

Incident Management

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Summary Advice to staff on the effective response to all corporate and clinical incidents that occur in the health system. Contains important information on the legal aspects of health care incident management, the requirements for a privileged Root Cause Analysis (RCA) and information on privilege and Reportable Incident Briefs (RIB)

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Author Branch Quality and Safety

Branch contact 9391 9200

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, Community Health Centres, Dental Schools and Clinics, NSW Ambulance Service, NSW Dept of Health, Public Health Units, Public Hospitals

Audience All staff including clinicians, managers and contractors

Distributed to Public Health System, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Government Medical Officers, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Health Units, Public Hospitals, Private Hospitals and Day Procedure Centres, Private Nursing Homes, Tertiary Education Institutes

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This Policy Directive may be varied, withdrawn or replaced at any time.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.

Incident Management Policy

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1 Introduction

The NSW Patient Safety & Clinical Quality Program ¹(PSCQP) was launched by the Minister in 2004. An effective incident management system is a key component of the Program. This includes the management of both clinical and corporate incidents.

To support implementation of the Program the electronic Incident Information Management System (IIMS) [based on the Advanced Incident Monitoring System (AIMS)] has been developed and implemented in the NSW health system. IIMS has been established to provide a system for notification of all incidents, including those with corporate consequences.

Everyone involved in the health system is responsible for the minimisation of all clinical and corporate risks that exist in health services. Central to this is the management of all health care incidents as they occur. Management of incidents requires that a number of steps are taken to ensure any immediate risks that an incident may have identified are managed appropriately, and effective action is taken to improve systems.

All health services are required to ensure local processes support the implementation of this Program.

2 Principles

The principles of the Patient Safety and Clinical Quality program are:

- **openness about failures** – errors are reported and acknowledged without fear of inappropriate blame, and patients and their families are told what went wrong and why
- **emphasis on learning** – the system is oriented towards learning from mistakes and extensively employs improvement methods for this
- **obligation to act** – the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit
- **accountability** – the limits of individual accountability are clear, individuals understand when they may be held accountable for their actions
- **just culture** – individuals are treated fairly
- **appropriate prioritisation of action** – action to address problems is prioritised and resources directed to those areas where the greatest improvements are possible
- **teamwork** – is recognised as the best defence of system failures and is explicitly encouraged and fostered within a culture of trust and mutual respect.

For the purposes of this policy, “health services” refers to Public Health Organisations and the Ambulance service of NSW.

Compliance with this policy is mandatory for all health service staff.

¹ NSW Department of Health, NSW Patient Safety and Clinical Quality Program 2004.

3 Objectives

The objectives of the Incident Management Policy Directive are to

- assist health services with timely and effective management of incidents
- establish a standard approach to incident management including the establishment of performance indicators to monitor compliance
- ensure a consistent and coordinated approach to the identification, notification, investigation, analysis of incidents with appropriate action on all incidents and allow the lessons learned to be shared across the whole health system
- provide an essential resource for developing the skills required to effectively manage all health care incidents
- Ensure health services establish processes that comply with the legal aspects of health care incident management including amendments to the Health Administration Act 1982 for Severity Assessment Code (SAC) 1 reportable incidents, and Root Cause Analysis (RCA) investigations as well as the management of Reportable Incident Briefs (RIB) submitted to the Department.

4 Other policies

This policy directive is to be read in conjunction with the following policies

PD2006_009	Legal matters of significance to government
PD2007_040	Open Disclosure
PD2005_634	Reportable Incident Definition under Section 20L of the Health Administration Act
PD2006_070	Lookback
PD2006_073	Complaint Management Policy
PD2006_058	Research and Investigation authorised under the Health Administration Act
PD2005_352	Coroners Cases and Amendments to Coroner's Act 1980
PD2005_234	Effective Incident Response: Framework for Prevention and Management in the Health Workplace
PD2005_631	NSW Health Plan – Counter disaster planning and coordination
PD2005_203	Management of Reportable Infection Control Incidents
PD2005_026	Reporting of thefts and losses

Maternal and Perinatal

PD2005_493	Death- Unexpected Infant – Hospital protocol
PD2007_025	Stillbirth management and Investigation
PD2005_219	Reporting of Maternal Deaths to the NSW Department of Health
PD2006_006	Deaths – Perinatal- Hospital procedures for review and reporting of perinatal deaths

See [Appendix H](#) for a list of other policies that relate to incident management.

Private health care facilities

Private health care facilities licensed under Private Hospitals and Day Procedure Centres Act 1988 must continue to report to the Private Health Care Branch in accordance with their statutory obligations.

5 Roles and responsibilities

Incident Management is everyone's responsibility within the NSW Health system.

Effective incident management requires a whole of organisation approach with clear points of accountability for reporting and feedback lines at all levels of the organisation. This incorporates both individual and organisational roles and responsibilities.

All Staff are responsible for

- notifying all incidents they identify using IIMS
- participating in the investigation of incidents as required
- participating in the implementation of recommendations arising from investigation of incidents
- encouraging colleagues to notify incidents identified.

Health Services are responsible for

- ensuring an effective incident management system is in place for investigating and actioning recommendations for all incidents
- ensuring that there is timely notification of incidents to the Minister's office, Director-General, Deputy Director-General and the Department's Media and Communications Branch by submitting a RIB and by telephone if urgent attention is required
- ensuring monitoring and risk rating of all incidents
- reporting all SAC1 incidents to the Department within 24 hours
- ensuring processes are in place to manage clinical Reportable Incident Briefs in accordance with Section 23 of the Health Administration Act, 1982
- conducting privileged RCAs on clinical SAC 1 incidents in accordance with Part 6C of the Health Administration Act 1982
- conducting a detailed investigation of all corporate SAC 1 incidents
- providing Clinical SAC 1 RCA reports to the Department within 70 calendar days of the incident notification in IIMS
- providing key findings from Corporate SAC 1 investigations within 70 calendar days to the Department;
- undertaking local actions to ensure appropriate incident management and preventing recurrence of incidents
- reporting of trended incident data and outcomes of RCAs and Corporate SAC 1 investigations to relevant groups within health services
- ensuring appropriate resources are available for effective incident management and patient safety initiatives
- implementing policies and local practices that support staff, including staff training on incident management and encouraging an environment where incident notification and active management of incidents is fostered.

Clinical Excellence Commission is responsible for

- providing advice and regular reports to the Minister for Health on clinical quality and patient safety issues and trends and providing information on lessons learned from the clinical incident management process
- providing advice to NSW Health on strategies to minimise clinical system errors across the state

- identifying education needs emerging from clinical incident management
- providing advice to the system in response to specific queries about clinical incident management, and in response to analysis of clinical incidents.

NSW Department of Health is responsible for

- ensuring health services have systems in place to report, investigate and implement the actions necessary to prevent incidents and protect patient safety and clinical quality
- reviewing clinical and corporate SAC1 health care incidents and developing statewide policies and strategies
- reviewing advice and reports provided by the CEC on trends analysis of RCAs and issues arising from all clinical incident (SAC) categories
- establishing and maintaining systems to monitor incidents reported to the Department to ensure appropriate action
- disseminating lessons learned from incident management
- providing advice to the system in response to specific queries about incident management
- publishing an Annual Report on the Patient Safety and Clinical Quality Program for the community
- providing advice to the Minister for Health on issues of public concern/media or public attention.

6 The incident management process

There are seven key steps to effective incident management: Identification; Notification; Prioritisation; Investigation; Classification; Analysis and Action; and Feedback.

6.1 Step 1 – Identification

It is important for all staff to recognise when an incident has occurred. This will only be achieved in a culture and environment that allows this to happen without fear of retribution, and where incidents are not an acceptable part of health care delivery. Each health service will need to foster this culture.

Following identification of an incident or near miss there may need to be immediate action. These actions may include

- providing immediate care to individuals involved in the event (patient, staff or visitors)
- making the situation/scene safe to prevent immediate recurrence of the event
- removing malfunctioning equipment or supplies
- gathering basic information about a chain of evidence
- or notifying police and security.

6.2 Step 2 – Notification

Staff are required to notify all identified incidents, near misses and complaints in the Incident Information Management System.

6.2.1 Documentation of the incident in the health record

All actual clinical incidents must be documented in the patient's health record. Care must be taken to ensure only clinically relevant information is included in the health record. Staff must document the IIMS ID number in the health record with the information about the incident.

If the incident was identified via a complaint, as per PD2006_073, then the complaint details are **NOT** to be recorded in the patient medical file.

6.2.2 Incident notification in IIMS – by the Notifier

- must occur as soon as practicable and preferably is to occur by the end of the notifier's work day
- can be identified or anonymous, apart from workplace injury notification

In IIMS there are a number of mandatory fields that must be entered into the system for each incident. It is important for notifiers to give as much information as possible to assist further review and management of the incident and allow optimal classification of incidents and comparison of data. The minimum dataset (MDS) required for each incident is guided by the incident category

The notifier is asked to undertake an initial assessment of severity of the incident using the SAC Matrix (see [Appendix A](#)) and give their opinion of how the incident may have been prevented

The patient and/or their family or carer can notify an incident through the complaints management process in place in each health service.

