**Canberra Health Services**

**Policy**

**Incident Management - Clinical**

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| Policy Statement |

Canberra Health Services (CHS) vision is *creating exceptional health care together*, and our role is *to be a health service that is trusted by our community*. One of the ways we achieve this is to ensure we have reliable clinical incident management governance and processes in place.

The CHS clinical incident management system supports a culture of reporting and accountability for patient care. CHS staff and our consumer and carer partners are committed to learning from incidents and using this information to improve our health service.

Our clinical incident management system reflects the Australian Commission on Safety and Quality in Health Care National Safety and Quality Health Service Standards (NSQHSS), the CHS Strategic Plan and CHS Corporate Plan.

CHS and its staff have a responsibility to identify, report, investigate, learn, improve and manage risks in relation to clinical incidents.

The principles of transparency, accountability, obligation to act, consumer focused, open ‘just’ culture and prioritisation are to be applied at each step of the incident management process to ensure the safety and quality of care to consumers.

Whether a healthcare incident results in minor or major harm, the impact can be significant for consumers and extend for months and even years, affecting personal health, relationships and careers. Ineffective management and communication in relation to an incident can further contribute to the harm and a loss of trust.

Incident management processes must occur in accordance with relevant legislation, standards and policies.

All clinical incidents, including near misses, are to be recorded in the RiskMan clinical Incident Notification System and are classified and allocated a Harm Score (**Attachment A**).

Consumers are encouraged to report incidents either directly to staff or via the Consumer Feedback and Engagement Team. The incident is managed in accordance with the CHS Incident Management Procedure.

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| Purpose |

All CHS staff apply a consistent process to clinical incident management (including timely

identifying, reporting, and managing all clinical incidents) to support patient safety and to

reduce the risk of patient harm.

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| Scope |

This policy applies to all CHS staff.

For the purposes of this policy:

* an ‘incident’ only relates to ‘Clinical Incidents’
* consumer means ‘patient, client, consumer, person’.

*A clinical incident is an event or circumstance that did result in unintended harm or could have resulted in unintended harm (near miss) to a patient/client/consumer resulting from, or contributed to, by health care provided by Canberra Health Services and outside the natural disease process. The resultant harm differed from the expected outcome of patient/client/consumer management.*

The following are not covered by this policy:

* Information related incidents
* Staff incidents - refer to CHS Work Health Safety Management System (WHSMS) Section 11 – Incident/Hazard Reporting and Investigation
* Notifications via RiskMan to Child and Youth Protection Services.

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| Roles & Responsibilities |

**All staff (includes medical, nursing, midwifery, allied health, administrative and operational)**

* Champion a positive safety culture and open communication
* Ensure the safety of consumers and carers involved in a clinical incident and that they are supported following the incident
* Identify and notify incidents when they occur to their immediate supervisor, including all adverse events and near misses
* Complete an incident notification (RiskMan) by the end of the working day
* Ensure the security of passwords and the correct assigning of managers when using the RiskMan incident notification module
* Participate in investigations of incidents as required
* Participate in the initial open disclosure conversation and formal open disclosure as required, in line with the CHS Open Disclosure Procedure
* Understand and comply with the CHS Clinical Incident Management Policy and Procedures and Open Disclosure Procedure
* Update the clinical record and RiskMan incident notification to reflect the initial conversation
* Participate in the implementation, monitoring and evaluation of recommended actions and associated learning opportunities and quality improvement activities
* Support and encourage colleagues to notify identified incidents.

