Government of Western Australia
Department of Health

CLINICAL INCIDENT MANAGEMENT SYSTEM (CIMS) and SEVERITY ASSESSMENT CODE 1 DATA REQUEST PROCESS

PATIENT SAFETY SURVEILLANCE UNIT

2012

Delivering a **Healthy WA**

1. CLINICAL INCIDENT MANAGEMENT

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

- The CIM Policy (2011)[1] integrates the processes of clinical incident management within WA Health, superseding the following policies:
  - The CIM Policy- using the Advanced Incident Management System (2006); and
  - The Sentinel Event Policy (2008).

- The CIM Policy introduced Severity Assessment Codes (SAC), which consist of three rating levels used to determine the appropriate level of analysis, action and escalation of a clinical incident

Severity Assessment Codes are defined as:

- **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.
- **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.[2]

Clinical Incident Management System (CIMS)

- In 2001, the Clinical Incident Management System (CIMS) was implemented across WA Health, to collect information about adverse events.

- The CIMS is a voluntary reporting system and therefore not all clinical incidents are captured. Recent studies have reported that clinical incidents constituted between 6.9% (n=67,435)[3] and 18% (n=423)[4] of all hospital admissions. Consequently, it cannot be assumed that the data is representative of all incidents.

1 The Clinical Incident Management Policy (2011).
2 Queensland Health. Clinical Incident Management Implementation Standard (CIMIS). Reform and Development Division., Editor: Queensland Government; 2008.
3 Ehsani, J., Jackson, T., Duckett, S. 2006. The incidence and cost of adverse events in Victorian hospitals 2003-2004. Medical Journal of Australia.
4 Landigran, C., Parry, G., Bones, C., Hackbath, A., Goldmann, D., Sharek, P. 2010. Temporal trends in rates of patient harm resulting from medical care. The New England Journal of Medicine.

Clinical Incident Management System (Continued)

- The CIMS is used to:
  - Support clinical incident identification and management in accordance with the CIM Policy (2011);
  - Provide a consistent and co-ordinated approach to the notification, analysis, reporting of clinical incidents and the development of recommendations addressing contributing factors; and
  - Share lessons learned by providing analysis and reporting of de-identified aggregated data at a WA public health system level.

- Clinical incidents investigated under the *Health Services (Quality Improvement) Act 1994*[5] or the *Commonwealth Health Insurance Act 1973, part VC*[6] means that the disclosure of information that identifies, directly or by implication, individual health care providers and/or patients may be prohibited and must be kept in a secure environment.

Severity Assessment Code 1 Clinical Incidents

- Prior to the introduction of SAC rating in 2011, the process of reporting serious adverse incidents was specified in the Sentinel Event Policy (2008). Events to be notified according to the Sentinel Event Policy included the eight nationally endorsed sentinel event categories, and 'other adverse events resulting in serious patient harm or death'.

- SAC 1 clinical incidents include the eight nationally endorsed sentinel event categories, and any other incident resulting in serious harm or death.

- The 2011 CIM Policy requires the mandatory reporting of SAC 1 clinical incidents by public and private licensed health care facilities (and non government organisations in accordance with their license or contract with WA Health).

Purpose

The purpose of this protocol is to ensure that state-wide CIMS/SAC 1 data is accessible and available for the purposes of quality improvement. The principles of CIM are to ensure the appropriate management of clinical incidents to prevent or reduce future harm to patients/consumers by:

- Identifying and treating hazards before they cause harm;
- Identifying when patients/consumers are harmed and intervening promptly to minimise the harm; and
- Taking preventative actions and sharing lessons learned.[7]

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5 Government of Western Australia. *Health Services (Quality Improvement) Act.1994*.
6 Commonwealth *Health Insurance Act 1973: Part VC, Health Insurance Amendment Act. 1992.* (QAA No3/2001).
7 The Clinical Incident Management Policy (2011).

Whilst CIMS/SAC 1 data collections are not performance monitoring systems, clinical incident data does give an insight into clinical issues that could be addressed by quality improvement programs/projects.

Out of Scope

Health Services currently receive monthly CIMS data extracts for their area from the Health Information Network. Staff wishing to access CIMS data from the Health Service (HIN) in which they work, need to contact their local Safety and Quality Unit/Risk Manager.

In Scope

This protocol applies to the state-wide CIMS data collection and to the SAC 1 data collection.

Information gained as a result of a clinical incident investigation conducted under the qualified privilege afforded by the *Western Australian Health Services (Quality Improvement) Act 1994,* or the *Commonwealth Health Insurance Act 1973, part VC* requires protection via secure access/restricted access. Based on the Qualified Privilege status of a clinical incident it may only be possible to provide **aggregate data** that can assist in quality improvement.

'Closing the loop' is the completion of the process where recommendations arising from the investigation into clinical incidents are disseminated at multiple levels of the health system resulting in change to procedure/policy/clinical practice to prevent the recurrence of health care related errors and ultimately increase patient safety. Essentially 'closing the loop' involves two key steps:[8]

1. Ensuring that information and recommendations arising from the investigation and analysis of a clinical incident are fed back to the health care system at various levels and in multiple forms (e.g. changes in processes and procedures, staff education and newsletters, patient safety alerts and notification, relevant committees etc).
2. Ensuring that these changes are implemented 'on the ground' and evaluating their effectiveness in altering practice and behaviour and preventing the recurrence of clinical incidents.

Health Services are required to disseminate de-identified information in accordance with their current processes to ensure the sharing of lessons learned.

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[8] Krohn R. Closing the loop of clinical performance improvement. Journal of Healthcare Information Management. Winter 2006; 20 (1): 12-14.

CIMS Data Request Types

There are two types of CIMS data request that can be made:

1. Focus Reports: This is where specific CIMS data is requested, with the analysis and report undertaken by the Patient Safety Surveillance Unit (PSSU).

2. Data Extraction: This data extraction request is for de-identified CIMS data with analysis to be conducted by the requestor. Data extraction and de-identification of the CIMS data is performed by the HIN (see Appendix 1 for the CIMS Data Fields Guide).

SAC 1 Data Request Type

Due to the small number of SAC 1 data and the potential for identification of individual patient data, only aggregated focus reports can be requested. Specifically, SAC 1 data is requested with the analysis and report undertaken by the PSSU (see Appendix 2 for SAC 1 Data Fields).

CIMS/SAC 1 Data Request Process

The process for requesting CIMS/SAC 1 data (focus report or data extraction) follows the same process as outlined in the Information Circular Guidelines for the Release of Data (IC 0125/12) located over the page.

2. GUIDELINES FOR THE RELEASE OF DATA (IC0125/12)

BACKGROUND

WA Health creates, collects and maintains a vast amount of information, much of which is confidential personal health information. The information collected is used for planning, management and monitoring of health services, epidemiological analysis and health related research. It is also used to meet funding and performance reporting obligations and direct patient care.

WA Health is committed to ensuring that information is available in a timely manner and is of high quality to authorised users.

The term 'data' generally refers to unprocessed information, whilst the term 'information' refers to data that has been processed in such a way as to be meaningful to the person who receives it. For the purpose of this document, the terms 'data' and 'information' have been used interchangeably and should be taken to mean both data and information.

This guideline has been developed to supplement the Information Access and Disclosure Policy (OD 0360/12) in relation to the release of data from WA Health data collections.

SCOPE

The guidelines outlined in this document apply to the release of record level and aggregate level data sets from electronic data collections within WA Health. It does not apply to the disclosure of individual patient information as part of the patient treatment process, Freedom of Information applications or for National reporting and mandatory statutory reporting obligations.

