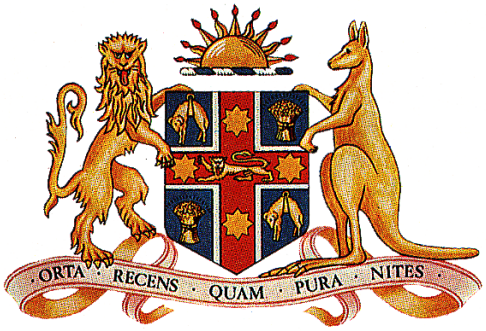

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By Authority
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NSW GOVERNMENT | Health

POISONS AND THERAPEUTIC GOODS REGULATION 2008

Authority

Possession and/or Supply of Poisons, Restricted Substances and Drugs of Addiction

I, BRUCE BATTYE, Deputy Chief Pharmacist, a duly appointed delegate of the Secretary, make this instrument pursuant to section 16(1)(d) of the *Poisons and Therapeutic Goods Act 1966* (NSW) [Act] and clause 170 of the *Poisons and Therapeutic Goods Regulation* 2008 (NSW) [Regulation] for the purposes of clause 17, clause 53 and clause 106(1) of the Regulation. Pursuant to section 16(1)(d) of the Act and clause 171(1) of the Regulation, this authorisation is granted subject to conditions.

BRUCE BATTYE
Deputy Chief Pharmacist
(Delegation Number PH60, PH380)
Date: 22 OCT 2020

Authorisation to Possess and/or Supply Poisons, Restricted Substances and Drugs of Addiction

1 Authorisation

This instrument authorises a person who belongs to a class of persons specified in paragraph 2, to supply poisons and restricted substances, and to possess prescribed restricted substances and drugs of addiction.

Note: clause 106(2) of the Regulation provides that a person who is so authorised to have possession of a drug of addiction is also authorised to administer the drug to another person in an emergency.

2 Class of Persons

A person who is employed or engaged as an ambulance officer by the ambulance service of a State of Territory of Australia, other than of New South Wales.

3 Conditions

a. The person must be assisting NSW Ambulance, for the time being, at the request of the Chief Executive of NSW Ambulance; or providing a service pursuant to a memorandum of understanding between NSW Ambulance and the ambulance service of the State or Territory in which the person is employed.

b. The person administers the poisons, restricted substances and drugs of addiction in accordance with the protocols that are approved for use by the ambulance service of the State or Territory in which the person is employed.

4 Validity

This authority commences on the day it is signed and dated, and expires on 31 October 2023, or otherwise on a date that this authority is suspended, cancelled or surrendered.

INCIDENT MANAGEMENT POLICY

POLICY STATEMENT

NSW Health Services must have incident management processes in place that are consistent with the requirements of this Policy and the *Health Administration Act 1982*, to effectively respond to clinical and corporate incidents and act on lessons learned.

SUMMARY OF POLICY REQUIREMENTS

All staff are responsible for identifying incidents and for taking immediate action to ensure the safety of patients, visitors and other staff.

Notify incidents and escalate

Clinical and corporate incidents, near misses and complaints are to be recorded in the incident management system, ims+.

For all clinical incidents with possible state-wide implications; the potential to become a matter of public interest; potential for the loss of public confidence; or involve contentious issues; the Chief Executive must immediately contact the Ministry of Health and the Clinical Excellence Commission Chief Executive.

For all corporate incidents with possible state-wide implications; the potential to become a matter of public interest; potential for the loss of public confidence; or involve contentious issues, the Chief Executive must immediately contact the Ministry of Health.

Serious incidents must be notified and escalated within the Health Service and to the Ministry of Health via a reportable incident brief (RIB). The RIB is to be submitted in ims+ within 24 hours of notification for RIB Part A, and within 72 hours (or earlier, as directed by the Chief Executive or Ministry of Health) for RIB Part B.

Open disclosure

Open disclosure must occur whenever a patient has been harmed, whether that harm is a result of an unplanned or unintended event or circumstance, or is an outcome of an illness or its treatment that has not met the patient's or the clinician's expectation for improvement or cure, as per the NSW Health *Open Disclosure Policy* (PD2014_028).

Clinical incident review

Health Services must undertake a preliminary risk assessment within 72 hours (or earlier, as directed by the Chief Executive or by the Ministry of Health) for reportable incidents (clinical Harm Score 1 incidents). The Chief Executive may also direct that a preliminary risk assessment be completed for other clinical incidents (Harm Score 2 – 4) that may be due to a serious systemic problem.

Any person appointed to undertake a preliminary risk assessment must immediately escalate to the Chief Executive, in writing, concerns of either continuing risk of harm to the patient, or serious or imminent risk of harm to other patients, carers, families or staff.

A serious adverse event review must be undertaken using an approved review method, following a clinical Harm Score 1 incident. The review is to identify any factors that caused or contributed to the incident, and any practices, processes or systems that

could be reviewed for the purposes of a recommendations report. The Chief Executive may also direct a serious adverse event review be undertaken for other clinical incidents (Harm Score 2 – 4) which may be due to serious systemic problems.

Preliminary risk assessment assessors and serious adverse event review team members are bound by strict confidentiality requirements and must not disclose information obtained during the preliminary risk assessment or serious adverse event review, unless it is for the purpose of the preliminary risk assessment or serious adverse event review.

The serious adverse event review findings report, and recommendations report (if there is one), must be submitted to the Ministry of Health within 60 calendar days of the incident notification in ims+.

At the completion of a serious adverse event review, the family is to be invited to meet to discuss the findings and recommendations and to be given copies of the findings report and recommendations report.

Corporate incident review

Health Services must undertake a safety check within 72 hours (or earlier, as directed by the Chief Executive or by the Ministry of Health) for corporate Harm Score 1 incidents.

Any person appointed to undertake a safety check must immediately escalate to the Chief Executive, in writing, concerns of either continuing risk of harm to the patient, or serious or imminent risk of harm to other patients, carers, families or staff, or continuing critical risk due to loss of service.

A corporate Harm Score 1 review must be undertaken following a corporate Harm Score 1 incident, using a review method determined by the type of corporate incident. The review is to identify any underlying factors as to why the incident occurred and make recommendations to prevent and minimise risk of recurrence.

A corporate Harm Score 1 review report is due to the Ministry of Health within 60 calendar days of incident notification in ims+.

Implementation and feedback

Health Services are to monitor the implementation of recommendations arising from incident reviews and have escalation processes in place for recommendations that cannot be progressed.

Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and recommendations. Health Services are also to share feedback on the lessons learned and proposed changes more broadly with clinicians, managers and staff.

REVISION HISTORY

Version	Approved by	Amendment notes
October 2020	Secretary, NSW Health	Introduces the preliminary risk assessment, additional approved review methodologies to root cause analysis and the separation of findings and recommendations, as per the *Health Administration Act 1982*.
June 2020 (PD2020_020)	Secretary, NSW Health	Appendix F updated.
June 2020 (PD2020_019)	Secretary, NSW Health	Includes reference to the ims+ incident management system introduced into local health districts and specialty networks beginning October 2019. For entities that have transitioned to ims+, the ims+ Harm Score replaces the IIMS SAC rating.
July 2019 (PD2019_034)	Deputy Secretary, Patient Experience and System Performance	Replaces the sentinel events with the version 2 sentinel events and includes definitions to support the sentinel events under "Key Definitions".
February 2014 (PD2014_004)	Director General	Contains changes to the national sentinel event definitions. Consolidates requirements from PD2005_634 'Reportable Incident Definition under section 20L of the *Health Administration Act 1982*'
July 2007 (PD2007_061)	Director General	Replaces PD2006_030
May 2006 (PD2006_030)	Director General	Consolidates requirements from PD2005_404 'Incident Information Management System (IIMS) Policy NSW'
November 2005 (PD2005_604)	Director General	Replaces PD2005_337 'Reportable Incident Briefs to the NSW Department of Health'

ATTACHMENTS

1. Incident Management: Procedures.

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1 BACKGROUND

An incident is an unplanned event that results in, or has the potential for: injury, damage or loss, including near misses[1]. An incident is also known as an 'adverse event'.

Health Services must seek to maintain the trust of the public when things go wrong. The principles of immediacy, accountability and kindness guide our interactions with patients, carers and families, staff and the broader community.

Immediacy	We act immediately when people are harmed or at risk of harm.
Accountability	We are open when things go wrong. We review to learn. We make changes to improve. We share what we find and learn.
Kindness	We are caring. We are fair and just. We support all who are affected.

1.1 About this document

This Policy sets out incident management requirements for Health Services and includes processes using the NSW Health incident management system, ims+. In organisations where other incident management systems are used, staff must follow local incident management requirements in a way that otherwise complies with this Policy. Tools and templates for this Policy are on the Clinical Excellence Commission website.

NSW Health has a policy framework for managing different types of corporate incidents. This Policy is intended to assist in the management of corporate incidents which are not covered by another NSW Health Policy.

All staff are to read sections 1, 2, 6 and 9, for general requirements of the incident management process, and specific requirements for Harm Score 3 (minor harm) and Harm Score 4 (no harm or near miss) incidents.

Managers, senior clinicians, Clinical Governance teams, Health Services leaders are to read the remaining sections for specific requirements for Harm Score 1 (death, Australian Sentinel Event or complete loss of service) and Harm Score 2 (major harm) incidents.

1.2 Key definitions

Adverse event
An incident.

Assessor
Staff member appointed by a Chief Executive (CE) to undertake a preliminary risk assessment (PRA).

Australian Sentinel Event (ASE)
An ASE is a wholly preventable patient safety incident resulting in death or serious patient harm. It is a category of incident defined by the Australian Commission on Safety and Quality in Health Care and approved by the Health Ministers. The ASE list is in Appendix D of this Policy.

Clinical Risk Action Group (CRAG)

[1] Organisation for Economic Co-operation (OECD) (2017).

The NSW Health CRAG is responsible for examining and monitoring serious clinical incidents reported to the Ministry of Health via reportable incident briefs (RIBs) and ensuring appropriate action is taken. The CRAG analyses information reported to it on specific incidents, identifies issues relating to morbidity and mortality that may have statewide implications and provides strategic direction and advice on policy development to effect health care system improvement. The workings of the CRAG are subject to special statutory privilege under section 23 of the *Health Administration Act 1982*.