**Directors/Supervisors/Managers (includes medical, nursing, midwifery, allied health, administrative and operational)**

* Champion a positive safety culture and open communication
* Understand and support clinical incident management procedures and staff compliance with requirements for incident management
* Ensure the safety and support for patients/clients/consumers following an incident
* Ensure support is offered and provided to staff who have been involved in an incident
* Escalate incidents in accordance with this policy and related procedures
* Ensure that open disclosure had been offered and that the clinical record and the RiskMan notification has been updated
* Notify the relevant Executive Director (ED) if a formal open disclosure has been offered and accepted by the consumer and/or carer
* Assist with open disclosure as required
* Ensure staff access to incident management and open disclosure education and training
* Support staff participation in incident investigations
* View all incidents submitted by staff who report to them within 5 calendar days
* Confirm incident Harm Scores and classifications of incidents relevant to their reporting line
* Participate in incident review and investigations of Harm Score 1 (HS1) and Harm Score 2 (HS2) incident investigations as required
* Ensure incidents with Harm Score 3 (HS3) and Harm Score 4 (HS4) are investigated within 28 calendar days of the incident notification
* Ensure the outcome of clinical incident investigations and any actions taken are documented within 28 calendar days of the incident notification
* Participate in morbidity and mortality activities
* Support learning opportunities and quality improvement activities from incident management processes
* Assist with development of actions and recommendations
* Share learnings and actions with relevant staff
* Monitor, implement and measure local recommendations/actions/controls.
* Identify and escalate concerning trends and risks.

**Executive Directors (ED)/ Executive Branch Managers (EBM)**

* Champion a positive safety culture and open communication
* Ensure application of the clinical incident management process in line with policy and procedure
* Ensure processes are in place to support staff involved in a clinical incident
* Ensure processes are in place to identify, report and manage incidents
* Ensure staff access to incident management and open disclosure education and training
* Support staff access to incident management and open disclosure training
* Escalate all HS1 and HS2 to the Chief Executive Officer (CEO), the Chief Operating Officer (COO) and Incident Management Team (IMT) via the RiskMan Incident Notification System
* Ensurethe completion of a Rapid Incident Assessment (RIA) for all suspected HS1 and HS2 clinical incidents within 72 hours
* Ensure initiation of formal open disclosure process in line with the CHS Open Disclosure Procedure
* Ensure an initial open disclosure conversation with the consumer/carer has occurred (and is documented) in line with the CHS Open Disclosure Procedure
* Ensure the patient is safe and supported following a HS1 or HS2 incident
* Participate in the consultation of recommendations
* Ensure divisional governance structures and processes are in place for the reporting, and monitoring of morbidity and mortality activities including the associated outcomes and actions
* Ensure recommendations arising from incident investigations and morbidity and mortality activities are implemented and monitored within the agreed timelines
* Escalate concerns to the CEO for the making of decisions on public notification, media management and notification to the ACT Minister for Health
* Report concerning trends and risks to the Clinical Executive Operations Committee
* Ensure there are divisional feedback processes on recommendations in place.

**Quality Safety Innovation and Improvement (QSII)**

* Champion a positive safety culture and open communication.
* Develop, implement and review the CHS Clinical Incident Management Policy and Procedure in consultation with relevant stakeholders
* Support clinical incident management processes including the reporting and investigation of all suspected clinical HS1 and HS2 incidents
* Administrative and investigation support for the CHS Clinical Review Committee (CRC)
* Support the escalation of incidents in line with the CHS Clinical Incident Management Policy and Procedure
* Coordinate and support clinicians and the open disclosure team for HS1 and HS2 incidents, by providing the administrative support and acting as a consumer liaison as required
* Provide incident data and reports for governance committees and divisions
* Coordinate incident management training and education, including open disclosure
* Coordination of Morbidity and Mortality Committees
* Provide advice and support to staff in relation to incident management processes
* Manage the release of incident reports.

**Chief Executive Officer (CEO)**

* Ensure there is an effective incident management system in place with robust governance and monitoring practices
* Champion a positive safety culture and open communication.

**Chief Operating Officer (COO)/ Deputy Chief Executive Officer (DCEO)**

* Ensure the implementation of an effective incident management system
* Monitor the clinical incident management system and ensure improvements from incident management processes are identified and actioned
* Champion a positive safety culture and open communication.

