.3% reported 'usually' having confidence. Regarding attention from health care professionals, 90.3% of respondents reported doctors spent as much time as was needed on the patient's care and treatment and 94.8% reported attention by nursing staff to their care was as much as needed. Patients felt that the doctors and other people looking after them were 'always' (75.9%) or 'usually' (12.7%) talking to each other about the patient's care.

Patient evaluation of discharge arrangements is also obtained through the PEHS. The majority of respondents (83.5%) rated the arrangements at discharge with their doctors and others continuing their care as either 'excellent' (43.5%) or 'good' (40.0%). The time waiting for a doctor to discharge the patient from hospital was rated as 'excellent' by 28.5% and 'good' by 41.4% of respondents. Most patients who required special equipment at discharge had this organised for them by hospital staff (67.5%).

Key Messages and Information: Quality of Clinical Care Complaint Issues

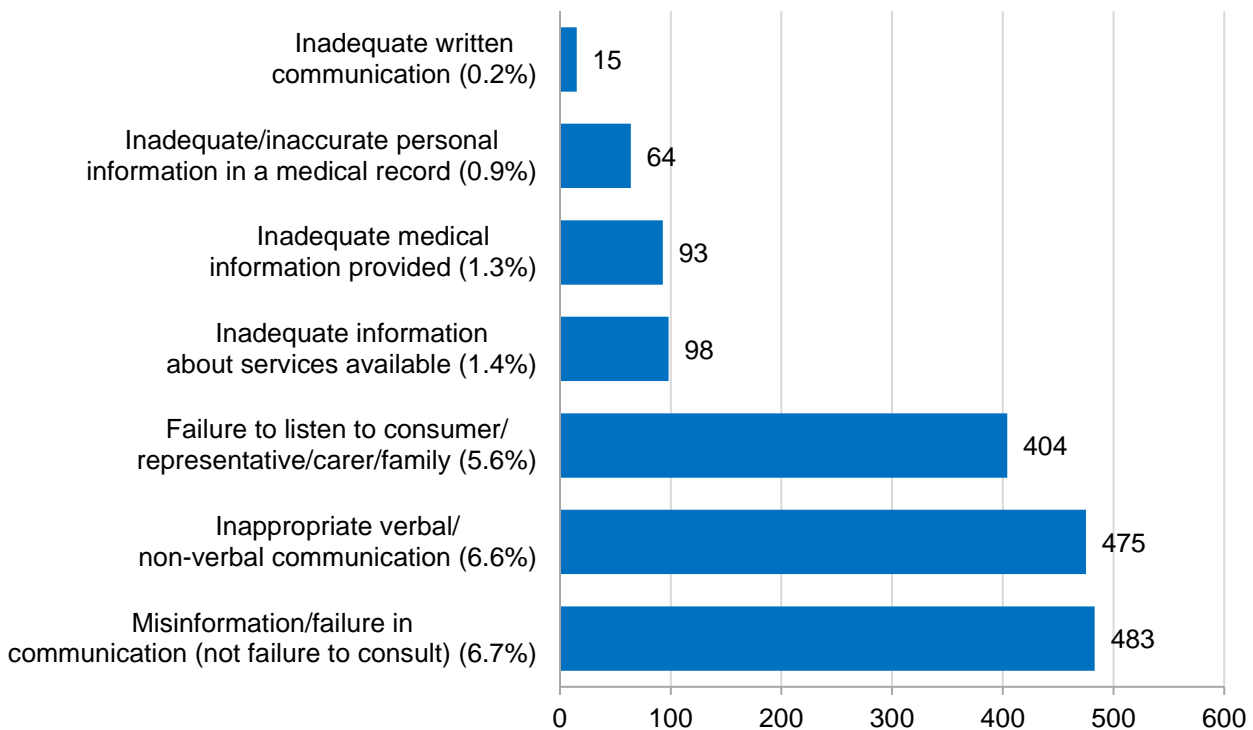
Most consumers place complaints for altruistic reasons and while they may request a resolution for themselves, ultimately, they want to know that the next person or family will have a better health care experience than theirs. Service improvements identified from quality of clinical care complaint issues have the potential to improve the safety of services provided for all patients. Quality of clinical care complaint issues identify situations where consumers felt their treatment or assessment was inadequate or where there were poor arrangements surrounding discharge or transfer. These stages of the health care journey all contain significant risks which can be addressed through capturing, monitoring, and acting upon consumer feedback.



Communication Complaint Issues

In 2019/20, there were 1,632 communication complaint issues reported, constituting 22.6% of total complaint issues registered in the WA health system. The most frequently reported communication complaint issue was 'Misinformation/failure in communication (not failure to consult)' with 483 issues identified (6.7% of total complaint issues; see Figure 80). This was closely followed by 'Inappropriate verbal or non-verbal communication' with 475 issues reported (6.6% of total complaint issues). These issues identify situations where information was delayed, confusing, or inaccurate, and where staff made careless comments or had an inappropriate demeanour. There were also 404 occasions of a 'Failure to listen to the consumer, their representative, carer, or family' which chiefly consisted of consumers and representatives feeling that their communication attempts were dismissed by WA health system staff (5.6% of total complaint issues).

Figure 80: Frequency and Percentage of Complaint Issues Relating to Communication for 2019/20



Communication in the care setting is extensively assessed in the PEHS. In 2019/20, most respondents rated the way health care professionals explained their condition or treatment as either 'excellent' (50.3%) or 'good' (34.9%). Similarly, the way health care professionals answered their questions was mostly rated as 'excellent' (50.2%) or 'good' (36.0%), and the way health care professionals responded to their concerns about their treatment and progress was most often rated as 'excellent' (49.0%) or 'good' (37.4%).

The majority of PEHS respondents stated they got as much information as needed about the purpose and results of tests (85.6%) and about medications (91.1%). Importantly, 92.3% of respondents reported that someone checked that they understood the information given to them. Most respondents (87.1%) reported that their family received as much information as was needed about their progress.

Key Messages and Information: Communication Complaint Issues

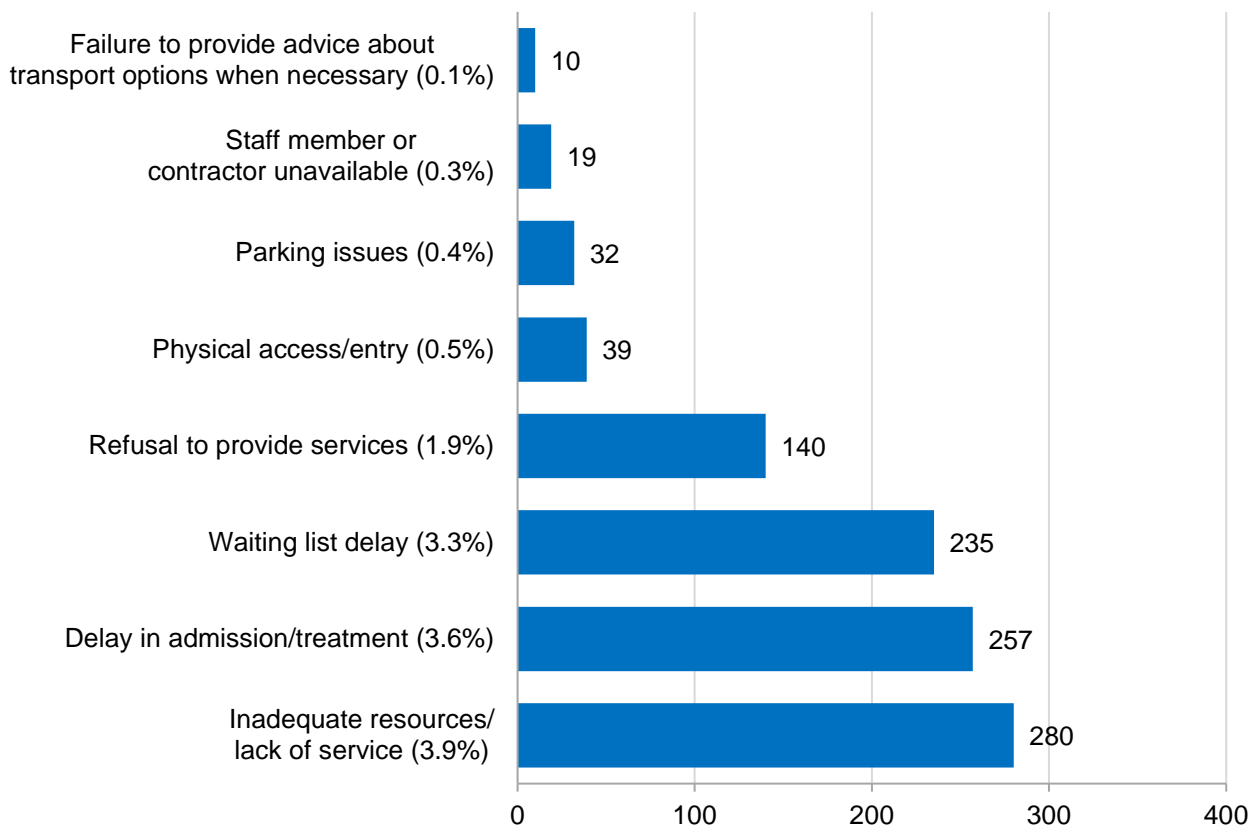
Interaction with the WA health system can be a stressful occurrence for health consumers and their loved ones. It can be a daunting time with a steep learning curve, complicated by the emotions surrounding an experience of ill-health. By truly partnering with consumers, their families, and their carers, services can alleviate a lot of the concerns and misunderstandings that can be caused by poor communication. Safe care is care that involves the consumer and/or their representative as a central point so that they can raise concerns when things don't seem right. The *Australian Charter of Healthcare Rights*⁶⁷ highlights the importance of communication in achieving consumer rights to access, safety, respect, partnership, and information.



