SESLHD PROCEDURE COVER SHEET

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FUNCTIONAL GROUP(S)	Workplace Health and Safety
KEY TERMS	Dangerous and notifiable incidents, injury, investigation, incident investigation, safety investigation,
SUMMARY	This procedure informs all SESLHD staff on the requirements for investigating for a safety related incident (also referred to as corporate incidents in the NSW Health Incident Management Policy).

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Health Safety and Wellbeing Incident Investigation

SESLHDPR/322

1. POLICY STATEMENT

This procedure has been developed to meet the requirements for the NSW Health Policy Directive PD2018_013 - Work Health and Safety: Better Practice Procedures, NSW Health Policy Directive PD2020_047 - Incident Management Policy, the Work Health and Safety (WHS) Act and Regulation, and outlines the process for investigating reported work health, safety and wellbeing related incidents.

2. BACKGROUND

The purpose of this procedure is to effectively respond to safety incidents and act on lessons learned across all South Eastern Sydney Local Health District.

Effective incident investigation requires an organised approach, with incidents being investigated in a timely and comprehensive manner, so that we can learn from incidents and prevent their recurrence.

3. DEFINITIONS

Refer to Appendix 1 - Definitions

4. RESPONSIBILITIES

Role	Responsibilities
All Workers	• Identify incidents • Notify incidents to their manager and report in the iMS+ incident reporting system, on the same day or as soon as practicable following an incident • Undertake training in incident notification and reporting • Participate in the incident investigation process as required • Participate in recommended improvements, in consultation with their management • Undertake any required emergency response actions • Preserve the incident site as required.
Managers	• Immediately report notifiable incidents to the General Manager of the facility / services and report in the iMS+ reporting system on behalf of the worker if the worker is not able to do so – on the same day or as soon as practicable • Ensure Harm Score 1 and 2 incidents are reported to senior management and NSW Health and to meet required regulatory obligations – within 24 hours • Undertake any required emergency response actions • Preserve the incident site as required • Conduct an incident investigation in consultation with staff, within 24 hours of becoming aware of the incident, to ensure appropriate measures are implemented to eliminate or manage the risk to as low as reasonably practicable

Role	Responsibilities
	• Monitor that incidents are recorded and updated in the iMS+ system and corrective actions completed within the required time frame. • Change incident status from 'New' to 'Investigate' in ims+ within 24 hours – Harm Score 1 incidents, and within 5 calendar days – Harm Score 2, 3, and 4 incidents • Confirm the Harm Score in ims+ as soon as possible • Complete the mandatory and relevant fields for each incident in ims+ • Complete service / unit level reviews for Harm Score 3 and 4 incidents within 45 calendar days of notification • Change incident status from 'Under Investigation' to 'Investigation Complete' in ims+: Within 60 calendar days of notification – Harm Score 1 incidents; Within 45 calendar days of notification – Harm Score 2, 3 and 4 incidents • Communicate corrective actions implemented, to all their staff • Ensure all risk control actions are monitored to ensure their completion and continued effectiveness • Review incident data in appropriate forums to monitor accident/incident trends and ensure appropriate action has been implemented • Undertake relevant incident management training
Heads of Departments, Service Managers and Stream Leaders, Senior Management	• Ensure compliance and monitoring with this procedure • Ensure an effective incident management system is implemented for the effective management and investigation of safety related incidents, in accordance with this procedure • Assist managers with incident management as needed • Support staff involved in incidents • Support staff participation in incident review • Analyse and discuss incident trends and related datasets • Escalate incidents, trends and risks as needed • Ensure that the corrective action plans are implemented in a timely manner as agreed • Ensure that any significant or notifiable incident has been reported through to the Health Safety and Wellbeing Services • Consult with Executive Management to ensure they are aware of the incident and the procedures for managing and investigation of the incident.
Health Safety and Wellbeing Services	• Monitor reported incidents and participate in the investigation as required for the following incidents: ○ where several similar incidents are reported, and a trend is identified ○ the confirmed HARM score rating is a Level 1 or 2 ○ the incident involves a visitor ○ a workers compensation claim has been lodged the relevant Recovery Partner and Health and Safety Partner are to conduct the investigation together. ○ the facility / services senior management has requested assistance to investigate an incident ○ a serious incident has occurred ○ when a situation requires further investigation. e.g., SafeWork

Role	Responsibilities
	investigation, or Regulator notifiable incident ○ where there are potential learnings across SESLHD. • Complete a Reportable Incident Brief (RIB) for any Harm Score 1 incidents, when appointed by the Chief Executive. A review report is due to the Ministry of Health within 60 calendar days • Provide incident trends and incident management reporting to Health and Safety Committees and Executives, and support incident prevention strategies • Provide support to Facility / Services Managers in completing investigations
Health and Safety Committee / Representatives	• Monitor trends and incident performance for the facility / services • Review significant incident investigations including the reported outcomes and monitor and report on the status and progress of corrective actions to address findings from investigations • Identify if further actions are required for the facility / services, including assistance where needed, for internal and external investigations.
Chief Executive	• Ensure processes are in place for timely incident identification • Provide access to training for incident management • Ensure processes are in place to support staff involved in incidents • Notify reportable incidents (Harm Score 1) within 24 hours for RIB Part A; and within 72 hours or earlier for RIB part B • Telephone the Ministry of Health if urgent attention is required for a corporate incident • Appoint safety check teams to undertake safety checks of corporate Harm Score 1 incidents • Appoint DFC for corporate Harm Score 1 incidents involving death of a staff member • Notify the NSW Treasury Managed Fund (TMF) of incidents with the potential to become legal claims • Undertake corporate Harm Score 1 review and submit report to the Ministry of Health within 60 calendar days of the notification in ims+ • Communicate regularly with the carer or family during corporate Harm Score 1 review of the death of a staff member, as per family's wishes • Monitor and rate risks identified via corporate Harm Score 1 reviews as per the relevant NSW Health policies e.g., Risk Management – Enterprise-Wide Risk Management Policy and Framework (PD2015_043) and Work Health and Safety Better Practice Procedures (PD2018_013) • Undertake corporate Harm Score 1 reviews within 45 calendar days of notification • Report trended incident data and outcomes of corporate Harm Score 1 reviews to peak safety committees, the Board and relevant groups within SESLHD • Contribute to state-wide improvements with the Ministry of Health, Clinical Excellence Commission and other Health Services.

5. PROCEDURE

This procedure should be implemented in conjunction with the NSW Health Policy Directive PD2020_047 - Incident Management Policy. All staff must be trained in the SESLHD emergency response, incident management procedures and be prepared to execute these procedures where required. Safety investigators must also be trained in investigation management procedures.

5.1 Safety Incident Management (All Staff)

Apply this procedure, in conjunction with **Appendix B** – HSW Incident Management Flow Chart, **Appendix C** - Incident management steps for corporate Harm Score (HS) 1 to 4 incidents, and **Appendix D** NSW Health Incident Management Process Flowchart - Corporate.

5.1.1 Step 1 - Identify

All staff are responsible for identifying incidents. Most incidents are identified at the time of an event, and some are identified after the event. Sources of incident identification may include reports in IMS+ incident report management system, or via a manager or phone call to the Head of Health Safety and Wellbeing, or Manager Health and Safety, team discussions, audits, safety committees, complaints and other methods.

NOTE: The most effective method for reporting an event is in the **IMS+ incident report management system** - reporting must take place **within 24 hours of identification of an event**. Reporting in ims+ will result in the appropriate managers and key stakeholders are contacted, timely and effective actions are taken as required, and regulatory compliance obligations are met.

