Clinical Incident Management Policy

Policy Name: Clinical Incident Management	Document Number: 1	Page 1 of 13
Policy Portfolio Owner: Manager, Quality and Clinical Governance/General Managers	Policy Contact Person: Manager, Quality and Clinical Governance/General Managers	
Approved by: Executive Team	Approval Date: 11/12/2013	
Date to be revised: 11/12/2016	Status: **FINAL**	
Sites where policy or procedure applies	Direct health services provided by NCML employees including but not limited to • Northern Rivers Family Care Centre • Mid North Coast Diabetes Educator • Hastings Macleay Foot Care Nurse • Care Coordination and Supplementary Services and • Contractors providing direct health services are required to comply with this policy as specified in their contracts and • Services provided by NCML and accredited against other national quality frameworks e.g. RACGP, must consider this policy in the development of local procedures	
Target audience	Workforce providing direct health services listed above	
Description	Outlines requirements for improving consumer quality and safety through effective clinical incident management.	
Replaces Existing Policy or Procedure?	No	
Related Legislation, Australian Standards, Policy, other NCML Documents, Professional Guidelines, Codes of Practice or Ethics:	NCML Policy – Open Disclosure NCML Policy – Quality Improvement NCML Policy – Clinical Quality Improvement NCML Clinical Governance Framework NCML Risk Management Framework 2013 National Safety and Quality Health Standards, 2011	

North Coast NSW Medicare Local

CLINICAL INCIDENT MANAGEMENT POLICY

Contents

1. Policy Statement

The purpose of the North Coast NSW Medicare Local (NCML) Clinical Incident Management Policy is to ensure appropriate management of clinical incidents to increase safety to consumers and decrease the likelihood of harm to consumers by:

- identifying and treating hazards before they cause harm
- identifying when consumers are harmed and intervening promptly to minimise the harm
- taking preventative actions and sharing lessons learned.

2. Background

A basic premise of quality health care is "to do no harm" however, to err is human, and sometimes error does occur. Often a combination of specific work circumstances and work environment combine to result in unwanted outcomes. The challenge for NCML is to design systems to prevent errors occurring in the first place, and to have a healthcare system that makes it easy to do the right thing and difficult to do the wrong thing. NCML's approach to clinical incident management is of prevention and not punishment, with an emphasis on processes and systems rather than individuals. The aim is to create an environment where teamwork is both achievable and valued, and staff are comfortable to speak up if they have any concerns about safety. By addressing clinical incidents in an environment that encourages reporting, and through analysis of system vulnerabilities, NCML's health care environments will be safer for consumers.

The objectives of this policy are to:

1 Assist NCML with the timely and effective management of clinical incidents
2. Establish a standard approach to clinical incidents management
3. Ensure that NCML workforce and management are aware of their responsibilities and are skilled to manage clinical incidents
4. Incident data is aggregated and trended to assess frequency and severity and patterns of incidents
5. Clinical practices are changed as a consequence of incident analysis.

3. Principles and Definitions

3.1 Principles

This policy is underpinned by the safety dimension of quality.

Safety - a major objective of any health care service should be the safe progress of consumers through all parts of the system. Harm from care, by omission or commission, as well as the environment where it is carried out, must be avoided and risk minimised in care delivery processes.

Just Culture - NCML is committed to supporting a just culture approach to incident investigation that fosters a systems approach, consumer centred care, continuous improvement and innovation in delivery of clinical care. Apportioning blame may disguise the real understanding or root cause of the incident that must be addressed if a reoccurrence of the incident is to be prevented.

Prioritisation of Actions - actions to assist in the investigation of incidents are prioritorised by NCML in order to facilitate timely and effective review especially of major or catastrophic incidents.

Transparency - full and open communication shall occur as part of clinical incident management. As appropriate, consumers, staff and visitors notifying clinical incidents should receive feedback on results of any investigation and preventative actions carried out.

