SA Health

Policy

Clinical Incident Management

Version 3.0
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Government of South Australia
SA Health

1. Name of policy

Clinical Incident Management

2. Policy statement

This policy provides the mandatory requirements in relation to clinical incident management, supported by guidelines for clinical incident review, root cause analysis, cluster incident review and open disclosure.

3. Applicability

This policy applies to all employees and contracted staff of SA Health; that is all employees and contracted staff of the Department for Health and Wellbeing (DHW), Local Health Networks (LHNs) including state-wide services aligned with those Networks and SA Ambulance Service (SAAS).

4. Policy principles

SA Health's approach to clinical incident management is informed by the Australian Commission on Safety and Quality in Health Care Incident Management Guide and underpinned by the following principles:

- We actively plan and design our work to reduce patient risk and minimise the likelihood of clinical incidents.
- We support the workforce and patients/families/carers to recognise and report incidents when they take place.
- We engage patients/families/carers and the workforce in the review of incidents.
- We provide patients/families/carers involved in an incident with an honest an open explanation of what happened, why it happened and will be taken, as a result.
- We foster a positive safe and just culture with a systems mindset and consideration of human factors in the investigation process and a forward-thinking accountability rather than retribution or blame.
- We foster a climate where staff and patients/families/carers feel psychologically safe to speak up with questions, concerns, mistakes, ideas and to report incidents without fear of retribution, embarrassment or blame.
- We will support patients/families/carers and the workforce who are impacted by incidents with the aim to heal harm.
- We use the learnings from incident review to improve safety and quality of care and provide feedback to teams for learning.
- We analyse clinical incident trends to inform leadership, the workforce and risk registers to improve safety and quality of care.
- We regularly monitor, review, and act to improve our incident management system.

5. Policy requirements

Governance

The DHW, LHNs, SAAS and state-wide services must:

- Prioritise and promote a safe, just and learning culture with a focus on providing the best quality care by a competent, confident and caring workforce.
- Allocate clinical governance roles and responsibilities to monitor incident management processes and outcomes and ensure compliance with this policy and supporting resources.

- Ensure that all contractual agreements with external agencies to provide care on behalf of SA Health include clinical incident management requirements aligned to this policy.

The DHW, LHNs, SAAS and state-wide services must:

- Establish and maintain local clinical incident management procedures that meet the requirements of this policy and mandatory instructions.
- Ensure staff are appropriately trained in incident management to enable compliance with this policy.
- Ensure students and volunteers are aware of their responsibilities for incident management.

Incident Reporting and Escalation

DHW, LHNs, SAAS and state-wide services employees must identify clinical incidents, where an event or circumstance that occurs during SA health care could have or did result in patient harm, and:

- Respond immediately to ensure the safety of all affected persons, taking actions to prevent further harm and providing appropriate treatment and support to those affected.
- Notify senior staff and escalate in accordance with local procedures.
- Document in the medical record, including the plan of care or treatment required.
- Notify the DHW Safety and Quality Unit of confirmed sentinel events (as defined in the Australian Sentinel Events List version 2), within 24 hours (1 business day).
- Notify senior staff, and local Safety and Quality Unit within 24 hours (1 business day) of identifying a cluster incident, where a group of five or more patients (3 or more for a small or specialised service) are affected as a result of a system failure(s) or issue(s).
    - Complex cluster incidents must be notified to the DHW Safety & Quality Unit, allocated a 'Cluster Title' and have a primary cluster incident entered into the Safety Learning System (SLS). Refer to How to Conduct a Cluster Incident Review Guideline.
- Record details of the incident in the SLS within 24 hours of incident identification.
- Allocate an initial manager Incident Severity Rating (ISR), within 48 hours (2 business days) of the incident reported date to guide appropriate escalation and review.
- Escalate to Executive via a clinical incident brief (CIB) in accordance with the requirements and timeframes of Appendix 2: Incident Escalation Mandatory Instruction.

Open Disclosure

DHW, LHNs, SAAS and state-wide services must ensure:

- Open, transparent, objective, accessible and culturally appropriate communication with patients/families/carers following an incident.
- Open disclosure takes place for incidents that result in harm (Manager ISR 1,2,3), as soon as practical and in accordance with Appendix 3: Open Disclosure Mandatory Instruction.

Incident Review

DHW, LHNs, SAAS and state-wide services must:

- Conduct a Patient Safety Huddle for incidents rated with an initial Manager ISR 1 and 2 (excluding falls), sentinel events, and complex cluster incidents within 48 hours (2 business days) of the incident reported date.
- Determine the incident manager, appropriate review type and required timeframes, as outlined in Appendix 4: Review Type and Timeframes Mandatory Instruction.
- Conduct incident review in accordance with Appendix 1: Clinical Incident Management Mandatory Instruction.
    - Manager ISR 1 and 2, sentinel event and complex cluster incidents must involve a complex review by a multidisciplinary team.
    - Manager ISR 3 or 4 incidents must involve a simple review by a suitability skilled reviewer.

