Incident Management

Policy

CDHB Incident Management Policy

Purpose

To provide staff with information and guidance on the management of incident reporting including clinical incidents, significant or sentinel events.

Scope

Patient related incidents that occur within W&CH which resulted in harm or had the potential to cause harm such as ;

- Patient Falls
- Medication Errors
- Blood/food/fluid administration errors (including breast milk)
- Equipment Failures
- Adverse outcomes (unexpected deterioration or death)
- Resource issues (equipment, staffing etc)

The following issues **may** be reported on an Incident Form but do not come under the remit of this Incident Management Policy and **shall** be reported on the other relevant documentation:

- Health and Safety related incidents – staff and visitors (Staff Accident Report Form, Ref 620)
- Blood/Body Fluid Exposure (Staff Accident Report Form, Ref 620)
- Patient or Staff Complaints (Suggestions, Compliments and Complaints Form Ref 152)
- Incidents that clearly relate to health practitioner competency (letter format and sent to relevant professional lead).

Definitions & Acronyms

Clinical Incident:

Is any event that has either resulted in, or had the potential to cause unintended and/or unnecessary harm or death (near miss) not related to the natural course of the patient's illness or underlying condition. Refer to CDHB Incident Management Policy

Root Cause Analysis (RCA) :
A process analysis method, which can be used to identify the factors that contribute to adverse events. The RCA process is a critical feature of any safety management system because it enables answers to be found to the questions posed by high risk, high impact events - notably, what happened, why it occurred, and what can be done to prevent it from happening again.

Root Cause Analysis Leader:
The person who leads the Root Cause Analysis team

Root Cause Analysis Team:
The staff chosen to participate in the Root Cause Analysis. Participants chosen will be based upon them having knowledge of the processes and systems being reviewed and /or them having decision making authority to affect necessary change to prevent recurrence of the event.

QCMS:

Quality and Complaints Management Systems (QCMS)

SAC Matrix:
Severity Assessment Code (SAC) grading matrix. A level 1 or 2 event can generally be described as a sentinel or significant event requiring a Root Cause Analysis.

Policy Statements

W&CH shall ensure that:

- All patient related incidents are adequately investigated and actioned as required to minimise recurrence
- SAC 1 & 2 incidents are reviewed using an RCA methodology and reported to Corporate Quality and Risk as per CDHB Incident Management Policy.
- All RCA shall be commenced and completed within 70 days.
- All staff involved in an incident are appropriately supported as required by having access to debriefing sessions, Employee Assistance Programme (EAP), mentorship, modification to work environment or hours
- All patient related incidents are reported using the Incident Report Form Ref: 1077
- All SAC 1 & 2 incidents shall be discussed in a multi-disciplinary

forum e.g. Incident Review Groups, Rolling Half Day etc.

- Incident trends are monitored and discussed regularly by SQU at Incident Review Groups and Clinical Governance Committees.
- Incident data is analysed and published quarterly with emerging issues and trends highlighted for action through Clinical Governance Committees

Associated Documents

Legislation:

Health Information Privacy Code 1994 (Revised in 2008)
Health Practitioners Competency Assurance Act 2003
Privacy Act 2003

Government Guidelines:

Ministry of Health Reportable Events Guideline 2001

CDHB Wide Documents:

CDHB Incident Management Policy
Legal & Quality Manual, Volume 2

- Tikanga Policy
- Health and Information Privacy Code 1994
- Incident Management
- Open disclosure policy

Health And Safety Manual, Volume 6

- Managing the Risk of Violence and Aggression in the Workplace.

Infection Control Manual, Volume 10

- Standard precautions Policy
- Blood/Body Fluid Exposure

Quality Strategic Plan 2007 – 2010
Quality and Complaints Management Systems (QCMS) Incident Users Guide
Incident Report Form, Ref: 1077
SAC Matrix

CDHB Corporate Quality and Risk Incident Management intranet

References

- National Policy for the Management of Healthcare Incidents, Working Draft (Communio Group)

Equipment

Nil.

