Department of Health

health

Victorian health incident management policy guide

State Government Victoria

Victorian health incident management policy guide

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www.health.vic.gov.au/clinrisk/vhims/

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Contents

Introduction

The *Victorian health incident management policy guide* (the guide) provides information to assist health services, agencies and their staff to identify, manage and review incidents as they occur across the health care environment in line with the *Victorian health incident management policy*.

This document should be read in conjunction with the *Victorian health incident management policy*.

This guide is comprised of three sections:

- incident management roles and responsibilities
- the incident management process
- incident severity rating.

1. Incident management roles and responsibilities

Incident management is the responsibility of everyone in the health care team. This reflects the overall Risk Management Standard (AS/NZS ISO 31000:2009).

Effective incident management requires a whole-of-organisation approach with clear points of accountability for reporting and feedback at all levels of the organisation.

- The first priority is to ensure that any person affected by the incident is safe and all necessary steps are taken to support and treat the patient, client or resident and prevent further injury to that person and others.
- Support for staff involved must be provided.
- All incidents should be reported to the person in charge or designated manager of the area at the time of the incident.
- All incidents should be recorded in the health services incident management system as defined in the Victorian health incident management system (VHIMS) data set specification and be allocated an incident severity rating (ISR).
- All incident reports should contain an objective and factual account of the incident or near miss.

The Department of Health

The Secretary, Department of Health (the department) has delegated the responsibility for the management of this policy to the Quality, Safety and Patient Experience Branch as appropriate.

Quality, Safety and Patient Experience Branch will:

1. establish, maintain and periodically review VHIMS and associated incident management processes and resources
2. encourage health services and agencies to foster a strong patient safety reporting culture that supports proactive identification of incidents and supports staff through the incident management process
3. undertake data analysis and reporting of de-identified clinical incident data reported to the department
4. disseminate lessons learned from statewide clinical incident reporting
5. provide advice to health services in response to specific queries on incident management and legislative requirements
6. provide advice to the Minister for Health on issues arising from analysis of statewide aggregate clinical incident data.

Chief Executive Officer (and equivalent)

Health service Chief Executive Officer (CEO) will:

1. ensure the organisation has systems in place to report, investigate and monitor actions necessary to reduce the likelihood of incidents recurring
2. ensure sufficient mechanisms are in place to enable the effective reporting, recording, investigation and implementation of recommendations as a result of an incident
3. ensure that staff are encouraged (and supported) to report incidents and near-miss events as a proactive preventative measure
4. ensure that recommendations derived from incident investigations are appropriately addressed and their effectiveness is evaluated
5. ensure analysis of incident data is made available to the organisation's clinical governance committee (or equivalent) for review
6. ensure the principles of open disclosure are observed when interacting with patients and their families or carers when an incident occurs and that these principles guide the overall management of the incident
7. ensure that all sentinel events and clinical ISR 1 incidents where the organisation has identified system or process issues directly contributed to the incident outcome; are reported to the department via the Sentinel Event Program.

Senior managers and heads of department

Health service senior health executives, senior managers and heads of department will:

1. manage incidents within their delegated areas and ensure the learning gained and recommendations from investigation and review processes are fully implemented, monitored and their effectiveness evaluated
2. develop, implement and monitor local (health service or agency) processes that support employees and other persons providing health care on their behalf to achieve effective incident management.
    a. These processes should include training of incident management processes (including open disclosure) and should encourage an environment where incident notification and active management of incidents (and near misses) is fostered
3. ensure timely notification and investigation of incidents in accordance with statutory and department guidelines[1]
4. ensure feedback on recommendations of incident reviews are provided to those who reported the incident and those involved in the management or investigation of the incident
5. ensure recommendations from review of ISR 1 and 2 incidents are included in the health service's governance process to enable monitoring, evaluation and effectiveness of recommendations within the organisation's enterprise risk management process.

