



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

WA Health Datix Clinical Incident Management System (CIMS)

SAC1 Management User Guide

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Disclaimer

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Please address any improvement suggestions to PSSU@health.wa.gov.au



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Clinical Incident Management

Clinical incident management is the process of effectively managing clinical incidents with a view to minimising preventable harm.

A clinical incident is an event or circumstance resulting from health care which could have, or did lead to unintended and/or unnecessary harm to a patient/consumer.

The WA Department of Health (DoH) Clinical Incident Management (CIM) Policy introduced Severity Assessment Codes (SAC), which are used to determine the appropriate level of analysis, action and escalation that occurs following a clinical incident. SAC ratings (SAC 1, 2 or 3) are based on the assessment of consequences associated with a clinical incident.

SAC 1 clinical incidents include all clinical incidents/near misses where serious harm or death is or could be specifically caused by health care rather than the patient's underlying condition or illness. In WA, SAC 1 clinical incidents include the eight nationally endorsed sentinel event categories. For further information regarding the categorisation of SAC 1 clinical incidents (including sentinel events) refer to the CIM Policy available at http://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system

The focus of this user guide is the management of SAC 1 clinical incidents utilising Datix CIMS, including the specific reporting requirements to the DoH. Please refer to local hospital / health service resources to guide management of SAC 2 and 3 clinical incidents using Datix CIMS.



Recommended Pre-Reading

The following user guides are recommended pre-reading:

1. Datix CIMS Notifier User Guide.
2. Datix CIMS Senior Staff User Guide.

Available: <https://hss-healthpoint.hdwa.health.wa.gov.au/business-at-health/ICT-servicedelivery-and-operations/cims/Pages/default.aspx>

About this Guide

1. In this guide, the web-based Datix CIMS application, available to all WA Health staff, is referred to as *DatixWeb*.
2. For clarity, the following font formatting has been used:
 - **Lavender** - functions, menu items and buttons in DatixWeb.
 - **Indigo** - hyperlinks to sections within this user guide.
 - **Teal** – web and email addresses.
3. Points to note are depicted in a box: 
4. A red box drawn on an image draws attention to particular DatixWeb functions or menu items discussed in the guide: 



Managing SAC 1 clinical incident notification processes utilising Datix CIMS

The CIM Policy identifies specific notification, investigation and management obligations that WA Public Hospitals / health services must undertake in relation to SAC 1 clinical incidents. At the time of writing this user guide the CIM Policy requires hospitals/ health services to:

- Inform the DoH Patient Safety Surveillance Unit (PSSU) of a SAC 1 clinical incident within 7 working days of the incident occurrence.
- Complete investigations into SAC 1 clinical incidents within 28 working days of informing the PSSU of a SAC 1 incident.
- Implement and evaluate the effectiveness of any recommendations made in the investigation of a SAC 1 clinical incident within six months of the completed investigation.

The CIM Policy also specifies the process of declassification of a SAC 1 clinical incident, which occurs following an investigation identifying that healthcare factors were not contributory to the outcome of the incident.

Whilst hospital and health service safety and quality governance structures vary, Datix CIMS is configured to enable sites to effectively manage SAC 1 notification and management processes, so as to ensure compliance with CIM Policy requirements.

To understand Datix processes to support the CIM Policy, it is useful to consider the processes following entry of an incident into Datix CIMS to the notification of a SAC 1 clinical incident to the PSSU, contextualised in figure 1.

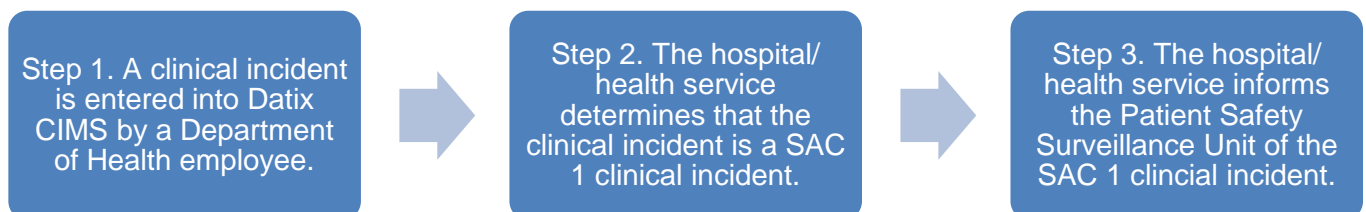


Figure 1 - Informing the PSSU of a SAC1 clinical incident

Step 1: A clinical incident is entered into Datix CIMS

Clinical incidents can be entered into Datix CIMS anonymously, or by the notifier logging onto Datix CIMS. The *Datix CIMS Notifier User Guide* provides a step by step guide to notifying a clinical incident, and can be accessed at: <https://hss-healthpoint.hdwa.health.wa.gov.au/business-at-health/ICT-servicedelivery-and-operations/cims/Pages/default.aspx>



Step 2: The hospital / health service determines that the clinical incident is a SAC 1 clinical incident

Upon the notification of a clinical incident into Datix CIMS, hospitals / health services must determine the SAC rating of the incident, which includes ascertaining if the incident is a SAC 1 clinical incident. This process may vary between health services, however Datix CIMS configuration, and agreement between Datix CIMS business users (for example concerning communication practices) accommodates local processes.

Figure 2 describes the key steps in the process that lead to a hospital /health service determining that a clinical incident is a SAC 1 clinical incident. Datix processes that align with each step are found in the respective sections, for example, Section 1 identifies how the notifier selects a SAC rating when notifying a clinical incident via Datix CIMS. 'Key points' in relation to each section are also provided.

