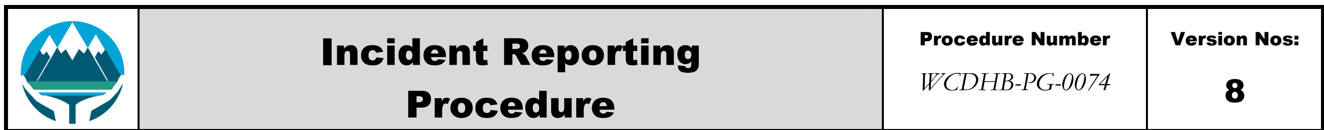

	Incident Reporting Procedure	Procedure Number *WCDHB-PG-0074*	Version Nos: **8**

1. Purpose

This Procedure outlines the process for reporting and investigating incidents that occur in the West Coast District Health Board (WCDHB) Services with a view to preventing recurrence.

2. Application

This Procedure is to be followed by all WCDHB staff members.

3. Definitions

For the purposes of this Procedure:

Incident
An incident is any unexpected or unplanned occurrence or near miss, which is not consistent with the normal or accepted operation of the WCDHB.

They include:

- Events that are physically, emotionally or culturally harmful to clients / patients, visitors or employees.
- Events that reflect an unsatisfactory situation in terms of the quality of clinical practice, or operational management, or of service delivery that requires reporting to managers. This may include events related to the DHB's interface with other organisations or service providers.
- Adverse events - incident which has resulted in unanticipated death or major loss of function not related to the natural course of the client / patient's illness or underlying condition.
- Loss or damage to property belonging to client / patients, visitors, employees or the WCDHB.
- Malfunctions of equipment.
- Events that could have caused harm / serious harm / damage / loss if
- The situation had not been rescued in time to prevent harm occurring.
- Staff foresee that a recurrence of the event could result in harm.

Examples of incidents include (but are not limited to):
Client / Patient related:

- Medication errors
- Adverse or allergic reactions to medications
- Incorrect treatment
- Falls, with or without injury
- Other accidental client / patient injury or death
- Mislabelled laboratory specimens
- Absence without leave
- The use of restraint , seclusion or force
- Threats, or use of violence
- Self harm or overdose
- Use of illicit drugs on DHB property

Property and Equipment related:
- Equipment failure, malfunction or damage
- Property damage by client / patient or employee
- Accidents involving WCDHB vehicles

Security
- Security of premises and personnel
- Fire
- Loss or failure of services (e.g. power, water supply)
- Theft or loss of equipment or property
- Breach of privacy

Staff related
Any workplace injury including
- Blood and body fluid exposure
- Chemical exposure
- Needlestick injury
- Handling injury
- Verbal abuse
- Violence perpetrated on staff

All incidents require an incident report to be completed, and an investigation conducted by the relevant line manager.

IRG – Incident Review Group (Incident Review Group in Secondary Health Services) *or* **REEM** (Reportable Events Evaluation and Monitoring in Mental Health Services) a multidisciplinary and multi-perspective group which views and evaluates all investigated reportable events with a view to identifying opportunities for service improvement and risk minimisation.

NZIMS – New Zealand Incident Management System – the national incident reporting system, adopted by all DHBs from 1 July 2009. A central reporting repository has been established to receive and monitor reports of events meeting the Severity Assessment Code (SAC) 1 & 2 definitions (high risk, high probability of recurrence). Guidelines, severity assessment code matrix, and report brief outlines are available from Clinical Managers and Heads of Department, and are found in Appendix One.

CNM / Clinical Manager – the manager of the team involved, and taken to include Clinical Nurse Manager, District Manager, Unit Manager.

HOD – Head of Department

4. Responsibilities

For the purposes of this Procedure:

All staff shall

- ensure the timely reporting of incidents that occur during the course of their work, including their suggestions for future prevention

Managers shall

- promote a culture of no blame incident reporting and investigation
- ensure their staff members are aware of their responsibility associated with this procedure
- undertake initial investigations of incidents as indicated in this procedure
- ensure timely processing and notification of incidents as required
- participate in relevant incident review group functions, contributing to identifying and implementing systems solutions where indicated
- provide timely feedback to staff members

5. Resources Required

This Procedure requires:

- WCDHB Incident Report Forms
- Severity Assessment Code (SAC) Matrix
- Incident Review Group

6. Process

1.00 Introduction

1.01 The WCDHB is committed to continual improvement of all processes and services that support the care of our patients/clients and a safe working environment for staff.

