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

Table 1: WA health system Severity Assessment Codes (SAC) – Summary

Excerpt from the Clinical Incident Management Guideline 2019.

	SAC 1	SAC 2	SAC 3
Actual/potential consequence to patient	**Physical/psychological serious harm** or **death;** that has, or could have (near miss), be attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.	**Physical/psychological Moderate harm** that has, or could have (near miss), be attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.	**Physical/psychological** Minor or **no harm** that has, or could have (near miss), be attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.
Type of event/ incident	**SAC 1 clinical incidents include (but not limited to):** • National Sentinel Event Categories • Any other clinical incident which results in serious harm (physical or psychological) or death of a patient • Escalation of care to inpatient setting • Increased length of stay greater than 7 days • Near miss that could have resulted in serious harm or death. **National Sentinel Event Categories** 1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death. 2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death. 3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death 4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death. 5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death. 6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward. 7. Medication error resulting in serious harm or death 8. Use of physical or mechanical restraint resulting in serious harm or death. 9. Discharge or release of an infant or child to an unauthorised person. 10. Use of an incorrectly positioned oro-or naso-gastric tube resulting in serious harm or death.	SAC 2 clinical incidents include, but are not limited to the following: • Increased length of stay (More than 72 hours to 7 days) • Additional investigations performed • Referral to another clinician • Surgical intervention • Medical intervention • Increased frequency of mental health clinician review • Near miss that could have resulted in moderate harm.	SAC 3 clinical incidents include, but are not limited to the following: • No harm • Only first aid treatment required • Minor harm resulting in increased length of stay of up to 72 hours • Increased frequency of mental health clinician review • Near miss that could have resulted in minor harm.
Actions – During Notification, Investigation	• **Inform relevant management/**appropriate executive within 24 hours, follow any local processes. • **Submit** information via Datix CIMS or equivalent by end of notifier's work day. • Document summary, essential information, actions in **patient's medical notes** by end of notifier's work day. • Within 48 hours, **review, confirm and allocate SAC** rating. • Within 48 hours commence **initial investigation** to identify human errors and critical system failures.	• **Inform** Unit Manager/Director within 24 hours. • **Submit** information via Datix CIMS and **document** the clinical incident in the patient's medical notes by end of notifier's work day. • Within 48 hours, **confirm** SAC rating.	• **Inform** Unit Manager within 24 hours. • **Submit** information via Datix CIMS and **document** the clinical incident in the patient's medical

	• Complete a **SAC 1 notification to PSSU** via Datix CIMS within **seven** working days • Implement a **higher level open disclosure response** for incidents causing serious harm or death, or a lower level response for near miss incidents***. • Undertake SAC 1 investigation by **Root Cause Analysis (RCA)/ equivalent*.**	• Within 48 hours commence **initial investigation** to identify human errors and critical system failures. • Investigate at a local level using clinical review as a minimum requirement or other appropriate methodology. • Implement an **appropriate level of open disclosure***.**	notes by end of notifier's work day. • Within 48 hours, **confirm** SAC rating • Within 48 hours commence **initial investigation** to identify human errors and critical system failures. • Investigate at a local level using aggregated analysis or other appropriate methodology. • Implement an **appropriate level of open disclosure***.**
Reporting requirements	• Final investigation reports with recommendations must be endorsed by the Chief Executive or from an approved delegation schedule. • Submit completed investigation reports which are due within 28 working days of notification to PSSU. • Refer to section 6.1 for any other applicable statutory reporting requirements.	• Complete investigation within 60 working days of incident notification**.	• Complete investigation within 60 working days of incident notification**.
Recommendations	• All SAC 1 recommendations must be both implemented and evaluated within six months (182 calendar days) of the investigation report submission. • An evaluation of SAC 1 recommendations must also be forwarded to PSSU within those six months (182 calendar days) of the investigation report submission.	• Monitoring, implementation and evaluation of recommendations managed at a service level within 6 months (182 calendar days) of the investigation being completed. • Lessons learned are shared at all levels of the service	• Monitoring, implementation and evaluation of recommendations managed at a service level within 6 months (182 calendar days) of the investigation being completed. • Lessons learned are shared at all levels of the service

* For other equivalent investigation methods and resources which can be used in place of an RCA please refer to the CIM Toolkit.
**The completion of the Datix CIMS clinical incident form (notification and investigation sections) can constitute a final report.
*** in accordance with the Australian Open Disclosure Framework.