



**Department of Health**  
Government of Western Australia

# **ANNUAL REPORT**

**Report on WA Data collected by the  
Advanced Incident Management System  
(AIMS)**

**1 July 2005 to 30 June 2006**

*Office of Safety and Quality in Health Care*

## TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>3</b>
<b>TRENDS IN REPORTING TO THE AIMS DATABASE: 2001-2006.....</b>	<b>5</b>
<b>RESULTS: 2005-2006.....</b>	<b>9</b>
PRINCIPAL INCIDENT TYPE	9
INCIDENT OUTCOMES	10
REPORTER CLASSIFICATION	12
FALLS	13
MEDICATION INCIDENTS	16
INJURY INCIDENTS	19
BEHAVIOUR INCIDENTS	22
OTHER INCIDENTS	24
<b>APPENDIX ONE - CAVEATS .....</b>	<b>26</b>

## EXECUTIVE SUMMARY

Data for this report were extracted from the Advanced Incident Management System (AIMS) database in October 2006 and covers all incidents reported to AIMS from 1 July 2005 to 30 June 2006. This report also includes trend data for reporting of clinical incidents to the AIMS database from October 2001 up to and including June 2006. Readers are reminded to note the limitations to the data, outlined in the caveats section at the end of this report.

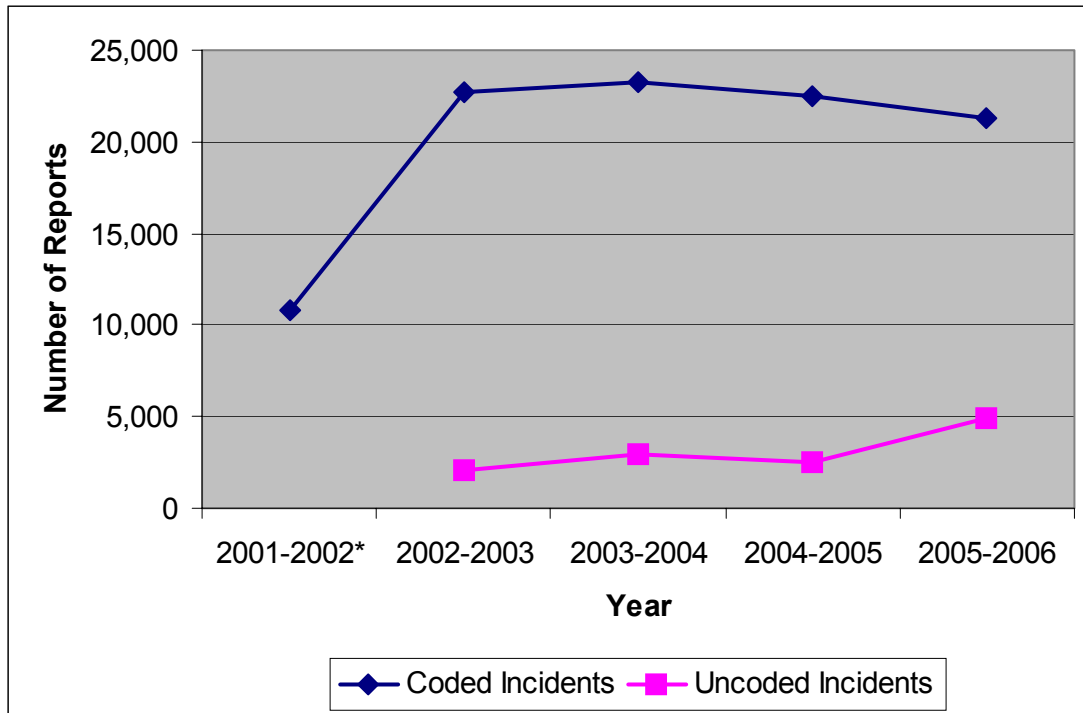
### Overview

- The number of clinical incidents reported to the AIMS database between 1 July 2002 and 30 June 2006 has remained relatively stable between 21,000 to 23,000 reports per year. However, there have been an increasing number of uncoded reports (almost 5,000 as of 30 June 2006) that makes analysis of reporting trends very difficult.
- When examining each of the ten Principal Incident Types (PITs) as a proportion of the total number of incidents reported to the AIMS database per year, the proportion of reported *fall* incidents has steadily decreased between 1 July 2002 to 30 June 2006, while the proportion of reported *medication* and *other* incident types has increased. The relative proportions of all other PITs have remained stable over this time.
- The number of clinical incidents reported to AIMS between 1 July 2005 and 30 June 2006 represents approximately 3% of all patient separations for public hospitals and health services.
- The majority of all reported incidents (60%) resulted in a minor outcome that did not require additional treatment (AIMS Level 4 or lower).
- *Fall* and *medication* incidents continued to be the two most commonly reported incidents in the AIMS database.
- The majority of *fall* incidents involved elderly patients (75+ years of age). Most of these incidents resulted in a minor outcome that did not require additional treatment. 58% of all reported *fall* incidents could be attributed to reports of individual patients falling more than one time (multiple fall incidents).
- Omissions are the most common type of reported *medication* incident. The most frequently omitted medication is paracetamol. Overdoses were the second most common type of reported *medication* incident, and the medication most frequently involved was paracetamol.

- The majority of *medication* incidents resulted in no harm to the patient. However, in a small percentage of *medication* incidents, the results were very harmful to the patient. These included missed Deep Vein Thrombosis (DVT) prophylaxis after surgery resulting in patient death, and a mis-programmed pump administering too much morphine, also resulting in patient death. 53% of all reported *medication* incidents could be attributed to individual patients with multiple *medication* incident reports.
- There was a sharp increase in the number of *medication* incidents reported between 8:00am and 9:00am that coincides with the administration of medication during this time. Thus, it may be prudent to exercise greater vigilance during this time period.
- *Behaviour* and *other* incidents are more likely to result in moderate and significant outcomes (AIMS Level 6 to 8). 58% of all reported *behaviour* incidents could be attributed to individual patients with multiple *behaviour* incident reports.
- Most Principal Incident Types classified as '*other*' refer to delayed, incorrect or the absence of treatments, procedures or assessments. Such incidents typically result in increased length of stay and require additional patient care and thus are costly to the health system.

## TRENDS IN REPORTING TO THE AIMS DATABASE: 2001-2006

Reporting to the AIMS database began in October 2001 and was phased in across Western Australia after that time. As of 30 June 2006, 100,651 reports had been entered into the database. Figure 1 shows the number of reports coded into the AIMS database, plus the number of reported incidents waiting to be coded as of June 30 of each financial year since June 2003.



**Figure 1. Number of reports, coded and uncoded, in the AIMS database, as of 30 June for each year**

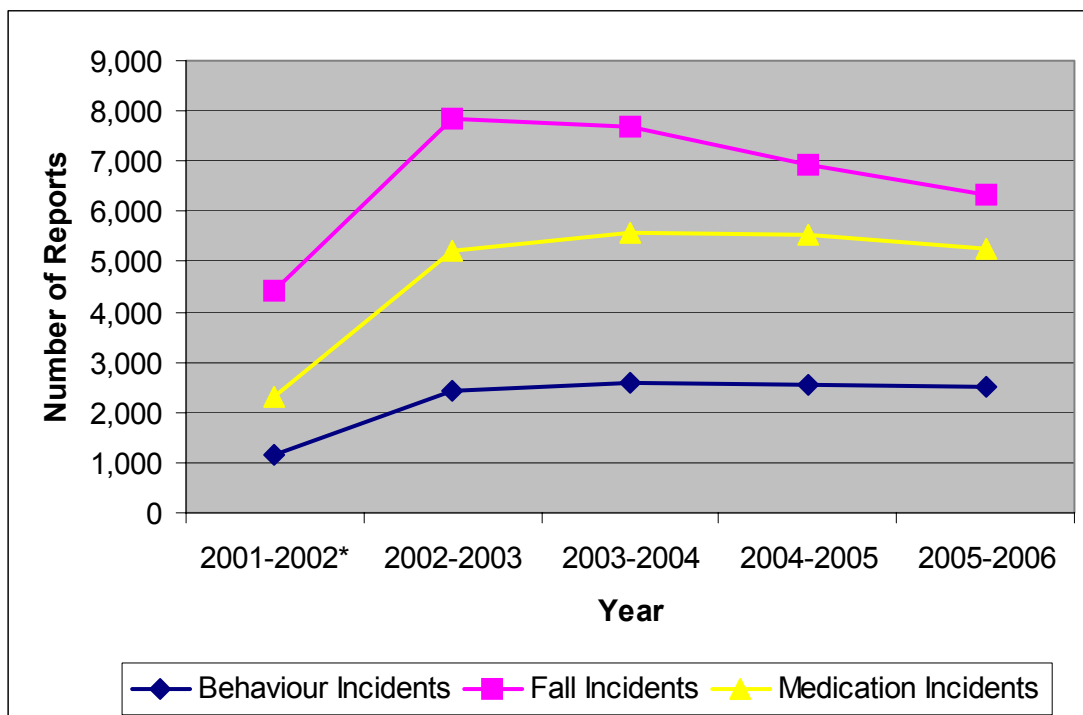
\* AIMS reporting was phased in across the state in the second half of 2001. Also, data for the number of incidents uncoded as of June 2002 are not available.