Key Responsibilities

Quality Coordinator

- May take the role of Root Cause Analysis Leader
- Selects the people for the RCA team
- Plans and coordinates the RCA process
- Prepares the Root Cause Analysis summary report and disseminates accordingly
- Monitors implementation, reports progress to clinical governance committee and updates Corrective action register.
- Ensures a process of evaluating effectiveness of actions is in place

SMO's with the quality portfolio

- Where applicable works in conjunction with the SQU Team Leader or Quality Coordinator on incident inquiries
- May take the role of RCA Leader for incidents
- Evaluates effectiveness of actions

Service Managers

- Provides final approval for the completion of SAC 3 and 4 Events

Professional Leaders

- Assist the Service Manager with incident reviews on professional and clinical related issues
- Ensures staff involved in clinical incidents are offered and provided ongoing support

Clinical Directors and Charge Midwives or Nurse Managers

- Conduct an inquiry into the reported incident validating the reporters information and clarifying the sequence of events and identifying contributing factors
- Provide initial approval for the completion of SAC 3 and 4 Events.
- Refer SAC 1 & 2 events to the Safety and Quality Unit within 24 hours of discovery.

All staff

- All staff have a duty to report any incident they are involved in or are witness to immediately. This includes hazard concerns and near misses that have the potential to cause harm or loss
- Ensure that the policy of Open Disclosure to patient and relatives is implemented at the time of the incident
- Incident Report Forms should ideally be completed within 24 hours of discovery of the event and sent to the Charge Midwife/ Nurse Manager or Clinical Director (as appropriate)
- Reporters should ensure the written account of the clinical incident is factual, clearly describes the sequence of events and does not apportion blame to any individual
- Protect (from unnecessary handling or tampering) and retain evidence that may be relevant to a subsequent inquiry. Evidence may include but is not limited to documentation, equipment, a product, packaging or medication. Retain the evidence and present it to Charge Midwife/Nurse Manager or Clinical Coordinator who should then retain and secure the evidence until collected by the SQU team.