1 Reporting the suspicion or allegations of, sexual or serious physical assault against the elderly (elder abuse) is to be made to the Department of Health and Ageing (DoHA) within 24 hours of the allegation being made, or the approved provider becoming suspicious that an assault may have occurred. Reportable assault is defined in sub section 63–1AA(9) of the Aged Care Act 1997 and in section 3 of the Compulsory Reporting Guidelines for Approved Providers of Residential Aged Care and includes unlawful sexual contact and unreasonable use of force. More information can be accessed at: www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-guidelines-cr-ap.htm#1

Safety, quality and risk managers

Health service managers of safety, quality and risk will:

1. ensure appropriate mechanisms are in place for training and education of health service or agency employees on incident management principles and processes (including open disclosure)
2. assist other managers and personnel within their organisation to ensure the health service meets their obligations under the *Victorian health incident management policy*
3. ensure health service incident management policies reflect the department policy and *Clinical governance policy framework*
4. ensure all incidents reported to the department are in the defined VHIMS data specification
5. ensure designated managers and senior staff have closed incidents appropriately
6. coordinate the review and investigation of ISR 1 and 2 incidents and ensure all sentinel events and clinical ISR 1 incidents where the organisation has identified system or process issues directly contributed to the incident outcome are notified to the department within the designated timeframe
7. ensure the effective management of incidents reported and referred by staff
8. provide support and advice to staff managing incidents.

All staff

All staff are responsible for:

1. notifying their designated manager of an incident at the time of the event
2. reporting incidents in the health service incident management system
3. participating in the investigation and review of incidents as required
4. participating in the implementation of recommendations arising from investigation of incidents
5. encouraging colleagues to notify all incidents identified.

2. The incident management process

There are seven steps to effective incident management:

- identification
- notification
- prioritisation
- investigation
- classification
- analysis and action
- feedback.

Identification

It is important for all staff to recognise when an incident has occurred. An incident is defined as and event or circumstance that could have, or did, lead to unintended and/or unnecessary harm.[2] This will only be achieved in a culture and environment that allows this to happen without fear of retribution, and where incidents (and the reporting of incidents) are an acceptable part of health care delivery.

Each health service will need to foster this culture.

Following identification of an incident or near miss there may need to be immediate action. These actions may include:

- providing immediate care to individuals involved in the incident (patient, staff or visitors)
- making the situation or scene safe to prevent immediate recurrence of the incident
- notify the manager in charge of the area that an incident has occurred
- removing malfunctioning equipment or supplies
- gathering basic information about a chain of evidence
- notifying police and security.

Notification

Staff are required to notify all incidents and near-miss events in the health service incident management system.

Documentation of the incident in the health record

All clinical incidents must be documented in the patient's health care record. Care must be taken to ensure only clinically relevant and factual information is included in the health record.

Incident notification in VHIMS – by the notifier

Reporting an incident must occur as soon as practicable and preferably is to occur by the end of the notifier's work day.

2 Australian Commission on Safety and Quality in Health Care incident definition accessed via: www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/inforx-lp

Anonymous reporting is a component of VHIMS; however follow-ups and feedback of outcomes to the reporter as a result of the incident notification are limited in this context.

In the VHIMS application there are a number of mandatory fields that must be completed in order to submit an incident.

It is important for notifiers to give as much information as possible to assist further review and management of the incident and allow optimal classification of incidents and comparison of data. Note the incident report should contain factual information not individual assumptions of what occurred.

The mandatory (minimum dataset) required for each incident is guided by the notification type.

The notifier is asked to undertake an initial assessment of the incident severity based on the answer to three questions:

- degree of impact
- level of care
- treatment required.

The combined answers to these three variables automatically derive the ISR.

The patient and their family or carer can notify an incident through the consumer feedback process in place in each health service or agency.

Incident notification – management responsibility

Managers are required to review the incident notification, complete the incident form with any additional information, and confirm the ISR rating according to the actual incident outcome or near miss.

Notification to patient (open disclosure)

All clinical ISR 1 and 2 events are to be managed by the open disclosure process. The initial disclosure to the patient, client or resident or their support person must occur within 24 hours of the incident, or as soon as is practicable, by the health care professional responsible for the care of the patient or their approved delegate.

When a clinical incident occurs to a patient, client or resident, an integral component of the notification process is to acknowledge the occurrence of the incident to the patient and their support person, as appropriate, and to inform them of the type of investigation that will be undertaken.

