Biannual Incident Report

1 January 2017 – 31 December 2020

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

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Table of Contents

Clinical Incidents

From 14 December 2020 serious incident management in NSW has changed. This report refers to incident management processes in place prior to 14 December 2020. Click *here* for information about the changes to incident management in NSW.

An incident is an unplanned event that results in, or has the potential for, injury, damage or loss, including near misses. An incident may also be referred to as an 'adverse event'. [1]

NSW Health staff are required to report all incidents (both clinical and corporate), near misses, and complaints so that risks to patient safety are recognised and action is taken to prevent them from happening again. This is supported by the NSW Health Incident Management Policy Directive PD2020_047.

The Incident Information Management System (IIMS) has been used across the NSW public health system to notify and manage incidents since 2005. From October 2019, NSW Health commenced a staged introduction of a new system, ims+, to report and manage incidents, hazards and near misses. Local Health Districts (LHDs) and Specialty Health Networks (SHNs) have progressively transitioned onto the new ims+ application, with all health services transitioning across to the new application by the end of 2020. The St Vincent's Health Network (SVHN) uses Riskman as their incident reporting system, and will continue to do so.

Analysing incidents allows the health system to identify significant issues, risk and trends relating to health care and to put systems in place to help prevent future incidents from occurring.

The risk of clinical incidents reported in IIMS is rated against a Severity Assessment Code (SAC), while incidents reported in ims+ use a Harm Score (HS). The key purpose of the SAC/Harm Score is to direct the level of investigation and action required for a particular incident. There are four SAC/Harm Score ratings, ranging from SAC/Harm Score1 (extreme risk) to SAC/Harm Score4 (low risk). The Harm Score in ims+ is based on the outcome for the patient and any additional care required as a result of the incident.

As outlined in the NSW Health Incident Management Policy, all SAC/Harm Score1 incidents are required to undergo a thorough investigation known as a Serious Adverse Event Review (SAER). The SAER investigation process aims to identify the causes and factors which may have contributed to the incident. Recommendations are made by SAER investigation teams to reduce the risks identified. The LHD/SHN is responsible for monitoring and implementing the recommendations of the SAER investigations. The NSW Ministry of Health (MoH) and the Clinical Excellence Commission (CEC) oversee SAER investigations across the state to ensure lessons are shared with the broader health system where appropriate.

The term SAER was introduced in the revised Incident Management Policy published in December 2020 and covers the four review methods for serious incidents in NSW Health facilities: Comprehensive Incident Analysis, Concise Incident Analysis, London Protocol and Root Cause Analysis (RCA). Prior to December 2020, only RCA was used to investigate serious clinical

incidents in NSW Health. All serious clinical incident investigations presented in this reporting period relate to RCAs.

Part of the investigation process involves notifying the appropriate people and organisations, investigating the incident, and completing Open Disclosure with patients, family members and staff involved (Figure 1 provides the framework for the investigation process used during the July – December 2020 reporting period).

The MoH is notified of SAC/Harm Score1 incidents, including Sentinel Events, and other significant clinical incidents. Incidents are reported in accordance with the NSW Health Incident Management Policy, through a Reportable Incident Brief (RIB).

Sentinel Events are a rare group of incidents that are considered wholly preventable and result in serious harm to, or the death of, a patient. Eight Sentinel Events were required to be reported in Australia between April 2004 and June 2019, as follows;

1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function
2. Suicide of a patient in an inpatient unit
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. Intravascular gas embolism resulting in death or neurological damage
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility
6. Medication error leading to the death of a patient reasonably believed to be due to the incorrect administration of drugs
7. Maternal death associated with pregnancy, birth and the puerperium
8. Infant discharged to the wrong family

In December 2018, a revised Australian Sentinel Events (ASE) list was endorsed by Australian Health Ministers and came into effect on 1 July 2019. The revised ASE list increased from eight to ten events. For more information, please see the Australian Commission on Safety and Quality in Health Care website.

Data on Sentinel Events is reported in the annual Report on Government Services (ROGS). Data for 2019-20 were published in the ROGS report released in February 2022.

The CEC reviews all clinical RIBs reported in NSW and analyses the data to determine focus areas for improvement. This report is informed by the IIMS, ims+, RIB, and SAER data.

During the reporting period, all NSW Health services commenced use of ims+. Due to the differences between the IIMS and ims+ applications with regards to the classification of clinical incidents and complaints, data displayed within this report is combined to include ims+ at a high level.

The CEC's role in Incident Reporting

The CEC is the lead agency supporting patient safety and clinical quality improvement in the NSW public health system and has a key role in analysing and reporting on the information contained in IIMS and ims+. The CEC has developed a number of quality improvement projects and programs in response to the analysis of statewide incident data. These programs include those focused on the recognition and management of the deteriorating patient (Between the Flags) and addressing patients with sepsis (SEPSIS KILLS).

The CEC continues to work with the health services to strengthen the management of incidents across NSW Health.

NSW Health was the first Australian jurisdiction to publicly report healthcare incident data. The first report was released in 2005. The CEC published its first web-based clinical incident management report in 2013. This regular publication of data is part of the CEC's commitment to be transparent, accountable and supportive of NSW Health clinicians and teams to provide the safest and highest quality care for every patient, every time.

For more information about the CEC, its programs, resources and publications see **http://www.cec.health.nsw.gov.au**

Included in this report

The information in this report includes data from the IIMS, ims+, the RIBs, SAERs, Riskman and Health Information Exchange (HIE). For more specific extract information, please contact the CEC Patient Safety Directorate via email **CEC-patientsafety@health.nsw.gov.au**

This report contains:

- An explanation of how to interpret the data and information;
- Clinical incident notification data by SAC/Harm Score
- Systems and risks factors in serious clinical incidents identified through SAER investigations
- Specific Clinical incidents involving:
    - Patient Identification
    - National Sentinel Events
- Complaints notified in IIMS and ims+

