AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Incident Management - Policy

Document Type	Policy
Function	Clinical Administration, Management and Governance
Directorate(s)	All Auckland District Health Board (Auckland DHB) directorates
Department(s) affected	All Auckland DHB departments & services
Patients affected (if applicable)	All Auckland DHB patients
Staff members affected	All Auckland DHB staff members
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1. Purpose of policy

The purpose of this policy is to outline the requirements for reporting, investigating and managing the outcomes of incidents involving consumers, workers, contractors or visitors that occur within all Auckland District Health Board (Auckland DHB) workplaces (including buildings, grounds, vehicles and other locations where Auckland DHB workers undertake their duties).

The primary goal of the incident reporting and management systems is to assist Auckland DHB to effectively manage the incident reporting and investigation process including serious sentinel events and serious harm i.e, by ensuring incident management follows a structured process.

Objectives

1. To ensure that the appropriate process is undertaken for the investigation of all incidents, near misses and adverse events.
2. To ensure that there is immediate management of an incident when required and that every incident is appropriately prioritised, investigated and managed.
3. To ensure transparency of approach that places the consumer, visitor and worker central to the response. This includes the process of open discussion and on-going communication with the consumer, visitor, worker and their support person(s).
4. To create a "just culture" where it is safe to report incidents and where a systems approach to incidents and investigation are used.
5. To identify opportunities to improve the quality and experience of care through ensuring the Incident system is a planned and co-ordinated process that links to the quality and risk management system.
6. To minimise risk and prevent future incidents through development of appropriate action plans, recommendations and reviews.
7. To meet statutory and/or regulatory requirements through informing workers of their responsibilities in relation to essential notification reporting and ensuring the correct authority is notified in an accurate and timely manner by the organisation.
8. To ensure integration of feedback, complaints, consumer and worker feedback, credentialed specialists and allied health personnel feedback where appropriate*.

[1]**Note:** This policy must be read in conjunction with the * Health and Safety Policy and Open Disclosure following an Adverse Event (see associated Auckland DHB documents).

[2]**Note:** There is *one procedure associated with this policy i.e. for all Occupational Health and Safety (OHSS) incidents refer to the Occupational Health & Safety (OH&S) Occurrence Policy (see associated Auckland DHB documents).

2. Definitions/Descriptions

Adverse event	An incident that has resulted in an unanticipated death or loss of function not related to the natural course of a consumer's illness or condition
Consumer	A person receiving care/treatment from Auckland DHB
Harm	Illness and/or injury, physical and/or mental harm
Hazard	Anything with the potential to cause harm or loss to any person, property or environment
Incident	An unplanned event that results in or has potential to result in injury, or loss. This applies to clinical and non-clinical events
Incident management	A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident and acting to prevent recurrence
Incident with harm	An unplanned event that results in injury, or loss. This applies to clinical and non-clinical events
Incident with no harm	An unplanned event that reaches the patient, employee or organisation without any injury, or loss but has the potential to result in injury, or loss
Just Culture	Staff should feel safe and supported when reporting incidents of patient harm in the knowledge that investigations seek to identify system issues and not apportion individual blame
Near miss/close call	An unplanned event with the potential to result in injury, or loss but was timely stopped before it reached the patient, employee or organisation
Notifiable event	Any events that arise from work that results in the death of a person, a notifiable injury/illness or a notifiable incident
Risk	The possibility (likelihood) of suffering harm or loss from a hazard
System failure	A fault, breakdown or dysfunction within process(es) or infrastructure
Worker	Any person who carries out work in any capacity for Auckland DHB (fulltime, part-time, casual and temporary), including associated personnel (contractors, students, visiting health professional etc.) working in, or contracted to provide a service on any Auckland DHB site
Workplace	Any place where work is carried out for or on behalf of Auckland DHB whilst a person is deemed at work

3. Scope of use

This policy applies to any incident resulting in harm, loss or damage, to any person, property or environment, including near miss events occurring in any Auckland DHB-controlled site or location deemed to be an Auckland DHB 'Place of Work'.

This policy is applicable to:

1. Any consumer or visitor within Auckland DHB places of work.
2. All Auckland DHB workers (full-time, part-time, casual and temporary), and associated personnel (including contractors, students, visiting health professional etc.) working in, or contracted to provide a service on any Auckland DHB site.