The number of reports entered into the database is reliant upon incident reports being data-entered and then coded, on-site at area health services and centrally at the Department of Health. While there appears to be a downward trend in the number of reported incidents (Figure 1, blue line), there is also an increase in the number of incidents that remain uncoded (Figure 1, pink line), with almost 5000 incidents waiting to be coded as of 30 June 2006.

Each reported incident is classified with a Principal Incident Type (PIT). A PIT is the component of the incident that is considered to have caused the most harm to, or had the most significant effect on, the patient. The ten PITs in the classification system are as follows:

- behaviour;
- blood, oxygen or gas;
- documentation;
- fall;
- injury;
- medication;
- nutrition;
- other;
- safety and security; and
- therapeutic devices.

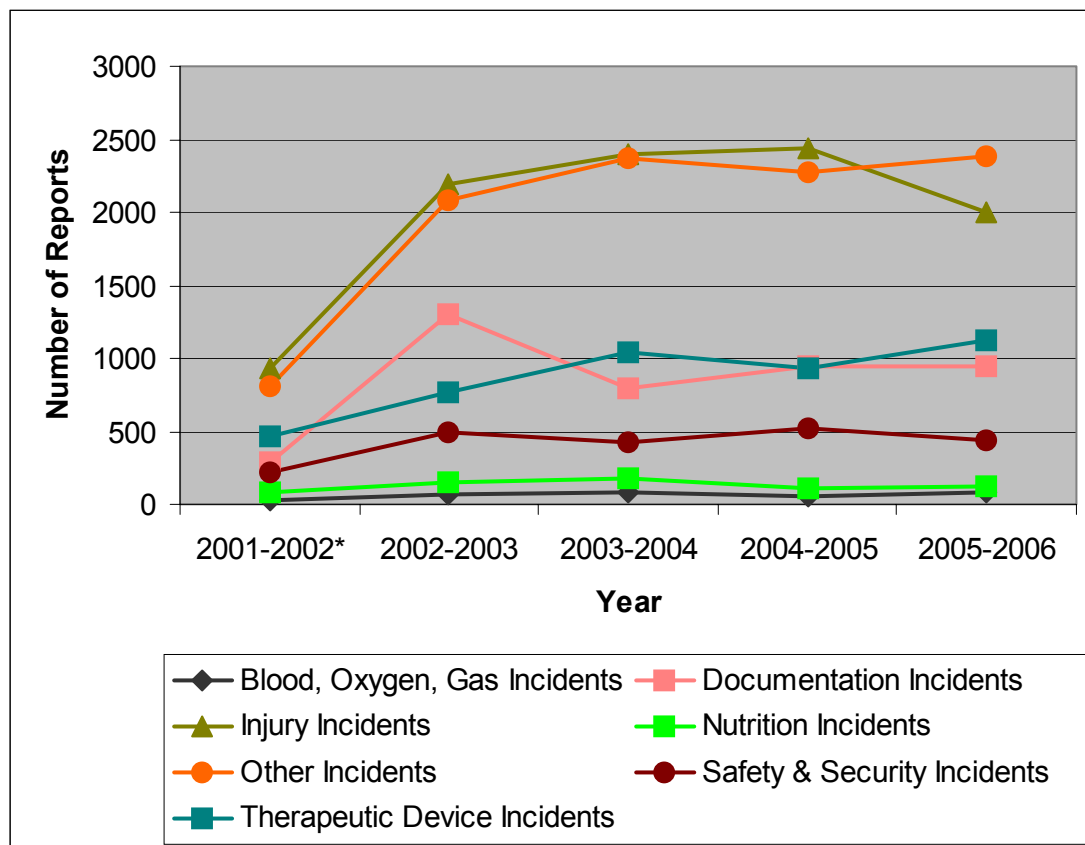
Figure 2 provides trend data for the number of reports received under the *behaviour*, *fall*, and *medication* Principal Incident Types (PITs). These three PITs have the greatest number of reports in the AIMS database. While the number of *medication* and *behaviour* incidents reported to AIMS per year remains stable over the past three years, there is a downward trend in the number of *fall* incidents reported to the system. However, since *fall* incidents make up almost one third of total incidents reported per year, it is difficult to determine if this is a real trend or due to the large backlog of reports waiting to be coded.



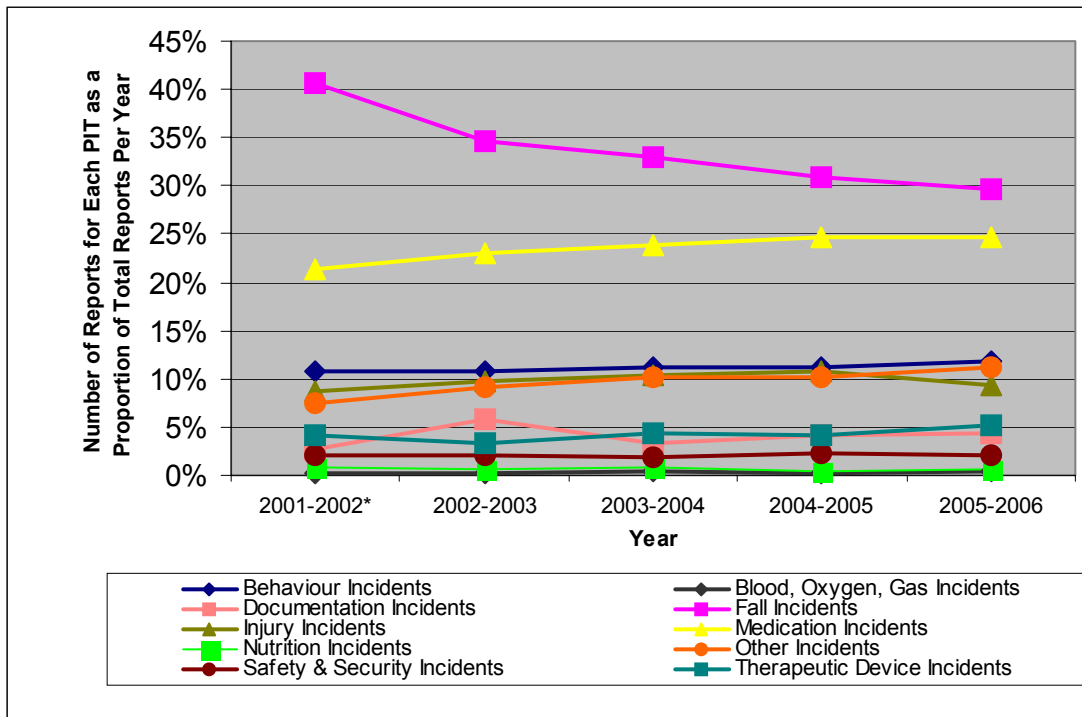
**Figure 2. Number of behaviour, fall and medication reports in the AIMS database, October 2001 to 30 June 2006**

Figure 3 provides trend data for the reports received against the remaining seven PITs in the AIMS database. Most of these PITs appear to have similar numbers of incidents reported to the AIMS database from year to year, except for the *injury* PIT that has experienced a decrease in reported incidents in 2005-2006. However, it is difficult to determine if this too is a real trend or is due to the large backlog of reported incidents waiting to be coded.

Figure 4 shows the number of reports for each PIT as a proportion of the total number of reports for each year. While reporting trends for most PITs remain stable across all years, there are three PITs that show reporting trends either consistently increasing (*medication* and *other* incidents) or consistently decreasing (*fall* incidents). Between October 2001 and 30 June 2006 the proportion of *fall* incidents reported has decreased from 40.7% in June 2002 to 29.6% in June 2006 (a 10.1% decrease over 4 years). Between these dates the proportion of *medication* incidents has steadily increased from 21.4% to 24.7% (a 3.3% increase over 4 years), while the proportion of *other* incidents has increased from 7.4% to 11.2% (a 3.8% increase over 4 years). It should be kept in mind that the large number of uncoded reports (as of 30 June 2006) may change the proportions for the PITs once the uncoded reports have been entered into the system.