Internal reporting

LHNs, SAAS and state-wide services must ensure incidents with internal reporting requirements are actioned.

- Incidents which involve Health Care Systems (such as Sunrise) must be indicated within SLS for appropriate escalation to Digital Health.
- Incidents which may result in potential legal action, must have a notification entered into the Notifications module of the SLS.
- Incidents which involve cyber security threat, must be reported to Digital Health.
- Incidents which involve alleged sexual assault or misconduct must be reported in accordance with the Suspected or Alleged Sexual Assault or Misconduct Policy.
- Incidents which involve alleged sexual assault or misconduct of a child within a SA Health facility must be reported in accordance with the Responding to Suspected or Alleged Offences Against a Child or Young Person Occurring at an SA Health Facility or Service Policy.

External reporting

LHNs, SAAS and state-wide services must ensure incidents with mandatory reporting requirements are actioned as outlined in the Appendix 5: External Agency Reporting Mandatory Instruction.

- Incidents that involve the following must have a mandatory report:
  - criminal acts must be reported to the South Australia Police (SAPOL).
  - reportable deaths must be reported to the Coroners Court of South Australia.
  - suspected harm or neglect of a child or young person must be reported to the Department for Child Protection's Child Abuse Report Line (CARL).
  - National Disability Insurance Scheme (NDIS) reportable incidents must be reported to the NDIS Quality and Safeguards Commission.
  - Aged care reportable incidents must be reported to the Aged Care Quality and Safety Commission.
  - Reportable clinician practice related to a clinical incident must be reported to the Australian Health Practitioner Regulation Agency (AHPRA) or the appropriate regulatory agency.
  - Privacy breaches must be reported to the Privacy Committee of South Australia, in line with the SA Government Personal Information data breaches guideline.

6. Mandatory related documents

The following documents must be complied with under this Policy, to the extent that they are relevant:

- *Ageing and Adult Safeguarding Act 1995*
- *Children and Young People Safety Act 2017*
- *Coroners Act 2003*
- Coronial Process and the Coroners Act Policy
- *Health Care Act 2008 (the Act)*
- *Health Care Regulations (the Regulations) 2023*
- *Health Practitioner Regulation National Law Act 2010*
- Mandatory Reporting of Suspicion that a Child or Young Person is or may be at Risk Policy
- *National Disability Insurance Scheme Act 2013*
- National Disability Insurance Scheme (Incident Management Reportable Incidents) Rules 2018

- Responding to Suspected or Alleged Offences Against a Child or Young Person Occurring at an SA Health Facility or Service Policy
- Suspected or Alleged Sexual Assault or Misconduct Policy
- Sentinel Events List specification, Australian Commission on Safety and Quality in Healthcare
- *Work Health and Safety Act 2012*

7. Supporting information

- Clinical Incident Management Resources
- How to Conduct a Clinical Incident Review Guideline
- How to Conduct a Cluster Incident Review Guideline
- How to Conduct Open Disclosure Guideline
- How to Conduct Root Cause Analysis Guideline

8. Definitions

- **Adverse incident:** means a category of serious patient incident used for commissioning a Root Cause Analysis under Part 8 of the Health Care Act 2008. The list of gazetted incidents can be found on page 2683 of the 11 July 2019 SA Government Gazette.
- **Carer/support person:** means anyone who is a legally appointed guardian and/or who the patient considers to be family, friend, support person or substitute decision maker.
- **Clinical incident:** means an event or circumstance that occurs during SA health care that could have or did result in harm to a patient, client or consumer of SA health services.
- **Cluster incident:** means an event or circumstance where a group of five or more patients (3 or more for a small or specialised service) could have or did experience harm, as a result of a system failure(s) or common issue(s). The commonality of these incidents may be related to time, place, and/or treatment.
- **Complex cluster incident:** means a cluster incident where patients are impacted with serious harm, or a large number of patients are impacted with minimal or no harm or where multiple patients are affected where significant safety implications are identified.
- **Complex review:** means an analysis of a patient incident, involving a multi-disciplinary review team and extensive analysis using a structured incident review methodology.
- **Consumer:** means the patient, family, carer, substitute decision maker or guardian.
- **Criminal act:** means any activity that is outlined in the *Criminal Law Consolidation Act 1935* or other relevant legislation.
- **Debrief:** means the formal or informal conversations after an incident to put the incident into perspective. It offers staff clarity about the incident they have experienced and provides opportunity to refer staff to support agencies if required.
- **Decision making capacity:** means a person is capable of agreeing to an action or arrangement. This capacity involves the person being able to (1) understand the information and nature of the decision (2) retaining the information provided even if only for a short time (3) use the information to make the decision and (4) communicate the decision.
- **Guardian:** means a person appointed by the South Australian Civil and Administrative Tribunal (or an equivalent in other states or territories) to make decisions for a person with impaired decision making capacity under the *Guardianship and Administration Act 1993*.