For the purpose of this document, a data collection includes both operational data collections and data repositories.

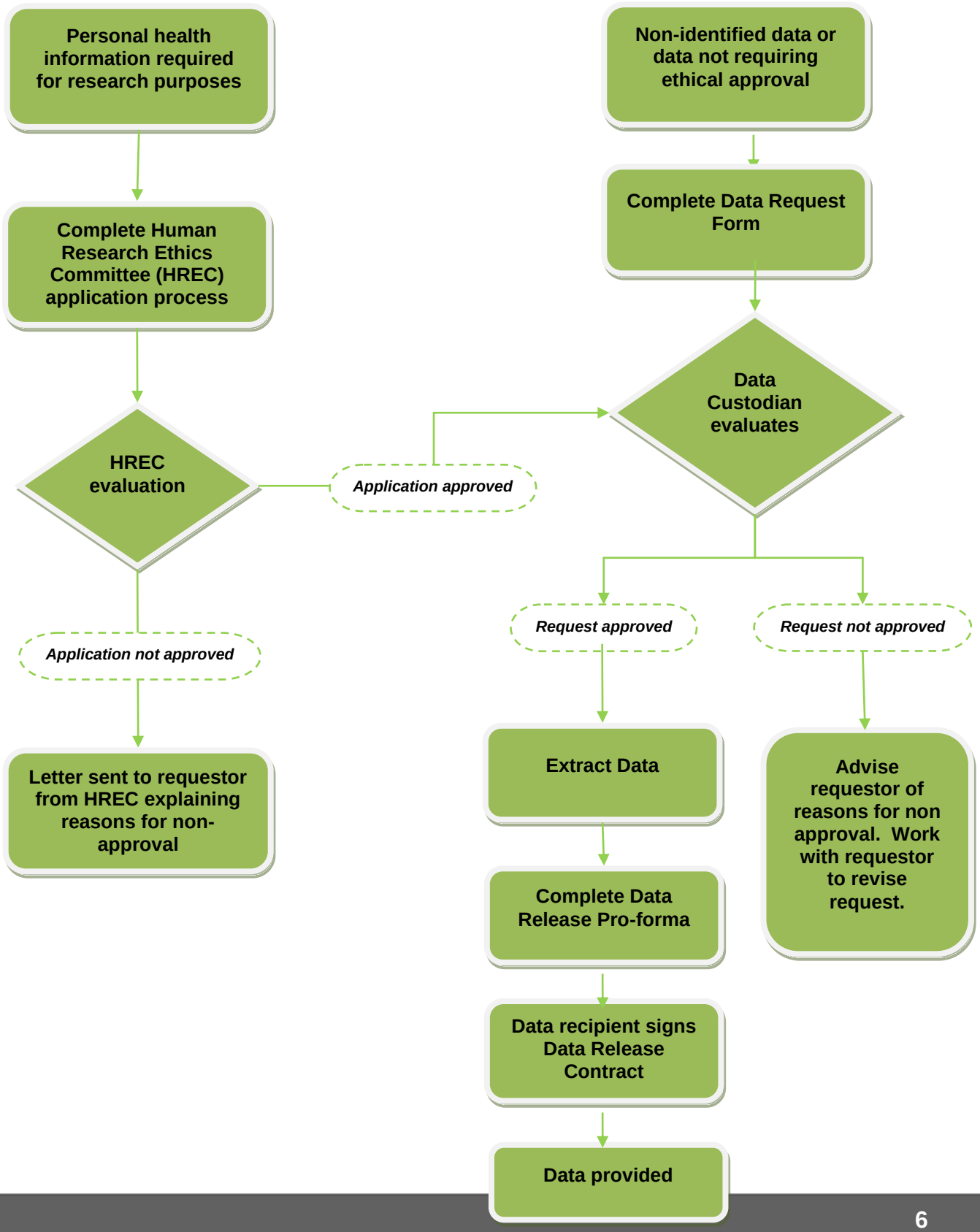
PURPOSE

These guidelines seek to ensure data is released adequately and meets the needs of the requestor. This is achieved through the proper documentation of the requestor's requirements and the completion of a Data Release Pro-Forma, highlighting specific details of the data provided. These guidelines also ensure that authorised recipients are adequately aware of their obligations to maintain confidentiality and security of the data received.

GUIDELINES

The following protocols should be applied when releasing data from electronic data collections within WA Health to authorised data recipients. A flowchart depicting the high level process is shown in Figure 1.

Figure 1: Data release flowchart



Request for Data

There are two types of data requests outlined in Figure 1: personal health information for research purposes and non-identified data or data not requiring ethical approval. These requests can either be ad-hoc/one-off or regular extractions of data sets.

Requests for **personal health information** for research purposes require completion of an application via the Human Research Ethics Committee (HREC). Contact should be made with the relevant Health Services or Department of Health HREC for details on the application process.

For **non-identified data or data not requiring ethical approval,** a written application to the relevant Data Custodian process applies. Please note that some data requests may still require HREC approval. The Data Custodian will assist in determining if the request requires HREC approval.

After the initial contact with the Data Custodian, a Data Request Form (Attachment A) should be completed and submitted. Where the request is required on a regular basis, completion of a new Data Request Form may not be required each time. The Data Request Form ensures that the request is clearly documented to enable the Data Custodian to assess the request and provide the data if appropriate.

The Data Request Form should include, as a minimum:

- The requestor's details (i.e. name, position, work location and contact details);
- The recipient's details (if not the same as the requestor);
- The data collection(s) from which the data will be sourced;
- Reason/purpose for the required data;
- Data items/variables required;
- Description on what is required;
- Any specific business rules to be applied to the data;
- Volume of data/reporting period required;
- Details as to how the data will be used;
- List of persons having access to the data;
- Data retention period; and
- Date required.

Data Release

When extracting data for release, the following should be adhered to:

- Data extracted should be checked against previously provided or related data to ensure consistency;
- Data release approvals must be in accordance with the Information Disclosure Model (refer to the Information Access and Disclosure Policy (OD 0360/12)) for the specific data collection;
- The product to be released should have a look and feel common to other WA Health products;
- Ensure that a contact person is available to handle enquiries from the requestor and/or recipient;
- Ensure that confidential or sensitive data is transferred to the recipient in a secure manner; and
- When releasing published tables or aggregate level data, the disclosure of information in small cells should be avoided to decrease the potential for the identification of individuals.

Prior to releasing data, a Data Release Pro-Forma (Attachment B) should be completed by the Data Custodian. This form documents the data that has been extracted for the recipient. It also serves as a record for the Data Custodian. The Data Release Pro-Forma should include, as a minimum:

- Details of a contact person for enquiries;
- Reporting definition or data extract criteria used (e.g., inclusions and exclusions);
- Data collection(s) from which the data was extracted;
- Reporting period (e.g., one quarter, one year);
- Known data quality issues;
- A definition of all variables provided; and
- Date that the data extract was produced.

For established routine data requests, a Data Release Pro-Forma only needs to be produced on the initial request for data, unless substantial modifications to the data request have been made.

Data Custodians need to ensure and be confident that the recipient of the data fully understands the conditions of data release and their related obligations. The Data Custodian administers this by signing a Data Release Contract (Attachment C) with the recipient of the data. This is particularly important when releasing confidential and/or sensitive data. The contract describes limitations on the usage of the data, security and storage requirements, as well as restrictions on further dissemination of the data to third parties.

3. DEFINITIONS

Aggregate level data is summed and/or categorised data that is analysed and placed in a format that precludes further analysis (for example; in tables or graphs) to prevent the chance of revealing an individual's identity (individual records cannot be reconstructed).

