INCIDENT AND ADVERSE EVENTS POLICY

Policy Applies To

- All Mercy Hospital Staff
- Credentialed Specialists are required to indicate understanding of the incident policy via the credentialing process and adherence to the Mercy By-Laws
- Board of Directors are required to analyse summarised incident information and provide informed guidance via Quality and Risk Advisory Committee and Board of Directors meetings.

Related Standards

- Ngā paerewa Health & Disability Services Standard 2.2

Cultural Considerations:

As per above standard, "Service Providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity." Where practicable hohou te rongo will be offered as a restorative practice approach to conflict resolution.

Rationale

This policy provides a framework for managing health care incidents that ensures we continually improve the quality of services for whānau, consumers and healthcare workers. It provides a consistent way to understand and improve through reporting, reviewing and learning from all types of harm.

Mercy Hospital Incident policy is based on the following principles.

- Consumer and whānau participation
- Culturally responsive practice
- Equity
- Open communication and transparency
- Restorative practice and hohou te rongo (restorative responses)
- Safe reporting focus on system, not individuals
- System accountability
- System learning

The aim of this process is to provide a safe and inclusive environment for patients, staff, visitors, and to provide reporting, healing, learning, and system improvement.

Definitions

Adverse event: an event in which a person receiving health care experienced harm.

Always report & review events: The list of events that should be reviewed and reported, regardless of whether a consumer experienced harm.

Consumer/patient: Anyone who has used or is currently using a health & disability service or is likely to do so in the future.
Harm: Negative consequences for consumers & whānau, directly arising from or associated with plans made, actions taken, or omissions during the provision of health care, rather than an underlying disease or injury. Harm maybe.

Physical; harm that leads to bodily injury or impairment or disease.
Psychological; causes mental or emotional trauma that causes behavioural change or physical symptoms.
Cultural; marginalisation of a consumer's belief and value systems.
Spiritual; related to the impaired ability to experience meaning in life.

Hohou te rongo: Peace-making from a te ao Māori world view. This process addresses harm by restoring the mana, power, authority and tapu of people and their relationships.

Incident: an incident is an event or circumstance which could have or did result in unintended or unnecessary harm to a person, and or a loss or damage to property.

Near Miss is an event that could have had adverse consequences but did not and is indistinguishable from an actual incident in all but outcome.

Open Communication: is a transparent approach to responding to an incident that places the patient/staff member/contractor central to the response. This includes the process of open discussion and ongoing communication. An open communication approach also includes support for staff and the development of an open communication culture where staff are confident that the associated investigations will have a quality improvement outcome rather than a punitive focus.

Learning Review: A process designed to explore the system's contribution to incidents and to relate the resulting learning products to normal work operations. There are a variety of review methodologies, some examples include: Learning Review, Root Cause Analysis (RCA), London Protocol, Serious Event Analysis, Critical Systems Analysis, Yorkshire Contributory Factors Framework and Serious Incident Review. Reviews can be undertaken at different levels, depending on the adverse event (e.g.: comprehensive, concise, desk review or single aggregated review of similar events)

Restorative Practice: A voluntary process, ideally where all those affected by an adverse event come together in a safe and supportive environment, with the help of skilled facilitators, to speak openly about what happened, to understand the human impacts and to clarify responsibility for the actions required for healing and learning.
Notifiable event See Appendix 2

Severity Assessment Code (SAC): is a numerical rating which defines the severity of an adverse event and as a consequence the required level of reporting and review to be undertaken for the event

(Appendix 1: SAC rating and Triage Tool for Adverse Event reporting) *Needs to be assigned according to the consumers lived experience- impact on the consumer*

Treatment injury: is an injury occurring as a result of treatment by a registered health professional.

Whānau: The family, extended family or family group of people who are important to a person who is receiving a service. Whānau includes a person's extended family, their partners, friends, guardians or other representatives chosen by the person. The Kōrero mai initiative implemented at Mercy strives to address this issue.

Objectives

1. To ensure that there is immediate management of an incident.
   Every incident is appropriately documented, prioritised, reviewed and managed.
2. Consumer and whānau who have experienced harm will be supported to work in partnership to determine involvement in incidents.
3. Culturally responsive practice ensures receptiveness to the cultural values & beliefs of all those involved in the incident & review process.
4. Incident review process addresses inequities by ensuring access to high quality services responsive to needs.
5. Transparency and open communication are apparent throughout a review process.
6. Restorative practice is offered in circumstances where appropriate or called for.
7. Safe reporting ensures that the focus is on the system, not on individuals
8. Emphasis is on learning and continuous improvement, to support participation and learning from health care workers, patients and whanau to enable safety and identify opportunities to improve systems.
9. System accountability processes are in place to support the recognition, reporting and learning from incidents.

Implementation

1. Education

- All staff are educated on the policy and process, the need for accurate and specific documentation of incidents, the appropriate use of the electronic Incident Management System (TPSC) via Mercy Intranet and the open communication process. This is addressed during staff training, new staff orientation and at specifically targeted staff forums. All staff are also educated on the Māori and Pacific plans and how these support equity for our consumers.
- Education is provided to new staff at time of orientation on the prevention and minimisation of risk and is co-ordinated by the Health & Safety Specialist and Quality Manager.
- All credentialed specialists are instructed in Mercy Hospital's Incident and Adverse Event Policy on commencing work at Mercy. Ongoing updates are provided via Medical Advisory and E-mail communication.

