Clinical Incident Policy and Procedure

Policy Statement

This policy outlines CheckUP's principles regarding clinical risks and clinical incidents, including that of open disclosure, as well as a consistent process for the management of incident reporting and risk management.

Purpose and Background

CheckUP has a commitment to ensuring the identification and management of clinical risks and incidents is an integral part of business practice and quality management and is in keeping with its Clinical Governance and Risk Management Frameworks.

This *Clinical Incident Policy and Procedure* has been developed to:

- increase the safety of services provided by contracted organisations,
- decrease the likelihood of harm to recipients of these services, and
- reduce organisational risk.

This *Clinical Incident Policy and Procedure* and the *Clinical Incident Report Form (F034),* are designed to provide a structured and consistent process, based on best practice to identify, prevent, manage and investigate clinical incidents in a timely manner, and act to improve future services based on the outcomes of the clinical incident investigation.

In addition, CheckUP is committed to a culture of reporting and open disclosure, both within its own organisation and contracted service providers.

Scope of Policy

This policy applies to all CheckUP employees and contracted organisations.

Related Documents

- CheckUP Risk Management Framework
- CheckUP Clinical Governance Policy
- CheckUP Clinical Governance Framework
- CheckUP Clinical Incident Report Form
- CheckUP Clinical Incident Register
- CheckUP Open Disclosure Policy
- CheckUP Feedback Policy and Procedure
- CheckUP Health Information Management Policy
- CheckUP Privacy Policy
- CheckUP Child Safety and Wellbeing Policy
- The Australian Charter of Health Care Rights (2nd edition, 2019)

Definitions

Clinical Incident

A clinical incident is defined by the Australian Commission on Safety and Quality in Health Care (ACSQHC, 2017) [1]as "an event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a person and/or a complaint, loss or damage".

A clinical incident can be related to safety, usability, technical, and privacy and/or data security issues. Clinical incidents can be identified by any stakeholder in the healthcare process

including employees of organisations CheckUP funds, CheckUP employees, consumers, and carers.

Clinical incidents relating to privacy and/or data security are to be processed in accordance with CheckUP's *Data Breach Response Plan* and are to be recorded in the *Data Breach Incident Register.*

Clinical incidents relating to child safety are to be processed in accordance with *CheckUP's Child Safety and Wellbeing Policy .*

This policy also recognises that non-clinical incidents resulting from interactions with consumers may also result in adverse effects on consumers. CheckUP manages these consumer interaction incidents in the same manner and with the same seriousness as clinical incidents.

Examples of non-clinical incidents relevant under this policy include:

- an administrative error or customer interaction relating to a consumer that may cause consumer harm, distress, is not reflective of a quality service, and/or is not patient centred.
- an interaction between a consumer and an employee or contracted service clinician with insufficient qualifications or experience to effectively manage the queries or information
- allegation or suspicions of criminal conduct or fraud by a contracted service employee or clinician, in relation to client care that may have resulted in patient harm or may include issues around child safety.

CheckUP Incident Management Principles:

1. Commitment to respond in a timely manner to clinical incidents
2. A just culture and open disclosure, with a focus on quality improvement

Severity Assessment Codes

CheckUP uses a Severity Assessment Code (SAC - Queensland Health 2017), to distinguish between levels of severity of clinical or consumer interaction incidents in order to determine the most relevant and appropriate responses required. The table below outlines the SAC Code definitions, level of incident severity and actions required.

Table 1 – Severity Assessment Codes (SAC)

Severity Assessment Code	Severity of incident	Description	Action
SAC 1 - Critical clinical incident or consumer interaction incidents	**Very high**	Death or likely harm that is not reasonably expected as an outcome of health service delivery or consumer interaction. Also called reportable or sentinel events. i.e., incorrect procedure being performed on the incorrect person or body part, retained instrument, stillbirths, haemolytic blood transfusion reaction, medication error resulting in serious harm or death, release of a child to an unauthorised person, suicide as a result of inpatient care or under a mental health services care, and incorrect ortho-naso gastro tube placement resulting in harm.	Requires immediate referral to the CEO or CEO's delegate for urgent action. *Clinical Incident Report* to be completed initially by the staff member identifying incident as best as possible. This is then forwarded with details to the Clinical Governance Advisor for further investigation but which may require external expert clinical or legal advisors (at CEO's or CEO's delegate's request) who are engaged to prepare a more comprehensive investigation action plan and investigation report for the CEO's or CEO's delegates review and action. Documentation in the *Clinical Incident Register* and ensure there are immediate changes to current controls and/or prevention strategies. Improvements to future processes also recorded in the *Quality Improvement Process (QIP) Register.* Delegate must ensure incident log remains active until action plan and all recommendations are complete. May require referral to Media and Communications team, and/or legal advice, and/or insurer.

