Policy and Procedure

Incident Management (Including Adverse Events)

Churchill Hospital

Purpose:

To describe the systems used at Churchill Private Hospital Trust (Churchill) to identify, report, document, investigate, review adverse events, including workplace injuries to ensure safety, reduce risk and continuously improve the delivery of care.

Scope:

All personnel employed by, or practising at, Churchill including credentialed specialists.

The policy applies to all incidents involving Churchill patients, clients, employees, volunteers, visitors, contractors, and sub-contractors.

Policy Statement:

Churchill undertakes to continuously improve patient care, to reduce risk and ensure the safety of everybody using its premises and facilities by promptly identifying, documenting and reviewing all incidents, and near misses.

Incidents will be documented, investigated and reviewed in a manner commensurate with their seriousness.

Churchill undertakes to treat information released by staff as part of any incident reporting or related process as confidential to the organisation, to the extent allowed by current legislation.

Objectives:

1. To ensure there is immediate management of an incident when required.

2. To ensure that the appropriate process is undertaken for the investigation of all incidents, near misses and adverse events.

3. To ensure an open approach when responding to an incident. This includes open discussion and ongoing communication with the consumer/staff member and their support person(s).

4. To ensure consumers and their whanau have the opportunity to share their story as part of an adverse event review and that review findings and recommendations will be shared with them.

5. To create a “just culture”, where if an incident arises from an honest mistake, staff are encouraged to report concerns, errors or near misses straight away.

6. Incidents involving a criminal act, substance abuse by a health practitioner/staff, a deliberate unsafe act or deliberate consumer harm will be managed in a separate process and may involve the relevant regulatory authorities.

7. To minimise risk and prevent future incidents occurring by undertaking reviews, developing recommendations that are focussed on process and system vulnerabilities, and realistic corrective action plans are then developed with outcomes measures.

8. To identify opportunities to improve care by ensuring the incident system is a planned and co-ordinated process linking to the risk management system.

9. Include integration of patient feedback, staff feedback, credentialed specialists and allied health personnel feedback where appropriate.

10. To ensure Churchill meets statutory and/or regulatory requirements in relation to essential notification reporting and ensures the correct authority is notified in an accurate and timely manner as per the Health Quality and Safety Commission New Zealand (2017) National Adverse Events Reporting Policy and Ngā Paerewa Health and Disability Service Standards NZS8134:2021

11. To undertake a formal review of all SAC 1 & 2 rated adverse events, plus events from the Health and Quality Safety Commission Always Report and Review list.

Definitions:

Adverse Event	An event with negative or unfavourable reaction or results that are unintended, unexpected or unplanned (also referred to as "incident" or 'reportable event')
Just Culture	A culture where staff are comfortable in disclosing incidents, including their own, while maintaining accountability. Individuals will not be held accountable for systems failure over which they have no control. It does not tolerate conscious disregard of clear risks to patients or misconduct.
Notifiable Injury or Illness	As defined by section 23 of the Health and Safety at Work At 2015 (*refer to appendix 1 for a full description)*
Near Miss/Good catch	This is an event which, under different circumstances, could have caused harm but did not, and which is indistinguishable from an adverse event in all but outcome.
Open disclosure/ communication	Refers to a timely and transparent communication and supporting patients and their family when clinical incidents occur.
Severity Assessment Code (SAC)	The SAC is a numerical rating which defines the severity of an adverse event and therefore the required level of reporting and review to be undertaken for the event. (refer to appendix 2)

Procedure:

Incidents can be reported by any staff member including the person first aware, most involved in, or to whom the incident is notified. Where patients, families, visitors or other providers notify an incident this is to be reported by the staff member notified. All healthcare incidents are to be reported and documented

Initial Response:

- Ensure safety and reduce risk.
- Inform the person in charge as soon as possible.

- In the case of injury to a Registered Nurse or other NMDHB direct employee, this must be reported to the NMDHB Health, Safety and Wellbeing Service as soon as possible, within 24 hours.
- In the case of a notifiable injury or illness, the staff member must inform the General Manager directly (in person or by phone) and immediately, as an immediate investigation may be required.
- In the event of a serious harm incident to a staff member, patient or contractor, where possible the scene of the incident should be secured by the person in charge of the area.
- Open disclosure with the effected person, using an appropriate, timely and transparent approach.

Documenting an incident:

Any information relating to the incident should be kept separate to the patient's clinical record. However, the clinical record must make reference to the fact that an incident report has been completed.

- Document the incident using the Reportable Events form.
- Include relevant known facts, persons involved, what specifically happened and when, specific relevant details such as procedure, medication, dosage etc, contributing factors and outcome for person affected.

