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CRITICAL INCIDENCE FRAMEWORK

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1. INTRODUCTION

CREAM of the Crop is committed to ensuring the health and safety of its patients and staff and providing a safe workplace. To enable this, an Incident Reporting framework is in place for documenting, assessing and managing all incidents that occur within CREAM of the Crop. This framework is underpinned by a culture that ensures that action is taken to identify, investigate and act to reduce the risk of recurrence of all incidents. In addition, the framework enables a pro-active approach to prevent future incidents and includes:

1. A policy and procedure to be followed in the event of any incident occurring.
2. Consistent Incident Reporting Tools which are comprehensive and easy to use.
3. Risk assessment and management tools to assess and manage individual and organisational risk.
4. A process of risk controls aimed at minimising recurrence of incidents through the implementation of prevention and improvement actions.
5. A process for facilitating in-depth investigation (e.g. Root Cause Analysis) to enable appropriate and timely investigation of Extreme and High Risk Incidents.
6. Formal feedback of incidents at facilities, reporting on incidents, outcomes and continuous improvement opportunities.

For the purposes of this framework, incidents are categorised into:

- Patient incidents (incorporating all patients/clients/residents or visitors).
- Staff incidents (incorporating all staff including casual and agency staff, students, contractors and volunteers).
- Security incidents (incorporating damage, theft or loss of property, corporate or patient).

2. PURPOSE

The systematic completion and investigation of incidents is an essential part of CREAM of the Crop's efforts to continually improve the standard of care, optimise patient and staff safety and to minimise adverse events. An overall goal is the reduction in the incidence of sentinel events, adverse events, incidents and near misses.

Incident Reports are designed to:

- Identify potential harm and adverse events (including injuries) that occur to patients and staff as a result of an incident.
- Identify and evaluate causal and contributing factors and hazards so appropriate corrective action is taken to ensure preventable incidents are not repeated.

- Establish and maintain an accurate record of events for internal (e.g. committees) and external (e.g. insurers, surveyors) parties that provides relevant information about the incidents, the actions taken, the outcomes and any other continuous improvement opportunities.
- Satisfy insurance notification purposes. It is a precondition of most insurance policies that incidents must be reported promptly when they occur.

3. DEFINITIONS

An **Adverse Event** is an incident in which unintended harm resulted to a person receiving care.

A **Hazard** is a source of potential harm or a situation with a potential to cause loss or harm.

A **Facility** is a location at which a CREAM of the Crop Staff Member is working. This may include a patient's home, aged care facility, hospital or other location as required under contractual agreement

A **Person in Charge** is the most senior responsible person available at the facility at the time of the incident. The CREAM of the Crop Staff Member may at times be the most senior person available and therefore must take action as required by the facility and CREAM of the Crop procedures.

Incident is an event or circumstance which could have, or did lead to unintended and/or unnecessary harm to a person and/or a complaint, loss or damage.

An **Injury** is damage to tissues caused by an agent or circumstance.

Individual Risk Assessment is the process of reviewing the likelihood of the incident occurring again based on the individual's intrinsic risk.

Dangerous Occurrences are:

- The collapse, overturning, failure or malfunction of, or damage to certain items of plant
- The collapse or failure of an excavation or of the shoring supporting an excavation
- The collapse of part of a building or structure
- An implosion, explosion of fire
- The escape, spillage or leakage of substances
- The fall or release from a height of any plant, object or substance

A **Near Miss or Close Call** is an event or situation that could have resulted in an Adverse Event but did not, either by chance or through timely intervention.

A **Notifiable Workcover Workplace Incident** is an incident at a workplace resulting in death, serious head injury, serious eye injury, separation of the skin from underlying tissue such as degloving or scalping, electric shock, spinal injury, loss of bodily function, serious laceration, immediate hospital treatment as an inpatient, medical treatment within 48 hours of being exposed to a substance such as chemical biological material or if there is a dangerous occurrence that creates an immediate risk to the health and safety of persons in the immediate vicinity (near miss).

Organisational Risk Assessment refers to the risk of the incident which has occurred resulting in organisational disruption and/or adverse publicity.