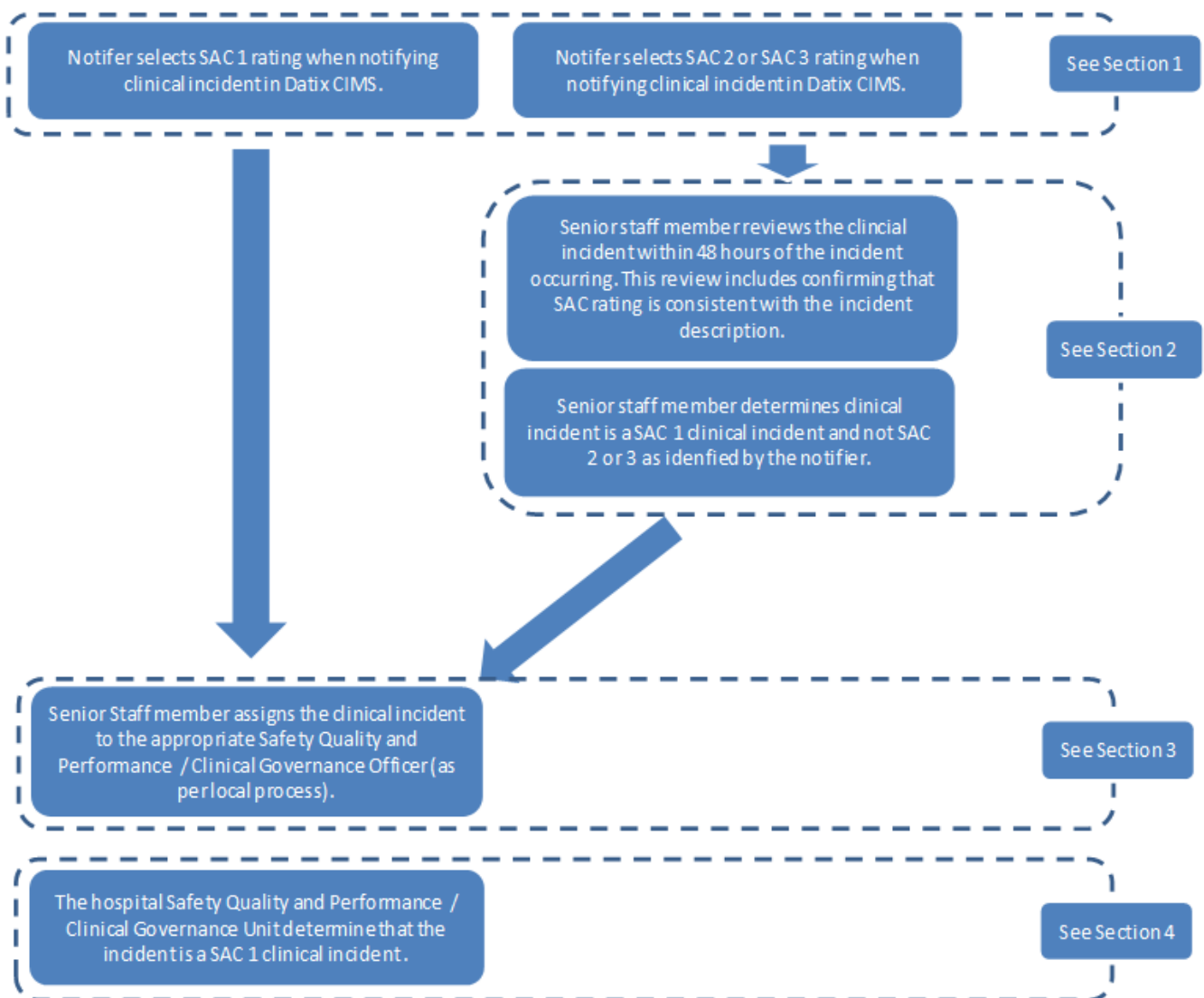


Figure 2 - Process of determining an incident is a SAC1 clinical incident



Section 1. The Notifier selects a SAC rating for the incident

When entering a clinical incident into Datix, the Notifier must select a SAC rating appropriate to the clinical incident.

Following notification, an email is automatically sent via Datix CIMS to the Senior staff individual responsible for investigating or progressing the clinical incident. This is based on the notified 'Place of Incident / Event'.

The email notification to Senior staff includes a CIMS reference number and hyperlink to login to Datix CIMS. (Refer to the *Datix CIMS Senior Staff Guide* for instruction on accessing a clinical incident in Datix, located at: <https://hss-healthpoint.hdwa.health.wa.gov.au/business-at-health/ICT-servicedelivery-and-operations/cims/Pages/default.aspx>).

A newly notified clinical incident has a workflow status of **New incident**. Senior staff members have 48 hours to 'acknowledge and review' new incidents, which ensures their timely investigation. This also assists the additional notification requirements to be met if the incident is a SAC 1 clinical incident.

Incidents not reviewed within 48 hours will be flagged 'overdue' and appear as overdue in Senior staff member's New incidents count in the 'Statuses' section.

Clinical Incident Management System	
Options	Searches
Add a new incident	Statuses
My reports	New incident 1980 records 1980 Overdue
Design a report	Snr staff evaluation/3rd Pty comment 4541 records 3689 Overdue
New search	Dept/Service Head/Director comment 1773 records
Saved queries	SAC1 investigation 116 records 107 Overdue
Help	Closed 58588 records
	Inactive 6215 records

It is the Senior staff member's responsibility to ensure that information entered by the notifier into Datix CIMS is accurate, factual, and objective, contains no staff names (only designations), and to amend the information as necessary to meet CIM Policy requirements.

Senior staff members are required to verify the content of a clinical incident, including;

- That the incident location is correct – NOTE changes to 'Place of Incident / Event' can lead to a change in clinical incident investigator if it is changed to outside your area of responsibility.
- The specific location where the incident occurred (e.g. bed / bay / bathroom).
- If a patient was involved in the clinical incident. If patient details have been manually entered into Datix by the Notifier, Senior staff are required to approve the patient details. To do so:
 - Open the patient hyperlink
 - Conduct a search – if a match is applicable select this and create a link, if not close the search, change the contact details status to approved and then return to the incident.
- That the date and time of incident are correct.



- Ensuring the selection in each Type of clinical incident classification tier (tiers 1, 2 and 3) is accurate.
- The information entered into the free text fields to ensure it is factual and objective and:
 - Does not include staff names - only designation/position
 - Avoids statements of blame
 - Does not second guess what happened.

Senior staff members DO NOT change the SAC rating selected by the Notifier on the Clinical incident details page.

- If the Notifier has selected SAC 2 or 3, the Senior staff member continues to review and progress the investigation into the incident. (see **Section 2: Senior staff member investigation of a clinical incident**).
- If the notifier of a clinical incident has selected SAC 1, the Senior staff member must confirm the SAC rating and assign the incident to the appropriate Safety Quality and Performance or Clinical Governance Officer at their hospital or service (see **Section 3: 'Assigning a SAC 1 incident to a hospital /health service Safety and Quality / Clinical Governance Officer'**).

Section 1 Key Points:

Senior staff members must review clinical incidents entered into Datix CIMS within 48 hours.

Senior staff members do not change the SAC rating selected by the Notifier on the Clinical incident details page.

If the Notifier has selected SAC 2 or 3, the Senior staff member continues to review and progress the investigation into the incident.

If the Notifier has selected SAC 1, the Senior staff member must confirm the SAC rating and assign the incident to the appropriate Safety Quality and Performance or Clinical Governance Officer at their hospital or health service.

Section 2. Senior Staff member investigation of a clinical incident

The Clinical incident investigation page within Datix is where information identified through the investigation of an incident, is entered.

In addition to confirming the Clinical incident details entered by the Notifier, Senior staff members are required to confirm the SAC rating (for example, confirm if the incident is a SAC 1, SAC 2 or SAC 3 incident), Patient outcome and whether the incident is a near miss. These fields are located at the top of the Clinical incident investigation page of an incident record.

If on review of the incident details the Senior staff member determines that the clinical incident meets the definition of a SAC 1 clinical incident, and not SAC 2 or 3 as selected by the Notifier, the incident must be assigned to the hospital/health service Safety and Quality/ Clinical Governance Officer. This process is described in section 3.



If the Senior staff member determines that the clinical incident meets the definition of a SAC 2 or 3 clinical incidents, the Senior staff member continues the investigation and management of the incident. Consult local resources for further information regarding SAC 2 and 3 clinical incident investigation and management.

Section 2 Key Points:

On further review / investigation of a clinical incident the Senior staff member confirms the Patient outcome and SAC rating of the incident, and whether the incident is a near miss.

If on review of the incident details the senior staff member determines that the clinical incident meets the definition of a SAC 1 clinical incident, and not SAC 2 or 3 as selected by the notifier, the incident must be assigned to the hospital/health service Safety and Quality/ Clinical Governance Officer.

