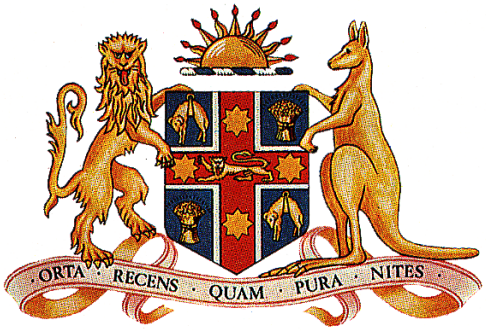

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Incident Management Policy

Summary Provides direction for a consistent approach to managing and investigating clinical and corporate incidents and ensures processes comply with the requirements of the Health Administration Act 1982.

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Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, NSW Health Pathology, Public Health System Support Division, Cancer Institute, Community Health Centres, NSW Ambulance Service, Public Hospitals

Distributed to Ministry of Health, Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Private Hospitals and Day Procedure Centres

Audience All Staff of NSW Health;Managers and Contractors

Secretary, NSW Health

POLICY STATEMENT

INCIDENT MANAGEMENT POLICY

PURPOSE

The purpose of this Policy is to provide direction to health services regarding the management of clinical and corporate incidents, including appropriate feedback to patients, families/support persons and clinicians and the sharing of lessons learned to prevent patient harm, and a statewide system for managing clinical and corporate incidents to ensure health practitioners, managers and staff respond effectively to them.

MANDATORY REQUIREMENTS

NSW Health entities are to manage incidents based on the following principles:

Openness about failures – incidents are reported and acknowledged without fear of inappropriate blame. Patients and their families/support persons are offered an apology and told what went wrong and why
Emphasis on learning – the system is oriented towards learning from mistakes and consistently employs improvement methods for achieving this
Obligation to act – the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit
Accountability – the limits of individual accountability are clear, individuals understand when they may be held accountable for their actions
Just culture – individuals are treated fairly
Appropriate prioritisation of action – action to address problems is prioritised and resources directed to the areas where the greatest improvements are possible
Cooperation, collaboration and communication –teamwork is recognised as the best defence of system failures and is explicitly encouraged and fostered within a culture of trust and mutual respect.

IMPLEMENTATION

All Staff are responsible for:

- Notifying incidents in the incident management system (IIMS and ims+)
- Commencing and/or participating in the open disclosure process as appropriate
- Participating in the investigation of incidents as required
- Participating in implementation of recommendations from incident investigation
- Encouraging colleagues to notify incidents that have been identified.

Local Health Districts and Special Health Networks are responsible for

- Ensuring staff are trained in incident management (including the incident management system) and able to investigate incidents and action recommendations
- Ensuring an effective incident management system is in place for investigating and actioning recommendations for all incidents
- Ensuring timely notification of incidents to the Minister's Office, Secretary, Deputy Secretaries and Patient Experience and System Performance Division, MoH via a Reportable Incident Brief (RIB) as required and notifying by telephone if urgent attention is required

- Ensuring there is timely notification to NSW Treasury Managed Fund (TMF) of all incidents that have the potential to become claims
- Ensuring the monitoring and rating of all risks identified from incident investigation and analysis as per the Risk Management - Enterprise-Wide Risk Management Policy and Framework (PD2015_043)
- Reporting all Severity Assessment Code (SAC) 1 incidents (IIMS) and Harm Score 1 incidents (ims+) to the MoH within 24 hours or the next business day
- Ensuring processes are in place to manage clinical RIBs as per this Policy to protect statutory privilege under *Section 23 of the Health Administration Act 1982*
- Conducting privileged Root Cause Analysis (RCA) on clinical SAC 1 incidents and Harm Score 1 incidents, and other incidents when appropriate, as per *Part 2, Division 6C of the Health Administration Act 1982*
- Conducting a detailed investigation of all corporate SAC 1 (IIMS) and Harm Score 1 (ims+) incidents
- Where a privileged RCA has been conducted, providing RCA reports to the MoH within 70 calendar days of the incident notification in the incident management system
- Providing a report on key findings from corporate SAC 1 (IIMS) and Harm Score 1 (ims+) investigations to the MoH within 70 calendar days
- Ensuring appropriate incident management and preventing recurrence of incidents
- Reporting trended incident data and outcomes of RCAs and Corporate SAC 1 (IIMS) and Harm Score 1 (ims+) investigations to relevant groups within health services
- Ensuring resources for effective incident management and patient safety initiatives
- Implementing policies and local practices to support staff and fostering incident notification and active management of incidents
- Contributing to statewide improvements as required.

Clinical Excellence Commission (CEC) is responsible for

- Reviewing clinical incidents and investigation reports
- Providing advice to the system in response to specific queries about clinical incident management, and in response to analysis of clinical incidents
- Providing advice and regular reports to the MoH on clinical quality, patient safety issues and trends and lessons learned from the clinical incident management process
- Disseminating lessons learned from clinical incident management
- Providing advice to the MoH on strategies to minimise statewide clinical system errors
- Developing policies and strategies about patient safety and health care quality
- Identifying education needs emerging from clinical incident management

NSW Ministry of Health (MoH) is responsible for

- Ensuring health services have systems in place to report, investigate and implement actions to prevent incidents, protect patient safety and improve clinical quality
- Having systems to monitor and manage incidents reported to the MoH
- Receiving and viewing notifications about clinical and corporate SAC1 (IIMS) and Harm Score 1 (ims+) incidents
- Reviewing advice and reports provided by the CEC on analysis of trends from RCAs and issues arising from all clinical incident categories
- Providing advice to the Minister for Health on media issues or ones of public concern
- Providing an appropriate statewide response to new risks as they are identified.

REVISION HISTORY

Version	Approved by	Amendment notes
June-2020 (PD2020_020)	NSW Health, Secretary	This amended policy includes reference to the ims+ incident management system which is being gradually introduced into local health districts and specialty networks from October 2019 onwards. For entities that have transitioned to ims+, the ims+ Harm Score will replace the IIMS SAC rating. This policy replaces PD2019_034. Following the completion of the roll out of ims+ statewide, the next iteration of the policy will remove all reference to IIM and SAC rating.
July 2019 (PD2019_034)	Deputy Secretary, Patient Experience and System Performance	This amended policy replaces the sentinel events with the version 2 sentinel events and includes definitions to support the sentinel events under "Key Definitions". This policy replaces PD2014_004.
February 2014 (PD2014_004)	Director General	This amended policy contains changes to the national sentinel event definitions and replaces PD2007_061 and PD2005_634.
July 2007 (PD2007_061)	Director General	Replaces PD2006_030.
May 2006 (PD2006_030)	Director General	Replaces PD2005_604 and PD2005_404.
November 2005 (PD2005_634)	Director General	Reportable Incident Definition under section 20L of the Health Administration.

ATTACHMENTS

1. Incident Management Policy: Procedures

Incident Management Policy

NSW GOVERNMENT

PROCEDURES

Issue date: June-2020

PD2020_020

CONTENTS

1 INTRODUCTION

1.1 Aim

The aim of the Incident Management Policy Directive is to

- Ensure a consistent and coordinated approach to incident management including the identification, notification, investigation and analysis of incidents resulting in appropriate action
- Allow the lessons learned to be shared across the whole health system
- Ensure Health Services establish processes that comply with the legal aspects of both clinical and corporate incident management
- Establish standard approaches to clinical and corporate incident management including performance indicators to monitor compliance.

1.2 Scope

This Policy Directive

- Applies to all incidents that occur in the health system
- Provides guidance on the difference between clinical and corporate incidents and the key elements of the different approaches required
- Is applicable to clinical and non-clinical staff
- Describes roles and responsibilities in the incident management process
- Articulates mandated reporting requirements from legal and policy perspectives
- Defines the timeframes within which incidents, and the results of the investigation of these incidents, are to be reported
- Identifies the state-level processes for incident aggregation, analysis, learning and action
- Outlines other policy and legislated incident reporting requirements.

For the purposes of this Policy, the term “Health Services” refers to Public Health Organisations including Statutory Health Corporations and Affiliated Health Organisations and the Ambulance Service of NSW.

Compliance with this Policy Directive is mandatory for all Health Service staff.

1.3 Associated Documents

This Policy Directive is to be read in conjunction with the Incident Management Policy Statement and other policies relating to incident management (see *Appendix A*)

1.4 Key Definitions

The following terms are used in this document

Actual SAC	The IIMS rating applied to each incident when it is reviewed by a manager. Further management of the incident is based on this confirmed rating. See Severity Assessment Code. See Harm Score for ims+ system.
Ambulance Service of NSW (ASNSW)	The Ambulance Service of NSW as defined in the *Health Services Act 1997*.
Apology	A key aspect of open disclosure is saying sorry or offering an apology to the patient 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.
Australian Sentinel Event (ASE)	ASEs as defined by the Australian Commission on Safety and Quality in Health Care (ACSQHC) and approved by the Health Ministers.
Australian sentinel event – discharge or release of a child to an unauthorised person[1]	A child defined as any person under the age of 15.
Australian sentinel event – discharge or release of a child to an unauthorised person[1]	Unauthorised person is defined as a person who is not a parent or legal guardian of the infant or child, or is a person who is the subject of a legal order preventing access to the infant or child.
Australian sentinel event – suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward[1]	Acute psychiatric unit or acute psychiatric ward is defined as a specialised unit or ward that is dedicated to the treatment and care of admitted patients with mental illness or mental disorder. This includes specialist psychiatric units or psychiatric wards within emergency departments. For the purposes of this sentinel event 'acute psychiatric unit' and 'acute psychiatric ward' refer to psychiatric units and wards where all three of the following criteria apply: 1. The psychiatric unit or psychiatric ward is specifically designed with fixtures and fittings that minimise the opportunity for patient suicide 2. The psychiatric unit or psychiatric ward is specifically

[1] Australian Commission on Safety and Quality in Australian Commission on Safety and Quality in Health Care. Advisory 18/09 Notification of significant risk.

	designed to prevent any unauthorised ingress or egress 3. Observation protocols are applied within the psychiatric unit or psychiatric ward.
Australian sentinel event – unintended retention of a foreign object in a patient after surgery or other invasive procedures resulting in serious harm of death[1]	Unintended incidents are where any relevant objects retained in a patient after surgery or other invasive procedure were not intentionally retained. A foreign object may be intentionally left in the patient where further action to locate and/or retrieve the object would be more damaging than retention or impossible, for example where the patient is not yet clinically stable.
Australian sentinel event – use of physical or mechanical restraint resulting in serious harm or death[1]	Restraint is defined as the restriction of an individual's freedom of movement by physical or mechanical means. Physical restraint means the bodily force that controls a person's freedom of movement. Mechanical restraint means a device that controls a person's freedom of movement.
Australian sentinel events – invasive procedure	An invasive procedure is defined as a medical procedure that enters the body, usually by cutting or puncturing the skin or by inserting a needle, tube, device or scope into the body.
Australian sentinel events - serious harm[1]	Serious harm is indicated where as a result of the incident the patient: • requires life-saving surgical or medical intervention, or • has shortened life expectancy, or • has experienced permanent or long-term physical harm, or • has experienced permanent or long-term loss of function. **Psychological harm** Psychological harm is recognised as an important harm. In the context of the sentinel events list, psychological harm has not been included in the definition of serious harm given the inability to measure psychological harm in the way that physical harm can be measured.
Classification	Capturing relevant information about an incident to ensure the complete nature of the incident, including causative and contributory factors from a range of perspectives, is documented and understood.
Clinical Excellence Commission (CEC)	A Board governed statutory health corporation established under the *Health Services Act (section 41*). It builds on the foundation work carried out by the Institute of Clinical Excellence established in 2001. Under the Act, a statutory health corporation is established to enable

	certain Health Services and support services to be provided within the State other than on an area/local health district basis.
Clinical Governance Unit (CGU)	The Clinical Governance Unit (CGU) has the role of support, performance and conformance to develop and monitor policies and procedures for improving systems of care. The CGU will contribute to the Patient Safety and Clinical Quality Program by ensuring it is uniformly implemented across the state and for overseeing the risk management of patient safety and clinical quality by building upon existing incident management and investigation.
Clinical Risk Action Group (formerly Clinical Risk Review Committee/Reportable Incident Review Committee)	The NSW Health Clinical Review Action Group (CRAG) is responsible for examining and monitoring serious clinical incidents reported to the MoH via Reportable Incident Briefs and ensuring that appropriate action is taken. The Committee analyses information reported to it on specific incidents, identifies issues relating to morbidity and mortality that may have statewide implications and provides strategic direction and advice on policy development to effect health care system improvement. The workings of this Committee are subject to special statutory privilege under section 23 of the *Health Administration Act 1982*.
Clinician	A health practitioner or Health Service provider of any profession regardless of whether the person is a registered health practitioner.
Clinician Disclosure	An informal process where the treating clinician discusses with a patient and/or their support person(s) the occurrence of a patient safety incident; actively seeks input and feedback from, and listens to, the patient and/or their support person(s); and provides and apology for the occurrence of the event.[2]
Complaint	A complaint is 1. An expression of dissatisfaction that may have one or more associated issues 2. A concern that provides feedback regarding any aspect of service that identifies issues requiring a response. A complaint may, for example be about policies, procedures, employee conduct, provision of information, quality of communication or treatment, or quality, access to or promptness of service. Complaints do not include requests for services or information or explanation of policies or procedures or industrial matters between Health Services and unions. Complaints may be made, for example, in person, by telephone, letter, survey and in some cases through the media.

