# SESLHD PROCEDURE COVER SHEET

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| **NAME OF DOCUMENT** | Assessment and Management of Serious Incidents |
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| **FUNCTIONAL GROUP(S)** | Clinical Governance |
| **KEY TERMS** | Incidents, clinical incidents, corporate incidents, reporting, Harm Score (HS) 1, Harm Score (HS) 2, clinical risk, analysis, revising, IMS+ |
| **SUMMARY** | This procedure outlines the approval process for revising/correcting the Harm Score (HS) of incidents initially reported as a HS 1. It also outlines the reporting requirements to the Chief Executive (CE) of HS 2 incidents. |

## 1. POLICY STATEMENT

This procedure outlines the immediate steps to be undertaken by SESLHD personnel following notification of Clinical and Corporate Harm Score (HS) 1 or HS 2 incidents, and the reporting requirements to the Chief Executive. It also outlines the approval process for the revision of the Harm Score of incidents initially reported as a HS1 and the steps to be undertaken for the analysis and escalation of clinical risk.

## 2. BACKGROUND

Following identification of any incident, it is necessary to take immediate action to mitigate any potential or actual harmful consequences of the incident.

NSW Ministry of Health Policy Directive PD2020_047 – Incident Management outlines the mandated response to serious adverse events.

A Harm Score is allocated within the IMS+ system depending on the outcome for the effected person, however, an incorrect HS can sometimes be allocated by the notifier.

The NSW Ministry of Health (MOH) has mandated that where it is determined that an initial HS 1 rating requires revision/correction, the Director Clinical Governance and the Chief Executive must give final approval before the HS 1 rating is revised/corrected.

## 3. RESPONSIBILITIES

### 3.1 Employees will:

- Immediately report HS 1 and HS 2 incidents to their Line Manager.
- Notify any identified incident (both clinical and corporate) in the Incident Management System (IMS+), as outlined in the NSW Ministry of Health Policy Directive – PD2020_047 - incident Management Policy.

### 3.2 Line Managers / Service Managers will:

- Ensure immediate action is undertaken in accordance with the NSW Ministry of Health Policy Directive – PD2020_047 - incident Management Policy.
- Review the incident notification and allocate an actual HS rating in line with the IMS+ categories.
- If the rating is a HS 1, the Line Manager/Service Manager must immediately report the incident to the After Hours managers/General Manager/Service Director and the Clinical Practice Improvement Unit (CPIU).
- If the HS 1 rating is incorrect and requires revision, inform relevant staff from CPIU as per local procedures and obtain approval for revision from the General Manager.
- If the rating is a HS 2, the Line Manager/ Service Manager must immediately report the incident to the CPIU as per local procedures.

### 3.3 CPIU staff will:

- Review all new incident notifications in the Incident Information Management System IMS+ on a daily basis (Monday – Friday) and ensure incidents have been assigned appropriate Harm Scores.

- Consult with the Line Manager/Service Manager to confirm the initial Harm Score for HS 1 and HS 2 incidents.
- Notify the General Manager/Service Director and District Clinical Governance staff of HS 1 and HS 2 incidents, and the need to revise a SAC 1 score when the initial rating is incorrect.
- Facilitate Preliminary Risk Assessment (PRA) meetings and/or Clinical Incident Review meetings as per NSW Ministry of Health Policy Directive – PD2020_047 - incident Management Policy.

### 3.4 General Managers and Service Directors will:

- Ensure that all HS 1 incidents are notified to the Chief Executive and Director Clinical Governance and Medical Services within 24 hours.
- If a HS 1 is incorrect and requires revision, notify the Deputy Director Clinical Governance and Medical Services for approval.
- Ensure that all confirmed HS 2 incidents are notified to the Deputy Director Clinical Governance and Medical Services within 24 hours of local confirmation (72 hours on weekends and public holidays).
- Ensure that the Director Clinical Governance and Medical Services is informed of any staff performance issues or risks to the organisation in relation to HS 1 and HS 2 incidents.
- Ensure there are processes in place for the trending and analysis of incidents and identification of clinical risk e.g. reoccurring incidents in particular services.

### 3.5 The Deputy Director Clinical Governance and Medical Services will:

- Ensure that all HS 1 Incidents are notified to the Chief Executive within 24 hours, with RIB submitted to MoH within mandated timeframe.
- Confirm if appropriate to revise/correct a HS 1 incident, and seek approval from the Chief Executive.
- Ensure that all confirmed HS 2 incidents are notified to the Chief Executive within 48 hours (72 hours on weekends and public holidays).
- Ensure that the Chief Executive is informed of any staff performance issues or risks to the organisation, in relation to HS 1 and HS 2 incidents, within 24 hours.
- Provide trended reports of all SAC 2 incidents to the SESLHD Clinical and Quality Council.