6.2.3 Incident notification – Management responsibility

The manager reviews the IIMS notification, completes the IIMS management screen, and either allocates or confirms the SAC score according to the actual incident or near miss.

If it has been necessary to use a paper-based notification form the incident form is not to be retained once entered into the IIMS database.

6.2.4 Notification to Patient (Open Disclosure)

All SAC 1 and 2 events are to be accompanied by the full open disclosure process. The initial disclosure to the patient and / or their support person must occur within 24 hours of the incident, by the health care professional responsible for the care of the patient. When an actual clinical incident occurs to a patient, an integral component of the notification process is to acknowledge the occurrence of the incident to the patient and their support person, as appropriate and to inform them of the type of investigation that will be undertaken (Please see section 8 for further information on privileged Root Cause Analysis).

An apology for the incident suffered is given at this stage. Refer to [PD2007_040 Open Disclosure](#) and [GL2007_007 Open Disclosure Guidelines](#) for further guidance on the open disclosure process.

6.3 Step 3 – Prioritisation

The purpose of prioritisation is to ensure that a standardised, objective measure of severity is allocated to each incident or near miss. This enables an appropriate level of investigation to be conducted. The Severity Assessment Code (SAC) is used to prioritise all notifications. The SAC is a matrix that takes into account both the consequences of the incident (or near miss), and the likelihood of recurrence of the incident (or near miss) to apply a numerical rating.

The SAC score guides the level of investigation and the need for additional notification. **All Severity Assessment Code (SAC) 1 incidents are escalated to the Chief Executive of the organisation.**

6.3.1 Severity Assessment Code scoring steps

The SAC score is to be applied to all incidents whether they are of a corporate or a clinical nature. The SAC matrix is the method by which the SAC score is derived ([Appendix A](#)). The steps are described below

- Using Step 1: determine the consequence or outcome of the incident

- Using Step 2: determine the likelihood of recurrence of this incident. This analysis will require knowledge of the facility or health service in which the incident occurred
- Using Step 3: allocate a SAC score to the incident
- Using Step 4: determine the appropriate action to be taken

Each incident is assessed for the actual consequence and the potential consequence. The potential consequence is the worst-case scenario for the incident being assessed.

6.4 Step 4 – Investigation

Investigation of the incident is an important component of any patient safety program. **All incidents notified in IIMS require an investigation.**

All **clinical** SAC 1 incidents must have the final RCA report completed and submitted to the Department within 70 calendar days from the notification of the incident in IIMS.

All **corporate** SAC 1 Incidents must have a detailed investigation completed and a report submitted to the Department within 70 calendar days from the notification of the incident in IIMS.

6.4.1 Levels of investigation

All notified incidents require a review to assess the level of investigation required. The SAC score guides the level of investigation.

All health services should:

- assign appropriate levels of responsibility for investigation and action of all incidents
- have policies and procedures in place for the investigation of incidents
- have training programs in place for investigation of incidents
- have appropriately trained staff to support staff involved in investigations.

As a general guideline, the following level of investigation is considered appropriate

SAC 1 Incidents

All SAC 1 incidents require a detailed investigation.

• **Clinical SAC 1 incidents**

- All clinical SAC 1 incidents require a privileged RCA investigation. This is a legislative requirement of the Health Administration Act 1982 and regulations thereunder. See section 8 of this policy for detailed information about the requirements for a privileged RCA investigation of Clinical SAC 1 reportable incidents
- The final report of the SAC 1 incident investigation should be presented to the Clinical Team involved in care of the patient and at relevant staff meetings to ensure all staff are aware of the factors contributing to the incident and the action being taken to improve safety.

- **Corporate SAC 1 incidents**
 - identify causes and contributing factors and determine appropriate recommendations to improve existing systems and prevent recurrence of the incident.

SAC 2 Incidents

- Require a detailed investigation of the incident
- Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project
- Responsibility assigned to a designated senior manager
- Investigation should be completed within 28 days as monitored in IIMS or a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager

SAC 3 / 4 Incidents

- The investigation of SAC 3 and 4 incidents can be undertaken at the local level but management responsibility for the investigation must be assigned
- Any financial loss must be reported to senior management
- As well as investigation at the local level, monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project
- Investigation of SAC 3/4 incidents may involve, interviews with staff and patient and/or family involved, review of policies/procedures, record review, clinical / performance indicators or other relevant material
- Investigation should be completed, where possible, within 28 days as monitored in IIMS or a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.

An aggregated deidentified report on all corporate SAC 1, 2, 3 & 4 incidents is to be provided to the health service's Audit and Risk Management Committee. An aggregated report on all OH&S incidents is to be provided to the Director, Workforce Development and any relevant OH&S Committee.

6.4.2 Investigations and individual performance

Investigations conducted under this policy should not canvass issues of individual performance. Where a question of individual performance arises, this is managed via the organisation's performance management system and/or [PD2006 007 Directive Complaint or Concern about a Clinician –Principles for Action](#).

6.4.3 Investigation of incidents across health service boundaries

The responsibility for managing clinical incidents across health service boundaries lies with the Directors of Clinical Governance. The responsibility for managing cross boundary corporate incidents rests with the most appropriate Area Director. The procedure for managing SAC 2 incidents across boundaries is as for SAC 1 incidents but may or may not include submission of a RIB to the Department. (See section 8 for further information about the management of SAC 1 incidents across health service boundaries).

6.4.4 Director General Inquiries under the Health Services Act

A limited number of clinical incidents can raise issues which may require a more formal inquiry to review a matter independently of the public health organisation. This may arise where a clinical incident raises broad statewide or general clinical practice issues, serious public interest matters or matters where there is a potential conflict of interest in the organisation overseeing an investigation itself. Where the CE considers an independent external inquiry may be required, they should contact the DOH Legal Branch and the DOH Corporate Governance and Risk Management Branch.

6.5 Step 5 – Classification

This is the process of capturing relevant information from a range of perspectives about an incident to ensure that the complete nature of the incident, including causative and contributory factors, is documented and understood. Classification of all incidents involving patients, staff, visitors, volunteers, contractors or corporate systems can be made in IIMS.

Classification is undertaken by nominated personnel according to the service delivery model of each health service and may include local managers, patient safety managers, OH&S managers and staff of Clinical Governance Units (CGU).

It is important that the minimum dataset in IIMS is completed for each incident.

The three levels of classification are:

1. SAC 1 Incidents

- All SAC 1 incidents require advanced classification in IIMS
- Classification of SAC1 incidents is undertaken by the assigned manager
- The advanced classification information in IIMS is not subject to statutory privilege as is other information from a privileged RCA and is therefore available as a public document.

2. SAC 2 Incidents

- The IIMS basic classification is to be completed
- The manager will need to confirm this classification.

3. SAC 3 / 4 Incidents

- The IIMS minimum data set is to be completed
- The notifier is able to classify all SAC 3 and 4 incidents at the time of notification by answering the additional questions related to incident type as a part of the minimum dataset. Incomplete minimum datasets are to be completed by the manager
- Further classification of SAC 3 and 4 incidents may be undertaken for trending purposes as required by the manager responsible for reviewing the incident.

The information provided through classification is included in reports available to managers. This will assist them in developing strategies based on trended data to understand cumulative risk and to minimise the recurrence of such incidents in their

area of responsibility. The standard classification system used in IIMS allows comparison of data across incident type.

6.6 Step 6 – Analysis and Action

The purpose of analysis is to understand how and why the incident occurred, and to identify ways of preventing a recurrence. The analysis should take into account all information gathered during the Investigation and Classification phases. Actions and recommendations are developed to prevent recurrence of the incident.

A suitable timeframe for the implementation of recommendations is documented in IIMS. Senior management is responsible for deciding whether recommendations are accepted and approved and for appropriate resource allocation.

A senior manager records the acceptance of recommendations and/or comments in IIMS once the recommendations have been approved by the CE, The IIMS system is used to capture actions and recommendations, and to flag follow up and review dates.

Ongoing monitoring is required to ensure recommendations are addressed in a timely manner and to evaluate the success of any action taken to achieve improvement.

6.7 Step 7 – Feedback following investigation

Feedback is an important component of a successful incident management program.

6.7.1 Feedback to Patients and/or Support Person (Open Disclosure)

Information about SAC 1 and SAC 2 clinical incidents should be offered to the patient and / or their support person. The information provided to the patient and / or their support person can be based on a variety of sources. The final report from a privileged RCA is one of the sources that may be used in providing feedback on a clinical SAC 1 incident.

Refer to the Open Disclosure Policy PD2006_069 for further guidance on the open disclosure process.

6.7.2 Feedback to Staff

The success of incident management is dependent on feedback to all staff on the results/outcomes of investigations in a timely manner. Staff involved in the incident need to be informed of the recommendations arising from any investigation.

The final RCA Report provides the basis for feedback on a clinical SAC 1 clinical incident . The findings of the Clinical SAC 1 RCA Report should be provided to the relevant clinical team and presented at relevant staff meetings. For a Corporate SAC 1 incident the final investigation report prepared for the Chief Executive is the basis of feedback to staff.