- **Harm:** means impairment of structure or function of the body and/ or psychological distress. Harm includes disease, injury, suffering, disability, and death.
    - Harmful incidents can occur because an unplanned or unintended variation in care has occurred, the patients or medical team's expectations of care were not met, or a complication of investigation, (e.g., colonoscopy) or treatment, (e.g., surgery) that results in a complication. (e.g., bowel perforation or pneumothorax).
    - Harm may also be self-inflicted or as a result of violence and aggression.
- **Incident management:** means the review and actions required to conduct immediate and ongoing activities that decrease the likelihood of avoidable patient harm, refer to the Clinical Incident Management Topic Guide.
- **Incident management best practice principles**: means those principles of transparency, accountability, consumer partnership, Safe and Just Culture, timely action, and shared learning outlined in the Incident Management Guide.
- **Incident manager:** means a staff member who is in involved in the incident review and is responsible for review quality and incident closure.
- **Incident review:** means a process of staff reflection and information collation/analysis, that improves patient safety and healthcare reliability. It considers avoidable patient incidents, and asks what happened, why it happened and how it happened, to prevent it from happening again.
- **Incident Severity Rating (ISR):** means a numerical score applied to a clinical incident based on the patient outcome and follow up treatment after an incident; Incident Severity Rating Topic Guide, Tool 2.
- **Just culture:** means a concept related to systems thinking which suggests that incidents are usually a product of organisational culture rather than the individual practitioner. After an incident the question asked is 'What went wrong' rather than 'Who caused the problem?' A just culture helps create an environment where individuals feel free to report errors and help the organisation to learn. It supports a culture of fairness, openness and learning.
- **Near miss:** means an incident which could have, but did not occur or result in harm, either by chance or through timely intervention.

  No harm incident: means an event or circumstance took place, but this did not result in harm.
- **Open disclosure:** means an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient/family/carer to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings.
- **Patient:** means a person receiving services from a SA Health service or a service funded by SA Health. For the purpose of this document, patients, consumers, clients and residents are equivalent terms.
- **Patient safety:** means a framework of organised activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce the impact of harm when it does occur.
- **Patient safety huddle:** means a meeting of senior staff following a clinical incident that provides an initial risk assessment, develops a plan of action, commences escalation if required and determines the initial Manager ISR and review type (e.g., PITSTOP Huddle).
- **Prescribed act:** an act where a staff member is alleged or suspected to have committed a criminal offence or is under investigation for unprofessional conduct reportable to a regulatory agency. Refer to *the Act Part 8 Section 70(3)* for more detailed information.
- **Recommendations:** means actions that decrease the likelihood of the root cause, contributing factors and issues of a patient incident. They must be:

- specific, measurable, achievable, realistic, and time limited
- system based and not focused on individual staff actions
- where appropriate, allocated to a senior manager who is responsible for implementation
- include a feedback mechanism for ensuring recommendations are actioned or reason for not completed.

- **Restorative just and learning culture:** means to avoid retributive, backward-looking accountability (which tends to blame individuals for things that went wrong) and instead focuses on the hurts, needs and obligations of all who are affected by the event. All stakeholders (staff, consumers, carers, the service and the community) should be engaged in collaboratively identifying responsibilities for changes and improvements. Processes in place for reviewing events need to facilitate this forwarding looking accountability to learn, improve and heal.
- **Root cause analysis (RCA):** means a methodology of systematic reflection and analysis of a patient incident to understand an incident problem. It aims to create a chronological map of the sequence of events for an incident and asks a series of questions about those events to identify the root cause of the incident.
- **SA Health aged care provider:** means a SA Health facility or service that has been approved by the Aged Care Quality and Safety Commission to deliver Commonwealth subsidised home, residential or flexible care services to eligible older Australians.
- **SA Health care:** means care provided by SA Health staff, students on placement, volunteers or contracted staff. This care can be provided at a facility, community location or in a person's home. In the instance of a facility that is a hospital site, this includes the surrounding grounds where hospital by-laws apply. Those patients under an inpatient treatment order (ITO) on day leave are considered inpatients of a hospital.
- **SA Health NDIS provider:** means a SA Health facility or service that is accredited to provide expert care to NDIS participants, as outlined in the *NDIS Act 2013.*
- **Safety culture:** means organisations with effective safety cultures share a constant commitment to safety as a top-level priority, which permeates the entire organisation. Components include:
    - acknowledgment of the high-risk, error-prone nature of an organisation's activities.
    - a blame-free environment where individuals are able to report errors or close calls without punishment.
    - an expectation of collaboration across ranks to seek solutions to vulnerabilities.
    - a willingness on the part of the organisation to direct resources to address safety concerns.
- **Safety Learning System (SLS):** means the SA Health Incident Management System for reporting patient incidents. It aims to support comprehensive clinical governance, embed a culture of patient safety and quality, provide opportunity for trending of patient incidents, and shared learning across SA Health to improve patient safety and quality.
- **Sentinel event:** means a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or the death of, a patient, as per the Australian Sentinel Event List version 2.
- **Serious harm:** means an outcome that involves a patient death or where a patient requires life-saving surgical or medical intervention, has shortened life expectancy, experiences permanent or long-term physical harm, or permanent or long-term loss of function.
- **Significant incident:** means an incident that did not result in serious harm, but where significant safety implications are identified.
- **Simple cluster incident:** means a cluster incident where patients are impacted with minimal or no harm.
- **Simple review:** means an incident that requires limited reflection and review and commonly only has one reviewer to determine the what, why and how of the patient incident.

