Guideline

How to Conduct a Clinical Incident Review

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1. Name of Guideline

How to Conduct a Clinical Incident Review

2. Relationship to parent policy

The Clinical Incident Management Policy is the parent policy to this How to Conduct a Clinical Incident Review Guideline.

3. Guideline Statement

Clinical incident review is a process of staff reflection about a patient incident to improve patient safety and build trust in the health service. This guideline provides information and tools to support the process of clinical incident review and aligns with the requirements of the Clinical Incident Management Policy.

4. Applicability

This guideline applies to all employees and contractors of SA Health; that is all employees and contractors 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).

5. Guideline details

Clinical incident review is one part of the incident management process as outlined in Appendix 1: Clinical Incident Management Process.

Preparing for review

To prepare for review incident managers should ask a series of questions of the incident to confirm incident validity, review type and reviewer involvement. Where the incident has been given an incident severity rating (ISR) score 1 or 2, these questions will have been addressed at the patient safety huddle.

Is the incident valid

- To determine if an incident is valid (i.e. is it a clinical/patient incident), incident managers should consider the SA Health definition of a clinical incident.
  - a clinical incident means an event or circumstance that occurs during SA health care that could have or did result in unintended or unnecessary harm to a patient, client or consumer of SA health services, this also includes near miss incidents.
- If the incident manager concludes that the patient event or circumstance did not occur, the incident can be rejected or allocated as a death/mortality – no incident.
  - e.g. the patient's death was an expected outcome (event) and the patient passed away peacefully (outcome).
- If the incident manager concludes that the event or circumstance is a clinical incident, but the incident did not take place during SA health care, the incident is not a SA Health incident.
  - When an incident is not a SA Health incident and requires mandatory reporting, it is entered into the Safety Learning System (SLS).
    - e.g. an aged care resident is admitted to the emergency department (ED) with suspected or obvious signs of neglect by an aged care provider.
  - When mandatory reporting of the incident is finalised and documented in the SLS the incident can be finally approved within the SLS.

Case Study 1: not a SA Health incident

ED discovery of poor care by external provider
Sue is a nurse in the ED and during her shift admits Joan, an 87 year old lady who lives in a residential aged care facility. Sue does a full skin check on admission and identifies a stage 4 full-thickness sacral pressure injury. Sue documents the pressure injury in the medical record and discusses Joan's presentation with other senior staff. Staff have concerns about neglect by the aged care provider. Collateral information is obtained from Joan and her daughter, as next of kin, regarding pressure injury care and the care provided at the aged care facility. The daughter expresses some concerns regarding the care provided. In conjunction with her manager, Sue provides feedback about the aged care provider to the Aged Care Serious Incident Reporting Scheme (SIRS). Sue enters the pressure injury in the SLS, with the location field as the ED. The local safety and quality team work with the ED Nurse Unit Manager (NUM) to prepare a clinical incident brief (CIB) and escalate the incident to the Chief Executive Officer (CEO). The CIB is further escalated to the SA Health Chief Executive (CE). The daughter is informed regarding the SIRS report. The SIRS report number and the CIB are uploaded to the SLS. The incident is then finally approved. No further review is required.

What review type is required

The incident manager should consider the accuracy of the notifier Incident Severity Rating (ISR) score and then determine the incident review type.

- The incident manager allocates an initial Manager ISR within 48 hours (2 business days) of the incident, to determine if a simple or complex review is required.
- Manager ISR 1 and 2 incidents require a complex review through one of the following review types:
  - Multi-disciplinary (MD) review such as team based review.
  - Root cause analysis (RCA) methodology as outlined in the How to Conduct a Root Cause Analysis Guideline.
  - Complex cluster incident review as outlined in the How to Conduct a Cluster Incident Review Guideline.
  - Protected investigation conducted under Part 7 of the *Health Care Act 2008*, as outlined in the Health Care Act (2008) Part 7 Committees Policy Directive.
  - Some incident types such as death by suicide may not have a clear cause. RCA methodologies can be used to identify system issues and failures but do not identify what could have prevented the incident. In these instances, a Restorative, Just and Learning Culture (RJLC) approach should be considered.
- Manager ISR 3 and 4 incidents require a simple review through:
  - Single/local clinician review.
  - Cluster incident review depending on the incident impact.
  - Some incidents may require a complex review where there are significant system wide implications.