Data Custodians are responsible for the day-to-day management of data from a business perspective. The Data Custodian aims to improve the accuracy, usability and accessibility of data within the data collection.

A **Data Collection** is a systematic gathering of data for a particular purpose from various sources, including manual entry into an information system, questionnaires, interviews, observation, existing records and electronic devices. This includes both operational data collections and data repositories.

A **Data Repository** includes data that is collected from various sources, including operational data collections, for the primary purpose of monitoring, evaluation, reporting and research. Examples of data repositories include data held within the Hospital Morbidity Data Collection, Finance Data Warehouse and the Emergency Department Data Collection (EDDC).

Human Research Ethics Committees (HREC) protect the welfare and rights of participants involved in research. HREC reviews research proposals that either involve humans directly or require the use and disclosure of personal health information. HREC is responsible for ensuring that research proposals are ethically acceptable and in accordance with relevant standards and guidelines.

An **Operational Data Collection** includes data that is collected as part of the day-to-day activities of an area for the primary purpose of tracking and managing the operational aspects of the area. The operational data collection is typically a transaction-based system which contains detailed data elements to represent the activities of the area. Examples of operational data collections include data held within Patient Administration Systems, TRIM and Financial Systems.

Personal Health Information pertains to all health information where the identity of a person is apparent or can reasonably be ascertained from the information itself. Information is also personal information if it is reasonably possible for the person receiving the information to identify the individual by using other information that they already hold.

Record level data is usually data at the level of an individual person. Record-level data need not directly identify the data subject, but is more vulnerable to re-identification than aggregate data.

ASSOCIATED POLICIES

Information Access and Disclosure Policy OD 0360/12

Data Stewardship and Custodianship Policy OD 0321/11

RELEVANT LEGISLATION

Freedom of Information Act 1992;
Freedom of Information Regulations 1993;
Health Act 1911;
Hospitals and Health Services Act 1927;
Commonwealth Health Insurance Act 1973, part VC.
Commonwealth Privacy Act 1988 (National Privacy Principles);
Criminal Code Act 1913;
Public Sector Management Act 1994;
WA Mental Health Act 1996; and
Western Australian Health Services (Quality Improvement) Act 1994.

Data Request Form Attachment A

SECTION 1: REQUESTOR DETAILS					
Name			**Contact Number**		
Position			**Work Location**		
Email Contact					
Recipient Name *(if not the same as the requestor)*			**Contact Number**		
Position			**Work Location**		
Email Contact					
Urgency *(Please circle. Please allow sufficient approval process time)*	**Urgent: 1-10 Working days**		**Semi-Urgent: 11-30 Working Days**		**Non-Urgent: 31 + Working Days**
Information/Data Collection(s)					
Reason/Purpose *(what the information/data is required for)*					
Description of Information/Data Required *(Please include data items/variables required using the Data Field Guides)*					
Reporting Period Required					
Details as to how the data will be used					
List all persons who will have access to the data					
Data Retention Period					
Frequency *(Circle as appropriate)*	*One off Request*			**Date Required**	
	Fortnightly	*Monthly*	*6 Monthly*	*Annually*	*Ongoing*	*Other (please specify)*
Requestor Signature				**Date**	
SECTION 2: APPROVAL DETAILS					
Request Number				**Date Received**	
Comments *(Discussion with requestor – revisions required? Agreement to proceed? Can data be provided?)*					
Data Custodian Recommendation	**Approved**			**Not approved**	
Data Custodian Signature				**Date**	
Approval Status* *(To be completed by Data Steward)*	**Approved**			**Not approved**	
Data Steward Signature				**Date**	
SECTION 3: COMPLETION DETAILS					
Date Completed				**Date Provided**	
Revisions Required					
Feedback/Comments					

Please scan and email this form to Data Custodian, Director, Patient Safety Surveillance Unit, Performance Directorate. For any data request queries please call 9222 0294. Data Steward approval is required for any data extraction request or request from non WA Health person.

Data Request Pro-Form Attachment B

TO BE COMPLETED BY THE PERSON EXTRACTING DATA			
Request Number		**Date**	
Description of Data Request			
Data Supplier Name		**Contact Number**	
Position		**E-mail Contact**	
Reporting Definition or data extract criteria used (*e.g., inclusions and exclusions – supply location or attach***)**			
Data Collection(s) from which the data was extracted from			
Reporting Period (e.g., one quarter, one year)			
Known data quality issues			
Definition of variables provided *(specify or attach)*			
Date that the data extract was produced		**Time taken to produce output**	
Signature		**Completion Date**	
Other Comments			

Data Release Contract Attachment C

The following contract is designed to protect the confidentiality and integrity of health information and patient data after its release upon request to an internal (WA Health) or external individual, department or organisation.

OBLIGATIONS OF THE REQUESTOR

By signing the contract, the requestor:

- Agrees to maintain the data in a confidential and secure manner in the location to which it was originally released;
- Acknowledges that the data released remains the property of WA Health;
- Agrees to, under no circumstances, pass on or divulge the released data to a third party without the prior approval of the Data Custodian;
- Agrees not to use the data for any purpose other than that for which it was originally requested;
- Agrees that the source of the data will be properly referenced whenever it is used in publications;
- Agrees not to copy or store parts or the whole of the released dataset in a directory that may be accessible to anyone else;
- Agrees not to leave printouts of datasets in any form in an area accessible to anyone else; and
- Agrees to destroy all copies of the data and hard copies upon completion of its use for the purpose intended and inform the Data Custodian of the outcome.

DISCLAIMER

All information/data provided is accurate and up to date at the time of release. WA Health cannot be held liable for the accuracy of the reports based on the analysis of the data.

CONTRACT

I _____ (please print)

Of _____ department/organisation

Acknowledge that I have read and agree to the above provisions of the contract and indicate the intended use of the information requested as follows:-

_____

I agree to retain the data in the following location in a secure manner:-

_____

Signed: _____

Position/Title: _____ Date: _____

Witnessed by _____ *Position:* _____

Signature: _____ *Date:* _____

Request Number: _____ Received by: _____

Appendix 1 CIMS Data Fields Guide (AIMS 2.4)

Area - Data	Field	Description	Extract Field Name	Tick
Subject of the Incident	Patient	Identifies subject of the incident. [#]*Note: This field is referred to as 'Equipment' on the Clinical Incident Form*	*Not available from extracts*	
	Visitor		*Not available from extracts*	
	Therapeutic device, equipment or property[#]		*Not available from extracts*	
Age of Subject		Automatically calculated from date of birth & date of incident, once both fields have been entered	Age Group	
Population Group		Extensive drop down list with 65 population groups / countries listed. Known as 'Country of Birth' on the Clinical Incident Management Form	*Not available from extracts*	
Sex of Subject	Male	Subject's gender	Gender	
	Female		Gender	
	Not stated		Gender	
	Unknown		Gender	
Mental Health Status	Not applicable	Legal status of patients in a mental health facility	MH_Legal Status	
	Unknown		MH_Legal Status	
	Detained		MH_Legal Status	
	Voluntary		MH_Legal Status	
Reporter Details - Classification	Nurse / Midwife*	*Drop down lists available to identify designation / level for each discipline (eg. Nurse / Midwife - may be specified as Registered Nurse, Staff Development Nurse, Nurse Manager etc)	Nurse classification	
	Doctor*		Doctor classification	
	Patient		Patient	
	Visitor		Visitor	
	Allied Health*		Allied classification	
	Other (includes free text field)		Other classification	
Place of incident	Ward / unit / place	Free text fields	*Not available from extracts*	
	Specific location		*Not available from extracts*	