Clinician disclosure
Incident disclosure within 24 hours to a patient, carer or family by the treating clinician/team or staff member.

Dedicated family contact
A staff member who is the primary contact for the patient, carer or family for a serious adverse event review (SAER) or corporate Harm Score 1 review of the death of a worker. They liaise between the patient, carer or family, open disclosure team and review team.

Escalation
A process of advising a more senior person or an external body of concerns or risks.

Harm
Patient harm is any unintended and unnecessary harm resulting from, or contributed to, by health care. This includes the *absence* of indicated medical treatment[2]. Harm may include staff (workers), visitors and family (relatives) or damage to property or the environment.

Harm Score
A score from 1 to 4 applied to clinical and corporate incidents based on the outcome and additional treatment and/or resources required.

- Clinical Harm Score 1 - Unexpected death or Australian Sentinel Event, as defined in Appendix D 'Reportable Incident Definition'
- Corporate Harm Score 1 - Unexpected death of a worker or visitor or a complete loss of service
- Harm Score 2 – Major harm
- Harm Score 3 – Minor harm
- Harm Score 4 – No harm or near miss.

Hazard
A source or situation with a potential for harm in terms of human injury or ill health, damage to property, damage to the environment or a combination of these.

Health Services
A local health district or a statutory health corporation, NSW Ambulance, HealthShare NSW, NSW Health Pathology, eHealth NSW, Health Protection NSW, Cancer Institute, and affiliated health organisations (AHOs).

ims+
NSW Health incident management system. This Policy describes processes using ims+. Some affiliated health organisations use other incident management systems (e.g.

[2] Organisation for Economic Co-operation (OECD) (2017) The Economics of Patient Safety.

Riskman) and must follow local incident management requirements in a way that otherwise complies with this Policy.

Incident category
Who or what was affected by the incident or near miss.

Incident management
Actions and processes for immediate and ongoing activities following an incident. Review is part of incident management[3].

Incident review
A structured process to identify what happened; how and why it happened; what could be done to reduce risk and make care safer; and what was learned[3].

Near miss
An incident that could have caused harm but did not or an incident that was intercepted before causing harm.

Notifiable incident
In the *Work Health and Safety (WHS) Act*, notifiable incident means: a) the death of a person, or b) a serious injury or illness of a person, or c) a dangerous incident. SafeWork NSW must be notified immediately after becoming aware of a notifiable incident.

Refer to the NSW Health Policy *Work Health and Safety: Better Practice Procedures* (PD2018_013) and SafeWork NSW website.

Notification
The process of entering or documenting data about an incident or near miss for any of the incident categories into ims+ or other incident management systems.

Open disclosure
Ongoing communication process with a patient, carer or family about an incident and its management. Formal open disclosure involves multidisciplinary discussion/s with the patient, carer or family and senior clinical leaders and/or hospital executive.

Preliminary risk assessment (PRA)
A preliminary risk assessment carried out pursuant to Part 2A, Division 2 of the *Health Administration Act 1982* and section 4.1.2 of this Policy.

A PRA is undertaken following clinical Harm Score 1 incidents to assist the Health Service to understand the events and identify immediate risks for action. The Chief Executive may direct a PRA be undertaken for clinical Harm Score 2, 3 or 4 incidents that may be due to a serious systemic problem.

Relevant Health Services organisation
As defined under Part 2A of the *Health Administration Act 1982* and Regulation, being:

- Local Health Districts (LHDs)
- NSW Ambulance
- Other divisions of the Health Administration Corporation that provide clinical services, including NSW Health Pathology, HealthShare NSW, and Health Protection NSW, and

[3] Queensland Health (2014). Best practice guide to clinical incident management.

- Statutory health corporations and affiliated health organisations as listed in Appendix A of this Policy.

The requirements of section 4 of this Policy only apply to relevant health services organisations.

Reportable incident
Clinical Harm Score 1 incidents defined in Appendix D that **must**:

- Be reported to the NSW Ministry of Health via a reportable incident brief
- Have a preliminary risk assessment
- Have a serious adverse event review.

Safety check
A safety check undertaken following corporate Harm Score 1 incidents to assist the Health Service to understand the events and identify immediate risks for action.

Serious adverse event review (SAER)
A SAER as defined in Part 2A of the *Health Administration Act 1982* and described in section 4 of this Policy. It is a root cause analysis (RCA) or other type of review prescribed by the Regulations undertaken by a SAER team for a reportable incident (clinical Harm Score 1 incident). A SAER can also be undertaken in relation to a clinical Harm Score 2, 3 or 4 incident the Chief Executive determines may be due to a serious systemic problem.

Serious adverse event review (SAER) team
A team appointed under the regulations to undertake a SAER.

1.3 Legal and legislative framework

The *Health Administration Act 1982* outlines the legal framework for undertaking preliminary risk assessments and serious adverse event reviews (s4 of this Policy).

The *Work Health Safety Act 2011* sets out legal obligations of occupiers of workplaces and other duty holders. It informs aspects of corporate incident management (s7, s8 and s9 of this Policy).

1.4 Responsibilities

All NSW Health Staff

- Identify incidents
- Notify incidents on the same day or as soon as practicable in ims+
- Must undertake training in incident notification.

Managers

- Undertake relevant incident management training
- Monitor incident notifications in ims+
- Change incident status from ‘New’ to ‘Investigate’ in ims+
    - Within 24 hours – Harm Score 1 incidents
    - Within 5 calendar days – Harm Score 2, 3 and 4 incidents
- Confirm the Harm Score in ims+ as soon as possible

- Complete the mandatory and relevant fields for each incident in ims+
- Support and/or undertake open disclosure
- Contribute to, or complete, reportable incident briefs (RIBs)
- Ensure preliminary risk assessment (PRA) assessors and review teams have access to patients, carers, families and staff, records and physical incident locations
- Complete service/unit level reviews for Harm Score 3 and 4 incidents within 45 calendar days of notification
- Change incident status from 'Under investigation' to 'Investigation complete' in ims+:
    - Within 60 calendar days of notification – Harm Score 1 incidents
    - Within 45 calendar days of notification – Harm Score 2, 3 and 4 incidents.

Heads of Department, Service Managers and Stream Leaders

- Assist managers with incident management as needed
- Assist with or undertake open disclosure
- Support staff involved in incidents
- Support staff participation in incident review
- Analyse and discuss incident trends and related datasets
- Escalate incidents, trends and risks as needed.

Health Services – Chief Executives

- Ensure processes are in place for timely incident identification
- Provide access to training for incident management
- Ensure processes are in place to support staff involved in incidents
- Notify reportable incidents (clinical Harm Score 1) and incidents specified in section 3 of this Policy to the Ministry of Health via reportable incident brief (RIB) within
    - Within 24 hours for RIB part A
    - Within 72 hours or sooner for RIB part B
- Telephone the Ministry of Health if urgent attention is required for a clinical incident (s4.1.1) or a corporate incident (s7.1.1)
- Appoint assessors to undertake a PRA for reportable incidents (clinical Harm Score 1) or clinical incidents that may be due to serious systemic problems
- Appoint safety check teams to undertake safety checks of corporate Harm Score 1 incidents
- Assign a dedicated family contact (DFC) for reportable incidents (clinical Harm Score 1) or clinical incidents which may be due to serious systemic problems
- Assign a DFC for corporate Harm Score 1 incidents involving death of a staff member
- Notify the NSW Treasury Managed Fund (TMF) of incidents with the potential to become legal claims

- Appoint serious adverse event review (SAER) teams for reportable incidents (clinical Harm Score 1), and for clinical incidents that may be due to serious systemic problems in respect of which the CE has determined a SAER should occur
- Ensure SAERs are completed with separate findings and recommendations stages
- Ensure the SAER findings report is submitted to the CE within an agreed Health Service timeframe
- Submit the SAER findings report and recommendations report (if there is one) to the Ministry of Health within 60 calendar days or sooner of the notification in ims+
- Ensure processes are in place to protect privileged information and documents
- Communicate regularly with the patient, carer or family during a SAER, as per the family's wishes
- Undertake a corporate Harm Score 1 review and submit a report to the Ministry of Health within 60 calendar days of the notification in ims+
- Communicate regularly with the carer or family during corporate Harm Score 1 review of the death of a staff member, as per family's wishes
- Monitor and rate risks identified via SAERs as per the relevant NSW Health policies e.g. *Risk Management – Enterprise-Wide Risk Management Policy and Framework* (PD2015_043)
- Monitor and rate risks identified via corporate Harm Score 1 reviews as per the relevant NSW Health policies e.g. *Risk Management – Enterprise-Wide Risk Management Policy and Framework* (PD2015_043) and *Work Health and Safety: Better Practice Procedures* (PD2018_013).
- Undertake clinical Harm Score 2 reviews within 45 calendar days of notification
- Undertake corporate Harm Score 2 reviews within 45 calendar days of notification
- Report trended incident data and outcomes of SAERs and corporate Harm Score 1 reviews to peak safety and quality committees, the Board and relevant groups within Health Services
- Contribute to state-wide improvements with the Ministry of Health, Clinical Excellence Commission and other Health Services.

Clinical Excellence Commission (CEC)

- Review clinical incidents and reports from serious adverse event reviews (SAERs)
- Support and advise the health system about clinical incident management and clinical incident analysis
- Provide advice and regular reports to the Ministry of Health on clinical quality and patient safety issues, trends and lessons learned from clinical incident management
- Disseminate lessons learned from clinical incident management
- Analyse systems failings and human factors contributing to incident trends and develop state-wide improvement plans and strategies to reduce harm events
- Advise the Ministry of Health on strategies to minimise state-wide clinical system errors
- Develop policies and strategies to improve patient safety and health care quality

- Identify education needs emerging from clinical incident management.

NSW Ministry of Health (MoH)

- Ensure Health Services have systems in place to report, review and take action to prevent incidents, protect people in healthcare settings, and improve clinical care and service quality
- Have systems to monitor and manage incidents reported to the Ministry of Health
- Receive and review clinical and corporate Harm Score 1 incident notifications
- Review advice and reports provided by the CEC on analysis of trends from SAERs and issues arising from clinical incidents (all Harm Scores)
- Provide advice to the Secretary and Minister for Health on contentious issues
- Ensure a state-wide response to emerging risks as they are identified.