Who needs to be involved in review

The incident manager is responsible for nominating members of the incident review team and should consider:

- an initial patient safety huddle for ISR 1 and 2 incidents to identify immediate risks/actions and those persons to be involved in the review.
- gathering information from the patient/family/carer to inform the review.
- invitations to subject matter experts, or other staff involved in the incident.
- opportunity for consumer representation.
- Aboriginal and Torres Strait Islander representation if the patient involved in the incident identifies as an Aboriginal or Torres Strait islander.

- the need for communication with other LHNs or SAAS when more than one LHN or a LHN and SAAS are involved in the incident to discuss opportunity for a joint review, clarify the incident manager, determine incident reviewers and the location exact of the incident in the SLS.
- For ISR 1 and 2 incidents, consider the need for an independent person to be involved in the review, e.g., a different LHN, DHW, Chief Child Protection Officer, to incorporate novel or systemic thinking into the review.

How to conduct a review

The review culture and structure influence how the clinical incident review is conducted, and directly influences review quality, safety improvements, and organisational learning.

Review Culture

- Reviewers play a significant role in building a Safe and Just Culture throughout the process of incident review.
- Throughout the process of incident review, reviewers can promote a Safe and Just Culture by:
  - a focus on improvements in systems, process and resources, not individual staff errors
    - systems influence how health care functions and how staff deliver care e.g. funding streams, electronic medical record platforms, discharge pathways.
    - processes influence how health care is tasked and how staff deliver care
    - e.g. staffing models, procedures, protocols.
    - resources influence the health care environment and how patients respond to care. e.g. staffing numbers, equipment, buildings
  - an acknowledgement that there are victims of patient incidents.
    - where a patient/family/carer (1st victims) have experienced distress because of an incident this should be acknowledged and supported. e.g. psychosocial counselling and support.
    - where staff (2nd victims) have experienced distress because of an incident this should be acknowledged and supported through the appropriate staff and agencies e.g. local team support, peer worker, education and/ or mentoring, and employee assistance programs.
  - where staff actions of concern are identified, these should be managed through the appropriate workforce investigation.

Review Structure

- The review structure recommended in this guideline is the ‘what, how and why structure’. Where possible, the patient/family/carer and staff should be involved in the clinical incident review.
- **The what (what happened):** The ‘what’, identifies the facts of an incident and their chronology.
  - Remember the facts cannot be assumptions or hearsay and should be sourced from reliable documents, staff discussion, and correspondence.
  - Some facts will be known at the beginning of the review and others will emerge over time.
  - The facts of the incident are best understood in the context of the patient journey.
    - Some complex reviews may require a timeline to map the facts as in the Patient Timeline Template.

Case Study 2: the What

Incident facts
Incident facts – George, an 89 year old patient with a mild cognitive impairment and gait deficits, was walking to the bathroom without his four wheel walker and fell sustaining a fractured neck of femur. Some falls prevention strategies were in place and George had been reviewed by the medical team that morning. On the morning of the fall, two staff members had called in sick and replacements could not be sourced. When staff spoke to George following the fall, he said he forgot to use his call bell.

- **The how did it happen:** The 'how', identifies contributing factors and issues.
  - Contributing factors are circumstances, actions or influences that have precipitated an incident. Contributing factors can be described in themes such as communication, knowledge/ skills/ competence, work environment, equipment, policies/ procedures/ guidelines, safety mechanisms and patient factors. These factors are outlined in the Contributing Factors Topic Guide
  - Issues are problems related to a contributing factor.
  - Tools such as flow diagrams or the cause and effect diagram may be helpful to identify contributing factors and issues; both are provided in the Flow Diagram Template and the Cause and Effect Template.