Note: *Steps 2, 3 and 4 may occur simultaneously.*

5.1.2 Step 2 - Ensure Safety

Check the area and act as needed to make the site safe, secure, preserve the site, prevent further injury and/or damage if it is safe to do so

- Provide care for any people involved in the incident as required
- Make the environment safe to prevent immediate recurrence
- Preserve the scene for regulators (such SafeWork NSW, NSW Environmental Protection Authority), the Coroner or NSW Police, if safe to do so
- Call for assistance as required, such as emergency services and security
- Secure the incident site to preserve evidence
- Determine if this is a notifiable incident and if so, preserve the scene for SafeWork NSW and report the incident as soon as is reasonably practicable to the appropriate manager. Refer to SafeWork NSW guide.

Note: In the case of a SafeWork NSW 'notifiable incident', the scene of the hazard, incident or injury cannot be disturbed. A 'notifiable incident' under the Work Health and Safety (WHS) Act 2011, Section 35 relates to:

- the death of a person
- a serious injury or illness of a person, or
- a dangerous incident.

The site where the incident occurred must not be disturbed in any way, other than to assist an injured person or make the area safe, until such time as a SafeWork NSW inspector arrives at the site or any earlier time that an inspector directs.

5.1.3 Step 3 - Notify

Staff must notify all incidents, hazards, risks, concerns and near misses in the NSW Health incident management system, IMS+. Corporate incidents may relate to people or environmental hazards.

- Notify in IMS+ on the same day or as soon as practicable. Reporting is mandatory within 24 hours of the event
- The manager and workers must determine at what stage it is necessary to implement an emergency alert code in accordance with the Facility Emergency Management Policy.

5.1.3.1 Corporate Harm Score 3 and 4 Incidents

A corporate HS3 incident involves minor harm to a worker or visitor, or minor loss or disruption of service. No harm or a near miss is a corporate HS4 incident.
Escalate concerns to a manager – corporate incidents Staff are to seek advice from a manager when:

- Another service/unit may need to be notified e.g., Biomedical engineering and HealthShare Procurement about a faulty device
- External discussion may be needed e.g., a supplier
- An external regulator may need to be notified e.g., SafeWork NSW, NSW Food Authority, NSW Environmental Protection Authority (EPA), Therapeutic Goods Administration (TGA)
- Police may need to be contacted e.g., suspected criminal activity
- You have any concerns.

5.1.4 Step 4 - Escalate

Escalation will depend on incident severity. The manager (person in charge of the area) when notified of an incident will immediately implement the relevant incident/emergency procedures, and notify the following:

- Senior Management - General Manager or Executive delegate
- Head of Health Safety and Wellbeing or Manager Health and Safety
- After Hours Hospital Manager (if incident occurred out of normal working hours).

Once the incident has been controlled or passed on to others as outlined in the facility / service emergency plan, the manager will:

- Assist with collecting evidence being careful to preserve the site as needed
- **Report the incident in IMS+, within 24 hours, incident report management system, if not completed in Step 3 - Notify**
- Refer impacted staff to Injury Net
- Complete any injury notification forms if required and confirm the Harm Score in IMS+.

5.1.5 Step 5 – Review

The review identifies what happened, why it happened and what could be done to improve safety and prevent recurrence. The type of review and level of oversight depends on the incident severity and risk. Refer to Appendix C and D of this procedure.

- Conduct an Incident Investigation and complete the system template for all significant or notifiable incidents, work injuries or where a worker's compensation claim is made
- Within 45 days (Harm Score 3 or 4 incidents) report to their manager and the HSW Team on the outcomes of the incident investigation and provide a copy of the investigation outlining the actions required to prevent a similar incident from re-occurring
- Consult with the workers regarding the outcome of the investigation, action plans and recommendations
- Close IMS+ investigation report in the incident management system.

5.1.5.1 Review of Corporate HS3 and 4 incidents

Managers are to undertake service/unit reviews. They:

- Review the medical record and/or documentation
- If concerned after initial review, escalate to senior management
- Liaise with clinicians and teams as needed
- Assess the physical location of the incident if needed

- Refer to relevant NSW Health and Health Service policies e.g., PD2013_043 - Medication Handling in NSW Public Health Facilities, PD2018_013 - Work Health and Safety: Better Procedures, Protecting People and Property Manual
- Refer to guidelines and local procedures
- Analyse the review findings
- Inform patients, carers, families and notifiers of progress
- Devise solutions with staff and patients, carers or families where possible. Managers can review similar incidents together to identify emerging issues and take action to reduce potential risks
- Engage with the Health and Safety Partners and Human Factors Consultant within the Health Safety and Wellbeing Services, for advice and support as required.
- Managers review complaints according to the NSW Health Policy Directive PD2020_013 - Complaint Management and the NSW Health Guideline GL2020_008 - Complaint Management Guidelines and review compliments for feedback to clinicians and teams. No Harm Score is allocated to complaints or compliments.

5.1.6 Step 6 - Implement and Monitor Actions

Once the findings are confirmed and their contributing factors and causes are established, develop an agreed action plan which addresses the findings and the causes as identified by the investigation. Actions should:

- Address the causes / contributing factors
- Control the hazard to an acceptable level
- Not introduce a new hazard
- Commit the owner to specific and *"smart"* action – Specific, measurable, achievable and practical, realistic and relevant, time-bound.

5.1.6.1 Implement and monitor actions – corporate HS3 and 4 incidents

Following review, managers are to:

- Develop and document action plans in iMS+
- Engage the team to implement actions
- Monitor and adjust actions as needed
- Track progress over time (e.g. control charts) to ensure positive change.

The primary purpose of an investigation is to learn from accidents and incidents by improving the organisational defences, reduce risk, and prevent re-occurrence, by

facilitating the development of sustainable actions. Actions are best formulated using a collaborative process to ensure effectiveness, feasibility, and reasonableness.

The facility / services management develops management actions, assigns action owners, and establishes implementation timeframes, to mitigate the threat or hazard. The management actions must be completed by the assigned facility / services management within the agreed timeframes.
Actions and timeframes are recorded in the iMS+ reporting incident management system.

Consider the "hierarchy of control" in structuring appropriate risk reduction activities. The hierarchy of controls addresses the preferred methods for eliminating or minimizing a hazard:

- Elimination: removing the hazard altogether e.g., by finding a different way of doing a task.
- Substitution: introducing a less hazardous process or substance
- Engineering: introducing physical protection to separate the hazard from persons or to contain the hazard, or to modify plant and equipment
- Administrative: procedures and processes such as training, risk assessments, Standard Operating Procedures and safety meetings
- Personal Protective Equipment (PPE): e.g., safety eyewear, hearing protection, safety footwear, safety gloves, protective overalls, the last line of defense.

5.1.7 Step 7 – Feedback and Consultation

Feedback supports learning and a just culture. It is an opportunity to discuss further ideas for improvement.

5.1.7.1 Feedback – Corporate HS 3 and 4 Incidents

Managers are to:

- Inform families, other people involved and notifiers of outcomes
- Present incident data and review findings at unit/team meetings
- Share the evaluation of actions with staff and seek suggestions as needed.

5.1.8 Record of Findings

Once the investigation is completed, the findings and actions are entered into iMS+, this can be done as an attachment in documents or in the progress notes section. This will also include the manager responsible for their implementation and the completion due date for action implementation.

