



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: 2019



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Foreword

Patient safety is fundamental to delivering high-quality health care that is effective and patient-centred. Tuesday 17 September 2019 marked the first-ever World Patient Safety Day,¹ with the World Health Organization launching a global campaign to create awareness of patient safety and urge people to show their commitment to making health care safer. The theme for the inaugural World Patient Safety Day was “Speak up for patient safety”.

While patient safety is gaining recognition as a top global health priority, more work needs to be done to reduce the avoidable harm that can occur to the patients we care for. In high-income countries, it is estimated that one in every 10 patients is harmed while receiving hospital care, and that 15% of hospital activity and expenditure in Organisation for Economic Co-operation and Development countries can be attributed to treating safety failures. Most of the burden is associated with common adverse events, such as healthcare-associated infections, venous thromboembolism, pressure injuries, medication errors and wrong or delayed diagnosis.²

Globally, several trends have been identified regarding patient safety that provide reasons for optimism.³ These include: the current understanding of patient safety being better than ever with a growing evidence base on patient harm and the interventions that improve patient safety; global leaders increasing recognition of patient safety as a priority; increasing international collaboration on patient safety; and expanding approaches and methods that could help improve patient safety such as digital and data-driven innovations.

This eighth 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. A longitudinal review of clinical incident data has been included, covering the five-year period from July 2014 to June 2019, to close out the first edition of the National Safety and Quality Health Service Standards (which were replaced by the second edition from January 2019).

High levels of clinical incident reporting coupled with a low or decreasing level of harm to patients is regarded as indicating a strong patient safety culture within a healthcare system. The five-year data in this report shows an increasing trend in the reporting of clinical incidents in the WA health system, while the level of avoidable harm that occurred to patients, albeit relatively low, appeared to remain stable over this period.

This suggests that while the overall safety of the WA health system remains high, little headway has been made in reducing avoidable harm to patients in WA. Further work is required by the WA health system to ensure the lessons learnt when a patient is harmed are translated into effective actions and risk management strategies that will avoid similar events causing harm to patients in the future.

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¹ Further information about World Patient Safety Day is available on the World Health Organization website: <https://www.who.int/campaigns/world-patient-safety-day/2019>

² Slawomirski L, Aaraaen A, Klazinga N. The Economics of Patient Safety: strengthening a value-based approach to reducing patient harm at national level. OECD; 2017 (<http://www.oecd.org/els/health-systems/The-economics-of-patient-safety-March-2017.pdf>, accessed 24 September 2019)

³ Fontana G, Flott K, Dhingra-Kumar N, Durkin M, Darzi A. Five reasons for optimism on World Patient Safety Day. *The Lancet* vol 394 issue 10203. September 2019 ([https://doi.org/10.1016/S0140-6736\(19\)32134-8](https://doi.org/10.1016/S0140-6736(19)32134-8) accessed 24 September 2019)

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Common Acronyms

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
ANZCA	Australian and New Zealand College of Anaesthetists
ARDS	Acute respiratory distress syndrome
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
CTG	Cardiotocography
CVA	Cerebrovascular accident
CVC	Central venous catheter
CVVHD	Continuous veno-venous haemodialysis
DVT	Deep vein thrombosis
ED	Emergency Department
GP	General Practitioner
HAC	Hospital-acquired complication
HaDSCO	Health and Disability Services Complaints Office
HAI	Healthcare-associated infection
HDU	High dependency unit
HMDC	Hospital Morbidity Data Collection
HSP	Health Service Provider
ICT	Information and communications technology
ICU	Intensive care unit
IHPA	Independent Hospital Pricing Authority
MHOA	Mental health observation area
NGO	Non-government organisation
NHRA	National Health Reform Agreement
NSQHS	National Safety and Quality Health Service (Standards)
NSTEMI	Non-ST-elevation myocardial infarction
PEHS	Patient Evaluation of Health Services (Survey)
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
SHR	Sustainable Health Review
STEMI	ST-elevation myocardial infarction
TGA	Therapeutic Goods Administration
WAASM	Western Australian Audit of Surgical Mortality
VTE	Venous thromboembolism
WHO	World Health Organization



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 2018/19, there were 34,272 clinical incidents notified across the WA health system of which 32,831 had been confirmed at the time of writing this report. The majority of clinical incidents reported in 2018/19 were classified as Severity Assessment Code (SAC) 3 (n=28,493; 83.1%) and most confirmed incidents resulted in no or minor harm to the patient (n=30,880; 94.1%).

The WA health system provided 615,689 episodes of care (amounting to 1,841,599 bed days) to inpatients at public hospitals and Contracted Health Entities (CHEs) in 2018/19. Inpatient clinical incidents (n=26,886) were associated with 1.7% of public hospital bed days and accounted for 5.4% of public hospital separations. Incidents related to medication (n=7,610; 23.2% of confirmed incidents) and falls (n=5,815; 17.7% of confirmed incidents) continue to be the most frequently reported categories that relate to the first edition of the Australian Commission for Safety and Quality in Health Care's (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards. Future editions of this report will be aligned to the second edition of the NSQHS Standards that took effect in WA from January 2019.

There were 601 SAC 1 clinical incidents confirmed in 2018/19 by WA's Health Service Providers, private licensed healthcare facilities and other contracted non-government organisations. A further 168 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 two incidents per 10,000 bed days or six incidents per 10,000 separations.⁴ Inpatient SAC 1 incidents accounted for 1.1% (n=293) of all confirmed inpatient incidents in WA public hospitals in 2018/19.

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 2018/19, 11.8% (n=71) of confirmed SAC 1 clinical incidents reported a patient outcome of no harm. The most frequently reported categories of SAC 1 clinical incidents in 2018/19 were infection control breaches (n=127; 21.8% of 'Other SAC 1' incidents), complications of an inpatient fall (n=73; 12.5%) and other incidents resulting in serious harm or death (n=71; 12.2%).

The 10 revised sentinel event categories endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in December 2017 commenced use in WA in 2018/19, and 19 sentinel events were reported in this period, representing 3.2% of all confirmed SAC 1 incidents. The most frequently reported sentinel event categories in 2018/19 were medication errors resulting in serious harm or death (n=5) and the unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death (n=4).

The most frequently identified contributory factor in SAC 1 clinical incidents in 2018/19 continues to be patient factors which were identified in 62.0% SAC 1 incidents investigated.

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. Bed day data have been introduced as it is more sensitive than separation data.

While patient factors are often beyond the control of hospitals and clinicians, issues with communication (identified in 61.4% of SAC 1 incidents investigated) and policies, procedures and guidelines (identified in 53.5%) are areas in which the WA health system can focus attention and deliver sustainable improvements in the quality and safety of the care it delivers.

The Independent Hospital Pricing Authority's (IHPA) national approach to pricing and funding for safety and quality in Australian public hospitals continued in 2018/19, with a second year of funding penalties for episodes of care that include a sentinel event. Sentinel event penalties in 2018/19 continued to be based on the original version of the Australian sentinel events list while the revised sentinel event categories were pending approval by the Council of Australian Governments (COAG) Health Council, which occurred in December 2018.

Australia's national list of hospital-acquired complications (HACs) consists of 16 categories of complication for which clinical risk mitigation strategies may reduce, but not necessarily eliminate the risk of that complication occurring. From July 2018, a second part of the IHPA's national approach to pricing and funding for safety and quality commenced with the introduction of funding adjustments for episodes of care that include one of 13 of the HAC categories. These funding adjustments are risk-adjusted to account for the increased likelihood that some patients may experience a HAC during their stay in hospital.

Data from the WA health system's Hospital Morbidity Data Collection (HMDC) shows that the most frequently identified HAC categories in 2018/19 continue to be healthcare-associated infections (HAIs) which were reported in 0.7% of separations (n=3,704) and cardiac complications which were reported 0.3% of separations (n=1,702). It is encouraging that the frequency of many of the HAC categories has declined between July 2016 and June 2019. This may reflect the funding penalties introduced in 2018/19, coupled with additional resources that support strategies to reduce the incidence of the HACs, driving improvements in the care provided to patients in WA's hospitals.

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 19,236 consumer feedback items⁵ were reported across the WA health system in 2018/19, of which 54.3% (n=10,440) were compliments, 24.1% (n=4,629) were complaints and 21.7% (n=4,167) were contacts. The 4,629 complaints identified 8,050 separate complaint issues, and the four most frequently identified categories of quality of clinical care, communication, access and rights, respect and dignity accounted for 85.0% of these issues. Data from the annual Patient Evaluation of Health Services (PEHS) survey, administered by the Department's Health Survey Unit, is included in this report to complement the data available from Datix Consumer Feedback Module (CFM).

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. Forty inquest findings were released in 2018/19 that resulted in 30 health-related recommendations. Twenty-eight of these recommendations related to mental health care and a significant number arose from the inquest into the deaths of 13 Aboriginal children and young persons in the Kimberley. The WA health system is contributing to the whole-of-government project led by the Department of Premier and Cabinet aimed at preventing similar deaths through healing and supporting this marginalised and disadvantaged community.

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.

All deaths in WA that occur under the care of a surgeon are notified to the WA Audit of Surgical Mortality (WAASM) and in 2018, 552 deaths met the WAASM inclusion criteria. For cases that had completed the audit process by 1 April 2019, the WAASM identified three adverse events that caused death in 2018 (none of which were definitely preventable) compared to 10 adverse events that caused death in 2017 (four of which were considered definitely preventable).

While an increasing trend in the reporting of clinical incidents (including SAC 1 incidents) has been observed from July 2014 to June 2019, this should not be taken as an indication that the safety of the WA health system is declining. It is recognised globally that healthcare systems that are proactive in reporting and investigating clinical incidents to determine contributory factors, and that implement robust improvement strategies in response, are more likely to reduce future incidents and avoidable harm to patients.

The five-year review of clinical incident data contained in this report indicates the level of avoidable harm that results from health care in WA is in stasis, suggesting that despite its best endeavours the WA health system has made little headway in reducing avoidable harm to patients. Investigating clinical incidents to identify what went wrong is only the first step, and further work is required by the WA health system to ensure the lessons learnt when a patient is harmed are translated into effective actions and risk management strategies that will reduce the likelihood of similar events causing harm to patients in the future.



About this Report

This comprehensive patient safety report for 2018/19 is the eighth 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 2018/19 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 2018 calendar year.
- The WAASM data are captured by calendar year and covers the period 1 January 2008 to 31 December 2018.
- Hospital-Acquired Complications includes data for the financial years 2016/17, 2017/18 and 2018/19.
- The PEHS includes a full 12 months of financial year data.⁶

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. 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.

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 Clinical Incident Management Policy was amended to incorporate the 10 revised sentinel event categories endorsed by the Australian Health Ministers' Advisory Council in December 2017 (see Appendix Two: 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.

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.

Sentinel events for 2018/19 are reported under the revised categories, while sentinel events prior to July 2018 are 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 are not directly comparable to that for prior years or contained in previous editions of this report.

This report includes data that focuses on the eight clinical standards in the first edition of the National Safety and Quality Health Service Standards. Sections include; preventing and controlling healthcare-associated infections clinical incidents, medication clinical incidents, patient identification clinical incidents, clinical handover clinical incidents, blood and blood products clinical incidents, pressure injury clinical incidents, clinical deterioration clinical incidents and falls clinical incidents.

While the second edition of the NSQHS Standards was implemented in the WA health system from January 2019, the clinical incident data in this report remains aligned to the first edition of the NSQHS Standards. A five-year review of incident data related to the first edition of the NSQHS Standards has been included in this report (see Appendix One: Longitudinal Review of Five-Year Clinical Incident Data). Clinical incident data will be reported against the second edition of the NSQHS Standards in future editions of this report.

Information regarding the context and processes for ensuring safety and quality in the WA health system is presented in the governance for safety and quality section relating to Standard 1 of the NSQHS Standards. Consumer feedback is a key component of Standard 2 of the NSQHS Standards and data regarding consumer feedback and complaints received by the WA health system during 2018/19 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 improvement which leads to increased consumer satisfaction are equally valuable. Data related to the top four complaint categories in 2018/19 are included in this report.

This report is further strengthened by the inclusion of administrative data 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. The Hospital-Acquired Complications clinical codes provided by the ACSQHC, which describe 16 complications that have been deemed to possibly respond to clinical risk mitigation strategies, are used as the basis to identify HACs within the HMDC.

The HACs specification was updated in August 2018⁷ to include mental health patients (who were excluded in earlier versions). The HACs data in this report includes complications that occurred in mental health patients from July 2016 to June 2019 and is not directly comparable with the HACs data presented in previous editions of this report.⁸

⁷ The HACs specification is available from the ACSQHC's website at: <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-20>

⁸ An error was identified in the extraction of the HACs data presented in the previous edition of this report whereby ICD-10-AM code I80.2 relating to DVT was not picked up. Data presented in this report for the HAC category 'Venous thromboembolism' and the HAC diagnosis 'Deep vein thrombosis' is complete but should not be compared to that in the previous (2018) edition of this report.



Clinical Incident Management: Overall Notifications

The WA public health system uses the Datix CIMS for the notification, investigation, analysis and evaluation of practice improvements of clinical incidents that occur within all public hospitals in Western Australia. Severity Assessment Code 1 is used to identify clinical incidents that result in serious harm/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.⁹ Severity Assessment Code 2 incidents (those that result in moderate harm or near miss) and SAC 3 incidents (those that result in minimal/no harm or near miss) occurring at private licensed health care facilities and contracted NGOs are managed locally and not reported into the Datix CIMS, and are not included in this report.

Between 1 July 2018 and 30 June 2019 there were 615,689 separations, with inpatients accumulating a total of 1,841,599 bed days, from public hospitals and public patients attending a Contracted Health Entity. During 2018/19, the CHEs were Peel Health Campus, Joondalup Health Campus and St John of God Midland.

During 2018/19, there were 34,272 clinical incidents notified of which 32,831 clinical incidents were confirmed at the time of this report. Of these confirmed incidents, 26,886 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.

Reported inpatient clinical incidents were associated with 5.4% (n=26,886) of public hospital separations from HSPs. The rate¹⁰ of inpatient clinical incidents observed between July 2018 and June 2019 was calculated at:

- 6 SAC 1 clinical incidents per 10,000 separations¹¹
- 63 SAC 2 clinical incidents per 10,000 separations
- 468 SAC 3 clinical incidents per 10,000 separations.

Reported inpatient clinical incidents were associated with 1.7% (n=26,886) of public hospital bed days at HSPs. Findings showed that there were:

- 2 SAC 1 clinical incidents per 10,000 bed days¹²
- 20 SAC 2 clinical incidents per 10,000 bed days
- 151 SAC 3 clinical incidents per 10,000 bed days.

Findings revealed that 305 clinical incidents were notified that related to non-admitted mental health patients, with 984,914 occasions of service delivered by WA's Mental Health Ambulatory Services. A rate of three clinical incidents per 10,000 occasions of service (across all SAC ratings) was calculated for the 2018/19 period.¹³

⁹ 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

¹⁰ 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

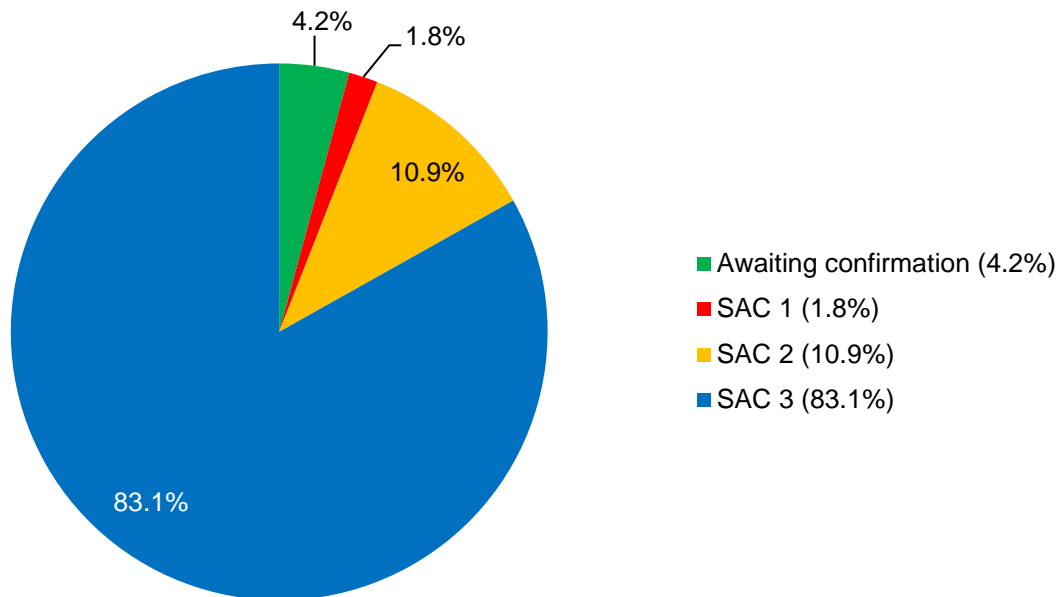
¹¹ The numerator for the SAC 1 incident rate includes incidents involving public patients treated at CHEs, and the denominator includes public patient separations from CHEs.

¹² 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.

¹³ The rate of clinical incidents for non-admitted mental health patients is not comparable with previous editions of this report.

Clinical incidents categorised as SAC 3 (n=28,493; 83.1%), were the most frequently reported category of clinical incidents (see Figure 1). The next most frequently reported category was SAC 2 clinical incidents (n=3,737; 10.9%), followed by SAC 1 clinical incidents (n=601; 1.8%).

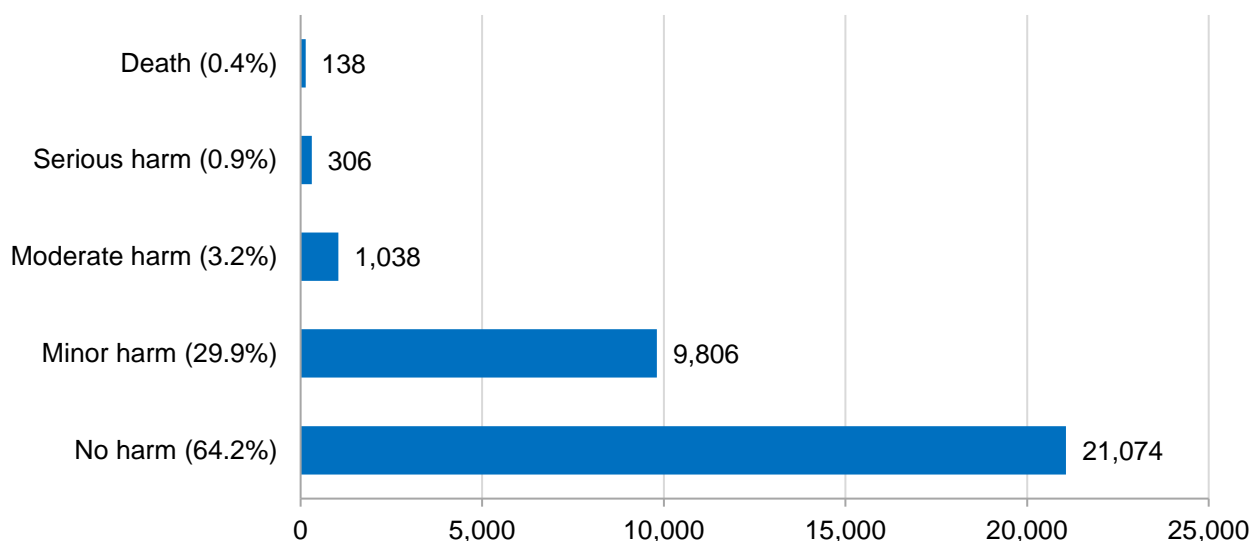
Figure 1: Percentage of Clinical Incidents by SAC Category for 2018/19



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 7 July 2019, there were 1,441 clinical incidents that had yet to have a SAC rating confirmed.

Figure 2 shows the patient outcome recorded for confirmed clinical incidents during 2018/19. Confirmed incidents were most often reported as resulting in no harm to the patient (n=21,074; 64.2%), followed by minor harm (n=9,806; 29.9%). A patient outcome of serious harm or death was recorded in 1.3% (n=444) of confirmed clinical incidents during this period.

Figure 2: Frequency and Percentage of Confirmed Clinical Incidents by Patient Outcome for 2018/19



Note: Patient outcome missing data n=469; 1.4%

The five most frequently reported SAC 1 clinical incident categories, representing 67.1% (n=403) of all confirmed SAC 1 incidents in 2018/19, are presented in Table 1. Infection control breaches were the most frequently reported SAC 1 clinical incident category (n=127; 21.1%) followed by complications of an inpatient fall (n=73; 12.1%).

Table 1: Frequency and Percentage of the Top Five Confirmed SAC 1 Clinical Incident Categories for 2018/19

SAC 1 Category	(n)	(%)
Infection control breach	127	21.1
Complications of an inpatient fall	73	12.1
Any other incident resulting in serious harm or death*	71	11.8
Delay in recognising/responding to clinical deterioration	69	11.5
Hospital process issues	63	10.5
Total	403	67.1

*In 2018/19, examples of incidents notified in this SAC 1 category included attempted self-harm or suicide, failed or delayed patient transfers, equipment failure/malfunction, medication errors not resulting in serious harm or death, pressure injuries and unexpected patient deaths.

The most frequent SAC 1 clinical incident category involving mental health patients involved high-risk patients missing or absent without leave, which accounted for 5.8% (n=35) of all confirmed SAC 1 clinical incidents in 2018/19 (see Table 2). Of these 35 incidents, 27 resulted in no harm to the patient and one resulted in minor harm. The unexpected death of a mental health client was the second most frequently reported SAC 1 category involving mental health patients (n=33; 5.5% of confirmed SAC 1 incidents).

Table 2: Frequency and Percentage of Confirmed SAC 1 Clinical Incident Categories Related to Mental Health Care for 2018/19

SAC 1 Category	(n)	%
Missing or absent without leave of any high-risk mental health patient/consumer	35	5.8
The unexpected death of a mental health client	33	5.5
Mental health clinical deterioration resulting in serious harm	23	3.8
Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	3	0.5
Patient missing or absent without leave with adverse outcome*	2	0.3
Total	96	16.0

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

The five most frequently reported Datix CIMS Tier One incident types represented 71.2% (n=22,960) of all confirmed SAC 2 and SAC 3 incidents reported during 2018/19 (see Table 3). Medication incidents (n=7,571; 23.5%) and falls (n=5,741; 17.8%) 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 2018/19

Tier One Incident Type (SAC 2/3 Incidents)	(n)	(%)
Medication	7,571	23.5
Falls*	5,741	17.8
Behaviour	4,675	14.5
Documentation	2,935	9.1
Therapeutic Processes/Procedures	2,038	6.3
Total	22,960	71.2

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 pressure injuries.

*Tier One category is titled patient accidents/falls, with patient accidents excluded from this figure.



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 18.1% (n=5,825) of all confirmed SAC 2 and SAC 3 clinical incidents.

Findings show that inappropriate or aggressive physical behaviour by a patient had the highest frequency, with 1,800 incidents (representing 38.5% of all SAC 2 and SAC 3 incidents in the Behaviour Tier One category) citing this type. Ambiguous, incomplete or incorrect documentation was identified in 1,572 confirmed SAC 2 and SAC 3 clinical incidents during 2018/19, representing more than half of all 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 2018/19

Tier Three Incident Type (SAC 2/3 Incidents)	(n)	(%)
Behaviour: Inappropriate or aggressive physical behaviour	1,800	5.6
Documentation: Ambiguous, incorrect or incomplete	1,572	4.9
Medication: Failure to administer medication	1,095	3.4
Falls: Activity at time of fall unknown or patient found on floor/ elsewhere	961	3.0
Therapeutic Processes/Procedures: Treatment/procedure was incomplete or incorrectly performed	397	1.2
Total	5,825	18.1

Data on eight categories in the first edition of the ACSQHC's NSQHS Standards accounted for 65.7% (n=21,564) of all confirmed clinical incidents during 2018/19 (see Table 5). Results show that medication clinical incidents (n=7,610) and falls clinical incidents (n=5,815) were the most frequently reported incidents related to these eight NSQHS Standards.

Table 5: Frequency and Percentage of Confirmed Clinical Incidents for Eight NSQHS First Edition Standard Indicators for 2018/19

Eight NSQHS First Edition Standards	(n)	(%)
Standard 3: Preventing and Controlling Healthcare-Associated Infections	1,304	4.0
Standard 4: Medication Safety	7,610	23.2
Standard 5: Patient Identification and Procedure Matching	1,433	4.4
Standard 6: Clinical Handover	2,381	7.3
Standard 7: Blood and Blood Products	160	0.5
Standard 8: Preventing and Managing Pressure Injuries	2,010	6.1
Standard 9: Recognising/Responding to Clinical Deterioration	851	2.6
Standard 10: Preventing Falls and Harm from Falls	5,815	17.7
Total	21,564	65.7



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 2018/19 reporting period is the fifth complete period Health Service Providers have reported SAC 1 clinical incidents via the web-based Datix CIMS.

In 2018/19, 601 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 168 events reported that were approved for declassification. The investigation of 130 SAC 1 clinical incidents notified during 2018/19 remained ongoing at 30 June 2019.

Of the 601 confirmed SAC 1 clinical incidents, 19 (3.2%) were identified as sentinel events with the remainder captured as ‘Other SAC 1 Incidents’ (n=582; 96.8%; see Figure 3).

Figure 3: Percentage of Confirmed SAC 1 Clinical Incidents by Type for 2018/19

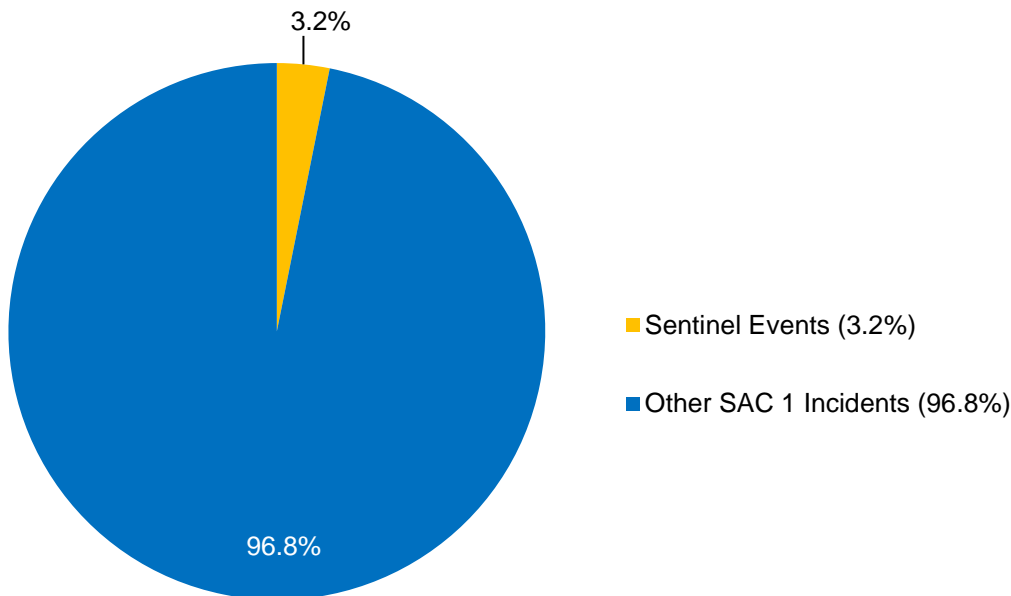


Table 6 shows the frequency of confirmed SAC 1 clinical incidents over the five-year period from July 2014 to June 2019. Findings show that there has been a relatively consistent increase in the reporting of confirmed SAC 1 clinical incidents over this time.

Table 6: Frequency of Confirmed SAC 1 Clinical Incidents by National Sentinel Event and Other SAC 1 Clinical Incident Types for 2014/15 to 2018/19

SAC 1 Categories	2014/15	2015/16	2016/17	2017/18	2018/19
Sentinel Events	10	14	13	12	19
Other SAC 1 Incidents	323	407	468	553	582
Total	333	421	481	565	601

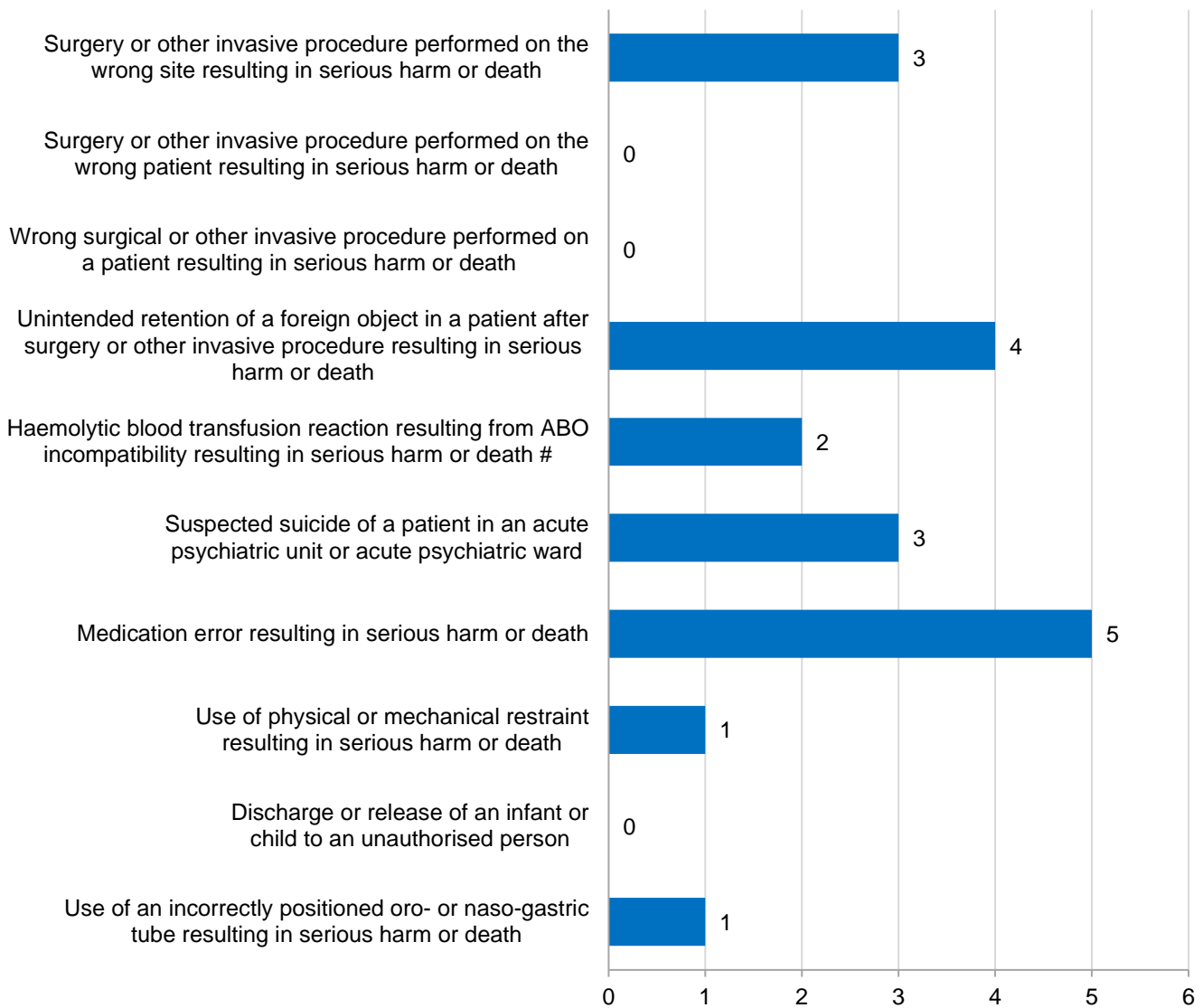
Sentinel Event Notifications

Sentinel events are unexpected occurrences involving death or serious physical or psychological injury, or risk thereof. Australian Health Ministers endorsed an original set of eight sentinel event categories in 2004, and these events (as amended from time-to-time) were included in WA's *Clinical Incident Management Policy* until June 2018.

Following a review led by the ACSQHC, Australian Health Ministers endorsed a revised set of 10 sentinel event categories in December 2017 (see Appendix Two: SAC 1 Clinical Incident Notification List). The revised sentinel event categories were implemented in the CIM Policy from 1 July 2018 and are not directly comparable to the previous sentinel event categories. The CIM Policy continues to require the reporting of near miss sentinel events in WA.

Figure 4 identifies sentinel events notified under the revised categories in 2018/19. The most frequently reported sentinel event was medication error resulting in serious harm or death of a patient (n=5). There were four notifications relating to unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death.

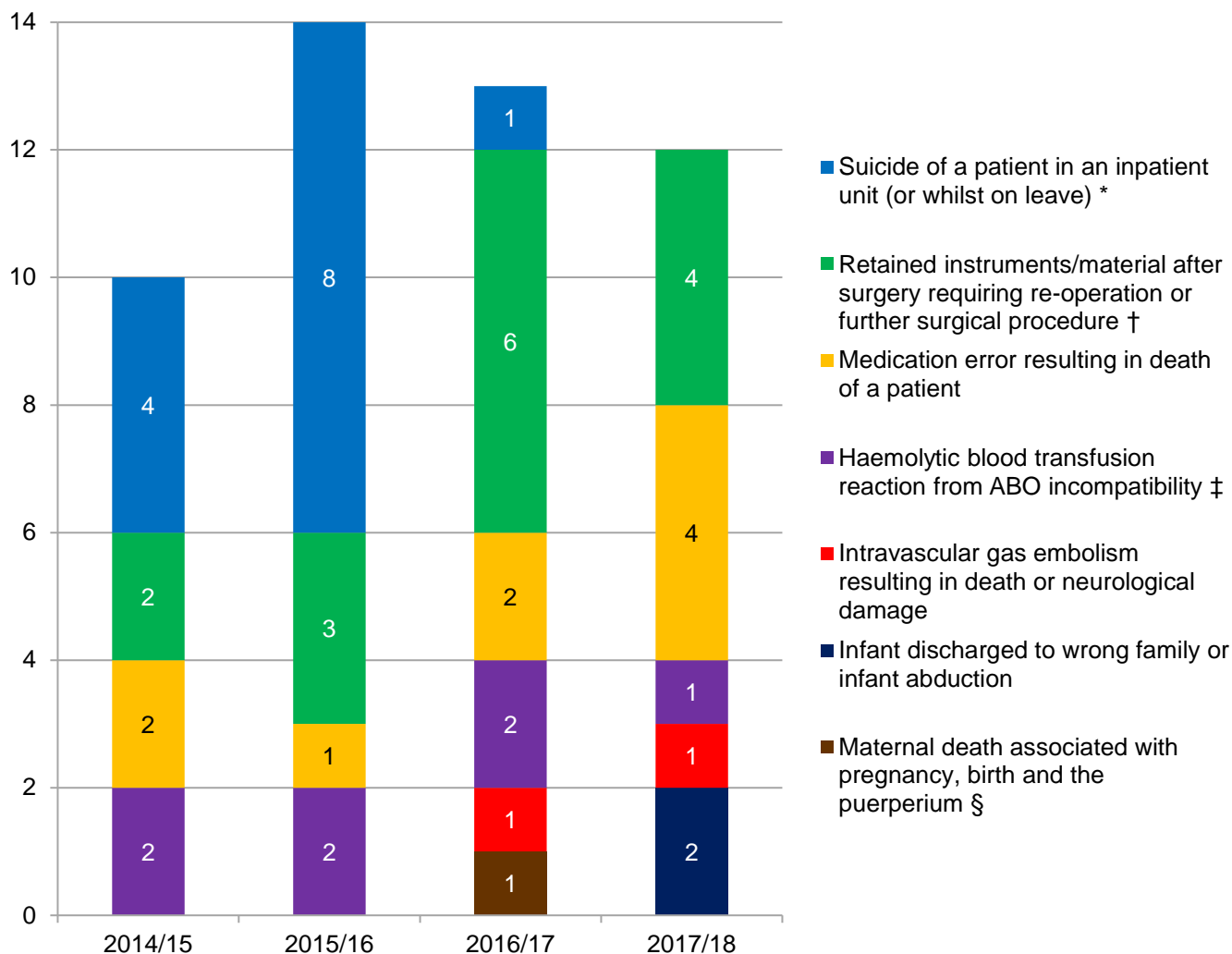
Figure 4: Frequency of Sentinel Events by Category for 2018/19



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

Figure 5 shows historical sentinel events notified from July 2014 to June 2018 and reflects the categories that were in use in WA at the time each event was notified into the Datix CIMS.

Figure 5: Frequency of Sentinel Events by Category for 2014/15 to 2017/18



* One sentinel event notified in 2015/16 was a near miss with the patient outcome reported as no harm.
 † Two sentinel events (one notified in 2015/16 and one notified in 2017/18) reported the patient outcome as no harm. One sentinel event notified into the Datix CIMS in 2017/18 was confirmed as a sentinel event in 2018/19 under the revised category 'Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death'.
 ‡ All sentinel events notified in 2014/15 and 2015/16 were near misses that resulted in no harm to the patients. One incident from 2017/18 resulted in no harm.
 § The national sentinel event definition regarding maternal death was changed in 2014 and applied in WA from 1 July 2015. Data from July 2015 reflects the updated definition however data for prior periods has not been revised and therefore reflects the previous definition of this sentinel event category (i.e. maternal death or serious morbidity associated with labour or delivery).

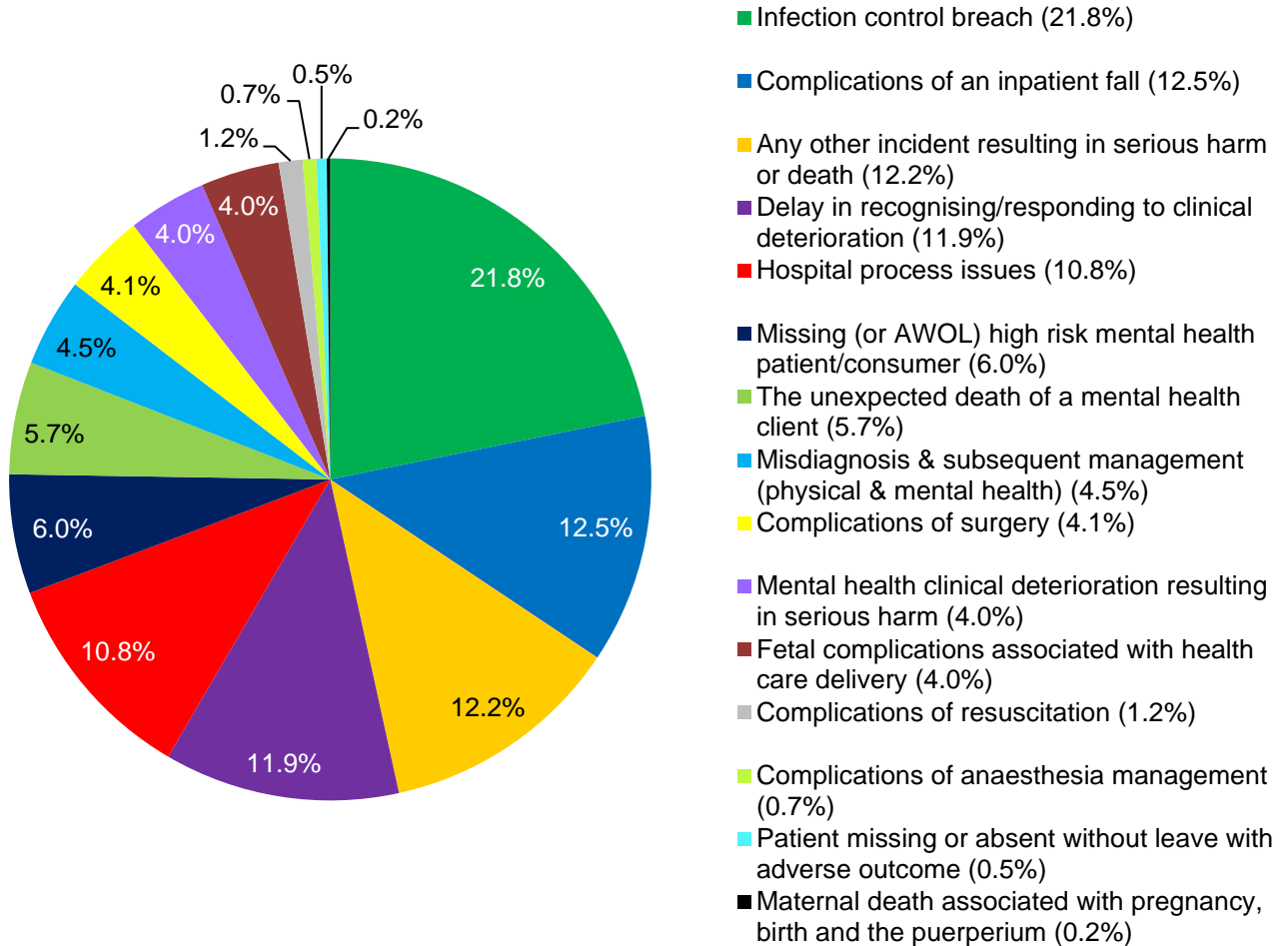
In addition to the reporting of sentinel events within this report, sentinel event notifications made by WA's public hospitals are included in the Australian Government Productivity Commission Report on Government Services (ROGS) annual report.¹⁴ Commencing on 1 July 2017, sentinel events are also reported to the IHPA in accordance with the Addendum to the National Health Reform Agreement (NHRA).

¹⁴ Productivity Commission 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 2018/19, there were 582 SAC 1 clinical incidents other than sentinel events confirmed (see Figure 6). Infection control breaches (n=127; 21.8%) were the most frequently reported category of other SAC 1 clinical incident, followed by complications of in an inpatient fall (n=73; 12.5%).

Figure 6: Percentage of Other Confirmed SAC 1 Clinical Incidents by Category for 2018/19



Of the 63 SAC 1 clinical incidents categorised as hospital process issues in 2018/19, 47.6% (n=30) identified communication issues between staff as a contributing factor; 20.6% (n=13) identified staff training/skills as a contributing factor; and 20.6% (n=13) identified issues in the application of policies, procedures or guidelines as contributing to the incident.

Other SAC 1 clinical incidents have increased from 323 clinical incidents in 2014/15 to 582 clinical incidents in 2018/19 (see Table 7). Over the five-year period from July 2014 to June 2019, the most frequently reported category of SAC 1 clinical incident was complications of an inpatient fall, followed by infection control breaches and hospital process issues.

Table 7: Frequency of Confirmed SAC 1 Clinical Incidents Other than Sentinel Events for 2014/15 to 2018/19

SAC 1 Categories	2014/15	2015/16	2016/17	2017/18	2018/19
Infection control breach	5	37	55	74	127
Complications of an inpatient fall	69	53	68	72	73
Any other incident resulting in serious harm or death	49	31	45	61	71
Delay in recognising/responding to clinical deterioration	25	34	38	41	69
Hospital process issues ^a	34	57	59	81	63
Missing or absent without leave of any high-risk mental health patient/consumer ^b	34	59	58	43	35
The unexpected death of a mental health client	38	38	24	40	33
Misdiagnosis and subsequent management	14	18	31	28	26
Complications of surgery	12	25	16	29	24
Fetal complications associated with health care delivery	18	16	17	14	23
Mental health clinical deterioration resulting in serious harm ^c	-	12	19	28	23
Complications of resuscitation	2	8	2	4	7
Complications of anaesthesia management	2	3	4	4	4
Patient missing or absent without leave with adverse outcome ^d	1	2	3	4	3
Maternal death associated with pregnancy, birth and the puerperium ^e	-	-	-	-	1
Medication error (not resulting in death)	19	14	29	30	-
Wrong route administration of oral/enteral treatment	1	-	-	-	-
Total	323	407	468	553	582

Note: Data reflects confirmed SAC 1 clinical incidents and excludes declassified SAC 1 clinical incidents. 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 Hospital 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.

^b Category redefined 1 July 2015. Data from 2015/16 onwards reflects the stated definition. Data for 2014/15 reflects the previous definition 'Absconding of any mental health patient'.

^c Category first included 2015/16 with data for 2015/16 representing incidents notified from September 2015 to June 2016.

^d Category redefined 1 July 2015. Data from 2015/16 onwards reflects the stated definition. Data for 2014/15 reflects the previous definition 'Patient absconding with adverse outcome'.

^e Category redefined 1 July 2018. Incidents prior to 2018/19 were categorised as sentinel events.

Harm Associated with SAC 1 Clinical Incidents

Of the 601 confirmed SAC 1 clinical incidents reported in 2018/19, 121 (20.1%) were associated with a patient outcome of death and 281 (46.8%) incidents were associated with a patient outcome of serious harm. Of the 121 deaths, 38 (31.4%) were mental health patients. Of the 281 incidents with a patient outcome of serious harm, 34 (12.1%) were mental health patients. Figure 7 provides a summary of the patient outcome recorded for confirmed SAC 1 clinical incidents during 2018/19. It is important to note that the patient outcome may not be a direct result of the clinical incident itself.

Figure 7: Frequency and Percentage of Confirmed SAC 1 Clinical Incidents by Patient Outcome for 2018/19

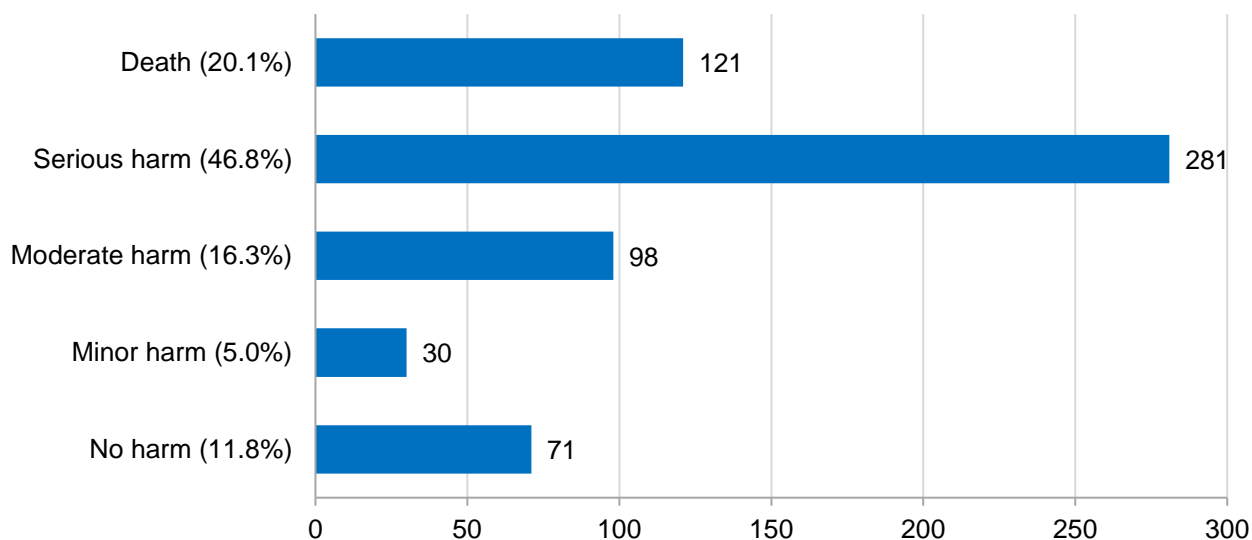


Table 8 provides the frequency by patient outcome for the five SAC 1 incident categories most often associated with a patient outcome of serious harm or death.

Table 8: Frequency of the Top Five Confirmed SAC 1 Clinical Incident Categories by Patient Outcome of Serious Harm or Death for 2018/19

SAC 1 Category	Death	Serious harm
Infection control breach	6	77
Delay in recognising/responding to clinical deterioration	24	37
Complications of an inpatient fall	9	49
Hospital process issues	12	30
Any other incident resulting in serious harm or death	12	26
Total	63	219

In 2018/19, there were also 33 confirmed SAC 1 clinical incidents categorised as 'the unexpected death of a mental health client'; six incidents categorised as 'misdiagnosis and subsequent management (physical and mental health)'; and five incidents categorised as 'complications of surgery' that described a patient outcome of death.

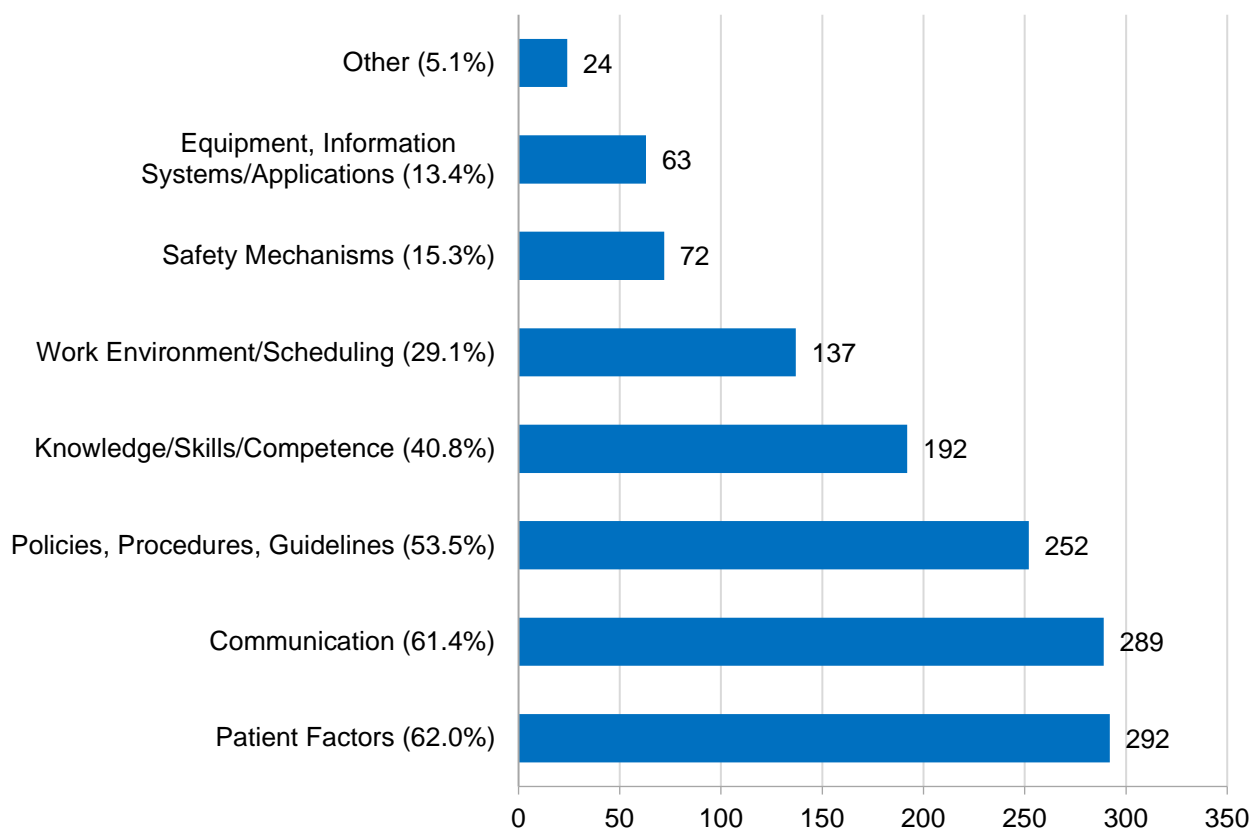
The majority of high-risk mental health patients who went missing or absent without leave sustained no harm (n=27). One patient sustained minor harm, three sustained moderate harm, two sustained serious harm and two incidents of these incidents were associated with a patient outcome of death.

SAC 1 Contributory Factors

Figure 8 shows the contributory factors identified following the investigation of 471 SAC 1 clinical incidents (including sentinel events) by HSPs, private licensed health care facilities and contracted NGOs (representing 78.4% of all confirmed SAC 1 incidents reported in 2018/2019). At the time of this report 130 SAC 1 clinical incident investigations were still being progressed by the respective health service organisations.

Aside from patient factors (n=292; 62.0%), the most frequently identified contributory factors were related to communication issues (n=289; 61.4%) followed by issues concerning policies, procedures and guidelines (n=252; 53.5%).

Figure 8: Frequency and Percentage of Contributory Factors for Closed SAC 1 Clinical Incidents for 2018/19

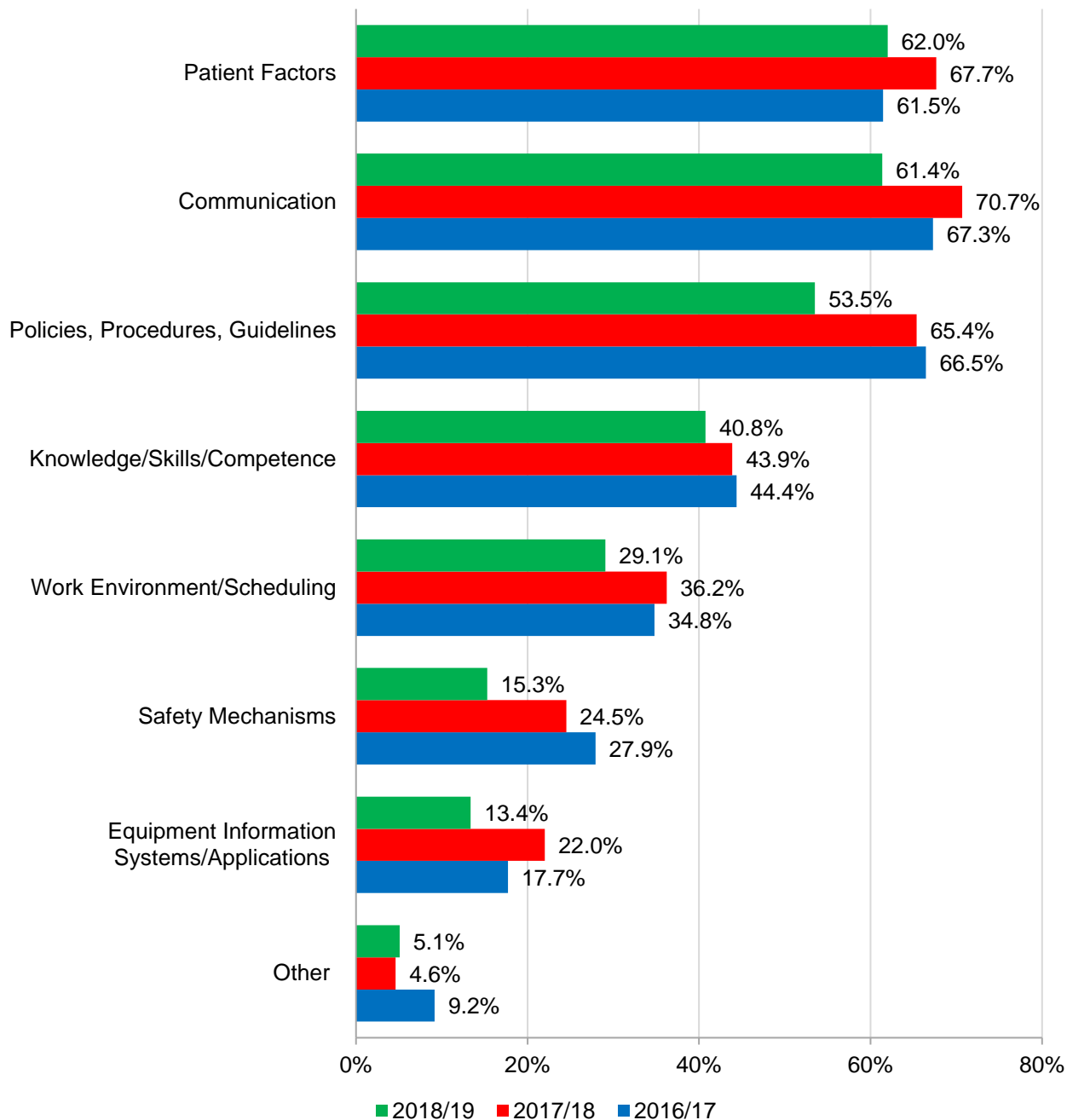


Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

A significant number of the 289 confirmed SAC 1 clinical incidents that reported communication issues identified communication issues between staff (n=184; 63.7%) and issues related to documentation (n=170; 58.8%). Of the 252 confirmed SAC 1 clinical incidents that reported contributory factors regarding policies, procedures and guidelines, 58.3% (n=147) identified concerns with the application of policies, procedures or guidelines, and 29.0% (n=73) identified an absence of relevant policies, procedures or guidelines.

Contributory factors identified in 2018/19 were compared with those identified in the two previous reporting periods (see Figure 9). The most frequently reported contributory factors recorded each year over the last three years were those related to patient factors, communication issues and issues related to policies, procedures and guidelines.

Figure 9: Percentage of Contributory Factors for Closed SAC 1 Clinical Incidents for 2016/17 to 2018/19



Note: More than one contributory factor can be identified for each clinical incident

Sentinel Events Recommendations

Of the 19 sentinel events notified in this period, all investigation reports had been received at the time of writing this report. Eighteen of the investigation reports submitted provided recommendations. Contributory factors identified through the investigation of selected sentinel events in 2018/19 are described in Table 9. The main themes revolved around enhancing communication between staff, improving documentation, and strengthening the application of policies and procedures to assist in improving patient safety.

