Policy

Incident Management

Policy Statement

Effective incident management requires an organisation wide approach with clear points of accountability for reporting and feedback at all levels in the organisation. The principles of transparency, accountability, obligation to act, no blame culture and collaboration should be applied at each step of the incident management process. The steps include identification, notification, classification, investigation, action and evaluation.

Open communication and documentation should occur throughout the entire process. Incident management should occur in accordance with relevant legislation, standards and policies.

This policy and associated Standard Operating Procedures (SOPs) aim to uphold the Australian Charter of Health Care Rights and the Human Rights Act.

Purpose

The purpose of this policy is to:

- outline the principles of incident management
- standardise the incident management process
- ensure consistency in definitions
- outline roles and responsibilities for incident management
- ensure that the rights of the consumer and staff safety are upheld in the process.

Scope

This policy is to be followed by all Health Directorate staff, including contractors.

Excluded are:

- Child Protection notifications
- incidents where the Underperformance Management Policy and Procedures need to be applied; and
- incidents that occur at Calvary Health Care ACT- see Special Circumstances in Incident Management Standard Operating Procedure (SOP).
Roles and Responsibilities

All staff are responsible for:

- identifying and notifying incidents to their immediate supervisor, including all adverse events, near misses and hazards through the Riskman incident notification and reporting module (Riskman)
- ensuring the security of passwords and the correct assigning of managers when using Riskman
- cooperating in the investigation of incidents
- participating in the implementation, monitoring and evaluation of actions from recommendations and subsequent learning opportunities
- encouraging colleagues to notify identified incidents

Directors/Supervisors/Managers are responsible for:

- familiarising themselves and their staff with this policy and Standard Operating Procedures (SOPs) and ensuring staff receive appropriate education and support
- escalating incidents in accordance with this policy and related policies and SOPs,
- viewing all incidents submitted by staff who report to them within 5 working days
- investigating all incidents submitted by staff who report to them, undertake local actions in a timely manner, and documenting these in Riskman
- reporting notifiable incidents to WorkSafe ACT in line with the Significant Incidents SOP
- supporting staff participation in high level incident investigation
- ensuring the security of passwords and the correct assigning of delegates when using the Riskman incident notification and reporting module
- ensuring learning opportunities are undertaken and embedded into mainstream practice
- distributing incidents to relevant staff who may also need to review them
- monitoring and reviewing the effectiveness of local recommendations

Executive Directors (or delegate) are responsible for:

- ensuring recommendations arising from incident investigations are implemented and monitored via the appropriate committee structures
- verbally reporting all significant incidents to the Deputy Director General/s and Director General within 12 hours of the incident and submitting all extreme and major incidents within 24 hours or 1 working day via the Riskman Significant Incident Reporting module
- approving submission of Significant Incident Briefs within their Division/Branch through the Riskman Incident and Notification reporting module
- initiation of the Look Back process as required
- decisions on public notification, media management and advising the ACT Minister for Health

Divisional Quality and Safety Officers (QSOs) are responsible for analysing aggregated incident data and high level incidents for improvement opportunities.
Quality and Safety Unit (QSU) is responsible for:

- reviewing this policy and associated SOPS as required in conjunction with relevant stakeholders
- ensuring documentation processes are followed in Riskman
- ensuring the ACT Insurance Authority is notified as required
- coordinating training for incident management, Riskman and open disclosure
- ensuring the Consumer Feedback and Engagement Team are involved with supporting consumers as required
- liaising within the Health Directorate regarding incidents as required

○ Safety Advisors in the Workplace Safety Section, QSU are responsible for:
  - preparing Significant Incident Briefs (SIBs) for incidents related to workers or notifiable incidents as per the Significant Incident Reporting SOP
  - reviewing all Staff Accident and Incident Reports (SAIR)
  - assigning risk ratings, classifications/mechanism of injury
  - reviewing for content completeness and accuracy
  - distributing relevant incident notifications to relevant staff as appropriate
  - monitoring and evaluating documentation of incident investigations and controls implemented by managers
  - providing information on support mechanisms available to staff such as the Employee Assistance Program and Early Intervention Physiotherapy as required
  - liaising with WorkSafe ACT as required
  - liaising within the Health Directorate regarding incidents as required, e.g. Business and Infrastructure Executive Officer is responsible for informing the Safety Advisor/s of incident details as required for reporting purposes if not included in the original incident notification

○ Clinical Review Team, QSU are responsible for overseeing significant incident investigation

○ Risk and Incident Management Team (Clinical Risk Coordinators and Incident Classifiers), QSU are responsible for:
  - coordinating the reporting of Significant Incidents excluding those involving staff.
  - co-ordinating reporting to the Director-General in line with the Significant Incident SOP, Open Disclosure SOP and the Look Back SOP.
  - viewing all incidents (except SAIR) and assigning incident classifications
  - distributing incident notifications to relevant staff
  - providing advice and support to staff through the Riskman Helpdesk

○ Consumer Feedback and Engagement Team are responsible for managing consumer feedback and liaising with the Clinical Risk Coordinators to ensure consumer feedback is incorporated into the incident management process as appropriate.
The Health Directorate Incident Management System includes the steps of the incident management process (inner circle) and the factors that relate to the whole system (outer circle). Each step of the process must be followed as per the Incident Management SOP.