2 INCIDENT MANAGEMENT PROCESS

The purpose of incident management is to understand and address system issues. It involves a series of steps for clinical and corporate incidents. The steps are:

Step 1 - Identify incident

Step 2 - Ensure safety of people and the environment

Step 3 - Notify incident in ims+

Step 4 - Escalate incident

Step 5 - Review incident

Step 6 - Implement and monitor actions

Step 7 - Feedback to staff and patients, carers and families.

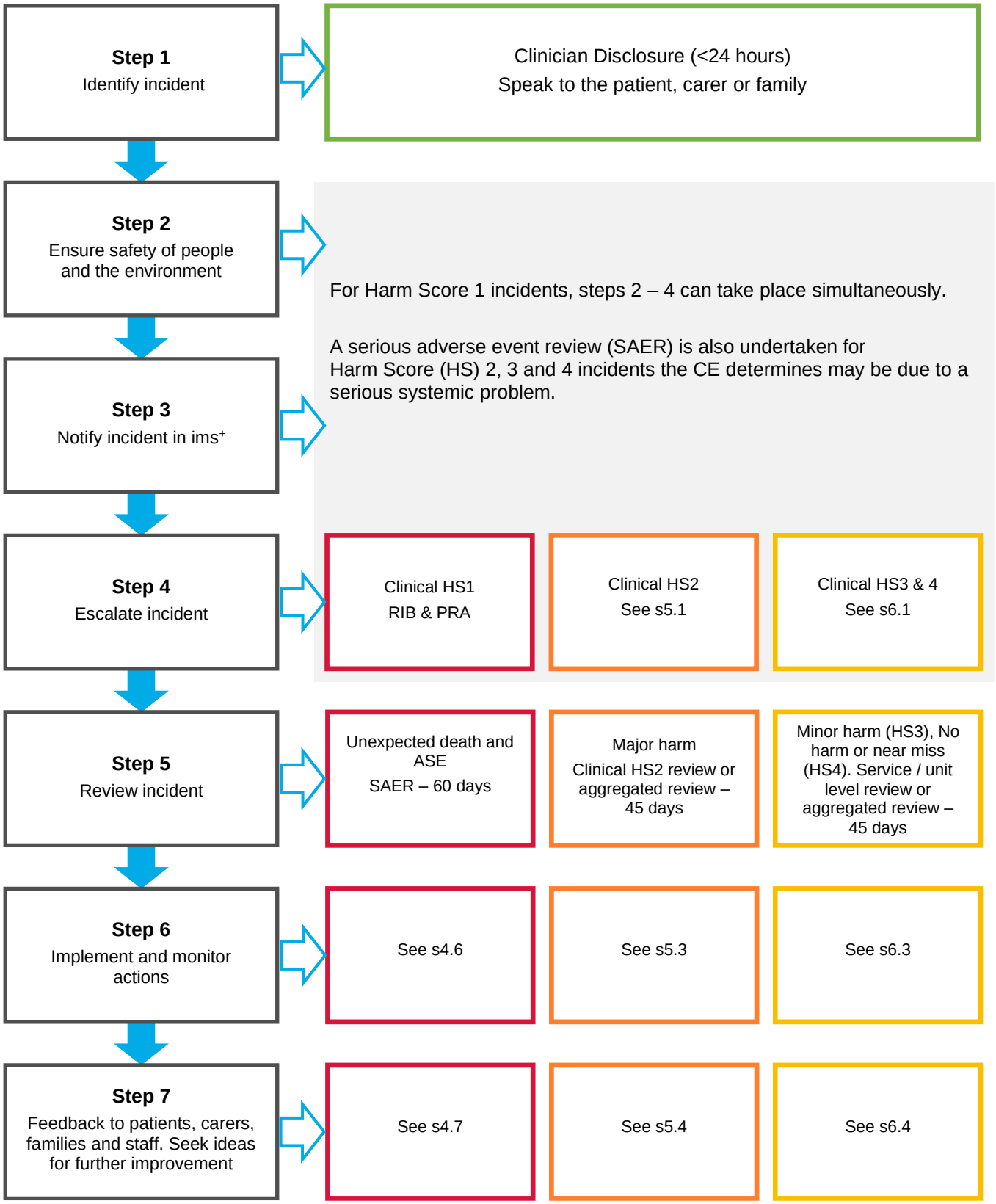
An incident rating or Harm Score determines the level of escalation and review.

Score	Detail
Harm Score 1 (HS1)	Clinical - Unexpected death or Australian Sentinel Event (ASE) Corporate – Unexpected death of a worker or visitor or Complete loss of service
Harm Score 2 (HS2)	Major harm
Harm Score 3 (HS3)	Minor harm
Harm Score 4 (HS4)	No harm or near miss

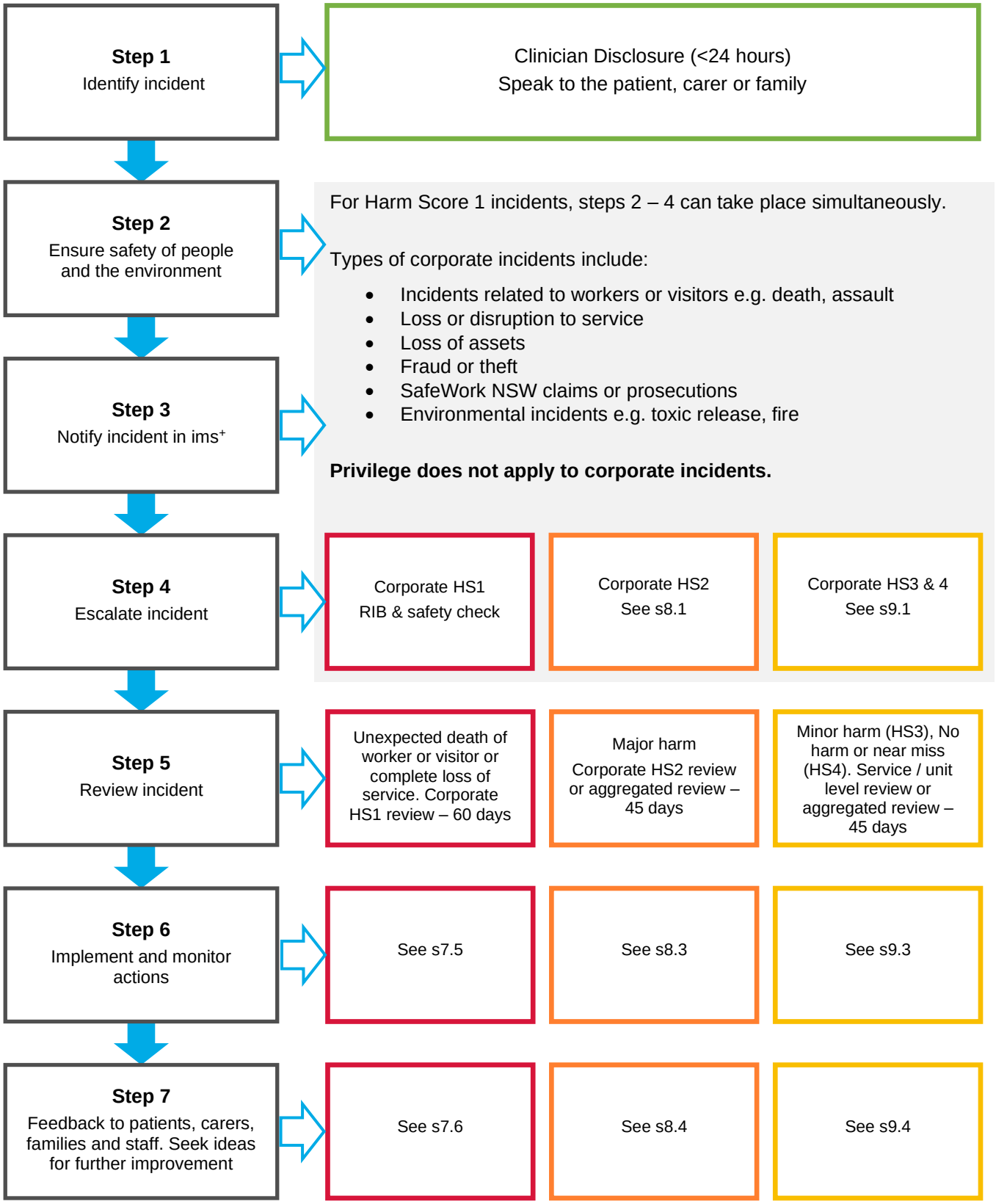
Timeframes for reporting

Element	Timeframe	Submit to
Reportable incident brief (RIB)		
Part A – basic information	24 hours	Ministry of Health (MoH)
Part B – further information	72 hours or sooner	MoH
CLINICAL		
Preliminary risk assessment (PRA)		
PRA report	72 hours or sooner	Chief Executive (CE)
Serious adverse event review (SAER)		
Findings report Findings report and Recommendations report (if there is one)	Health Service determined 60 calendar days or sooner	CE MoH
Clinical HS2 review		
Clinical HS2 review report	45 calendar days	Health Service Clinical Governance
CORPORATE		
Safety check		
Safety check report	72 hours or sooner	CE
Corporate Harm Score 1 review		
Corporate HS1 review report	60 calendar days or sooner	MoH
Corporate HS2 review		
Corporate HS2 review report	45 calendar days	Health Service Corporate Governance or General Manager

NSW Health incident management process – clinical



NSW Health incident management process – corporate



2.1 Step 1: Identify

All staff are responsible for identifying incidents. Most incidents are identified at the time and a few are identified sometime after the event. They are identified via different sources, such as team discussions, audits, morbidity and mortality meetings, safety committees, and complaints.

Clinician disclosure must take place within 24 hours of identification, in accordance with the NSW Health *Open Disclosure Policy* (PD2014_028).

2.2 Step 2: Ensure safety

Staff must take any immediate action needed to ensure safety. This may include:

- Providing immediate care to the patients, visitors or staff involved
- Making the environment safe to prevent immediate recurrence
- Preserving the scene for regulators (e.g. SafeWork NSW, NSW Environmental Protection Authority), the Coroner or NSW Police, if safe to do so
- Removing faulty equipment or supplies, if safe to do so; isolate and keep intact for biomedical engineering or the manufacturer
- Notifying security or police if needed
- Support to patients, carers and families as needed
- Support to staff as needed e.g. Employee Assistance Program (EAP)
- Any other immediate actions as needed.