Section 3. Assigning a SAC 1 incident to a hospital /health service Safety and Quality / Clinical Governance Officer

The Workflow status of a clinical incident must be changed to **SAC 1 Investigation**, and the incident assigned to the appropriate Safety and Quality / Clinical Governance officer at the hospital / or health service if one of the two conditions below have been met:

- The Notifier has selected Severity Assessment Code 1 (SAC 1) when notifying a clinical incident, or
- The Senior staff member determines that the incident is a SAC 1 clinical incident.

Assigning the incident informs the hospital / health service Safety and Quality / Clinical Governance Unit via automated email, and enables further decision making processes to occur with respect to the appropriate investigation of the incident, including informing the PSSU.

Assigning a SAC 1 incident to a hospital /health service Safety and Quality / Clinical Governance Officer.

1. Go to the **Workflow status** drop down menu on the **Clinical incident details** page, and change the **Workflow status** after save field from **New incident** to **SAC 1 Investigation**.

Workflow status	
Current workflow status	New incident
* Workflow status after save	SAC1 investigation

2. Change the **Clinical incident investigator** to the nominated **Safety and Quality or equivalent Officer** for your hospital / health service / region tasked with the progression of SAC 1 clinical incidents. Select the officer's name from the drop down box. Typing part of their name in the box will bring up a list of matching names.



Clinical incident ownership/responsibility

Clinical incident investigator

3. Click the **save** icon (found in the bottom left corner of the web page)



Unless advised by the Safety and Quality / Clinical Governance Officer, no further editing or investigation is required by the senior staff member.

Section 3 Key Points:

The Workflow status of a clinical incident must be changed to SAC 1 Investigation, and the incident assigned to the appropriate Safety and Quality / Clinical Governance officer if

1. The Notifier has selected Severity Assessment Code 1 (SAC 1) when notifying a clinical incident, or
2. The Senior staff member determines that the incident is a SAC 1 clinical incident.

Assigning the incident informs the hospital / health service Safety and Quality / Clinical Governance Unit via automated email, and enables further decision making processes to occur with respect to the appropriate investigation of the incident, including informing the PSSU

Section 4. The hospital Safety and Quality / Clinical Governance Unit determine that the incident is a SAC 1 clinical incident

Hospital / Health service organisation structures / communication processes and business rules to determine that an incident is a SAC 1 clinical incident may vary significantly. For example Hospital A might require that potential SAC 1 incidents are determined by a group of Executive staff such as the Director of Clinical Services and Director of Nursing. Alternatively Health Service B might task the Clinical Governance Unit manager with determining if an incident is a SAC 1 clinical incident. Local practices should be identified by contacting the Hospital /Health Service Safety and Quality Unit.

To facilitate communication between hospital / health service officers Datix CIMS includes a **Communication and feedback** tab. This tab's function is to generate emails regarding a specific clinical incident between staff (see Step 3: Communicating a SAC 1 incident to the Patient Safety Surveillance Unit). Emails sent via the Communication and feedback tab are logged within the specific Datix CIMS incident record, providing a convenient method of storing communication.



Qualified Privilege

Information and documentation created for the investigation of a clinical incident that is investigated in accordance with provisions of the *Health Services (Quality Improvement) Act 1994* (QI Act) may be prohibited from disclosure.

State Qualified Privilege is applicable **ONLY** to investigations conducted by an approved Quality Improvement Committee established under the QI Act. Datix CIMS is configured to ensure the application of the QI Act. SAC 1 clinical incident qualified privilege will be managed by hospital / health service Safety and Quality Units.

Safety and Quality Staff will determine if the investigation is to be investigated under Qualified Privilege.

<p>★ Is this incident using Qualified Privilege? Yes/No</p>	<p><input type="radio"/> Yes</p> <p><input checked="" type="radio"/> No</p> <p><input type="radio"/> N/A</p> <p><input type="radio"/> Unknown</p>
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Section 4 Key Points:

Hospital / health service business rules and local processes to determine an incident is a SAC 1 clinical incident may vary significantly.

Datix CIMS Communication and feedback tab can be used to facilitate local decision making processes.

Step 3: Informing the Patient Safety Surveillance Unit (PSSU) of a SAC 1 clinical incident

Once a hospital has determined that a clinical incident is a SAC 1 clinical incident, the PSSU must be informed, as per the CIM Policy. The Datix CIMS *Communication and feedback* tab, and the *SAC 1 Action chains* are utilised by hospitals /health services to inform the PSSU and to demonstrate compliance with CIM Policy requirements respectively. These functions are explained in sections 1 and 2 below.

Prior to communicating to the PSSU, fields within the Clinical incident investigation page **must be completed**, including:

- **Severity Assessment Code (Confirmed)** - SAC 1 should be selected
- **Is this incident a near miss?**
- **Patient outcome**
- **Type of SAC 1 clinical incident** (either 'Sentinel event' or 'Other SAC 1 clinical incident')
- **The Sentinel event category or Other SAC 1 incident category**
- **Has the clinical incident notification to PSSU occurred following review of a patient death according to the Review of Death policy?**



When Datix CIMS is unavailable due to technical reasons, services are expected to have downtime procedures to meet policy requirements.

To meet any other Policy investigation and evaluation requirements, please inform the PSSU of the downtime and submit any completed investigations or evaluations that are due via email to SAC1.events@health.wa.gov.au

Note this action does not replace an electronic Datix record of the clinical incident and Communication to PSSU via the “communication and feedback’ tab within Datix must be completed as soon as possible.

Clinical incident investigation	
To allow for full evaluation of the clinical incident, ensure all results are available e.g. blood tests, x-rays.	
Severity Assessment Code (Confirmed)	
Used to determine the appropriate level of investigation, analysis, action and escalation of a clinical incident.	
★ Severity Assessment Code (Confirmed) ?	<input type="radio"/> SAC 1 <input type="radio"/> SAC 2 <input type="radio"/> SAC 3
★ Is this incident a near miss?	<input type="text"/>
Describe the results of the investigation and findings *Do NOT repeat a description of the clinical incident *Be factual *Do NOT second guess *Do NOT include staff member names but do include their Designation	<input type="text"/>
Patient Outcome	
★ 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.	<input type="radio"/> Death <input type="radio"/> Serious harm <input type="radio"/> Moderate harm <input type="radio"/> Minor harm <input type="radio"/> No harm
SAC 1 Clinical Incident Investigation	
All Severity Assessment Code (SAC) 1 clinical incidents, including sentinel events are to be notified to the Patient Safety Surveillance Unit (PSSU) within seven working days of the incidents occurrence.	
Severity Assessment Code (SAC) 1 - serious harm or death that is specifically caused by healthcare rather than the patient's underlying condition or illness. Sentinel event refers to unexpected occurrences involving death or serious physical or psychological injury, or risk thereof.	
★ Type of SAC1 clinical incident	<input type="text" value="Sentinel event"/>
★ Sentinel event category	<input type="text" value="Medication error resulting in death of a patient"/>
★ Has the clinical incident notification to PSSU occurred following review of a patient death according to the Review of Death policy? Refer to OD 0448/13.	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Not applicable

Other fields on the Clinical incidents investigation page that should be filled in are:

- Was the patient absent without leave?
- Was a fetus harmed in this incident?
- Did this incident involve patient care from another service?