Data Interpretation

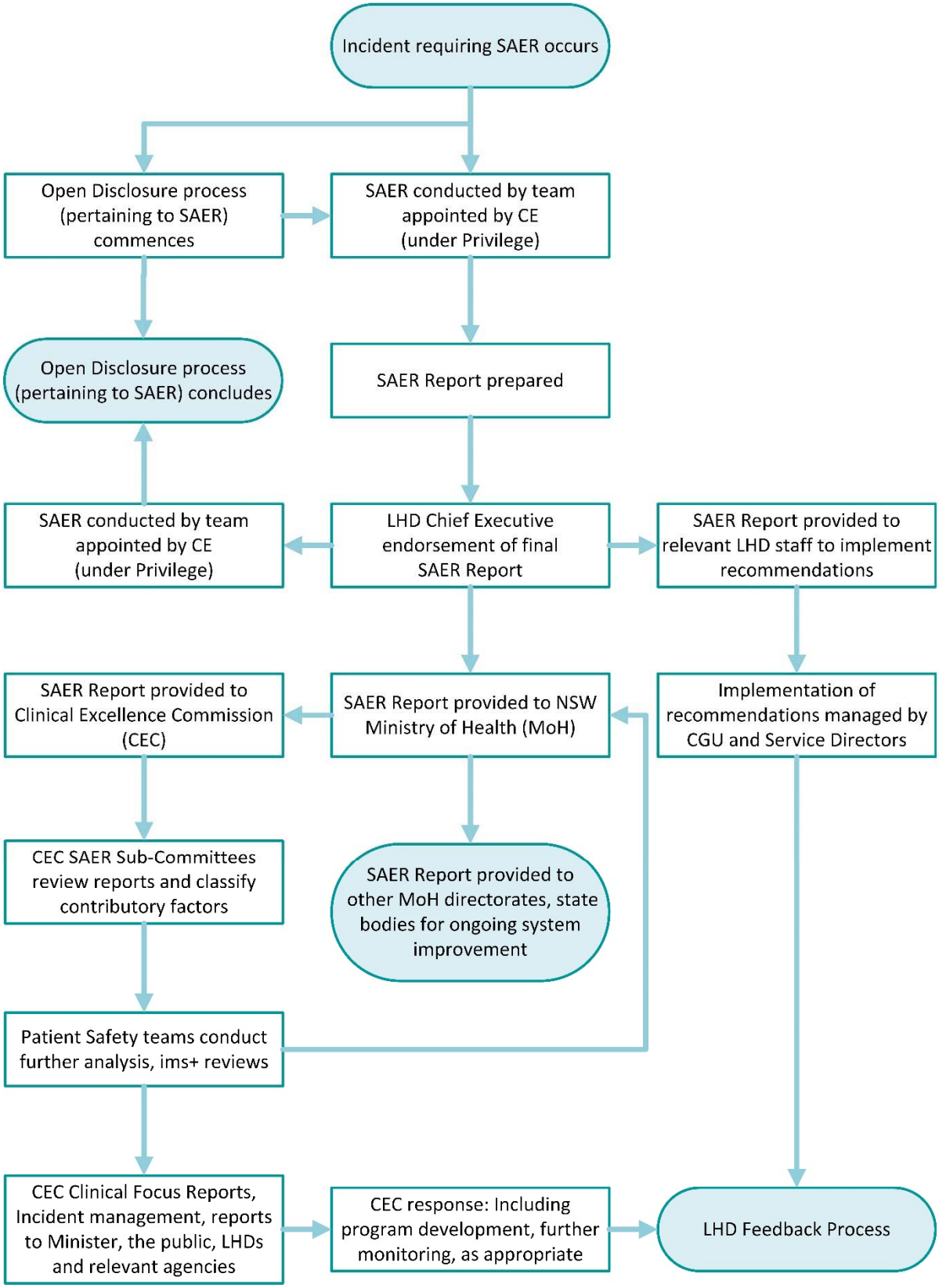
Analysis of the information contained within the incident management system may provide greater insight into how incidents occur, provide context, highlight issues and identify system-related opportunities for improvement.

Given the wide variation between services and facilities, it is difficult to make accurate comparisons based on notification numbers alone. Many variables influence incident reporting. Incident rates or reporting counts should not be used as the single source of benchmarking data for a project or

program. Lower rates of reporting are not a reliable indicator of safer care, therefore, further qualitative, rather than quantitative, interpretation of the data is recommended.

[1] Organisation for Economic Co-operation (OECD) (2017)

Figure 1: Serious clinical incidents requiring RCA investigation during the period July - December 2020



Clinical Incident Data

Severity of Clinical Incidents

Clinical incidents notified in IIMS and Riskman are allocated a Severity Assessment Code (SAC) rating, while incidents reported in ims+ use the Harm Score. In line with NSW Health Incident Management Policy PD2020_047, the SAC/Harm Score directs the level of investigation and action required for an adverse event.

The most serious types of clinical incidents are rated as SAC/Harm Score1 (the other possible scores are SAC/Harm Score2, SAC/Harm Score3 or SAC/Harm Score4 in declining order of severity). In ims+, the Harm Score is based on the incident outcome and additional care and/or resources that are needed as a result of the incident. The SAC/Harm Score must be reviewed and confirmed by a manager within five days of the incident notification. All SAC/Harm Score1 incidents and Sentinel Events require a Reportable Incident Brief (RIB) to be submitted to the NSW Ministry of Health.

During the July – December 2020 reporting period, ims+ continued to be rolled out across NSW, with all health services transitioning across to the new application by the end of 2020. Due to the differences between IIMS and ims+ in relation to the classification of clinical incidents and complaints, data displayed within this report is limited to SAC/Harm Score rating of clinical incidents and rates of clinical incidents and complaints in relation to hospital activity.

There has been a slight decrease (one per cent) in the overall number of clinical incident notifications across July - December 2020 when compared to the previous reporting period. This decrease may be reflective of the new capabilities within the ims+ application, which enable users to report incidents that are not specifically related to an individual patient's care (such as a measles outbreak in a ward or reporting lost/stolen accountable medications) as a corporate incident. Previously in IIMS, these types of events were reportable as clinical incidents.

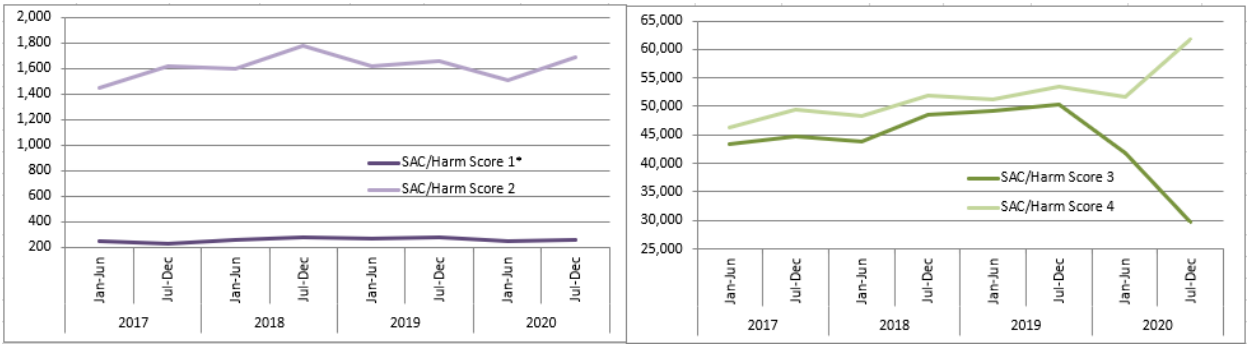
The data shows that serious clinical incidents in healthcare are extremely rare, with two per cent of incidents notified rated as SAC/Harm Score1 or SAC/Harm Score2. Most reported incidents (94 per cent), were rated as SAC/Harm Score3 or SAC/Harm Score4 and resulted in minimal or no harm to the patient involved.

Table 1: Clinical Incidents notified by Actual SAC/Harm Score rating, January 2017 – December 2020

Actual SAC/Harm Score Rating	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
SAC/Harm Score 1*	248	232	255	279	272	283	246	263
SAC/Harm Score 2	1,446	1,619	1,603	1,774	1,615	1,654	1,508	1,684
SAC/Harm Score 3	43,405	44,764	43,842	48,471	49,193	50,222	41,844	29,767
SAC/Harm Score 4	46,210	49,486	48,321	51,893	51,285	53,494	51,684	61,694
No SAC/Harm Score Allocated	3,309	3,274	3,325	3,377	3,248	3,372	2,923	3,410
Total	**94,618**	**99,375**	**97,346**	**105,794**	**105,613**	**109,025**	**98,205**	**96,818**

*Caveats: *SAC/Harm Score1 data obtained from the CEC RIB Database. SAC/Harm Score2-4 obtained from IIMS, ims+ and SVHN Riskman.*

Figure 2 and 3: Clinical SAC/Harm Score1 & SAC/Harm Score2 and SAC/Harm Score3 & SAC/Harm Score4 incident notifications, January 2017 – December 2020



*Caveats: *SAC/Harm Score1 data obtained from CEC RIB Database, SAC/Harm Score2-4 obtained from IIMS, ims+ and SVHN Riskman*

