Government of **Western Australia**
Department of **Health**

SAC 1 Clinical Incident Notification Form

All Severity Assessment Code (SAC) 1 clinical incidents, including sentinel events, are to be notified to the Patient Safety Surveillance Unit (PSSU), Department of Health within seven working days of the incident occurring.

A SAC 1 is a clinical incident that has or could have (near miss), caused serious harm or death; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness. Sentinel events are a subset of serious clinical incidents that has caused or could have caused serious harm or death of a patient. It refers to preventable occurrences involving physical or psychological injury, or risk thereof.

To complete this form, type responses into the relevant fields or select from the pick lists where available and then save the completed version. This form can be edited after saving and printed if desired.

Forward the completed SAC 1 Clinical Incident Notification form via email to Events.SAC1@health.wa.gov.au. On receipt of the initial notification of a SAC 1 clinical incident the PSSU will provide the hospital/health facility with a CIM reference number, to be indicated on all future correspondence regarding the notified event, and a due date for the investigation report in line with the requirements of the Department of Health's Clinical Incident Management (CIM) Policy.

Local incident reference number:

INCIDENT LOCATION AND TIME

Hospital name:

Date of incident (dd/mm/yyyy):

Time of incident (24 hour format):

If unknown, please provide time of discovery:

PATIENT DETAILS

Patient type:

Patient care funding type:

Patient age:

Patient gender:

Status with respect to Mental Health Act:

Current and relevant diagnosis/problems/mental state:

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CLINICAL INCIDENT DETAILS

Treating specialty:

Incident description:

Please include the immediate response/action and outcome. Explain what happened, how did this clinical incident lead to injury, and which objects or substances were involved.

For medication incidents state all drugs involved.

For blood related clinical incidents state the patient's symptoms.

Were any actions taken immediately following the incident to prevent future harm to patients?

If yes, describe the actions taken immediately following the incident to prevent future harm to patients:

Treatment/investigations required as a result of the clinical incident:

E.g. x-ray, blood test, ECG, EEG, dressings, new medications, referral for review by another clinician.

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Type of SAC 1 clinical incident:

◯ Sentinel event ◯ Other SAC 1 clinical incident

If 'Other, please specify' is chosen, please provide further detail below. Please note this category should only be chosen if there is no suitable alternative in the existing list.

PATIENT HARM

Patient outcome:

Patient outcome refers to patient harm (physical or psychological) as a direct result of a clinical incident and not their underlying condition or illness.

Is this incident a near miss?

Incidents that may have, but did not cause harm, either by chance or through timely intervention.

OTHER INCIDENT DETAILS

Was the patient absent without leave?

If yes, what was the date and time of return (24-hour format):

Was a fetus harmed in this incident?

For clinical incident management purposes, a fetus is considered any unborn human of any gestational age from conception to birth. Please note this may differ from clinical services definitions.

If yes, what was the fetal outcome? Was this a multiple pregnancy?

Gestational age at time of incident (weeks):

Did this incident involve patient care from another site?

Access the Guideline for the investigation of Multi-Site clinical incidents.

If yes, please state which site:

Name and position of the contact person:

Will a multi-site review be undertaken?

If yes, please state which site / service will lead this review:

Has the clinical incident notification to PSSU occurred following review of a patient death according to the Review of Death policy?

Access the Review of Death policy.

Is this incident investigation using State Qualified Privilege?

For further information on State Qualified Privilege, please refer to Qualified privilege.

Has the Open Disclosure process been initiated?

Access the Open disclosure framework.

Staff member initiating Open Disclosure:

If applicable, please provide the reason for the Open Disclosure Process not being initiated:

If 'Other' is chosen, please provide further detail below. Please note this category should only be chosen if there is no suitable alternative in the existing list.

STATUTORY REPORTING REQUIREMENTS

Has the Chief Health Officer been notified for maternal death?

For further information on deaths reportable to the Chief Health Officer, please refer to Notification of death of a woman as a result of pregnancy or childbirth.

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Has the Chief Health Officer been notified for perinatal / infant death?

For further information on deaths reportable to the Chief Health Officer, please refer to Notification of perinatal and infant deaths.

Has the Chief Health Officer been notified for death of persons under anaesthesia?

For further information on deaths reportable to the Chief Health Officer, please refer to Notification of death of persons under anaesthetic.

Has the Coroner been notified for reportable deaths?

The Death in Hospital *form provides a summary or checklist of the key statutory and mandatory reporting obligations that arise following an inpatient hospital death.*

Has the Chief Psychiatrist been notified for mental health notifiable incidents?

Definitions and details about the clinical information required by the Chief Psychiatrist are in the Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist.

If statutory reporting requirements have not been completed, please provide further explanation:

For further information regarding the management and investigation of SAC 1 clinical incidents (including sentinel events) and additional reporting requirements, please refer to the Clinical Incident Management Policy, available at:
http://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system

To obtain an electronic copy of this form, please go to:
http://ww2.health.wa.gov.au/Articles/S_T/Severity-assessment-codes