

## Incident - Effective Incident Response Framework for Prevention & Management in the Health Workplace

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**Functional Sub group** Personnel/Workforce - Occupational Health & Safety  
Clinical/ Patient Services - Incident management

**Summary** Policy to assist health care facilities to minimise the potential for incidents to occur and to develop a planned response to such incidents.

**Author Branch** Workplace Relations and Management Branch

**Branch contact** 9391 9357

**Applies to** Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Affiliated Health Organisations - Declared, Public Health System Support Division, NSW Ambulance Service, NSW Dept of Health

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### Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

**CIRCULAR**

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<b>Contact</b>	Ms Jennifer Thomas (02) 9391 9850 Employee Relations Policy Group

**EFFECTIVE INCIDENT RESPONSE:****A Framework For Prevention and Management in the Health Workplace**

This circular rescinds circular number 97/97.

*Effective Incidence Response: A Framework for Prevention and Management in the Health Workplace* has been developed to assist Health Services to minimise the potential for incidents to occur and to develop a planned response to incidents if and when they occur. Such incidents would have the potential to result in, for example, death, injury, ill health, damage or other loss and would impact upon either an individual or a group of people. The circular focuses on the impact of incidents on employees and provides a framework to assist employees to deal with their experience.

Every health care facility is to develop or review current arrangements to ensure that they have a systematic and coordinated Incident Management Program. The Program is to be based on risk management principles and have protocols in place to reduce trauma to employees and others who experience a distressing incident. It will also ensure the timely reporting, investigation and post-incident action of incidents.

This policy applies to public health organisations as defined under Section 7 of the Health Services Act 1997 (including Area Health Services), Corrections Health Service, the Children's Hospital at Westmead and the NSW Ambulance Service. Employees include permanent, casual, agency staff and contractors.

This circular should be brought to the attention of executive and management staff, staff counsellors, human resource managers, risk managers and occupational health safety and rehabilitation coordinators within the health facility.

Robert McGregor  
**Acting Director-General**

Distributed in accordance with circular list(s):

<b>A</b> 18	<b>B</b>	<b>C</b> 12	<b>D</b>	<b>E</b>	73 Miller Street North Sydney NSW 2060
<b>F</b>	<b>G</b>	<b>H</b> 7	<b>I</b>	<b>J</b>	Locked Mail Bag 961 North Sydney NSW 2059
<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>	<b>P</b>	Telephone (02) 9391 9000 Facsimile (02) 9391 9101

In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.

**EFFECTIVE INCIDENT RESPONSE:**

**A Framework for Prevention and  
Management in the Health Workplace**

**NSW HEALTH**

**JANUARY 2002**

## **TABLE OF CONTENTS**

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<b>1.0</b>	<b>ABOUT THIS DOCUMENT</b>	<b>1</b>
<b>2.0</b>	<b>INTRODUCTION</b>	<b>2</b>
<b>3.0</b>	<b>A RISK MANAGEMENT APPROACH TO INCIDENT MANAGEMENT</b>	<b>5</b>
<b>4.0</b>	<b>INCIDENT PREVENTION PROGRAM</b>	<b>10</b>
<b>5.0</b>	<b>THE INCIDENT MANAGEMENT PLAN</b>	<b>12</b>
<b>6.0</b>	<b>MANAGING STAFF REACTIONS</b>	<b>19</b>
<b>7.0</b>	<b>EVALUATION OF THE INCIDENT MANAGEMENT PROGRAM</b>	<b>22</b>
	<b>Appendix A: Psychological Terms</b>	<b>23</b>
	<b>Appendix B: Workplace Health And Safety Model</b>	<b>27</b>
	<b>Appendix C: Staff Support Service Providers</b>	<b>28</b>

## 1.0 ABOUT THIS DOCUMENT

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<b>Responsibilities</b>	This document was prepared jointly by the Centre for Mental Health and the Employee Relations Division, Department of Health.
<b>Version</b>	January 2002
<b>Updates and Feedback</b>	This document will be updated to reflect consultation and changes in legislation and policy. Feedback is sought, and should be addressed to the Director Employee Relations.
<b>Rescinds</b>	This circular rescinds Circular 97/97 <i>Critical Incident Manual Policy and Guidelines</i> .
<b>Authority</b>	It is a condition of subsidy under the Accounts and Audit Determination that Health Services comply with all Department of Health Circulars and Policies.
<b>Related NSW Health Policies</b>	<ul style="list-style-type: none"><li>• Workplace Health and Safety – A Better Practice Guide, Circular 2001/22</li><li>• Incidents Reportable to the Department, Circular 97/58 (under review)</li><li>• Policy Framework and Better Practice Guidelines for the Development of Employee Assistance Programs (EAPS), Circular 2000/42</li><li>• Policy and Guidelines for the Management of Occupational Rehabilitation in NSW Public Health Care Facilities, Circular 97/89 (under review)</li></ul>
<b>Additional References/ Resources</b>	<ul style="list-style-type: none"><li>• NSW Health Occupational Health and Safety and Rehabilitation Guide (under review)</li><li>• NSW Health Disaster Mental Health Response Handbook, 2000</li><li>• NSW Health Safety and Security Manual, 1998</li><li>• NSW State Disaster Plan – DISPLAN</li><li>• NSW HEALTH PLAN</li><li>• Standing Operating Procedures for Mental Health Services, NSW Health, 2000</li><li>• Taking Safety Seriously – Improving Workplace Safety Management in the NSW Public Sector 1999.</li><li>• DRAFT Occupational Stress, Hazard Identification and Risk Management Strategy, Public Sector Management Office, Premier’s Department, NSW (2000)</li></ul>

## 2.0 INTRODUCTION

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### 2.1 Introduction

NSW Health is committed to providing a safe environment for staff, clients and the public. However, unexpected and unusual incidents do happen in workplaces. Effective planning is aimed at minimising risks to staff and others and will assist staff to respond appropriately and in a timely and coordinated manner to such incidents.

This document expands on the principles of incident management as described in the *Workplace Health and Safety – A Better Practice Guide* (Circular No 2001/22). Its focus is on the prevention and management of incidents where there is significant impact on the functioning of the Health Service and/or persons involved in the incident.