Clinical Incidents per 1,000 Acute Care Bed Days

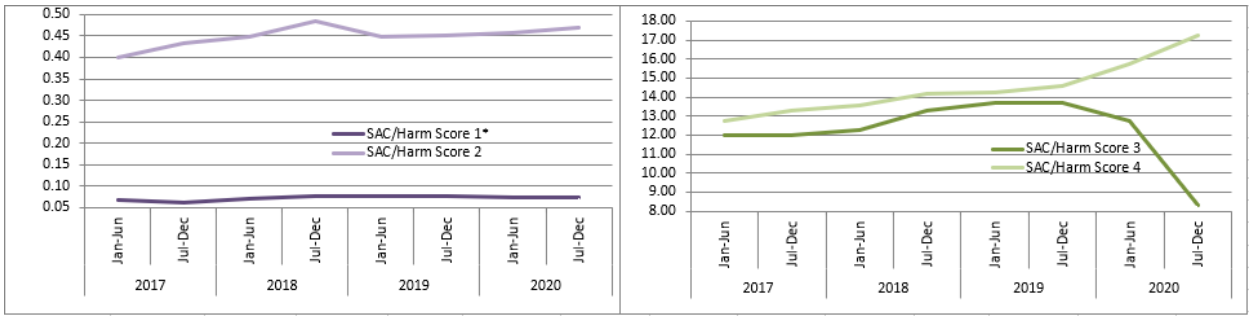
Reporting the number of clinical incidents in relation to activity i.e. per 1,000 acute care bed days, provides greater insight than reporting only the number of incidents. The rate of SAC/Harm Score1 and SAC/Harm Score2 incidents from 2017 – 2020 has remained stable. A decrease in SAC/Harm Score3 incidents is noted, while SAC/Harm Score4 incidents that result in little or no harm, have increased slightly during the current reporting period. The overall rate of incidents per 1,000 acute care bed days declined over December - July 2020 when compared with the previous reporting period.

Table 2: Clinical Incident notifications by SAC/Harm Score per 1,000 acute care bed days, January 2017 – December 2020

Per 1,000 bed days	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
SAC/Harm Score 1*	0.07	0.06	0.07	0.07	0.07	0.07	0.07	0.07
SAC/Harm Score 2	0.40	0.43	0.44	0.46	0.44	0.42	0.42	0.47
SAC/Harm Score 3	12.00	12.00	12.08	12.67	13.28	12.64	11.62	8.31
SAC/Harm Score 4	12.78	13.27	13.32	13.57	13.84	13.47	14.35	17.21
No SAC/Harm Score Allocated	0.91	0.88	0.92	0.88	0.88	0.85	0.81	0.95
Total	**26.16**	**26.65**	**26.83**	**27.66**	**28.51**	**27.45**	**27.27**	**27.02**

*Caveats: *SAC/Harm Score1 data obtained from CEC Patient Safety Database, SAC/Harm Score2-4 obtained from IIMS, ims+ and SVHN Riskman.*

Figure 4 and Figure 5: SAC/Harm Score1 & SAC/Harm Score2 and SAC/Harm Score3 & SAC/Harm Score4 clinical incidents per 1,000 acute care bed days, January 2017 – December 2020



SAC/Harm Score1 Reportable Incident Briefs (RIBs)

The total number of SAC/Harm Score1 clinical incident notifications has increased by 7 per cent over the July – December 2020 reporting period, compared to the previous period.

The most frequently reported SAC/Harm Score1 clinical incidents continued to be categorised under the Principal Incident Type (PIT) of *Clinical Management*. This category includes incidents associated with the diagnosis, treatment and monitoring/observations of patients in any inpatient care setting (Table 3).

Table 3: SAC/Harm Score1 Clinical Incidents by PIT, January 2017 – December 2020

Service or Principle Incident Type*	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Clinical Management - all clinical streams includes patient identification**	94#	71#	96#	97#	106#	105#	79#	83
Retained accountable items	7	5	5	10	7	2	0	2
Behavioural/Human performance (includes suspected suicides)	62	42	57	42	46	50	66	71
Maternal and perinatal stream	14	15	14	20****	15	22	22^	22^
Incidents from all groups determined to be non-preventable or unclassifiable, follow SAER	32	28	18	44	26	35	22	22
Falls	16	23	28	21	33	17	23	19
Aggression	7	2	4	4	2	7	5	3
Other†	16	46	33	41	37	45	29	41
Total	**248**	**232**	**255**	**279**	**272**	**283**	**246**	**263**

Caveats:
**SAC/Harm Score1 data obtained from the CEC Patient Safety Database*
***All clinical streams, includes patient identification errors*
****Patient identification reporting requirements changed on 10th February 2014*
***** Includes an incident which involved retained materials*
† Other includes Healthcare Associated Infection, Medical Devices/Equipment, Medication/IV Fluid, Undetermined cause of death, SAERs not received, SAERs not reviewed and Decommissioned.
 # Includes patient identification incidents
^ Includes fetal, maternal death and stillbirths

SAER Data

System Factors in Clinical Incidents

During the July – December 2020 reporting period, a SAER was required for all clinical incidents submitted with a SAC/Harm Score1 rating, and selected SAC/Harm Score2-4 as endorsed by the Chief Executive.

SAER is the new terminology which came into effect with the revised NSW Health Incident Management Policy (PD2020_047) on 14 December 2020. Under the revised policy four types of SAER can be used to investigate serious clinical incidents in NSW Health.

- Concise Incident Analysis
- Comprehensive Incident Analysis
- London Protocol
- Root Cause Analysis (RCA)

Before 14 December 2020, the RCA methodology was used to investigate all serious clinical incidents. All serious clinical incident investigations submitted in this reporting period are RCAs.The RCA methodology aims to identify what factors caused or contributed to a clinical incident occurring. The CEC analyses RCA report findings and state-wide data to develop state-wide system improvements which aim to prevent similar incidents occurring in the future. Examples of these system improvements include programs and quality tools such as Between the Flags, Sepsis Kills and Patient Safety Watches.

The CEC reviewed all clinical SAER reports submitted to the NSW Ministry of Health through four sub-committees of the Clinical Risk Action Group (CRAG). The SAER review sub-committees are:

- Clinical Management
- Maternal and Perinatal
- Mental Health/Drug & Alcohol
- Child and Young Person.

The sub-committees classify each SAER report using a standard classification system. This system is revised as new issues and clinical practice changes emerge.

During the reporting period of July - December 2020, the top system factor identified by the Clinical Management, Maternal and Perinatal, and Mental Health/Drug & Alcohol review sub-committees related to *Care Planning.* The top system factor related to Child and Young Person review sub-committee was *Communication.*

The system factor *Care Planning* relates to incidents where there may have been gaps or failures in collaborative planning for patients receiving care from more than one team. This includes care continuity and care co-ordination within a facility or between health care facilities and may relate to private and public providers and inpatient and community-based services. *Care Planning* also

includes incidents which occur when a patient's risk factors have not been adequately assessed or managed, such as falls risk or the capacity of their carers to manage ongoing care.

System Factors - Clinical Management

In the July – December 2020 reporting period, 155 Clinical Management SAER reports (all SAC/Harm Score levels) were reviewed and analysed. The top three system factors identified by the Clinical Management review sub-committee (Table 4) relate to *Care Planning*, *Communication* and *Workforce.* System factors are further categorised into subcategories:

- *Care planning* consists of 15 system factors which include *Care Continuity, Care Coordination, Child Protection, Discharge planning and End of Life.*
- *Communication* consists of four system factors including *Inadequate documentation* and *Inadequate communication* between care providers.
- *Workforce* consists of six system factors which include *Availability senior staff, Training and Education*, *Rostering* and *Credentialing/scope of practice*.