- **State-wide services:** means State-wide Clinical Support Services, Prison Health, SA Dental Service, BreastScreen SA and any other state-wide services that fall under the governance of the Local Health Networks or DHW.
- **Substitute Decision Maker:** means a person appointed under an Advance Care Directive to make health, accommodation and lifestyle decisions when the patient has impaired decision-making capacity. Substitute Decision Maker's cannot make decisions about finances, property or legal affairs.
- **Unexpected death:** means death in circumstances whereby reasonable steps were not taken by the service to prevent the death and/or the death is the result of care or services provided by the service or a failure by the service to provide care and services.

9. Compliance

This policy is binding on those to whom it applies or relates. Implementation at a local level may be subject to audit/assessment. The Domain Custodian must work towards the establishment of systems which demonstrate compliance with this policy, in accordance with the requirements of the Risk Management. Integrated Compliance and Internal Audit Policy.

Any instance of non-compliance with this policy should be reported to the Domain Custodian for the Clinical Governance, Safety and Quality Policy Domain and the Domain Custodian for the Risk, Compliance and Audit Policy Domain.

10. Document ownership

Policy owner: Director Safety and Quality, Clinical System Support & Improvement, as Domain Custodian for the Clinical Governance, Safety, and Quality Policy Domain.

Title: Clinical Incident Management Policy

Objective reference number: A5574335

Review date: 15/04/2029

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11. Document history

Version	Date approved	Approved by	Amendment notes
3.0	15/04/2024	A/Chief Executive, DHW	Clinical Incident Management Policy replaces the Patient Incident Management and Open Disclosure Policy Directive (version 2.3), the Lookback Review Policy Directive (version 1.0), the Root Cause Analysis Policy Directive (version 1.0) and the and the NDIS Serious Reportable Incident Policy (version1.0). Transfer of the existing policies to the new SA Health Policy Framework Template.
2.3	15/05/2021	Director, Safety and Quality	Minor changes to reflect the introduction of the Governing Boards insertion of clause in s3.4.4 so the CE can waive the requirement for OD in rare cases Insertion of clause 3.4.1 DPR Change of template
2.2	29/09/2021	Executive Director, Quality Information and Performance	Minor changes to s 4.11 relating to the protection of SLS information
2.1	03/01/2017	Executive Director, Quality Information and Performance	Minor changes to s4.4 open disclosure of near miss incidents, some criminal and self-harm incidents and for some service providers, s 4.11 after removal of protection of SLS information under Part 7 of Health Care Act 2008, s 4.9 regarding notification to executives and briefing to DHA

2.0	14/07/2021	Portfolio Executive	Updated information and integration of incident management policy D0162, Open Disclosure Policy D0247 and Incident Management Policy Guideline incorporating Open Disclosure Response G0075

12. Appendices

1. Clinical Incident Management Mandatory Instruction
2. Incident Escalation Mandatory Instruction
3. Open Disclosure Mandatory Instruction
4. Review Type and Timeframes Mandatory Instruction
5. External Agency Reporting Mandatory Instruction
6. Key Performance Indicators

Appendix 1: Clinical Incident Management Mandatory Instruction

The following Instruction must be complied with to meet the requirements of this policy.

1. Prevent incidents

1.1 The DHW, LHNs, SAAS and state-wide services must have the following accountabilities in place:

a) A clinical governance framework providing the structure to support safety and quality systems related to clinical incident management.

b) Local procedures related to clinical incident management that are compliant with relevant policy, legislation and / or best practice standards.

c) Mechanisms to involve patients/families/carers in clinical incident management processes.

d) Reporting schedules to monitor clinical incident management outcomes, clinical risks and management practices to reduce the likelihood of incidents.

e) Quality improvement registers to record and track recommendations resulting from clinical incidents that are reported to health service staff, executive and Governing Boards.

f) Scheduled audit and analysis to inform improvement and prevention strategies.

g) Relevant induction and training for staff that reinforces the importance of incident reporting, management and analysis to ensure safe, high quality person-centred health care.