Access Complaint Issues

There were 1,012 complaint issues identified in 2019/20 that related to access to WA hospitals and health services, which comprised 14.0% of total complaint issues received. Figure 81 shows the most commonly reported access issue was 'Inadequate resources/lack of service' (n=280; 3.9% of total complaint issues) which mainly included situations where there was a perceived lack of service, but also issues of inadequate human resources, equipment, and facilities. Delays in access including both 'Delay in admission/treatment' (n=257; 3.6% of total issues), and 'Waiting list delay' (n=235; 3.3% of total issues), were the next most common complaint issues relating to access, and consisted mainly of delays once the consumer was already at the point of service or long time periods to be allocated an outpatient appointment.

Figure 81: Frequency and Percentage of Complaint Issues Relating to Access for 2019/20



Most respondents to the PEHS (74.1%) stated they received as much information as needed regarding the reason for any long delays. Of the respondents who needed to see a doctor during their hospital stay, 38.5% rated the time they had to wait to see a doctor as 'excellent' and 35.2% rated the wait time as 'good'.

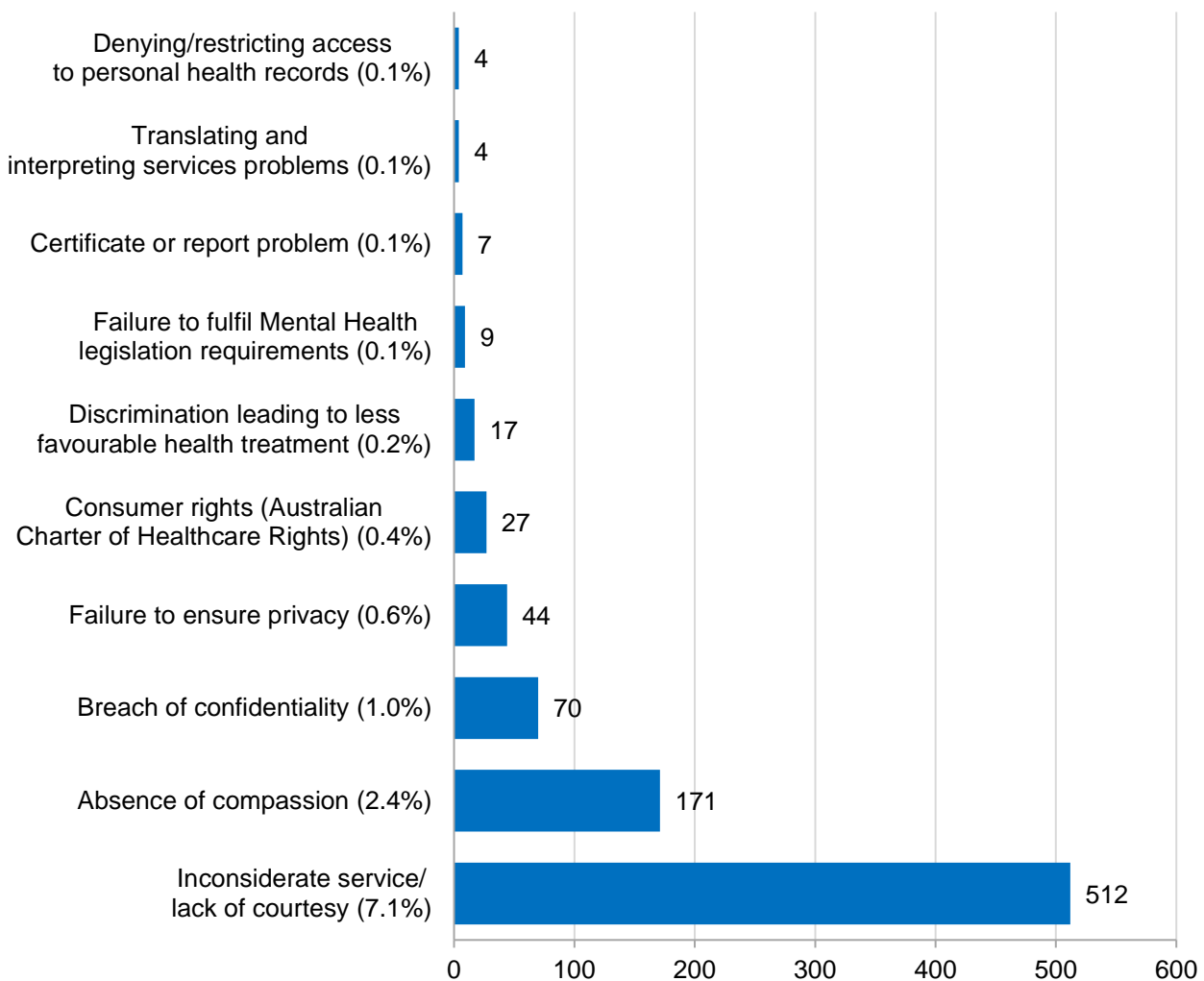
Key Messages and Information: Access Complaint Issues

The limited availability of public health resources necessitates that policies are in place to ensure access to health services is equitable. Consumer complaints around access issues may identify situations where consumers have fallen through the gaps in the system. It is vital that hospitals and health services capitalise on the opportunity to make improvements when these situations are identified, to prevent access issues potentially causing harm to consumers. Conversely some access complaint issues may highlight situations where expected wait times and levels of service have not been adequately explained to the consumer, leading to a perceived situation of inadequate access. Spending time to outline these circumstances at the outset can help the consumer to develop realistic expectations about their care.

Rights, Respect and Dignity Complaint Issues

In 2019/20, there were a total of 866 complaint issues lodged relating to the ‘Rights, respect and dignity’ category, accounting for 12.0% of total complaint issues received. Issues identified in this category include situations where consumers of health services in WA did not feel they were treated in line with their human and health care rights. There were 512 issues raised involving inconsiderate or uncourteous service (7.1% of total complaint issues; see Figure 82). This included situations where the consumer found the staff member to be impolite or lacking kindness, or that the staff member did not have a helpful manner. There were 171 instances reported where there was a lack of compassion (2.4% of total complaint issues). Consumers reported 70 issues involving breaches of confidentiality (1.0% of total issues), identifying situations where information was provided to a third party without the consent of the consumer.

Figure 82: Frequency and Percentage of Complaint Issues Relating to Rights, Respect and Dignity for 2019/20



Note: Rights, Respect and Dignity Issues missing data n=1; 0.1%

The majority of PEHS respondents reported that they were ‘always’ treated with politeness and consideration (86.5%) and shown respect while being examined or interviewed (90.7%). Privacy was provided to respondents the majority of the time, with 88.2% stating that screens were ‘always’ around the bed during examinations, and 76.9% stating hospital staff used low voices when speaking so that others couldn’t overhear. The PEHS survey also asks, “Were you asked who, other than hospital staff, could be given information about your condition?”, to which 68.4% of respondents answered ‘Yes’.

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

Many healthcare professionals choose to enter the healthcare field due in part to their innate compassionate nature. They do not intend for consumers to feel they are not being respected while in their care. The health care journey can be a challenging time for consumers, filled with stress and emotions, that call for support from the people around them, including healthcare professionals. By partnering with consumers in a person-centred approach where the person is treated, not just the condition or illness, healthcare professionals can determine what is important to each individual in order for them to feel respected. The constant demand for compassion can however lead to burnout among healthcare professionals, which can be detrimental to staff wellbeing and reduce their capacity to provide compassionate care. It is important that health service organisations have policies and procedures in place to support their employees in providing compassionate care, including recognising staff burnout. This is more important than ever due to the extra stress that COVID-19 has placed on health workers.