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3. Any person undertaking work activity on an Auckland DHB controlled site, eg sales representative, stall holder.

4. Policy

Incident management is a continuous process with many components. It is not simply about reporting incidents. The process involves 10 key steps - see the flow diagram in appendix for details on the Incident Management Framework.

5. Incident reporting

All Auckland DHB workers described within the scope above or their representative (where applicable) and where physical injury is involved, have a professional, moral and legal responsibility to report any incident. This includes clinical, corporate and environmental incidents involving or affecting (or where there is potential to affect) consumers, visitors, workers and contractors.

1. Incidents should be reported promptly and accurately as soon as practicable, preferably on the same working day.
2. The primary mode of reporting consumer, workers and visitor incidents is through the *electronic organisational incident reporting system.
3. There is also a responsibility to notify relevant managers and/or senior clinical workers where appropriate.

6. Notifiable events

Where a Notifiable Event has occurred, there are legal and contractual responsibilities to report incidents to external parties. A Notifiable event includes a Notifiable Injury or Incident (see Definitions/descriptions). Any notifiable event must be reported immediately to the *OHSS or Clinical Nurse Manager (after hours). Auckland DHB will endeavour to report all such events to the respective regulatory body in accordance with legislative requirements.

7. Incidents involving consumers

All consumer incidents resulting in serious injury or death (includes notifiable injury) as a result of clinical care processes or non-clinical care processes (All SAC scores) are to be notified to the Adverse Events Review Committee (AERC) (see Incident Management Guideline in associated Auckland DHB documents)*.

Any consumer incidents (all SAC codes) involving non-clinical causes** are also to be reported to OHSS* for further follow up to ensure all involved hazards are identified and mitigated.

***** Incidents involving consumers may involve*** ***non-clinical causes*** *(for example: slipping on a wet floor, faulty equipment, unsafe environment). This is in contrast to incidents that occur due to* ***a clinical care process*** *(for example: medication error, wrong site surgery, delayed diagnosis).*

8. Incident investigation

A 'systems approach' is to be used in the investigation of all incidents; this involves determining what went wrong with the systems of work, systems of care and/or services, why the incident occurred and what corrective action is needed to mitigate the risk of recurrence. It is not intended to identify who was at fault or to assign blame.

Investigation of incidents involving consumers

Consumer incidents occurring as a result of clinical processes of care are managed at the appropriate organisational, service management and clinical levels as per the appropriate consumer incident investigation procedure.

Where harm involving a consumer has occurred as a result of a non-clinical process, OHSS will also be involved in the investigation process and must lead the investigation where appropriate in accordance with OHSS Incident investigation procedure.

Investigation of incidents involving workers

Worker incidents are investigated and followed up to resolution by the worker's manager with support from the OHSS. All workplace hazards/risks identified by the investigation are to be mitigated in accordance with Auckland DHB procedures and recorded in the Directorate/Service Hazard/Risk Register.

Any OHSS investigation will involve the manager, affected workers and a health and safety representative, as appropriate and all information regarding the findings and corrective actions required will be recorded on the electronic Incident Reporting System (IRS). Notifiable injuries or incidents must also be recorded on the Incident Reporting System.

Non notifiable incidents will be investigated by the appropriate manager and the findings, corrective action and feedback to workers will be recorded on the incident report. OHSS will review the findings and corrective action.

Investigation of incidents involving visitors and contractors

Incidents involving all visitors are followed up to resolution by the appropriate directorate/service manager with support from the OHSS and/or the contracts manager where the incident involves a contractor.

Where incidents have occurred involving contractors, the contractor and contractor's employer will also be responsible for investigating and following up the incident, this will include providing notification to Auckland DHB and to record incident in the IRS.

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9. Responsibilities

Managers are responsible to ensure workers report incidents via the appropriate process and to ensure investigations are completed in accordance with this policy.

Workers are responsible for reporting any incident or near miss incident that occurred to themselves or any service consumer in their care in accordance with the Auckland DHB Incident Management Policy and Incident Management Guideline (see associated Auckland DHB documents). Workers are expected to participate as required in any incident investigation that involves them or their consumers in their care.