2. Incident response

2.1 An immediate response to patient incidents by clinicians and managers must include:

a) Immediate actions to ensure the safety of all people affected:

- Ensure the affected patient is safe and all necessary steps are taken to support and treat the person/s to prevent further injury.
- Provide support to the affected patient/family/carer.
- Provide support to affected staff.
- Preservation of evidence if the incident is associated with a criminal act.
- Urgent contact with the SA Police (SAPOL) and local security if the incident involves a criminal act.
- Accelerated changes to the immediate environment or systems to prevent further harm.
- Staff debrief if the incident involves serious harm, a significant incident or where there is potential for significant psychological harm.

2.2 Timely response to clinical incidents by clinicians, managers and Safety and Quality (S&Q) teams must include:

a) A patient safety huddle for incidents that involve serious harm (e.g., ISR 1, 2, sentinel events and complex cluster incidents) within 48 hours (two business days) of the incident being reported to identify immediate system, process, or resource improvements.

- Patient safety huddle outcomes / documents must be saved in the SLS.

b) Escalation of incidents involving serious harm or a significant incident to senior staff and executive as outlined in Appendix 2: Incident Escalation Mandatory Instruction.

c) Mandatory reporting obligations as outlined in Appendix 5: External Agency Reporting Mandatory Instruction.

d) Open disclosure with the affected patient/family/carer in line with Appendix 3: Open Disclosure Mandatory Instruction.

- Where the patient does not have decision making capacity, open disclosure must include the family, substitute decision maker or guardian.

2.3 Initial documentation about the incident must include:

a) Documentation in the medical record about the incident, patient outcome and care and/or treatment requirements.

b) Notification in the SLS within 24 hours of identification of the incident.

c) An initial Manager ISR within 48 hours (two business days) of the incident being reported.

2.4 Contractual agreements with external agencies to provide care on behalf of SA Health must include documented requirements for the external agency to:

a) Maintain an incident management system to record and manage all clinical incidents.

b) Provide regular clinical incident reports to the contract manager, that include incident types, patient outcomes, and details of incident review.

c) Notify the contract manager within 24 hours of identification of a clinical incident that meets the ISR1 or ISR2 rating.

- SA Health Contract Managers must report ISR1 and ISR2 rated incidents in the SLS to ensure joint management and documentation of the incident, including escalation, review and outcome.

3. Review the incident

3.1 To build a strong patient safety culture and inform improvement activities, incident reviewers must:

a) Conduct the review in the required timeframes, as outlined in Appendix 4: Review Type and Timeframes Mandatory Instruction.

- Stakeholder review and representation should be inclusive of all relevant parties, with respectful patient-focused engagement.

b) Coordinate a partnership approach when more than one SA Health Service (LHN, SAAS or state-wide service) are involved in the same clinical incident.

c) If a joint review is warranted, the incident manager must schedule a patient safety huddle with stakeholders to determine the incident facts, confirm the SLS information, including location field, manager ISR rating and the individuals who need to be involved in joint review.

d) Confirm that all relevant mandatory reporting has occurred and determine appropriate reporting requirements.

e) Gather information from patients/family/carers to inform the review and consider consumer representation.

f) Document in the structured review tab of SLS if the incident is a sentinel event, complex cluster, Part 7 Committee review or Part 8 RCA review and inform DHW S&Q via Health:DHWClinicalGovernance@sa.gov.au.

g) Use an appropriate review methodology to investigate the incident.

h) Address the findings of the incident review with strong recommendations.

- Review findings and recommendations must be documented in the SLS.

3.2 To maintain therapeutic relationships and trust the incident manager must:

a) Protect staff and patient privacy.

b) Coordinate open disclosure with the patient/family/carer. Refer to How to Conduct Open Disclosure Guideline.

3.3 When a Part 7 or Part 8 investigation is undertaken, South Australian legislation must be complied with. Incident managers and S&Q Teams must:

a) Conduct reviews for Part 7 Authorised Committees in accordance with the *Health Care Act 2008* (the Act), Regulations and Part 7 Committees Policy.

- Part 7 Authorised Committees must provide an annual report to DHW Safety & Quality providing an overview of their activities in accordance with the Act and Regulations.

b) Conduct Part 8 Authorised RCA Investigations in line with the Act and Regulations.