**Figure 3. Number of incidents for various Principal Incident Types reported to the AIMS database each year from October 2001 to 30 June 2006**



**Figure 4. Number of reports for each Principal Incident Types as a proportion of the total reports for the year, October 2001 to 30 June 2006**

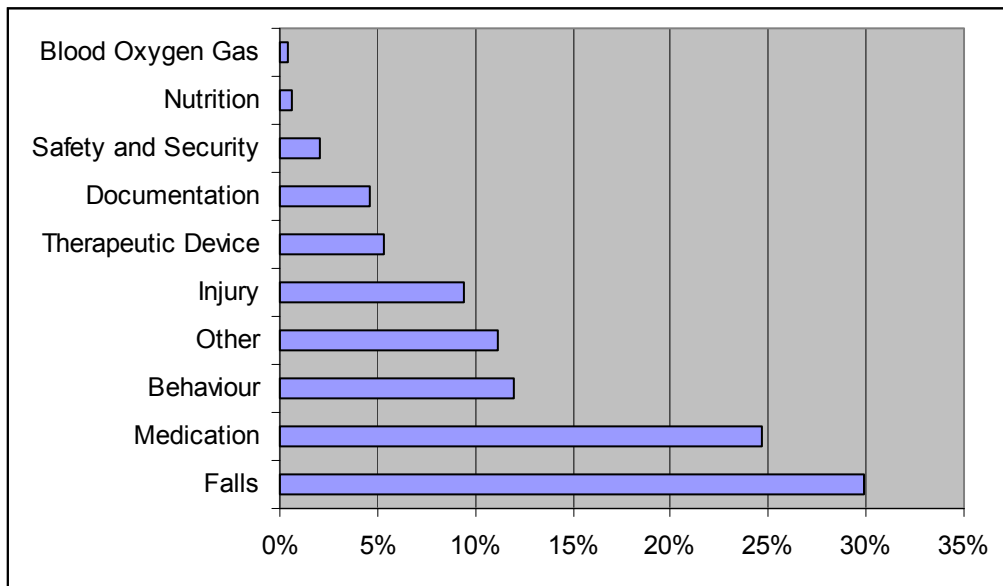
Overall, reporting of the 10 PITs to the WA AIMS database since the inception of AIMS has remained fairly stable. The proportion of *blood, oxygen, gas* incidents, *nutrition* incidents, *safety and security* incidents, *therapeutic device* incidents, and *documentation* incidents consistently falls into less than 5% of all incidents reported. *Other* incidents, *injury* incidents and *behaviour* incidents consistently fall around 10% of all reported incidents, while *medication* incidents consistently rank as the second highest proportion of reports. *Fall* incidents consistently rank as the highest reported PIT.

## RESULTS: 2005-2006

At 16 October 2006, 20,799 incidents had been coded for the 2005-2006 financial year. Review of the Hospital Morbidity Data System figures reveals that there were 662,569 patient separations recorded for all the hospitals and health services that utilise the AIMS database in 2005-06. This represents approximately 3% of all patient separations. However, it is important to note the caveats outlined at the end of the report.

### Principal Incident Type

Figure 5 shows all of the reported incidents for the 2005-2006 financial year according to the Principal Incident Type (PIT). As can be seen below, *falls* and *medication* incidents are the most commonly reported PITs to AIMS.



**Figure 5. All Incidents by Principal Incident Type, 2005-2006 financial year**

As can be seen in Figure 5, the Principal Incident Type classified as *other* accounts for approximately 11% of all reported incidents. The Principal Incident Type classified as *other* includes:

No, wrong or delayed procedure, treatment or assessment.	54%
No or delayed admission, inappropriate bed or ward.	8%
Medical emergency	6%
No, wrong or delayed diagnosis	2%
Poor discharge planning.	4%
Hospital acquired infection	3%
Wrong patient or body part or side.	2%
Other (e.g. post operative or procedural complications, communication problems between staff, premature discharge).	21%

Examples of *other* incidents include:

- low respiration rate;
- retained placenta;
- operation cancelled due to not enough time; and
- radiology films marked incorrectly.

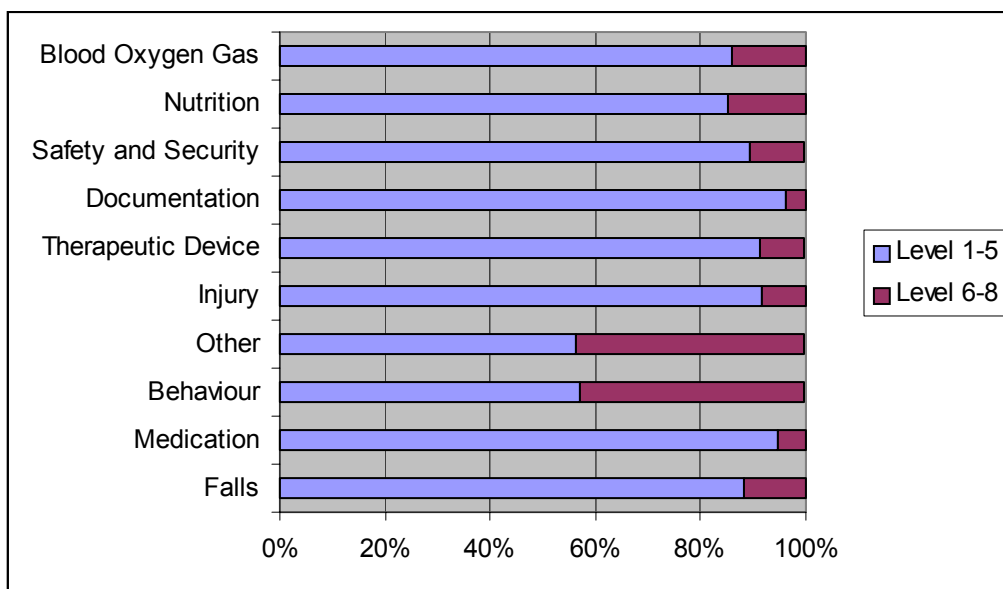
### **Incident Outcomes**

Each incident is assigned an incident outcome level ranging from 1 to 8. Levels 1 and 2 represent potential incidents (i.e. near misses) and Levels 3 to 8 represent actual incidents. Table 1 provides a definition of outcome levels, and shows all reported incidents according to outcome level. As can be seen in Table 1, over half of incidents (58%) resulted in little or no injury to the patient (Level 3 and 4 outcomes).

	2005-2006 FY (% of incidents)	Outcome Definition
1	0.1%	A dangerous state or possibility of harm occurring.
2	1.8%	An event occurred but was intercepted prior to causing harm.
3	31.7%	An event occurred with no adverse outcome.
4	26.7%	An event occurred resulting in a minor outcome not requiring treatment (e.g. extra observation).
5	22.7%	An event occurred resulting in a moderate outcome (e.g. minor diagnostic investigations or treatment).
6	13.3%	An event occurred resulting in a moderate outcome (e.g. diagnostic investigations, surgical intervention, treatment with another medication).
7	3.4%	An event occurred resulting in significant outcome (e.g. hospital admission, increased length of stay, morbidity which continued on discharge).
8	0.2%	An event occurred resulting in permanent disability or death. This is classified as a sentinel event and should be reported as such.

**Table 1. All Reported Incidents by Outcome Level, 2005-2006 financial year**

Figure 6 shows all of incidents according to the Principal Incident Type, by the outcome level for the 2005-2006 financial year. As can be seen below, the PITs classified as *behaviour* incidents and *other* incidents had a greater proportion of incidents that resulted in moderate to significant outcomes (Level 6 to 8).



