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
- EQuIP Standard 2.1 Criterion 2.1.3.

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."

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, transparency & open disclosure
- 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 may be;

> **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 Disclosure (OD) / 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 OD approach also includes support for staff and the development of an OD culture where staff are confident that the associated investigations will have a quality improvement outcome rather than a punitive focus.

Review (Learning): A process designed to explore the system contribution to incidents and to relate the resulting learning products to normal work operations. There are a variety of review methodologies, some examples include: 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

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 ensure 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 disclosure 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 disclosure 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 Co-ordinator.
- 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 on line 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 2 incidents are reviewed using a learning review process
- 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, whanau and staff involved in incidents is evaluated via restorative justice processes, (where able), patient feedback, complaints process and audit
- Transparency and open disclosure is 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

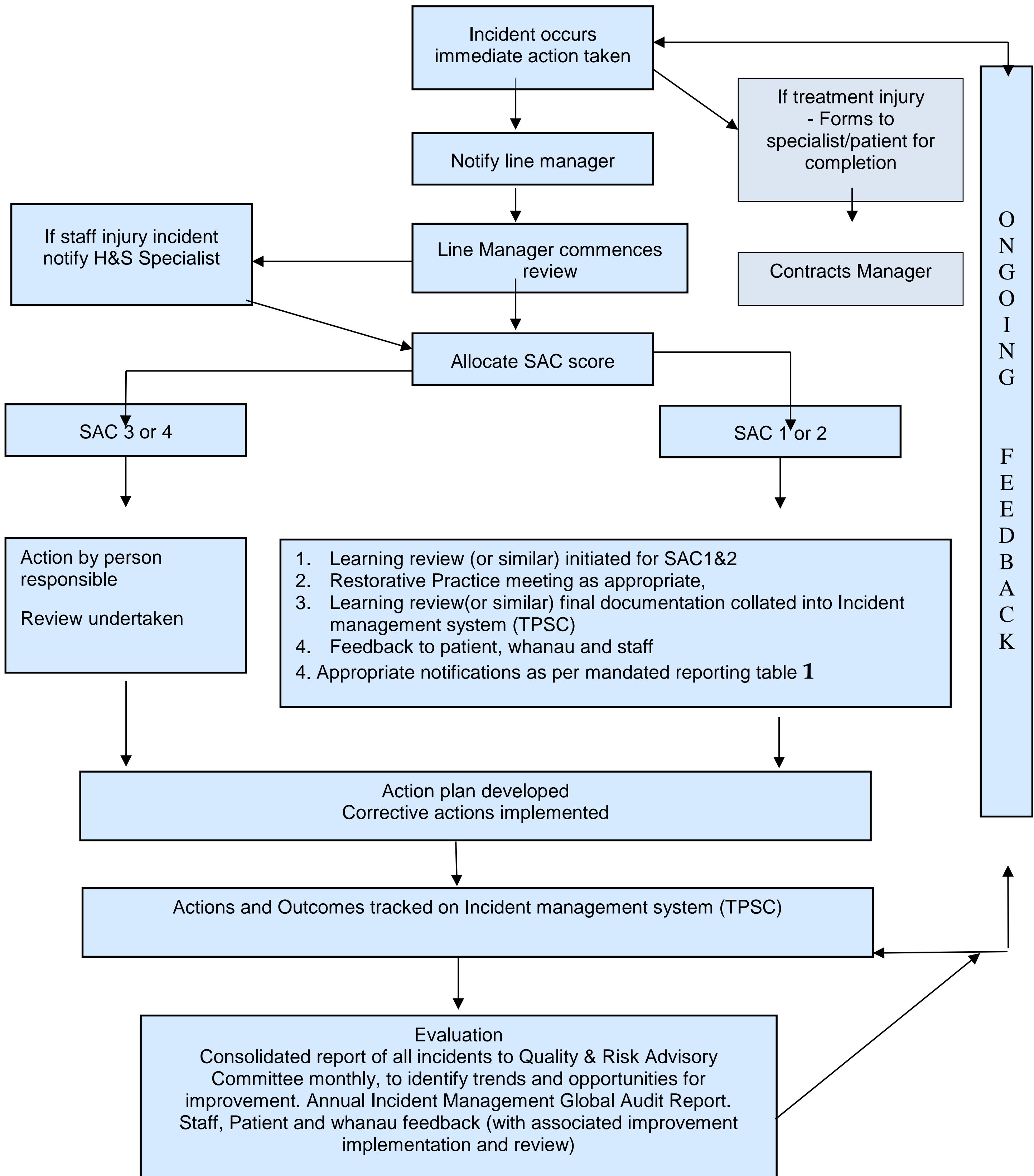
- Health & Disability Services (Safety) Act 2001
- HQSC 2022 Code of expectations for health entities engagement with consumers & whanau
- Health Quality & Safety Commission NZ – Healing, learning and improving from harm New Zealand Health and Disability Services – National Adverse Events Reporting Policy 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
- Maori Plan
- Pacific Plan

