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 *LogiqcQMS Incident Register* 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 organisations.

Scope of Policy

This Policy applies to **all CheckUP employees and contracted organisations**.

Related Documents

- doc_0109_CheckUP Risk Management Framework
- doc_0007_CheckUP Clinical Governance Policy
- doc_0022_CheckUP Clinical Governance Framework
- LogiqcQMS Incident Register
- doc_0364_Incident Management Procedure
- doc_0213_CheckUP Open Disclosure Policy
- doc_0170_CheckUP Feedback, Compliments and Complaints Policy
- doc_0136_CheckUP Health Information Management Procedure
- doc_0023_CheckUP Privacy Policy
- doc_0184_CheckUP Child Safety and Wellbeing Policy
- doc_0137_CheckUP Data Breach Response Plan
- 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.

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 *LogiqcQMS Incident Register* and catergorised accordingly.

Incidents relating to child safety are to be processed in accordance with *CheckUP's Child Safety and Wellbeing Policy* and are to be recorded in the *LogiqcQMS Incident Register* and categorised accordingly.

This policy also recognises other 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 robust manner as clinical incidents and in accordance with the *Incident Management Procedure*.

Examples of non-clinical incidents 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 organisation clinician with insufficient qualifications or experience to effectively manage the queries or information
- allegation or suspicions of criminal conduct or fraud by a contracted organisation 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	**Extreme/Severe**	Death or likely permanent/severe loss of function not related to the natural course of the patient's illness and differing from the expected 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.	The incident must be reported immediately via the LogiqcQMS Incident Register by the CheckUP staff member identifying/receiving notification of the incident. The incident requires immediate referral to the CheckUP CEO or CEO's delegate and Senior Manager Quality and Compliance for urgent action, investigation and risk management plan. For SAC 1 clinical incidents: CheckUP contracted organisations are required to undertake mandatory reporting to the Queensland Health. This includes: • Immediate reporting of the incident in the Queensland Health RiskMan clinical incident reporting system, and no later than 1 business day after becoming aware of the event • A formal analysis – a Root Cause Analysis (RCA) within 90 days

			The incident may require immediate changes to current controls and/or prevention strategies. The incident 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. The CheckUP CEO delegate undertakes/or ensures that communication with the patient/consumer/family as per the Open Disclosure Policy requirements, occurs. The incident may require referral to Media and Communications team, and/or insurer. All supporting evidence such as emails, reports, and any further investiagative documentation to be included as records with the incident. Improvements to future processes are recorded in the *LogiqcQMS Improvement Register* All confirmed SAC 1 incidents are reported to the Finance and Risk Management (FARM) Committee and the CheckUP Board.

			Please Note - As part of the contract requirements with CheckUP, a contracted organisation must follow the requirements for clinical incidents outlined within the Terms and Conditions In addition, SAC 1 and SAC 2 incident reporting requirements contained within this Table (above) - to Queensland Health and CheckUP, still apply.
SAC 2 – Moderate clinical or consumer interaction incidents	**High/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, medication errors requiring treatment or monitoring, healthcare-associated infections (HAIs) that require significant clinical intervention but are not life-threatening.	The incident to be reported via the LogiqcQMS Incident Register by staff member identifying incident/issue. Requires immediate referral to the CheckUP CEO or CEO's delegate and Senior Manager Quality and Compliance for urgent action, investigation and risk management plan. The incident may require immediate changes to current controls and/or prevention strategies. The CheckUP CEO's delegate undertakes/or ensures communication with the patient/consumer/family as per the Open Disclosure Policy requirements, occurs

			All supporting evidence such as emails, reports, and any further investigative documentation to be included as records with this incident. Improvements to future processes are recorded in the *LogiqcQMS Improvement Register*. Clinical Governance Advisory Group (subgroups) may be consulted if process change or expert guidance required. All confirmed SAC 2 incidents are reported to the Finance and Risk Management (FARM) Committee and the CheckUP Board. **Please Note** - As part of the contract requirements with CheckUP, a contracted organisation must follow the requirements for clinical incidents outlined in the Terms and Conditions. In addition, SAC 1 and SAC 2 incident reporting requirements contained within this Table (above) - to Queensland Health and CheckUP, still apply.

SAC 3 – Minor clinical or consumer interaction incidents	**Minor**	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 minimal or no harm it is given a category rating of SAC 3 i.e., a missed or delayed medication dose that did not adversely affect the patient, a minor patient fall resulting in no injury or only first-aid treatment, an quipment malfunctions that were identified prior to use on a patient.	The incident to be reported via the *LogiqcQMS Incident Register* by staff member identifying incident/issue. Requires referral to the relevant Senior Business Manager and Senior Manager Quality and Compliance Generally resolved at the local level by CheckUP's General Managers, Senior Manager Quality and Compliance or delegate, and possibly the CEO's delegate. Improvements to future processes are recorded in the LogiqcQMS Improvement Register.
SAC 4 – No harm or near miss	Low	An incident which could have, but did not, result in harm, either by chance or through timely intervention.	The incident to be reported in the LogiqcQMS Incident Register by staff member identifying incident/issue. Requires referral to the relevant manager.

		i.e., out of date medication was identified before use, correct procedure prevented more serious harm.	Analysis undertaken to gain learning from how incidents can be prevented in the future, or acknowledge if current procedures successfully managed, prevented or minimised more serious harm from occurring.
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 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.	The Incident to be reported in the *LogiqcQMS Feedback Register* by staff member identifying incident/issue. Requires referral to the relevant manager. Where a complaint reflects a systems issue that could be improved Generally resolved at the local level with CheckUP staff and possibly the Senior Manager Quality and Compliance, if required. 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 LogiqcQMS Improvement Register and actioned accordingly

Child Safety	N/A	Reports of child abuse or neglect of children or young people.	The Incident to be reported via the *LogiqcQMS Incident Register* by staff member identifying incident/issue.
			
			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 Territory: Call 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/ 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 record and report the clinical incident in CheckUP's Quality Management System - LogiqcQMS Incident Register, collecting all the necessary information prompted in the register.
- The CheckUP employee may assign an initial SAC. The actual SAC must be confirmed by the Senior Manager Quality and Compliance within seven (7) business days of the incident notification.
- 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 Senior Manager Quality and Compliance immediately. Further actions are outlined in the SAC Table 1 above.
- For SAC 1 and 2 incidents the CEO's delegate undertakes communication with the patient/consumer/family as per the Open Disclosure Policy requirements.
- 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

Refer to *doc_0170_CheckUP Feedback, Compliments and Complaints Policy*

Reviews and Appeals

As referenced in *doc_0170_CheckUP Feedback, Compliments and Complaints Policy* , if a person making a complaint or the subject of a clinical incident is not satisfied with CheckUP's response, they may seek a review of the response from the CheckUP CEO. If they are not satisfied after the CEO's review, they may seek review from the CheckUP Board.

Appendix 1

References

- Guideline for Clinical Incident Management (health.qld.gov.au), 2014
- National Safety & Quality Health Service Standards (Standard 1 Clinical Governance, 2017)
- Reportable events form | Queensland Health
- Incident Management and Sentinel Events | Australian Commission on Safety and Quality in Health Care