Area - Data	Field	Description	Extract Field Name	Tick
	Date of Incident	Mandatory field, case cannot be completed without 'Date of Incident'	Date/Time	
	Time of Incident	Free text field, displayed as am or pm	Incident Time	
Relevant current diagnosis or problems		Free text field describing patient's diagnosis/condition	*Not available from extracts*	
Medical Specialty		Extensive drop down list available. Known as 'Treating Specialty' on the Clinical Incident Form	Medical Speciality	
Was the next of kin / guardian notified?	Yes	*Note: A User Defined Field (UDF) is used to identify whether the Open Disclosure Process has been initiated*	Next of kin or guardian notified	
	No		Next of kin or guardian notified	
	N/A		Next of kin or guardian notified	
Was treating medical practitioner notified?	Yes		Medical Practitioner notified	
	No		Medical Practitioner notified	
	N/A		Medical Practitioner notified	
Medical practitioner examination of subject	Assessment of patient's condition	Free text field describing assessment of patient after the incident. Includes follow up treatment and investigation	*Not available from extracts*	
Incident summary	Describe what happened including immediate response	Free text field describing the incident	Describe what happened	
	Contributing factors	Free text field describing the contributing factors	*Not available from extracts*	
	Treatment or investigations ordered	Free text field listing treatment and investigations	*Not available from extracts*	
	What factors minimised the outcome?	Free text field describing factors that minimised the outcome	*Not available from extracts*	
	How could the incident have been prevented?	Free text field describing preventative strategies that could have prevented the incident	*Not available from extracts*	

Area - Data	Field	Description	Extract Field Name	Tick
Senior staff member's comments	Results of evaluation following investigation	Free text field outlining investigation	Results of evaluation	
Has the incident been documented in the medical record?	Yes		*Not available from extracts*	
	No		*Not available from extracts*	
	N/A		*Not available from extracts*	
Was the patient informed of the incident?	Yes	*Note: A User Defined Field (UDF) is used to identify whether the Open Disclosure Process has been initiated*	*Not available from extracts*	
	No		*Not available from extracts*	
	N/A		*Not available from extracts*	
Department head who completed and 'signed off' that the appropriate steps have been taken	Comment on action taken or needed to prevent recurrence or comment on resource implications	Free text field describing corrective actions to prevent recurrence	Comment on action	
	Did the incident result in an increase of costs or length of stay, or consume extra resources?	Free text field describing extra costs incurred as a result of the incident	*Not available from extracts*	
Have you relayed this information back to the reporter?	Yes		*Not available from extracts*	
	No		*Not available from extracts*	
	N/A		*Not available from extracts*	
Have the relevant authorities been notified?	ADRAC	Adverse Drug Reactions Advisory Committee	*Not available from extracts*	
	TGA	Therapeutic Goods Administration	*Not available from extracts*	
	Work related injury body		*Not available from extracts*	
	Other (includes free text field)		*Not available from extracts*	

Area - Data	Field	Description	Extract Field Name	Tick
Specify ward or department allocated		Specifies the Ward / Department from the Organisational Tree in AIMS, that is responsible for the follow-up and investigation of the incident	Workplace	
Third Party Comments		Free text field for third party to comment on incident	3rd party comments	
Day of Week		*Note: This information is calculated from fields within Data Manager, but are not actual data entry fields.*	Week Day	
Month			Month	
Financial Year			Fin Year	
Calendar Year			Cal Year	
Shift Time		*Morning/Afternoon/Evening/Night. Note: This information is calculated from fields within Data Manager, but is not an actual data entry field*	Shift Time	
Medication	**Incident Types**		**Incident Type**	
	Wrong medication additive or fluid	Patient received wrong medication. Includes wrong formulation.	Nature of Incident Type	
	Wrong frequency	Medication given more or less often than ordered.	Nature of Incident Type	
	Wrong time	Medication was given at the wrong time of day or night	Nature of Incident Type	
	Wrong route	Medication was administered via a route other than that ordered.	Nature of Incident Type	
	Wrong patient	The correct medication was given to the wrong patient.	Nature of Incident Type	
	Wrong infusion rate	Rate of the infusion or device was set incorrectly. Note: Overdose or under dose should also be selected during coding.	Nature of Incident Type	
	Reaction to medication	Incident involved side effects as a result of medication.	Nature of Incident Type	
	Given without order	Medication given without a written or verbal order.	Nature of Incident Type	
	Given but not signed for	Medication was given, but there is no signature to verify administration.	Nature of Incident Type	

Area - Data	Field	Description	Extract Field Name	Tick
	No or incorrect labelling	Medication bottle, box or fluid was not labelled or was labelled incorrectly.	Nature of Incident Type	
	Expired medication	Medication had passed use by date.	Nature of Incident Type	
	Damaged product	Product was in an unusable state at time of incident.	Nature of Incident Type	
	Theft or loss	Medication could not be located. Note: If a DDA is involved, DDA discrepancy should also be included.	Nature of Incident Type	
	DDA check not done or discrepancy	There is a difference between the actual DDA count and that documented in the register or DDA count was not attended.	Nature of Incident Type	
	Omission	Ordered medication was not administered.	Nature of Incident Type	
	Under dose	Subject was given less than ordered.	Nature of Incident Type	
	Overdose	Unintentional overdose; an excessive amount of a medication was given, but not ordered.	Nature of Incident Type	
	Self inflicted overdose	Patient intentionally self administered an excessive dose of medication.	Nature of Incident Type	
	Problem during therapeutic use	Medication had no or inadequate effect despite being administered as per orders.	Nature of Incident Type	
	Other (includes free text box)	Incident does not fit into the above categories.	Nature of Incident Type	
Medication	**Cause of Incident**			
	Incorrect calculation	Medication amount or rate was incorrectly calculated.	Medication - cause of incident	
	Failure to read or misread	Existing order was misinterpreted or overlooked.	Medication - cause of incident	
	New order overlooked	Incident occurred because of new medication orders, stat medication orders or changes in medication orders were not noted.	Medication - cause of incident	
	Administered when held or ceased	Medication given when it was to be withheld either temporarily or permanently.	Medication - cause of incident	

Area - Data	Field	Description	Extract Field Name	Tick
	Failure to follow policy or procedure	Staff did not follow hospital policy or procedures.	Medication - cause of incident	
	Prescription or order error	Script or order was not completed correctly.	Medication - cause of incident	
	Unclear or incomplete order	Medication order was ambiguous or not fully completed.	Medication - cause of incident	
	Dispensing error	Utilised for pharmacy errors; also included filling of unit dose dispensers (eg. Dosette, Webster packs); not utilised for administration errors or for patients that self medicate.	Medication - cause of incident	
	Medication not available	Medication not available either within the institution or externally.	Medication - cause of incident	
	Patient self medicating	Used when the patient is responsible for dispensing own medication.	Medication - cause of incident	
	Previous known adverse reaction	Medication given to the patient despite a known past reaction.	Medication - cause of incident	
	Other (includes free text box)	Incident does not fit into the above categories.	Medication - cause of incident	
Medication	**Medication(s) involved in incident**		**Medication(s) involved**	
		Lists medications using generic names only (ie 'panadeine' will be coded as paracetamol and codeine phosphate). For incidents involving the wrong medication being given to a patient, only the incorrect drug is listed in this field.	Medication(s) involved	
Medication	**Route ordered**		**Route Ordered**	
	IV	This field captures the 'Routed ordered' when the 'Wrong Route' box has been selected. *Note: This field is only used when the incident has been classified as 'Wrong Route'.*	Route Ordered	
	SC or IM		Route Ordered	

