



# Serious Incident Reporting & Review Procedure

Procedure Number

WCDHB-PG-0002

Version Nos.

9

## 1. Purpose

This Procedure outlines the process by which the West Coast District Health Board (WCDHB) will report on and undertake a full review of all aspects of care following a serious incident.

## 2. Application

This Procedure is to be followed by all staff throughout the WCDHB.

## 3. Definitions

For the purpose of this Procedure:

**Incident** – is defined as an event or circumstance that could have, or did, result in unintended or unnecessary harm to a person and/or a complaint, loss or damage.

**Serious Incident** – the seriousness of incidents is determined by the Severity Assessment Code, a matrix that measures both the consequence and likelihood of recurrence within certain timeframes. Examples of incidents considered serious include:

- Clinical incident that has resulted in, or could have resulted in (under varying circumstances) the unintended and/or unnecessary harm/death of the patient which is not related to the natural course of the illness or condition.
- Permanent disability or loss of function to staff member, visitor, contractor requiring major additional medical or surgical intervention
- Physical or verbal assault of client or staff requiring Police intervention
- Those which have the potential to seriously undermine public confidence or attract serious adverse media attention
- Major system failure with multiple Team, Department Or Service involvement
- Potential harm to a group of patients/clients/consumers
- Natural disaster requiring evacuation of WCDHB Facility
- Near miss events that may have resulted in death or serious harm
- Suicide of a WCDHB Mental Health Service Inpatient client.
- Suicide of a WCDHB Mental Health Service Outpatient client within three months of contact with the service
- Unexpected death of any WCDHB Mental Health Service client subject to a Compulsory Treatment Order
- Unauthorised leave of a client with an assessed high risk of serious harm to self or others
- Homicide committed by any client of the WCDHB Mental Health Service
- Unauthorised leave of a WCDHB Mental Health Service Special Patient

**Serious Harm** – is taken to mean an injury or illness or condition that will result in admission to hospital or being off work for more than one week. This relates to staff incidents only.

**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 reportable event brief outlines are available from the Quality Assurance & Risk Manager, and from the MoH website.

**Manager** – is the Manager of the team involved, and taken to include Clinical Nurse Manager, District Manager, Unit Manager, Departmental or Service Manager.

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**Reportable Event** – any incident that meets the definition for SAC 1 or SAC 2

**Reportable Event Brief** – documentation required by the National Incident Reporting Body if incidents meet the definition for SAC 1 or SAC 2.

#### 4. Staff Responsibilities

For the purpose of this Procedure:

*All WCDHB staff* are responsible for ensuring the timely reporting of all serious incidents that occur within the WCDHB service, and where required their active engagement with the review process.

#### 5. Resources Required

This Procedure requires:

- WCDHB Accident/Incident Reporting Form
- All documentation (including clinical) associated with the serious incident
- WCDHB Operational Debrief Template
- Ministry of Health Reportable Events Briefing Form

#### 6. Process

##### 1.00 Introduction

- 1.01 The focus of reporting and investigating incidents is on the improvement of systems and processes, and the development of corrective actions to prevent or minimise re-occurrence in order to provide a safer environment for service users, staff and others.
- 1.02 The WCDHB recognizes that despite the best intentions of competent and caring professionals, adverse events may occur and the WCDHB takes a no-blame approach towards staff, and is committed to the ongoing development of a culture where everyone has a constant and active awareness of the potential for things to go wrong, that is fair and open, where staff are able to learn from errors and act upon them. To this aim, no disciplinary action will result from complaints, or the reporting of incidents, mistakes or near misses, except in circumstances where there are criminal or malicious acts, or acts of gross negligence.
- 1.03 In the event it becomes clear that staff competency is the root cause of an incident, WCDHB management will make every reasonable effort to ensure staff can reliably deliver safe care. If it becomes clear that a staff member cannot practice in a reliably safe manner by providing support such as education and mentoring, this situation will be treated as a staff competency issue through normal disciplinary procedures.
- 1.04 Historically incidents have been prioritised with terms such as reportable, serious and sentinel. However, the introduction of the NZIMS the Severity Assessment Code (SAC) Matrix is used to identify the level of action and investigation needed with any given incident. This procedure outlines additional reporting, documentation, and investigation requirements when the severity of the incident is significant (i.e. it has serious or major consequences – SAC 1 or SAC 2). It is closely linked to the Incident Reporting Procedure for MH Services and should be read in conjunction with it.