Appendices

1. Severity assessment code (SAC) Rating and Triage Tool for Adverse reporting (HQSC 2023)
2. Notifiable event
3. Incident Management Workflow and Process Just culture – Duties, Outcomes and Flowchart (4)


Incident occurs
immediate action taken
Notify line manager
If treatment injury
- Forms to
specialist/patient for
completion
Contracts Manager
If staff injury incident
notify H&S Specialist
Line Manager commences
review
Allocate SAC score
SAC 3 or 4
SAC 1 or 2
Action by person
responsible
Review undertaken
1. Learning review (or similar) initiated for SAC1&2
2. Restorative Practice meeting as appropriate,
3. Learning review(or similar) final documentation collated into Incident management system (TPSC)
4. Feedback to patient, whanau and staff
4. Appropriate notifications as per mandated reporting table 1
Action plan developed
Corrective actions implemented
Actions and Outcomes tracked on Incident management system (TPSC)
Evaluation
Consolidated report of all incidents to Quality & Risk Advisory
Committee monthly, to identify trends and opportunities for
improvement. Annual Incident Management Global Audit Report.
Staff, Patient and whanau feedback (with associated improvement
implementation and review)
ONGOING FEEDBACK

Incident management Process

1. Identification
2. Immediate action
3. Notification
4. Prioritisation
5. Investigation
6. Classification
7. Analysis
8. Improvement Action
9. Feedback
10. Evaluation

1. Identification

- Incidents
- Adverse events; Never events
- Near miss events: identification and reporting of all accidents or near-miss incidents which lead to, or could have led to harm — to determine if they were caused by a significant hazard or serious risk
- ACC treatment injury
- Complaints process (in this case the person dealing with a complaint must bring the complaint to the attention of the relevant member of the Executive and it is dealt with as both a complaint and an incident),
- Patient comments via Cemplicity, verbal or other
- Staff Feedback
- Consultant feedback
- Audits
- Staff meetings
- Team discussion

Once an incident has been identified by a person, the online Incident management system (TPSC) is activated via 'log an incident' on the Mercy intranet (My Mercy – no log-in required).

2. Immediate Action

Immediate action may need to be taken to mitigate the harmful consequences of the incident. This includes appropriate clinical care and support for the person(s) involved.

3. Notification required for all Incidents, Near Miss, and Adverse events

Incident notification- by the notifier (Staff)

In the event of a serious harm incident to a staff member or contractor, where possible the scene of the incident should be secured by the person in charge of the area. The appropriate Executive member or Executive on call must be notified so that WORKSAFE can be notified accordingly. (WORKSAFE can be notified online - see appendix 2)
http://www.business.govt.nz/worksafe/notifications-forms/accident-serious-harm

For notifiable event incidents that involve patients the above notification also applies.