2.3 Step 3: Notify

Staff must notify all clinical and corporate incidents, near misses and complaints in the NSW Health incident management system, ims+. Clinical incidents relate to patient care. Corporate incidents can relate to people (e.g. worker slips, trips and falls) or environmental hazards (e.g. faulty lock).

- Notify in the incident management system on the **same day** or as soon as practicable
- Log into ims+ to notify, as this supports conversations with notifiers and managers. Staff who wish to notify anonymously do not log in
- Respond to key questions about outcome and additional care or resources needed for ims+ to automatically calculate an incident rating (ims+ Harm Score)
- Document contemporaneously in the medical record with:
    - Incident number and clinically relevant information for clinical incidents
    - Incident number only for complaints

In the event of ims+ downtime, incidents are to be recorded using the eHealth ims+ Incident Notification Downtime Form. The information from the form is to be transferred as soon as possible to ims+. The form is uploaded to ims+ and then the paper record securely destroyed.

Patients, carers, families, visitors or contractors can notify via an ims+ web link. If they ask for help or prefer to notify via letter, email or phone, staff are to notify on their behalf.

Further information about ims+ is available at http://imsplus.health.nsw.gov.au/ and via My Health Learning modules.

2.4 Step 4: Escalate

Escalation depends on incident severity. Refer to “Escalate” sections in this Policy.

2.5 Step 5: Review

A review identifies what happened, why it happened and what could be done to improve safety. The type of review and level of oversight depends on the incident severity. Refer to “Review” sections in this Policy.

2.6 Step 6: Implement and monitor actions

Further actions are taken to improve safety following an incident review. Refer to “Implement and monitor actions” sections in this Policy.

2.7 Step 7: Feedback

Feedback supports learning and a just culture. It is an opportunity to discuss further ideas for improvement. Refer to “Feedback” sections in this Policy.

2.8 System wide learnings

Health Services review incident management data and related data sets for action at an organisational level.

The Clinical Excellence Commission (CEC) analyses clinical incident data to understand whole of system harm and emerging trends. The CEC communicates findings and co-ordinates state-wide action by Health Services.

The Clinical Risk Action Group (CRAG), CRAG subcommittees or other s23 committees can direct state-wide initiatives.

The NSW Health Pillar organisations, under the coordination and leadership of the CEC, support system-based learning. They have a safety and quality role in areas such as training, models of care, technologies and specific clinical areas.

2.8.1 Driving continuous improvement

Incident data and feedback from staff and patients, carers and families can identify system vulnerabilities to inform quality improvement (QI) efforts.

Local QI facilitators can advise QI methods (e.g. Practice Improvement, Model for Improvement, Clinical Redesign and rapid cycle testing) and evaluation measures.

Learning is best when several sources of data are viewed together. Sources include incidents, death screening data and morbidity and mortality (M&M) meetings, hospital acquired complications (HACs), audits, clinical indicators and real-time surveillance.

The CEC Quality Improvement Data System (QIDS) combines data sources e.g. Health Information Exchange (HIE) and ims+. It allows users to understand incidents in relation to other metrics e.g. falls per 1000 patient days, medication errors per 1000 separations. Staff can speak to their manager or Clinical Governance team about access.

The CEC Quality Improvement Academy and QIDS provide tools to support continuous improvement.

2.8.2 ims+ Safety Learnings module

The ims+ Safety Learnings module enables sharing of lessons learned from incident management and other safety and quality processes. It is searchable by all staff.

2.9 Secretary convened reviews

The Secretary may convene a review or inquiry independent of the Health Service for a clinical or corporate incident. This may arise where an incident raises state-wide or general clinical practice issues, serious public interest or where there is a potential conflict of interest with Health Service oversight of the review.

If the Secretary convenes a review or inquiry, the Ministry of Health and Health Service consult on whether the Health Service also undertakes a serious adverse event review (SAER) or corporate HS1 review.

Where the Chief Executive considers an external inquiry is needed for a clinical or corporate incident, he/she contacts the relevant Deputy Secretary.

The Clinical Excellence Commission Chief Executive is advised of Secretary convened clinical reviews by the Ministry of Health.

3 REPORTABLE INCIDENT BRIEF (RIB)

Serious incidents are notified and escalated within the Health Service and to the Ministry of Health via a RIB. Clinical RIBs are privileged, and corporate RIBs are not.

3.1 Incidents which require a RIB

3.1.1 Clinical Incidents

- Reportable incidents (clinical Harm Score 1) – defined in Appendix D
    - Unexpected death
    - Suspected suicide
    - Suspected homicide
    - Unexpected intrapartum stillbirth
    - Australian Sentinel Event (ASE).
- Chief Executive determined specific clinical incidents
    - Clinical incidents due to serious systemic problems
    - Clinical incidents that warrant particular attention e.g. Lookback anticipated
    - Patient on patient or patient on staff assaults resulting in serious injury or death with reasonable clinical grounds to suspect a connection to care.
- Term babies with suspected or confirmed harm[4]
    - Early neonatal deaths (0 – 6 days)[5]
    - Severe brain injury diagnosed in the first seven days of life

[4] RCOG. (2018). *Each Baby Counts*. London: Royal College of Obstetricians and Gynaecologists Retrieved from https://www.rcog.org.uk/eachbabycounts.

[5] Unexpected deaths that exclude known congenital abnormalities which are incompatible with life.

- Diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) OR
- Therapeutically cooled (active cooling only) OR
- Decreased central tone AND was comatose AND seizures of any kind.

3.1.2 Corporate Incidents

- Corporate Harm Score 1 incidents
  - Death of a staff member, potentially arising from the activities or the workplace of that staff member
  - Suspected suicide by a staff member potentially arising from the activities or the workplace of that staff member.
- Chief Executive determined specific corporate incidents
  - Attempted suicide by a staff member who was not a consumer of a mental health service (MHS)
  - Serious threats affecting the facility's operation e.g. fire, bomb or other threatening activities, critical equipment breakdown or failure
  - Complete loss of service i.e. power, water, communication system failure
  - Criminal activity in, or related to, the workplace
  - Kidnapping or abduction of a patient
  - Non-accreditation of service provider e.g. College or accrediting agency
  - Violence or threats of assaults on patients, staff, contractors or visitors.

3.1.3 Mandated - Legal and Policy Requirements

- When methadone or buprenorphine is associated, or suspected, with a child's presentation or admission to hospital regardless of the outcome for the child – as per NSW Clinical Guidelines: Treatment of Opioid Dependence - 2018
- Unexpected deaths in custody
- Significant legal action initiated by or against a Health Service – as per the NSW Health Policy *Significant Legal Matters and Management of Legal Services* (PD2017_003)
- Industrial disputes affecting a facility's operation
- The commencement of a SafeWork NSW prosecution
- Radiation incidents reportable to the NSW Environmental Protection Authority[6] under the *Radiation Control Act 1990* and *Radiation Control Regulation 2013*
- Child related allegations, charges and convictions against staff which are notifiable to the Child Protection Helpline or Child Wellbeing Unit (where appropriate), NSW Police and/or NSW Children's Guardian and require investigation by the Health Service. These allegations may be work or non-work related and include historical matters.

[6] NSW Environmental Protection Authority (EPA) Radiation accident notification form

- Criminal charges and convictions against a staff member related to the workplace or outside of work but with potential risk in the workplace e.g. sexual assault criminal charges or convictions
- Accreditation agency notification to a Health Service of significant patient harm risk/s[7]
- A privacy breach where a privacy internal review is required – as per *NSW Health Privacy Internal Review Guidelines* (GL2019_015)

3.2 RIB process

The RIB is completed in ims+ by a nominated staff member who:

- Does not identify patients, staff, services or facilities in the body of the RIB
- Includes details of external mandatory reporting in the RIB e.g. Ombudsman, Child Protection, National Disability Insurance Scheme (NDIS) and Aged Care.

The Chief Executive or delegate approves the RIB within ims+.

The RIB is submitted via MOH-RIBs@health.nsw.gov.au in ims+ to the Ministry of Health and is due within:

- 24 hours of notification, for RIB part A
- 72 hours or sooner, as directed by CE or Ministry of Health, for RIB part B.

RIB parts A (basic information) and B (further information) can be submitted together. When a RIB is completed without a preliminary risk assessment (PRA), RIB part B responses can be marked “Not applicable”.

The Ministry of Health confirms receipt by sending a Ministry of Health RIB number. RIB update is allowed for further information or change in Harm Score via:

- Marking RIB “Update” with reason
- Reference to the Ministry of Health RIB number
- The CE authorises the update
- Resubmission in ims+ to MOH-RIBs@health.nsw.gov.au.

The RIB is stored in ims+, or securely elsewhere, if using another incident management system. When an incident involves more than one agency, the RIB can be seen and edited in ims+ by those agencies.

4 CLINICAL HARM SCORE 1 INCIDENTS

Clinical Harm Score 1 incidents, known as “reportable incidents”, are Unexpected death or Australian Sentinel Events (ASEs) as defined in Appendix D. They require a preliminary risk assessment (PRA) followed by a serious adverse event review (SAER), under Part 2A of the *Health Administration Act 1982*.

The Chief Executive appoints PRA and SAER teams whose work is privileged (see s4.5 Privilege). A CE may direct a privileged PRA and/or SAER be undertaken for clinical Harm

[7] The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme also requires approved accrediting agencies to notify regulators if a significant patient risk is identified during an onsite visit to a health service organisation.

Score 2, 3 or 4 incidents the Chief Executive considers may be due to a serious systemic problem.

The requirements in this section only apply to "relevant health services organisations", as defined in the *Health Administration Act 1982* and Regulation, being:

- Local Health Districts (LHDs)
- NSW Ambulance
- Other divisions of the Health Administration Corporation that provide clinical services, including NSW Health Pathology, HealthShare NSW, and Health Protection NSW
- Relevant statutory health corporations and affiliated health organisations as listed in Appendix A.

This section does not apply to Health Services which are not "relevant health services organisations".

4.1 Escalate clinical Harm Score 1 incidents

- Managers are to notify senior management
- Health Services are to complete a reportable incident brief (RIB)
- Health Services are to undertake a preliminary risk assessment (PRA).