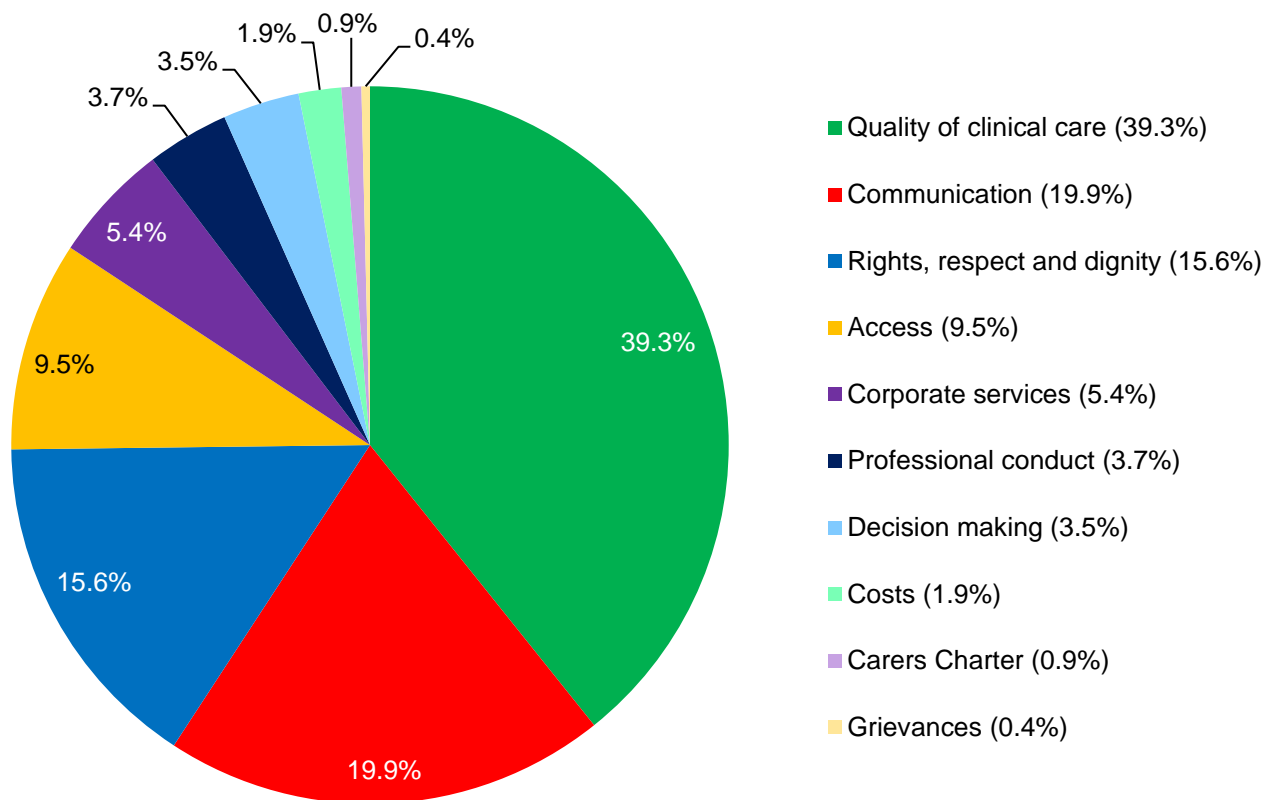


Mental Health Complaints

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

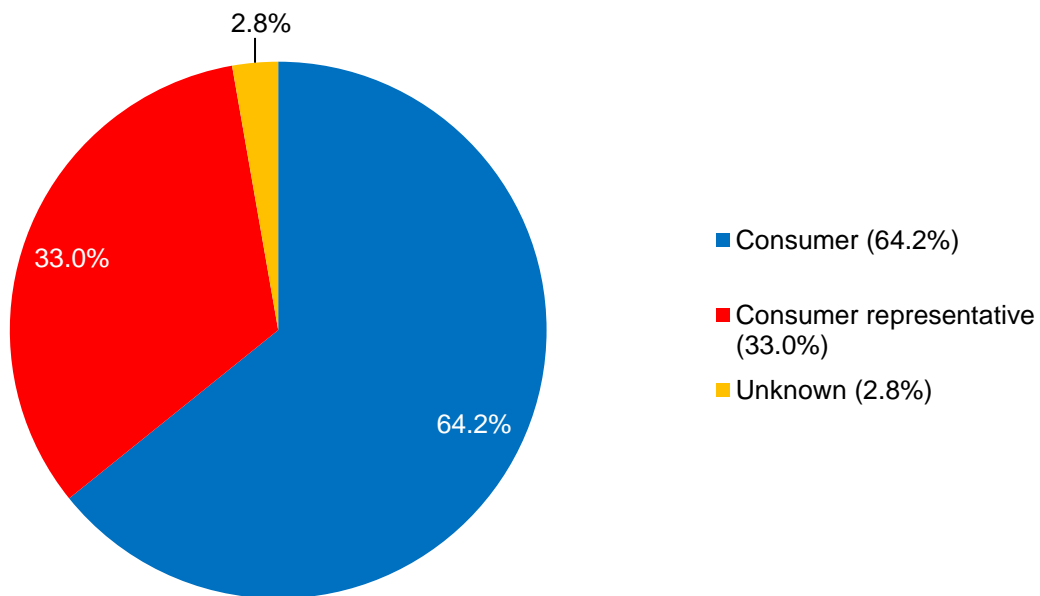
In 2019/20, there were 431 mental health complaints reported across the WA health system which identified 782 complaint issues. Figure 83 shows the distribution of these complaint issues in the first level of the two-level categorisation described in the *Health and Disability Services (Complaints) Regulations 2010*.

Figure 83: Issues Identified by Persons Reporting the Feedback in Mental Health Complaints Received by the WA Health System for 2019/20



In 2019/20, a higher proportion of mental health complaints were received directly from the consumer compared to the previous year (n=1,073; 64.2%; see Figure 84; compared to 51.4% in 2018/19). This was similar to the proportion of total complaints received directly from consumers in the WA health system in 2019/20 (see Figure 75). Families, carers, nominated persons and advocates provide important support to people experiencing mental health illnesses, including support in interactions with consumer feedback processes.

Figure 84: Person Reporting the Mental Health Feedback Item to the WA Health System for 2019/20