It replaces Circular 97/97 *Critical Incident Manual Policy and Guidelines* as current research no longer supports the provision of Critical Incident Debriefing as a required intervention.

### 2.2 Purpose and Scope

The purpose of this document is to assist health care facilities to minimise the potential for incidents to occur and to develop a planned response to such incidents if and when they occur.

This document provides guidelines for planning incident prevention and management protocols or procedures, and essential components for incident management.

The policy focuses on the impact of incidents on staff and provides a framework to assist staff to deal with their experience. All relevant requirements for a culturally sensitive response, gender equity and occupational health and safety should be encompassed.

### 2.3 Legislative Responsibilities

Employers under the *NSW Occupational Health and Safety Act 2000* have a duty of care for the health and safety of all people in the workplace. This requires employers to:

- Ensure that premises controlled by the employer where people work are safe and without risk to health.
- Ensure that systems of work and the working environment are safe and without risk to health.
- Ensure that any plant or substance provided for use by the employees at work is safe and without risk to health when properly used.
- Provide necessary information, instruction, training and supervision for the health and safety of their employees.

- Provide adequate facilities for the welfare of the employees at work.
- Ensure that people (other than employees – eg volunteers and contractors) are not exposed to risks to their health and safety in the workplace.

Employees are required to cooperate with the employer in their efforts to comply with health and safety requirements. Employee cooperation ensures their own health and safety and the health and safety of others in the workplace.

## 2.4 Definitions

### **Incident**

Any unplanned event resulting in, or with the potential to result in, death, injury, ill health, damage or other loss.

Within the Health Service an incident would impact either an individual or a group of people but would not overwhelm the facility's ability to cope. Should that situation occur, it would trigger the NSW State Disaster Plan – DISPLAN. The following types of incident would all fall within the framework of this document, requiring prevention and management strategies:

- Any violent death.
- Suicides or serious attempted suicides by a patient or staff member.
- Criminal activity in or related to the workplace.
- Fire, bomb or other threatening activities in the facility.
- Violence and threats of assault on staff or other.
- Unexplained complications or death of patients.
- Patients dead on arrival to hospital, particularly children.
- Sudden deaths of patients or staff members.
- Unusual or serious exposure to blood and or body fluid.
- Critical equipment breakdown.
- Serious threats affecting the facility's operation.
- Deaths in custody.
- Incident involving assaults on, and or abuse of, patients including children and other vulnerable patients.
- Safety incidents and or accidents.
- Any other incident likely to cause public concern.

### **Hazard**

An object or situation that has a potential for causing harm in the form of human injury or ill health, damage to the environment or a combination of these.

### **Risk**

The combination of frequency, or probability of an occurrence. Also the consequence of a specified hazardous event.

**Risk Assessment**

The overall process of establishing the extent of risk and deciding whether a risk is tolerable.

**Risk Control**

The part of risk management that involves implementing policies, standards and procedures to eliminate, avoid or minimise the risks facing an enterprise.

**See also Appendix A for psychological terms**

## **3.0 A RISK MANAGEMENT APPROACH TO INCIDENT MANAGEMENT**

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### **3.1 Policy**

The workplace Health and Safety Model (Appendix B) illustrates how a systematic approach to incident prevention and incident management leads to a safer workplace.

It is the policy of NSW Health that every health care facility shall develop a systematic and coordinated Incident Management Program. The Program shall:

- Identify, establish and promote a range of measures which minimise or eliminate the occurrence of an incident.
- Allocate responsibilities of all parties.
- Identify the action to take should an incident occur, including provision of first aid and medical treatment for physical injuries.
- Have protocols in place to reduce the trauma to staff and others who experience a distressing incident.
- Ensure a timely investigation and reporting of the incident.
- Be evaluated regularly and amended as necessary, to ensure ongoing effectiveness.
- Consider the specific needs of community workers when responding to incidents.
- Be effectively communicated to all employees of the Area Health Service.

### **3.2 Planning Process**

An incident management program should:

- Be developed in consultation with staff, unions, and other stakeholders, for example, through the OHS committee.
- Be consistent with legislative risk management principles and current NSW Health policies as listed in section one.
- Include measures to eliminate or reduce the potential for the occurrence of an incident through identifying, assessing and controlling risks and monitoring of control effectiveness.
- Ensure staff receive appropriate training in the procedures developed to manage incidents.

- Include consideration of activities, products or services of contractors and suppliers when developing the program.
- Be able to be integrated, where appropriate, with Internal Hospital Emergency procedures, NSW Health Plan and Displan for external incidents and the NSW Mental Health Disaster Training Manual.

### **3.3 The Incident Management Plan**

The purpose of a plan is to establish a structure and a set of operational procedures and protocols that will ensure the policy objectives of the Health Service are achieved.

### **3.4 Aim of the Incident Management Plan**

The aim of an incident management plan is to ensure that the response is initiated in a timely, organised and effective way, comprehensive investigation occurs, staff support is available and a review of the incident occurs. Training of staff is a key to ensuring the effective implementation of the plan.

The following values should underpin the development of an Incident Management Plan:

- Safety.
- Appropriate, timely and effective response.
- Respect & dignity.
- Empathy & recognition of the person's experience.
- Access to support and care as needed.
- Support for rapid and effective rehabilitation.

Health Service or facility emergency procedures should be utilised when developing an incident management plan. Emergency procedures will include emergency notification procedures (eg emergency numbers), response procedures, identify key staff involved in managing the incident.

The plan should also link with emergency notification procedures for community workers.

### **3.5 Consultation**

Consultation is essential in the planning process. Not only is it a requirement of the Occupational Health and Safety legislation but it also ensures that the policy and procedures developed will be realistic and achievable in the workplace.

A planning committee is one mechanism that may be used to ensure consultation during the development of the incident management program. Membership may include senior management, risk manager, staff representatives, HR Manager, Security Manager, and other relevant staff as deemed necessary. OHS committees and OHS Representatives should also be involved in the planning process. Employee input should be sought and valued.

Consultation procedures should be developed, implemented, maintained and documented.

Health Unions and other stakeholders eg Police should be consulted as necessary.