2 Queensland Government, Queensland Health Clinical Incident Management Policy including Root Cause Analysis and Open Disclosure, Queensland Health, Brisbane, 2012.

Harm Score	The score applied to each incident in the ims+ system which is automatically calculated based on the outcome and treatment and/or resources required.
Hazard	A source or situation with a potential for harm in terms of human injury or ill health, damage to property, damage to the environment or a combination of these.
Health Service	Refers to Public Health Organisations including Statutory Health Corporations and Affiliated Health Organisations, and the Ambulance Service of NSW.
IIMS	The NSW Health Incident Information Management System3.
ims+	The incident management system replacing IIMS.4
Incident	Any unplanned event resulting in, or with the potential for, injury, damage or other loss. This includes a near miss.
Incident category	Grouping of incidents in the incident management system, for example clinical, staff, visitor/contractor incidents, property, security, hazard incidents and complaints.
Incident Investigation or review	The management process by which underlying causes of undesirable events are uncovered5.
Incident Management	A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident and the steps taken to prevent similar occurrences.
Incident type	The core issues of the incident such as a fall or medication error. There can be more than one type of incident associated with each recorded incident.
Local Health Districts (LHDs)	Bodies corporate constituted under section 17 Health Services Act 1997 that are principally concerned with the conduct of public hospitals and health institutions and the provision of Health Services to residents within a designated geographic area.
Minimum Dataset	The minimum amount of information to be captured for the incident notification to be considered completed in the incident management system. It refers to the datasets associated with the incident type

[3] The Incident Information Management System (IIMS) incorporates the Advanced Incident Management System (AIMS®) software application as its underlying database.

4 NSW Health organisations will be progressively transitioning from IIMS to ims+ from October 2019 onwards.

[5] Woloshnowych M, Rogers S, Taylor-Adams S, Vincent C. "The investigation and analysis of critical incidents and adverse events in healthcare". Health Technology Assessment, 2005 9 (9): viii.

	selected.
Near miss	Any event that could have had adverse consequences but did not. An arrested or interrupted sequence where the incident was intercepted before causing harm e.g. an incorrect medication added to an infusion but not administered.
Notification	The process of entering or documenting data about an incident or near miss for any of the incident categories into the incident management system.
Notifier	Any member of staff of the NSW health system who enters information into the incident management system of an incident or near miss, for any incident category. Consumers may notify an incident via the complaints process.
Open Disclosure	The process of communicating with a patient and/or their support person about a patient related incident. See also Clinician Disclosure.
Registered user	An authorised person nominated by the health district/ network/ service with registered access to the incident management system.
Reportable Incident	A reportable incident is an incident as described in Appendix E for NSW Health organisations using ims+ and Appendix D in other cases (including users of IIMS).
Reportable Incident Brief (RIB)	The method for reporting defined health care incidents to the MoH. The RIB process encompasses clinical and corporate incidents. Clinical RIBs are created for the purpose of authorised investigation and research and are privileged under the *Health Administration Act 1982*
Root Cause Analysis (RCA)	A method used to investigate and analyse incidents to identify the root causes and factors that contributed to the incident. The process yields recommended actions directed at the prevention of a similar occurrence. All clinical SAC 1 (IIMS) or Harm Score 1 (ims+) incidents are reportable requiring an RCA.
Severity Assessment Code (SAC)	A numerical score in IIMS applied to an incident based predominantly on its consequence. Its prime purpose is to direct the level of investigation required for a particular incident (see Appendix B).
Significant Patient Risk6	A significant risk is one where there is a high probability of a substantial and demonstrable adverse impact for patients if the

[6] ***Australian Commission on Safety and Quality in Health Care. Advisory 18/09 Notification of significant risk.***

	practice is to continue. In each case a significant risk will be sufficiently serious to warrant an immediate response to reduce the risks to patients. This may include interventions or changes to systems, the clinical care service environment, or clinical practice.
Specialty Health Networks	Statutory health corporations constituted under section 41 Health Services Act that are specialty network governed pursuant to section 52F *Health Services Act 1997.*
Support Person	An individual identified by the patient as a nominated recipient of the information regarding their care. This may include the patient's family members, partner, carer or friends. In cases of dispute between the patient's family members, partner or carer and /or friends about who should receive information the patient's wishes should be paramount. Where a patient is unable to give consent, the next person responsible under the *Guardianship Act 1987* should be approached.

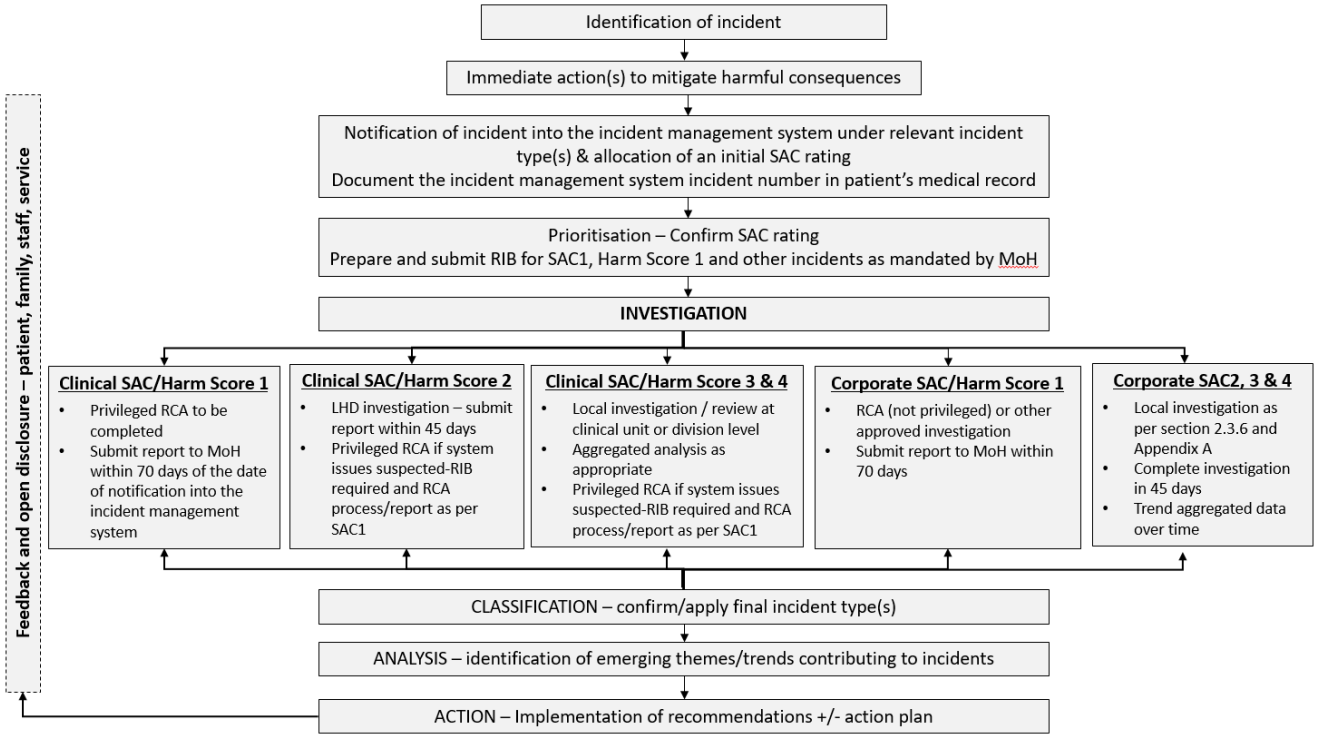
1.5 Acronyms

CE	Chief Executive
CEC	Clinical Excellence Commission
CGU	Clinical Governance Unit
CHASM	Collaborating Hospitals Audit of Surgical Mortality Committee
CRAG	Clinical Risk Action Group
DCG	Director of Clinical Governance
MoH	Ministry of Health
ID	Identification (number)
IIMS	Incident Information Management System
ims+	Incident management system replacing IIMS
LHD	Local Health District
MDS	Minimum Data Set
PD	Policy Directive
RCA	Root Cause Analysis
RIB	Reportable Incident Brief
SAC	Severity Assessment Code
SCIDUA	Special Committee for Investigating Deaths Under Anaesthesia
SHN	Specialty Health Network
GIPA	Government Information (Public Access) Act 2009
WH&S	Work Health and Safety

2 THE INCIDENT MANAGEMENT PROCESS

When an incident occurs in a Health Service a series of actions must follow. The importance of identifying these as separate steps is to ensure that all appropriate action is taken. The incident management process is represented in Diagram 1.

Diagram 1: The NSW Health Incident Management Process



2.1 Step 1 – Identification

Incidents may be identified through a number of methods. These may include: direct observation, team discussion, Coroner's reports, mortality and morbidity review meetings, death review processes, staff meeting discussions, complaints, audits and/or chart reviews.

Incidents may be identified at the time they occur or at any time after the event. Health Services need to implement processes which facilitate the identification and reporting of all incidents in a timely manner.

2.2 Step 2 – Immediate action

Timely review and response to incidents is important. It may be necessary to take immediate actions following incidents causing minor or no harm. These actions may include:

- Immediate care as needed to the patient, staff or visitor involved in the incident
- Make the situation/scene safe to prevent immediate recurrence of the incident
- Remove malfunctioning equipment or supplies, isolate and preserve them intact
- Gathering basic information from staff while the details are still fresh in the minds

2.2.1 Immediate action following serious incidents

In the event of reportable incidents or incidents potentially due to serious systemic problems, the Health Service takes immediate actions to identify, mitigate and escalate immediate risks including:

- continuing risk of harm to the patient,
- imminent risk of harm to other patients, carers, families or staff,
- potential state-wide implications (e.g. faulty equipment),
- potential notifications required, or
- potential media interest

The early information is collected which can be used to

- confirm the incident severity
- confirm or complete the RIB content
- inform the subsequent Root Cause Analysis (RCA) investigation.

Processes to ensure privilege is maintained when gathering basic early information from staff can be found in Section 4.2.3. Information will not attract privilege unless it is prepared for the dominant purpose of assisting an appointed RCA team in the conduct of its investigation.

2.3 Step 3 – Notification

Staff members are required to notify all identified clinical and corporate incidents, near misses and complaints in the incident management system.

NSW Health is transitioning from the Incident Information Management System (IIMS) to ims+ and this Policy document supports users of both systems. During this transition period, where both systems will be used, some organisations will continue to use IIMS while others will commence reporting using ims+[7]. Organisations with IIMS will use the SAC rating and SAC Matrix (see Appendix B) and organisations that have transitioned to ims+ will use the Harm Score (see below and Appendix N). HealthShare NSW and NSW Health Pathology will be working across IIMS and ims+ for a period of time, as their on-site services which support LHDs/SHNs will transition to ims+ along with the LHD/SHN.

Incident rating using the ims+ Harm Score

- Harm Score 1 – Death and Sentinel Event
- Harm Score 2 – Major harm
- Harm Score 3 – Minor harm
- Harm Score 4 – No harm or near miss

2.3.1 Documentation of the clinical incident in the health record

- All actual clinical incidents must be documented in the patient's health record.
- Only clinically relevant information is included in the health record.
- Staff must document the incident management system ID number in the health record with the information about the incident.
- If the incident has been identified via a complaint, the complaint details should not be recorded in the health record.

2.3.2 Incident notification in the incident management system – by the Notifier

All clinical and corporate incidents, once identified, need to be recorded in the incident management system. The IIMS notifier undertakes an initial assessment of severity of the incident using the SAC (see *Appendix B*). The ims+ notifier provides information known at that time and a Harm Score is automatically calculated.

Notifiers give their opinion of how the incident may have been prevented and may choose to remain anonymous or include identifying information.

Notification must:

- Occur as soon as practicable and preferably by the end of the notifier's work day
- Not include identifiable details such as staff names

[7] ims+ website: http://imsplus.health.nsw.gov.au/

There are several mandatory fields that must be entered into the system for each incident. The minimum dataset (MDS) that guides further review, management and classification for each incident is determined by the incident category.

Health Services should have in place a mechanism for patients and/or their family members or carer to report an incident. The use of the complaints management process may be appropriate in some instances, but the patient/family member or carer should be able to notify that the incident has occurred, without the need to register a complaint. In this instance it may be appropriate for a clinician or manager to record the incident in the incident management system.

If it has been necessary initially to record an incident using a paper-based system with a notification subsequently made in the incident management system, it is unnecessary to retain the paper based record once the notification is made in IIMS or ims+ so long as the notification retains all information included in the paper record. .

2.3.3 Incident notification – Management responsibility

The manager reviews the incident notification, completes the incident management screen. The manager must change the incident status from 'new' to 'investigate' within 5 days of incident notification for Actual SAC 2, 3 and 4 incidents (IIMS) and Harm Score 2, 3 and 4 incidents (ims+). The incident status of Actual SAC1 incidents (IIMS) and Harm Score 1 incidents (ims+) must be changed within 24 hours.

Managers using IIMS need to apply an actual SAC to change the incident status according to the details of the incident or near miss. Further guidance is provided in Section 4.2.

2.3.4 Notification to Patient – Open Disclosure

As early as possible after the incident, the provider should share with the patient and/or their family or carer what is known about the event and what actions have been taken to immediately mitigate or remediate the harm to the patient. An expression of apology or regret can be extended at that time.

Refer to NSW Health policy and guidelines on open disclosure for further guidance (see *Appendix A*).

2.3.5 Notification to NSW Treasury Managed Fund (TMF)

Incidents with the potential for a medico legal claim must be reported to the TMF as soon as possible.