**Figure 6. All incidents (PIT) by outcome level 1 to 5 and 6-8 for the 2005-2006 financial year**

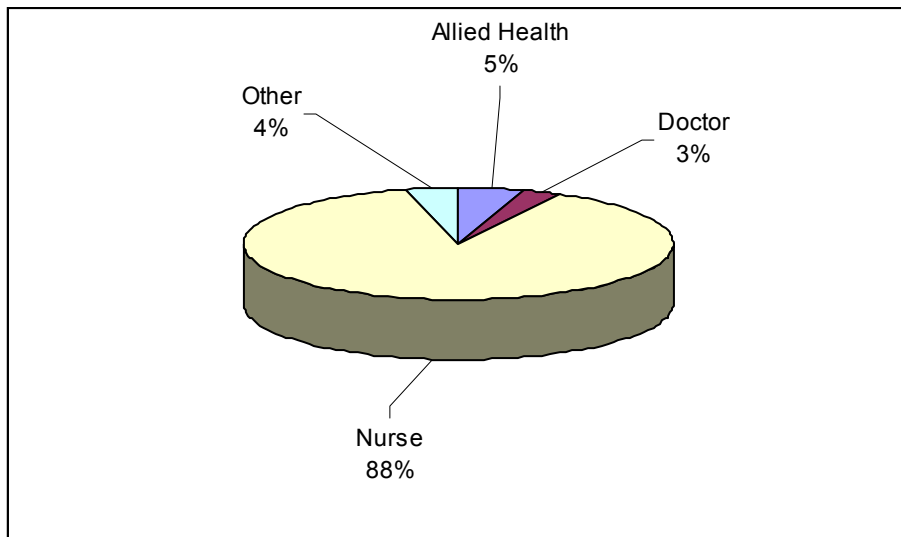
Incidents with outcomes of Level 6 and Level 7 typically result in greater harm to the patient, and require additional care and increased length of stay. Therefore, these incidents are costly to the health system.

### **Reporter Classification**

Figure 7 shows all of the reported incidents according to the classification of people who report them. As can be seen below, nurses report the majority of incidents (88%). The 'other' reporter classification category includes patient care assistants, orderlies, patients, visitors and carers.

Most of the incidents that Nurses tended to report were *falls* and *medication* incidents. Allied Health Professionals generally reported *medication* incidents and Doctors tended to report *other* incident types (e.g. no, wrong or delayed diagnosis, procedure, treatment or assessment).

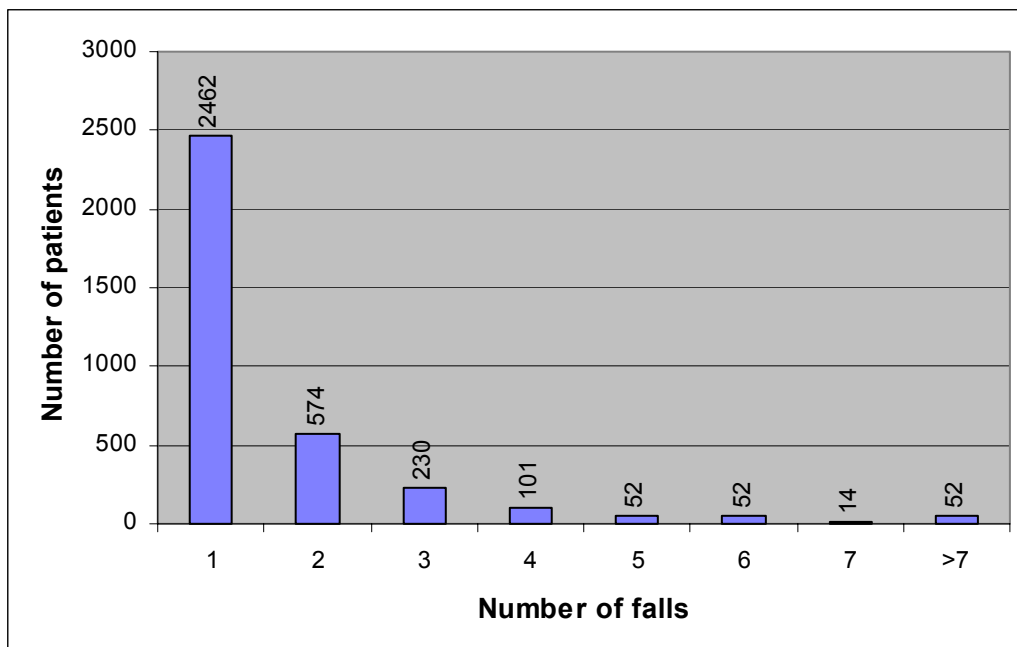
It is important to note that AIMS is just one of several parallel and complementary incident reporting systems in place in WA hospitals. While doctors report only relatively few incidents to AIMS, they do report to other incident reporting systems such as sentinel events, statutory notifications to Chief Psychiatrist, Anaesthesia Mortality Committees, WAASM (West Australian Audit of Surgical Mortality), or Coronial notifications. Thus, the full complexity of clinical incidents are identified and managed.



**Figure 7. All reported incidents by Reporter Classification, 2005-2006 year**

### Falls

Overall there was a total of 6,141 *falls* reported in 2005-2006. Of the reported *falls*, 5,902 could be attributed to a specific patient Unit Medical Record Number (UMRN) with the remaining 239 cases being unidentified. 58% of these *falls* could be attributed to individual patients falling multiple times. Figure 8 outlines the numbers of single and multiple fallers reported in 2005-2006.



**Figure 8. Falls data demonstrating "multiple fallers" in 2005-2006**

### Age of Subject

The greatest proportion of reported *fall* incidents (60%) occurred in the elderly population (75+ years). *Fall* incidents were highest in the 80 to 84 age group (18%).

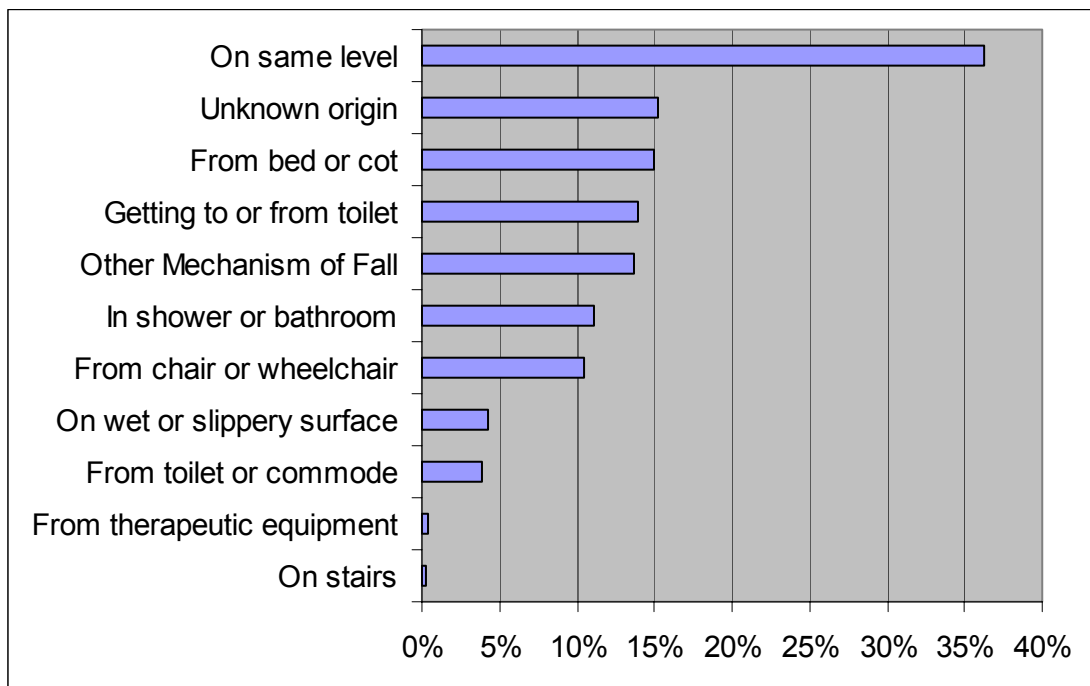
### **Result of Incident**

Over half of all reported falls (56%) did not result in any injury to the patient at all. One quarter of falls (25%) resulted in abrasions or lacerations or skin tear. A small percentage of patients sustained bruises/swelling/reddening of the area (12%) or experienced pain (13%) as a result of the fall incident.