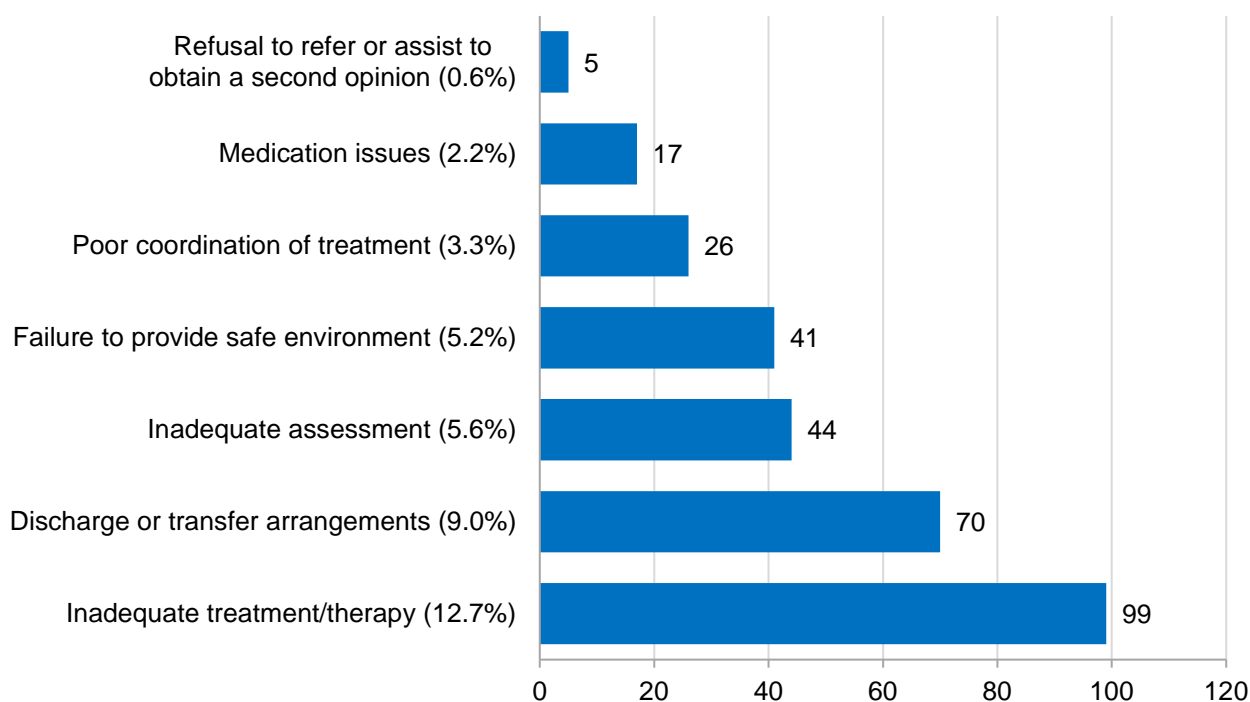


Mental Health Complaint Issues Relating to Quality of Clinical Care

In 2019/20, 307 mental health complaint issues surrounding the quality of clinical care provided were identified, accounting for 39.3% of all mental health complaint issues. The most frequently reported quality of clinical care issue was 'Inadequate treatment/therapy' as shown in Figure 85 (n=99; 12.7% of total mental health complaint issues). This encompassed situations where it was felt there was an inadequate standard of performance of a treatment or procedure, where treatment was rough or inadequate, or where there was a failure in duty of care.

Complaint issues related to 'Discharge or transfer arrangements' accounted for 9.0% of total mental health complaint issues (n=70) and mostly included situations where discharge was considered premature or inadequately planned. Complaint issues of 'Inadequate assessment' constituted 5.6% of total mental health complaint issues (n=44) and most frequently identified situations where there was inadequate investigation of symptoms, where a condition was overlooked or wrongly identified, or where there was inadequate level of diagnosis.

Figure 85: Frequency and Percentage of Mental Health Complaint Issues Relating to Quality of Clinical Care for 2019/20

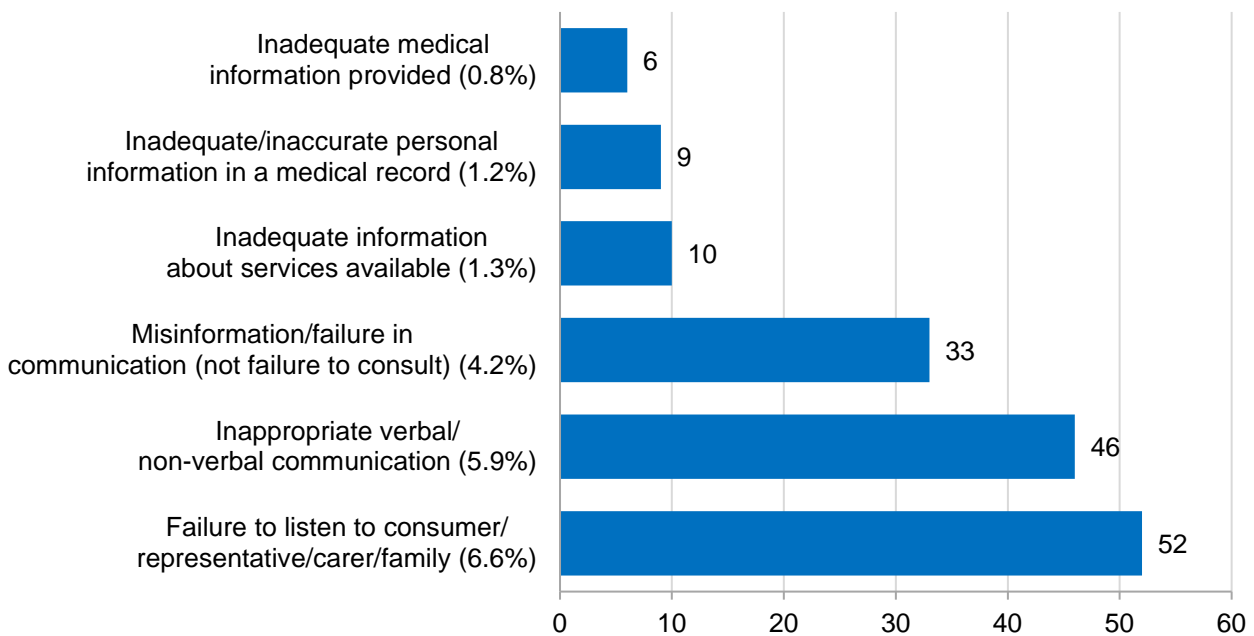


Mental Health Complaint Issues Relating to Communication

Almost one in every five mental health complaint issues reported across the WA health system in 2019/20 related to communication of WA health system staff with mental health service consumers and their representatives (n=156; 19.9%). As shown in Figure 86, the most commonly reported issue was 'Failure to listen to consumer, representative, carer, or family' which represented 6.6% (n=52) of total mental health complaint issues and included situations where the consumer's attempts to communicate with a health care professional were dismissed.

'Inappropriate verbal or non-verbal communication' issues constituted 5.9% (n=46) of total mental health complaint issues and included situations where there were reports of careless comments or staff speaking beyond their authority. There were 33 issues reported relating to 'Misinformation or failure in communication (not failure to consult)' representing 4.2% of total mental health complaint issues, where consumers experienced delays in information, or were given confusing, conflicting, inaccurate, or wrong information.

Figure 86: Frequency and Percentage of Mental Health Complaint Issues Relating to Communication for 2019/20

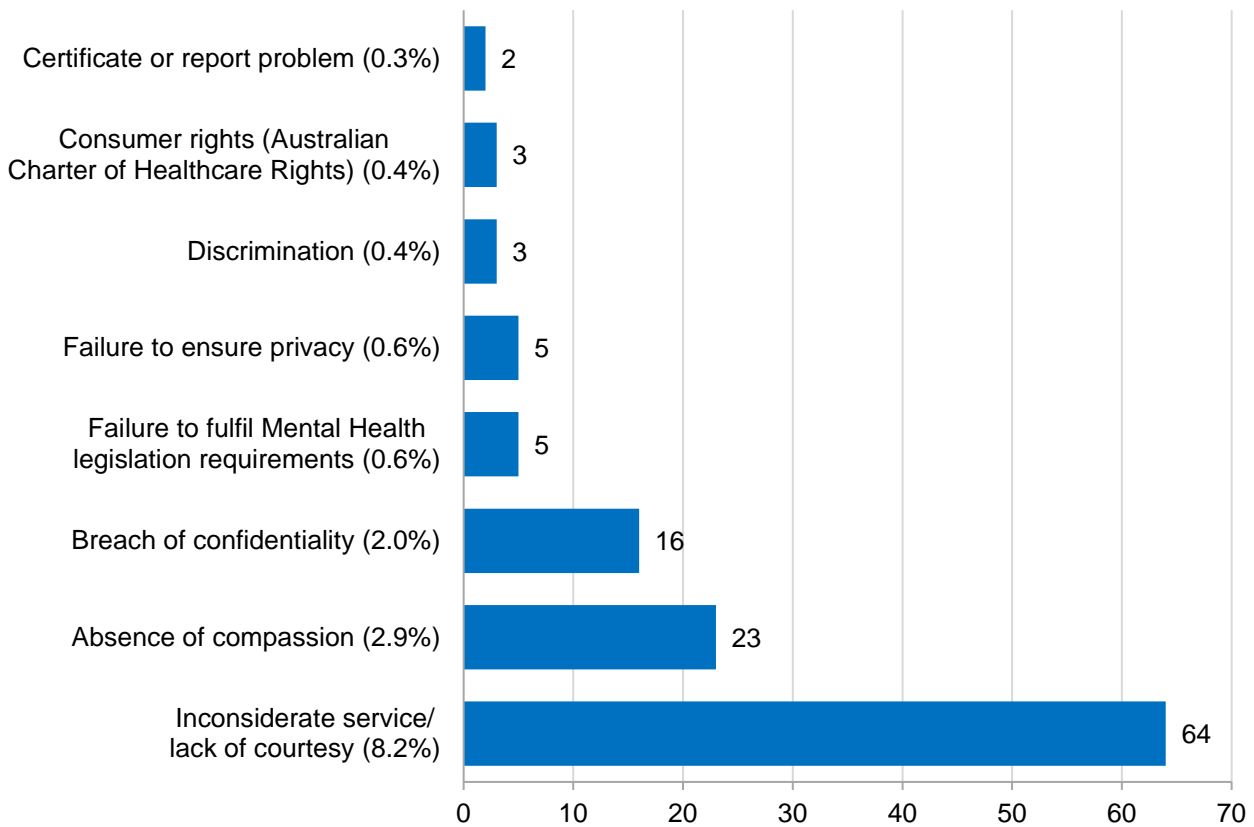


Mental Health Complaint Issues Relating to Rights, Respect and Dignity

A total of 121 complaint issues related to rights, respect and dignity were reported in mental health complaints in 2019/20, representing 15.6% of total mental health complaint issues. 'Inconsiderate service or lack of courtesy' was the mostly frequently reported issue (n=64) and constituted 8.2% of total mental health complaint issues (see Figure 87). These occasions included times where politeness or kindness were lacking, or staff were unhelpful, patronising, overbearing, negative, or displayed an ignoring attitude.