4.1.1 CE escalation to the Ministry of Health and CEC – clinical incidents

For clinical incidents with possible state-wide implications, potential to become a matter of public interest, potential loss of public confidence, or contentious issues, the CE or delegate must immediately contact the Ministry of Health (MoH) and the CE or delegate at the Clinical Excellence Commission (CEC). The CEC will lead the review process on a case by case basis.

The relevant Deputy Secretary advises the Secretary as needed, who in turn advises the Minister's Office as appropriate.

4.1.2 Preliminary risk assessment (PRA)

Undertake a PRA for clinical Harm Score 1 incidents within 72 hours, or sooner as directed by the Chief Executive or Ministry of Health. The purpose of a PRA is to provide advice to the Chief Executive to:

- Understand the events, and may include advice as to whether the incident is a reportable incident
- Identify immediate actions for people and the environment to be safe
- Identify, mitigate and escalate immediate risks
- Guide the response to an incident and subsequent review.

The PRA team is one or more people appointed by the Chief Executive. The Chief Executive appoints PRA assessors via:

- Memo template
- Email or
- Standing appointment arrangement.

The PRA team's composition and expertise are incident dependent e.g. an electronic medical record (eMR) manager may be appointed to a PRA for a potential eMR issue. It is recommended to include a Clinical Governance member for clinical incidents. Assessors must not have been directly involved in the incident, unless unavoidable.

PRA advice

Assessors are to undertake a PRA of the incident and may attend the incident location. They complete a PRA report documenting their advice and understanding of events.

A NSW Health PRA Report template must be used for submission to the Chief Executive. It is accessed via ims+ or the Clinical Excellence Commission (CEC) website.

A PRA action log can be used to support actions arising from the PRA.

The PRA team is to immediately escalate to the CE in writing concerns of:

- Continuing risk of harm to the patient
- Serious or imminent risk of harm to other patients, carers, families or staff.

For concerns about individual issues (conduct, performance, impairment) refer to s4.3.

Sharing PRA advice

The advice provided by the PRA team is necessarily preliminary in nature, and the incident subject to a serious adverse event review (SAER).

When a PRA is carried out in the circumstances pursuant to Part 2A, Division 2 of the *Health Administration Act 1982*, it is subject to statutory privilege, that is reportable incidents (clinical Harm Score 1 incidents) and clinical Harm Score 2, 3 and 4 incidents determined by the CE to be due to a potential serious systemic problem.

The legislation places limits on how the contents of PRA advice can be used and to whom it can be disclosed. It may, for example, be shared with the family (s4.1.4). Refer to s4.5.4 for other circumstances when PRA advice may be disclosed.

4.1.3 Dedicated family contact (DFC)

The DFC is a primary staff contact who provides continuity during a SAER and beyond if required. DFC resources are on the CEC website. The role is assigned during the PRA and when more than one organisation is involved, they are from the lead Health Service.

The DFC has (or establishes) rapport, credibility and trust with patient, carer and family. They:

- Understand the family's preferred communication approach and concerns
- Provide practical assistance e.g. Social Worker, Interpreter, parking
- Liaise with the serious adverse event review (SAER) team and Open Disclosure team
- Organise meetings (e.g. following PRA)
- Invite the family to provide information to the SAER team leader
- Pass on family queries, recollections or recommendation ideas to the SAER team leader if a family declines the opportunity to engage directly
- Explain incident management processes and timelines

- Recognise and support cultural needs e.g. Aboriginal people (Communicating Positively), culturally and linguistically diverse (CALD) communities
- Consider the needs of people with a disability
- Set expectations about the scope of the review:
    - The focus is systems issues, not individuals
    - The review team do not determine the cause of death
    - Recommendations are approved by the Chief Executive.
- Suitable positions for this role may be:
    - Complaints Manager/Officer
    - Patient Experience Officer
    - Social Worker
    - Clinician or Senior Clinician
    - Nurse Unit Manager or Midwifery Unit Manager
    - Divisional Manager (Service Manager)
    - Aboriginal Health Practitioner
    - Aboriginal Liaison Officer.

In the event of conflict, the family or DFC may escalate to the Director of Clinical Governance for support. The Director of Clinical Governance may suggest an alternate DFC be assigned.

4.1.4 Sharing findings with the family

Following a clinical Harm Score 1 incident, what is known is to be shared with the patient, carer or family as it comes to hand, and in accordance with the NSW Health *Open Disclosure Policy* (PD2014_028).

Clinician disclosure is the first step in the open disclosure process, when a clinician or nominated person apologises to the patient, carer or family, and shares what is known and what actions have been taken.

Further guidance is in the NSW Health *Open Disclosure Policy* (PD2014_028) and in the *Open Disclosure Handbook*.

A DFC can arrange meetings for the family and open disclosure team

- As per the family's wishes
- After the PRA
- After completion of the serious adverse event review (SAER) findings report
- At completion of the SAER.

Following the PRA

The contents of a PRA report, or information obtained from that report, can be used for the purposes of discussion with the patient, carer or family via open disclosure following approval by the Chief Executive or delegate (e.g. Director of Clinical Governance).

Care must be taken with any such disclosures, as the contents of the advice are privileged, which means they are not admissible in any proceedings. It is therefore important that any

disclosure of PRA advice is identified as such. If there is a meeting a formal record must be kept of this meeting and marked as such. If a written document is provided to the patient, carer or family that contains information obtained from the PRA advice, it is important that that document is marked as such.

The disclosure should seek to avoid identifying any staff member or other person (other than the patient). It is also important that any disclosure of such information to the family is expressly stated to be preliminary information, and that it does not make any findings or conclusions, noting there will be a SAER.

As part of serious adverse event review

The findings of the SAER can be shared verbally with the family following approval by the Chief Executive or delegate.

At the completion of the SAER, the family is invited to a meeting for questions and is given the findings report and recommendations report, as per their wishes.

Serious incidents are often subject to review from a range of clinical perspectives. It may be appropriate to share relevant information from such reviews with the family via open disclosure.

4.2 Review of clinical HS1 incidents – serious adverse event review (SAER)

The Health Service conducts a SAER to identify and address systemic issues. A SAER is undertaken in two stages; findings and recommendations. For organisations using ims+, it is completed in the ims+ Investigation module, from team appointment through to reporting.

The SAER team prepares a findings report for the Chief Executive (CE). After considering the findings report, the CE may direct the team to prepare a recommendations report. The CE must direct a recommendations report if the findings report identifies areas for review findings. The CE may appoint additional team members to prepare the recommendations report.

The SAER findings report and recommendations report (if there is one) must be submitted to the Ministry of Health within 60 calendar days or sooner of notification in ims+. For incidents where the outcome changes to a Harm Score 1, the 60-day timeframe commences on the date the outcome changed.

The team may, at any point, determine the incident is beyond the scope of the SAER (refer to s4.3).

A referral to the Coroner or the NSW Police to investigate a death does not remove the requirement to undertake a SAER. A police or coronial investigation should not delay commencing a SAER. Seek advice from the Ministry of Health Legal Branch or facility lawyers as needed.

4.2.1 Approved review methods

Unless the Secretary directs otherwise, the CE determines the review method for each incident from the permitted methods outlined in the *Health Administration Act 1982* or the Regulations, being:

- Root cause analysis (RCA)
- The Systems Analysis of Clinical Incidents: The London Protocol published in August 2004 by the Imperial College London; or
- NSW Health Concise Incident Analysis; or

- NSW Health Comprehensive Incident Analysis.

A description of the NSW Health Concise Incident Analysis method is set out in Appendix E to this policy directive, and a description of the NSW Health Comprehensive Incident Analysis method is set out in Appendix F. Both the NSW Health Concise Incident Analysis and the NSW Health Comprehensive Incident Analysis methods are adapted from Parts 3.6.3 and 3.6.4 of the Canadian Incident Analysis Framework[8]. The choice between Concise or Comprehensive Incident Analysis is to be made by the Chief Executive based upon advice from the preliminary risk assessment (PRA) team.

Toolkits and workbooks for each review method are also available on the CEC website.

RCA

A method used to review and analyse incidents to identify the root causes and factors that contributed to an incident, and recommended actions. In NSW Health, the endorsed model of RCA is root cause analysis and action (RCA[2]), developed by the National Patient Safety Foundation[9], to ensure focus on the actions needed to reduce harm and improve safety.

The Systems Analysis of Clinical Incidents: The London Protocol

Otherwise known as the London Protocol, this review method seeks to identify care delivery problems and contributory factors. It was specifically designed for the acute healthcare setting by patient safety experts, Sally Taylor-Adams and Charles Vincent, and then enhanced for use across a broad range of healthcare settings[10].

NSW Health Concise Incident Analysis

This review method is described in Appendix E to this policy directive. In summary, this review method seeks to identify issues related to an incident and to consider those issues against categories of contributing factors. Incident analysis emphasises the interconnection between factors using a constellation diagram. The NSW Health Incident Analysis method is adapted from the Canadian Incident Analysis Framework.

NSW Health Comprehensive Incident Analysis

This review method is described in Appendix F to this policy directive. This review method is similar to the NSW Health Concise Incident Analysis, except that it involves a more comprehensive review including consideration of all nine IA domains and all guiding questions; and it is expected that the entire review process will require up to 60 calendar days from incident notification

4.2.2 Engaging staff, patients, carers and families

Patients, carers and families are to be engaged in the serious adverse event review process as per their wishes. The dedicated family contact can help to facilitate this.

Staff are to be provided with information about the SAER process.

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[8] https://psnet.ahrq.gov/issue/canadian-incident-analysis-framework

[9] https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-improving-root-cause-analyses-actions-prevent-harm.ashx

[10] Taylor-Adams, S. and Vincent, C. (2004) Systems analysis of clinical incidents: the London Protocol. *Clinical Risk* (10): 211 – 220.

Throughout the SAER, staff are to be reminded of the availability of support services (e.g. the Employee Assistance Program). Where applicable, provide staff with information on processes consistent with NSW Health Policy *Injury Management and Return to Work* (PD2013_006).