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- 1.05 Where the incident involved the unexpected death of a client of the **WCDHB's Mental Health Service**, the **WCDHB MHS Unexpected Death Procedure** is to be consulted as it contains additional processes around discovery of death, contact with family and Police, and specific documentation requirements, and should be read in addition to this Procedure.
- 1.06 Where the incident involves a **staff member/visitor/contractor** in an accident, or Occupational Health and Safety issues, the WCDHB Health and Safety Reporting System is to be used. Staff incidents that are to be reported through the WCDHB Health and Safety Reporting System include where harm has, or could have occurred, including
- Illness, injury or both and
  - Physical or mental harm caused by work related stress

### **2.00 Incident Identification**

- 2.01 Once a serious incident has been recognised the person that identified the incident has a responsibility to ensure that any action and notification that is required, occurs immediately.

### **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. The relevant Manager is responsible to ensure this occurs. The immediate action needed will depend on the nature of the incident, and is likely to include
- Support for the person involved
  - Defusing of the situation and those involved (an immediate opportunity to vent emotional impact in a safe environment)
  - Any required clinical and emotional care for those involved
  - Ensuring the local environment is safe and secure
  - Gathering basic information about a chain of events,
  - Possibly notifying Police (where appropriate and necessary)
  - Contact with the patient/client and/or family, expressing regret for the incident occurring and offering support (for further guidance see *WCDHB Immediate Care Of Relatives Following Patient Death/Serious Incident Procedure*)

### **4.00 Notification**

- 4.01 Incident notification will occur immediately to the relevant Manager  
*Note: After hours this reporting should be directly to the After Hours Coordinator with notification to the relevant Manager at start of business the following day.*
- 4.02 The WCDHB Incident Reporting Form is to be completed and submitted to the appropriate Manager responsible for acting on the notification. The WCDHB Incident Reporting Form is to:
- Contain facts – opinion and subjective comment are to be avoided
  - Give as much information as possible to assist with further review and management of the incident
  - Give an indication as to the severity of the incident from the perspective of the staff member reporting the incident.



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- 4.03 Managers who receive Incident Reports related to a Serious Incident must:
- Notify the relevant Senior Manager (or designate), Quality Assurance & Risk Manager and relevant Clinical Director immediately indicating the level of severity and the immediate action taken to date.
  - Ensure immediate action (as noted above) has occurred
  - Complete a summary of the event (on the WCDHB Operational Debrief Form) and forward with a copy of the WCDHB Incident Report Form to the relevant third-tier Manager and the WCDHB Quality Assurance & Risk Manager within 48hrs of the event occurring. Summary is to include:
    - Date and time of event
    - Person/s involved
    - Responsible clinician
    - Events leading up to incident (review of notes)
    - Description of event
    - Description of staff response
    - Outcome of event
  - Organise for a formal debriefing of staff and others involved or closely associated with the client and /or situation. This should occur within the first few days following a distressing incident.
- 4.04 The relevant third-tier Manager will also complete additional notification as required:
- Notify the relevant Senior Manager and CEO; and
  - For Mental Health only, notify the Director of Mental Health, Ministry of Health in the following circumstances:
    - Death of a person under the Mental Health Act
    - Any adverse events involving special patients
    - Any adverse events that are likely to draw media attention
    - Any client death reported by Police to the Coroner (see Precautions)
- 4.05 Information to be provided by the relevant third-tier Manager is to include:
- Name
  - Incident category
  - DOB
  - Incident date
  - Ethnicity
  - Date of last contact with service
  - Gender
  - Diagnosis
  - NHI
  - Brief description /issues
  - Legal status
- 4.06 The relevant third-tier Manager is also to ensure that where the serious incident involves the suicide or unexpected death of a client, the Responsible Clinician (in discussion with the Manager) completes a report for the Coroner following receipt of a request for such from the Inquest Office. This report will focus on the clinical management; assessment and care provided to the client and attend to any specific information requested by the Coroner. The report should be simple, to the point and avoid speculation as to the cause of death. A copy of this report is to be forwarded to the WCDHB Quality Assurance and Risk Manager. As a general rule, the Report for the Coroner will include:
- Demographics
  - Date of Death