An apology for the incident suffered is given at this stage; refer to the departments Open Disclosure e-Learning module and toolkit for further guidance on the open disclosure process: www.health.vic.gov.au/clinrisk/opendisc.htm

Prioritisation

The purpose of prioritisation is to ensure that a standardised, objective measure of severity is allocated to each incident or near miss. This enables an appropriate level of investigation to be conducted.

The ISR is used to prioritise all notifications. The ISR was developed based on the World Health Organization (WHO) Incident Classification for Patient Safety (ICPS) Conceptual Framework. VHIMS will derive the ISR from an algorithm structured on the responses to the three questions relating to:

- degree of impact
- level of care
- treatment required.

The ISR rating guides the level of investigation and the need for additional notification.

All ISR 1 incidents should be notified to the Chief Executive Officer of the organisation through the local clinical governance notification and escalation process.

All sentinel events and clinical ISR 1 incidents where the organisation has identified system or process issues directly contributed to the incident outcome require a detailed and thorough investigation using the root cause analysis (RCA) methodology. Clinical ISR 1 incidents not deemed to be related to hospital (agency) system or process issues should be reviewed with either in-depth case review or RCA methodology.

From 1 March 2011 all sentinel events and ISR 1 clinical incidents where the organisation has identified system or process issues directly contributed to the incident outcome are to be notified to the department's Sentinel Event Program as outlined in the *Victorian health incident management policy*.

Investigation

Investigation of the incident is an important component of any patient safety program. All incidents notified in VHIMS require an investigation or review process.

Investigations conducted under this policy should not canvass issues of individual performance. Where a question of individual performance arises, this is to be managed via the organisation's performance management system.

All incidents, irrespective of their ISR rating, require a review to assess the level of investigation required.

The ISR rating guides the level of investigation. All health services should:

- assign appropriate levels of responsibility for investigation and management of all incidents
- have policies and procedures in place to guide the investigation of incidents that reflect the principles of open disclosure
- have staff training programs in place for investigation of incidents
- have appropriately trained staff to support staff involved in incident investigations
- ensure feedback mechanisms are in place so that staff are informed of outcomes related to incidents reported

- all sentinel events and ISR 1 clinical incidents where the organisation has identified system or process issues directly contributed to the incident outcome receive a detailed and thorough investigation using the RCA methodology
- all ISR 1 clinical incidents where the organisation has identified the contributing factors to the incident outcome relate directly to the patient's illness or management phase of their chronic illness require an in depth case review
- all ISR 2 incidents are investigated using the in-depth case review methodology or principles
- all ISR 3 and 4 incidents are reviewed as an aggregate (as a minimum) over a designated time period (either weekly, monthly or quarterly) as prescribed within the individual health service clinical governance policy and procedures.

ISR 1 incidents

All ISR 1 incidents must be reviewed by health services to determine causation and opportunities for system improvement.

On identification of an ISR 1 clinical incident, the health service is to review the incident to determine whether the outcome was directly related to system or process issues.

If this initial review signifies hospital (or agency) processes contributed to the incident outcome, an RCA is to be undertaken to explore causation and indentify contributing factors, and the following notifications are to be made:

- Notification to the department's Sentinel Event Program must be made within three days of the incident occurring.
- The final de-identified RCA summary report is to be provided to the department within 60 days of notification.

The summary report of the ISR 1 incident investigation should be presented to the team involved in care of the patient. The outcomes should also be presented or made available at relevant staff meetings to ensure staff are aware of the factors contributing to the incident and the action being taken to improve safety.

Recommendations stemming from the RCA report, where possible, should be linked to the health service's risk register to ensure continuity of the monitoring of both the evaluation and effectiveness of the recommended actions as a corporate risk management strategy.

ISR 2 incidents

All ISR 2 incidents require a detailed investigation of the incident preferably utilising the in-depth case review methodology.

Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a quality or practice improvement project.

Responsibility for reporting ISR 2 incident reviews should be assigned to a designated senior manager in order to link into the health service clinical governance policies and procedures.

ISR 3 and 4 incidents

The investigation of ISR 3 and 4 incidents can be undertaken at the local level but management responsibility for the investigation or review process must be assigned.

Monitoring of trended aggregate incident data may also identify and prioritise issues requiring a quality or practice improvement project.