Regular reports on trended aggregated data and outcomes of RCAs are to be provided to ward staff/ clinical and management teams. Feedback needs to include the changes made and improvements achieved as a result of these changes.

7 Reportable Incident Briefs

The Reportable Incident Brief (RIB) system is designed for the reporting of specific health care incidents to the NSW Department of Health. The RIB process encompasses clinical and corporate incidents.

- **Clinical incidents:** all clinical incidents reported in RIBs are referred to the NSW Health Reportable Incident Review Committee (RIRC). The Committee is responsible for examining and monitoring serious clinical adverse events collected by the Committee in Reportable Incident Briefs (RIBs). The Committee analyses information and identifies issues relating to morbidity and mortality that may have Statewide implications and provides advice on policy development to effect health care system improvement. Both the RIBs and the work of this Committee are subject to special statutory privilege under section 23 of the Health Administration Act. For more information, see [PD2006_058 Authorised Research and Investigation under the Health Administration Act 1982](#)
- **Corporate incidents** occurring in the health care setting are those involving staff, visitor, contractor incidents, property, security and hazard incidents.

7.1 RIB reporting requirements

All actual SAC 1 incidents, both clinical and corporate, are required to be notified to the Department, via a RIB, within 24 hours of notification in IIMS. Please see the SAC Matrix in [Appendix A](#) for further guidance on SAC score.

The Reportable Incident Brief does not replace the requirement for early notification of an incident to the appropriate Deputy Director-General and the Department's Media & Communications Branch.

Chief Executives or their nominated delegate are responsible for notifying the Minister's Office, the Director-General, the Deputy Director-General and the Department's Media and Communication Branch when there are incidents which have the potential to become matters of public interest.

Where there is a need to notify the Department out of business hours, the relevant Deputy Director-General and the "on-call" Media Unit officer, [on pager (02) 9214 9972], is to be contacted.

The following list is a guide to the types of incidents that would generally warrant prompt advice to the Department as a RIB.

7.1.1 Clinical

- Death of a patient unrelated to the natural course of illness
- Suspected suicide of a person (including a patient or community patient) who has received care or treatment for a mental illness from the relevant health services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation

- Suspected homicide committed by a person who has received care or treatment for mental illness from the relevant health services organisation within six months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.
- The National Sentinel Events
 - Procedures involving the wrong patient or body part
 - Suicide of a patient in an inpatient unit
 - Retained instruments or other material after surgery requiring re-operation or further surgical procedure
 - Intravascular gas embolism resulting in death or 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 the incorrect administration of drugs
 - Maternal death or serious morbidity associated with labour or delivery
 - Infant discharged to the wrong family.

When health services are reporting incidents involving patient on patient or patient on staff assaults resulting in injury or death of a patient or staff member and there are reasonable clinical grounds to suspect a connection between the assault/death and care provided by the organisation these are to be reported as a clinical RIB.

Clinical matters are subject to privilege in accordance with Section 23, Health Administration Act, and should be maintained securely and not used for purposes other than providing information to RIRC. For further information, see [PD 2006_058 Research and Investigation Authorised Under the Health Administration Act 1982](#).

Where an incident has clinical and corporate components, it will be covered by the statutory privilege, and so should be marked as "clinical" on the RIB form. For example the assault of another patient or staff member by a patient where there may be concerns about the clinical management of that patient

If the RIB is not marked clinical, it will NOT be covered by privilege

7.1.2 Corporate

- Unexplained death of a staff member
- Suspected suicide or attempted suicides by a staff member where the staff member was not a client of mental health services.
- Fire, bomb or other threatening activities in the health facility
- Critical equipment breakdown or failure
- Serious threats affecting the facility's operation
- Complete loss of service i.e. power or water failure
- Criminal activity in or related to the workplace
- Non accreditation of service provider
- Violence or threats of assaults on patients, staff or other persons in the health service. This includes incidents involving
 - assaults on, and or abuse of, patients including children and other vulnerable patients by staff or other persons
 - staff members assaulting other staff members

7.2 Mandated reporting- Legal and Policy Requirements

There are matters that require mandatory notification via a RIB to the Department, regardless of the SAC score.

These include but are not limited to

- Deaths or other incidents reportable to the Mental Health and Drug & Alcohol Office
- When methadone or buprenorphine is associated with or potentially associated with a child's presentation or admission to hospital
- Deaths in custody (any unexpected death of a client in custodial care is also an RCA reportable incident)
- Significant legal action initiated by or against a Health Service. See [PD2006 009 Legal matters of significance to government](#), for further information concerning the notification of significant legal matters
- Industrial disputes, particularly where an interruption may be marked
- The commencement of a WorkCover prosecution
- Other matters either raising issues likely to have a major impact on the health service or have statewide implications such as the assault or violence against a patient/client by an employee.

See [Appendix H](#) for policy directives and legislation outlining existing reporting requirements.

7.3 RIB reporting process

The RIB reporting process is as follows

- RIBs are to be completed in IIMS
- A SAC score is to be applied to all incidents reported via the RIB system
- The Chief Executive (CE) is responsible for authorising the SAC score assigned to each RIB
- The RIB is then emailed to the Department's Executive Support Unit (ESUMAIL) within 24 hours of the incident being notified in IIMS. RIBs must be forwarded under the signature of the CE or nominated delegate and dated
- If the issue is urgent, the Area Health Service or other Public Health Organisation is to provide telephone advice to the ESU [(02) 9391 9621] and to the Department's Media and Communication branch [(02) 9391 9121] that a RIB has been emailed
- The CE is responsible for authorising any change to the SAC score documented in the RIB submitted to the Department. Once the CE authorises the change to the RIB SAC score then the RIB is resubmitted to the Department's Executive Support Unit. When the RIB is resubmitted the text of the RIB must clearly indicate that this is an update on a previously submitted RIB.
- All RIBs involving suspected suicide or suspected homicide by patients of mental health services must be referred to the Area Director of Mental Health Services for review of the SAC rating prior to submission of the RIB to the Director of Clinical Governance

- With the privilege that is now in effect, there are restrictions on the distribution of the clinical RIBs. They should not be used for purposes other than providing information to RIRC in accordance with [PD 2006 058 Research and Investigation Authorised Under the Health Administration Act 1982](#). Area Health Services should have processes in place to ensure security of RIBs.

7.4 Information required in the RIB report

- RIBs must state the incident type and the reason for reporting to the Department
- RIBs must be de-identified and treated as confidential
- The RIB is to contain facts, initial analysis and future actions to be undertaken. Opinion and subjective comment are to be avoided
- The RIB is to capture the information around open disclosure
- If an incident involves the death of a mental health patient, the notifier must also complete the Client Death Report Form. As identifying details are required on the Client Death Report Form, it is to be sent directly to the Mental Health and Drug & Alcohol office via the health service's standard communication processes
- The RIB must contain sufficient information to identify the severity of the incident and the background facts that are known at the time of reporting. It is important to provide all relevant information necessary to ensure the appropriate management of the issues
- Attachments such as medical records, pathology or autopsy reports and other patient identifying reports are **not** to be forwarded with the RIB.

8 Privileged Root Cause Analysis under the Health Administration Act 1982

All clinical SAC 1 incidents under Division 6C of the Health Administration Act 1982 require an RCA. The provisions under the Health Administration Act 1982 apply to all Area Health Services and those Public Health Organisations are listed in [Appendix B](#).

The RCA Report must be provided to the Department within 70 calendar days of the incident being notified in IIMS.

8.1 A SAC 1 Incident requiring an RCA

The Health Administration Act 1982 confines privileged RCAs to those matters which have been prescribed as “clinical reportable incidents” under the Health Administration Regulation.

The criteria for a “reportable incident” are based on the SAC 1 definition, and are confined to those incidents with serious clinical consequences that have either a frequent, likely, possible or unlikely probability of recurrence and those incidents with major clinical consequences that have a frequent or likely probability of recurrence. The legislation does not cover incidents with serious or major corporate consequences such as staff injury, financial loss or environmental consequences.

The definition of what will be considered a “reportable incident” under the Act is set out in [PD2005 634 Reportable Incident Definition under section 20L of the Health Administration Act](#). All matters falling within this definition are SAC 1 clinical incidents and must be subject to an RCA.

‘Reportable incidents’ under the Act (Clinical SAC 1 incidents) represent a subset of incidents that must be reported to the NSW Department of Health as a RIB. This distinction is important as:

- An RCA must, under the terms of the Health Administration Act 1982, be conducted on a “reportable incident”
- The statutory privilege is restricted to these ‘reportable incidents’.

8.1.1 Suspected suicides and homicides

A suspected suicide of, or a homicide by, a patient is a SAC 1 clinical incident requiring an RCA in the following circumstances:

- Suspected suicide of a person (including a patient or community patient) who has received care or treatment for a mental illness from an Area Health Service or other PHO where the death occurs within 7 days of the person’s last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;
- Suspected homicide committed by a person who has received care or treatment for mental illness from an Area Health Service or other PHO within 6 months of the person’s last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.