### **3.6 Legal Issues**

It is essential that during the development of an incident management program that all relevant legal requirements are taken into consideration. These may include:

- Internal requirements to meet relevant legislative responsibilities, including OHS, Sex Discrimination and Child Protection legislation.
- Professional ethics.
- Police involvement in criminal matters.
- WorkCover NSW involvement in investigations.
- Industrial issues.
- Victims' compensation issues.
- Public liability or other civil action.
- Workers' compensation and injury management.
- Public health and safety.

### **3.7 Role of Managers/ Supervisors**

- Implement the facility's incident management program and procedures
- Ensure staff attend relevant training.
- Ensure a preventative and risk management approach
- Promote the health facility's incident management plan amongst staff.
- Promote the safety, security and wellbeing of staff, patients and the public within facilities of the Health Service.
- Ensure incidents are reported in accordance with the health facility protocols and legislative requirements.
- Ensure affected staff are supported and receive any necessary medical treatment.
- Ensure that the consequences of the incident's impact on service provision within their area are identified, assessed and managed effectively and efficiently.
- Attend the appropriate training so that they can recognise in their staff, the psychological reactions and symptoms that may follow an incident.
- Ensure that counselling and or other professional assistance is arranged and accessible to staff as the need arises.
- Participate in post-incident review/investigation and initiate any recommended preventative action.

#### Legal Support

Where there are legal proceedings related to an incident it is important to coordinate legal and practical support for employees who may be required to give evidence. This may involve:

- Educating staff on what to expect (eg the format of various court procedures).
- Making provision for legal representation and advice (where appropriate).

### **3.8 Role of Staff**

- Notify their supervisor of the incident.
- Provide assistance that is within their capacity and training.
- Await further direction during the incident.
- Assist with any formal investigation and reporting of the incident.
- Assist with implementing any preventative measures identified by a post-incident review or investigation.
- Report any personal injury sustained as a result of an incident.
- Attend training as determined by their manager.

### **3.9 Clearly defined Procedures**

The procedures developed should be simple and easy to understand. The use of checklists or flowcharts may assist in ensuring all the activities are carried out. Procedures should include:

- Roles, responsibility and authority
- Communication (internal and external)
- Training
- Consultation
- Planning

### **3.10 Education and Training**

An important element in planning the incident management program is the preparation of the staff to deal with an incident. Education and training of all staff is essential to this process, including casuals and contractors, for example, Visiting Medical Officers.

This training is in addition to any OHS preventative training as discussed in section 4.4.

The incident management training should be aimed at increasing the awareness of what staff can do to manage the incidents. The content of the training should include the following:

- Detailed discussion on the definition of an incident.
- Detailed discussions of the procedures to be followed in the event of an incident.
- Legal issues which may apply to some incidents and the legal responsibility to report certain incidents to external agencies eg Police, Department of Community Services, Department of Health, WorkCover NSW.
- An awareness of what a person may experience during and after an incident (eg shock, anger, anxiety, grief and numbness).
- The range of support services available for staff following an incident.

- Access to NSW Health Circulars and legislation, which guide the response to, and reporting of, incidents.

Training should be provided at orientation and when being inducted into a facility or when transferring to an unfamiliar section of the facility; as plans are reviewed and changed; as a regular update; at times when there is an increased risk of incidents.

Staff should also receive education and training in conflict management and incident management. There should be both initial training as well as ongoing training and the training should provide the opportunity to practice duress response procedures.

Advanced training should be given to response staff (eg Senior Managers, After Hours Managers, medical staff, security staff, clerical staff on switch). More frequent training may be required for departments with greater risk of incidents eg Emergency Departments, Mental Health units, Drug and Alcohol units and other relevant settings.

### **3.11 Communication Devices**

Communication devices may need to be installed to enable signalling for assistance and an early incident response. During the planning phase it will be necessary to determine the types of communication devices that may need to be installed. Such items as portable two-way radios, mobile telephones and/or duress alarms may be made available to staff.

The situations in which these devices are provided would be determined by a risk assessment and determined in consultation with staff. The community environment should be taken into consideration when assessing communication devices (eg two-way radios, mobile duress alarms and telephone satellite services).

## 4.0 INCIDENT PREVENTION PROGRAM

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**4.1 Incident Prevention Program** To prevent or minimise incidents threatening safety, there needs to be a systematic approach to hazard identification, risk assessment, risk elimination or risk control and evaluation.

**4.2 Hazard Identification and Risk Assessment** Hazard identification involves establishing the nature and range of incidents to which various employee groups within a Health Service may be exposed. Community workers and people working in isolation should be included in this process. An analysis of incident and injury records will identify those circumstances where staff and others may be most at risk. Regular workplace inspections by managers and safety committee members may also determine by observation hazards that may exist. All employees (no matter what their position) should be encouraged to speak out about situations they feel are a risk. Senior managers are responsible for acting on these concerns to improve the safety of the environment.

Risk assessment involves the analysis of the potential outcomes associated with a hazard (anything with the potential to harm life, health or property). Following risk assessment a priority list can be developed to address hazards.

Risk assessment should include those risks associated with human violence or aggression, or factors in the environment which may decrease safety eg small crowded spaces, no easy exit, and working in isolation.

**4.3 Control Strategies** Control strategies can be many and varied. They are grouped into the following hierarchy of controls:

**Eliminate the hazard** wherever possible.

**Design out the hazard**- Try to ensure that the hazards are “designed out”, eg when undergoing building refurbishments, and when systems of work are being planned.

**Isolate the hazard** from the person put at risk.

**Substitute the hazard** with a hazard that possesses a lower risk of harm.

**Introduce engineering controls** –modifications to the work environment or equipment which minimises the risk of injury, Examples are:- locks, equipment guarding, automated chemical mixing devices, electronic hoists and security screens

**Use administrative controls** to minimise the risk – policies and procedures, staff training, routine maintenance of equipment and safe work practices will assist in controlling hazards.

**Provide personal protective equipment** – provide and maintain appropriate personal protective equipment, eg appropriate duress alarms, two way radios. Ensure that staff receive training in their use.

If one of these measures is not enough to minimise the risk to the lowest possible level a combination is required.

#### **4.4 Consultation**

Employees should be consulted throughout the risk management process of identifying, assessing and controlling hazards.