2.3.6 Notifications for Corporate Incidents

The following policies outlining notification responsibilities may be relevant depending on the nature of the corporate incident (the list is not exhaustive and further relevant policies are listed in Section 6.1.2):

- Work Health and Safety: Better Practice Procedures PD2018_013 – notifications to SafeWork NSW

- Significant Legal Matters and Management of Legal Services PD2017_003 - notification to the General Counsel, MoH
- Corrupt Conduct - Reporting to the Independent Commission Against Corruption (ICAC) PD2016_029 - notification to ICAC
- Public Interest Disclosures PD2016_027 - may involve notification to ICAC or NSW Police
- Child Related Allegations, Charges and Convictions against NSW Health Staff PD2016_025 – notification to NSW Ombudsman, Police, Family and Community Services
- Managing Misconduct PD2018_031 - notification to NSW Police.

2.4 Step 4 – Prioritisation

The purpose of prioritisation by the manager is to determine the level of investigation and action required for an incident or near miss and guides determines the need for additional notification. The Chief Executive of the organisation must be advised of all clinical and corporate SAC 1 (IIMS) and Harm Score 1 (ims⁺) incidents via a RIB.

ims⁺ will automatically generate a Harm Score in the management screen based on a manager's responses to mandatory questions about outcome and additional care and/or resources required. This is the agreed method for determining the incident rating and reporting requirements. Changing the ims⁺ Harm Score is not recommended.

In IIMS, managers prioritise incident notifications by using the NSW Health SAC Matrix to apply an Actual SAC (see Appendix B). The key consideration for managers is the degree of harm as predicting the likelihood of recurrence can be unreliable. In some situations it has led to inappropriate downgrading of incidents and inadequate analysis and management. Caution is therefore recommended when applying the "frequency" component.

2.4.1 Severity Assessment Code Scoring Steps in IIMS

A SAC is to be applied to all incidents in IIMS. Details about the SAC process can be found at *Appendix B*. There are two steps required:

Step 1: Determine the consequence or outcome of the incident by assessing the actual outcome of the incident based on the definitions provided in the consequence table. The matrix also provides for the calculation of likelihood of recurrence. This can be difficult to assess, and adds little value in the context of deciding the level of investigation for an incident that has already occurred.

Step 2: Implement appropriate action

Each incident is assessed for the actual consequence and the potential consequence. The potential consequence is the worst-case scenario for the incident being assessed. There is a great deal of benefit in investigating near miss incidents especially if the potential consequence of the near miss could have been a SAC 1 or SAC 2 incident.

Wherever possible, and as early as practicable, the patient and/or the family/carer and other relevant persons should be given the opportunity to provide information (verbal or written), as part of the investigation process.

2.4.2 Immediate review following a serious incident

The collection of evidence and basic facts about the incident should commence at the earliest possible time, preferably when the incident is first recognised. For clinical SAC 1 (IIMS) or Harm Score 1 (ims+) incidents, direction is provided at 4.2.3 about the process for appointing core personnel of the RCA team, as soon as possible after the event so that statutory privilege under the *Health Administration Act 1997* attaches to the information obtained.

2.5 Step 5 – Investigation

All notified incidents require review at an appropriate level. The SAC (IIMS) or Harm Score (ims+) applied in the manager prioritisation stage guides the level of investigation. If additional input is needed for accurate prioritisation, steps should be taken to address this immediately so that legislated requirements can be met without delay. It may be necessary to make a "judgement call" based on the best evidence available, where the gathering of further evidence will amount to an unacceptable delay.

All Health Services should:

- assign appropriate levels of responsibility for investigation and action on all incidents
- have procedures in place for the investigation of incidents
- provide access to training programs for the investigation of incidents
- have appropriately trained staff to support staff involved in investigations
- assign appropriate levels of resourcing to enable effective investigations to be undertaken
- ensure that Clinical Governance and/or Corporate Governance (or equivalent) provides appropriate oversight of the quality of investigation processes and outcomes

2.5.1 Levels of Investigation

As a general guideline, the following levels of investigation are considered appropriate.

Clinical Incidents

Clinical SAC 1 incidents (IIMS) and Clinical Harm Score 1 incidents (ims+)

- All clinical SAC 1 and Harm Score 1 incidents require a privileged RCA investigation. This is a legislative requirement of the *Health Administration Act 1982* and Regulations. See section 4 of this policy for detailed information about the requirements for a privileged RCA investigation of clinical SAC 1 and Harm Score 1 incidents. The methodology taught and promoted by the Clinical Excellence Commission should not be deviated from without prior agreement with that

organisation. This is to ensure that important considerations of investigation such as privilege and fairness are adhered to.

- All clinical SAC1 and Harm Score 1 incidents must have the final RCA report completed and submitted to the MoH within 70 calendar days from the notification of the incident in the incident management system.

Clinical SAC 2 Incidents (IIMS) and Clinical Harm Score 2 incidents (ims+)

The following are the key components of management of clinical SAC 2 and Harm Score 2 incidents.

- Senior management is to be notified and management responsibility must be specified.
- An investigation is to be undertaken. This may be in the form of an RCA or any other investigation methodology which enables drilling down to the causative or contributory factors of the event. Each organisation is to have policies and procedures in place for the investigation of incidents and training programs in place for staff to investigate incidents.
- It should be noted that under the legislation a privileged RCA may be conducted for SAC 2, 3 or 4 incidents (IIMS) or Harm Score 2, 3 or 4 incidents (ims+), if the Chief Executive is of the opinion that the incident may be the result of a serious systemic problem that justifies the appointment of an RCA team. The commissioning of the RCA must be in accordance with this Policy, as outlined at 4.2, to attract the statutory privilege. The RCA Report must be submitted to the MoH within the 70 day timeframe.
- If there is disagreement in relation to the type of investigation to be undertaken on a clinical SAC 2 or Harm Score 2 incident, the Director of Clinical Governance (DCG) is to make the final determination. Ongoing monitoring and analysis by the organisation of aggregated incident data must occur.
- Organisational level improvement activities are to be developed and implemented.
- Investigation should be completed, where possible, within 45 days of being notified in the incident management system or a progress report outlining the management plan with a revised completion date should be submitted to the appropriate senior manager.
- Where available, State-wide or LHD tools and templates should be utilised for SAC 2 and Harm Score 2 investigation reports.

Clinical SAC 3 & 4 Incidents (IIMS) and Clinical Harm Score 3 & 4 incidents (ims+)

- All SAC 3 and 4 incidents (IIMS) and Harm Score 3 and 4 incidents (ims+) need to be reviewed. Such reviews will be undertaken at the local level, but management responsibility for the review process must be assigned.
- It may be considered appropriate to aggregate a number of similar SAC 3 or 4 incidents (IIMS) or Harm Score 3 or 4 incidents (ims+) and to perform a review of the aggregated incidents

- As well as investigation or review at the local level, monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
- Investigation should be completed, where possible, within 45 days of being notified in the incident management system or a progress report outlining the management plan with a revised completion date should be submitted to the appropriate senior manager.
- As with SAC 2 (IIMS) and Harm Score 2 (ims+) incidents, a privileged RCA may be conducted for clinical SAC 3 and 4 incidents (IIMS) and clinical Harm Score 3 and 4 incidents (ims+) in the circumstances where the Chief Executive considers the incident may be the result of a serious systemic problem. In these circumstances the RCA report must be submitted to the MoH within the required timeframe of 70 days.

Corporate Incidents

Corporate SAC 1 Incidents (IIMS) and Corporate Harm Score 1 incidents (ims+)

- Investigations of SAC 1 (IIMS) and Harm Score 1 (ims+) corporate incidents will be determined by the nature of the incident. They may be in the form of an RCA or any other investigation methodology which involves ascertaining the causative or contributory factors of the event. Relevant MoH and Health Service policy documents should inform the level and nature of the investigation (Appendix A).
- All Corporate SAC 1 (IIMS) and Harm Score 1 (ims+) incidents must have a detailed investigation completed and a report submitted to the MoH within 70 days from the notification of the incident in the incident management system.

Corporate SAC 2, 3 and 4 Incidents (IIMS) and Corporate Harm Score 2, 3 and 4 incidents (ims+)

- All corporate SAC 2, 3 and 4 incidents (IIMS) and corporate 2, 3 and 4 incidents (ims+) need to be reviewed.
- The nature and the level of the investigations will be determined by the incident and its severity. Relevant MoH and Health Service policy documents should be referred to inform the level and nature of the investigation (Appendix A).
- Ongoing monitoring of trended aggregated incident data may identify and prioritise issues requiring a quality improvement project
- Investigation should be completed within 45 days of being notified in the incident management system or a progress report outlining the management plan with a revised completion date being submitted to the appropriate manager.
- An aggregated de-identified report on all corporate SAC 1, 2, 3 and 4 (IIMS) or Harm Score 1, 2, 3 and 4 (ims+) incidents is to be provided by each LHD and SHN to its Internal Audit Committee. Similarly, an aggregated report on all Workplace Health and Safety (WHS) incidents is to be provided to the Director, Workforce Development and any relevant WH&S Committee.

2.5.2 Investigations and conduct/impairment/performance issues with individual clinicians

Investigations conducted under this Policy should not attempt to assess the adequacy of an individual's performance or competence. Where a question of individual performance or competence arises, it is to be managed via the organisation's performance management system and/or PD2018_032 Managing Complaints and Concerns about Clinicians with support from Human Resources as required.

Professional Misconduct, Unsatisfactory Professional Conduct and Impairment

Under *section 20O(1) of the Health Administration Act 1982*, where the RCA team forms the opinion that an incident may involve professional misconduct, unsatisfactory professional conduct or impairment by an individual clinician/s, the RCA team **must** notify the CE in writing. In relation to the meaning of "professional misconduct" and "unsatisfactory professional conduct", see Part 8, Division 1 of the *Health Practitioner Regulation National Law (NSW*). In relation to the meaning of "impairment", see S5 of the *Health Practitioner Regulation National Law (NSW)*.

Unsatisfactory Professional Performance

Under *Section 20O(2)* of the *Health Administration Act 1982* where the RCA team forms the opinion that an incident may involve unsatisfactory professional performance by a clinician, the RCA team **may** notify the CE in writing. Although the RCA team holds discretion to report in these circumstances, it should err on the side of caution and notify the concerns to the CE. "Unsatisfactory professional performance' means professional performance that is unsatisfactory within the meaning of Division 5 of Part 8 of the *Health Practitioner Regulation National Law (NSW)*.

Content of Notification of Conduct, Performance or Impairment issues

The RCA team's notification is to disclose the identity of the person to whom the notification relates, regardless of whether the person consents to the disclosure. The notification is also to specify whether the concern relates to professional misconduct, unsatisfactory professional conduct or unsatisfactory professional performance or whether the person is or may be suffering from impairment together with a brief description of the nature of the concern. No other information obtained during the privileged RCA should be provided.

See *Appendix C* for a template letter that may be used by the RCA Team Leader to inform the CE of an incident involving suspected individual conduct, performance or impairment issues.

The CE will determine appropriate action which will be in accordance with PD2018_032 Managing Complaints or Concerns About Clinicians.

The RCA Team will take no further action on the matter that relates to the individual.

The RCA Team may continue to investigate the systems issues in the incident. Investigators are expected to explore **why** staff involved in incidents acted as they did, and should be encouraged to pose appropriate questions to explore the human factors aspects of the incident in question. Typical issues might include fatigue, training and

communication. In this way, the team is not endeavouring to judge the competence or adequacy of performance of any individual.

2.5.3 Decommissioning RCAs

The only reason for decommissioning an RCA is where the RCA team identifies individual clinician conduct, impairment or performance issues that may be responsible for the incident and there are no readily identifiable systems issues to consider.

The Health Service notifies the MoH following the decommissioning of the RCA and provides the reason for the decommissioning of the RCA by completing the front page of the RCA template and submitting this to the MoH – email address MOH-Quality@health.nsw.gov.au .

This is also the email address for submission of completed RCAs.

2.5.4 The management of SAC 1/Harm Score 1/Privileged clinical incident investigations across Health Service boundaries

Clinical incidents may occur in one Health Service but be notified through another e.g. when there has been a patient transfer or services provided across organisational boundaries. It is the responsibility of each DCG to oversee the management of cross-boundary incidents.

The management process is:

- The incident is notified through the incident management system and a RIB is completed
- The authority for transfer of a clinical incident from one Health Service to another and acceptance of that transfer resides with the DCGs of each organisation
- If responsibility for managing the clinical incident is transferred to another Health Service this is to be reassigned in the incident management system. A request is to be provided to NSW Health Share helpdesk to arrange incident relocation in the incident management system
- The MoH is informed of action taken in regard to liaison with the other Health Service via the RIB
- The DCG of the Health Service with agreed primary responsibility for managing the clinical incident is responsible for overseeing management of the incident including the RCA and informing the notifying Health Service of their staff's involvement in the RCA process.

On occasion, both organisations may need to be involved in the clinical incident management when there are issues relevant to both parties, for example by participating in an RCA and accepting responsibility for implementation of recommendations. In that case, the incident should be copied and linked in the incident management system. Both parties may also need to be involved in the open disclosure process.

RCA teams seeking to access patient health information for the purpose of an investigation across two or more Health Services are able to share the information for

this purpose without patient consent under the *Health Records and Information Privacy Act 2002* and *Health Records and Information Privacy Regulation 2012*.

2.5.5 Investigation of clinical incidents across sectors

Some incidents may occur across more than one sector, for example in primary and in secondary care settings or between the public and the private or non government organisation sectors. It is the responsibility of each DCG to ensure appropriate management of cross-boundary incidents. Depending on the severity of the incident, the DCG may need to involve personnel from the other sector(s) in the incident reporting and investigation processes. The incident management process should be discussed and agreed with an appropriate senior representative of the other entity and the process progressed in a manner that meets the legislated/licensing requirements of each and every entity.