There were also 23 occasions where the consumer reported an absence of compassion in their care, accounting for 2.9% of total mental health complaint issues. Consumers of mental health services reported 16 issues involving a breach of their rights to confidentiality (2.0% of total mental health issues), which included situations where the consumer's information was provided to a third party without consent.

Figure 87: Frequency and Percentage of Mental Health Complaint Issues Relating to Rights, Respect and Dignity for 2019/20

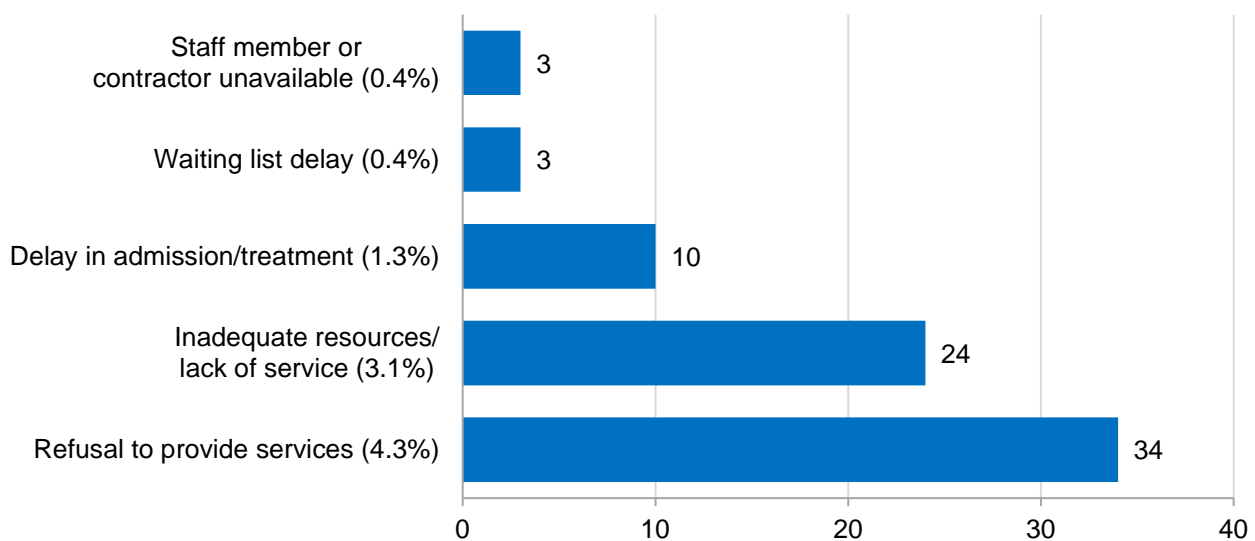


Mental Health Complaint Issues Relating to Access

Complaint issues about access to health services constituted 9.5% (n=74) of total mental health complaint issues reported in the WA health system in 2019/20. As shown in Figure 88, the most frequently reported access issue was 'Refusal to provide services' (n=34; 4.3% of total mental health complaint issues), with approximately two-thirds of these complaints relating to a refusal to treat or accept the consumer.

Complaints related to 'Inadequate resources or lack of service' comprised 3.1% of total mental health complaint issues (n=24) and mainly identified situations where service was lacking, while 'Delay in admission or treatment' accounted for 1.3% of total mental health complaint issues (n=10) and related mostly to delays when the client was already at the point of service.

Figure 88: Frequency and Percentage of Mental Health Complaint Issues Relating to Access for 2019/20



Key Messages and Information: Mental Health Complaints

Reviewing mental health complaints as a subset of total complaints enables services to assess how well they are meeting the specific needs of mental health consumers and identify the gaps in service where quality improvement initiatives would be of benefit. Consumers of mental health services experience unique challenges, making them a vulnerable group in the WA health system. These consumers face additional challenges in giving feedback and should be encouraged and supported throughout the feedback management process.

While complaint issues identified in mental health complaints in 2019/20 were similar to total complaints there were some differences, including higher rankings of issues surrounding refusal to provide services, discharge or transfer arrangements, and failure to listen to the consumer, their representative, carer or family. This suggests that consumers of mental health services hold greater concerns about not receiving sufficient care and not being involved in their care planning. The *Mental Health Act 2014* requires that the patient and personal support persons are involved in the preparation and review of treatment, support, and discharge plans. While not all consumers who receive mental health care are under the *Mental Health Act 2014*, this principle should be adopted as best practice where possible to facilitate safe mental health care.



Current Achievements

Adoption and implementation of initiatives to address and improve patient safety are essential to the transformation of health care delivery. The WA health system continues to foster a strong patient safety ethos that is demonstrated by the following achievements:

- The PSSU's Senior Clinical Advisers reviewed and provided feedback to HSPs and private health care providers on more than 700 SAC 1 clinical incident investigation reports received during 2019/20. This provides the Department of Health with oversight and ensures consistency in the investigation of serious clinical incidents across the WA health system.
- The Patient Safety Dashboards⁷³ were migrated to the Power BI platform in March 2020. The Patient Safety Dashboards is a web application which includes three dashboards displaying metrics based on data from the Datix CIMS and CFM. The aim of the Patient Safety Dashboards is to provide information on an accessible platform to assist staff in improving safety and quality across the WA health system.
- Complementing the Patient Safety Dashboards, the Clinical Incident Check Up Reports⁷⁴ focus on specific types of clinical incidents to provide staff in the WA health system with a snapshot of clinical incidents and the types of clinical actions that can be implemented to address the underlying causes. In 2019/20, four state-wide Clinical Incident Check Up Reports were released covering: Hospital overcrowding, Medical devices, Medication incidents, and Restrictive practices.
- A Clinical Incident Management Focus Report was produced in November 2019 that examined incidents from February 2014 to October 2019 where telehealth services may have contributed. The most common theme identified in these incidents was a lack of staff awareness of telehealth services, equipment or procedures.⁷⁵
- The Coronial Review Committee discussed 17 inquest findings in 2019/20. This included inquests with nine health-related recommendations, and some inquest findings where no recommendations were made. Members of the CRC consider current systems and processes and identify quality improvement opportunities.
- The Coronial Liaison Unit continued to provide the six-monthly *Progress Report for Health Related Coronial Recommendations* to the State Coroner, detailing actions taken across the WA health system in response to coronial recommendations. In support of increased transparency of the WA health system's response to coronial recommendations, the Executive Summary of this report is now routinely published on the Coronial Liaison internet page.⁷⁶ In addition to this, the full progress report is available on the PSSU intranet page.⁷⁷ The PSSU supports the sharing of lessons learnt and quality improvement initiatives across the WA health system.