#### **4.5 Specific Hazard Management Relevant to Incident Prevention**

A wide variety of hazards exist in any Health System. NSW Health and individual Health Services have developed a range of policies and guidelines to minimise the occurrence of incidents.

These include:

- Safety and Security policies
- Hazardous Substances policies
- Fire and emergency policies

Evaluation of specific hazard management programs and controls strategies should occur on a regular basis to determine appropriateness and effectiveness.

The *Safety and Security Manual Minimum Standards for Health Care Facilities 1998* (currently under review) highlights the types of security risks which can be found in health care facilities (eg assault), and procedures and personal protective equipment which may be adopted to prevent an incident. The needs of community workers are addressed in a separate section of this document. NSW Health requires that an internal review of security be undertaken every 12 months. The NSW Health OHS Audit Profile requires that an OHS profile be undertaken at least every two years. Any hazards identified must be addressed.

#### **4.6 Education and Training**

Education and training is a fundamental component of prevention strategies. Employees, supervisors and managers require information on how to apply a risk management model to their work environment and estimate the level of risk associated with various work activities as part of a cycle of risk management.

Section 3.10 also refers to the need for training staff in the incident management process.

## 5.0 THE INCIDENT MANAGEMENT PLAN

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### 5.1 Components of the Incident Management Plan

An incident management plan should include:

1. Early response and management of the incident.
2. Follow up response, investigation and review.

### 5.2 Early Response

In order to ensure an early response to an incident it is essential to provide guidelines to staff on how to notify the occurrence of an incident. This may simply involve contacting the switch or may involve the activation of a duress system.

Clear communication procedures should be implemented so that the appropriate people are contacted and respond, including immediate contact to the senior manager on duty at the time. The telephone switch operator may often be a key person in relating information regarding the incident.

Duress systems should be linked to multiple people.

### 5.3 Initiate Strategies to Control the Incident

The Senior Manager on duty at the time must be contacted and is responsible for coordinating the emergency response and additional resources, and establishing normal operations following the incident.

In responding to the incident some or all of the following actions may be undertaken. It should be noted that much of the activity is concurrent; which emphasises the need for effective communication flow, clear and unequivocal allocation of roles, responsibilities and authority and an effective centralised coordination unit or process.

- Assess the incident to determine its magnitude, severity, type, the numbers of people involved and the nature of any physical trauma to patients, staff and others, as well as damage to the Health facility.
- Safety as a priority. It should be a first priority to ensure safety of all involved wherever there continues to be a threat. It is also a first rule that those responding should not place themselves at risk of becoming further casualties.

### 5.4 Co-ordinate Emergency Services

- Emergency response. The response may include resuscitation, first aid, security measures, containment of aggression or external services eg police, fire or ambulance.
- Effective Communication between the senior manager responsible for managing incident and all personnel involved in the incident (including external support services)

## 5.5 Re-establish Normal Operations

When the incident is concluded, staff should be provided with clear guidelines regarding support services and the option to return to duty. Operational debriefing(s) should be set up and coordinated.

Staff returning to duty should be provided with clear instruction as to the priority tasks to be achieved. If the incident has taken some time it is unrealistic to expect the employees to try to “catch up” on hours of work.

It may be necessary to organise additional staff to come to the department to assist in re-establishing the normal operations.

## 5.6 Immediate Support for People Involved

- Obtain the names and contact numbers of all those involved in the incident to enable follow up. This includes staff, visitors and members of the community.
- Provide first aid and follow up medical attention as required for persons injured in the incident. Notify the rehabilitation coordinator of staff injured in the incident so that prompt follow up can occur.
- Provide prompt support services to any people involved in the incident. These early services may include:
  - Comfort and support for affected or distressed persons.
  - Responding to immediate physical needs eg fluids.
  - Making phone calls to assist with personal needs (eg contacting family, organising childcare pick up).
  - Linking the person/s to ongoing support (see section 6) with explanation and provision of follow up procedures.

As part of effective management it is important to provide appropriate support and acknowledgment of staff on an ongoing basis – both verbally and by realistic, practical assistance as described above. This support should take into consideration culturally specific issues and adapted for individuals from Non English Speaking Backgrounds.

## 5.7 Follow up Response

After the initial response to the incident and when the department is functioning again there is a range of activities to ensure the Health Service continues to manage the outcomes of the incident. These activities follow:

## 5.8 Reporting the Incident

*Incident Report Protocols are currently under review and this section may be upgraded at a later time.*

All incidents must be reported and recorded eg using a hospital incident form, incident database or a hazard log if appropriate. Incidents may need to be reported to the Executive of the Health Service. These communication protocols should be clearly documented.

Many incidents are likely to be Reportable Incidents to the Department of Health (Circular 97/58) eg incidents likely to be the subject of media interest. The Circular outlines the types of reportable incidents that require a report to the Department and the procedures for reporting.

In addition, incidents may need to be reported to external agencies such as NSW WorkCover, Police, Community Services and the Treasury Managed Fund for legal reasons. Incident reports should be in the approved form eg in accordance with the requirements of the OHS and Workers Compensation Legislation.

Reporting guidelines should be documented to assist managers to determine when an incident requires a written report for an external agency.

All reports relating to incidents should be kept in accordance with legislative and Health Service guidelines.

All reports should be treated as confidential documents and only be made available to those with a need to know. Summaries of the report, with the identity of participants suppressed, may be made available more widely in the interests of avoiding rumour and misinformation.

## **5.9 Media Considerations**

There are special considerations for handling incidents that may attract, or have attracted, media attention. A carefully coordinated media response will minimise the risk of distorted facts and sensationalism in the media, and may help in some instances by quickly providing essential information to a large number of people.

The best media results occur when a media response is carefully considered, prepared and issued by someone experienced in dealing with the media. It is essential that in the event of an incident which is likely to attract media interest the designated Media Liaison Officer for the facility or Area Health Service is contacted as early as possible.

Media responses must be made in line with Health Services media release policies and the Department of Health's Media Unit guidelines.

It is essential that employees do not provide comment to the media without authorisation by the Health Service Manager/General Manager/CEO and Media Liaison Officer. If a journalist contacts a staff member for comment about an incident, without having gone through the Media Liaison Officer, the staff member is not to respond.