Case Study 3: the How

Contributing factors
Contributing factor (issue) 1.Staffing (staffing numbers were low on the morning of the fall) 2. Communication (visual cues were not in the room to remind George to use his walker), and 3. Process (the sick leave procedure limits staff ability to notify the hospital about sickness until 7am).

- **The why (why did it happen):** The 'why', considers the root cause of an incident. The root cause means the primary reason that led to the incident.
  - The why, should be considered in the context of complex adaptive health systems and other contemporary theories. e.g. systems thinking, complexity theory, human factor science
  - Tools such as the Five Whys may be helpful to understand the root cause of an incident as provided in the Five Whys Template.
  - Some patient incidents may not have a clear cause e.g., patient suicide.
  - The death of a patient should only be reported where there is an identified incident that contributed to or resulted in the patient's death. Occasionally, following investigation, it may be identified that the death of the patient could not be linked to an incident. Under these circumstances the incident can be recorded as Mortality (investigation confirmed no incident); e.g. mental health consumer who died in the community five months after contact with the service.

Case Study 4: the Why

Root cause
The 5 Whys: Why 1. **Why** did George fall? **Because** he needs assistance to mobilise but walked unaided. Why 2. **Why** did George walk unaided? **Because** there were insufficient staff to support George. Why 3. **Why** did George walk unaided? **Because** he had a cognitive impairment and forgot to call for assistance. Why 4. **Why** were there insufficient staff? **Because** there was unplanned sick leave and limited availability for short notice cover. (Why questions 4 and 5 not needed to identify root cause). **Root cause:** There was insufficient staff that impacted on the ability to supervise George.

Develop and manage recommended actions: How to stop incidents happening again or reduce the risk of recurrence requires recommendations to address the identified root cause, contributing factors and issues.

- Recommendations are actions that decrease the likelihood of the root cause, contributing factors or issues of a patient incident.
  - Recommendations should be specific, measurable, achievable, realistic, and time limited.
  - Recommendations should be system based and not focused on individual staff actions as outlined in Appendix 2: Hierarchy of Recommendations.
  - Recommendations should address the incident findings.
  - Recommendations, where appropriate, should be allocated to senior managers who are responsible for implementation.
  - Recommendations should be reviewed for completeness and closed when implemented.