Where a clinical incident involves both an LHD/SHN and a private health facility licensed under the *Private Health Facilities Act 2007*, then both entities may be required or permitted to carry out a privileged RCA under legislation (under the *Private Health Facilities Act 2007* licensed private health facilities are required to carry out an RCA in relation to clinical SAC 1 incidents, and are also permitted to carry out an RCA in respect of other clinical incidents where the incident indicates there may be a serious systemic problem).

In that event, it is possible for the LHD/SHN and licensed private health facility to elect to carry out a “joint” RCA investigation as follows:

- Each entity would separately appoint the same RCA team members and each team is then able to carry out the statutory functions, on behalf of each entity, concurrently.
- The RCA team members conduct meetings, interviews and other investigations acting in the capacity of both RCA teams, effectively at the same time. It is important that documentation of these processes makes it explicit that the RCA team is acting in two different statutory capacities simultaneously in carrying out these activities.
- Team members need to ensure that they address the notification requirements of both the *Health Administration Act 1982* and the *Private Health Facilities Act 2007* e.g. in relation to concerns about possible misconduct or unsatisfactory professional performance.
- A separate RCA report is required in respect of each Act, although, depending upon the team’s findings and recommendations, the content of these Reports could be the same.

Such a joint RCA process is only appropriate where there may be common factual issues or issues relating to the interaction of the two service providers, for example issues relating to communication between the services or to transfer processes.

Incidents Involving Multiple States/Territories

- There are several ways in which other jurisdictions may be engaged in an investigation by an RCA team appointed by an LHD or SHN.

- Representatives from the involved service or facility can be invited to participate actively as an RCA team member.
- The team can request a copy of the relevant medical records and related documentation from the other jurisdiction, to inform the analysis.
- RCA team members can include involved parties from the other jurisdiction in the interviewing and fact finding process.
- Formal correspondence from the CE to his or her equivalent in the other State or Territory would assist the team in achieving its objectives. This should state clearly what the team is seeking and remind the recipient that participation on the team and provision of information to the team during interviews will be covered by privilege.
- Access to relevant medical records held by another jurisdiction for the purposes of the RCA team's investigation will generally be governed by applicable privacy legislation in that jurisdiction. Further advice may be sought from the CEC.

Management of Corporate Incidents across Health Service Boundaries

The responsibility for managing cross boundary corporate incidents rests with the most appropriate Health Service CE.

The management process is:

- The incident is notified through the incident management system and a RIB is completed.
- The authority for transfer of an incident from one Health Service to another and acceptance of that transfer resides with the CE of each Health Service.
- If responsibility for managing the incident is transferred to another Health Service this is to be reassigned in the incident management system. A request is to be provided to NSW Health Share helpdesk to arrange incident relocation in the incident management system.
- The MoH is informed of action taken in regard to liaison with the other Health Service via the RIB.
- The CE of the Health Service with agreed primary responsibility for managing the clinical incident is responsible for overseeing management of the incident including the RCA and informing the notifying Health Service of their staff's involvement in the RCA process.

On occasion, both organisations may need to be involved in the corporate incident management when there are issues relevant to both parties, for example by participating in an RCA and accepting responsibility for implementation of recommendations. In that case, the incident should be copied and linked in the incident management system. Both parties may also need to be involved in the open disclosure process.

2.5.6 Secretary Inquiries under the *Health Services Act 1997*

Clinical and corporate incidents can raise issues which may require a more formal inquiry that is independent of the Health Service. This may arise where a clinical or corporate

incident raises broad State-wide or general clinical practice issues, serious public interest matters or matters where there is a potential conflict of interest in the organisation overseeing its own investigation. Where the CE considers an independent external inquiry may be required, he/she should contact the MoH's Legal and Regulatory Services Branch. In the event that the matter being investigated is clinically focused, the CEC will also have a role in determining further action.

2.6 Step 6 – Classification

This is the process of capturing relevant information from a range of perspectives about an incident to ensure that the complete nature of the incident, including causative and contributory factors, is documented and understood. Classification of all incidents involving patients, staff, visitors, volunteers, contractors or corporate systems can be made in the incident management system.

Classification is undertaken by nominated personnel according to the service delivery model of each Health Service and may include local managers, patient safety managers, Workplace Health & Safety managers and Clinical Governance Units (CGUs).

The SAC (IIMS) or Harm Score (ims+) will determine the amount of information required in order to classify the incident. SAC 1 and Harm Score 1 incidents require advanced classification. SAC 2 and Harm Score 2 incidents require the basic classification. SAC 3 and 4 incidents and Harm Score 3 and 4 incidents require completion of the minimum dataset.

2.7 Step 7 – Analysis

The purpose of analysis is to understand how and why the incident occurred, to identify ways of improving the systems of care and prevent recurrence. Analysis must take place at a number of levels in the system: at the level at which the incident occurred (for example the ward or the patient interface in a primary care setting); at the organisational level and at the State and National level. Different data are analysed and different action is expected at these various levels. Groups of incidents may be analysed to identify trends or emerging themes.

Health Services are responsible for analysis and action at the health organisation level; the MoH and the CEC are responsible for analysis and action at the State level.

2.8 Step 8 – Action

Action is the implementation of recommendations from the investigations and reviews and the development of better systems to ensure improved practice.

A suitable timeframe for the implementation of recommendations must be documented in action plans and the incident management system. Information should also include who will be accountable for the actions.

Where an RCA is involved, the CE is responsible for deciding whether recommendations are accepted and approved and for ensuring implementation of the approved recommendations. The CE must be able to justify in writing at the time of submitting the

RCA Report why a particular recommendation is not supported or actioned and what alternative actions might occur. The CE may consult with other staff about the RCA team's recommendations and provide feedback to the RCA team prior to signoff (see 4.1.4).

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.

2.9 Step 9 – Feedback following investigation

Feedback is an important component of a successful incident management program.

2.9.1 Feedback to Patients and/or Support Person - Open Disclosure

Information about SAC 1 and SAC 2 clinical incidents (IIMS) and Harm Score 1 and 2 clinical incidents (ims+) should be offered to the patient and/or their support person and/or family as it comes to hand. Feedback should be provided in accordance with NSW Health policy on Open Disclosure (see Appendix A).

- Disclosures should be made to the individual patient and any family/key support person the patient would like to be present
- In circumstances where discussion with the patient is not possible or appropriate, his or her next of kin, designated contact person, or representative should be informed
- Consideration must be given to the patient's cultural and ethnic identity and first language and the support needed.

The information provided to the patient and/or their support person and/or family can be based on a variety of sources. The final report from a RCA is one of those sources. A copy of the RCA report may be given to the patient/support person/family. Ideally, the report should be discussed with the patient/support person/family in person. This will allow for questions to be addressed and to ensure that the often impersonal and clinical nature of the report can be explained.

2.9.2 Feedback to Staff

The success of incident management is dependent on feedback to all staff on the results/outcomes of investigations in a timely manner.

Feedback must be provided to staff involved in the incident and should occur as soon as possible, including after the completion of the RCA. The information to be provided is limited to that which is included in the final RCA report. This way staff involved in the incident will be informed of the conclusions reached by the team and of the recommendations arising from any investigation.

Feedback should also be given to the broader group of clinical providers and managers within the organisation. This feedback will focus on the lessons to be learned by the organisation and system amendments that will provide a greater chance that the incident will not happen again. Such feedback and discussion could take place at; for example, ward meetings, mortality and morbidity review meetings and Grand Rounds.

Regular reports on trended aggregated data and outcomes of RCAs are to be provided to the executive team and board of management, peak quality committee (or other relevant committee) and staff. Feedback should include updates as the changes are made and improvements achieved as a result of these changes. This will also provide a level of accountability for implementation of the recommendations that come from the RCA or other investigation.

3 REPORTABLE INCIDENT BRIEFS

The Reportable Incident Brief (RIB) system is designed for the reporting of specific health care incidents to the MoH. It is an early declaration, locally and to the MoH, of specific serious clinical and corporate incidents.

Clinical incidents:

All clinical incidents reported in RIBs are referred to the NSW Health Clinical Risk Action Group (CRAG). CRAG is responsible for examining and monitoring serious clinical incidents via a number of mechanisms, including RIBs. The clinical incident RIBs and the work of this Group are subject to special statutory privilege under *Section 23 of the Health Administration Act 1982*.

Corporate incidents:

Corporate incidents occurring in the health care setting are those involving staff, visitor, contractors, property, security and hazards.

All mandated clinical and corporate incidents must be notified to the MoH via a RIB, within 24 hours of notification of the incident and confirmation by the manager in the incident management system. Where additional information is needed to confirm the incident severity, the Health Service is required to act immediately to obtain such information or advice so that legislated requirements are met.

The RIB does not replace the requirement for early notification of an incident to the appropriate Deputy Secretary and System Management, Patient Experience and System Performance Division of the MoH.

The Chief Executive or his/her delegate is responsible for notifying the Minister's Office, the Secretary, the Deputy Secretaries and the MoH's Media Unit when there are incidents which have the potential to become matters of public interest.

Where there is a need to notify the MoH outside of business hours, the relevant Deputy Secretary is to be notified, as well as the on-call Media Unit officer, on pager 9962 9980.

Clinical RIBs are privileged in accordance with Section 23*, Health Administration Act 1982,* and should be maintained securely and not used for any other purpose.

An incident that has both clinical and corporate components will be covered by statutory privilege. Such incidents should be marked as "clinical" on the RIB.

3.1 RIB reporting requirements

All actual SAC 1 incidents (IIMS) and Harm Score 1 incidents (ims$^+$), both clinical and corporate, must be notified to the MoH via a RIB, within 24 hours of notification of the

incident in the incident management system (the RIB does not replace the requirement for early notification of an incident to the appropriate Deputy Secretary and System Management, Patient Experience and System Performance Division of the MoH).

The Chief Executive or his/her delegate is responsible for notifying the Minister's Office, the Secretary, the Deputy Secretaries and the MoH's Media Unit when there are incidents which have the potential to become matters of public interest.

Where there is a need to notify the MoH outside of business hours, the relevant Deputy Secretary is to be notified, as well as the on-call Media Unit officer, on pager 9962 9980.

Clinical RIBs are privileged in accordance with Section 23*, Health Administration Act 1982,* and should be maintained securely and not used for any other purpose.

An incident that has both clinical and corporate components will be covered by statutory privilege. Such incidents should be marked as "clinical" on the RIB.

A RIB is to be submitted within 24 hours of a SAC 1 (IIMS) or Harm Score 1 (ims$^+$) being confirmed by the manager. Where additional information is needed to confirm the incident severity, the Health Service is required to act immediately to obtain such information or advice so that legislated requirements are met.

The following types of incidents require prompt advice to the MoH as a RIB:

3.1.1 Clinical Incidents

- **Death** of a patient unrelated to the natural course of illness
- **Suspected suicide** of a person (including a patient or community patient) who has received care or treatment for a mental illness from the relevant Health Services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation
- **Suspected homicide** committed by a person who has received care or treatment for mental illness from the relevant Health Services organisation within six months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation
- Unexpected **intra-partum stillbirth**

OR

The Australian Sentinel Events, those being:

- Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death.
- Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death.
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death.

- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death.
- Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death.
- Suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward.
- Medication error resulting in serious harm or death.
- Use of physical or mechanical restraint resulting in serious harm or death.
- Discharge or release of a child to an unauthorised person.
- Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death.

OR

An incident with "**major clinical consequences**" and a "**frequent**" or "**likely**" **probability of recurrence** being:

- Major permanent loss of function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management;
- Significant patient disfigurement as a result of the incident;
- At significant risk due to being absent against medical advice/absconding;
- Subjected to threatened or actual physical or verbal assault requiring external or police intervention.

OR

- Intravascular gas embolism resulting in death or neurological damage (former National Sentinel Event)
- Maternal death associated with pregnancy, birth or the puerperium (former National Sentinel Event)
- Procedures involving the wrong patient / body part regardless of the outcome (that is, SAC 1 to SAC 4 or Harm Score 1 to 4)

For reportable clinical incidents which require a privileged RCA investigation, refer to:

- **Appendix D** for incident management systems other than ims+ (including IIMS)
- **Appendix E** for the ims+ incident management system

3.1.2 Corporate Incidents

- Unexplained death of a staff member
- Suspected suicide or attempted suicides by a staff member where the staff member was not a client of mental Health Services

- Fire, bomb or other threatening activities in the health facility
- Critical equipment breakdown or failure
- Serious threats affecting the facility's operation
- Complete loss of service i.e. power or water failure
- Criminal activity in or related to the workplace
- Non-accreditation of service provider
- Violence or threats of assaults on patients, staff or other persons in the Health Service. This includes incidents involving:
- Assaults on, and or abuse of, patients (including children) and other vulnerable patients by staff or other persons and incidents involving abuse of staff by patients or other persons
- Staff members assaulting other staff members.
- Incidents for which reporting is mandated – (see 3.1.3 below)

Note that when Health Services are reporting incidents involving patient on patient or patient on staff assaults resulting in injury or death of a patient or staff member and there are reasonable clinical grounds to suspect a connection between the assault/death and care provided by the organisation these are reported as a clinical RIB.