Patient Outcome	
<p>★ Patient outcome</p> <p>Patient outcome refers to patient harm (physical or psychological) as a direct result of a clinical incident and not their underlying condition or illness.</p>	<p><input type="radio"/> Death</p> <p><input type="radio"/> Serious harm</p> <p><input checked="" type="radio"/> Moderate harm</p> <p><input type="radio"/> Minor harm</p> <p><input type="radio"/> No harm</p>
Was the patient absent without leave?	<input type="text"/>
Was a fetus harmed in this incident?	<input type="text"/>
Did this incident involve patient care from another service?	<input type="text"/>
<p>Click here to access Guidelines for the investigation of clinical incidents across health service boundaries</p>	

If the answer is 'Yes' to the field 'Was a patient absent without leave?' further fields will appear for further information to be collected.

Was the patient absent without leave?	Yes <input type="text"/>
Date of return	<input type="text"/>
Time of return	<input type="text"/>
<p>Assessment performed on patient's return</p> <p>Please state the patient's outcome (eg. physical, psychological). If the patient did not return, then please document in this field.</p>	<input type="text"/>

If the answer is 'Yes' to the field, 'Was a fetus harmed in this incident?', further fields will appear for further information to be collected.

Was a fetus harmed in this incident?	Yes <input type="text"/>
Is this a multiple pregnancy? ?	<input type="text"/>
Gestational age at time of the incident (weeks)	<input type="text"/>
Fetal outcome ?	<input type="text"/>

Note: Incidents that result in death or serious harm to a fetus should be confirmed as SAC1 incidents.

Common mistakes to note regarding the fetal harm fields

Patient outcome vs fetal outcome

Note that a fetus will not have a UMRN and so the patient recorded in the incident is usually the mother. So if the patient against the record is the mother, then the patient outcome field should reflect the mother's outcome as seen in the screenshot below. If the mother did not pass away, then do not note death as the outcome (the fetus' outcome is recorded separately). You can see an example of this in the screenshots below.



Incorrect if the mother did not pass away but the fetus did:

Patient Outcome

* 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.

Death
 Serious harm
 Moderate harm
 Minor harm
 No harm

Was the patient absent without leave?

Was a fetus harmed in this incident?

Is this a multiple pregnancy?

Gestational age at time of the incident (weeks)

Fetal outcome

Did this incident involve patient care from another service?

[Click here to access Guidelines for the investigation of clinical incidents across health service boundaries](#)

Mother

Fetus

Correct if the mother did not pass away but the fetus did:

Patient Outcome

* 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.

Death
 Serious harm
 Moderate harm
 Minor harm
 No harm

Was the patient absent without leave?

Was a fetus harmed in this incident?

Is this a multiple pregnancy?

Gestational age at time of the incident (weeks)

Fetal outcome

Did this incident involve patient care from another service?

[Click here to access Guidelines for the investigation of clinical incidents across health service boundaries](#)

Mother

Fetus



Baby harm vs fetal harm

If a baby was delivered and then involved in an incident from health care provision, then the baby would be considered the patient. The baby’s UMRN would be used to record the incident in Datix CIMS and the “*Patient outcome*” field would be used to record the baby’s level of harm. The fetal harm question would be answered ‘No’ as seen in the example below:

Patient Outcome	
<p>★ Patient outcome</p> <p>Patient outcome refers to patient harm (physical or psychological) as a direct result of a clinical incident and not their underlying condition or illness.</p>	<p><input type="radio"/> Death</p> <p><input checked="" type="radio"/> Serious harm</p> <p><input type="radio"/> Moderate harm</p> <p><input type="radio"/> Minor harm</p> <p><input type="radio"/> No harm</p>
Was the patient absent without leave?	<input type="text"/>
Was a fetus harmed in this incident?	<input type="text" value="No"/>
Did this incident involve patient care from another service?	<input type="text"/>
<p>Click here to access Guidelines for the investigation of clinical incidents across health service boundaries</p>	

If the answer is ‘Yes’ to the field ‘**Did this incident involved patient care from another service?**’ further fields will appear for further information to be collected.

Did this incident involve patient care from another service?	<input type="text" value="Yes"/>
<p>Click here to access Guidelines for the investigation of clinical incidents across health service boundaries</p>	
Please state which site / service	<input type="text"/>
Name and position of the contact person	<input type="text"/>
<p>Please state the name and position of the person who contacted you from the other site / service to inform you that a clinical incident had occurred</p>	
Will a multi-site review be undertaken?	<input type="text"/>



Depending on the nature of the clinical incident notification to other statutory bodies may also be required. Prior to informing the PSSU, notifying sites must complete questions within the [Notification to Statutory /Other Bodies](#) section on the [Clinical incident investigation](#) page (screenshots below).

Notification to Statutory/Other Bodies	
Have the relevant authorities/statutory bodies been notified, where appropriate?	
* Advisory Committee on the Safety of Medicines informed?	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown
* Therapeutic Goods Administration informed?	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown
* OSH informed?	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown
* Radiation Safety informed?	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown
Other areas informed	<div style="border: 1px solid #ccc; height: 60px; width: 100%;"></div>
* Executive Director, Public Health and Clinical Services informed for: maternal death	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown
* Executive Director, Public Health and Clinical Services informed for: perinatal / infant death	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown



<p>★ Executive Director, Public Health and Clinical Services informed for: death of persons under anaesthesia ?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown</p>
<p>★ Coroner informed for reportable deaths ?</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown</p>
<p>★ Chief Psychiatrist: Is this a mental health notifiable incident? ?</p> <p>Click here to access the Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist</p>	<p><input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A <input type="radio"/> Unknown</p>
<p>Other Bodies informed</p>	<div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p style="text-align: right;">abc</p>
<p>Explanation as to why Statutory Requirement notification was not completed (if applicable)</p>	<div style="border: 1px solid black; height: 80px; width: 100%;"></div> <p style="text-align: right;">abc</p>
<p>★ Has the Open Disclosure process been initiated?</p>	<p><input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A <input type="radio"/> Unknown</p>
<p>Open Disclosure decision date</p>	<input type="text" value=""/>
<p>Staff member initiating Open Disclosure</p>	<input type="text" value=""/>
<p>★ Is this incident using Qualified Privilege? Yes/No</p>	<p><input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> N/A <input type="radio"/> Unknown</p>
<p>Post Mortem Report Received?</p>	<p><input type="radio"/> None <input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> N/A</p>



Section 1. Communicating to the Patient Safety Surveillance Unit via 'Communication and feedback'

Informing the PSSU of a SAC 1 clinical incident is achieved through the use of the *Communication and feedback* tab within Datix.

To inform the PSSU of a SAC1 clinical incident:

The screenshot shows the 'Communication & Feedback' tab in the Datix system. The interface includes a left-hand navigation menu with options like 'Clinical incident details', 'Communication & Feedback', and 'Send message'. The main content area is divided into sections for 'Recipients' (Staff and contacts, All users, Additional recipients), 'Message' (Subject, Body of message), and a 'Send message' button at the bottom.

1. Open the specific clinical incident record and select the Communication and Feedback tab.

2. Select *SAC1.Events@health.wa.gov.au* from the **All users** field, and then double click the email address.

Health services may also require Notifiers to cc the respective health services Safety and Quality/Governance Unit at the same time as informing the PSSU.

This can be achieved by selecting from the 'All users' or adding an email address to the 'Additional recipients' field.