8.2 The Privileged RCA Process

All clinical SAC 1 incidents under Division 6C of the Health Administration Act 1982 require an RCA. The provisions under the Health Administration Act 1982 apply to all Area Health Services and those Public Health Organisations listed in [Appendix B](#).

8.2.1 Variation in RCA process

There are times when a variation to the RCA process is acceptable. These variations include:

- Assigning more than one incident to an RCA team where incidents are of the same classification
- Resolution of the RCA processes in a shorter timeframe due to completion of the investigation with identification of the root cause/s or contributing factors or where there were no systems issues or gaps in service delivery.

Any variation to the RCA process is to be documented in the final Report for sign off by the CE or their nominated delegate.

8.2.2 Membership of the RCA Team

All persons involved in conducting or assisting in the management of the RCA process itself should be appointed members of the RCA Team. This will ensure they are covered by statutory privilege. The members of the Team should have fundamental knowledge about the care processes in the area where the incident occurred, but not have been directly involved in the incident.

For an RCA of suspected suicides, one member of the team must be a senior mental health clinician independent of the service or facility involved in care. In the case of an alleged homicide by a patient, one member of the team must be a senior mental health clinician independent of the health service involved in care.

8.2.3 Appointment of the RCA Team

The CE is responsible for appointing an RCA Team. The CE must sign off on the appointment of the RCA team. A template Appointment letter to be used for this purpose is at [Appendix C](#). Team members are to receive a copy of this Appointment letter.

8.2.4 Informing Team members of their roles and responsibilities

Those appointed to RCA team are to be informed of their role and responsibilities as member of an RCA team. See [Appendix D](#) for a template letter outlining the role and responsibilities of team members.

8.2.5 Record of RCA team appointment

The statutory privilege will only apply if it can be shown that the RCA was properly constituted under the Health Administration Act. As such, it is critical that comprehensive records are prepared and retained relating to the appointment of the RCA Team including

- The original appointment of the RCA Team
- The date of appointment
- Clear identification of the incident on which the RCA is to be conducted

- The names of the RCA Team members.

8.2.6 Notification to staff involved in the incident

The RCA Team will contact staff involved to discuss the incident. A template that can be used to notify staff of the RCA team members and the roles and responsibilities of the team is available at [Appendix E](#).

8.2.7 RCA Steps

There are six key steps in undertaking an RCA

1. Simple flow charting – a process to determine what the team knows about the sequence of events and what they don't know and need to find out
2. Final flow charting – identification of relevant actions and/or inactions and the most significant points where barriers might interrupt the flow of events
3. Cause and effect – where the team defines the problem statement and identifies in sequence the elements which led to the incident
4. Causation statements – a description of the causal chain as a statement from the root cause to the incident
5. Barriers and recommendations – from the causal statements identify the barriers that would most likely prevent or mitigate the problem – then determining appropriate recommendations
6. Reporting to the DCG, CE and the Department.

8.2.8 Timeframes for RCA Process

RCA Reports must be submitted to the Department within 70 calendar days of the incident being notified in IIMS.

Suggested breakdown of timeframes for RCA process

Process	Timeframes
Incident notified in IIMS and SAC 1 incident notified to the CE and then the Department via a RIB.	Within 24 hours (as per policy see 7.1)
Appointment of RCA team by CE	12 Calendar days from date of incident notification.
Conduct RCA and team sign off	45 days from appointment of RCA Team.
CE signs off on recommendations and submit to the Department	12 Calendar days from team sign off
Total time	Within 70 Calendar Days of incident notification in IIMS

8.2.9 Incidents involving the Coroner or Police

A referral or investigation of a death to the Coroner or the Police does not affect the requirement to undertake an investigation of an incident, including, where appropriate, an RCA.

A police or coronial investigation **should not** delay the commencement of an RCA.

However, the police officer in charge of the investigation or the Crime Manager of the relevant Local Area Command should be notified of the intention to commence the RCA. Only the final RCA Report is available to the Coroner and the Police to assist with their enquiries.

8.2.10 The management of SAC1 incidents across health service boundaries

Incidents may occur in one health service but be notified through another health service when there has been a patient transfer or services provided across organisational boundaries. The management of such incidents will depend on the SAC score. It is the responsibility of each Director of Clinical Governance (DCG) to oversee the management of cross-boundary incidents.

The management process is:

- The incident is notified through the IIMS and a RIB is complete
- The authority for transfer of an incident from a health service to another and acceptance of that transfer resides with the DCGs of each organisation
- If responsibility for managing the incident is transferred to another health service this is to be reassigned in IIMS: request is to be provided to HealthTechnology helpdesk to arrange incident relocation in IIMS
- The Department is informed of action taken in regard to liaison with another health service via a RIB
- DCG of the health service with agreed primary responsibility for managing the incident is responsible for overseeing management of the incident including the RCA and informing the notifying health service of their staff's involvement in the RCA process.

On occasion, both relevant organisations may need to be involved in incident management when there are issues relevant to both parties, for example by participating in an RCA undertaken and accepting responsibility for implementation of recommendations. In that case, the incident should be copied and linked in IIMS.

RCA teams seeking to access patient health information necessary for an investigation from another Area Health Service are to receive the relevant information on request. The release of the patient health information can occur without the consent of the patient in accordance with the Health Records and Information Privacy Act 2002 and the [NSW Health Privacy Manual, Version 2](#), as it pertains to a recognised quality assurance or clinical audit activity.

8.2.11 The Final RCA report

All privileged RCA Teams must prepare a final report. This final report is not protected by statutory privilege. The report must contain:

- a description of the reportable incident
- the incident ID from IIMS
- a causation statement/s that indicates the reasons why the RCA team considers the incident occurred
- recommendations for system changes to improve procedures or practices to minimise recurrence of the incident (usually 3-5 recommendations).

The final RCA report should **not** include the name or address of an individual patient or service provider involved in the incident, unless that person has consented, in writing, to their name being disclosed

The RCA Team is also obliged not to disclose, as far as is practicable, any other material that identifies or may lead to the identification of that person.

See [Appendix F](#) for the final report template. Organisations should use this template to ensure the final report meets legislative and policy requirements.

8.2.12 Signing off on the final report

- At the end of the RCA, the RCA Team is to provide a copy of their Report (but no other documentation) to the CE.
- The CE reviews the recommendations for consideration and endorsement before the Report is submitted to the Department.
- The CE may seek clarification from the RCA team if the rationale for any recommendation is unclear
- The CE may add recommendations to the final report but this must be clearly documented.

If the CE does not agree with any of the recommendations in the final report, this is documented in the final report with the reason/s why and the proposed alternative action.

The CE may delegate the responsibility for signing off on the final report.

8.2.13 Decommissioning RCAs

The only reason for decommissioning an RCA is where the RCA team identifies individual performance issues such as professional misconduct or unsatisfactory professional conduct that may be responsible for the incident (see 8.3.3 for further information on RCA and individual conduct) and that there are no readily identifiable systems issues to consider.

The health service notifies the Department following the decommissioning of the RCA and provides the reason for the decommissioning of the RCA by completing the front page of the RCA template and submitting this to the generic Quality and Safety Branch email address quality@doh.health.nsw.gov.au

8.3 Statutory Privilege

8.3.1 What the Privilege covers

The privilege provided under the Health Administration Act 1982, applies to Team members and internal documentation prepared by them as part of the RCA.

It means

- RCA Team members cannot be compelled to produce or give evidence of any document created by, at the request, or solely for the purpose of the RCA Team OR any matter or thing which came to their attention as part of the RCA Team
- Reports of RCA Teams are not admissible as evidence in any proceedings claiming a procedure or practice was careless or inadequate
- RCA Team members acting in good faith for the purposes of an RCA Team function are also protected from personal liability, including actions for defamation.

The legislation also establishes tight confidentiality protections, making it an offence for a Team member to disclose any information obtained during the RCA outside the purposes of the RCA.

The privilege does not apply to the Final RCA report.

8.3.2 Internal Working Documents of the Privileged RCA Team

During the RCA process, the team will generate many documents, including preliminary notes, records of interviews with staff/clinicians, minutes of meetings and records of discussions with various people either involved in the incident or with fundamental knowledge about the incident or processes involved. **All this material is privileged.**

a. Storage of privileged RCA material

To protect the privilege these records are to be maintained on a separate RCA Team file marked “privileged” and stored securely in a location nominated by the Director of Clinical Governance to ensure the privilege is upheld in the event of a subpoena or FOI application. Privileged material is not to be sent in the general post but should be sent by secure internal transport processes. Health services need to have appropriate policies and procedures in place to manage the transfer of materials.

b. Retention of RCA documents related to clinical incidents

Records relating to RCAs are required to be retained under the same rules applying to *“legal matters and incident management”* under clause 1.14 of the General Retention and Disposal Authority — Public Health Services: Patient/Client Records (GDA 17). Under this requirement, where the incident does not involve legal action the RCA records must be retained for a minimum of 7 years after last action. Where the incident does involve legal action, the RCA records are to be retained for a minimum of 15 years after legal action is completed and resolved (where known) or after last contact for legal access purposes.