**Clinical and Corporate Executive Operations Committees**

* Champion a positive safety culture and open communication.
* Monitor CHS incident data, trends and actions
* Endorse incident investigation recommendations
* Monitor recommendation processes and completion
* Endorse recommendation completion
* Members share learning and improvements more broadly across CHS.

**CHS Clinical Review Committee (CRC)**

* Oversee the investigation of Harm Score 1 and 2 clinical incidents
* Liaise with clinical groups to promote a positive safety culture and learning from incidents

**Morbidity and Mortality Committees**

* Champion a positive safety culture and learning environment from morbidity and mortality review
* Share learnings and actions from review activities to Quality and Safety Committees and staff
* Monitor the completion and improvement from actions
* Provide reports and advice on clinical incident trends and risks to the relevant Divisional Quality and Safety Committee.

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| Evaluation  |

**Outcome**

* The document is current and accessible to all staff
* Staff understand and comply with the clinical incident management process and their responsibilities for incident management
* Clinical incidents are investigated within required timeframes
* Appropriate Harm Scores are allocated to clinical incidents
* Incidents with a Harm Score 1 or 2 are escalated
* Evidence of action and improvement from clinical incidents
* Open disclosure occurs.

**Measures**

* Report from clinical incident register determining timeframes from incident reporting to completion of the investigation.
* Reporting from incident register on open disclosure
* Review a selection of incidents to confirm appropriate Harm Scores and escalation occurred.

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| Related Policies, Procedures, Guidelines and Legislation |

**Policies**

* Consumer Feedback Management Policy
* CHS Work Health Safety Management System (WHSMS)
* CHS Work Health Safety (WHS) Policy
* Clinical Records Management Policy
* Administrative Records Management Policy
* CHS Policy – Information Privacy
* CHS Policy – Consumer Privacy

**Procedures**

* Consumer Feedback Management Procedure
* CHS Operational Procedure – Open Disclosure
* Clinical Incident Management Procedure
* Clinical Records Management Procedure
* Consumer Compensation Claims Procedure

**Guidelines**

* Australian Commission on Safety and Quality in Healthcare – National Safety and Quality Health Service Standards
* Partnering with Consumers Framework
* Exceptional Care Framework
* Clinical Governance Framework
* Morbidity and Mortality Guidelines

**Legislation**

* *Health Act* 1993 *(ACT)*
* *Information Privacy Act* 2014
* *Health Records (Privacy and Access) Act* 1997

**Other**

* Australian Charter of Healthcare Rights

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| Definition of Terms  |

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| **Australian Sentinel Event****(ASE)** | An ASE is a wholly preventable patient safety incident resulting in death or serious patient harm. It is a category of incident defined by the Australian Commission on Safety and Quality in Health Care and approved by the Health Ministers. The ASE list is at Attachment A. |
| **Harm** | Patient/client/consumer/person harm is any unintended and unnecessary harm resulting from, or contributed to, by health care.  |
| **Harm Score** | A score from 1 to 4 applied to clinical incidents based on the outcome and additional treatment and/or resources required as defined in Attachment A. * Clinical Harm Score 1 (HS1)- death related to a clinical incident or an Australian Sentinel Event
* Harm Score 2 – Major harm
* Harm Score 3 – Minor harm
* Harm Score 4 – No harm or near miss.
 |
| **Incident (Clinical)** | A clinical incident is an event or circumstance that did result in unintended harm or could have resulted in unintended harm (near miss) to a patient/client/consumer resulting from, or contributed to, by health care provided by Canberra Health Services and outside the natural disease process. The resultant harm differed from the expected outcome of patient/client/consumer management. |
| **Incident Management** | Actions and processes for immediate and ongoing activities following an incident.  |
| **Manager/Supervisor** | A designated senior staff member who manages and mentors another staff member and who will assist in the management of an incident. |
| **Near miss** | An incident that could have caused harm but did not or an incident that was intercepted before reaching the patient/client/consumer.  |
| **Notice** | A notification submitted in the RiskMan Incident Register that does not meet the definition of an incident. |
| **Notification** | The process of entering or documenting data about an incident or near miss into the RiskMan Incident Management System. |
| **Open disclosure** | Open Disclosure is an open conversation between CHS staff and a consumer and/or carer relating to an incident that could have resulted, or did result, in harm whilst receiving healthcare.  |
| **RiskMan incident module** | An online web based system used to report incidents within CHS. |