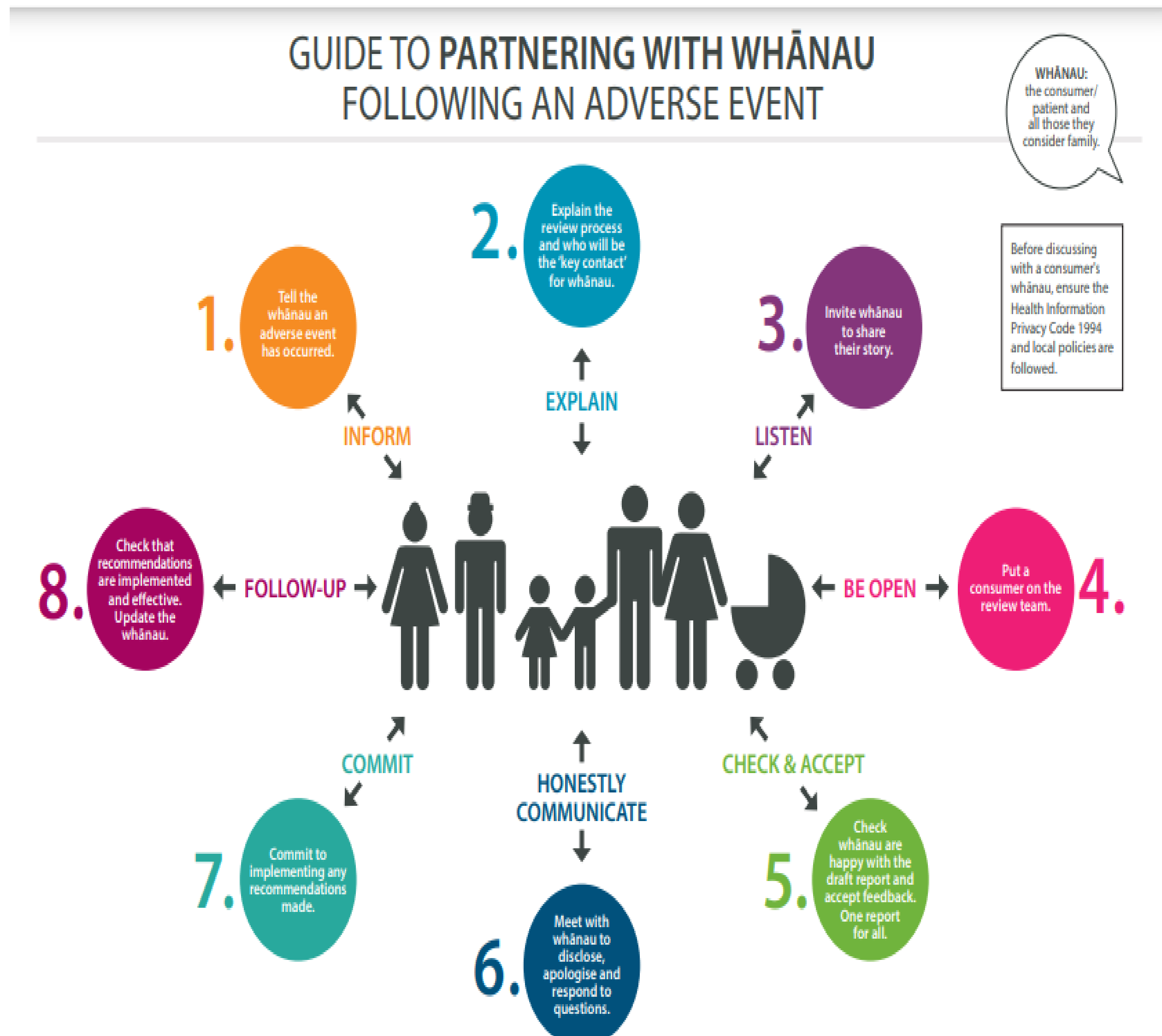
Incident notification - by the notifier (Patient)

Notification of an incident may be made on the Mercy Hospital Compliments & Concerns form and given to the appropriate Line Manager or be sent to Reception, via Cemplicity, email or by phone

Incident notification – by the Manager

Completed on the Incident Management on line System (TPSC)

Informing and involving the Patient



Transparency and open disclosure is a right under the Code of Health & Disability Services Consumers Rights 1996.

- Open communication (open disclosure) refers to the timely and transparent approach to communicating with, engaging with and supporting patients and their whānau when an adverse event occurs.
- Restorative Practice meeting supported as appropriate/desired
- Care must be taken to avoid pre-empting any investigation or jumping to conclusions about cause.