External Notification:

- In the event of a work related notifiable event to a staff member, patient, visitor or contractor, the General Manager must be notified so that Worksafe New Zealand can be notified on line http://forms.worksafe.govt.nz/notifiable-event-notification
- The table below identifies certain events and those agencies the event is required to be reported to:

Event	Reported To
Notifiable Injury or Illness (those that are related to work related activities ie: not medical situations)	Worksafe New Zealand
Any SAC1 or SAC2 event, or any event on the HQSC "Always Report and Review" list as updated from time to time on the HQSC website.	Health & Quality Safety Commission within 15 working days from the date the event is first reported.
Death as result of an adverse event	Coroner Minister of Health (under Section 31 of the Health and Disability Services (safety) Act 2001
Death (as a result of workplace incident)	Worksafe New Zealand
Serious issues involving quality of medicines	Compliance team at Medsafe, Ministry of Health
Adverse reaction to medicines	Centre of Adverse Reactions Monitoring (CARM)
Medical devices that caused or could have caused injury to the patient or user	Compliance team at Medsafe, Ministry of Health
Public health emergencies	Ministry of Health

	Nelson Marlborough Health – Public Health
Treatment Injury	ACC
Professional misconduct	The health professional's registration body.

Investigation and review:

All incidents will initially be triaged by (a member of) the Quality Committee, and an appropriate Severity Assessment Code (SAC) score based on the consequences will be assigned. If the committee decides a further investigation is required, the General Manager will escalate the incident for investigation as appropriate.

- The investigation should reflect the seriousness of the actual or potential risk of harm. A SAC score of 3 or 4 is generally regarded as a less serious incident, whilst a SAC score of 1 or 2 is generally a more serious incident.
- A more serious incident demands a more thorough investigation process known as a root cause analysis and should be conducted in accordance with industry approved standards.
- Review focus should be on systems, process and human factors in the first instance.
- "Supporting Staff following an adverse event Staff guide" made available. Human Resources and legal advice may be sought, where appropriate.

The investigation outcome will be recorded on the reverse of the incident form, or in an attached report, and may include:

- immediate risk-reduction actions
- findings, contributory and causal factors (immediate and underlying)
- corrective actions including any changes to systems and processes with measured outcomes
- organisational learning

Analysis:

Reportable incidents are reviewed and analysed, by the Quality Committee for trends, such as:

- frequency of reported incidents by type and outcome
- correlations and relationships between variables such as communication, workload, teamwork, equipment, environment, staffing, time of day, etc

Improvement Actions:

- Corrective actions resulting from reportable incidents are recorded in the Improvements Register on Logiqc Quality Management online system detailing actions and review processes.
- Where appropriate, a PDSA cycle can be used to document quality improvement activities initiated from reportable events.

Reporting of findings and quality cycle follow-up:

- The Quality Committee will summarise findings on a monthly basis, and ensure a copy of the report is forwarded to the Board of Trustees.
- The Quality Committee will ensure feedback is provided to the person who reported the incident.
- Changes to practise, or corrective actions will be documented

and discussed with staff at regular quality and safety meetings.

- Any hazards identified will be added to the hazard register
- Any risks identified will be added to the risks register
- A delegate from the Quality Committee will contact patient/consumer, staff involved and external providers as required (ie NMDHB theatre charge nurse).

Benchmarking:

Clinical reportable event data is submitted to the New Zealand Private Surgical Hospitals Association (NZPSHA) bi-annually for benchmarking purposes. These reports are forwarded by NZPSHA to Health and Quality Safety Commission and ACC as aggregated reports for all private surgical hospitals.

Benchmarking reports are used by the Quality Committee as part of the continuous quality improvement process or confirm good practice.

References and Associated Documents

Accident Compensation Act 2001

EQuIP6 criterion 2.4.3

Coroners Act (2006)

Health & Disability Services (Safety) Act 2001

Health and Disability Commission Code of Rights

Health and Disability Services (Safety) Act 2001: Section 31 Reporting Guidelines

Health Practitioners Competency Assurance Act 2003

Health Quality & Safety Commission New Zealand – National Adverse Events Reporting Policy 2017

Health & Safety at Work Act 2015

Ministry of Health (2021) Ngā Paerewa Health and Disability Standards NZ8134:2021

Ministry of Health Severity Assessment Code (SAC) rating and triage tool for adverse event reporting

New Zealand Private Surgical Hospitals Association Inc (2010). Clinical Indicators guide final. NZPSHA.