3.1.3 Mandated reporting - Legal and Policy Requirements

There are matters that require mandatory notification via a RIB to the MoH regardless of the SAC or Harm Score. These include but are not limited to:

- Deaths or other incidents reportable to the Mental Health and Drug & Alcohol Office
- When methadone or buprenorphine is associated with or potentially associated with a child's presentation or admission to hospital
- Deaths in custody
- Significant legal action initiated by or against a Health Service. See Significant Legal Matters and Management of Legal Services PD2017_003, for further information concerning the notification of significant legal matters
- Industrial disputes, particularly where an interruption may be marked
- The commencement of a SafeWork prosecution
- All incidents that involve the incorrect patient, procedure or site
- Radiation incidents reportable to the Radiation Advisory Council (RAC) under the Radiation Control Act (2003)
- Other matters either raising issues likely to have a major impact on the Health Service or have State-wide implications such as assault or violence against a patient/client by an employee

- Child related allegations, charges and convictions against staff which are notifiable to the Child Protection Helpline or Child Wellbeing Unit (where appropriate), NSW Police and/or Ombudsman and require investigation by the Health Service. These allegations may be work or non-work related
- Criminal charges against a staff member related to the workplace or that are outside of work but impact on the workplace in terms of risks, e.g. sexual assault criminal charges
- Accreditation agency notification to a health service of the detection of one or more significant risks to patient harm[8].

See *Appendix A* for policy directives and legislation outlining existing reporting requirements.

3.2 RIB reporting process

The RIB reporting process is as follows:

- RIBs are to be completed in the incident management system or its approved equivalent
- The Chief Executive (CE) is responsible for authorising the RIB.
- The RIB is then submitted to the MoH (MOH-RIBs@health.nsw.gov.au) within 24 hours of the incident being notified in the incident management system[9]. RIBs must be forwarded under the signature of the CE or nominated delegate and dated. Where IIMS or ims+ is in use, this will be by a system generated email.
- If the issue requires urgent State-level response and/or involvement, the Health Service is to provide telephone advice that a RIB has been emailed. This information should be relayed to the Chief Executive at CEC and to the System Management.
- Patient Experience and System Performance Division of the MoH during business hours. After hours the on call media officer for the MoH should be notified.
- If further relevant information becomes available, the RIB can be updated and re-submitted. The text of the RIB must indicate that this is an update of a previously submitted RIB and include the MoH TRIM number. The updated RIB should be sent to the MoH within 48 to 72 hours or as directed by MoH.
- If there is a requirement for the SAC or Harm Score to be altered after a RIB has been submitted, the CE is responsible for authorising any change to the SAC or Harm Score documented in the RIB. Once the CE authorises the change, the RIB is resubmitted to the MoH. When the RIB is resubmitted the text of the RIB must clearly indicate that this is an update of a previously submitted RIB, quote the previous MoH TRIM number and provide a reason for the update.

[8] The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme also requires approved accrediting agencies to notify regulators if a significant patient risk is identified during an onsite visit to a health service organisation.
[9] Or later if it is not possible to determine that the incident is a SAC 1 or Harm Score 1 at this time. See Section 3.1 for further explanation.

- All RIBs involving suspected suicide or suspected homicide by patients of Mental Health Services must be referred to the local Director of Mental Health Services for review of the SAC or Harm Score prior to submission of the RIB to the DCG.
- Clinical RIBs are privileged documents. There are restrictions on their distribution.
- They should not be used for purposes other than providing information to CRAG in accordance with the *Health Administration Act 1982*.
- Health Districts/ Networks/Services should have processes in place to ensure security of RIBs.

3.3 Information required in the RIB report

- RIBs must provide a succinct description which clearly outlines the key issues and the circumstances of the event
- The RIB template follows an SBAR structure familiar to clinicians[10]
- RIBs must state the incident type (clinical or corporate), the actual SAC (IIMS) or manager's Harm Score (ims+) and the reason for reporting the incident to the MoH
- The RIB must not have patient, staff, facility or service identifiers
- The RIB is to contain facts
- Opinion and subjective comments are to be avoided
- The RIB information must include:
    - Initial analysis
    - Actions taken to ensure people and the environment are safe
    - Planned future actions and, confirmation that clinician disclosure has occurred
- Do **not** send attachments such as health care records, pathology or autopsy reports and other patient identifying reports with the RIB
- As identifying details are required on the Client Death Report Form that is completed for notification of deaths of mental health patients, this form should be sent directly to the Mental Health office at the MoH.

[10] Situation – Background – Assessment - Recommendation

4 PRIVILEGED ROOT CAUSE ANALYSIS UNDER THE *HEALTH ADMINISTRATION ACT 1982*

All clinical SAC 1 (IIMS) and Harm Score 1 (ims+) incidents under Division 6C of the *Health Administration Act 1982* require the appointment of an RCA team, and the RCA process is afforded statutory privilege (see *Appendix D for IIMS and Appendix E for ims+*). The provisions under the *Health Administration Act 1982* apply to all LHDs, the statutory health corporations and the affiliated health organisations listed in *Appendix F*.

Further, the CE has discretion to appoint an RCA team to investigate any clinical incident of a lesser severity than SAC 1 (IIMS) or Harm Score 1 (ims+), if the CE is of the opinion that the incident may be the result of a serious systemic problem that justifies the appointment of such a team. In that event, the RCA process will also enjoy statutory privilege. Health Services should implement processes to allow local quality assurance committees and mortality and morbidity committees to recommend to the CE that an RCA team be appointed to review incidents or issues that may be indicative of serious systemic problems.

The legislation does not provide privilege for the investigation of corporate SAC 1 (IIMS) or Harm Score 1 (ims+) incidents.

4.1 Statutory Privilege

4.1.1 What the Privilege covers

The privilege provided under Division 6C of the *Health Administration Act 1982*, applies to:

- any document prepared, and
- any communications, whether written or verbal, between RCA team members and any other person (e.g. clinicians involved in the incident),

where the document is prepared, or the communications are made, for the dominant purpose of the conduct of the investigation by the RCA team. Privilege will not apply to documents or communication created before an RCA team has been commissioned.

This means that:

- RCA team members cannot be compelled to produce or give evidence of any document created by or on behalf of, at the request of, the RCA Team, where the document was for the dominant purpose of the conduct of the investigation by the RCA team
- Any person who is not a member of the RCA team who creates a document or makes communications (written or verbal) that is for the dominant purpose of assisting with the conduct of the investigation by the RCA team (this may include administrative assistants to the RCA team, clinicians involved in the incident investigated by the team, or experts engaged by the RCA team to assist it with the investigation) cannot be compelled to produce or give evidence of the document or communication

- The final RCA report prepared by the RCA team cannot be adduced or admitted as evidence in any proceedings (including coronial proceedings, or any proceedings in which it is claimed a procedure or practice was careless or inadequate)
- RCA team members acting in good faith for the purposes of the exercise of the RCA team's function are also protected from personal liability, including actions for defamation.

The legislation also establishes tight confidentiality requirements, making it an offence for a team member to disclose any information obtained during the investigation, unless it is for a purpose that is part of the RCA process.

4.1.2 Internal Working Documents of the Privileged RCA team

During the RCA process, the team will generate documents, including preliminary notes, records of interviews with staff/clinicians, minutes of meetings and records of discussions with various people either involved in the incident or with fundamental knowledge of the incident or processes involved. During the RCA process some of these items may need to be transferred to other team members or, in limited circumstances, to the CE e.g. in relation to proposed recommendations. **All of this material is privileged**.

Storage and transfer of privileged RCA material

To protect the privilege, these records are to be maintained in a separate RCA team file marked "privileged" and stored securely in a location nominated by the Director of Clinical Governance to ensure the privilege is upheld in the event of a subpoena or application for access under GIPA.

Privileged material is not to be sent in the general post but should be sent by secure internal transport processes. Health Services need to have appropriate policies and procedures in place to manage the transfer of such materials.

Retention of RCA documents related to clinical incidents

Records relating to RCAs are required to be retained under the same rules applying to "legal matters and incident management" *under clause 1.14 of the General Retention and Disposal Authority — Public Health Services: Patient/Client Records (GDA 17)*. Under this requirement, the RCA records must be retained for a minimum of 7 years after the last action. As the records are not admissible in court or other proceedings, and can only be accessed by members of the RCA team, the 7 year period applies whether or not legal proceedings have been commenced.

4.1.3 What the privilege does not cover

Statutory privilege does not cover:

- Pre-existing documents, such as clinical incident summaries, medical records or other records created in the course of providing general care of patients or management of the Health Service, and not as part of the RCA
- Notifications made by the RCA team under section 20O of the *Health Administration Act 1982,* which relates to the responsibility of the RCA team to notify the CE where the RCA team forms the opinion that the incident raises matters that may involve

professional misconduct, unsatisfactory professional conduct, impairment or unsatisfactory professional performance of an individual clinician

- Information entered into the incident management system
- The final RCA report
- Any communication that is not for the dominant purpose of the RCA process.

4.1.4 Disclosure of information

The privilege does not prevent information being given by an RCA team to another privileged committee (for example an RCA team is entitled to give information to The Special Committee for Investigating Deaths Under Anaesthesia (SCIDUA), The Collaborating Hospitals Audit of Surgical Mortality Committee (CHASM); and the NSW Clinical Risk Action Group (CRAG)). Information provided in this way will retain privilege through the protections granted to those committees under Section 23 of the *Health Administration Act* 1982.

Further, an RCA team may disclose information about recommendation(s) proposed by the team to the CE of the Health Service that appointed the RCA team; for the purposes of informing the CE about the proposed recommendation(s) and enabling the CE to consult with other staff members of the Health Service about the proposed recommendation(s), and provide feedback to the RCA team regarding the proposed recommendation(s). All such communication between the CE and the RCA team about the proposed recommendation(s) will remain privileged, and should be done formally in writing.

4.2 The Privileged RCA Process

There are four key tasks involved in the root cause analysis process.

4.2.1 Task 1 – Appointment and membership of the RCA Team

The CE is responsible for appointing and signing off the membership of an RCA team.

At least some of the members of the team should have fundamental knowledge of the care processes in the area where the incident occurred. No member of the RCA team should have been directly involved in the incident or in the care of the patient.

Where possible, the RCA team should include at least one member who is external to the LHD or Health Service. Further, RCA team members should not have any personal or non-professional connection with any clinician who has been involved in the incident. A direct line manager should not be a member of an RCA team which is investigating an incident involving his or her department or unit. All persons involved in overseeing the quality of the RCA process itself should be appointed members of the RCA Team. This will ensure they are covered by statutory privilege.

An RCA team investigating suspected suicide should include a senior mental health clinician who is independent of the facility involved in care. An RCA team investigating suspected homicides or other serious crimes should in its membership include a senior

mental health clinician who is independent of the service involved in care. Team members receive a letter of appointment (see template at *Appendix G*).

Informing team members of their roles and responsibilities

When appointed, RCA team members are to be informed of their role and responsibilities. (see template letter at *Appendix H*).

Record of RCA Team appointment

The statutory privilege will only apply if it can be shown that the RCA team was properly constituted under the *Health Administration Act 1982*. As such, it is critical that comprehensive records are prepared and retained relating to the appointment of the RCA team.

Records will include:

- An original copy of the letters of appointment of the RCA team members
- The date of appointment
- Clear identification of the incident under RCA investigation
- The names of the RCA team members.

Process for appointment of RCA Team

- The identification of appropriate personnel for appointment to an RCA team can delay the appointment of the RCA team. Best practice in conducting RCA investigations globally recognises the advantages of the immediate collection of evidence and facts pertaining to the event, particularly in the first 48 hours following a serious clinical incident. Health Services should have in place a process that enables the immediate appointment by the CE of core personnel to an RCA team as soon as a clinical SAC 1 incident (IIMS) or Harm Score 1 incident (ims+) is notified to the CE. This process would involve a standing instrument of appointment for certain experienced and trained personnel, who can facilitate the early collection of such information and material for the RCA investigation e.g. the DCG and/or Patient Safety Manager. A template for the immediate appointment of a “core” RCA team member is provided at *Appendix I*.
- Once the remaining proposed RCA team members are identified, a further instrument of appointment should be executed by the CE that refers to the earlier instrument of appointment, and appoints the balance of the members of the RCA team. A template for the later appointment of additional members after appropriately qualified and/or expert individuals have been identified, is provided at *Appendix J*.
- This process will ensure that statutory privilege attaches to all documents and communications prepared for the purposes of the RCA team in the initial period immediately following the incident, and prior to the appointment of the full RCA team.

Documents provided to the RCA team

- To support the RCA investigation, the RCA Team receive a copy of the incident record.

4.2.2 Task 2 – Notification to staff involved in the incident

The RCA team will contact staff involved to discuss the incident and gather information as part of the investigation. A template that can be used to inform staff of the RCA process and to explain the staff members' legal rights and responsibilities is provided at *Appendix K*.

4.2.3 Task 3 – The RCA Investigation

There are six key steps in undertaking an RCA investigation:

1. Interviews and gathering information– interviews of people relevant to the incident are undertaken. This must include clinicians who were involved in the incident as well as the patient and/or the family or carers. It may also include people relevant to current policy and process e.g. the pharmacist, the biomedical engineer or the hospital architect
2. Simple flow charting – a process to help determine what the team knows about the sequence of events, what they do not know and what they need to find out
3. Detailed flow charting – to enable the identification of the most significant problems where barriers might interrupt the flow of events for future prevention of similar events. Further causal analysis will centre on these issues to determine the underlying root causes
4. Causal/contributory factor charting – by asking what changed, what conditions were present and what was not done at each of the key potential barrier points, the team identifies the underlying causal issues and depicts them in a causal sequence. These causal factors are then analysed to determine root causes. A complex healthcare case will typically identify between 3 and 5 root causes, although this number can vary
5. Causation/contributory factor statements – a written description of each of the causal/contributory sequences presented in a statement linking the root causes/contributory factors to the outcome
6. Recommendations – the team recommends actions that would most likely prevent or mitigate the root causes/contributory factors.