- Communication will include acknowledgment of the incident, an explanation of what happened, how it happened and where appropriate what actions have been taken. A disclosure must also include a sincere apology. The patient will be given details about the local H&D consumer advocate as well as options for making a complaint. (**available at all Reception areas**)
- Where appropriate, patient require assurance that they may be entitled to compensation under ACC. (**ACC Treatment injury forms are kept in the Director of Clinical Services and Contract Manager's offices**) If the forms are given out by staff the number on the ACC 45 plus patient details must be forwarded to the Contracts Manager.
- The health professional with overall responsibility for the patients care will usually communicate about the incident.
- The communication must take place in a private room as soon as is practicable following the incident, taking into account whether the consumer is medically stable enough to understand the information. Communication will generally be with the individual patient and whānau / support people the consumer wishes to be present. In circumstances where discussion with the patient is not possible or appropriate, their next of kin, designated contact person or representative should be informed.
- Documentation of the conversation and any subsequent action, must be recorded in the patients clinical notes.
- It is important to note that open disclosure is not a single conversation, but a process of ongoing communication.
- Appropriate consideration must be given to the patients cultural customs as well as any special needs the person may have.
- One contact person must be identified for the patient to communicate with, in order to ensure all information is available and current.
- Support for the staff member undertaking the disclosure is integral to ensuring that open disclosure is the norm using restorative process
    a. Deciding who should attend (a senior colleague accompanying a staff member for the disclosure may be helpful)
    b. Good pre planning in terms of content
    c. Anticipating patient and family / whānau needs
    d. Education about open communication / disclosure for staff
- Additional support for the health professional or staff member will be available from their Line manager or member of the Executive and through employee assistance programme – Vitae (EAP).

Incident Notification to Executive

All SAC 1 incidents must be reported to the appropriate Executive member or Executive on call as soon as possible

Notification to Central Agency

SAC 1 and SAC 2 incidents are required to be reported to the Health Safety Quality Commission

Mandated reporting Table 1

Event related to	Reported to
Adverse Clinical Events (SAC 1 & SAC 2 + Never events)	Health Quality & Safety Commission
Misadministration of radioactive materials	National Radiation Laboratory
Electricity related incidents causing injury, death or electronically initiated fires	Energy Safety Service, Ministry of Consumer Affairs
Gas accidents	Energy Safety Service, Ministry of Consumer Affairs
Serious issues involving quality of medicines	Compliance Team at Medsafe, Ministry of Health ? Pharmac
Medical devices that caused or could have caused injury to the patient or device user	Pharmac
Serious harm to patients	Ministry of Health; Health Quality Safety Commission
Deaths	Coroner and Ministry of Health
Public health emergencies	Ministry of Health
Communicable diseases	Ministry of Health
Treatment Injury	ACC, Southern Cross (if insurer)
Nursing Competency/Health issues	Nursing Council of New Zealand
Anaesthetic Tech Competency/Health Issues	Medical Sciences Council
Physiotherapist Competency/Health Issues	Physiotherapy Board
Occupational Therapist Competency/Health Issues	Occupational Therapy Board
Dietician Competency/Health Issues	Dieticians Board
Privacy breach	Privacy Commissioner (from Dec 1st 2020)

4. Prioritisation

All incidents must be prioritised, to ensure that the appropriate action is taken on each incident. This is undertaken using SAC scoring (online TPSC). The score must be assigned at the notification and re-assessed following completion, by rating the actual outcome.

5. Review

All incidents notified will be reviewed by an Executive member

SAC 1 and SAC 2 must be reviewed by staff trained in appropriate methodology e.g.: Learning review Root Cause Analysis; London Protocol. Review team to include a Consumer where able.

Key points of concern identified by the patient should ideally be recorded via a Restorative practice meeting

The report must include an action plan that includes recommendations for change of system, process or practice, as appropriate.

All SAC 1 and SAC 2 events must be reported to HQSC
Part A within 30 working days
Part B within 120 working days
All reviews will sit in a central repository.

SAC 3 & SAC 4

The review of these incidents will be undertaken at a ward and department level by the appropriate Clinical Nurse Manager, Line Manager/Team Leader/Associate Charge Nurse.
Staff involved will be encouraged to utilise the '5 whys' model documented in the investigation stage of the Incident Management System (TPSC)

If the incident / event is on the Always Report and Review list i.e.:

Wrong blood component

Actual or near-miss transfusion of ABO-incompatible red cells.

Wrong site

A procedure/intervention performed on the wrong site (e.g., wrong knee, wrong eye, wrong level spinal surgery, wrong limb, wrong tooth or wrong organ); the event is detected at any time after the start of the procedure/intervention.