8.3.3 RCA and individual conduct

RCA Teams do not have authority to conduct an investigation relating to an individual providing care.

Where the RCA Team forms the opinion that an incident may involve professional misconduct, unsatisfactory professional conduct or impairment issues, they have an obligation to notify the CE in writing. See [Appendix G](#) for a template letter that may be used by the RCA Team Leader to inform the CE about an incident involving individual performance.

The CE will consider appropriate action and the RCA Team will take no further action on the individual matter. The RCA Team also has discretion to notify the CE if they consider an incident may involve other performance issues.

The RCA Team may continue to investigate the systems issues in the incident.

Under the legislation, the RCA Team is to apply the rules of natural justice to the extent they are relevant to the function of the team. This means the team has a duty to act fairly and without bias, and not to prejudge issues before them.

8.3.4 What the privilege does not cover

Statutory privilege does not cover:

- Pre- existing documents, such clinical incident summaries, medical records or other records created providing general care of patients or management of the health service, and not as part of the RCA;
- Documentation prepared and submitted to the RCA by a person who is not a Team member where it is the possession of that other person
- Information that the Team is required to report on, including any notification under section 200 of the Health Administration Act 1982 which relates to the responsibilities of the RCA team in notifying the CE of matters relating to individual conduct and the content of the report prepared at the end of the RCA
- The IIMS advanced classification of the RCA reportable incident.

The privilege does not prevent information being given to another privileged committee (for example RCA teams are entitled to give information to NSW Mental Health Sentinel Event Review Committee SERC, Special Committee investigating Deaths Under Anaesthesia, SCIDUA Special committee Investigating Deaths Associated with Surgery SCIDAWS; NSW Maternal and Perinatal Committee and the NSW Reportable Incident Review Committee (RIRC). Information provided in this way will retain privilege through the extensive protections granted to those committees.

9 Detailed investigation for Corporate SAC 1 incidents

All corporate SAC 1 incidents require a detailed investigation to be undertaken.

The Detailed Investigation Report must be provided to the Department within 70 calendar days after the incident is notified in IIMS.

Detailed investigations of corporate SAC 1 incidents do not attract the statutory privilege outlined in section 8.3.1 that applies to RCAs conducted in respect of clinical SAC 1 incidents.

Nevertheless, it is important that any serious or major corporate incident that receives a SAC 1 rating be properly investigated, so that the cause of the incident can be identified, and any appropriate remedial action is implemented to mitigate against a similar incident occurring again.

9.1 Membership of the Corporate Investigation Team

The Detailed Investigation Team should generally consist of 3 to 5 members. The members should have fundamental knowledge about the corporate processes in the area where the incident occurred, but not have been directly involved in the incident.

9.2 Steps in the Investigation

There are six key steps in undertaking the detailed investigation

1. Assessment of the incident to determine the issues, eg negligence, criminal, corruption and make initial reports if appropriate eg police ICAC
2. planning the investigation – identify scope, potential sources of information and resources required
3. Conduct interviews and collect detailed information about the incident
4. Assessing the results- once all information has been gathered, analyse the findings
5. Barriers and recommendations – identify the barriers that would most likely prevent or mitigate the problem – then determine appropriate recommendations
6. Reporting to the CE and the Department.

9.3 Timeframes for Corporate Investigation Process

Detailed Investigation Reports must be submitted to the Department within **70 calendar days** of the incident being notified in IIMS.

9.4 The Final Detailed Investigation Report

All Detailed Investigation Teams must prepare a final Report.

The Report must contain

- A description of the reportable incident
- The Incident ID from IIMS
- A causation statement/s that indicates the reasons why the Investigation Team considers the incident occurred;
- Recommendations for system changes to improve procedures or practices to minimise recurrence of the incident.

9.5 Signing off the final report

- At the end of the investigation, the Investigation Team is to provide a copy of their Report to the CE.
- The CE reviews the recommendations for consideration and endorsement before the Report is submitted to the Department.
- The CE is able to seek clarification from the Investigation Team if the rationale for any recommendation is unclear.
- The CE is also able to add recommendations to the final report but this must be clearly documented.
- If the CE does not agree with any of the recommendations then this is documented in the final report with the reason/s why and the proposed alternative action.

10 Evaluation and review

The Director of Clinical Governance is responsible for the evaluation of the Incident management system at the local level to ensure

1. the effective management of incidents that occur within health facilities
2. the effectiveness of risk mitigation strategies²
3. compliance with the CEC Quality Systems Assessment Program

The Directors of Clinical Governance are to provide a report to the Area Health Service Quality Committee on the effectiveness of Incident management within the area health service on a regular basis. This report will include a suite of performance indicators relevant to the health service including those listed below.

10.1.1 Performance Indicators

The performance indicators in this policy are:

- Submission of a Reportable Incident Brief to the Department, concerning all actual SAC 1 incidents, both clinical and corporate, within 24 hours of notification in IIMS.
- Submission of final RCA Report to the Department within 70 calendar days of incident notification in IIMS.
- Submission of Corporate final detailed investigation report within 70 calendar days of incident notification in IIMS.

The following performance indicators are to be included in the quarterly reports to the Area Health Service Quality Committee:

- Proportion of SAC 2 incident investigations completed within 28 days as monitored in IIMS or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager
- Proportion of SAC 3 and 4 investigations completed, where possible, within 28 days as monitored in IIMS or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.

[The Patient Safety and Clinical Quality Program Implementation Plan \(PD2005_609\)](#) indicators are also included in the quarterly report to the Quality Committee. These are

- Proportion of SAC 1 incidents notified where incident status = new for \leq 24hs of incident.

² NSW Patient Safety and Clinical Quality Program PD2005_608 Standard 3: “An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent reoccurrence.”

- Proportion of SAC 2, 3 & 4 incidents notified where incident status = new for ≤ 5 days of incident occurring
- Proportion of all actual SAC 2, 3 & 4 incidents where incident status = complete in ≤ 28 days.
- Proportion of RCA recommendations completed within stated timeframe
- Proportion of incidents notified which have recommendations for action entered
- Proportion of incidents notified where recommendations have been completed.

11 Definitions & terms used in this document

Area Health Services (AHS)

Organisations constituted under the Health Services Act 1997 that are principally concerned with the provision of health services to residents within a designated geographic area.

Ambulance service of NSW

The Ambulance service of NSW as defined in the Health Services Act 1997.

Apology

A key aspect of open disclosure is saying sorry or offering an apology to the patient and their family/carer following an incident. An apology is an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter whether or not the apology admits or implies an admission of fault in connection with the matter.

Clinical Excellence Commission (CEC)

A Board governed statutory health corporation established under the Health Services Act (section 11) as part of the NSW Patient Safety and Clinical Quality program. It builds on the foundation work carried out by the Institute of Clinical Excellence established in 2001. Under the Act, a statutory health corporation is established to enable certain health services and health support services to be provided within the State other than on an area basis.

Clinical Governance Units

The Clinical Governance Unit (CGU) has the role of support, performance and conformance to develop and monitor policies and procedures for improving systems of care. The CGU will contribute to the Patient Safety and Clinical Quality program by ensuring it is uniformly implemented across the state and for overseeing the risk management of patient safety and clinical quality by building upon existing incident management and investigation.

Clinician

A health practitioner or health service provider regardless of whether the person is registered under a health registration act.

Classification

The process for capturing relevant information about an incident to ensure the complete nature of the incident, including causative and contributory factors from a range of perspectives is documented and understood.

Complaint

A complaint is

1. An expression of dissatisfaction by a complainant that may have one or more associated issues
2. A concern that provides feedback regarding any aspect of service that identifies issues requiring a response.

A complaint may, for example be about policies, procedures, employee conduct, provision of information, quality of communication or treatment, or quality, access to or promptness of service. Complaints do not include requests for services or information or explanation of policies or procedures or industrial matters between health services and unions.

Complaints may be made, for example, in person, by telephone, letter, survey and in some cases through the media.

Department

The NSW Department of Health. Under the Health Administration Act 1982, The “Department” is the “Department of Health”.

Hazard

A source or situation with a potential for harm in terms of human injury or ill health, damage to property, damage to the environment or a combination of these.

IIMS

The NSW Health Incident Information Management System³.

Incident

Any unplanned event resulting in, or with the potential for, injury, damage or other loss⁴. An “**Adverse event**” is an unintended patient injury or complication from treatment that results in disability, death or prolonged hospital stay and is caused by health care management⁵. This term is not used in the policy as the more generic term “incident” is used.

Incident category

Grouping of incidents in IIMS, for example clinical, staff, visitor/contractor incidents, property, security, hazard incidents and complaints.

Incident Investigation

The management process by which underlying causes of undesirable events are uncovered and steps are taken to prevent similar occurrences⁶.

Incident Management

A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident.

³ The Incident Information Management System (IIMS) incorporates the Advanced Incident Management System (AIMS®) software application as its underlying database.

⁴ Australian Patient Safety Foundation cited in NSW Health Department. The Clinician’s Toolkit for Improving Patient Care. 2001.

⁵ NSW Health Department. The Clinicians Toolkit for Improving Patient Care. 2001.