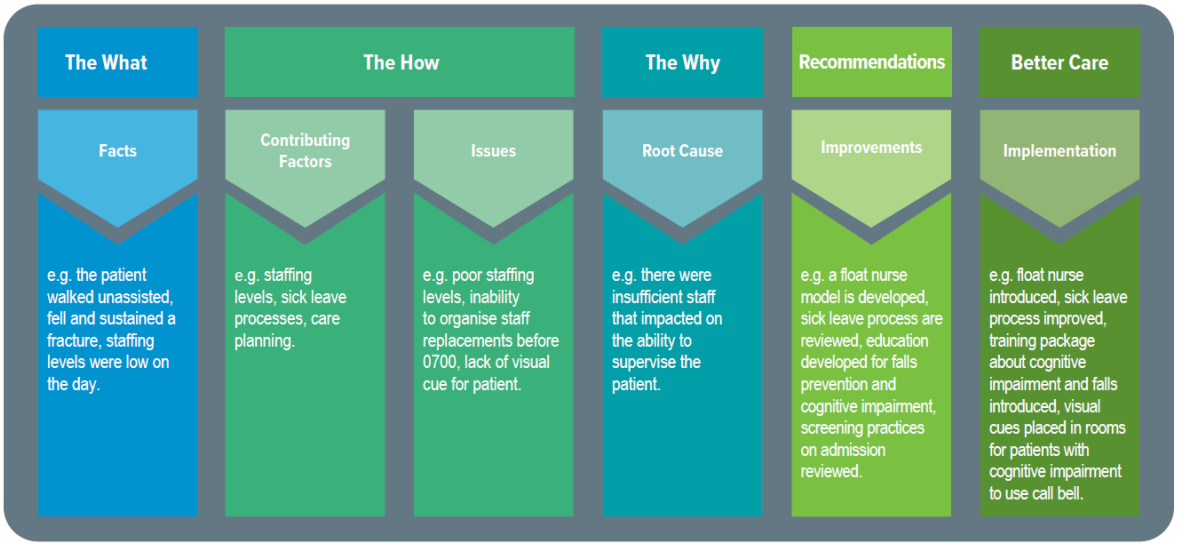
Case Study 5: Recommendations

Recommendations
Contributing factor (recommendation) 1. Staffing (a float staff member is introduced to cover low staffing levels and provide routine care for patients with cognitive impairment, including timed toileting and meal assistance.) 2. Communication (staff education is developed that includes a falls prevention care plan specifically for patients with cognitive impairment.) 3. Process (the sick leave procedure is reviewed, providing opportunity for staff roster deficits to be filled in a timely manner.) and 4. Patient factors (patients are screened on admission for clinical risk and behaviour triggers, these screens inform comprehensive care plans, and visual cues for the patient are placed in the room to remind George to press the call bell when he wants to walk).

Improve Patient Safety

- Each step of the clinical incident review process relies on the other for success, with the final step being implementation. It is important for incident managers to ensure that all steps of the review process are completed (Figure 1).
- Throughout the process of review, the patient/ family/ carer and clinical staff should be included in the review and review outcomes, where appropriate.
- Open disclosure is not outlined in this guideline but is foundational to clinical incident management. Refer to the How to Conduct Open Disclosure Guideline.
- The implementation of recommendations is crucial to improve patient safety and restore trust in the health service.

Figure 1: Patient incident review process: case studies 2-5



6. Supporting information

- Clinical incident management guideline | Health service directive guideline | Queensland Health- July 2024
- Canadian Incident Analysis Framework, Canadian Patient Safety Institute 2012
- Complex adaptive systems, the Health Foundation, UK, 2010
- Contributing Factors Classification Topic Guide, SA Health
- Health Care Act 2008, Government of South Australia
- Health Care Act 2008 Part 7 Committees and Activities Policy
- Healthcare Variation Resources, Australian Commission on Safety and Quality in Health Care
- How to Conduct Root Cause Analysis Guideline
- How to Conduct a Cluster Review Guideline
- How to Conduct Open Disclosure Guideline
- How to Improve, Institute for Healthcare Improvement
- Human Factors for Health and Social Care : A white paper, Chartered Institute of Ergonomics and Human Factors July 2018.
- Incident Management, Clinical Excellence Commission, NSW Government
- Incident Management Guide 2021, Australian Commission on Safety and Quality in Healthcare
- Improvement Exchange, Clinical Excellence Queensland, QLD Health
- Improvement Resources, Clinical Excellence Commission, NSW Government
- Model for Improvement & PDSA cycles - Clinical Excellence Commission, NSW Government
- National Patient Safety Education Framework, Australian Commission on Safety and Quality in Healthcare
- National Safety and Quality Health Service Standards 2012, Australian Commission on Safety and Quality in Healthcare
- NHS Safety 1 and 2 White Paper 2015
- PARIHS revisited: from PARIHS revisited: from heuristic to integrated framework for the successful implementation of knowledge into practice, Harvey G and Kitson A, Implementation Science (2015) 11:33 (2)
- Patient Safety Education Program (PSEP)-Module 1 Systems Thinking: Moving Beyond Blame to Safety, Patient Safety Institute Canada 2017
- Patient Safety Incident Response Framework, National Health Service
- Patient Safety Education Program PEPS: Module 1 Systems Thinking
- PICMoRS Fact Sheet 2020, Australian Commission on Safety and Quality in Healthcare
- Quality and Patient Safety Resources, Agency for Healthcare Research and Quality Patient Safety Resources
- Quality Improvement Tools, Clinical Excellence Commission, NSW Government
- Restorative Just and Learning Culture (RJLC) Fact Sheet
- Restorative Just and Learning Culture - Sidney Dekker – multiple academic papers.
- Restorative Just and Learning Culture, Towards Zero Institute Australasia
- Retributive and Restorative Just Culture, Zero Suicide Sidney Dekker – YouTube video