Table 9: Sentinel Events Identified Contributory Factors and Actions for 2018/19

Identified Issues	Health Service Providers Improvement Initiatives
Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death	
<p>The surgical technique for removal of the adjustable gastric band system and the degradation of the device (after years in situ) posed particular risks for the surgical procedure.</p>	<p>A local safety alert was issued to all relevant clinical staff in the specialty to inform them of the risks inherent in the procedure.</p>
<p>The lack of a formal process for the documentation of intentionally retained packs/gauze may have contributed to the subsequent unintentional retention.</p>	<p>A form was developed and implemented which aimed to document surgical/orifice packing and drainage. An audit program was implemented to monitor compliance with local requirements regarding this form.</p> <p>A new requirement was established for the documenting of all surgical packs intentionally retained within a body cavity on the existing operation report form.</p> <p>A new operating theatre process was established which was to follow the final surgical count and required one staff member to prompt another to complete the surgical/orifice packing and drain record.</p> <p>The local Surgical Safety Checklist Committee was to review and consider strategies to emphasise the importance of communication between the scrub team.</p> <p>Configuration changes were being considered by the Theatre Management System Business User Group regarding the recording of intentionally retained packs/ gauze.</p>
<p>The lack of adherence to the relevant guideline and safety checks resulted in a vaginal pack being retained and left in situ and contributed to readmission.</p>	<p>The relevant guideline was to be updated to clearly outline the responsibilities of the operator and the assistant.</p> <p>The relevant form was to be updated to indicate the requirement for two separate signatures for pre- and post-pack checks.</p> <p>Learnings from this incident, and information about the changes, were to be disseminated through multiple communication channels.</p> <p>Audit activity was planned to monitor compliance with the requirements.</p>

Identified Issues	Health Service Providers Improvement Initiatives
<p>There was a lack of standardised equipment/pack checking processes across guidelines to prevent retention of foreign objects which was identified as a risk for future patients.</p>	<p>The relevant guideline was to be amended to reflect the requirement for two staff members to check the count of instruments and/or packs prior to the procedure and afterwards.</p> <p>The relevant form was to be updated to indicate the requirement for two separate signatures for checking and for a record of the count.</p> <p>Learnings from this incident, and information about the changes, were to be disseminated through multiple communication channels.</p> <p>Audit activity was planned to monitor compliance with the requirements.</p>
<p>Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward</p>	
<p>The perimeter fence around the courtyard is inadequate to contain patients with unpredictable impulsive behaviours and who are inclined to abscond increasing the likelihood that a patient could abscond during a short moment of inattention.</p>	<p>Remediation work to fencing was planned to reduce the likelihood of a patient absconding over the fence.</p>
<p>The presence of 1:1 security gives the impression of risk mitigation, but security staff are untrained in the anticipation of impulsive and unexpected behaviours which increases the likelihood of patient harm through unanticipated actions.</p>	<p>A local procedure or guideline was to be developed which would assist staff in determining the appropriate 1:1 special to care for mental health patients.</p> <p>A local specific patient instruction handover communication tool was to be developed for security services/personnel.</p> <p>The use of security guards to provide 1:1 specialised monitoring of patients who are acutely unwell in the mental health inpatient unit was to be reviewed.</p>
<p>Asphyxiation hazard available and accessible within patient areas in mental health facility.</p>	<p>Specific asphyxiation hazard was removed from all patient areas.</p>
<p>The follow up process following discharge from an inpatient admission requires strengthening.</p>	<p>The local standard operating procedure for the discharge and seven-day follow up was to be reviewed to ensure a robust process including the completion of a competency education program for all staff involved in the seven-day follow up; and standardisation of the telephone questions.</p>
<p>Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death</p>	
<p>Failure to use the three-point checking process to confirm a patient's identity when performing phlebotomy with potential for mislabelling.</p>	<p>A regular auditing program was to be developed and implemented which will include 'spot' audits with the aim to improve compliance behaviour.</p> <p>Information regarding specific safety and quality topics will be included in the Executive's presentation at induction, which will incorporate three-point patient identification and the correct processes when taking blood samples.</p>

Identified Issues	Health Service Providers Improvement Initiatives
<p>Failure to recognise the risks associated with phlebotomy of the wrong patient or incorrectly labelling blood tubes. A busy clinical environment which may increase the likelihood of errors.</p>	<p>An exemplar facility will be used in a benchmarking exercise and consideration will be given to adopting strategies identified as mitigating the risk of error. Education resources inclusive of an Infographic Education pamphlet were to be developed and implemented. Ward clerks to receive re-education to ensure that there are correct patient labels available at the patient bedside so that when venepuncture is performed, the blood tubes can be labelled at the bedside.</p>
<p>A lack of appropriate equipment to eliminate error when performing phlebotomy.</p>	<p>A policy will be developed and implemented which will include a requirement to confirm the ABO blood group for any first-time transfused patient who does not have a historic ABO group recorded in the laboratory system (by requesting a second sample).</p>
<p>Failure to adhere to the requirements of the local patient identification policy while performing phlebotomy.</p>	<p>This issue will be reinstated as a risk on the organisational risk register for ongoing monitoring and review. Options to improve venepuncture within the emergency department will be considered including introducing a task-focussed role, no interruptions during phlebotomy, and spot audits.</p>
<p>Failure to conduct a three-point patient identification check led to incorrect entries in the medical record that had the potential for incorrect treatment being provided to the incorrect patient.</p>	<p>The practice of using pre-signed blood forms within the respective service was to cease. Education to be provided to medical and nursing staff within the respective service around the importance of three-point patient identification, the task of phlebotomy, labelling of tubes and dispatching them to the laboratory.</p>
<p>Failure to adhere to the local patient identification and collection of blood specimen policies led to unsafe sample collection and the mislabelling of blood.</p>	<p>Several relevant local policies/guidelines were to be updated to include a requirement for the checking of labelled blood tubes and request forms with the patient to confirm the patient's identification. The existing venepuncture nursing practice guideline was to be converted to a clinical practice guideline.</p>
<p>Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death</p>	
<p>Failure to adhere to local requirements for correct documentation resulted in a missed opportunity for earlier review of the tube placement and identification of perforation.</p>	<p>A lessons learnt poster was developed to address requirements for the ongoing care and documentation for a nasogastric tube in alignment with the relevant local nursing practice standard. A case study scenario was to be completed by nursing staff in the relevant wards either by face-to-face toolbox scenario or an online case study scenario.</p>
<p>Surgeons have reported variation between different dilators with regard to firmness of the tips.</p>	<p>This case was to be presented at the next clinical review meeting to discuss the variation in dilators and consider if they are fit for purpose, or if a formal product complaint should be submitted.</p>

Identified Issues	Health Service Providers Improvement Initiatives
Medication error resulting in serious harm or death	
Failure to document the findings of a VTE risk assessment in the patient progress notes.	A documentation audit of random patient files was to be undertaken to determine a baseline level of compliance, checking for documentation in the progress notes if the VTE risk assessment box is ticked.
Communication between clinicians about the responsibility for recommending anticoagulation post-operatively was not explicit.	Responsibility for post-operative medication orders was to be established. Case was to be discussed at the department meetings.
While the nursing risk assessment indicated the patient was at a high risk for a thromboembolic event, this did not prompt discussion with the doctor to determine whether chemical prophylaxis was required.	A new process was implemented whereby an anticoagulation chart was to accompany all patients assessed as high risk for VTE to theatre.
The medical VTE risk assessment was not completed on the medication chart and the documentation on the medication management plan was incomplete.	The VTE risk assessment as included in the medication chart is to be completed by the anaesthetist intra-operatively. The design and flow of the medication management plan form will be reviewed, with the form to include clear indication of the responsibilities for completion.
Pharmacy was not aware that the patient was high risk for a thromboembolic event as per policy criteria.	A system will be established to make patient health information as contained in the portal available to Pharmacy to allow for timely referral and review of high-risk patients.
There was a lack of metabolic screening on admission which contributed to a delay in identification of a metabolic disorder.	The relevant clinical practice guideline will be updated to include 'unexplained respiratory alkalosis' in the clinical presentation and findings section.
The lack of a current written guideline for the preparation of the treatment, in conjunction with the relocation of the service, resulted in a new method of storing and dispensing medications and contributed to delays in administering the treatment.	An evidence-based guideline relating to the safe administration of the treatment will be developed and will reflect literature confirming that the drugs are compatible when combined in a single syringe. The guideline will provide guidance on dosing, administration, prescribing and monitoring of the medication regimen.
A lack of escalation, Speaking up for Safety and/or failure to seek further advice from the on-call consultant contributed to treatment delays.	This case was to be presented to staff to raise awareness about: <ul style="list-style-type: none"> ▪ The requirement for advice to be sought from the treating specialist and for care to be escalated where a medical management plan is not able to be

Identified Issues	Health Service Providers Improvement Initiatives
	<p>progressed due to a lack of clarity and definitive guidance</p> <ul style="list-style-type: none"> ▪ The Speaking up for Safety message. <p>The presentation was to include information about the newly developed guidelines and revised clinical practice guidelines.</p>
<p>A specific blood test was missed, contributing to delayed identification of the need for treatment and missed opportunity for earlier management.</p>	<p>Relevant ward managers will initiate an education program to ensure that all staff:</p> <ul style="list-style-type: none"> ▪ Are aware of the relevant clinical practice guideline ▪ Are reminded of the importance of following a consultant's advice correctly and in a timely manner and/or advising the consultant if there are delays in performing investigations or initiating the prescribed treatment ▪ Are provided with a Speaking up for Safety refresher. <p>The relevant clinical practice guideline will be revised to incorporate a 'key points' section to specify that consultant/s are to be advised immediately if there are delays in undertaking prescribed investigations or treatments.</p>
<p>There was a lack of standardisation for the layout of anaesthetic trolleys in theatres across the region/state.</p>	<p>A set of standards will be produced detailing the preferred layout of anaesthetic medication trolleys for all sites across the region as per ANZCA guideline. The standardised layout of the anaesthetic trolley will optimise the separation of more dangerous drugs. To account for a variation in capabilities across the regions, standardisation may be high-level where appropriate (e.g. standards to be applied to a broad class of drug).</p>
<p>The lack of visual cues to alert users to high risk drugs.</p>	<p>A request will be submitted to the Australian Commission on Safety and Quality in Health Care to propose that the drug be added to the Tall Man lettering list.</p>
<p>Failure to seek expert opinion about continuing the procedure.</p>	<p>This case will be incorporated into the HSP's patient safety publication to promote learning across health services.</p>
<p>Limited accessibility of guidelines and lack of clarity regarding the use of the drug, which may have provided sufficient blood pressure support to protect renal blood flow and function.</p>	<p>The current hospital guideline for the drug will be reviewed to consider automated prophylactic dosing based on set parameters.</p> <p>Anaesthetic staff will be educated regarding the recent pharmacy-led initiative to allow one Special Access Scheme (SAS) form to be completed for all prescribed doses of the medication.</p>
<p>Use of physical or mechanical restraint resulting in serious harm or death</p>	
<p>De-escalation strategies failed to pacify the patient and there was a missed opportunity to involve security staff at a critical point of interaction.</p>	<p>Aggression Prevention and Intervention (API) team will review API training with consideration given to using this incident as a case study; the training's coverage of 'breakaway techniques'; and the inclusion of a discussion point relating to risk versus benefit of security in treatment planning in unpredictable volatile consumers, considering evidence-based practice principles of least restrictive practice.</p>

Identified Issues	Health Service Providers Improvement Initiatives
Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	
There was a failure to seek confirmation regarding the biopsy site with the consultant prior to marking the procedure site.	This case will be discussed at the next departmental morbidity and mortality meeting, with a focus on: <ul style="list-style-type: none"> ▪ the requirements for escalation to the consultant when there is uncertainty of clinical markers (biopsy sites) ▪ possible improvements in clinical documentation for small resection sites ▪ possible use of photographic images to support the procedural consent practices.
The patient's consent form was removed from the medical record to allow visualisation by a staff member during the procedure set-up.	An audit program will be established to assess compliance with the requirement to keep the surgical consent form in the patient's medical record.
Timing of the anaesthetic time out, specifically the regional block check, did not occur immediately prior to administration of the nerve block.	An audit program will be established to assess compliance with the requirements regarding the anaesthetic time out, which is to be led by the anaesthetic technician/nurse and occur directly between the anaesthetist and anaesthetic technician/nurse. A second check (final check of the site to be blocked) must occur prior to needle to skin.
The "Stop before you block" procedure was not followed.	"Stop before you block" alerts will be prominently displayed on all ultrasound machines. The Correct Person, Correct Procedure and Correct Site Surgery/Procedure policy will be reviewed with attention given to requirements for regional/local nerve block and "Stop before you block". ¹⁵
The flow of the anaesthetic time out is fragmented and includes non-anaesthetic checks (e.g. implants/prosthesis/equipment).	The flow of information on the anaesthetic time out section of the surgical safety checklist will be amended to align with the roles accountable for sign-off.
There were communication issues relating to the roles of staff involved in the anaesthetic time out.	The anaesthetic time out is to occur between the anaesthetist and the anaesthetic technician only.
The anaesthetic time out checklist did not confirm the site or who checked the site.	The anaesthetic time out checklist will be altered to include the site of nerve block, with designation and signature of those confirming and marking the block.

¹⁵ "Stop before you block" is an initiative supported by ANZCA that started at Nottingham University Hospital in 2010 following a series of inadvertent wrong-sided nerve blocks. Further information is available at: <http://www.anzca.edu.au/documents/stop-blocking-flyer-a4-p1.pdf>

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*¹⁶ and instructions were added to the existing Datix CIMS user guides.¹⁷

Table 10 provides the frequency of confirmed SAC 1 clinical incidents where fetal harm was indicated. Thirty-three (5.5%) confirmed SAC 1 incidents in 2018/19 reported fetal harm. Retrospective completion of the fetal harm fields was discretionary for incidents notified prior to 1 July 2017.

Table 10: Frequency of Confirmed SAC 1 Clinical Incidents Where Fetal Harm was Indicated for 2015/16 to 2018/19

SAC 1 Category	2015/16 ^a	2016/17 ^a	2017/18	2018/19
Fetal complications associated with health care delivery	12	13	14	21
Delay in recognising/responding to clinical deterioration	2	2	2	8
Hospital process issues	1	3	4	1
Misdiagnosis and subsequent management (physical and mental health)	1	-	2	1
Any other incident resulting in serious harm or death	1	-	2	1
Maternal death associated with pregnancy, birth and the puerperium	-	-	-	1
Infection control breach	1	1	-	-
Complications of surgery	2	-	-	-
Total	20	19	24	33

^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 33 incidents identifying fetal harm in 2018/19, 19 resulted in fetal death and 10 resulted in serious harm to the fetus. Four incidents resulted in moderate harm (n=2) or minor harm (n=2) to the fetus. One of the incidents with a fetal outcome of death was a multiple (twin) pregnancy.

In 2018/19, incidents where fetal harm was indicated most frequently involved pregnancies with a gestational age of 40 or more weeks (n=11; 33.3%), or 35-39 weeks (n=6; 18.2%).

¹⁶ Datix CIMS Business Rules for Fetal Harm are available at:

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

¹⁷ Datix CIMS User Guides are available at: <https://hss-healthpoint.hdwa.health.wa.gov.au/business-at-health/ICT-servicedelivery-and-operations/cims/Pages/default.aspx>

Key Messages and Information: SAC 1 Clinical Incidents

The number of SAC 1 clinical incidents notified continues to increase, with 601 confirmed SAC 1 clinical incidents being notified in 2018/19. Of these, 19 were reported as sentinel events. Two of these sentinel events related to the death of a patient following a medication error. These two incidents were classified as a delay in administering medication to a patient and administration of a medication contraindicated for a patient. Four sentinel events were reported following the retention of instruments or other material after surgery, three of which required readmission for further treatment and/or to remove the foreign material.

This report is the first in this series which incorporates data for the revised sentinel event categories. WA implemented the revised list of 10 sentinel event categories with an amendment to the *Clinical Incident Management Policy* from 1 July 2018. Regarding national reporting of sentinel events, the PSSU is managing the transition of sentinel event definitions in accordance with the respective reporting specifications released by the Productivity Commission (for ROGS) and the IHPA (Pricing for Safety and Quality).

While the number of sentinel events with a patient outcome of serious harm or death remains relatively low, the number of other SAC 1 clinical incidents continues to increase, with 582 incidents confirmed in 2018/19 compared to 553 in 2017/18 and 468 in 2016/17. High levels of clinical incident reporting coupled with a low or decreasing level of harm to patients is regarded as indicating a strong patient safety culture within a healthcare system.

The three most commonly reported SAC 1 categories for 2018/19 were infection control breaches, complications of an inpatient fall and delays in recognising/responding to clinical deterioration. There were also 71 incidents reported under the category 'any other incident resulting in serious harm or death'. The types of incidents reported under this category vary across a broad scope, although there is significant patient harm associated with these incidents. Twelve incidents reported as 'any other incident resulting in serious harm or death' described a patient outcome of death, and 24 reported the patient outcome as serious harm.

Infection control breaches were the most frequently reported SAC 1 incident category in 2018/19. Six of these incidents were associated with a patient outcome of death in 2018/19 and 77 were associated with a patient outcome of serious harm. It is thought that the release of the guidance document *Reporting of healthcare-associated Staphylococcus aureus bloodstream infections as a severity assessment code 1 (SAC 1)*¹⁸ in 2018 has had some effect on the considerable increase in reporting of infection control breaches as SAC 1 incidents.

Of the 601 confirmed SAC 1 clinical incidents notified in 2018/19, 71 were identified as resulting in no harm to the patient. In addition to the 601 confirmed SAC 1 incidents, 168 events were approved for declassification following investigation as no health care factors were found to have contributed to the event. Where there is uncertainty about whether an event is a clinical incident, the PSSU advocates for a risk mitigation approach to clinical incident investigation and recognises the value in the investigation of these events to identify areas for improvement.

Communication issues continue to be frequently identified as contributory to SAC 1 clinical incidents with 61.4% of closed incidents in 2018/19 reporting communication issues. In SAC 1

¹⁸ Department of Health. (2018). Reporting of healthcare-associated *Staphylococcus aureus* bloodstream infections as a severity assessment code 1 (SAC 1), Healthcare associated infection unit, Department of Health, Perth, https://ww2.health.wa.gov.au/~/_/media/Files/Corporate/general%20documents/Infectious%20diseases/PDF/HISWA/SAB%20Resources/HA-SABSI-as-SAC-1.pdf .

incidents where communication-based factors were identified, 63.7% found communication issues between staff, and 58.8% found issues related to documentation.

Effective communication is recognised as a critical component in the coordination and provision of safe care to patients in the second edition of the NSQHS Standards. The Communicating for Safety Standard outlines requirements including those to ensure that organisational processes are in place to support effective communication throughout the patient's journey and to ensure timely documentation in health care records.

In October 2017, fetal harm fields were added to Datix CIMS which allowed the differentiation of maternal and fetal outcomes. For the 2018/19 period there were 33 SAC 1 clinical incidents where fetal harm was indicated, with 21 of these categorised under '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.

Individuals place a significant level of trust in the WA health system and clinicians to provide safe, high-quality care and good outcomes are largely achieved through the dedication and commitment of health care staff. When a clinical incident results in serious harm or death to a patient the distress that it causes to the staff involved, as well as to the patient and their loved ones, can be devastating. How an organisation responds to clinical incidents is critical in minimising the impact to all involved, maintaining the integrity of the process, and preventing future harm to patients.

Cultivating a no-blame environment in the investigation of SAC 1 clinical incidents is an important principle of clinical incident management. By now, health care professionals are likely to have an awareness of the second victim phenomenon, which describes the trauma suffered by health care providers directly involved in an event which results in patient harm. The PSSU discussed this phenomenon in foreword of the previous edition of this report in the context of Dr Bawa-Garba's case in the United Kingdom. While the no-blame principle appears to be broadly accepted across the WA health system, its application still proves to be challenging.

Though it may be the path of least resistance to re-educate or counsel the staff member/s involved in a clinical incident on the 'right way to do things', recommendations that target individual staff members only succeed in perpetuating a blame culture. For example, instead of "counselling staff member about requirements of a policy", better outcomes may be achieved by looking deeper into the system factors that prevented staff compliance with the policy in that instance.

A relatively new concept, referred to as the third victim, has been proposed which describes the psychosocial impact for patient safety professionals involved in the investigation of clinical incidents and management of improvements.¹⁹ This harm is thought to arise because of a combination of sources: acute and cumulative clinical incident stress; emotional labour (through victim support, investigation process, implementation of improvements); bullying and intimidation; and in the management of competing loyalties, duties and motivations.

By continuing to target individuals rather than system factors in quality improvement strategies and failing to address the remnants of a blame culture, the system fosters the development of negative perceptions about the role of patient safety professionals. Not only does an adversarial

¹⁹ Julie Holden and Alan J Card. 'Patient safety professionals as the third victims of adverse events', *Journal of Patient Safety and Risk Management* 24, no. 4 (June 2019), 166-175.

relationship have the potential for harm to patient safety professionals, it has the potential to compromise the openness and transparency in the investigation process.

Undoubtedly the primary focus of clinical incident management is the patient who has suffered harm and who deserves our utmost care. By demonstrating a commitment to a no-blame culture and the prevention of harm to our peers, we also work more effectively to prevent future harm to patients.



Standard 1: Governance for Safety and Quality

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”.

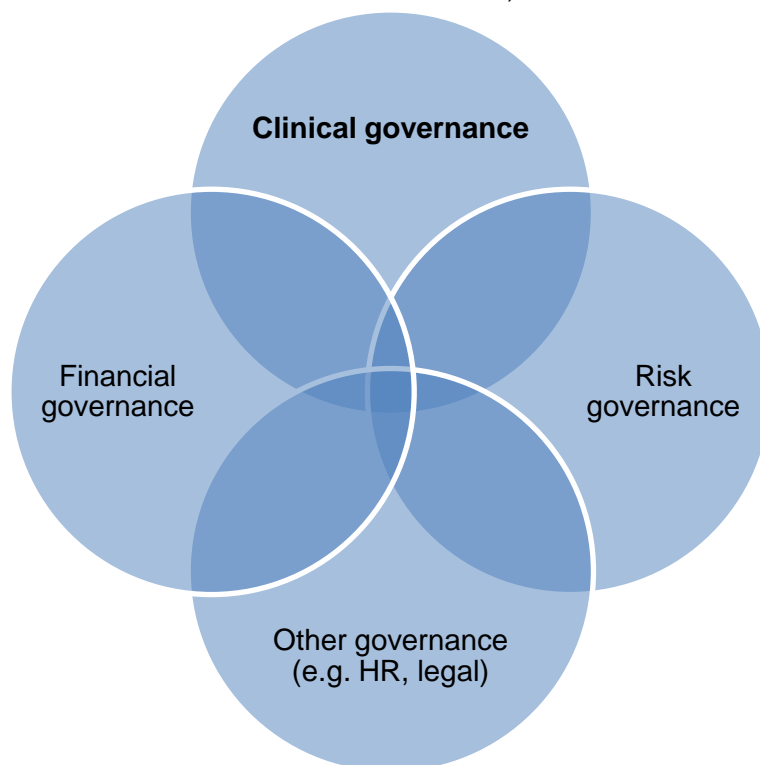
The importance of strong clinical governance in health service organisations is highlighted in Standard 1 of the NSQHS Standards (second edition). This Clinical Governance Standard, against which the WA health system has been assessed since January 2019, has maintained its focus on risk, monitoring, quality improvement, training and performance management.²⁰

In support of the delivery of safe and high-quality care for patients and consumers the ACSQHC has developed the National Model Clinical Governance Framework²¹ 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 10), 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 10: Elements of Corporate Governance

(Adapted from the National Model Clinical Governance Framework)



²⁰ ACSQHC NSQHS Standards (2nd edition) Clinical Governance Standard available at: <https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard>

²¹ 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 second edition of the NSQHS Standards also 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*²² 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.

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.

The WA health system remains 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 focussed on preventing and reducing the impact of clinical incidents.

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*.²³

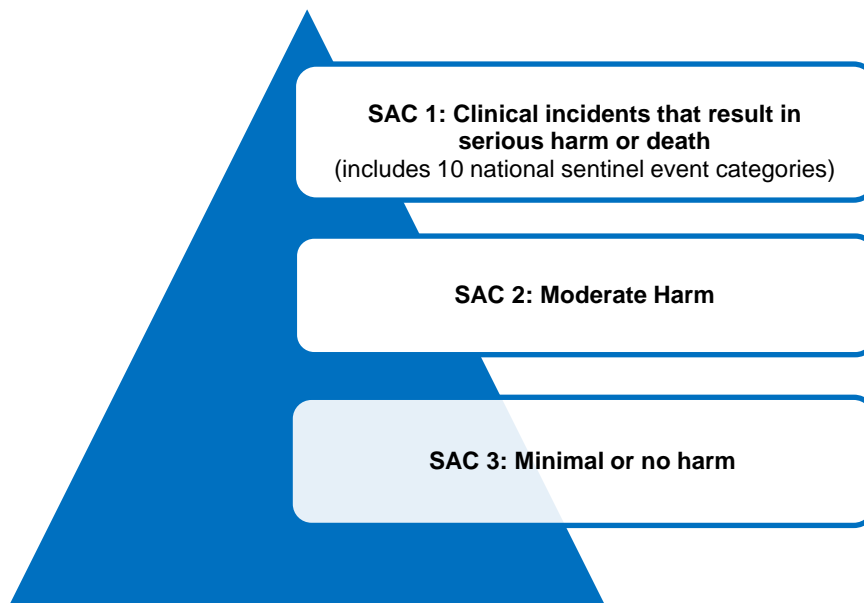
To enhance the clinical incident management process, Severity Assessment Codes are used in WA to guide incident analysis, action and escalation (see Figure 11). Clinical incidents are categorised according to the harm that did or could result to the patient from the delivery of health care rather than the patient's underlying condition/illness:

- **SAC 1** rating refers to clinical incidents resulting in serious harm/death or near miss and includes 10 nationally endorsed sentinel event categories.
- **SAC 2** rating refers to clinical incidents resulting in moderate harm or near miss.
- **SAC 3** rating refers to clinical incidents resulting in minimal/no harm or near miss.

²² The WA Health Clinical Risk Management Guidelines is available at: https://ww2.health.wa.gov.au/Articles/A_E/Clinical-risk-management

²³ The Clinical Incident Management Policy is available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Clinical-Incident-Management-Policy>

Figure 11: 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 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. Clinical incidents resulting in serious harm or death (SAC 1) require a detailed and rigorous investigation to be undertaken.

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 result. 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 focuses on specific state-wide clinical incident trends. These resources are available to WA's public health system staff via the PSSU's intranet pages.²⁴

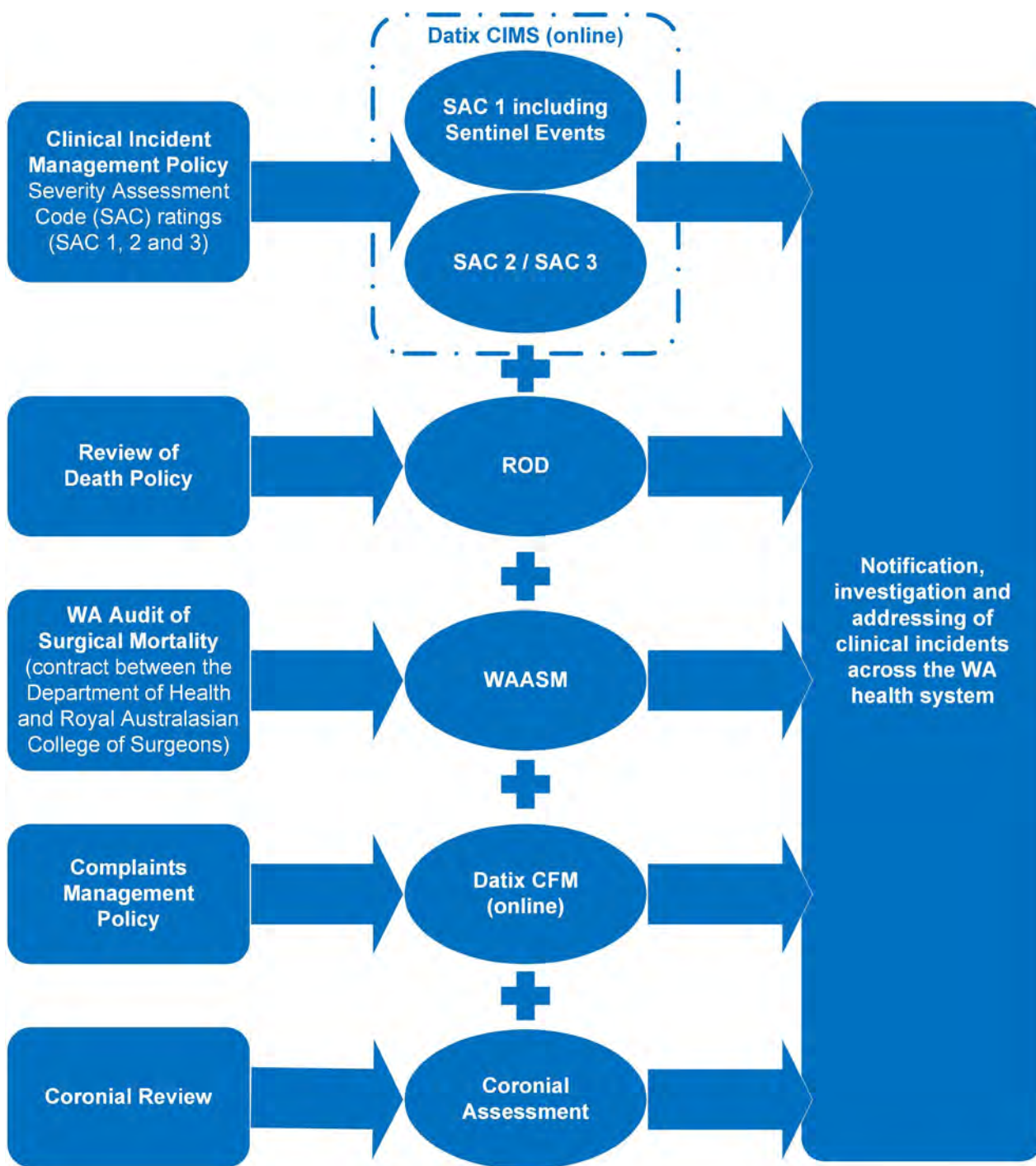
Considerable resources have been invested to improve patient safety in the WA health system. Resources to guide clinical incident management in WA include the CIM Policy and CIM Toolkit, which are updated to keep abreast with state and national changes. The PSSU also continues to work collaboratively 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 the clinical incident management process include the Review of Death Policy and the WA Audit of Surgical Mortality. The purpose of ROD and WAASM is to systematically review patient deaths to identify those 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.

²⁴ The PSSU's intranet pages can be accessed by WA's public health system staff at: <https://doh-healthpoint.hdwa.health.wa.gov.au/directory/Clinical%20Services%20and%20Research/Patient%20Safety%20Clinical%20Quality/PSSU/Pages/About%20Us.aspx>

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 integral component of CIM as it informs the provision of patient centred care. Figure 12 shows the relationship of these processes to clinical incident management.

Figure 12: Clinical Incident Management Processes



Potential exists for the recently implemented Enterprise Risk Management System to assist with incorporating the lessons learnt from clinical incidents into a comprehensive and proactive approach to managing clinical risk in WA's public health system.

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

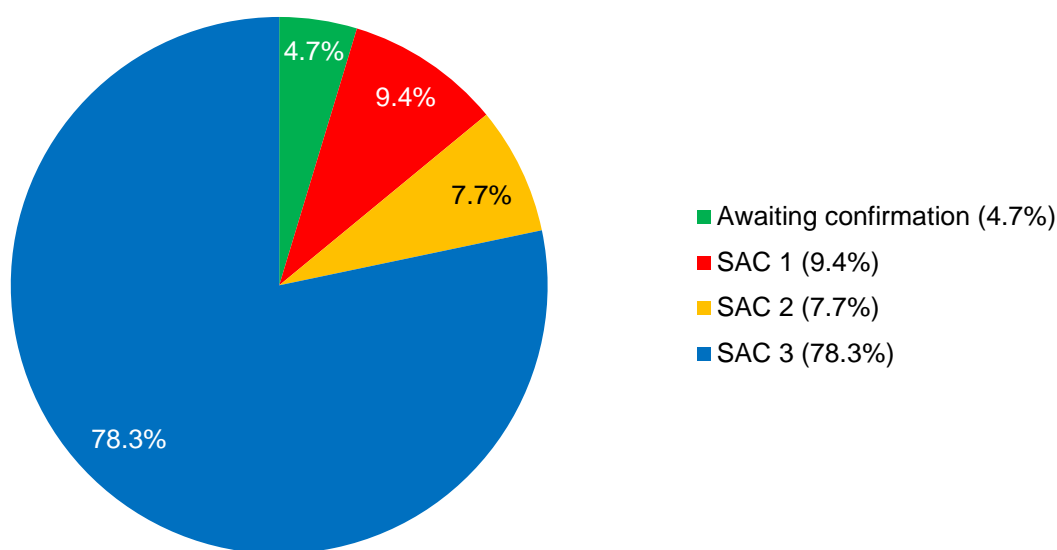
Healthcare-associated infections are infections acquired as a direct or indirect result of the provision of health care. There is evidence to suggest a considerable number of HAIs are preventable adverse events rather than complications of care. Standard 3 of the NSQHS Standards (first edition) refers to preventing and controlling healthcare-associated infections. The intention is to prevent patients from acquiring preventable HAIs and effectively manage infections when they occur by using evidence-based strategies (ACSQHC, 2013).

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 ensuring prevention of HAIs is everyone's responsibility. The successful implementation of standard precautions, which includes high-level compliance with hand hygiene, to reduce the risk of transmission of infections is of paramount importance in preventing HAIs.

In 2018/19 there were 1,368 clinical incidents notified that related to HAIs, of which 1,304 were confirmed and 64 incidents were awaiting confirmation at the time of this report. Incidents related to HAIs accounted for 4.0% of all clinical incidents notified in this period.

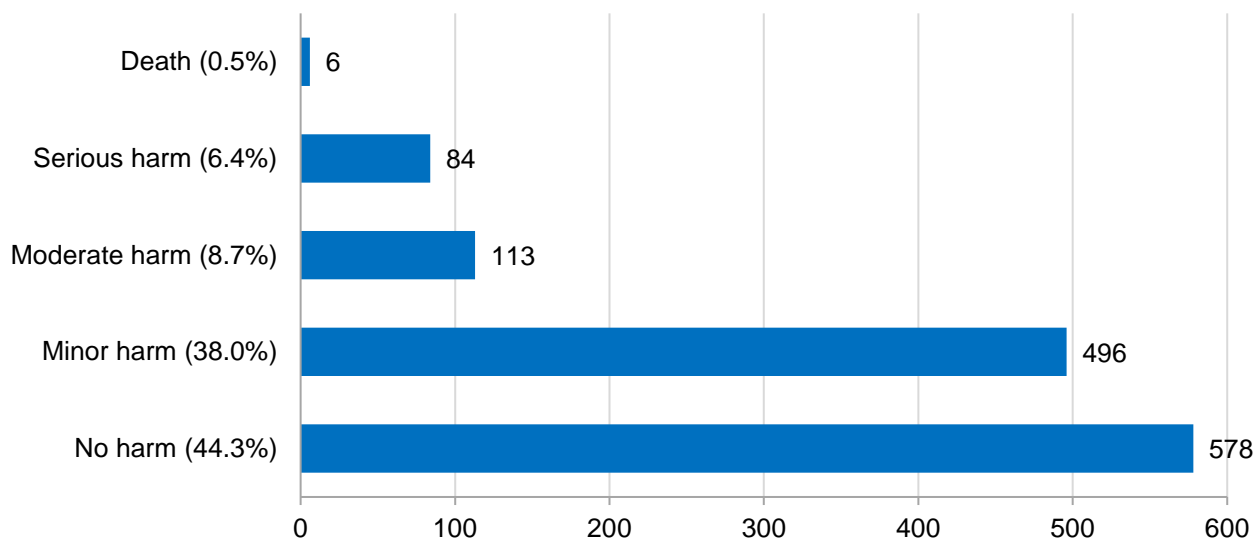
Most clinical incidents related to HAIs were confirmed as SAC 3 incidents (n=1,071; 78.3%), with more incidents confirmed as SAC 1 (n=128; 9.4%) than SAC 2 (n=105; 7.7%; see Figure 13). Three-quarters (n=96) of confirmed SAC 1 incidents related to HAIs were categorised as being associated with contamination due to hospital processes (other than sterilisation) (n=66) or a breach in sterile techniques (n=30).

Figure 13: Percentage of HAI Clinical Incidents by SAC Rating for 2018/19



The majority of confirmed clinical incidents related to HAIs resulted in no harm (n=578; 44.3%) or minor harm (n=496; 38.0%) to the patient. Six confirmed incidents during 2018/19 described a patient outcome of death (see Figure 14). In all six of these cases the patients had developed septicaemia, with five identified as developing a healthcare-associated *Staphylococcus aureus* bloodstream infection (HA-SABSI).

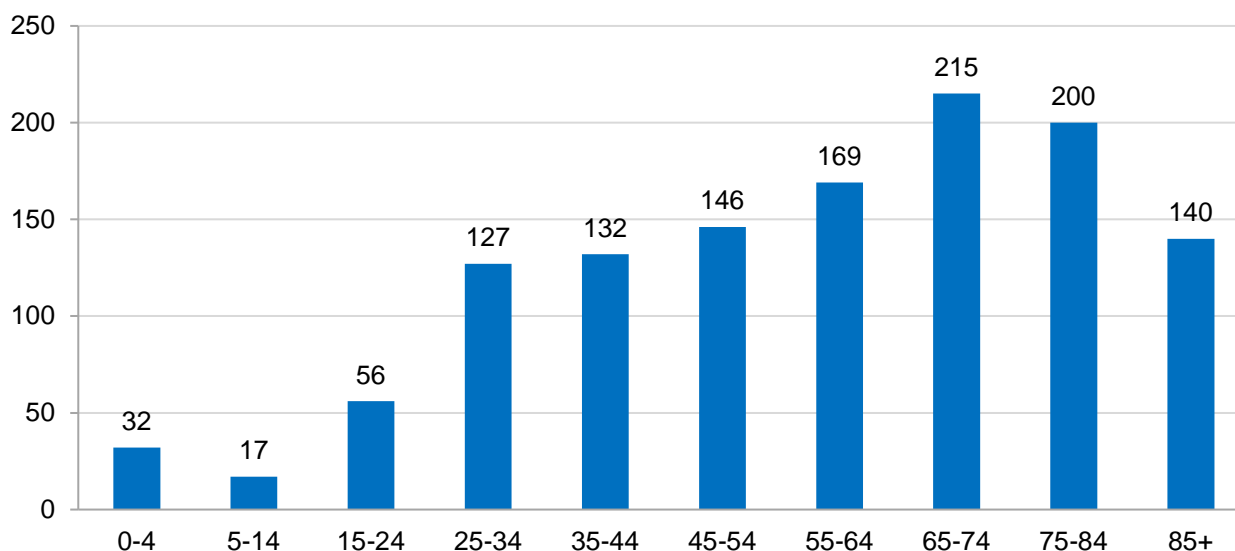
Figure 14: Frequency and Percentage of Confirmed HAI Clinical Incidents by Patient Outcome for 2018/19



Note: Patient outcome missing data n=27; 2.1%

Females accounted for 56.0% (n=709) of patients involved in confirmed clinical incidents related to HAIs, with males making up 44.0% (n=556; missing n=69). Patient ages ranged from 0-110 years with a median age of 61 years (see Figure 15).

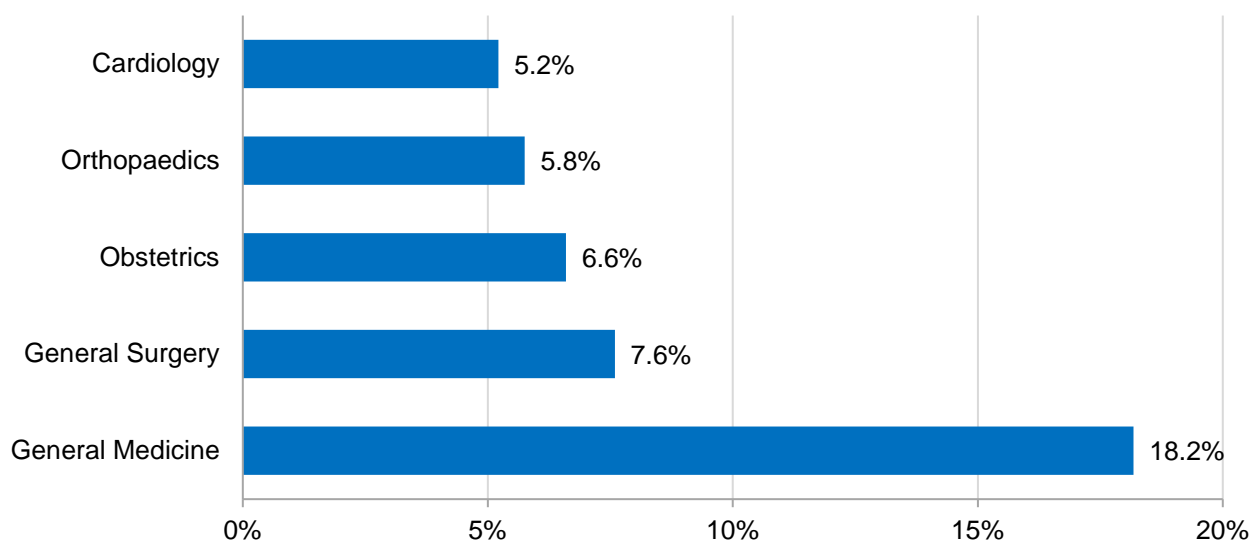
Figure 15: Distribution of Patients Affected by Confirmed HAI Clinical Incidents by Age Group for 2018/19



Note: Patient age missing data n=100; a clinical incident may affect multiple patients

The treating specialties that most frequently reported clinical incidents related to HAIs are shown in Figure 16. These five specialties accounted for 43.3% (n=565) of all confirmed incidents related to this NSQHS Standard in 2018/19. The General Medicine specialty reported the highest number of confirmed incidents related to HAIs (n=237; 18.2%).

Figure 16: Percentage of Confirmed HAI Clinical Incidents by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=309; 23.7%

The five most frequent Tier Three incident categories accounted for 93.0% (n=1,213) of confirmed clinical incidents related to HAIs in 2018/19 (see Table 11). Most of these incidents were categorised as contamination due to hospital processes (other than sterilisation) (n=485; 37.2%) or established processes/protocols for infection prevention and control not being followed or adhered to (n=428; 32.8%).

Table 11: Frequency and Percentage of Top Five Tier Three Confirmed HAI Clinical Incidents Categories for 2018/19

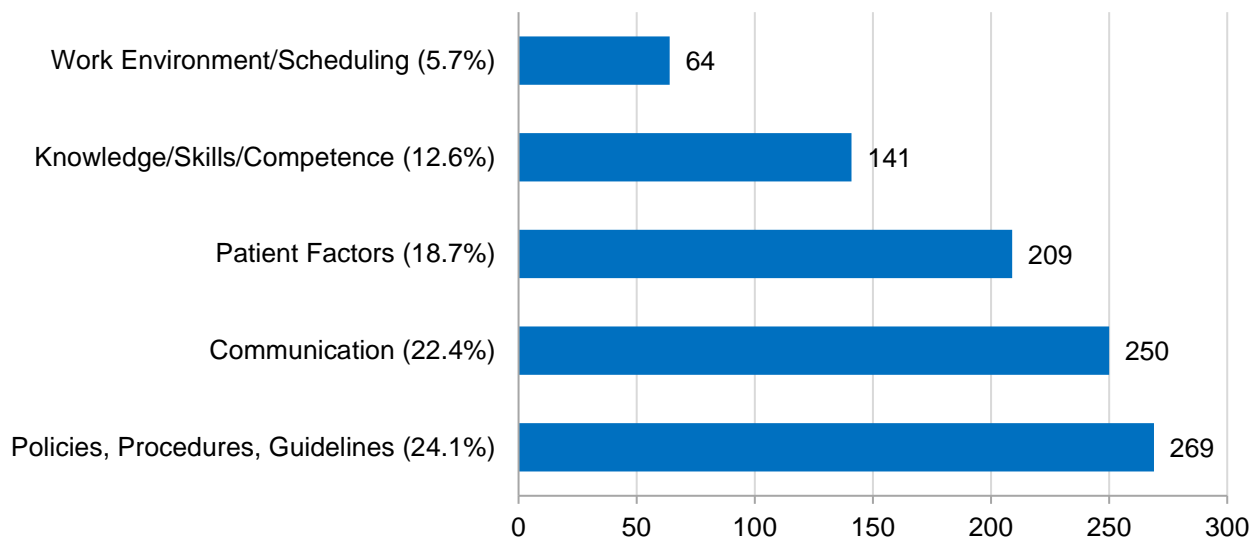
Tier Three Preventing and Controlling HAI Categories	(n)	(%)
Contamination due to hospital processes (other than sterilisation)*	485	37.2
Processes/protocols established but not followed/adhered [†]	428	32.8
Breach in sterile techniques	168	12.9
Delayed diagnosis	78	6.0
Processes/protocols not established [†]	54	4.1
Total	1,213	93.0

* Incidents for this Tier Three category 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 and handling of infected patients, performance of clinical procedures, safe injection/sharps disposal and sterilisation.

The most common contributory factor identified in the investigation of incidents related to HAIs was issues regarding policies, procedures and guidelines which was cited in 24.1% (n=269) of closed incidents (see Figure 17). Issues regarding policies, procedures and guidelines most frequently related to problems in their application (n=160) or implementation issues (n=103). Communication issues were identified as contributory in 22.4% (n=250) of incidents related to HAIs investigated in 2018/19.

Figure 17: Frequency and Percentage of the Top Five Contributory Factors for Closed HAI Clinical Incidents for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.



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 Standards²⁵, and the WA health system has a long-standing program of healthcare infection surveillance.

In June 2019, the Department of Health released an updated *Healthcare Associated Infection Surveillance in Western Australia Policy*.²⁶ This policy and the related surveillance manual make it clear that HAI surveillance needs to be an integral component of clinical governance in order to identify trends and engage clinicians in minimising infection risks and the incidence of HAIs.

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 2018/19, more than half of all confirmed incidents (n=662), three-quarters of SAC 1 incidents (n=96) and five of the six deaths related to HAI clinical incidents were associated with a medical device, medication or fluid.

Key concepts for minimising the risk of infection related to the use of invasive medical devices include²⁷:

- Only using invasive medical devices when clinically indicated and considering the infection-risk during decision making
- Ensuring all staff are adequately trained and competent in the skills required for safe insertion, maintenance and removal of a device
- Choosing the most appropriate device and system for the patient
- Checking the device at every shift and removing as soon as no longer necessary
- Regularly monitoring patients, the insertion site and the device for any signs and symptoms of infection
- Minimising the period of time that devices remain in patients
- Providing patient education on the infection risk associated with the insertion of devices and the importance of proper maintenance
- Clearly documenting the insertion, maintenance and removal of the device, as well as daily review of device necessity
- Implementing appropriate surveillance systems to monitor infection rates and ensuring feedback is provided to clinicians.

These measures should be implemented as part of comprehensive approach to infection prevention and control that includes other established strategies, including hand hygiene, aseptic techniques and antimicrobial stewardship.

²⁵ ACSQHC NSQHS Standards (2nd ed) Standard 3: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/preventing-and-controlling-healthcare-associated-infection-standard>

²⁶ The Healthcare Associated Infection Surveillance in Western Australia Policy is available at: <https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Public-Health/Mandatory-requirements/Communicable-Disease-Control/Infection-Prevention-and-Control/Healthcare-Associated-Infection-Surveillance-in-Western-Australia-Policy>

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



Standard 4: Medication Clinical Incidents

Standard 4 of the NSQHS Standards (first edition) refers to medication safety and “describes systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients” (ACSQHC, 2013).

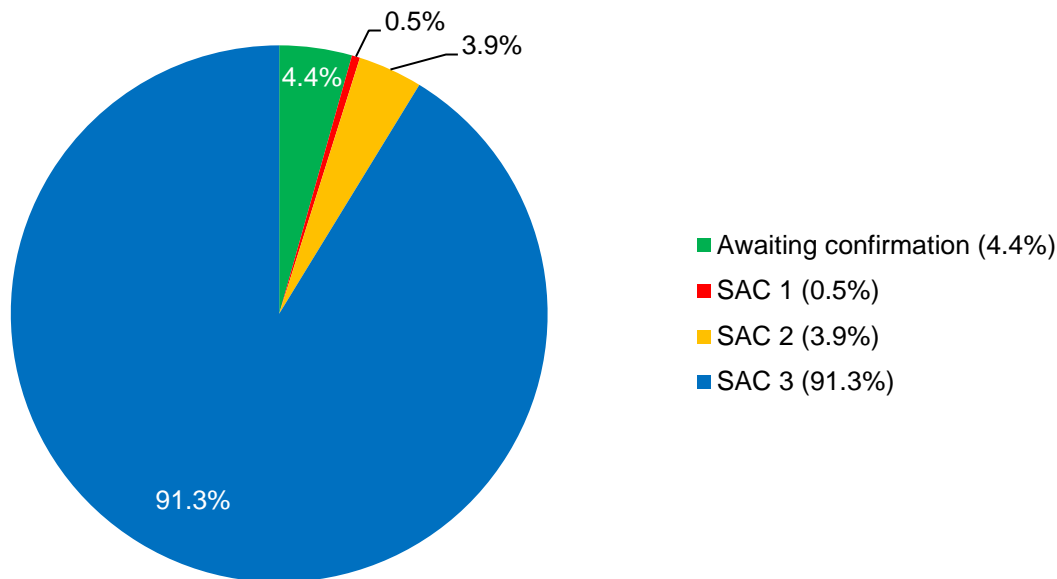
Medications (medicines) are the most frequent form of treatment used in health care and as such tend to be more frequently involved in clinical incidents than other forms of treatment. While the appropriate use of medications can provide substantial benefits to patients, when errors occur the adverse effects can be severe.

There are many reasons that may lead 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).

Medication-related clinical incidents are captured under the Tier One category in Datix CIMS that includes medications, biologics and fluids. During 2018/19, there were 7,958 medication incidents reported of which 7,610 were confirmed and the remainder (n=348) were awaiting confirmation. Medication-related clinical incidents represented 23.2% of all clinical incidents reported in this period.

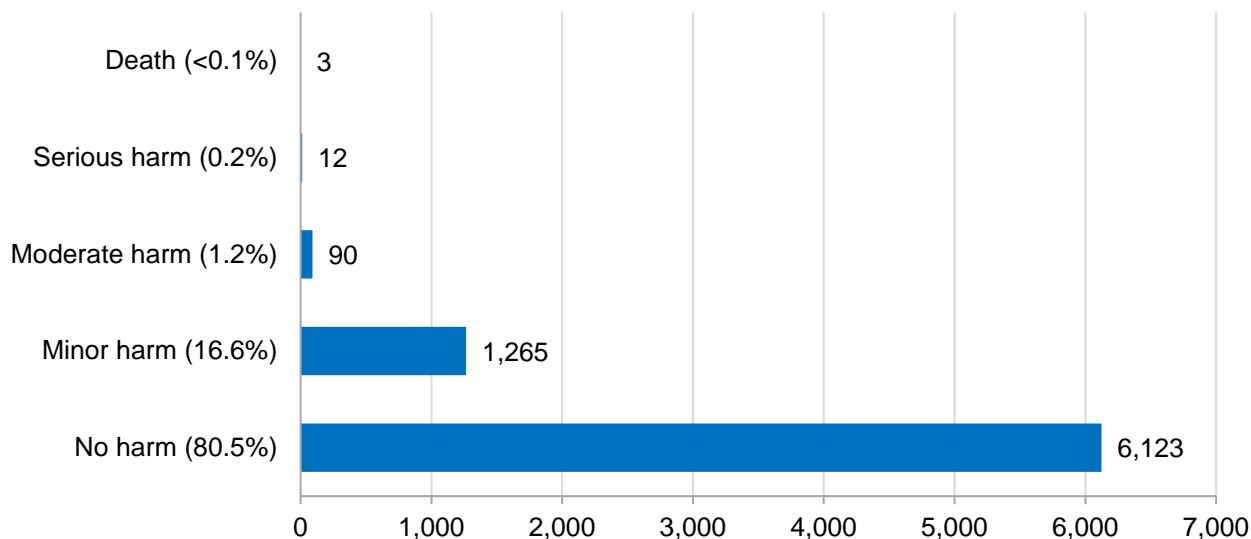
Most medication-related incidents were confirmed as SAC 3 clinical incidents (n=7,262; 91.3%). There were 39 medication-related clinical incidents confirmed as SAC 1, accounting for 0.5% of medication incidents (see Figure 18).

Figure 18: Percentage of Medication Clinical Incidents by SAC Rating for 2018/19



During 2018/19, 80.5% (n=6,123) of confirmed medication-related clinical incidents resulted in no harm to the patient, and 16.6% (n=1,265) resulted in minor harm (see Figure 19). One-third (n=13) of the 39 confirmed SAC 1 medication incidents were near misses resulting in no harm, while three incidents described the patient outcome as death.

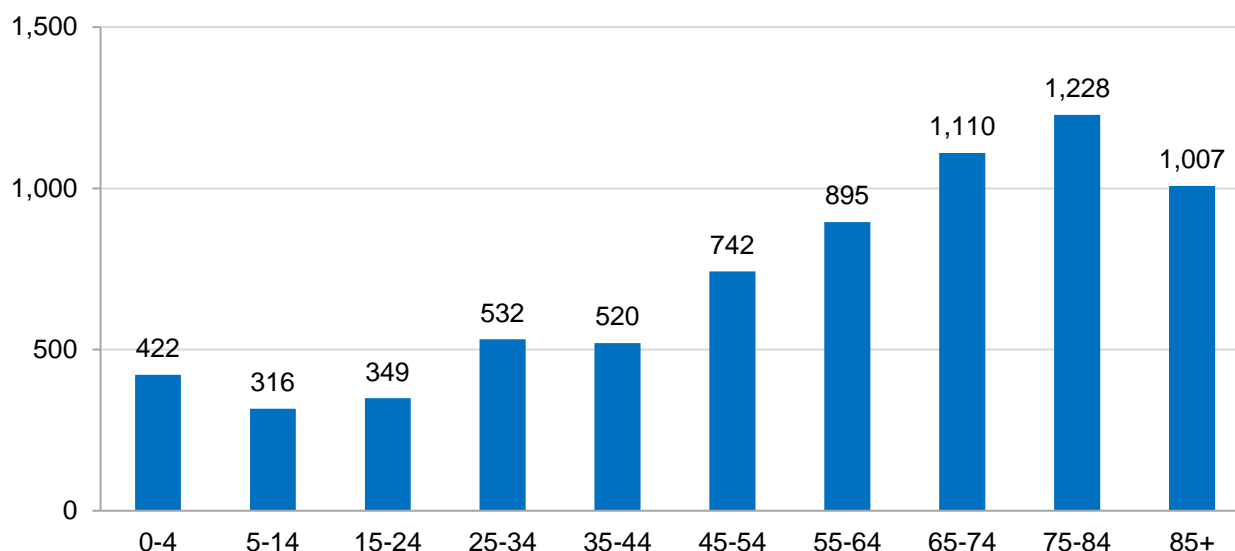
Figure 19: Frequency and Percentage of Confirmed Medication Clinical Incidents by Patient Outcome for 2018/19



Note: Patient outcome missing data n=117; 1.5%

Females accounted for 51.2% (n=3,651) of patients involved in confirmed medication-related clinical incidents, with males making up 48.8% (n=3,481; missing n=511). Ages ranged from 0-106 years with a median age of 62 years (see Figure 20).

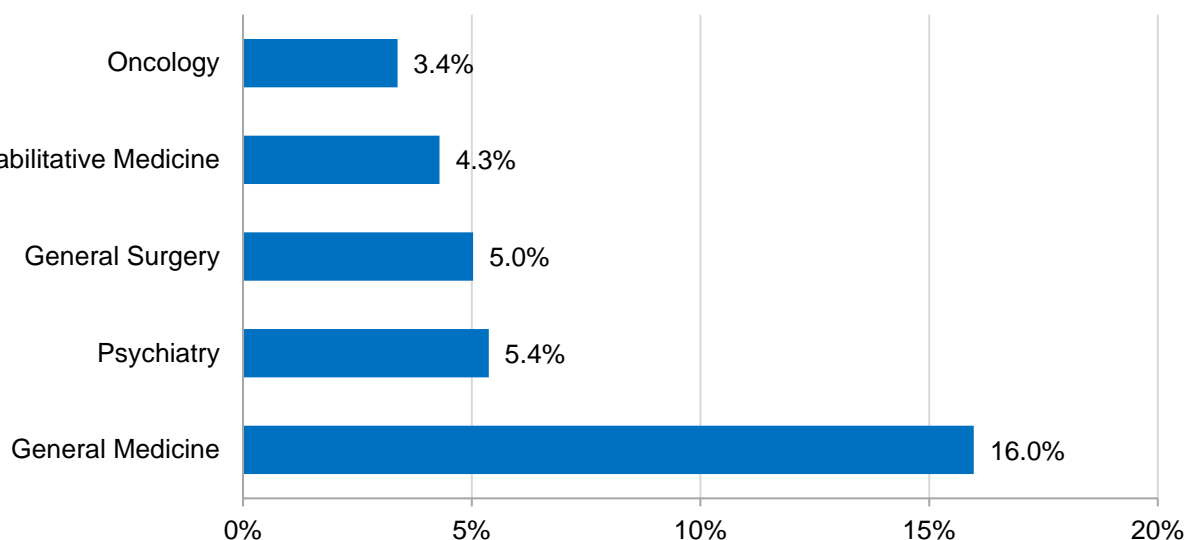
Figure 20: Distribution of Patients Affected by Confirmed Medication Clinical Incidents by Age Group for 2018/19



Note: Patient age missing data n=522; a clinical incident may affect multiple patients

Five specialties accounted for 34.1% (n=2,592) of confirmed medication-related clinical incidents in 2018/19. The General Medicine specialty reported the greatest number of medication incidents, accounting for 16.0% (n=1,216; see Figure 21).

Figure 21: Percentage of Confirmed Medication Clinical Incidents by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=2,281; 30.0%

In 2018/19, the five most frequent medication clinical incident categories accounted for 44.1% of confirmed medication-related clinical incidents (see Table 12). Findings show that medication-related clinical incidents were most frequently categorised as a failure to administer medication (n=1,097; 14.4%), followed by an incorrect medication dose (n=822; 10.8%).

Table 12: Frequency and Percentage of Top Five Tier Three Confirmed Medication Clinical Incidents Categories for 2018/19

Tier Three Medication Categories	(n)	(%)
Failure to administer medication*	1,097	14.4
Incorrect medication dose†	822	10.8
Incorrect medication/fluid†	577	7.6
Dose of medication omitted*	470	6.2
Extravasation	388	5.1
Total	3,354	44.1

* 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.

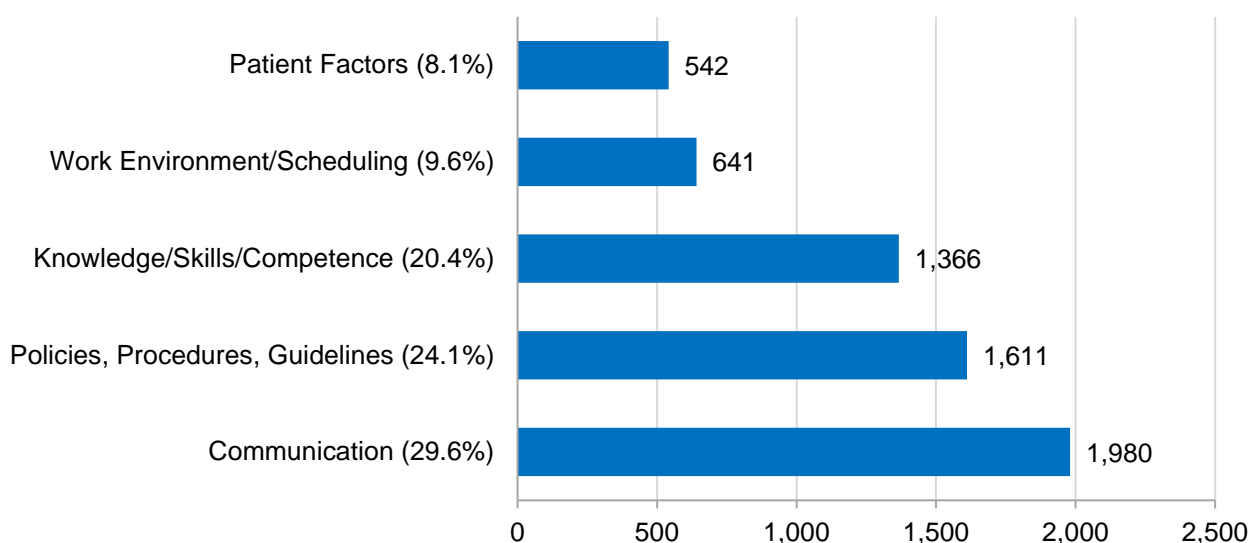
The 10 most frequent categories of medication involved in clinical incidents in 2018/19 accounted for 56.6% (n=4,305) of confirmed medication-related clinical incidents. Opioid analgesics (n=951; 12.5%) were again the most frequently reported category of medication involved, representing one in every eight confirmed medication clinical incidents (see Table 13). This was followed by antibacterials (n=783; 10.3%) and anticoagulants (n=503; 6.6%).

Table 13: Frequency and Percentage of Top Ten Categories of Medications Involved in Confirmed Clinical Incidents 2018/19

Top Ten Medication Categories	(n)	(%)
Opioid analgesics (opioid based pain relievers)	951	12.5
Antibacterials (antibiotics)	783	10.3
Anticoagulants (blood thinning medications)	503	6.6
Insulins (medications used for diabetes)	468	6.1
Antipsychotics (medications for major psychiatric disorders)	364	4.8
Medications for anxiety and sleep disorders	298	3.9
Non-opioid analgesics (non-opioid pain relievers)	273	3.6
Antihypertensives (medications for high blood pressure)	272	3.6
Antiepileptics (medications for epilepsy)	204	2.7
Medications for heart failure	189	2.5
Total	4,305	56.6

Communication issues (n=1,980; 29.6%; see Figure 22) continue to be the most commonly identified factor contributing to medication-related clinical incidents in 2018/19, followed by issues with policies, procedures and guidelines (n=1,611; 24.1%).

Figure 22: Frequency and Percentage of the Top Five Contributory Factors for Closed Medication Clinical Incidents for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

Key Messages and Information: Medication Clinical Incidents

In 2018/19, medication-related clinical incidents continue to be the most frequently reported type 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 patient safety culture that exists regarding medication safety in WA.

The type of medications involved in these incidents continues to follow the pattern seen in previous years, with four high-risk medications (opioid analgesics, antibacterials, anticoagulants and insulins) most often reported to be involved in confirmed medication-related clinical incidents. These four types of medication accounted for 35.5% of these incidents.

The most common category of medication-related clinical incident was a failure to administer medication, and omitted dose of medication returned to the top five most frequent medication incident categories in 2018/19. Collectively, 22.0% 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.

The NSQHS Standards continue to recognise the danger that high-risk medications can pose to patients and require that health service organisations identify the high-risk medications they use and have systems in place to store, prescribe, dispense and administer them safely. This should include regularly assessing the use and misuse of high-risk medications; and developing and implementing evidence-based risk-reduction strategies for high-risk medications.²⁸ The *WA High Risk Medication Policy*²⁹ continues to support HSPs in meeting these requirements.

The second edition of the NSQHS Standards also introduced new actions relating to the continuity of medication management, including medication review. In support of HSPs' implementation of these new requirements, the Department of Health released the *Medication Review Policy* in February 2019.³⁰ The *Medication Review Policy* sets the minimum requirements for the review of a patient's medications on presentation to hospital, during hospitalisation and prior to transition back into the community or transfer to other health care facilities, with the intent of reducing preventable medication-related adverse events and improving patient safety. This policy also covers the importance of providing medication education to the patient, both during hospitalisation and at discharge.

In 2019, linked to its third Global Patient Safety Challenge: Medication Without Harm,³¹ the World Health Organization released three technical reports covering medication safety in transitions of care, medication safety in polypharmacy and medication safety in high-risk situations to facilitate early priority actions and planning to address each of these areas. The WHO's goal is to reduce medication errors and adverse drug events by 50% by 2025, and the ACSQHC is developing a national response to this challenge, in consultation with key stakeholders throughout Australia, which will provide the foundations for a national plan.

²⁸ ACSQHC NSQHS Standards (2nd ed) Medication Safety Standard available at:

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

²⁹ The WA High Risk Medication Policy is available at:

<https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Supporting-information/Mandatory-requirements/Clinical-Governance-Safety-and-Quality/WA-High-Risk-Medication-Policy>

³⁰ The Medication Review Policy is available at:

<https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Medication-Review-Policy>

³¹ WHO Global Patient Safety Challenge: Medication Without Harm:

<https://www.who.int/patientsafety/medication-safety/en/>

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Standard 5: Patient Identification Clinical Incidents

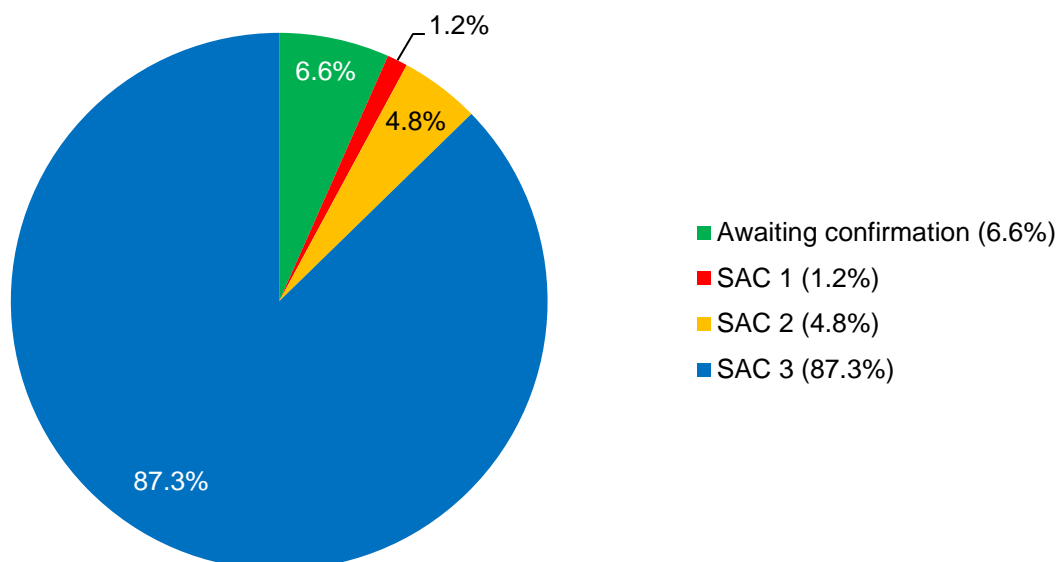
Standard 5 of the NSQHS Standards (first edition) refers to patient identification and procedure matching, the intent of which is to “describe the systems and strategies to identify patients and correctly match their identity to the correct treatment” (ACSQHC, 2013).