⁶ Woloshnowych M, Rogers S, Taylor-Adams S, Vincent C. The investigation and analysis of critical incidents and adverse events in healthcare. Health Technology Assessment, 2005 9 (9): vii.

Incident type

The core issues of the incident such as a fall or medication error. There can be more than one type of incident type associated with each registered incident.

MDS

Minimum Dataset. The minimum amount of information to be captured for the incident notification to be considered completed in IIMS.

Near miss

Any event that could have had adverse consequences but did not, such as:

- Arrested or interrupted sequence: the incident was intercepted before causing harm eg wrong medication drawn up but not administered.
- Hazardous event or circumstance: the incident involved a dangerous state or the possibility of harm occurring eg torn floor coverings but no incident.

Notifier

Any member of staff of the NSW health system who enters information into IIMS of an incident or near miss, for any of the four incident categories. Consumers may notify an incident via the complaints process.

Notification

The process of entering or documenting data about an incident or near miss for any of the incident categories into the IIMS.

Open Disclosure

The process of communicating with a patient and their support person about a patient related incident.

Registered user

An authorised person nominated by the health service with registered access to the IIMS.

Reportable Incident Brief (RIB)

The method for reporting defined health care incidents to the NSW Department of Health. The RIB process encompasses clinical and corporate incidents. Clinical RIBs are created for the purpose of authorized investigation and research and are privilege under the NSW Health Administration Act 1982, For further information see PD 2006_058

Reportable Incident

An incident requiring a RIB. This includes both clinical and corporate SAC 1 incidents and also any matter that requires direct notification to the Department under existing legislative reporting requirements or Departmental policy directive. See section 5 of this policy.

Reportable Incident Review Committee

The NSW Health Reportable Incident Review Committee (RIRC) is responsible for examining and monitoring serious clinical adverse events reported to the Department of Health via Reportable Incident Briefs (RIBs)* and ensuring that appropriate action is taken. The Committee will analyse information reported to it on specific incidents and identify issues relating to morbidity and mortality that may have Statewide

implications and provide strategic direction and advice on policy development to effect health care system improvement.

The works of this Committee are subject to special statutory privilege under section 23 of the Health Administration Act. The privilege applies on and from the 14 December 2004 being the date on which the RIRC was established.

Root Cause Analysis (RCA)

A method used to investigate and analyse a clinical SAC 1 incident to identify the root causes and factors that contributed to the incident and to recommend actions to prevent a similar occurrence.

SAC 1 Reportable Incidents

A clinical SAC 1 incident requiring an RCA. See PD2005_634 Definition of a Reportable Incident – Section 20L of the Health Administration Act.

Severity Assessment Code (SAC)

A numerical score applied to an incident based on the type of event, its likelihood of recurrence and its consequence. A matrix is used to stratify the actual and/or potential risk associated with an incident ([Appendix A](#)).

Statutory Privilege according to Division 6C of the Health Administration Act 1982

Provides that documents created by an RCA team during an RCA investigation (other than the final report of the investigation team containing causation statements) cannot be disclosed, or produced in answer to a court order and provides that RCA team members are neither competent or compellable to give evidence about the RCA before a court or tribunal.

Support Person

May be an individual identified by the patient as a nominated recipient of the information regarding their care. This may include the patient's family members, partner, carer or friends. In cases of dispute between the patient's family members, partner or carer and /or friends about who should receive information the patients wishes should be paramount. Where a patient is unable to give consent, the next person responsible should be approached.

Appendix A: Severity Assessment Code (SAC) November 2005

(This matrix should be used with the NSW Health Incident Management Policy)

STEP 1 Consequences Table (For notification, consider the actual consequence or outcome using this table as a guide. The examples listed here are not exhaustive.)

		Serious	Major	Moderate	Minor	Minimum
CORPORATE CONSEQUENCE	Environment	Toxic release off-site with detrimental effect. Fire requiring evacuation	Off-site release with no detrimental effects or fire that grows larger than an incipient stage	Off-site release contained with outside assistance or fire incipient stage or less	Off-site release contained without outside assistance	Nuisance releases
	Financial	Loss of assets replacement value due to damage, fire etc > \$1M, loss of cash/investments/assets due to fraud, overpayment or theft >\$100K or WorkCover claims > \$100K	Loss of assets replacement value due to damage, fire etc \$100K-\$1M, loss of cash/investments/assets due to fraud, overpayment or theft \$10K-\$100K or WorkCover claims \$50K-\$100K	Loss of assets replacement value due to damage, fire etc \$50K to \$100K or loss of cash/investments/assets due to fraud, overpayment or theft to \$10K	Loss of assets replacement value due to damage, fire etc to \$50K	No financial loss
	Service	Complete loss of service or output	Major loss of agency / service to users	Disruption to users due to agency problems	Reduced efficiency or disruption to agency working	Services: No loss of service
	Visitors	Death of visitor or hospitalisation of 3 or more visitors	Hospitalisation of up to 2 visitors related to the incident / injury or pending or actual WorkCover prosecution	Medical expenses incurred or treatment of up to 2 visitors not requiring hospitalisation	Evaluation and treatment with no expenses	No treatment required or refused treatment
	Staff	Death of staff member related to work incident or suicide, or hospitalisation of 3 or more staff	Permanent injury to staff member, hospitalisation of 2 staff, or lost time or restricted duty or illness for 2 or more staff or pending or actual WorkCover prosecution, or threatened or actual physical or verbal assault of staff requiring external or police intervention	Medical expenses, lost time or restricted duties or injury / illness for 1 or more staff	First aid treatment only with no lost time or restricted duties	No injury or review required
CLINICAL CONSEQUENCE	Patient	Patients with Death unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management or: <ul style="list-style-type: none"> ■ Suspected suicide¹ ■ Suspected homicide² or any of the following: The National Sentinel Events <ul style="list-style-type: none"> ■ Procedures involving the wrong patient or body part ■ Suspected suicide in hospital ■ Retained instruments ■ Unintended material requiring surgical removal ■ Medication error involving the death of a patient ■ Intravascular gas embolism ■ Haemolytic blood transfusion ■ Maternal death associated with labour and delivery ■ Infant discharged to the wrong family 	Patients suffering a Major permanent loss of function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: <ul style="list-style-type: none"> ■ Suffering significant disfigurement as a result of the incident ■ Patient at significant risk due to being absent against medical advice ■ Threatened or actual physical or verbal assault of patient requiring external or police intervention 	Patients with Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management or any of the following: <ul style="list-style-type: none"> ■ Increased length of stay as a result of the incident ■ Surgical intervention required as a result of the incident 	Patients requiring Increased level of care including: <ul style="list-style-type: none"> ■ Review and evaluation ■ Additional investigations ■ Referral to another clinician 	Patients with No injury or increased level of care or length of stay

¹ Suspected suicide of a person (including a patient or community patient) who has received care or treatment for a mental illness from an Area Health Service or other PHO where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.

² Suspected homicide committed by a person who has received care or treatment for mental illness from an Area Health Service or other PHO within 6 months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation

STEP 2 Likelihood Table

Probability Categories	Definition
Frequent	Is expected to occur again either immediately or within a short period of time (likely to occur most weeks or months)
Likely	Will probably occur in most circumstances (several times a year)
Possible	Possibly will recur – might occur at some time (may happen every 1 to 2 years)
Unlikely	Possibly will recur – could occur at some time in 2 to 5 years
Rare	Unlikely to recur – may occur only in exceptional circumstances (may happen every 5 to 30 years)

STEP 4 Action Required Table

Action Required	
1	Extreme risk – immediate action required – Reportable Incident Brief (RIB) for all SAC 1 incidents must be forwarded to the DoH within 24 hours. A Privileged Root Cause Analysis (RCA) investigation must be undertaken for all Clinical SAC 1 incidents with a report being submitted to the DoH.
2	High risk – need to notify senior management. Detailed investigation required. Ongoing monitoring of trended aggregated incident data may also identify and prioritise issues requiring a practice improvement project.
3	Medium risk – management responsibility must be specified – Aggregate data then undertake a practice improvement project. Exception – all financial losses must be reported to senior management.
4	Low risk – manage by routine procedures – Aggregate data then undertake a practice improvement project.
NB – An incident that rates a SAC 2, 3 or 4 should only be reported to the DoH if there is the potential for media interest or requires direct notification under existing DoH legislative reporting requirements or NSW DoH Policy Directive.	

