

# CEC eChartbook Portal Extract

## Incident Management System

Clinical incident notifications: Strengthening the learning and reporting culture in healthcare

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### Contributors:

Drafted by: CEC Patient Safety team

Data analysis by: CEC eChartbook team

Reviewed by: CEC Patient Safety team

Edited by: CEC eChartbook team

### Any enquiries or comments about this publication should be directed to:

André Jenkins, Director, Information Management; A/Director, Corporate Services

Clinical Excellence Commission, Locked Bag A4062, Sydney South NSW 1235

Phone: (02) 9269 5500 Email: [echartbook@cec.health.nsw.gov.au](mailto:echartbook@cec.health.nsw.gov.au)

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# CLINICAL INCIDENT NOTIFICATIONS: STRENGTHENING THE LEARNING AND REPORTING CULTURE IN HEALTHCARE

## Incident Management System

**Why is this important?** The Incident Information Management System (IIMS) was established in 2005, as a key component of the NSW Patient Safety and Clinical Quality Program. Gathering information on all incidents that might affect patient safety, whether or not harm occurred, enables contributory factors to be analysed and system-wide lessons learned. All NSW Health staff are responsible for notifying all incidents, near-misses and complaints, using IIMS. Each incident notified in IIMS requires an investigation, in accordance with the level of risk it presents. The Severity Assessment Code (SAC) is used to rate incidents by assessing the consequences and the likelihood of re-occurrence. Of the four ratings, SAC1 is the most serious:

- Clinical SAC1 incidents must be reported to the Ministry of Health within 24 hours and are investigated using root cause analysis (RCA). This category includes the unexpected death of any patient, suspected suicide of mental health patients and procedures involving the wrong patient or body part
- SAC2 incidents require investigation at the local health district (LHD) level
- SAC3 and SAC4 require local action, including assigning management responsibility.

St Vincent's Health Network applies the same approach, but uses a different incident management system. Their clinical incident data is now included in the following chart and table. LHDs are responsible for ensuring monitoring and risk rating of all incidents. The Clinical Excellence Commission (CEC) is responsible for reviewing trends in incidents and providing information on clinical risks. The NSW Ministry of Health and the CEC have systems in place to disseminate lessons learned from incident management and to report their findings broadly. During 2011 there were over 15,000 notifications per month (up to 16,245), of which up to 13,000 were clinical incidents. (Total incidents -181,000, total clinical incidents - 134,000).

**Findings:** The overwhelming majority of IIMS clinical notifications (95%) are in categories SAC3 and SAC4, where there has been minimal, or no harm, to the patient, but where staff have identified risk. In 2011, SAC1 incidents comprised half of one per cent of clinical incident notifications, as shown below. Analysis of incident data occurs at State level in a number of ways and the findings are used to drive improvements in clinical care systems across NSW. The table below and further information about incidents and actions taken in response to them, can be found in the Incident Management reporting series and on the CEC Patient Safety Program web page.

There is substantial variation in IIMS reporting rates. High-reliability organisations (those with the best safety records) recognise the importance of no-blame incident reporting systems as a method of learning about the types of errors which may occur. This enables systems to be put in place to reduce the risk of these errors recurring (Reason, 2000). In health, a high rate of reporting is a positive situation and may suggest that staff are more vigilant in identifying anything that may constitute a risk to patient safety. The relative rate allows us to monitor variation in the proportion of the component SAC ratings.

**Implications:** The analysis of clinical incident data trends and contributing factors provides the opportunity to improve the management in the environment where they occurred. This information also informs Statewide programs such as Falls Prevention, Medication Safety and Sepsis Kills, which were initiated following detailed analysis of IIMS and RCA reports.

**What we don't know:** It is inappropriate to attribute any direct relationship between the numbers of incidents reported and the safety and quality of clinical care. It is the content of notifications, not the count, which informs the system about where improvements need to occur. Fostering a reporting culture where staff speak-up about issues which they may previously not have regarded as incidents, is vital for patient safety.

Table IM01- Clinical incident notifications and episodes of inpatient care, July - December 2011