4.2.4 Task 4 – Reporting

All privileged RCA Teams must prepare a final report. Once this final report is signed off by the CE it is not protected by statutory privilege. The report must contain:

- A de-identified description of the reportable incident
- A clear written description of the findings of the analysis of the information gathered about the reportable incident
- The incident ID from the incident management system and MoH RIB number
- Causation and/or contributory factors statement/s that indicate the reasons the RCA Team considers the incident occurred (assuming that causation has been

established).These should be written in accordance with the rules of causation established by NSW Health (see *Appendix L*)

- Recommendations for system changes to improve procedures or practices to minimise recurrence of the incident if root causes have been determined and such recommendations can be made.

The final RCA report must not include the name or address of an individual patient or service provider involved in the incident, unless that person has consented, in writing, to that information being disclosed. The final report must also not disclose, as far as is practicable, any other material that identifies or may lead to the identification of such an individual. It should not contain details about the membership of the RCA team.

The final RCA report may contain recommendations about system improvement opportunities that have been identified during the investigation, but have not contributed to the adverse outcome.

See *Appendix M* for the final report template. Organisations should use this template to ensure the final report meets legislative and policy requirements.

Signing off the final report

- Prior to final sign-off, the RCA team may seek a formal written opinion from the CE about any proposed recommendations, in accordance with 4.1.4
- At the conclusion of the RCA, the RCA team must submit a copy of its signed report (but no other documentation) to the CE
- The CE is to review the RCA report and endorse the report prior to submission to the MoH
- Any disagreement that the CE may have with any of the recommendations in the final report is to be documented separately and submitted with the final report. It should outline the reason/s for the disagreement and any proposed alternative action. The original RCA team report is to be submitted unchanged accompanied by this additional documentation.

The CE may delegate the responsibility for endorsing the final report prior to submission to the MoH, but remains ultimately accountable for its content.

4.2.5 Variation in RCA Process

There are instances when a variation to the RCA process is acceptable. These instances include:

- Assigning more than one incident to an RCA team where incidents are of the same classification
- Resolution of the RCA process in a shorter timeframe due to early completion of the investigation.

Any variation to the RCA process is to be documented in the final Report for sign off by the CE or nominated delegate.

4.2.6 Timeframes for RCA Process

The maximum time allowed for an RCA to be completed and the final report to be submitted to the MoH is 70 calendar days from when the incident was notified in the incident management system. This time frame and requirement for submission applies to all privileged RCAs.

4.2.7 Incidents involving the Coroner or Police

A referral for investigation of a death to the Coroner or the Police does not affect the requirement to undertake an investigation of an incident, including, where appropriate, an RCA.

If the Coroner requests a copy of the final RCA report, the LHD should provide it so that the Coroner is aware of any system changes that are occurring since the incident. The RCA report cannot, however, be tendered in evidence. If lawyers have been engaged to represent the LHD/SHN, the panel firm should forward the RCA report to the Coroner using a standard pro-forma letter which alerts the Coroner to S20R of the *Health Administration Act 1982*. If lawyers are not engaged, the CE should provide a covering letter with the report noting that the RCA has been provided for information only and that pursuant to S20R of the *Health Administration Act 1982*, it cannot be adduced or admitted in any proceedings.

A police or coronial investigation **should not** delay the commencement of an RCA.

4.3 The Corporate RCA Process

4.3.1 Detailed investigation for Corporate SAC 1 (IIMS) and Harm Score 1 (ims+) incidents

All corporate SAC 1 and Harm Score 1 incidents require either a root cause analysis or a detailed investigation to be undertaken. The RCA Report or Detailed Investigation Report must be provided to the MoH within 70 calendar days after the incident is notified in the incident management system. RCAs of corporate SAC 1 and Harm Score 1 incidents do not attract the statutory privilege outlined in section 4 that applies to RCAs conducted in respect of clinical SAC 1 and clinical Harm Score 1 incidents.

Nevertheless, it is important that any serious or major corporate incident that receives a SAC 1 (IIMS) or Harm Score 1 (ims+) rating be properly investigated, so that the cause of the incident can be identified, and any appropriate remedial action is implemented to mitigate against a similar incident occurring again.

4.3.2 Membership of the Corporate Investigation Team

The RCA or Detailed Investigation Team should generally consist of 3 to 5 members. The members should have fundamental knowledge about the corporate processes in the area where the incident occurred, but not have been directly involved in the incident.

4.4 Steps in the Investigation

There are six key steps in undertaking the detailed investigation.

1. Assessment of the incident to determine whether the issues, e.g. negligence, criminal, corruption and make initial reports if appropriate e.g. police, ICAC
2. Planning the investigation – identify scope, potential sources of information and resources required
3. Conduct interviews and collect detailed information about the incident
4. Assessing the results – once all information has been gathered, analyse the findings
5. Barriers and recommendations – identify the barriers that would most likely prevent or mitigate the problem – then determine appropriate recommendations.
6. Reporting to the CE and the MoH.

4.5 Timeframes for Corporate Investigation Process

The RCA Report or Detailed Investigation Report must be submitted to the MoH within 70 calendar days of the incident being notified in the incident management system.

4.6 The Final RCA or Detailed Investigation Report

All RCA Teams or Detailed Investigation Teams must prepare a final Report. The Report must contain:

- A description of the reportable incident
- The Incident ID from the incident management system
- A causation statement/s that indicates the reasons why the Investigation Team consider the incident occurred
- Recommendations for system changes to improve procedures or practices to minimise recurrence of the incident.

Signing off the final report

- At the end of the investigation, the Investigation Team is to provide a copy of their Report to the CE.
- The CE reviews the recommendations for consideration and endorsement before the Report is submitted to the MoH.
- The CE is able to seek clarification from the Investigation Team if the rationale for any recommendation is unclear.
- The CE is also able to add recommendations to the final report but this must be clearly documented.
- If the CE does not agree with any of the recommendations then this is documented in the final report with the reason/s why and the proposed alternative action.
- The CE is to ensure that any relevant final internal and external notification requirements as outlined in legislation and relevant policies is attended to including the NSW Health Service Check Register.

5 EVALUATION AND REVIEW

Clinical Incidents

The DCG is responsible for monitoring and evaluating notifications in the incident management system at the local level to ensure:

- The effective management of incidents that occur within health facilities
- The effectiveness of risk mitigation strategies

The DCGs are to provide a report to their peak quality committee on the management of risks identified through incident management on a regular basis. This report includes a suite of performance indicators relevant to the LHD or SHN including those listed in Section 6.1.

5.1 Performance Indicators

5.1.1 Clinical Incidents

The key performance indicator in this Policy is:

- Submission of final RCA Report to the MoH within 70 calendar days of incident notification in incident management system.

The following performance indicators should be included in the quarterly reports to the peak LHD/SHN quality committee:

- Submission of a RIB to the MoH, concerning all SAC 1 (IIMS) and Harm Score 1 (ims$^+$) incidents, both clinical and corporate, within 24 hours of notification in the incident management system
- Proportion of obligatory external notifications made within required time frames
- Proportion of SAC 2 (IIMS) and Harm Score 2 (ims$^+$) incident investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager
- Proportion of SAC 3 and 4 (IIMS) and Harm Score 3 and 4 (ims$^+$) investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager
- Proportion of SAC 1 (IIMS) and Harm Score 1 (ims$^+$) incidents notified where incident status = new in ≤ 24hrs of incident occurring
- Proportion of SAC 2, 3 and 4 (IIMS) and Harm Score 2, 3 and 4 (ims$^+$) incidents notified where incident status = new in ≤ 5 days of incident occurring
- Proportion of all actual SAC 2, 3 and 4 (IIMS) and Harm Score 2, 3 and 4 (ims$^+$) incidents where incident status = complete in ≤ 45 days of incident occurring
- Proportion of RCA recommendations completed within stated timeframe

- Proportion of incidents notified which have recommendations for action
- Proportion of incidents notified where recommendations have been completed.

5.2 Corporate Incidents

The key performance indicator in this Policy is:

- Submission of final RCA Report (where relevant) to the MoH within 70 calendar days of incident notification in the incident management system.

The following performance indicators should be included in the incident management framework at a Health Service level for corporate incidents:

- Submission of a Reportable Incident Brief to the MoH, concerning all SAC 1 (IIMS) and Harm Score 1 (ims$^+$) corporate incidents within 24 hours of notification in the incident management system
- Proportion of obligatory external notifications made within required timeframes
- Proportion of SAC 2 (IIMS) and Harm Score 2 (ims$^+$) incident investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager
- Proportion of SAC 3 and 4 (IIMS) and Harm Score 3 and 4 (ims$^+$) investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager
- Proportion of SAC 1 (IIMS) and Harm Score 1 (ims$^+$) incidents notified where incident status = new in ≤ 24hrs of incident occurring
- Proportion of SAC 2, 3 and 4 (IIMS) and Harm Score 2, 3 and 4 (ims$^+$) incidents notified where incident status = new in ≤ 5 days of incident occurring
- Proportion of all actual SAC 2, 3 and 4 (IIMS) and Harm Score 2, 3 and 4 (ims$^+$) incidents where incident status = complete in ≤45 days of incident occurring
- Proportion of RCA recommendations completed within stated timeframe
- Proportion of incidents notified which have recommendations for action
- Proportion of incidents notified where recommendations have been completed.

6 APPENDICES

6.1 Appendix A – Relevant NSW Health legislation, Policy Directives, Guidelines, Information Bulletins and other resources

6.1.1 Relevant NSW Health legislation

NSW Health Legislation can be accessed at

https://www.health.nsw.gov.au/legislation/Pages/legal-compendium.aspx:

1) *Health Administration Act 1982*
2) *Health Administration Regulation 2018*
3) *Health Care Complaints Act 1993 (NSW)*
4) *Health Records and Information Privacy Act 2002*
5) *Health Records and Information Privacy Regulation 2012*
6) *Health Services Act 1997*
7) *Privacy and Personal Information Protection Act 1998*
8) *Private Health Facilities Act 2007*
9) *Private Health Facilities Regulation 2010*

6.1.2 Relevant NSW Health Policy Directives and Guidelines

NSW Health Policy Directive, Guidelines and Information Bulletins can be accessed at: http://www.health.nsw.gov.au/policies/pages/default.aspx

Child Related Allegations, Charges and Convictions Against Employees	PD2016_025
Clinical Procedure Safety	PD2017_032
Complaint Management Guidelines	GL2020_008
Complaint Management Policy	PD2020_013
Coroners Cases and the Coroner's Act 2009	PD2010_054
Corrupt Conduct – Reporting to the Independent Commission Against Corruption (ICAC)	PD2016_029
Data collections – Disclosure of unit record data held for research or management of Health Services.	PD2015_037
Death - Management of a Sudden Unexpected Death in Infancy	PD2019_035
Deaths – Reporting of Maternal Deaths to the NSW Department of Health	PD2005_219
Deaths – Review and Reporting of Perinatal Deaths	PD2011_076
Electronic Information Security Policy – NSW Health	PD2013_033
Injury Management and Return to Work	PD2013_006
Lookback Policy	PD2007_075
Managing Complaints and Concerns About Clinicians	PD2018_032
Managing Misconduct	PD2018_031
Medication Handling in NSW Public Health Facilities	PD2013_043
New South Wales Health Services Functional Area Supporting Plan (NSW HEALTHPLAN)	PD2014_012
NSW Health Code of Conduct	PD2015_049
Open Disclosure Policy	PD2014_028
Public Interest Disclosures	PD2016_027
Risk Management – Enterprise-wide risk management Policy and Framework	PD2015_043
Significant Legal Matters and Management of Legal Services	PD2017_003
Working with Children Checks and Other Police Checks	PD2019_003
Work Health and Safety: Better Practice Procedures	PD2018_013

6.2 Appendix B – Severity Assessment Code (SAC) June 2019

Step 1: Consequences Table (For notification, consider the actual consequence or outcome using this table as a guide. The examples listed here are not exhaustive

Consequences		Action Required: Serious	Major	Moderate	Minor	Minimum
CLINICAL	Patient	Patients with **Death** unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or: ■ **Suspected suicide**[11] ■ **Suspected homicide**[12] ■ **Unexpected intra-partum stillbirth,** or any of the following: **Sentinel Events** ■ Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death. ■ Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death. ■ Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death. ■ Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death. ■ Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death. ■ Suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward. ■ Medication error resulting in serious harm or death. ■ Use of physical or mechanical restraint resulting in serious harm or death. ■ Discharge or release of a child to an unauthorised person. ■ Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death.	Patients suffering a **Major permanent loss of function** (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Suffering significant disfigurement as a result of the incident ■ Patient at significant risk due to being absent against medical advice ■ Threatened or actual physical or verbal assault of patient requiring external or police intervention	Patients with **Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychological)** unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: ■ Increased length of stay as a result of the incident ■ Surgical intervention required as a result of the incident	Patients requiring **Increased level of care** including: ■ Review and evaluation ■ Additional investigations ■ Referral to another clinician	Patients with **No injury or increased level of care or length of stay**
CORPORATE	Staff	Death of staff member related to work incident or suicide, or hospitalisation of **3** or more staff	Permanent injury to staff member, hospitalisation of **2** staff, or lost time or restricted duty or illness for **2** or more staff or pending or actual SafeWork NSW prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention	Medical expenses, lost time or restricted duties or injury / illness for **1** or more staff	First aid treatment only with no lost time or restricted duties	No injury or review required
	Visitors	Death of visitor or hospitalisation of **3** or more visitors	Hospitalisation of up to **2** visitors related to the incident / injury or pending or actual SafeWork NSW prosecution	Medical expenses incurred or treatment of up to **2** visitors not requiring hospitalisation	Evaluation and treatment with no expenses	No treatment required or refused treatment
	Service	Complete loss of service or output	Major loss of agency / service to users	Disruption to users due to agency problems	Reduced efficiency or disruption to agency working	No loss of service
	Financial	**Loss of assets** replacement value due to damage, fire etc > $1M, **loss of cash/investments/assets** due to fraud, overpayment or theft >$100K or **SafeWork NSW claims** > $100K	**Loss of assets** replacement value due to damage, fire etc $100K-$1M, **loss of cash/investments/assets** due to fraud, overpayment or theft $10K-$100K or SafeWork NSW **claims** $50K-$100K	**Loss of assets** replacement value due to damage, fire etc $50K to $100K **or loss of cash/investments/assets** due to fraud, overpayment or theft to $10K	**Loss of assets** replacement value due to damage, fire etc to $50K	No financial loss
	Environment	Toxic release off-site with detrimental effect. Fire requiring evacuation	Off-site release with no detrimental effects or fire that grows larger than an incipient stage	Off-site release contained with outside assistance or fire incipient stage or less	Off-site release contained without outside assistance	Nuisance releases

[11] Suspected suicide of a person (including a patient or community patient) who has received care or treatment for a mental illness from a Health Service or other PHO where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.