3.2 Definitions

Apology	A key aspect of open disclosure is saying sorry or offering an apology to the client and their family/carer following an incident. An apology is an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter.
Clinician	A health practitioner or health service provider regardless of whether the person is registered under a health registration act.
Clinical Incident	Any unplanned event resulting in, or with the potential for, injury, damage or other loss. An "**Adverse event"** is an unintended consumer injury or complication from treatment that results in disability, or death and is caused by health care management. This term is not used in the policy as the more generic term "incident" is used.
Incident Investigation	The management process by which underlying causes of undesirable events are uncovered and steps are taken to prevent similar occurrences**.**
Incident Management	A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident.
Incident type	The core issues of the incident such as a fall or communication error. There can be more than one incident type associated with each reported incident.
Near miss	Any event that could have had adverse consequences but did not, such as: • Arrested or interrupted sequence: the incident was intercepted before causing harm e.g. incorrect treatment planned but not administered • Hazardous event or circumstance: the incident involved a dangerous state or the possibility of harm occurring e.g. torn floor coverings but no incident.
Notifier	Any workforce member of NCML who reports an incident or near miss. Consumers may notify an incident via the complaints process.
Notification	The process of documenting information about an incident or near miss for any incidents on the NCML Form – Clinical Incident Report.
Open Disclosure	The process of communicating with a consumer and their support person about a patient related incident.
Severity Assessment Rating	A numerical score applied to an incident based on the type of event, its likelihood of recurrence and its consequence. The NCML Risk Rating matrix is used to rate the severity of the actual and/or potential incident.

4. Scope

This policy applies to direct health services provided by NCML workforce, including but not limited to:

- Northern Rivers Family Care Centre
- MNC Diabetes Educator
- HM Foot Care Nurse
- NCML CCSS.

Contractors providing direct health services are required to comply with this policy as specified in their contracts.

Services provided by NCML and accredited against other national quality frameworks e.g. RACPG, must consider this policy in the development of local procedures.

5. Roles and Responsibilities

Chief Executive

- Approves the policy
- Ensures services are of a high quality and predicated on a culture of continuous leadership and improvement
- Ensures any extreme or high rated incidents are reported to the Board in line with the NCML Risk Management Framework
- Provides oversight for organisational performance, introducing corrective action when departures or deficits to standards/legislation are identified

Executive Team

- Provide leadership to staff working in direct health services regarding policy implementation
- Ensure organisational performance by introducing corrective action when departures or deficits to standards are identified
- Report on and recommend changes to practice/policy/process/education as a consequence of clinical incident management
- Escalate any extreme or high rated incidents to the Chief Executive in line with the NCML Risk Management Framework
- Convene an incident investigation team for clinical incidents rated as extreme or high

Manager, Quality and Clinical Governance

- Provides oversight of the clinical incident system and maintains tools to support policy implementation
- Collates incident data reports for the NCML Quality Committee.
- Oversees policy change and education as a result of incident analysis

Program Managers

- Provide leadership to staff working in direct health services regarding policy implementation
- Ensure activities relating to the policy are implemented, reported and adhered to
- Provides oversight of clinical practice change as a consequence of incident analysis

Workforce members

- Demonstrate NCML values of honesty and transparency and participate in a continuous improvement culture
- Ensure activities relating to the policy are implemented, reported and adhered to
- Notify all incidents using the NCML Form - Clinical Incident Report
- Participate in the implementation of recommendations arising from investigation of incidents
- Encourage and support colleagues to report incidents.

6. Process

6.1 Identification

A clinical incident is any unplanned event resulting in, or with the potential for, injury, damage or other loss to a consumer. A clinical incident may be identified by a consumer, visitor, or any NCML workforce member. It is important for all staff to recognise when an incident has occurred or almost occurred (a near miss).

Clinical Incident types – are defined by the core issues of the incident, e.g. fall or a communication error. There can be more than one incident type associated with each reported incident. Incident types may include:

- slip
- fall
- incorrect identification of consumer
- human behaviour e.g. communication, staff manner
- failing of an organisational system or process
- environmental
- skills, competency
- equipment
- needle stick injury
- mucous membrane exposure to blood or bodily fluids
- other adverse consumer outcomes.

When a clinical incident is identified, immediate action should be taken to reduce risk to the consumer. Actions may include:

- Providing immediate care to the consumer involved in the incident
- Making the surroundings safe to prevent immediate recurrence of the incident
- Removing malfunctioning equipment or supplies
- Gathering essential information about the chain of events

- Notifying a medical officer or ringing an ambulance if a person suffers any harm or injury as a result of a clinical incident.

6.2 Notification of Clinical Incidents

All NCML workforce can identify that a clinical incident has occurred. Consumers or visitors to NCML can also notify clinical incidents using the NCML Complaint Management Policy.

Clinical incidents assessed as extreme or high (refer to 6.3, Assessment of Severity) must be notified immediately to the relevant Program and/or Branch Manager and documentation completed by the end of the notifier's workday.