Risk is the chance of something happening that will have an impact upon objectives. It is measured in terms of consequence and likelihood.

Risk Analysis is the systematic process to understand the nature of and to deduce the level of risk.

Risk Criteria are the terms of reference by which the significance of risk is assessed e.g. associated cost and benefits, legal and statutory requirements, socioeconomic and environmental aspects, the concerns of stakeholders

Risk Identification is the process of determining what, where, when, why and how something could happen.

Risk Evaluation is the process of comparing the level of risk against risk criteria.

Risk Assessment is the overall process of risk identification, risk analysis and risk evaluation.

Risk Management is the culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects.

Root Cause Analysis (RCA) is a process of investigation to identify the most basic cause of an incident that is within the organisation's control to fix. It focuses primarily on systems and processes not individual performance and uses incidents as an opportunity to identify improvements that could be made in systems

Sentinel Events are relatively infrequent, clear-cut events that occur independently of a patients condition. They commonly reflect hospital and facility system and process deficiencies which potentially result in unnecessary outcomes for patients. Some , include:

- Procedures involving the wrong patient or body part
- Suicide in an inpatient unit
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- Intravascular gas embolism resulting in serious neurological damage
- Haemolytic Blood transfusion reaction resulting from ABO incompatibility
- Medication Error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
- Maternal death or serious morbidity associated with labour or delivery
- Infant discharged to the wrong family; and
- Other catastrophic event.

Staff Member – means the CREAM of the Crop employee who is involved in the incident, or who has first become aware of the incident, and who is responsible for reporting the Incident

4. POLICY & PROCEDURE

Which Incidents Should Be Reported?

• All incidents and near misses must be reported on an Incident Report. Completing an Incident Report Form is not optional. If you are unsure whether an incident should be reported, contact the Team Leader CREAM Health and the person in charge of the shift at the time.

• The more significant the event, generally the more information that will be required. For more serious incidents, staff involved may be asked to complete separate written accounts to be attached to the Incident Report.

• Any attachments prepared at the same time as the Incident Report must be noted on the original Incident Report Form and any stapled. The following words must be added to all additional pages and statements: ***"Confidential, prepared for the purposes of legal and insurance advice".***

• Any incident that results in harm, potential harm or a potential to cause loss must be reported. The following are examples of patient incidents that must be reported. These are examples only and are not an all inclusive listing.

Patient fall (with or without harm)
Medication error (with or without harm)
Unplanned return to Theatre
Delay in diagnosis
Missed diagnosis (e.g. fracture)
Foreign body left in situ
Unexpected obstetric complication (e.g. baby born in poor condition).
Perforation during surgery
Patient absconded
Patient discharged self against medical advice
Patient starting a fire
Patient complaint alleging harm
Aggressive incident (verbal or physical)
Equipment malfunction causing patient harm.

• Examples of Security/Property Incidents that must be reported include missing or stolen property, motor vehicle damage and IT security breaches.

• Examples of Staff Incidents that must be reported include staff needle stick injuries and assault of staff members.

• Incident Reports should contain a brief summary of the facts. They should not contain opinions about what went wrong or what policies may have been breached. Nor should Incident Reports be used for criticising staff or systems, or making allegations against staff requiring investigation and potential disciplinary action. Such complaints should be reported via other operational means (eg to Managers on comments/complaints forms or by letter). If an adverse event appears to involve both harm to a patient and staff issues, the Incident Report Form should be used to report the harm to the patient and the facts of what happened, not other issues that might be relevant to an internal investigation.

• The following are examples of complaints that do not belong on an Incident Report. These are examples only and are not an all inclusive listing:

Supervision issues
Staffing/rostering complaints
Patient complaint not alleging any harm
Complaints about access to services
Patients using foul/abusive language (unless threatening or aggressive)
Performance management issues.

• All incidents where the Aggression Management Team (AMT) is called must complete a Patient Incident Report Form and must record the names of all Aggression Management Team members in Section 3.

How Should Incidents Be Reported?

• Incidents must be documented and the Report Form must be completed within 4 hours of the incident occurring and preferably immediately following any incident. It is a condition of CREAM of the Crop's insurance cover that an Incident Report must be completed in a timely way, *'as soon as practicable'* after the incident occurs. If this is not complied with, it could potentially compromise insurance cover of a claim in the future.