Factors that relate to the whole incident management system include:

- Clinical Governance: Incident management is governed by Standard 1 of the National Safety and Quality Health Standards (Australian Commission on Safety and Quality in Health Care).
- Quality Improvement: Quality improvement activities may arise as a result of incidents and the recommendations formed following an investigation in order to improve care to consumers.
- Risk Management: A risk management and systems improvement approach to incident management supports openness, trust, continuous learning, service improvement and will assist in preventing incident recurrence and create a more resilient safety system.
- Policy and Procedures: This policy and associated SOPs are reviewed regularly and updated as appropriate.

Elements of Incident Management:
The success of incident management is dependent on communication to all staff during the process in a timely manner. Staff involved in an incident need to be informed of the recommendations arising from any investigation. Feedback to consumers can occur in the form of open disclosure (see definition of terms) and can occur at multiple steps as appropriate.

All documentation related to an incident at each step of the incident management process should occur in the electronic incident form in Riskman and in the Clinical Record (if an incident relates to a consumer). Documentation in Riskman should be in the same manner as the Clinical Record.
Identification
It is important for all staff to recognise when an incident has occurred. Immediate action should take place to ensure the safety of people involved and the environment where the incident took place.

Notification
The Health Directorate uses the Riskman incident notification and reporting module to document the notification of incidents on standardised electronic forms. Staff should also notify their immediate supervisor when an incident occurs. Managers are required to review incidents lodged by their staff to ensure local action is taken.

Improvements can only occur when there is notification of a matter identifying that improvement is required.

Classification
This is the process of capturing relevant and complete information about an incident to enable managers to generate reports and analyse incident data to identify trends, risks and initiate, monitor and/or evaluate system improvements. The incident classifier confirms the final classifications in line with the Incident Management SOP.

Investigation
Investigation and analysis of incidents is an essential component of incident management. The incident outcome rating and complexity of the incident determines the level of investigation. Once the incident investigation is complete, recommendations to prevent incident recurrence are made.

NB: This Policy and related SOPs describe a process related to system issues. Any issue arising from an incident that relates to staff skills or competency will be addressed through performance management and/or clinical competence processes.

Action
Actions are developed for each recommendation. Accountability for each action will be given to a nominated position. Progress on the implementation of actions is monitored regularly. Mechanisms for monitoring include recommendation registers, risk registers, Quality and Safety committees, aggregated analysis of Riskman data on a regular basis and risk assessments as required.

Evaluation
Evaluation monitors whether the action has been successful in preventing incident recurrence.

Evaluation
- **Outcome Measures**
  - All sentinel events have been investigated using root cause analysis methodology
  - All staff incidents have documented evidence in Riskman of investigation and controls implemented 5 days post incident date

- **Method**
  - All sentinel events are investigated in line with the clinical review processes
  - Specific Key Performance Indicators are described and evaluated under each SOP as relevant to the subject matter
  - Trends in incidents will be routinely monitored as part of safety and quality reporting systems.
Related Legislation and Policies

Legislation
- Health Act 1993 (ACT).
- Human Rights Act
- Freedom of Information Act 1989
- Safety Rehabilitation and Compensation Act 1988
- Work Health and Safety Act 2011
- Work Health and Safety Regulation 2011
- Public Interest Disclosure Act 1994 (ACT)
- Work Health and Safety Codes of Practice

Standards
- ACHS EQuIP 5, Support, Criteria 2.1.2 & 2.1.3
- Australian Commission on Safety and Quality in Healthcare – National Safety and Quality Health Service Standards
- Open Disclosure Standard: a National Standard for Open Communication in Public and Private Hospitals, Following an Adverse Event in Health Care 2003 (under review)
- Australian Charter of Healthcare Rights

Policies and Standard Operating Procedures (SOPs)
- Health Directorate “Incident Management” SOP (draft)
- Health Directorate “Significant Incidents” SOP (draft)
- Health Directorate “Open Disclosure” SOP (draft)
- Health Directorate “Look Back” SOP (draft)
- Health Directorate “Release of Riskman Incident Notifications” SOP (draft)
- Health Directorate “Risk Management” Policy, SOP and Guidelines
- Health Directorate “Consumer Feedback Management” Policy and SOP
- Little Company of Mary Health Care, Significant Events Policy
- Little Company of Mary Health Care, Clinical Governance Framework
- Little Company of Mary Health Care, Incident, Accident and Near Miss
- Health Directorate Records Management Policy
- Employees Assistance Program Policy
- Preventing and Managing Aggression and Violence Policy
- Health Directorate Public Interest Disclosure Policy (under review)
- Mental Health, Justice Health and Alcohol and Drug Services policy: “Incidents Reportable to the Director of Mental Health” (under review)
- Health Directorate Safety Management System (under review)
- Health Directorate “Complaints and concerns regarding the clinical Competence of a Doctor or Dentist” Policy and SOP
**Definition of Terms**

**Adverse event**

an incident in which harm resulted to a person receiving health care.