6.2.1 How to Notify?

All NCML workforce are required to notify all identified incidents and near misses using the NCML Clinical Incident Report Form (see Appendix 1) and inform the Branch/Program Manager. Notifications can be made electronically (via Intranet form) or can be recorded on a hard copy form and submitted to the manager. Notifiers are asked to provide as much factual/objective information as possible to assist with:

- Further review and management of incident
- Accurate classification of the clinical incident
- Documentation of the clinically relevant aspects of the incident in the consumer's health record.

Classification of the incident is the process of capturing relevant information from a range of perspectives about the incident to ensure the complete nature of the incident, including causative and contributory factors, is documented and understood.

The notifier must record relevant aspects of the incident in the Branch Clinical Incident Register (see Appendix 2), located at General/Quality/Clinical Incident Register and inform their manager that this has been completed. Information recorded in the register must have consumer and workforce information de-identified

The relevant Program Manager/Branch Manager is responsible for ensuring the incident has been entered into the register with consumer and workforce information de-identified. The relevant Program Manager/Branch Manager is responsible for establishing a system at Branch level for filing and storing completed incident report forms securely.

6.3 Assessment of Severity and Prioritisation of Action

The purpose of assessment of severity of the clinical incident is to ensure that a standardised, objective measure of severity is allocated to each incident or near miss and appropriate level of action taken. Assessment of severity also enables an appropriate level of investigation to be conducted. The NCML Risk Rating Matrix must be used to assess the severity of all notifications on two parameters 1. its likelihood of recurrence and 2. its consequence ranking which is recorded on the NCML Clinical Incident Report Form by the notifier. The risk rating matrix classifies all incidents into four categories based on the ratings of risk likelihood and consequence ranking:

- Extreme – Immediate action required by Executive, notify Chief Executive and continue to monitor
- High – Action to be taken in less than a month, escalate to management and monitor
- Medium – Action to be taken within three months, notify manager and monitor
- Minor – Manage by routine procedures

The relevant Program Manager/Branch Manager is responsible for ensuring the incident has been rated appropriately by the notifier and recorded in the NCML Clinical Incident Register.

6.4 Investigation

Investigation of the incident is an important component of any consumer safety program. All extreme and high rated incidents need to be investigated by a review team which will be nominated by either the Chief Executive, Executive or Branch General Manager/delegate. The Manager Quality and Clinical Governance will provide support to each investigation. Investigation teams will utilise the Root Cause Analysis and Reportable Incident Brief processes and tools detailed in the NSW Health Incident Management Policy available at http://www0.health.nsw.gov.au/policies/pd/2007/PD2007_061.html

A suitable timeframe for implementation of the investigation is to be documented. The Executive Team is responsible for deciding whether recommendations are accepted and approved, and appropriate resource allocation where relevant.

Incidents rated as minor or medium must be reviewed by the relevant manager and outcomes of the review process recorded in the NCML Clinical Incident Register.

6.5 Analysis and Action

The purpose of analysis is to understand how and why the incident occurred, and to identify ways of preventing recurrence. The analysis should take into account all information gathered during the investigation and analysis phases. Actions and recommendations are developed to prevent recurrence of the incident. Recommendations are to be recorded in the Branch's Quality Improvement Plan (refer to NCML Clinical Quality Improvement Policy).

Ongoing monitoring is required to ensure recommendations are addressed in a timely manner and to evaluate the success of any action taken to achieve improvement.

The relevant Program Manager/Branch Manager is responsible for ensuring the incident outcomes have been documented and recorded in the NCML Clinical Incident Register.

6.6 Feedback following investigation

Feedback is an important component of an effective incident management system.

6.6.1 Feedback to consumers and/or support person (Open Disclosure)

Information about clinical incidents should be offered to consumers and/or their support people. Information can be based on a variety of sources including preventative actions and investigation recommendations. Refer to the NCML Open Disclosure Policy for more information.

6.6.2 Feedback to staff

The success of incident management is dependent on feedback to all staff on the results/outcomes of incident review and investigation in a timely manner. Staff involved in the incident need to be informed of recommendations arising from any investigation. Regular reports on trended aggregated data and outcomes of clinical incident investigations are to be provided to clinical and management teams. Feedback needs to include the changes made and improvements achieved as a result of these changes.

The relevant Program Manager/Branch Manager is responsible for ensuring feedback has been provided to consumers and/or staff and recording this in the NCML Clinical Incident Register and reported at the NCML Quality Committee.