- Contractors are notified via the Information Handbook for Contractors which is issued at the commencement of the contract and thereafter at contract renewal.
- Core members of staff are appropriately trained in incident review, learning reviews and restorative justice practice via HQSC online resources and by participating in relevant educational forums.
- Māori & Pacific plans are developed with appropriate external support and are operationalised through the plans leadership team, to ensure this policy meets these objectives.
- Where relevant, or desired consumers and whānau are supported to engage in the incident/event review process- SAC 1-3.

2. Reporting

Reporting of incidents /adverse events is an integral part of Mercy Hospital's legal responsibilities and quality programmes. This includes but is not limited to the following:

- Severity assessment code (SAC) 1 will be notified to the Chief Executive Officer who will escalate to the Board of Directors as appropriate. This will be done within one working day of the incident occurring.
- An initial notification (part A) of any SAC 1 or 2 or always report and review (ARR) event will occur within 30 working days of the event being notified. A review will be undertaken using appropriate review methodology.
- An anonymous final report (part B) highlighting system and learning opportunities and actions will be forwarded to HQSC within 120 working days of the event being reported to Mercy.

- ACC 45 and ACC 2152 Treatment injury forms are completed by the treating physician, as soon as possible after a treatment injury event.
- Reporting to designated agencies will occur promptly as defined by statutory/regulatory requirements.
- A monthly report of all registered incidents / events will be tabled at the Quality and Risk Advisory Committee Meeting. These will have been SAC scored and categorised to show trends. This report will be collated monthly.

3. Evaluation

- All incidents /events are risk rated, using the Severity Assessment Code (SAC) Rating and Triage Tool for Adverse Event Reporting (Appendix 1)
- All incidents/events are reviewed and where appropriate, actions are planned and developed for change of process, practice, policy and or education
- All SAC 1 and SAC 2 incidents have a full review that includes a learning review (or appropriate alternate methodology) and opportunity for restorative justice process to be undertaken, where appropriate, and development of recommendations for change of process, practice, policy and education, as relevant

- All SAC 1 & 2 incidents are reviewed with a view to escalating to the risk register
- The designated 'Responsible Manager' is responsible for ensuring the recommendations are carried out and efficacy of any change is evaluated.
- All incidents are tabled at the monthly Quality and Risk Advisory Committee meetings. Where relevant, incidents will be forwarded to IPC and / or the Medical Advisory for further review and comment
- All incidents which fulfil the mandatory reporting criteria, where relevant, will be reported to e.g.: WORKSAFE, HQSC, MOH, CARM, and Privacy Commissioner reporting
- Compliance for the above points will be monitored via audit (Annual Global Incident Management Audit)
- Support for, patients, whānau and staff involved in incidents is evaluated via restorative justice processes, (where appropriate), patient feedback, complaints process and audit
- Transparency and open communication are evident via clinical records, electronic Incident Management System (TPSC) and audit.

Associated Legislation

- Coroners Act 2006 (reprint 2020)
- Births, Deaths & Marriages and Relationships Registration Act 1995
- Health & Safety at Work Act 2015
- Health & Disability Services (Safety) Act 2001
- HQSC 2022 Code of expectations for health entities engagement with consumers & whanau
- Health Quality & Safety Commission NZ – Healing, learning and improving from harm New Zealand Health and Disability Services – National Adverse Events Reporting Policy 2023
- Aotearoa New Zealand Code of Health & Disability Consumers Rights
- Health Quality & Safety Commission. 2021. Guide to partnering with whānau following an adverse event. Wellington: Health Quality & Safety Commission. URL: www.hqsc.govt.nz/resources/resourcelibrary/guide-to-partnering-with-whanau-following-an-adverseevent/
- New Zealand Public Health & Disability Act 2000 (Part 4A repealed and replaced with New Zealand Public Health & Disability Amendment Bill 2020)
- Health Practitioners Competence Assurance Act 2003
- Accident Compensation Act 2001
- Privacy Act 2020

Associated Documents

- Mercy Hospital By-Laws for Credentialed Specialists
- Hazard Management Policy
- Section 7, In-house Rules, Human Resources Manual

- Terms of Reference Quality and Risk Committee
- Terms of Reference Health and Safety Representatives Committee
- Information Handbook for Contractors
- Risk Management Policy
- Absence Management Policy
- ACC Elective Surgery contract; All Southern Cross contracts
- Complaints Policy
- Cultural Policy
- Māori Plan
- Pacific Plan

Te Ara Hohou Ronga (The Path to Peace) Māori Conceptualisations of Inter-group Forgiveness

Appendices

1. Severity assessment code (SAC) Rating and Process Tool for Adverse reporting (HQSC 2023)
2. Serious Harm Definition of notifiable events.
3. Incident Management Workflow
4. Just Culture Flow Chart
5. Five Why's Tool
6. National Adverse Events Policy
7. Always Report and Review List
8. HQSC Learning Review Report Template
9. Shared Learning Tool for Learning from Harm
10. Terms of Reference for Learning Review
11. Healing, Learning and Improving from Harm National Adverse Events Policy
12. Policy Implementation Template
13. Healing, Learning and Improving from Harm Poster
14. SAC Examples – Healthcare Associated Infection
15. Incident Management Process