5.1.9 Communication of Findings

Findings and outcomes of the investigation are communicated to all relevant Senior Management, General Managers, Managers and employees for their information and learning. Procedures are updated to reflect the findings if required. Safe Work NSW should also receive communication on the findings and outcomes as required.

5.1.10 Review and Follow Up

To ensure that actions arising from an investigation are implemented, progress is monitored against assigned timelines and the actions recorded in IMS+. The status, completion and effectiveness of actions are reported to the respective facility / services / district committees for reporting health, safety and wellbeing matters and performance.

5.2 HSW Incident Management - Health Safety and Wellbeing (HSW) Services

a. Summary of NSW Health Policy Requirements – Refer to Appendix E
b. Where an injury has occurred, the HSW Workers Compensation and Injury Management Team review the iMS+ incident notification and review the claim if one has been made.
c. When alerted of the incident, make an assessment to determine if the incident is Significant or Notifiable. Escalate the incident to Manager, General Manager, Director, as per the Incident Management Flow Chart (Appendix B and Appendix C - Incident management steps for corporate Harm Score (HS) 1 to 4 incidents)
d. Any Significant Incidents (Harm Score 1, Harm Score 2 or a High Risk Near Miss incidents) are investigated and finalised by the Health and Safety Partners within the required NSW Health time frame of 60 calendar days for HS1 or 45 calendar days for HS2 incident
e. If the incident meets the criteria of Notifiable Incident, then notify SafeWork NSW with the required details within 48 hours of the event. Refer to SafeWork NSW guide.
f. Engage with other Health and Safety Partners, Wellbeing and Safety Culture Partner and Human Factors Consultant within the Health Safety and Wellbeing Services, for advice and support as required.
g. Where required, review the investigation conducted by the facility / services manager and ensure the accuracy and completeness of this investigation, including recommendations and corrective actions that have been and/or plan to be implemented.

5.3 Harm Score 1 Corporate Incidents (HSW Services)

5.3.1 Escalate

- Managers are to notify senior management
- HSW Services are to complete a RIB – refer to NSW Health Policy Directive PD2020_047 - Incident Management

- HSW Services are to undertake a safety check.

5.3.2 CE escalation to the Ministry of Health

For corporate incidents with possible state-wide implications, potential to become a matter of public interest, potential loss of public confidence, or contentious issues, the CE or delegate must immediately contact the Ministry of Health.

The relevant Deputy Secretary advises the Secretary as needed, who in turn advises the Minister's office as appropriate.

5.3.3 Safety check

Undertake a safety check for corporate Harm Score 1 incidents within 72 hours, or sooner as directed by the Chief Executive (CE) or Ministry of Health. A safety check is not privileged.

The purpose of a safety check is to provide advice to the CE to:

- Understand the events
- Identify immediate actions for people and the environment to be safe
- Identify, mitigate and escalate immediate risks
- Guide the response to an incident and subsequent review.

The safety check team is one or more people appointed by the CE via:

- Memo template
- Email or
- Standing appointment arrangement.

The safety check team's composition and expertise are incident dependent. It is recommended to include a Clinical Governance member for corporate incidents where there is possible clinical impact. Team members must not have been directly involved in the incident, unless unavoidable.

5.3.4 Safety check advice

The safety check team are to undertake a safety check of the incident and may attend the incident location. They complete a safety check report documenting their advice and understanding of events.

NSW Health safety report template must be used for submission to the CE.
A safety check action log can be used to support actions arising from the safety check.

The safety check team is to immediately escalate to the CE in writing concerns of:

- Serious or imminent risk of harm to patients, visitors or staff
- Continuing critical risk due to loss of service.

5.3.5 Sharing safety check advice

The advice provided by the safety check team is necessarily preliminary in nature, and the incident subject to a corporate HS1 review. For incidents involving death or suspected suicide of a staff member, safety check advice may be shared with the family.

Dedicated family contact (DFC)

The DFC is a primary staff contact assigned to a family during a safety check for incidents involving death or suspected suicide of a staff member. They provide continuity during a corporate HS1 review and beyond if required. DFC resources are on the CEC website.

In the event of conflict, the family or DFC may escalate to the Director of Corporate Governance (or equivalent) for support and an alternate DFC may be assigned.

5.3.6 Sharing findings with family

Following a corporate HS1 incident involving staff death or suspected suicide, what is known is to be shared with the family as it comes to hand. Any communications or documents arising from a safety check or corporate HS1 review are not privileged.

A dedicated family contact can arrange meetings for the family and open disclosure team

- As per the family's wishes
- After the safety check
- At completion of the corporate HS1 review.

5.3.7 Review of corporate HS1 incidents

Health Services are to undertake corporate Harm Score (HS) 1 reviews of corporate HS1 incidents. A corporate HS1 review report is due to the Ministry of Health within 60 calendar days of incident notification in iMS+. For incidents where the outcome changes to a Harm Score 1, the 60-day timeframe commences on the date the outcome changed.

Systems and investigation teams in place for clinical HS1 incidents can be used to support or complement the HSW investigation team where required, however privilege does not apply to corporate incidents. Findings and recommendations can be separated, and additional team members considered for the development of recommendations, however this is not required by legislation.

The NSW Health Corporate HS1 Review Report template is to be used. Alternatively, the Serious Adverse Event Review (SAER) Findings Report template and Recommendations Report template may be adapted for use.

Care is to be taken when undertaking a corporate HS1 review that it does not prejudice a Police or coronial investigation. Any review by the Health Service is to be limited to whether there were any systems issues that may have contributed to the incident.

5.3.8 Approved methods

The review method is determined by the type of incident and undertaken using corresponding review processes set out in a NSW Health Policy, for example:

- WHS incidents, see NSW Health Policy Directive PD2018_013 - Work Health and Safety: Better Procedures
- Security related incidents, see the Protecting People and Property Manual
- Suspected privacy breaches, see:

  NSW Health Policy Directive PD2015_036 - Privacy Management Plan
  NSW Health Guideline GL2019_015 - Privacy Internal Review Guidelines
  Privacy Manual for Health Information

5.3.9 Engage staff and families

Families are to be engaged in the review process as per their wishes. The dedicated family contact can help to facilitate this.

Engage staff by providing information about the review process. Advise staff they can also contact their professional association or union for further advice.

Throughout the review, staff are to be reminded of the availability of support services (e.g., the Employee Assistance Program). Where applicable, staff are provided with information on injury management and return to work processes consistent with NSW Health Policy Directive PD2022_002 - Injury Management and Return to Work, and procedure SESLHDPR/276 – Injury Management and Return to Work.

5.3.10 Review team

Team composition is incident dependent. The team is made up of approximately 3 to 5 members appointed by the Chief Executive (CE) or nominated officer.

- Some members have essential knowledge of the corporate processes in the area where the incident occurred, but were not directly involved
- One member (usually team leader) has WHS experience
- A human factors consultant
- Preferably one member is external to the facility/service
- Consider including relevant services (e.g., eHealth NSW)
- Consider including of persons with cultural expertise (e.g., Aboriginal Community Controlled Health Services) or specialised expertise (e.g., senior clinicians with experience responding to violence, abuse and neglect)

- For suspected suicide, a senior mental health clinician
- Safety check team members can be appointed to the team
- Team members should not:
- Have a conflict of interest
- Be the manager of the department or unit where the incident occurred.

5.3.11 Variation in team appointment process

The same review team can review more than one incident at the same time where incidents are of the same classification. The team reviews both/several incidents together and writes separate reports for each incident with common recommendations. There may be team leaders appointed for each incident within the review team. This variation to the review process is to be documented in the report.