7. Equity

This policy requires NCML to continuously improve in ways that promote equitable access and prevent discrimination on the basis of age, gender, sexual orientation, disability, culture, ethnicity or religion. There will be occasions when additional support and time needs to be given to consumers involved in an incident. Those with special needs, the aged, people from different cultures and people with a disability may require additional support.

8. Supporting documentation

NCML Policy - Open Disclosure

NCML Policy – Quality Improvement

NCML Policy – Clinical Quality Improvement

NCML Clinical Governance Framework

NCML Risk Management Framework 2013

NSW Health Incident Management Policy at
http://www0.health.nsw.gov.au/policies/pd/2007/PD2007_061.html

9. Employee Acknowledgement

All workforce are required to complete the Employee Acknowledgement form (see Appendix 3) and provide a signed copy to their manager who is responsible for filing this form on the employee's personal file.

10. Appendices

Appendix 1 – NCML Clinical Incident Report Form (use form on the Intranet)

Appendix 2 – NCML Clinical Incident Register – excerpt – please use the register for your branch at General/Quality/Clinical Incident Register

Appendix 3 – NCML Employee Acknowledgement Form

Appendix 1 - NCML Clinical Incident Report Form (use form on the Intranet)

Clinical Incident Report Form

Clinical Incident Report Form			
Date of incident:	____ / ____ / ____	**Time of incident**	_____ am/pm
Location: (Include address, where applicable.)			
Name of person completing form:			
Position of person completing form:		**Contact number:**	
Employees or contractors involved in incident:			
Name:		**Contact number:**	
1.			
2.			
3.			
4.			
Consumers or community members involved in incident:			
Name:		**Contact number:**	
1.			
2.			
3.			
4.			
Description of incident and background: (Include all relevant circumstances and information leading up to the incident, whether the incident was witnessed, contributing factors, and any other relevant issues.)			
_____ _____			

Clinical Incident Report Form	
_____	
_____	
Incident Rating (use NCML Risk Rating Tools to assess incident)	
1. Consequence ranking - 1, 2, 3, 4, 5	2. Likelihood ranking – 1, 2, 3, 4 ,5
3. Risk Rating – **Low**, **Medium**, **High**, **Extreme**	4. Action required per the incident rating:
Extreme – Immediate action required by the Executive, notify CE and monitor	**High** – Action to be taken in less than one month, escalate to management, monitor
Medium – actions to be taken within 3 months, monitor	**Low** – manage by routine procedures, monitor
Who else was informed of the incident? **(For example, General Manager, Program Manager, police, fire brigade, family members)**	
1.	2.
3.	4.
Actions taken to date: (Including date and time of contact, contact number, and other contact numbers of agencies or people who were informed, as well details of support provided.)	
1.	
2.	
3.	
Follow up actions planned:	
1. Enter clinical incident in Branch Clinical Incident Register, review at Branch Quality Meeting	
2. Notify Manager, Quality and Clinical Governance about High and Extreme Clinical Incidents	
3.	
Clinical Incident Report Form authorised by:	
_____ (Signature of employee)	Date: ____ / ____ / ____
_____ (Signature of manager)	Date: ____ / ____ / ____

Appendix 2 – NCML Clinical Incident Register – EXCERPT – refer to your branch register on General drive

NORTH COAST NSW MEDICARE CLINICAL INCIDENT REGISTER															
BRANCH NAME:									**YEAR:**	**2013/2014**					
Incident Number	**Date of Incident**	**Incident Reported By**	**Location of Incident**	**Incident Type**	**Incident Description**	**Risk Category (primary)**	**Likelihood**	**Consequences**	**Current Risk rating**	**Incident Owner**	**Action Date**	**Actions taken**	**Review Date**	**Feedback to Consumer and/or Staff**	**Outcome**	**Date completed**
						Clinical Care & Safety	3	3	Medium							
						Clinical Care & Safety	3	4	High 19							
						Clinical Care & Safety	4	4	High							
						Clinical Care & Safety	4	4	High							
						Clinical Care & Safety	4	4	High							
						Clinical Care & Safety	4	4	High							

Appendix 3 – Employee Acknowledgement

Employee Acknowledgement

I acknowledge:

On receipt of this Policy or Procedure:

- I will comply with the policy or procedure
- I understand if I fail to comply with this policy or procedure there may be disciplinary consequences which may result in the termination of my employment.

Name: _____

Signed: _____

Date: _____