## **5.10 Staff - Follow Up**

After the incident is finished it is important to have a plan to follow up all staff involved in the incident. The aim of this follow up is to identify any employees who may require further support services or time away from the particular department. Section 6 provides detail on managing staff reactions.

Staff should be supported by their immediate manager in returning to their normal work after the incident. Support for staff in returning to work is critical to their ongoing well being.

All staff involved, even when they have declined immediate support or other assistance, must be contacted around 2 weeks after the incident when indicators of ongoing risk or need may surface. Staff can then be linked to effective care systems. Further follow-up of staff that have not indicated a need to be linked to care systems is also advisable at around 4 weeks after the incident.

Other people involved in an incident may also need to be contacted to ensure support is provided as necessary.

Occasionally an employee may require a period of time away from the particular work area. A range of early staged rehabilitation options should be available to staff, for example, a short term transfer out of the particular location. The rehabilitation should be coordinated by the rehabilitation coordinator and linked with ongoing support services.

## **5.11 Investigation**

The best way to stop an incident from occurring again is to objectively investigate why it happened and determine if it was preventable. Organisational commitment to change the problem is also required.

It is important that the tone and approach in the investigation is a supportive one that acknowledges the experience of the staff in the “front line” of the incident. Harsh or judgemental attitudes, however unintended, in investigations can cause additional levels of distress for staff involved.

Investigation of aggressive incidents should aim to determine the underlying cause(s) of the aggression.

### **5.11.1 Investigating the root cause/s**

Investigating the incident to determine the root cause/s or interplay of factors that contributed to the incident is an integral part of the OHS process. This assists in maintaining and improving OHS programs and procedures.

Incident investigation does not seek to apportion blame but to identify systems breakdown and control measures that will prevent similar or more serious incidents from occurring. A system focus should be maintained at all times.

Managers and supervisors should undertake the investigation. However, in complex situations OHS personnel should be involved. It is important that people involved in the systems under investigation are included in the process.

All incidents should be investigated, although the degree of investigation will vary depending on the risk involved and the complexity of the problem. The investigation should be undertaken promptly.

Once the causes have been identified the potential or risk of the incident being repeated will need to be determined.

#### Establish the facts:

The six questions What?, Who?, Where?, When?, How? and Why? will assist to establish the facts or define the problem. There will often be an interplay of causes, not one cause.

Information should be collected via, for example, accident report forms, a site inspection (including, for example, examining the environment, equipment and chemicals in use), interviewing witnesses and by gaining expert advice (ie from OHS or Risk Management personnel).

Witnesses and others should be interviewed at the scene if possible and as soon as possible after the incident – privately and informally.

Contributing factors should be considered, for example, work environment, equipment, work practices, supervision, staff skills, education and training.

Systems breakdowns that may contribute to an incident may include:

- Product failure (plant, equipment or substance)
- Safe systems of work not in place
- Non compliance with work procedures/safe systems of work
- Inadequate supervision of work systems
- Inadequate or poor compliance with maintenance program
- Inadequate job induction
- Workplace design deficiencies
- Unfamiliarity with work environment

- Lack of training in
  - OHS policy and programs
  - Equipment use
  - Work systems
  - Personal protective equipment use
- Lack of equipment or poorly chosen equipment

Continue to ask **why** until a root cause is identified.

At the end of the interview seek advice from the interviewee concerning what could be done to prevent similar events occurring in the future.

At the conclusion of the investigation, the following questions should have been answered:

- Are all the facts and details known regarding the cause(s), response and management of the incident?
- Who was or should have been involved in the response and management of the incident?
- Were systems already in place to minimise the occurrence of an incident?
- What were the identified system failures?
- What were the achievements/positive actions and outcomes?
- Were all policy/legislative requirements met concerning pre and post incident management?
- How could this or similar incidents be prevented?
- What are the recommendations for changes to policies, procedures, equipment, environment, staffing or competencies? Recommendations arising from the investigation should be clearly set out in terms of who is responsible for implementation, for what and by when.
- How and when will the implemented control measures be evaluated and monitored? (Controls should be developed to prevent a similar incident occurring -see control strategies at 4.3).

## **5.12 Operational Review/Debriefing**

Operational Review is the process of analysing the effectiveness of the response, and management of the incident. It allows for improvement to be made to the incident management plan and procedures. It also assists in making meaning of what happened in terms of the 'facts', shared perceptions and so forth. Operational reviews would include:

- Review by the team of workers or the working group who have experienced the incident.
- Discussion of the incident as experienced over time and analysis of components of response.
- Clarification of successes and negative aspects of response.

At the conclusion of the review the following would be answered:

- What were the achievements and successes of response and have these been identified?
- Learning conclusions: what can be done better in future, what has been learnt.
- How could the management of this incident have been improved?
- Who needs to know about the recommendations of the review?
- Has everyone who needs to be notified about the outcomes of the incident been notified?

Recommendations arising from the review should be clearly set out in terms of who is responsible for implementation, for what and by when.

Some of the questions a reviewing committee might consider when gathering information are:

- What went wrong and what went right in responding to an incident?
- What gaps need to be attended to?

It is also important that the findings of reviews and operational debriefings are incorporated into a cycle of improvement: that achievements and learning can be identified along with other outcomes of the event.

This emphasises not only the concept of the organisation as a learning organisation, but also builds the memory of the organisation for quality provision in the future.

Some formal, even if brief report or summary of the incident should be available to assist closure and to indicate the active learning that has occurred. This is also to assist personal resolutions.

## 6.0 MANAGING STAFF REACTIONS

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People who experience an incident may have a variety of reactions. They may be numb and shocked. They may feel cut off, unreal, as though this is happening to someone else. They may feel fearful and helpless. They may feel angry and vulnerable. If an incident is severe, for example life threatening, those involved may become highly aroused. These initial reactions usually settle rapidly. In the early days there may be a sense of preoccupation or flashbacks about what has happened or the person may feel cut off. Others may feel calm and in control.

For the vast majority of people these normal reactive processes settle over the early days and weeks and there are no adverse consequences. The interventions described below recognise and support these normal and appropriate adaptations. Some people at some times will be more vulnerable and their reaction to their experience may continue and interfere with their capacity to sleep and eat and with relationships. Specialised help is needed in these circumstances.