Patient identification clinical incidents are captured under Tier Three categories in Datix CIMS³² which include:

- Product mislabelled
- Investigation performed on incorrect patient
- Preparation of patient for investigation insufficient, incorrect or incomplete
- Ambiguous, incorrect or incomplete documentation
- Illegible documentation
- Incorrect patient
- Documentation permanently or temporarily unavailable, or delay in accessing
- Incorrect treatment or procedure
- Medication dispensed to incorrect patient
- Treatment or procedure performed on incorrect body part/site.

In 2018/19, 1,535 patient identification clinical incidents were notified of which 1,433 incidents were confirmed, with the remainder (n=102) awaiting confirmation. Patient identification incidents accounted for 4.5% of all clinical incidents reported in this period and were most often categorised as SAC 3 (n=1,340; 87.3%; see Figure 23).

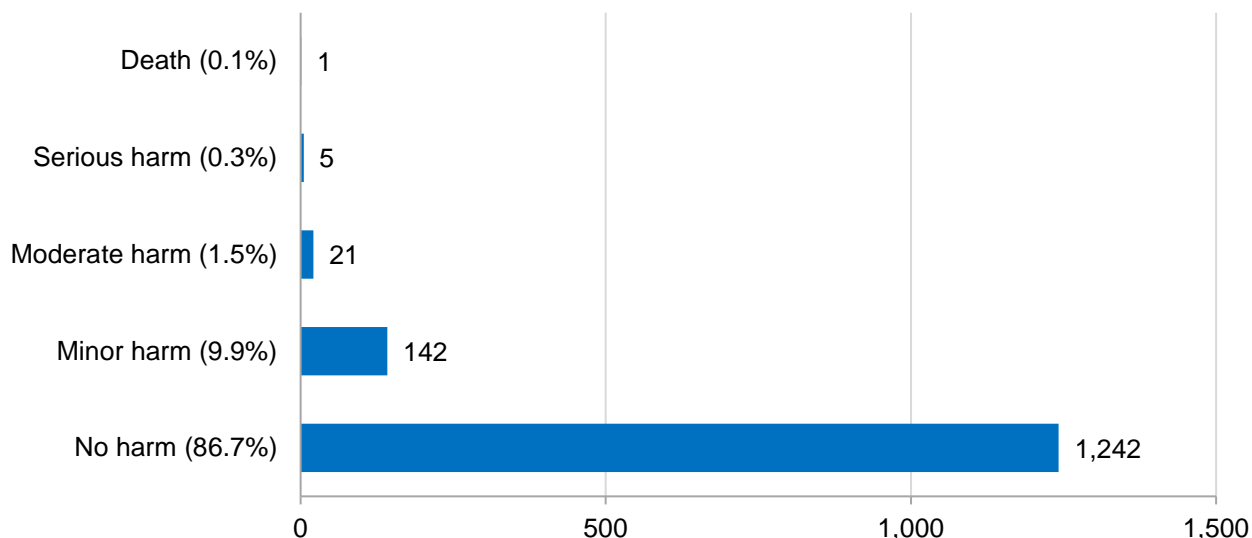
Figure 23: Percentage of Patient Identification Clinical Incidents by SAC Rating for 2018/19



³² The three-tiered Datix CIMS clinical incident classification list was reviewed in 2015, with codes relevant to NSQHS Standard 5 agreed. The classification list was updated in April 2017, and codes relating to Standard 5 were updated. The data presented for Standard 5 in this report is comparable to 2017/18, but not to earlier editions of this report.

Most confirmed patient identification clinical incidents resulted in no harm to the patient (n=1,242; 86.7%; see Figure 24). Seven of the 19 patient identification incidents categorised as SAC 1 resulted in no harm to the patient and one described the patient outcome as death.

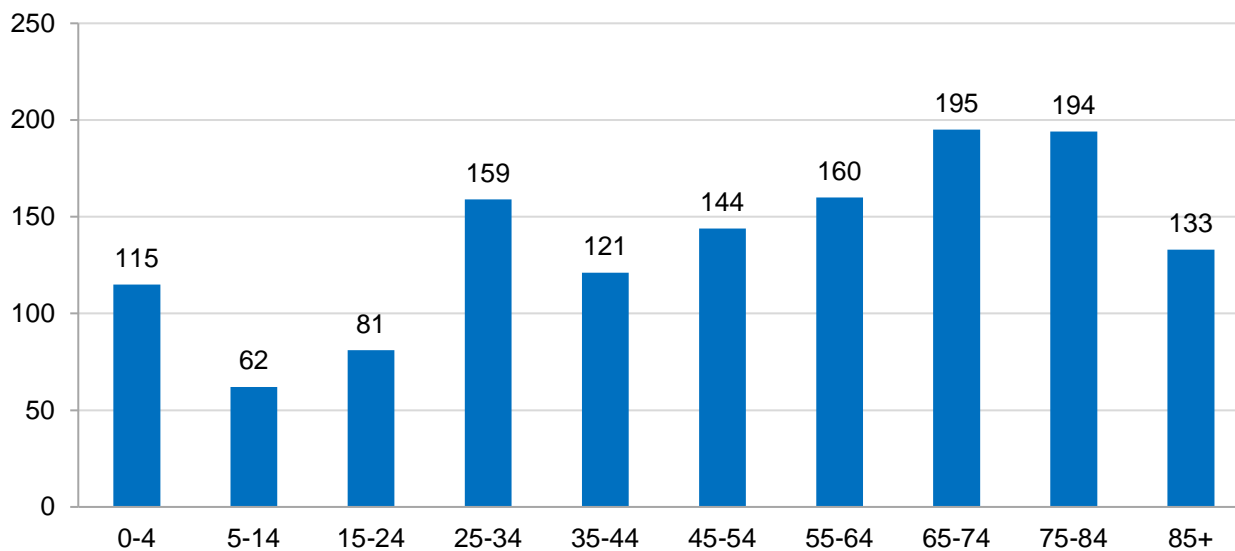
Figure 24: Frequency and Percentage of Confirmed Patient Identification Clinical Incidents by Patient Outcome for 2018/19



Note: Patient outcome missing data n=22; 1.5%

Females accounted for 50.5% (n=692) of patients involved in confirmed patient identification clinical incidents, with males making up 49.5% (n=678; missing n=147). The age of patients involved ranged from 0-100 years with a median age of 55 years (see Figure 25).

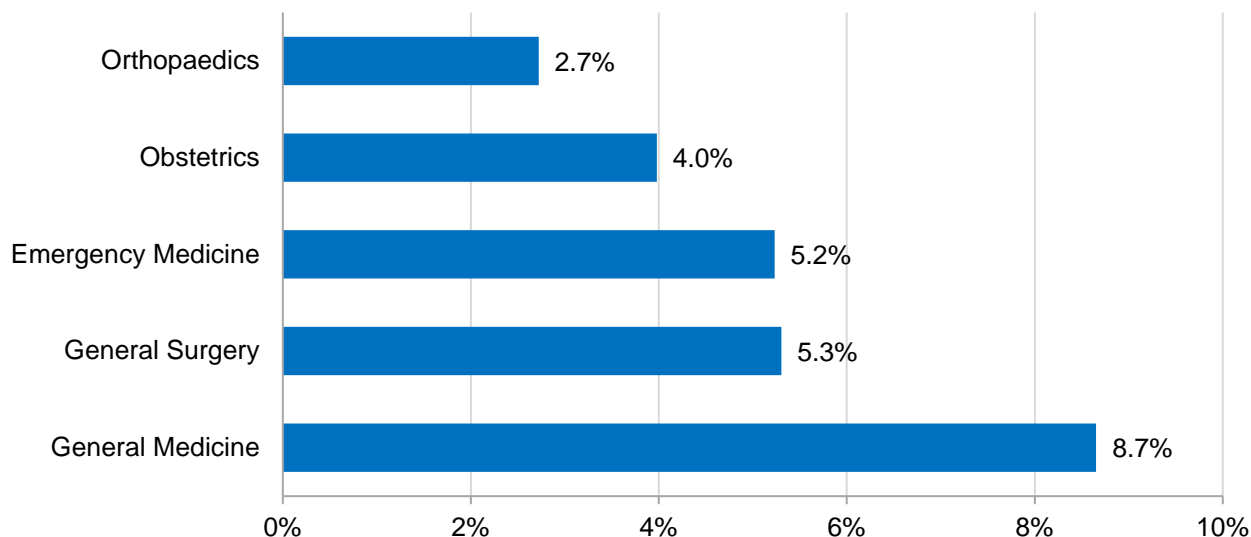
Figure 25: Distribution of Patients Affected by Confirmed Patient Identification Clinical Incidents by Age Group for 2018/19



Note: Patient age missing data n=153; a clinical incident may affect multiple patients

The five specialties that most frequently reported patient identification clinical incidents accounted for 25.9% (n=371) of these incidents in 2018/19 (see Figure 26). Patient identification incidents were most frequently reported by the General Medicine specialty (n=124; 8.7%), followed by General Surgery (n=76; 5.3%) and Emergency Medicine (n=75; 5.2%).

Figure 26: Percentage of Confirmed Patient Identification Clinical Incidents by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=621; 43.3%

The five most frequently reported Tier Three categories accounted for 97.2% (n=1,393) of confirmed patient identification clinical incidents (see Table 14). Incorrect patient was reported in more than two-thirds (n=958; 66.9%) of these incidents in 2018/19.

Table 14: Frequency and Percentage of Top Five Tier Three Confirmed Patient Identification Clinical Incidents Categories for 2018/19

Patient Identification Categories	(n)	(%)
Incorrect patient*	958	66.9
Incorrect treatment/procedure†	182	12.7
Illegible documentation§	108	7.5
Ambiguous/incorrect/incomplete documentation	83	5.8
Preparation of patient for investigation insufficient/incorrect/incomplete	62	4.3
Total	1,393	97.2

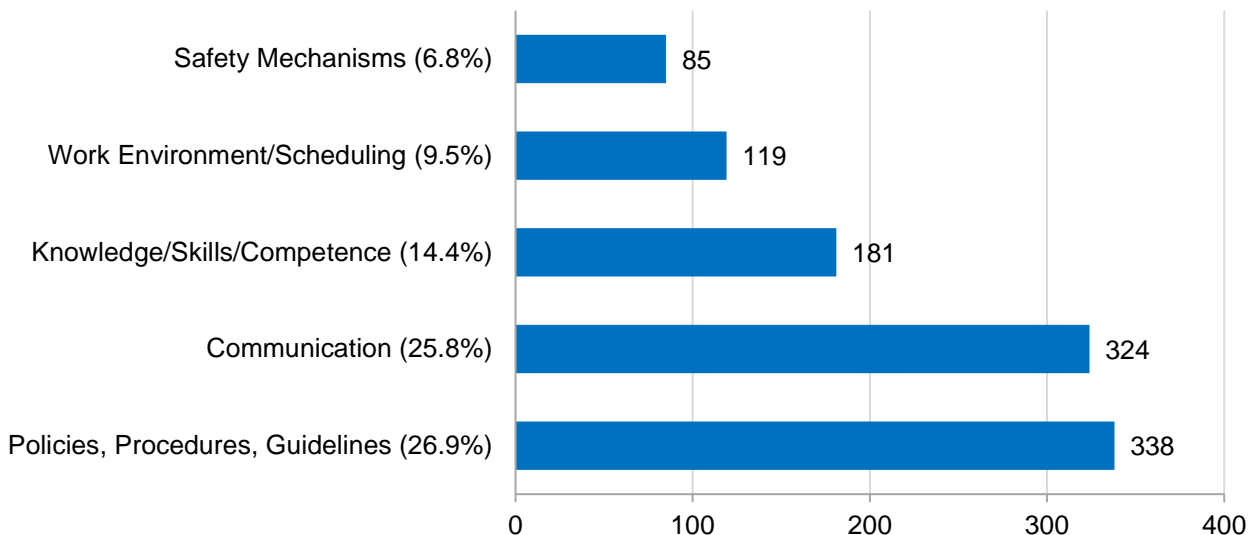
* Incidents in this Tier Three category include incorrect patient information in health care documentation/records, prescribing, dispensing and administration of medication to the wrong patient, and therapeutic and diagnostic procedures performed on the wrong patient.

† Incidents in this Tier Three category include procedures performed at the wrong site, and incorrect manual handling and patient restraint procedures.

§ Incidents in this Tier Three category relate to illegible prescriptions.

Figure 27 shows the contributory factors most frequently identified in patient identification clinical incidents investigated during 2018/19. Issues with policies, procedures and guidelines were identified in 26.9% (n=338) of closed patient identification clinical incidents, followed closely by communication issues, which were cited in 25.8% (n=324) of these incidents.

Figure 27: Frequency and Percentage of Top Five Contributory Factors for Closed Patient Identification Clinical Incidents for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

Key Messages and Information: Patient Identification Clinical Incidents

In 2018/19, more than half (n=720) of confirmed patient identification clinical incidents across the WA health system involved an incorrect patient in health care documentation. Examples of this included test request forms and results issued with an incorrect patient name, medical information for one patient being entered in another patient's health care record, and the incorrect patient record being accessed.

While most of these incidents resulted in no harm, many will have resulted in inconvenience to staff, re-work to resolve the errors that were made, and potentially delayed treatment of the patient. In a health system with limited resources, time spent resolving issues with patient documentation is time that could be better spent caring for our patients.

Issues with communication and policies, procedures and guidelines were the most commonly identified contributory factors in patient identification clinical incidents in 2018/19. It is not surprising that 62.0% (n=201) of incidents where communication issues occurred identified concerns with documentation, and nearly half (n=162) of incidents where issues with policies, procedures or guidelines occurred identified problems with their application.

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 essential information in patient health care records are essential components of communication in a safe and high-quality health system. The WA health system must ensure that its staff are adequately skilled and supported to achieve this for every patient.

Standard 6: Clinical Handover Clinical Incidents

Standard 6 of the NSQHS Standards (first edition) refers to clinical handover, which describes “the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient’s care is transferred” (ACSQHC, 2013).

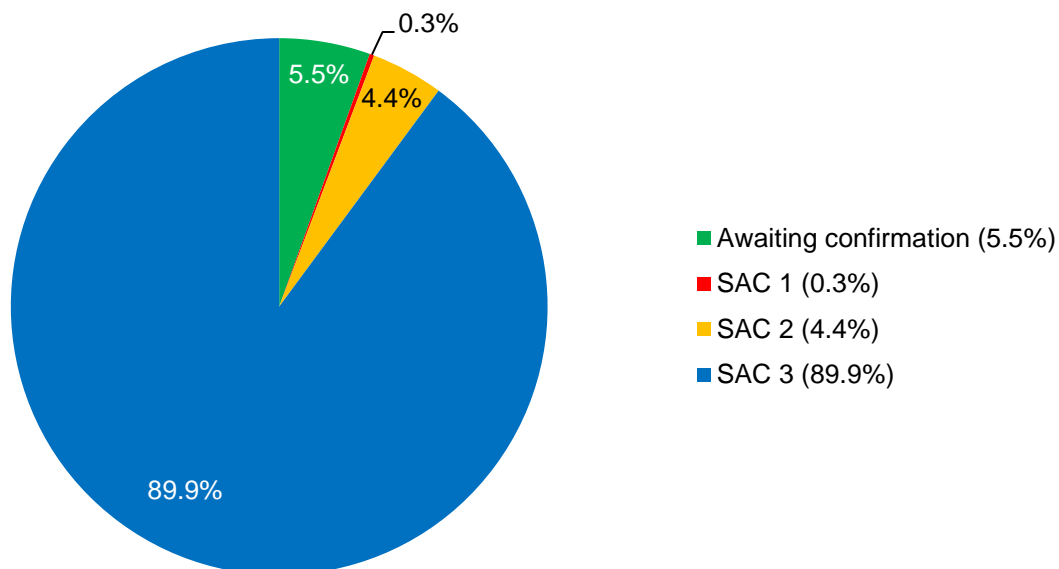
The Datix Clinical Incident Management System incident classification was reviewed to identify responses that would best capture clinical handover incidents and includes the following categories:

- Incorrect/insufficient/delayed handover
- Discharge processes being inappropriate/insufficient/incomplete
- Medical records/forms/bar codes/labels/results/reports being unavailable/ambiguous/incorrect/incomplete/illegible/misfiled/mislabelled
- Patient discharge information/instructions being unavailable/ambiguous/incorrect/incomplete/illegible
- Health care referrals/discharge correspondence being unavailable/ambiguous/incorrect/incomplete/illegible.

In 2018/19, 2,519 clinical incidents related to clinical handover were reported, of which 2,381 incidents were confirmed and the remainder (n=138) were awaiting confirmation. Clinical handover incidents accounted for 7.4% of all clinical incidents reported in this period.

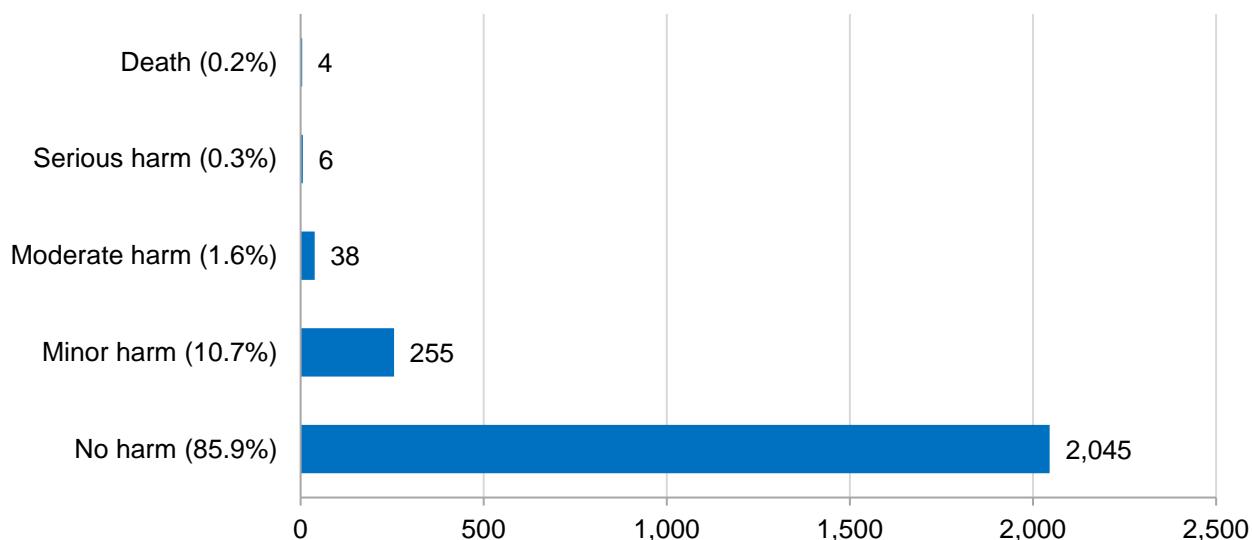
Clinical handover clinical incidents were most frequently categorised as SAC 3 incidents (n=2,264; 89.9%; see Figure 28). Of the seven incidents confirmed as SAC 1, four related to discharge processes and three related to incorrect or insufficient handover of the patient.

Figure 28: Percentage of Clinical Handover Clinical Incidents by SAC Rating for 2018/19



Most confirmed clinical handover clinical incidents in 2018/19 resulted in no harm to the patient (85.9%; n=2,045). Four incidents described the patient outcome as death (see Figure 29).

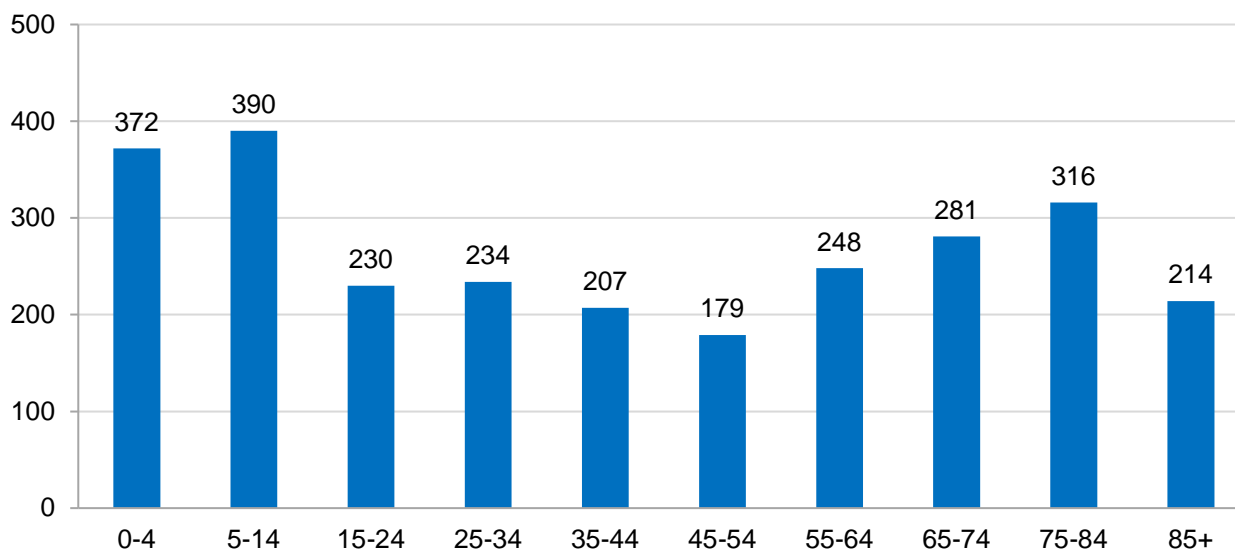
Figure 29: Frequency and Percentage of Confirmed Clinical Handover Clinical Incidents by Patient Outcome for 2018/19



Note: Patient outcome missing data n=33; 1.4%

Males and females each accounted for 50.0% of patients involved in confirmed clinical handover clinical incidents in 2018/19 (male n=1,338; female n=1,339; missing n=260). Patient ages ranged from 0-101 years with a median age of 39 years (see Figure 30).

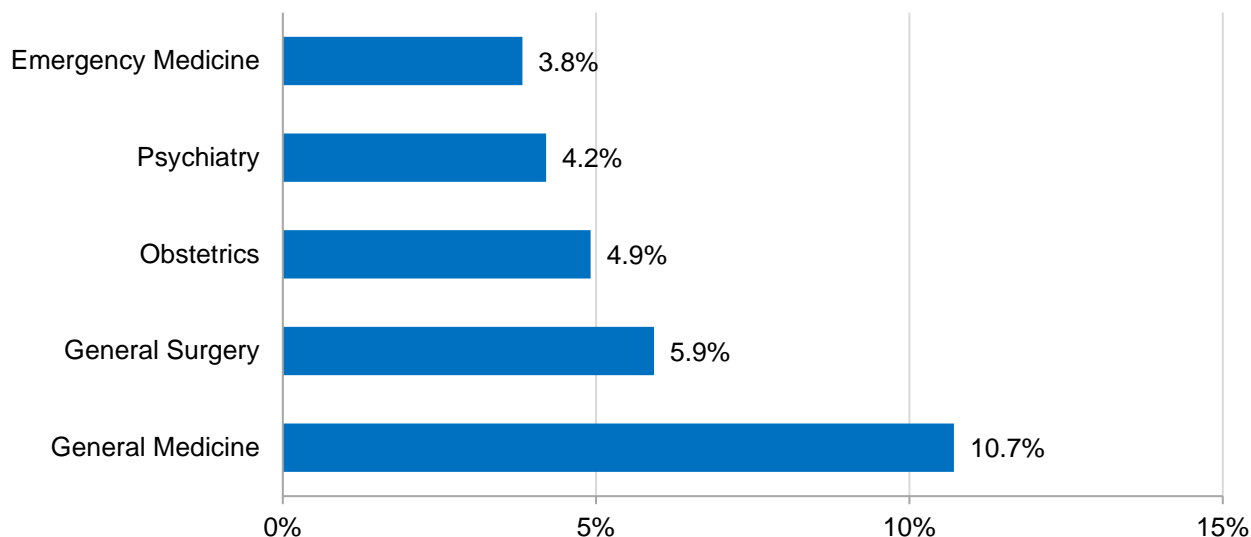
Figure 30: Distribution of Patients Affected by Confirmed Clinical Handover Clinical Incidents by Age Group for 2018/19



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

The treating specialties that reported clinical handover clinical incidents more frequently during 2018/19 are shown in Figure 31. These five specialties accounted for 29.6% (n=704) of confirmed clinical handover incidents in this period, with the General Medicine specialty reporting the most clinical handover incidents (n=255; 10.7%).

Figure 31: Percentage of Confirmed Clinical Handover Clinical Incidents by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=888; 37.3%

The five most frequent Tier Three categories accounted for 90.8% (n=2,161) of confirmed clinical handover clinical incidents in 2018/19. Information that was ambiguous, incomplete or incorrect was identified in half of all confirmed incidents related to clinical handover (n=1,191; see Table 15), with temporary unavailability or delays in accessing information cited in a further 15.3% (n=364).

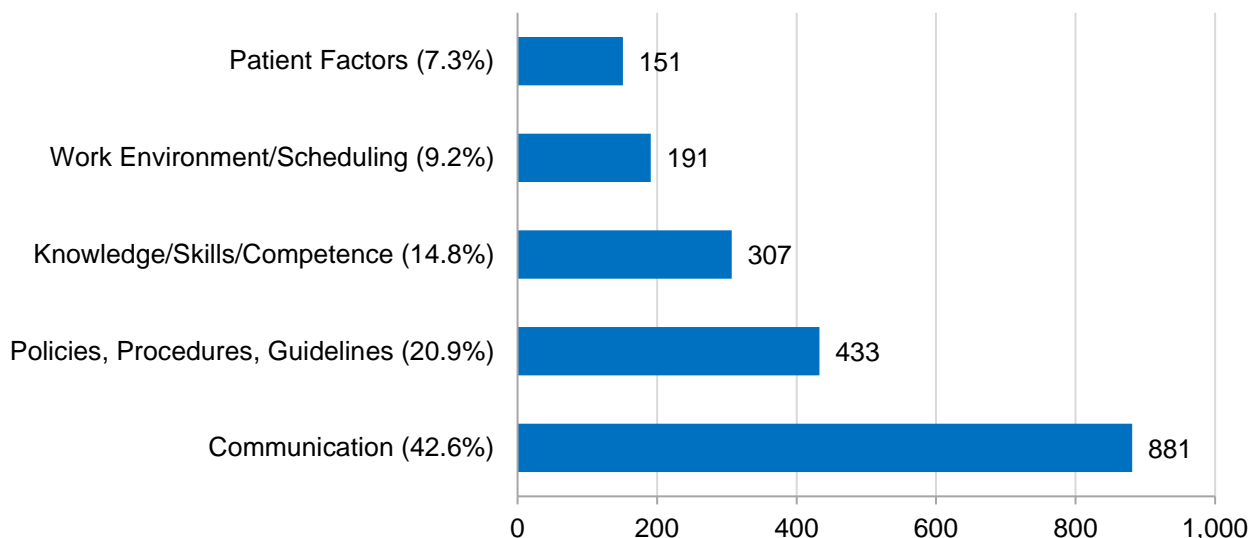
Table 15: Frequency and Percentage of Top Five Tier Three Confirmed Clinical Handover Clinical Incidents Categories for 2018/19

Tier Three Clinical Handover Categories	(n)	(%)
Ambiguous/incorrect/incomplete*	1,191	50.0
Temporarily unavailable/delay in accessing*	364	15.3
Between healthcare professionals insufficient/incorrect/ incomplete	309	13.0
Incorrect/insufficient handover	167	7.0
Discharge insufficient/incomplete	130	5.5
Total	2,161	90.8

* Incidents for these Tier Three categories relate to health care records/documentation including consultation referrals/requests, electronic medical records, forms, healthcare provider discharge correspondence, healthcare provider referral/consultation correspondence, imaging reports/results, informed consent documentation, labels, laboratory reports/test results, other test reports/results, paper medical records, patient discharge information/ instructions and test request forms.

In 2018/19, the most commonly identified contributory factors in clinical handover incidents were communication issues which were cited in 42.6% (n=881) of closed incidents, and issues related to policies, procedures and guidelines (20.9%; n=433; see Figure 32).

Figure 32: Frequency and Percentage of the Top Five Contributory Factors for Closed Clinical Handover Clinical Incidents for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

Key Messages and Information: Clinical Handover Clinical Incidents

Review of the first edition NSQHS Standards found that clinical handover was often interpreted as only referring to shift-to-shift handover. The Communicating for Safety Standard in the second edition 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.³³

In 2018/19, half (n=1,191) of all confirmed clinical handover clinical incidents in the WA health system related to information in health care documentation (such as patient medical records, forms and discharge information) that was ambiguous, incorrect or incomplete. Deficiencies in the information available at handover can hinder the effective transition of care and place the patient at increased risk of receiving inadequate or incorrect ongoing treatment.

Communication issues continue to be the most frequently identified contributory factor in clinical handover clinical incidents in 2018/19. Problems with communication between staff were found in 60.2% (n=530) of incidents where communication issues occurred, and issues with health care documentation were found in 57.0% (n=499). This reinforces the need for the WA health system to ensure structured approaches to clinical handover are used whenever patient care transitions, as required by the Department of Health's *Clinical Handover Policy*.³⁴

³³ ACSQHC NSQHS Standards (2nd ed) Communicating for Safety Standard Action 6.8:

<https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover/action-68>

³⁴ 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>

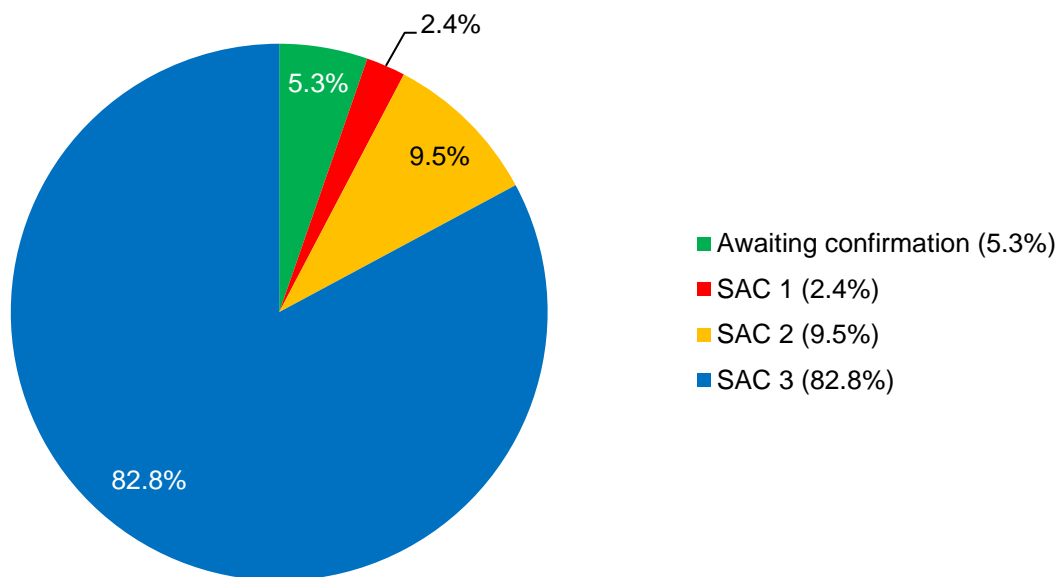
Standard 7: Blood and Blood Products Clinical Incidents

Standard 7 of the NSQHS Standards (first edition) refers to “systems and strategies for the safe, effective and appropriate management of blood and blood products” (ACSQHC, 2013).

In 2018/19, there were 169 blood and blood products clinical incidents notified with 160 clinical incidents confirmed, and the remaining nine awaiting confirmation. Blood and blood products clinical incidents accounted for 0.5% of all clinical incidents reported in this period.

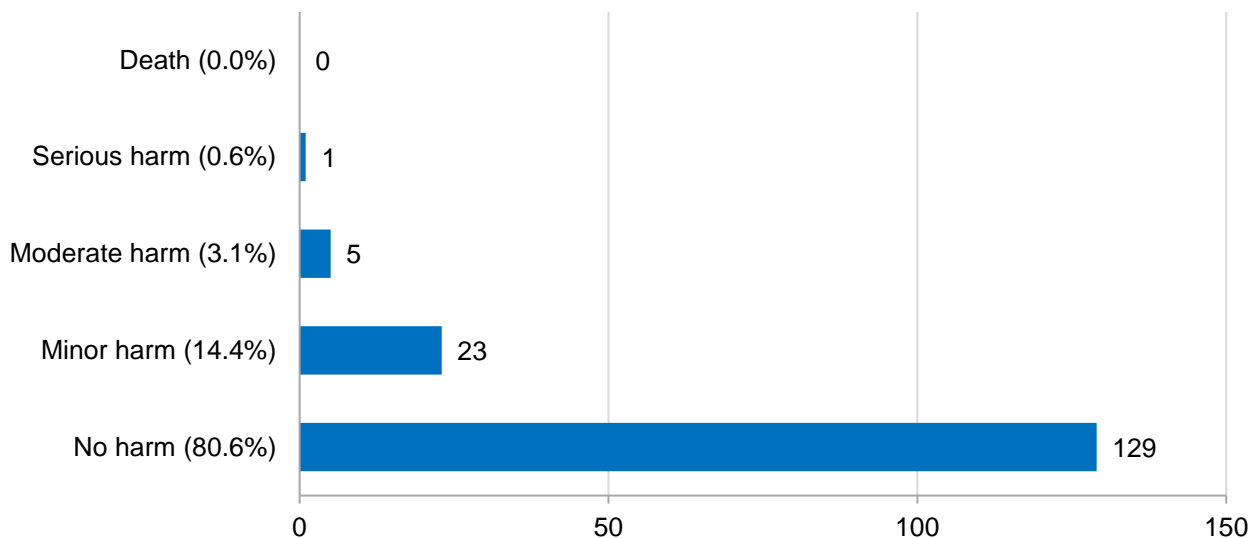
Blood and blood products clinical incidents were most frequently categorised as SAC 3 incidents (n=140; 82.8%; see Figure 33). The four blood and blood products clinical incidents confirmed as SAC 1 related to a pre-transfusion procedural error, a mislabelled blood product, product administration to the incorrect patient, and delay in administration of a blood product.

Figure 33: Percentage of Blood and Blood Products Clinical Incidents by SAC Rating for 2018/19



Most confirmed blood and blood products clinical incidents in 2018/19 resulted in no harm to the patient (n=129; 80.6%), with one incident reporting an outcome of serious harm (see Figure 34).

Figure 34: Percentage of Confirmed Blood and Blood Products Clinical Incidents by Patient Outcome for 2018/19

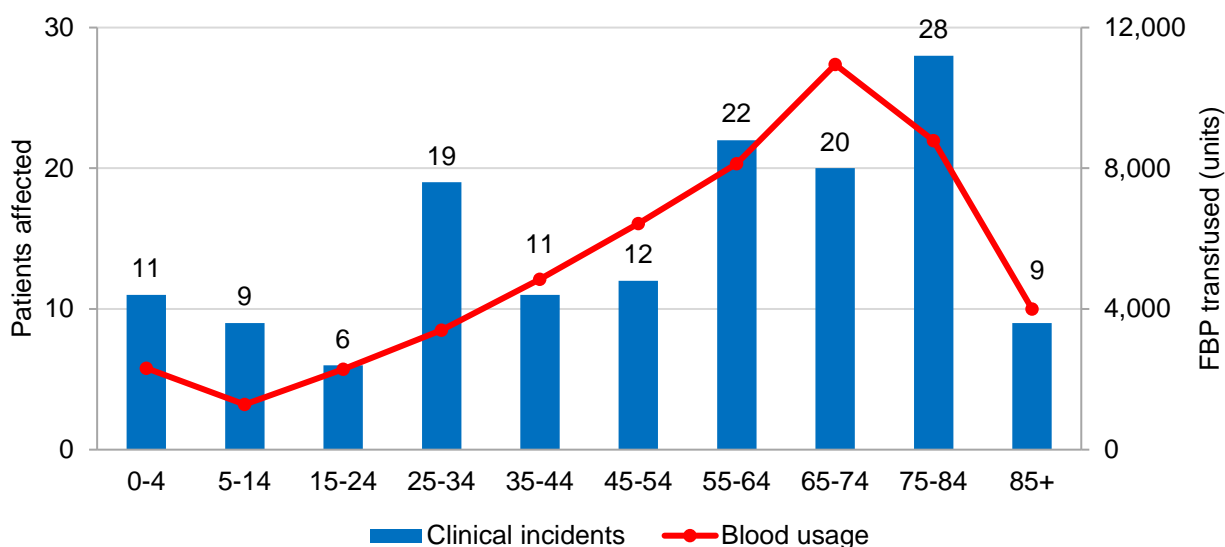


Note: Patient outcome missing data n=2; 1.3%

Males accounted for 50.3% (n=75) of patients affected by confirmed blood and blood products clinical incidents in 2018/19, with females making up 49.7% (n=74; missing n=16). The age of patients affected ranged from 0-99 years with a median age of 57 years.

Figure 35 shows the age distribution of patients involved in confirmed blood and blood products clinical incidents as well as the total units of fresh blood products (FBP) transfused at WA public hospitals in these age groups during 2018/19. The distribution of blood and blood products clinical incidents by patient age was similar to that of FBP usage in this period.

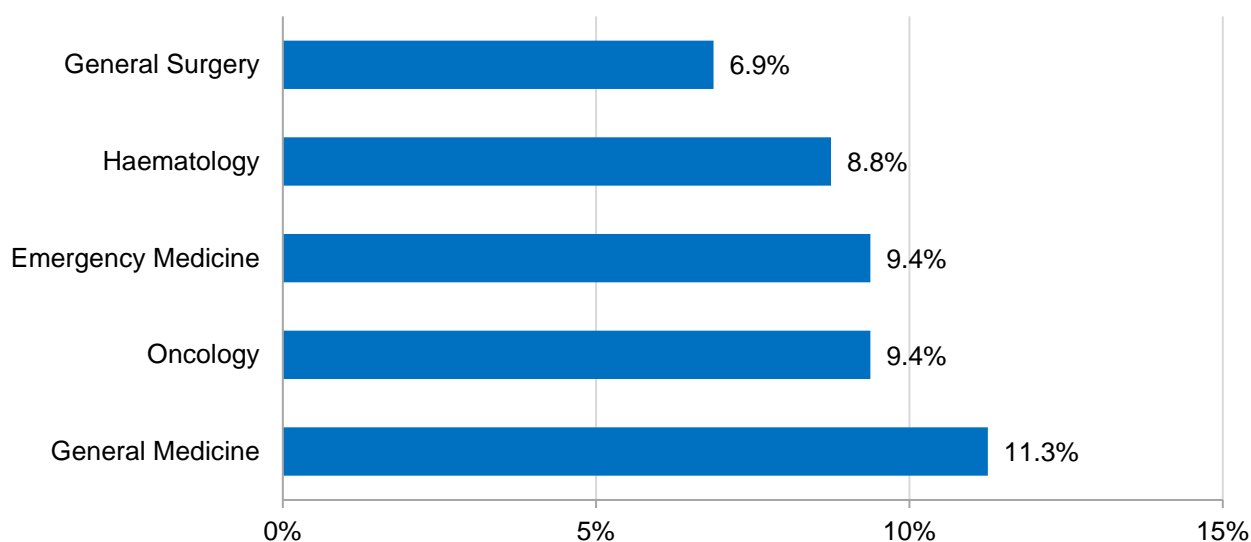
Figure 35: Distribution of Patients Affected by Confirmed Blood and Blood Products Clinical Incidents by Age Group and Fresh Blood Products Transfused for 2018/19



Notes: Patient age missing data n=18; 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.

The treating specialties that reported blood and blood products clinical incidents most frequently are shown in Figure 36. These five specialties accounted for 45.6% (n=73) of confirmed blood and blood products clinical incidents during 2018/19. The General Medicine specialty reported the highest number of blood and blood products clinical incidents (n=18; 11.3%) followed by the Emergency Medicine and Oncology specialties (n=15; 9.4% each).

Figure 36: Percentage of Confirmed Blood and Blood Products Clinical Incidents by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=31; 19.4%

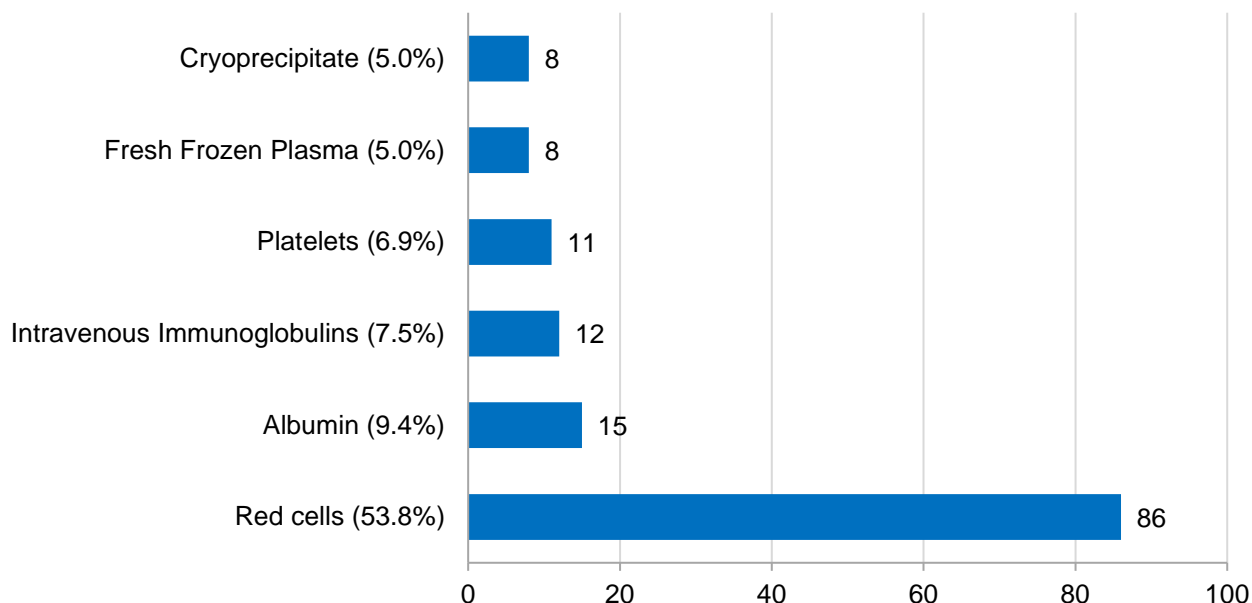
The five most frequent blood and blood products clinical incident Tier Three categories accounted for 39.4% (n=63) of confirmed blood and blood products clinical incidents in 2018/19 (see Table 16). In 10.6% (n=17) of confirmed blood and blood products clinical incidents there was a delay in administration of blood/blood products or they were not given when indicated. Blood and blood products administered at the incorrect rate or frequency was reported in 9.4% (n=15) of confirmed blood and blood products clinical incidents in this period.

Table 16: Frequency and Percentage of Top Five Tier Three Confirmed Blood and Blood Products Clinical Incidents Categories for 2018/19

Tier Three Blood and Blood Products Categories	(n)	(%)
Not given when indicated/administration delayed	17	10.6
Incorrect rate/frequency of administration	15	9.4
Insufficient/incomplete monitoring during or after transfusion	11	6.9
Product delivery to ward/unit delayed	10	6.3
Product mislabelled (product type/traceability details)	10	6.3
Total	63	39.4

The types of product most frequently associated with confirmed blood and blood products incidents are shown in Figure 37. Red cells were involved in more than half of these incidents (n=86; 53.8%) in 2018/19, and accounted for 62.1% of fresh blood products used in this period.

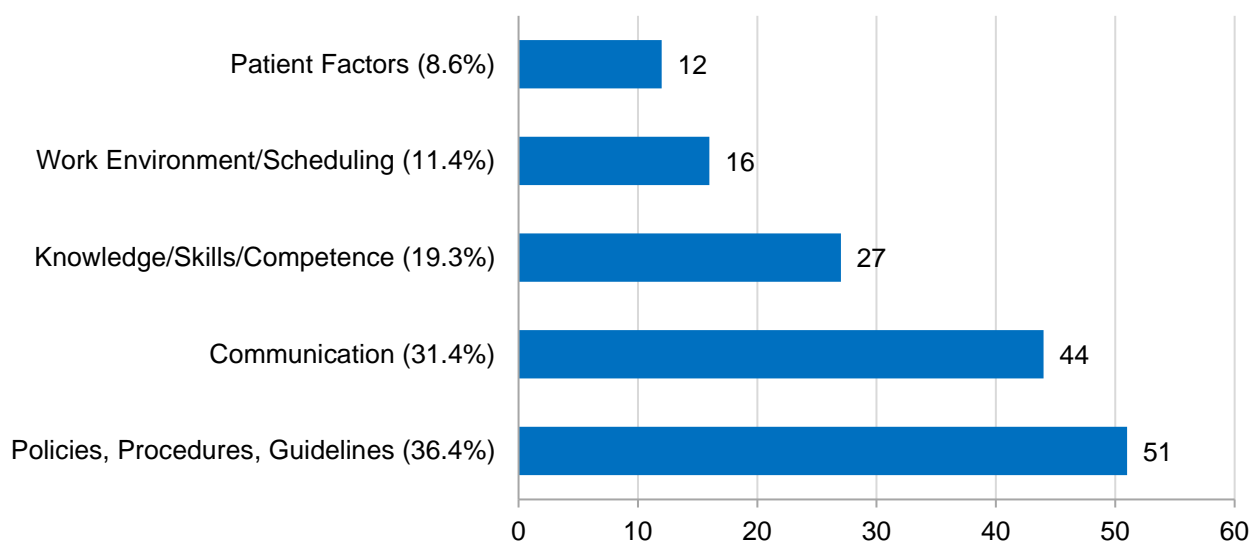
Figure 37: Frequency and Percentage of the Top Five Product Types for Confirmed Blood and Blood Products Clinical Incidents for 2018/19



Note: A blood and blood products 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.

The most common contributory factor identified in closed blood and blood products clinical incidents in 2018/19 was issues with policies, procedures and guidelines (n=51; 36.4%; see Figure 38). The next most frequent contributory factor was communication issues which were identified in 31.4% (n=44) of blood and blood products clinical incidents investigated.

Figure 38: Frequency and Percentage of the Top Five Contributory Factors for Closed Blood and Blood Products Clinical Incidents for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

Key Messages and Information: Blood and Blood Products Clinical Incidents

While the number of blood and blood products 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.

The administration of blood and blood products to acutely unwell patients can be both life-saving and time-critical. In 2018/19, the most frequently identified category of blood and blood products clinical incidents related to delayed administration or blood/blood products not being given when indicated (n=17). More than half of these incidents (n=9) identified a breakdown in communication between staff as contributing to the incident.

The one blood and blood products clinical incident in 2018/19 that resulted in serious harm to the patient was associated with a delay in the administration of blood products to a patient that developed a major gastrointestinal bleed during a diagnostic procedure. While the decision to activate the Major Haemorrhage Pack (MHP) was taken quickly, the event occurred at a time when the hospital was experiencing a major and unscheduled ICT outage. When staff went to use the back-up telephony system to activate the MHP there were no instructions advising the correct number to call. A staff member was sent to the Transfusion Medicine Unit with the MHP activation form to alert them to this urgent need for blood products.

The investigation of this incident identified that the delay to the patient receiving the blood products was approximately 10 minutes, however had the delay been significantly longer the outcome could have been catastrophic. In response, the hospital programmed the back-up telephony system with numbers relevant to each area, developed a set of instructions to be kept next to each handset, and commenced a program of education to ensure staff are educated about downtime procedures both during induction and on an ongoing basis.

This incident highlighted the need for all staff to be familiar with the downtime procedures that should be used in emergency situations when normal systems or processes have failed, and the learnings are applicable across the WA health system. The need for health service organisations to plan for, and manage, internal and external emergencies and disasters is a key aspect of risk management described in the NSQHS Standards.

In recognition that blood and blood products are a limited resource, a key element of the Blood Management Standard³⁵ in the second edition of the NSQHS Standards is the requirement to manage the need for, and minimise the inappropriate use of, blood and blood products. 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.³⁶

³⁵ ACSQHC NSQHS Standards (2nd ed) Blood Management Standard available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards/blood-management-standard>

³⁶ Further information about Patient Blood Management is available at: https://ww2.health.wa.gov.au/Articles/A_E/Blood-management



Standard 8: Pressure Injury Clinical Incidents

Standard 8 of the NSQHS Standards (first edition) relates to preventing patients from developing pressure injuries and effectively managing pressure injuries when they do occur. Pressure injuries may result from immobility, such as that associated with prolonged bed rest in hospital, however in most cases they are preventable. Strategies to identify risk factors and reduce the likelihood of pressure injuries developing have been identified, and the management of established pressure injuries has improved with advances in wound care.

In 2016, the National Pressure Ulcer Advisory Panel (NPUAP) updated pressure injury definitions. A pressure injury can be defined 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.”³⁷ Pressure injuries in adults occur most commonly on the lower leg or sacral area but can develop anywhere on the body.

There are several stages of pressure injury development, defined³⁷ 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 NPUAP has also published other definitions³⁷ relating to pressure injuries:

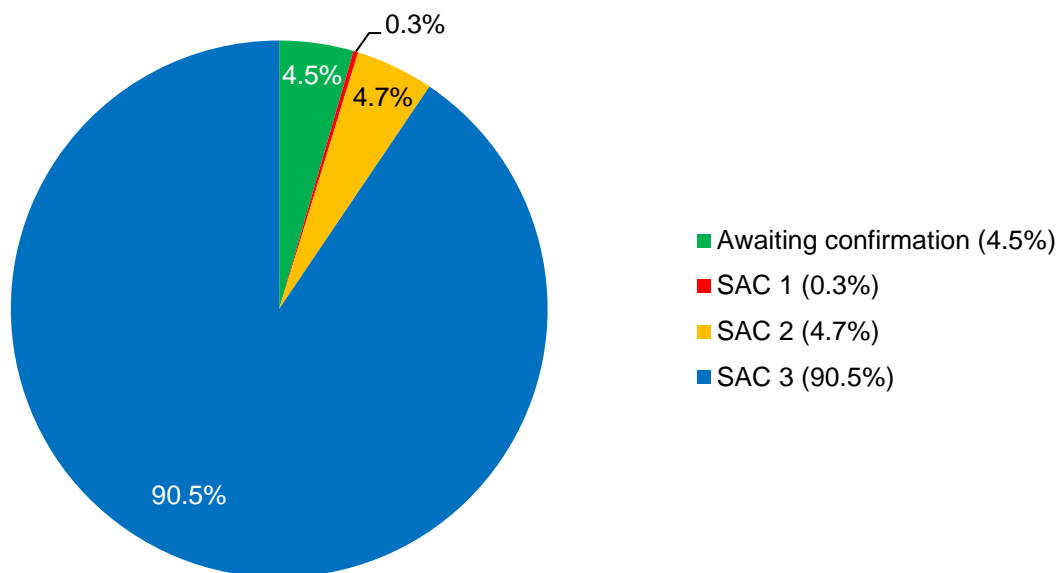
- **Medical Device Related Pressure Injury:** “Results from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.”
- **Mucosal Membrane 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.”

³⁷ https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf

In 2018/19, there were 2,104 pressure injury clinical incidents notified with 2,010 of these incidents confirmed and the remaining 94 awaiting confirmation. Pressure injury clinical incidents accounted for 6.1% of all clinical incidents reported in this period.

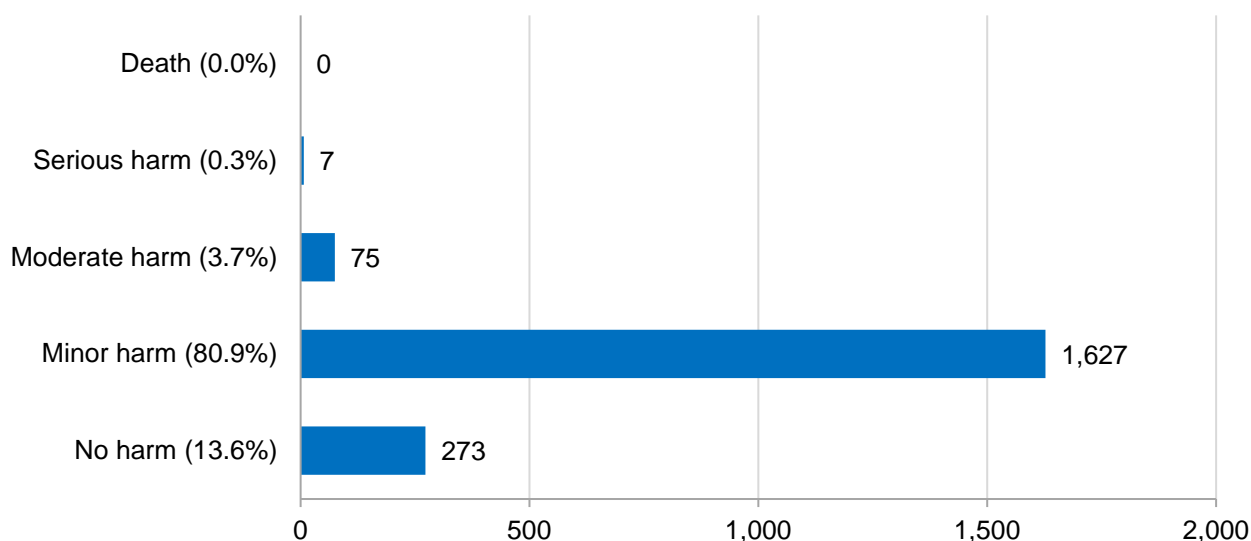
Most pressure injury clinical incidents were categorised as SAC 3 incidents (n=1,905; 90.5%; see Figure 39) in this period, with six pressure injury clinical incidents categorised as SAC 1. Of these, three related to suspected deep tissue pressure injuries, one to a Stage 3 pressure injury, one to a Stage 4 pressure injury, and one to an unstageable pressure injury.

Figure 39: Percentage of Pressure Injury Clinical Incidents by SAC Rating for 2018/19



In 2018/19, most confirmed pressure injury clinical incidents were reported to result in minor harm to the patient (n=1,627; 80.9%) and a further 13.6% (n=273) resulted in no harm (see Figure 40). No pressure injury incidents described the patient outcome as death in this period.

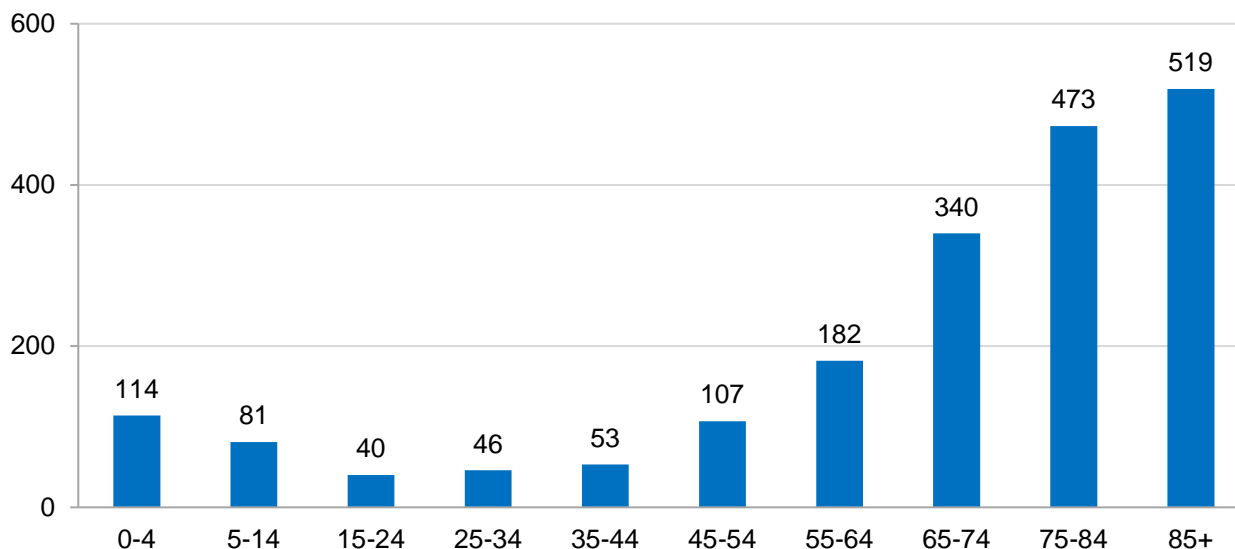
Figure 40: Frequency and Percentage of Confirmed Pressure Injury Clinical Incidents by Patient Outcome for 2018/19



Note: Patient outcome missing data n=28; 1.4%

Males accounted for 56.7% (n=1,109) of patients involved in confirmed pressure injury clinical incidents in 2018/19, with females making up 43.3% (n=848; missing n=57). Ages ranged from 0-103 years with a median age of 75 years (see Figure 41).

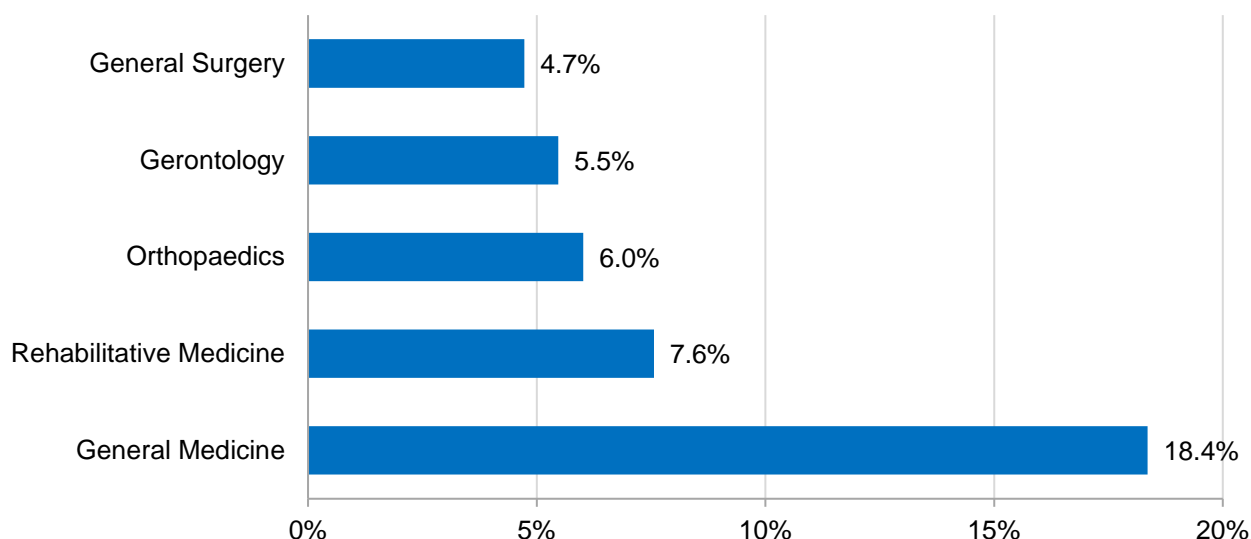
Figure 41: Distribution of Patients Affected by Confirmed Pressure Injury Clinical Incidents by Age Group for 2018/19



Note: Patient age missing data n=59; a clinical incident may affect multiple patients

The treating specialties that reported pressure injury clinical incidents most frequently are shown in Figure 42. These five specialties accounted for 42.1% (n=847) of confirmed pressure injury clinical incidents in 2018/19. The General Medicine specialty reported the most pressure injury incidents (n=369; 18.4%) followed by the Rehabilitative Medicine specialty (n=152; 7.6%).

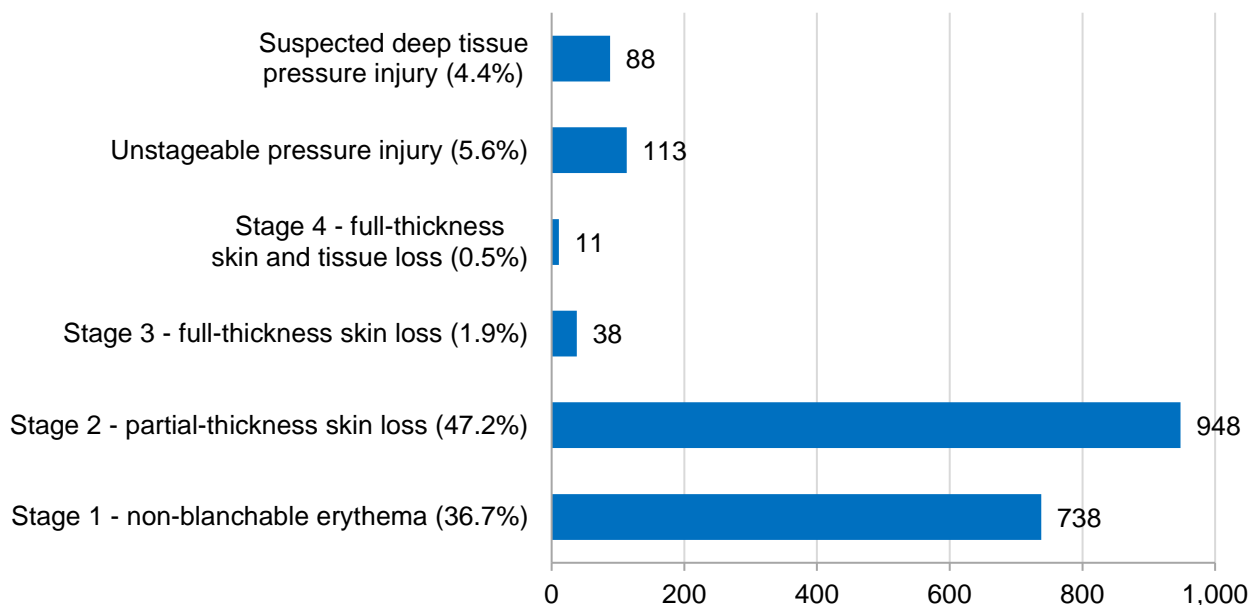
Figure 42: Percentage of Confirmed Pressure Injury Clinical Incidents by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=424; 21.1%

Figure 43 shows the stage of pressure injuries reported in confirmed pressure injury clinical incidents in 2018/19. Stage 2 pressure injuries were most frequently reported (n=948; 47.2%) followed by Stage 1 pressure injuries (n=738; 36.7%).