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- Date of our notification of death
- Clinicians understanding of circumstances of death if known
- The involvement of WCDHB Services in the patient's care which should include a brief history, including diagnosis, as well as
- Time of first presentation
- Relevant history including medications, responses
- Risk assessments, initial and ongoing, including last one done
- Reviews of care
- Treatments offered, accepted or refused
- Responses to and compliance with treatment
- Our contact with family and other health professionals during care
- Any other pertinent issues
- Details of last contact
- Family contact after death
- A one paragraph summary of our contact and understanding of the case

(For further information see *WCDHB Guidelines For Preparing A Report For the Coroner*)

- 4.07 The WCDHB Quality Assurance & Risk Manager is to report the event to the National Reporting Body using the Reportable Event Brief (as per NZIMS procedure) within 5 working days if identified as SAC 1 or SAC 2.

### **5.00 Incident Investigation & Review**

- 5.01 The relevant General Manager, in conjunction with the WCDHB Quality Assurance & Risk Manager, will decide on the level and scope of the investigation that will be completed, based on the seriousness of the actual or potential harm, and the likelihood of recurrence. This may include:
- Review of incident and documentation by appropriate staff; and/or
  - Investigation and review of incident and documentation by appointing an Investigation team, using the process outlined by the NZIMS; and/or
  - External investigation/review.
- 5.02 The relevant General Manager will also ensure that a specific staff member is designated to keep in regular contact with the patient/client and their family/whanau regarding the progress of the investigation.
- 5.03 The investigation is to be focused on systems, and be conducted in a manner that supports open disclosure and a no blame culture. For this reason, the root cause analysis methodology is to be used.
- 5.04 If, during the course of the investigation, staff competency appears to be the root cause for a pattern of errors, this will be appropriately reported to the relevant Manager and Professional Leader. They are to engage with the relevant staff member and make every reasonable effort to ensure the staff member is supported to regain and demonstrate the delivery of safe care by providing support, education and mentoring.



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- 5.05 The investigation is to be completed within 40 working days and will focus on identifying systems issues related to the incident. It will include but is not limited to
- Interview of all involved persons – staff, clients, family members
  - Review of all clinical documentation and operational debrief
  - Review of the person’s clinical treatment, condition, risk status and mental state in the days leading up to the incident
  - Establishment of timelines and identification of any parts of the process where problems may have occurred
  - Identification of contributing or causal factors – both active and latent factors
  - Identification of root causes
  - Development of a corrective action plan
- 5.06 The size and composition of the Investigating Team will be determined on a case-by-case basis, with a minimum of two persons being involved. Participants should have an understanding of root cause analysis methodology, and at least one needs to have a clinical background as that in which the incident occurred. No Team member is to have been involved in the incident.
- 5.067 The Investigation Team will complete the investigation report, using either the NZIMS Root Cause Analysis report template or the following headings, whichever is more applicable. The purpose of the Investigation Team’s report is to convey the results in a manner that will help the reader to understand what happened (the event description and chronology), why it happened (the causal factors and root causes) and what can be done to prevent a recurrence (the proposed corrective action).
- a. Summary**
    - States the event
    - Summary of root causes
    - Summary of action
  - b. Introduction**
    - A brief background description of the sentinel event and its results; a statement regarding the team assigned to conduct the investigation
    - Description of the scope of the investigation, its purpose, timeframe, methodologies employed in conducting the investigation and the findings.
  - c. Analysis and findings**
    - A factual description of the event, including chronology and responses to the event
    - A brief descriptions of and results from analyses that were conducted (events and causal factor analysis, change analysis, root cause analysis)
    - Include charts and diagrams in the appendix section of the report
  - d. Recommendations**
    - Root causes identified and the rationale for selecting the root causes
    - Proposed and/or implemented corrective actions.
    - Rationale for choice of corrective action
    - Plans for evaluating the effectiveness of corrective actions, eliminating, minimizing and isolating the root cause.
  - e. Learning Points**
    - Specific list of learning points. These need to be shared across appropriate departments/ staff either through formal training or through some other means i.e. individual feedback, required reading.