3. Construct the message in the **Body of message** field, for example: *Please note the notification of a SAC1 clinical incident referred to in this email message.*

4. Once the message has been composed, click 'Send message'. This informs the PSSU of the incident.

5. Click 'Save' after the 'message sent' icon appears.



Section 2. SAC 1 Action Chains

SAC 1 Action chains within Datix CIMS provide a mechanism for hospitals/ health services to demonstrate compliance with CIM Policy with respect to SAC 1 clinical incidents. SAC 1 Action chains include steps that must be ‘completed’ following informing the PSSU of a SAC 1 clinical incident, on submission of the investigation report into a SAC 1 clinical incident, and when the implementation and evaluation of recommendations arising from the investigation is completed.

A SAC 1 Action chain will appear within the Clinical incident investigation page of a clinical incident when the Patient details are approved, the **Severity Assessment Code (Confirmed)** is selected as SAC 1, and the **Patient outcome** field (found on the **Clinical incident investigation** page) is completed.

SAC 1 Action Chains appear as below:

The function of each Action Chain is defined by the Description

Action chain steps appear as ‘assigned to’ the Safety and Quality / Clinical Governance Unit Officer that was initially assigned the clinical incident

SAC1 Clinical Incident Investigation							
Step	Type	Description	Assigned To	Start date	Due date	Date completed	Active
1	Notify	Notify the Patient Safety Surveillance Unit (PSSU) within 7 working days.	CIMS Senior Staff (P cims_ss1 Demo)	17/08/2016	26/08/2016	17/08/2016	Y
2	Investigate & Submit	Complete the SAC1 Clinical Incident Investigation using Root Cause Analysis or similar investigative methodology & submit completed Investigation Report to PSSU (due within 28 working days). Close event.	CIMS Senior Staff (P cims_ss1 Demo)	17/08/2016	27/09/2016	Complete	Y
3	Implement	Review SAC1 Clinical Incident Recommendations to ensure completion within 6 months.	CIMS Senior Staff (P cims_ss1 Demo)				N
4	Evaluate	Review evaluation of SAC1 Clinical Incident Recommendations within 6 months.	CIMS Senior Staff (P cims_ss1 Demo)				N

The Start date and Due date fields are populated by Datix CIMS depending on when the incident was confirmed as SAC 1, and when the Date completed in the previous Action Chain steps are completed

Add a new action chain



Table 1 below lists SAC 1 Action chain steps, and describes when each step should be 'Completed', in order to indicate compliance with the CIM Policy. The PSSU will complete Action chain steps 1, 2 and 4 in response to receipt of communication from hospitals/health services notifying the incident and advising that the investigation and evaluation components of the CIM process have been completed. It is the responsibility of hospitals/health services to complete Action chain step 3.

Health Service business rules vary with respect to local notification requirements. Please refer to local guidelines.

Table 1 - SAC1 Action Chain steps

SAC 1 Action chain step	Responsibility for completing Step	When Step should be completed
1. Notify the Patient Safety Surveillance Unit (PSSU) within 7 working days.	PSSU	After communicating to the PSSU (via the Communication and feedback tab) to inform of a new SAC 1 clinical incident. The date completed is the date PSSU was informed.
2. Complete the SAC1 Clinical Incident Investigation using Root Cause Analysis or similar investigative methodology & submit completed Investigation Report to PSSU (due within 28 working days). Close event.	PSSU	When the investigation report has been completed and entered into the incident record and after communicating this to PSSU (via the Communication and feedback tab). The date completed is the date PSSU was informed.
3. Review SAC1 Clinical Incident Recommendations to ensure completion within 6 months.	Site	When all recommendations arising from the investigation of the incident have been implemented.
4. Review evaluation of SAC1 Clinical Incident Recommendations within 6 months.	PSSU	When evaluation of the effectiveness of all recommendations arising from the incident has been completed and uploaded/entered into the incident record and after communicating this to the PSSU (via the Communication and feedback tab). The date completed is the date PSSU was informed.



To complete an Action Chain step:

Action chains

SAC1 Clinical Incident Investigation

Step	Type	Description	Assigned To	Start date	Due date	Date completed	Active
1	Notify	Notify the Patient Safety Surveillance Unit (PSSU) within 7 working days.	CIMS Senior Staff (P cims_ss1 Demo)	17/08/2016	26/08/2016	17/08/2016	Y
2	Investigate & Submit	Complete the SAC1 Clinical Incident Investigation using Root Cause Analysis or similar investigative methodology & submit completed Investigation Report to PSSU (due within 28 working days). Close event.	CIMS Senior Staff (P cims_ss1 Demo)	17/08/2016	27/09/2016	Complete	Y
3	Implement	Review SAC1 Clinical Incident Recommendations to ensure completion within 6 months.	CIMS Senior Staff (P cims_ss1 Demo)				N
4	Evaluate	Review evaluation of SAC1 Clinical Incident Recommendations within 6 months.	CIMS Senior Staff (P cims_ss1 Demo)				N

Add a new action chain

1. Click the Complete button

Complete action

Implementation Evidence

Apply Cancel

2. A pop up box will appear. Enter text if appropriate then click 'Apply'

Action chains

SAC1 Clinical Incident Investigation

Step	Type	Description	Assigned To	Start date	Due date	Date completed	Active
1	Notify	Notify the Patient Safety Surveillance Unit (PSSU) within 7 working days.	CIMS Senior Staff (P cims_ss1 Demo)	17/08/2016	26/08/2016	17/08/2016	Y
2	Investigate & Submit	Complete the SAC1 Clinical Incident Investigation using Root Cause Analysis or similar investigative methodology & submit completed Investigation Report to PSSU (due within 28 working days). Close event.	CIMS Senior Staff (P cims_ss1 Demo)	17/08/2016	27/09/2016	Complete	Y
3	Implement	Review SAC1 Clinical Incident Recommendations to ensure completion within 6 months.	CIMS Senior Staff (P cims_ss1 Demo)				N
4	Evaluate	Review evaluation of SAC1 Clinical Incident Recommendations within 6 months.	CIMS Senior Staff (P cims_ss1 Demo)				N

Add a new action chain

3. The 'Date completed' field will populate with the date the step was completed.

SAC 1 Action chains Key Points:

The PSSU will complete Action chain steps 1, 2 and 4 in response to receipt of communication from hospitals/health services notifying the incident and advising that the investigation and evaluation components of the CIM process have been completed. It is the responsibility of hospitals/health services to complete Action chain step 3.



Investigating SAC 1 clinical incidents

The Department of Health Clinical Incident Management Toolkit provides a useful resource to assist staff in undertaking the management of clinical incidents. The Toolkit can be accessed at http://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system

The key steps to effective clinical incident management comprise:

1. Identification of a clinical incident, immediate action to reduce risk to the patient/ consumer and undertake the Open Disclosure process.
2. Notification
3. Prioritisation of investigation
4. Analysis and investigation
5. Development of recommendations
6. Reporting of investigation outcomes
7. Feedback
8. Implementation of recommendations
9. Monitoring of recommendations
10. Evaluation of recommendations.

SAC 1 clinical incidents require the undertaking of an investigation utilising a robust methodology appropriate to the incident. SAC 2 clinical incidents require clinical review or investigation using an appropriate methodology, while SAC 3 clinical incidents require investigation using aggregated analysis or a similar tool. The CIM Toolkit provides examples of investigation methodologies.

Datix CIMS is configured to enable hospitals/ health services to appropriately manage a clinical incident. The Communication and feedback tab, elements of the Clinical incident investigation page, and SAC 1 Action chain functions have been discussed earlier, with additional Datix functions related to the following pages; Clinical incident investigation, Third party comment, Department/Service Head/Director and Documentation, explored below.