Area - Data	Field	Description	Extract Field Name	Tick
	Topical		Route Ordered	
	Epidural		Route Ordered	
	Intrathecal		Route Ordered	
	Inhalation		Route Ordered	
	Rectal		Route Ordered	
	Enteric		Route Ordered	
	Aural		Route Ordered	
	Optic		Route Ordered	
	Intranasal		Route Ordered	
	Sub-lingual		Route Ordered	
	Oral		Route Ordered	
	Other (includes free text box)		Route Ordered	
Medication	**Route given**		**Route given**	
	IV	When the incident has been classified as 'Wrong Route' this field is utilised to indicate which route was actually used. *Note: This field is only used when the incident has been classified as 'Wrong Route'.*	Route given	
	SC or IM		Route given	
	Topical		Route given	
	Epidural		Route given	
	Intrathecal		Route given	
	Inhalation		Route given	
	Rectal		Route given	
	Enteric		Route given	
	Aural		Route given	
	Optic		Route given	
	Intranasal		Route given	
	Sub-lingual		Route given	
	Oral		Route given	
	Other (includes free text box)		Route given	

Area - Data	Field	Description	Extract Field Name	Tick
Fall	**Mechanism of fall**		**Incident Type**	
	From bed or cot	Patient fell from a sitting or lying position in or on a bed, trolley, stretcher etc.	Nature of Incident Type	
	From chair or wheelchair	Patient fell while sitting on a chair or wheelchair, or attempting to stand from a chair or wheelchair.	Nature of Incident Type	
	From therapeutic equipment	Patient fell from any equipment intended for direct patient treatment.	Nature of Incident Type	
	From toilet or commode	Patient fell while sitting or attempting to transfer from the toilet or commode.	Nature of Incident Type	
	In shower or bathroom	Fall occurred in the shower, bathroom or toilet.	Nature of Incident Type	
	Getting to or from toilet	Fall occurred while the patient was walking to or from toilet or commode.	Nature of Incident Type	
	On same level	Fall did not involve the patient falling from 'something' and was either partially or fully weight bearing.	Nature of Incident Type	
	On stairs	Fall occurred while walking up or down stairs.	Nature of Incident Type	
	On wet or slippery surface	Fall occurred on a surface that was wet or slippery for some reason.	Nature of Incident Type	
	Unknown origin	Patient was found on the floor and circumstances leading to fall cannot be established. This code is usually used when there were no witnesses present.	Nature of Incident Type	
	Other (includes free text box)	Incident does not fit into the above categories.	Nature of Incident Type	
Fall	**Mobility aid at time of fall**		*Not available from extracts*	
	Indicated but not ordered	Mobility aid was indicated, but not ordered by doctor or physio at time of incident.	*Not available from extracts*	
	Ordered but not used	Mobility aids were prescribed, but were not being used by the patient at the time of the fall.	*Not available from extracts*	

Area - Data	Field	Description	Extract Field Name	Tick
	Used	Prescribed mobility aid was being used at the time of the fall, includes wheelchairs, walkers, limb splints etc.	*Not available from extracts*	
	Unknown	Not possible to determine whether a mobility aid was in use at the time.	*Not available from extracts*	
	Not applicable	Mobility aids aren't relevant to the incident.	*Not available from extracts*	
Fall	**Level of independence**		*Not available from extracts*	
	Independent	Patient was able to mobilise without assistance from another individual or use of a walking aid, at the time of the fall.	*Not available from extracts*	
	Dependent on staff	Patient required assistance or supervision from staff to mobilise.	*Not available from extracts*	
	Dependent on aids	Patient required assistance from therapeutic equipment to mobilise.	*Not available from extracts*	
	Dependent on parent or carer	Patient required assistance or supervision from a parent or carer to mobilise.	*Not available from extracts*	
Fall	**Activity at time of fall**		*Not available from extracts*	
	Transferring	Patient was involved in the actual process of moving from one piece of furniture or therapeutic device to another.	*Not available from extracts*	
	Walking	Patient was mobilising.	*Not available from extracts*	
	Attempting to stand	Patient was involved in the process of standing up.	*Not available from extracts*	
	Playing	Patient was playing at time of fall, this can include falls from play equipment, falls on the same level, running etc.	*Not available from extracts*	
	Attempting to sit	Patient was in the process of attempting to sit down.	*Not available from extracts*	
	Not specified	Patient's activity at the time of fall is unknown or unspecified.	*Not available from extracts*	
	Other (includes free text box)	Incident does not fit into the above categories.	*Not available from extracts*	

Area - Data	Field	Description	Extract Field Name	Tick
Fall	**If escaping from restraints**		*Not available from extracts*	
	Not applicable		*Not available from extracts*	
	Limb restraints		*Not available from extracts*	
	Over cot sides		*Not available from extracts*	
	Seat belt		*Not available from extracts*	
	Posey		*Not available from extracts*	
	Not known		*Not available from extracts*	
	Other (includes free text box)		*Not available from extracts*	
Fall	**Risk assessment**		*Not available from extracts*	
	Not applicable	Indicates whether the individual was noted to be at risk prior to the fall occurring.	*Not available from extracts*	
	Yes		*Not available from extracts*	
	No		*Not available from extracts*	
Behaviour	**Incident Types**		Incident Type	
	Verbal abuse or aggression	Individual involved in the incident used language that was of an insulting nature.	Nature of Incident Type	
	Physical abuse, aggression or assault	Individual involved in the incident displayed physically aggressive or threatening behaviour.	Nature of Incident Type	
	Self discharge	Patient left the hospital against medical advice, but staff were aware of the occurrence.	Nature of Incident Type	
	Non-compliance	Individual involved in the incident deliberately failed to follow requests or instructions, defied rules or regulations.	Nature of Incident Type	

Area - Data	Field	Description	Extract Field Name	Tick
	Intended self harm	The incident involves self-mutilation or inappropriate behaviour, but without stated suicidal intent.	Nature of Incident Type	
	Suicidal behaviour or attempted suicide	Individual involved in the incident indicated an intent to suicide, lacks value of their life or has attempted or successfully taken his/her own life.	Nature of Incident Type	
	Absconding	A patient was away from the ward, hospital or unit without permission. Length of time away is irrelevant.	Nature of Incident Type	
	Inappropriate behaviour	Individual involved exhibited unacceptable behaviour (suspicious behaviour; aggressive behaviour, but report does not specify physical or verbal; loitering; placing self on the floor).	Nature of Incident Type	
	Inappropriate sexual behaviour	The individual involved in the incident exhibited unacceptable sexually orientated behaviour (eg. sexual contact with another patient, regardless of whether consensual; sexual innuendos; flashing others).	Nature of Incident Type	
	Other (includes free text box)	Behaviour-related incident is specified, but the categories above do not apply.	Nature of Incident Type	
Therapeutic Device (Property)*				
Note: This field is referred to as 'Property' in the Data Manager Module and 'Therapeutic Device' in Analyser		Lists therapeutic devices	*Not available from extracts*	
Therapeutic Device (Property)*	**Incident Types**		Incident Type	
	Unavailable	Therapeutic device, equipment or property was not available when required.	Nature of Incident Type	
	Failure to use	Equipment, device or property should have been used (and was available), but not utilised.	Nature of Incident Type	