1.02 The WCDHB believes that:

- There must be a no-blame culture, supportive of staff to report incidents and near misses
- Despite the best intentions of competent and caring professionals adverse events may occur
- Many incidents result from an inadequate or complex system
- Incidents should be recorded, investigated and monitored in an attempt to identify trends and patterns and learn from them to prevent recurrence
- A systems approach, rather than an individual approach will be taken in investigating incidents

1.03 There may be particular circumstances where individuals need to be held accountable for their actions. These include:

- Intentional unsafe or deceitful acts
- If the incident involved a criminal act
- Use of illicit drugs or alcohol by the staff person
- Deliberate patient harm

1.04 Where staff competency is the root cause for a pattern of errors, every reasonable effort will be made to ensure staff can reliably deliver safe care by providing support, education and mentoring through normal performance management procedures.

1.05 Where incidents are deemed to be serious (serious or major consequences, and/or meet Severity Assessment Code 1 or 2 NZIMS definitions) the WCDHB Serious Incident Reporting and Review Procedure will be followed.

1.06 Where the incident involves the unexpected death of a client / patient the WCDHB Unexpected Death Procedure will also be followed, which deals with discovery of death, contact with the family and Police, and additional documentation requirements.

1.07 Where there is a complaint between staff members, this is directed to the relevant manager(s) to address and is not recorded as an incident.

2.00 Identification of Incident

2.01 Incidents may be identified in a number of ways, including by direct observation, team discussion, the complaints process, audit or chart reviews. They may be identified at the time of the incident, or at any time after the event.

2.02 Once an incident has been recognised however, the person that identified the incident has a responsibility to ensure that reporting occurs.

3.00 Immediate Action

3.01 Following the identification of an incident, immediate action may be needed to mitigate the harmful consequences of the incident. This will depend on the nature of the incident, and may include:

i) Support for the person(s) involved
ii) Any required clinical care for those involved
iii) Ensuring the local environment is safe and secure
iv) Gathering basic information about a chain of events

4.00 Reporting and Notification

4.01 Incident reporting will occur within the **same working day** as it occurred or was identified. The WCDHB Incident Reporting Form will be used for this process, with the front side of the Form completed by the staff person identifying the incident.

4.02 The Incident Form

i) Will contain facts – opinion and subjective comments are to be avoided.

ii) Will give as much information as possible about what happened, the nature of the incident, the nature and severity of the impact, and what happened following the incident

iii) Will include any suggestions from the staff member's perspective about changes that would prevent recurrence or minimise the impact in future.

Note: Where an incident involves staff injury only, the Occupational Health Staff Injury form will be used. While additional notifications and processes may be needed for staff injury, all incidents will also follow the incident reporting and review process below.

If the incident affects clients / patients and results in a staff injury the information pertaining to the client / patient will be recorded on the Incident Reporting Form. Additional information will be added to the Staff Injury Form which may reference an attached copy of the Incident Reporting form.

4.03 The incident form will be submitted to the appropriate immediate Line Manager (CNM/HOD) responsible for acting on the notification.

4.04 Managers who receive Incident Reports will:

i) Complete the incident investigation

ii) Assess the severity of the incident and the action required

iii) Notify the Service / Operations Manager if the incident is deemed to be of a serious nature (meets the definition of a serious incident, or rated SAC 1 or SAC 2 under the NZIMS severity assessment code ratings *(For further guidance refer to the WCDHB Serious Incident Reporting and Review Procedure).*

5.00 Investigation

5.01 The Line Manager (CNM / HOD) will complete their investigation of the event, and document their findings on the reverse side of the incident report **within 10 working days** to a depth that reflects:

i) The seriousness of the actual or potential harm/loss

ii) The likelihood of recurrence.