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### f. Residual Risks

- Where the root causes are not addressed or there is outstanding risk
- Likelihood of recurrence
- Consequence of recurrence
- Control effectiveness if recommended actions are taken

5.08 For serious incidents rated in the NZIMS as SAC 1 or SAC 2, the completed investigation will be reported to the National Central Agency within 70 working days of the event notification.

*Note: while there is a defined time limit for furnishing reports to the National Central Agency, requests for information or investigations relating to incidents may be made at any time by the Ministry of Health, Coroner, or WCDHB Managers.*

5.09 Upon completion of the investigation, the investigation file is to be past to the WCDHB Quality Assurance & Risk Manager who is to ensure that it is files according to the requirements of the WCDHB Archiving Procedure.

### **6.00 Review And Monitoring For Systems Improvement**

6.01 The completed investigation is forwarded to the chair of the relevant Clinical Governance Committee for noting outcomes/following up on recommendations and decisions on how to progress these. A quality improvement approach is useful, and may include:

- Communicating the results
- Investigating policies and procedures
- Implementing training
- Establishing plans for ongoing monitoring
- Identifying other areas where the improvement could be implemented
- Identifying barriers to change
- Piloting actions
- Testing the effectiveness of change

6.02 A summary report will also be forward to the WCDHB Audit, Risk and Finance Committee for their information.

6.02 An audit of recommendations from serious incidents is to be included as part of the regular Service quality audit cycle to ensure that recommendations have been implemented, and that they have effected the desired change. Such an audit answers the questions:

- Has the recommendation been implemented?
- Has the root cause been addressed?
- Has recurrence has been reduced or eliminated?
- Have relevant lessons been learnt and communicated?
- Have identified barriers to change been unfrozen?

### **7.00 Feedback Following Investigation**

7.01 Feedback to the client and/or support person (open disclosure) is an important component of managing incidents successfully. Careful consideration will be given to the client's cultural identity, first language and support needs before open disclosure occurs. (See *WCDHB Immediate Care Of Relatives Following Patient Death/ Serious Incident Procedure*)



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- 7.02 Feedback to staff will be provided regarding the outcomes of investigations, in a timely manner. Staff involved in the incident will be informed of the recommendations arising from an investigation, and where an investigation report has been developed, the relevant clinical staff members are to be provided with a copy of the report. The relevant Manager will also ensure that the notifier is informed of the organisations response to the incident.

### 7. Precautions And Considerations

- All activities described by this procedure are to occur within the stated timeframes
- All reviews are to be objective, consider all relevant facts and documents and comply with the principles of openness, fairness and natural justice.

### 8. References

- MoH: Reportable Events Guidelines 2001
- NZS HB: 8152:2001 Sentinel Event Workbook: Process for Standardised Investigation and Reporting in the Health Sector
- National Policy Reportable Events (MoH) and NZIMS Guidelines

### 9. Related Documents

- NZIMS Root Cause Analysis Report Template
- WCDHB MHS Unexpected Death Procedure
- WCDHB Patient Death-Serious Incident - Immediate Care Of Relatives Procedure
- WCDHB Operational Debrief Form

### 10. Guidelines

#### Coroners Act 2006

##### Section 13 Deaths that must be reported to the Coroner

- Every death that appears to have been without known cause, or suicide, or unnatural or violent
- Every death in respect of which no doctor has given a doctor's certificate
- Every death that occurred while the person concerned was undergoing a medical, surgical, dental, or similar operation or procedure; or
  - that appears to have been the result of an operation or procedure of that kind; or that appears to have been the result of medical, surgical, dental, or similar treatment received by that person; or
  - that occurred while that person was affected by an anaesthetic; or
  - that appears to have been the result of the administration to that person of an anaesthetic or a medicine; or
  - any death that occurred while the woman concerned was giving birth, or
  - that appears to have been a result of that woman being pregnant or giving birth.
- The death of a patient required to be detained in an institution pursuant to an order under section 9 of the Alcoholism and Drug Addiction Act 1966
- The death of any patient as defined in section 2(1) of the Mental Health (Compulsory Assessment and Treatment) Act 1992



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- The death of a child or young person while that child or young person is in the custody or care of an Iwi Social Service or a Cultural Social Service, or the Director of a Child and Family Support Service, pursuant to section 43 or 78 or 110 or 139 or 140 or 141 or 234 or 238 or 345 of the Children, Young Persons, and Their Families Act 1989.

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