Area - Data	Field	Description	Extract Field Name	Tick
	Failure or malfunction or faulty	Equipment, device or property was not working effectively.	Nature of Incident Type	
	Damaged	Equipment, device or property was damaged or broken.	Nature of Incident Type	
	Not sterile or contaminated	Sterilisation process was not performed, was inadequately performed or equipment, device or property was contaminated post-sterilisation.	Nature of Incident Type	
	Misuse, inappropriate use or misassemble	Equipment, device or property was used, but not as indicated for its intended purpose; the equipment was misassembled; the incorrect type of equipment was used; or the equipment was not put away in the correct place.	Nature of Incident Type	
	Infrastructure, maintenance or design problem	Incident resulted from a failure to properly maintain equipment, a problem with the design, limitations of the equipment, or a problem due to a system error.	Nature of Incident Type	
	Unintended removal, dislodgement or disconnection	Equipment, device or property was moved from the original site or was inadvertently disconnected.	Nature of Incident Type	
	Deliberate removal by staff or client	Equipment, device or property was intentionally removed.	Nature of Incident Type	
	Theft or loss	Equipment, device or property cannot be found.	Nature of Incident Type	
	Other (includes free text box)	Incident does not fit into the above categories.	Nature of Incident Type	
Injury	**Incident Types**		Incident Type	
	Needle stick or medical sharps	Needle stick or a sharp medical object caused injury. Does not include sharp objects used for self harm. Not used for staff injuries.	Nature of Incident Type	

Area - Data	Field	Description	Extract Field Name	Tick
	Burn	Injury was a burn caused by spillage or hot food or fluid, a hot pack or some other hot objects. *Note: Does not include burns caused by procedural complications (eg. diathermy).*	Nature of Incident Type	
	Result of impact or collision	Injury resulted from a person or an object colliding or becoming entangled.	Nature of Incident Type	
	Pressure area or sore	Injury involved a reddened area, or the injury was a broken area of skin caused by pressure.	Nature of Incident Type	
	Pressure injuries	Indicates whether pressure area was present on admission. *Note: This is taken from the additional pressure ulcer health incident type (HIT) not from CedOC*	Timing of Incident	
	Injury of unknown origin	Subject sustained an injury, but the origin of the injury is unclear.	Nature of Incident Type	
	Unintended injury during procedure or treatment	The incident was an unintentional injury caused to a patient during a medical procedure or treatment.	Nature of Incident Type	
	Staff injury	Not used by WA Health - staff injuries should be referred to OSH.	Nature of Incident Type	
	Other (includes free text box)	Incident does not fit into the above categories.		
Safety & Security	**Incident Types**		Incident Type	
	Contamination, environmental hazard or hazardous environment	Contamination, environmental hazards or hazardous environment caused a dangerous state.	Nature of Incident Type	
	Lack of or inappropriate staff	Actual incident being reported is the lack of, or inappropriate staff. Note: Not used if the lack of or inappropriateness of staff was the contributing factor to the incident.	Nature of Incident Type	

Area - Data	Field	Description	Extract Field Name	Tick
	Patient safety and security compromised	Safety or security of a patient was compromised (eg. sharp objects left in the vicinity of a self mutilating patient, assault on a patient, patient allocated to an inappropriate bed).	Nature of Incident Type	
	Staff safety or security compromised	Staff safety or security was compromised. Used as a secondary incident type when aggressive behaviour is directed towards staff.	Nature of Incident Type	
	Breach of security procedures	Security procedure breached (eg. DDA keys left unattended on a desk, ID badges stolen).	Nature of Incident Type	
	Possession or use of substance abuse	Individual had either consumed, or had possession of banned substances (eg. Illicit drugs, implements used for drug usage).	Nature of Incident Type	
	Other (includes free text box)	Incident does not fit into the above categories.	Nature of Incident Type	
Nutrition	**Incident Types**		Incident Type	
	No meal or feed ordered	Staff or patient failed to order meal or feed (eg menu not filled in, TPN not ordered).	Nature of Incident Type	
	Wrong meal or feed ordered	Meal or feed was ordered, but it was incorrect or inappropriate (eg. standard diet was ordered when patient was on clear fluids, wrong TPN ordered).	Nature of Incident Type	
	Meal or feed not delivered	Meal or feed was ordered, but was not delivered to the subject.	Nature of Incident Type	
	Wrong meal or feed delivered	Meal or feed delivered to the subject, but was not the same as that which was ordered.	Nature of Incident Type	
	Fed when nil by mouth	Patient was given a meal when fasting.	Nature of Incident Type	
	No or wrong meal or feed given	Meal or feed wasn't given or was incorrect for the individual.	Nature of Incident Type	

Area - Data	Field	Description	Extract Field Name	Tick
	Aspiration of feed or fluid	Incident involved food or fluid being involuntarily inhaled into the airways. Cause may include choking, vomiting, incorrect positioning of patient.	Nature of Incident Type	
	Assistance with feeding not provided	Subject required nutritional assistance but staff failed to assist.	Nature of Incident Type	
	Contamination of food or fluid	The meal or feed was affected by an impurity. Includes foreign bodies and airborne matter (eg. TPN bag pierced during connection, plastic wrap found in a meal).	Nature of Incident Type	
	Expired or out of date	Food or feed has passed use by date or had expired from the time of opening.	Nature of Incident Type	
	Out of hours meal or feed not available	Out of hours meal or feed was unavailable (eg. parenteral feeds not being arranged, under-supply of after hours provisions).	Nature of Incident Type	
	Difficulties with packaging	The incident related to difficulties with packing of food or feed.	Nature of Incident Type	
	Other (includes free text box)	Incident does not fit into the above categories.	Nature of Incident Type	
Blood, Gas & Oxygen	**Incident Types**		Incident Type	
	Problem or reaction when receiving blood	Incident occurred during a transfusion.	Nature of Incident Type	
	Other blood or blood products problem (includes free text box)	Incident does not fit the above categories (eg. incorrect labelling, blood not available when required, wrong blood given).	Nature of Incident Type	
	Excessive or inappropriate oxygen or gas given	Incident occurred during the actual process of administering oxygen / gas.	Nature of Incident Type	
	Other oxygen or gas problem (includes free text box)	Incident does not fit the above categories (eg. Inappropriate delivery system, problem with requisition, wastage / storage, no oxygen transferred with patient).	Nature of Incident Type	

Area - Data	Field	Description	Extract Field Name	Tick
Documentation	**Incident Types**		Incident Type	
	Documentation error or omission	Paperwork is incomplete or incorrect (commonly used as a secondary incident type with medications).	Nature of Incident Type	
	Illegible or unclear	Incident resulted from an inability to read or fully understand paperwork (commonly used as a secondary incident type with medications).	Nature of Incident Type	
	Filed incorrectly	Paperwork was filed in the incorrect place.	Nature of Incident Type	
	Patient ID incorrect or absent	Patient details are incorrect or inadequate.	Nature of Incident Type	
	Specimen ID incorrect or absent	Specimen labelling inadequate, incorrect or omitted.	Nature of Incident Type	
	Documentation unavailable or lost	Paperwork inaccessible or missing.	Nature of Incident Type	
	Confidentiality breach	Information not intended for public knowledge was disclosed.	Nature of Incident Type	
	No, incomplete or incorrect consent	Consent has not been completed or was incorrectly completed, either by medical staff, patient or both.	Nature of Incident Type	
	Other (includes free text box)	Incident does not fit the above categories.	Nature of Incident Type	
Other	**Incident Types**		Incident Type	
	No or delayed admission, inappropriate bed or ward	The admission process was not attended to as per protocol or the ward or bed allocated is inappropriate for the patient (eg. Lack of available beds required the patient to wait in the A&E Dept for an extended period; MRSA patient not in a single room, aggressive psychotic patient allocated a medical unit bed).	Nature of Incident Type	
	No, wrong or delayed diagnosis	No diagnosis was made or the diagnosis was incorrect or was unreasonably delayed.	Nature of Incident Type	