- The designated authority who appoints the RCA Team, must do so with an appointment letter; the RCA Team appointment date must be detailed in the letter.
- Health services must notify DHW Safety and Quality of the commencement and completion of Part 8 RCA investigations via email at: Health.DHWClinicalGovernance@sa.gov.au.
- Protected RCAs are prohibited from investigating issues relating to staff competence or where the incident involves a prescribed act. If during the course of conducting a protected RCA, the team has reason to suspect that its investigations may relate to an adverse incident that involves a prescribed act, the RCA team must suspend its activities and comply with the procedures prescribed by the regulations.
- All Part 8 RCA Form 1 and 2 Investigation Reports must be submitted to DHW Safety and Quality in a secure folder.

3.4 To finalise clinical incident management, the incident manager must:

a) Document the incident review outcomes in the SLS.

b) For complex incident reviews, attach the incident review report that includes a summary of the incident, review findings and recommendations and relevant documentation in the SLS.

c) Confirm the Manager ISR and finally approve the incident in the SLS.

- If the event does not fit the definition of a clinical incident, the incident manager can rate the incident as no incident / mortality if the event involves a death or consult with local S&Q team to reject the incident.

3.5 To maintain incident management best practice principles, S&Q teams must:

a) Provide oversight and guidance to clinical incident managers and review teams.

b) Monitor the progress and appropriateness of incident management, including finally approved Manager ISR allocations and timelines.

c) Ensure the appropriate use of the SLS to document the management of clinical incidents through local audit and reporting processes.

d) Ensure that required additional reporting is undertaken.

e) Actively engage patients/families/carers and staff in clinical incident review or forums and consider lived experience to understand human factors in healthcare design and patient safety improvements.

4. Improve safety and quality of health care

4.1 To ensure that the endeavours of staff to report patient incidents are worthwhile, every effort must be made to effectively implement incident recommendations to prevent future incidents. Incident managers and S&Q teams must:

a) Educate and mentor staff about the development of strong recommendations.

b) Implement recommendations and preventative strategies in the required timeframes and evaluate the effectiveness of recommendations.

c) Share incident outcomes, recommendations and improvements with the local team and the organisation through reporting to governance committees, Executive and the Governing Board.

d) Finalise open disclosure with patients/families/ carers including sharing the review findings and recommendations for improvement.

e) Acknowledge the efforts of staff throughout the clinical incident management process and celebrate safety and quality improvements by sharing learnings across SA Health.

f) Seek feedback from those affected by the incident and those involved in the review to identify areas for improvement in the whole experience.

Appendix 2: Incident Escalation Mandatory Instruction

The following Instruction must be complied with to meet the requirements of this policy.

Refer to the Clinical Incident Brief Escalation Tool

Purpose of the Clinical Incident Brief (CIB)

A CIB is developed to provide early escalation to SA Health Executives about patient incidents that cause serious harm.

It aims to provide executives with timely information that includes an initial summary of the incident, immediate response, and future actions.

At the discretion of the CE and/or LHN or SAAS CEOs and Governing Board Chairs, CIBs may also be escalated to the South Australian Minister for Health and Wellbeing.

CEO CIB Template and CE CIB Cover Minute

This guide provides direction about the CIB escalation pathway to SA Health Chief Executive Officers (CEOs) and the Department for Health and Wellbeing (DHW) Chief Executive (CE).

CIB Escalation Matrix

✓ Requires CIB	Escalation Pathway		
Patient Incident Type	LHN CEO	DHW CE*	CIB Timeframe#
Sentinel Event	✓	✓	48 hours
Manager ISR 1 incident	✓	✓	48 hours
Alleged Sexual Assault or Misconduct Category 1 incident	✓	✓	48 hours
Complex Cluster Incident or SA Health System Failure	✓	✓	48 hours
Manager ISR 2 incident (excluding falls)	✓	at CEO discretion**	48 hours

* Those incident types that involve a mental health consumer should also be escalated to the Chief Psychiatrist.

\# Initial Manager ISR score is required within 48 hours of the incident notification date.

** ISR 2 incidents that must be escalated to CE include reportable incidents that involve a NDIS or SIRS notifications, or likely media attention.

Refer to the Suspected or Alleged Sexual Assault or Misconduct Policy for details relating to the notification and escalation of these incidents.

Appendix 3: Open Disclosure Mandatory Instruction

The following Instruction must be complied with to meet the requirements of this policy.

3.1 Open disclosure must occur for all incidents that result in patient harm. Staff must:

a) Conduct open disclosure to ensure the intent of the Charter of Health and Community Services Rights is upheld. Openly and willingly disclose all harmful patient incidents (Manager ISR 1,2,3) with the patient/family/carer.