⁷³ The Patient Safety Dashboards are available to WA health system staff at: <http://patientsafetydashboards/>

⁷⁴ Check Up Reports are available to WA health system staff via the PSSU intranet: <https://doh-healthpoint.hdwa.health.wa.gov.au/directory/Clinical%20Services%20and%20Research/Patient%20Safety%20Clinical%20Quality/PSSU/Pages/Clinical-Incident-Management.aspx>

⁷⁵ CIMS Focus Reports are available to WA health system staff via the PSSU intranet: <https://doh-healthpoint.hdwa.health.wa.gov.au/directory/Clinical%20Services%20and%20Research/Patient%20Safety%20Clinical%20Quality/PSSU/Pages/CIM-Focus-Reports.aspx>

⁷⁶ The Executive Summary of the Progress Report for Health Related Coronial Recommendations is available at: https://ww2.health.wa.gov.au/Articles/A_E/Coronial-Liaison-Unit

⁷⁷ The full Progress Report for Health Related Coronial Recommendations is available to WA health system staff at: <https://doh-healthpoint.hdwa.health.wa.gov.au/directory/Clinical%20Services%20and%20Research/Patient%20Safety%20Clinical%20Quality/PSSU/Pages/Coronial.aspx>

- *From Death We Learn 2018 (2019 Edition)*⁷⁸ was released in December 2019. This annual publication reviews the coronial inquests that have taken place and provides key messages, recommendations and actions taken by the WA health system to address concerns. This publication also includes discussion points to promote conversation about key issues and raise awareness of existing strategies to address them.
- Participation in ongoing Commonwealth initiatives regarding pricing and funding for safety and quality, including the third year of reporting sentinel events to the IHPA and transition of this reporting to the 10 revised sentinel event categories.
- The revised *Clinical Incident Management Policy, Guideline and Toolkit*¹⁴ took effect in the WA health system in November 2019. The revisions align the CIM Policy with the *Health Services Act 2016* and, together with its supporting documents, provides clearer and easier to use resources to implement effective clinical incident management in the WA health system. The PSSU supports the WA health system's implementation of the CIM Policy.
- Complementing the revised CIM Policy, an updated *Guideline for the Investigation of Multi-Site Clinical Incidents*⁷⁹ was released in December 2019. A multi-site clinical incident is when, during a patient's journey across multiple health service organisations, the different transitions in care and treatments received may have contributed to an adverse outcome for the patient. This guideline provides a framework for health service organisations to effectively investigate multi-site clinical incidents.
- In December 2019, the State Datix Committee added new fields to the Datix CIMS to allow staff to identify SAC 1 incidents that are the realisation of known risks recorded in the Enterprise Risk Management System. It is hoped this will further strengthen the link between incident and risk management in WA's public health system, and lead to more proactive management of clinical risk.
- In December 2019, the State Datix Committee also approved changes to the Datix CIMS that give the staff member who notified a clinical incident read-only access to both the notification details and the clinical investigation screen for that incident. This change assists with 'closing the loop' and feeding back to notifiers what has been investigated and implemented following a clinical incident.
- The updated *Review of Death Policy*⁵⁶ took effect in the WA health system from January 2019, with health service organisations first reporting under the updated policy in November 2019. The updated ROD Policy requires that public health care providers and private licensed health care facilities review patient deaths to identify potentially preventable deaths and opportunities for improvement in the delivery of health services, including the quality of end-of-life care. The PSSU supports the WA health system's implementation of the ROD Policy.
- The updated *Complaints Management Policy*⁶⁴ took effect in February 2020. The updated Complaints Management Policy promotes best practice in complaints management and advocates an efficient, proactive approach to complaints management that results in the best possible outcomes for health consumers. The Policy has been strengthened to recognise the additional challenges in providing feedback faced by vulnerable groups including Aboriginal and Torres Strait Islander people, children and young people, people of culturally and linguistically diverse backgrounds, people with disabilities, people experiencing mental health issues, and LGBTIQ+ people. The high importance of advocacy groups to these groups of people is recognised and encouraged.

⁷⁸ From Death We Learn is available at: <http://ww2.health.wa.gov.au/Reports-and-publications/From-Death-We-Learn>

⁷⁹ The Guideline for the Investigation of Multi-Site Clinical Incidents is available at: https://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system

Future Focus

The WA health system is committed to improving patient safety by reducing clinical risk, including patients acquiring healthcare-associated infections. This is evident in the Department of Health's investment in an electronic infection prevention and control surveillance system (ICNET) which has been successfully rolled out to 34 hospitals across the WA health system.

This system enables our hospital infection prevention and control teams to have access to real-time patient and laboratory data, ensuring valid and reliable surveillance data is captured, and prompt action is taken to manage patients with multi-resistant organisms and prevent further transmission. Electronic data management will allow for increased allocation of resources to clinical care, education and prevention strategies. Adoption of this system also allows the WA health system to capture data on HAIs that are currently not under surveillance, and identify further areas where improvements in patient safety and clinical outcomes can be made.

During 2020/21, work will continue the development of ICNET Protect. This is a module designed to capture all staff health immunisation and screening requirements, with interfaces with the HR systems and the Adult Immunisation Register (AIR) being developed. This will allow for comprehensive data management across the WA health system and ensure early recognition of staff at risk of any infectious agents, thus preventing further spread to both patients and staff in our hospital systems.

The PSSU has commenced a full review of the implementation of the Datix CFM, incorporating complaint management and consumer feedback processes, which is planned to be completed in early-2021. The Datix CFM was implemented in WA's public health system in January 2015 and has seen varied application across HSPs. The review aims to consider systems and processes relating to consumer feedback to identify potential improvements, implement enhancements to the Datix CFM, and widen the user base for the Datix CFM to allow for more comprehensive capture of consumer feedback. A working group with representatives from each HSP (including Health Support Services), the PSSU, and the Health Consumers' Council are collaborating to complete the review. Consultation with consumers and staff will inform the outcomes of the review.

The second edition of the National Safety and Quality Health Service Standards³ commenced operation in WA in January 2019 and is applicable to all hospitals, day procedure services and most public community and dental health services. This is the first report relating to clinical incidents that presents data and clinical case findings related to the revised standards. The second edition explicitly recognises the importance of leadership and culture in establishing an effective system of clinical governance.

The PSSU will also continue to review how it can assist HSPs in sharing the lessons learnt from clinical incidents in the context of the WA health system. Although interventions to make care safer need to be tailored to local environments, and there is no single strategy that will work everywhere, sharing best practices and collaborating on solutions across organisations and countries can accelerate improvements in patient safety.

Over the last few years, the focus for the PSSU has been on ensuring an integrated approach to patient safety policy, systems and processes in the WA health system. To further mature clinical governance, the PSSU's focus moving forwards will be both the maintenance of these integrated systems and strengthening the role of the people that access and use them. We will be working in collaboration with HSPs and stakeholders to support a patient safety first culture, establishing partnerships that build patient safety capacity and capability.

Appendix One: SAC 1 Clinical Incident Notification List

Clinical incidents that must be reported as SAC 1 (includes 10 national sentinel event categories*).

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)

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. Note: this list is NOT EXHAUSTIVE.

Medication error (not resulting in death, serious harm or a near miss sentinel event) may include:

- The inappropriate administration of daily oral methotrexate.
- The intravenous administration of epidural medication.
- Wrong gas being administered.

Fetal complications associated with health care delivery:

- Unrelated to congenital abnormality in an infant causing death, or serious and/or ongoing perinatal morbidity.
- Complications not anticipated yet arose and were not managed in an appropriate/timely manner resulting in death or serious and/or ongoing morbidity.
- 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.

Misdiagnosis and subsequent management (refers to physical and mental health)

- Failure to monitor and respond to oxygen saturation.

Severity Assessment Code 1 Categories (Other)

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. Note: this list is NOT EXHAUSTIVE.

Clinical deterioration of a mental health patient resulting in serious harm (physical, verbal, or sexual) or death to staff, other patients, or other persons

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.