[12] Suspected homicide committed by a person who has received care or treatment for mental illness from a Health Service or other PHO within 6 months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation

STEP 2 Likelihood Table

Probability Categories	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

STEP 4 Action Required Table

Action Required	
1	**Extreme** risk – immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the MoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the MoH.
2	**High** risk – need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
3	**Medium** risk – management responsibility must be specified – Aggregate data then undertake a practice improvement project. **Exception** – all financial losses must be reported to senior management.
4	**Low** risks – manage by routine procedures – Aggregate data then undertake a practice improvement project.
NB – An incident that rates a SAC 2, 3 or 4 should only be reported to the MoH if there is the potential for media interest or requires direct notification under existing MoH legislative reporting requirements or NSW MoH Policy Directive.	

STEP 3 SAC Matrix

		CONSEQUENCE				
		Serious	Major	Moderate	Minor	Minimum
LIKELIHOOD	Frequent	1	1	2	3	3
	Likely	1	1	2	3	4
	Possible	1	2	2	3	4
	Unlikely	1	2	3	4	4
	Rare	2	3	3	4	4

Every incident assessed against the Severity Assessment Code Matrix should be scored separately for both their actual and potential consequence or outcome

6.3 Appendix C – Sample letter informing CE of issues that may involve individual performance

DATE

INSERT NAME

INSERT FACILITY

INSERT ADDRESS

Dear [Insert Name])

I am writing to advise you that the RCA Team appointed on [Insert date] to investigate the Clinical incident [insert the incident management system ID], has identified that the incident raises issues that may relate to individual conduct.

The RCA Team is of the opinion that the incident raises matters that may involve (Please delete which ever of the following is not relevant).

- professional misconduct or unsatisfactory professional conduct
  (mandatory reporting requirement)

or

- a person suffering from an impairment
  (mandatory reporting requirement)

or

- unsatisfactory professional performance
  (discretionary reporting)

The above concerns of the RCA Team relate to [insert name of the staff member who is of concern]. In brief the matter of concern is [Insert a brief outline of the matter of concern]

The matter is referred to you in accordance with the terms of section 20O of the Health Administration Act 1982 for appropriate action.

The RCA Team will continue to investigate the systems issues related to the incident. / The RCA Team will now conclude its investigation of this incident. (Please delete whichever is not relevant).

Yours sincerely

Signature

Name

Designation

RCA Team Leader

6.4 Appendix D – Reportable Incident Definition under Section 20L of the Health Administration Act 1982 – For users of an incident management system other than ims+

Under the provisions of Division 6C of Part 2 of the Health Administration Act 1982 when a "reportable incident" involving a relevant Health Services organisation is reported to the Chief Executive of the organisation, the organisation is to appoint a root cause analysis team in relation to the reportable incident.

For the purposes of the Health Administration Regulation 2020, a "Reportable Incident" is defined as follows.

(1) The incident must have had "serious clinical consequences" (as defined below) and the probability of recurrence must fall into one of categories (i) to (iv) and be excluded from (v) (listed below);

OR

(2) The incident must have had "major clinical consequences" (as defined below) and the probability of recurrence must fall into one of categories (i) to (ii) listed below;

Under section 20M of the Act, an RCA is required to be conducted once the incident has been reported to the Chief Executive.

The Chief Executive should be notified via a Reportable Incident Brief in accordance with this Policy.

"Serious Clinical Consequence"

An incident with "serious clinical consequence" is one that involves:

- The death of a patient unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management;
- Suspected suicide of a person (including an inpatient or community patient) who has received care or treatment for a mental illness from the relevant Health Services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;
- Suspected homicide committed by a person who has received care or treatment for mental illness from the relevant Health Services organisation within six months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;
- Unexpected intra-partum stillbirth; OR

An Australian Sentinel Event being:

- Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death.

- Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death.
- Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death.
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death.
- Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death.
- Suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward.
- Medication error resulting in serious harm or death.
- Use of physical or mechanical restraint resulting in serious harm or death.
- Discharge or release of a child to an unauthorised person.
- Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death.

"Major Clinical Consequences"

An incident with "major clinical consequences" is one which involves a patient:

- Suffering a major permanent loss of function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management;
- Suffering significant disfigurement as a result of the incident;
- At significant risk due to being absent against medical advice/absconding;
- Subjected to threatened or actual physical or verbal assault requiring external or police intervention.

Probability of Recurrence

(i) Frequent - expectation that the incident will recur immediately or within weeks or months

(ii) Likely - probability incident will recur more than once within 12 months;

(iii) Possible - possibility incident may recur at some time every 1 to 2 years;

(iv) Unlikely - possibility incident may recur at some time in 2 to 5 years.

(v) Rare - unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

Note: Under s20M of the Health Administration Act, and Section 4 of this policy, the CE has discretion to appoint an RCA team to investigate any clinical that does not meet the definition of reportable incident above, if the CE is of the opinion that the incident may be the result of a serious systemic problem that justifies the appointment of such a team. In that event, the RCA process will also enjoy statutory privilege.

6.5 Appendix E – Reportable Incident Definition under Section 20L of the Health Administration Act 1982 – For NSW Health organisations using ims+

Under the provisions of Division 6C of Part 2 of the Health Administration Act 1982 when a "reportable incident" involving a relevant Health Services organisation is reported to the Chief Executive of the organisation, the organisation is to appoint a root cause analysis team in relation to the reportable incident.

For the purposes of the Health Administration Regulation 2020, a "Reportable Incident" is defined as a clinical incident which involves:

- The death of a patient unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management;
- Suspected suicide of a person (including an inpatient or community patient) who has received care or treatment for a mental illness from the relevant Health Services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;
- Suspected homicide committed by a person who has received care or treatment for mental illness from the relevant Health Services organisation within six months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;
- Unexpected intra-partum stillbirth;

OR

- An Australian Sentinel Event being:
    - Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death.
    - Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death.
    - Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death.
    - Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death.
    - Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death.
    - Suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward.
    - Medication error resulting in serious harm or death.

- Use of physical or mechanical restraint resulting in serious harm or death.
- Discharge or release of a child to an unauthorised person.
- Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death.

Note: Under s20M of the Health Administration Act, and Section 4 of this policy, the CE has discretion to appoint an RCA team to investigate any clinical incident that does not meet the definition of reportable incident above, if the CE is of the opinion that the incident may be the result of a serious systemic problem that justifies the appointment of such a team. In that event, the RCA process will also enjoy statutory privilege.

6.6 Appendix F – Statutory health corporations and Affiliated health organisations

In addition to Local Health Districts, the Ambulance Service of NSW and NSW Health Pathology, the following facilities are defined as "relevant health Services organisations" subject to the RCA privilege provisions under the *Health Administration Act 1982*:

Statutory health corporations

- The Justice Health and Forensic Mental Health Network
- The Sydney Children's Hospitals Network (Randwick and Westmead) (incorporating The Royal Alexandra Hospital for Children)

Affiliated health organisations

Name of organisation	Recognised establishment or recognised service
Calvary Health Care (Newcastle) Limited	• Calvary Mater Newcastle.
Calvary Health Care Sydney Limited	• Calvary Health Care Sydney.
Catholic Healthcare Limited	• St Vincent's Health Service, Bathurst. • Lourdes Hospital and Community Health Service (other than Holy Spirit Dubbo).
Hammondcare Health and Hospitals Limited	• Braeside Hospital, Prairiewood. • Greenwich Hospital, Greenwich. • Neringah Hospital, Wahroonga. • Northern Beaches Palliative Care Service
Karitane	• Child and Family Health Services at Carramar, Fairfield, Liverpool and Randwick.
Mercy Hospitals NSW Ltd	• Mercy Care Centre: Young, excluding Mount St Joseph's Nursing Home. • Mercy Health Service Albury.
Royal Rehab	• General rehabilitation services. • Brain injury rehabilitation services.

	• Spinal injury rehabilitation services. • Extended care services.
Royal Society for the Welfare of Mothers and Babies	• Tresillian Family Care Centres at Belmore, Broken Hill, Coffs Harbour, Dubbo, Lismore, Penrith, Queanbeyan, Taree, Willoughby and Wollstonecraft
St Vincent's Hospital Sydney Limited	• Sacred Heart Health Service. • St Joseph's Hospital (Auburn) • St Vincent's Hospital, Darlinghurst.
Uniting Church in Australia	• War Memorial Hospital (Waverley).

6.7 Appendix G – Appointment of RCA Team

In accordance with Part 2, Division 6C of the Health Administration Act 1982

I, *(insert name of Chief Executive)* in accordance with section 20M of the *Health Administration Act 1982*, do hereby appoint the following persons to a Root Cause Analysis Team:

Insert name, title, background, employing organisation (team leader)
Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)
Insert name, title, background, employing organisation (team member)

to consider and determine the root causes and contributing factors for the Clinical incident (*insert the incident management system incident ID*)

[insert summary of incident (include date)]

and to prepare a report of the root cause analysis in accordance with section 20O of the *Health Administration Act 1982.*

A root cause analysis conducted in accordance with this appointment shall be privileged in accordance with the terms of Part 2, Division 6C of the *Health Administration Act 1982.*

(signed)

(name of CE)

(date

6.8 Appendix H – Letter to RCA Team Member

DATE

INSERT NAME

INSERT FACILITY

INSERT ADDRESS

Dear (Insert Name)

I am writing to you to advise that in accordance with Division 6C of the Health Administration Act 1982 and the NSW Health Incident Management Policy, you have been appointed to an RCA team to determine the root cause and contributing factors for the Clinical SAC 1 reportable incident (insert the incident management system ID), as set out in the attached appointment document.

You have been selected as a member of this team because your expertise and experience is essential to the review of this incident.

The work of the RCA team will be privileged in accordance with the Health Administration Act. This has a number of implications, of which you should be aware:

1. Restrictions on disclosure of information

You are required to maintain confidentiality in relation to your work as a member of this team, and you must not make your own record or discuss the investigation with anyone who is not part of the team, except for the purposes of exercising the function or any recommendation of an RCA team or for the purposes of preparing a report on the RCA.

2. Statutory Privilege

The internal workings of RCA Teams appointed under the Health Administration Act are privileged. This means:

- Members of the team cannot be compelled to give evidence about information obtained by them as part of their work on the RCA Team;
- Members of the team cannot be compelled to produce to court, papers created or communications (written or verbal) made for the dominant purpose of the RCA Team carrying out its functions;
- The final RCA report prepared by the RCA Team cannot be adduced or admitted as evidence in any proceedings (including coronial proceedings, or any proceedings in which it is claimed a procedure or practice was careless or inadequate).

- Members of the team are protected from personal liability, including actions for defamation, provided they act in good faith as a part of the RCA Team function.
- Team members should be aware there are limits to the privilege:
- The privilege will not apply to pre-existing documents such as a notification in the incident management system, or medical records or other records created for general care or management reasons;
- The privilege does not prevent release of the final report outside the organisation, to the patient or family of the patient.

3. Concerns or complaints about an individual clinician not to be investigated

The RCA Team does not have any authority to investigate concerns or complaints about an individual clinician. Under the terms of the Health Administration Act, where the RCA Team considers the reportable incident may involve professional misconduct or unsatisfactory professional performance or possible impairment issues the team must notify the CE in writing.

The RCA Team may, at its discretion, notify the CE if an incident may involve unsatisfactory professional performance.

Following notification to the CE the team will take no further action on the individual matter.

4. Requirements for the Final RCA Report

The final report must contain:

- the incident management system incident number
- the MoH RIB number
- a description of the incident
- causation statements outlining root causes, where root causes have been determined
- recommendations for change and improvement where appropriate and
- monitoring processes for follow-up of recommended actions

The final report is to be submitted to the CE on the (insert date)

Thank you for your participation in this important patient safety activity. Yours sincerely

Signature

Name

Designation

6.9 Appendix I – Appointment of Core RCA Team Members

In accordance with Part 2, Division 6C of the *Health Administration Act 1982* I, *(insert name of Chief Executive)* in accordance with section 20M of the *Health Administration Act 1982*, do hereby appoint the following person/s to a Root Cause Analysis Team:

Insert name, title, background, employing organisation (Team leader)

Insert name, title, background, employing organisation (Team member)

to consider and determine the root causes and contributing factors for the Clinical incident (*insert the incident management system incident ID*)

[insert summary of incident (include date)]

and to prepare a report of the root cause analysis in accordance with section 20O of the*Health Administration Act 1982*.