5.3.12 Determine findings and recommendations

The review team is to:

- Gather information from a range of sources and undertake interviews
- Visit the incident location where appropriate
- Analyse findings and develop recommendations as needed
- Consider any suggested recommendations from others involved or concerned
- Prepare a report for the Chief Executive including:
- Incident description and iMS+ incident number
- A summary of the findings
- Any underlying factors as to why the incident occurred
- Any recommendations to prevent and minimise the risk of recurrence.

The NSW Health Corporate Harm Score 1 Review Report template is to be used, or the Serious Adverse Event Review (SAER) Report templates adapted for use.

5.3.13 Corporate HS1 review report sign off

Once finalised, the report is to be progressed to sign off. This may include a formal sign off meeting with the team leader or delegate and key stakeholders.

- The final corporate HS1 review report is submitted within iMS+ to the CE
- The CE reviews the report and:
- Endorses the recommendations; or
- Does not agree with one or more recommendations, documents reason/s and proposes alternate recommendation/s which are attached to the report.
- The CE can clarify the rationale for any recommendation with the team and/or consult with other staff about the team's recommendations The report is to be

submitted to the Ministry of Health at MOH-Quality@health.nsw.gov.au and the CE is to ensure final notifications are completed as required by legislation and/or relevant policies, including the NSW Health Policy Directive PD2021_017 - Service Check Register for NSW Health.

5.3.14 Document storage

Documents for storage include meeting notes, interviews, interviewee letters, confirmation emails approving findings and recommendations, email discussions within the team, and internal working documents (e.g., butchers' paper and post-it notes).

Documents are to be stored securely in a physical location or electronic system with permission controls e.g., iMS+, secure electronic filing system or eHealth SharePoint.

Team members must return paperwork to the team leader for confidential disposal.

5.3.15 Beyond the scope of corporate HS1 review teams

Issues with individuals Corporate HS1 reviews conducted under this Policy must not attempt to assess an individual. Where a question of individual negligence or misconduct arises, it is managed via the performance management system and/or NSW Health Policy Directive PD2018_032 - Managing Complaints and Concerns about Clinicians, with support from Human Resources, as required.

Corporate HS1 review teams can use decision trees to help determine individual versus systemic issues (see Resources).

5.3.16 When to discontinue a corporate HS1 review

A corporate HS1 review is discontinued when:

- the review team believe issues with an individual may be responsible with no potential system issues, and
- the CE considers the incident was substantially caused by issues with an individual and that the team is not likely to identify other root causes, contributory factors or system improvements. The Health Service notifies the Ministry of Health stating the reason/s for discontinuing and submits the completed front page of the report to MOH-Quality@health.nsw.gov.au.

5.3.17 When more than one organisation is involved

- Oversight responsibility is with the lead Chief Executive (CE) or delegate
- Each Health Service may be involved in open disclosure

- Each Health Service is represented on the safety check and corporate HS1 review teams
- Each CE signs off the corporate HS1 review report
- The CE with agreed primary responsibility oversees the corporate HS1 review and informs the other Health Service of their staff's involvement
- iMS+ is the preferred document storage location for cross boundary incident reviews.

5.3.18 Implement and monitor actions

Managers are responsible for implementing report recommendations arising from an incident review. Health Services are to:

- Monitor the implementation of recommendations
- Have local escalation processes for recommendations that cannot be progressed
- Report to relevant peak Health Services committees, Executive team and Board.

5.3.19 Feedback

Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and their recommendations.

Health Services are to feedback lessons learned and proposed changes to a broader group of clinicians and managers e.g., at service or unit meetings.
The Health Service is to inform families of the outcome of a corporate HS1 review staff death or suspected suicide.

5.4 Harm Score 2 Corporate Incidents (HSW Services)

A corporate HS2 incident involves major harm to a worker or visitor, or major loss or disruption of service. Refer to Appendix C and D for additional guidance.

5.4.1 Escalate corporate HS2 incidents

- Staff escalate as per Harm Score 3 and 4 incidents
- Managers notify senior management
- Health Services complete a RIB as required
- Health Services undertake a safety check if needed.

5.4.2 Review of corporate HS2 incidents

When reviewing corporate HS2 incidents, Health Services are to:

- Specify management responsibility
- Undertake formal open disclosure as needed for WHS incidents

- Identify relevant NSW Health Policy requirements
- Engage with other agencies where indicated
- Appoint a review team to undertake an incident review, including a Health and Safety Partner to lead the investigation and the Human Factors Consultant
- Consider members from relevant departments for the review team. Where relevant, include the Wellbeing and Safety Culture Partner
- Include worker representation on review teams for WHS incidents
- Undertake aggregate reviews of similar Harm Score 2 incidents as needed
- Identify, plan, implement and evaluate organisational activities.

5.4.3 Incident review teams

Review teams are to use a review method and tools set out in NSW Health Policy, for example:

- WHS incidents, see NSW Health Policy Directive PD2018_013 - Work Health and Safety: Better Procedures. SESLHD has internal investigation process and safety incident investigation report template.
- Security related incidents, see the Protecting People and Property Manual
- Suspected privacy breaches, see:
  - NSW Health Policy Directive PD2015_036 - Privacy Management Plan
  - NSW Health Guideline GL2019_015 – NSW Health Privacy Internal Review Guidelines
  - Privacy Manual for Health Information

If no relevant NSW Health Policy exists, the review team uses a structured method and Health Service tools to analyse the incident and recommend actions to improve safety and reduce risk.

The review team engages relevant departments e.g., HSW, Human Resources, Engineering, Security. A report is to be written up with findings and recommendations, using NSW Health Policy specified or Health Service report template.

5.4.4 Implement and monitor actions

Managers are to implement report recommendations arising from an incident review. Health Services are to:

- Monitor the implementation of recommendations
- Have local escalation processes for recommendations that cannot be progressed
- Report to relevant peak Health Services committees, Executive team and Board.

5.4.5 Feedback

Health Services are to provide feedback to staff **involved** in an incident, so staff understand reviewers' conclusions and their recommendations.

Health Services are to also feedback lessons learned and proposed changes to a broader group of staff and managers e.g., at service or unit meetings.

The Health Services are to inform families or other people involved of outcomes and provide a corporate HS2 report or written summary to the family as appropriate.

5.5 Confidential or Sensitive Safety Incidents

Where there is a safety related incident which requires the confidentiality of the reporter, these can be reported directly to the Head of Health Safety and Wellbeing, as the iMS+ reporting system does not currently have functionality for a reporter to flag confidential safety reports.

5.6 Collection of Factual Information

An important initial step in the investigation process is the collection of all the available information and facts relating to the incident. The purpose is to collect relevant data with a view to establishing the facts relevant to the investigation. Key activities include:

The initial phase of the investigation process should focus on defining and obtaining data relevant to the event. In particular, highly perishable data should be given priority. Data collection will often develop into an on-going process as more is learned about events surrounding the occurrence. Therefore, data collected early in the investigation may be combined with other data collected at later stages as a method of reaffirming and validating possible contributing factors.

The following evidence is typical of what may be required:

- witness statements and records of interviews - involved persons interview notes resulting from interviews with the people directly involved in the Incident or Notifiable Incident e.g., injured person; witnesses; manager and/or supervisor of the location
- photographic and video evidence, and diagrams
- inspection of the incident site
- equipment test results
- training and performance records
- technical data from operational and safety systems
- re-enactments to determine the sequence of events; and

- review of relevant documentation e.g., training records, performance records, risk assessments, standard operating procedures; ims+ reports; Health and Safety Committee minutes.