Figure 43: Frequency and Percentage of Confirmed Pressure Injury Clinical Incidents by Stage for 2018/19



At the time of this report 2.4% (n=49) of pressure injury clinical incidents had not been staged, and a further 1.2% (n=25) had been classified as mucosal membrane pressure injuries.

Most pressure injury clinical incidents reported that the patient had one pressure injury at the time the incident was notified (n=1,183; 58.9%), however 597 patients were identified as having multiple pressure injuries, with two patients reported as having 10 or more (see Figure 44).

Figure 44: Frequency of Pressure Injuries in Confirmed Pressure Injury Clinical Incidents for 2018/19

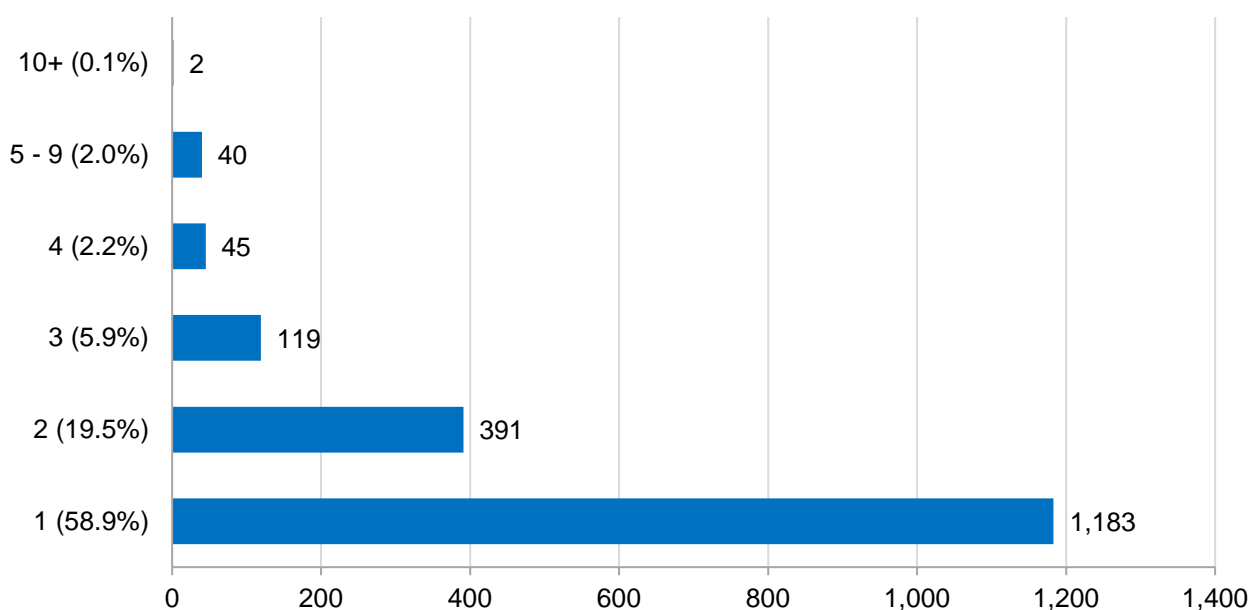
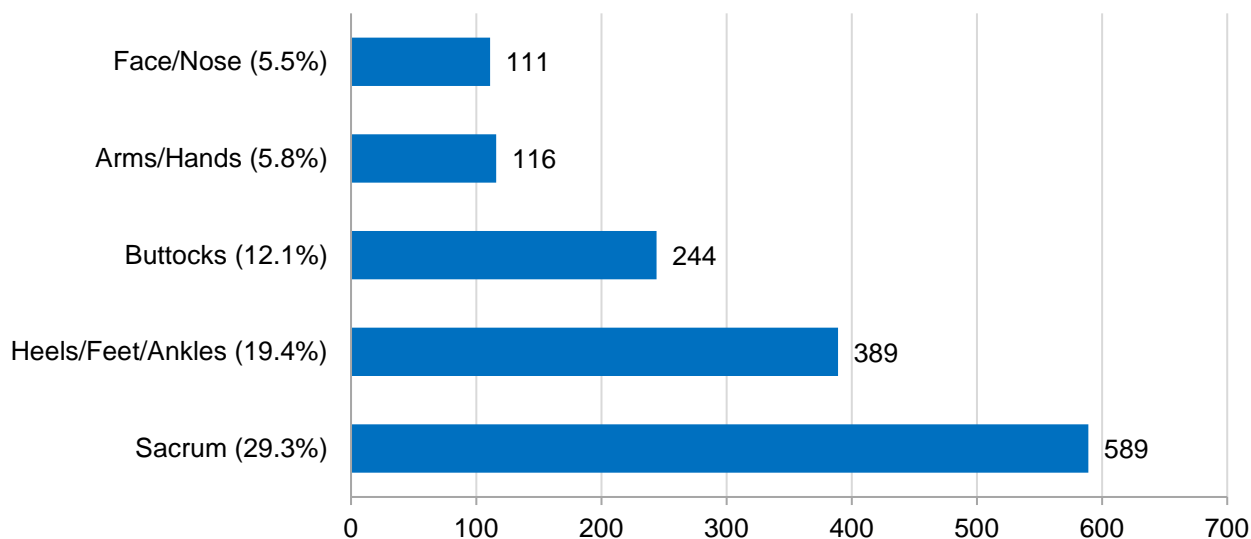


Figure 45 shows the anatomical locations where pressure injuries were most frequently reported in confirmed pressure injury clinical incidents in 2018/19. These five locations accounted for 72.1% (n=1,449) of pressure injury anatomical locations. Sacral pressure injuries were reported most frequently (n=589; 29.3%) followed by pressure injuries to the heels, feet or ankles (n=389; 19.4%).

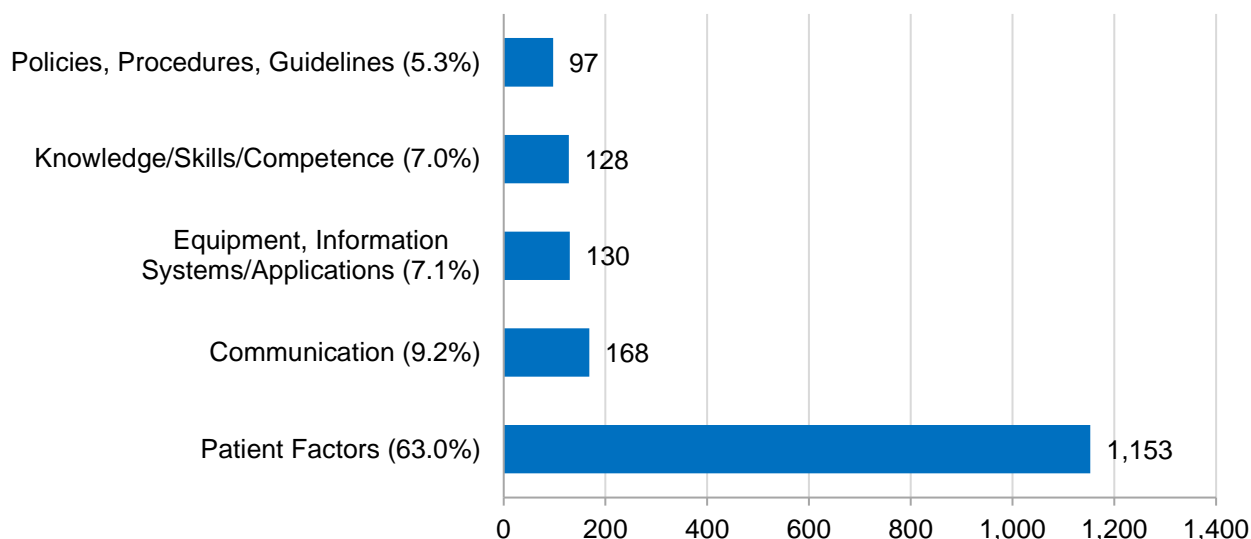
Figure 45: Frequency and Percentage of Top Five Anatomical Locations for Confirmed Pressure Injury Clinical Incidents for 2018/19



Note: Anatomical location of pressure injury missing data n=198; 9.9%

Patient factors were identified as contributory in 63.0% (n=1,153) of pressure injury clinical incidents investigated in 2018/19. The next most frequently identified contributory factor was communication issues, which were found in 9.2% (n=168) of these incidents (see Figure 46).

Figure 46: Frequency and Percentage of Top Five Contributory Factors for Closed Pressure Injury Clinical Incidents for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

Pressure Injuries Not Present on Admission

Pressure injuries are largely considered avoidable and two-thirds (n=1,338) of confirmed pressure injury clinical incidents in 2018/19 related to pressure injuries that were not present at the time of admission of the patient (see Table 17).

Table 17: Frequency and Percentage of Confirmed Pressure Injury Clinical Incidents by Tier Two Categories for 2018/19

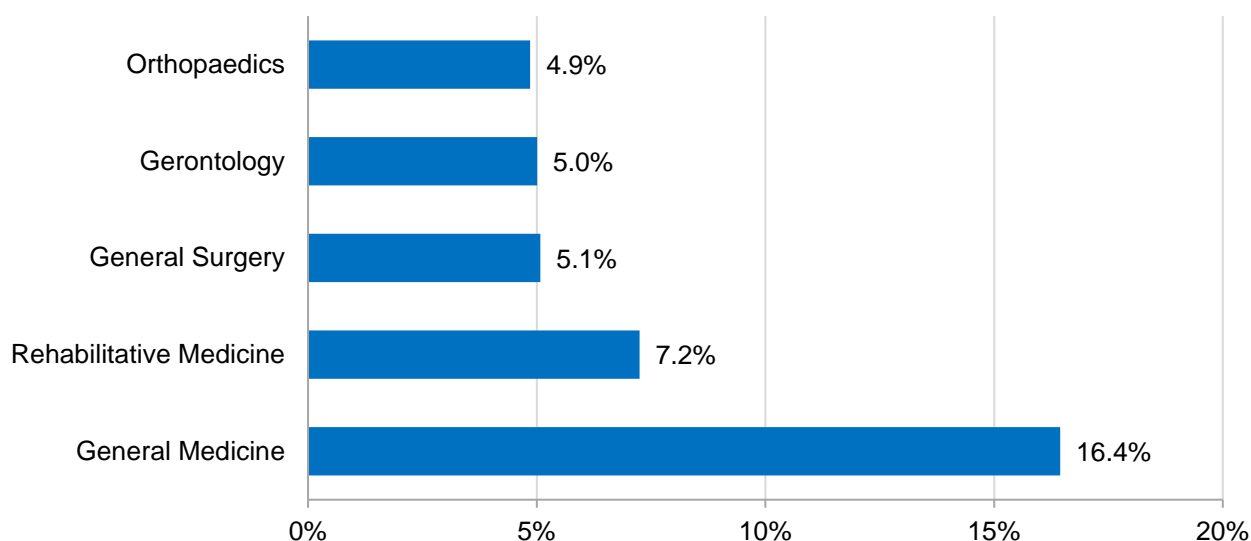
Pressure Injury Category	(n)	(%)
Not present on admission	1,338	66.6
Unknown whether present on admission	381	19.0
Present on admission	291	14.5
Total	2,010	100.0

Pressure injuries that were present on admission (n=291; 14.5%) 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.

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 58.4% (n=756) of patients involved in incidents where pressure injuries developed in hospital in 2018/19, with females making up 41.6% (n=539; missing n=47). Ages ranged from 0-103 years with a median age of 73 years.

The five treating specialties that most frequently reported clinical incidents related to pressure injuries that developed while in hospital accounted for 38.6% (n=517) of these incidents (see Figure 47). The General Medicine specialty reported the most incidents related to pressure injuries that were not present on admission (n=220; 16.4%).

Figure 47: Percentage of Confirmed Pressure Injuries Not Present on Admission by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=268; 20.0%

In 2018/19, most clinical incidents related to pressure injuries that developed while in hospital involved Stage 1 (n=510; 38.1%) or Stage 2 (n=621; 46.4%) pressure injuries (see Table 18).

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 15 incidents related to Stage 3 pressure injuries, and one of four incidents related to Stage 4 pressure injuries confirmed as SAC 1.

Table 18: Frequency of Confirmed Pressure Injuries Not Present on Admission by Stage and SAC Rating for 2018/19

Pressure Injury Category	SAC 1	SAC 2	SAC 3	Total
Stage 1 – non-blanchable erythema	-	4	506	510
Stage 2 – partial-thickness skin loss	-	29	592	621
Stage 3 – full-thickness skin loss	1	4	10	15
Stage 4 – full-thickness skin and tissue loss	1	-	3	4
Unstageable pressure injury	1	10	55	66
Suspected deep tissue pressure injury	2	17	42	61
Total	5	64	1,208	1,277

Mucosal membrane pressure injuries accounted for 1.6% (n=21) of confirmed pressure injury clinical incidents that occurred following admission, and the remainder (n=40; 3.0%) had not been staged at the time of this report.

More than half of patients had developed only one pressure injury in hospital when the clinical incident was notified (n=763; 57.0%), however 411 patients were identified as having multiple pressure injuries, with two of these patients reported as having 10 or more (see Figure 48).

Figure 48: Frequency of Pressure Injuries Not Present on Admission in Confirmed Pressure Injury Clinical Incidents for 2018/19

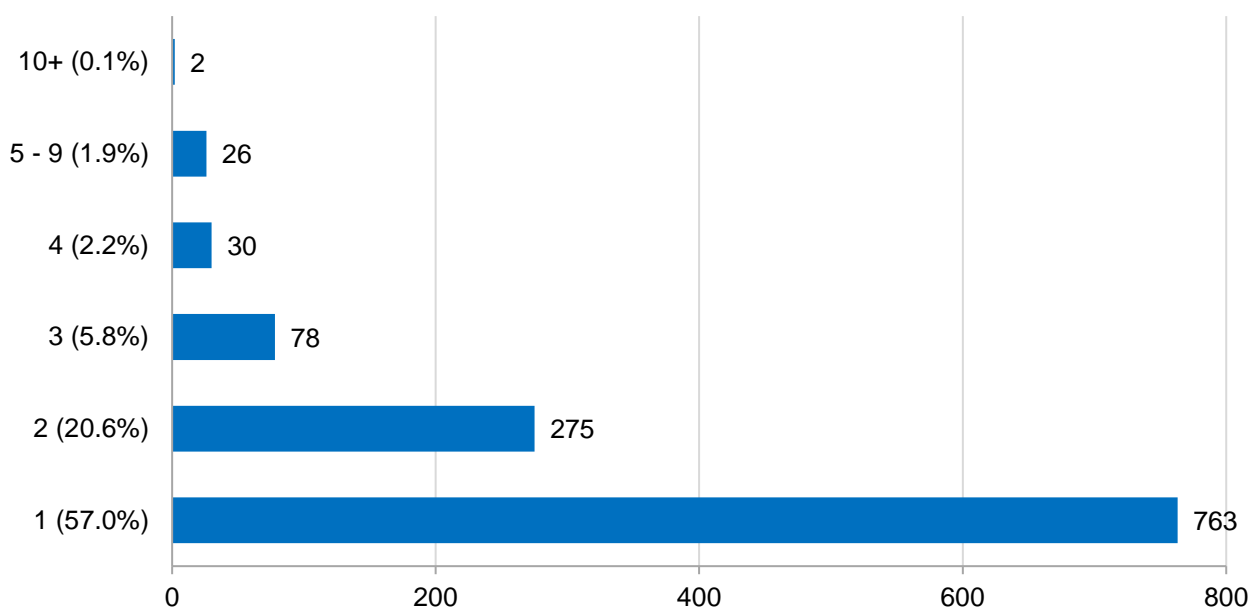
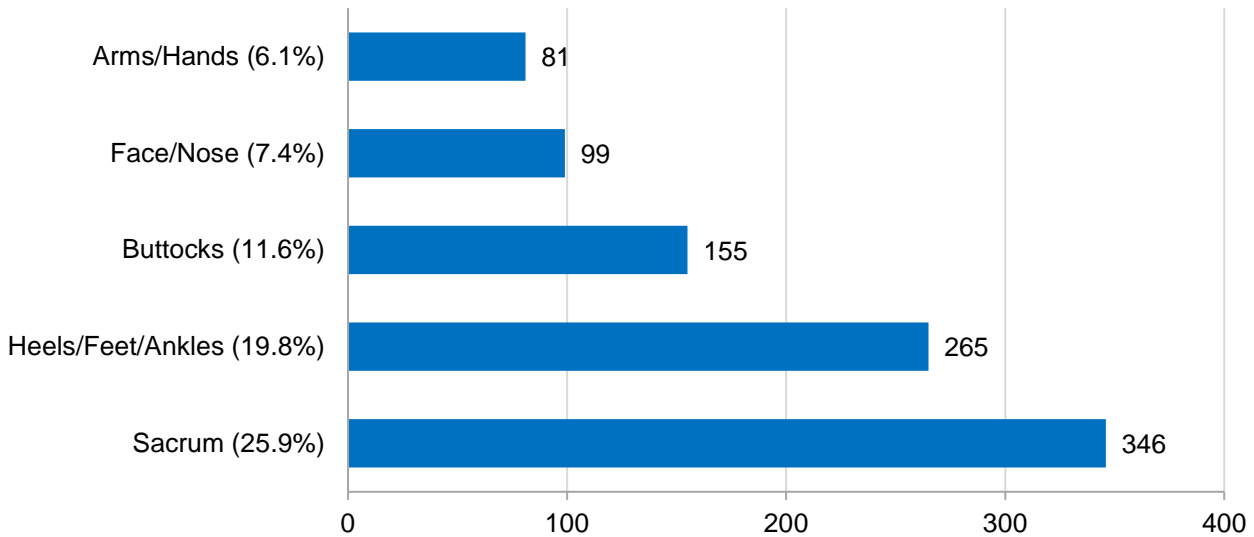


Figure 49 shows the anatomical locations where pressure injuries were most frequently reported to have developed in hospital for confirmed pressure injury clinical incidents. These five locations accounted for 70.7% (n=946) of pressure injury anatomical locations in 2018/19. Sacral pressure injuries were reported to have developed after admission in more than one-quarter of incidents (n=346; 25.9%), followed by pressure injuries to the heels, feet or ankles (n=265; 19.8%).

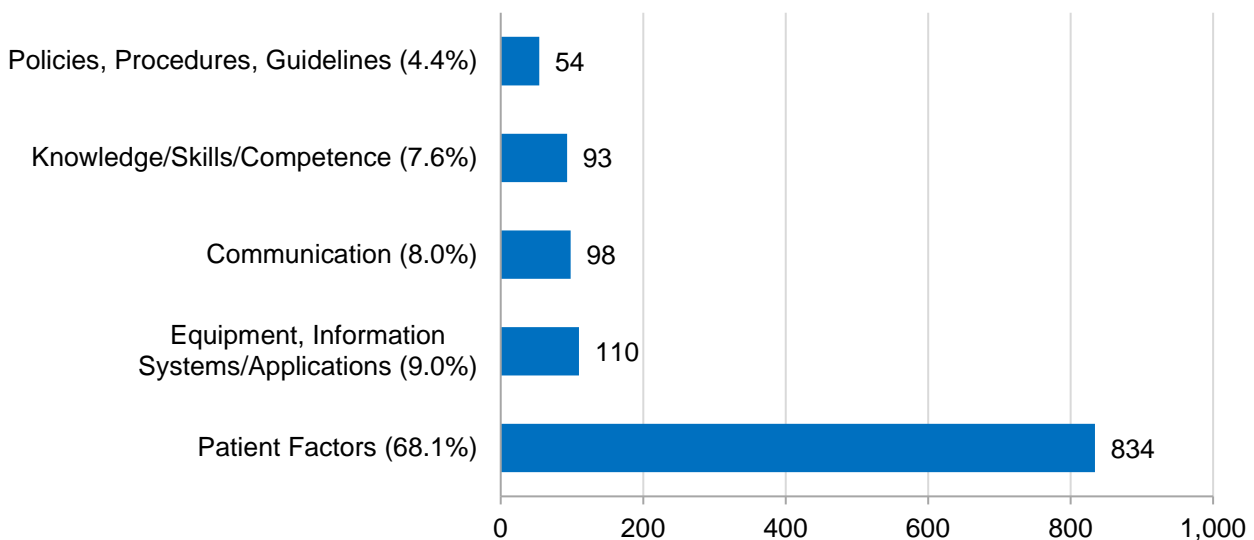
Figure 49: Frequency and Percentage of Top Five Anatomical Locations for Pressure Injuries Not Present on Admission for 2018/19



Note: Anatomical location of pressure injury missing data n=114; 8.5%

Patient factors were cited as contributory in 68.1% (n=834) of clinical incidents related to pressure injuries that developed in hospital (see Figure 50). The next most frequent contributory factor was issues related to equipment which were identified in 9.0% (n=110) of these incidents.

Figure 50: Frequency and Percentage of Top Five Contributory Factors for Pressure Injuries Not Present on Admission for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

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 2018/19, two-thirds (n=1,338) of confirmed pressure injury clinical incidents related to pressure injuries that developed after admission to hospital. Of these, 78.7% (n=1,053) were categorised as due to preventive and/or therapeutic interventions having been provided but not effective, and a further 17.0% (n=227) were attributed to preventive and/or therapeutic interventions not being used. Pressure injuries that developed due to risk assessments or skin inspections being delayed or not performed (n=58; 4.3%) made up the remainder of clinical incidents related to pressure injuries that were not present on admission.

In the second edition of the NSQHS Standards, actions related to the prevention and management of pressure injuries have been placed into the Comprehensive Care Standard. This Standard aims to ensure that patients receive comprehensive health care that meets their individual needs and considers the impact of their health issues on their life and wellbeing. It also aims to ensure that risks of harm for patients during health care are prevented and managed through targeted strategies.³⁸

Key elements for the provision of comprehensive care include:

- Clinical assessment and diagnosis
- Identifying goals of care
- Risk screening and assessment
- Developing a single comprehensive care plan
- Delivering comprehensive care
- Reviewing and improving comprehensive care delivery.

In the context of pressure injuries, comprehensive care includes the use of systems and processes, including equipment, devices and regular skin inspections, for preventing and managing pressure injuries which are consistent with best-practice guidelines.

The second edition of the *Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline (2014)*³⁹ provides internationally-recognised evidence-based recommendations for the prevention and treatment of pressure injuries. The third edition of this clinical practice guideline is scheduled for release in November 2019, ahead of World-Wide Pressure Injury Prevention Day on 21 November 2019.

The WA Pressure Injury Prevention Network aims to assist in reducing the incidence of hospital acquired pressure injuries and improve the documentation and reporting of pressure injuries if they occur. A pressure injury alert sticker has been developed to improve the consistency of pressure injury documentation and the provision of safe and high-quality care. This sticker is used throughout WA's hospitals and is available from the Department of Health's website.⁴⁰

³⁸ ACSQHC NSQHS Standards (2nd ed) Comprehensive Care Standard available at:

<https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard>

³⁹ Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline available at: <http://www.internationalguideline.com/>

⁴⁰ Department of Health Pressure Injury Prevention website:

https://ww2.health.wa.gov.au/Articles/N_R/Pressure-Injury-Prevention



Standard 9: Clinical Deterioration Clinical Incidents

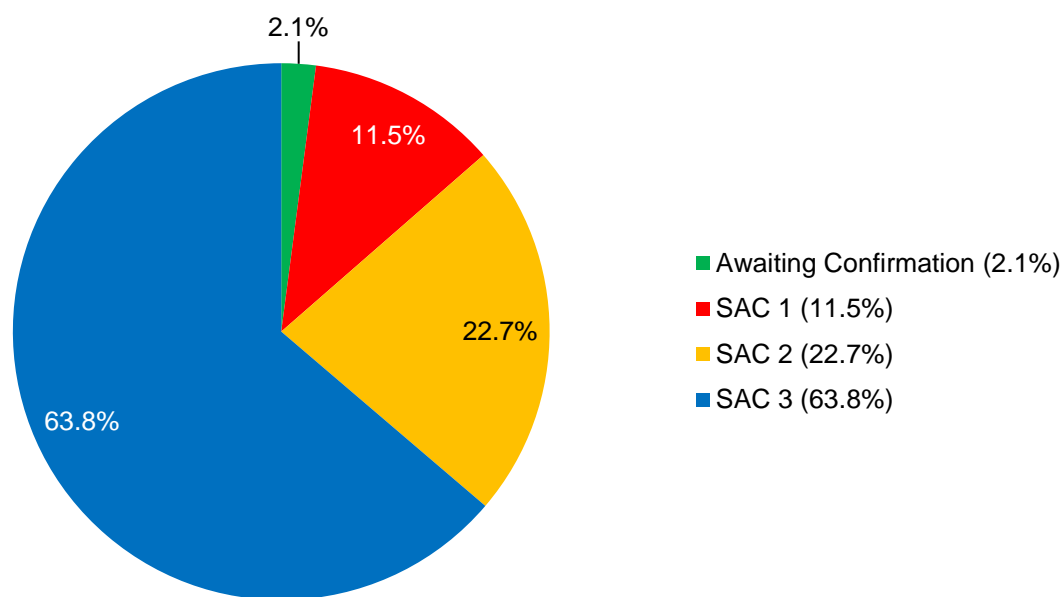
Standard 9 of the NSQHS Standards (first edition) relates to “recognising and responding to clinical deterioration in acute health care” (ACSQHC, 2013) and its intention is to ensure patients’ physical deterioration is recognised promptly. Clinical deterioration incidents are captured under several Tier Three categories in Datix CIMS⁴¹ which include:

- Alteration of established early warning score parameters
- Early warning scores miscalculated
- Failure/insufficient recognition of significant change in patient status
- Failure/insufficient response to significant change in patient status
- Failure to activate rapid response/resuscitation team
- Unplanned elevation of care to intensive care setting
- Unplanned return to surgery.

The SAC 1 category of delay in recognising and responding to clinical deterioration is also captured in addition to the Tier Three definitions stated above.

In the 2018/19 reporting period, there were 869 clinical deterioration clinical incidents notified with 851 confirmed, and the remaining 18 awaiting confirmation. Clinical deterioration incidents accounted for 2.5% of all clinical incidents reported in this period and were most frequently categorised as SAC 3 clinical incidents (n=554; 63.8%; see Figure 51).

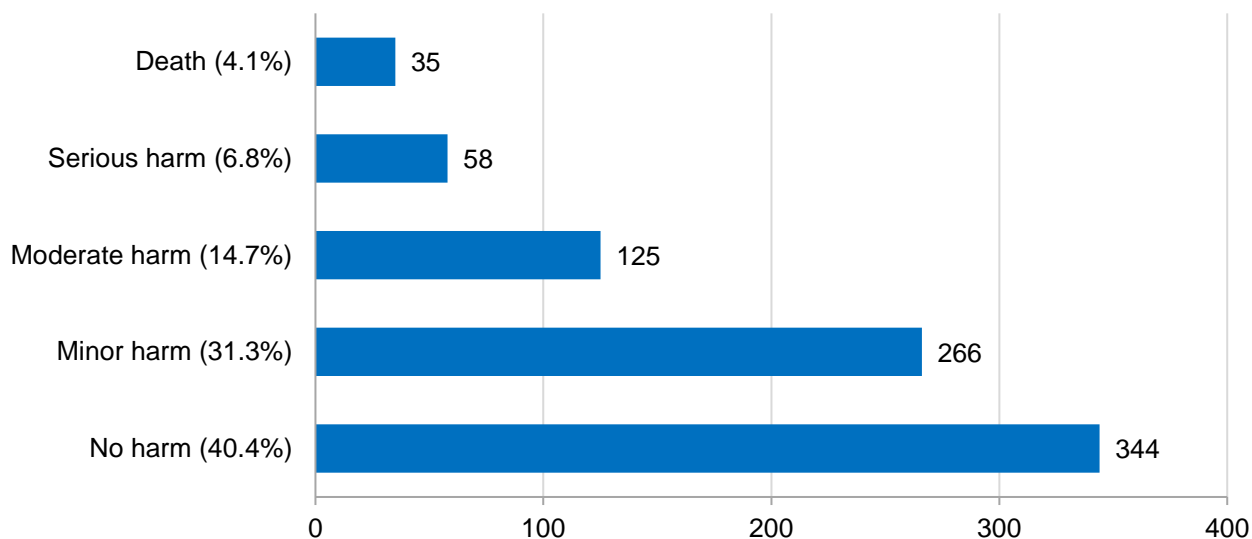
Figure 51: Percentage of Clinical Deterioration Clinical Incidents by SAC Rating for 2018/19



⁴¹ The three-tiered Datix CIMS clinical incident classification list was reviewed in 2015, with codes relevant to NSQHS Standard 9 agreed. The classification list was updated in April 2017, and codes relating to Standard 9 were updated. The data presented for Standard 9 in this report is comparable to 2017/18, but not to earlier editions of this report.

Reviewing patient outcomes from confirmed clinical deterioration clinical incidents shows the most frequently reported outcome was no harm to the patient (n=344; 40.4%) followed by minor harm (n=266; 31.3%; see Figure 52). A patient outcome of death was described in 4.1% (n=35) of confirmed clinical deterioration incidents in 2018/19, highlighting the risk to patients posed by delays in recognising and/or responding to clinical deterioration.

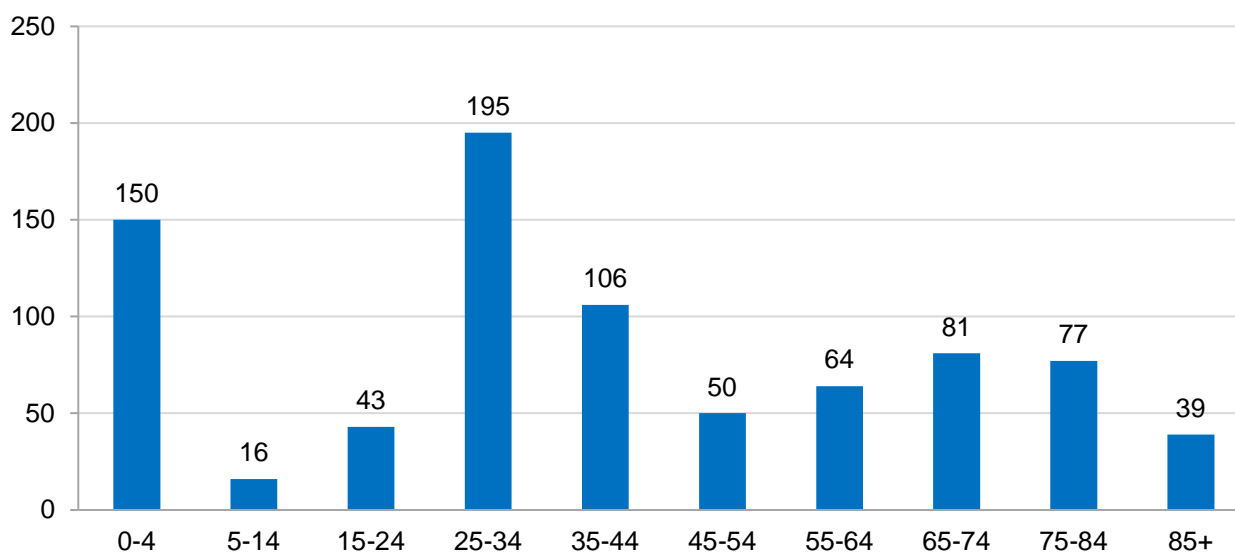
Figure 52: Percentage of Confirmed Clinical Deterioration Clinical Incidents by Patient Outcome for 2018/19



Note: Patient outcome missing data n=23; 2.7%

Females accounted for 67.3% (n=565) of patients involved in confirmed clinical deterioration incidents in 2018/19, with males making up 32.7% (n=275; missing n=17). Patients ranged in age from 0-106 years with a median age of 35 years (see Figure 53). Clinical deterioration incidents occurred most often in patients aged 25-34 years (n=195) and children aged 0-4 years (n=150). On review it was found that the majority of incidents in the 25-34 years age group related to the Obstetrics specialty and reported the patient outcome as no harm or minor harm.

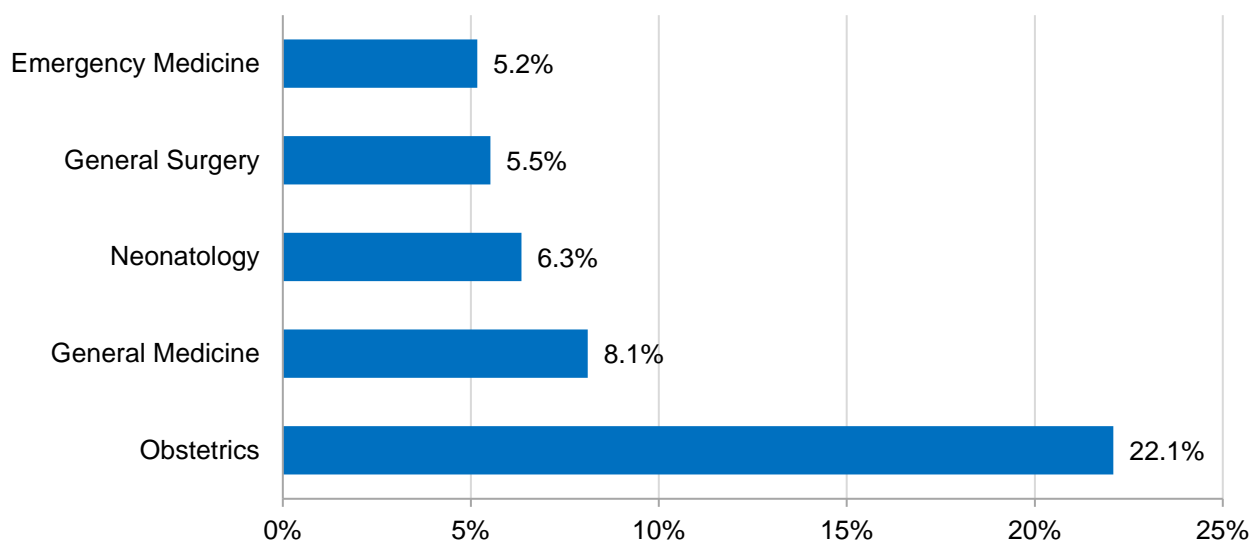
Figure 53: Distribution of Patients Affected by Confirmed Clinical Deterioration Clinical Incidents by Age Group for 2018/19



Note: Patient age missing data n=36; a clinical incident may affect multiple patients

The treating specialties that reported clinical deterioration clinical incidents most frequently in 2018/19 are shown in Figure 54. These specialties accounted for 47.2% (n=402) of all confirmed clinical deterioration incidents reported in this period. The Obstetrics specialty reported the highest number of clinical deterioration incidents (n=188; 22.1%). Further review showed that 68.1% (n=128) of confirmed clinical deterioration clinical incidents related to Obstetrics were categorised as SAC 3 incidents.

Figure 54: Percentage of Confirmed Clinical Deterioration Clinical Incidents by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=169; 19.9%

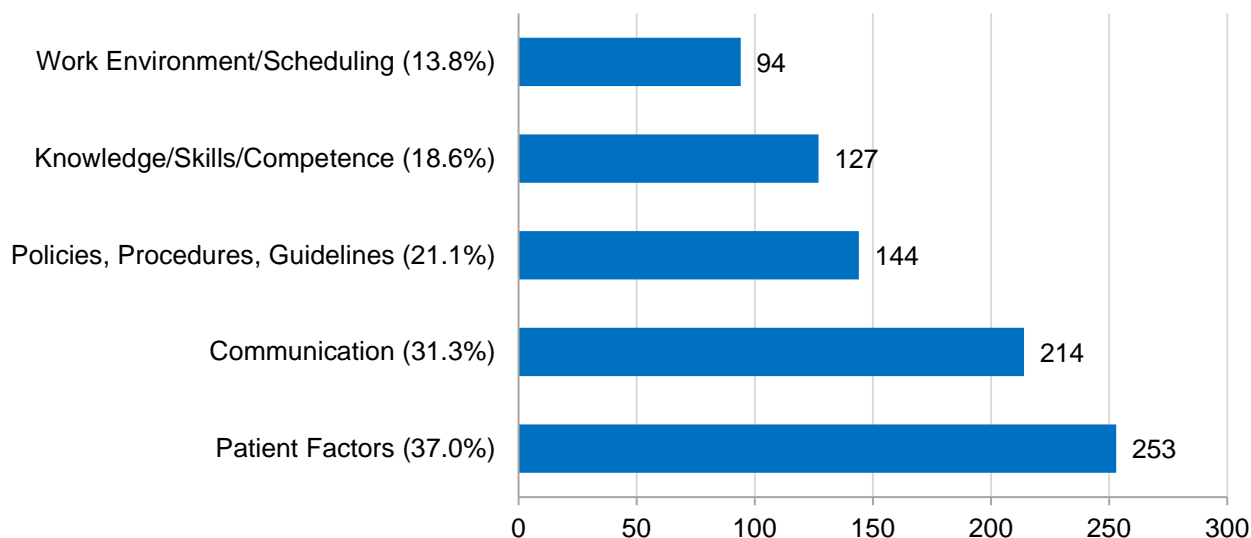
The five most frequent clinical deterioration clinical incident Tier Three categories accounted for 94.5% (n=804) of all confirmed clinical deterioration incidents in 2018/19 (see Table 19). Unplanned elevation of care to an intensive care setting continues to be the most frequent category of clinical deterioration incident reported, accounting for 33.7% (n=287) of confirmed incidents in this period.

Table 19: Frequency and Percentage of Top Five Tier Three Confirmed Clinical Deterioration Clinical Incidents Categories for 2018/19

Tier Three Clinical Deterioration Categories	(n)	(%)
Unplanned elevation of care to intensive care setting	287	33.7
Failure/insufficient response to significant change in patient status	210	24.7
Failure/insufficient recognition of significant change in patient status	186	21.9
Unplanned return to surgery	72	8.5
Failure to activate rapid response/resuscitation team	49	5.8
Total	804	94.5

Patient factors were identified as contributory in 37.0% (n=253) of closed clinical deterioration clinical incidents in 2018/19 (see Figure 55 overleaf). The next most frequently cited contributory factor was communication issues, which were identified in 31.3% (n=214) of clinical deterioration incidents investigated.

Figure 55: Frequency and Percentage of the Top Five Contributory Factors for Closed Clinical Deterioration Clinical Incidents for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

Key Messages and Information: Clinical 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*⁴² sets the minimum requirements, to be implemented by HSPs through the development of local 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.

In 2018/19, there was a significant cohort in the Obstetrics specialty which accounted for 22.1% of confirmed clinical deterioration incidents, and the majority of these reported no or minor harm resulted to the patient. 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 guidelines⁴³ designed for both the hospital and community settings and the *Cardiotocography Monitoring Policy*.⁴⁴ 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.

An ongoing focus on maturing key clinical processes such as the measurement and documentation of vital signs, escalation of care, rapid response systems and good communication will continue to assist in strengthening clinical practices to recognise and respond to circumstances where the patient is acutely deteriorating.

⁴² 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>

⁴³ King Edward Memorial Hospital Obstetrics & Gynaecology Clinical Deterioration Clinical Practice Guidelines available at: <https://www.kemh.health.wa.gov.au/For-health-professionals/Clinical-guidelines/OG>

⁴⁴ 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>

Standard 10: Falls Clinical Incidents

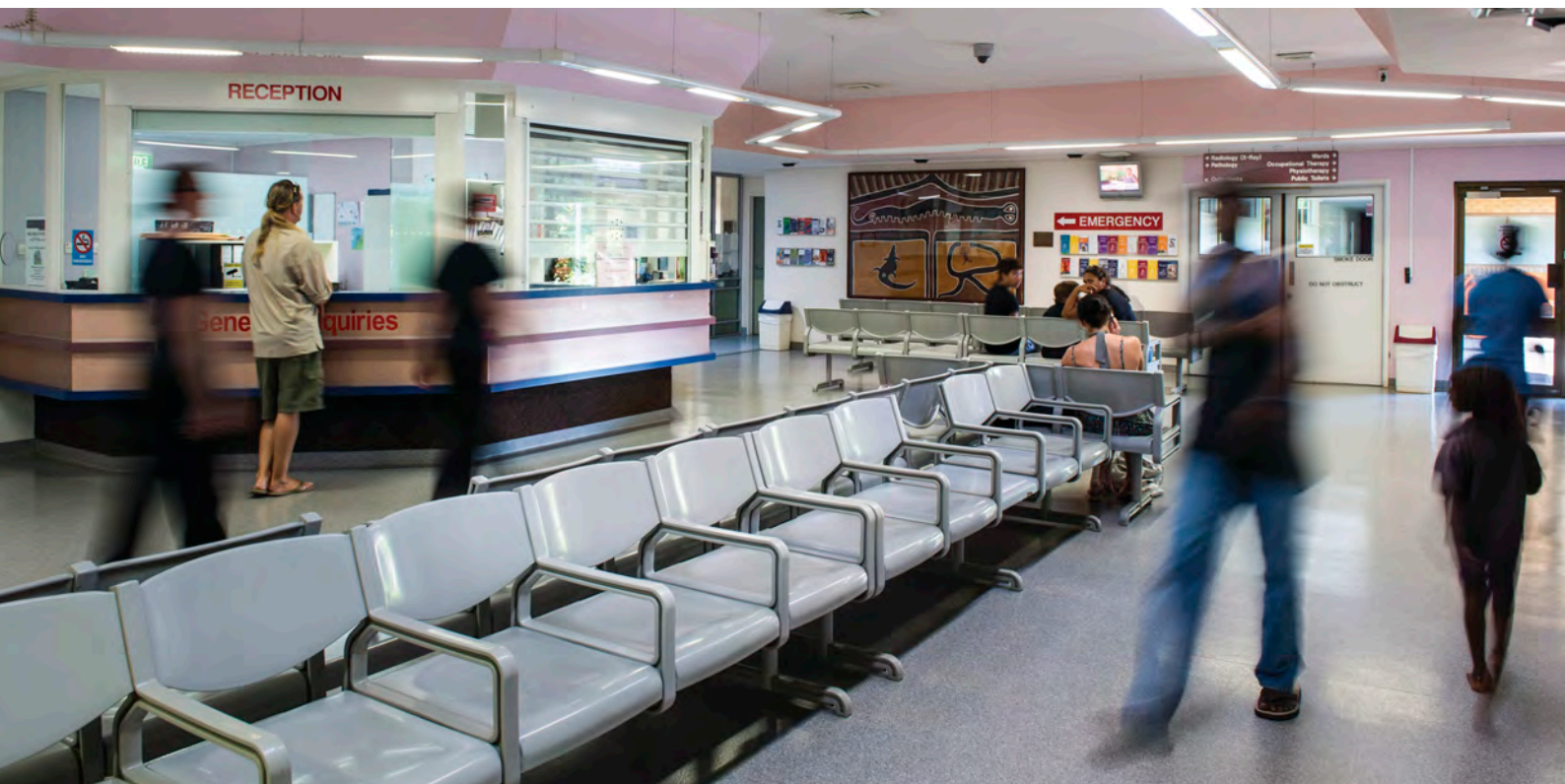
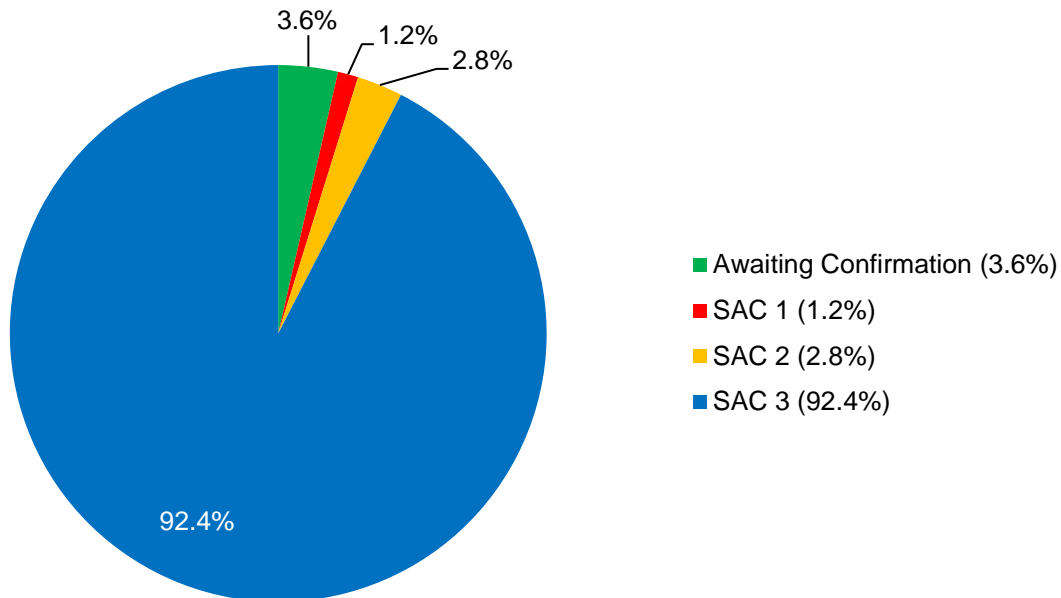
Standard 10 of the NSQHS Standards (first edition) refers to “preventing falls and harm from falls” (ACSQHC, 2013), the intent of which is to properly screen and assess patients’ risk of falling, to try and prevent falls from occurring and minimise the harm that results. Patients and carers are to be engaged in the development of falls prevention plans.

Falls clinical incidents are captured under two Tier Two categories within Datix CIMS:

- Witnessed Slips/Trips/Falls (includes faints)
- Suspected Slips/Trips/Falls (unwitnessed, includes faints).

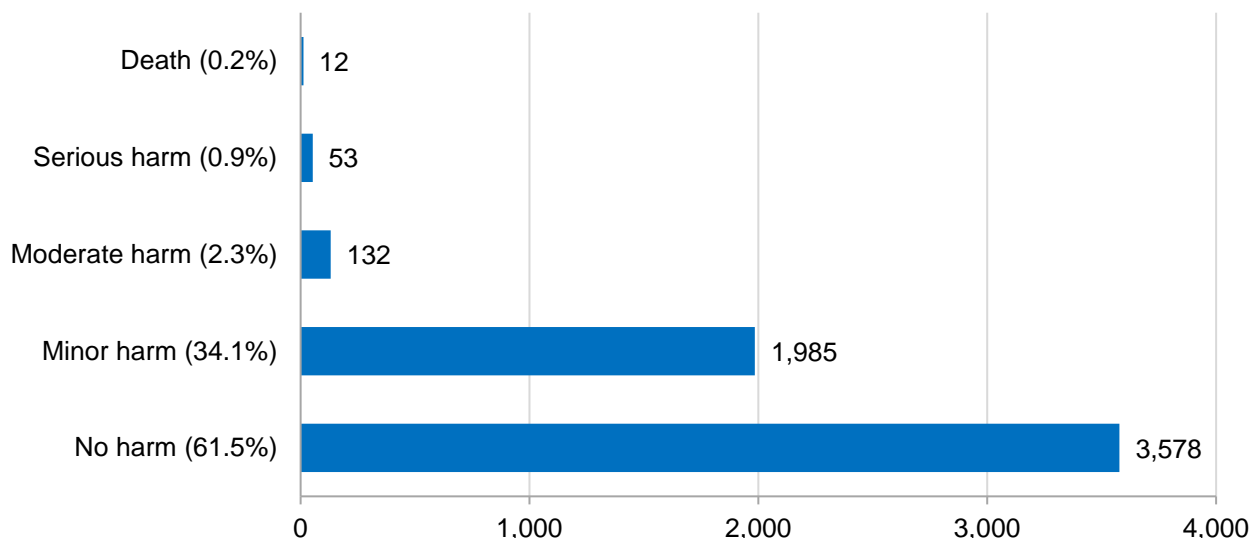
Within the 2017/18 reporting period there were 6,031 falls incidents notified with 5,815 falls confirmed, and a further 216 awaiting confirmation. These incidents accounted for 17.6% of clinical incidents reported in this period. The majority of falls clinical incidents were categorised as SAC 3 incidents (n=5,575; 92.4%; see Figure 56).

Figure 56: Percentage of Falls Incidents by SAC Rating for 2018/19



Most confirmed falls incidents resulted in the patient sustaining no harm (n=3,578; 61.5%) or minor harm (n=1,985; 34.1%; see Figure 57). Twelve falls incidents in 2018/19 described the patient outcome as death.

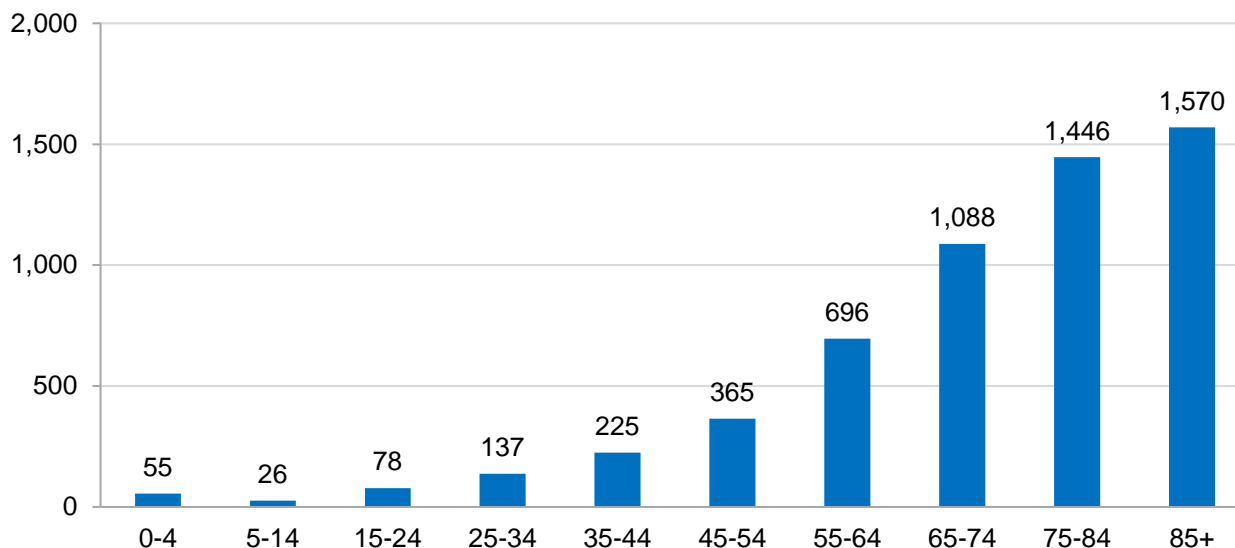
Figure 57: Frequency and Percentage of Confirmed Falls Clinical Incidents by Patient Outcome for 2018/19



Note: Patient outcome missing data n=55; 0.9%

Males accounted for 57.0% (n=3,246) of patient affected by confirmed falls clinical incidents, with females making up 43.0% (n=2,451; missing n=124). Ages ranged from 0-110 years with a median age of 76 years (see Figure 58).

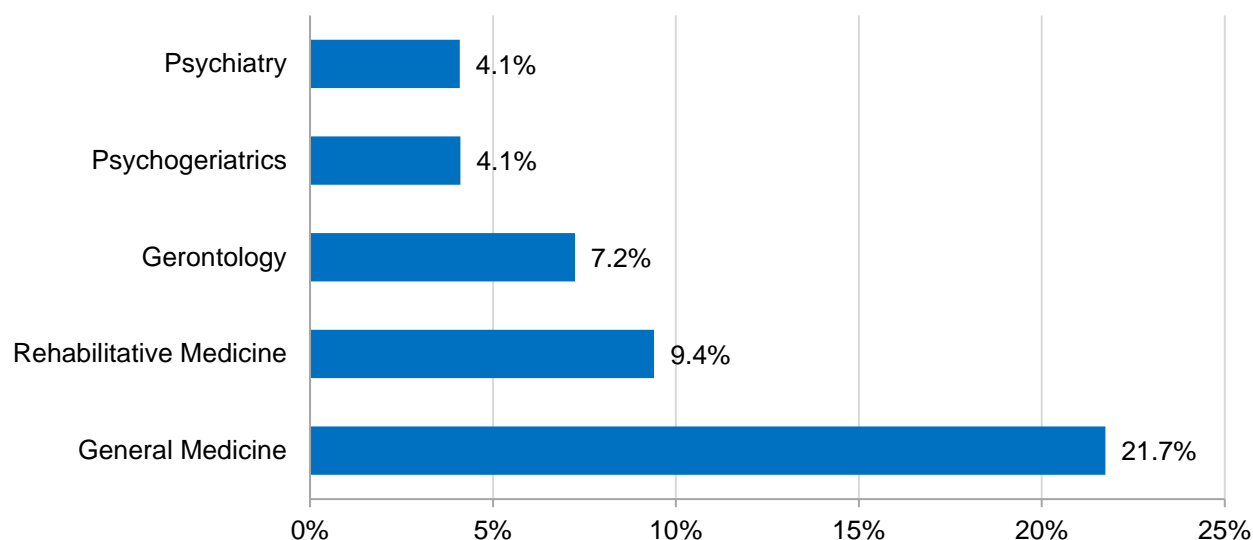
Figure 58: Distribution of Patients Affected by Confirmed Falls Clinical Incidents by Age Group for 2018/19



Note: Patient age missing data n=135; a clinical incident may affect multiple patients

The top five treating specialties accounted for 46.6% (n=2,709) of confirmed falls incidents in 2018/19. General Medicine continued to be the specialty reporting the highest frequency of falls incidents in this period (n=1,264; 21.7%), followed by Rehabilitative Medicine (n=547; 9.4%; see Figure 59).

Figure 59: Percentage of Confirmed Falls Incidents by Top Five Treating Specialties for 2018/19



Note: Treating specialty missing data n=1,397; 24.0%

More than two-thirds of falls clinical incidents (n=3,918; 67.4%) were categorised as “suspected slips/trips/falls” within Datix CIMS as they were unwitnessed (see Table 20).

Table 20: Frequency and Percentage of Confirmed Tier Two Falls Categories for 2018/19

Tier Two Falls Category	(n)	(%)
Unwitnessed falls	3,918	67.4
Witnessed falls	1,897	32.6
Total	5,815	100.0

When identifying the height from which the patient fell, 36.9% (n=2,145) of confirmed falls clinical incidents were classified as a low fall from a height of 0.5 metres or less, with a further 32.0% (n=1,862) occurring from a standing position.

The top five most frequent activities at the time of patient falls accounted for 71.1% (n=4,136) of confirmed falls incidents. At the time of the fall, 20.1% (n=1,167) of patients were walking while a further 16.5% (n=961) of patients were attempting to sit or stand (see Table 21).

Table 21: Frequency and Percentage of Top Five Falls Incidents by Activity for 2018/19

Falls by Activity at Time of Fall	(n)	(%)
Walking	1,167	20.1
Attempting to sit/stand	961	16.5
Toileting or attempting to toilet	883	15.2
Getting in/out of bed	668	11.5
Bending/leaning/reaching over	457	7.9
Total	4,136	71.1

Note: Activity at time of fall missing data n=539; 9.3%

Places where falls incidents occurred most frequently in 2018/19 were at the bedside (n=1,985; 34.1%) and in a ward setting (n=1,756; 30.2%; see Table 22).

Table 22: Frequency and Percentage of Top Five Places Where Falls Incidents Occurred for 2018/19

Place of Fall	(n)	(%)
Bed	1,985	34.1
Ward	1,756	30.2
Bathroom	1,189	20.4
Dining Room	171	2.9
Allied Health Treatment Area	110	1.9
Total	5,211	89.6

Note: Place of fall missing data n=336; 5.8%

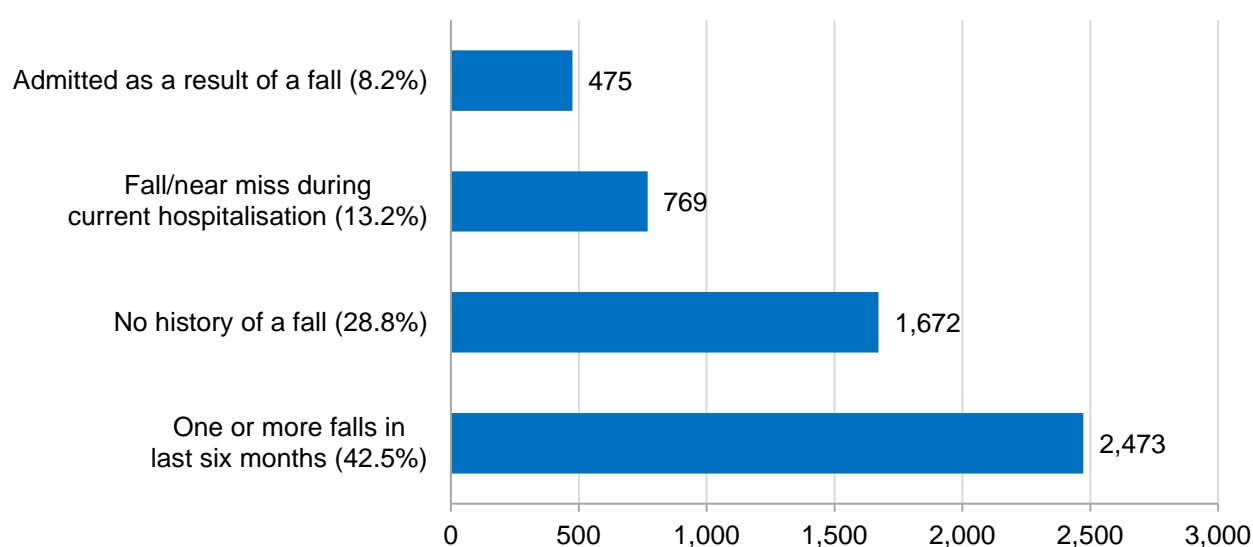
The outcome of falls incidents was not well documented, possibly due to the configuration of the Datix CIMS which allows users to pick one answer from a limited number of options. Seventy falls incidents (1.2%) were reported as resulting in a fracture, 28 as resulting in a subdural haematoma (0.5%) and 1,092 incidents (18.8%) stated an 'other' outcome. No outcome was stated in the Datix CIMS for 79.5% (n=4,625) of confirmed falls incidents.

Most falls incidents (n=3,845; 66.1%) were reported as having an unknown mechanism as to why the patient fell, which aligns with the data in Table 20 that shows 67.4% of falls were unwitnessed. Slipping on a usually wet or slippery floor (n=739; 12.7%) and tripping over an object (n=340; 5.8%) were the most frequently identified fall mechanisms (missing data n=671).

Ninety-three percent (n=5,408) of patients who sustained a fall were reported to have a falls risk assessment in place, with 45.6% (n=2,653) of patients having had their most recent falls risk assessment completed within the last 24 hours, and 25.7% (n=1,497) within the last week.

It was reported that 28.8% (n=1,672) of patients who fell had no previous history of a fall, while 42.5% (n=2,473) of patients had experienced a fall within the last six months (see Figure 60).

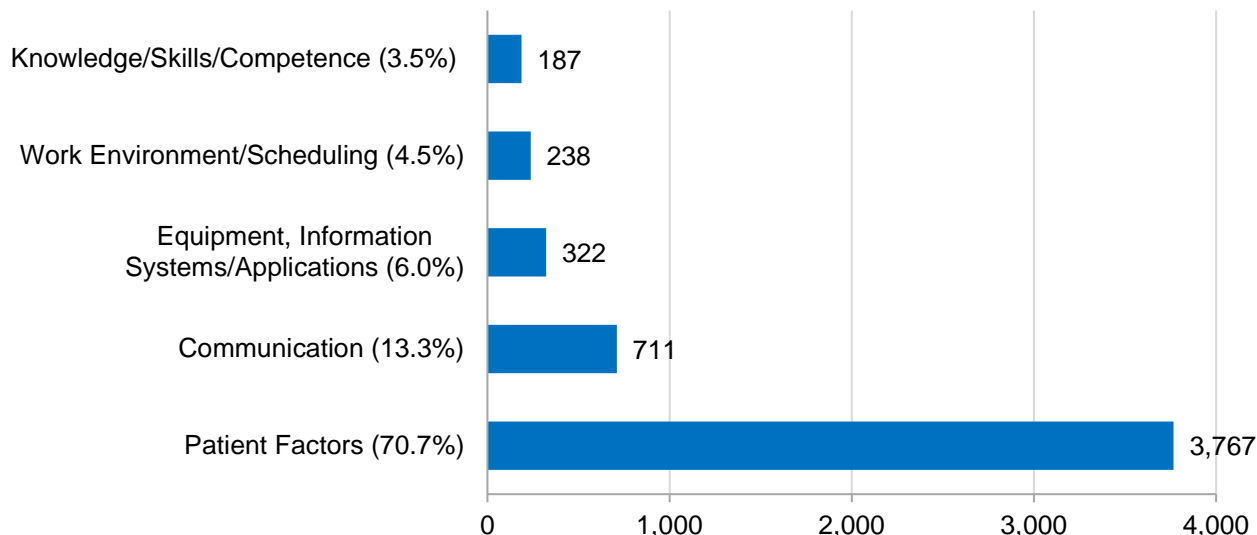
Figure 60: Frequency and Percentage of Falls History for 2018/19



Note: Falls history missing data n=426; 7.3%

Investigation of falls clinical incidents in 2018/19 identified that patient factors continue to be the most frequently identified contributor to falls, being cited in 70.7% (n=3,767) of closed falls clinical incidents (see Figure 61). Issues with communication were identified in 13.3% (n=711) of completed falls investigations.

Figure 61: Frequency and Percentage of Top Five Contributory Factors for Closed Falls Clinical Incidents for 2018/19



Note: More than one contributory factor can be identified for each clinical incident. Prior to 2017/18 contributory factor data was reported using confirmed incidents rather than closed incidents. As such the data presented in this report is comparable to 2017/18, but not to earlier reports.

Review of the risk factors for falls 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=2,507; 66.6% of closed falls incidents where patient factors were contributory), patients requiring assistance to mobilise and/or standby assistance (n=2,323; 61.7%), patients taking more than five medications (n=1,804; 47.9%), patients requiring a walking aid or similar (n=1,721; 45.7%) and patients with dementia or cognitive impairment (n=1,346; 35.7%).