Clinical incident investigation

In addition to housing information such as the incident category, SAC 1 Action Chains and fields relating to notification of other statutory bodies, the Clinical incident investigation page is where contributory/ causative factors to the incident identified in an investigation and recommendations to address causative factors are detailed. The page also includes fields for sign-off of the investigation.

Causative / Contributing Factors

The investigation of SAC 1 clinical incidents is used to establish the course of events and to identify the contributing factors to the incident. Contributory factors become the basis for the development of recommendations to prevent or reduce the reoccurrence of same or similar clinical incidents.

Contributing Factors are grouped in Datix CIMS and can include issues reflecting:



- Communication
- Knowledge / Skills / Competence
- Work Environment / Scheduling
- Patient Factors
- Equipment, Information Systems / Applications
- Policies Procedures and Guidelines
- Safety Mechanisms
- Other Factors

Information with respect to each of the listed contributing factor groups is entered into Datix using the **Yes, No** or **Unknown at this time** radio buttons. If **Yes** is selected, additional fields enabling more specific information on contributing factors, including free text, appears (see example screenshot below (remember that tick boxes allow you to select multiple responses)):

Communication	
<p>★ Were Communication issues a factor?</p> <p>For IT system/clinical application incidents complete Communication and Equipment factors.</p>	<p><input checked="" type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Unknown at this time</p>
<p>Causative/Contributing Factor: Communication</p>	<p><input type="checkbox"/> Between Staff</p> <p><input type="checkbox"/> Between Staff and Patient/family/carers</p> <p><input type="checkbox"/> Documentation</p> <p><input type="checkbox"/> Patient assessment</p> <p><input type="checkbox"/> Information not provided</p> <p><input type="checkbox"/> Misinterpretation of information</p> <p><input type="checkbox"/> Language interpretation</p> <p><input type="checkbox"/> Other</p>
<p>Communication details</p>	<div style="border: 1px solid black; height: 80px; width: 100%;"></div>

Recommendations

The development of recommendations is a fundamental component of clinical incident management. Recommendations provide the framework for action in improving or preventing adverse events from occurring. Recommendations arising from clinical incident investigations are to be implemented and evaluated for effectiveness within six months of the finalised investigation. The CIM Toolkit provides further information on developing appropriate recommendations and implementation and evaluation methodologies.

Inputting Recommendations into Datix CIMS allows hospitals /health services to search and track Recommendations that are marked as outstanding. A Recommendation will become Overdue once the specified Due date for completion has passed.

Note: The information contained in this section is limited. For more detailed information about alternate ways of accessing recommendation records, and managing recommendation records



in Datix CIMS please refer to the *WA Health Datix CIMS Recommendations User Guide* available at <https://hss-healthpoint.hdwa.health.wa.gov.au/business-at-health/ICT-servicedelivery-and-operations/cims/Pages/default.aspx>

To add a Recommendation to an incident record click 'Create a new action' in the Recommendations section of the 'Clinical incident investigation' screen.

Recommendations								
Module	Linked record ID	ID	Recommendation / Action Text	Assigned To	Outcome measure	Due date	Date completed	Done date
Clinical Incident Management System	222654	28219	Recommendation / Action Text					
								Complete
Create a new action								

The Recommendation / Action Form will open:

Reference	
Module	
Linked record ID	213599
Recommendation/Action ID	
Recommendation/Action Details	
<p>★ Severity Assessment Code (Confirmed)</p> <p>This SAC rating must match the SAC rating (confirmed) as per the incident investigation</p>	<input type="text"/>
<p>Causation Statement Summary</p> <p>Summarise the cause of the incident. A cause is a deficiency, which if removed would probably have prevented or reduced the harm.</p> <p>See CIMS Toolkit page 33 for examples of causation summaries.</p>	<input type="text"/>
<p>★ Contributing factors</p> <p>These are the factor/s related to THIS recommendation that contributed to the incident as identified by the incident investigation.</p>	<input type="text"/>
<p>★ Recommendation title</p> <p>This is a brief description of the aim of the recommendation.</p>	<input type="text"/>
<p>★ Recommendation detail</p> <p>Describe in detail what is planned. The recommendation should be SMART - Specific, Measurable, Accountable, Realistic, Time related.</p> <p>See CIMS Toolkit page18 for an explanation of SMART recommendations.</p>	<input type="text"/>
<p>★ Recommendation type</p> <p>Select from the list the most appropriate description of your recommendation.</p> <p>See CIMS Toolkit page 17 for examples of types of recommendations.</p>	<input type="text"/>
<p>What will be measured / what will your outcome be?</p> <p>See CIMS Toolkit page 15-20 for examples of outcome measures and evaluation methodologies.</p>	<input type="text"/>



How will this be measured?	<input type="text"/>
Priority	<input type="text"/>
Start date (dd/MM/yyyy)	24/02/2017
★ Assigned To <small>The recommendation should be assigned to the person with the authority to implement the recommendation.</small>	<input type="text"/>
Implementation Details	
Implementation due date <small>Maximum total of 6 months to implement and evaluate recommendations. See CIM Policy for further information.</small>	<input type="text"/>
Implementation complete date	<input type="text"/>
Implementation Evidence <small>Enter a summary of the actions taken to implement the recommendation (e.g. checklist updated, new equipment purchased). Additional evidence can be attached to the recommendation as a document.</small>	<input type="text"/>
Evaluation Details	
Due date (dd/MM/yyyy) <small>Maximum total of 6 months to implement and evaluate recommendations. See CIM Policy for further information.</small>	<input type="text"/>
Complete date (dd/MM/yyyy)	<input type="text"/>
Evaluation Evidence <small>Enter a summary of the evaluation of the effectiveness of the recommendation (e.g. summary of audit results). Additional evidence can be attached to the recommendation as a document.</small>	<input type="text"/>
Executive concur with the evaluation of this recommendation?	<input type="text"/>
Senior Staff discussed recommendations and actions with the notifier?	<input type="text"/>
Is further quality improvement activity required? <small>Please also refer to your local quality improvement system.</small>	<input type="text"/>
Additional comments	<input type="text"/>
<input type="button" value="Submit action"/> <input type="button" value="Cancel"/>	

Note: A recommendation may be assigned to a Third Party, for example a Committee such as the WA Medication Safety Group. If assigning Recommendations to a user with a Third Party Profile the user needs to be added to the incident via the 'Invite Third Party comment' box as well as the Recommendation being assigned to them. As the Third Party profile has read-only access to the investigation screen they will need to access the Recommendation through the Recommendations/Actions module.

For information about how to complete recommendations and alternate ways to access and manage recommendations in Datix CIMS please refer to the *WA Health Datix CIMS Recommendations User Guide* available at: <https://hss-healthpoint.hdwa.health.wa.gov.au/business-at-health/ICT-servicedelivery-and-operations/cims/Pages/default.aspx>

Investigation Sign Off fields

The Clinical incident investigation page contains Investigation Sign Off fields (see screenshot below) that provide the opportunity for appropriate officers / executives to enter their details, signifying the approval of the completed incident investigation. As local processes may vary as to when these fields are completed, and who completes them (reflecting potential delegation of duties), local guidance is advised.



