Policy Applies To

- All Mercy Hospital Staff
- Credentialed Specialists and Allied Health Personnel 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

- Health & Disability Sector Standard 2.4 Criteria 2.4.1, 2.4.2, 2.4.3, 2.4.4
- EQuIP Standard 2.1 Criterion 2.1.3.

Rationale

Mercy Hospital manages health care incidents to ensure improvements to the systems of care are patient / whanau focused.

Mercy Hospital Incident policy is based on the following principles;

- Transparency and open disclosure
- Openness of incident reporting i.e.: seeing events as opportunities to improve our understanding of risk
- Focus on systems, not individuals
- Emphasis on learning and continuous improvement
- Obligation to act
- Accountability
- Fairness
- Appropriate prioritisation of action

The aim of this process is to provide a safe and inclusive environment for patients, staff, visitors, and all others involved in the provision of services at Mercy Hospital.

Definitions

Adverse event: an event with negative or unfavorable reactions or results that are unintended, unexpected or unplanned.
In practice this is most often understood as an event which results in harm or has the potential to result in harm to a consumer.

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. A near miss may occur when a chain of events is interrupted.

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: is another name for a formal process that is carried out by the health or disability service provider to analyse an adverse event or near miss and develop recommendations based on the findings. 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)

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)

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

Objectives

1. To ensure that there is immediate management of an incident when required and that every incident is appropriately documented, prioritised, reviewed and managed

2. To ensure that the appropriate process is undertaken for the review of all incidents, near miss and adverse events

3. To ensure transparency of approach when responding to an incident that places the consumer /staff member central to the response. This includes the process of open disclosure and ongoing communication with the consumer/staff member and their support person(s)

4. To create "a just culture" where it is safe to report incidents and where a systems approach to incidents and investigation is used (Appendix 4)

5. To identify opportunities to improve the quality of care through ensuring the **Incident system** is a planned and co-ordinated process that links to the quality and risk management system

6. To minimise risk and prevent future incidents through development of appropriate action plans, recommendations and review

7. To meet statutory and/or regulatory requirements through informing staff of their responsibilities in relation to essential notification reporting and ensuring the correct authority is notified in an accurate and timely manner by the organisation

8. Ensure integration of complaints, patient feedback, staff feedback, credentialed specialists and allied health personnel feedback where appropriate

9. Ensure credentialed specialists and allied health personnel meet contractual obligations through reporting of treatment injury events.

Implementation

1. Education

- All staff are educated on the Incident 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.

- 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 Coordinator and Quality Co-ordinator.

- All credentialed specialists and allied health personnel are instructed in Mercy Hospital's Incident 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 via HQSC on line resources and by participating in relevant educational forums.

2. Reporting

Reporting of incidents /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.

- ACC45 and ACC 2152 Treatment injury forms completed by treating physician as soon as possible after the 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 and placed on the staff café noticeboard, in the communication book in the Theatre tearoom and in the Manaaki staff noticeboard. Staff incident reports will be also be reported at the monthly Health & Safety Representatives meetings.

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 incidents have a full review that includes root cause analysis (or appropriate alternate methodology) and development of recommendations for change of process, practice, policy and education as relevant.

- All SAC 2 incidents are reviewed using appropriate methodology / tools.

- The designated 'Responsible Manager' is responsible for ensuring the recommendations are carried out and efficacy of any change is evaluated.

- All SAC 1 & 2 incidents are reviewed with a view to escalating to the risk register.

- All SAC 1 & 2 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 and Privacy Commissioner reporting.

- Compliance for the above points will be monitored via audit (Annual Global Incident Management Audit).

- Support for consumers, patients and staff involved in incidents is evaluated via patient feedback, complaints process and audit.

- Transparency and open disclosure is evident via clinical records, electronic Incident Management System (TPSC) and audit.

Associated Legislation

- Health Act 1956 reprint 2010
- 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
- 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