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*

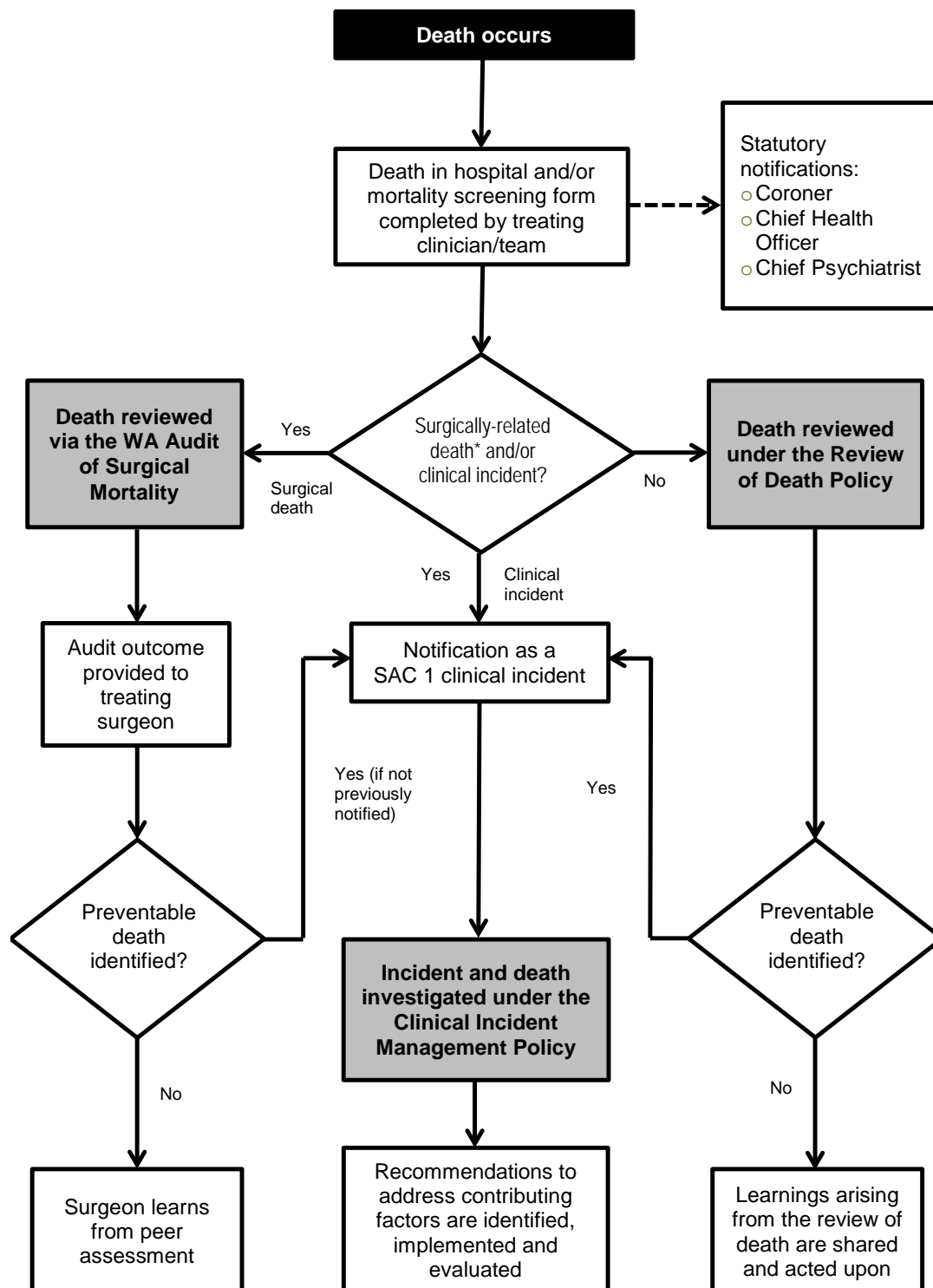
The death of a woman whilst pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

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

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

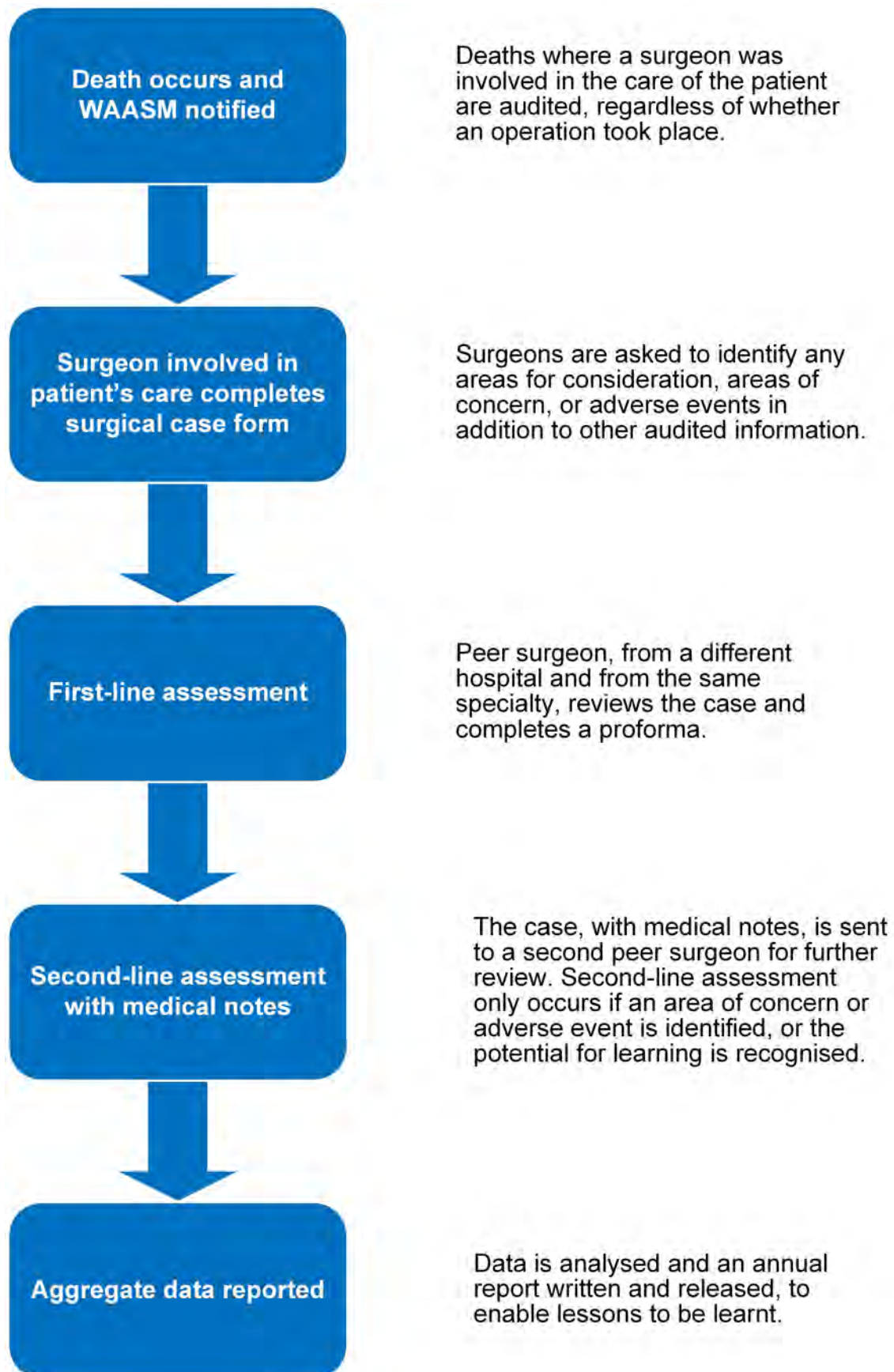
* These categories were recognised as sentinel events prior to 1 July 2018.

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.

Appendix Three: Western Australian Audit of Surgical Mortality Process



Data Quality Statement for this Report

Quality Dimensions	
Institutional Environment	<p>Clinical Incident data are obtained from across WA health system hospitals and health care providers. It is mandatory to report all SAC 1 and SAC 2 clinical incidents. SAC 1 clinical incidents are also received from all 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.</p> <p>Hospital separation and bed day data are extracted from the Hospital Morbidity Data Collection and are provided by Data Integrity Management. The HMDC captures inpatient activity and discharge data related to WA's public hospitals and CHEs. Data in the HMDC is entered by clinical coders, based on the information recorded by clinicians in each patient's medical record.</p> <p>Consumer feedback data are obtained from WA health system hospitals, including complaints from public patients treated by CHEs. It is mandatory for public hospitals and CHEs to report complaints data in accordance with the WA Health Complaints Management Policy.</p> <p>The WAASM data are obtained from the Royal Australasian College of Surgeons. The PEHS survey is conducted by Edith Cowan University via Computer Assisted Telephone Interviews (CATI) as contracted by the Department of Health's Health Survey Unit, Epidemiology Branch.</p>
Relevance	<p>The purpose of the clinical incident data is to report all state-wide clinical incidents notified within the 2019/20 period. SAC 1 incidents include data from the WA health system which includes hospitals and community health care providers plus data from licensed private hospitals (including CHEs) and contracted NGOs. Rates 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.</p> <p>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 CFM database, as well as complaints data reported to the PSSU by CHEs within the 2019/20 period. Complaints inform about patient centred care and are an integral component of clinical governance.</p> <p>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.</p> <p>The PEHS survey is administered to gauge patient satisfaction with the WA health system. Questions asked in the PEHS survey are dependent on hospital size and length of stay. Percentages reported from the PEHS are the valid percent (that is, excluding patients who selected the 'no opinion' and 'doesn't apply' response options). Frequencies are omitted from this report to avoid confusion due to variable denominators.</p>
Timeliness	<p>Datix CIMS and CFM data was extracted on 4 July 2020. The reference period for this data is 1 July 2019 to 30 June 2020. 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. In some parts of this report clinical incident data has been presented for the five-year period July 2015 to June 2020.</p> <p>HMDC data was extracted on 14 August 2020 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.</p>

WAASM data includes cases that had completed the review process by the census date of 31 March 2020. WAASM data includes cases where the death occurred over the period 1 January 2010 to 31 December 2019. Coronial inquest summaries include all health-related inquest findings released between 1 July 2019 and 30 June 2020. The status of coronial recommendations is current as at the most recent *Progress Report for Health-Related Coronial Recommendations* (August 2020).