Senior Staff Details	
Name	<input type="text"/>
Designation	<input type="text"/>
Signature (HE number)	<input type="text"/>
Signature date	<input type="text"/>
Signature time (24 hour format)	<input type="text"/>
SAC 1 Investigation Sign Off - Chief Executive/Executive Director/Director Medical Services	
Name	<input type="text"/>
Signature (HE number)	<input type="text"/>
Date	<input type="text"/>
SAC 1 Investigation Sign Off - Director SQ&P/CGU	
Name	<input type="text"/>
Signature (HE number)	<input type="text"/>
Date	<input type="text"/>
SAC 1 Investigation Sign Off - Chief Investigator	
Name	<input type="text"/>
Signature (HE number)	<input type="text"/>
Date	<input type="text"/>

Closed Incident

Department / Service Head / Director approval is required for an investigator to change the workflow status of an incident to 'Closed'; which signifies the completion of a clinical incident investigation (the investigation report for the SAC 1 clinical incident has been entered in Datix and communication sent to the PSSU).

Business rules for re-opening closed records

Datix CIMS users may be required to re-open a 'Closed' clinical incident record for a variety of reasons. These business rules apply when the purpose of re-opening the record is to continue an investigation or re-investigate an incident. They do not apply when the purpose is for administrative changes to the record (i.e. correcting typographical errors, omissions or incorrect information).

Re-opening closed records

When re-opening a closed record, the 'Closed date' field should only be updated when the record is being moved from closed to open i.e. changing the 'Workflow status' from 'Closed' to an active 'Workflow status'. The following steps should be undertaken:

1. Open a closed record. Remove the 'closed date'.

Date Closed
★ Closed date (dd/MM/yyyy) <input type="text" value="13/02/2018"/>



2. Change the 'Workflow status' from 'Closed' to either 'Snr staff evaluation/3rd Pty comment', 'Dept/Service Health/Director' or 'SAC1 Investigation'. Note: when the 'Workflow status' has been changed, the 'Closed date' field box disappears.

Workflow status	
Current workflow status	Closed
* Workflow status after save	Closed
Date closed	
* Closed date (dd/MM/yyyy)	<ul style="list-style-type: none"> New incident Snr staff evaluation/3rd Pty comment Dept/Service Head/Director comment SAC1 investigation Closed Inactive
Place of clinical incident (Where did the clinical incident occur?)	
* Place of Incident / Event	Closed
Service Sub-Division	Inactive

3. Click the 'save' button at the bottom of the page to ensure your changes are saved. The once closed record is now an active record.

Closing re-opened records

When closing a re-opened record, the following steps should be undertaken:

1. Open the record. Change the 'Workflow status' to 'closed'.

Workflow status	
Current workflow status	SAC1 investigation
* Workflow status after save	SAC1 investigation
Place of clinical incident (Where did the clinical incident occur?)	
* Place of incident / event	<ul style="list-style-type: none"> New incident Snr staff evaluation/3rd Pty comment Dept/Service Head/Director comment SAC1 investigation Closed Inactive
Service Sub-Division	
Service Division	

2. The closed date field box will appear. Enter a closed date.

Date Closed	
* Closed date (dd/MM/yyyy)	<input type="text"/>

3. Click the 'save' button at the bottom of the page to ensure your changes are saved. The re-opened record is now once again 'closed' with a new closed date.

Third party comment

The Third party comment tab of Datix CIMS can be used to request advice or information from other WA Health officers in relation to a clinical incident. Note that only personnel with a @health.wa.gov.au email address can be invited to comment on an incident via the Datix Third party comment page. Datix CIMS includes four spaces for third party comments.

To obtain comments from WA Health employees:


- Click on the **Third party comment** page, begin typing the name of the staff member required and the drop down menu will generate available choices. Double click on the applicable staff member.



- The person requesting comment from a third party can enter text in the third party comment box, for example describing specific feedback that is being requested (it may assist the third party to include instruction to overwrite or enter feedback beneath the request).
- Click save.


An email that includes a link to the incident record will be automatically sent to the staff member inviting comment. The **Third party** staff member will have read only access to the investigation pages and enters their feedback on the **Third party comment** page. Third parties have access to the Communication and feedback tab, and can email the requestor via this function that their comments have been entered.


Third party comment
If applicable, invite third party comment from relevant 3rd Party(s) or liaise with 3rd Party for comment, prior to determining contributing factors/recommendations e.g. Medical Practitioner, Pharmacy, Radiology, Allied Health, Pain Service, etc.

Invite third party comment from 

Third party comment 1
Please review this clinical incident and investigation and offer any additional relevant information.

Comment

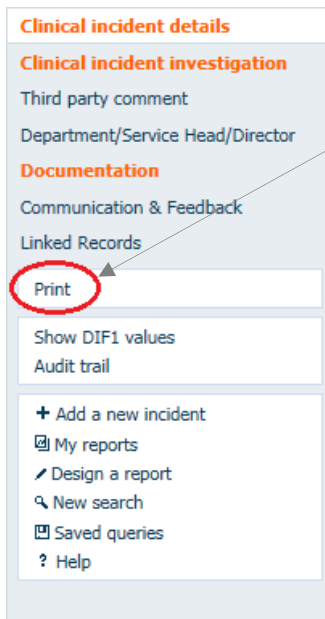


Name	<input type="text"/>
Designation	<input type="text"/>
Signature (HE number)	<input type="text"/>
Signature date	<input type="text"/> 
Signature time (24 hour format)	<input type="text"/>

To obtain comments from non-WA Health employees two processes are authorised for use:

1. The incident record is printed from Datix and sent via registered post to the appropriate individual(s), or
2. The incident record is saved as an electronic file format and sent via email, using WinZip to secure the incident information.

To obtain a print output of the incident record:



1. Click on the Print icon of the incident record. This generates a pop up web page containing all information in the incident record.

2. Select the Print function (which may vary depending on the internet web browser used) to output the incident record to a local printer for sending via registered post.

3. The print output is sent via registered post.

To save the incident record in an electronic file format for secure communication via email:

1. Click on the **print** icon of the incident record. This will generate a pop up web page containing the incident record.
2. Depending on the internet web browser used, the pop up web page is then saved in an electronic file format (for example as a .PDF or .XPS file).
3. Encrypt the electronic file using WinZip.
4. The encrypted file is then sent via email to the appropriate individual, with the email describing the feedback that is requested.
5. The password to access the encrypted file is sent in a subsequent email (Note: the password is **not** sent with the encrypted file).
6. The individual uses the password to un-encrypt the incident record for viewing.

Feedback returned to the requestor can be attached to the incident record using the Documentation function (see Documentation, p.26). For example if feedback is received via email, the email message can be attached to the incident record.

Department/Service Head/Director

The Department / Service Head/ Director tab (screenshot below) is used to enable the entering of comments regarding the incident investigation. As local processes may vary regarding the use of this Datix function, guidance from the appropriate Safety and Quality / Clinical Governance Unit is advised.



Department/Service Head/Director
Comment on recommendations made and actions taken to prevent recurrence. Do NOT repeat the senior staff evaluation

Comment

Name

Designation

Signature (HE number)

Signature date

Signature time (24 hour format)

Documentation

It is possible to attach electronic documents to an incident record. Once attached, these documents can be accessed by anyone who has permission to view the incident. Example documents that might be considered for attaching include flow charts that detail the patient journey or guidelines referred to in the incident investigation.