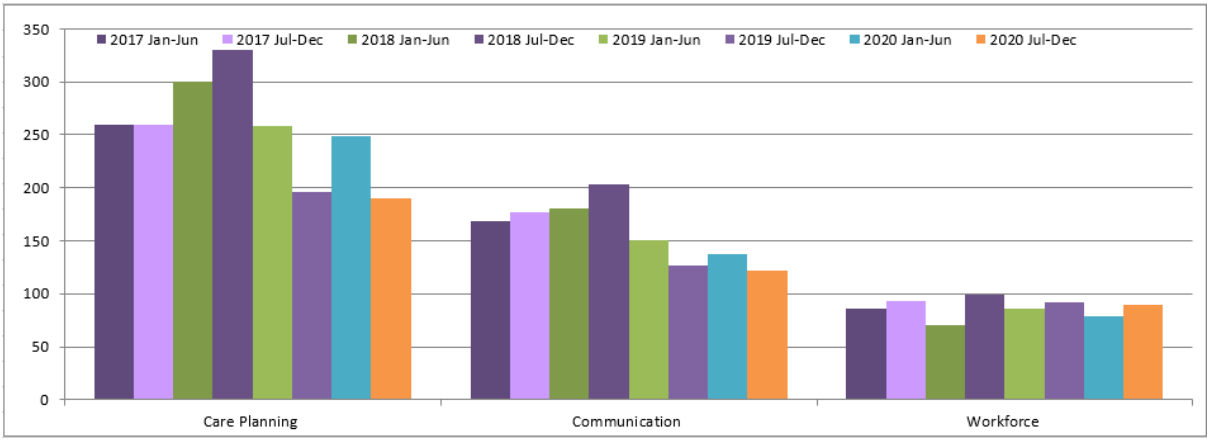
Table 4 outlines the system factors identified in Clinical Management SAERs reviewed between July 2017 and December 2020 and figure 6 outlines the top three system factors identified through Clinical Management SAERs identified during the current reporting period.

Table 4: System factors identified through Clinical Management SAER reports, January 2017 – December 2020

Clinical Management SAER System Factors	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Care Planning	260	260	300	330	258	196	249	190
Communication	169	177	181	203	151	127	138	122
Workforce	86	93	71	99	86	92	79	90
Assessment	108	119	131	132	120	83	98	85
Policy & Guidelines	112	146	131	146	119	88	128	84
Observations & Monitoring	89	79	86	94	81	70	84	65
Investigations	61	73	59	72	66	61	56	56
Supervision	73	61	61	61	50	53	46	53
Environment	43	71	77	53	53	35	48	47
Equipment	35	33	41	53	37	31	33	36
Teamwork	65	48	58	55	34	26	35	32
Access	28	39	40	31	26	25	23	24
No factors identified*	1	0	8	8	15	15	7	19
Transfer	4	2	4	8	3	6	4	3
Total	**1,134**	**1,201**	**1,248**	**1,345**	**1,099**	**908**	**1,028**	**906**

Caveats:
Denotes number of reports received during the specified reporting period including those received from private health facilities.
** 'No factors identified' was added as a system factor in January - June 2017*
*** Multiple system factors can be applied to each SAER*

Figure 6: Top three system factors identified through Clinical Management SAER reports, January 2017 – December 2020



*Caveats: * Top three system factors for July 2020 – December 2020*

System Factors - Mental Health/Drug and Alcohol

In the July 2020 – December 2020 reporting period, 93 mental health, drug and alcohol SAER reports (all SAC/Harm Score levels) were reviewed and analysed. The top three system factors for mental health, drug and alcohol SAERs during the reporting period were *Care Planning*, *Assessment* and *Communication.*

System factors are further categorised into subcategories;

- *Care Planning* is further categorised into sub-categories related to *care plan development, the role of the patient, family and carers in care planning, risk assessment* and *communication deficiencies when implementing the care plan.*
- *Assessment* is further categorised into sub-categories related to *risk assessment, assessment of the patient's physical and mental health* and *assessment of concerns raised by patients, family and carers.*
- *Communication* is further categorised into sub-categories related to *documentation*, *communication among clinicians* and with the *patient, family or carer.*

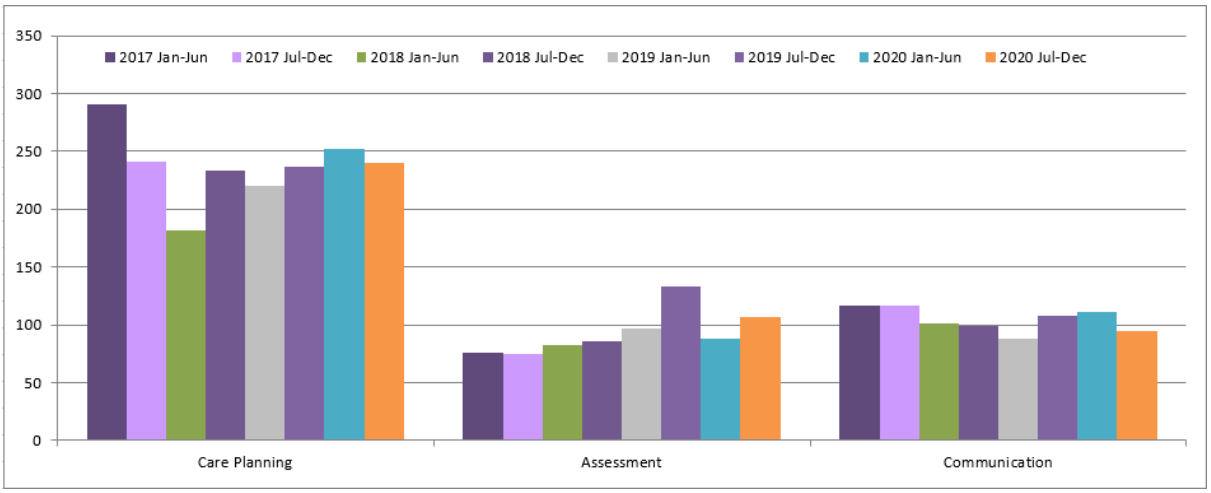
Table 5 outlines the system factors identified in mental health, drug and alcohol RCAs for the period January 2017 to December 2020, and figure 7 displays the top three system factors identified through analysis of mental health, drug and alcohol SAERs during the current reporting period.