• An Incident Report should be completed in an objective, factual and professional manner. Record facts and first-hand observations rather than judgments, opinions or complaints. Incident Reports should be accurate, unambiguous and legible. They must be completed in ink, not in pencil. All amendments must be crossed out and initialed. Liquid paper is not to be used.

• The Incident Report should be succinct but provide enough information to allow the matter to be investigated and provide a full account, in years to come if necessary.

• One of the purposes of completing Incident Reports includes notifying the insurer and seeking legal advice. Incident Reports can potentially be privileged from external disclosure. However, this cannot be guaranteed and Incident Reports must sometimes be disclosed in Court proceedings. Staff should always complete an Incident Report in a manner that they would be prepared for others to read.

• All incidents involving patients must also be noted in the progress notes of the patient's medical record. This must be a factual account. Only record first-hand observations in the medical record, not assumptions or complaints. The medical record should contain all clinically relevant information regarding the incident (e.g. the assessment by the doctor after a fall or medication error). Any relevant investigations and observations occurring at the time of and following the incident should be noted. Record the time and date of the incident and any action taken.

• Incident Reports are not to be filed in the patient's medical record and Incident Reports do not form part of a patient's medical record. They are to be forwarded to Team Leader CREAM Health.

• An Incident Report Form must be filled out for each patient / staff / security episode and multiple forms may be required. For example, where two patients are having a dispute, a staff member intervenes and is assaulted, a Patient Incident Report is required for each patient and a Staff OH&S Incident Report is required for the staff member.

Who Should Report Incidents?

• Any member of staff can report an incident and complete sections 1 & 2 of the Patient Incident Report Form and Section 1 of the OH&S and Security Report Forms.

• If staff disciplinary action might follow an incident, those likely to be conducting the investigation and making decisions about the incident or the staff involved, should not complete Sections 1 and 2 of any Incident Report, although a person in a management position may sign off Sections 3 to 6.

• Staff members who facilitate a Root Cause Analysis relating to a specific incident should not complete sections 1 and 2.

What is the Incident Reporting Process?

1. As CREAM of the Crop is a provider of contract services to facilities where incidents may have occurred, CREAM of the Crop staff must ensure that their action also complies with the requirements of the facility that they are working within. As soon as an incident occurs, the most senior person attending the incident should take specific and immediate action to manage the incident. Assistance through emergency codes should be sought as required.

2. All incidents must be reported immediately to the Person in Charge of the facility at the time.

3. All incidents resulting in a moderate/major/severe consequence (refer Attachment A) should result in immediate communication to the facilities Person in Charge and then to the CREAM of the Crop Team Leader CREAM Health and then risk managed by the CREAM of the Crop Managing Director.

4. All incidents which are likely to have a major/severe consequence must be reported immediately by the Team Leader CREAM Health to the Managing Director.

5. All incidents resulting in patient harm or any incidents where there is reasonable index of suspicion of potential harm must be reported to the Person in Charge of the facility for review of the patient and completion of the relevant section of the Report Form.

7. Staff members who identify an Alert must record it on the Incident Report Form. This information must be forward to the Team Leader CREAM Health at the next available opportunity.

8. Where relevant, incidents must be reported according to Client Contract agreement arrangements. Team Leader CREAM Health will be required to determine if this is the case and what action must be taken under contractual obligations.

9. Sections 1 and 2 of the Patient Incident Report Form, and Section 1 of the Security Incident Report Form, and Section 1 of the Staff Incident Report Form must be completed as soon as practicable after an incident by the Staff Member reporting the incident. Section 3 of the Patient Incident Report Form and Section 2 of the Security Incident Report Form and the Staff Incident Report Form, will be completed by the Person in Charge at the time of the Incident. The Person in Charge of the Area must complete the relevant section by the end of the shift in which the incident occurred and forward the Form to Team Leader CREAM Health

10. Details of all patient incidents must be recorded in the Medical Record if required by the client facility.

11. All falls related incidents must follow the *Post Fall Response Protocol,* which includes a reassessment of falls risk.