STEP 3 SAC Matrix

		CONSEQUENCE				
		Serious	Major	Moderate	Minor	Minimum
LIKELIHOOD	Frequent	1	1	2	3	3
	Likely	1	1	2	3	4
	Possible	1	2	2	3	4
	Unlikely	1	2	3	4	4
	Rare	2	3	3	4	4

Every incident assessed against the Severity Assessment Code Matrix should be scored separately for both their actual and potential consequence or outcome

Appendix B: Statutory Health Corporations and Affiliated Health Organisations

The following facilities are defined as “relevant health services organisations” subject to the RCA privilege provisions under the Health Administration Act 1982:

Statutory Health Corporations

Justice Health;
The Children’s Hospital at Westmead

SCHEDULE 3 Affiliated Health Organisations

Name of organisation	Recognised establishment or recognised service
Calvary Health Care Sydney Limited	Calvary Hospital, Kogarah.
Catholic Health Care Services Limited	St Vincent’s Health Service, Bathurst. Lourdes Hospital and Community Health Service (other than Holy Spirit Dubbo).
Hope HealthCare Ltd	Graythwaite Nursing Home, North Sydney. Greenwich Hospital, Greenwich. Braeside Hospital, Prairiewood. Neringah Hospital, Wahroonga.
Karitane	Child and Family health services at Carramar, Fairfield, Liverpool and Randwick.
Mercy Care Centre, Young	Mercy Care Centre, Young excluding Mt St Joseph’s Residential Care Facility.
Mercy Health Care (Newcastle) Limited	Newcastle Mater Misericordiae Hospital
Mercy Health Service Albury Limited	Mercy Health Service Albury.
Royal Rehabilitation Centre Sydney	Royal Rehabilitation Centre Sydney.
Royal Flying Doctor Service of Australia (South Eastern Section)	All services.
Royal Society for the Welfare of Mothers and Babies	Tresillian Family Care Centres at Belmore, Penrith, Willoughby and Wollstonecraft.
Sacred Heart Hospice Limited	Sacred Heart Hospice.
St Joseph’s Hospital Ltd	St Joseph’s Hospital (Auburn).
St Vincent’s Hospital Sydney	St Vincent’s Hospital, Darlinghurst Ltd
The Trustees of the Roman Catholic Church for the diocese of Lismore	St Vincent’s Community Hospital (Lismore) in respect of the day hospital, the rehabilitation unit and the community health facilities.
Uniting Church in Australia	Lottie Stewart Hospital. War Memorial Hospital (Waverley).

Appendix C: Appointment of RCA team

In accordance with Part 6C Health Administration Act 1982

I, *(insert name of Chief Executive)* in accordance with section 20M of the Health Administration Act 1982, do hereby appoint the following persons to a Root Cause Analysis Team:

Insert name, title, background, employing organisation (team leader)
 Insert name, title, background, employing organisation (team member)
 Insert name, title, background, employing organisation (team member)
 Insert name, title, background, employing organisation (team member)
 Insert name, title, background, employing organisation (team member)
 (Note –each RCA Team should have 3-5 members)

To consider and determine the root cause and contributing factors for the Clinical SAC 1 reportable incident (*insert IIMS incident ID*)

*insert summary of incident (include date)

And to prepare a report of the root cause analysis in accordance with section 20O of the Health Administration Act 1982

A root cause analysis conducted in accordance with this appointment shall be privileged in accordance with the terms of Part 6C of the Health Administration Act 1982.

(signed)

(name of CE)

(date)

Appendix D: Letter to RCA team members

DATE

INSERT NAME
 INSERT FACILITY
 INSERT ADDRESS

Dear (Insert Name)

I am writing to you to advise that in accordance with *Division 6C of the Health Administration Act 1982* and the *NSW Health Incident Management Policy*, you have been appointed to an RCA team to determine the root cause and contributing factors for the Clinical SAC 1 reportable incident (*insert IIMS ID*), as set out in the attached appointment document.

You have been selected as a member of this team because your expertise and experience is essential to the review of this incident. Other members of the team are as listed in the Appointment.

The work of the RCA team will be privileged in accordance with the Health Administration Act. This has a number of implications, of which you should be aware:

1. Restrictions on disclosure of information

You are required to maintain confidentiality in relation to your work as a member of this team, and you must not make your own record or discuss the investigation with anyone who is not part of the team, except for the purposes of exercising the function or any recommendation of an RCA team or for the purposes of preparing a report on the RCA.

2. Statutory Privilege

The internal workings of RCA Teams appointed under the Health Administration Act are *privileged*. This means:

- Members of the Team cannot be compelled to give evidence about information obtained by them as part of their work on the RCA Team;
- Members of the Team cannot be compelled to produce to court papers created by, at the request of or solely for the purposes of the RCA;
- The report of the team is not admissible as evidence in any proceedings that a procedure or practice was careless or inadequate.
- Members of the Team are protected from personal liability, including actions for defamation, provided they act in good faith as a part of the RCA team function.

Team members should be aware there are limits on the privilege:

- The privilege will **not** apply to pre-existing documents such as a notification in IIMS, or medical records or other records created for general care or management reasons;
- The privilege does not prevent release of the final report outside the organisation, to the patient or family of the patient or under the Freedom of Information Act.

3. Concerns or complaints about an individual clinician not to be investigated

The RCA team does not have any authority to investigate concerns or complaints about an individual clinician. Under the terms of the Health Administration Act, where the RCA team considers the reportable incident *may* involve professional misconduct or unsatisfactory professional or possible impairment issues it **must** notify the CE in writing.

The RCA team may, at its discretion, notify the CE if an incident may involve a performance issue of a lesser degree.

Following notification to the CE the team will take no further action on the individual matter.

4. Requirements for Final RCA Report

The final report must contain:

- the IIMS incident number;
- a description of the reportable incident;
- a causation statement; and
- recommendations for change improvement.

The final report is to be submitted to the CE on the (*insert date*)

Thank you for your participation in this important patient safety activity.

Signature
Name
Designation

Appendix E: Notification of staff involved in incident

DATE

INSERT NAME
 INSERT FACILITY
 INSERT ADDRESS

Dear (Insert Name)

Following the recent reporting of incident number xxx in the Incident Information Management System and in accordance with the Health Administration Act 1982 and the NSW Health Incident Management Policy, the XXXAHS Chief Executive has appointed a Root Cause Analysis (RCA) Team. The team will review systems and processes surrounding the incident to determine the root cause and contributing factors for the Severity Assessment Code (SAC) 1 incident (*provide a brief description of the incident*). Because of your knowledge of this incident, a member of the RCA team may contact you to arrange a suitable time to discuss the circumstances around the incident. You are entitled to have a support person with you during the interview.

For your information, the members of this RCA team are as follows

Insert name, title, background, employing organisation (team leader)
 Insert name, title, background, employing organisation (team member)
 Insert name, title, background, employing organisation (team member)
 Insert name, title, background, employing organisation (team member)
 Insert name, title, background, employing organisation (Clinical advisor)

The Health Administration Act 1982 outlines specific restrictions on and responsibilities of RCA Teams. These include

1. Restrictions on disclosure of information

Members of the Root Cause Analysis Team are required to maintain confidentiality in relation to this investigation. They must not make their own records or discuss the investigation with anyone who is not part of the team, except for the purposes of the RCA Team or for the purposes of preparing a report on the RCA.

2. Statutory Privilege

The internal workings of RCA Teams appointed under the Health Administration Act are *privileged*. This means:

- Members of the team cannot be compelled to produce to court papers created by, at the request of or solely for the purposes of the RCA;
- The report of the team is not admissible as evidence in any proceedings that a procedure or practice was careless or inadequate.
- Members of the Team are protected from personal liability, including actions for defamation, provided they act in good faith as a part of the RCA Team function.

There are limits on the privilege:

- The privilege will **not** apply to pre-existing documents such as IIMS notification classification, or medical records or other records created for general care or management reasons;
- The privilege does not prevent release of the final Report outside the organisation, to the patient or family of the patient or under the Freedom of Information Act.

3. Concerns or complaints about an individual clinician not to be investigated

The RCA Team does not have any authority to investigate concerns or complaints about an individual clinician. Under the terms of the Health Administration Act, where the RCA team considers the reportable incident *may* involve professional misconduct or unsatisfactory professional conduct or possible impairment issues it **must** notify the Chief Executive in writing.

The RCA team may, at its discretion, notify the Chief Executive in writing if an incident may involve a performance issue of a lesser degree.

Once the CE has been notified the team will take no further action on the individual matter.

If you wish to discuss this matter, further please contact

insert name, title and contact number

Thank you for your participation in this important patient safety activity.

Signature
Name
Designation

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Appendix F Final RCA Report

Area Health Service:	
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Final RCA Report

Reference Numbers (where applicable)

DoH RIB No:	IIMS No:
AHS TRIM No:	AHS File No:
RCA No:	AHS RIB No:

Incident Details

Date of Incident:

Date of Incident Notification in IIMS:

Reporting Details

Staff member/s responsible for feedback to staff / _____

Staff member/s responsible for feedback to patient/support person _____
(enter position held)

By when?

Final RCA report signed off by RCA Team on:

Date report due to CE:

Date signed by CE:

Date due to be submitted to NSW Department of Health:

Date submitted to NSW Department of Health

Date submitted to NSW Department of Health:

Notification of decommissioning of RCA

RCA decommissioned: **YES / NO**
(please select)

Reason for decommissioning: _____

Comments

Referral to other committees/agencies

SERC	<input type="checkbox"/>	Maternal/Perinatal	<input type="checkbox"/>
SCIDUA	<input type="checkbox"/>	SCIDAWS	<input type="checkbox"/>
Coroner	<input type="checkbox"/>	Other	

If 'Other' please specify: _____

Area Health Service Details

Area Health Service: _____

Contact Person: _____

Telephone Number: _____

Email Address: _____

Final RCA Report

Description of Reportable Incident

Summary of RCA Team Findings

On investigation, the RCA Team found...