### 6.1 Providing Appropriate Staff Support

When planning to manage incidents and events it is important to recognise the resilience and personal strengths of individuals to recover after an incident. Individuals handle trauma and stress in different ways and in their own time. Therefore it is important to have a staged and appropriately timed approach to managing individual staff reactions to incidents and events in the workplace. (See also Appendix C: Staff Support Service Providers)

The Plan should identify support programs or professional assistance where appropriate, but in non-stigmatising ways. It should include immediate, short term and long term interventions tailored to individual need. The types of support which can be offered to staff following an incident are:

- Psychological First Aid/Immediate Social and Practical Help
- Employee Assistance Programs and Peer Support Programs
- Supportive Counselling
- Supportive Group Discussion
- Operational Debriefing
- Specialised Counselling
- Mental Health Care

**6.2 Psychological First Aid/Immediate Social and Practical Help**

Psychological first aid should be the initial intervention following an incident or stressful event and focuses on the establishment of safety, the provision of basic human needs and physical care ie comfort, support, safety and communication. The provision of practical help may ultimately be seen as more helpful and positive than the specific psychological care offered at this early stage. (see Appendix A for further information)

**6.3 Employee Assistant Programs and Peer Support Programs**

Health Services could consider when developing /implementing an Employee Assistance Program, the use of a Peer Support Program (see Circular 2000/42). Peer Support Programs should be based on thorough preparation and ongoing training.

Peer Support is the use of volunteers from a work group, trained in appropriate methods of assisting colleagues in their workplace. Particular staff members may be identified as Peer Support Persons. **This is not counselling or therapy.** After a severe incident, individual Peer Support Persons who have not been directly involved may be identified as a Special Support Person for a colleague who has been through an adverse experience. Such assistance is only implemented if agreed by the affected persons.

**6.4 Supportive Counselling**

Supportive counselling by a trained counsellor can be provided to anyone acutely distressed. This can be provided by relevant persons such as counsellors, chaplains and through the Health Services Employee Assistance Program which may involve either internal or external services.

Supportive counselling involves comforting and reassurance, practical advice, allowing the person to discuss their experience (only if they feel the need to do so), linking them to support networks, and identifying those at risk who may need follow-up and specialised services.

**6.5 Supportive Group Discussion**

Groups of people who have been affected by an incident may come together naturally in the aftermath and talk through or discuss their experience. This is often perceived as helpful and people may consider it an opportunity to "debrief" about their experience. Formal psychological debriefing is not however recommended. (US Consensus Guidelines 2001)

Debriefing in this or any other form should never be mandatory. There is no evidence that formal debriefing can prevent Post Traumatic Stress Disorder (PTSD) and it may increase the risk for some.

**Critical incident debriefing is no longer recommended by NSW Health** as a structured intervention post-incident. (US Consensus Conference 2001)

**6.6 Operational Debriefing**

Operational debriefing is a routine process for organisations following an incident and can provide an effective mechanism for Health Services to review the organisational response procedures and protocols. This is an active learning process with a feedback cycle for future response. (For further information see 5.12)

**6.7 Specialised Counselling**

Specialist Counselling is provided for people experiencing severe or prolonged distress or disturbance following an incident, or for those determined to be at significant risk of adverse outcomes and is provided after appropriate clinical assessment. A specialist clinical professional (usually mental health) provides this counselling and it may be linked to a range of other interventions, which are appropriately timed. The specialised counselling should ideally be provided by clinicians who have no working relationship with the distressed staff member. See appendix C.

**6.8 Mental Health Care**

Specialised Mental Health Care may also involve psychiatric treatment which may include counselling and possible medication for those who have developed psychiatric problems.

**6.9 Referring Staff to Counselling**

Deciding whether to and when to refer people to other sources of professional assistance (eg EAP services or specialist counselling) requires careful consideration. Sensitivity in referral is vital and it is recognised that managers and supervisors face a difficult decision when strongly recommending that a staff member seek further assistance. Especially if the staff member is resistant to such suggestions.

Supervisors and managers may need to monitor affected persons or staff members closely to determine whether any of the following signs and symptoms are present which would be indicative of the need for referral:

- Decreased work performance
- high level of sick leave by affected staff
- excessive concentration on work
- inappropriate anger
- neglect of health and/or personal appearance
- carelessness in safety measures (eg driving recklessly)
- high reactivity to related issues
- feeling unsafe in the workplace
- withdrawal

## **7.0 EVALUATION OF THE INCIDENT MANAGEMENT PROGRAM**

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### **7.1 Evaluation of the Incident Management Program**

The program must remain current. The health facility will need to consider an appropriate document management system, which ensures that the program is current regarding legislation, professional and technical information related to the management of such incidents and Health Department Policies and Circulars.

For each preventative program put in place there should be a regular review and evaluation process. This continuous improvement process is essential to ensure effective preventative programs are in place.

### **7.2 Strategies for Evaluating your Program**

Program review should include the OHS Committee, senior management at the facility, staff and topic experts, eg Mental Health experts if reviewing the effectiveness of relevant interventions. The following should be considered during the review.

If an incident occurs determine whether the whole process was managed well. What improvements can be made to the response plan?

Ensure that the program is integrated into management procedures eg planning and budgeting.

Seek advice from staff whether any improvements can be made and check whether they feel that the control strategies eg work procedures are working and if they perceive any problems.

Develop performance indicators which indicate the success of the program ie measure preventative strategies against performance indicators.

Evaluate and review your education and training program.

Evaluate the knowledge of the incident management program amongst staff given involvement in incidents may only occur rarely.

## APPENDIX A: PSYCHOLOGICAL TERMS

### Stress Reaction

Many people may show stress reactions after an incident. For the great majority however, reactions will be transient, a *normal response to an abnormal event*, and will be managed through people's use of existing coping strategies, support networks and material resources. This reactive process usually settles progressively in the first week to ten days.

Mild to moderate stress reactions in the immediate period after an incident are highly prevalent as those affected come to terms with the threat, real or perceived, imposed by the incident.