4.2.3 Appointing the SAER team

Team membership

The Chief Executive appoints a SAER team, which should generally be composed of approximately 3 to 5 members (although an SAER team can consist of one or more persons). The composition and number of the SAER should have regard to the following considerations:

- Some have essential knowledge of the care processes where the incident occurred
- No team member is to have been directly involved in the incident
- Preferably one member is external to the facility/service
- One team member (usually team leader) has SAER expertise
- Consider including representation on the team from relevant services e.g. eHealth NSW
- Consider including persons with relevant cultural expertise (e.g. Aboriginal Community Controlled Health Services) or specialised expertise (e.g. senior clinicians with experience responding to violence, abuse and neglect)
- For suspected suicide, a senior mental health clinician independent of the facility
- For suspected homicide or other serious crimes, a senior clinician from the relevant specialty independent of the service involved in care
- PRA assessors can be appointed to the team
- Team members should not:
    - Have a conflict of interest
    - Have been central to a patient's care
    - Be the manager of the department or unit where the incident occurred.

Team appointment

Team members receive a letter of appointment from the Chief Executive (CE) and are informed of their roles and responsibilities.

A Health Service CE can put a standing appointment in place for certain experienced staff to be core members of all SAERs (e.g. DCG, Patient Safety Manager). Once the remaining team members are identified, a CE appoints them with reference to the standing appointment using the template for additional members.

It is important records are maintained to demonstrate the team was properly constituted under the *Health Administration Act 1982*. Records to be retained include:

- An original copy of the letters of appointment
- The date of appointment
- The incident number and brief description

- The names of the team members.

Variation in team appointment process

The same review team can review more than one incident at the same time where incidents are of the same classification. The team reviews both/several incidents together and writes separate reports for each incident with common recommendations. There may be team leaders appointed for each incident within the review team. This variation to the review process is to be documented in the report.

4.2.4 Determine and write up findings report

The SAER team are to gather information from a range of sources and undertake interviews, in accordance with the relevant review method, to:

- Describe what happened
- Identify how it happened
- Identify any factors that caused or contributed to the incident, and link these to the outcome
- Identify any practices, processes or systems that could be reviewed (areas for review findings) for the purposes of a recommendations report.

The team must write up a findings report for the CE. They:

- Use the NSW Health Findings Report template
- Agree on the findings at a meeting or via email confirmation to the team leader
- Submit the findings report within ims+ to the CE or delegate
- The CE or delegate approves for the findings to be shared verbally with the family (s4.1.4)
- The CE or delegate must direct that a recommendations report be prepared if areas for review findings have been identified
- The CE or delegate may direct that a recommendations report be prepared if areas for review findings have not been identified
- If the CE or delegate does not direct a recommendations report be prepared, he or she can progress the findings report to Ministry of Health submission.

4.2.5 Assess need for additional team members

The CE is to decide whether to appoint additional members to the team to prepare the recommendations report. Expertise may include a:

- Clinician with knowledge of the service
- Quality improvement (QI) expert
- Human factors expert
- Redesign expert
- Senior manager
- Manager or leader from another service, facility or agency to support feasibility e.g. eHealth NSW for digital health tools such as the eMR

- Manager or leader from another service, facility or agency responsible for implementing a recommendation e.g. NSW Ambulance, Ministry of Health, eHealth NSW, NSW Health Pathology.

If additional experts are needed, a template for additional members is completed. The request is sent to the CE for approval and new members are formally appointed.

- The team leader sends the additional members a copy of the findings report
- The team meet (face-to-face where possible) and the team leader updates the new members about the review to date.

4.2.6 Develop and write up recommendations report

The SAER team develop and write up recommendations to address system issues. They are to:

- Use the NSW Health Recommendations Report template
- Recommend actions aimed at preventing or mitigating any factors that caused or contributed to the incident and/or system improvements unrelated to the incident
- Consider any suggested recommendations from the family
- Consult with another service if actions are recommended for a service not represented on the SAER team (issue interview letter beforehand)
- Consult with another organisation if actions are recommended for an organisation not represented on the SAER team (issue interview letter beforehand) and ensure CE from other organisation approves the recommendation/s
- Inform the CE about the proposed recommendations to enable the CE to consider and consult as required with other staff members and provide feedback to the team regarding the proposed recommendations. All such communication between the CE and the SAER team is privileged and in writing.
- Finalise and agree on the report within the SAER team via email confirmation to the team leader and progress the recommendations report to sign off.
- Store SAER documents as per “Storage and transfer of privileged material” in s4.5.2.

4.2.7 Sign off and submission to the Ministry of Health

A sign off meeting with the team leader (or delegate) and stakeholders may take place.

- The recommendations report is submitted within ims+ to the CE
- The CE reviews the recommendations report and:
    - endorses the recommendations; or
    - does not agree with one or more recommendations, documents reason/s and proposes alternate recommendation/s which are attached to the report.
- The CE can clarify the rationale for any recommendation with the team and/or consult with other staff about the team’s recommendations
- The recommendations report, with its findings report, is submitted to the Ministry of Health at MOH-Quality@health.nsw.gov.au.

The CE may choose to delegate responsibility for endorsing the recommendations, but remains accountable for the report and ensuring recommendations are implemented.

4.3 Beyond the scope of PRA assessors and SAER teams

4.3.1 Issues with individual clinicians

Preliminary risk assessments (PRAs) and serious adverse event reviews (SAERs) conducted under this Policy must not attempt to assess an individual's conduct, performance or competence. Where a question of individual conduct, performance or competence arises, it is managed via the performance management system and/or the NSW Health Policy *Managing Complaints and Concerns about Clinicians* (PD2018_032), with support from Human Resources, as required.

PRA and SAER teams can use decision trees to help determine individual versus systemic issues (available from the CEC website).

Professional misconduct, unsatisfactory professional conduct and impairment

Under section 20J(1) of the *Health Administration Act 1982*, where the serious adverse event review (SAER) team forms the opinion that an incident may involve professional misconduct, unsatisfactory professional conduct by a clinician, or that a clinician may be suffering from an impairment, the team **must** notify the CE in writing. "Professional misconduct", "unsatisfactory professional misconduct", and "impairment" have the same meaning as in Part 8 of the *Health Practitioner Regulation National Law (NSW)*.

Unsatisfactory professional performance

Under section 20J(2) of the *Health Administration Act 1982*, where the SAER team forms the opinion that an incident may involve unsatisfactory professional performance by a clinician, the team **may** notify the CE in writing. Although the team holds discretion to report in these circumstances, it would generally be expected that the team notify their concerns to the CE. "Unsatisfactory professional performance" means professional performance that is unsatisfactory within the meaning of Division 5 of Part 8 of the *Health Practitioner Regulation National Law (NSW)*.

Content of notification of conduct, performance or impairment issues

The SAER team's notification is to disclose the identity of the person to whom the notification relates. The notification is also to specify whether the concern relates to professional misconduct, unsatisfactory professional conduct or unsatisfactory professional performance or whether the person is or may be suffering from impairment together with a brief description of the nature of the concern.

A template letter can be used to inform the CE of an incident involving suspected individual conduct, performance or impairment issues.

The CE will determine appropriate action in accordance with the NSW Health Policy *Managing Complaints or Concerns About Clinicians* (PD2018_032).

Following the notification, the team will take no further action on the matter that relates to the individual.

The team may continue to review the **systems issues** in the incident. This may include exploring why staff involved in incidents acted as they did, and to pose appropriate questions to explore the human factors aspects of an incident (e.g. communication processes).

4.3.2 When to decommission

A serious adverse event review (SAER) is only decommissioned when:

- the SAER team believes individual clinician conduct, impairment or performance issues may be responsible for an incident with no potential system issues; and
- the Chief Executive considers that the incident was substantially caused by the conduct, performance or impairment issue and the team is not likely to identify other root causes, contributory factors or system improvements.

The Health Service notifies the Ministry of Health, stating the reason/s for decommissioning and submitting the completed front page of the report to MOH-Quality@health.nsw.gov.au.

4.4 When more than one organisation is involved

When multiple organisations are involved, the Clinical Excellence Commission (CEC) provides expertise in patient safety, quality improvement and governance.

Incidents may occur across:

- Health Service boundaries e.g. LHD and NSW Ambulance;
- Sectors e.g. primary and secondary care settings, public and private or non-government organisation (NGO);
- Jurisdictions.

Across Health Service boundaries

Where a reportable incident occurs across organisations, the Chief Executive (CE) of each organisation is still required to appoint assessors to conduct a preliminary risk assessment (PRA) and reviewers to undertake a serious adverse event review (SAER).

The CEs of the different organisations may decide to appoint the same assessors to the PRA and/or reviewers to the SAER, and each PRA and/or SAER team carry out the statutory functions on behalf of each entity concurrently.

- Oversight responsibility is with each DCG
- Each Health Service may be involved in open disclosure
- Each Health Service is represented on the PRA and SAER teams
- DCGs agree on whether to appoint one SAER team leader or co-leads to an incident
- Each CE signs off the findings report and recommendations report of the SAER
- Lead Health Service is incident specific and determined via communication between DCGs and the CEC. A key factor is the patient's primary care provider at the time of the incident.
- The DCG of the lead Health Service oversees the review and informs the other Health Service of their staff's involvement
- ims$^+$ incident transfer authority from one Health Service to another is with the DCGs
- The lead Health service is responsible for incident management within ims$^+$
- ims$^+$ is the preferred document storage location for cross boundary incident reviews.
- Issues that cannot be resolved between DCGs are referred to Director Patient Safety, CEC.

PRA and SAER teams can access patient health information for the purpose of a review across two or more Health Services and share the information without patient consent in accordance with the requirements in the *Health Records and Information Privacy Act 2002*.

Across sectors

The Director of Clinical Governance (DCG) is responsible for incident management and the process discussed and agreed on with a senior representative from the other sector to meet the legislated/licensing requirements of each entity. The DCG may involve staff from the other sector in the incident reporting and review, depending on the incident severity.

On commencement of the amendments introduced with the *Health Legislation Amendment Act (No. 3) 2018,* where a clinical incident involves both a public Health Service and a private health facility licensed under the *Private Health Facilities Act 2007*, both entities may be required or permitted to carry out a PRA and/or SAER under legislation (under the *Private Health Facilities Act 2007*, licensed private health facilities are required to carry out a PRA and SAER in relation to reportable incidents, and are also permitted to carry out a PRA and/or SAER in respect of other clinical incidents where the incident indicates there may be a serious systemic problem).