Table 5: System factors identified through review of Mental Health/Drug & Alcohol SAER reports, January 2017 – December 2020

Mental Health/Drug & Alcohol SAER System Factors	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Care Planning	291	241	182	233	220	237	252	240
Assessment	76	75	83	86	97	133	88	107
Communication	117	117	101	99	88	108	111	95
Policy & Guidelines	72	68	60	73	63	75	61	69
Environment	39	38	22	21	28	38	30	47
Observations & Monitoring	34	22	12	35	37	40	16	42
Workforce	49	39	37	52	37	31	44	37
Teamwork	41	42	35	25	31	37	31	28
Supervision	19	20	13	7	16	10	14	12
Equipment	10	5	2	9	7	5	3	12
No factors identified*	5	0	6	8	9	13	3	11
Access	24	24	14	17	14	12	10	9
Transfer	6	2	0	0	8	2	3	5
Investigations*	10	9	7	4	5	7	3	4
Total	**793**	**702**	**574**	**669**	**660**	**748**	**669**	**718**

Caveats:
Denotes number of reports received during the specified reporting period, including those received from private health facilities.
** Changes were made to Mental Health/Drug & Alcohol SAER System Factors in January 2017 - June 2017. New categories are now included*
*** Multiple system factors can be applied to each SAER*

Figure 7: Top three system factors identified through review of Mental Health/Drug & Alcohol SAER reports, January 2017 – December 2020



Caveats:

** Top three system factors for July 2020 – December 2020*

*** Definitions revised in 2016*

**** New category collected from July-December 2020*

***** New category collected from January – June 2018*

******Category renamed from Deterioration/management of physical comorbidity from Jul-Dec 2017*

System Factors - Maternal and Perinatal

In the July - December 2020 reporting period, 29 SAER reports (all SAC/Harm Score levels) were reviewed and analysed. This review identified *Care Planning*, *Communication* and *Teamwork* as the most frequent system issues affecting care provision. The category *Care Planning* has consistently been the most commonly identified system factor in maternal and perinatal SAER investigations since 2013. Care planning encompasses a number of issues such as the plan being inadequate to meet the woman's/fetus'/neonate's clinical care requirements; high risk not being considered during care planning; a lower standard of care continuity; and coordination.

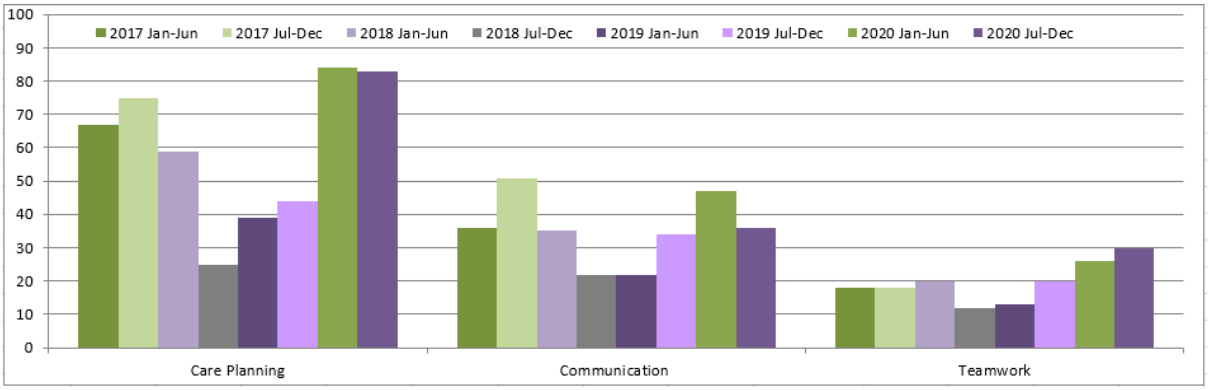
The system factor *Teamwork* is applied to incidents where it is identified there are issues relating to how the maternity care team work together. This includes no identified lead clinician coordinating care and unclear roles and responsibilities of team members. Table 6 outlines the system factors identified in maternal and perinatal SAERs across the period January 2017– December 2020 and Figure 8 outlines the top three system factors identified through maternal and perinatal SAERs during the current reporting period.

Table 6: System factors identified through Maternal and Perinatal SAER reports, January 2017 – December 2020

Maternal and Perinatal RCA System Factors	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Care Planning	67	75	59	25	39	44	84	83
Communication	36	51	35	22	22	34	47	36
Teamwork	18	18	20	12	13	20	26	30
Policy & Guidelines	30	27	22	19	24	23	30	27
Observations & Monitoring	23	21	23	16	19	21	28	26
Investigations	11	18	15	7	14	11	37	21
Workforce	25	25	35	24	18	16	19	21
Assessment	20	17	8	11	11	4	17	18
Environment	16	18	14	12	14	14	20	17
Supervision	12	13	22	11	11	14	19	16
Equipment	16	13	11	10	10	10	8	8
Access	6	2	4	4	3	10	2	5
No factors identified	0	0	0	0	0	4	2	1
Transfer	1	0	1	2	0	0	0	1
Total	**281**	**298**	**269**	**175**	**198**	**225**	**339**	**310**

Caveats:
Denotes number of reports received during the specified reporting period, including those received from private health facilities.
Multiple system factors can be applied to an individual SAER.
System factors are attributed to SAERs for classification purposes.
An increase in the number of system factors identified does not indicate an increased risk.

Figure 8: Top three system factors identified through Maternal and Perinatal SAER reports, January 2017 – December 2020



Caveats: Top three system factors for July 2020 – December 2020

The CEC Maternity and Neonatal Safety Program aims to strengthen and align safety and quality functions and activities associated with maternity and neonatal care. The Perinatal Safety Education Program aligns with the Deteriorating Patient Education Strategy and provides pathways for clinical learning.

The program's aim is to focus on improving the recognition, response to, and management of the deteriorating fetus and the deteriorating woman. In addition, the CEC is involved in the Safer Baby Bundle, an evidence-based initiative to reduce the number of stillborn babies in Australia. Further information is available at *https://www.cec.health.nsw.gov.au/keep-patients-safe/maternity-and-neonatal-safety-program/Safer-Baby-Bundle*

System Factors - Child and Young Person

The Children and Young Person SAER review sub-committee was established in 2016. In the July - December 2020 reporting period, 6 SAER reports (all SAC/Harm Score levels) were reviewed and analysed. *Communication, Care Planning* and *Workforce* were the most frequent system issues identified. Table 7 outlines the system factors identified in Child and Young Person RCAs across January 2017 – December 2020.

The system factor *Communication* relates to inadequate documentation in the health care record about the child's condition or management, inadequate communication between care providers and inadequate communication between care providers and the child and their family and carers.

Table 7: System factors identified through Child and Young Person SAER reports, January 2017 – December 2020

Child and Young Person SAER System Factors	2017		2018		2019		2020	
	Jan-Jun**	Jul-Dec***	Jan-Jun***	Jul-Dec***	Jan-Jun***	Jul-Dec***	Jan-Jun***	Jul-Dec***
Communication	11	13	11	9	15	20	1	11
Care Planning	26	12	15	13	13	37	0	9
Workforce	7	13	8	5	8	10	2	7
Policy & Guidelines	11	10	6	12	13	8	2	7
Supervision	6	3	1	2	3	4	1	5
Observations & Monitoring	8	7	5	5	6	10	4	3
Teamwork	7	3	3	3	2	6	0	3
Equipment	2	3	2	3	5	2	0	3
Assessment	7	11	7	7	9	8	1	2
Investigations*	7	1	1	3	3	6	3	1
Access	4	1	3	0	3	6	1	1
Environment	3	3	2	2	4	4	0	1
Transfer	0	0	0	0	0	0	0	0
No factors identified	0	0	0	0	0	2	0	0
Total	**99**	**80**	**64**	**64**	**84**	**123**	**15**	**53**

Caveats:
** Included as a systems factor in July 2016 - December 2016*
*** SAER reports involving Paediatric Mental Health were included for the period January 2017 - June 2017. All SAERs reviewed at the Child and Young Persons SAER Review Sub-Committee are included, regardless of Primary SAER Review Sub-Committee*
**** Excludes SAER reports involving Paediatric Mental Health for period July 2017 – December 2017 onwards. Includes SAERs reviewed where Child and Young Persons was identified as being the Primary SAER Review Sub-Committee.*

Risk Factors in Clinical Incidents

The clinical risk factors identified by the SAER review sub-committees relate to the conditions or situations that were identified as being a direct cause, or contributing factor, to the incident. In August 2013, the classification system for reviewing risk factors was refined to be more detailed and provide improved analysis. Tables 8, 9, 10 and 11 highlight the top five risk groups that were identified in the SAER review sub-committees over the January 2017 to December 2020 reporting periods.