Ensure that evidence is properly and methodically documented, catalogued and relevant copies are retained. Provision is also needed for storing of 'hard' evidence such as material objects.

At all times be conscious of the need to maintain the confidentiality of the reporter. Be mindful of the requirements and obligations inherent in the NSW Health confidentiality obligations.

Interview authors of documents such as policies and procedures (where relevant) to gain a more complete understanding of the intent and the context.

Prepare factual information / preliminary investigation report (where applicable). Engage the Human Factors Consultant to support the human factors / just culture analysis, and to conduct interviews with directly impacted staff.

5.7 Causal Analysis and Contributing Factors

5.7.1 The **objective** of an investigation is to learn from these incidents and prevent recurrence. Analysis of the contributing factors and causes relating to the incident assists in developing effective strategies to address the causes and prevent the incident from recurring.

The aim of conducting analysis is to examine evidence for the purpose of identifying the contributing and other safety factors, to establish findings and determine causes.

5.7.2 Key activities include:

Review and evaluate available evidence / data and convert into a series of logical facts / arguments based on supporting evidence, that link directly and logically to conclusions and findings. The review should consider the following:

a. events which modified risk (either increased or decreased)
b. effectiveness of key controls
c. human factors /non-technical skills (actions / inactions or system design)
d. task being performed
e. technical failures
f. local and environmental conditions
g. risk controls (preventive and recovery)

h. the extent to which organisational factors / influences contributed to the hazard or occurrence and
i. the potential influence of fatigue, stress, workload, and/or distraction on the actions of individuals involved

5.7.3 When conducting an analysis, ensure that the process is:

a. objective and fact based (who, what, when, where and why)
b. iterative
c. structured and
d. robust

5.7.4 Data analysis is conducted in parallel with data collection.

Often the analysis of data initiates additional questions that require further data collection, simulation and consultation. Seldom do the results of an analysis show an isolated cause with a specific resolution.

5.7.5 Output includes:

1. Contributing factors and other safety factors are accurately identified, described and confirmed

2. Findings and the causes are accurately recorded.

5.7.6 When conducting analysis also consider:

Safety, Health, Security, Quality and the Environmental aspects and impacts, to determine whether to engage subject matter expertise to assist in analysis of the occurrence in these aspects or in other areas such as:

1. The factors that affect human performance and limitations in the workplace (such as human factors, ergonomics), compliance, health and wellbeing, or the operations including the potentially impacted people and the tasks they perform, physically / manually and mentally.

2. Consider other expertise that may be required to assess the risks relating to safety, health, security, quality, the environment, and the operations including physical / manual handling and mental tasks conducted. This may include ergonomic risk assessment for manual handling tasks, or bow-tie analysis for operations, utilising appropriate tools where needed and/or made available

5.7.8 Methods

There are several methods that can be used for analysing the contributing and causal factors during the investigation of health, safety, and wellbeing incidents. One of these

methods is known as “The 5 Whys” and enables the consideration of human factors and organisational management and other system failures in the analysis.

Five Whys (5 Whys) is a problem-solving method that explores the underlying cause-and-effect of particular problems. The primary goal is to determine the root cause of a defect or a problem by successively asking the question “Why?”

- The number ‘5’ here comes from the anecdotal observation that five iterations of asking why is usually sufficient enough to reveal the root cause.
- In some cases, it may take more or fewer whys, depending on the depth of the root cause.
- The main benefit of the Five Whys is that it is one of the most powerful assessment methods of all non-statistical analyses.
- It can uncover and trace back to problems that were not very clear or obvious.

The Benefits of Five Whys

- Helps identify the root cause of a problem
- Understand how one process can cause a chain of problems
- Determine the relationship between different root causes
- Highly effective without complicated evaluation techniques

When Should You Use This Method?

- For simple to moderately difficult problems
- More complex problems may require this method in combination with some others
- When problems involve human factors or interactions. So any time human error is involved in the process.

How to Complete a Five Whys Root Cause Analysis

1. Begin with a specific problem. What is it that you are having an issue with? This can also help the team focus on the same problem.
2. Ask why the problem happened and write the answer down below the specific problem you listed in step one.
3. Keep asking “why” to each of the successive answers you write down until you reach the root cause of the problem.
4. Again, this may take more or less than five “whys”. Make sure your team sees eye-to-eye with each of the questions being answered as well as the final root cause.

Key Things to Keep in Mind

- Distinguish causes from symptoms or causal factors
- To make sure that you are attributing the correct answer to each "why", try working backwards. (Answer to the "Why?" + "and therefore" + the Problem Identified for that Question)
- You can break down your answers as much as you like. The more the better.
- Answers should always be based on facts and data
- Last but not least, assess the process and system, not the people.

References to analysis tools:

A Guide to Root Cause Analysis
What is the difference between a causal factor and root cause
Fishbone Diagram (Cause-and-Effect Analysis)
Incident management resources and tools - Clinical Excellence Commission

5.8 Draft Investigation Report

5.8.1 To prepare and distribute a draft investigation report which leads logically into the findings and the causes.

5.8.2 Key activities include:

1. Prepare draft investigation report using the standard report format applicable to the type of investigation being conducted, and as pre-agreed between the lead investigator and the investigation sponsor. The investigation report is the foundation for initiating the safety actions which are necessary to prevent further occurrences from similar causes. Therefore, the report must establish in detail:
   a. "what happened" b. "how it happened" and c. "why it happened"

2. The lead investigator collaborates with key stakeholders to ensure all findings are identified and are regarded as reasonable

3. Findings should:
   a. be categorised into contributing safety factors, other safety factors and observations
   b. be a concise statement of what went wrong, not what happened
   c. represent a hazard or threat that is a condition, which if left uncorrected could lead to negative consequences (future oriented)
   d. detail the causes which led to the finding
   e. represent a single problem as this will simplify the causal analysis and
   f. be assigned to facility or service single owner / department / unit which either owns the risk or is most able to affect change

5.8.3 **Note:** In the event of a finding involving an entity external to SESLHD, the finding should be allocated to the internal owner of the relationship with that entity (such as the contract owner)

5.8.4 The lead investigator reviews the draft investigation report and distributes to the facility / services management and key stakeholders, as pre-agreed during the planning and scoping phase of the investigation. This will include the Executive responsible for safety, health and wellbeing and facility / services representatives.

5.8.5 The output is a draft investigation report distributed to the facility / services as agreed, for comment within a specified timeframe.

6. AUDIT

This procedure will be audited through the Ministry of Health WHS audit every two years. The implementation of management actions resulting from incident investigations, are monitored and reported into the SESLHD health and safety committees for the respective facility / services, and the relevant executive management committee.

