Document facilitator:	Patient Safety Coordinator
Senior document owner:	CCDHB CEO
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Type: Policy

Name: Adverse Event and Incident Management

Purpose
The purpose of this policy is to articulate how all adverse events and health and safety incidents are managed at Capital & Coast District Health Board (CCDHB).

Policy Statement
CCDHB aims for a *just culture* where employees are not blamed for system failings and feel comfortable disclosing adverse events and incidents. The fundamental role of an adverse events reporting system is to enhance safety by learning from adverse events and near misses that occur in health and disability services. Adverse events and incidents will be reviewed and managed in a professional and respectful manner that ensures lessons are learnt, to improve quality and safety for patients and their family/whānau and employees.

These practices comply with legislative requirements:

- The New Zealand Health and Disability Services (CORE) Standards (2008)
- HDC Code of Rights
- The Health & Safety at Work Act (2015)
- Health & Disability Services (Safety) Act (2001)
- Privacy Act (1993), the Health Information Code (1994), and the DHB General Disposal Authority

Scope
Includes:

- All CCDHB employees (permanent, temporary and casual), visiting medical officers and practitioners, students and other partners in care
- All clinical adverse events and incidents (including good catches) that occur or have the potential to occur to any person as a result of the provision of health and disability services (managed in alignment with the National Adverse Events Reporting Policy 2017)
- Health and safety events affecting any employee, contractor or volunteer (managed under the Health and Safety at Work Act (2015).

Excludes:

- Employment relationship issues and events; these are managed under the Employment Relations Act (2000), and should be referred to Human Resources.
- Incidents involving a criminal act, use of illicit drugs or alcohol, deliberate unsafe action or deliberate patient harm should be referred to Human Resources.

Principles

CCDHB supports the principles that underpin the National Adverse Events Reporting Policy (HQSC 2017) for clinical adverse events. These include:

- open communication
- consumer participation
- culturally appropriate review practice
- system changes
- accountability
- reporting must be safe

Definitions

Clinical/non-clinical

Clinical events are those that affect patients/consumers during an episode of care.

Non-clinical events are those that do not directly involve patient care.

Good catch (near miss)
An event which under different circumstances could have caused harm, but did not, and which is indistinguishable from an incident in all but outcome.

Incident
An event with potential or actual negative or unfavourable reactions or results that are unintended, unexpected or unplanned (also referred to as *adverse event or reportable event*).

Just Culture – (No blame)
One in which employees are comfortable disclosing errors**,** including their own, while maintaining accountability. It recognises individual practitioners should not be held accountable for system failings over which they have no control, yet does not tolerate conscious disregard of clear risks to patients or gross misconduct.

Notifiable Event
When any of the following occurs as a result of a work accident: a death, notifiable illness or injury.

Open communication
The timely and transparent approach to communicating with, engaging with and supporting consumers, their families and whānau when clinical incidents occur.

Review
A formal process that is carried out to analyse an incident or good catch and develop recommendations based on the findings.

SQUARE
Safety Quality and Reportable Events electronic reporting system (RL 6) where incidents are reported

Third Party Administrator (TPA)
An organization that processes and handles ACC claims for an employer (e.g. Wellnz - manages ACC claims for CCDHB)

Role and responsibilities

Role	Accountability and Responsibility
All CCDHB employees	• Report all incidents using SQUARE. For a clinical event, this should also be documented in the patient's clinical record
Business Manager on-call, or Afterhours Duty Nurse Manager	• Provide expert advice, support and leadership in relation to the management and reporting of adverse events and incidents after hours
Charge Managers and Clinical Leaders	• Ensure staff are aware of their responsibilities in relation to incident management. • Manage, monitor and review incidents within areas of delegated responsibility and implement corrective actions from reviews • Participate in reviews of clinical severe/major incidents and Always Report & Review list 2018-19 (HQSC, 2017) in conjunction with the quality teams.
Chief Executive	• Overall management responsibility for the DHB's safety processes in relation to clinical and non-clinical incidents and adverse events
Clinical Governance Board	• Governance for implementation and compliance with this policy • Oversight of the management of clinical adverse events
Director of Area Mental Health	• Reports patient deaths as required under Section 132 of the Mental Health Act (1992)
Directorate Executive Directors	• Oversight across their directorate including service incident and adverse event data, compliance, analysis, trends and risk identification and management • Responsibility to ensure compliance with policy within their directorate for reporting, reviewing reportable events and implementation of corrective actions
Directorate Quality Teams	• Provide support and expertise with review and management of incidents and adverse events with the purpose of highlighting where systems, processes, human factors, policy, or procedure could be improved; emerging trends; and/or where further change is required. • Provide *adverse event and incident management* education to managers/senior staff • Support open communication process • Oversight of trends emerging from adverse events and incidents
Executive Leadership Team	• Strategic oversight of all events and incidents
Executive Director QIPS	• Ensure training for review of incidents and adverse events • Support the identification of areas for quality improvement, particularly in relation to patient care • Supports the clinical adverse events reporting and reviewing system
General Manager Corporate Services	• Strategic oversight of non-clinical incidents, work injury rates and notifiable events
General Manager	• Strategic oversight of clinical incidents and adverse event reviews and