### **Mode of fall**

Figure 9 shows the mode in which fall incidents occurred. As can be seen below, the largest proportion of fall incidents occurred on the same level (36%). The manner in which the patient fell was unknown in 15% of incidents. A sizable proportion of falls were classified as *Other*. Falls classified as other include:

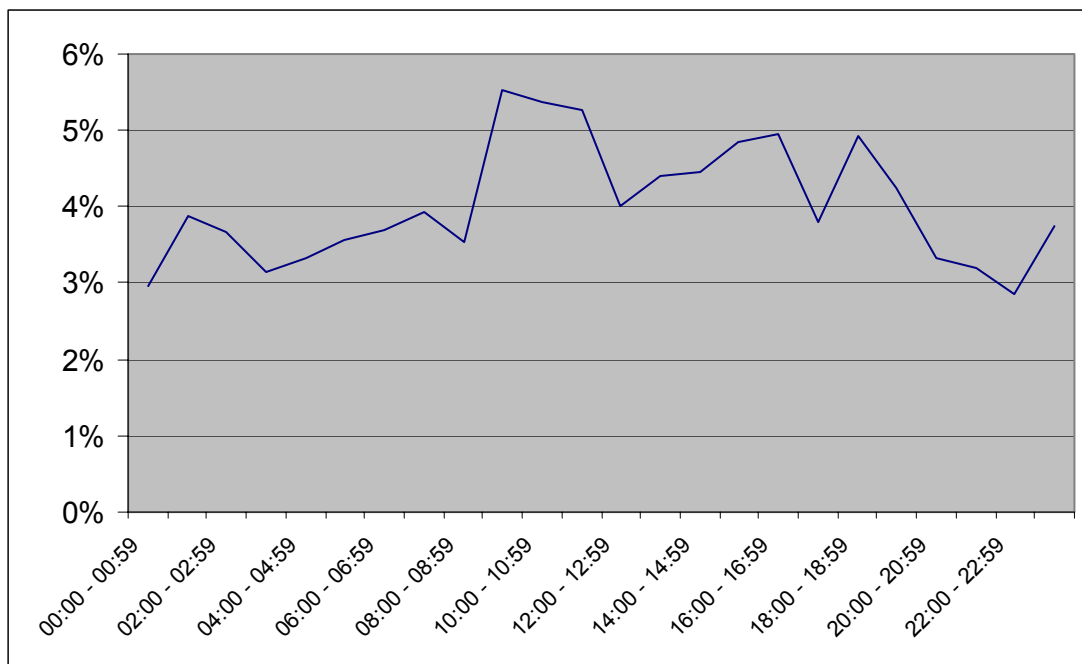
- Patient slid off chair;
- Loud noise heard. Patient found with chair on top of him;
- Infant not restrained in pram. Baby slipped out; and
- Patient found on floor. Would not tell staff how he got there.



**Figure 9. Mode of fall incident**

### **Time of day**

Figure 10 shows the time of day that reported *fall* incidents occurred. The graph below demonstrates that *fall* incidents, as would be expected, are at times of highest patient activity (9am to 12pm) and lowest during the night (9pm to 5am).



**Figure 10. Time of day of fall incidents**

### **Outcome Level**

Almost half of all *fall* incidents resulted in a Level 4 outcome (45%). This means that the *fall* incident resulted in little or no harm, and the patient required little or no treatment or monitoring. Over a quarter of *fall* incidents resulted in a Level 5 outcome (26%). This indicates that the patient involved in the fall incident required extra monitoring or treatment (for example, a cold pack was applied). Slightly more than 2% of reported fall incidents resulted in Level 7 or 8 outcomes. While this percentage is low, a number of these represent significant injury to the patient, such as:

- Patient fell to floor sustaining haematoma to left side of head requiring increased length of stay.
- Patient fell while attempting to use toilet sustaining significant T12 crush fracture, requiring increased length of stay.
- Patient fell and sustained 4cm haematoma on right forehead. Patient later died.

### **Contributing Factors**

The most frequent patient factors that contributed to *fall* incidents included:

- Pathophysiological factors (49%);
- Physical impairments (48%);
- Other (39%);
- Failure to follow advice or instructions (31%);
- Confusion or disorientation (24%) and;
- Dementia (21%).

It should be noted that a single incident may have multiple contributing factors and therefore, percentages add up to greater than 100%.

Staff factors that contributed to *fall* incidents included:

- Failure to follow advice or instruction (0.8%);
- Insufficient or inadequate staff (1.4%);
- Other (1.6%); and
- Distraction or inattention (0.9%).

Please note: A Falls Action Group has been established in WA. The aim of the group is to decrease patient falls through wide consultation to develop a consistent framework for assessing and managing falls across the health continuum, including in the acute care hospital setting.

### Medication Incidents

Overall there were a total of 5,068 *medication* incidents reported in 2005-2006. Of the reported *medication* incidents, 4,699 could be attributed to a specific patient UMRN, with the remaining 369 cases being unidentified. 53% of these *medication* incidents could be attributed to individual patients with multiple *medication* incident reports. Figure 11 outlines the number of single and multiple *medication* incidents reported in 2005-2006.

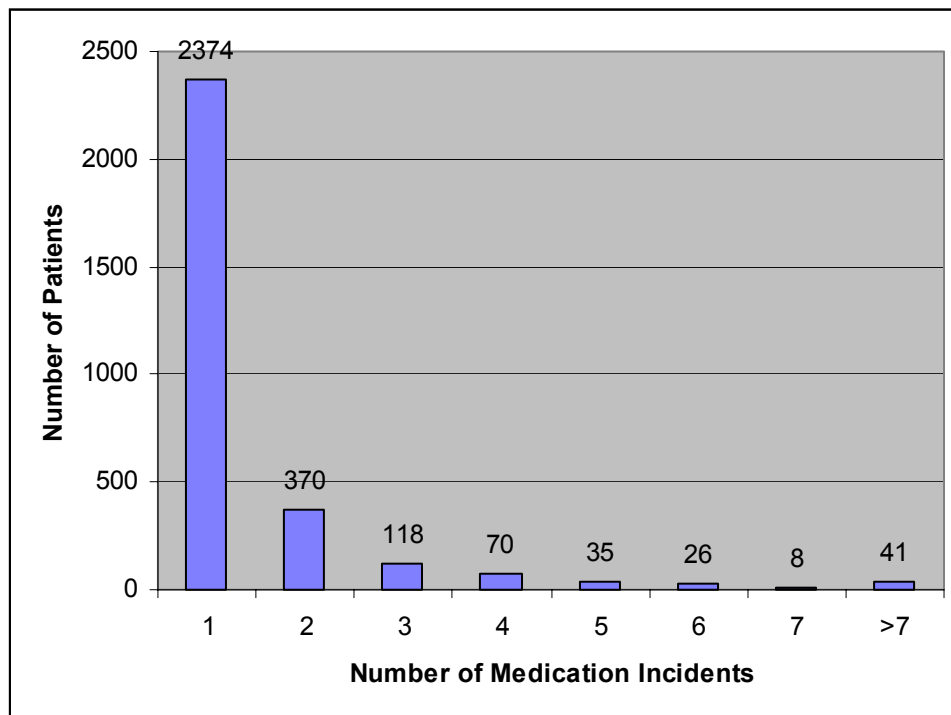


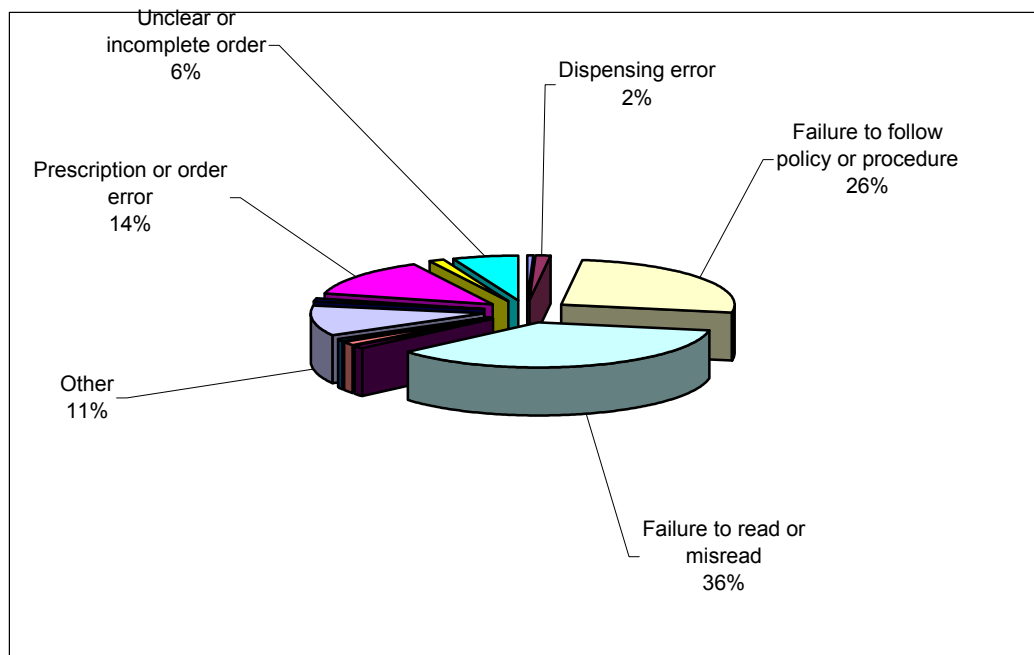
Figure 11. Medication incident data demonstrating single and multiple incidents in 2005-2006

### **Outcome of medication incidents**

Most of the reported *medication* incidents resulted in no injury to the patient (85%). A small percentage of *medication* incidents resulted in pain (2%) and an altered level of consciousness (1%). Most *medication* incidents resulted in a Level 3 (55%) or Level 4 (25%) outcome. Slightly more than 5% of *medication* incidents resulted in a moderate to severe outcome. **Nevertheless, it is important to note that although the majority of *medication* incidents result in little or no harm, there is the potential for *medication* incidents to result in serious harm to the patient.**

### **Cause of incident**

Figure 12 shows the cause of *medication* incidents for the 2005-2006 financial year. The most common cause of *medication* incidents was the failure to read or misread documentation, which accounted for almost half of all *medication* incidents (47%). Failure to follow policy or procedure resulted in 34% of *medication* incidents. Prescription or order error also accounts for a sizable proportion of *medication* incidents (18%).