Once the amendments to the *Private Health Facilities Act 2007* commence, the Health Service and licensed private health facility can elect to carry out a "joint" PRA and/or SAER, as follows:

- Each entity separately appoints the same PRA assessors and/or SAER team members and each team carries out the statutory functions, on behalf of each entity, concurrently.
- The PRA assessors and SAER team conduct meetings and interviews in the capacity of both teams, effectively at the same time. Documentation of these processes makes it explicit that the team is acting in two different statutory capacities simultaneously in carrying out these activities.
- SAER team members need to ensure that they address notification requirements of the *Health Administration Act 1982* and the *Private Health Facilities Act 2007* e.g. in relation to possible misconduct or unsatisfactory professional conduct.
- A report is required for each entity, although, depending upon the findings and recommendations, the content of these reports could be the same.

Across jurisdictions

Other Australian States and Territories may be engaged in a Health Service SAER through:

- Being represented on, or interviewed by, the SAER team
- Providing a copy of requested medical records and/or other documents.

Access to another jurisdiction's medical records for the purpose of a SAER is generally governed by privacy legislation in that jurisdiction. Seek further advice from the CEC or the Ministry of Health Legal Branch as needed.

Formal correspondence from the Chief Executive to his or her equivalent in the other jurisdiction supports the SAER team and outlines what the team is seeking and that the information and process are covered by privilege.

4.5 Privilege

4.5.1 Why privilege is important

When a reportable incident occurs, it is important that staff feel safe to speak frankly about what happened and what they observed. Health Services can then learn from such

incidents. Privilege supports people who feel concern for their confidentiality when asked for their recollections of an incident.

4.5.2 What the privilege covers

The work of preliminary risk assessment (PRA) assessors and serious adverse event review (SAER) teams convened by Chief Executives for reportable incidents attracts statutory privilege. The privilege provided under Part 2A of the *Health Administration Act 1982* applies to:

- Any document prepared for the dominant purpose of the exercise of functions of a PRA or SAER
- Any communication, written or verbal, between a PRA assessor and another person, for the dominant purpose of the PRA. This may include, for example, communications between the PRA assessor and clinicians involved in the incident, or expert advice sought by an assessor from a clinical governance or other expert for the purpose of the PRA.
- Any communication, written or verbal, between a SAER team member and another person, for the dominant purpose of the SAER. This may include, for example, communications between the SAER team and clinicians involved in the incident, or expert advice sought by the SAER team from a clinical governance or other expert for the purpose of the SAER.
- Examples of privileged documents may include internal working documents generated during the PRA or SAER process, including preliminary notes, records of interviews with staff/clinicians, minutes of meetings and records of discussions with various people either involved in the incident or with fundamental knowledge of the incident or processes involved.

This means that:

- PRA assessors and SAER team members cannot be compelled to produce or give evidence of any such documents or communications
- Any person who is not an assessor or SAER team member who creates a document or makes communications (written or verbal) for the dominant purpose of assisting with the conduct of the PRA or SAER (this may include administrative assistants to the PRA or SAER, clinicians involved in the incident, or experts engaged by the team to assist with the review) cannot be compelled to produce or give evidence of the document or communication
- The advice of the PRA assessor and the SAER report cannot be adduced or admitted as evidence in any proceedings (including coronial proceedings, or any proceedings in which it is claimed a procedure or practice was careless or inadequate)
- PRA assessors and SAER team members acting in good faith for the purposes of the exercise of their statutory functions are also protected from personal liability, including actions for defamation.

To protect privilege, documents or written communications are marked ‘privileged’ and verbal communications are noted as ‘privileged’.

Confidentiality requirements

PRA assessors and SAER team members are bound by strict confidentiality requirements, making it an offence for them to disclose information obtained during the PRA or SAER, unless it is for the purpose of the PRA or SAER or in other limited defined circumstances.

Privilege for reportable incident briefs (RIBs) and the CRAG

Clinical RIBs and the work of the Clinical Risk Action Group (CRAG) are subject to separate statutory privilege under *s23* of the *Health Administration Act 1982*. Clinical RIBs are solely for the purpose of advice to the CRAG, and to be maintained securely and not used for any other purpose.

Storage and transfer of privileged material

To protect the privilege, internal working documents are to be maintained in a separate PRA or SAER team file marked "privileged" and stored securely in a location nominated by the Director of Clinical Governance to ensure the privilege is upheld in the event of a subpoena or application for access under the *Government Information (Public Access) Act 2009 (GIPA)*. This can be in a physical location or electronic system, such as ims+ with access permissions for people appointed to a team, a secure electronic filing system (e.g. TRIM) with specific permissions for each incident or eHealth SharePoint.

Privileged material is not to be sent in the general post. It must be sent by secure internal transport. Health Services require policies and procedures in place to manage the transfer of such materials.

Documents for storage include meeting notes, interviews, interviewee letters, confirmation emails approving findings and recommendations, email discussions within the team, and internal working documents (e.g. butchers paper and post-it notes).

Team members return paperwork to the team leader for confidential disposal consistent with *State Records Act* obligations.

Retention of privileged documents

Records relating to PRA and SAER team functions are to be retained under the same rules applying to "legal matters and incident management" under clause 1.14 of the *General Retention and Disposal Authority — Public Health Services: Patient/Client Records (GDA 17)*. Under this requirement, the records must be retained for a minimum of 7 years after the last action, or until the patient attains, or would have attained, the age of 25, whichever is longer. As the records are not admissible in court or other proceedings and can only be accessed by members of the PRA and SAER teams, the 7-year period applies whether or not legal proceedings have been commenced.

4.5.3 What the privilege does not cover

Statutory privilege does not cover:

- Pre-existing documents, such as clinical incident summaries, medical records or other records created in the course of providing general care of patients or management of the Health Service, and not as part of the PRA or SAER
- Notifications made by the SAER team under section 20J of the *Health Administration Act 1982* which relates to a team notification to the CE where the team forms the opinion that the incident raises matters that may involve professional misconduct, unsatisfactory professional conduct, impairment or unsatisfactory professional performance of an individual clinician
- Incident notification, including information entered into ims+

- Any communication not for the dominant purpose of the PRA or SAER
- Documents created or communications made before a PRA or SAER team was commissioned.

4.5.4 Disclosure of information

PRA assessors and SAER teams to s23 Committees

Information exchanged between PRA assessors and/or SAER teams to one or more of the following committees will retain privilege through the protections granted to the committees under s23 of the *Health Administration Act 1982*.

- Clinical Risk Action Group (CRAG)
- Special Committee for Investigating Deaths Under Anaesthesia (SCIDUA)
- Collaborating Hospitals Audit of Surgical Mortality Committee (CHASM)
- Maternal and Perinatal Mortality Review Committee (MPMRC).

PRA Disclosure

Information is to be disclosed to the patient, carer or family via Open Disclosure, in accordance with s4.5.2 above.

The CE may authorise release of the PRA advice to:

- the SAER team;
- the Secretary, NSW Health;
- a person or committee authorised under s23;
- a law enforcement agency or regulatory body;
- others prescribed in the Regulations;

in accordance with s4.5.2 above.

Disclosure of SAER reports

The SAER findings report and recommendations report remain privileged (in that they cannot be adduced in any proceedings) but can be lawfully provided to any person.

Incidents for the Coroner or Police

If the Coroner requests the SAER findings and recommendations reports, the Health Service is to provide it so the Coroner is aware of any system changes since the incident. They cannot, however, be tendered in evidence. If lawyers have been engaged to represent the Health Service, the panel firm should forward the findings and recommendations reports to the Coroner using a standard pro-forma letter which alerts the Coroner to S20O and S20P of the *Health Administration Act 1982*. If lawyers are not engaged, the CE provides a covering letter with the reports noting they are for information only and cannot be adduced or admitted in any proceedings, pursuant to S20P of the *Health Administration Act 1982*.

4.6 Implement and monitor actions – clinical HS1 incidents

Managers are responsible for implementing recommendations arising from a SAER.

Health Services are to:

- Monitor the implementation of recommendations
- Have escalation processes for recommendations that cannot be progressed
- Report to peak Health Services committees, Executive team and Board.

4.7 Feedback – clinical HS1 incidents

Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and their recommendations

Health Services are to also feedback lessons learned and proposed changes to a broader group of clinicians and managers e.g. at service or unit meetings, morbidity and mortality (M&M) meetings and Grand Rounds.

The Health Service is to inform families of the outcome of a serious adverse event review (s4.1.4).

5 CLINICAL HARM SCORE 2 INCIDENTS

Major harm to a patient is a clinical HS2 incident.

5.1 Escalate clinical HS2 incidents

- Staff escalate as per Harm Score 3 and 4 incidents (s6.1)
- Managers notify senior management
- Health Services complete a RIB as required (s3.1.1 and s3.1.3)
- Health Services undertake a PRA if directed by the CE for incidents that may be due to a serious systemic problem (s4.1.2).

5.2 Review of clinical HS2 incidents

Health Services have procedures in place for the review of major harm incidents.

Health Services are to:

- Specify management responsibility
- Initiate and maintain communication with the patient, carer and family in keeping with their wishes
- Undertake formal open disclosure as needed
- Engage with other agencies where indicated e.g. eHealth NSW
- Appoint a review team to undertake an incident review
- Consider members from relevant departments for the review team
- Determine a review method, and if in dispute, the Director of Clinical Governance decides the review method for an incident
- Undertake aggregate reviews of similar Harm Score 2 incidents as needed
- Identify, plan, implement and evaluate organisational Quality Improvement activities.

5.2.1 Incident review teams

Review teams are to:

- Use a structured review method to identify underlying factors and recommend actions to improve patient safety and reduce risk of harm
- Use Health Service review tools
- Engage with relevant departments e.g. Pharmacy, patient flow, Aboriginal Medical Service (AMS)
- Write up their findings and recommendations using a Health Services report template.

5.3 Implement and monitor actions – clinical HS2 incidents

Managers are responsible for implementing report recommendations arising from the incident review.

Health Services are to:

- Monitor the implementation of recommendations
- Have local escalation processes for recommendations that cannot be progressed
- Report to relevant peak Health Services committees, Executive team and Board.

5.4 Feedback – clinical HS2 incidents

Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and their recommendations.