			All confirmed SAC 1 incidents reported to the Clinical Governance Advisory Group, Finance and Risk Management (FARM) Committee and the CheckUP Board. Ensure all SAC1 events are reported to the relevant state authority by the CheckUP contracted agency.
SAC 2 - Moderate clinical or consumer interaction incidents	**Moderate**	Temporary harm that is not reasonably expected as an outcome of health service delivery or consumer interaction. i.e., incorrect procedure being performed on the incorrect person or body part causing temporary harm, surgical procedure causing temporary harm.	*Clinical Incident Report* to be completed by staff member identifying incident/issue. The risk is referred to the CEO's delegate and the Clinical Governance Advisor for an investigation, and risk management plan. Incident documented in the *Clinical Incident Register*. Incident requires immediate changes to current controls and/or prevention strategies. Clinical Governance Advisory Group (subgroups) may be consulted if process change or expert guidance required. Improvements to future processes also recorded in the *QIP Register*. Delegate must ensure incident log remains active until action plan and all recommendations are complete.

SAC 3 – Minor clinical or consumer interaction incidents.	**Low**	Temporary and minimal harm event that is not reasonably expected as an outcome of health service delivery or consumer interaction. Where an incident has resulted in no or minimal harm it is given a category rating of SAC 3 i.e., first aid treatment may be required.	*Clinical Incident Report* to be completed and forwarded to the Clinical Governance Advisor. Generally resolved at the local level by CheckUP's General Managers, Clinical Governance Advisor or delegate, and possibly the CEO's delegate. Details recorded in the *Clinical Incident Register* with localised action taken. Any organisational systems improvements also recorded in the *QIP Register*. Delegate must ensure incident log remains active until action plan and all recommendations are complete.
SAC 4 no harm or near miss.	Zero	An incident which could have, but did not, result in harm, either by chance or through timely intervention. i.e., out of date medication was identified before use, correct procedure prevented more serious harm.	Consider analysis – to gain learning from how incidents can be prevented, or acknowledge if current procedures successfully managed, prevented or minimised more serious harm from occurring. *Clinical Incident Report* to be completed and forwarded to the Clinical Covernance Advisor. Details recorded in the *Clinical Incident Register.*
Consumer complaint or negative feedback not considered a clinical incident.	N/A	No harm to clients or family but issue reflects where a systems' issue could be	Generally resolved at the local level with CheckUP staff and possibly the Clinical Governance Advisor, if required.

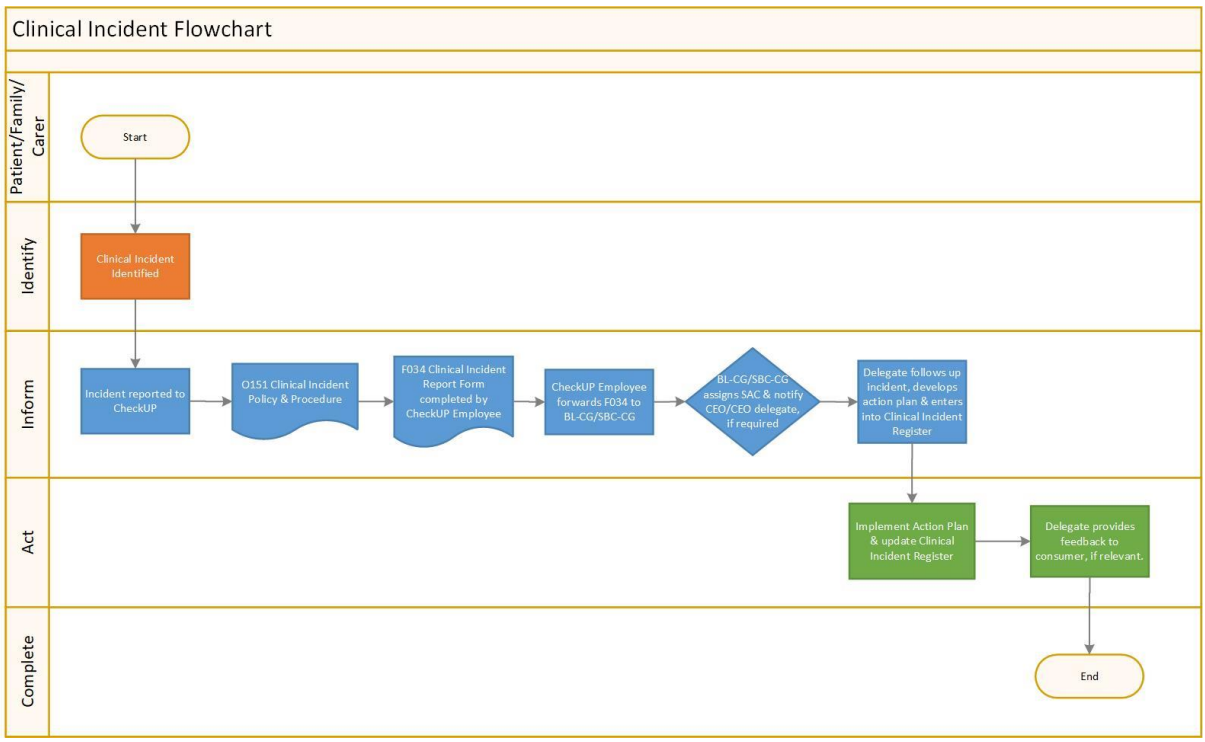
		improved to ensure better coordination, and/or person-centred care. i.e. an administrative error relating to a consumer, an interaction between a consumer and an employee that causes offence, allegation or suspicions of criminal conduct or fraud in relation client care.	Details are recorded in *Feedback Register* with localised action taken. Consult with the Queensland Office of Health Ombudsman guidelines and comply with Registered health practitioner notifications. No investigation required. Complaints/feedback may still require a quality improvement strategy and if so, to be recorded in the *QIP Register.*