7. REFERENCES

External

WHS Act 2011 NSW
WHS Regulation 2017 NSW
Safe Work Australia - Code of Practice – Work, Health and Safety Consultation, Cooperation and Coordination
Safe Work Australia - Code of Practice – How to Manage Work Health and Safety Risks
Safe Work NSW - Code of Practice – Work, Health and Safety Consultation, Cooperation and Coordination – August 2019
Safe Work NSW - Code of Practice – How to Manage Work Health and Safety Risks - August 2019
Safe Work NSW Notifiable Incidents guide
Incident management resources and tools - Clinical Excellence Commission
NSW Health Policy Directive PD2018_013 - Work Health and Safety: Better Practice Procedures
NSW Health Policy Directive PD2020_047 - Incident Management Policy

Internal

SESLHDPR/727 - Safety Incident Report Management
SESLHDPD/265 - Emergency Management Policy
SESLHDPR/212 – Work Health and Safety - Risk Management Procedure

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
January 2014	0	Revised by WHS Officer, Health Safety & Wellbeing
July 2014	1	Approved by District Executive Team 24 July 2014
August 2017	2	Desktop Revision and Links Update - John Parkinson, WHS Consultant
October 2017	2	Updates endorsed by Executive Sponsor
August 2021	3	Major review commenced. Revised by Wayne Gibson, Manager Health and Safety
February 2022	4	Revised by Agah Smith, A/Manager Health and Safety
April 2022	4	Revised by Rosanna Martinelli, Head of Health Safety and Wellbeing. Major review. Draft for Comments period.
May 2022	5	Approved by Executive Sponsor. To be tabled at Executive Council for approval.
June 2022	5	Endorsed by SESLHD Executive Council.
July 2022	5	Formatted and published by SESLHD Policy.

APPENDIX A – Definitions

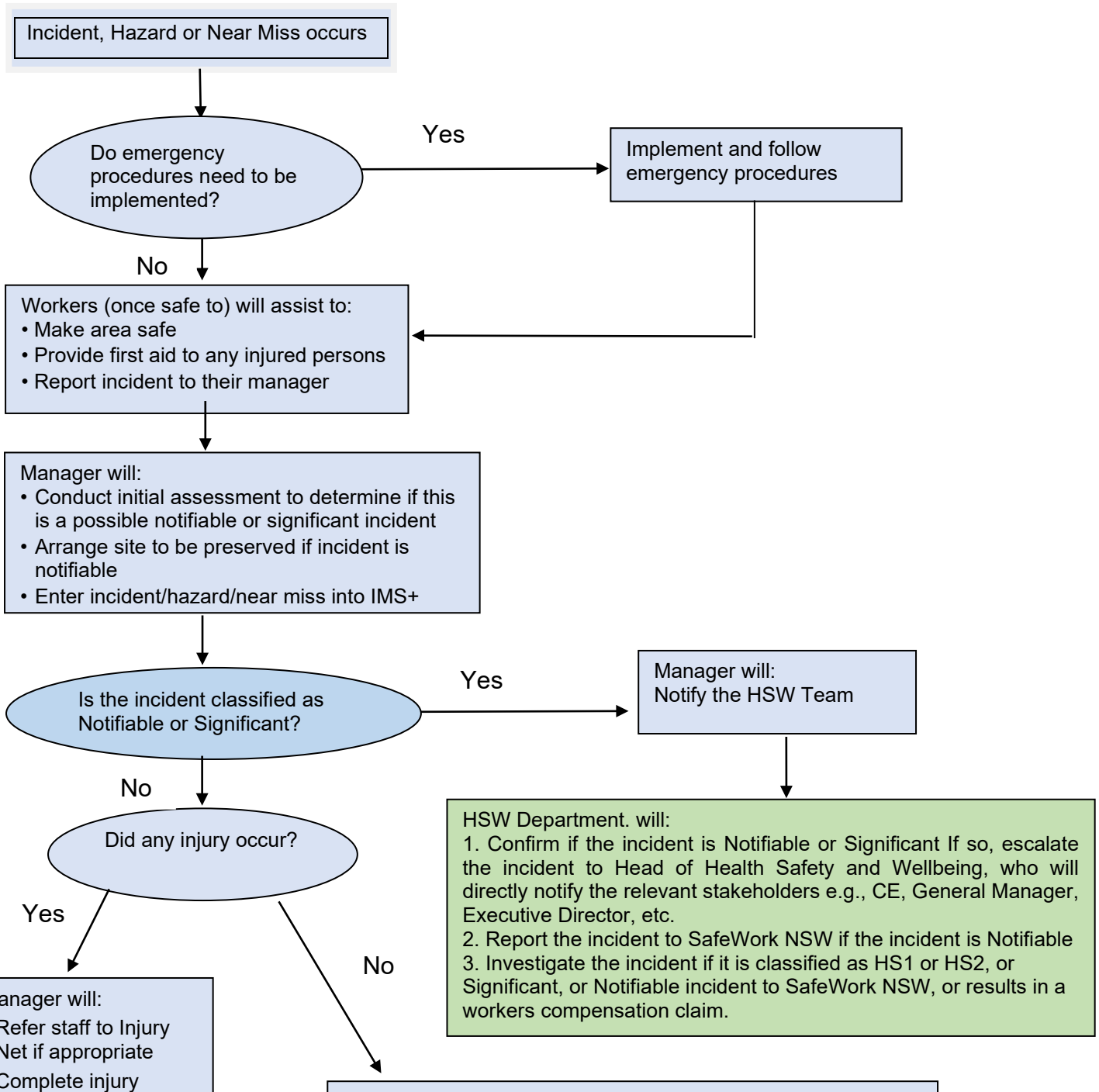
Term	Definition
Causal Analysis	A methodology for identifying the true or actual causes of events, to formulate problems and solve them, rather than to simply address the symptomatic result. Focusing corrective action on the findings and their causes has the goal of preventing their recurrence
Cause	The 'source' of or 'reason' for, an event or action which produces or affects a result. The fundamental reason for an event, which if corrected, would prevent recurrence. (The last cause in the chain). "Root cause" may be described as the point in a causal chain where applying a corrective action or intervention would prevent the problem from occurring.
Causal Factor	Aspects of systems, processes and practices that could directly result in the occurrence of an incident or accident and hence become a finding in the investigation.
Contributing Safety Factor	A contributing safety factor to an occurrence is a safety factor that, if it had not occurred or existed at the relevant time, then either: • the occurrence would probably not have occurred, or • adverse consequences associated with the occurrence would probably not have occurred or have been as serious, or • another contributing safety factor would probably not have occurred or existed.
Control	Any action taken by management, the board, and other parties to manage risk and increase the likelihood that established objectives and goals will be achieved. Management plans, organises, and directs the performance of sufficient actions to provide reasonable assurance that objectives and goals will be achieved. A measure (including, but not limited to, any process, policy, device, practice or other action) that is currently in place to modify risk.
Corrective Action	Action taken to eliminate the cause(s) and eliminate or reduce the potential for recurrence of an existing (detected) undesirable condition / situation or a finding (ISO 9000). Action taken to correct or improve the condition noted in the event by changing the direct cause or the direct cause and the effect. Cause Analysis and Corrective Action Process: Proper establishment of the cause or causes and contributing factors, leads to effective corrective actions. Effective corrective actions, lead to reduced repeat findings and incidents. Reduced repeat findings and incidents, lead to increased safety and reduced costs.
Harm Score 1	Unexpected death or a worker or visitor or A complete loss of service
Harm Score 2	Major harm to a worker or visitor, or major loss or disruption of service.
Harm Score 3	Minor harm to a worker or visitor, or minor loss or disruption of service.