- Provide opportunity for the patient/family/carer to discuss their experience of the incident and their ideas on improvement.
- In the instance where the patient does not have decision making capacity the incident must be communicated with the family, substitute decision maker or appointed guardian.
- Where the provider of care is a SA Health Contracted Service, the contracted service must lead and provide open disclosure.

b) An adapted open disclosure using a low level response (Level 2) must be considered for no harm and near miss incidents (Manager ISR 4) in accordance with the ACSQHC Australian Open Disclosure Framework.

c) Determine appropriate timing for open disclosure considering the patient/family/carer wishes, cognitive impairment, physical illness or family grief.

d) Plan open disclosure in accordance with the level required:

- Level 1 Open Disclosure is considered a high-level response and is required for Manager ISR 1 and 2 incidents, Sentinel Events, and Complex Cluster Incidents. Level 1 Open Disclosure is a planned conversation and must include a documented summary of the discussion.
- Level 2 Open Disclosure is a briefer open disclosure process for incidents resulting in minor harm (ISR 3), no harm and near miss (ISR4).

e) Use a restorative, just and learning culture approach to open disclosure with awareness of the impact serious incidents can have on all parties involved.

f) Document open disclosure in the medical record and/or in the SLS, including attaching the documented open disclosure summary.

g) Actions arising from the open disclosure discussion/s must be incorporated in the incident review process.

h) Inform legal services if the patient/family/carer intends to have legal representation at the open disclosure meeting.

- Staff must not enter into discussions about legal action or financial renumeration.

Appendix 4: Review Type and Timeframes Mandatory Instruction

The following Instruction must be complied with to meet the requirements of this policy.

4.1 Incident managers must review incidents in accordance with the appropriate review type:

a) Simple reviews must be:

- Undertaken for ISR3 and ISR4 rated incidents.
- Conducted by a suitably skilled reviewer.
- Completed and finally approved within 30 calendar days of the incident being reported in the SLS.

b) Complex reviews must be:

- Undertaken for ISR1 and ISR2 rated incidents, Sentinel Events, complex cluster incidents and significant incidents.
- Completed within 70 days of the incident being reported and finally approved within SLS.
- Conducted with a multidisciplinary team using an appropriate review methodology, for example, Root Cause Analysis (RCA).
- Each complex review report must contain: a factual description of the event, the factors identified as having contributed to the event and recommendations to prevent or reduce the likelihood of a similar event happening again.

c) Incident reviews for Part 7 Authorised Committees must be:

- Undertaken in accordance with Part 7 of the Health Care Act and Regulations and Policy for the purpose of quality improvement and research.
  - Part 7 investigations have legal protection of information except for information or documents that do not identify, either expressly or by implication, a particular person or particular persons related to the incident are admissible in court (the Act, Part 7, Section 66(4)).
- Submitted to the Part 7 Authorised Committee within 70 days of the incident being reported and finally approved within the SLS.

d) Part 8 protected RCA reviews must be:

- Undertaken in accordance with Part 8 of the Health Care Act and Regulations. Refer to the How to Conduct Root Cause Analysis Guideline.
- Approved by the designated authority (Chief Executive Officer or delegate, Chief Psychiatrist or Part 7 Committee) who will appoint an RCA team.
- Commenced within 14 days of the RCA Team appointment date with commencement and completion dates documented in the structured review tab of the SLS.
  - Part 8 RCA investigations have legal protection of information except for Report 1 – Public Report or any information or document that does not identify, either expressly or by implication, a particular person or particular persons related to the incident is admissible in court (the Act, Part 8, Section 73, (4)(b)).
- Completed within 70 days of the RCA Team commencement date and finally approved within the SLS.

Appendix 5: External Agency Reporting Mandatory Instruction

The following Instruction must be complied with to meet the requirements of this policy.

Clinical incidents can involve events that require mandatory reporting to external agencies.

1. Criminal Offences

1.1 If a clinical incident involves a criminal act, senior managers must:

a) Report the incident to SAPOL.

b) Respond to any suspected or alleged sexual assault or neglect of a child, in line with the Responding to Suspected or Alleged Offences Against a Child or Young Person Occurring at an SA Health Facility or Service Policy and Mandatory Reporting of Suspicion that a Child or Young Person is or may be at Risk of Harm Policy.

c) Respond to any suspected or alleged sexual assault or misconduct involving an adult, in line with the Suspected or Alleged Sexual Assault or Misconduct Policy.

d) Report any reasonable belief of a criminal act by a staff member to professional regulatory agencies (e.g., AHPRA, Office of Public Integrity, Safe Work SA).

2. Reportable Death | State Coroner

2.1 If a clinical incident involves an reportable death, senior clinicians must:

a) Determine if it is a reportable death as outlined in the *Coroners Act 2003* and respond in line with the Coronial Process and Coroners Act 2003 Policy.

- Notification to the South Australian Coroner must occur within 24 hours.
- A coronial notification must be entered in the notifications module of the SLS.