Reports and analysis of aggregate ISR 3 and 4 incidents should be an agenda item for the ward, department or unit on a regular basis. This provides an opportunity for the clinical team to review incidents relating to their area and identify opportunities for change.

The reporting back also acts as a feedback loop for managers to inform staff and the clinical teams of outcomes relating to reported incidents.

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, contributory and preventative factors, are documented and understood.

Classification of all incidents involving patients, staff, visitors, volunteers, contractors or corporate systems can be made in VHIMS.

Classification is undertaken by nominated personnel according to the individual health service incident management policy. This undertaking may differ between sites and health services. Classification for specialist incident types may include local managers, patient safety managers, occupational health and safety (OH&S) managers and staff of clinical governance units.

It is important the mandatory fields in VHIMS report fields are completed for each incident.

The information provided through classification is included in reports available to managers. This will assist them to develop strategies based on trended data to understand cumulative risk and to minimise the recurrence of such incidents in their area of responsibility.

Analysis and action

The primary purpose of incident analysis is to understand how and why the incident occurred, and to identify ways of preventing a recurrence. The analysis should take into account information gathered during the investigation and classification phases. Actions and recommendations are developed to prevent recurrence of the incident.

A timeframe for the implementation of recommendations from incident investigations is documented in VHIMS. Senior management is responsible for deciding whether recommendations are accepted and approved and for appropriate resource allocation.

A senior manager records the acceptance of recommendations and comments once the recommendations have been endorsed by the health service governance process.

The statewide incident management system, VHIMS is used to capture actions and recommendations, and to flag follow up of outstanding actions and review dates.

Ongoing local monitoring is required to ensure recommendations are addressed in a timely manner and to evaluate the success of any action taken to achieve improvement. This is best achieved when recommendations and the corresponding actions are linked to the health service risk register.

Health services can analyse their own incident data through the monitoring of trend and aggregate reports designed and managed at the local level.

At the state level analysis of aggregate de-identified data and actions taken to minimise re-occurrence will provide the platform for sharing of lessons learned from across the state and over multiple care setting types.

The department will develop and circulate statewide aggregate reports for health services to compare their incident data with broader, statewide, de-identified data. The department will also provide a series of reports on trends indentified through analysis of multi-severity level clinical incidents.

Feedback

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

Feedback to patients and support person (open disclosure)

Information about ISR 1 and 2 clinical incidents should be offered to the patient, client or resident or their support person. This feedback process reflects principles of the open disclosure process.

The information provided to a person can be based on a variety of sources, but above all should be factual and presented in a manner that is understood by the recipient audience.

The summary report from an RCA is one of the sources that may be used in providing feedback on a clinical ISR 1 incident.

The principles of open disclosure should be observed through this feedback process, refer to www.health.vic.gov.au/clinrisk/odtoolkit.htm for additional information on this process.

Feedback to staff

It is well-documented that the success of incident management systems, regardless of their level of sophistication, is dependent on feedback to staff on the results and outcomes of investigations in a timely manner.