## 4. PROCEDURE

### 4.1 Harm Score 1 Incidents

- All staff will report clinical and corporate incidents and complaints in the Incident Management System, and immediately report HS 1 incidents to their Line Manager.
- The Line Manager will allocate an actual HS 1 rating and report the incident to the Service Manager.
- The Service Manager will immediately report the incident to the General Manager with involvement of the CPIU as per local processes.
- The General Manager or delegate will immediately notify the Chief Executive and the Deputy Director Clinical Governance and Medical Services.

- A PRA meeting will be arranged, as per NSW Ministry of Health Policy Directive – PD2020_047 - incident Management Policy.
- Identify staff performance issues and if required, refer to the relevant manager for follow up as per NSW Ministry of Health Policy Directive PD2018_032 - Managing Complaints and Concerns about Clinicians.
- The approved Reportable Incident Brief (RIB) Part A should be sent to the Deputy Director Clinical Governance and Medical Services via the IMS+ system for approval by the CE and submission to the MoH within 24 hours.
- A SAER team will be commissioned to investigate and report, as per NSW Ministry of Health Policy Directive – PD2020_047 - incident Management Policy.
- Information regarding identified staff performance issues or risks to the organisation should be sent to the Deputy Director, Clinical Governance and Medical Services with the RIB, for escalation to the Chief Executive.

### 4.2 REVISING THE HARM SCORE (HS) OF INCIDENTS INITIALLY REPORTED AS A HS 1

- If it is identified that a HS 1 score may be incorrect, CPIU staff must confirm the clinical outcome of the patient incident and check the rating with the IMS+ categories
- If the score is incorrect, CPIU staff must seek approval from the General Manager and the Deputy Director Clinical Governance and Medical Services, who will seek approval from the Chief Executive to revise the H Score.
- Once approved the SESLHD Clinical Governance Unit will revise the HS score in the Incident Information Management System (IMS+), and document the approval and rationale for the HS 1 revision in the progress notes section of the incident notification.
- Facilities/Directorates must table the HS 1 incidents that are revised at local Patient Safety and Clinical Quality meetings.
- CPIU staff are to provide feedback to notifiers and their managers.

### 4.3 HS 2 INCIDENTS

- All staff will report clinical and corporate incidents and complaints in the Incident Management System (IMS+) and immediately report HS 2 incidents to their Line Manager.
- The Line Manager will allocate an actual HS 2 rating and report the incident to the Service Manager and the CPIU as per local processes.
- The CPIU and Service Manager will ensure that Open Disclosure occurs.
- The Service Manager should immediately report any identified performance issues or organisational risks related to HS 2 incidents to the General Manager.
- The CPIU staff will notify the General Manager and Clinical Governance Unit within 24 hours (72 hours on weekends and public holidays) that a confirmed HS 2 incident has occurred.
- The Clinical Governance Unit will notify the Chief Executive and Director of Operations that a HS 2 incident has been reported, and if there are identified organisational risks or staff performance issues.

## 5. CLINICAL RISK

- All SESLHD Facilities and Directorates must ensure that a thematic analysis of all HS 2 incidents is conducted and reported to the Facility/Directorate Patient Safety and Clinical Quality Committee quarterly.

- The trended report should include monthly data over two years and include principle incident type (PIT), location, speciality and further analysis of principle incident type to identify areas of concern.
- Emerging risks associated with reoccurring incidents in particular services should be addressed.
- The Clinical Governance Unit will provide a monthly trended HS 2 report to the SESLHD Clinical and Quality Council.
- The Clinical Governance Unit will provide an annual HS 1/SAER themed report to the Clinical and Quality Council.

## 6. DOCUMENTATION

- Incident Management System
- Reportable Incident Brief

## 7. AUDIT

Nil

## 8. REFERENCES

NSW Ministry of Health Policy Directive PD2020_047 - Incident Management Policy
NSW Ministry of Health Policy Directive PD2014_028 - Open Disclosure Policy
NSW Ministry of Health Policy Directive PD2018_032 - Managing Complaints and Concerns about Clinicians

## 9. REVISION AND APPROVAL HISTORY

| Date | Revision No. | Author and Approval |
|---|---|---|
| October 2016 | 1 | Kim Brookes, Acting Director Clinical Governance |
| December 2016 | 1 | Endorsed by DET |
| February 2019 | 2 | Major review endorsed by Executive Sponsor – Kim Brookes, Director Clinical Governance |
| March 2019 | 2 | Draft for comment period. |
| May 2019 | 2 | Feedback incorporated and final version approved by Executive Sponsor.<br>Formatted by Executive Services prior to tabling at June 2019 Clinical and Quality Council meeting for approval. |
| June 2019 | 2 | Approved by Clinical and Quality Council |
| June 2021 | 3 | Minor review by Patient Safety Manager. Changes to RCA/SAER terminology and ims+. |
| September 2021 | 3 | Approved by Deputy Director of Clinical Governance and Medical Services<br>Approved by Executive Sponsor. |