Area - Data	Field	Description	Extract Field Name	Tick
	No, wrong or delayed procedure, treatment or assessment	Examples include delayed transfer, observations not done, incorrect investigations performed, procedure inappropriate or contradicted, premature removal of sutures, drains, IV cannula, patient not specialled 1:1 when ordered. Note: Not used if the incident involved activities of daily living.	Nature of Incident Type	
	Medical emergency	Medical event occurred that is not an incident by definition (eg. Cardiac / respiratory arrest, fainting whilst sitting in a chair, seizure). Discouraged from use in WA, doesn't fit the definition of a clinical incident.	Nature of Incident Type	
	Poor discharge planning	Incident involved an ineffective discharge process (eg. Patient leaving hospital without proper instructions, adequate human support or supplies, delayed discharge, x-rays or discharge medications not being given to patient prior to leaving).	Nature of Incident Type	
	Hospital acquired infection	Incident involved an infection acquired in hospital.	Nature of Incident Type	
	Wrong patient or body part or side	The incident involved the wrong patient body part or side of the body. Generally used for theatre or radiology related incidents.	Nature of Incident Type	
	Other (includes free text box)	Incident does not apply to the above categories.	Nature of Incident Type	
Contributing Factors	**Subject or incident factors**			
	Confusion or disorientation	Subject's confusion or disorientation contributed to the incident.	CFsu Confusion or disorientation	
	Dementia	Subject's dementia contributed to the incident.	CFsu Dementia	
	Mental health related	Subject's mental health related disorder contributed to the incident.	CFsu Mental health related	

Area - Data	Field	Description	Extract Field Name	Tick
	Physical impairment	Subject's physical impairment contributed to the incident (eg. Dependent on mobility aids, hemiparesis)	CFsu Physical impairment	
	CVA or TIA	Subject's CVA or TIA contributed to the incident occurring.	CFsu CVA or TIA	
	Very ill, fragile or general deterioration	Subject was receiving palliative care, has a terminal illness, or has general debility.	CFsu Very ill, frail, debilitated or general deterioration	
	Unsteady on feet	Should not be automatically assumed on the basis that the patient had a fall.	CFsu Unsteady on feet	
	Wrong or no footwear	Subject was wearing socks, TEDS or inappropriate footwear.	CFsu Wrong or no footwear	
	Pathophysiological factors	Subject has a medical condition/diagnosis that is not covered by other contributing factors.	CFsu Pathophysiological factors	
	Failure to follow advice or instructions	Subject failed to abide with advice or instructions.	CFsu Failure to follow advice or instructions	
	Affected by medication	Subject was under the influence of medications.	CFsu Affected by medication	
	Alcohol or drug intoxication	Subject was intoxicated following the consumption of alcohol or an illicit substance.	CFsu Alcohol or drug intoxication	
	Language or speech barriers	Subject's communication was affected due to nationality or pathophysiological factors.	CFsu Language or speech barriers	
	Distraction or inattention	Subject was not paying attention at the time of the incident.	CFsu Distraction or inattention	
	Other (includes free text box)	Contributing factor does not fit the above categories.	CFsu Other	
Contributing Factors	**Staff factors**			
	Inadequate knowledge or inexperience	Staff involved was new to the ward or hospital or inexperienced in the area they were working.	CFst Inadequate knowledge or inexperience	
	Failure to follow advice or instructions	Verbal or written instructions or advice was not followed.	CFst Failure to follow advice or instructions	

Area - Data	Field	Description	Extract Field Name	Tick
	Misread or did not read documentation	Staff failed to read or misinterpreted documentation.	CFst Misread or did not read documentation	
	Pressure to proceed	Staff were forced to perform in undesirable circumstances due to the unavailability or resources, time or system based factors.	CFst Pressure to proceed	
	Insufficient or inadequate staff	Staffing levels were inadequate or the staff themselves were inadequately trained for the duties required.	CFst Insufficient or inadequate staff	
	Failure to follow policy or procedure	A staff member failed to comply with set protocols or standards.	CFst Failure to follow policy or procedure	
	Staff did not attend when required	A staff member was requested to attend to a patient or area, but failed to respond to the request.	CFst Staff did not attend when required	
	Communication problem	Communication problem between staff or between staff and a patient.	CFst Communication problem	
	Poor teamwork or supervision	Poor teamwork or supervisions of other staff / patients.	CFst Poor teamwork or supervision	
	Multiple staff or poor continuity	More than one staff member is responsible for the delivery of care for the patient (eg. Team nursing during shift; two doctors treating a patient resulting in conflicting treatment).	CFst Multiple staff or poor continuity	
	Medication not reviewed	Medication has not been reassessed when required.	CFst Medication not reviewed	
	No PRN medications ordered	Medications were indicated and required, but were not ordered.	CFst No PRN medications ordered	
	PRN medication not used	PRN medications were ordered, but were not used when indicated.	CFst PRN medication not used	
	Distraction or inattention	Staff were 'not paying attention' or were performing other duties at the time of the occurrence.	CFst Distraction or inattention	
	Fatigue or stress or unwell	Staff were experiencing fatigue, stress or went home sick.	CFst Fatigue or stress or unwell	

Area - Data	Field	Description	Extract Field Name	Tick
	Other (includes free text box)	Contributing factor does not fit into the above categories.	CFst Other	
Contributing Factors	**System factors**			
	Security problem	Security problem contributed to the incident	CFsy Security problem	
	Call bell or paging problem	Call bell or paging problem contributed to the incident.	CFsy Call bell or paging problem	
	Environmental hazard or hazardous environment	Factor or exposure that may adversely affect health.	CFsy Environmental hazard or hazardous environment	
	Other (includes free text box)	Contributing factor does not fit the above categories.	CFsy Other	
Incident Outcomes	**Action taken or required**			
	Patient notified or educated	Patient was notified of incident or was counselled, spoken to, orientated, debriefed or reminded.	A_Patient	
	Relative notified or educated	The subject's relative was informed, debriefed or counselled; includes next of kin being informed or educated or follow up calls.	A_Relative	
	MO or consultant or home team notified	Doctor notified of the incident.	A_Dr	
	Restraint team called	Restraint team was required; includes security being called to restrain individuals	A_Restraint	
	Police or security called	Police or security were required or were notified of the incident; does not include security being contacted as part of a restraint team capacity.	A_Police	
	Transferred to another service or area	Individual required transfer (eg to another hospital, ward, ICU, A&E, Seclusion, secure ward management, another hospital or ward).	A_Transfer	
	Staff educated	Staff have been spoken to, counselled, debriefed or informed	A_Staff	

Area - Data	Field	Description	Extract Field Name	Tick
	Change in treatment	Care needs or treatment changed as a result of the incident.	A_Tx	
	Equipment and property managed	Equipment was withdrawn from use, investigated or actions taken to manage the problem; does not include food products or medications.	A_Equip	
	Relevant person notified	Relevant third party was notified of the incident or patient was referred (eg. Allied health)	A_Relevant	
	Policy or protocol development (or review or revision)	Policy or protocol reviewed to identify effectiveness and adequacy.	A_Policy	
	Other (includes free text box)	Actions taken do not fit the above categories.	A_Other	
Incident Outcomes	**Result of incident**	**Definition**		
	No injury	No harm has come to the subject as a result of the incident.	R_None	
	Abrasion, laceration or skin tear	Cuts, grazes, abrasions etc.	R_Tear	
	Bruise, swelling or reddened area	Bumps, soft tissue swelling, swelling from infected IV sites, haematoma. Does not include any burn related injury.	R_Bruise	
	Burn	Reddened areas from burn related incidents, scorching / erythema/blisters from heat, skin loss from heat.	R_Burn	
	Sprain or strain	Twisted ankles, back pain / injury, pulled muscles.	R_Strain	
	Fracture or dislocation	Fracture or dislocation of any bone.	R_Fact	
	Altered level of consciousness	Drowsiness, loss of consciousness, concussion.	R_Consc	
	Altered emotional state	Emotional responses such as upset, angry, distressed, anxious, teary, frightened, shaken or shocked.	R_Emot	
	Pain	Pain/tenderness/soreness.	R_Pain	