5.02 The investigation will focus on identifying systems issues related to the incident, and will include:

i) How the Incident was investigated

ii) The sequence of events leading up to the incident

iii) Contributing factors – for example things about the client / patient condition, work environment, team, staff, or organisation

iv) Actions taken following incident outcomes, including debriefing and support where relevant

v) Further recommendations about system changes or questions remaining for further investigation

vi) Any additional information about the impact of the Incident including a SAC score from the Manager's perspective

vii) Any other notifications that have occurred

5.03 Following investigation the a copy of the WCDHB Incident Form is filed in the client/patient's clinical file and a copy is sent to the Incident Review Group Co-ordinator.

6.00 Review And Monitoring For Systems Improvement

6.01 The incident is entered into the relevant incident database by the Incident Review Group Co-ordinator.

6.02 The Incident Review Group will review and evaluate each incident, acknowledging exemplary practice and making recommendations on systems improvement when indicated, to ensure the ongoing quality of service provision. Where further action is recommended, this will be monitored by the Incident Review Group until completed.

6.03 The Incident Review Group outcomes document (summary of meeting and recommendations which take care to protect privacy) will be communicated with meeting membership for timely feedback to teams as relevant. It will also be communicated with Service/Operations Managers, relevant General Manager and Quality and Risk Manager.

6.04 The Incident Review Group Co-ordinator will supply relevant Senior Managers, Clinical Leaders and the Clinical Governance Group with a summary of incidents monthly outlining any relevant emerging issues recommended action for discussion and decision. In addition six monthly trend data will be supplied to these forums, and to the relevant Health and Safety Committee.

6.05 The Incident Review Group Coordinator will send agreed information regarding medication related incidents to the Medication Safety Committee who retain a role in addressing organisation wide trends in medication-related incidents, education, and relevant procedures.

7. Precautions And Considerations

- ➔ All WCDHB staff members as well as clinical students, volunteers, contractors and their employees are required to report incidents, accidents or hazards, within 24 hours of the accident/incident occurring
- ➔ The Manager is to undertake a review investigation into the accident/incident
- ➔ Manager is also required to provide feedback form to the staff member

8. References

- MoH: Reportable Events Guidelines 2001
- WCDHB Incident Review Group Terms of Reference
- National Policy Reportable Events (MoH) and NZIMS Guidelines

9. Related Documents

- WCDHB Serious Incident Reporting and Review Procedure.
- WCDHB Unexpected Death Procedure

10. Guidelines

New Zealand Incident Management System

A NATIONAL APPROACH TO THE MANAGEMENT OF HEALTHCARE INCIDENTS

Severity Assessment Code (SAC)

STEP 1 - Consequences Table

Analyse all incidents against ACTUAL and POTENTIAL outcomes

	Serious	Major	Moderate	Minor	Minimal
CLINICAL CONSEQUENCE	Unexpected patient(s) death resulting from the process of health care, which is unrelated to the expected outcome of a patient's management Or any of the following events: • Inpatient suicide • Wrong patient, wrong site or wrong invasive procedure, wrong implant events • Retained equipment / swabs etc requiring surgical removal • Misadministration of radioactive materials • Patient / infant abduction / discharge to the wrong family • Any investigation commenced by police related to patient abuse (eg rape) • Blood transfusion resulting in haemolysis	Major permanent disability or loss of function (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management Or any of the following: • Suicide of an outpatient known to the mental health service within 7 days of contact with the service • Unauthorised leave of a mental health patient with an assessed high risk of serious harm to self or others • Unauthorised leave of Special Patient • Threatened or actual physical or verbal assault of patient or staff requiring police intervention	Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management Or any of the following: • Increased length of stay as a result of the incident • Surgical or other intervention required as a result of the incident • Patient at risk, absent against medical advice	An increased level of care including: • Review and evaluation • Additional investigations • Referral to another clinician	No injury or increased level of care or length of stay
CORPORATE CONSEQUENCE	**Staff, contractor, visitor:** Death(s) of staff member contractor or visitor	**Staff, contractor, visitor:** Permanent disability or loss of function to staff member, contractor or visitor; requires major additional medical or surgical intervention	**Staff, contractor, visitor:** Staff member, contractor or visitor requires extended treatment	**Staff, contractor, visitor:** Staff member or contractor requires short term treatment only with no lost time or restricted duties. Visitor requires short term treatment	**Staff, contractor, visitor:** Minimal injury to staff member, contractor or visitor; first aid required
	Services: Non delivery of a key service; loss of Certification / accreditation status	**Services:** significant ongoing disruption to a key service; Certification for 1 year or less / recommendations requiring action within 6 weeks	**Services:** Disruption to a key service; Certification awarded for 2 years or less / recommendations requiring action within 3 months	**Services;** Disruption to service; Certification recommendations requiring action within 6 months	**Services:** Minimal disruption to; low impact on Certification / accreditation status service
	Finances: Cost overrun or reduction in revenue: the lower of >$3M or > 10%	**Finances:** Cost overrun or reduction in revenue: the lower of >$2M or > 7-10%	**Finances:** Cost overrun or reduction in revenue: the lower of >1.2M or > 4-7%	**Finances:** Cost overrun or reduction in revenue: the lower of >$0.5M or > 2-4%	**Finances:** Cost overrun or reduction in revenue: the lower of >$0.1M or > 0-2%
	Environment: Toxic release off-site with detrimental effect. Fire requiring evacuation	**Environment:** Off-site release with no detrimental effects or fire that grows larger than an incipient stage	**Environment:** Off-site release contained with outside assistance or fire at incipient stage or less	**Environment:** Off-site release contained without outside assistance	**Environment:** Nuisance releases