3. Reportable Incident | National Disability Insurance Scheme (NDIS)

3.1 If an incident involves a patient who is a participant of the NDIS and the event occurred or is alleged to have occurred in connection with the provision of supports or services by the registered NDIS provider, senior clinicians must:

a) Notify the NDIS Commission of all reportable incidents, as directed by the NDIS Quality and Safeguards Commission, in accordance with the *NDIS Incident Management and Reportable Incidents Rules 2018.*

b) Notification must be made through the NDIS Commission Portal within 24 hours of becoming aware of the incident (except where the incident relates to a restrictive practice that is unauthorised or not in accordance with a behaviour support plan and the event resulted in no harm, whereby the report must be made to the commission within five business days).

c) For incidents that involve an external NDIS provider, the incident should be discussed with the external provider and confirm if a report has been made. Where ongoing concern remains, a complaint to the NDIS Commission must be made.

d) Use and save the NDIS Reportable Incident Checklist and Flowchart Tool in the SLS.

e) Details relating to notifications made to the NDIS Commission must be recorded on the structured review tab of the SLS.

f) All incidents resulting in a NDIS Notification must follow the CIB escalation process, in line with Appendix 2: Incident Escalation Mandatory Instruction.

4. Reportable Incident | Aged Care Quality and Safety Commission (ACQSC)

4.1 The ACQSC Serious Incident Response Scheme (SIRS) applies to providers of Commonwealth subsidised aged care services, if an incident occurs, senior clinicians must:

a) Notify the ACQHC Commission of all SIRS reportable incidents, as directed by the ACQSC, in accordance with the *Aged Care Legislation Amendment (Serious Incident Response Scheme and Other Measures) Bill 2020.*

- Priority 1 SIRS incidents must be notified through the My Aged Care portal within 24 hours of becoming aware of the incident.
- Priority 2 SIRS incidents must be notified through the My Aged Care portal within 30 days of becoming aware of the incident.
- Use and save the Aged Care SIRS Incident Report Checklist and Flowchart in the SLS.
- Details relating to notifications made to the ACQHC must be recorded on the structured review tab of the SLS.
- All incidents resulting in a SIRS Notification must follow the CIB escalation process, in line with Appendix 2: Incident Escalation Mandatory Instruction.

5. Child Abuse Report Line (CARL)

5.1 *Section 30 of the Children and Young People (Safety) Act 2017* outlines requirements for mandated reporters. If a clinical incident occurring in a SA Health facility is reported, which involves suspicion that a child or young person is, or may be, at risk of harm, mandated reporters must:

a) Telephone the Child Abuse Report Line (CARL) as soon as is reasonably practicable after forming suspicion.

- Details relating to notifications made to CARL must be recorded on the structured review tab of the SLS.
- All clinical incidents occurring in a SA Health facility resulting in a CARL Notification must follow the CIB escalation process, in line with Appendix 2: Incident Escalation Mandatory Instruction.

6. Mandatory Notification | Australian Health Practitioner Regulation Agency (AHPRA)

6.1 If a clinical incident identifies concerns that a health practitioner may be putting public safety at risk, senior managers must:

a) Notify AHPRA, in accordance with 141B of the *Health Practitioners Regulation National Law.*

Appendix 6: Key Performance Indicators

The following Instruction must be complied with to meet the requirements of this policy.

Clinical Incident Management Key Performance Indicators (KPIs) to measure policy implementation.

KPI	Description
CIM1	Clinical Incidents must be entered in the Safety Learning System (SLS) within 24 hours of incident identification
CIM2	Clinical incidents must be allocated an initial Manager ISR within 48 hours (2 business days) of the incident being reported
CIM3	ISR 1, ISR 2 and complex cluster incidents must have a clinical incident brief uploaded to SLS in the required timeframes
CIM4	ISR 1, ISR 2 and complex cluster incidents must have a patient safety huddle within 48 hours (2 business days) of the incident being reported
CIM5	ISR 1, ISR2 and complex cluster incident reviews must be completed in 70 days of the incident being reported
CIM6	ISR 3 and ISR 4 incident reviews must be completed in 30 days of the incident being reported
CIM7	All ISR 1, ISR 2 and complex cluster incidents must have reports uploaded to SLS, excluding protected documents
CIM8	Staff must identify Part 7 and 8 reviews, simple and complex clusters in the structured review tab
CIM9	Protected Root Cause Analysis (RCA) Report 1 must be uploaded to SLS and Report 2 is sent to DHW at RCA completion
CIM10	Part 8 Protected RCAs must be completed in the legislated timeframes
CIM11	Part 7 Committees must provide a report to the Department for Health and Wellbeing annually
CIM12	ISR 1, ISR, 2 and ISR 3 harmful incidents must be disclosed to patients/family/carers
CIM13	ISR 1 and ISR 2 incidents must have an open disclosure summary uploaded to the SLS