Area - Data	Field	Description	Extract Field Name	Tick
	Formal complaint	Formal complaint (written or verbal) was made.	R_Complaint	
	Other (includes free text box)	Incident result does not fit into the above categories. *Note 1: If the incident relates to a Hospital Acquired Infection the organism (if stated) should be entered here; Note 2: If the incident resulted in the death of a patient then the word 'Death' should be entered here.*	R_Other	
Incident Outcomes	**Incident Outcome Criterion**	**Definition**		
	Unknown	The outcome is unknown or not reported.	Incident Outcome	
Potential	Level 1	Dangerous state / potential for harm (eg. Understaffed ICU, torn floor covering etc).	Incident Outcome	
	Level 2	The incident was intercepted prior to causing harm (eg. Wrong drug drawn up, but not given).	Incident Outcome	
Actual	Level 3 (no outcome)	The incident occurred, but there was no harm to the patient or no change in condition or treatment.	Incident Outcome	
	Level 4 (minor outcome)	An incident occurred, but there was only minor harm to the individual, not requiring treatment.	Incident Outcome	
	Level 5 (moderate outcome)	An incident occurred and resulted in minor diagnostic investigations, minor treatment, dressings / cold pack, analgesia, security / emergency services called, allied health review etc.	Incident Outcome	
	Level 6 (moderate to significant outcome)	Incident resulted in diagnostic investigations such as MRI / CT scan, cancellation or postponement of treatment, transfer to another area not increasing length of stay, treatment with another drug.	Incident Outcome	
	Level 7 (significant outcome)	Incident resulted in hospital admission, increased length of stay, readmission, transfer to ICU / HDU / secure ward / seclusion etc.	Incident Outcome	

Area - Data	Field	Description	Extract Field Name	Tick
	Level 8 (severe outcome)	Incident resulted in permanent disability or death.	Incident Outcome	
Area – User Defined Fields (UDF's)	**Field**	**Definition**	**Extract Field name**	**Tick**
	01 Form - ATSI	Entered by Data Entry Staff. Aboriginal or Torres Strait Islander (Page 1 of Clinical Incident Form).	UDF 01 ATSI	
	03 Form - Open Disclosure Initiated	Entered by Data Entry Staff. Open disclosure process has been initiated (Page 3 of Clinical Incident Form).	*Not available from extracts*	
	06 D Entry - Restraint	Entered by Data Entry Staff for cases involving restraint in relevant mental health setting. UDF requested by one of the Mental Health Services. Note: Additional 19 restraint UDF's available.	UDF 06 Restraint	
	06 D Entry - Seclusion	Entered by Data Entry Staff for relevant cases involving seclusion in relevant mental health setting. UDF requested by one of the Mental Health Services. Note: Additional 14 seclusion UDF's available.	UDF 06 Seclusion	
	10 Coding - Clinical handover Issue	Selected by Classifiers. Incorrect or incomplete handover identified.	UDF 10 Clinical Handover Issue	
	10 Coding - Smoking related issue	Selected by Classifiers. Incident related to patient smoking in hospital or grounds.	UDF 10 Smoking related issue	
	10 Coding - SAC 1	Entered by Data Entry Staff. 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.	UDF 10 SAC 1	
	10 Coding - SAC 2	Entered by Data Entry Staff. 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.	UDF 10 SAC 2	

Area – User Defined Fields (UDF's)	Field	Definition	Extract Field name	Tick
	10 Coding - SAC 3	Entered by Data Entry Staff. 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.	UDF 10 SAC 3	
	10 Coding - Transfer issues	Selected by Classifiers. Includes inadequate care in preparation for transfer, inadequate care during transfer, inadequate or no escort, transfer issues between wards/lodges/hospitals/regions, policy issues, transfer communication issues, larger hospital refusing to take patient from smaller hospital, delayed transfer of patient on MHA forms.	UDF 10 Transfer issues	
	10 Coding - Transport issues	Selected by Classifiers. Ambulance or RFDS or other required mode of transport unavailable / inappropriate mode of transport used.	UDF 10 Transport issues	
	20 General - National Inpatient Medication Chart	Selected by Classifiers. A medication error occurred which was a direct result of the implementation/design of the National Inpatient Medication Chart (NIMC). Selected by classifiers.	UDF 20 National Inpatient Medication Charts	

Appendix 2 SAC 1 Data Fields

SAC 1 Field/Description	Data contained within field	Tick Field Required
Event Month Identifies the month that the incident occurred.	Month e.g. January	
Financial year Identifies the financial year that the incident occurred.	Financial year e.g. 2011/2012	
Public or Private Identifies if the incident occurred within the WA Health (public) or non WA Health (private) system.	Public	
	Private	
Sentinel Event category Nationally endorsed sentinel event categories.	Procedure involving the wrong patient or body part resulting in death or major permanent loss of function.	
	Suicide of a patient in an inpatient unit (or whilst on leave)	
	Retained instruments or other material after surgery requiring reoperation or further surgical procedure	
	Intravascular gas embolisation resulting in death or neurological damage	
	Haemolytic blood transfusion reaction resulting from ABO incompatibility	
	Medication error resulting in the death of a patient	
	Maternal death or serious morbidity associated with labour or delivery	
	Infant discharged to wrong family or infant abduction	
Non sentinel event SAC 1 Categories Non sentinel event SAC 1 incident categories.	Medication error (not resulting in death)	
	Fetal complications	
	Misdiagnosis and subsequent management	
	Complications of resuscitation	
	Complications of anaesthetic management	
	Complications of surgery	
	Complications of an inpatient fall	
	Hospital process issues	
	Infection control breach	
	The unexpected death of a mental health client	
	Absconding of any mental health patient/consumer	

SAC 1 Field/Description	Data contained within field	Tick Field Required
	Any other incident resulting in serious harm or death of a patient.	
WARM Identifies if the SAC 1 incident was notified following investigation via a process of mortality review identified in the WA Review of Mortality Policy	Yes	
	No	
Mental Health Identifies if the SAC 1 incident concerns a mental health patient / client.	Yes	
	No	
Qualified Privilege Identifies whether the investigation of the SAC 1 incident will occur under the protection of qualified privilege.	Yes	
	No	
Contributory Factors Factors identified through the investigation of a SAC 1 incident that may have contributed to the issues, problems or difficulties observed.	Communication	
	Equipment	
	External Factors	
	Health Information	
	Human Resources	
	Inter-Hospital Issues	
	Knowledge Skills Competence	
	Physical Environment	
	Policies, Procedures, Guidelines	
	Safety Mechanisms	
	Transportation Issues	
	Work Environment	
	Other (Patient Factors)	

Further description of sentinel event categories, non sentinel event SAC 1 Incident categories, and contributory factors can be found in the Clinical Incident Management Toolkit located on the Office of Safety and Quality in Healthcare Website. (http://www.safetyandquality.health.wa.gov.au/clinical_incid_man/aims.cfm

Patient Safety Surveillance Unit

Performance Directorate

Performance Activity and Quality Division

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This document can be made available in alternative formats on request for a person with a disability.