Although stress reactions may seem extreme and cause distress they generally do not become chronic problems. Typical responses may include:

- **emotional effects** such as shock, anger, irritability, helplessness and loss of control;
- **physical effects** such as fatigue, sleep disturbances, hyperarousal (eg hypervigilance), and somatic complaints (presenting psychological disorders with physical symptoms eg stomach aches);
- **cognitive effects** such as concentration and memory difficulties, worry and intrusive thoughts; and
- **interpersonal effects** such as social withdrawal and relationship difficulties.

In addition, positive reactions such as resilience, altruism (selfless actions), increased sense of personal worth and achievement may also be seen after an incident.

An event which may precipitate some of the stress reactions described above may have some of the following characteristics:

- sudden and unexpected
- violent and shocking
- unpredictable and uncontrollable
- threat to life or encounter with death
- inescapable horror
- exposure to acute or subtle threat to life and health (eg toxic or noxious exposure)
- feelings of powerlessness and helplessness
- feelings of being abandoned
- bereavement, loss or dislocation
- physical harm or injury
- feelings of being responsible in some way
- human malevolence
- high degree of damage

## **Psychological First Aid/Immediate Social and Practical Help**

By far the most frequently studied risk factor is **severity of the exposure** (ie. extent of life threat, loss, and injury). The research literature clearly states that the greater the degree of perceived threat to life and the greater the sensory exposure, the more likely it is that stress reactions will be intense, disruptive to functioning, and may become prolonged, for instance lasting more than two weeks.

Psychological First Aid involves approaching and offering support to people involved in the incident, and focus on the establishment of safety, the provision of practical help in meeting basic human needs and physical care ie shelter, fluids, food, contact with loved ones. This is really part of a common sense human response.

### **The ABC of psychological first aid:**

**Arousal:** this involves reducing very high arousal, comforting and consoling, protecting from further threat, and ensuring physical necessities.

These types of indicators relate to fear generated by the threat, or to distress over separation from loved ones and from usual sources of security. Thus it is diminished by protecting from further threat, reassurance and linking to loved ones and sources of security.

**Behaviour:** protecting those showing behavioural disturbances from harm that may result from these, linking them to systems of support and restoring a sense of being in control.

Disturbed behaviour may relate to fear, anger, shock, and distress about loved ones.

**Cognition:** thought and memory disturbances should be dealt with through general support, information provision and good orientation to specific reality-based tasks. If there are concerns that the person remains confused and out of touch he or she should be referred to a mental health professional for a formal assessment of their mental state. Mental state assessments should include potential organic factors such as head injury or toxic effects. Refer the person to ongoing systems of social support and clinical care if needed.

## **Supportive Counselling**

**Supportive Counselling** is the provision of information and/emotional support by a trained counsellor in order to support a person through a crisis or period of distress, and to refer for further assessment and management if necessary.

It involves comforting and reassurance, practical advice, allowing the person to discuss their experience (only if they feel the need to do so), linking them to support networks, and identifying those at risk who may need follow-up and specialised services.

### **Specialist Counselling**

Specialised Counselling may involve trauma counselling or grief counselling and other targeted psychological interventions provided by appropriately qualified and experienced mental health professionals. These are usually more appropriate and effective in the period after the initial 2 weeks and where there are indicators of ongoing risk or need.

It is the responsibility of all concerned to ensure, as far as possible, that appropriate professional interventions are available. Referral to these services should be managed through a registered practitioner following assessment. Family interventions may also be required. These services may be provided through organised service providers. Guidelines for determining service providers are provided at Appendix C.

### **Critical Incident Debriefing**

Critical incident debriefing is psychological debriefing as a formal immediate response to incidents. **NB Critical incident debriefing cannot be recommended by NSW Health as a structured intervention post-incident.** Although previously used, is now known to be inappropriate for the majority of people, and may be associated with negative outcomes for some.

### **Operational Debriefing**

Operational debriefing is a routine process for organisations following an incident and can provide an effective mechanism for Health Services to review the organisational response procedures and protocols. This is an active learning process with a feedback cycle for future response.

### **Supportive Group Discussion**

Groups of people who have been affected by an incident may come together naturally in the aftermath and talk through or discuss their experience. This is often perceived as helpful and people may consider it an opportunity to "debrief" about their experience. Formal psychological debriefing is not recommended. (US Consensus Guidelines 2001).

Debriefing in this or any other form should never be mandatory. There is no evidence that formal debriefing can prevent Post Traumatic Stress Disorder (PTSD) and it may increase the risk for some.

## **Mental Health Outcomes**

The majority of people exposed to a stressful or traumatic event will not experience a major mental health disorder and of those who do, most will recover within one to two years. Of those who do develop disorders, these may include: major depression, acute stress disorder, posttraumatic stress disorder, generalised anxiety disorder, somatisation disorders, substance abuse, adjustment disorder, complications of bereavement, family violence, and child or spousal abuse.