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| References |

1. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards.
2. Australian Commission on Safety and Quality in Health Care, Australian Sentinel Events (version 2), Publication Year 2020.
3. NSW Government, Incident Management Policy and Procedure, Issue date December 2020.
4. NSW Government, Clinical Excellence Commission, Incident Management Policy Resources, [www.cec.health.nsw.gov.au](http://www.cec.health.nsw.gov.au).
5. Best Practice Guide to Clinical Incident Management, State of Queensland (Queensland Health), First Addition 2014.
6. Victorian sentinel event guide, State of Victoria, Safer Care Victoria, June 2019.

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| Search Terms |

Incident, open disclosure, Harm Score, investigation, RiskMan, Quality Assurance Committee, Clinical Review Committee

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| Attachments |

Attachment A – Harm Score table

**Disclaimer**: *This document has been developed by Canberra Health Services specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Canberra Health Services assumes no responsibility whatsoever.*

*Policy Team ONLY to complete the following:*

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| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval*  |
| *9 June 2021* | *Complete Review* | *Kellie Lang, A/g EBM, QSII* | *CHS Policy Committee* |
| *29 August 2023* | *Amendments made to the policy to reflect current practise* | *Helen Milne, A/g EBM, QSII* | *CHS Policy Team* |

*This document supersedes the following:*

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| --- | --- |
| *Document Number* | *Document Name* |
| *DGD18-017* | *Incident Management – Policy*  |
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## Attachment A – Harm Score table

**Clinical Incident:** *an event or circumstance that did result in unintended harm or could have resulted in unintended harm (near miss) to a patient/client/consumer resulting from, or contributed to, by health care provided by Canberra Health Services and outside the natural disease process. The resultant harm differed from the expected outcome of patient/client/consumer management.*

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| **HARM SCORE 1 - Death and Sentinel Events** |
| * **Death** of a Patient/client/consumer/person as the result of a clinical incident.
* **Suicide or suspected suicide** of a Mental Health consumer discharged from a CHS inpatient facility within the previous seven days.
* **Suicide** of a current inpatient of Canberra Health Services.
* **Sentinel Event**:
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.
 |
| **HARM SCORE 2** **-** **Major Harm**  |
| * **Major Harm** to a Patient/client/consumer/person as the result of an incident:
* requiring life saving surgical or medical intervention or
* shortened life expectancy or
* permanent or long-term physical harm or long-term loss of function.
* **Attempted Suicide** of a Mental Health consumer discharged from a CHS inpatient facility within the previous seven days.
* requiring life saving surgical or medical intervention or
* shortened life expectancy or
* permanent or long-term physical harm or long-term loss of function.

**Note:** *If the incident meets the definition of a Sentinel Event it is a Harm Score 1* |
| **HARM SCORE 3 – Minor Harm**  |
| * **Minor Harm** to a Patient/client/consumer as the result of an incident:
* resulting in transfer to a higher level of care or
* surgical or medical intervention or
* increased level of care.

**Note:** *An assessment is not an increased level of care* |
| **HARM SCORE 4 – No Harm / Near Miss** |
| * **No harm** acquired as the result of an incident and includes a near miss event
* The event reached the patient/client/consumer/person **but did not result** in harm *(the person did not require a higher level of care or surgical/medical intervention)* **OR**
* The event was intercepted before reaching the patient/consumer/client
 |
| **NOTICE -** **No incident identified, No Classification** |
| * Does not meet the definition of a clinical incident

**Note:** *an intervention such as a MET or seclusion/restraint is a response, not an incident.* |