Term	Definition
Harm Score 4	No harm or Near miss or A hazard
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.
High Risk Near Miss	An incident involving high potential consequences, such that could have caused a serious injury or death resulting in a Harm Score 1 or 2 if the occurrence had eventuated to its potential.
Human Factors Considerations	The minimisation of human error and its consequences by optimising the relationships within systems, between people, activities and equipment. Human factors is a field of study that aims to optimise the way people think, react and interact with people and systems within the workplace, in order to minimise error and optimise individual and organisational performance. It addresses how people use equipment, interpret policies, and work with procedures and manuals. It also addresses effective coordination between work colleagues, and the factors influencing individual and team human performance. Improving the relationship between the system and individuals can lead to improvements in safety, health, quality, efficiency, and job satisfaction.
Human Factors in Investigations	The overall aim of considering human factors throughout the investigation process is to understand why actions or behaviours occurred, in order to prevent error and undesirable behavioural choices, and to improve future performance of both individuals involved in the event being investigated and other employees. When identifying contributing human factors to individual actions, it is not sufficient to conclude that an occurrence was caused by “human error” or “at risk behaviour”; the factors contributing to the error or behaviour must be investigated. Health Safety and Wellbeing Department - Human Factors consultant can provide expertise and tools to support investigations.
Investigation	A systematic and independent process to objectively review and identify system deficiencies (management systems, procedures, processes and practices) which, if corrected, can reduce the risk of negative safety, health, security and environmental outcomes.
Investigation Plan	A document that details the activities to be followed during an investigation, designed to achieve the investigation objective, including the objective, scope milestones, responsibilities, approach and processes.
Investigation Sponsor	A senior manager who has requested or initiated the investigation, with overall responsibility for the investigation
Investigation Team	A group of investigators that coordinate and work together cohesively to complete an investigation.

Term	Definition
Just Culture	Creating an environment of trust in which people are encouraged to provide essential information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behaviour. Just Culture involves managing behavioural choices in line with organisational values and beliefs, whilst balancing both system and individual accountability The investigation should identify as far as reasonably practicable, all factors which contributed to the event and not stop at individual action or inaction Investigators should apply Just Culture principles throughout investigation activities including: • Reassuring individuals assisting the investigation that they will be treated fairly based on the quality of their behavioural choices • Treating individuals fairly and providing them with enough information about the process to ensure that they perceive that they have been treated fairly. The perception of fair treatment matters as much as the actual fair treatment • Providing factual details of the event to business unit managers, so that they can conduct a Just Culture review • Focusing on systemic issues that influence behaviours, rather than individual actions.
Lead Investigator	An investigator designated to manage an investigation is known as the lead investigator. To perform an investigation, the lead investigator must be suitably independent and appropriately qualified
Near Miss	An incident that could have caused harm but did not or an incident that was intercepted before causing harm
Notifiable Incident	• the death of a person, or • a 'serious injury or illness of a person' or • a 'dangerous incident' arising from the conduct of a business or undertaking at a workplace. Further definitions of '*serious injury or illness*' and '*dangerous incident*' can be found under Section 36 and 37 of the Work Health and Safety Act 2011.
Observation	Observations identified during the investigation that did not directly contribute to the event, but based on facts and data show a potential improvement opportunity
PCBU	A 'Person Conducting a Business or Undertaking' is used to describe all forms of modern working arrangements, commonly referred to as businesses.
Risk	The effect of uncertainty on what we want to achieve, our objectives and our

Term	Definition
	purpose. Risk is neither positive nor negative. The way we describe risk is dependent on whether we see the potential consequences as advantageous or not
Safety Factor	A safety factor is an event or condition that increases safety risk i.e., it is something that, if it occurred in the future, would increase the likelihood of an occurrence, and/or the severity of the adverse consequences associated with an occurrence.
Significant Incident	A workplace or worksite-related incident with any one of the following: • An incident resulting in a Harm Score 1 • An incident resulting in a Harm Score 2 • An incident resulting in a High Risk Near Miss
Sensitive or Confidential Incident	An incident is classified as 'sensitive' if it involves any of the following factors: • Bullying or harassment within the workplace (but does not include harassment of workers by members of the public) • Person affected by drugs or alcohol • Any other health, safety or wellbeing matters that require confidentiality or sensitivity in managing.
Worker	An employee, conjoint, student on work experience, contractor, sub-contractor, and or volunteer.

APPENDIX B – Incident Management Flow Chart (Apply in conjunction with Appendix C and D)



APPENDIX C – Incident management steps for corporate Harm Score (HS) 1 to 4 incidents
(Reference Appendices Table 2 – NSW Health Policy Directive PD2020_047 - Incident Management for specific section references)

CORPORATE	HS1 PD2020_047 s.7	HS2 PD2020_047 s.8	HS3 PD2020_047 s.9	HS4 PD2020_047 s.9
Incident Description	**Death of a worker or visitor or Complete loss of service**	**Major harm to worker or visitor OR Major loss or disruption**	**Minor harm to worker or visitor OR minor loss of disruption**	**No harm Near miss**
Step 1. Identify incident				
Clinician disclosure (<24 hours)	Yes, for death of worker	No	No	No
Step 2. Ensure safety. People, the environment and assets				
Immediate care to people involved	Yes	Yes	Yes	Yes
Make the environment safe	Yes	Yes	Yes	Yes
Support to patients, carers and families	Yes, for death of worker	No	No	No
Support to staff	Yes	Yes	Yes	Yes
3. Notify incident. Record in incident management system (IMS+) under relevant incident type and allocate initial Harm Score rating.				
Incident management system (<24 hours)	Yes	Yes	Yes	Yes
Step 4. Escalate and prioritise incident. Confirm Harm Score rating, Prepare and Submit RIB for all Harm Score 1 incidents and others mandated by Ministry of Health, and complete Safety Check.				
Escalate as required	Staff to manager to senior manager	Staff to manager to senior manager	Staff to manager	Staff to manager
RIB: Part A – 24 hours Part B – 72 hours or earlier	Yes, always	Yes, if determined by Chief Executive (CE) (PD2020_047 s.3.1.2) or a mandatory matter (PD2020_047 s.3.1.3)	Generally, no	Generally, no
Safety check: 72 hours or earlier	Yes	As determined by risk	Generally, no	Generally, no
Dedicated family contact assigned	Yes, for death of worker	No	No	No
Step 5. Review incident and Conduct investigation.				
Type of review	Corporate HS1 review by Health, Safety and wellbeing review team	Corporate HS2 review by Health, Safety and Wellbeing review team	Facility / Service / Unit level review by manager	Facility / Service / Unit level review by manager
Report	Yes	Yes	Yes, within iMS+ system	Yes, within iMS+ system
Submission timeframe	Corporate HS1 report to MoH in 60 calendar days or earlier	Corporate Governance or General Manager in 45 calendar days	Finalised within iMS+ in 45 calendar days	Finalised within iMS+ in 45 calendar days

CORPORATE	HS1 PD2020_047 s.7	HS2 PD2020_047 s.8	HS3 PD2020_047 s.9	HS4 PD2020_047 s.9
Potential for aggregate review	No	Yes	Yes	Yes
Step 6. Implement and monitor actions. Report on status and completion of actions.				
Implement	As per recommendations	As per recommendations	Yes	Yes
Monitoring oversight	Executive	Senior management	Manager (facility/service/unit level)	Manager (facility/service/unit level)
Step 7. Feedback to staff and patients, carers and families and management. Discuss ideas for further improvement.				
To staff	Yes	Yes	Yes	Yes
To patients, carers and families	Yes, for death of worker	No	No	No

Note 1:

3.1.2 Corporate Incidents

- Corporate Harm Score 1 incidents
  - Death of a staff member, potentially arising from the activities or the workplace of that staff member
  - Suspected suicide by a staff member potentially arising from the activities or the workplace of that staff member.
- Chief Executive determined specific corporate incidents
  - Attempted suicide by a staff member who was not a consumer of a mental health service (MHS)
  - Serious threats affecting the facility's operation e.g., fire, bomb or other threatening activities, critical equipment breakdown or failure
  - Complete loss of service i.e., power, water, communication system failure
  - Criminal activity in, or related to, the workplace o Kidnapping or abduction of a patient
  - Non-accreditation of service provider e.g., College or accrediting agency
  - Violence or threats of assaults on patients, staff, contractors or visitors.