10. A systems approach

Auckland DHB recognises that in a large and complex system such as healthcare, incidents and accidents will occur. When they do, the response should not be one of blame and retribution, but of learning and the need to reduce risk for future patients, visitors and staff. This policy will ensure that all incidents and accidents that occur within Auckland DHB facilities are managed in a standardised and coordinated manner, and that the implementation of recommendations from the reviews are required to develop better systems to ensure improved practices.

Incident management is a key strategy used by Auckland DHB for managing the risks of clinical care, non-clinical and corporate risks. When implemented correctly, incident management is an effective mechanism for systematically identifying problems and failures in the system of care, the workplace and Auckland DHB as a whole and, for informing the development of preventive strategies. Effective incident management includes an investigation that focuses on system failures as opposed to individual performances. It does however work in parallel with effective performance management processes.

Auckland DHB's aim is to have a *just culture* in which people feel they are and will be treated fairly. A *just culture* is characterised by learning from mistakes; openness and frankness; robust, safe systems; and management of behavioural choices. Learning requires open, honest and timely reporting of both near misses (where harm has been prevented) and actual events. Auckland DHB recognises that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts or 'routine rule violations'). No disciplinary action will result from reporting adverse events/patient safety incidents and near misses unless one or more of the following applies:

- Use of the Auckland Incident Decision Tree[1] indicates that the disciplinary process should be initiated
- The incident has resulted in a police investigation that results in a prosecution
- There are repeated incidents involving the same individual
- In the view of Auckland DHB and/or any professional body the action causing the incident did not meet acceptable practice; and could be considered to constitute serious misconduct

The disciplinary process must however be invoked where this policy has not been complied with and a serious adverse event has **not** been reported.

[1] Based on James Reason's Culpability Model and The National Health Service's Incident Decision Tree.

11. Open disclosure

Open disclosure refers to the open and timely communication/discussion of adverse events occurring as a consequence of the provision of healthcare by Auckland DHB's employees. The disclosure of adverse events to patients/clients or their families who have been affected is considered to be a central feature of high quality and safer patient care. As well, Right 6 of the Code of Consumer Rights (see Legislation) gives all consumers the right to be fully informed and to know what has happened to them.

Open disclosure involves the health care organisation acknowledging and apologising when things go wrong, reassuring patients, staff (and their carers) that the knowledge gained from such events will help prevent them from happening again, and having the appropriate processes in place to achieve this. In this regard, communication between health practitioners is also important so that there can be learning from potentially preventable adverse events. Refer to the Open Disclosure following an Adverse Event policy (see associated Auckland DHB documents) for further details.

12. Prioritisation

Prioritisation is the standardised process of assigning a risk assessment score to every incident. The score, known as the Severity Assessment Code (SAC) and it is based on the outcome or consequence of the event and the likelihood of its recurrence and determines the appropriate level of investigation and action (see details in the Incident Management Guideline in associated Auckland DHB documents).

13. Policy success indicators

- 90 % of SAC 3 and 4 incident investigations are completed and the information about the investigation is sent to Quality & Patient Safety within 30 working days (six weeks) of incident notification
- 90% of the notifications of SAC 1 and 2 events to the Health & Quality Safety Commission (HQSC) (Part A and Part B Reportable Event Briefs) meet required time frames (See Incident Management Guideline in associated Auckland DHB documents)
- 95% of notifications to WorkSafe New Zealand meet required time frames

Outcomes

- Declining trend in serious patient harm
- Declining trend in staff lost time injury rate
- 80% of recommendations arising from serious and sentinel event reviews are implemented within the agreed time frames

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14. Legislation

- Health and Safety at Work Act 2015
- Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996
- Health and Disability Sector Standards (2008)
- Health and Disability Services (Safety) Act 2001
- Mental Health (Compulsory Assessment and Treatment) Act 1992

15. Associated Auckland DHB documents

- Blood & Body Fluid Accidents
- Consumer Complaint Management
- Health and Safety
- Incident Management Guideline
- Occupational Health & Safety (OH&S) Occurrence
- Open Disclosure following an Adverse Event

16. Disclaimer

No policy can cover all the variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB policy to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this policy.