Incident Reporting Procedure

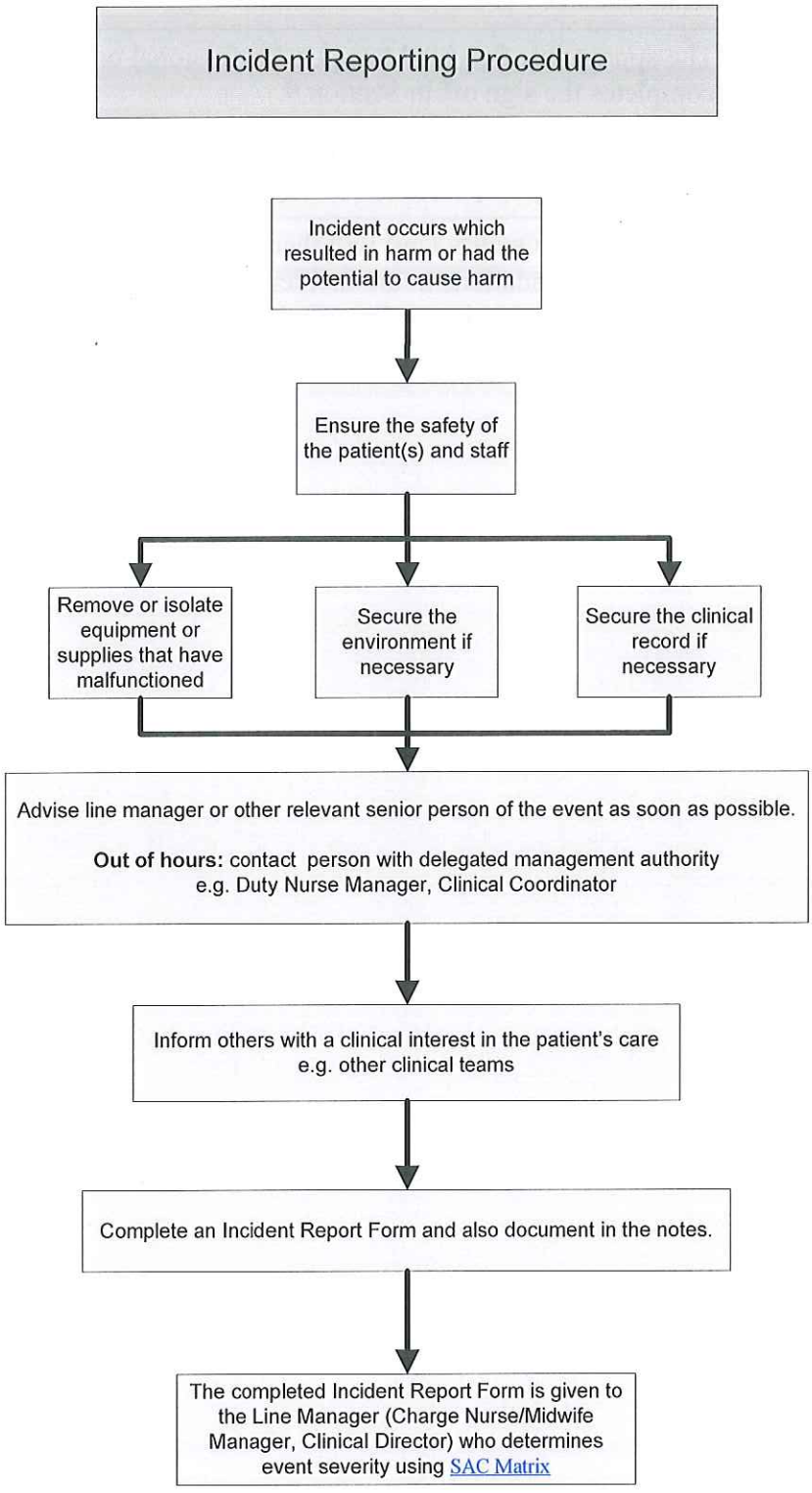
Step	Action
1	Staff directly or indirectly involved in an incident which resulted in harm or had the potential to cause harm. The first priority is to ensure the safety of the patient(s) and staff. As required and with the assistance of the area Charge or Coordinator • provide immediate care and comfort to individuals involved in the event (patient, staff or visitors) • make the environment safe • remove or isolate equipment or supplies that have or may have malfunctioned • secure the environment if necessary • secure the clinical record if necessary
2	Advise line manager or other relevant senior person of the event as soon as possible. **Out of hours**: Contact the person with delegated management authority for the hospital after hours e.g. Duty Nurse Manager, Duty Clinical Team Coordinator, Night Coordinator, Birthing Suite Clinical Coordinator, Associate Clinical Nurse Manager.
3	Inform others with a clinical interest in the patient's care e.g. other clinical teams
4	Complete an Incident Report Form before going home and also document the incident in the clinical records. It is helpful if all staff involved can write an account of the events and their involvement in them before leaving the shift. Attach these to the incident form.
5	Give the completed Incident Report Form to Line Manager, in most cases either a Charge Nurse or Midwife Manager or Clinical Director.
6	The Line Manager considers the severity of the incident and refers the matter directly to the Safety and Quality Unit Team Leader if they feel that the event is a SAC 1 or 2 event (refer to the SAC Matrix).
7	If the matter is a SAC 3 or 4 event, the Line Manager undertakes an initial investigation as to the circumstances of the incident and makes recommendations for implementation as required. This is documented on the reverse of the Incident Report Form
8	The Line Manager provides the Incident Report Form to the Safety and Quality Team within 10 days.
9	The Quality Coordinator reviews the incident and takes it to the Incident Review Group where, in consultation with the appropriate Professional

	and Clinical Leaders, the events, investigation and any recommendations made are reviewed. The Line Manager's review is either endorsed or further information sought.
10	The appropriate Service Manager, Professional or Clinical Lead completes the sign off in Section 9.
11	The Safety & Quality Unit will enter the details of the incident into QCMS and action points into the Quality Improvement Action Register.
12	The Safety & Quality Unit will then report on incident trends, actions and recommendations to the Incident Review Groups, Clinical Governance Committee, all staff via SQU publications and to the staff who completed the incident form via letter.