## **Posttraumatic Stress Disorder (PTSD)**

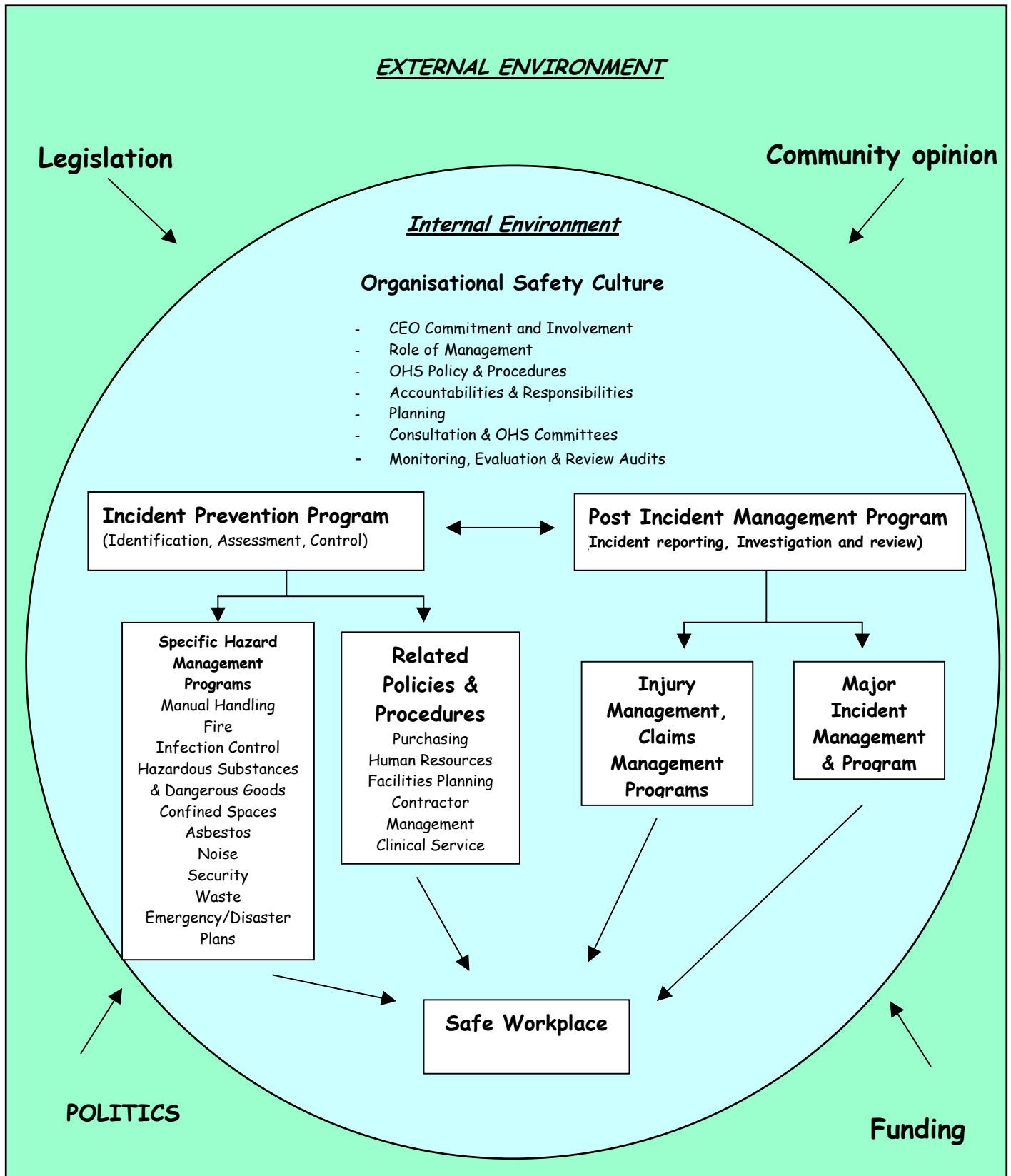
PTSD is a recognised psychiatric disorder, which may result from exposure to a very severe or life threatening incident. PTSD is not the normal response to a stressful incident or event. To meet the stressor criterion of PTSD, the individual must experience severe threat and the response to the traumatic experience must involve helplessness, intense fear or horror. Symptoms of PTSD range across three distinct clusters comprising *re-experiencing* (eg. flashbacks, intrusive recollections, nightmares); *avoidance and numbing* (eg avoidance of reminders of the trauma, emotional detachment and withdrawal); and *hyperarousal* symptoms (eg. Hypervigilance, concentration and memory problems). Symptom duration must be of at least one month post-incident and symptoms must be severe enough to impair normal functioning.

## **Acute Stress Disorder (ASD)**

ASD is a relatively new diagnosis. It is listed as one of the anxiety disorders and is regarded as an acute form of PTSD. For a diagnosis of ASD to be met, an individual must experience symptoms of dissociation, re-experiencing, avoidance and hyperarousal. Symptom duration must be between 2 days and 4 weeks after a traumatic event and there must be significant impairment in functioning. If symptoms last longer than four weeks post-incident a diagnosis of PTSD is considered.

APPENDIX B: WORKPLACE HEALTH AND SAFETY MODEL

**Workplace Health and Safety Model**



## APPENDIX C: STAFF SUPPORT SERVICE PROVIDERS

### Service Providers

The service provider is an agent who provides counselling and/or other professional services to the Health Service. The service provider may be internal or external to the Health Service. This person should have demonstrated knowledge and expertise.

A service provider is one who meets the professional, skill and experience requirements outlined below. It may be a Staff Counsellor, who will provide a range of other services as well, or it may be an external agency. An external agency may be used as a service provider for post incident support and counselling. If an internal staff counsellor is not available or there is a requirement for back-up services, a contract with an external agency may provide the necessary service.

Service providers for the delivery of counselling services must be tertiary qualified and professionally trained mental health professionals, experienced in the delivery of such services, be eligible for membership of their professional association; and where appropriate, be registered with their professional registration board in NSW. There should be evidence that the service provider is up to date with the current theories and practice of post incident management.

Service providers need to be independent of those involved in an incident. It is acknowledged that facilities in remote and rural areas may have some difficulty in meeting this requirement where access to, and availability of professional support may be limited. Linkages with larger health facilities, neighbouring services and options for outreach, telephone counselling or telepsychiatry may assist in providing care.

Service providers must liaise with the Health Service to identify and develop what is necessary for the provision of a timely and professional response for staff affected by an incident. There is a range of options available. That option, which best suits a facility will be influenced by its size, location and the availability of resources.

### Skills and Experience of Service Providers

It is essential that service providers have the necessary clinical and counselling skills and experience in the field of contemporary incident response management. As well as having the necessary knowledge, skills and experience in managing or referring those affected by major health problems/disorders or other adverse outcomes which may arise out of incidents, they should also have:

- Knowledge of the Health Service is important. Awareness and sensitivity to particular cultures within Health Services should shape strategies for support eg Emergency Department, acute Mental Health and general health settings. Knowledge of the Incident Management program and associated policies, protocols and procedures is also necessary.
- Knowledge of the normal reactive processes and adaption that follows incidents.
- Knowledge of the reactions and disorders which may become apparent as a result of an incident.
- Knowledge of the range of symptomatology, post-incident assessment and treatment interventions and skills to provide treatment as required or refer if required.
- Knowledge of the Health Service environment and culture would be an advantage.
- Training in the latest assessment and treatment techniques for those at high risk following psychological trauma or other stressors.

The following professions could be considered appropriate as service providers:

- Psychiatrists
- Clinical psychologists and psychologists experienced in mental health work
- Mental health nurses
- Social workers with mental health expertise