**Figure 12. Cause of medication incidents, 2005- 2006 financial year**

Note: For ease of understanding, *causes of medication errors* with less than or equal to 1% have had labels removed.

### **Type of Medication Incident**

#### **Omission**

Omission was the most common type of *medication* incident and accounted for 37% of all reported *medication* incidents. The most common medications involved in

omissions are detailed below. Please take into account the caveats at the end of this report when interpreting these statistics.

- Paracetamol (6%)\*
- Frusemide (4%)\*
- Warfarin sodium (3%)\*
- Calcium carbonate (3%)\*

\*A proportion of *medication* incidents involving these medications included several instances of omission for the same patient.

### **Overdose**

Overdose was the second most common type of *medication* incident, and accounted for 19% of all reported *medication* incidents. The most common medications involved in overdoses are listed below. Please note the caveats at the end of this report.

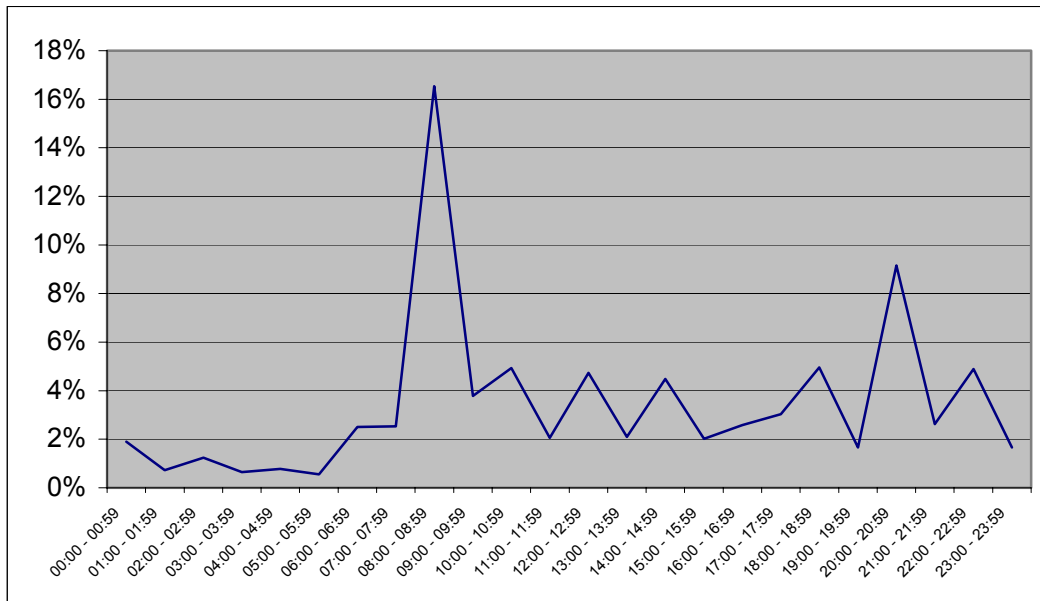
- Paracetamol (9%)\*
- Prednisolone (4%)\*
- Enoxaparin sodium (3%)\*
- Frusemide (3%)\*
- Heparin (3%)

\*A proportion of medication incidents involving these medications included several instances of overdose for the same patient.

### **Time of the day**

Figure 13 shows all reported *medication* incidents according to the time of the day. As can be seen below, there is a peak in *medication* incidents occurring between 8:00am and 9:00am, which coincides with the administration of medications at this time. Thus, it may be prudent to exercise added vigilance during this time period.

The National Inpatient Medication Chart (NIMC) was introduced in 2006. The introduction of a common medication chart across organisations is considered a significant quality improvement strategy, aimed at reducing patient harm resulting from medication errors and the medication documentation process.



**Figure 13. All reported medication incidents according to the time of the day**

### **Injury Incidents**

Figure 14 shows the cause of injury incidents for the 2005-2006 financial year. As can be seen below, the largest proportion (33%) of injury incidents were *Pressure Ulcers*.

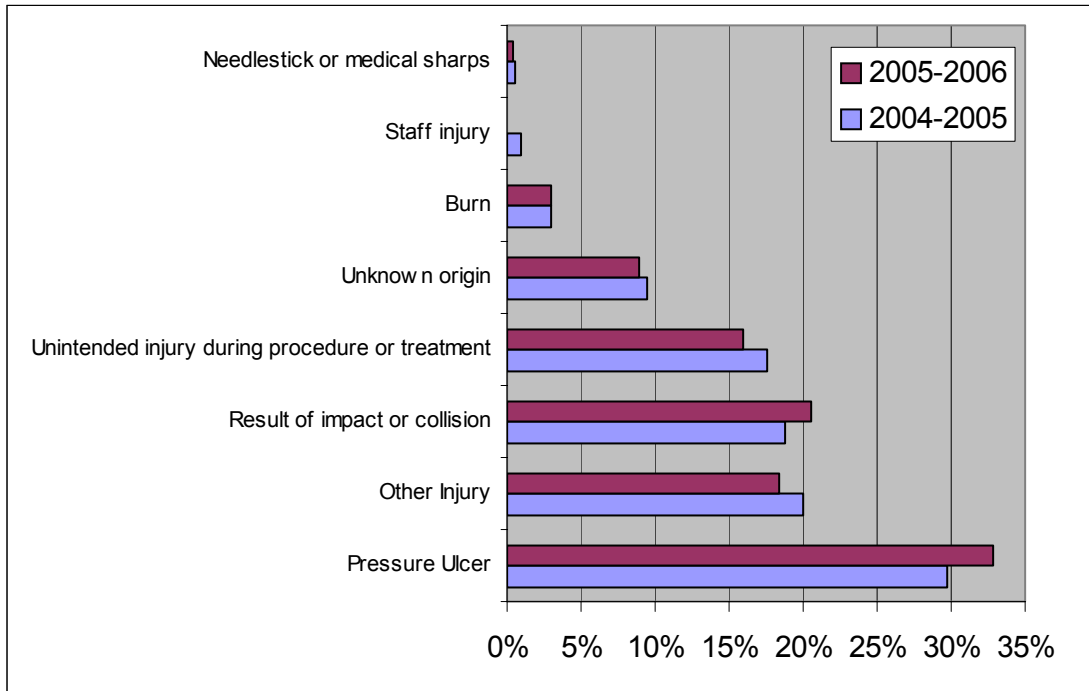
#### ***Cause of Injury Incident***

- 21% of injuries were the result of an impact or a collision, for example, a patient collides with a door whilst manoeuvring in wheelchair.
- 18% of injuries were classified in the *other* category which includes:
  - Patient punched another patient;
  - Visitors assaulting patients;
  - Carpet burn sustained by patient after dragging himself across floor; and
  - Small skin tear sustained whilst readjusting position on chair.
- 9% of reported injury incidents were the result of unknown origin. For example, a bruise or skin tear found on a patient's leg and the patient is unable to accurately state the cause.
- 16% of reported injury incidents were the result of unintended injury during procedure or treatment.

Some examples of unintended injury during procedure or treatment include:

- Patient received large skin tear when being helped out of bed;
- Dental device broke during operation, damaging teeth;

- Towel clip caused skin abrasion during operation;
- Skin tear upon removal of dressing; and
- Skin under the breast split and bled during x-ray.