Accuracy Data are entered into the Datix CIMS and CFM databases on a routine basis by WA health system 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. Missing data are identified and rounding errors of + or –1 are deemed acceptable. Data regarding clinical incidents related to 2nd edition NSQHS Standards 3 to 8 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. WAASM data are reported in accordance with that reported to the PSSU by the Royal Australasian College of Surgeons. Data from the PEHS are reported in accordance with the data provided to PSSU from the Health Survey Unit, Epidemiology Branch. The Health Survey Unit reports that reliability testing was conducted to test the questions used in the interview and the CATI methodology. Data is self-reported and is checked by the Health Survey Unit for valid values, logical consistency and historical consistency.

Coherence The 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.

Accessibility The data are only accessible to WA health system employees who have been granted permission to access the Datix CIMS and/or CFM databases. The PSSU does allow access to de-identified CIMS 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. Data from the PEHS were requested from the Health Survey Unit, Epidemiology Branch. Reports on the survey results for each hospital, health region and the State are provided by the Health Survey Unit to key WA health system employees for further dissemination as required.

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 ATSI status) 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.

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.

Anastomosis - an operative union of two structures (e.g. blood vessels, intestines, ureters).

Anorexia nervosa - a mental disorder manifested by extreme fear of becoming obese and an aversion to food, usually occurring in young women and often resulting in life-threatening weight loss accompanied by a disturbance of body image.⁸⁰

Bed days - the number of days a patient stays in hospital between admission and discharge. An aggregate measure of health service utilisation.

Bilateral - affecting both sides of the body.

Bipolar affective disorder – a mental disorder characterised by one or more episodes of mania which is usually accompanied by one or more episodes of depression.⁸⁰

Bronchopneumonia - acute inflammation of the walls of the smaller bronchial tubes in the lungs with varying amounts of pulmonary consolidation.⁸⁰

Cerebral palsy - a condition which affects a person's posture and their ability to move. In severe cases it can affect all areas of the person's body, which impacts on their ability to swallow, speak, move and sit.⁸¹

Cerebrovascular accident (CVA) - also known as stroke. When an artery supplying blood to a part of the brain becomes blocked or bursts. As a result, that part of the brain is damaged because it is deprived of its blood supply.⁸²

Chronic kidney disease - reduced kidney function over a long period of time, often permanent.

Chronic obstructive pulmonary disease (COPD) - reduced lung function over a long period of time, often permanent.

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.¹⁴

Clinical Incident Management (CIM) - the process of effectively managing clinical incidents with a view to minimising preventable harm.¹⁴

⁸⁰ Stedman's Medical Dictionary. 27 ed. Baltimore: Lippincott Williams & Wilkins: 2000.

⁸¹ Healthy WA website: https://healthywa.wa.gov.au/Articles/A_E/Cerebral-palsy

⁸² Healthy WA website: https://www.healthywa.wa.gov.au/Articles/S_T/Stroke

Congestive heart failure - when the heart muscle is weakened and cannot pump as well as normal. Symptoms include shortness of breath, unexplained coughing and wheezing, muscle fatigue, tiredness and swelling of the legs and ankles.

Contact - 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.⁶⁴

Contracted Health Entity (CHE) - a non-government entity that provides health services under a contract or other agreement entered into with the CEO, Department of Health on behalf of the State, a Health Service Provider or the Minister.⁸³

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.⁸⁴

COVID-19 - Coronavirus disease (COVID-19) is an infectious disease caused by a recently discovered coronavirus. Coronaviruses are a large family of viruses that cause respiratory infections. The symptoms of COVID-19 include fever, sore throat, cough, fatigue and difficulty breathing.

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.⁸⁵

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 incidents.¹⁴

Decubitus ulcer - a skin ulcer that develops from lying in one position too long, so that the circulation in the skin is compromised by the pressure.

Dysphagia - difficulty in swallowing.⁸⁰

Embolism - a plug that occludes a vessel. Could be composed of a thrombus, vegetation, mass of bacteria or some other foreign body.⁸⁰

Enteral feeding - a method of supplying nutrients directly into the gastrointestinal tract.⁸⁶ Methods include orogastric, nasogastric and gastrostomy tube feeding.

⁸³ Health Services Act 2016 available at:

https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13761_homepage.html

⁸⁴ World Health Organization. Conceptual Framework for the International Classification for Patient Safety Technical Report. Version 1.1. January 2009.

⁸⁵ For further information about the Datix CCS2 see: https://healthmatrixcorp.com/MediaStorage/file/file_63.pdf

⁸⁶ The Royal Children's Hospital Melbourne:

https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Enteral_feeding_and_medication_administration/

Extravasation - to exude from or pass out of a vessel into the surrounding tissues.⁸⁰ Can occur during the infusion or injection of medication into a blood vessel.

FISH® retractor - a device used in surgery to retain the omentum and viscera during closure of the peritoneal cavity.⁸⁷

Health Service Provider (HSP) - 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.⁸³

Hypertension - high blood pressure; transitory or sustained elevation of systemic arterial blood pressure to a level likely to induce cardiovascular damage or other adverse consequences.⁸⁰

Hyponatremia - abnormally low sodium level in the bloodstream.⁸⁰

Injury - in the context of CIM includes burns, injury due to an impact or collision, pressure injuries, injury of unknown origin, unintended injury during a procedure or treatment and other injuries not classifiable in the previous categories.

Ischaemic heart disease - reduced blood supply to the heart muscle, usually due to blockage of the blood vessels that supply the heart. This can lead to chest pain and heart attack.

Mental health patient - refers to any involuntary or voluntary mental health patient as well as any referred mental health patient.

Merkel cell carcinoma - a rare type of skin cancer that usually appears as a flesh-coloured or bluish-red nodule, often on the face, head or neck.⁸⁸

Myocardial infarction - sudden insufficiency of blood supply to a segment of the heart muscle, usually due to blockage of a coronary artery.⁸⁰

Nephrotic syndrome - a group of symptoms that indicate damage to the kidney.

Nephrotoxic - toxic to, or capable of, causing injury to the kidneys.

Osteomyelitis - inflammation of the bone marrow and adjacent bone.⁸⁰

Pandemic - a disease affecting or attacking the population of an extensive region, country, continent or the world.⁸⁰

Parkinsonism - a syndrome similar to Parkinson's disease that can appear as a side effect of treatment with antipsychotic medications. Symptoms can include rhythmic muscular tremors, rigidity of movement, droopy posture, and mask-like faces.⁸⁰

Pulse oximetry - a non-invasive technique, usually performed on the finger or ear lobe, which is used to calculate the oxygen level (saturation) in the blood.⁸⁰

Rheumatoid arthritis - pain and swelling of the joints that occurs when the body's immune system attacks the lining of the joints causing inflammation and joint damage.

⁸⁷ For further information see: <http://adeptmed.com/the-fish/>

⁸⁸ Mayo Clinic website: <https://www.mayoclinic.org/diseases-conditions/merkel-cell-carcinoma/symptoms-causes/syc-20351030>

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).¹⁴

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.⁸⁹

Sepsis - the presence of pathogenic organisms, or their toxins, in the blood or tissues.⁸⁰

Septicaemia - systemic disease caused by the spread of micro-organisms and their toxins within the blood.⁸⁰

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.¹⁴

Spastic quadriplegia - the most severe form of spastic cerebral palsy which affects all four limbs, the trunk, and the face. People with spastic quadriplegia usually cannot walk and often have other developmental disabilities such as intellectual disability, seizures, or problems with vision, hearing or speech.⁹⁰

Type 2 diabetes - a progressive condition in which the body becomes resistant to the normal effects of insulin and/or gradually loses the capacity to produce enough insulin.⁹¹

Venous thromboembolism (VTE) - the formation of a blood clot, usually in a deep vein.⁸⁰

Ventricular fibrillation (VF) - a life threatening heart rhythm disturbance where the lower chambers of the heart quiver instead of contracting normally, stopping the heart from pumping blood.

⁸⁹ Department of Health WA. Admissions, Readmissions, Discharge and Transfer Reference Manual (2017). Department of Health, Western Australia, editor. Perth. 2017.

⁹⁰ Centres for Disease Control and Prevention: <https://www.cdc.gov/ncbddd/cp/facts.html>

⁹¹ Diabetes Australia: <https://www.diabetesaustralia.com.au/type-2-diabetes>

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