Key Messages and Information: Falls Clinical Incidents

Falls management strategies within the health care setting focus on falls prevention, measures to minimise harm should falls occur and comprehensive post-fall treatment.

While most falls clinical incidents in 2018/19 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 do indeed play a major role in falls, an integral part of falls prevention is communication. This is important not only at the time of delivering a plan to reduce falls and educating patients, but also in regard to clinical staff developing plans between team members, identifying the surrounding supportive environment to prevent falls from occurring which includes carers and families, and being clear about the current strategies being implemented to assist in reducing the risk of falls.



Fremantle Hospital & Health Service
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OR YOUR FAMILY TO ARRANGE TRANSPORT
HOME WHEN YOU ARE DISCHARGED
FROM THE HOSPITAL.

2

DR. M. MARSHALL
DOCTOR

Quality of Care

Quality in health care is imperative from both an individual and patient population perspective. The delivery of health care occurs in a highly complex system, and when system processes break down the quality of care provided can be compromised. Mitigating these risks can reduce complications of treatment, which can affect patient recovery and outcomes, increase the time spent in hospital and cost to the health system, and divert resources away from other patients.

From a patient population perspective, the WA health system utilises administrative data collections such as the Hospital Morbidity Data Collection to better understand the quality of health care delivery. The HMDC captures all inpatient activity and discharge data, which may include hospital-acquired conditions captured by the condition onset flag (COF) code.

The PSSU has used HMDC data to complement data notified to the Datix CIMS and to review the quality of care that has been delivered to our patients. The codes from the ACSQHC's Hospital-Acquired Complications list have also been used to gain a better understanding of the types of HACs experienced by patients in the WA health system.

Hospital-Acquired Complications

A hospital-acquired complication refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.⁴⁵ Since 2012, the ACSQHC has been working with clinicians to identify HACs which could be reduced if appropriate risk mitigation strategies were in place.

Australia's national list of HACs consists of 16 categories of complication, with some HAC categories being comprised of multiple diagnoses (see Table 23 overleaf). As part of a broad quality improvement approach, the HACs can be monitored by clinicians, safety and quality staff, managers and executives, and governing bodies to provide insight into the state of safety and quality within a health service.

The national HACs list was developed via a thorough process that included reviews of the literature, expert clinical advice and testing with public and private hospitals. The national HACs list and data specification is reviewed on an ongoing basis, and the ACSQHC established the HACs Curation Clinical Advisory Group in July 2018 to facilitate this. In August 2018, the HACs specification was updated to include complications of care affecting mental health patients.

The ACSQHC, in consultation with clinical experts from across Australia, has developed the HACs information kit⁴⁶ to improve the safety and quality of health services and outcomes for Australian patients. The HACs information kit includes a suite of resources to assist health service organisations to put in place strategies to reduce the occurrence of HACs.

From July 2018, the funding level for acute episodes of care in hospitals has been reduced where one of 13 HACs occurs. Separate funding adjustments have been determined for each HAC, and these are further risk-adjusted to account for the increased likelihood that some patients may experience a HAC during their stay in hospital.⁴⁷

⁴⁵ Further information regarding the HACs is available at the ACSQHC website: <https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications/>

⁴⁶ The HACs information kit is available at: <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/complications/hacs-information-kit>

⁴⁷ The IHPA National Efficient Price Determination 2019-20 is available at: https://www.ihipa.gov.au/sites/default/files/publications/national_efficient_price_determination_2019-20.pdf

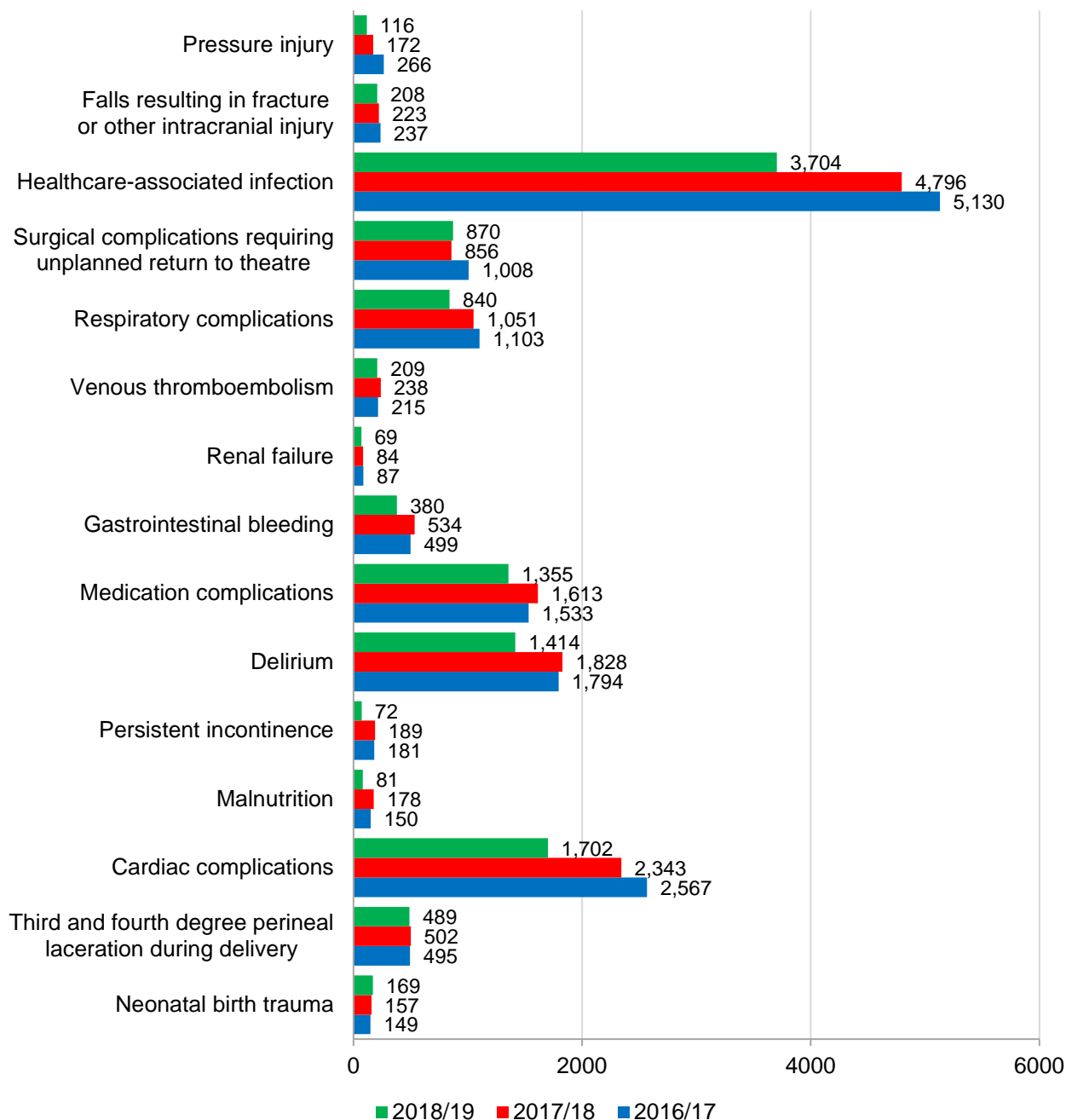
Table 23: National List of Hospital-Acquired Complications

Hospital-Acquired Complication	Diagnosis
1. Pressure injury	Stage III ulcer Stage IV ulcer Unspecified decubitus ulcer and pressure area
2. Falls resulting in fracture or other intracranial injury	Intracranial injury Fractured neck of femur Other fractures
3. Healthcare-associated infection	Urinary tract infection Surgical site infection Pneumonia Bloodstream infection Central line and peripheral line associated bloodstream infection Multi-resistant organism Infection associated with prosthetics/implantable devices Gastrointestinal infections
4. Surgical complications requiring unplanned return to theatre	Post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre Surgical wound dehiscence Anastomotic leak Vascular graft failure Other surgical complications requiring unplanned return to theatre
5. Unplanned intensive care unit admission*	Unplanned intensive care unit admission
6. Respiratory complications	Respiratory failure including acute respiratory distress syndromes requiring ventilation Aspiration pneumonia
7. Venous thromboembolism	Pulmonary embolism Deep vein thrombosis
8. Renal failure	Renal failure requiring haemodialysis or continuous veno-venous haemodialysis
9. Gastrointestinal bleeding	Gastrointestinal bleeding
10. Medication complications	Drug related respiratory complications/depression Haemorrhagic disorder due to circulating anticoagulants Hypoglycaemia
11. Delirium	Delirium
12. Persistent incontinence	Urinary incontinence
13. Malnutrition	Malnutrition
14. Cardiac complications	Heart failure and pulmonary oedema Arrhythmias Cardiac arrest Acute coronary syndrome including unstable angina, STEMI and NSTEMI (heart attack)
15. Third and fourth degree perineal laceration during delivery*	Third and fourth degree perineal laceration during delivery
16. Neonatal birth trauma*	Neonatal birth trauma

* Denotes HACs not subject to funding adjustment in 2018/19 or 2019/20

Western Australian hospital morbidity data were reviewed with regard to HACs for the 2016/17, 2017/18 and 2018/19 years.⁴⁸ A decreasing trend in the frequency of many HACs has been observed between July 2016 and June 2019 (see Figure 62). The most frequently reported HACs in the WA health system continue to be healthcare-associated infections which were reported in 0.7% of separations in 2018/19 (n=3,704) and cardiac complications which were reported 0.3% of separations in 2018/19 (n=1,702). These two HAC categories have also seen the greatest decrease in frequency since July 2016.

Figure 62: Frequency of Hospital-Acquired Complications by Year for 2016/17 to 2018/19



⁴⁸ Data includes WA public hospitals and public patients at CHEs. Separations with HACs and the corresponding denominators have been identified using version 1.1 of the HACs specification issued by the ACSQHC in August 2018 and data includes mental health patients. A separation is counted once within each HAC category but is counted multiple times across HAC categories. Denominators used for HAC categories 15 and 16 are different to those for HAC categories 1-14. Due to changes in the HACs specification over time this data may not be comparable to that contained in previous editions of this report.

The frequency of the HAC categories for renal failure, gastrointestinal bleeding, delirium, persistent incontinence and malnutrition have all shown declines from 2016/17 to 2018/19, while the frequency of the complications related to childbirth (third and fourth degree perineal laceration during delivery and neonatal birth trauma) have remained relatively stable.

The updated specification for the HACs issued by the ACSQHC in August 2018 did not change the clinical codes for each HAC category but did include complications that occur in mental health patients. The nature of the HAC categories means that most are less likely to be observed in mental health patients than patients receiving other types of admitted health care. Review of the HACs data from July 2016 to June 2019 showed that HACs reported for mental health patients represented 2.0% (n=854) of all HACs reported across the WA health system.

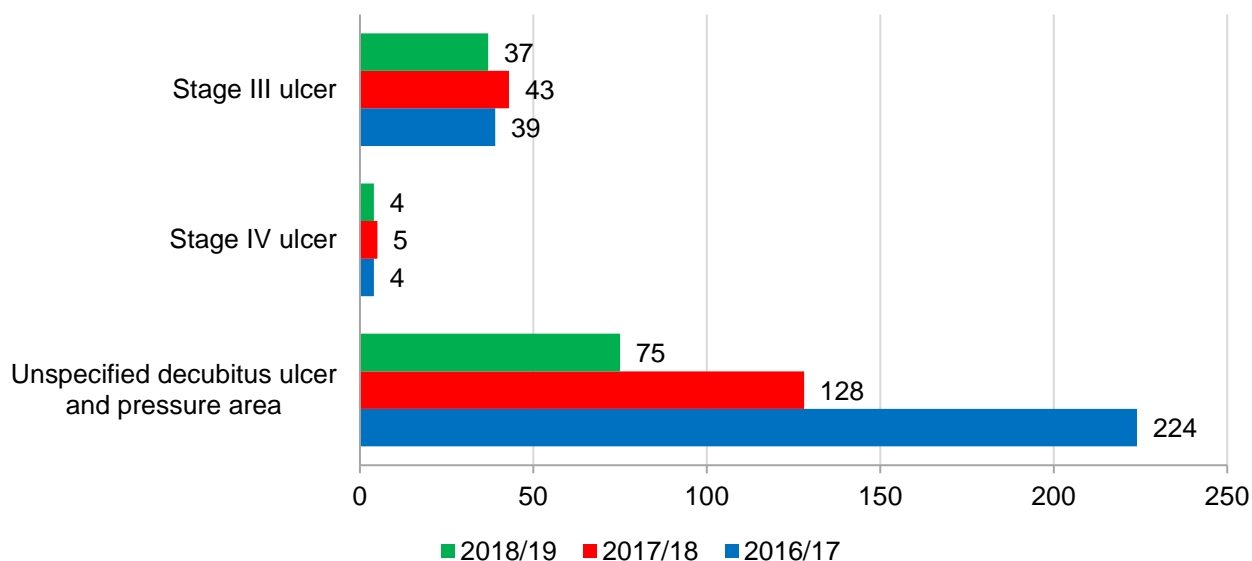
While the frequency of HACs reported for mental health patients is low, there are two HAC categories where it was observed that the rate of HACs was higher in mental health patients than patients receiving other types of admitted health care. These were falls resulting in fracture or other intracranial injury (reported in eight patients per 10,000 mental health separations versus four patients per 10,000 non-mental health separations) and persistent incontinence (reported in six patients per 10,000 mental health separations versus three patients per 10,000 non-mental health separations).

Data for the HAC categories that are comprised of multiple diagnoses are presented below for the 2016/17, 2017/18 and 2018/19 periods. As an individual separation may meet the criteria for multiple diagnoses within a HAC category the frequencies reported below may not directly align with those for the overall HAC categories shown in Figure 62.

Pressure injury

Most patients who developed a pressure injury meeting the criteria for this HAC category were diagnosed with an unspecified decubitus ulcer or pressure area (see Figure 63). There has been a large decline in the reporting of these pressure injuries as HACs from five patients per 10,000 separations (n=224) in 2016/17 to two patients per 10,000 separations (n=75) in 2018/19. The frequency of Stage III and Stage IV ulcers that developed during a hospital stay remained low and relatively stable over this period.

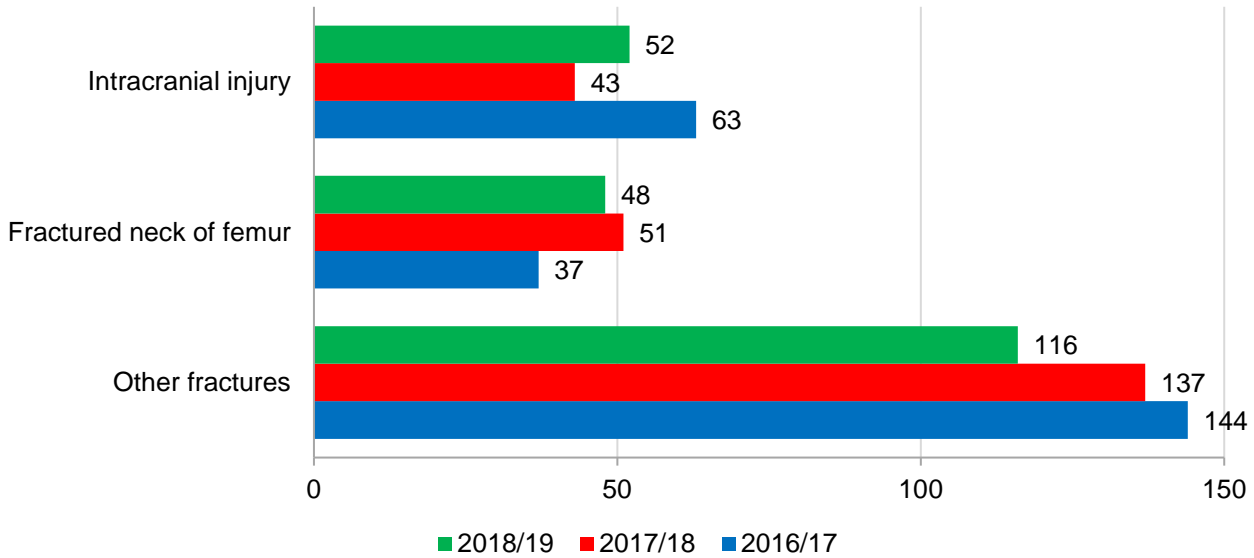
Figure 63: Frequency of Patients Developing Pressure Injury by HAC Diagnosis and Year for 2016/17 to 2018/19



Falls resulting in fracture or other intracranial injury

In 2018/19, 53.7% (n=116) of patients who suffered a fall in hospital meeting the criteria for this HAC category were diagnosed with a fracture other than an intracranial injury or fractured neck of femur (see Figure 64). Falls resulting in an intracranial injury accounted for 24.1% (n=52) of diagnoses in this HAC category in 2018/19, and falls resulting in a fractured neck of femur accounted for 22.2% (n=48). A small decline in falls resulting in other fractures has been observed in WA hospitals from 2016/17 to 2018/19, while the frequency of falls resulting in a fractured neck of femur or intracranial injury have remained relatively stable.

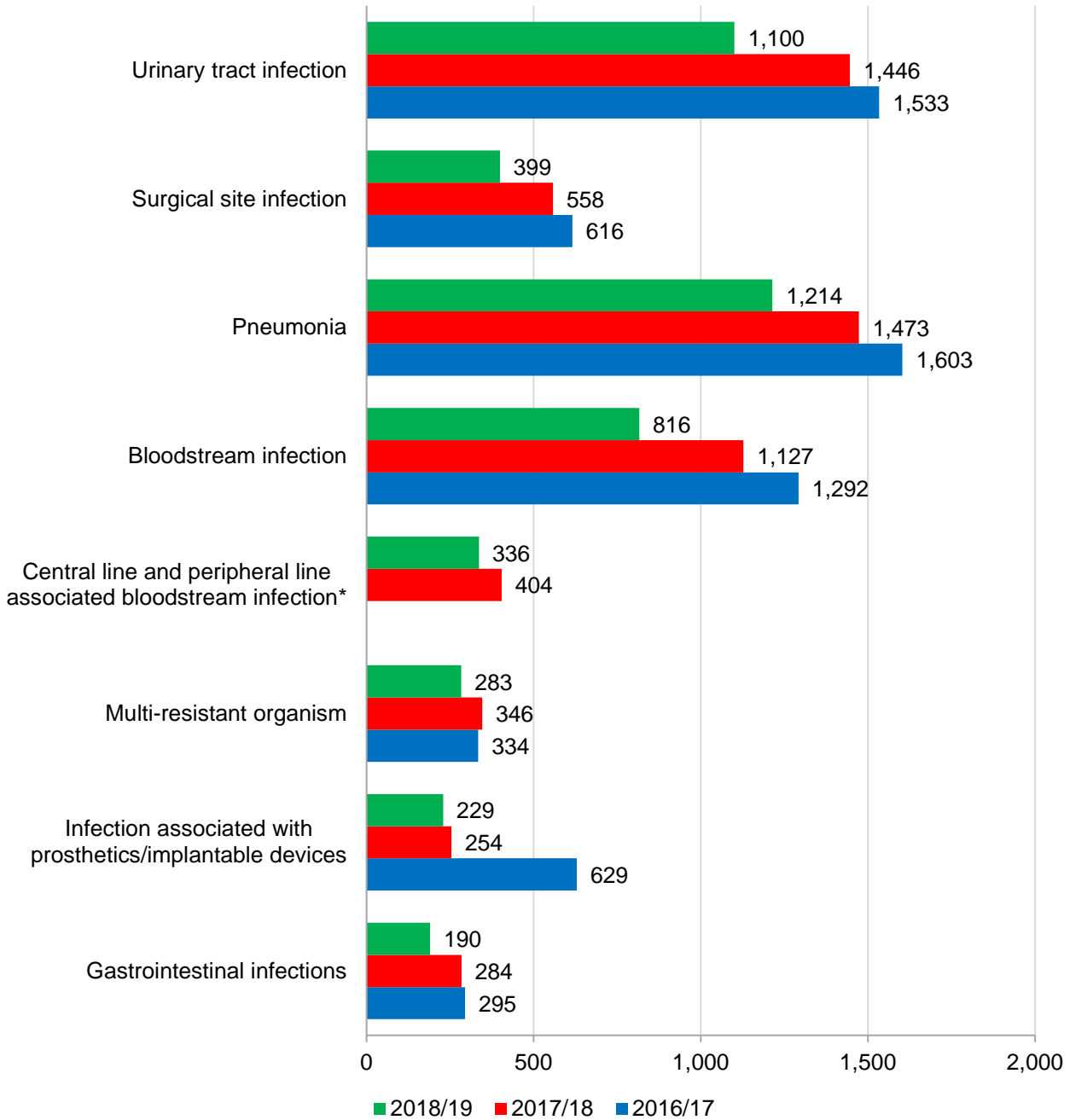
Figure 64: Frequency of Patients Experiencing Falls Resulting in Fracture or Other Intracranial Injury by HAC Diagnosis and Year for 2016/17 to 2018/19



Healthcare-associated infection

Figure 65 shows the diagnoses for the healthcare-associated infection category of the HACs from 2016/17 to 2018/19. The overall rate of HAIs reported as HACs has declined from 109 patients per 10,000 separations (n=5,130) in 2016/17 to 74 patients per 10,000 separations (n=3,704) in 2018/19, with a decreasing frequency seen across all eight diagnoses within this HAC category. Pneumonia, urinary tract infections and bloodstream infections were the most frequently reported diagnoses in this HAC category from July 2016 to June 2019 and accounted for 68.5% (n=3,130) of HAI HAC diagnoses in 2018/19.

Figure 65: Frequency of Patients Identified with Healthcare-Associated Infection HACs by HAC Diagnosis and Year for 2016/17 to 2018/19



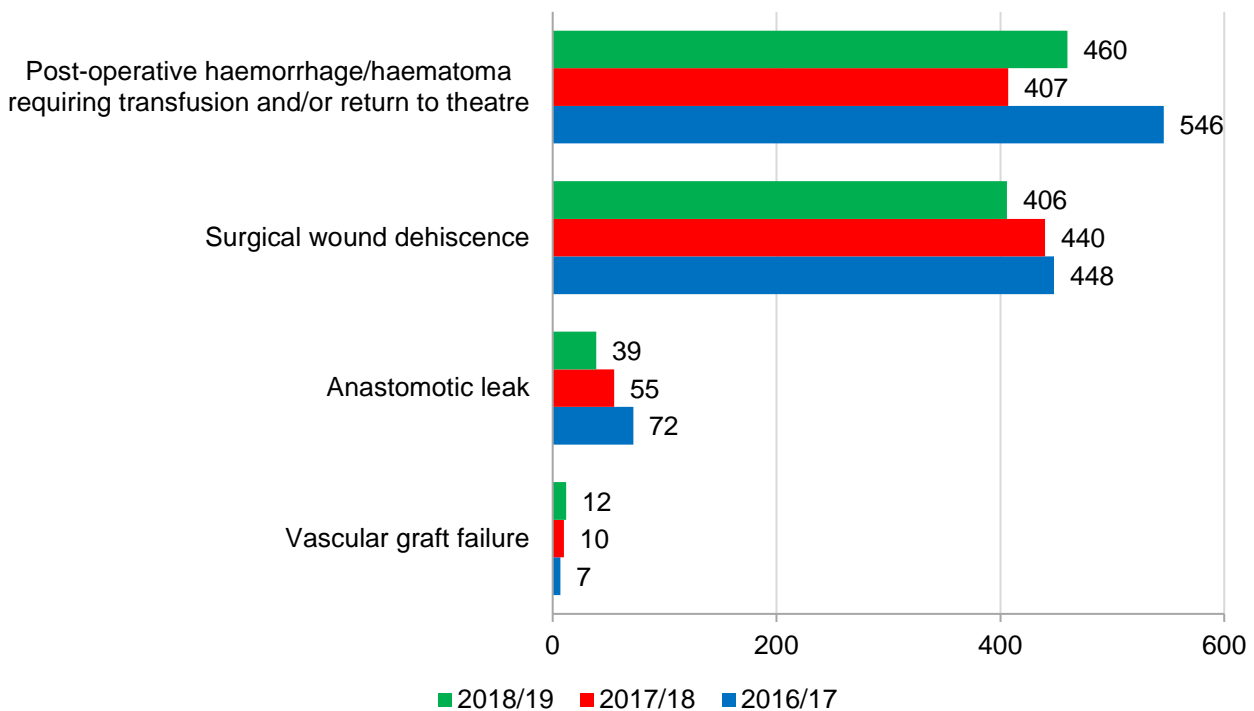
*Note: Data relating to the diagnosis “Central line and peripheral line associated bloodstream infection” cannot be separated from, and is reported under, “Infection associated with prosthetics/implantable devices” for 2016/17. The ability to report these diagnoses separately was created by refinement of the ICD-10-AM codes that was implemented in the WA health system from 1 July 2017.

Surgical complications requiring unplanned return to theatre

Figure 66 shows the HAC diagnoses for patients that experienced surgical complications requiring them to be returned to theatre between July 2016 and June 2019. Post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre and surgical wound dehiscence (rupture of a surgical wound along the incision line) accounted for most diagnoses in this HAC category.

The frequency of surgical wound dehiscence over this period has declined marginally, affecting 448 patients in 2016/17 and 406 patients in 2018/19, while the frequency of post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre decreased from 546 patients in 2016/17 to 407 patients in 2017/18 but then rose to 460 patients in 2018/19. The frequency of anastomotic leaks in the WA health system has decreased from 2016/17 to 2018/19 while vascular graft failures have increased, although numbers are small.

Figure 66: Frequency of Patients Experiencing Surgical Complications Requiring Unplanned Return to Theatre by HAC Diagnosis and Year for 2016/17 to 2018/19

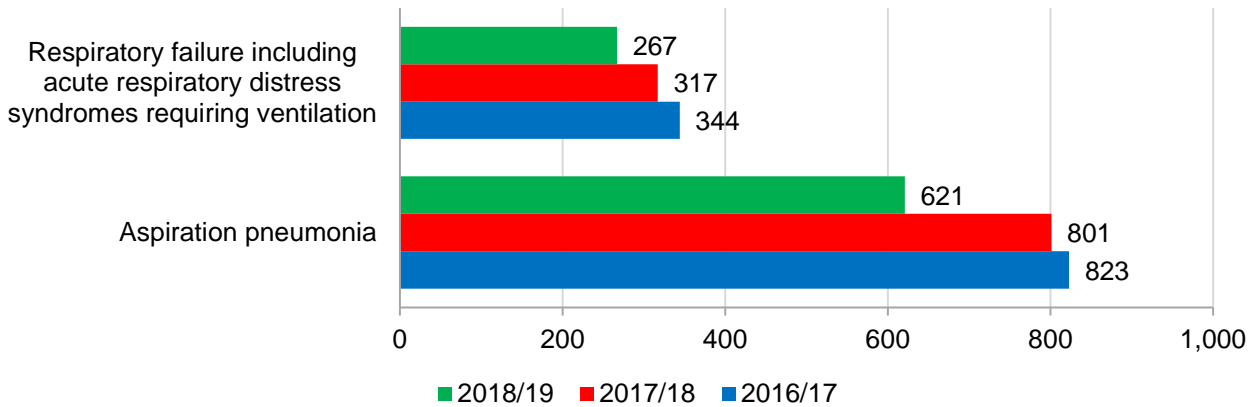


Note: Data relating to the fifth diagnosis in this HAC category, "Other surgical complications requiring unplanned return to theatre", is not currently available as the as the data item "Unplanned return to theatre" is of insufficient quality for use.

Respiratory complications

From July 2016 to June 2019, the frequency of both aspiration pneumonia and respiratory failure including acute respiratory distress syndromes (ARDS) requiring ventilation has decreased across the WA health system (see Figure 67). Seventy percent of complications (n=621) falling within this HAC category in 2018/19 related to aspiration pneumonia, and 5.7% of patients (n=48) experienced both aspiration pneumonia and respiratory failure including ARDS requiring ventilation.

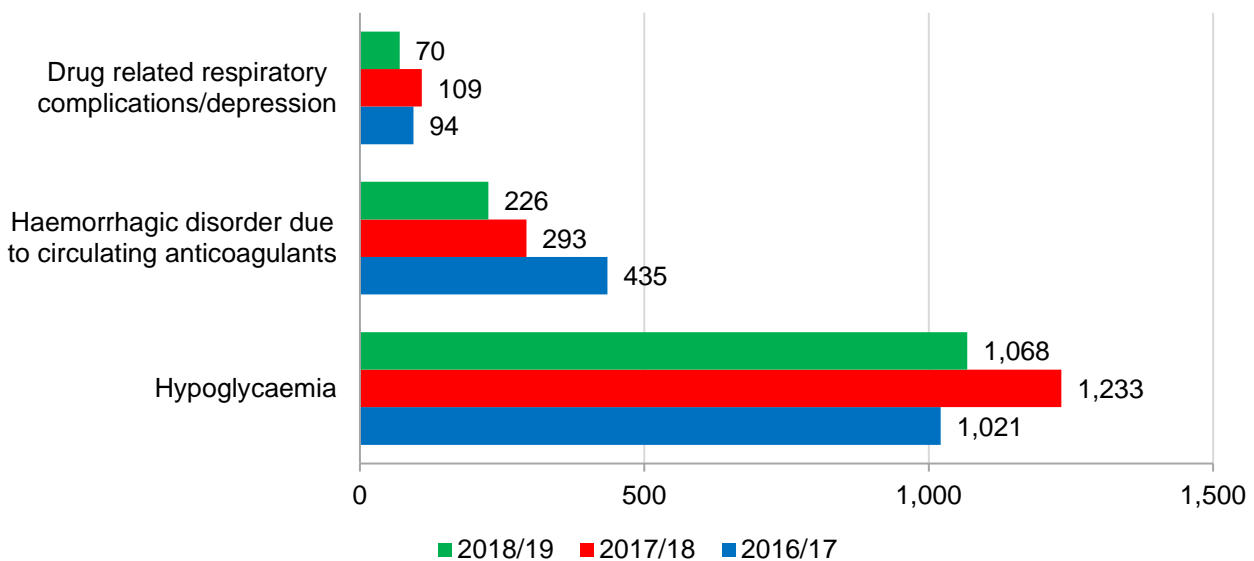
Figure 67: Frequency of Patients Experiencing Respiratory Complications by HAC Diagnosis and Year for 2016/17 to 2018/19



Medication complications

Hypoglycaemia (low blood sugar) continues to be the most frequently identified complication in this HAC category, and while the number of cases in 2018/19 (n=1,068) is similar to 2016/17 (n=1,021), it has decreased appreciably from the 1,233 cases seen in 2017/18 (see Figure 68). A similar pattern has been observed for medication-related respiratory complications/depression from 2016/17 to 2018/19, while the frequency of haemorrhagic disorders due to circulating anticoagulants has showed a decreasing trend over this period.

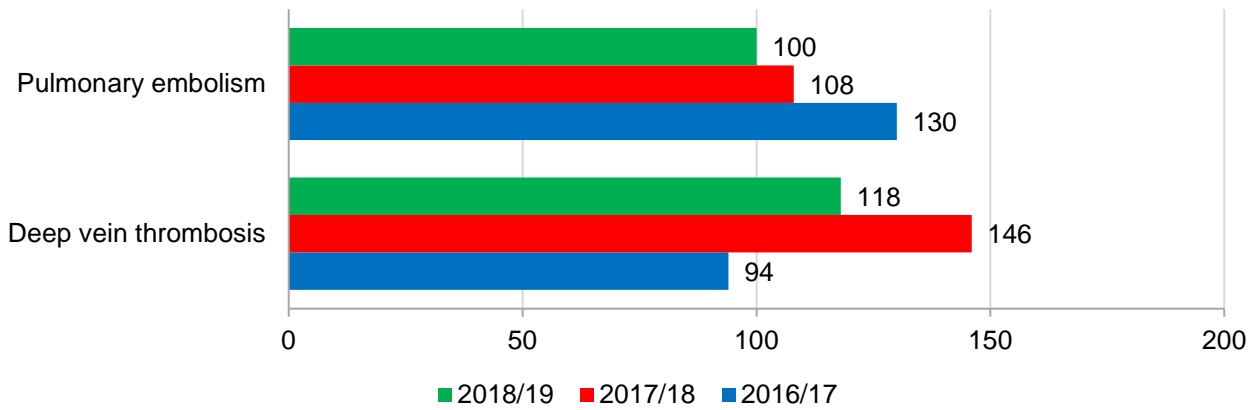
Figure 68: Frequency of Patients Experiencing Medication Complications by HAC Diagnosis and Year for 2016/17 to 2018/19



Venous thromboembolism

The number of patients developing pulmonary embolism while in hospital continued to remain low from July 2016 to June 2019, with a small declining trend (from 130 cases in 2016/17 to 100 cases in 2018/19) seen over this time (see Figure 69). The frequency of patients developing deep vein thrombosis has increased from 94 cases in 2016/17 to 118 cases in 2018/19, however this has decreased from the 146 cases reported in 2017/18.

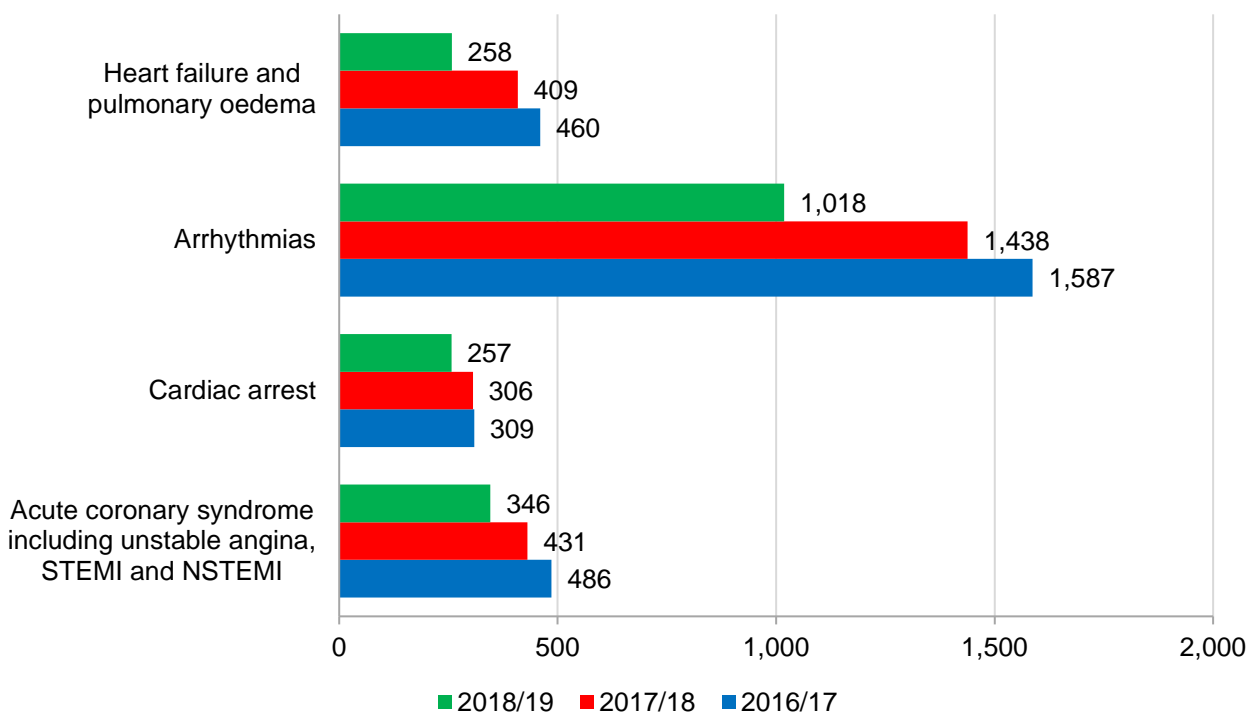
Figure 69: Frequency of Patients Experiencing Venous Thromboembolism by HAC Diagnosis and Year for 2016/17 to 2018/19



Cardiac complications

Arrhythmias were the most frequently diagnosed complication within this HAC category between July 2016 and June 2019, however there has been a significant decrease from 1,587 cases in 2016/17 to 1,018 cases in 2018/19 (see Figure 70). The frequency of the other complications in this HAC category have also declined over this period.

Figure 70: Frequency of Patients Experiencing Cardiac Complications by HAC Diagnosis and Year for 2016/17 to 2018/19



Key Messages and Information: Hospital-Acquired Complications

The national list of 16 HACs does not cover all possible complications that can occur in hospitals, however it does include high-priority complications on which clinicians, managers and others can work together to address and improve patient care.⁴⁵ The HACs can be monitored by clinicians, safety and quality staff, managers and executives, and governing bodies to provide insight into the state of safety and quality, as part of a broad approach to quality improvement.

Since July 2018, the funding level for acute episodes of care in Australian hospitals has been reduced where one of 13 HACs occurs. The HACs data presented in this report covers the period during which these funding penalties commenced, and the key observation is that the frequency of many of the HACs decreased from 2016/17 to 2018/19, with much of this decrease being seen in 2018/19.

It is not possible to say whether these funding penalties alone have driven the reduction in the frequency of HACs reported in the WA health system, or whether the HACs information kit⁴⁶ produced by the ACSQHC has assisted hospitals to reduce complications by making evidence-based improvements in the care provided to patients. It is quite likely a combination of these and other factors is at play, and the WA health system should strive to sustain the decreasing trend observed for many of the HACs over the last three years, while seeking to reduce the complications whose frequency has remained relatively stable over this time.



Coronial Review

The Coronial Liaison Unit 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 report. The CLU continues to work effectively with the Office of the State Coroner to share lessons learnt from mortality review to improve future patient care within the WA health system.

Table 24 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 24: Overview of Coronial Liaison Unit Activity for 2016/17 to 2018/19

	2016/17	2017/18	2018/19
Total number of health-related coronial inquest findings received by CLU	22	21	40
Total number of health-related recommendations (including mental health) ⁴⁹	8	7	30
Number of general health related recommendations	5	7	2
Number of general health related recommendations completed/closed ⁵⁰	4	7	1
Number of mental health related recommendations	3	-	28
Number of mental health related recommendations completed/closed ⁵⁰	3	-	28

The Coronial Review Committee was established in January 2014. The Committee 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 Committee exists to improve the governance and decision-making in relation to the state-wide implementation and response to coronial recommendations. Committee members review and endorse the sharing of the WA health system’s progress against coronial recommendations in the bi-annual report to the Coroner.

⁴⁹ 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).

⁵⁰ Status as at most recent report to the State Coroner (August 2019). 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 2018 to 30 June 2019 (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: <http://www.coronerscourt.wa.gov.au/default.aspx>.

Mr F (July 2018)

Mr F was a 29-year-old man with a history of drug and alcohol abuse and mental illness. Mr F was arrested and brought to hospital but refused treatment. The psychiatric liaison nurse found no acute psychiatric illness requiring hospital admission. The day after, he was released on bail and his car was seen parked near a beach. He was reported missing and after an investigation, his death was established beyond all reasonable doubt.

The Coroner noted that drowning was the likely cause of death but made an open finding as to how the death occurred. No recommendations were made.

Mr K (July 2018)

Mr K was a 45-year-old man who died as a result of his coronary artery disease with laryngeal dystonia, severe psychosis (treated) and obesity, following an apparent respiratory arrest.

At the time of his death Mr K was receiving treatment in hospital for schizophrenia. During the admission Mr K experienced periods of breathlessness, which required treatment with benzotropine and withholding of his antipsychotic medication. It was believed that Mr K had developed laryngeal dystonia – a rare and potentially lethal extrapyramidal side effect of antipsychotic medication. Mr K collapsed during the admission and resuscitation was commenced immediately but was unsuccessful.

The Deputy State Coroner was satisfied that the supervision, treatment and care was reasonable in the circumstances, but stated that the case needs to be used as a learning exercise as to the potential for a fatal outcome with lingual laryngeal dystonic reactions and recommended that those caring for patients treated with antipsychotic medication be trained to recognise the potential for laryngeal dystonia and prompt medication and intensive breathing support prior to arrest.

Baby A (August 2018)

Baby A was born prematurely at 28 weeks gestation. He had remained in hospital to gain weight and was treated for a number of medical problems common to premature babies. He was eight weeks old when he was found by medical staff unresponsive at his mother's breast in bed. Resuscitation attempts were unsuccessful.

The inquest focused primarily on the events that occurred at hospital and the issues surrounding co-sleeping. The Coroner used the term 'co-sleeping' to describe the practice of parent/carer and baby both sleeping at the same time on the same bed surface. During the inquest, information was provided about a Pepi-Pod program that was being trialled in Queensland. A Pepi-Pod is a safe sleeping box which can sit in the bed so that the baby can be in the bed with his or her parent without the risk that the parent will roll over onto the child or become caught in the bedding.

The Coroner made a recommendation in relation to the Pepi-Pod to improve and educate the cultural practice of co-sleeping.

Mr D (August 2018)

Mr D was a 34-year-old man who died from multiple injuries after stepping in front of a passing truck. Mr D had a long history of mental health issues.

The Coroner found that his death was by way of suicide and the decision to end his life was unexpected and he did not show signs to his treating mental health team prior to doing so. The Coroner was satisfied with the treatment and care provided to Mr D both in hospital and the community and did not make any recommendations.

Mr F (August 2018)

Mr F was a 36-year-old man who died from combined effects of benzhexol, amphetamine-type stimulants and dehydration with renal impairment. Mr F was a man with cardiomyopathy and morbid obesity. He had an extensive history of polysubstance abuse and was suspected to misuse prescription drugs.

Mr F was attended to by police at a park after causing a disturbance at a nearby restaurant. He deteriorated rapidly, and resuscitation attempts at the scene and at hospital were unsuccessful.

The Deputy State Coroner concluded that the supervision, treatment and care provided was of a high standard and made no recommendations.

Mr G (September 2018)

Mr G was a 45-year-old man who died from a cardiac event on the background of a significantly enlarged heart and coronary atherosclerosis. He had a history of psychotic illness and was an involuntary patient at the time of his death.

The inquest focused primarily on the medical care, both physical and mental, provided to Mr G in the weeks prior to his death, as well as the events surrounding his death. Mr G's family had expressed some concern about the failure to diagnose the deceased's heart related issues prior to his death. These concerns were addressed at the inquest hearing by an expert medical witness.

The Coroner concluded the medical care leading up to the deceased's death and his supervision, treatment and care were reasonable and appropriate in the circumstances and did not make any recommendations.

Mr J (September 2018)

Mr J was a 50-year-old man who died as a result of drowning in the water behind his home by way of suicide.

On the day before Mr J's suicide, he had presented to his GP in crisis and admitted to having suicidal thoughts. He was then transferred to hospital for assessment and was reviewed by staff. After the consultation Mr J denied any current suicidal thoughts and left with a management plan. However, Mr J had not allowed staff to speak to his family and did not disclose his previous family history of mental illness and suicide.

The Coroner was satisfied that the hospital staff had appreciated the risk of suicide but that they were missing key pieces of information. The Coroner made comments on public health matters connected to the death and noted the greater emphasis that has since been placed on the involvement of family and carers.

Mr D (September 2018)

Mr D was a 35-year-old man who was an inpatient on a treatment order under the *Mental Health Act 2014* at the time of his death. He died from bronchopneumonia and hypoxic brain injury after choking on food.

Mr D had challenging physical and mental health issues that he was being treated for and the Coroner was satisfied with the supervision, treatment and care that he was provided. No recommendations were made.

Ms R (September 2018)

Ms R died after a long period of illness from multiple sclerosis and undiagnosed cancer while at home with her long-term carer.

The Coroner found the conduct and care provided by the deceased's carer and her GP were reasonable in the circumstances that they faced, taking into account the deceased's unwillingness to accept help from outside services. There were no recommendations made.

Mr P (September 2018)

Mr P was a 41-year-old man who had a history of drug use and related mental illness. He was reported missing by his father and a lengthy investigation was conducted into his disappearance.

The Coroner was satisfied death had been established beyond all reasonable doubt and made an open finding as to the death as no cause could be determined. No recommendations were made.

Mr H (October 2018)

Mr H was a 70-year-old man who was a sentenced prisoner who died as a result of acute myocardial infarction. He was in hospital when he deteriorated following a procedure for his ischaemic heart disease.

The Deputy State Coroner concluded the supervision, treatment and care was of a good standard and did not make any recommendations.

Mr S (December 2018)

Mr S was a 27-year-old man who died unexpectedly from combined drug toxicity. He had been suffering from chronic back pain for several years after a motor vehicle accident and attempts to limit his use of strong opioid drugs were unsuccessful. Mr S had been self-medicating with unlicensed drugs he sourced over the internet.

The Coroner commented on the increasing trend and concerning use of psychoactive substances that are purchased over the internet and that members of the public need to understand the dangers and risks involved. No recommendations were made.

Mr N (December 2018)

Mr N was a man who died from an epileptic seizure while in a detention centre. He was known to have epilepsy and was prescribed antiepileptic medication.

The Coroner considered there had been a failing in the medication dispensing system at the detention centre in the days leading up to Mr N's death and that the failure to provide the medication to him would have increased the risk of him having a seizure.

The Coroner was satisfied with changes made since Mr N's death to ensure medication is received by detainees and made no recommendations.

Mr J (January 2019)

Mr J was a detainee who died from thermal injuries from a fire he lit deliberately. He was known to have a propensity to self-harm. Mr J was provided mental health care by experienced staff.

The Coroner noted the investigation that occurred after the death and the relevant recommendations for improvements, including the establishment of a set of practices relating to visits among detainees in various compounds of the detention centre, and a 'buddy system' of support for vulnerable detainees to allow nominated companions to move between compounds. The Coroner was satisfied that the supervision, treatment and care provided were reasonable and appropriate in the context of detention and made no further recommendations.

Mr S (January 2019)

Mr S was a 43-year-old man who died from complications of a neck injury after a motorcycle accident.

The inquest focussed on the events leading up to the death, the safety of the helmet worn and the safety of the road on which the accident occurred. The Coroner noted the improvements made to the safety of the road after the death of Mr S but commented that more could be done.

The Coroner made a recommendation to consider implementing regulations to require the provision of information to purchasers about whether the helmet being purchased complies with approved standards for protective helmets used when riding a motorcycle in WA.

Mr D (February 2019)

Mr D was a 37-year-old man who died from subarachnoid haemorrhage due to a ruptured berry aneurysm and death occurred by way of natural causes. He was a prisoner at the time of his death.

He had received treatment by prison medical staff for his various medical and mental health issues. The Coroner was satisfied with the supervision, treatment and care provided and made no recommendations.

Mr T (February 2019)

Mr T was a 15-year-old boy who died from multiple organ failure associated with hyperthermia. He was engaged in rugby league training on a warm summer evening and was overcome with heat stroke. Mr T was provided with first aid and taken to hospital where he died.

The inquest reviewed the appropriateness to hold the training session, the quality of first aid provided and the appropriateness of the first aid training to sports trainers with respect to heat stroke.

The Coroner concluded the adults responsible for Mr T's welfare acted responsibly but due to the training they had received were not equipped with the means of recognising and treating heat stroke compared to heat exhaustion. The Coroner recommended that the relevant first aid training be amended to incorporate information about heat stroke in line with recent developments in this area.

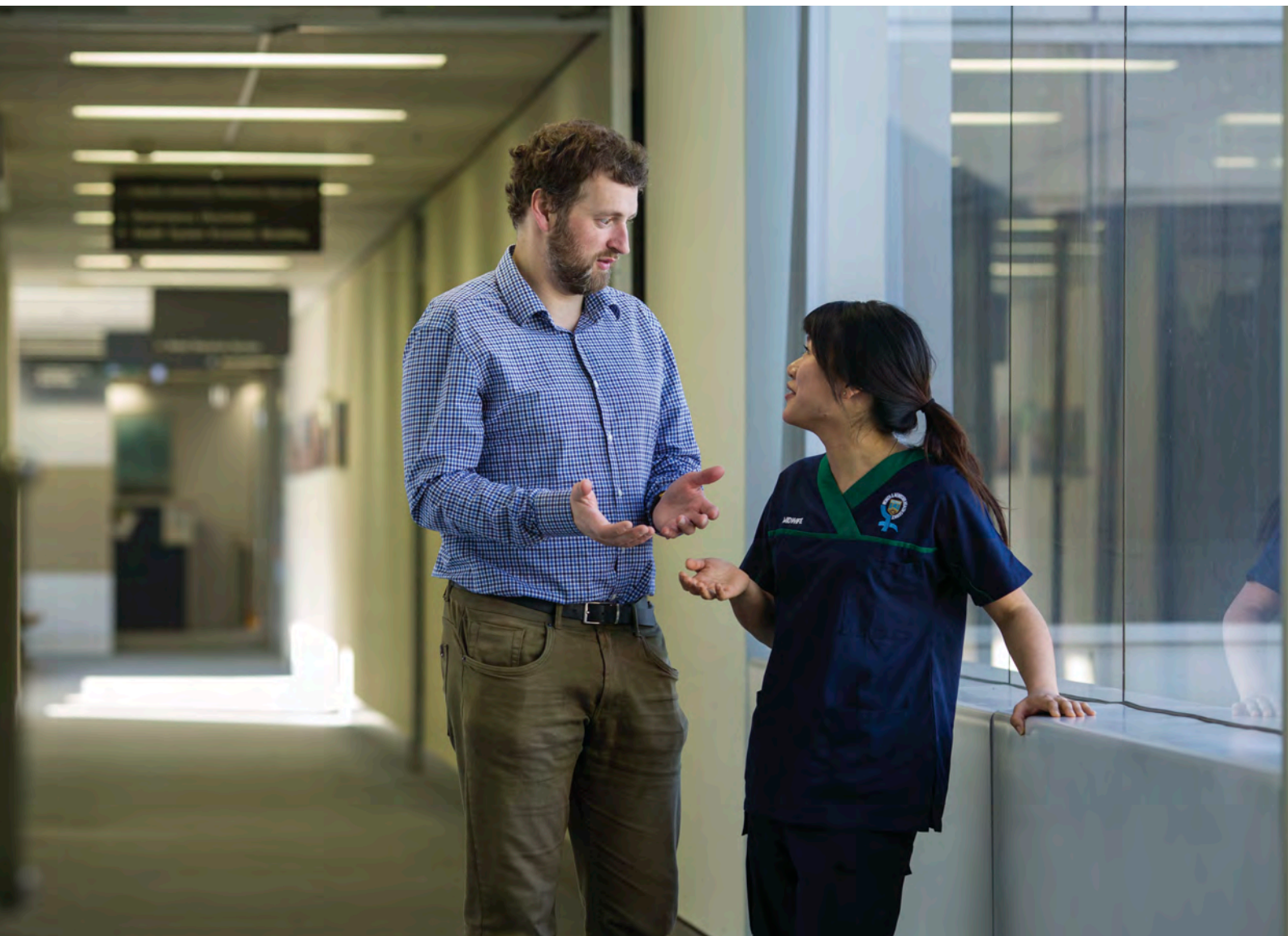
Thirteen Youth Suicides in the Kimberley Region (February 2019)

The deaths of 13 Aboriginal children and young persons in the Kimberley Region were investigated together because there were similar circumstances, life events, developmental experiences and behaviours that appeared to have contributed to vulnerability to suicide. The State Coroner looked not just at the circumstances surrounding each death, but at the effects of intergenerational trauma, poverty, and colonisation on whole communities, as longitudinal factors that contributed to pre-existing vulnerabilities of the children and young persons, affecting their capacity to regulate emotion and manage ongoing trauma and stress.

The State Coroner noted that “Given the multifactorial problems that have been experienced in the Kimberley Region for generations, there is no justification for finding that the act or omission of a particular person, officer or agency caused or contributed to a suicide” and “No adverse comment is made against any family member. These are the people who have themselves endured significant trauma and disadvantage”.

The State Coroner agreed with the Department of Premier and Cabinet that providing existing Government departments with more funding is not the solution and that there are difficulties inherent in providing services to small dispersed remote communities.

The effects of intergenerational trauma upon Aboriginal persons are not generally understood in the wider community, and service providers need to adapt their programs to account for this. The diversity of Aboriginal peoples is to be recognised in connection with the offering of the programs. Intergenerational trauma is endured by entire communities. The State Coroner’s wide-ranging recommendations were aimed at preventing similar deaths through healing and supporting this marginalised and disadvantaged community.



Mr O (March 2019)

Mr O was a 30-year-old man when he died from methadone toxicity and respiratory depression while an involuntary patient under the *Mental Health Act 1996* (which was in force at the time). The Coroner was unable to determine how the methadone came into his system so made an open finding as to how the death occurred.

Two broad areas for improvement were identified in the inquest findings; the monitoring of vital signs and managing risk of absconding. Three recommendations were made that detailed changes to the documentation used to record observations of mental health patients when asleep and/or given sedating medications.

Ms W (March 2019)

Ms W was a 39-year-old woman who died from pulmonary thromboembolism due to deep vein thrombosis and sepsis due to pyelonephritis on a background of metastatic ovarian cancer. She was subject to an inpatient treatment order under the *Mental Health Act 2014* and thus was an involuntary patient. Ms W had a complex medical and mental health history.

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

Mr G (April 2019)

Mr G was a 79-year-old man who died from a cardiac arrest while a sentenced prisoner. He was found by another prisoner in his cell and despite a prompt response, could not be revived.

The Deputy State Coroner was satisfied the deceased's naturally occurring coronary arteriosclerosis was appropriately dealt with during his incarceration and that he died without warning as the result of a fatal cardiac arrest, the effects of which could not be reversed. The Deputy State Coroner was satisfied the deceased's supervision, treatment and care while in custody were of a good standard.

Mr K (April 2019)

Mr K was a 68-year-old man who died as the result of bronchopneumonia with a background of chronic obstructive pulmonary disease. He was a long-term involuntary patient with multiple medical and mental health issues.

Mr K was admitted and treated for his declining health and received palliative care. The Deputy State Coroner was satisfied with the supervision, treatment and care and made no recommendations.

Mr C N (May 2019)

Mr C N was a 34-year-old man who was a detainee at the time of his death. He had escaped from the detention centre and was found dead nearby.

Mr C N had spent a long time in the immigration detention system and over time the prolonged detention led to deterioration in his mental health. There was little continuity of care in the mental health treatment that was provided to him.

The Coroner concluded the mental health treatment provided to Mr C N was of good standard but the constant transfers of Mr C N between detention centres led to inconsistent provision of care. The Coroner made two recommendations relating to improving the psychiatric services provided to detainees.

Mr J (May 2019)

Mr J was a 36-year-old man who died by suicide in prison from ligature compression of the neck (hanging). Mr J had a significant criminal history of violence reflecting his alcohol and illicit substance use. He had a long history of mental health issues and treatment with mental health services but was not always compliant with medication.

After being unsuccessful in seeking release on bail, Mr J was transferred from court to prison without effective communication of his withdrawn behaviour pending transfer. He was assessed, and prison officers had no concerns regarding his state of mind. Mr J was found in the shower block, which was old and with accessible hanging points, a short time after being orientated into the prison.

The Deputy State Coroner found that even with the proper communication of his prior behaviour and knowledge of Mr J's previous attempts at self-harm, the condition and systems in place at the prison at the time would not have made a difference to how he was dealt with in the two and a half hours he was present in the prison. The Deputy State Coroner made six recommendations relating to improving well-being and minimising the risks associated with prisoners suffering from mental health issues.

Mr T (May 2019)

Mr T was a 24-year-old man who died of bronchopneumonia complicating oxycodone toxicity. Mr T was an Australian Army veteran. He became addicted to prescription drugs and doctor-shopped in order to obtain the drugs.

The main issues raised at the inquest were how Mr T was able to obtain opioids by prescription despite his known drug seeking behaviour and the status of a proposed real-time monitoring system for the dispensing of prescription opioid drugs. The recommendation made by the Coroner arose from the difficulty faced by medical practitioners in WA when attempting to obtain medical records from the Australian Defence Force or the Department of Defence.

Mr A (May 2019)

Mr A was a 44-year-old man who died as a result of a gunshot wound to his abdomen. He was taken to hospital after being shot by a police officer who had responded to a call out concerning an alleged domestic violence incident with his wife.

Police officers attempted to control Mr A's threatening behaviour with repeated deployment of a Taser and capsicum spray. Once Mr A lunged toward the police officers with a knife, a police officer shot him in the abdomen. Paramedics treated him at the scene and transferred him to hospital. He was taken to theatre for surgery and despite extensive resuscitative efforts, he was unable to be revived.

The State Coroner was satisfied that within the time frame of the incident, there were minimal opportunities to de-escalate the situation and the deceased was shot in self-defence. The State Coroner noted improvements made by the WA Police Service and the WA health system following this incident and made no recommendations.

SM (May 2019)

SM was a 7-year-old boy who was under the care of the CEO of the Department of Communities. SM had profound disabilities and was only able to smile and vocalise loud sounds, but not words. He was fed by a percutaneous endoscopic gastrostomy (PEG) tube and required 24/7 care.

While in hospital being treated for multiple seizures, SM's condition deteriorated, and he was admitted to the paediatric Intensive Care Unit (ICU). He died after his life support was removed.

The Deputy State Coroner concluded the overall view of the deceased's supervision, treatment and care were appropriate while in the care of the Department of Communities and made no recommendations.

Five Deaths in Casuarina Prison (May 2019)

At the time of their deaths all five men were prisoners at Casuarina Prison and the cause of death in each case was suicide. The five men were of varying ages:

- Mr B was 28 years old
- Mr C was 26 years old
- Mr H was 61 years old
- JS was 68 years old
- Mr W was 31 years old

Pursuant to a direction by the State Coroner, all five deaths were investigated at one inquest. That inquest focused on the supervision, treatment and care provided to each of the men while they were prisoners, as well as the circumstances of their respective deaths. The Coroner heard evidence about the management of at-risk prisoners, some of the risk factors impacting on prisoner management and the strategies and tools employed to address those factors.

The Coroner made eight recommendations relating to improving prisoner welfare and enhancing the security of Casuarina Prison.

Ms A (May 2019)

Ms A was a 64-year-old woman who died from a cardiac arrhythmia with a background of obstructive sleep apnoea and while suffering an acute psychotic episode requiring sedation.

The Deputy State Coroner found the death occurred by way of natural causes. Expert opinion was given at the inquest that there are difficulties with the current mental health system which makes it impossible for mental health facilities to properly care for acutely unwell mental health patients. Highly aroused patients must be treated but the environment in a dedicated psychiatric facility is not protective of their clinical state, while an Emergency Department (ED) or acute setting is not therapeutic for their mental state. The recommendation was for the provision of mental health observation units.

Mr D (May 2019)

Mr D was a 40-year-old man who died as the result of his combined undiagnosed cardiomyopathy and reported obstructive sleep apnoea following a cardiorespiratory arrest. Mr D was pending an involuntary patient assessment after being admitted to hospital due to a relapse of his mental health issues.

The Deputy State Coroner was of the opinion that the supervision, treatment and care of the deceased in this case was reasonable but expressed concerns regarding a lack of prior investigation of cardiac and respiratory conditions and being in a facility that did not have extensive monitoring.

The Deputy State Coroner made four recommendations that highlighted the need for good discharge planning to involve all stakeholders in care; the need for appropriate clinical investigation of community mental health patients with physical conditions; good documentation and communication; and the development of more acute care units for highly aroused mental

health patients at high risk of cardiorespiratory arrest, such as Mental Health Observation Areas (MHOAs) attached to acute facilities such as EDs, ICUs and High-Dependency Units (HDUs).

Mr H (May 2019)

Mr H was a 57-year-old man who was a prisoner at the time of his death. He was diagnosed with metastatic lung cancer and registered as terminally ill. After his condition deteriorated, he was transferred for end-of-life care where he remained until his death.

The Coroner found that the supervision, treatment and care provided during his incarceration was reasonable and appropriate. No recommendations were made.

Mr M (May 2019)

Mr M was a 62-year-old man who died as a result of bronchopneumonia on a background of metastatic colon cancer.

Mr M was diagnosed with metastatic sigmoid colon cancer and surgery was recommended. However, Mr M initially refused treatment. After his cancer had progressed, he agreed to have the surgery and then continued with numerous treatments for further metastases. Following a fall, he was admitted to hospice care where he remained until his death.

Having regard to all of the circumstances of the deceased's case, the Coroner found that the supervision, treatment and care provided to Mr M during his incarceration was reasonable and appropriate. No recommendations were made.

Ms T (May 2019)

Ms T was a 31-year-old woman who died at home as a result of incised wounds to the neck and arms after being discharged from a hospital's ED without full psychiatric assessment. The manner of death was found to be suicide.

The Coroner highlighted the lack of resources put towards mental health treatment in WA, translating to a lack of mental health beds, a lack of properly trained and available psychiatrists and mental health professionals, and a lack of appropriate areas in which to assess an increasing number of patients. The recommendation made by the Coroner was to give priority to commissioning a MHOA at the hospital's ED.

The Coroner also urged those reviewing the mental health services provided at public hospitals to focus on ways of ensuring mental health emergencies are treated as seriously as any other medical emergency, with appropriate resources directed to ensuring that they are treated by properly trained staff in appropriate therapeutic environments.

Mr C (May 2019)

Mr C was an 80 year-old-man who died as a prisoner receiving palliative care in hospital.

Mr C was diagnosed with end stage renal failure, uraemic encephalopathy, hypercalcaemia and urinary retention. While terminally ill, Mr C remained relatively stable for quite a long time and was cared for appropriately within the prison system. When his health issues became too great, he was moved to a hospital, where a greater level of medical care could be provided. He was given palliative care and kept as comfortable as possible until his death.

The Coroner found the deceased's treatment, supervision and care were of an appropriate standard and made no recommendations.

Mr G (May 2019)

Mr G was a 56-year-old man who died while receiving palliative care for advanced metastatic lung cancer. He was a sentenced prisoner at Casuarina Prison.

Mr G was a heavy smoker and had developed severe emphysema and chronic obstructive pulmonary disease. He was diagnosed with lung cancer and was identified as a terminally ill prisoner. After frequent transfers to hospital for treatment, he was admitted for palliative care and died.

The State Coroner found the mental and physical health needs of Mr G were managed and treated to a high standard and made no recommendations.