**Figure 14. Cause of Injury incidents, 2004-2005 and 2005-2006 financial years**

**Outcome Level**

Most *injury* incidents resulted in a Level 5 (64%) or a Level 4 outcome (23%). A small percentage of *injury* incidents resulted in a Level 3 outcome (6%). Few *injury* incidents resulted in a Level 6 outcome (7%) or a Level 7 outcome (1%). A Level 7 outcome does not necessarily mean a patient suffered significant injury. A Level 7 outcome could indicate that additional resources (i.e. constant supervision) were required to manage the patient. There were no incidents with Level 8 outcomes reported.

**Result of Injury Incident**

The largest proportion of *injury* incidents were classified under the *other* category (38%).

Examples of *injury* incidents classified as *other* include:

- Patient sustained cut from intravenous (IV) drip pole;
- Patient accidentally received skin tear from staff member;
- Unprovoked attack on a patient by another patient; and
- Patient pushed through window by another patient.

A sizable proportion of *injury* incidents (33%) resulted in abrasions, lacerations or skin tear. A further 15% of *injury* incidents resulted in a bruise, or swelling/reddening

of the area. A small percentage of *injury* incidents resulted in pain (6%). There were a number of incidents that did not result in any injury (11%).

### ***Contributing Factors to Injury Incidents***

The most common patient factors that contributed to *injury* incidents were pathophysiological factors (47% of reported *injury* incidents). Physical impairments were also common contributing factors to *injury* incidents (31%). A sizable proportion of *injury* incidents were classified as *Other* (24%).

Examples of *other* contributing patient factors to *injury* incidents include:

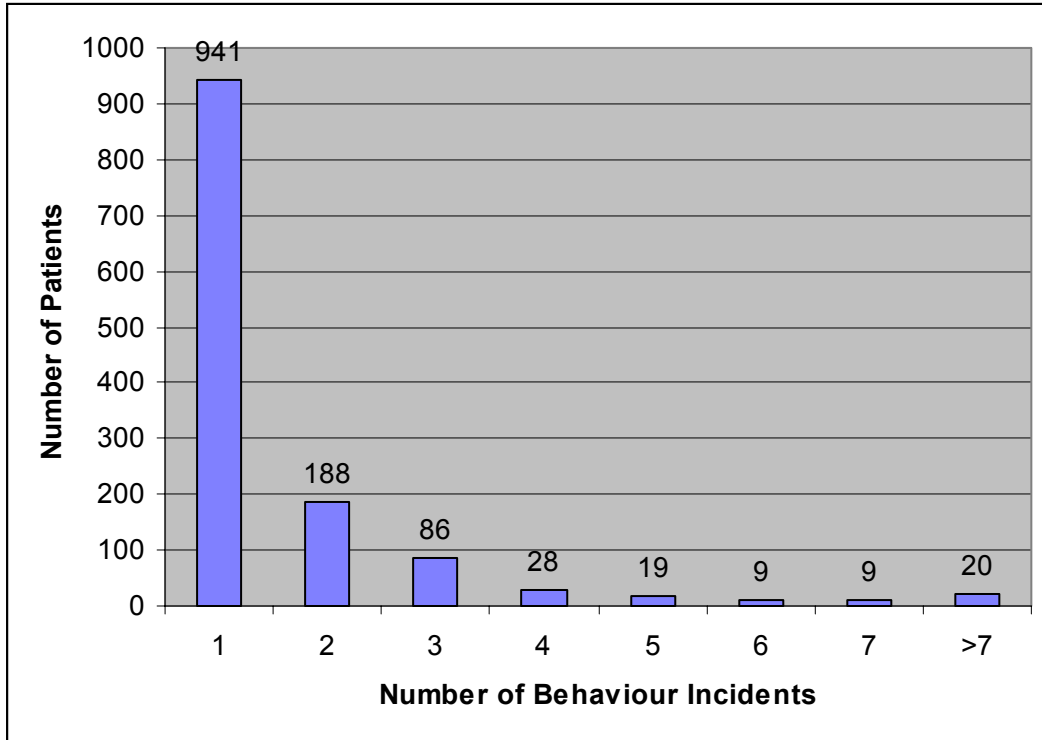
- Mental health problems;
- Confusion/disorientation;
- Incontinence; and
- Aggression.

It should be noted that a single incident may have multiple contributing factors and therefore percentages add up to greater than 100%.

The most common staff contributing factor to *injury* incidents was failure to follow policy or procedure (3%). Failure to follow advice or instruction contributed to 1% of *injury* incidents, and inadequate knowledge or experience also contributed to 1% of *injury* incidents.

## Behaviour Incidents

Overall there were a total of 2,472 *behaviour* incidents reported in 2005-2006. Of the reported *behaviour* incidents, 2,218 could be attributed to a specific patient UMRN with the remaining 254 cases being unidentified. 58% of these *behaviour* incidents could be attributed to individual patients with multiple *behaviour* incident reports. Figure 15 outlines the number of single and multiple *behaviour* incidents reported in 2005-2006.



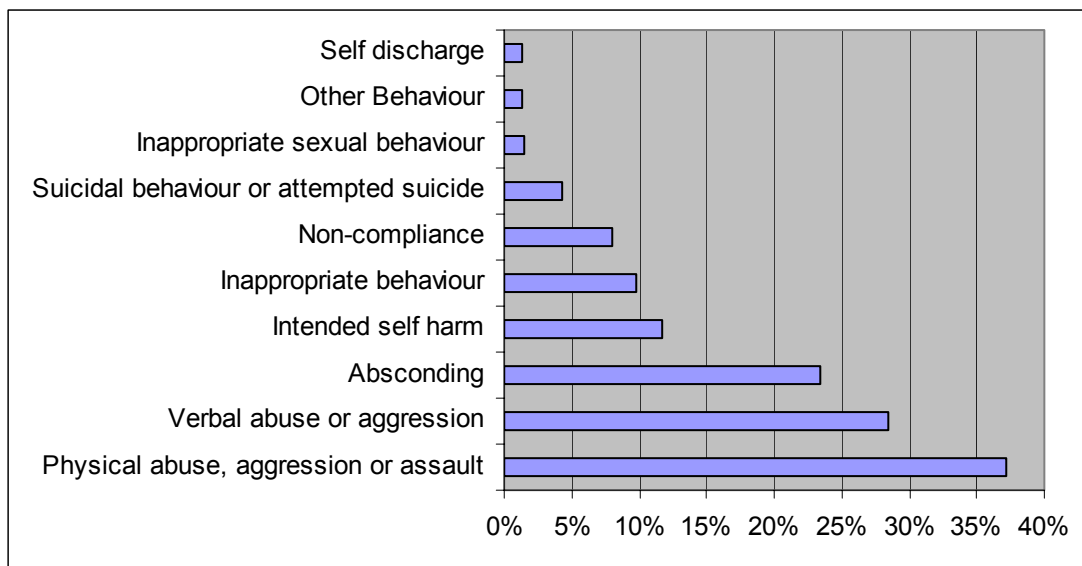
**Figure 15. Behaviour incident data demonstrating patients with single and multiple behaviour incidents from 2005-2006**

### ***Cause of behaviour incidents***

Figure 16 shows the causes of reported *behaviour* incidents for the 2005-2006 financial year. The largest proportion of *behaviour* incidents involved physical abuse, aggression or assault (37%). A large percentage of *behaviour* incidents involved verbal aggression or verbal abuse (28%). Patient absconding behaviour was reported in 23% of *behaviour* incidents. Inappropriate behaviour was reported in 10% of incidents, and intended self harm was reported in 12% of *behaviour* incidents.

Examples of *behaviour* incidents include:

- Patients absconding;
- Physical aggression towards staff/other patients;
- Verbal aggression towards staff/other patients; and
- Inappropriate sexual behaviour.



**Figure 16. Cause of behaviour incident, 2005-2006 financial year**

***Level of harm of behaviour incidents.***

The largest proportion of reported *behaviour* incidents resulted in Level 6 outcomes (33%) or Level 5 outcomes (28%). A sizable proportion of reported *behaviour* incidents resulted in Level 3 (16%) or Level 4 (12%). A small percentage of Level 7 incidents were reported (9%). A Level 7 outcome does not necessarily mean a patient suffered significant injury. A Level 7 outcome could indicate that additional resources (i.e. constant supervision) were required or the incident contributed to an increased length of stay.