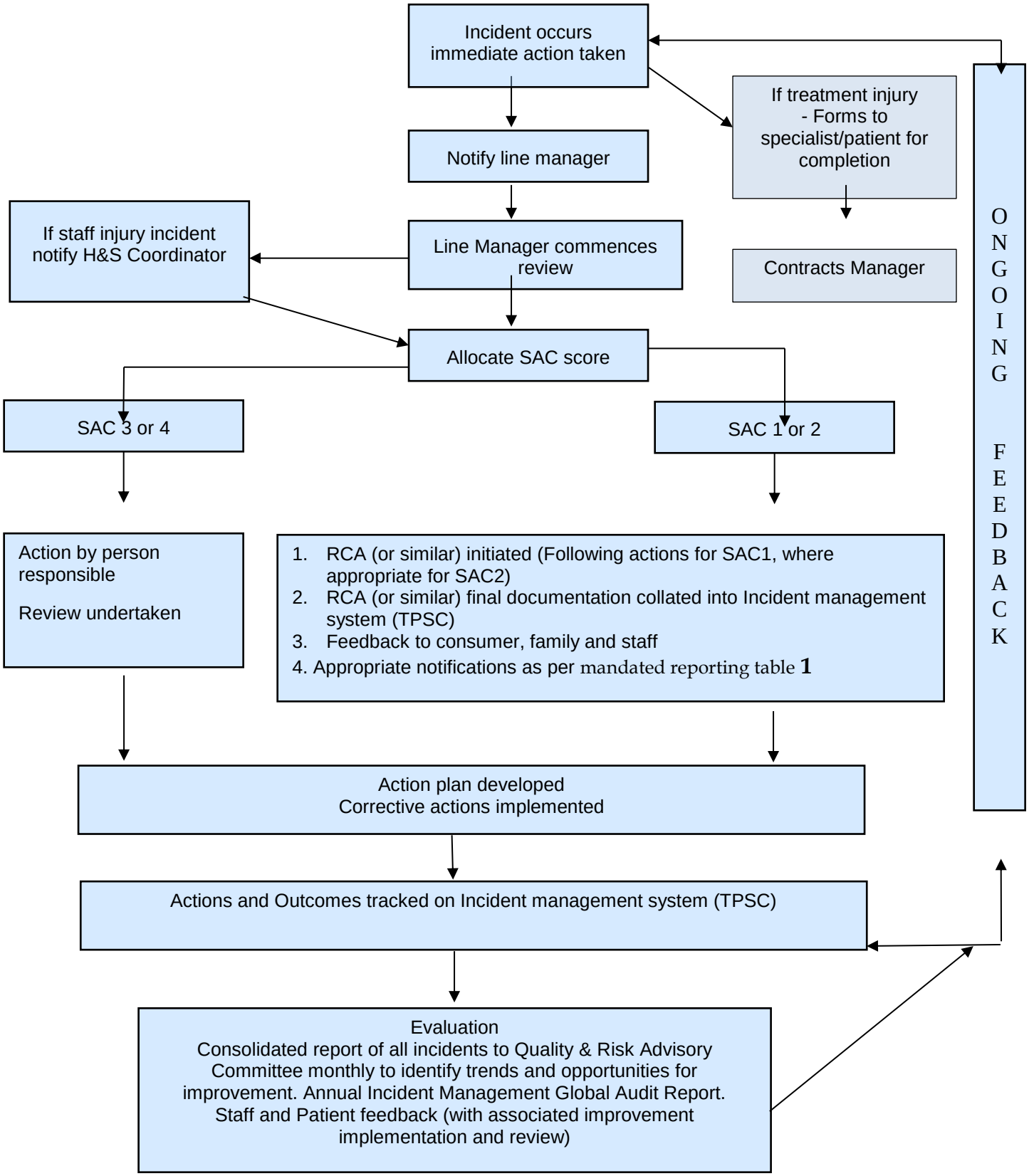
Associated Documents

- 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
- Health Quality & Safety Commission NZ - New Zealand Health and Disability Services – National Adverse Events Reporting Policy June 2017
- Risk Management Policy

- Absence Management Policy
- ACC Elective Surgery contract; All Southern Cross contracts

Appendices

1. Severity assessment code (SAC) Rating and Triage Tool for Adverse reporting (HQSC June 2017)
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 Coordinator
Line Manager commences review
Allocate SAC score
SAC 3 or 4
SAC 1 or 2
Action by person responsible
Review undertaken
1. RCA (or similar) initiated (Following actions for SAC1, where appropriate for SAC2)
2. RCA (or similar) final documentation collated into Incident management system (TPSC)
3. Feedback to consumer, family 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 and Patient 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 Patient Feedback form
- Staff Feedback
- Consultant/Allied health feedback
- Audits
- Staff meetings
- Team discussion

Once an incident has been identified by a person, the on line Incident management system (TPSC) is activated via 'log an incident' on the Mercy intranet (useful links – 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 on line - 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.

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 consumers and their whanau when an adverse event occurs.
- 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 consumer 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 consumer's 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 consumer and whanau / support people the consumer wishes present. In circumstances where discussion with the consumer is not possible or appropriate, his or her next of kin, designated contact person or representative should be informed.

- Documentation of the conversation and any subsequent action must be recorded in the consumer's 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 consumer's cultural customs as well as any special needs the person may have.
- One contact person must be identified for the Consumer 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:
    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 / whanau 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 Staff assistance programme (SAP).

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
Notifiable event to employees/patients/contractors	WORKSAFE
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
Medical devices that caused or could have caused injury to the patient or device user	Compliance Team at Medsafe, Ministry of Health
Explosive events	Dangerous Goods Inspector
Serious harm to patients	Ministry of Health; Health Quality Safety Commission
Deaths	Coroner
Deaths	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 (on line 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

SAC1 and SAC2 must be reviewed by staff trained in appropriate methodology e.g.: Root Cause Analysis; London Protocol.

Key points of concern identified by the consumer must be recorded.

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 15 working days
Part B within 70 working days
All reviews will sit in a central repository.

SAC3 & SAC4

The review of these incidents will be undertaken at a ward and department level by the appropriate Line Manager/Team Leader/Clinical Coordinator.
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 administration of incorrect, incompatible or contaminated blood product.

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 of 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 patient'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/patient 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/patient.
• Excludes where the implant/prosthesis placed in the consumer/patient 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/patient is intentionally planned and placed but later found to be suboptimal.

Retained foreign object post-procedure:
Retention of a foreign object in a consumer/patient after a surgical/invasive procedure.
• Includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of 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 prior to the completion of the procedure and may be within the consumer/patient (e.g., screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention. This should be documented in clinical notes.

Wrong consumer/patient:
Any invasive procedure/investigation performed on the wrong consumer/patient; the event is detected at any time after the start of the procedure/investigation.
• Includes radiology and invasive procedures (such as biopsy, endoscopic procedures, and cardiology procedures).

Child/infant abduction or discharge to wrong whanau / family:
• Includes all events regardless of time absent from area or successful return.
(Ref:https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/National_Adverse_Events_Policy_2017/Always_Report_and_Review_list_2017-18_FINAL.pdf)

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)
- Monthly trending may also identify and prioritise issues requiring improvement.

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 SAC1 & SAC2 which sits with the Quality and Risk Committee
- Resource approval for these recommendations sits with the Executive
- Responsibility for actioning the recommendations for SAC3 & 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 consumers, staff, Credentialed Specialists and Allied health personnel. 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
- Non recurrence of incidents/review of further incidents

Staff/patient feedback.