Table 8: Top five risk factors identified through Clinical Management SAER reports, January 2017 – December 2020*

Clinical Management SAER Clinical Risk Factors	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Co-morbidities-Physical**	n/a	n/a	67	93	107	106	106	107
Deteriorating patient - failure to recognise	60	57	60	57	42	46	50	41
Confusion/Delirium	23	27	26	22	32	28	22	28
Sepsis	29	23	27	29	35	26	22	28
Deteriorating patient - delay/failure to escalate	43	48	47	45	29	29	40	27

Caveats:
**Top five risk factors for July 2020 – December 2020*
***New category collected January 2018 - June 2018*

Patients with *'Co-morbidities- Physical'* has remained the most common risk factor identified within the reviewed clinical management SAER reports since it was introduced to the classification system in January – June 2018. This risk factor refers to the presence of two or more overlapping conditions in the same person. Examples include diabetes, cardiovascular issues and cancer.

Table 9: Top five risk factors identified through Mental Health/Drug & Alcohol SAER reports, January 2017 – December 2020*

Mental Health SAER Clinical Risk Factors	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Risk Assessment - MH***	33	39	35	34	41	47	42	47
Deteriorating MH - Failure to recognise**	38	39	34	44	33	43	32	33
Co-morbidities - Physical*****	18	19	20	27	31	33	30	31
Therapeutic relationships not achieved/Sustained	28	29	18	22	17	15	31	25
Drug and alcohol assessment****	n/a	0	14	28	17	38	28	24
Medication Changes****	n/a	n/a	10	25	25	16	24	24

Caveats:
**Top five risk factors for July 2020 – December 2020*
***Definitions revised in 2016*
****New category collected from July 2016 - December 2016*
*****New category collected from January 2018 – June 2018*
****** Category renamed from Deterioration/management of physical comorbidity as of July 2017 - December 2017*

'Risk Assessment-Mental Health' was the top clinical risk factor over the July to December 2020 reporting period. This risk factor relates to any issues identified in relation to the timeliness, completion and / or accuracy of the mental health risk assessment.

Table 10: Top five risk factors identified through Maternal and Perinatal SAER reports, January 2017 – December 2020*

Maternal and Perinatal SAER Clinical Risk Factors	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Deteriorating patient - Failure to recognise	12	17	13	10	10	8	18	12
Out of hours presentation/Admission	7	7	5	6	3	5	5	10
Fetal monitoring	14	10	7	10	7	6	10	8
Neonatal resuscitation	7	5	6	2	4	1	7	6
Deteriorating patient - Delay / Failure to escalate	7	11	10	2	7	1	10	5
Deteriorating patient - Inappropriate / delayed response to escalation	6	6	5	4	6	6	9	5
Sepsis	1	3	7	1	3	1	4	5

Caveats:
**Top five risk factors for July 2020 – December 2020*

Table 11: Top risk factors identified through Child and Young Person SAER reports, January 2017 – December 2020*

Child and Young Person SAER Clinical Risk Factors	2017		2018		2019		2020	
	Jan-Jun**	Jul-Dec***	Jan-Jun***	Jul-Dec***	Jan-Jun***	Jul-Dec***	Jan-Jun***	Jul-Dec***
Paediatric resuscitation	1	1	1	0	1	3	0	4
Deteriorating patient - Delay / Failure to escalate	5	3	3	2	2	2	1	3
Comorbidities - Physical	0	0	2	1	2	5	3	2
Deteriorating patient - Failure to recognise	6	3	3	3	4	5	3	2
Post-surgical /Procedural care	3	1	1	1	1	5	3	2
Sepsis	4	1	3	0	2	2	1	2

Caveats:
**Top risk factors for July 2020 – December 2020*
*** SAER reports involving Paediatric Mental Health were included for the period January 2017 - June 2017. All SAERs reviewed at the Child and Young Persons Review Sub-Committee are included, regardless of Primary Review Sub-Committee*
**** Excludes SAER reports involving Paediatric Mental Health for period July 2017 onwards. Includes SAERs reviewed where Child and Young Persons was identified as being the Primary Review Sub-Committee.*

The failure to recognise patient deterioration is a common risk factor identified by all SAER committees. To address the problems associated with these risk groups, the CEC's Between the Flags program provides a suite of standard observation charts which provide a guide for the range of observations that are considered safe for a patient, and what observations are outside of that range (or in other words 'outside the flags') and should raise concerns. This program assists clinicians in the recognition of deterioration and when to escalate care of patients.

The program also includes minimum standards for escalation, including processes for both Clinical Review and Rapid Response in all NSW Health facilities. The CEC continues to reinforce the importance of early recognition and response to patients who are clinically deteriorating through the SEPSIS KILLS and REACH programs.

Beginning in 2013 in emergency departments, health services have adopted the implementation of Between the Flags (BTF) into the electronic medical record (eMR). Released in March 2019, V4 of the BTF charts in the eMR provides significant enhancements including the addition of electronic versions of maternity and newborn observation charts. This has increased access to the program and will assist staff in recognising abnormal clinical observations and deterioration earlier, and escalating care requirements rapidly.

Patient Identification

Patient identification and the matching of a patient to an intended treatment is performed routinely in all care settings. Incorrect identification can result in wrong person, wrong site procedures, medication errors, transfusion errors and diagnostic testing errors.[1] The NSW Health policy Clinical Procedure Safety PD2017_032 describes the steps that must be taken to reduce the risk of patient identification incidents.

Prior to 10 February 2014 all patient identification incidents were classified as serious incidents (SAC/Harm Score1) in the IIMS and subsequently underwent a SAER. From 2014, incidents which did not result in actual harm to a patient were no longer automatically recorded as a SAC/Harm Score1 incident.

During the reporting period, incidents involving the wrong patient or body part, regardless of the outcome to the patient, required mandatory notification to the NSW Ministry of Health through the submission of a RIB. As of 14 December 2020, with the publication of the updated NSW Health Incident Management Policy PD2020_047 patient identification incidents that do not result in serious harm or death to a patient, no longer require a RIB submission to the Ministry of Health.

There was a single SAC/Harm Score1 incident related to patient identification during the July - December 2020 reporting period (Table 12). The total number of SAC/Harm Score2-4 patient identification incident reports remained in line with the previous January – June 2020 reporting period (Table 13). The majority of these incidents involved failure to perform the procedure on the correct site or side in diagnostic imaging and did not result in actual harm to the patient.

Lower rates of reporting are not a reliable indicator of safer care. NSW Health staff are always encouraged to report all incidents.