Child Safety	N/A	Reports of child abuse or neglect of children or young people.	Report directly to CEO, Executive Director Corporate Services | CFO or a General Manager, as per *CheckUP's Child Safety and Wellbeing Policy).*
			
			When a child safety concern, allegation or disclosure arises it must be reported to the police and relevant child safety authority.
			
			• In an emergency, call 000 and ask for police for advice; and
			• Call the relevant State/Territory child safety authority and ask for advice. For example:
			  ○ For Queensland: Call Queensland child safety authority: 1800 177 135; or
			  ○ For Northern Terrirory: all the Northern Territory child safety authority: 1800 700 250.

- The contracted organisation identifies that an incident has occurred that has involved a CheckUP funded service.
- The incident is managed by the contracted organisation as per their own Clinical Incident/Risk Management Framework and/or Policy/Procedure and CheckUP's Clinical Incident Policy and Procedure .
- A clinical incident involving a consumer of a CheckUP contracted organisation may also be reported by any stakeholder in the healthcare system and brought to the attention of a CheckUP employee.
- The CheckUP employee receiving the incident is required to complete the *Clinical Incident Report Form* taking as much detail as possible and forward to the Clinical Governance Advisor but may assign an initial SAC. The actual SAC must be confirmed by the Clinical Governance Advisor within seven (7) business days of the incident notification.
- An exception to completing the Clinical Incident Report Form rule is if the Clinical Governance Advisor is the identifying staff and is able to directly transcribe sufficient details into the *Clinical Incident Register* and save relevant correspondence in files).
- For SAC 1 and SAC 2 incidents, the contracted organisation must report the incident immediately to CheckUP as well as follow state reporting requirements through relevant state authorities such as Queensland Health, or the Queensland Office of the Health Ombudsman.
- For a confirmed SAC 1 and SAC 2 incident, the CheckUP staff member reporting incident must notify the CEO or CEO's delegate and the Clinical Governance Advisor immediately. Further actions are outlined in the SAC Table 1 above.
- It is not mandatory for contracted organisations to report SAC 3 and SAC 4 incidents to CheckUP. It is the responsibility for the contracted organisation to manage all clinical incidents in accordance with relevant legislative and Queensland Health incident reporting and risk management requirements.

Complaint Management Procedure

- A complaint relating to CheckUP or a contracted organisation, may be made by any stakeholder in the healthcare system.
- The complaint is received by the CheckUP employee.
- The complaint is managed per the SAC Table 1 - actions required for complaints.



Appendix 1

References

- Guideline for Clinical Incident Management (health.qld.gov.au), 2014
- National Safety & Quality Health Service Standards (Standard 1 Clinical Governance, 2017)
- Best Practice Guide to Clinical Incident Management – Queensland Health, First edition, (2014)
- Reportable events and clinical indicators | Queensland Health
- Australian sentinel events list | Australian Commission on Safety and Quality in Health Care