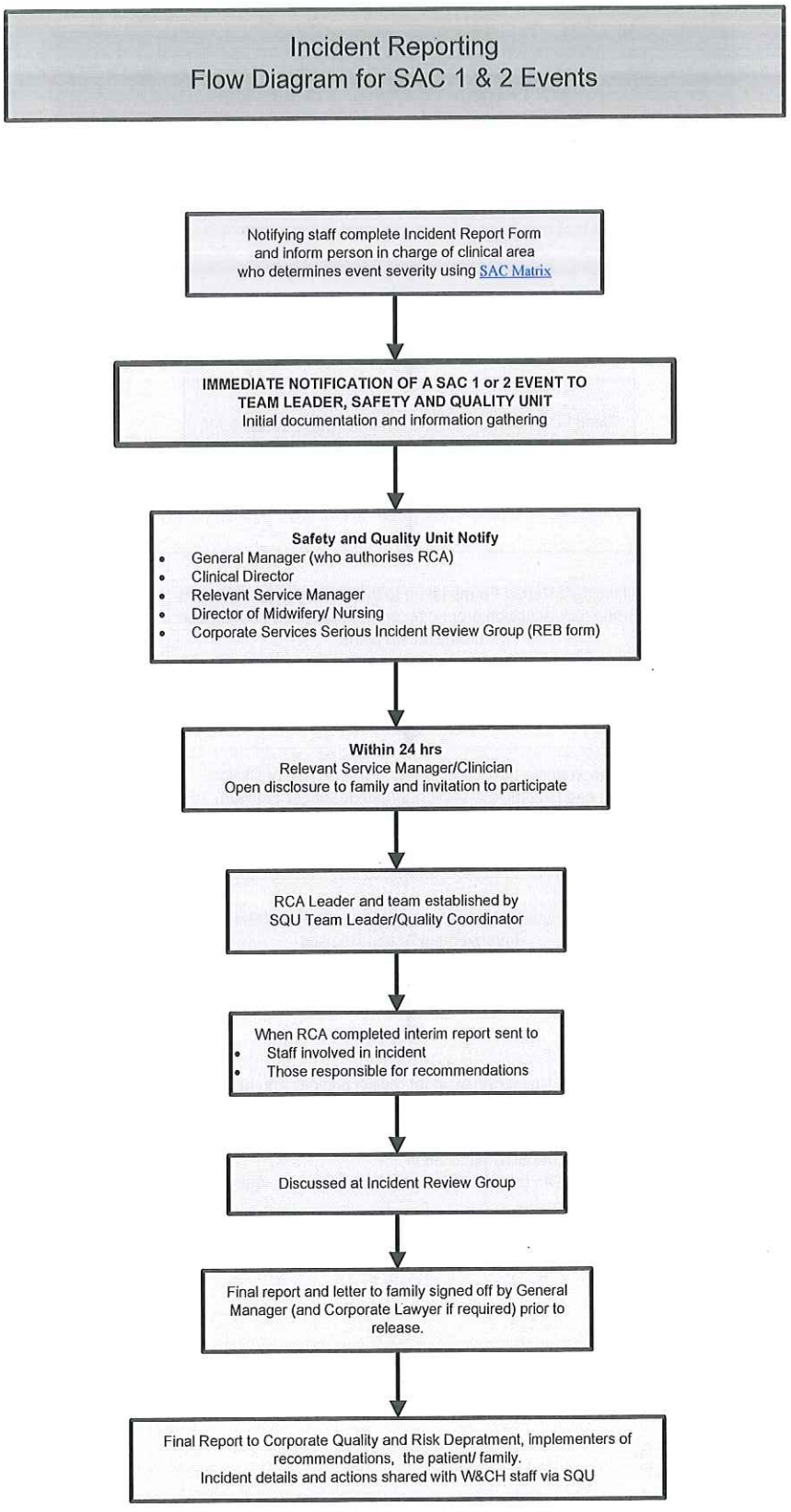
SAC Matrix

SAC Matrix

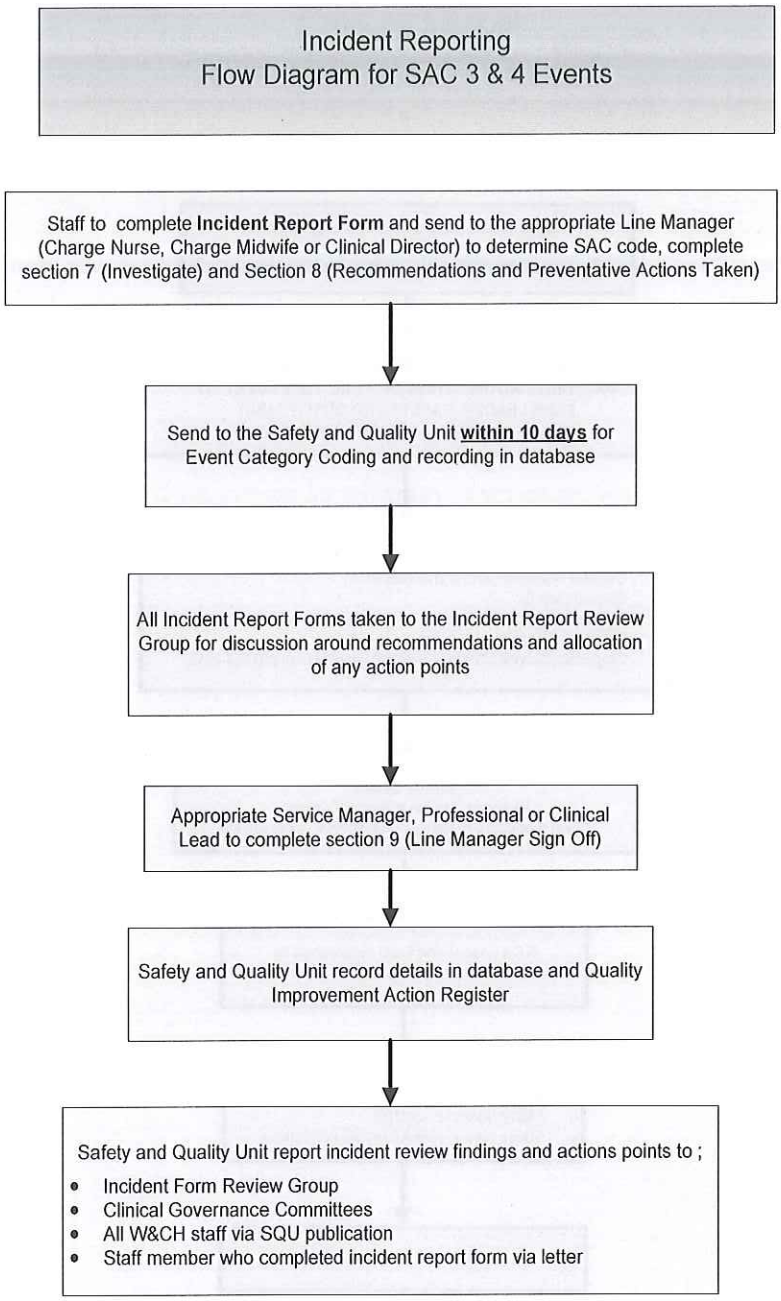
Incident Reporting Procedure



SAC 1 & 2 Events Procedure



SAC 3 & 4 Events Procedure



Root Cause Analysis (RCA)

The RCA methodology is used to assist the investigation of all incidents classified as SAC 1 or 2, except in cases of professional misconduct. It aims to focus on the event and systems rather than individuals and is conducted independent of any enquiry or investigation undertaken by Accident Compensation Corporation (ACC)

Objectives

- To have a positive impact in improving patient care, treatment and services and preventing sentinel events
- To focus attention on understanding the cause/s that underlie the event, and on changing the system and processes to reduce the probability of such an event in the future
- To increase the general knowledge about sentinel events, their causes and, and strategies for improving the safety culture