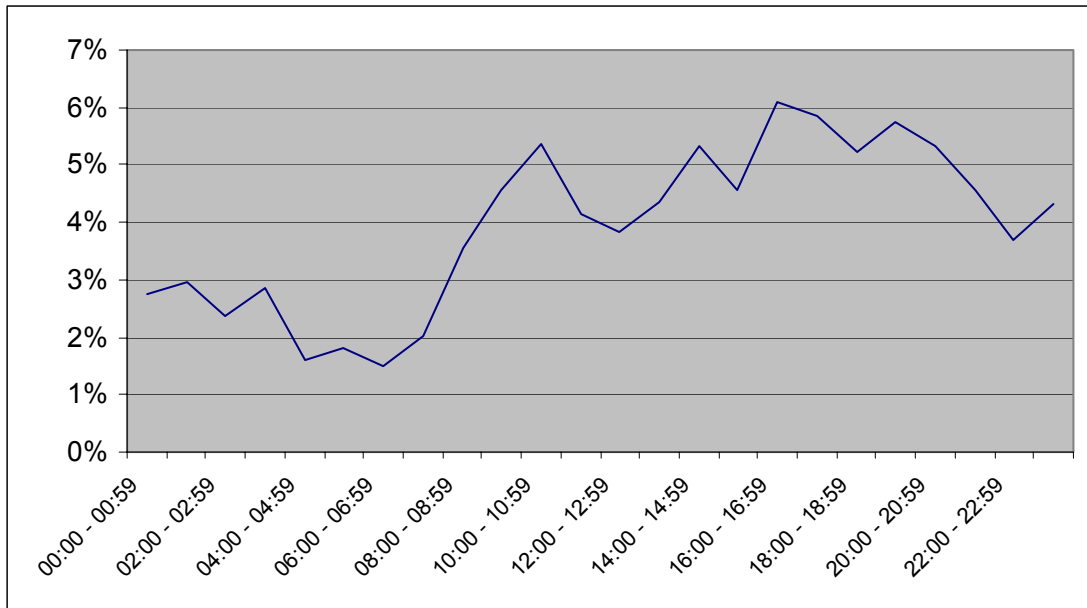
Most reported *behaviour* incidents resulted in no injury to the patient (61%). A small percentage of *behaviour* incidents resulted in abrasions or skin tear (11%).

***Age of patients***

One quarter of *behaviour* incidents involved individuals aged 25 to 34 years (25%). Over half of all *behaviour* incidents involved individuals aged between 15 and 49 years (62%).

***Behaviour incidents according to the time of the day.***

Figure 17 shows *behaviour* incidents according to the time of the day that they occurred. *Behaviour* incidents were lowest from between 6:00am and 7:00am, and rose steadily throughout the day, before peaking between 9:00am and 11:00am and again between 2:00pm and 10:00pm.



**Figure 17. Behaviour incidents according to time of the day**

***Contributing Factors to Behaviour Incidents***

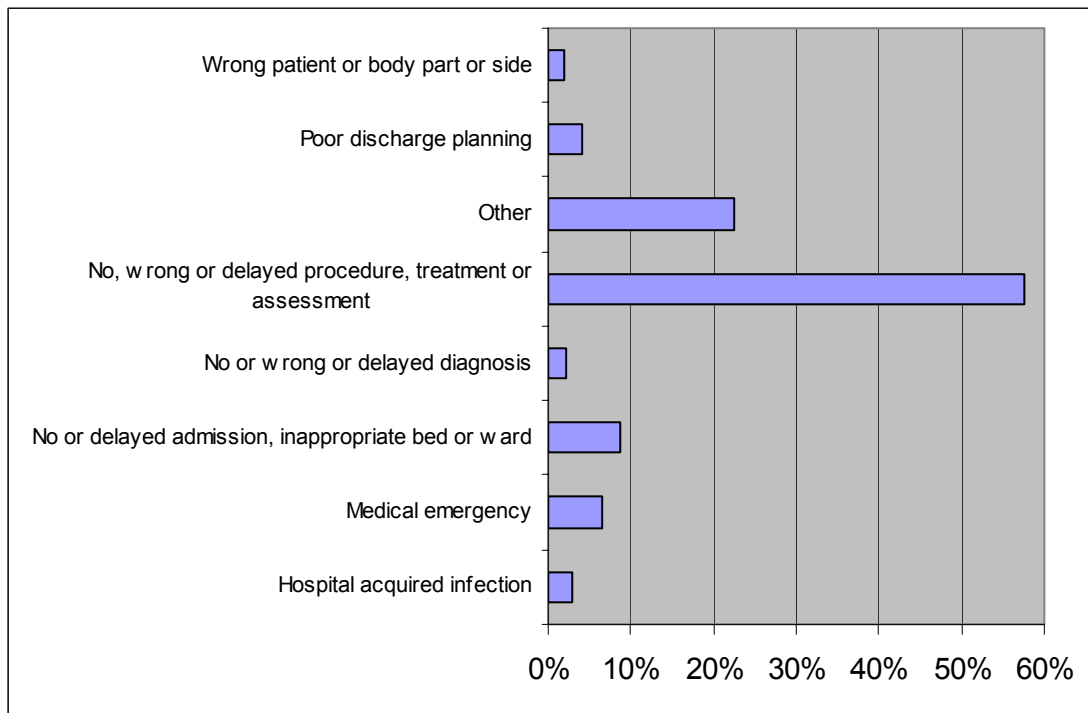
A large proportion of *behaviour* incidents were related to the mental health of the patients (64%). For example, 14% of patients involved in all reported *behaviour* incidents were recorded as suffering from dementia. A small percentage of patients were confused or disorientated (11%) or acting under the influence of drug and/or alcohol (13%).

**Other Incidents**

Figure 18 shows the types of *Other* Incidents that occurred. As can be seen below, most incidents were due to delayed, absent or incorrect treatment, procedures or assessments (57%). Nearly a quarter of *Other* incidents were classified as ‘*other*’ (23%).

Examples of *Other ‘other’* include:

- Patient did not present for operation;
- Episiotomy extended to third degree tear at delivery;
- Operation cancelled due to patient chest infection;
- Unplanned representation to Emergency Department;
- Patient incorrectly booked for a scan; and
- Wound needed resuturing.



**Figure 18. Types of Other Incidents**

***Outcome of Other incidents***

The largest proportion of *other* incidents did not result in injury to the patient (56%). Twenty percent (20%) of *other* incidents resulted in an outcome classified as ‘other’.

The largest proportion of incidents classified under the *other* incident category resulted in a Level 3 outcome (29%) or a Level 6 outcome (32%). A smaller percentage of incidents resulted in a Level 4 outcome (14%). A number of *other* incidents (12%) resulted in a significant or severe outcome (Level 7 or 8).

***Contributing Factors***

***Staff***

The largest proportion of contributing factors were communication problems (21%). Staff failure to follow policy or procedure was also a contributing factor (21%). Inadequate knowledge or experience was a contributing factor in 13% of *other* incidents.

***Patient***

The largest proportion of patient contributing factors were pathophysiological (25%). A sizable proportion of contributing factors were classified under the ‘other’ category (11%). Communication difficulties and mental health issues each accounted for 4% of incidents.

## APPENDIX ONE - CAVEATS

Readers of this report are advised to note the following limitations to the data collected by AIMS.

1. The literature suggests that approximately 10% of patients admitted to acute care hospitals experience some kind of iatrogenic injury. The Australian Patient Safety Foundation, developers of AIMS, estimates that there is under-reporting of incidents. Consequently, we cannot assume that the data is representative of all incidents.
2. AIMS has been implemented across WA, however, not all health services (particularly some rural sites) are using the system to full capacity.
3. There is a time lag between data collection, data entry and coding.
4. There are occasions when several incidents are reported for the same patient and the same incident. For example, a medication omission that occurs several times to a patient before being rectified may result in several separate incidents being reported to AIMS. This can act to artificially inflate the number of incidents.

### **Duplicate reports**

There is a number of safety nets in the AIMS process to minimise or avoid duplicate records entering the system:

- The person raising the form puts a note in the medical record advising that an AIMS form has been raised. This reduces the risk for a duplicate if the medical record is checked.
- The AIMS forms usually go through the same, or a small number of Senior Staff or Department Heads for investigation and sign off. It is likely that they would recognise a duplicate case.
- One person usually performs the data entry task. This person is likely to recognise a duplicate when keying.
- A specific coder codes for a specific site. This presents a final opportunity to identify a duplicate for the same patient.

The chances of getting a duplicate record into the system are rare, but not impossible. Were duplicates to enter the system, they would have little effect on the quality, given the volume of data.