Note 2:

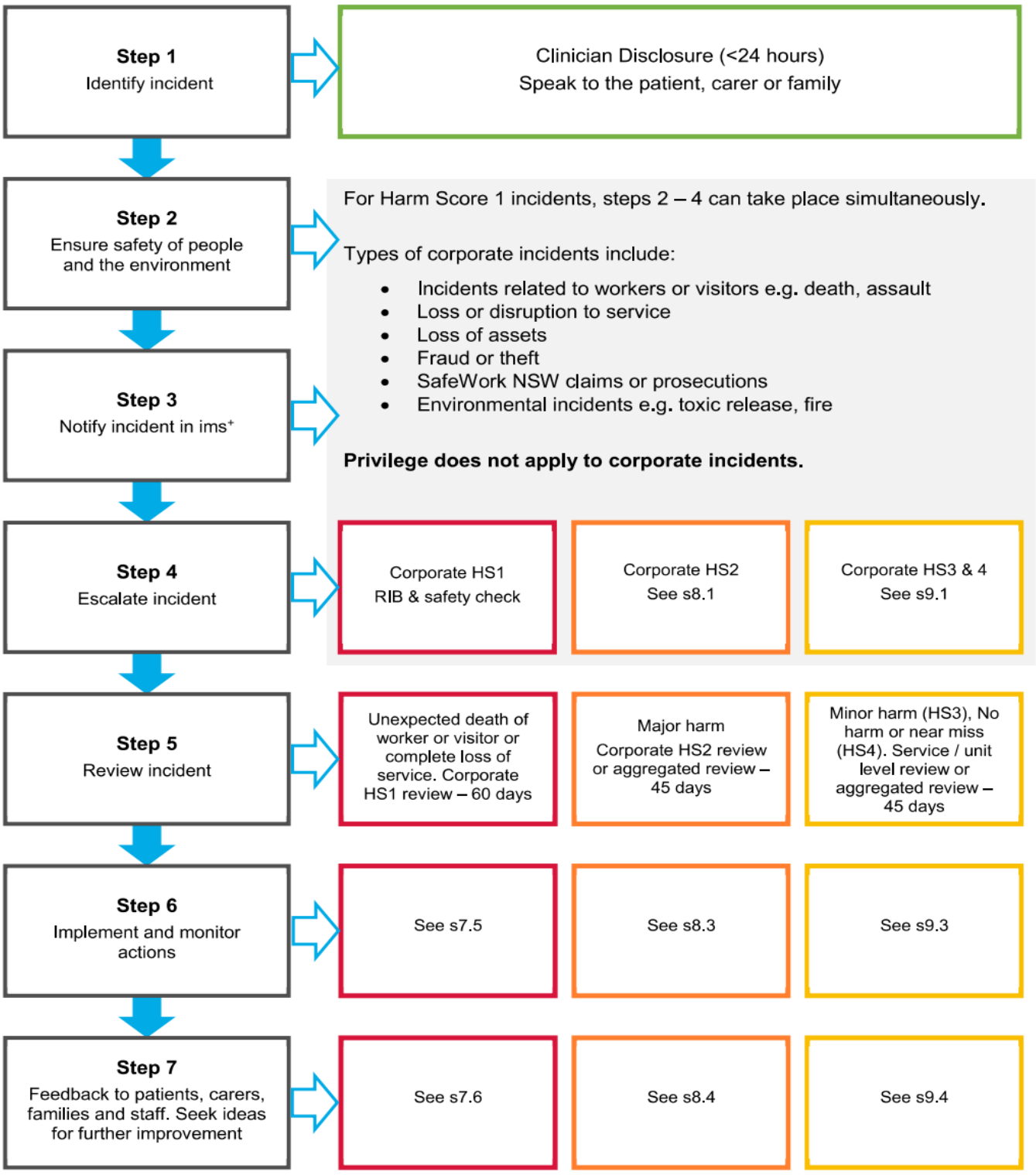
3.1.3 Mandated - Legal and Policy Requirements

- When methadone or buprenorphine is associated, or suspected, with a child's presentation or admission to hospital regardless of the outcome for the child – as per NSW Clinical Guidelines: Treatment of Opioid Dependence – 2018
- Unexpected deaths in custody
- Significant legal action initiated by or against a Health Service – as per the NSW Health Policy Significant Legal Matters and Management of Legal Services (PD2017_003)
- Industrial disputes affecting a facility's operation
- The commencement of a SafeWork NSW prosecution
- Radiation incidents reportable to the NSW Environmental Protection Authority6 under the Radiation Control Act 1990 and Radiation Control Regulation 2013
- 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 NSW Children's Guardian and require investigation by the Health Service. These allegations may be work or non-work related and include historical matters.
- Criminal charges and convictions against a staff member related to the workplace or outside of work but with potential risk in the workplace e.g., sexual assault criminal charges or convictions
- Accreditation agency notification to a Health Service of significant patient harm risk/s7
- A privacy breach where a privacy internal review is required – as per NSW Health Privacy Internal Review Guidelines (GL2019_015)

APPENDIX D – NSW Health Incident Management Process (Corporate)

(Reference Appendix C for Steps 4-7 section instructions)

NSW Health incident management process – corporate



APPENDIX E - SUMMARY EXTRACT OF POLICY REQUIREMENTS - NSW Health Incident Management Procedure - PD2020_047

All staff are responsible for identifying incidents and for taking immediate action to ensure the safety of patients, visitors and other staff.

Notify incidents and escalate
Clinical and corporate incidents, near misses and complaints are to be recorded in the incident management system, iMS+.

For all corporate incidents with possible state-wide implications; the potential to become a matter of public interest; potential for the loss of public confidence; or involve contentious issues, the Chief Executive must immediately contact the Ministry of Health.

Serious incidents must be notified and escalated within the Health Service and to the Ministry of Health via a reportable incident brief (RIB). The RIB is to be submitted in iMS+ within 24 hours of notification for RIB Part A, and within 72 hours (or earlier, as directed by the Chief Executive or Ministry of Health) for RIB Part B.

Open disclosure
Open disclosure must occur whenever a patient has been harmed, whether that harm is a result of an unplanned or unintended event or circumstance or is an outcome of an illness or its treatment that has not met the patient's or the clinician's expectation for improvement or cure, as per the NSW Health Open Disclosure Policy (PD2014_028).

Corporate incident review
Health Services must undertake a safety check within 72 hours (or earlier, as directed by the Chief Executive or by the Ministry of Health) for corporate Harm Score 1 incidents.

Any person appointed to undertake a safety check must immediately escalate to the Chief Executive, in writing, concerns of either continuing risk of harm to the patient, or serious or imminent risk of harm to other patients, carers, families or staff, or continuing critical risk due to loss of service.

A corporate Harm Score 1 review must be undertaken following a corporate Harm Score 1 incident, using a review method determined by the type of corporate incident. The review is to identify any underlying factors as to why the incident occurred and make recommendations to prevent and minimise risk of recurrence. A corporate Harm Score 1 review report is due to the Ministry of Health within 60 calendar days of incident notification in iMS+.

Implementation and feedback Health Services are to monitor the implementation of recommendations arising from incident reviews and have escalation processes in place for recommendations that cannot be progressed. Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and recommendations. Health Services are also to share feedback on the lessons learned and proposed changes more broadly with clinicians, managers and staff.