Goal

- To meet legal and statutory obligations
- To ascertaining the circumstances around significant/sentinel events and report on the factual circumstances surrounding the provision of care
- To highlight where services can be improved and remedial actions can prevent reoccurrence
- To ensure that factors that have been identified as contributing to a significant or sentinel event are discussed and utilised to promote learning and change practice
- To ensure that patient and staff confidentiality are respected throughout the RCA process
- To have a final report produced within 70 working days of commencement of the RCA

Accountability

- The General Manager, W&CH sanctions all RCA
- The RCA team reports to the Safety and Quality Unit Team Leader and to the General Manager W&CH, via the monthly Safety and Quality Unit report
- Following the recommendations of the RCA, action plans will be formulated by the services that are required to make improvements to a system or process

Responsibility

- The Lead Investigator will liaise regularly with the Safety and Quality Unit Team Leader on progress of the investigation and additional support that may be required
- SMO involved in an RCA is expected to dedicate the necessary priority required to complete RCA investigations in a timely manner
- The General Manager, W&CH and (if required, the CHDB corporate solicitor) will view RCA reports prior to distribution

RCA Lead

- Is required to have completed appropriate training in RCA investigations and may be a clinician or member of the Safety and Quality Unit.
- The Lead Investigator must be given the necessary time required to complete RCA investigations in a timely manner.

RCA Procedure

Step	Action
1	The Team Leader or Quality Coordinator approaches and appoints an appropriate RCA Lead and RCA team who conduct the remainder of these procedures.
2	Initial fact finding is undertaken, using the clinical records and the Incident Report Form to create a timeline of the events.
3	The timeline is used to determine what further information is required and to guide who should be interviewed.
4	Interviews of key staff are conducted by the team and written statements may be requested.
5	Complete the fact finding aspects of the review. This includes: • **What** happened • **When** did it happen • **Where** did it happen • **Who** was involved • **How** did it happen • **What** can be done to prevent recurrence
6	Once all the facts are learnt, the casual factors for the event are determined

7	The review team analyses the casual factors to determine the root cause(s). Ideally a single root cause should be determined.
8	The review team then draft recommendations for changes to practice that will help either minimise or prevent recurrence of the root cause to minimise future incidents.
9	The strength of recommendations should be considered in the context of the following hierarchy of the effectiveness of controls: 1. Elimination 2. Substitution 3. Creating redundancies or forcing functions 4. Developing policies, procedures and guidelines 5. Issuing protective equipment 6. Providing staff education 7. Accepting the consequences without taking any further action
10	In consultation with the staff responsible for implementation assign responsibilities and timeframes to the recommendations.
11	Provide feedback to staff involved in the event on the causal factors, root causes and proposed recommendations.
12	Submit a draft de-identified report to the General Manager (and Corporate Solicitor if required) for consideration.
13	Provide the final draft report to the Incident Form Review Group for endorsement of the findings and recommendations.
14	Provide the final report to the General Manager, W&CH for authorisation.
15	Distribute the final report to the Corporate Quality & Risk Department, CDHB Corporate Solicitor, those with responsibility to implement recommendations, the patient or family (if requested) and any others as required. Complete the REB and send to Corporate Services Serious Incident Review Group.
16	Ensure that the recommendations are included on the W&CH Quality Improvement Action Register for ongoing monitoring
17	SQU will update the Divisional SAC Log as required.

Performance Indicators/Benchmarks

- RCA reviews are completed within 70 days of the event;
- 90% of reported incidents are received by the Safety and Quality Unit within 10 days of the date that the incident occurred

Record/Evidence

- Incident Report Forms, maintained by the Safety and Quality Unit
- Quality and Complaints Management System (QCMS)
- Sentinel Event Review Files, maintained by the Safety and Quality Unit

Policy/Procedure Owner	Team Leader, Safety and Quality Unit
Date of Authorisation	Issue 1: 21 July 2009 Issue 2: 18th April 2011