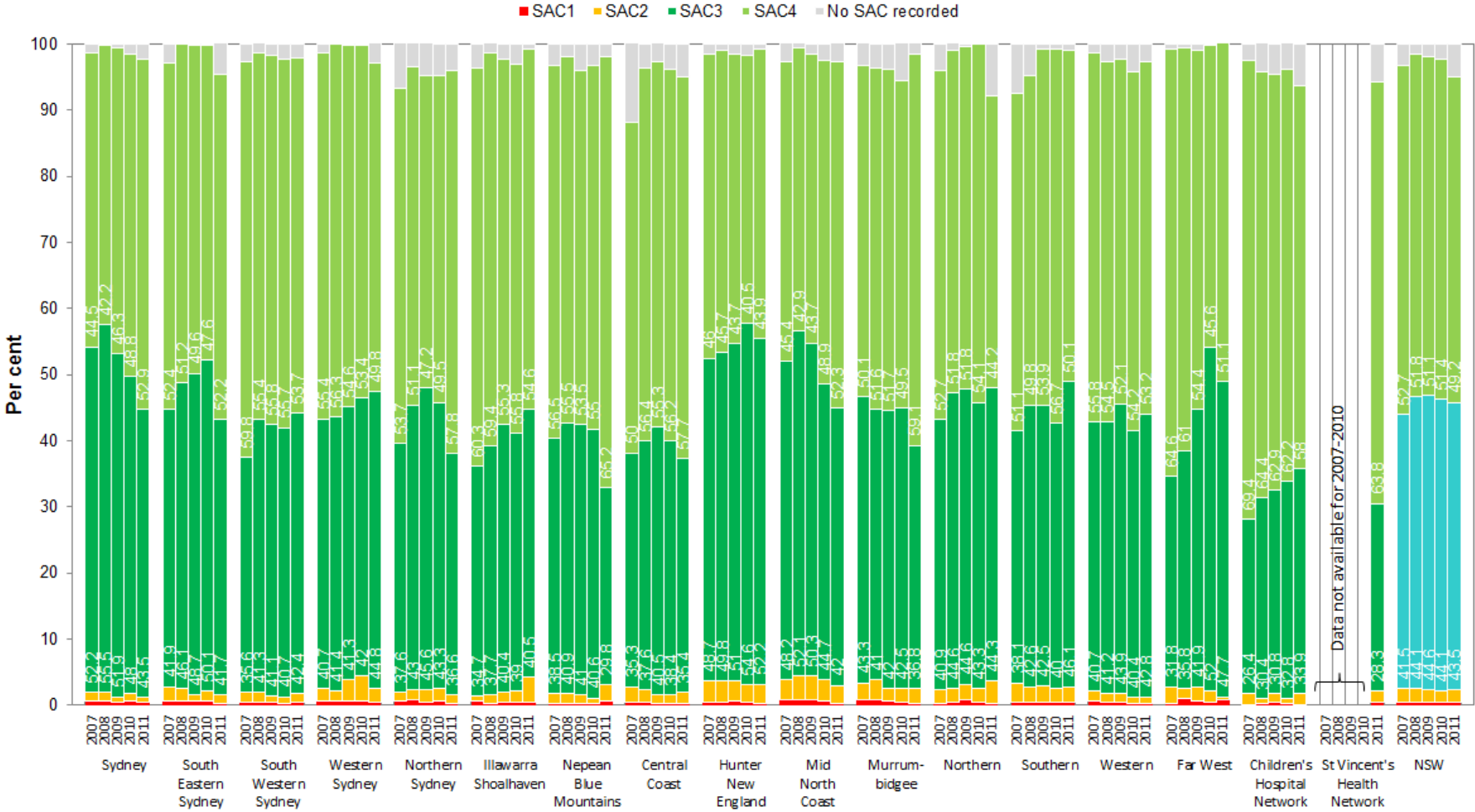
Clinical Incident notifications and episodes of inpatient care, July - December 2011				
SAC Rating	Number	SAC ratings as a percentage of notifications	Percentage of separations about which an incident was reported	Clinical incidents per 1,000 bed days
SAC 1	309	0.44	0.04	0.1
SAC 2	1,384	1.95	0.16	0.4
SAC 3	30,688	43.2	3.63	9.2
SAC 4	34,775	48.96	4.11	10.5
No SAC allocated	3,874	5.45	0.46	1.2
Total	71,030	100	8.39	21.4

Table IM02- Clinical incident notifications and episodes of inpatient care, January - June 2011

Clinical incident notifications compared with episodes of inpatient care, January - June 2011				
SAC Rating	Number	SAC ratings as a percentage of notifications	Percentage of separations about which an incident was reported	Clinical incidents per 1,000 bed days
SAC1	269	0.4	0.03	0.1
SAC 2	1,261	1.9	0.16	0.4
SAC 3	29,059	43.7	3.6	9.1
SAC 4	32,869	49.43	4.07	10.3
No SAC allocated	3,034	4.56	0.38	0.9
Total	66,492	100	8.24	20.8

Source: NSW Ministry of Health, Clinical Excellence Commission  
 Note: The NSW total included all clinical incidents notified by St Vincent's Health Network.

Chart IM01 - Percentage distribution of IIMS notifications by SAC classification and local health district of treatment, 2007-2011



Source: NSW Ministry of Health, Clinical Excellence Commission (NSW 2011 data included all clinical incidents notified by St Vincent's Health Network).

## Data Definitions

<b>Chart:</b>	IM01
<b>Admin Status:</b>	Current
<b>Indicator Name:</b>	Clinical incident notifications per 100 separations
<b>Description:</b>	Rate of IIMS notifications by SAC classification per 100 separations by local health district of treatment, 2007-2011
<b>Dimension:</b>	Performance of health service provider: reporting culture in health care
<b>Clinical Area:</b>	Initiatives in safety and quality
<b>Data Inclusions:</b>	All IIMS and St Vincent's Health Network (SVHN) clinical incident notifications included
<b>Data Exclusions:</b>	None
<b>Numerator:</b>	Total number of IIMS notifications and SVHN clinical incident (for 2011) by SAC classification (SAC1, SAC2, SAC3, SAC4)
<b>Denominator:</b>	Total number of separations by SAC classification (SAC1, SAC2, SAC3, SAC4)
<b>Standardisation:</b>	None (crude rate per 100 was calculated)
<b>Data Source:</b>	Incident Information Management System (IIMS), Clinical Excellence Commission and NSW Ministry of Health, SVHN Clinical Governance Unit
<b>Comments:</b>	Not Applicable