Child L (June 2019)

Child L was a 13-year-old boy who died from epileptic seizure with aspiration. He lived with his brother and father and was supported at school by education assistants and the Disability Services Commission. The Department of Communities was involved with the family with respect to ongoing concerns regarding the child's parents and allegations of domestic violence, illicit drug use, and unsecured and loaded firearms in the house.

Child L was diagnosed with autism spectrum disorder with behavioural issues and cognitive impairment at age three, and with generalised epilepsy syndrome at age 11. Optimal management of this was challenging, with multiple missed appointments and concerns over adherence to prescribed medication regimes.

The involvement of the Department of Communities and the Disability Services Commission was discussed, and it was conceded that a stronger response to concerns was warranted. The Coroner noted improvements within the Department of Communities relating to its ability to respond to significant issues impacting on child safety, such as alcohol and substance abuse by care-givers and domestic and family violence and did not make any recommendations.

Ms H (June 2019)

Ms H was a 25-year-old woman who died from complications of opioid toxicity. Ms H had started using oxycodone and heroin in her early twenties but had been largely abstinent for a period of six months prior to her death with the assistance of a drug and alcohol treatment service.

Ms H attended a friend's house and used intravenous (IV) methadone with him. She went to work the next day and returned to his house the next evening where she had two injections of methadone with him again. The following morning, she appeared to still be asleep or comatose, so her friend placed part of a Suboxone⁵¹ wafer under her tongue with the intention that the naloxone in it would counteract the methadone. He asked another person in the house to check on her before going out to a drug rehabilitation appointment. When the other person checked, Ms H was unrousable and paramedics were unsuccessful in their resuscitation attempts when they arrived soon after.

The Deputy State Coroner noted the suggestions provided by Ms H's mother on ways to reduce the number of deaths from drug overdose. There were no recommendations made.

⁵¹ Suboxone is a medication containing a combination of buprenorphine and naloxone used for maintenance therapy in patients with opioid dependence. Naloxone is included to discourage IV use but has little clinical effect when used sublingually.

Mr O (June 2019)

Mr O was a 66-year-old man who died at Acacia Prison, from acute myocardial infarction on a background of atherosclerotic cardiovascular disease.

Mr O had a complex medical history including heart disease and vascular disease and he attended numerous medical and specialist appointments with respect to his conditions. He was housed in the assisted care unit at Acacia Prison which is designed to provide additional help to prisoners unable to cope in mainstream cells. Prisoners in this unit are subject to regular checks. Mr O was found unresponsive in his cell. A medical emergency was called but despite the efforts of custodial and nursing staff, Mr O could not be revived.

The Coroner was satisfied that the supervision, treatment and care provided was reasonable and appropriate and made no recommendations.

Ms D (June 2019)

Ms D was a 44-year-old woman who died as a result of pulmonary thromboembolism in conjunction with likely myeloproliferative neoplasm. At the time of her death, Ms D was recovering from gastrectomy sleeve surgery and developed complications from a rare blood condition, which was not reasonably detectable prior to her undergoing bariatric surgery.

The Coroner was satisfied with the operative and post-operative care Ms D received but reviewed the appropriateness of her undergoing surgery and if she met bariatric surgery guidelines. The Coroner accepted that the surgeon was entitled to make his own opinion regarding patient suitability. It was noted that the surgeon had changed his practice around documentation, and now requires patients to write a letter as to why they want surgery. No recommendations were made.

Mr C (June 2019)

Mr C was a 35-year-old man who had known significant cardiac disease but continued to smoke and abuse alcohol and drugs. His family called emergency services after he climbed onto the roof of their house throwing tiles. This was after he had been drinking, smoking and taking methylamphetamine and displaying increasingly agitated and erratic behaviour.

Police and ambulance paramedics attended, and he was eventually restrained by police officers. Mr C was given two sedatives and after the second sedative was administered he went into cardiac arrest and could not be resuscitated.

Medical evidence indicated the sedatives played no role in his death. The Coroner found the deceased died as a result of the effect of methylamphetamine in combination with his pre-existing heart disease coupled with his exertion on the roof and his violent struggles against the physical restraint. The Coroner was satisfied the police officers acted appropriately and made no recommendations.

Review of Death

In January 2019, an updated *Review of Death Policy*⁵² took effect in the WA health system. The ROD Policy revision took into account 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 Three: 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 that for deaths occurring during the period 1 January to 31 December 2018, 93.5% of hospital deaths were reviewed within four months of the date of death (see Table 25). This data represents the final reporting under the previous (2013) WA Review of Death Policy.

Table 25: Review of Death Indicator for 2018

Indicator	Outcome
Percentage of deaths with a completed review within four months of the date of death (for deaths that occurred between 1/1/2018 and 31/12/2018)	93.5%

Note: Data comprises public and private hospitals. A completed review includes a death: a) where no further investigation is required; b) with a completed WAASM audit; c) notified as a SAC 1 clinical incident following identification of a potentially preventable death.

Public and private hospitals are also required to indicate when notifying a SAC 1 clinical incident if the notification was an outcome of a mortality review process. From July 2018 to June 2019, 4.5% (n=27) of confirmed SAC 1 clinical incidents were reported as being notified following a mortality review.

⁵² 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>



Western Australian Audit of Surgical Mortality

The Western Australian Audit of Surgical Mortality⁵³ 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) Guide⁵⁴ 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".⁵⁵ 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,⁵⁶ an area of concern⁵⁷ 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 Four: Western Australian Audit of Surgical Mortality Process for an overview of the WAASM process).

In 2018, 552 deaths across public and private hospitals met the WAASM criteria. Sixty-one cases were referred for second-line assessment (representing 15.6% of the 391 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, lead to temporary or permanent impairment or disability of the patient at the time of discharge or contribute to/or cause death". The WAASM has identified 10 adverse events that caused death in 2017 (four of these were considered definitely preventable) and three adverse events that caused death in 2018⁵⁸ (none were considered definitely preventable; see Table 26 overleaf).

⁵³ Information regarding the WAASM is available at:

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

⁵⁴ The RACS' CPD Guide is available at:

<https://umbraco.surgeons.org/media/1278/racs-continuing-professional-development-cpd-guide-2017.pdf>

⁵⁵ <https://www.surgeons.org/research-audit/surgical-mortality-audits/more-about-anzasm>

⁵⁶ Area of consideration: The clinician believes an area of care could have been improved

⁵⁷ Area of concern: The clinician believes an area of care should have been better

⁵⁸ 2018 data includes cases for which the audit process was complete at 1 April 2019

Table 26: Frequency Adverse Events Causing Death that were Considered Definitely Preventable and Associated Deaths for 2008 to 2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
AEs considered definitely preventable ^{a,b}	6	5	4	7	4	1	6	2	2	4	0
Deaths associated with preventable AE ^a	6	5	3	7	2	1	4	2	2	4	0
Total surgical deaths ^c	682	602	592	570	592	566	578	581	591	568	552
Deaths as % of surgical deaths	<1%	<1%	<1%	1.2%	<1%	<1%	<1%	<1%	<1%	<1%	0%

^a Data includes cases complete at 1 April 2019 (incomplete cases are excluded) and will be updated in future editions of this report.

^b Multiple adverse events that caused death and were considered definitely preventable may have been recorded for a single surgical death.

^c For 2008 surgical deaths are total deaths reported to WAASM and for 2009-2018 surgical deaths are those reported as meeting the WAASM criteria (as contained in the WAASM 2019 Report).



In 2018, three adverse events causing death were identified including one each that related to adverse factors in management, CVA following open surgery and patient-related factors (see Table 27).

Table 27: Frequency of Adverse Events Causing Death for 2016 to 2018 (Including Events that were Considered Not Preventable)

Adverse Event	2016	2017	2018
Accidental arterial rupture	1	-	-
Adverse factors in management	-	1	1
Allergy to blood or blood products	-	1	-
Anastomotic leak after open surgery	1	-	-
Aspiration pneumonia	1	-	-
Aspiration pneumonia during anaesthesia	1	-	-
Better to have done different operation or procedure	-	1	-
Colonic complication of laparoscopic operation	-	1	-
CVA following open surgery	-	-	1
Decision to operate	-	1	-
Delay in recognising complications	1	-	-
Injury to heart during open surgery	-	1	-
Patient-related factors	-	-	1
Perforation of duodenum during endoscopic operation	-	1	-
Post-operative bleeding after open surgery	1	-	-
Post-operative pancreatitis	1	-	-
Premature discharge from hospital	1	-	-
Pulmonary embolism	-	1	-
Surgeon too junior	-	1	-
Wrong anaesthetic technique	-	1	-
Total	8	10	3

Note: Data includes those cases that were complete at 1 April 2019 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.

A total of 144 adverse events were identified by the WAASM surgeon assessors during the period 2008 to 2018. The most frequently reported adverse events over this period were complications of surgery (n=24), anastomotic leaks (n=15) and delays to medical and surgical treatment (n=15; see Table 28).

Table 28: Most Frequently Reported Adverse Events Causing Death for 2008 to 2018 (Including Events that were Considered Not Preventable)

Adverse Event	2008 - 2018
Complication of surgery	24
Anastomotic leak	15
Delay to treatment (medical and surgical)	15
Bleeding associated with operation	11
Decisions relating to surgical treatment	11
Medical management/assessment issues	10
Gastrointestinal perforation	9
Pulmonary embolus	9
Injury caused by fall in hospital	7
Other adverse events	33
Total	144

Note: Data includes cases complete at 1 April 2019. 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 airway management issues, communication issues, diagnosis issues, DVT/DVT prophylaxis, equipment/device issues, infections (including septicaemia), medication-related issues and patient factors.

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>

Consumer Feedback Review

Obtaining feedback from health consumers is a vital component of the quality improvement cycle, offering the WA health system insight into how its consumers view the services it provides. Consumer feedback may be received as compliments, complaints or contacts. Compliments indicate the areas where the health system is meeting consumers' expectations and efforts should be made to maintain or improve services in these areas. Complaints highlight those areas of health services that are not meeting consumers' expectations and where there is the potential for lesser quality care. Greater attention should be given to improving these services through focused quality improvement initiatives. 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 WA's 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. Service improvement recommendations made following investigation of complaints and contacts are recorded in the Datix CFM.

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

The second edition of the National Safety and Quality in Health Service Standards⁵⁹ came into effect in January 2019, meaning hospitals and health services undergoing accreditation from this date will be evaluated against these revised standards. Accreditation between July and December 2018 involved assessment against the first edition of the NSQHS Standards. The accreditation process provides consumers with assurance that the health services they receive meet minimum standards for safety and quality. The Partnering with Consumers Standard (Standard 2) specifically aims to actively involve consumers as partners in decisions about their care and the broader decision making, policy development and planning of the hospital or health service. The Partnering with Consumers Standard recognises the contribution consumers can make to ensuring high quality health care.

For the third year, data from the Patient Evaluation of Health Services survey, managed by the Health Survey Unit at the Department of Health, is 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 2018/19, the PEHS included interviews of 3,928 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.

⁵⁹ ACSQHC NSQHS Standards (2nd edition) available at: <https://www.safetyandquality.gov.au/standards/nsqhs-standards>

The Australian Commission on Safety and Quality in Health Care reviewed the *Australian Charter of Healthcare Rights* (the Charter) throughout 2018/19. Following extensive consultation by the ACSQHC, the second edition of the Charter was released in August 2019.⁶⁰ The Charter has been endorsed by the Department of Health's Director General, and the *WA Public Patients Hospital Charter*, first released by the Department of Health in 2004, has been retired.

The Charter has a wide range of supporting resources including editions in 19 languages, Auslan, Braille and Easy English. The Charter highlights the need for a transparent feedback process where consumers can provide feedback about their experiences without any repercussions for their treatment.

The *Mental Health Act 2014* mandates a separate charter for patients receiving psychiatric treatment. The *Charter of Mental Health Care Principles*⁶¹ remains in place and explains the rights of this specific group of patients. It is important that all WA health system consumers and staff are aware of both charters and the rights described.

Consumer Feedback Story

Peter*, an elderly man, was admitted to hospital as a palliative patient. His family had made the decision not to share with him that he was being palliated, choosing to protect him from this information as they believed this was the best approach for him as an individual. While being visited by his daughter Jennifer*, a nurse entered the room and asked Jennifer if she would like to fill out the bereavement form. Jennifer said no, quickly waving the nurse away, hoping her father had not heard what the nurse had said.

She followed the nurse out of the room to request she didn't speak of this in front of her father. The nurse obliged and placed a note in Peter's file stating he was not aware of his palliative status and bereavement issues were not to be discussed in front of him.

When Jennifer returned to her father's room, he asked her what the nurse had said. Jennifer tried to appease her father, stating the nurse was wanting to confirm his personal details, but he asked the same question a second and then a third time, before eventually letting it go.

Jennifer felt heartbroken that her dad had heard this question.

The hospital explained that generally in the palliative care setting the patient and their family are included in these conversations. They apologised to Jennifer for her family's experience. They reviewed their bereavement processes and policies to improve options for families in similar situations in the future.

This is an example of the irreversible impact the WA health system can have on our consumers and their loved ones. We need to strive to make their experiences the best they can possibly be. Stopping events from reoccurring through acting on reported consumer feedback is a great place to start.

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

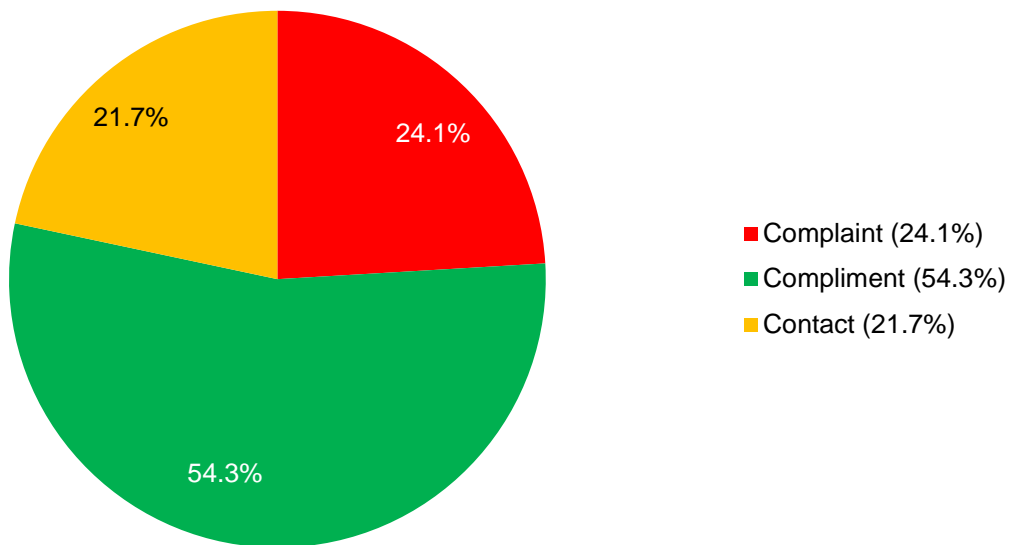
⁶⁰ The Australian Charter of Healthcare Rights (2nd ed) is available at: <https://www.safetyandquality.gov.au/australian-charter-healthcare-rights>

⁶¹ The Charter of Mental Health Care Principles is available at: https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/11/OMH-Charter_of_Mental_Health_Brochure.pdf

Consumer Feedback Overview

Consumers and their representatives provided feedback about the WA health system on 19,236 occasions in 2018/19.⁶² More than half of this feedback was positive in nature, with 10,440 compliments (54.3%; see Figure 71) received about the WA health system in this period. Complaints constituted 24.1% (n=4,629) of all consumer feedback received in 2018/19, providing valuable information about where to focus quality improvement activities to have the greatest impact on improving consumers' experience in the WA health system. The remainder of consumer feedback received (n=4,167; 21.7%) was recorded as contacts.

Figure 71: Type of Consumer Feedback Received by the WA Health System for 2018/19



The health care experience extends beyond the direct consumer of clinical services, and includes their family, friends, and carers, all of whom may provide feedback about their experience interacting with the WA health system. The Charter⁶⁰ highlights the importance of the consumer involving who they choose in their care planning and decision-making. There will be circumstances where the consumer is not willing or not able to provide feedback.

Feedback received from others involved in the consumer's care should be seen as equally important as feedback received directly from the consumer. In 2018/19, the majority of feedback was received directly from the consumer (n=12,893; 67.0%), with 30.3% (n=5,828) of feedback received from a consumer representative (see Figure 72 overleaf).⁶³

⁶² 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.

⁶³ 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 72 and 81.

Figure 72: Person Reporting the Feedback Item to the WA Health System for 2018/19

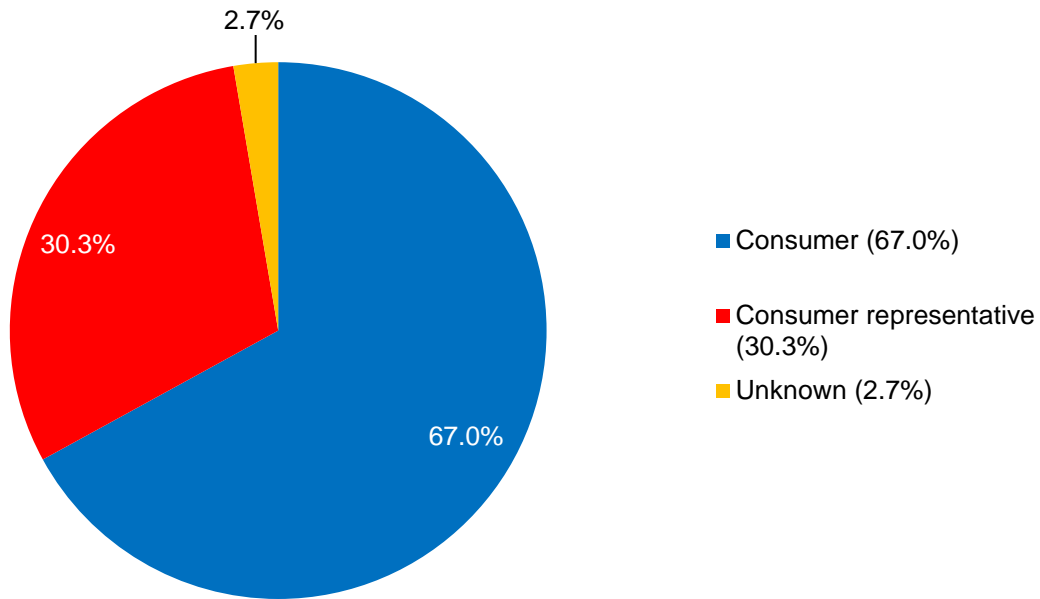
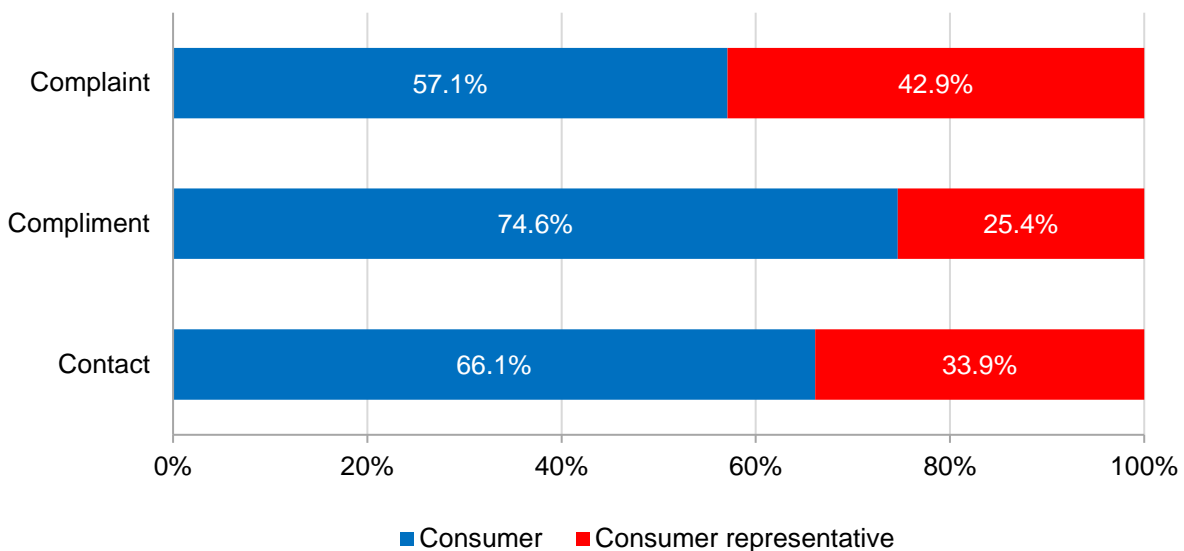


Figure 73 shows that consumers are more likely to give positive feedback about their own care, with 74.6% (n=7,790) of compliments received directly from the patient or client. In comparison, a greater proportion of complaints were received from consumer representatives (42.9%; n=1,766), with 57.1% (n=2,348) being received directly from the patient or client.

Figure 73 Person Reporting by Type of Consumer Feedback Received for the WA Health System for 2018/19



No matter who is providing the feedback, consumers in the WA health system need to be aware of the opportunity to make a complaint or give other feedback to do so. The PEHS asks respondents whether they were aware that each hospital has a complaints service. In 2018/19, 77.1% of respondents to the PEHS stated they were aware of the complaints service at hospitals. Hospitals and health services need to continue to advocate for consumers to provide feedback regarding their experiences to capture this valuable information.

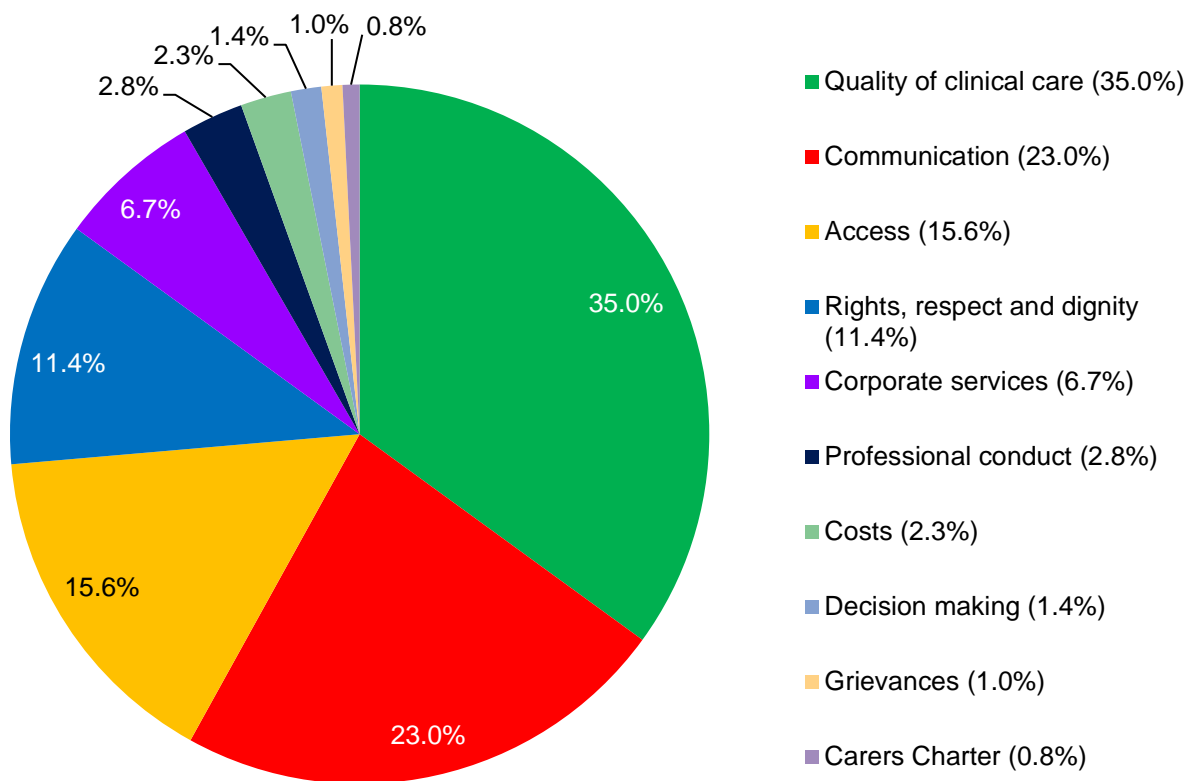
Complaints Overview

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 *WA Health 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 2018/19, a total of 8,050 issues were identified in the 4,629 complaints received. The proportion of issues identified in each category in 2018/19 is displayed in Figure 74. The top four broad complaint categories remain unchanged from previous years and constituted 85.0% of all issues identified.

Figure 74: Issues Identified by Person Reporting the Feedback in Complaints Received by the WA Health System for 2018/19



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

Complaints Demographics

Different people interact with health systems in different ways, and it is crucial to review whether our hospitals and health services are meeting the expectations of diverse consumer groups. Consumers from at-risk groups may require special consideration and assistance in lodging feedback about their experiences. It is particularly important to encourage feedback from these groups, which includes young people and the elderly, people with disabilities, migrant and refugee populations and people for whom English is not their first language, and Aboriginal and Torres Strait Islander (ATSI) people. A variety of demographic information is captured in the Datix CFM⁶⁵ which can be used to analyse the experiences of these at-risk groups within our health system.

The age of the person affected was recorded for 1,564 complaints reported in 2018/19, and was skewed to young people and the elderly, with over two-thirds of people belonging to these groups (n=652; 41.7% and n=434; 27.7% respectively). There were only eight complaints received from young people aged 10-17 years old. The subject of these complaints varied from the appropriateness of the news service displayed on televisions in young people's care areas of hospitals, to serious clinical care complaints about mental health services provided. Young people are a vulnerable group in our health system as they may lack confidence in dealing with the health system, not have well-developed health literacy, and be unsure of their health care rights. It is important that hospitals and health service organisations empower young people to provide feedback about their care so that the health system can assess how it is meeting the needs of young people from their perspective.

A total of 63 people affected identified at least one disability, of which 14 identified more than one disability. The most frequently reported disability was psychiatric (n=24) followed by physical (n=19) and mobility impairment (n=10). Only seven of these 63 people lodged the complaint on their own behalf, with the remainder lodged by consumer representatives. Obtaining feedback from consumers who identify as having disabilities is a valuable means of engagement to obtain their unique perspective on how to design health services to better meet the needs of this group.

Consumers of migrant and refugee background can find the WA health system especially unfamiliar if it differs significantly from the health system of their country of origin. These consumers may also experience language barriers and cultural differences that make interacting with the WA health system challenging. Differing expectations of the health system and challenges in interacting with it can negatively impact the level of feedback received from these groups. A total of 118 people who lodged a complaint (2.9% of all people who lodged a complaint) and 45 people who were affected by a complaint (1.1% of all people who were affected by a complaint) reported their country of birth to be outside of Australia. Only seven people who lodged a complaint and five people who were affected by a complaint reported needing a translator.

In the 2018/19 PEHS, 2.4% 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 needs to be sensitive to the individual needs of consumers of migrant and refugee backgrounds and work to be supportive of these consumer groups in providing their feedback to the hospitals

⁶⁵ 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.

and health care providers they visit. This could include advertising the availability of interpreter services in all settings and at all stages of health care.

Of the 4,114 people reporting a complaint in 2018/19, 108 (2.6%) identified as being Aboriginal or Torres Strait Islander. It is known that ATSI people are more likely to be hospitalised than the broader population in WA, yet complaints received about the care received by ATSI patients represented only 0.9% (n=37) of all complaints received. In contrast, 9.6% of respondents to the PEHS in 2018/19 were Aboriginal or Torres Strait Islander.

Feedback from ATSI patient groups 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. Strategies can then be put in place to address the reasons identified.

The Sustainable Health Review's⁶⁶ first Enduring Strategy for sustainability, 'Commit and collaborate to address major public health issues', identifies the need to address health care disparities for Aboriginal and Torres Strait Islander people. Discovering the perspective of Aboriginal and Torres Strait Islander people through obtaining their feedback could assist the WA health system to grow to become more culturally responsive.

Complaints Resolution

The complaint management process provides a mechanism for hospitals and health services to investigate and respond to issues encountered by consumers in their health care experiences. The recording of complaint resolutions provides a register of the measures taken by the hospital or health service to address the issues raised in complaints. Each complaint should have at least one resolution recorded, with more than one resolution possible for each complaint.

In the 3,588 complaints where at least one resolution was recorded⁶⁷ in 2018/19, the most common resolution was 'Explanation provided' which was recorded as a resolution in more than two-thirds of complaints (n=2,411; 67.2%), followed by 'Apology provided' (n=2,309; 64.4%), and 'Concern registered' (n=1,784; 49.7%; see Figure 75 overleaf). These rankings are consistent with previous years and highlight the importance of communication between the service provider and the consumer in the complaint management process.

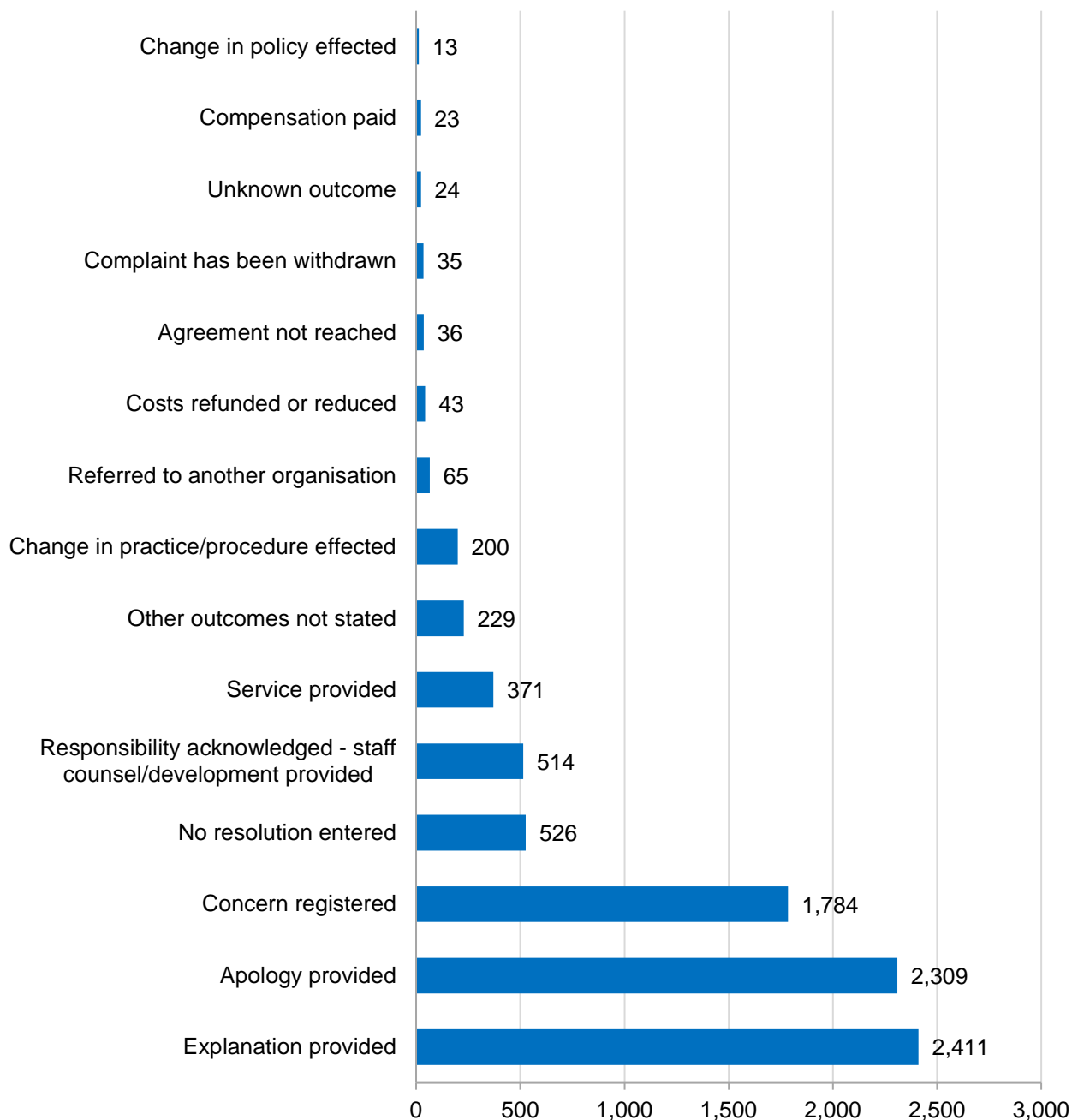
The PEHS asks respondents to rate the way any complaints were dealt with by the hospital at which they placed a complaint. The majority of respondents who made a complaint (78.4%) rated the complaints service as 'excellent', 'good', or 'adequate' (29.1%, 35.0%, and 14.3% respectively). However, 21.5% of respondents who made a complaint rated the complaints service at the hospital they attended as 'poor'. This suggests that hospitals could improve consumer experiences by undertaking quality improvement initiatives focused at improving their complaint management process, including the determining of resolutions.

⁶⁶ The Sustainable Health Review Final Report is available at:

<https://ww2.health.wa.gov.au/Improving-WA-Health/Sustainable-health-review/Final-report>

⁶⁷ 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 75: Complaints Resolution Achieved in 2018/19



A total of 65 complaints were referred to another organisation. This may include the Health and Disability Services Complaints Office (HaDSCO) which provides an impartial resolution service for complaints about health and other services in Western Australia. In 2018/19, the PEHS found that only 40.2% of people were aware of the role of HaDSCO in assisting with complaints that were not able to be resolved through direct contact with the hospital.

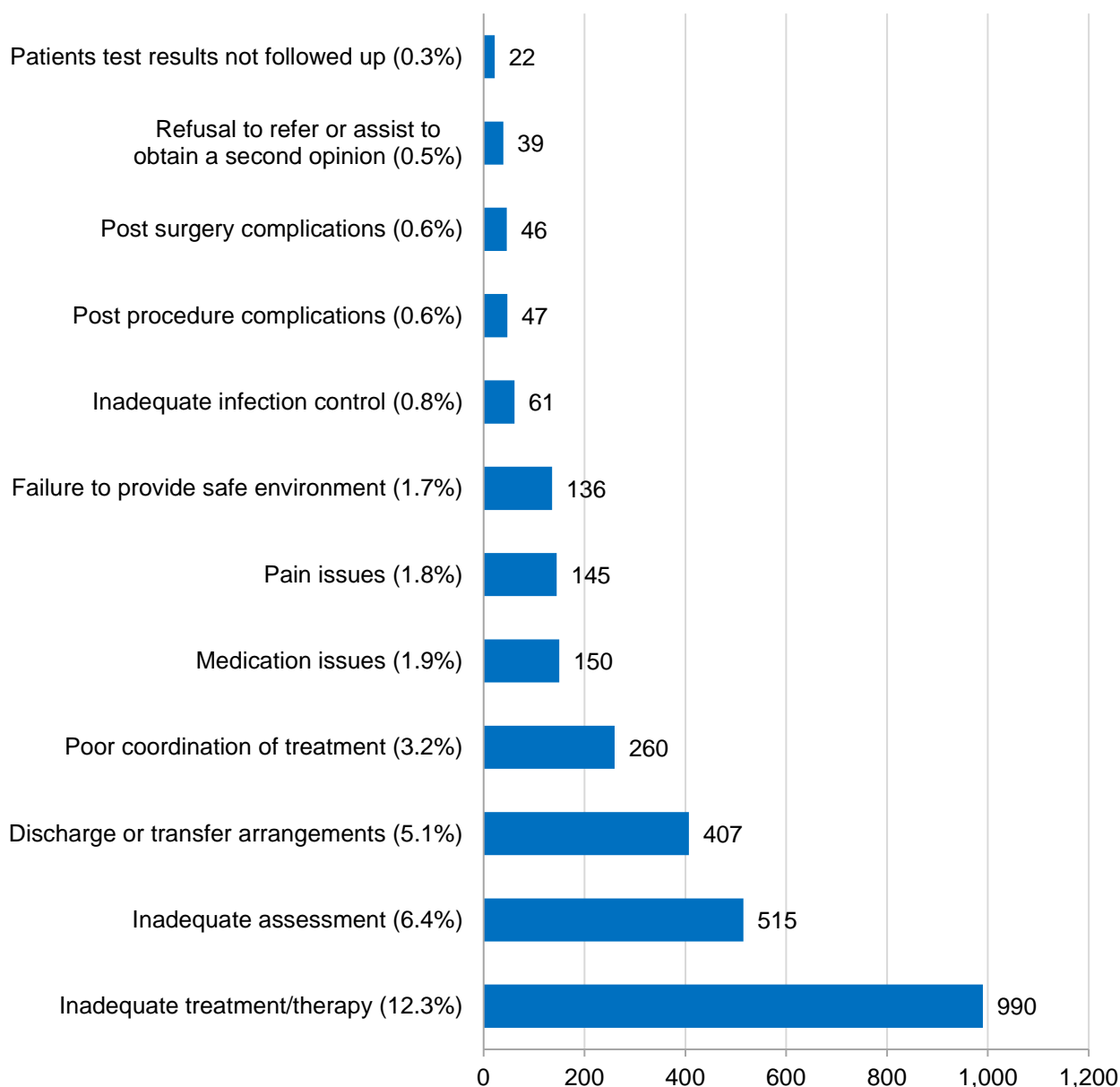
While this figure appears low and suggests there is an opening for improving health consumers' knowledge of the role of HaDSCO, the *WA Health Complaints Management Policy*⁶⁴ stipulates that complainants are informed of the role of HaDSCO and other advocacy bodies when lodging a complaint. All complainants should therefore be aware of this avenue for assistance in the resolution of their complaint.

Quality of Clinical Care Complaint Issues

Quality of clinical care issues were the largest contributor to total complaint issues, constituting 35.0% of all issues reported in 2018/19 (see Figure 74). Complaints involving these issues recognise situations where the consumer or representative did not feel the health care they received was adequate or appropriate. Due to their inherently clinical nature, quality of clinical care complaint issues are more likely to identify the occurrence of clinical incidents. Quality improvement initiatives arising from these issues are therefore likely to increase the safety and quality of care provided by hospitals and health service organisations.

The three most frequently reported quality of clinical care issues were 'Inadequate treatment/therapy' (n=990; 12.3% of total complaint issues), 'Inadequate assessment' (n=515; 6.4% of total complaint issues), and 'Discharge or transfer arrangements' (n=407; 5.1% of total complaint issues) as shown in Figure 76.

Figure 76: Frequency and Percentage of Complaint Issues Relating to Quality of Clinical Care for 2018/19



The quality of care received from the consumer's perspective is explored through the PEHS. In 2018/19, 83.9% of respondents reported 'always' and 8.7% reported 'usually' having confidence in their doctors. When asked how they would rate the time doctors spent on the patient's care and treatment, 91.4% reported 'as much time as was needed'. With regard to nursing, 86.1% of respondents reported 'always' and 7.9% reported 'usually' having confidence in nursing staff, with 94.6% reporting 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' (79.0%) or 'usually' (9.4%) talking to each other about the patient's care.

Patient evaluation of discharge arrangements is also obtained through the PEHS. The majority of respondents (83.3%) rated the arrangements at discharge with their doctors and others continuing their care as either 'excellent' (44.4%) or 'good' (38.9%). The time waiting for a doctor to discharge the patient from hospital was rated as 'excellent' by 31.6% and 'good' by 41.4% of respondents. Most patients who required special equipment at discharge had this organised for them by hospital staff (62.2%).

Overall, 88.4% of respondents to the PEHS felt that their hospital stay was worthwhile in achieving the results they expected, suggesting that patient satisfaction with the quality of care in WA hospitals is high.

Key Messages and Information: Quality of Clinical Care Complaint Issues

Where quality of clinical care complaint issues are identified hospitals and health service organisations can be proactive and take the opportunity to act on these potential early warning signs for the occurrence of clinical incidents. These complaint issues can also highlight opportunities to improve other aspects of care such as communication. Consumers in the WA health system may feel that their assessment, treatment or therapy, or arrangements for discharge were inadequate due to poor communication by their treating team and the omission of the consumer as a partner in the care planning process. Standard 2 of the NSQHS Standards stresses the importance of involving consumers and their chosen representatives as partners in their health care experience. Emphasis on the inclusion of consumers in the care planning process may help to alleviate some of the dissatisfaction experienced by our consumers.

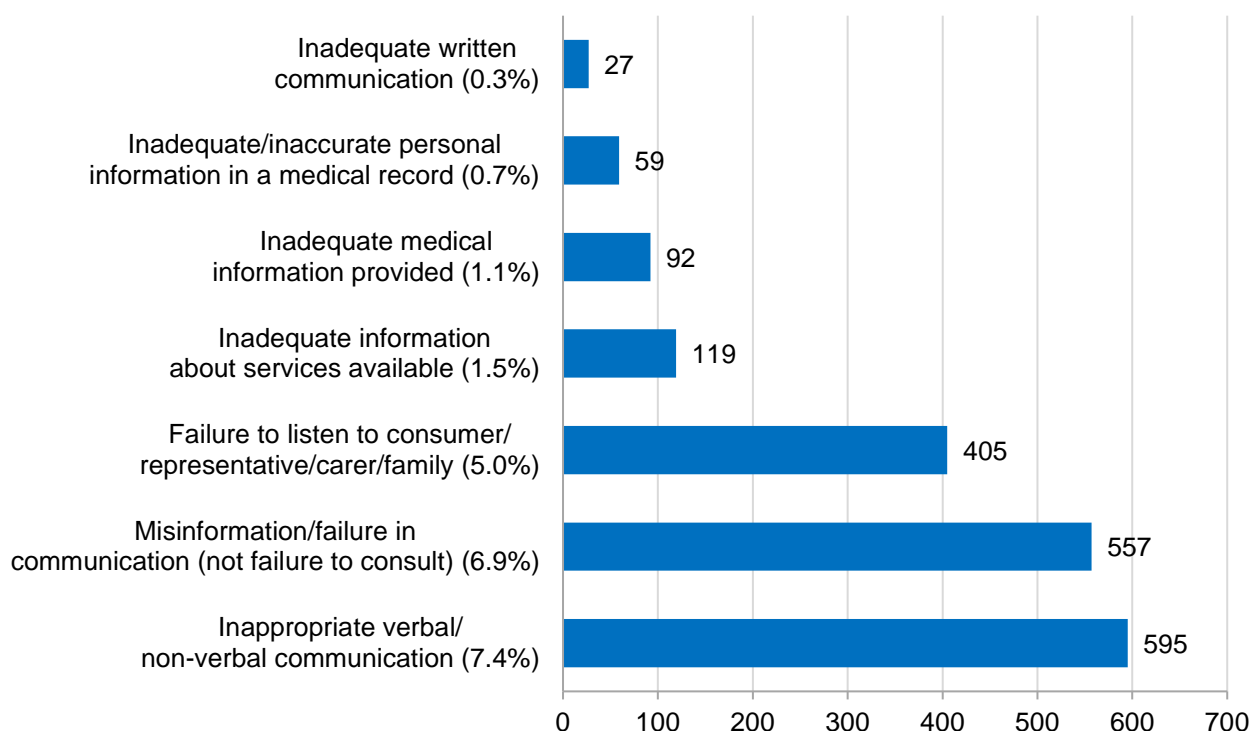


Communication Complaint Issues

There were 1,854 communication complaint issues reported in 2018/19, constituting 23.0% of total complaint issues reported in the WA health system. 'Inappropriate verbal or non-verbal communication' was the most frequently reported issue with 595 occasions reported, representing 7.4% of total complaint issues (see Figure 77).

Provision of 'Misinformation or failure in communication (not failure to consult)' was the second most commonly reported communication issue with 557 issues reported (6.9% of total complaint issues). There were 405 complaint issues reported where there was 'Failure to listen to the consumer, their representative, carer, or family' member (5.0% of total complaint issues).

Figure 77: Frequency and Percentage of Complaint Issues Relating to Communication for 2018/19



The PEHS extensively assesses communication between health care professionals and the patient or their representatives. The majority of respondents rated the way health care professionals explained their condition or treatment as 'excellent' or 'good' (53.7% and 32.8% respectively), the way health care professionals answered their questions as 'excellent' or 'good' (53.3% and 33.5% respectively), and the way health care professionals responded to their concerns about their treatment and progress as 'excellent' or 'good' (51.8% and 35.1% respectively).

The majority of PEHS respondents stated they got as much information as needed about the purpose and results of tests (85.0%) and about medications (91.8%), and 93.0% reported that someone checked that they understood the information given to them. When asked about the information given to their family about their progress, 86.9% reported their family received as much information as was needed.

Key Messages and Information: Communication Complaint Issues

The Charter stresses the importance of partnership and information as rights of consumers of our health system. Both rights are underpinned by good communication; the right to ask questions and be involved in open and honest communication, and the right to receive clear information about their condition, test and treatments, services, waiting times and costs.

Good communication is vital to a safe and patient-centred health system and improving communication can reduce the risk of clinical incidents occurring while simultaneously improving consumers' experience within our health system.

We all have different styles of communicating and there will be times when what is seen as appropriate communication by one person will not be considered appropriate by another. The WA health system needs to ensure that the consumer is kept central to all communication considerations and that we are receptive in our listening and remain open to communication with consumers, their families, representatives and carers.

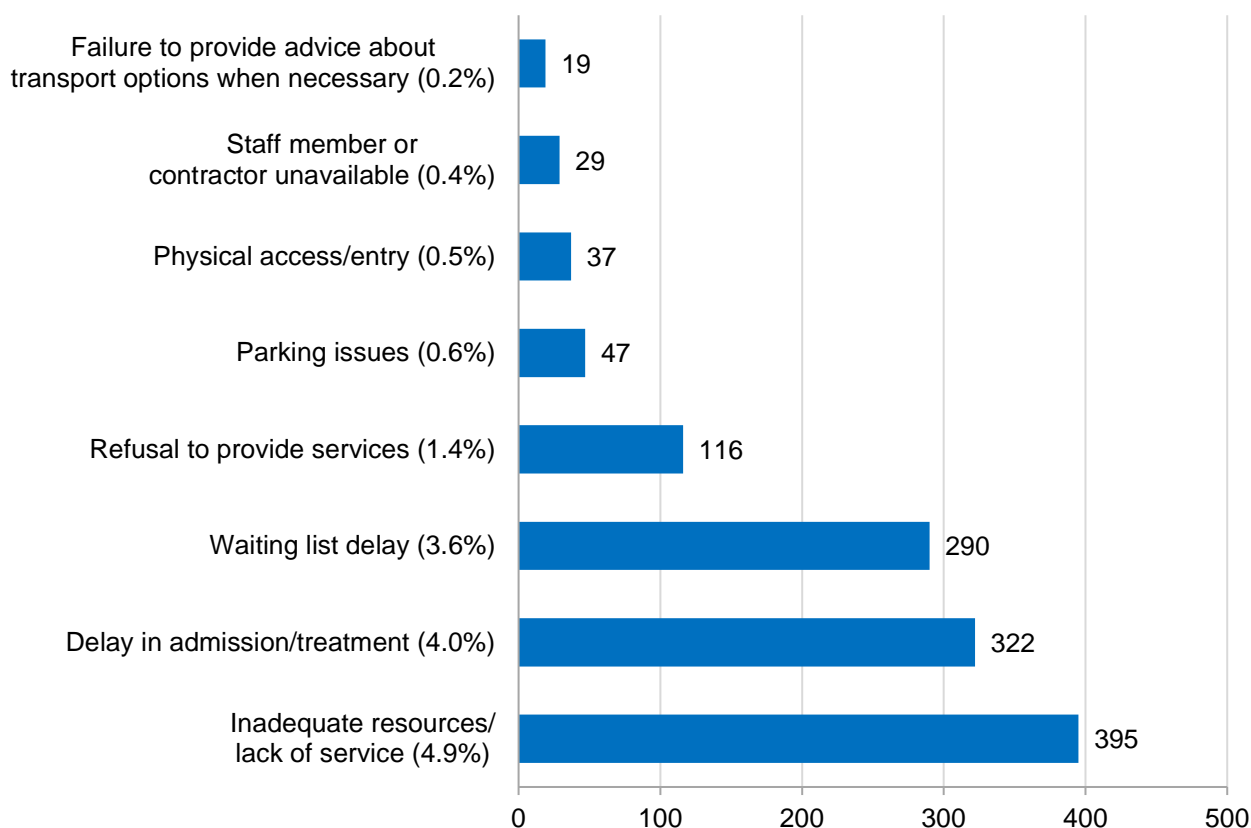


Access Complaint Issues

Consumers identified issues relating to access to hospitals and health services on 1,255 occasions in 2018/19, including inadequate, lack of, and delays in access to health care.

As shown in Figure 78, the most commonly reported access issue was 'Inadequate resources/lack of service' (n=395; 4.9% of total complaint issues), followed by issues of delays, including 'Delay in admission/treatment' (n=322; 4.0% of total complaint issues) and 'Waiting list delay' (n=290; 3.6% of total complaint issues).

Figure 78: Frequency and Percentage of Complaint Issues Relating to Access for 2018/19



Of the respondents to the PEHS who needed to see a doctor during their hospital stay, 40.5% rated the time they had to wait to see a doctor as 'excellent' and 32.6% rated the wait as 'good'. Most respondents (76.9%) stated they received as much information as needed regarding the reason for any long delays.

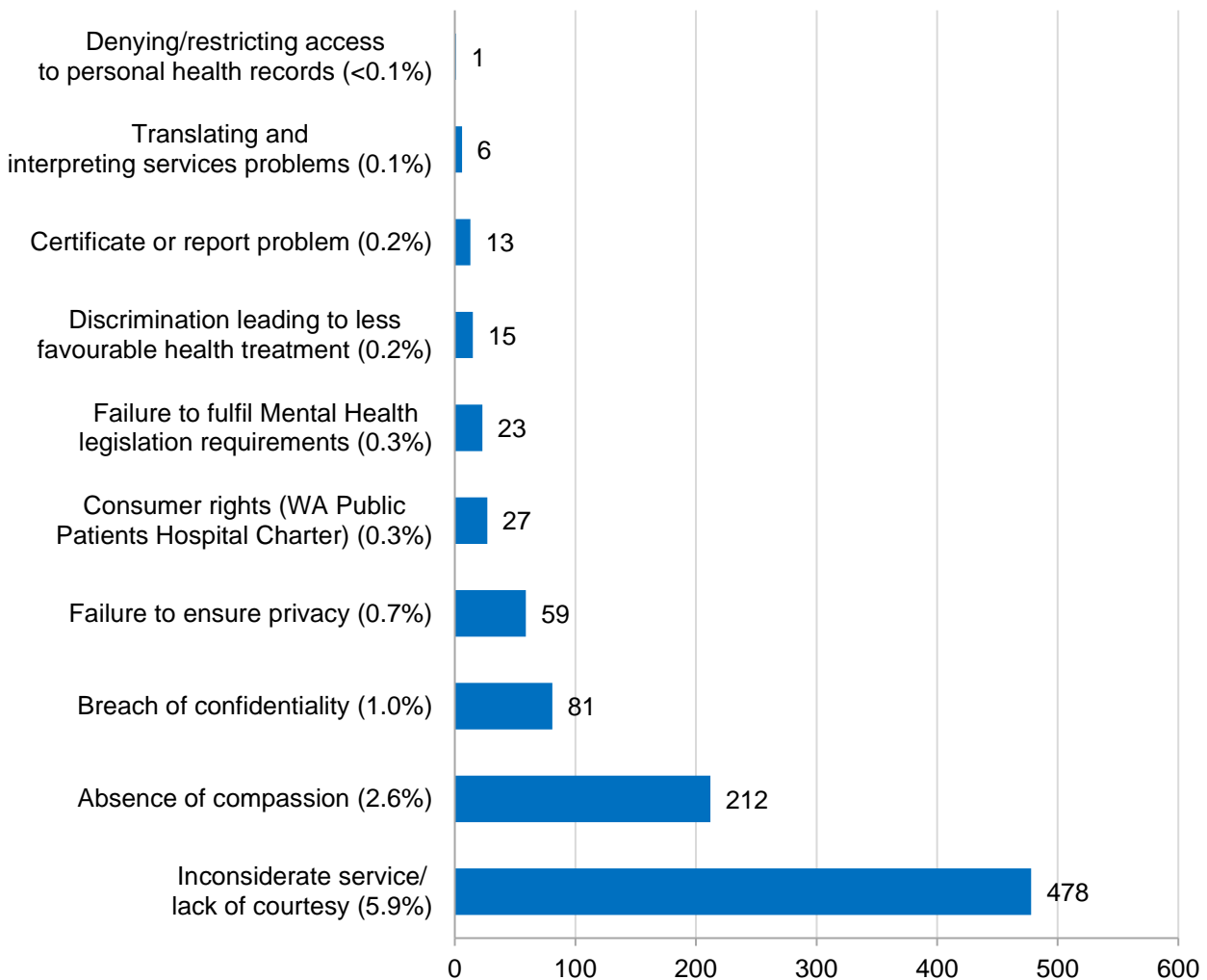
Key Messages and Information: Access Complaint Issues

Access issues around the adequacy of, and delays in providing health care may be inevitable in a public health system with finite resources. Hospitals and health service organisations need to ensure that prioritisation systems are in place and functioning optimally so that the consumers who require health services the most can access them. Thoroughly explaining expected timeframes to consumers and ensuring the timeframes explained are realistic enables consumers to set their expectations for care or treatment appropriately. Complaint issues surrounding access should be analysed for opportunities to improve health services and redirect resources to optimise patient safety.

Rights, Respect and Dignity Complaint Issues

A total of 915 complaint issues identified in 2018/19 fell within the ‘Rights, respect and dignity’ category. 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. Figure 79 shows there were 478 issues raised involving inconsiderate or uncourteous service (5.9% of total complaint issues), 212 issues where the expected level of compassion was not shown (2.6% of total complaint issues) and 81 issues involving breaches of confidentiality (1.0% of total complaint issues). With the release of the second edition of the *Australian Charter of Healthcare Rights*⁶⁰ it is timely to note there were 27 complaint issues relating to consumer rights outlined in the *WA Public Patients Hospital Charter* (0.3% of total complaint issues).

Figure 79: Frequency and Percentage of Complaint Issues Relating to Rights, Respect and Dignity for 2018/19



The majority of PEHS respondents reported that they were ‘always’ treated with politeness and consideration (87.1%), with 8.0% reporting ‘usually’, 4.1% ‘sometimes’, and 0.8% reporting ‘never’. When asked “How often were you shown respect while being examined or interviewed?”, 91.3% of PEHS respondents reported ‘always’, 5.1% reported ‘usually’, 2.6% ‘sometimes’, and 1.1% ‘never’. The PEHS survey also asks, “Were you asked who, other than hospital staff, could be given information about your condition?”, to which 69.5% of respondents replied ‘Yes’. Only 48.7% of respondents reported being aware of the Public Patients Charter listing their rights as a patient.

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

As the PEHS indicated, there is significant room for improvement in patient awareness of the Public Patients Charter (formally WA Public Patients Hospital Charter). With the release of the second edition of the *Australian Charter of Healthcare Rights* and the endorsement of this by the Department of Health's Director General, WA's hospitals and health care providers have the opportunity to implement strategies to ensure more consumers and staff are aware of consumer health care rights. Considerate service and compassionate care can go a long way to engaging consumers in their healthcare, making them feel comfortable so that they can communicate openly with their health care professionals, leading to safer care.

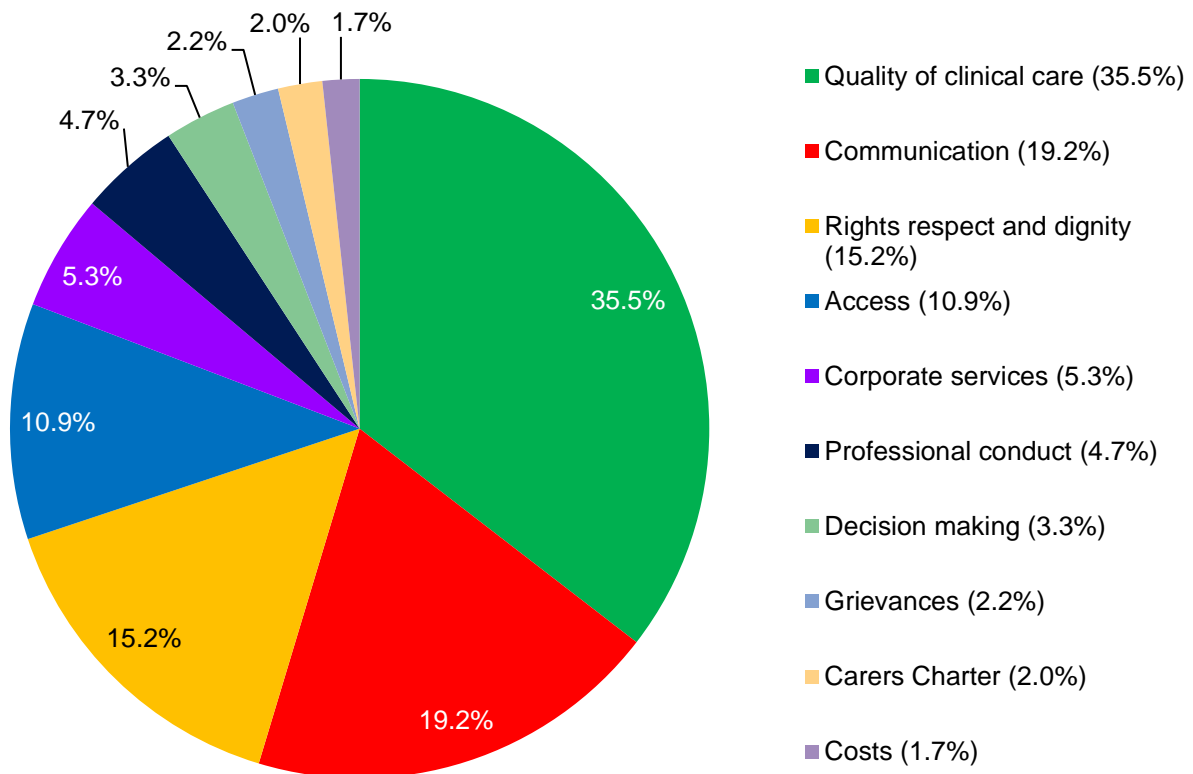


Mental Health Complaints

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

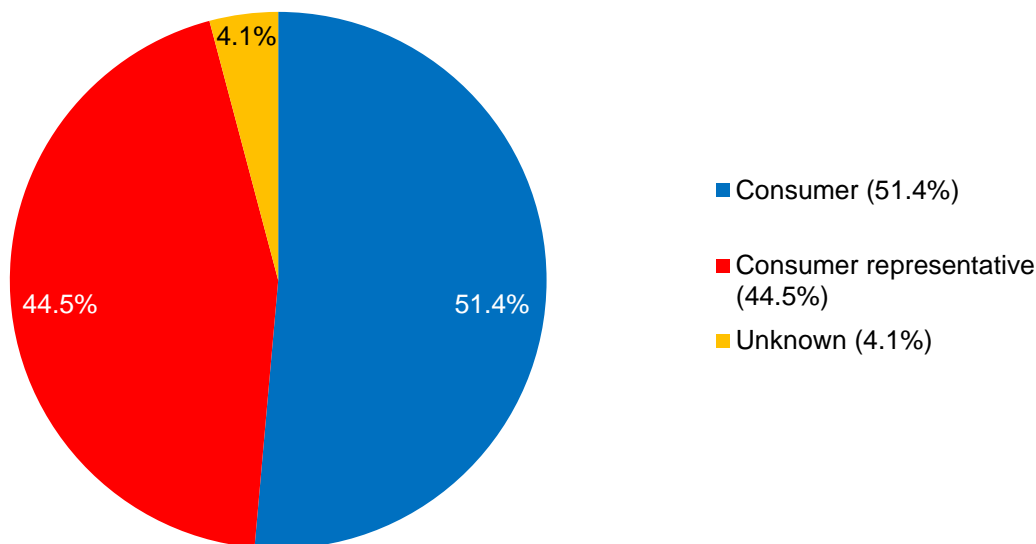
In 2018/19, there were 533 mental health complaints reported across the WA health system which identified 880 complaint issues. Figure 80 shows the distribution of these complaint issues in the two-level categorisation described in the *Health and Disability Services (Complaints) Regulations 2010*.

Figure 80: Issues Identified by Persons Reporting the Feedback in Mental Health Complaints Received by the WA Health System for 2018/19



In the WA health system in 2018/19, a greater proportion of mental health complaints were received from consumer representatives (44.5%; see Figure 81)⁶³ compared to all complaints (where 30.3% were received from consumer representatives; see Figure 72). The mental health services consumer population is vulnerable, and families, carers and advocacy groups play an important role in assisting some of these consumers to navigate the WA health system.