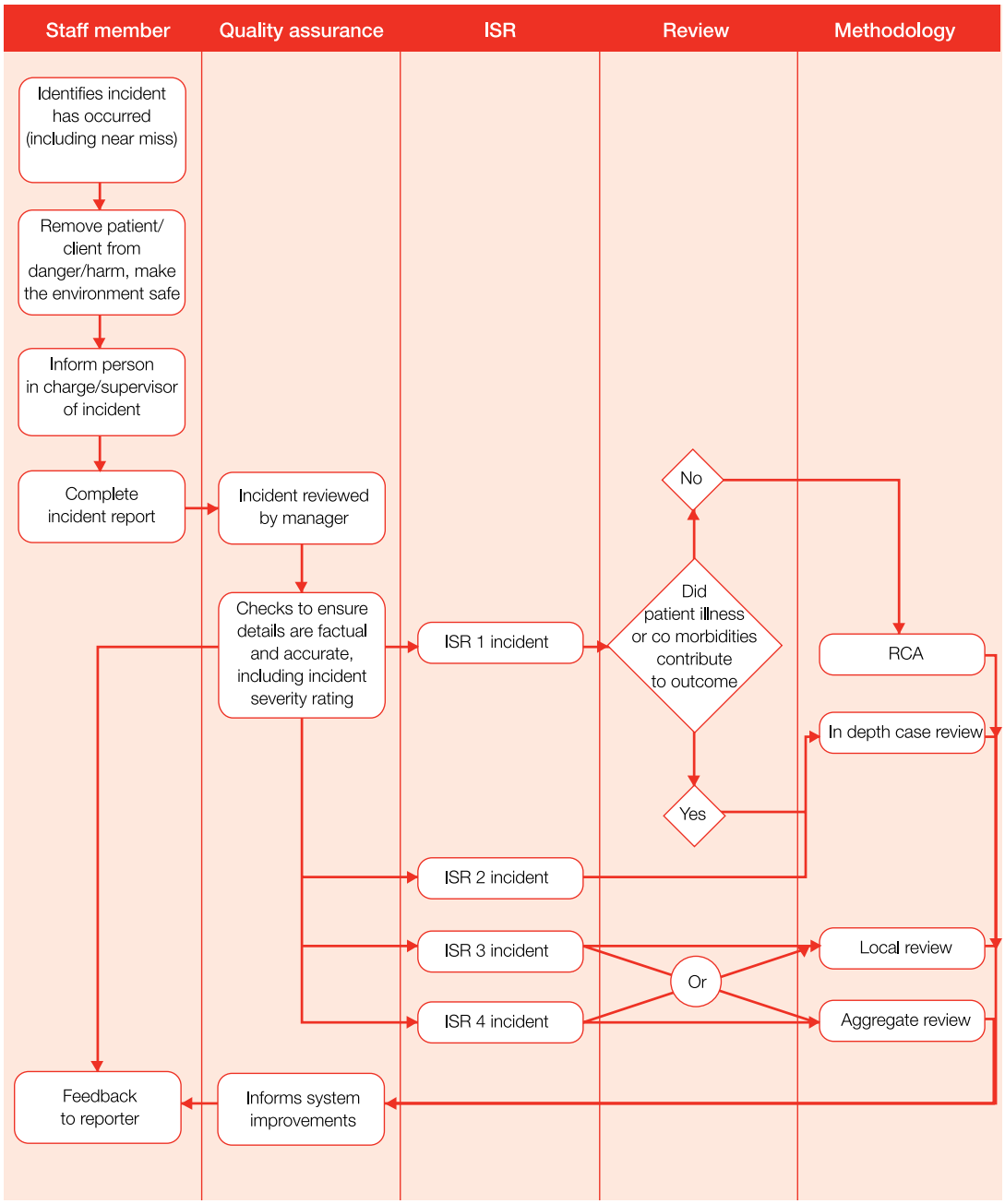
It is imperative staff involved in an incident be informed of the recommendations arising from any investigation.

The summary RCA report provides the basis for feedback on a clinical ISR 1 incident. The findings of these and other incidents should be given to the relevant clinical team and presented at staff meetings.

Regular reports on trended aggregate incident data and outcomes of clinical case reviews and other forms of investigation should be provided to ward staff or clinical and management teams.

Feedback should also include the changes made and improvements achieved as a result of these amendments to practice.

A diagrammatic overview of the incident management process is outlined below



3. Incident severity rating (ISR)

The VHIMS ISR methodology was developed following analysis of methodologies used nationally and internationally. This included methodologies suggested by the World Health Organization and used by the National Health Service in the United Kingdom.

The ISR methodology provides a more consistent classification of incident severity. It also allows Victorian incident data to be mapped to a variety of other methodologies.

The ISR methodology can be consistently applied across all clinical (patient) and occupational health and safety (OHS) incidents.

The ISR is based on:

- the actual and potential impact to those involved in the incident
- the actual and potential impact to the organisation.

The impact to the people involved is automatically derived from three related questions, these are:

1. degree of impact
2. level of care
3. treatment required.

VHIMS will derive an ISR depending on the values selected by the end user in each of the three lead questions. Following are the specific details relating to each element of the ISR algorithm.

ISR scale

1	Severe/death
2	Moderate
3	Mild
4	No harm/near miss

Definition – degree of impact

Where harm includes disease, injury, suffering, disability and death:[3]

- disease – a physiological or psychological dysfunction
- injury – damage to tissues caused by an agent or circumstance
- suffering – experiencing anything subjectively unpleasant. This may include pain, malaise, nausea, vomiting, loss (any negative consequence, including financial) depression, agitation, alarm, fear or grief
- disability – any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with a past or present harm.