QIPS	management processes • Maintain a system of reporting and reviewing clinical adverse events which engages with consumers and aligns with National Adverse Events policy (HQSC 2017)
Health & Safety Service	• Review of health and safety events where an employee or other person was seriously harmed • Notification of work related injuries resulting in treatment to TPA • Assist and support managers with incident investigation • Report notifiable events to WorkSafe
Medical Staff	• Coroners notification, notifiable diseases, ACC treatment injuries
Non-clinical Managers	• Ensure all reporting staff are aware of their responsibilities in relation to incident management. • Manage, monitor and review incidents within areas of delegated responsibility and implement corrective actions from reviews
Operations Managers	• Ensure oversight of service compliance, data analysis and risk management • Inform directorate executive management of serious adverse events.
Patient Safety Coordinator	• Develops organisational learnings from patient safety issues • Strengthens the patient safety culture through the development and coordination of relevant patient safety projects • Monitors compliance with the National Adverse Events Reporting policy • Provides monthly reports to HHS, annual serious adverse events report and facilitates reporting SAC 1&2 and *Always Report and Review* events to the HQSC.
The Board	• Governance oversight of DHB safety in relation to adverse events and incident management

External Reporting Requirements

Incident Description	Reporting Agency
Always Report Events and SAC 1&2 Clinical Incidents	Health Quality & Safety Commission (HQSC)
Deaths that must be reported under Section 13 (2) 2 & 3 Coroners Act (2006)	Coroner
Notifiable Diseases under the Health Act (1956)	Medical Officer of Health, Ministry of Health
Treatment injuries	ACC
Employee work related ACC injury	TPA
Death, notifiable illness, injury or incident occurring as a result of work (Notifiable Event)	Worksafe
Unintended adverse reaction to medicine, psychoactive substances, recreational substance and legal high substances	Centre of Adverse Reactions Monitoring (CARM)
Incidents related to quality of medicines or medical devices	Medsafe, Ministry of Health
Any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided. Any investigation commenced by a member of the police into any aspects of the service. Any death of a person to whom you have provided services, or occurring in any premises in which services are provided, that is required to be reported to a Coroner under the Coroner's Act (2006)	Director General, Ministry of Health
Events relating to misadministration of radioactive material	Office of Radiation Safety, Ministry of Health

CCDHB-related Documents

Risk management policy policy

Health and safety policy policy

First Aid at Work procedure

Control of Contractors procedure

2DHB Workplace rehabilitation Procedure – under review

Clinical Adverse Event procedure – under review

CCDHB Consequence Table – under review

References

Health and Disability Services (CORE) Standards (2008)
Health Quality & Safety Commission (June 2017). National Adverse Events Reporting Policy 2017: New Zealand health and disability services.

HQSC (December 2012). Serious Incidents involving users of Mental Health services.
Occupational Health and Safety Management Systems – specification with guidance for use (2001). Standards New Zealand and Standards Australia

Legislation

The documentation, notification and disclosure of incidents are subject to the following legislation:

Coroners Act 2006

Health Act (1956)

Health and Disability Commissioner Act 1994

Health and Disability Services (Safety) Act 2001

Health and Safety at Work Act (2015)

Health Practitioners Competence Assurance Act 2003

Injury Prevention Rehabilitation and Compensation Act 2001

Mental Health Compulsory Assessment and Treatment Act 1992

Accident Compensation Act 2001