Table 12: Location of SAC/Harm Score1 incidents involving patient identification where clinical procedure has occurred, January 2017 – December 2020

Location of SAC/Harm Score1 incidents involving patient identification	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Operating Theatre (includes Anaesthetics)	2	0	1	0	1	1	0	1
Imaging / Nuclear Medicine / Radiotherapy	0	0	0	0	0	0	0	0
Wards and Other areas	0	4	0	1	4	0	0	0
NICU / SCN / Maternity & Paediatrics (includes EBM)	0	0	0	0	0	0	0	0
Dental	0	0	0	0	0	0	0	0
Total	2*	4*	1*	1*	5*	1*	0	1*

Caveats:
Incorrect patient / procedure / site reporting requirements changed 10 February 2014
**Incidents already accounted for in SAC/Harm Score1 data displayed in Table 3.*

Table 13: Location of SAC/Harm Score2, SAC/Harm Score3 and SAC/Harm Score4 incidents involving patient identification where clinical procedure has occurred, January 2017 – December 2020

Location of SAC/Harm Score1 incidents involving patient identification	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Imaging / Nuclear Medicine / Radiotherapy	16	20	22	31	19	23	25	19
Wards and Other areas	26	23	20	15	26	9	11	12
Operating Theatre (includes Anaesthetics)	4	12	4	8	3	9	10	8
NICU / SCN / Maternity & Paediatrics (includes EBM)	3	5	5	4	9	3	5	2
Dental	2	0	1	5	1	1	1	1
Total	**51**	**60**	**52**	**63**	**58**	**45**	**52**	**52**

Caveats: Incorrect patient / procedure / site reporting requirements changed 10 February 2014.

[1] Australian Commission on Safety and Quality in Health Care
https://www.safetyandquality.gov.au/our-work/communicating-safety/patient-identification

Sentinel Events

Sentinel Events are preventable adverse events that result in death or serious harm to a patient. In 2002, Australian States and Territories agreed to contribute to a set of eight core National Sentinel Events (NSEs) which were reported nationally between 2004 and June 2019. Public reporting of these events was an opportunity for jurisdictions to share learnings, and to reduce the risk of their recurrence. It is important to note that Sentinel Events occur infrequently and are often due to an issue with the way a system or process works in our health care system.

From 2007, Sentinel Events have been reported by each Australian jurisdiction for inclusion in the Productivity Commission's *Report on Government Services (ROGS).* The ROGS provides information on the effectiveness and efficiency of government services in Australia and contains annual data on the equity, efficiency, and cost effectiveness of government services. Sentinel Event data is displayed at Table 14.

Australian States and Territories have historically interpreted and reported these Sentinel Events differently. NSW has adopted a broad interpretation of these events and therefore comparison of the data across states requires caution.

Revised Australian Sentinel Event (ASE) List

A revised ASE list was endorsed by Australian Health Ministers in December 2018. Commencing on 1 July 2019, NSW Health required all ASEs on the revised list to be notified to the NSW Ministry of Health via a Reportable Incident Brief (RIB) and to be investigated accordingly. The revised ASE list identifies ten Sentinel Events, while the previous list identified eight. Maternal death or serious morbidity associated with labour and delivery, and intravascular gas embolism resulting in death or neurological damage have been removed. The revised ASE list includes:

1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death
6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward
7. Medication error resulting in serious harm or death
8. Use of physical or mechanical restraint resulting in serious harm or death (New)
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 (New)

Data on Sentinel Events is reported in the annual Report on Government Services (ROGS). At present, Sentinel Event data is available for 2019-20. Data for 2020-21 will be published in the next ROGS release in January 2023.

In 2019-20, there was a total of 57 sentinel events reported across all Australian jurisdictions (Table 14). NSW accounted for 9 of these events.

Sentinel event data for prior years, reported against the previous version of the sentinel events list, are available in earlier editions of ROGS.

Table 14: Australian Sentinel Events by Jurisdiction, 2019-20*

Selected sentinel event	NSW	VIC	Qld	WA	SA	Tas	ACT	NT	Aus
Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	-	-	-	1	-	1	-	-	2
Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death	-	-	1	-	-	-	-	-	1
Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death	-	-	-	-	-	-	-	-	0
Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm of death	1	2	1	1	2	-	-	-	7
Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death	-	-	-	-	-	-	-	-	0
Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	2	8	3	2	-	-	-	-	15
Medication error resulting in serious harm or death	3	13	2	2	1	3	1	-	25
Use of physical or mechanical restraint resulting in serious harm or death	0	0	0	0	0				3
Discharge of an infant or child to an unauthorised person	-	-	-	-	-	-	-	-	0
Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death	3	-	-	-	1	-	-	-	4
Total Events	**9**	**24**	**8**	**6**	**5**	**4**	**1**	**0**	**57**

Caveats:
** – Nil or rounded to zero.*
Australian health ministers agreed version 2 of the Australian sentinel events list in December 2018. All jurisdictions implemented these categories on 1 July 2019.
Sentinel event data for prior years, reported against the previous version of the sentinel events list, are available in earlier editions of ROGS.
Data are comparable (subject to caveats) across jurisdictions and over time.
Data are complete (subject to caveats) for the current reporting period.
Source: Report on Government Services 2022, Part E, Section 12: Released on 1 February 2022
12 Public hospitals - Report on Government Services Productivity Commission (pc.gov.au)

Complaints

A key priority of the NSW public health system is its focus on patient-centred care. Feedback from consumers, their families and carers about their health care experiences is encouraged and is a valuable resource for monitoring and improving patient safety. Analysing data on patient experiences improves the ability of health care organisations to detect system-wide problems in care.

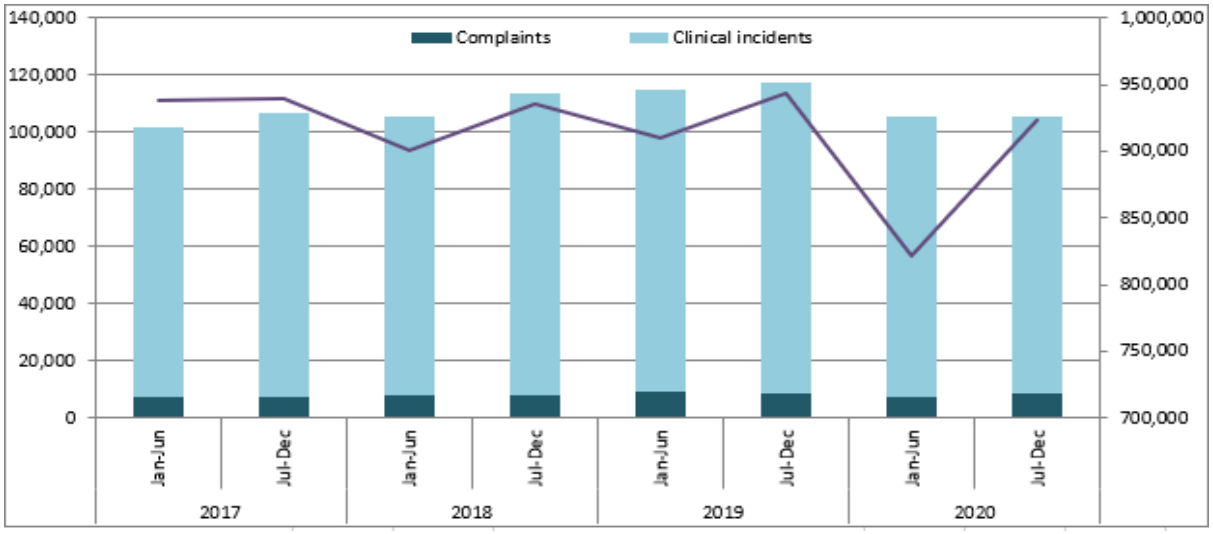
Encouraging staff to work together with patients and families when providing care improves communication, and results in a better experience of care. The CEC's **Person Centred Care** program was established to work with Local Health Districts (LHDs) and Specialty Health Networks (SHNs) to help include patients and family as care team members, improve consumer engagement and promote safety and quality in health care.

During the July – December 2020 reporting period, complaints were entered into both IIMS and ims+ while the transition to ims+ was ongoing. Complaints management within ims+ has been broadened to enable the notification of complaints, compliments and observations/suggestions provided by patients and carers.