12. Staff de-briefing should be organised where appropriate.

13. Where the incident has resulted in staff injury, Workcover reports must be completed. Please refer to Team Leader CREAM Health for further information.

14. Section 4 of the Patient Incident Reporting Form and Section 3 of the Security Incident Report Form and Staff Incident Report Form, must be completed within 5 working days of the incident occurring, by the Team Leader CREAM Health and forwarded to the Managing Director.

15. The Managing Director must undertake the risk rating and manage the incident according to the assessed level of risk -

a. **For all Incidents assessed as resulting in Extreme Risk –** Managed by the Managing Director involving a detailed plan and timeframe. The initiation of a Root Cause Analysis (RCA) and Risk Reduction Action Plan (RRAP) is also required.

b. **For all Incidents assessed as resulting in High Risk** – Managed by or under the direct supervision of the Managing Director. The initiation of a Root Cause Analysis (RCA) and Risk Reduction Action Plan (RRAP) is also required. CREAM of the Crop Workcover / Return to Work Unit / OH&S representative must be contacted immediately of a Notifiable Workplace Incident and a written report submitted to WorkCover within 48 hours for either a Notifiable Workplace Incident or Dangerous Occurrence.

c. **For all Incidents assessed as resulting in Medium Risk – Managed by** the Team Leader CREAM Health. For staff incidents, the action is taken in consultation with the OH&S representative.

d. **For all Incidents assessed as resulting in Low Risk – Managed by** the Team Leader CREAM Health

16. The Incident Report Form will be forwarded by the Team Leader CREAM Health to the relevant service areas within ten working days of the incident.

17. Root Cause Analysis (RCA) Management High-risk, high-impact events, including Sentinel Events, must have a RCA completed within 60 days on the appropriate templates and in the appropriate format. The Managing Director responsible for the service in which the incident occurred is responsible for commissioning the RCA and notifying the Managing Director. The Manager of the Patient Safety Unit is the RCA Program

Coordinator and is responsible for ensuring that the RCA Program is coordinated overall across the health service and that individual investigations are completed and reported back to the Managing Director.

18. The RCA Coordinator can either facilitate a RCA or delegate this to an experienced facilitator within the health service. The RCA is undertaken by a Team comprising trained staff and a Team Leader who is a senior manager. The Risk Reduction Action Plan must be developed after agreement with all relevant stakeholders, including the Managing Director(s). A Risk Register of Risk Reductions Action Plans will be kept and monitored by the Managing Director and the Team Leader CREAM Health.

5. RESPONSIBILITIES

(a) The staff member reporting the incident is responsible for ensuring:

- All incidents are documented.
- The person in charge of the facility is notified.
- Sections 1 and 2 of the Patient Incident Report Form and Section 1 of the Security Incident Report Form and Staff Incident Report Form are completed within 4 hours of an incident.
- Assistance through emergency codes is sought as required by the facility and CREAM of the Crop, and intervention appropriate to the incident is implemented to ensure any injury is treated and any hazard removed.
- Details of patient incident are recorded in the Medical Record as required by the facility.
- All Falls related incidents refer to the *Post Fall Response Protocol,* which includes a reassessment of falls risk.
- Staff members who identify an Alert which needs recording or review have forwarded this information to the Alerts Co-Coordinator within Health Information Services and must confirm with their supervisor at the next available opportunity.
- Appropriate incident management has occurred, including removal of hazards and hazard risk assessment in conjunction with OH&S representatives as required.

(b) The Team Leader CREAM Health is responsible for ensuring:

- Staff de-briefing is organised as appropriate.
- The Managing Director is advised if the consequence of the incident is moderate, major or severe.
- The facility , or contractual representative.
- Workcover, where necessary.
- All appropriate sections of the form are completed and forward to the Managing Director.