This policy will align with the Health Quality & Safety Commission (HQSC) National Reportable Events Policy therefore this policy will be updated as and when HQSC update their National Reportable Events Policy.

17. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Clinical Policy Facilitator without delay.

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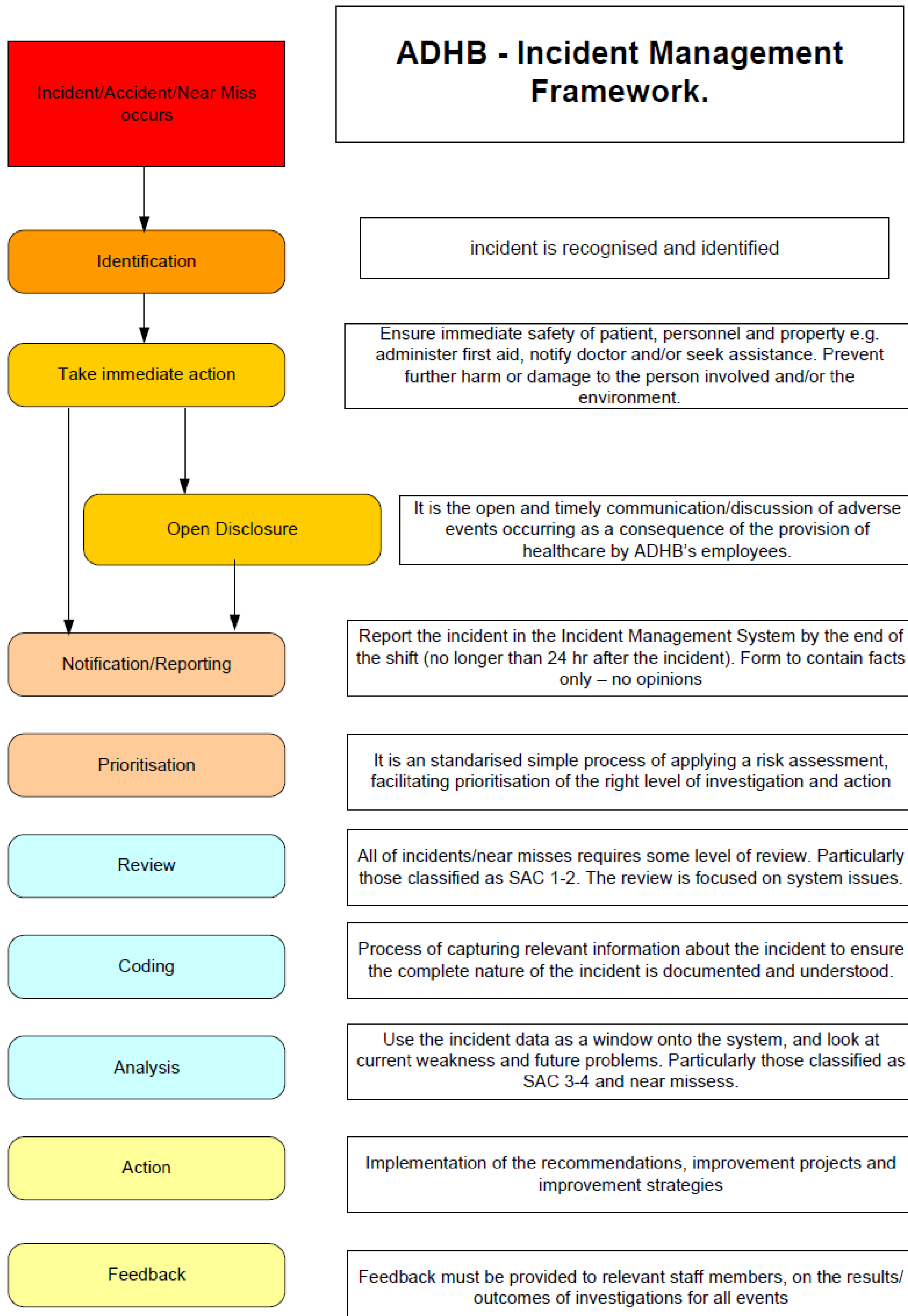
18. Appendix

Incident Management Framework



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