**Dangerous incident**

any incident in relation to a workplace that exposes a worker or any other person to a serious risk to a person's health or safety emanating from an immediate or imminent exposure to:
- an uncontrolled escape, spillage or leakage of a substance
- an uncontrolled implosion, explosion or fire
- an uncontrolled escape of gas or steam
- an uncontrolled escape of a pressurised substance
- electric shock
- the fall or release from a height of any plant*, substance or thing
- the collapse, overturning, failure or malfunction of, or damage to any plant that is required to be authorised for use in the regulations
- the collapse or partial collapse of a structure
- the collapse or failure of an evacuation or of any shoring supporting an excavation
- the inrush of water, mud or gas in workings, in an underground excavation or tunnel
- the interruption of the main system of ventilation in an underground excavation or tunnel or
- another event prescribed in the regulations.

A dangerous incident can also be referred to as a Significant Incident and/or a Notifiable Incident. *See definition of “plant” below.

**Hazard**

a circumstance or agent that can lead to harm, damage or loss (includes within a consumers home)

**High risk incident**

any event that would have resulted in a significant incident should it have eventuated (also referred to as a significant near miss), incidents that could attract significant media attention and possible significant incidents where the status is unclear until further investigation is undertaken.

**Incident**

An event or circumstance which could have resulted in, or did result, in unintended or unnecessary:
- harm
  - to a worker
  - to a patient/client/consumer
- complaint, loss or damage
  - to property and services (including infrastructure)
  - to the environment
  - regarding financial management
  - regarding information management
  - regarding the reputation of the organisation
- deviations
  - from endorsed plans/processes.
Look Back

A standardised process that is triggered when a notification of a clinical incident, or concern, from any source leads to the need for the notification, investigation and the management of a group of commonly affected consumers. The clinical incident may arise from complications or errors relating to diagnostics, treatment or products that consumers have received.

Near miss

An incident that did not cause harm.

Notifiable incident (staff)

An incident which occurs to a staff member and requires immediate notification to the Workplace Safety Section of the Quality and Safety Unit and WorkSafe ACT. It includes:

a) The death of a staff member or
b) A serious injury or illness of a staff member or
c) A dangerous incident (also see definition)

A notifiable incident can also be referred to as a Significant Incident.

Open disclosure

Is a process of communication with consumers following an adverse event and is not a legal process. Apologising and disclosing an adverse event to a consumer is not the same as admitting fault, rather it is an expression of regret and statements of fact. The standard outlines a clear and consistent process which includes:

- an apology
- an invitation for the consumer to relay their perspective on the event
- a factual explanation of what occurred, including actual and potential consequences, and
- the steps being taken to manage the event and prevent its recurrence

Refer to the Open Disclosure SOP for more information.

Outcome rating

See Appendix A of the Incident Management SOP.

Plant (related to a dangerous incident)

Includes any machinery, equipment, appliance, container, implement and tool or anything fitted or connected to machinery, equipment, appliance, container, implement or a tool.

Riskman

An online web based system used to report incidents.

Root Cause Analysis

Is a rigorous indepth investigation in which a multidisciplinary team is selected to investigate and analyse a serious adverse event. It focuses on identifying system vulnerabilities that allowed the incident to occur and developing recommendations to prevent recurrence.

Root Cause Analysis (RCA) methodology

A structured and detailed process that helps to identify what happened in an incident why it happened and how to prevent future harm.

Sentinel events

The Australian Commission for Safety and Quality in Health Care has worked closely with all jurisdictions to develop a national core set of sentinel events. The agreed national list of core sentinel events consists of:

- Procedures involving the wrong patient or body part resulting in death or permanent loss of function
- Suicide of a patient in an inpatient unit
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- Intravascular gas embolism resulting in death or neurological damage
• Haemolytic blood transfusion reaction resulting from ABO incompatibility
• Medication error leading to the death of patient reasonably believed to be due to incorrect administration of drugs
• Maternal death or serious morbidity associated with labour or delivery
• Infant discharged to the wrong family.

A sentinel event can also be referred to as a Significant Incident.

**Significant Incident**
an incident with an Extreme or Major outcome occurring in relation to Health Directorate services and care, requiring immediate notification to the Director General/Deputy Director General. Significant Incidents include Sentinel events and Notifiable Incidents.

**Work Injury**
an injury or illness contracted as a result of duties performed during the course or work activities.

**References**

Australian Commission on Safety and Quality in Healthcare 2008; *National Safety and Quality Health Service Standards*, Commonwealth of Australia.


Government of Western Australia Department of Health 2011; *Clinical Incident Management Policy*; Western Australian Department of Health, Western Australia.

**Attachments**

Nil
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