No harm – did not reach the subject	There was no harm to the subject, that is, the incident did not reach the subject.
No harm – did reach the subject	The incident reached the subject, but there was no harm caused.
No harm – significantly inconvenienced	The subject was significantly inconvenienced in relation to time, travel, wages, lifestyle and family impact as a result of the issue and/or incident.
Harm – but no loss or reduction in functioning	The subject experienced harm but did not have a loss or reduction in functioning as a result of the incident.
Harm – temporary reduction in functioning	One or more systems or components of the subject's body are able to operate, fulfilling their purpose or role, but not to the level they could prior to the incident. The subject is likely to recover from this reduction in the short-medium term.
Harm – temporary loss in functioning	One or more systems or components of the subject's body are no longer able to operate normally, fulfilling their purpose or role. The subject is likely to recover from this loss within the short-medium term.
Harm – permanent reduction in functioning	One or more systems or components of the subject's body are able to operate, fulfilling their purpose or role, but not to the level they could prior to the incident. The subject is not likely to recover from this reduction.
Harm – permanent loss in functioning	One or more systems or components of the subject's body are no longer able to operate normally, fulfilling their purpose or role. The subject is not likely to recover from this loss.
Harm – death	The subject died unexpectedly at the time of, or following the incident.
Unknown	The degree of harm caused to the subject, due to the incident, is not known at this time.

3 Australian Commission on Safety and Quality in Healthcare (ACSQHC)

Definition – level of care

No significant change	The subject did not require any significant extra care or increased length of stay or higher care as a result of the incident.
Current setting – increased observation, monitoring or length of stay	The subject required increased observation, monitoring or length of stay within their current setting, for example, ward. The subject was not transferred elsewhere to a higher level of care.
Internal transfer to a higher level of care or specialled	The subject was transferred internally within current organisation to a higher level of care, for example, ICU, or required specialling, that is one-on-one care.
External transfer – non inpatient	The subject was transferred externally to another health care provider for care, but was not admitted.
External transfer – inpatient admission	The subject was transferred externally to another health care provider, for a higher level of care, for example ICU.
Not applicable	The level of care is set to 'not applicable' when the degree of impact was 'death'.
Unknown	The change in level of care required by the subject, due to the incident, is not known at this time.

Definition – treatment required

No treatment	Following a clinical review, intervention was deemed not required.
Minor treatment including first aid	The subject required a simple or minor intervention as a result of the incident. For example, blood tests, xray, dressings, medications such as panadol, peripheral IVT, urinary catheter insertion, nasogastric tube et cetera.
Advanced treatment	The subject required significant medical, diagnostic or surgical intervention as a result of the incident. For example, MRI, CT, medications such as adrenaline, insertion CVC or PICC line.
Not applicable	The treatment required is set to 'not applicable' when the degree of impact was 'death'.

4. Relevant department policies, procedures, guidelines and documents

Sentinel Event Program

www.health.vic.gov.au/clinrisk/sentinel/ser.htm

Blood Matters Program, Serious Transfusion Incident Reporting (STIR)

www.health.vic.gov.au/best/tools/stir.htm

Compulsory Reporting Guidelines for Approved Providers of Residential Aged Care – includes unlawful sexual contact and unreasonable use of force.

www.health.vic.gov.au/agedcare/services/psracs.htm

Radiation Safety Program, Environmental Health, Public Health

www.health.vic.gov.au/environment/radiation/licensing/management.htm

Department Health – Incident Reporting Instruction 2010

http://intranet.health.vic.gov.au/resources-and-tools/policies-and-standards/incident_reporting.pdf and www.fac.dhs.vic.gov.au

Victorian health incident management system e-Learning module

www.health.vic.gov.au/clinrisk/vhims/index.htm

Open disclosure e-Learning module and toolkit

www.health.vic.gov.au/clinrisk/odtoolkit.htm

Victorian clinical governance policy framework

www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy.htm

Further information

Please contact QSPE branch on 9096 7258 for further details. Additional information is also available at www.health.vic.gov.au/clinrisk/vhims/