Figure 81: Person Reporting the Mental Health Feedback Item to the WA Health System for 2018/19



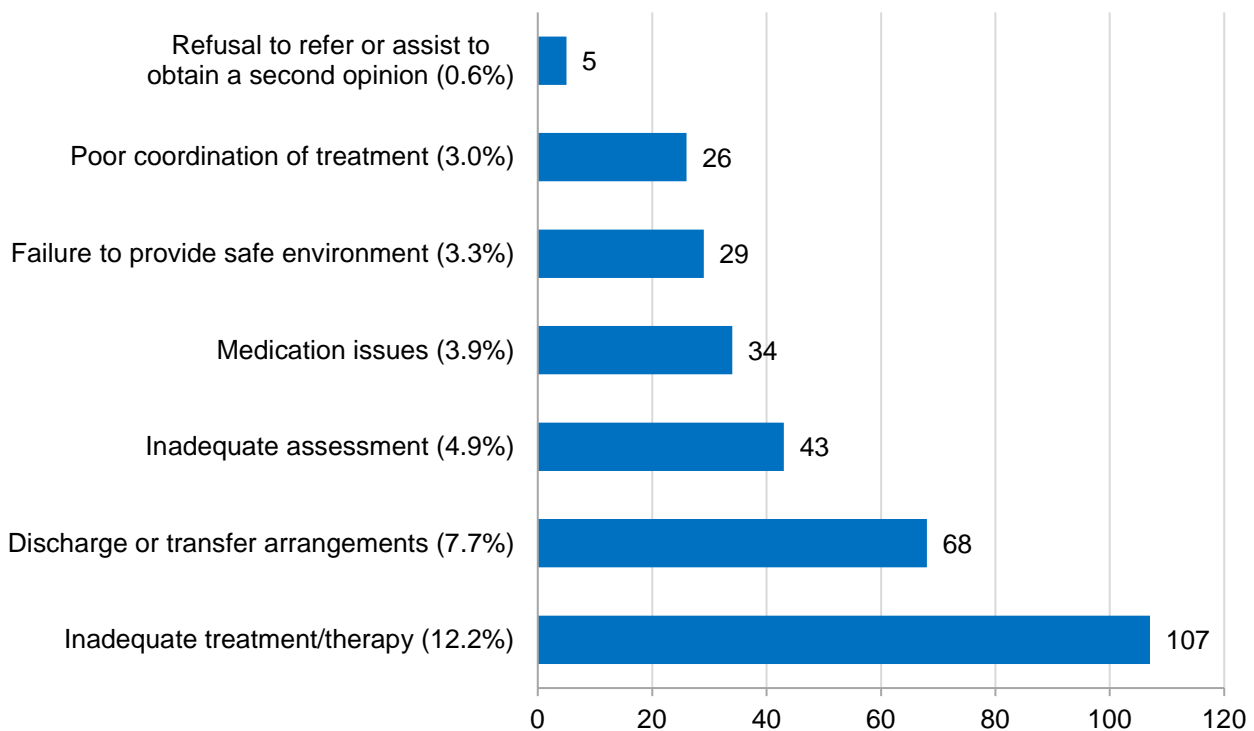
Mental Health Complaint Issues Relating to Quality of Clinical Care

In 2018/19, 312 mental health complaint issues surrounding the quality of clinical care were identified, accounting for 35.5% of all identified mental health complaint issues. As shown in Figure 82, the most frequently reported quality of clinical care issue was ‘Inadequate treatment/therapy’ (n=107; 12.2% of total mental health complaint issues) which included complaints about the standard of performance of a treatment or procedure, or an inadequate amount of therapy.

Complaint issues involving ‘Discharge or transfer arrangements’ constituted 7.7% of total mental health complaint issues (n=68) and included situations where discharge was considered premature, inadequately planned, unsuitable or delayed, or there was a lack of continuity of care or follow-up post discharge.

Consumers who made complaints in relation to ‘Inadequate assessment’ (n=43; 4.9% of total mental health complaint issues) were most frequently concerned that a condition was overlooked or wrongly identified, or that there was inadequate investigation of symptoms or level of diagnosis.

Figure 82: Frequency and Percentage of Mental Health Complaint Issues Relating to Quality of Clinical Care for 2018/19

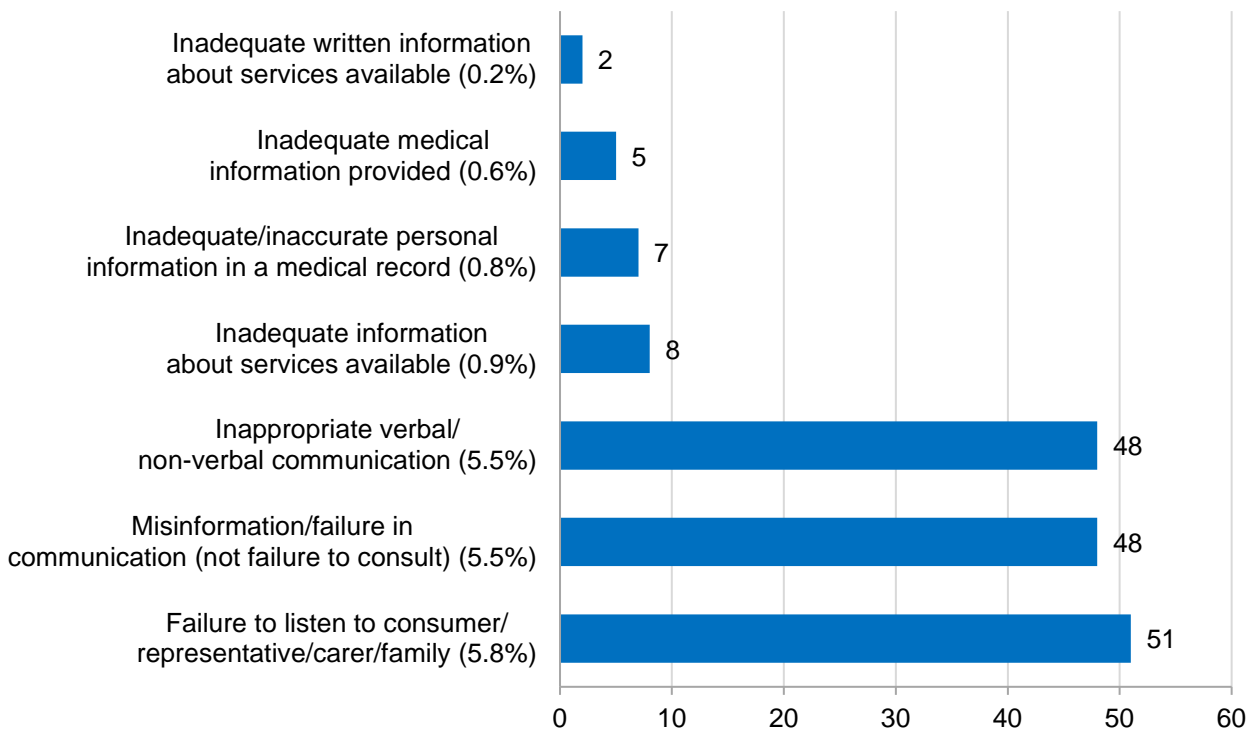


Mental Health Complaint Issues Relating to Communication

Issues related to communication comprised 19.2% (n=169) of total mental health complaint issues reported across the WA health system in 2018/19. Figure 83 shows the second level categorisation of these issues. The most commonly reported issue was 'Failure to listen to consumer, representative, carer, or family' (n=51) representing 5.8% of total mental health complaint issues and included situations where the consumer's attempts to communicate with a health care professional were dismissed.

There were 48 issues reported relating to both 'Misinformation or failure in communication (not failure to consult)' and 'Inappropriate verbal or non-verbal communication' (each 5.5% of total mental health complaint issues). The former category includes issues around delays in information, and being given confusing, conflicting, inaccurate, or wrong information, with the latter incorporating reports of careless comments or people speaking beyond their authority.

Figure 83: Frequency and Percentage of Mental Health Complaint Issues Relating to Communication for 2018/19

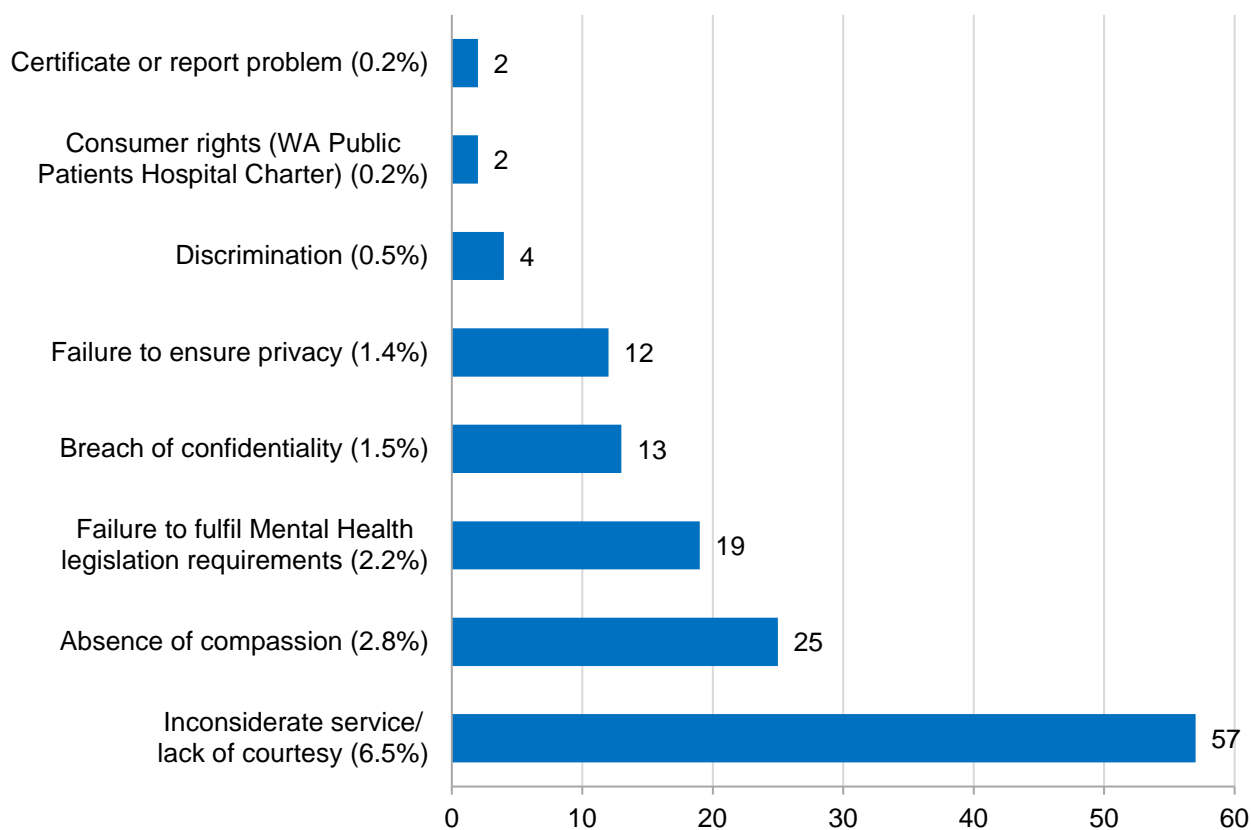


Mental Health Complaint Issues Relating to Rights, Respect and Dignity

A total of 134 complaint issues related to rights, respect and dignity were reported in mental health complaints in 2018/19, representing 15.2% of total mental health complaint issues. The mostly frequently reported issue was 'Inconsiderate service or lack of courtesy' which was reported on 57 occasions, constituting 6.5% of total mental health complaint issues (see Figure 84). These occasions included times where politeness or kindness were lacking, or staff were unhelpful, patronising, overbearing, negative, or displayed an ignoring attitude.

Situations where the consumer reported an absence of compassion occurred 25 times, representing 2.8% of total mental health complaint issues. Importantly, there were 19 issues identified that constituted a failure to fulfil the requirements of mental health legislation (2.2% of total mental health complaint issues). The majority of these issues were surrounding a failure to provide information about consumer rights under the *Mental Health Act 2014*. The *Charter of Mental Health Care Principles*⁶¹ outlines consumer rights under the *Mental Health Act 2014* and measures should be taken to ensure these rights are adhered to.

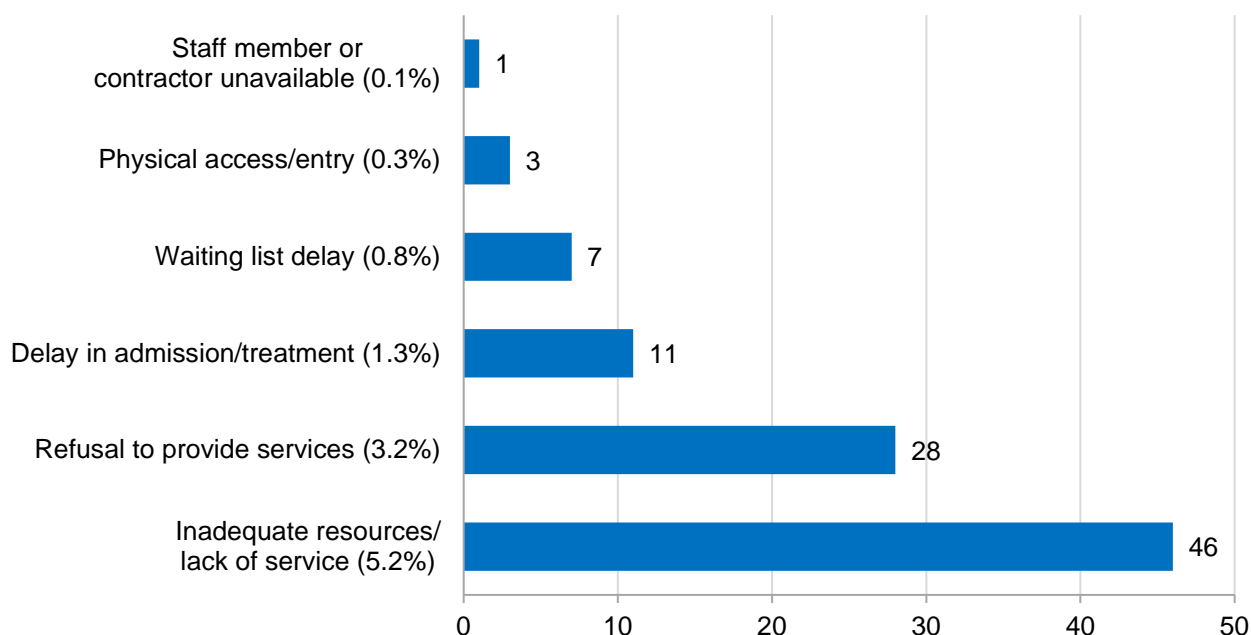
Figure 84: Frequency and Percentage of Mental Health Complaint Issues Relating to Rights, Respect and Dignity for 2018/19



Mental Health Complaint Issues Relating to Access

Mental health complaint issues related to access constituted 10.9% (n=96) of total mental health complaint issues reported in the WA health system in 2018/19. Figure 85 shows the most frequently reported access issue was 'Inadequate resources or lack of service' (n=46; 5.2% of total mental health complaint issues), followed by 'Refusal to provide services' (n=28; 3.2%) and 'Delay in admission or treatment' (n=11; 1.3%) which related mostly to delays when the client was already at the point of service.

Figure 85: Frequency and Percentage of Mental Health Complaint Issues Relating to Access for 2018/19



Key Messages and Information: Mental Health Complaints

While some quality improvement initiatives that stem from the broader complaint dataset will likely also lead to improvements in mental health services, dedicated mental health service quality improvement initiatives stemming from analysis of mental health complaint data are also vital. Focusing on mental health complaints as a subset of all complaints provides a means to assess how well services are meeting the specific needs of mental health consumers and identify the gaps in service where quality improvement initiatives would be of benefit.

There are similarities to total complaint issues in the complaint issues reported in the mental health subset, with the top four most frequently reported complaint issue categories the same. However, the ranking of frequencies does differ, with complaint issues relating to rights, respect and dignity constituting a larger proportion of mental health complaints than complaint issues relating to access.

At the second level of complaint issue categorisation, the communication issue of 'failure to listen to consumer, representative, carer or family' ranks as a higher concern for mental health consumers. The *Charter of Mental Health Care Principles*⁶¹ outlines the importance of planning that includes families and carers, and of recognising mental health consumers' life experiences, needs, preferences, aspirations, values and skills. These details can only be obtained through listening to the consumer.

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 2018/19. 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 Dashboards⁶⁸ were released in May 2019 and replace the Clinical Incident Management and Complaints Quarterly Reports. The Patient Safety Dashboards is a web application which includes three dashboards displaying metrics based on data from the Datix Clinical Incident Management System and Consumer Feedback Module. 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.
- Developed to complement the Patient Safety Dashboards (and previous quarterly reports) the Clinical Incident Check Up Reports⁶⁹ 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 2018/19, state-wide Clinical Incident Check Up Reports were released covering:
 - Blood and blood products
 - Texture-modified diets
 - Venous thromboembolism
 - Objects we left behind (retained foreign objects)
- The fifth in the series of 'Closing the Loop' (CLP) audit reports was completed in June 2019, reviewing clinical incident investigation and evaluation reports submitted in 2018. While findings suggest there has been some improvement in CLP, this report focuses on reviewing new initiatives to assist HSPs in maturing their CLP processes.⁷⁰
- The Coronial Review Committee members discussed 40 inquest findings in 2018/19. This included inquests with 30 health related recommendations and some inquest findings where no recommendations were made. Members 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 Coronial Review Committee agreed to publish the Executive Summary of this report on the Coronial Liaison internet page.⁷¹ In addition to this, the full progress report was published online for the first time on the PSSU intranet page.⁷² The

⁶⁸ The Patient Safety Dashboards are available to WA health system staff at: <http://patientsafetydashboards/>

⁶⁹ 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>

⁷⁰ Closing the Loop audit 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>

⁷¹ 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

⁷² 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>

PSSU supports the sharing of lessons learnt and quality improvement initiatives across the WA health system.

- *From Death We Learn 2017 (2018 Edition)*⁷³ was released in October 2018. 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 second year of reporting sentinel events, and the first year of reporting hospital-acquired complications to the IHPA.
- Participation in the approval process for version 2 of the Australian sentinel events list which was completed in December 2018.
- Revision of the *Clinical Incident Management Policy* and *Clinical Incident Management Toolkit* commenced in 2018, with consultation taking place in May 2019. The revised CIM Policy, Guideline and Toolkit took effect in November 2019. The revisions align this policy with the *Health Services Act 2016* and provide clearer and easier to use resources to implement effective clinical incident management in the WA health system.
- The State Datix Committee updated the notifier form for medication clinical incidents in the Datix CIMS in September 2018. The notifier form was redesigned to be more user friendly with clearer help text when reporting a medication clinical incident. A medication safety guidance document was also released to assist staff using the Datix CIMS in choosing the correct type of medication incident.
- Other Datix CIMS enhancements included an extensive review of the classification system to allow incident reporting aligned with the second edition of the NSQHS Standards, and continuing work to scope out integration with the statewide medicines formulary to deliver an improved medication list for medication clinical incidents.
- A suite of data quality reports was developed in the Datix CIMS in December 2018 focusing on the areas of highest risk for data accuracy and completeness that were identified by a data quality assessment undertaken in 2017. These reports allow HSPs and the PSSU to review CIMS data at a field level to identify the highest areas of risk, and to develop remediation strategies, in line with the duties of the data custodian.
- The updated *Review of Death Policy* took effect in the WA health system from January 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).
- Revision of the *WA Health Complaints Management Policy* commenced in 2019, with consultation taking place in June 2019. A revised Complaints Management Policy is anticipated to take effect in early-2020 and will reflect best-practice for complaint management and recognise the changes to the structure of the WA health system that have occurred since this policy was last reviewed.

⁷³ From Death We Learn is available at: <http://ww2.health.wa.gov.au/Reports-and-publications/From-Death-We-Learn>

Future Focus

Having commenced in 2017, the Sustainable Health Review's Final Report⁶⁶ was published in April 2019. The final report has eight Enduring Strategies and 30 recommendations which seek to drive a cultural and behavioural shift across the WA health system. The Enduring Strategies were developed following extensive engagement with stakeholders in metropolitan and country areas and are informed by evidence and best-practice.

Many of the Enduring Strategies and recommendations seek to further improve the safety and quality of the WA health system in a manner that will be sustainable well into the future. Implementation of the recommendations arising from the SHR is being undertaken in a structured and collaborative approach between the Department of Health and Health Service Providers and will be a key focus for the WA health system for the foreseeable future.

The second edition of the National Safety and Quality Health Service Standards⁵⁹ commenced operation in WA in January 2019 and is applicable to all hospitals, day procedure services and most public community and dental health services. The second edition of the NSQHS Standards maintains the focus on risk, monitoring, quality improvement, training and performance management from the first edition, and explicitly recognises the importance of leadership and culture in establishing an effective system of clinical governance.

As HSPs and private health care providers work towards accreditation or re-accreditation of their health care facilities and service delivery against the second edition of the NSQHS Standards a key focus should be on delivering health care systems that meet these requirements 24 hours a day, seven days a week.

The series of Closing the Loop audits conducted since 2013 have assisted the Patient Safety Surveillance Unit in monitoring how HSPs have fared in meeting CLP requirements. The latest report has shown that while there has been some improvement in understanding the development of recommendations, there is still a heavy reliance on people-focused actions. Other initiatives, training and education are required to mature this workspace and assist HSPs in developing strong actions in response to clinical incidents that will lead to sustainable improvements in the safety and quality of care and reduce avoidable harm to our patients.

Linked to the work on the Patient Safety Dashboards, the PSSU will continue to review how it is best placed to effectively monitor the increasing number of SAC 1 clinical incidents that are reported each year across the WA health system. This monitoring is vital to the Director General of the Department of Health as the manager of the WA health system and ensures consistency in the investigation of serious clinical incidents that occur in WA.

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.³

The PSSU has planned a full review of the implementation of the Datix CFM, incorporating complaint management and consumer feedback processes, which is planned to commence in late-2019. The Datix CFM was implemented in WA's public health system in January 2015 and has seen varied application across HSPs. The review will aim to improve the consistency of consumer feedback recording and use of the Datix CFM as a management system, strengthen

system-wide business rules, and where desirable and possible, make enhancements to the configuration of the Datix CFM.

A further way the WA health system is committed to improving patient safety is reducing the risk of patients acquiring healthcare-associated infections. This is evident in the Department of Health's investment in an Infection Prevention and Control system which is currently in pilot phase, with roll out across the WA health system due for completion during 2020.

This system will enable 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 will also allow the WA health system to capture valid and reliable data on HAIs that are currently not under surveillance and identify further areas where improvements in patient safety and clinical outcomes can be made.

In 2019, the Department of Health's *Clinical Incident Management Policy* and *Complaints Management Policy* underwent review and revision, including extensive stakeholder consultation. The revised *Clinical Incident Management Policy* took effect in November 2019 and the revised *Complaints Management Policy* is planned to take effect in early-2020. The PSSU will continue to support the implementation of these revised policies by HSPs, private health care providers and non-government organisations moving forwards.

The first reporting about mortality review processes under the requirements of the revised *Review of Death Policy* will occur in late-2019. While the revised policy requires HSPs, private health care providers and NGOs to review patient deaths to identify opportunities for improvement in the delivery of health services as well as potentially preventable deaths, the enhanced reporting requirements should better enable the PSSU to confirm that all deaths within a health care facility have been reviewed in a timely and appropriate manner.



Appendix One: Longitudinal Review of Five-Year Clinical Incident Data

The Datix CIMS has been in use in the WA health system since February 2014, meaning there is now more than five years of accumulated clinical incident data. The following longitudinal review looks at confirmed clinical incident data over the five-year period from July 2014 to June 2019 for WA's five main Health Service Providers.

This review includes both the overall reporting of clinical incidents, SAC 1 clinical incidents, and incidents related to the first edition of the NSQHS standards. The second edition of the NSQHS standards commenced use in January 2019 and reporting of incidents relating to the NSQHS Standards will be revised in future editions of this report to align with the second edition.

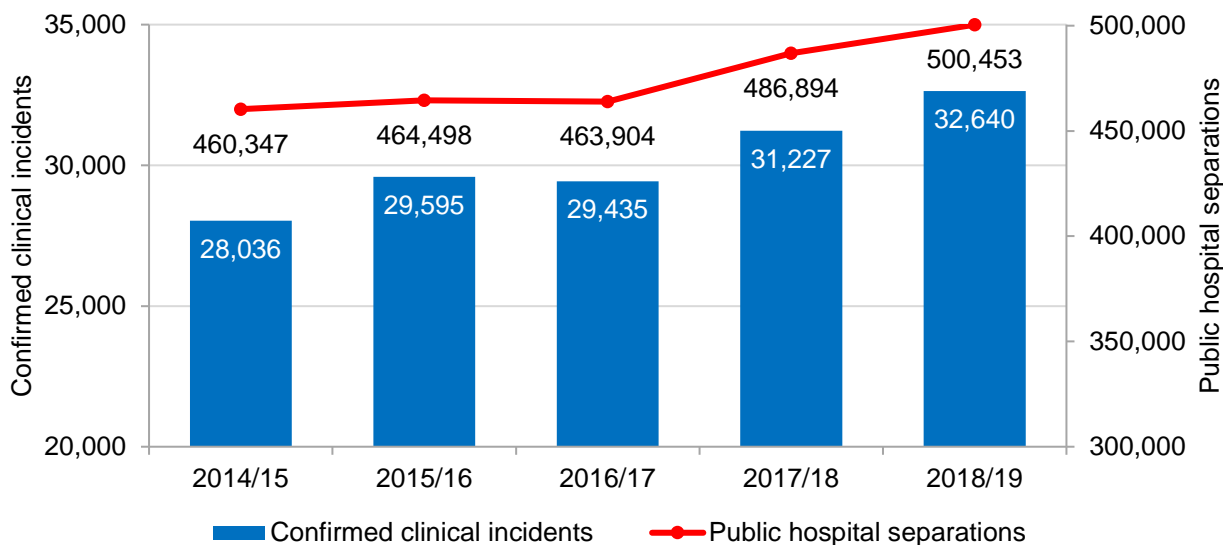
When considering the data that follows, it should be noted that a high level of incident reporting, coupled with a low or decreasing level of harm to patients, may indicate a strong patient safety culture within a healthcare system.



Overall Clinical Incident Notifications

The number of confirmed clinical incidents reported by HSPs increased from 28,036 in 2014/15 to 32,640 in 2018/19. Figure 86 shows that this is in line with increasing activity within the public hospital system, which has increased from 460,347 separations in 2014/15 to 500,453 separations in 2018/19.

Figure 86: Frequency of Confirmed Clinical Incidents and Activity (Separations) Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 1,450 clinical incidents awaiting confirmation, with 1,419 of these incidents notified during 2018/19

Most confirmed incidents reported by HSPs were categorised as SAC 3 (n=133,358; 88.4%). Clinical incidents confirmed as SAC 2 (n=15,600; 10.3%) were the next most frequent, followed by SAC 1 (n=1,975; 1.3%; see Table 29).

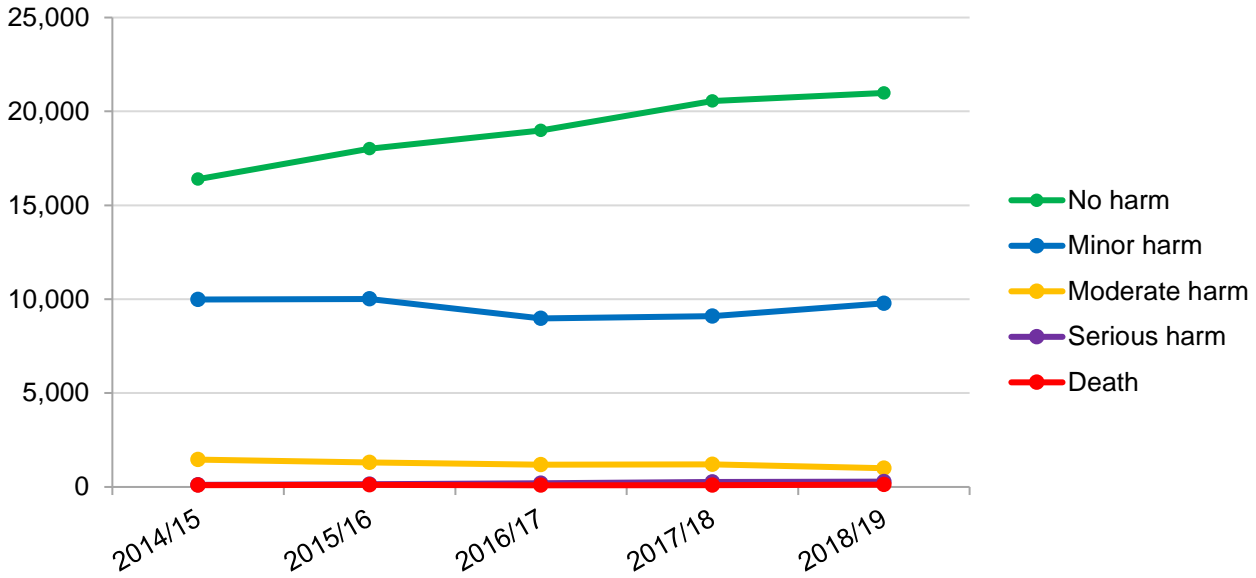
Table 29: Frequency of Confirmed Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

Year	SAC 1	SAC 2	SAC 3	Total
2014/15	290	2,878	24,868	28,036
2015/16	332	2,994	26,269	29,595
2016/17	369	2,960	26,106	29,435
2017/18	471	3,044	27,712	31,227
2018/19	513	3,724	28,403	32,640
Total	1,975	15,600	133,358	150,933

Note: As of 7 July 2019, there were 1,450 clinical incidents awaiting confirmation, with 1,419 of these incidents notified during 2018/19

While there has been an increase in clinical incident reporting by HSPs observed over this period, the level of harm associated with clinical incidents has remained relatively stable, with most of the increased reporting being incidents that resulted in no harm to the patient (see Figure 87).

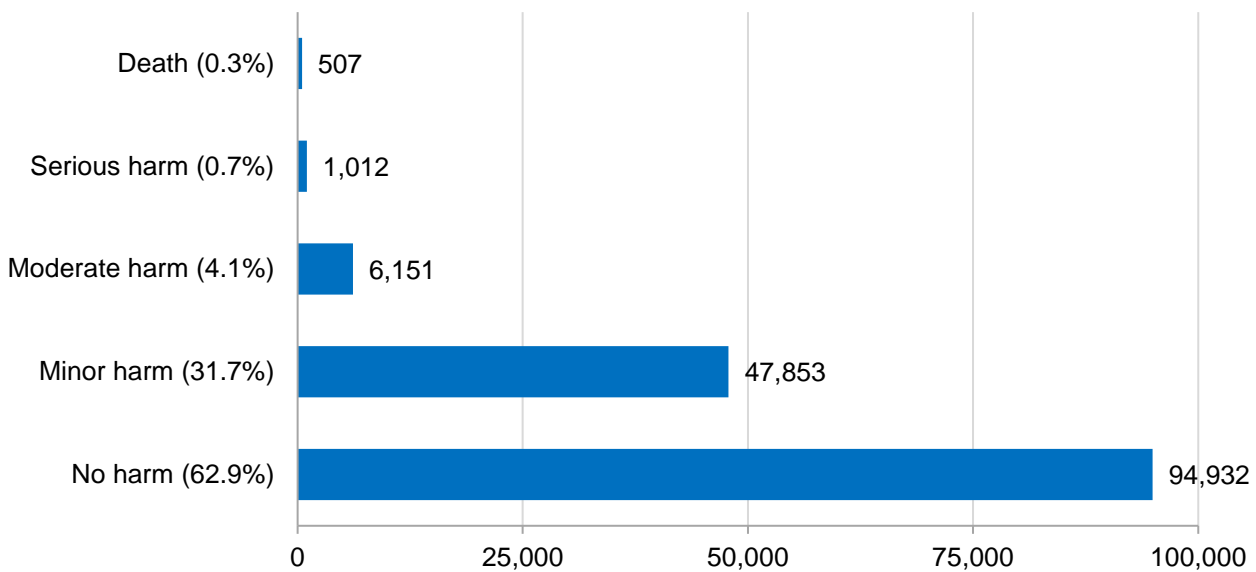
Figure 87: Frequency of Confirmed Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=478; 0.3%

The majority of confirmed clinical incidents reported by HSPs between July 2014 and June 2019 described a patient outcome of no harm (n=94,932; 62.9%). A patient outcome of death was described in 0.3% of confirmed incidents (n=507) over this time (see Figure 88).

Figure 88: Frequency and Percentage of Confirmed Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019

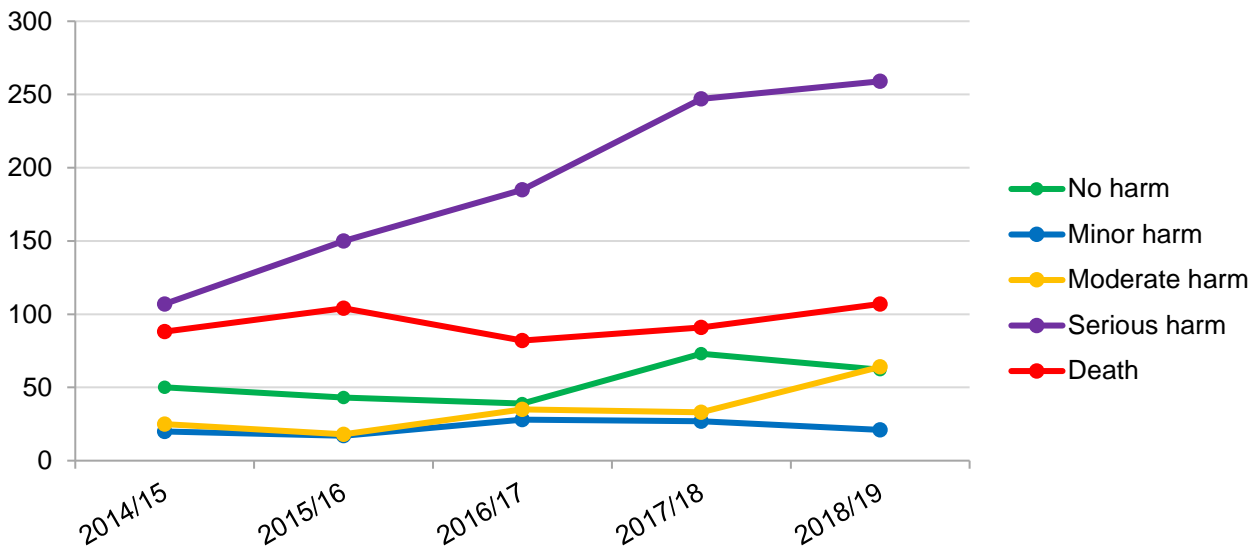


Note: Patient outcome missing data n=478; 0.3%

SAC 1 Clinical Incidents

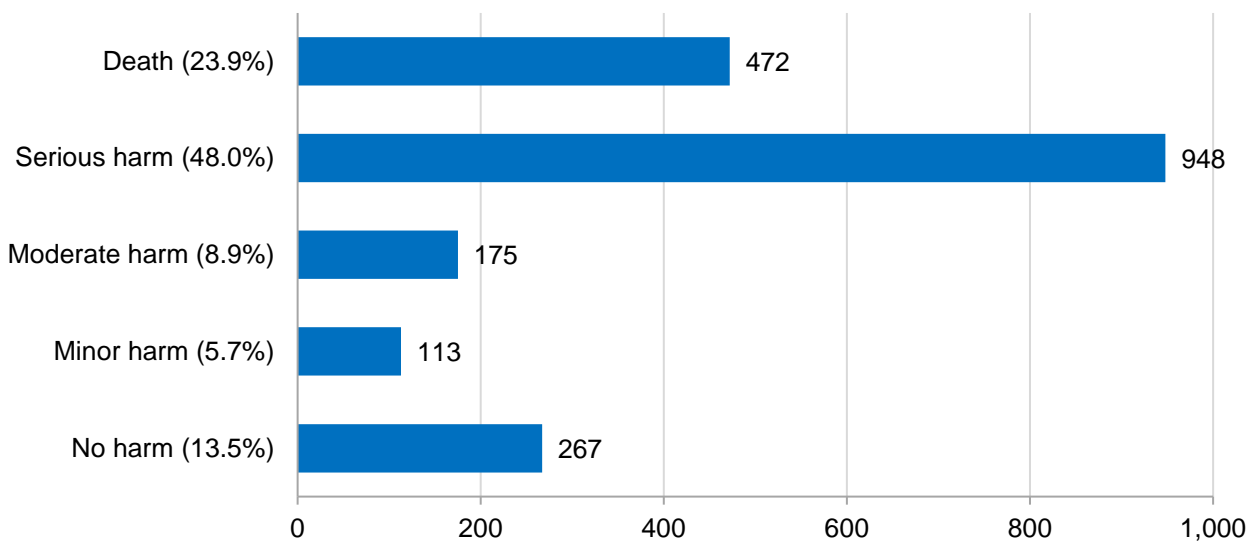
Figure 89 shows the patient outcome described for confirmed SAC 1 clinical incidents reported by HSPs from July 2014 to June 2019. Most of the increase in reporting of SAC 1 incidents over this time related to incidents describing the outcome for the patient as serious harm, with a modest increase in incidents resulting in moderate harm also observed. The number of clinical incidents reported by HSPs describing a patient outcome of death remained relatively stable over this time.

Figure 89: Frequency of Confirmed SAC 1 Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



The majority of confirmed clinical incidents reported by HSPs between July 2014 and June 2019 described a patient outcome of serious harm (n=948; 48.0%) or death (n=472; 23.9%). Of the 1,975 incidents confirmed as SAC 1 by HSPs over this time, 13.5% (n=267) were near misses that resulted in no harm to the patient (see Figure 90).

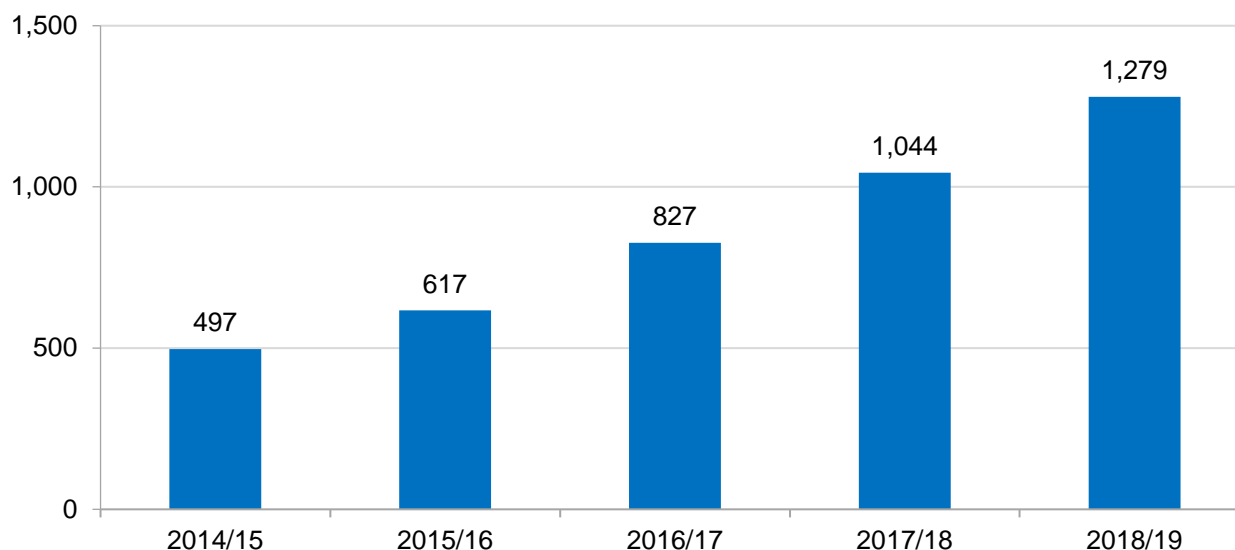
Figure 90: Frequency and Percentage of Confirmed SAC 1 Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019



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

The number of confirmed clinical incidents reported by HSPs related to healthcare-associated infections increased from 497 in 2014/15 to 1,279 in 2018/19 (see Figure 91). This increase in reporting may be related in part to increasing recognition within the WA public health system that HAIs are often preventable events, rather than inevitable complications of medical care.

Figure 91: Frequency of Confirmed HAI Clinical Incidents Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 62 preventing and controlling HAI clinical incidents awaiting confirmation, which were all notified during 2018/19

Clinical incidents related to HAIs accounted for 2.8% (n=4,264) of all confirmed clinical incidents reported by HSPs from July 2014 to June 2019. Most confirmed clinical incidents reported by HSPs that related to HAIs were categorised as SAC 3 (n=3,503; 82.2%; see Table 30).

The increased reporting of SAC 1 incidents over this period may be due in part to increasing recognition that some types of healthcare-associated *Staphylococcus aureus* bloodstream infections are largely preventable.¹⁸

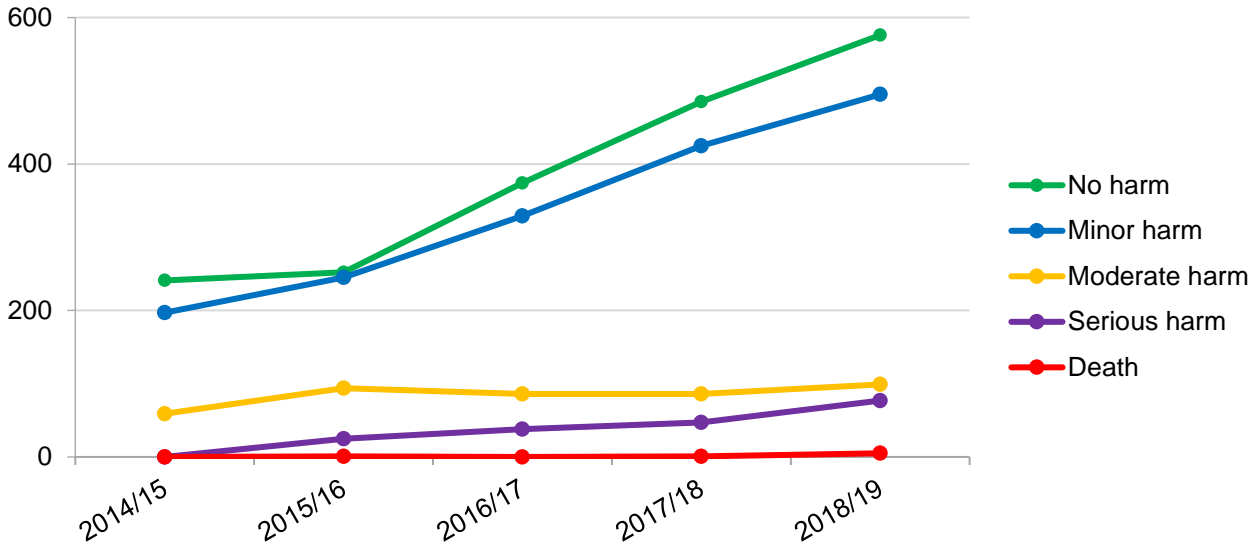
Table 30: Frequency of Confirmed HAI Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

Year	SAC 1	SAC 2	SAC 3	Total
2014/15	5	63	429	497
2015/16	36	102	479	617
2016/17	54	111	662	827
2017/18	61	120	863	1,044
2018/19	104	105	1,070	1,279
Total	260	501	3,503	4,264

Note: As of 7 July 2019, there were 62 preventing and controlling HAI clinical incidents awaiting confirmation, which were all notified during 2018/19

Most of the increased reporting of clinical incidents related to HAIs seen across this period can be attributed to incidents that resulted in no harm or minor harm to the patient. A modest increase in the reporting of incidents related to HAIs leading to serious harm was also observed (see Figure 92).

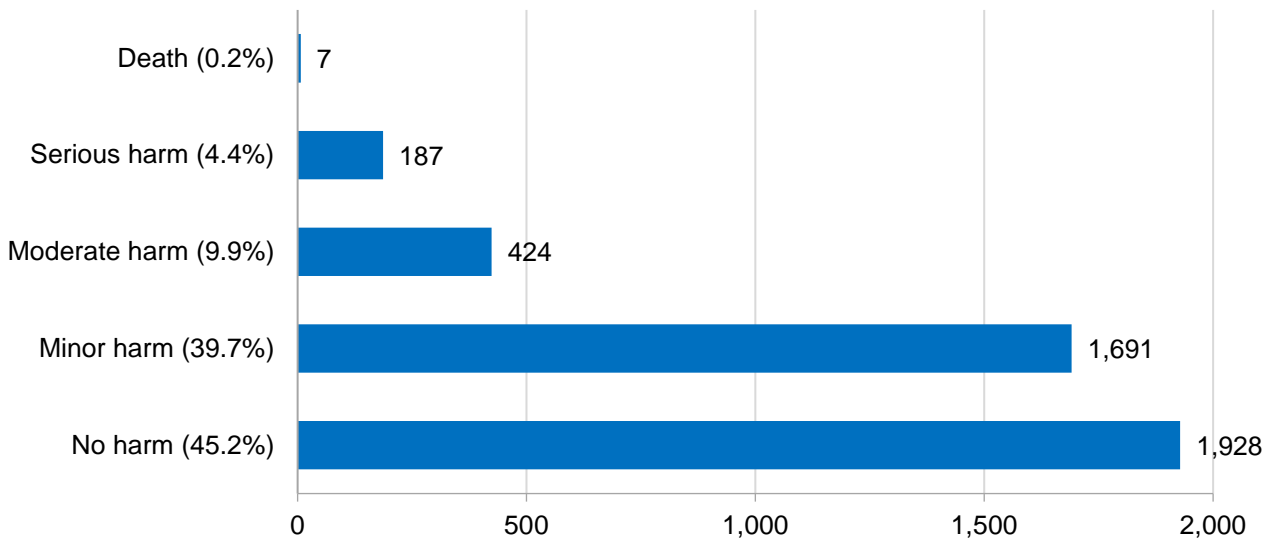
Figure 92: Frequency of Confirmed HAI Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=27; 0.6%

The majority of confirmed clinical incidents related to HAIs reported by HSPs between July 2014 and June 2019 described a patient outcome of no harm (n=1,928; 45.2%) or minor harm (n=1,691; 39.7%; see Figure 93). A patient outcome of death was described in seven confirmed clinical incidents related to HAIs over this time.

Figure 93: Frequency of Confirmed HAI Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019

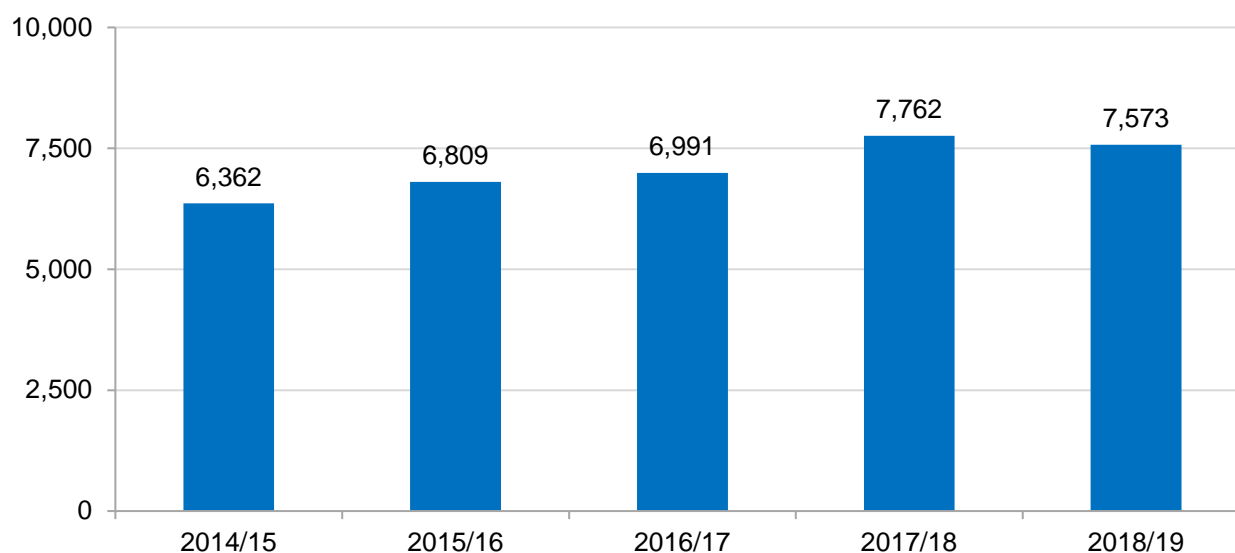


Note: Patient outcome missing data n=27; 0.6%

Standard 4: Medication Clinical Incidents

The number of confirmed medication clinical incidents reported by HSPs increased from 6,362 in 2014/15 to 7,573 in 2018/19 (see Figure 94). As incidents notified during 2018/19 that are awaiting confirmation at the time of this report are reviewed, it is likely that this figure will increase and confirm a gradual increasing trend in the reporting of medication clinical incidents over this period.

Figure 94: Frequency of Confirmed Medication Clinical Incidents Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 359 medication clinical incidents awaiting confirmation, with 345 of these incidents notified during 2018/19

Medication incidents accounted for 23.5% (n=35,497) of all confirmed clinical incidents reported by HSPs from July 2014 to June 2019. The majority of confirmed medication incidents reported by HSPs were categorised as SAC 3 (n=33,682; 94.9%), and these also accounted for most of the increase in reporting of medication incidents observed over this period (see Table 31).

The reporting of SAC 1 and SAC 2 medication clinical incidents by HSPs has remained relatively stable, with SAC 2 incidents accounting for 4.7% (n=1,682) and SAC 1 incidents accounting for 0.4% (n=133) of confirmed medication incidents over this time.

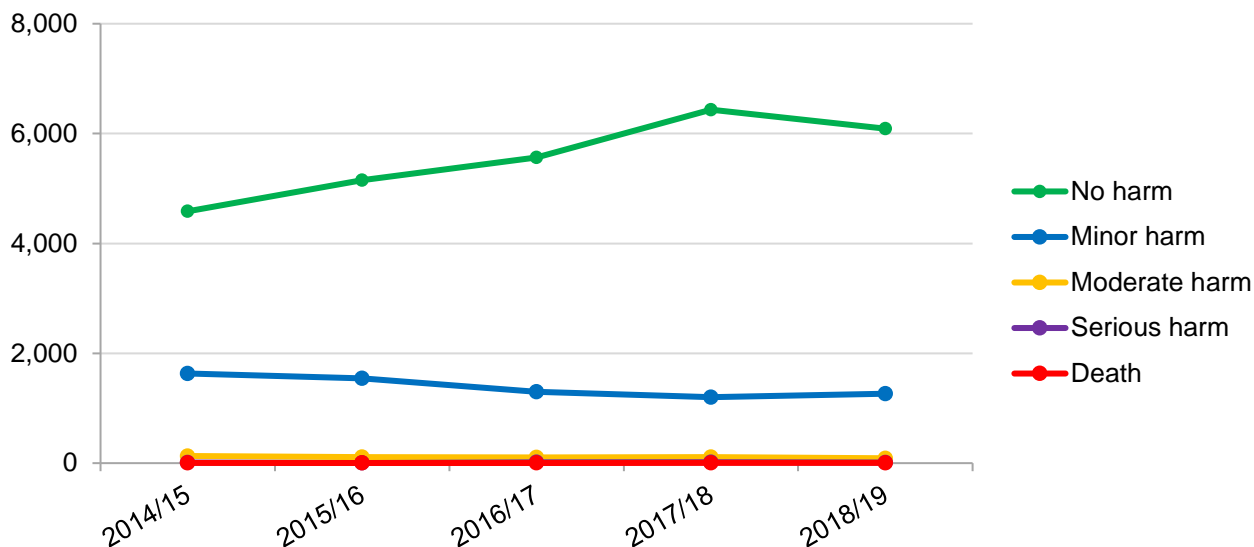
Table 31: Frequency of Confirmed Medication Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

Year	SAC 1	SAC 2	SAC 3	Total
2014/15	27	280	6,055	6,362
2015/16	16	380	6,413	6,809
2016/17	27	386	6,578	6,991
2017/18	30	327	7,405	7,762
2018/19	33	309	7,231	7,573
Total	133	1,682	33,682	35,497

Note: As of 7 July 2019, there were 359 medication clinical incidents awaiting confirmation, with 345 of these incidents notified during 2018/19

Most of the increased reporting of medication clinical incidents seen across this period related to incidents that resulted in no harm to the patient (see Figure 95). A small decline in the number of medication incidents reported by HSPs resulting in minor harm was also observed.

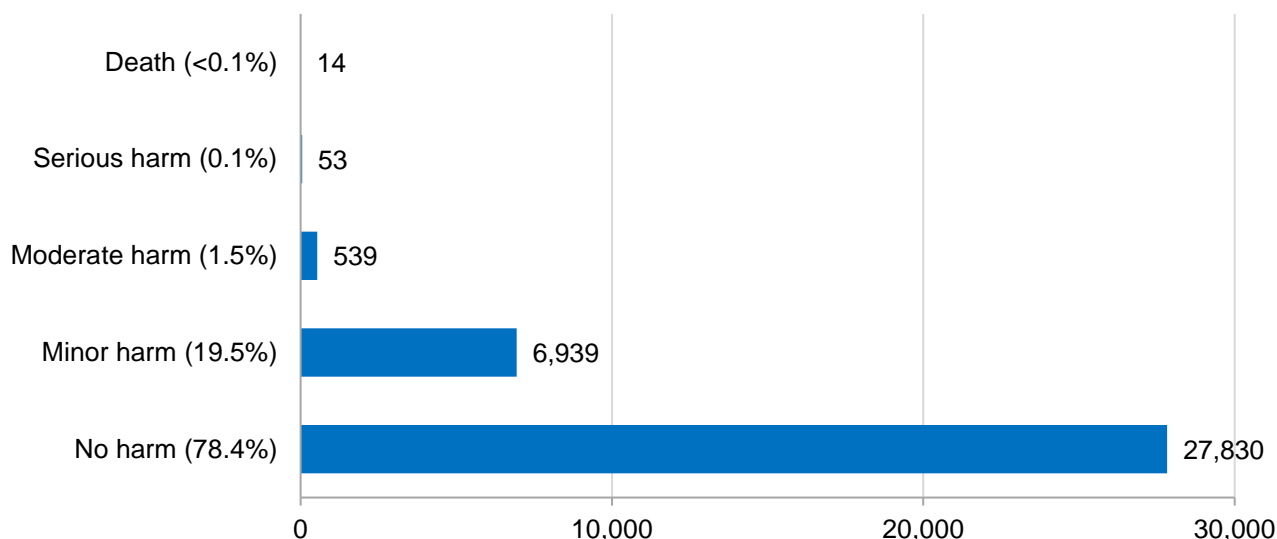
Figure 95: Frequency of Confirmed Medication Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=122; 0.3%

Most confirmed medication clinical incidents reported by HSPs between July 2014 and June 2019 described a patient outcome of no harm (n=27,830; 78.4%) or minor harm (n=6,939; 19.5%; see Figure 96). A patient outcome of death was described in 14 confirmed medication incidents reported by HSPs over this time. Of the 133 medication clinical incidents categorised as SAC 1 by HSPs, 28.6% (n=38) were near misses that resulted in no harm to the patient.

Figure 96: Frequency of Confirmed Medication Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019

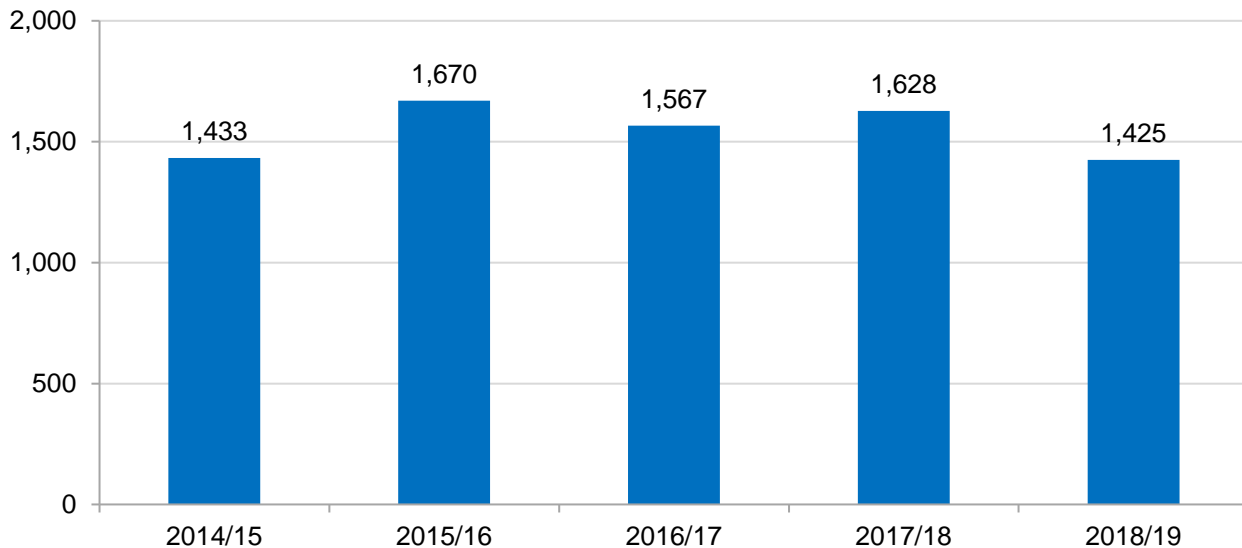


Note: Patient outcome missing data n=122; 0.3%

Standard 5: Patient Identification Clinical Incidents

The number of confirmed patient identification clinical incidents reported by HSPs has remained relatively stable from 2014/15 to 2018/19, with the highest frequency of these incidents seen in 2015/16 (n=1,670; see Figure 97).

Figure 97: Frequency of Confirmed Patient Identification Clinical Incidents Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 102 patient identification clinical incidents awaiting confirmation, which were all notified during 2018/19

Patient identification incidents accounted for 5.1% (n=7,723) of all confirmed clinical incidents reported by HSPs from July 2014 to June 2019. Most confirmed patient identification incidents were categorised as SAC 3 (n=7,286; 94.3%; see Table 32).

Patient identification clinical incidents confirmed as SAC 2 (n=365; 4.7%) were the next most frequent, followed by SAC 1 (n=72; 0.9%). The frequency of SAC 1 and SAC 2 patient identification clinical incidents has been relatively consistent over this period, with most of the annual fluctuation attributable to the number of SAC 3 incidents reported by HSPs.

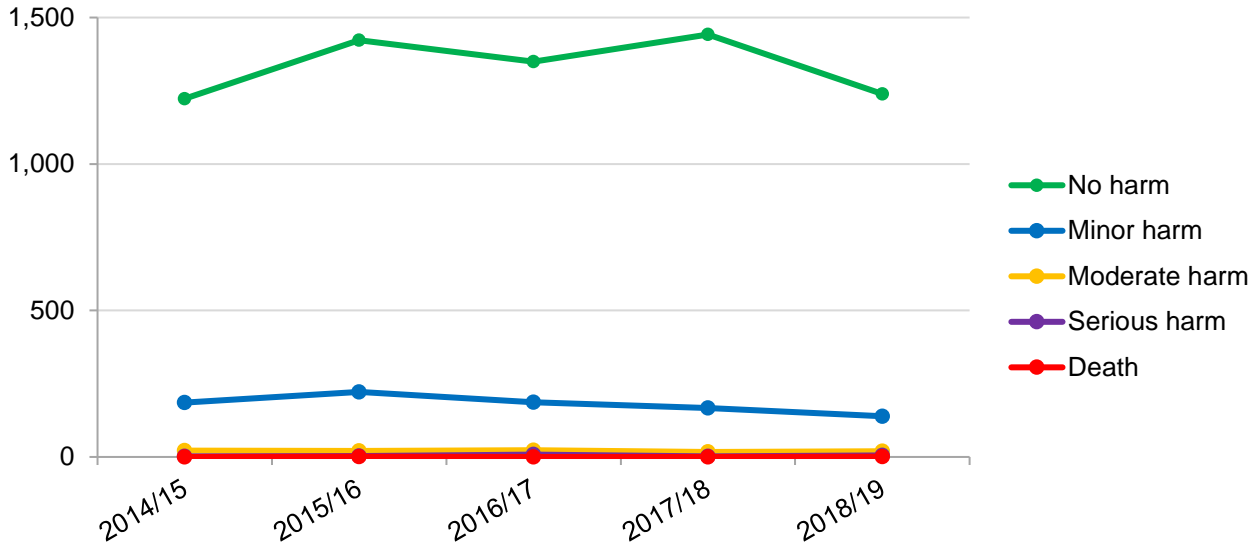
Table 32: Frequency of Confirmed Patient Identification Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

Year	SAC 1	SAC 2	SAC 3	Total
2014/15	12	47	1,374	1,433
2015/16	18	100	1,552	1,670
2016/17	19	72	1,476	1,567
2017/18	9	72	1,547	1,628
2018/19	14	74	1,337	1,425
Total	72	365	7,286	7,723

Note: As of 7 July 2019, there were 102 patient identification clinical incidents awaiting confirmation, which were all notified during 2018/19

Correspondingly, Figure 98 shows that most of the annual fluctuation in the frequency of patient identification clinical incidents in HSPs is attributable to the number of incidents reported that resulted in no harm to the patient. A slight decline in the number of patient identification incidents resulting in minor harm can be seen from 2014/15 to 2018/19.

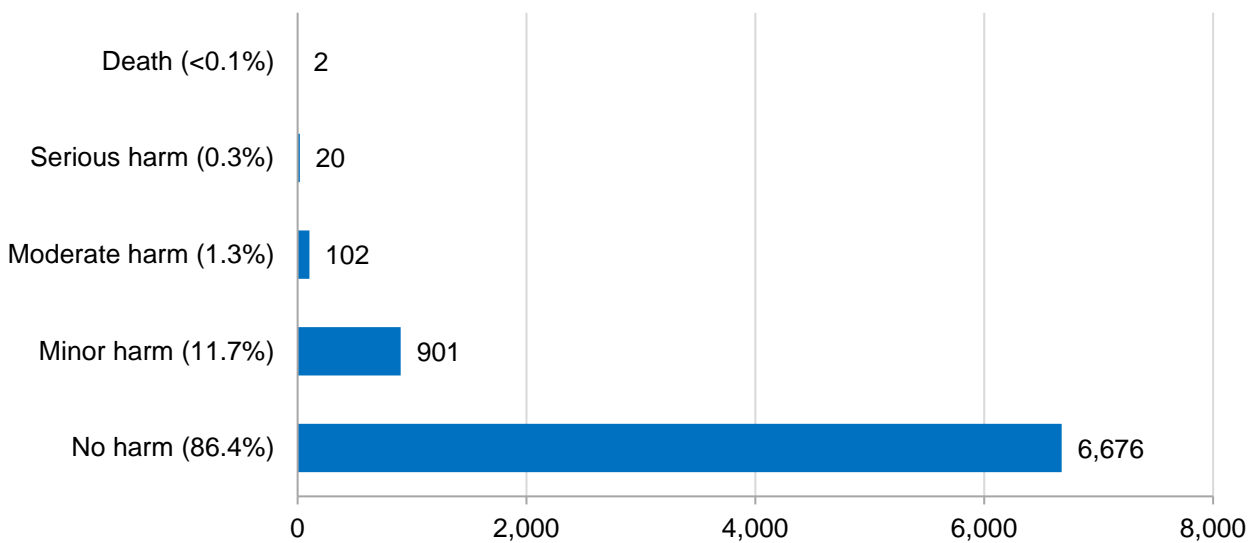
Figure 98: Frequency of Confirmed Patient Identification Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=22; 0.3%

Most confirmed patient identification incidents reported by HSPs between July 2014 and June 2019 described a patient outcome of no harm (n=6,676; 86.4%) or minor harm (n=901; 11.7%). A patient outcome of death was described in two patient identification incidents over this time (see Figure 99). Half of all patient identification clinical incidents categorised as SAC 1 by HSPs were near misses that resulted in no harm to the patient (n=36).