The dot point lists provided above relate mostly to secondary and tertiary care. Primary care and other health and disability services must assess the consequence of the incident using the descriptors provided

STEP 2 – Likelihood Table

PROBABILITY CATEGORIES	DEFINITION
Certain	Is expected to occur again either immediately or within a short period of time (likely to occur at least once in the next 3 months)
Almost certain	Will probably occur at least once in the next 4-12 months
Likely	Is expected to occur within the next 1 to 2 years
Unlikely	Event may occur at some time in the next 2 to 5 years
Highly unlikely	Unlikely to recur – may occur only in exceptional circumstances ie 6+ years)

STEP 4 – Action Required Table

ACTION REQUIRED FOR 'ACTUAL' INCIDENT RATING	
1	Extreme risk – immediate action required – A Root Cause Analysis (RCA) investigation must be completed within 70 calendar days. Reportable Event Brief (REB) must be forwarded to the national central agency
2	High risk – senior management attention needed – Notification to the national central agency and a detailed investigation must be completed within 70 calendar days
3	Medium risk – All incident forms to be reviewed, review in common incident types may be most appropriate to develop a common action plan. Responsibility for management of these incidents must be assigned.
4	Low risk – manage through team level review and improvement procedures.

Incidents rating a SAC of 3 or 4 may also be reported to the national central agency if the incident is considered by the organisation's senior manager to represents potential risk of serious harm, that should be widely known.

STEP 3 – SAC Matrix

LIKELIHOOD	CONSEQUENCE: Serious	Major	Moderate	Minor	Minimal
Certain	1	1	2	3	3
Almost certain	1	1	2	3	4
Likely	1	2	2	3	4
Unlikely	1	2	3	4	4
Highly unlikely	2	3	3	4	4

Incident Reporting Process Flow Chart

Staff Member → Incident Identified

Staff Member → Immediate Action
- Person in Charge Notified
- Support / Clinical Care / Safety
- Basic Info re Chain of Events

Staff Member → Incident Reported

CNM / Direct Manager → Incident Investigated

Serious?

Yes → SERIOUS INCIDENT REVIEW

Notification to Service Manager

Notification to CEO / Senior Managers / Clinical Leaders / MoH / Coroner *(as appropriate)*

Notification to National Central Agency

Senior Mgrs, Clinical Leaders & QR Mgr decide Investigation Team

Root Cause Analysis

Report to Senior Managers / Clinical Leaders for Sign off

To National Central Agency

No

CNM / Direct Manager → Send to IRG Co-ordinator

IRG Co-ordinator → Entered in Database

Documentation Prepared

IRG Reviews or Follows up Incident

Findings / Recommendations

Outcomes to Managers

Review Outcomes

IRG Co-ordinator

6 Monthly Trend Report

Monthly Report to Clin Gov, Snr Mgrs & Clinical Leaders

System Changes – Quality Team or IRG

Revision History		
	Version:	8
	Developed By:	Quality Improvement Co-Ordinator
	Authorised By:	Chief Executive Officer
	Date Authorised:	April 2000
	Date Last Reviewed:	July 2011
	Date Of Next Review:	July 2013