- SA Chief Psychiatrist Standard – Notification of Deaths of People with a Mental Health Condition into SLS
- Systems Analysis of Clinical Incidents: the London Protocol
- Systems Analysis of Clinical Incidents: the London Protocol Toolkit (NSW Clinical Excellence Commission)
- The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. Sexton JB et al. BMC health services research. 2006 Dec;6(1):1-0
- Whole System Quality, A Unified Approach to Building Response, White Paper, Resilient Healthcare Systems, Institute for Healthcare Improvement

7. Definitions

- **Clinical incident:** means an event or circumstance that occurs during SA Health Care that could have or did result in unintended or unnecessary 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.
- **Complexity theory:** means a theory that suggests errors, or incidents are more likely to occur and are more difficult to understand when complicated presentations, systems, resources or processes are present. It also suggests that interactions between any of these complexities may influence the other.
- **Contributing factor:** means a circumstance, action or influence that is thought to have played a part in an incident.
- **Harm:** means any unintended and unnecessary harm resulting from, or contributed to, by health care. This includes the absence of indicated medical treatment. Harm outcomes from an incident can be:
    - **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.
    - **No harm**: means an event or circumstance took place, but this did not result in harm.
- **Human Factor Science:** means a theoretical model that considers the human users of healthcare when designing and improving care.
- **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, 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 reviewer:** means a staff member involved in an incident review.
- **Incident Severity Rating (ISR):** means a numerical score applied to patient incident based on the patient outcome and follow up treatment after an incident; Incident Severity Rating Topic Guide, Tool 2.