Due to the differences that exist between the IIMS and ims+ applications with regards to the classification of complaints and their resolution, complaints data presented in this report are combined to provide a high-level analysis only.

The number of consumer complaints between July – December 2020 has increased by 14 per cent compared with the preceding six-month period. The number of clinical incidents per occasions of service decreased during July – December 2020, while the number of complaints per occasions of service has increased. Complaint volume in the current reporting period (July – December 2020) is within normal variation and at similar volumes to previous years. The previous period (January – June 2020) had far fewer complaints reported which is likely associated with reduced activity across the health care system due to COVID-19 (Figure 9).

Figure 9: Notification of clinical incidents and complaints by NSW separations, January 2017 – December 2020



During the July – December 2020 reporting period, NSW Health Services continued their transition across to the new ims+ application. Complaints notified in ims+ are not given a Harm Score rating, and as a result data relating to this period appear in the total only (Table 15).

Table 15: Complaints by SAC rating, January 2017 – December 2020

Complaint SAC Rating	2017		2018		2019		2020	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec*	Jan-Jun	Jul-Dec**
SAC 1	5	13	5	2	2	3	7	-
SAC 2	49	64	64	60	48	41	41	-
SAC 3	1,676	1,874	1,995	1,967	2,492	2,065	1,343	-
SAC 4	5,375	5,517	6,063	5,943	6,431	5,989	4,214	-
No SAC allocated	85	120	84	97	123	57	36	-
Total	**7,190**	**7,588**	**8,211**	**8,069**	**9,096**	**8,494**	**7,491**	**8,548**

Caveats:
Data obtained from IIMS and ims+. Excludes St Vincent's Health Network
**ims+ complaints data included in totals only. Excludes compliments and observations/suggestions received*
***IIMS/ims+ complaints data included in totals only. Excludes compliments and observations/suggestions received*

Glossary

Acute bed day data

Acute bed day data has been provided to the CEC from the Health System Information and Performance Reporting Branch of NSW Health. The following exclusions have been applied for the reports:

1) Care type is 0 (Hospital Boarder).
2) Bed types are 25 (Hospital in Home - General), 66 (Delivery Suite), or 67 (Operating Theatre/Recovery).

(reference for bed types can be found in PD2012_054 Appendix 2)

Clinical incident/incident

An incident is an unplanned event that results in, or has the potential for, injury, damage, or loss, including near misses.[1] An incident may also be referred to as an 'adverse event'.

Harm Score

The rating system for incidents reported in ims+. The Harm Score indicated the severity of the incident and the action required in response (e.g. Serious Adverse Event Review). The Harm Score is automatically calculated in ims+. More information is contained in the NSW Health Incident Management Policy PD2020_047.

Human Factors

Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings.[2]

Incident Information Management System (IIMS)

An online incident reporting and management system developed in Australia for NSW Health. Use of IIMS by NSW Health ceased in December 2020.

ims+

The new online incident management system used in NSW Health services which replaces the IIMS.

Incident management

The cycle of activities required to recognise, report, understand and reduce the risk of unplanned events occurring. In the health system, feedback to the notifier and sharing of learnings are essential components of this cycle.

Near miss

An unplanned event that did not result in injury, illness, or damage but had the potential to do so. A break in the chain of events prevented harm, due to either staff recognition and action, or a fortuitous event.

Notification

The initial report made within the incident management system that an incident or near miss may have occurred. All staff are required to report incidents and must complete the mandatory fields within

the system. Notifications can be anonymous and reflect the information known by the reporter at the time.

Patient Safety Watch
A series of focused summary reports based predominantly on incidents which have been subjected to root cause analysis or other investigative methodologies. The aim is to feed the lessons learned back to Local Health Districts and Specialty Health Networks, highlighting key risks and recommending preventative actions for local implementation.

Perinatal
The perinatal period commences at 20 completed weeks (140 days) of gestation and ends 28 completed days after birth.

Retained accountable items
Unintended material retained in a patient's body during a surgical procedure (such as a swab) which requires surgical removal.

Reportable Incident Brief (RIB)
A document used to notify NSW Health of a reportable incident. RIBs are subject to statutory privilege under section 23 of the Health Administration Act. For more information refer to the NSW Health Incident Management Policy PD2020_047

Root Cause Analysis (RCA)
A method used to review and analyse incidents to identify the root causes and factors that contributed to an incident, and recommended actions. RCAs are subject to statutory privilege under section 23 of the Health Administration Act.

Severity Assessment Code (SAC)
The system by for incidents and complaints in IIMS. The SAC score indicates the severity of the incident and the action required in response.

Serious Adverse Event Review (SAER)
The process by which all serious clinical incidents in NSW Health are investigated. A SAER can take on of four forms: Root Cause Analysis (RCA), Concise Incident Analysis, Comprehensive Incident Analysis, or London Protocol. SAERs are subject to statutory privilege under section 23 of the Health Administration Act.

Abbreviations

CEC	Clinical Excellence Commission
EBM	Expressed Breast Milk
MoH	Ministry of Health
PIT	Principal Incident Type
RCA	Root Cause Analysis
RIB	Reportable Incident Brief
SAC	Severity Assessment Code
SAER	Serious Adverse Event Review

[1] Organisation for Economic Co-operation (OECD) (2017)

[2] Dr Ken Catchpole, Cedars-Sinai, 'How to' guide: volume 2 Implementing Human Factors in healthcare 'Taking further steps', https://chfg.org/how-to-guide-to-human-factors-volume-2/

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Email: CEC-PatientSafety@health.nsw.gov.au

Program and Publication Links

Between The Flags	https://cec.health.nsw.gov.au/keep-patients-safe/between-the-flags
Clinical Focus Reports	https://cec.health.nsw.gov.au/Review-incidents/mortality-review-authorised-committees/clinical-focus-reports
Falls Prevention	https://www.cec.health.nsw.gov.au/keep-patients-safe/older-persons-patient-safety-program/falls-prevention
High Risk Medicines	https://www.cec.health.nsw.gov.au/keep-patients-safe/medication-safety/high-risk-medicines
Master Clinician's Guide To Quality And Safety	https://cec.health.nsw.gov.au/__data/assets/pdf_file/0008/402587/Master-Clinicians-Guide-to-Quality-and-Safety.pdf
Medication Safety & Quality	https://www.cec.health.nsw.gov.au/keep-patients-safe/medication-safety
Person Centred Care	https://www.cec.health.nsw.gov.au/improve-quality/teamwork-culture-pcc/person-centred-care
REACH (Patient and Family Escalation)	https://www.cec.health.nsw.gov.au/keep-patients-safe/reach
Sepsis Kills	https://www.cec.health.nsw.gov.au/keep-patients-safe/sepsis
Team Stripes (Point of Care Teamwork)	https://www.cec.health.nsw.gov.au/improve-quality/teamwork-culture-pcc/teamwork/team-stripes

NSW Health Policy Directives

NSW Health Incident Management Policy PD2020_047	https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_047.pdf
NSW Health Clinical Handover - Standard Key Principles Policy PD2019_020	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2019_020
NSW Health Clinical Procedural Safety Policy PD2017_032	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2017_032
NSW Health High-Risk Medicines Management Policy PD2020_045	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_045
NSW Health Recognition and Management of Patients who are Deteriorating Policy PD2020_018	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2020_018
NSW Health Pressure Injury Prevention and Management Policy PD2021_023	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2021_023
NSW Health Prevention of Venous Thromboembolism Policy PD 2019_057	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2019_057
NSW Health Reporting of Maternal Deaths to the Clinical Excellence Commission PD2021_006	https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2021_006