NMDHB (2021). Notifiable Injury, Illness or Incident Policy

NMDHB (2019) Adverse Event Management

Privacy Act (2020), the Health Information Privacy Code (2020)

Appendix 1

Health and Safety at Work Act 2015 – Section 23 Meaning of notifiable injury or illness

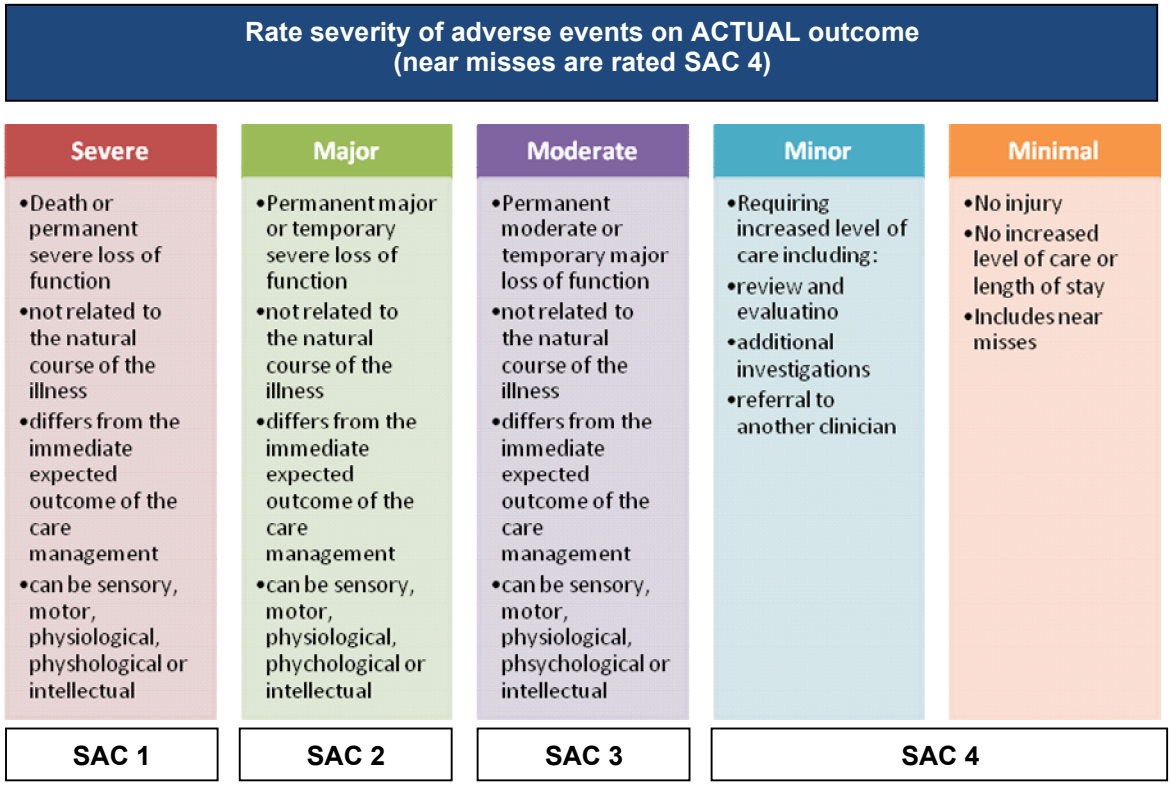
1. In this Act, unless the context otherwise requires, a **notifiable injury or illness**, in relation to a person, means—
    a. any of the following injuries or illnesses that require the person to have immediate treatment (other than first aid):
        i. the amputation of any part of his or her body:
        ii. a serious head injury:
        iii. a serious eye injury:
        iv. a serious burn:
        v. the separation of his or her skin from an underlying tissue (such as degloving or scalping):
        vi. a spinal injury:
        vii. the loss of a bodily function:
        viii. serious lacerations:

    b. an injury or illness that requires, or would usually require, the person to be admitted to a hospital for immediate treatment:
    c. an injury or illness that requires, or would usually require, the person to have medical treatment within 48 hours of exposure to a substance:
    d. any serious infection (including occupational zoonoses) to which the carrying out of work is a significant contributing factor, including any infection that is attributable to carrying out work—
        i. with micro-organisms; or
        ii. that involves providing treatment or care to a person; or
        iii. that involves contact with human blood or bodily substances; or
        iv. that involves handling or contact with animals, animal hides, animal skins, animal wool or hair, animal carcasses, or animal waste products; or that involves handling or contact with fish or marine mammals:

    e. any other injury or illness declared by regulations to be a notifiable injury or illness for the purposes of this section.

Appendix 2

Severity Assessment Code (SAC) rating tool



See also the Severity Assessment Code (SAC) rating and triage tool for adverse event reporting (www.hqsc.govt.nz/our-programmes/adverse-events/publications-and-resources/publication/2937).