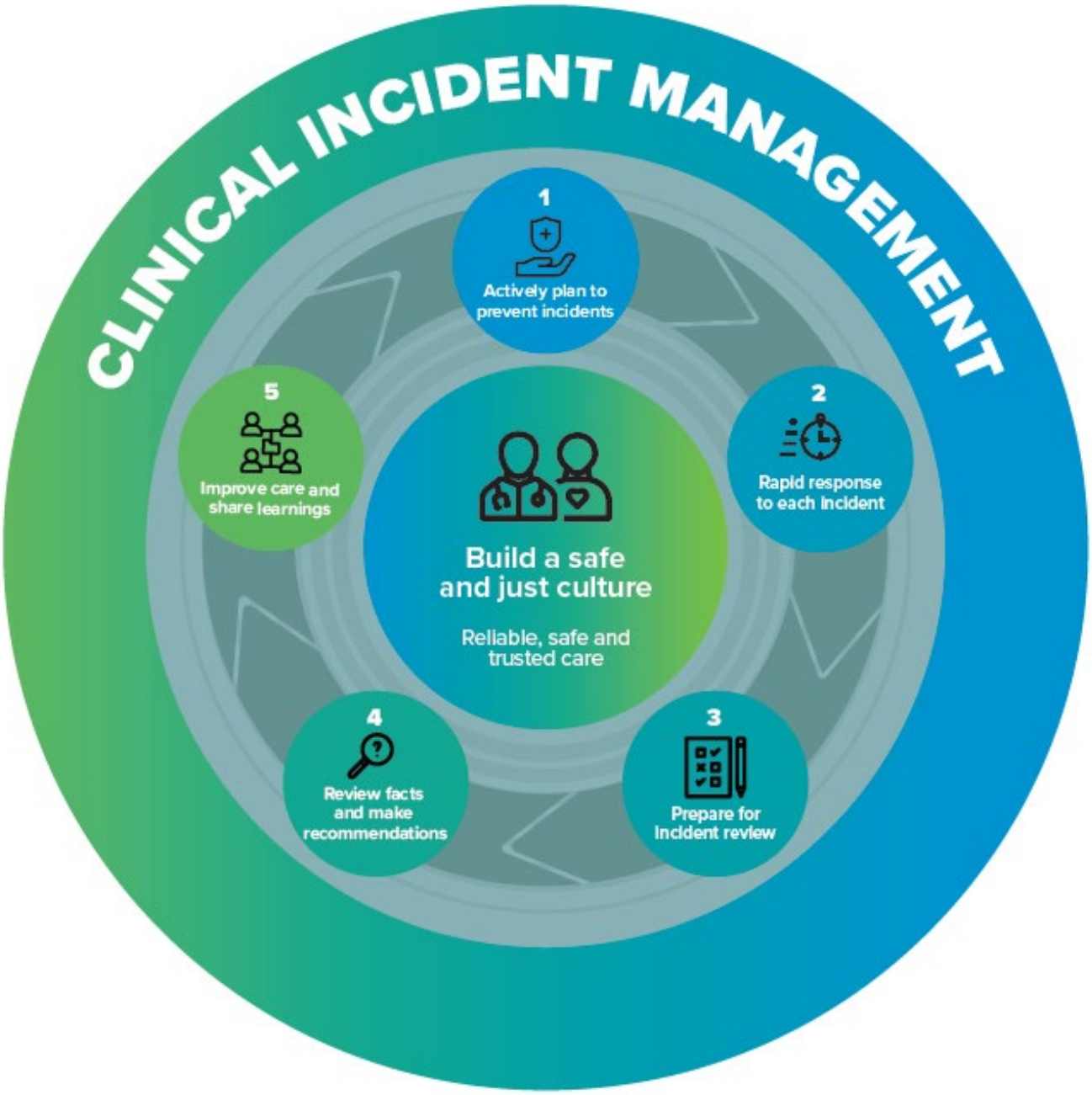
- **Issues:** means problems that are related to a contributing factor.
- **Just culture:** means a concept related to systems thinking which suggests that incidents are usually a product of organisational culture rather than the individual practitioner. After an incident the question asked is 'What 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 incident:** an incident or potential incident that was averted and did not cause harm, but had the potential to do so.
- **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 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 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).
- **Protection:** means protection of information provided under the *Health Care Act 2008*.
- **Recommendations:** means actions that decrease the likelihood of the root cause, contributing factors and issues of a patient incident. They should 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 avoids 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.
- **Review quality:** means a robust analysis of a clinical incident that includes:
    - facts from reliable documents, discussions or correspondence
    - a focus on system, process and resource issues that precipitate the incident
    - support of patient, family and staff distress following an incident
    - engagement of staff and patient/family/carer in review of the incident
    - identified contributing factors and issues, with associated actions to improve patient safety
    - an accurate manager ISR and review in the required timeframe.
- **Root cause:** means the primary reason an incident happened.
- **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 in an incident and ask a series of questions about those events to identify the root cause of the incident.

- **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 bi-laws apply. Those patients under an inpatient treatment order (ITO) on day leave are considered inpatients of a hospital.
- **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.
- **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 commonly only has one reviewer or local clinicians 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 LHNs and DHW**.**
- **Systems thinking:** means a theory that the health system is a series of non-linear dynamic systems, often influencing the other in direct and/ or indirect ways.