Figure 99: Frequency of Confirmed Patient Identification Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019

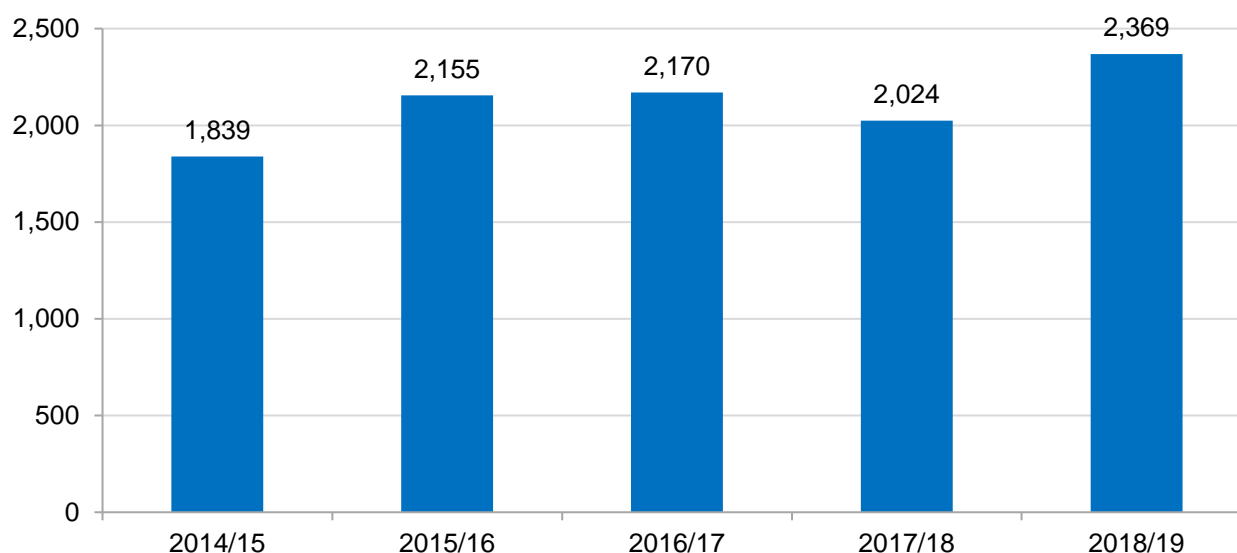


Note: Patient outcome missing data n=22; 0.3%

Standard 6: Clinical Handover Clinical Incidents

The number of confirmed clinical handover clinical incidents reported by HSPs increased from 1,839 in 2014/15 to 2,369 in 2018/19 (see Figure 100). While a decrease in the number of clinical handover incidents reported by HSPs was seen in 2017/18, the increasing trend seen in earlier years returned in 2018/19.

Figure 100: Frequency of Confirmed Clinical Handover Clinical Incidents Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 139 clinical handover clinical incidents awaiting confirmation, with 132 of these incidents notified during 2018/19

Clinical handover incidents accounted for 7.0% (n=10,557) of all confirmed clinical incidents reported by HSPs from July 2014 to June 2019. Most confirmed clinical handover incidents reported by HSPs were categorised as SAC 3 (n=10,068; 95.4%; see Table 33)

Clinical incidents confirmed as SAC 2 (n=454; 4.3%) were the next most frequent, followed by SAC 1 (n=35; 0.3%). Most of the increase in reporting of clinical handover clinical incidents by HSPs seen over this period is related to incidents categorised as SAC 3.

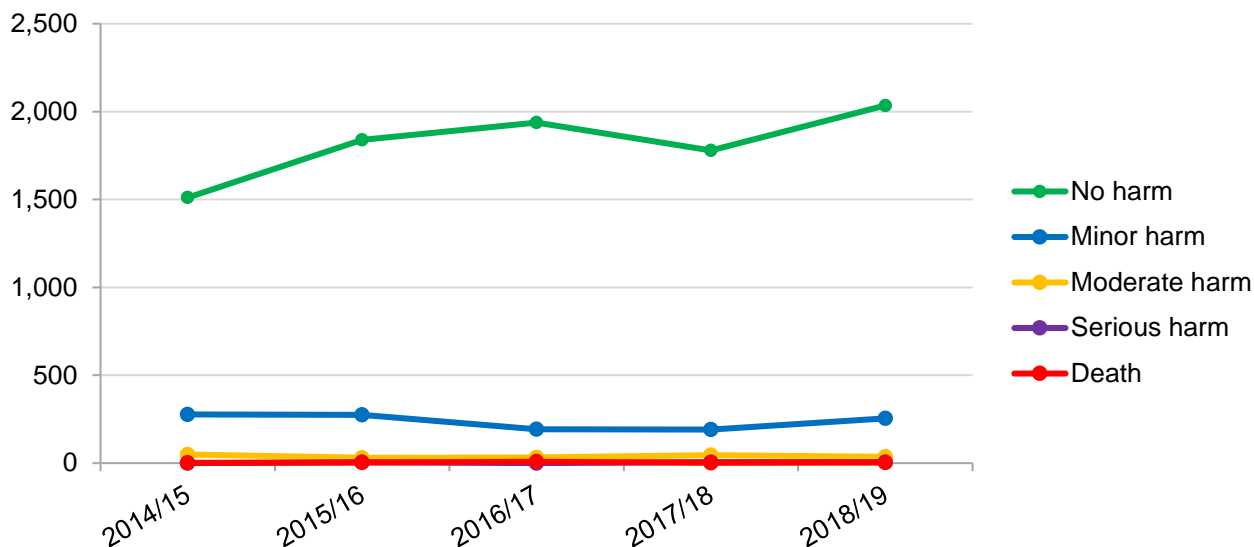
Table 33: Frequency of Confirmed Clinical Handover Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

Year	SAC 1	SAC 2	SAC 3	Total
2014/15	3	81	1,755	1,839
2015/16	9	83	2,063	2,155
2016/17	7	79	2,084	2,170
2017/18	9	104	1,911	2,024
2018/19	7	107	2,255	2,369
Total	35	454	10,068	10,557

Note: As of 7 July 2019, there were 139 clinical handover clinical incidents awaiting confirmation, with 132 of these incidents notified during 2018/19

Correspondingly, Figure 101 shows that most of the increased reporting of clinical handover clinical incidents in HSPs from July 2014 to June 2019 is attributable to incidents that resulted in no harm to the patient.

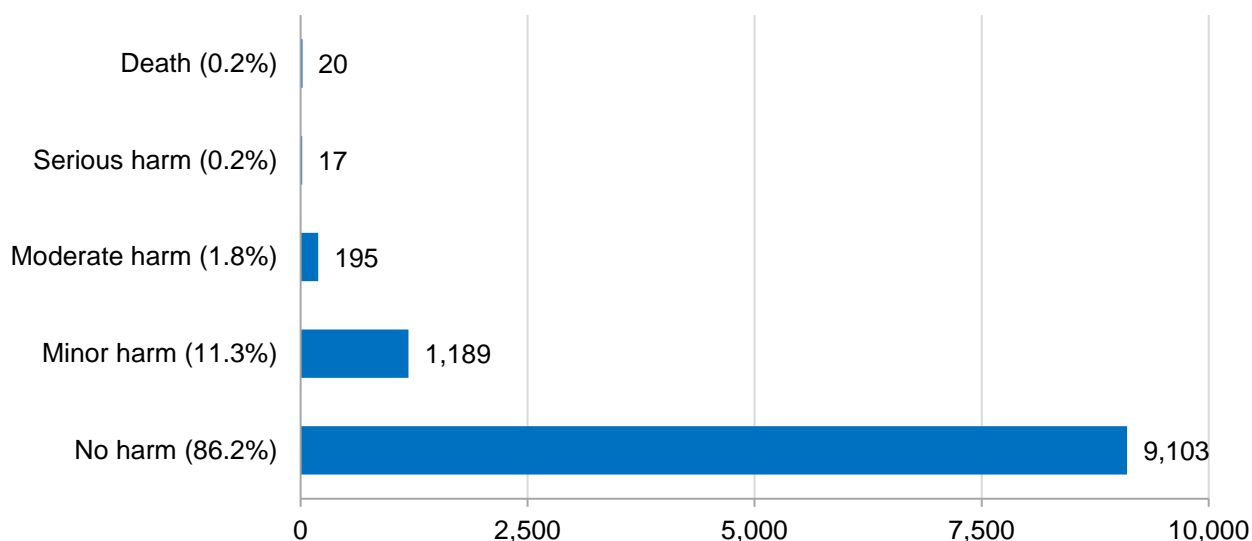
Figure 101: Frequency of Confirmed Clinical Handover Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=33; 0.3%

Most confirmed clinical handover clinical incidents reported by HSPs from July 2014 to June 2019 described a patient outcome of no harm (n=9,103; 86.2%) or minor harm (n=1,189; 11.3%). A patient outcome of death was described in 20 clinical handover incidents over this period (see Figure 102).

Figure 102: Frequency of Confirmed Clinical Handover Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019

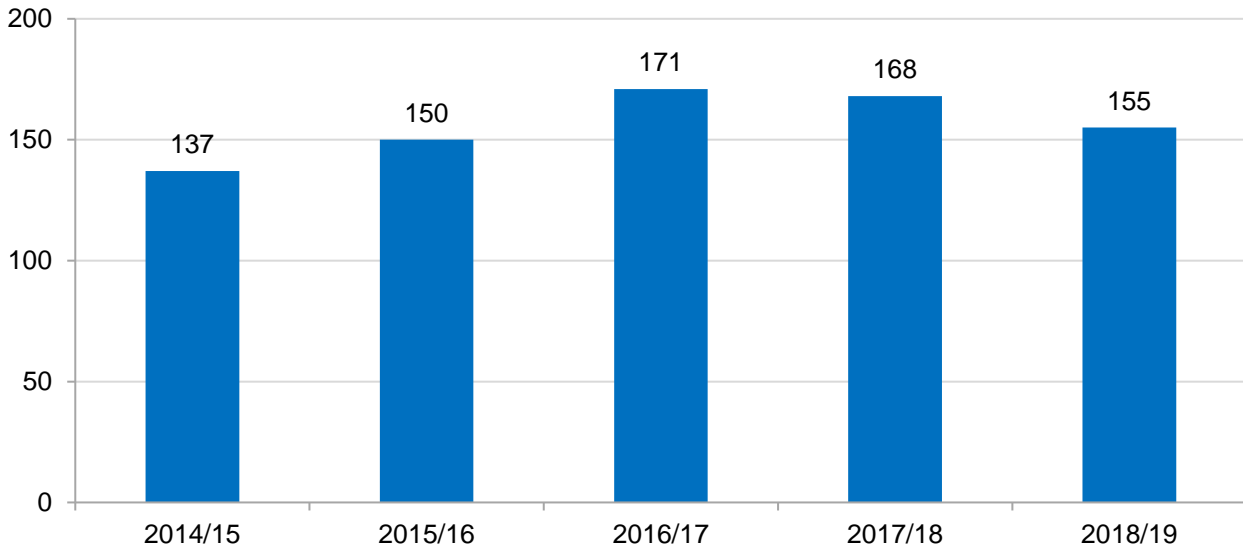


Note: Patient outcome missing data n=33; 0.3%

Standard 7: Blood and Blood Products Clinical Incidents

The number of confirmed blood and blood products clinical incidents reported by HSPs has remained relatively low and stable from 2014/15 to 2018/19, with the highest frequency of these incidents seen in 2016/17 (n=171; see Figure 103).

Figure 103: Frequency of Confirmed Blood and Blood Products Clinical Incidents Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 9 blood and blood products clinical incidents awaiting confirmation, which were all notified during 2018/19

Blood and blood products clinical incidents accounted for 0.5% (n=781) of all confirmed clinical incidents reported by HSPs from July 2014 to June 2019. Most confirmed blood and blood products incidents were categorised as SAC 3 (n=704; 90.1%; see Table 34).

Blood and blood products clinical incidents confirmed as SAC 2 (n=63; 8.1%) were the next most frequent, followed by SAC 1 (n=14; 1.8%). The frequency of SAC 1 and SAC 2 blood and blood products clinical incidents has been relatively consistent over this period.

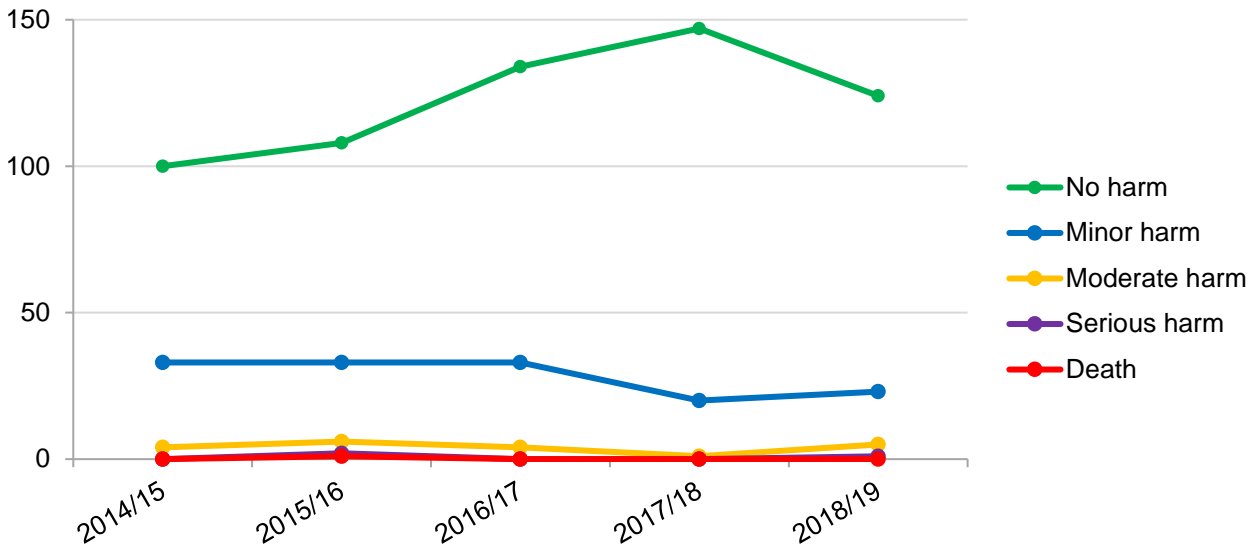
Table 34: Frequency of Confirmed Blood and Blood Products Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

Year	SAC 1	SAC 2	SAC 3	Total
2014/15	2	7	128	137
2015/16	5	14	131	150
2016/17	2	16	153	171
2017/18	2	10	156	168
2018/19	3	16	136	155
Total	14	63	704	781

Note: As of 7 July 2019, there were 9 blood and blood products clinical incidents awaiting confirmation, which were all notified during 2018/19

Figure 104 shows that there has been a modest increase in HSPs' reporting of blood and blood products clinical incidents that resulted in no harm to the patient, and a slight decline in incidents resulting in minor harm.

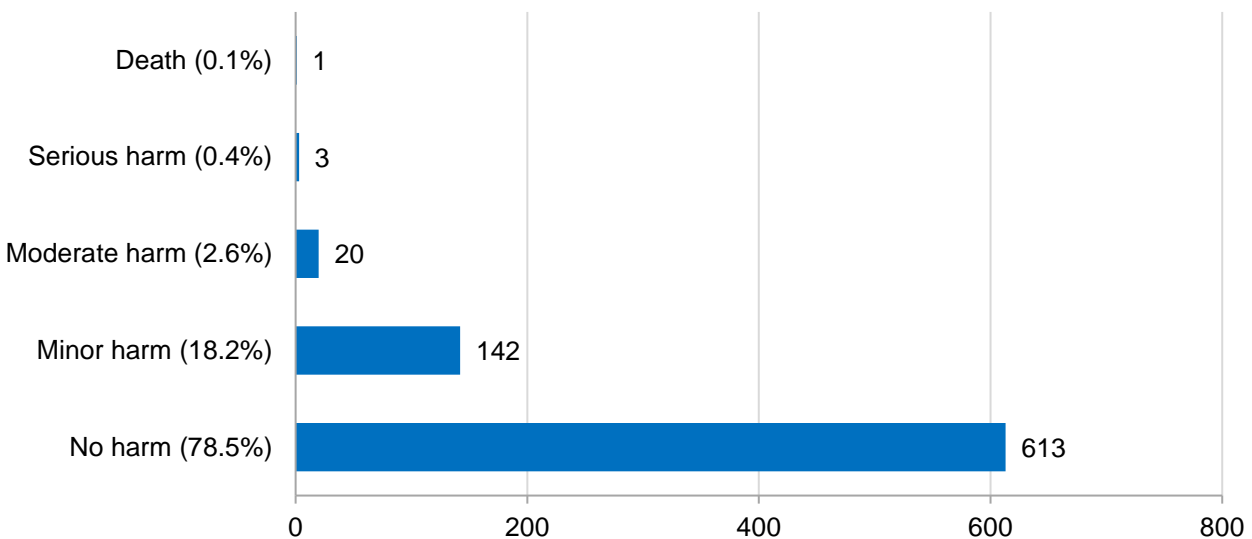
Figure 104: Frequency of Confirmed Blood and Blood Products Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=2; 0.3%

Most confirmed blood and blood products incidents reported by HSPs between July 2014 and June 2019 described a patient outcome of no harm (n=613; 78.5%) or minor harm (n=142; 18.2%), with one incident describing a patient outcome of death (see Figure 105). Ten of the 14 blood and blood products clinical incidents categorised as SAC 1 by HSPs were near misses that resulted in no harm to the patient.

Figure 105: Frequency of Confirmed Blood and Blood Products Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019

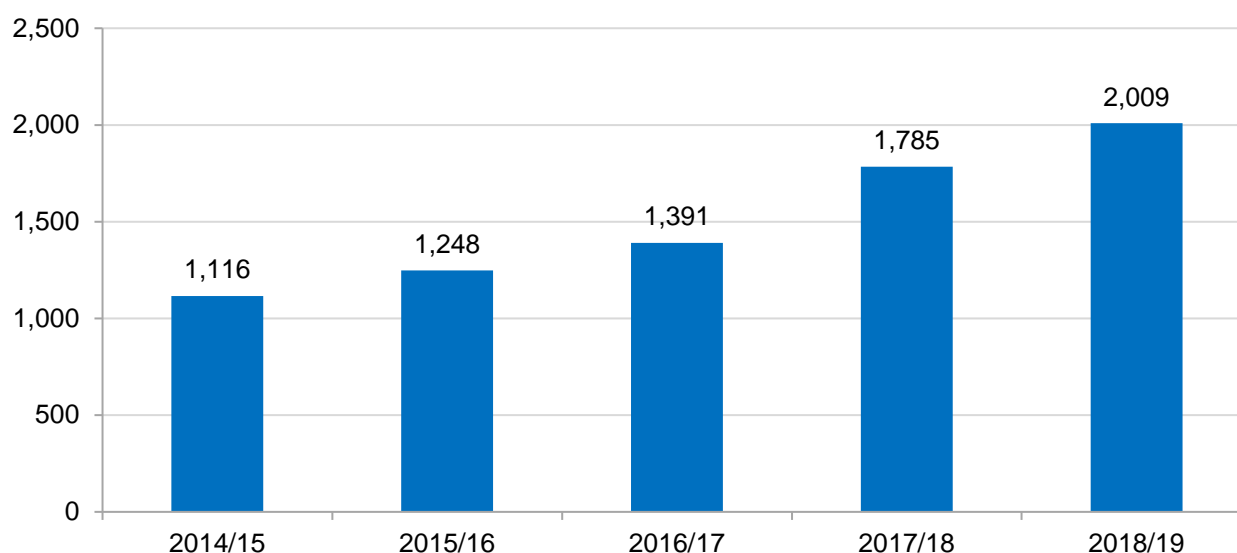


Note: Patient outcome missing data n=2; 0.3%

Standard 8: Pressure Injury Clinical Incidents

The number of confirmed clinical incidents reported by HSPs related to pressure injuries increased from 1,116 in 2014/15 to 2,009 in 2018/19 (see Figure 106). This increase in reporting of pressure injuries as clinical incidents may be due in part to increasing awareness that pressure injuries are now considered largely avoidable, through timely screening and assessment of risk factors, engagement of patients and their carers, and using individualised care plans that address risk factors and are focussed on prevention.⁷⁴

Figure 106: Frequency of Confirmed Pressure Injury Clinical Incidents Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 94 pressure injury clinical incidents awaiting confirmation, with 93 of these incidents notified during 2018/19

Pressure injury clinical incidents accounted for 5.0% (n=7,549) of all confirmed clinical incidents reported by HSPs from July 2014 to June 2019. Most confirmed pressure injury incidents were categorised as SAC 3 (n=6,751; 94.3%; see Table 35), followed by SAC 2 (n=763; 4.7%) and SAC 1 (n=35; 0.9%). The number of SAC 3 pressure injury incidents reported by HSPs increased substantially over this period.

Table 35: Frequency of Confirmed Pressure Injury Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

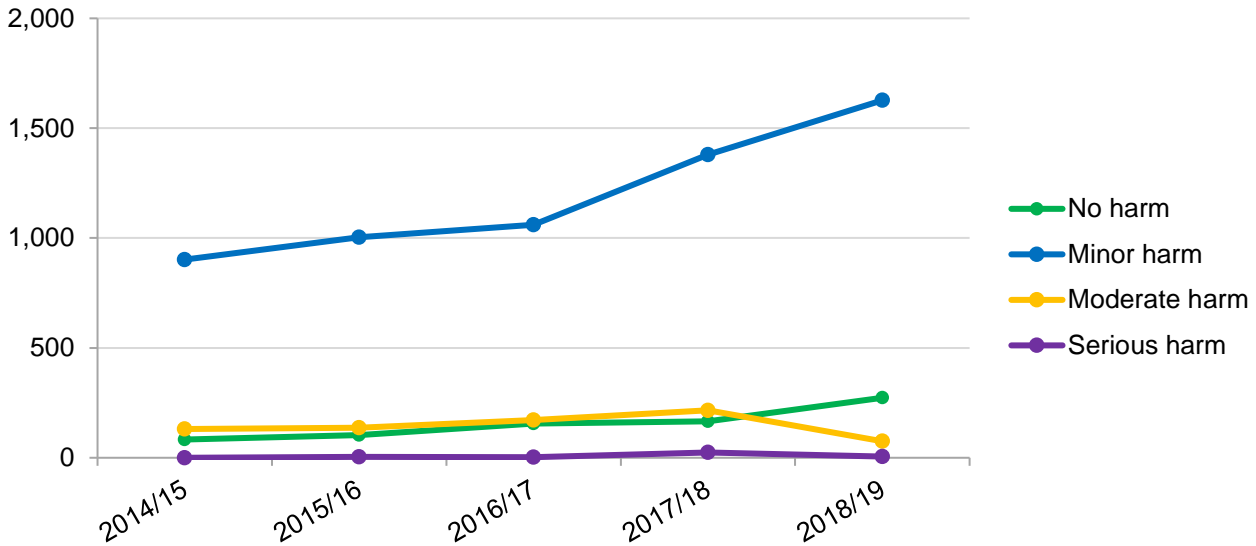
Year	SAC 1	SAC 2	SAC 3	Total
2014/15	1	129	986	1,116
2015/16	4	144	1,100	1,248
2016/17	3	175	1,213	1,391
2017/18	22	216	1,547	1,785
2018/19	5	99	1,905	2,009
Total	35	763	6,751	7,549

Note: As of 7 July 2019, there were 94 pressure injury clinical incidents awaiting confirmation, with 93 of these incidents notified during 2018/19

⁷⁴ The WA Pressure Injury Prevention and Management Clinical Guideline is available at: https://ww2.health.wa.gov.au/~/_/media/Files/Corporate/general%20documents/safety/PDF/Pressure-injury-guideline.pdf

Most of the increase in reporting of pressure injury clinical incidents in HSPs from July 2014 to June 2019 is related to incidents that resulted in minor harm to the patient. Over this period there was also a modest rise in the reporting of pressure injury incidents that resulted in no harm to the patient, and a recent downturn in the number of incidents describing a patient outcome of moderate harm (see Figure 107).

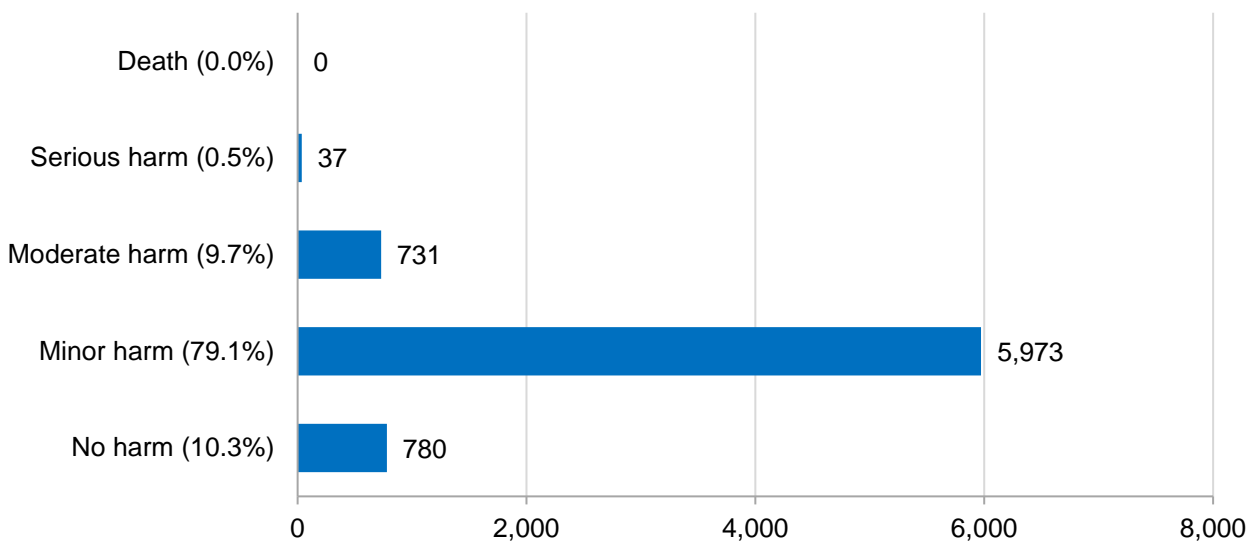
Figure 107: Frequency of Confirmed Pressure Injury Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=28; 0.4%

Most confirmed pressure injury incidents reported by HSPs between July 2014 and June 2019 described a patient outcome of minor harm (n=5,973; 79.1%), followed by no harm (n=780; 10.3%) and moderate harm (n=731; 9.7%; see Figure 108). No pressure injury clinical incidents reported by HSPs described a patient outcome of death during this time.

Figure 108: Frequency of Confirmed Pressure Injury Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019



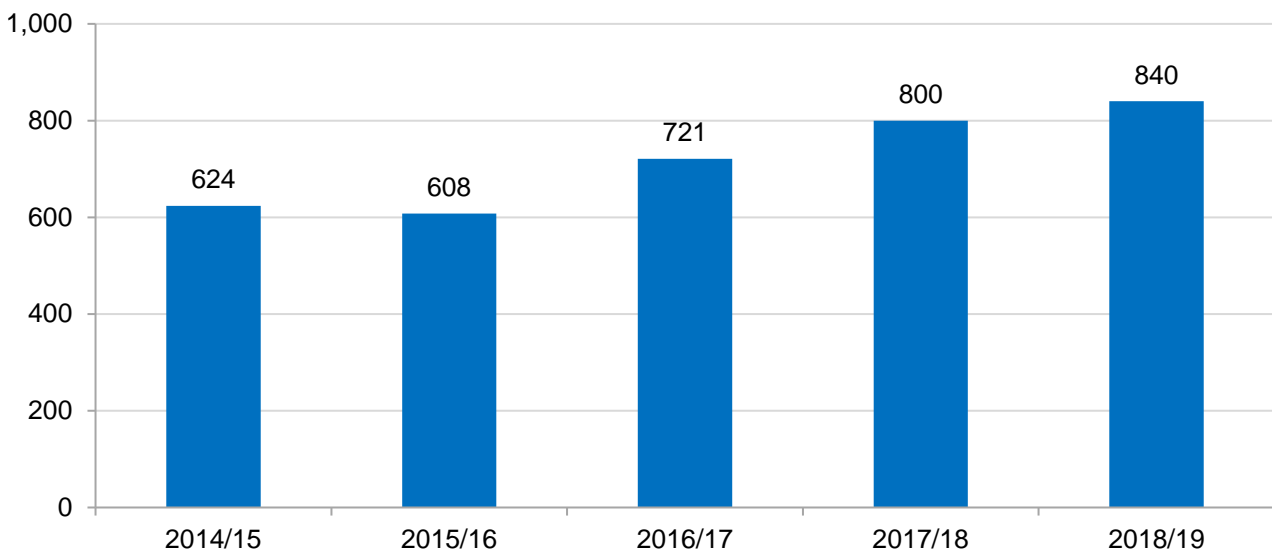
Note: Patient outcome missing data n=28; 0.4%

Standard 9: Clinical Deterioration Clinical Incidents

Early recognition of clinical deterioration, followed by prompt and effective action, can improve patient outcomes and reduce adverse events. The number of confirmed clinical deterioration clinical incidents reported by HSPs increased from 624 in 2014/15 to 840 in 2018/19 (see Figure 109).

This increase in reporting of clinical deterioration incidents may in part be due to improved identification of incidents where the patient’s condition was deteriorating, but the recognition and/or response was not timely or adequate.

Figure 109: Frequency of Confirmed Clinical Deterioration Clinical Incidents Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 18 clinical deterioration clinical incidents awaiting confirmation, which were all notified during 2018/19

Clinical deterioration clinical incidents accounted for 2.4% (n=3,593) of all confirmed clinical incidents reported by HSPs from July 2014 to June 2019. Most confirmed clinical deterioration incidents were categorised as SAC 3 (n=2,364; 65.8%; see Table 36), followed by SAC 2 incidents (n=924; 25.7%) then SAC 1 incidents (n=305; 8.5%). The frequency of SAC 1 clinical deterioration clinical incidents reported by HSPs doubled over this period, while the frequency of SAC 2 clinical deterioration incidents remained relatively stable.

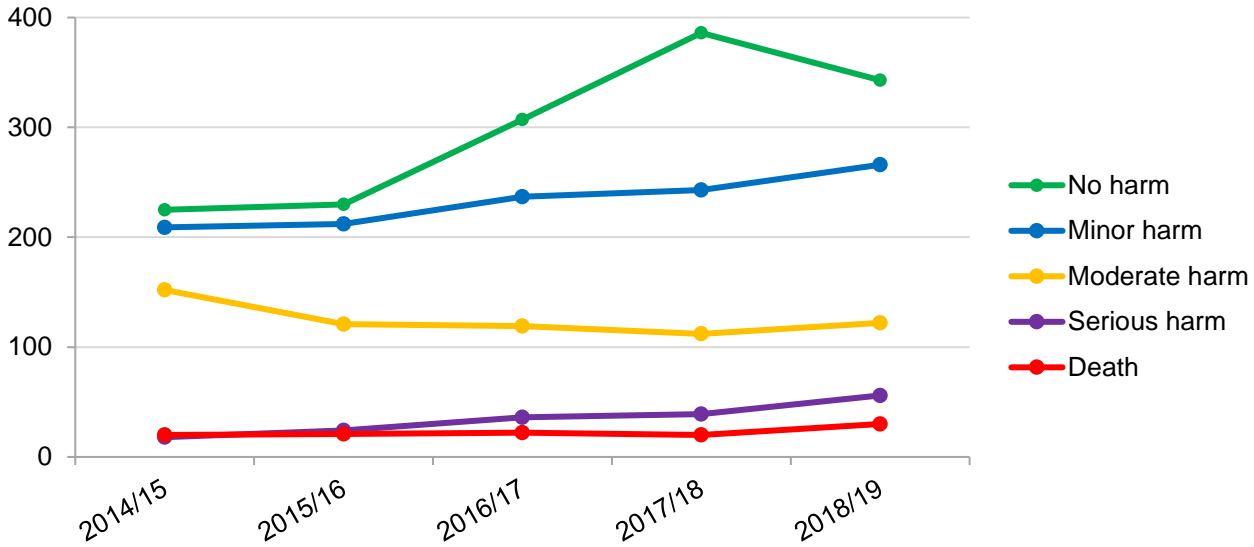
Table 36: Frequency of Confirmed Clinical Deterioration Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

Year	SAC 1	SAC 2	SAC 3	Total
2014/15	42	191	391	624
2015/16	47	168	393	608
2016/17	61	181	479	721
2017/18	65	187	548	800
2018/19	90	197	553	840
Total	305	924	2,364	3,593

Note: As of 7 July 2019, there were 18 clinical deterioration clinical incidents awaiting confirmation, which were all notified during 2018/19

Figure 110 shows that the increased reporting of clinical deterioration clinical incidents in HSPs between July 2014 and June 2019 is related to all levels of patient outcome, apart from incidents describing the outcome for the patient as moderate harm, which showed a slight decline over this period.

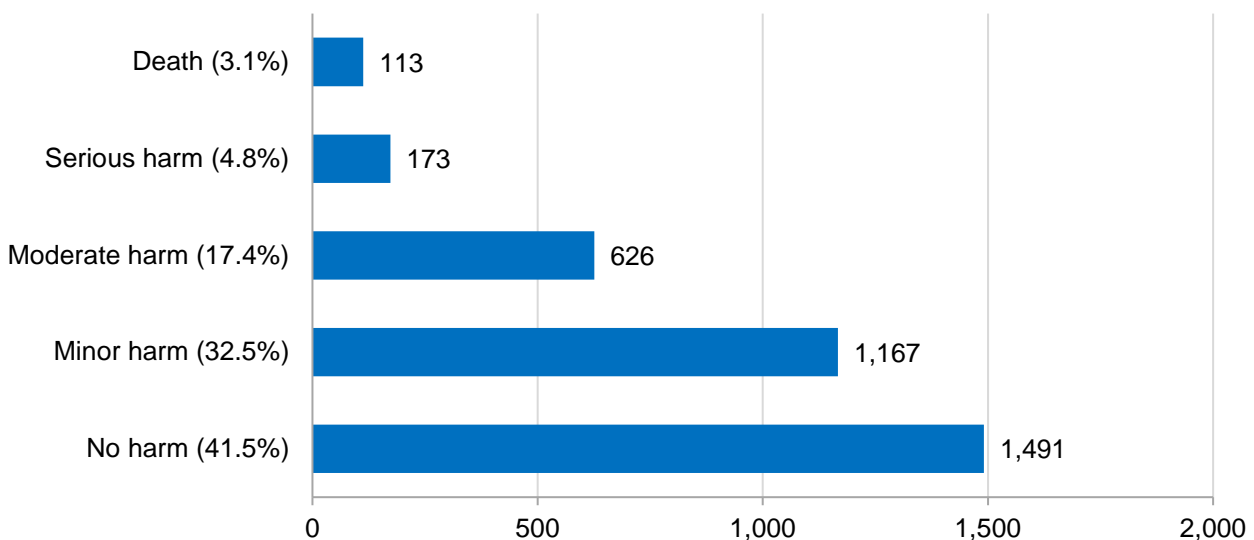
Figure 110: Frequency of Confirmed Clinical Deterioration Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=23; 0.6%

While the most frequently reported outcome of clinical deterioration clinical incidents reported by HSPs between July 2014 and June 2019 was no harm to the patient (n=1,491; 41.5%), it should be noted that a patient outcome of death was described in 3.1% (n=113) of these incidents (see Figure 111). The proportion of clinical deterioration incidents describing a patient outcome of death is consistently higher than that seen for other NSQHS Standards, highlighting the risk to patients posed by delays in recognising and/or responding to clinical deterioration.

Figure 111: Frequency of Confirmed Clinical Deterioration Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019

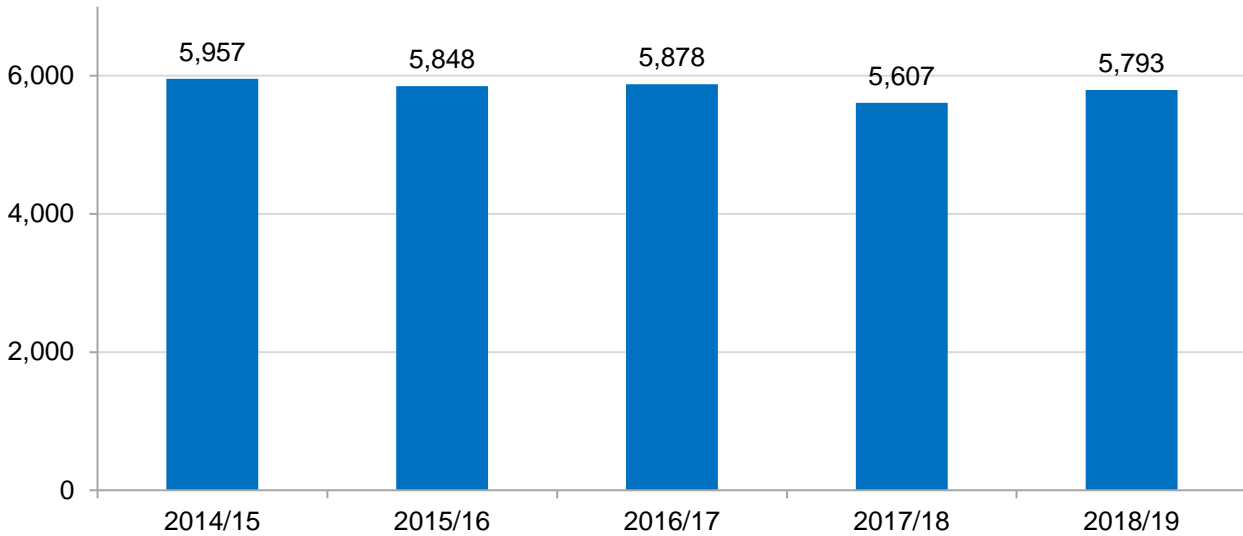


Note: Patient outcome missing data n=23; 0.6%

Standard 10: Falls Clinical Incidents

The number of confirmed falls clinical incidents reported by HSPs decreased slightly from 5,957 in 2014/15 to 5,793 in 2018/19 (see Figure 112) however, as incidents notified during 2018/19 that are awaiting confirmation at the time of this report are reviewed, it is likely that this figure will increase, giving an essentially flat trend over this time.

Figure 112: Frequency of Confirmed Falls Clinical Incidents Reported by HSPs by Year for July 2014 to June 2019



Note: As of 7 July 2019, there were 220 falls clinical incidents awaiting confirmation, with 216 of these incidents notified during 2018/19

Falls clinical incidents accounted for 19.3% (n=29,083) of all confirmed clinical incidents reported by HSPs from July 2014 to June 2019. Most confirmed falls incidents were categorised as SAC 3 (n=27,578; 94.8%; see Table 37).

Falls clinical incidents confirmed as SAC 2 (n=1,236; 4.2%) were the next most frequent, followed by SAC 1 (n=269; 0.9%). The frequency of SAC 2 falls clinical incidents reported by HSPs halved over this period, while the frequency of SAC 1 and SAC 3 falls incidents remained relatively stable.

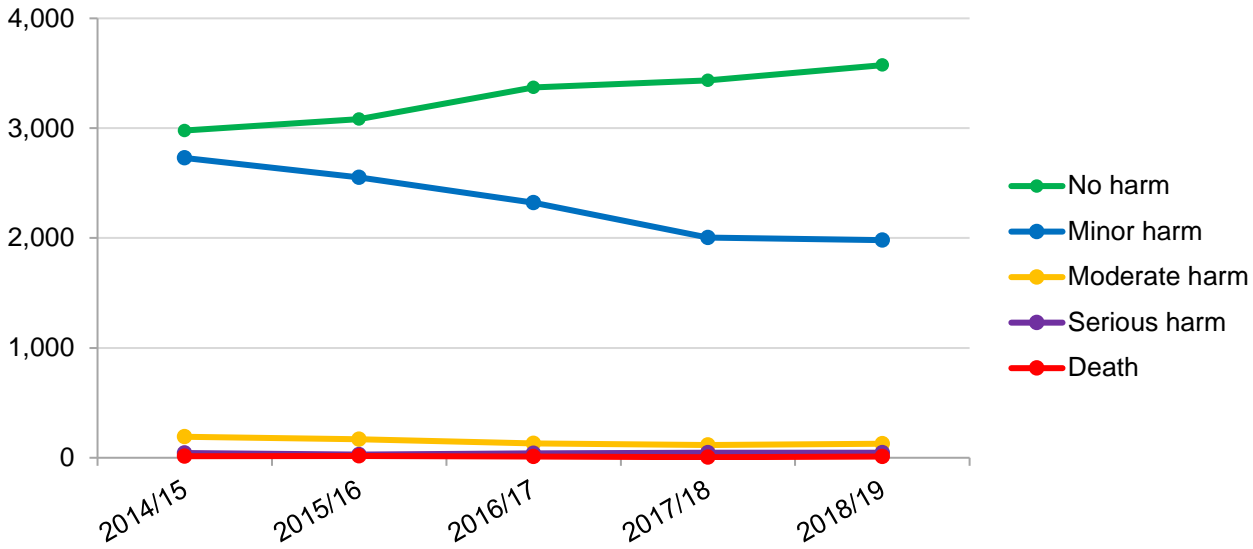
Table 37: Frequency of Confirmed Falls Clinical Incidents Reported by HSPs by SAC Rating and Year for July 2014 to June 2019

Year	SAC 1	SAC 2	SAC 3	Total
2014/15	61	334	5,562	5,957
2015/16	46	335	5,467	5,848
2016/17	54	222	5,602	5,878
2017/18	50	179	5,378	5,607
2018/19	58	166	5,569	5,793
Total	269	1,236	27,578	29,083

Note: As of 7 July 2019, there were 220 falls clinical incidents awaiting confirmation, with 216 of these incidents notified during 2018/19

Figure 113 shows that while there was a decrease in the reporting of falls clinical incidents that resulted in minor harm to the patient in HSPs between July 2014 and June 2019, this was offset by an equivalent increase in the number of falls incidents resulting in no harm. This suggests that while many patients continue to fall within the health care setting, the harm resulting from those falls is being more effectively mitigated via the use of appropriate interventions.

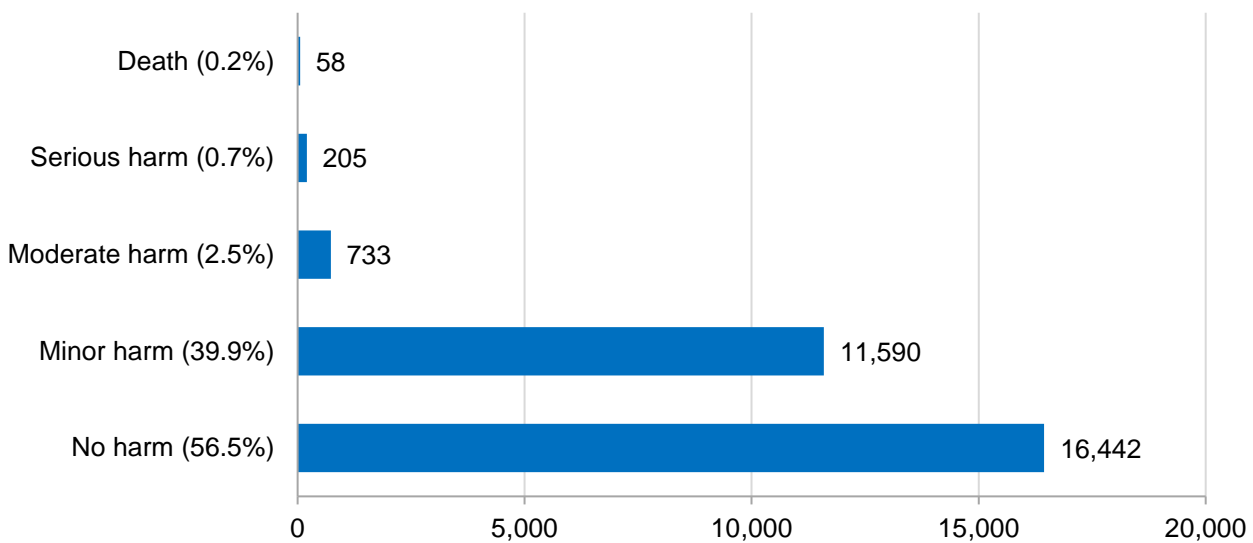
Figure 113: Frequency of Confirmed Falls Clinical Incidents Reported by HSPs by Patient Outcome and Year for July 2014 to June 2019



Note: Patient outcome missing data n=55; 0.2%

Most confirmed falls clinical incidents reported by HSPs between July 2014 and June 2019 described a patient outcome of no harm (n=16,442; 56.5%) or minor harm (n=11,590; 39.9%; see Figure 114). A patient outcome of death was described in 58 falls clinical incidents reported by HSPs over this period.

Figure 114: Frequency of Confirmed Falls Clinical Incidents Reported by HSPs by Patient Outcome for July 2014 to June 2019



Note: Patient outcome missing data n=55; 0.2%

Appendix Two: 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 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 reporting in this document includes those events reported under these revised categories in 2018/19, as well as those reported in prior years in accordance with the sentinel event categories in place at the time of notification into the Datix CIMS (for incidents notified prior to 1 July 2018 this may include two categories no longer defined as sentinel events: 'Intravascular gas embolism resulting in death or neurological damage' and 'Maternal death associated with pregnancy, birth and the puerperium').

Severity Assessment Code 1 Categories (Other)

SAC 1 includes all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition or illness. Note: this list is NOT EXHAUSTIVE.

Medication error (not resulting in death) includes:

- 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 having a birth weight greater than 2500 grams 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.

Severity Assessment Code 1 Categories (Other)

SAC 1 includes all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition or illness. Note: this list is NOT EXHAUSTIVE.

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

- Failure to monitor and respond to oxygen saturation.

Delay in recognising/responding to physical clinical deterioration

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:

- Wrong site surgery **not** resulting in death or major permanent loss of function.
- Pulmonary embolism.
- Injury to major blood vessels.

Complications of an inpatient fall

Hospital process issues:

- Events in which hospital 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.

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

The unexpected death of a mental health client

(e.g. suspected suicide, unnatural or violent death).

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

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

Wrong route administration of oral/enteral treatment

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

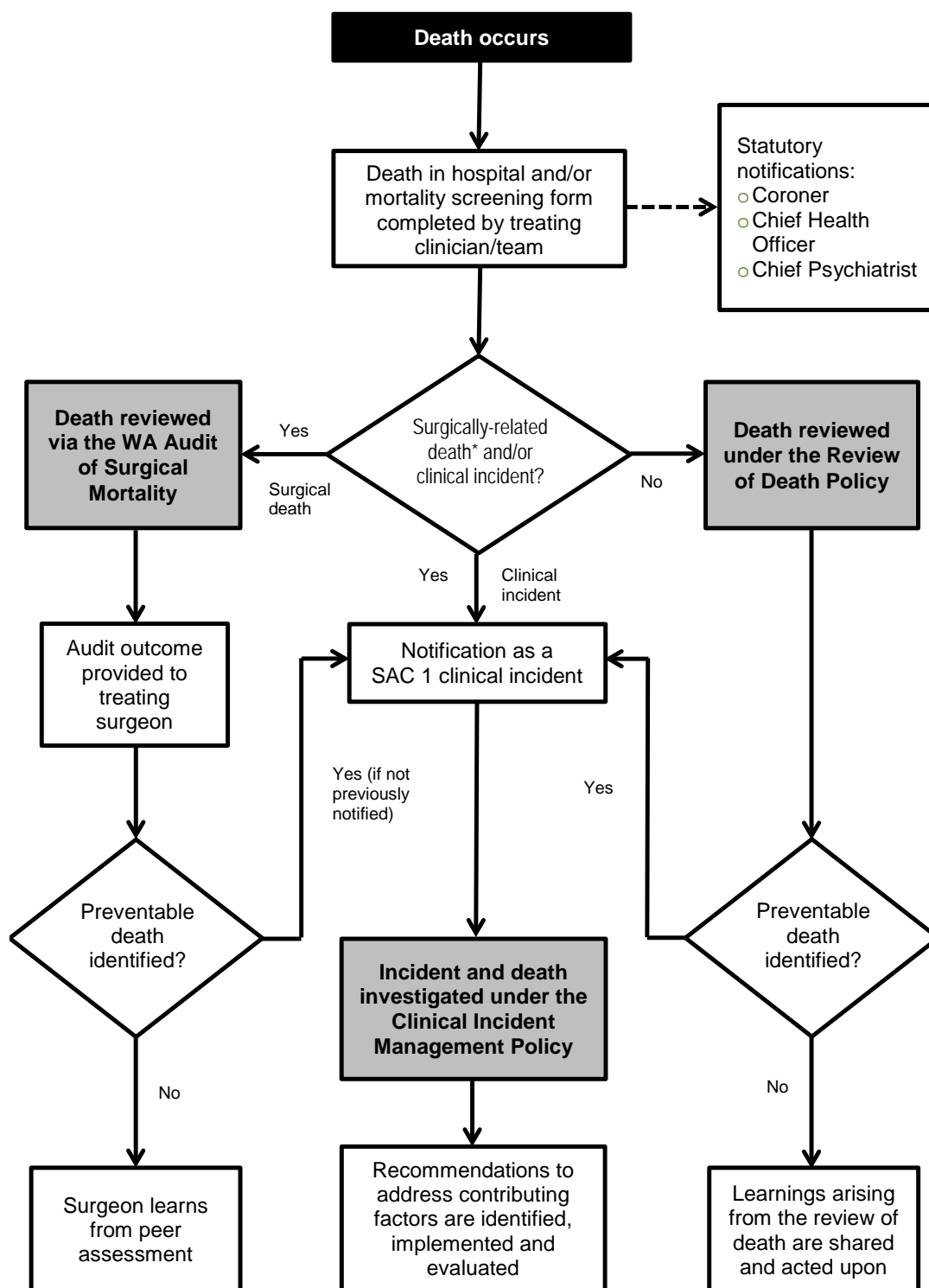
Intravascular gas embolism resulting in death or neurological damage*

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.

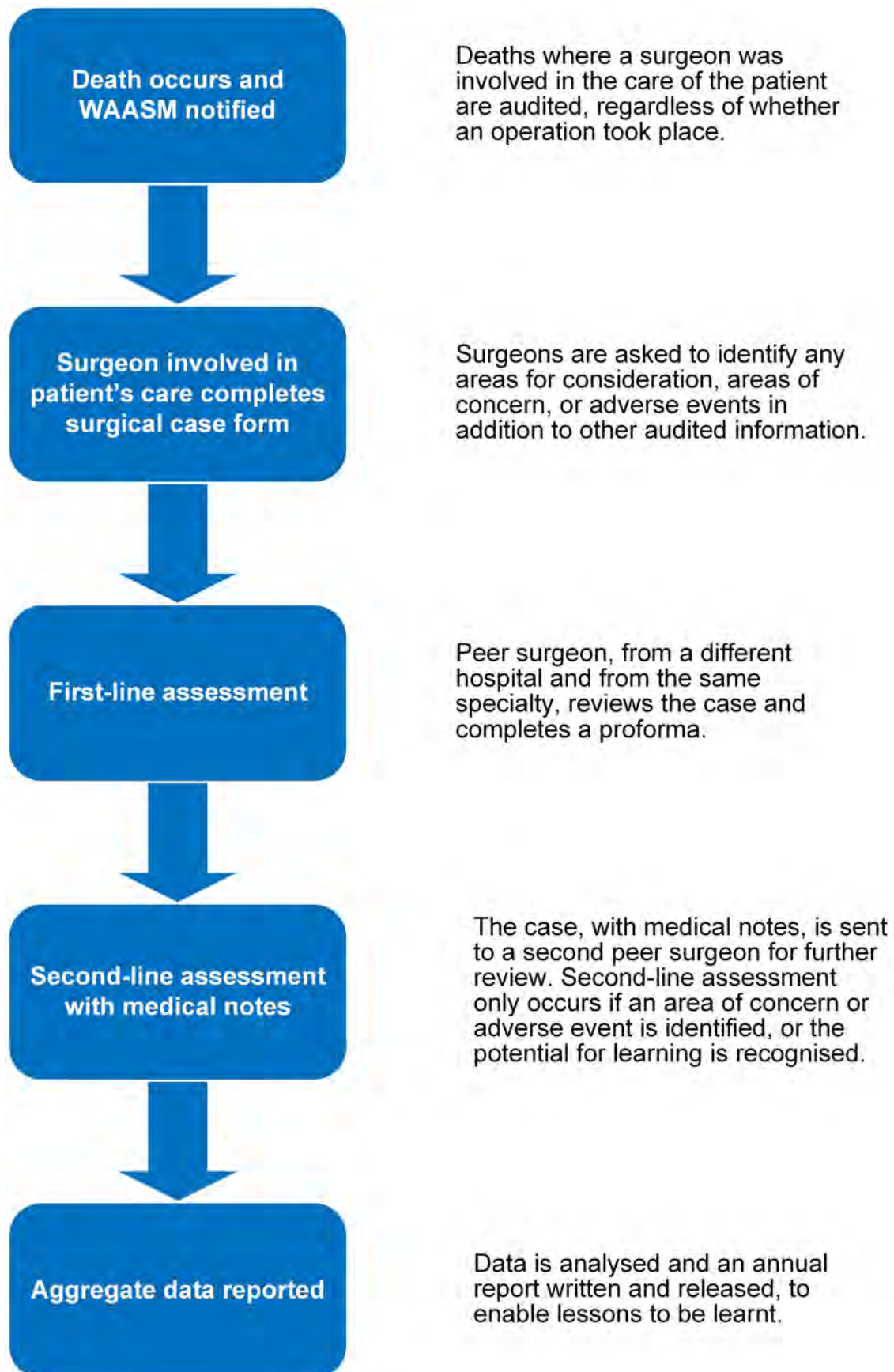
* These categories were recognised as sentinel events prior to 1 July 2018.

Appendix Three: 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 Four: Western Australian Audit of Surgical Mortality Process



Data Quality Statement for this Report

Quality Dimensions

Institutional Environment

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.

Hospital separation and bed day data, and hospital-acquired complications data are extracted from the Hospital Morbidity Data Collection and are provided by Data Integrity Management. HACs data are extracted based on version 1.1 of the HACs specification issued by the ACSQHC in August 2018.

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.

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.

Relevance

The purpose of the clinical incident data is to report all state-wide clinical incidents notified within the 2018/19 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. Mental health clinical incidents rates include mental health incidents notified in the community with non-admitted mental health occasions of service data used as the denominator. The web based Datix CIMS has improved rates analysis by providing more specific location information.

The purpose of the consumer feedback data is to report all complaints and other consumer feedback received by the WA public health system to the Datix CFM database, as well as complaints data reported to the PSSU by CHEs within the 2018/19 period. Complaints inform about patient centred care and are an integral component of CIM.

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

The HACs are complications of care for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. As part of a broad quality improvement approach, the HACs can be monitored by clinicians, safety and quality professionals, managers, executive, and governing bodies to provide insight into the state of safety and quality in a health service organisation. The HACs data, including rate calculations, is based on version 1.1 of the HACs specification issued by the ACSQHC in August 2018.

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 representative of the sample size for each question asked. Frequencies are omitted from this report to avoid confusion due to variable denominators.

Timeliness	<p>The reference period for this data is 1 July 2017 to 30 June 2018. 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 2014 to June 2019. WAASM data includes cases that had completed the review process by the census date of 1 April 2019. WAASM data includes cases where the death occurred over the period 1 January 2008 to 31 December 2018.</p> <p>The HACs data was extracted from HMDC on 12 September 2019. The data was extracted using version 1.1 of the HACs specification issued by the ACSQHC in August 2018, limiting comparison of this data with previous editions of this report. Coronial inquest summaries include all health-related inquest findings released between 1 July 2018 and 30 June 2019. The status of coronial recommendations is current as at the most recent <i>Progress Report for Health Related Coronial Recommendations</i> (August 2019).</p>
Accuracy	<p>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 relating to NSQHS Standards 3-10 are reported from the Datix CIMS via the three-tiered Common Classification System (CCS2). The CCS2 was reviewed in 2015, with codes relevant to NSQHS Standards agreed by the State Datix Committee. The CCS2 was updated in April 2017 and codes relating to some NSHQS Standards were also updated.</p> <p>WAASM data are reported in accordance with that reported to PSSU by the Royal Australasian College of Surgeons.</p> <p>HACs data are reported in accordance with data provided to PSSU by Data Integrity Management. HACs data were extracted from the HMDC based on version 1.1 of the HACs specification issued by the ACSQHC in August 2018. 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.</p>
Coherence	<p>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.</p>
Accessibility	<p>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.</p> <p>All requests for HMDC data require approval from Data Integrity Management. The WAASM data is protected under the Commonwealth's <i>Health Insurance Act 1973</i>. The release of aggregate data is subject to the authorisation of the Royal Australasian College of Surgeons.</p> <p>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.</p>
Interpretability	<p>Any queries regarding the data found in this report can be directed to the Patient Safety Surveillance Unit, Department of Health.</p>

Glossary

Anastomosis - an operative union of two structures (e.g. blood vessels, intestines, ureters).⁷⁵

Aneurysm - dilation of an artery or a cardiac chamber, usually due to an acquired or naturally occurring weakness of the wall of the artery or chamber.⁷⁵

Bed days - the number of days a patient stays in hospital between admission and discharge. An aggregate measure of health service utilisation.

Block (nerve block) - a technique that interrupts the transmission of nerve impulses by injecting local anaesthetic solution.⁷⁵

Bronchopneumonia - acute inflammation of the walls of the smaller bronchial tubes in the lungs with varying amounts of pulmonary consolidation.⁷⁵

Cardiomyopathy - disease of the heart muscle.⁷⁵

Clinical incident - an event or circumstance resulting from health care which could have or did lead to unintended and/or unnecessary harm to a person. Clinical incidents include:

- **Near miss** which is an incident that may have, but did not cause harm, either by chance or through timely intervention.
- **Adverse event** which is an injury/harm caused by medical management or complication thereof, instead of the underlying disease. It results in an increase in the level of care and/or prolonged hospitalisation and/or disability at the time of discharge. Medical management refers to management under health care services.
- **Sentinel event** which refers to unexpected occurrences involving death or serious physical or psychological injury, or risk thereof.²³

Clinical Incident Management (CIM) - the process of effectively managing clinical incidents with a view to minimising preventable harm.²³

Clinical Incident Management System (CIMS) - a database system developed for collecting and analysing information on clinical incidents. It covers voluntary reporting, investigating, analysing and monitoring of clinical incidents.

Contact - consumer feedback regarding a minor aspect of service where the individual is seeking information or assistance, or does not wish to lodge a formal complaint, or is satisfied that the feedback has been adequately addressed at the point of contact, negating the need for any follow up actions.

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.⁷⁶

⁷⁵ Stedman's Medical Dictionary. 27 ed. Baltimore: Lippincott Williams & Wilkins: 2000.

⁷⁶ Health Services Act 2016 available at:

https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13761_homepage.html

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.⁷⁷

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. This can only be done if no causative factors contributed to the patient's/consumer's outcome and in fact the clinical incident was not preventable.²³

Datix CIMS - is 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.

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.

Dehiscence - a bursting open, splitting or gaping along natural or sutured lines.⁷⁵

Embolism - a plug that occludes a vessel. Could be composed of a thrombus, vegetation, mass of bacteria or some other foreign body.⁷⁵

Extravasation - to exude from or pass out of a vessel into the surrounding tissues.⁷⁵ Can occur during the infusion or injection of medication into a blood vessel.

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.⁷⁶

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.⁷⁵

Hyperthermia - high body temperature.

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, or other injuries not classifiable in the previous categories.

Laryngeal dystonia - uncontrolled spasms of the muscles of the voice box (larynx).⁷⁸

Mental health patient - refers to any involuntary or voluntary mental health patient as well as any referred mental health patient.

Myocardial infarction - sudden insufficiency of blood supply to a segment of the heart muscle, usually due to blockage of a coronary artery.⁷⁵

⁷⁷ World Health Organization. Conceptual Framework for the International Classification for Patient Safety Technical Report. Version 1.1. January 2009.

⁷⁸ National Organization for Rare Disorders – Laryngeal Dystonia: <https://rarediseases.org/rare-diseases/laryngeal-dystonia/>

Never events - serious, preventable patient safety incidents that should not occur if preventative measures are in place.²³

Phlebotomy - incision into or needle puncture of a vein for the purpose of drawing blood.⁷⁵

Schizophrenia - a type of psychosis characterised by abnormalities in perception, content of thought and thought processes (hallucinations and delusions) and by withdrawal of interest from other people and the outside world.⁷⁵

Sentinel event - refers to unexpected occurrences involving death or serious 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 Two: SAC 1 Clinical Incident Notification List).²³

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.⁷⁹

Septicaemia - systemic disease caused by the spread of micro-organisms and their toxins within the blood.⁷⁵

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 all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient's underlying condition or illness. In WA, SAC 1 also includes the 10 nationally endorsed sentinel event categories.
- SAC 2 includes all clinical incidents/near misses where moderate harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.
- SAC 3 includes all clinical incidents/near misses where minimal or no harm is/could be specifically caused by health care rather than the patient's underlying condition or illness.²³

Sleep apnoea - a disorder characterised by recurrent interruptions of breathing during sleep due to temporary obstruction of the airway.⁷⁵

Tall Man lettering - a typographic technique that uses selective capitalisation to help make look-alike, sound-alike medicine name pairs easier to tell apart (e.g. tRAMadol, tEMOdal, tORadol and tAPENTadol).⁸⁰

Venepuncture - the puncture of a vein, usually to withdraw blood or inject a solution.⁷⁵

Venous thromboembolism (VTE) - the formation of a blood clot, usually in a deep vein.⁷⁵

⁷⁹ Department of Health WA. Admissions, Readmissions, Discharge and Transfer Reference Manual (2017). Department of Health, Western Australia, editor. Perth. 2017.

⁸⁰ ACSQHC National Tall Man Lettering List: <https://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-medicines/national-tall-man-lettering-list>

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