- Includes interventions that are considered surgical but may be done outside a surgical environment. For example, wrong site block (unless being undertaken as a pain control procedure), biopsy,

interventional radiology procedures, cardiology procedures, drain insertion and line insertion (e.g., peripherally inserted central catheter (PICC)/Hickman lines).
- Includes events where the wrong site surgery is due to incorrect laboratory reports/results or incorrect referral letters.
- Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the consumer's anatomy. This should be documented in clinical notes.

Wrong implant/prosthesis

Surgical placement of the wrong implant or prosthesis where the implant/prosthesis placed in the consumer is other than that specified in the surgical plan; the event is detected at any time after the implant/prosthesis is placed in the consumer.

- Excludes where the implant/prosthesis placed in the consumer is intentionally different from the surgical plan, where this is based on clinical judgement at the time of the procedure. This should be documented in clinical notes.
- Excludes where the implant/prosthesis placed in the consumer is intentionally planned and placed but later found to be suboptimal.

Retained foreign object post procedure

- Retention of a foreign object in a consumer after a surgical/invasive procedure.
- Includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside the surgical environment (e.g., central line placement in ward areas, procedures performed in 'rooms-based' and outpatient settings).
- Excludes items inserted during a procedure that are subject to the counting/checking process but are intentionally retained after completion of the procedure, with removal planned for a later time or date. This should be documented in clinical notes. If these items are not subsequently removed at the planned date, this would become an 'always report and review' event.
- Excludes items that are known to be missing before the completion of the procedure and may be inside the consumer (e.g., screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or more damaging than retention. This should be documented in clinical notes.

Wrong consumer

Any invasive procedure/investigation performed on the wrong consumer; the event is detected at any time after the start of the procedure/investigation.

- Includes radiology imaging and invasive procedures (such as biopsy, endoscopic procedures, cardiology procedures).

Child/infant abduction or discharge to wrong whānau

Includes all events regardless of time absent from area or successful return.

Unconsented treatment

- Seclusion while not subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- Electroconvulsive therapy (ECT) without consent and not subject to section 60 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Ref: Always Report and Review list 2021–22 | Health Quality & Safety Commission (hqsc.govt.nz)

Following review of individual incident forms, it may be more beneficial to investigate common incident types and develop an action plan.
This level of review might identify:

- System issues that need to be addressed
- Appropriate quality improvement action to prevent recurrence where possible
- Review must be completed within timeframe nominated (as per Mercy reporting requirements – generally within 28 days)Timeframes monitored via TPSC
- Monthly trending may also identify and prioritise issues requiring improvement. This is monitored and discussed. E.g.: at the Quality and Risk Advisory or at the Medicines Committee.

6. Classification

All incidents must be classified into categories to ensure accurate identification of hazards and risks, to enable the development of appropriate risk management strategies, to decrease likelihood of harm.

7. Analysis

All patient incidents will be classified, trended according to this classification and presented to the Quality and Risk Advisory Committee for further review on a monthly basis. All patient incidents will be coordinated by the Quality Coordinator and staff incidents by the Health & Safety Coordinator

8. Improvement Action

The implementation of recommendations from any review must include:

- Responsibility for accepting the recommendations for SAC 1 & SAC 2, which sits with the Quality and Risk Committee.
- Resource approval for these recommendations sits with the Executive.
- Responsibility for actioning the recommendations for SAC 3 & SAC 4 sits with the appropriate line Manager/Team Leader/Clinical Coordinator.
- A timeframe must be nominated in all action plans.
- Those responsible for actions must be identified and held accountable for the action.

Those responsible for the action must report on their implementation and must put in place a mechanism for evaluation of the action at a date no later than 6 months following implementation.

9. Feedback

Feedback on the investigation, recommendations and implementation will be shared with those involved in the original incident including patients, staff, and Credentialed Specialists. The level of the incident (SAC rating) will dictate who gives the feedback.

SAC 3 & 4 will be notified by a link to the completed form, via Mercy email.
SAC 1 & 2 feedback will be provided by those involved in the incident review.

10. Evaluation

Evaluation of effectiveness of measures implemented will be via:

- Audit
- Incident trends / reports via TPSC reports
- Analysis and review of incident themes
- Non recurrence of incidents/review of further incidents
- Staff/patient feedback