Following the investigation, the RCA team (Please select the appropriate box/boxes)

- was unable to identify any root causes or contributory factors
- was unable to identify any gaps in service delivery
- identified systems improvement opportunities unrelated to the root causes / contributing factors.

For Internal use only:

<input style="width: 90%;" type="text"/>	Attached in TRIM	<input style="width: 90%;" type="text"/>	Date
<input style="width: 90%;" type="text"/>	Copied to the CEC	<input style="width: 90%;" type="text"/>	Date
<input style="width: 90%;" type="text"/>	Filed	<input style="width: 90%;" type="text"/>	File No.

Table 1 – Root Cause / Contributing Factors Table (a Legislative requirement)

Documentation of causation statements is a legislative requirement.

Each root cause displayed must be addressed in the action plan.

Describe the root cause and categorise the cause or contributing factor according to the triage cards and flip chart definitions

Where no direct causal factors have been identified, include any systems issues of concern in a separate table.

Item No.	Description (of Root Cause / Contributory factor)	Category (described in the Checklist Flip Chart for Root cause Analysis Teams)						
		Communication	Knowledge, skills and competence	Work environment / scheduling	Patient factors	Equipment	Policies / procedures	Safety Mechanisms
1								
2								
3								
4								
5								

Table 2 – RCA Team Recommendations (a Legislative requirement)
 (Insert more rows as required up to seven recommendations only)

Causation statement number ¹	Recommendation/s Description of action to be taken	Risk Classification. Eliminate, Control Accept ²	Position of person responsible for implementation Recommendation/s	Outcome measure	Completion date e.g. 3 months = 22/02/06	Management Concurrent Y/N
1						
2						
3						
4						
5						

¹ The number here relates to the numbered causation statement in **Table 1 ROOT CAUSE / CONTRIBUTING FACTORS TABLE**

² Actions can be classified as eliminating, controlling or accepting the risk. If accepting the risk, risk minimisation strategies need to be in place. Weaker actions are those that accept the risk and include redundancy/double checks, warnings and labels, new procedures and policies, new memorandums, training in absence of knowledge deficit and additional study/ analysis. Medium actions are those taken to control the risk and include checklists and cognitive aids, increased staffing, decreased workload, use of read backs, eliminating look-alikes and sound alike and eliminating or reducing distractions. Stronger actions are those taken to eliminate the risk and include simplified processes that remove unnecessary steps, standardise equipment, processes or care plans.

Table 3 – Systems improvement opportunities unrelated to the root causes / contributing factors (optional).

Item No	Description	Recommendation	Position of person responsible for implementation Recommendation/s	Outcome measure	Completion date e.g. 3 months = 22/02/06	Management Concurrence Y/N
1						
2						
3						
4						
5						

Final Sign Off

The recommendation/s from the Root Cause Analysis of the incident are endorsed/not endorsed.

Name	Title	Signature	Date
[Service Director]			
Name	Director of Mental Health Services (where applicable)		
Name			
Name			

I, _____ from _____
 (name of CE), (Area Health Service),

endorse /endorse with the following provisions/ do not endorse³ the recommendations this RCA.

(Signature) _____

Chief Executive
 Date

³ If not endorsed, please provide reasons and document revised action.

Appendix G: Sample letter informing CE of issues that may involve individual performance

DATE

INSERT NAME
INSERT FACILITY
INSERT ADDRESS

Dear (Insert Name)

I am writing to advise you that the RCA Team appointed on *(Insert date)* to investigate the Clinical SAC 1 reportable incident *(insert IIMS ID)*, has identified that the incident raises issues that may relate to individual conduct.

The RCA Team is of the opinion that the incident raises matters that may involve

- professional misconduct or unsatisfactory professional conduct
(mandatory reporting requirement)

or

- a person suffering from an impairment
(mandatory reporting requirement)

or

- unsatisfactory professional performance
(discretionary reporting)

(Please delete which ever is not relevant)

The matter is referred to you in accordance with the terms of section 200 of the Health Administration Act for appropriate action.

The RCA Team will continue to investigate the systems issues related to the incident. / The RCA Team will now conclude its investigation of this incident. *(Please delete which ever is not relevant).*

Yours Sincerely

Signature
Name
Designation
RCA Team Leader

Appendix H: Relevant NSW Health legislation, policy directives, guidelines & other resources.

Legislation <http://www.legislation.nsw.gov.au/>

Health Administration Act 1982

Health Care Complaints Act 1993

Health Services Act 1997

Health Records and Information Privacy Act 2002

NSW Health Policy Directives and Guidelines and Information Bulletins

NSW Health Policy Directives and Guidelines can be accessed at <http://www.health.nsw.gov.au/policies/index.html>

PD2005_234	<u>Effective Incident Response: Framework for Prevention and Management in the Health Workplace</u>
PD2005_206	<u>Policy on Handling Medication in NSW Public Hospitals</u>
PD2005_380	<u>Correct Patient, Correct Site, Correct Procedure Model Policy 2004</u>
PD2005_631	<u>NSW Health Plan – Counter disaster planning and coordination</u>
PD2005_203	<u>Management of Reportable Infection Control Incidents</u>
PD2005_352	<u>Coroners Cases and Amendments to Coroner’s Act 1980</u>
PD2005_493	<u>Death- Unexpected Infant – Hospital protocol</u>
PD2005_026	<u>Reporting of thefts and losses</u>
PD2005_219	<u>Reporting of Maternal Deaths to the NSW Department of Health</u>
PD2006_007	<u>Complaint or Concern about a Clinician- Management – Principles for Action</u>
GL2006_002	<u>Complaint or Concern about a Clinician- Management – Management Guidelines</u>
PD2005_409	<u>Workplace Health and Safety: Policy and Better Practice Guide</u>
PD2005_328	<u>NSW Health Policy and Procedures for Injury Management and Return to Work</u>
PD2005_314	<u>NSW Health Electronic Information Security Policy</u>
PD2005_593	<u>NSW Health Privacy Manual (Version 2) 2005</u>

PD2005_339	<u>Protecting People and Property: NSW Health Policy and Guidelines for Security Risk Management in Health Facilities</u>
PD2005_173	<u>Reporting Possible Corrupt Conduct to the Independent Commission Against Corruption</u>
PD2005_585	<u>Framework for Managing the Quality of Health Services in NSW, NSW Health 1999</u>
GL2005_062	<u>NSW Health Clinician's Toolkit for Improving Patient Care, 2001</u>
PD2005_626	<u>Codes of Conduct – NSW Health</u>
PD2006_006	<u>Deaths – Perinatal- Hospital procedures for review and reporting of perinatal deaths</u>
PD2006_009	<u>Legal matters of significance to government</u>
PD2005_105	<u>Medication Handling in Community-Based Health Services / Residential Facilities in NSW – Guidelines</u>
PD2005_109	<u>Improper Conduct – Procedures for Recruitment/Employment of Staff and Other Persons</u>
PD2006_025	<u>Child Related Allegations, charges and Convictions Against Employees</u>
PD2005_634	<u>Reportable Incident Definition under Section 20L of the Health Administration Act</u>
PD2006_026	<u>Criminal Allegations, Charges and Convictions Against Employees</u>
PD2006_070	<u>Lookback</u>
PD2006_073	<u>Complaint Management Policy</u>
GL2006_023	<u>Complaint Management Guidelines</u>
PD2007_040	<u>Open Disclosure</u>
GL2007_007	<u>Open Disclosure Guidelines</u>
PD2006_058	<u>Research and Investigation authorized under the Health Administration Act</u>
PD2006_077	<u>Data collections-Disclosure of unit record data held for research or management of health services.</u>

Other resources

[Easy Guide to Clinical Practice Improvement: A Guide for Healthcare Professionals. 2002](#)

IIMS Training Coordinator Guide

<http://internal.health.nsw.gov.au/quality/iims/projectinfo/>

[Patient Matters Manual](#)

Documentation retention and disposal

IB2005_027

[General Retention & Disposal Authority - Public Health Services: Administrative Records - GDA 21](#)

IB2004_20

[General Retention and Disposal Authority – Public Health Services: Patient/ Client Records \(GDA 17\)](#)

NSW Health Patient
Matters Manual

[Patient Matters Manual: Chapter 9 Health records and information](#)

Other Investigation resources

Contact the Internal Audit Unit of your organisation for further information.

[ICAC Fact Finder, A 20-step guide to conducting an inquiry in your organisation](#), Nov 2003.

[NSW Ombudsman, Investigating Complaints – A manual for Investigators](#)

[NSW Ombudsman, Natural justice / Procedural fairness, Fact Sheet](#), 2004.

[NSW Ombudsman, Reasons for Decisions Fact Sheet](#), June 2005

Woloshynowych, M. Rogers S, Taylor-Adams S and Vincent C, [The investigation and analysis of critical incidents and adverse events in healthcare. Health Technology Assessment 2005; Vol 9: number 19](#)