- Appropriate intervention has occurred including further investigation.
- Feedback is provided to staff about the outcome of the incident investigation.
- Section 4 of the Patient Incident Report Form, Section 3 of the Security Incident Report Form and of the Staff Incident Report Form is completed and forwarded to the Managing Director within 5 working days of the incident occurring.
- The risk rating of the incident is undertaken.
- The Falls Service has been notified of all falls resulting in serious injury or death
- A Root Cause Analysis is initiated where appropriate.
- The Incident Report Form is forwarded to the relevant area within ten working days of the incident:

c) The Managing Director

- Oversees management of extreme or high risk incidents.
- Commissions RCA's.
- Ensures implementation of Risk Reduction Action Plans.
- Liaises with the insurer where further information is required.
- Liaises with the insurer regarding settlement of low level claims,
- Coordinates the RCA Program.

6. TRAINING

All new staff will receive initial training at orientation. Refresher training will be made available to all other staff through the training plan every 12 months.

7. KEY PERFORMANCE INDICATORS

100% of Incident Reports satisfactorily completed (by audit).
100% of Incidents managed according to risk rating (by audit).
Annual audit of consistency of risk rating by Director.
All staff will have access to ongoing training in Incident Reporting.

Attachment A : Risk Consequence

Risk Consequences/Impact	Patient/ Client/Resident/Visitor	Staff/Volunteer/ Contractor/Student	Security/Property	Organisation
SEVERE CONSEQUENCE	An unexpected death of a visitor or patient not related to the natural course of the patient's illness or underlying condition OR a Sentinel Event.	Death of a staff member.	Huge financial loss leading to disruption of business.	Significant adverse publicity. DHS Investigation. Extended service closure.
MAJOR CONSEQUENCE	Permanent disfigurement or disablement of a visitor or patient not related to the natural course of the patient's illness or underlying condition.	Disfigurement or disablement causing inability to work in the future.	Damage equal to or more than $100,000	Local adverse publicity. Temporary closure of service. Serious complaint anticipated.
MODERATE CONSEQUENCE	Healthcare service required for a patient or a visitor as a result of the incident.	Healthcare service required for staff member as a result of the incident.	Damage more than $10,000 but less than $100,000	Complaint anticipated
MINOR CONSEQUENCE	No additional healthcare service required for patient or visitor.	Only First Aid treatment required.	Damage less than $10,000 or loss of any utility without adverse patient outcome	Minimal risk to Organisation

Note: Consider Impact on CREAM of the Crop / not an individual when determining Patient, Staff or Security Consequences

Attachment B : Risk Likelihood

	Risk Likelihood Categories
Frequent	Likely to re-occur immediately or within a short period (may happen 12 times in the one year)
Probable	Will probably re-occur but not everyday (event may happen every couple of months)
Occasional	May re-occur but occasional (event may happen several times in 1 – 2 years)
Uncommon	Do not expect it to happen again but possible (event may happen once in every 5 years)
Remote	Can’t believe that this will ever happen again (event may happen once in 20 years)

Attachment C: Risk Matrix

Consequence and likelihood	Severe	Major	Moderate	Minor
Frequent (almost certain)	E	H	M	L
Probable (likely)	E	H	M	L
Occasional (possible)	E	H	M	L
Uncommon (unlikely)	H	M	M	L
Remote (rare)	H	M	L	L

How the Risk Matrix Works: When you assess the consequence of an incident (refer attachment A) against the likelihood (refer attachment B) of an incident occurring, a risk rating level (Extreme, High, Medium or Low) is determined

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Attachment D : Risk Management Plan

Extreme Risk	• Substantial disruption to services, may even threaten survival or continuity of organisation; • Potential for extensive publicity with long term consequences to reputation of organisation; • Requires urgent management by Managing Director, with rectification as soon as practicable. • Progress in rectifying risk reported to WorkCover, Client and Insurer until issue is rectified.
High Risk	• Major or significant impact, harm or damage to Health Service operations; • Potential for significant publicity and impact upon reputation • Managed by or under the direct supervision of an Managing Director • Requires management tasks and progress to be specified; • Rectification to be undertaken promptly recognising expert advice and costs;
Medium Risk	• Moderate impact or disruption • Local concerns regarding the matter; • Requires specific monitoring and response processes; • Managed and rectified (where appropriate) at a level approved by the Managing Director
Low Risk	• Local issue, minor or negligible impact, harm or damage • Normally use routine procedures to manage the risk