To attach a document to an incident record:

1. Select **Documentation** from the left hand tab menu.
2. Select **Attach a new document**.

Clinical incident details
Clinical incident investigation
Third party comment
Department/Service Head/Director
Documentation
Communication & Feedback
Linked Records

Documentation
Documents
No documents.
Attach a new document

3. On the **link as** drop down button, select the **document type**, such as 'Letter' or 'Agenda'.
4. Add a description of the document in the **Description** section.
5. Click the **browse** button to search for the document to be attached. Once found, double click to select it.
6. When returned to the **Attachment details** screen, click on the **Save** button to confirm the attachment.



New document

- + Add a new incident
- My reports
- Design a report
- New search
- Saved queries
- Help

Attachment details

* Link as

* Description

* Attach this file

Documentation

Documents

Created	Type	Description	ID	
21/07/2016	Letter	Letter from Dr	43168	[edit]

Attach a new document

7. Repeat the process to attach other electronic documents

To access the document from the documents list, click on the description for that document, then select the open option.



Advising of delays in the completion of a SAC 1 clinical incident investigation

The CIM Policy specifies that hospitals/health services must complete the investigation into a SAC 1 clinical incident within 28 business days of informing the PSSU of the incident.

If an investigation is not anticipated to be completed within this timeframe (for example due to the absence of personnel integral to the investigation process) hospitals/health services are to inform the PSSU of the reason for the delay and provide an estimated date for completion of the investigation via the Communication and feedback tab.

The percentage of SAC 1 investigations completed within 28 business days of informing the PSSU is incorporated into the Health Service Performance Report (measure E2-2) and does not adjust for extensions to the timeframe for the completion of SAC 1 investigations.



Requesting declassification of a SAC 1 clinical incident

Following the investigation of a SAC 1 clinical incident, it may be determined that no causative factors contributed to the outcome and in fact the event was not preventable.

Hospitals/health services reaching these conclusions may request declassification of the incident by completing the Declassification request section located at the base of the Clinical incident investigation page (screenshot below). It is important to clearly explain the rationale for declassification.

Declassification	
Is declassification of this clinical incident requested?	<input type="radio"/> None <input checked="" type="radio"/> Yes <input type="radio"/> No
★ Declassification explanation:	<div style="border: 1px solid #ccc; height: 80px; width: 100%;"></div> <p>abc</p>

When informing the PSSU (via the Communication and feedback tab) that the clinical incident investigation has been completed, include within the communication that declassification is being requested.

Declassification requests received by PSSU are reviewed in conjunction with the investigation report to determine if the clinical incident is to be declassified.

If a clinical incident is declassified, the CIM Policy requires hospitals/health services to continue to implement any recommendations that may have been developed by the investigation.

If a declassification request for a SAC 1 clinical incident is approved, the hospital/ health service is informed, and the incident record is then inactivated by the hospital/ health service by selecting the workflow status 'Inactive'.

1. Select **Inactive** as the **Workflow status after save**

Workflow status	
Current workflow status	Closed
★ Workflow status after save	Inactive



2. Select 'Other reason' as the reason for marking as inactive.

The screenshot shows the 'Inactivated details' form. The 'Reason for marking as Inactive' dropdown menu is open, displaying three options: 'Duplication', 'Submitted via incorrect module/form', and 'Other reason'. The 'Other reason' option is highlighted. The 'Further Details' section is empty.

3. Within the Further Details section indicate that the incident has been declassified and approval communicated by the PSSU (entering the date this occurred).

The screenshot shows the 'Inactivated details' form. The 'Reason for marking as Inactive' dropdown menu is set to 'Other reason'. The 'Further Details' section contains the text: 'PSSU advised declassification approved 1/8/2016'. Below the form, there are fields for 'Date inactivated (dd/MM/yyyy)' and 'Inactivated by'.

4. Click **Save**, and the date the incident record was updated will be entered into Datix below the Further Details section. The name of the officer who completed this section will also be recorded.

Note: If a declassification request for a SAC 1 clinical incident is rejected, the hospital/ health service is informed, and the workflow status of the incident record remains 'Closed'.





WA Health Datix CIMS


Accessing WA Health Datix CIMS

Window XP Computers

To open the application on your computer screen,


click Start 

→ Health 

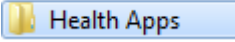
→ Datix CIMS icon  Datix CIMS


Window 7 Computers

To open the application use the Windows icon,

click 


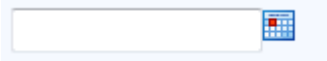

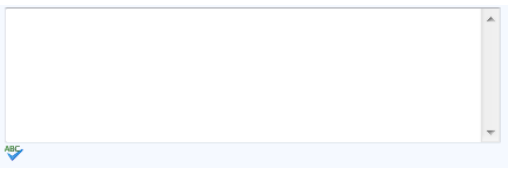
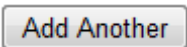
→ Click All Programs, then click on Health

 Health Apps




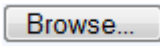
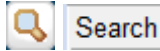

→ Datix CIMS icon  Datix CIMS

General Navigation Information

A number of features are common to many areas of the WA Health Datix CIMS.

Item	Item title	Description
	Mandatory Field	This indicates the field is mandatory and you are required to complete it prior to saving or submitting the form.
	Date field	Open the calendar to select a date or type in the date using dd/mm/yyyy.
	Pick list	Type the first few letters of the required value and the pick list will generate a list of possible matches to select from. Alternatively click the arrow and scroll through the alphabetical list provided.
	Free text field	Type text in to this field. Spell check function is available.
	Add another	Click on this to add an identical



Item	Item title	Description
		section without copying content.
	Clear section	This enables the section within the form to be cleared of all entered data.
	Spell check	Click to check your spelling.
	Pencil	Click to close spell check and return to entering text.
	Help Icons	Click to display additional information. Please note this may be general Datix help that is not specific to the WA Health system configuration.
	Round Radio Buttons	Round radio buttons allow a single selection only.
	Square Tick Boxes	Square tick box buttons allow multiple selections
	Delete	In a multi-select field, where more than one option can be chosen, highlight selected item, click icon to remove the selected value(s).
	Browse	Allows the selection of documentation to be attached.
	Save/Submit	Save/Submit button located at the bottom of the 'Feedback notification form' or in floating menu (bottom left of page)
	Search	This allows a 'search' of the data to be conducted
	Cancel	The cancel function located at the bottom of the forms or in the floating menu (bottom left of page)



Timeout Feature

In order to maintain system security, the WA Health Datix CIMS will automatically end a session if it has been inactive for 15 minutes. Once the time limit has been reached, a message will appear on the screen advising that the session will be ended unless the option to “Extend session” is selected.

Alert

Your session has been inactive for more than 15 minutes. For your security, your connection will be logged out if there is no activity after one further minute.

If you do not wish to be logged out, click 'Extend session' and your session will be extended for a further 15 minutes.

Seconds remaining: 41



Further Information

For further information with regard to notifying a clinical incident please refer to the:

- WA Health Datix CIMS ELearning Notifier Guide which is located at the Clinical Incident Management System website. http://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system
- The Clinical Incident Management Policy which is located at the Clinical Incident Management System website. http://ww2.health.wa.gov.au/Articles/A_E/Clinical-incident-management-system

Additionally, please contact your supervisor or Safety and Quality staff member for further assistance.



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

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