The Root Cause Analysis Team member/s listed above shall form the core personnel of the team, and may commence work immediately gathering material relevant to the discharge of the RCA Team's statutory functions under the *Health Administration Act*. I intend to appoint additional members to the RCA Team to assist it in its work as soon as further individuals with appropriate expertise and/or experience have been identified.

A root cause analysis conducted in accordance with this appointment, including any activities carried out by the core RCA Team members appointed by this instrument in carrying out their statutory functions, shall be privileged in accordance with the terms of Part 2, Division 6C of the *Health Administration Act 1982*.

_____

(signed)

_____

(name of CE)

_____

(date)

6.10 Appendix J – Appointment of Additional Member to RCA Team

On [*insert date*] in accordance with Part 2, Division 6C of the *Health Administration Act 1982*, I appointed core members of an RCA Team to consider and determine the root causes and contributing factors for the Clinical incident [*insert the incident management system incident ID*].

A copy of the original instrument of appointment is **attached** and marked "A".

Having regard to the nature of the incident and the appropriate expertise and/or experience required by the RCA Team in order to properly carry out its statutory functions, in accordance with section 20M of the *Health Administration Act 1982*. I have determined to appoint the following additional members to that RCA Team:

Insert name, title, background, employing organisation (team member)

Insert name, title, background, employing organisation (team member)

Insert name, title, background, employing organisation (team member)

Insert name, title, background, employing organisation (team member)

and to prepare a report of the root cause analysis in accordance with section 20O of the *Health Administration Act 1982*.

A root cause analysis conducted in accordance with this appointment shall be privileged in accordance with the terms of Part 2, Division 6C of the *Health Administration Act 1982*.

(signed)

(name of CE)

(date)

6.11 Appendix K – Notification of staff involved in incident

DATE

INSERTNAME

INSERT FACILITY

INSERT ADDRESS

Dear [insert name]

Following the recent reporting of incident number xxx in the Incident Information Management System and in accordance with the *Health Administration Act 1982* and the NSW Health Incident Management Policy, the [insert name] Local Health District Chief Executive has appointed a Root Cause Analysis (RCA) Team. The team will review systems and processes surrounding the incident to determine the root cause and factors contributing to the clinical incident [*provide a brief description of the incident*]. Because of your knowledge of this incident, a member of the RCA Team may contact you to arrange a suitable time to discuss the circumstances of the incident from your perspective. You are entitled to have a support person with you during the interview should you so wish.

The *Health Administration Act 1982* outlines specific restrictions on and responsibilities of RCA Teams. These include

1. *Restrictions on disclosure of information*

Members of the Root Cause Analysis Team are required to maintain confidentiality in relation to this investigation. They must not make their own records or discuss the investigation with anyone who is not part of the team, except for the purposes of the RCA Team or for the purposes of preparing a report on the RCA.

2. *Statutory Privilege*

The internal workings of RCA Teams appointed under the *Health Administration Act* are *privileged.* This means:

- RCA Team members cannot be compelled to produce or give evidence of any document created by or on behalf of, at the request of, the RCA Team, where the document was for the dominant purpose of the conduct of the investigation by the RCA Team
- Any document that you prepare, or any communication (written or verbal) that you make, that is for the dominant purpose of assisting with the conduct of the investigation by the RCA Team cannot be produced before any court, tribunal or other person
- The final RCA report prepared by the RCA Team cannot be adduced or admitted as evidence in any proceedings (including coronial proceedings, or any

proceedings in which it is claimed a procedure or practice was careless or inadequate).

- RCA Team members acting in good faith for the purposes of the exercise of the RCA Team's function are also protected from personal liability, including actions for defamation.

There are limits to the privilege:

- The privilege will not apply to pre-existing documents such incident management system notification classification, or medical records or other records created for general care or management reasons;
- The privilege does not prevent release of the final Report outside the organisation, to the patient or family of the patient.

For further information, refer to the provisions of Part 2, Division 6C of the *Health Administration Act* 1982

3. *Concerns or complaints about an individual clinician not to be investigated*

The RCA Team does not have any authority to investigate concerns or complaints about an individual clinician. Under the terms of the *Health Administration Act*, where the RCA Team considers the reportable incident *may* involve professional misconduct or unsatisfactory professional conduct or possible impairment issues the team **must** notify the Chief Executive in writing.

The RCA Team may, at its discretion, notify the Chief Executive in writing if an incident may involve an unsatisfactory professional performance.

Once the CE has been notified the team will take no further action on the individual matter. If you wish to discuss this matter, further please feel free to contact

insert name, title and contact number

Thank you for your participation in this important patient safety activity.

Yours sincerely

Signature

Name

Designation

6.12 Appendix L – The Five Rules of Causation

***Adapted from David Marx and the Veterans Affairs National Center for Patient Safety**

The five rules of causation are designed to improve the analysis and documentation of causal issues within the RCA process

Rule 1 - Causal Statements must clearly show the "cause and effect" relationship.

When describing why an event has occurred, you should show the link between your root cause and the bad outcome. Focus on showing the link from your root cause to the undesirable patient outcome you are investigating.

Example:

- **Incorrect**: The established rostering practices in the surgical unit were inappropriate
- **Correct**: The established rostering practices in the surgical unit led to the resident's fatigue which increased the likelihood that he submitted a test request for the incorrect patient via the electronic system

Rule 2 – Use specific and accurate descriptors for what occurred, avoiding negative or vague words

To force clear cause and effect expressions (and avoid inflammatory statements), avoid the use of vague or negative words that can be replaced by a more accurate, clear description. Even words like "carelessness" and "complacency" are bad choices because they are broad, negative judgments that do little to describe the actual conditions or behaviours that led to the mishap.

Example:

- **Incorrect:** Poorly trained nurse
- **Correct:** The level of the nurse's training increased the likelihood that she misunderstood the IV pump controls which led to missing steps in the programming of the dose and rate. This resulted in the patient receiving a rapid infusion of the drug and his cardiac arrest.

Rule 3 – Identify the preceding cause(s), not the human error

Most of our mishaps involve at least one human error. Unfortunately, the discovery that a human has erred does little to aid the prevention process. You must investigate to determine WHY the human error occurred. It can be a system-induced error (e.g., step not included in medical procedure) or an at-risk behaviour (doing task by memory, instead of a checklist).

For every human error in your causal chain, you must have a corresponding cause. It is the cause of the error, not the error itself, which leads us to productive prevention strategies.

Example

Incorrect: The registrar did not review the discharge summary

Correct: The absence of replacement medical staff to cover registrars on sick leave led to the registrar being rushed and taking short cuts resulting in the patient being discharged with the wrong discharge summary. This resulted in the GP continuing the wrong dose of anticoagulant therapy and the patient's gastro intestinal bleed.

Rule 4 - Each procedural deviation must have a preceding cause.

Procedural violations are like errors in that they are not directly manageable. Instead, it is the cause of the procedural violation that we can manage. If a clinician is violating a procedure because it is the local norm, we will have to address the incentives that created the norm.

Example

Incorrect: The pharmacy technician did not follow the correct dispensing procedure

Correct: The absence of an orientation programme led to the pharmacy technician being unaware of the practice of routine checking by two persons which resulted in the incorrect dispensing of the medication. This led to the provision of the wrong strength of solution resulting in the respiratory arrest of the child.

Rule 5 - Failure to act is only causal when there was a pre-existing duty to act.

The duty to act may arise from standards and guidelines for practice; or other duties to provide patient care. We need to find out why this mishap occurred in our system as it is designed today. For instance, a doctor's failure to prescribe a cardiac medication after an infarct can only be causal if he was required by established guidelines to do so.

Example

- **Incorrect:** The Visiting Medical Officer (VMO) did not review the patient after surgery
- **Correct:** The absence of a requirement for VMOs to review patient's after they have undergone a surgical procedure led to the patient not being attended by a specialist for 10 days which contributed to the delay in recognition of the patient's deterioration and her subsequent death.

6.13 Appendix M – Final RCA Report

Health District Network			
Final RCA Report			
Reference Numbers (*where applicable*)			
MoH RIB No:		**IIMS No:**	
LHD TRIM No:		**LHD File No:**	
RCA No:		**LHD RIB No:**	
Incident Details			
Date of Incident:	_ _ / _ _ / _ _ _ _		
Date of Incident Notification in IIMS:	_ _ / _ _ / _ _ _ _		
Reporting Details			
Staff member/s responsible for feedback to staff (include position)			
Staff member/s responsible for feedback to patient/support person (include position)			
By when?	_ _ / _ _ / _ _ _ _		
Final RCA report signed off by RCA Team on	_ _ / _ _ / _ _ _ _		
Date report due to CE:	_ _ / _ _ / _ _ _ _		
Date signed by CE:	_ _ / _ _ / _ _ _ _		
Date due to be submitted to NSW Ministry of Health:	_ _ / _ _ / _ _ _ _		
Date submitted to NSW Ministry of Health:	_ _ / _ _ / _ _ _ _		
Date submitted to NSW Ministry of Health:	_ _ / _ _ / _ _ _ _		
Notification of decommissioning of RCA			
RCA decommissioned:	**YES / NO** (please select)		
Reason for decommissioning:			
If the RCA has been decommissioned has an investigation been undertaken on the systems issues:	**YES / NO** (please select)		
Comments			
Referral to other committees/agencies			
Health Care Complaints Commission	☐	**Coroner**	☐
Other	☐		
If 'Other' please specify:			
Contact Details			
LHD / SHN			
Contact Person:			
Telephone Number:			
Email Address:			

Description of incident that was investigated (this is a concise chronological account of what happened to the patient)
Summary of RCA Team findings and recommendations The following summary provides an analysis of the event, any contributing factors and what the team is recommending to prevent a similar occurrence in the future.
On investigation, the RCA Team found…

Following the investigation, the RCA team (Please select the appropriate box/boxes)

☐ was unable to identify any root causes or contributory factors
☐ was unable to identify any gaps in service delivery
☐ identified systems improvement opportunities unrelated to the root causes / contributing factors

For Internal use only:

	Attached in TRIM		Date
	Copied to the CEC		Date
	Filed		File No.

Table 1 – Root Cause / Contributing Factors Table (a requirement when causes have been identified)
Documentation of causation statements is a legislative requirement. All causation statements must comply with the Rules of Causation. Each root cause displayed must be addressed in the action plan.
Describe the root cause and categorise the cause or contributing factor according to the triage cards and flip chart definitions.

Item No.	Description (of Root Cause / Contributory factor)	Category (described in the Checklist Flip Chart for Root cause Analysis Teams)						
		Communication	Knowledge, skills and competence	Work environment / scheduling	Patient factors	Equipment	Policies / procedures	Safety Mechanisms
1								
2								
3								
4								
5								

Table 2 – RCA Team Recommendations (a requirement when causes have been identified)

Causation statement number[13]	Recommendation/s Description of action to be taken	Risk Classification. Eliminate, Control Accept[14]	Position of person responsible for implementation Recommendation/s	Outcome measure	Completion date e.g. 3 months = 22/02/06	Management Concurrence Y/N
1						
2						
3						
4						

[13] The number here relates to the numbered causation statement in **Table 1 ROOT CAUSE / CONTRIBUTING FACTORS TABLE**

[14] Actions can be classified as eliminating, controlling or accepting the risk. If accepting the risk, risk minimisation strategies need to be in place. Weaker actions are those that accept the risk and include redundancy/double checks, warnings and labels, new procedures and policies, new memorandums, training in absence of knowledge deficit and additional study/ analysis. Medium actions are those taken to control the risk and include checklists and cognitive aids, increased staffing, decreased workload, use of read backs, eliminating look-alikes and sound alikes and eliminating or reducing distractions. Stronger actions are those taken to eliminate the risk and include simplified processes that remove unnecessary steps, standardise equipment, processes or care plans

Table 3 – Systems improvement opportunities unrelated to root causes or contributing factors (modification of these issues would not have helped to prevent the event)

Item No	Description	Recommendation	Position of person responsible for implementation Recommendation/s	Outcome measure	Completion date e.g. 3 months = 22/02/06	Management Concurrence Y/N
1						
2						
3						
4						
5						

RCA Report Final Sign Off

The recommendation/s from the Root Cause Analysis of the incident are endorsed/not endorsed.

Name	Title	Signature	Date
[CE / Service Director]			
Name			
Name			
Name			

I, _____ from _____

endorse /endorse with the following provisions/ do not endorse[15] the recommendations of this RCA.

(Chief Executive / Service Director)

Date

[15] If not endorsed, please provide reasons and document revised action.

6.14 Appendix N – Overview of ims+ Harm Score

Impact/Outcome	Harm Score
Unexpected Death or Sentinel Event (Clinical) Death (WHS) Complete loss of service (Corporate)	1
Major harm[16] (Clinical & WHS) Major loss or disruption (Corporate)	2
Minor harm (Clinical & WHS) Minor loss or disruption (Corporate)	3
No harm or near miss (all)	4

- The Harm Score is auto calculated in ims+ based on the incident outcome and the additional treatment / resources required
- It applies to:
    - Clinical - Patient
    - Corporate – Worker, Visitor, Relative
    - Corporate – No Person
    - It does not apply to consumer feedback or complaints

[16] Refer to Appendix B for definitions of harm.