8. Appendices

1. *Clinical Incident Management Process*
2. *Hierarchy of Recommendations*

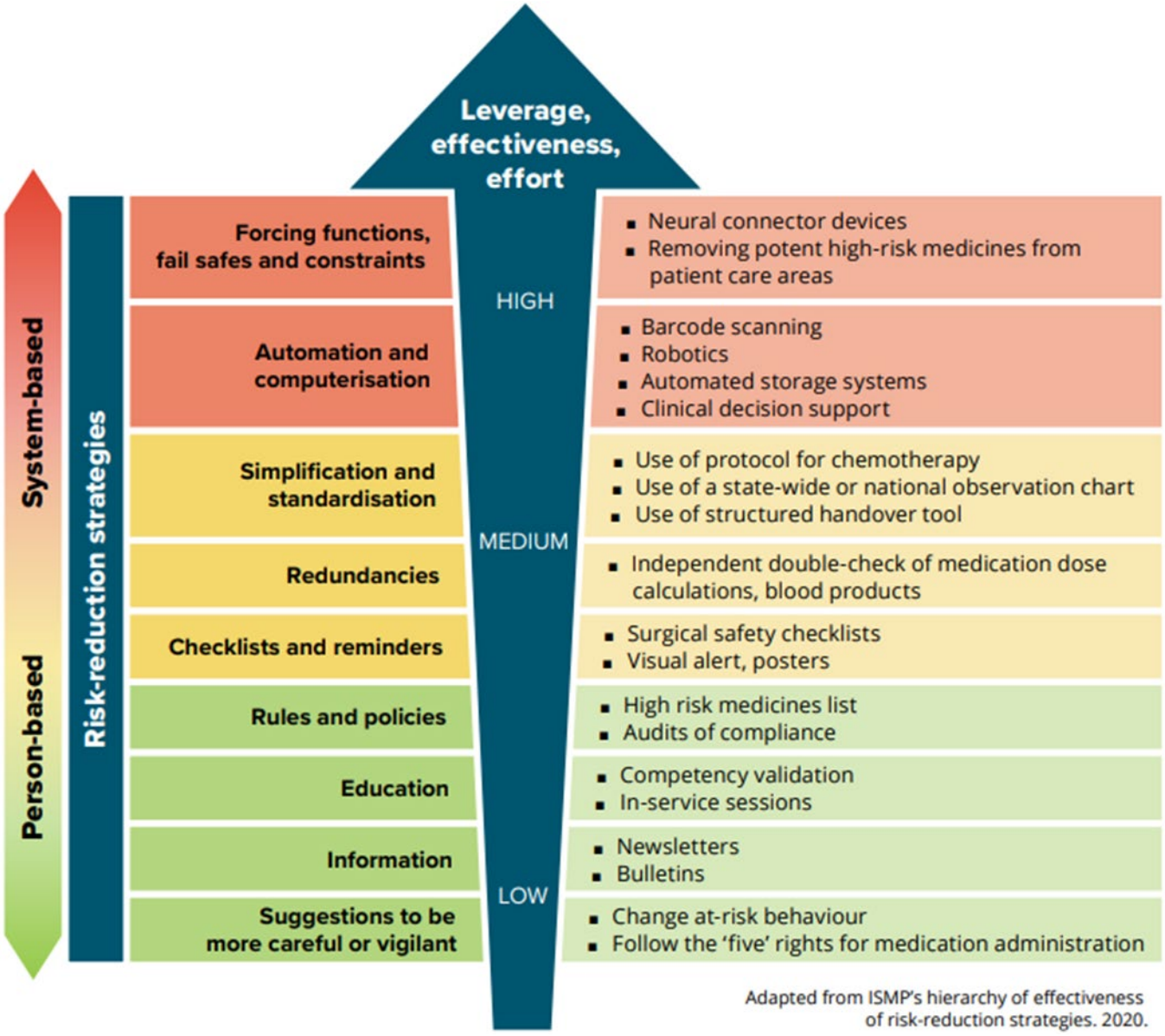
Appendix 1: Clinical Incident Management Process



Appendix 2: Hierarchy of Recommendations

Strategies that are system-based such as forcing functions have high leverage and are more effective in preventing errors. However, these strategies may require more planning and effort to implement. Medium leverage strategies are moderately effective but may require periodic updating and reinforcement. Strategies that are person-based are easier to implement but have low leverage and are least effective in preventing errors.

Incident Management Guide 2021, Australian Commission on Safety and Quality in Healthcare



Infographic sourced from the Incident Management Guide 2021, Australian Commission on Safety and Quality in Healthcare