Health Services are to also feedback lessons learned and proposed changes to a broader group of clinicians and managers e.g. at service or unit meetings, mortality and morbidity (M&M) meetings and Grand Rounds.

Health Services are to inform patients, carers, families or other people involved of outcomes and provide a clinical HS2 report or written summary to the family as appropriate.

6 CLINICAL HARM SCORE 3 AND 4 INCIDENTS

Minor harm to a patient is a clinical Harm Score (HS) 3 incident. No patient harm or a near miss is a clinical HS4 incident.

6.1 Escalate concerns to a manager

Staff are to seek advice from their manager when:

- A patient may not have been informed of an incident at the time it occurred
- Potentially more than one patient may be affected (e.g. Lookback process)
- Another service/unit may need to be notified e.g.
    - Pharmacy about a medication error
    - Pathology services about a blood product issue
    - NSW Ambulance about a transfer incident
    - Biomedical engineering and HealthShare Procurement about a faulty device
- External discussion may be needed e.g. general practitioner

- An external regulator may need to be notified e.g. SafeWork NSW, NSW Food Authority, NSW Environmental Protection Authority (EPA), Therapeutic Goods Administration (TGA)
- NSW Police may need to be contacted e.g. suspected criminal activity
- You have any concerns.

If the CE determines a clinical Harm Score 3 or 4 incident may be due to a serious systemic problem, the Health Service will complete a reportable incident brief and, if directed by the CE, undertake a preliminary risk assessment.

6.2 Review of clinical HS3 and 4 incidents

Managers are to undertake service/unit reviews. They:

- Review the medical record and/or documentation
- If concerned after initial review, escalate to senior management
- Liaise with clinicians and teams as needed
- Assess the physical location of the incident if needed
- Refer to relevant NSW Health and Health Service policies e.g. *Medication Handling in NSW Public Health Facilities* (PD2013_043), *Work Health and Safety: Better Procedures* (PD2018_013), Protecting People and Property Manual
- Refer to guidelines and local procedures
- Analyse the review findings
- Inform patients, carers, families and notifiers of progress
- Devise solutions with staff and patients, carers or families where possible.

Managers can review similar incidents together to identify emerging issues and take action to reduce potential risks.

Managers review complaints according to the NSW Health *Complaint Management Policy* (PD2020_013) and NSW Health *Complaint Management Guidelines* (GL2020_008) and compliments for feedback to clinicians and teams. No Harm Score is allocated to complaints or compliments.

6.3 Implement and monitor actions – clinical HS3 and 4 incidents

Following review, managers are to:

- Develop and document action plans in ims+
- Engage the team to implement actions
- Monitor and adjust actions as needed
- Track progress over time (e.g. control charts) to ensure positive change.

6.4 Feedback – clinical HS 3 and 4 incidents

Managers are to:

- Inform patients, carers, families, other people involved and notifiers of outcomes
- Present incident data and review findings at unit/team meetings

- Share the evaluation of actions with staff and seek suggestions as needed.

7 CORPORATE HARM SCORE 1 INCIDENTS

A corporate HS1 incident is death of a worker or visitor, or complete loss of service.

7.1 Escalate corporate HS1 incidents

- Managers are to notify senior management
- Health Services are to complete a RIB
- Health Services are to undertake a safety check.

7.1.1 CE escalation to the Ministry of Health – corporate incidents

For corporate incidents with possible state-wide implications, potential to become a matter of public interest, potential loss of public confidence, or contentious issues, the CE or delegate must immediately contact the Ministry of Health.

The relevant Deputy Secretary advises the Secretary as needed, who in turn advises the Minister's office as appropriate.

7.1.2 Safety check

Undertake a safety check for corporate Harm Score 1 incidents within 72 hours, or sooner as directed by the Chief Executive (CE) or Ministry of Health. A safety check is not privileged.

The purpose of a safety check is to provide advice to the CE to:

- Understand the events
- Identify immediate actions for people and the environment to be safe
- Identify, mitigate and escalate immediate risks
- Guide the response to an incident and subsequent review.

The safety check team is one or more people appointed by the CE via:

- Memo template
- Email or
- Standing appointment arrangement.

The safety check team's composition and expertise are incident dependent. It is recommended to include a Clinical Governance member for corporate incidents where there is possible clinical impact. Team members must not have been directly involved in the incident, unless unavoidable.

Safety check advice

The safety check team are to undertake a safety check of the incident and may attend the incident location. They complete a safety check report documenting their advice and understanding of events.

A NSW Health safety report template must be used for submission to the CE.

A safety check action log can be used to support actions arising from the safety check.

The safety check team is to immediately escalate to the CE in writing concerns of:

- Serious or imminent risk of harm to patients, visitors or staff
- Continuing critical risk due to loss of service.

For concerns about individual issues (conduct, performance, impairment) refer to s7.3.

Sharing safety check advice

The advice provided by the safety check team is necessarily preliminary in nature, and the incident subject to a corporate HS1 review. For incidents involving death or suspected suicide of a staff member, safety check advice may be shared with the family (s7.1.4).

7.1.3 Dedicated family contact (DFC) – corporate incidents

The DFC is a primary staff contact assigned to a family during a safety check for incidents involving death or suspected suicide of a staff member. They provide continuity during a corporate HS1 review and beyond if required. DFC resources are on the CEC website.

The DFC has (or establishes) rapport, credibility and trust with the family. They:

- Understand the family's preferred communication approach and concerns
- Provide practical assistance e.g. social worker, interpreter, parking
- Liaise with the review team and Open Disclosure team
- Organise meetings (e.g. following PRA)
- Invite the family to provide information to the review team leader
- Pass on family queries, recollections or recommendation ideas to the review team leader if a family declines the opportunity to engage directly
- Explain incident management processes and timelines
- Recognise and support cultural needs e.g. Aboriginal people (Communicating Positively), culturally and linguistically diverse (CALD) communities
- Consider the needs of people with a disability
- Set expectations about the scope of the review
- The focus is systems issues, not individuals
- The review team do not determine the cause of death
- Recommendations are approved by the CE.
- Suitable positions for this role may be:
- Complaints Manager/Officer
- Patient Experience Officer
- Social Worker
- Clinician or Senior Clinician
- Nurse Unit Manager or Midwifery Unit Manager
- Divisional Manager (Service Manager)
- Aboriginal Health Practitioner
- Aboriginal Liaison Officer.

In the event of conflict, the family or DFC may escalate to the Director of Corporate Governance (or equivalent) for support and an alternate DFC may be assigned.

7.1.4 Sharing findings with family – corporate HS1

Following a corporate HS1 incident involving staff death or suspected suicide, what is known is to be shared with the family as it comes to hand. Any communications or documents arising from a safety check or corporate HS1 review are not privileged.

A dedicated family contact can arrange meetings for the family and open disclosure team

- As per the family's wishes
- After the safety check
- At completion of the corporate HS1 review.

7.2 Review of corporate HS1 incidents

Health Services are to undertake corporate Harm Score (HS) 1 reviews of corporate HS1 incidents. A corporate HS1 review report is due to the Ministry of Health within 60 calendar days of incident notification in ims+. For incidents where the outcome changes to a Harm Score 1, the 60-day timeframe commences on the date the outcome changed.

Systems in place for clinical HS1 incidents (e.g. team appointment, sign off etc.) can be used, however privilege does not apply to corporate incidents. Findings and recommendations can be separated, and additional team members considered for the development of recommendations, however this is not required by legislation.

The NSW Health Corporate HS1 Review Report template is to be used. Alternatively, the Serious Adverse Event Review (SAER) Findings Report template and Recommendations Report template may be adapted for use.

Care is to be taken when undertaking a corporate HS1 review that it does not prejudice a Police or coronial investigation. Any review by the Health Service is to be limited to whether there were any systems issues that may have contributed to the incident.

7.2.1 Approved methods – corporate

The review method is determined by the type of incident and undertaken using corresponding review processes set out in a NSW Health Policy, for example:

- WHS incidents, see *Work Health and Safety: Better Procedures* (PD2018_013)
- Security related incidents, see the *Protecting People and Property Manual*
- Suspected privacy breaches, see:
    - *Privacy Management Plan* (PD2015_036)
    - *NSW Health Privacy Internal Review Guidelines* (GL2019_015)
    - *Privacy Manual for Health Information*.

7.2.2 Engage staff and families

Families are to be engaged in the review process as per their wishes. The dedicated family contact can help to facilitate this.

Engage staff by providing information about the review process. Advise staff they can also contact their professional association or union for further advice.

Throughout the review, staff are to be reminded of the availability of support services (e.g. the Employee Assistance Program). Where applicable, staff are provided with information on injury management and return to work processes consistent with NSW Health Policy *Injury Management and Return to Work* (PD2013_006).

7.2.3 Review team – corporate

Team composition is incident dependent. The team is made up of approximately 3 to 5 members appointed by the Chief Executive (CE) or nominated officer.

- Some members have essential knowledge of the corporate processes in the area where the incident occurred, but were not directly involved
- One member (usually team leader) has WHS experience
- Preferably one member is external to the facility/service
- Consider including relevant services (e.g. eHealth NSW)
- Consider including of persons with cultural expertise (e.g. Aboriginal Community Controlled Health Services) or specialised expertise (e.g. senior clinicians with experience responding to violence, abuse and neglect)
- For suspected suicide, a senior mental health clinician
- Safety check team members can be appointed to the team
- Team members should not:
    - Have a conflict of interest
    - Be the manager of the department or unit where the incident occurred.

Variation in team appointment process

The same review team can review more than one incident at the same time where incidents are of the same classification. The team reviews both/several incidents together and writes separate reports for each incident with common recommendations. There may be team leaders appointed for each incident within the review team. This variation to the review process is to be documented in the report.

7.2.4 Determine findings and recommendations – corporate

The review team is to:

- Gather information from a range of sources and undertake interviews
- Visit the incident location where appropriate
- Analyse findings and develop recommendations as needed
- Consider any suggested recommendations from others involved or concerned
- Prepare a report for the Chief Executive including:
    - Incident description and ims+ incident number
    - A summary of the findings
    - Any underlying factors as to why the incident occurred
    - Any recommendations to prevent and minimise the risk of recurrence.

The NSW Health Corporate Harm Score 1 Review Report template is to be used, or the Serious Adverse Event Review (SAER) Report templates adapted for use.

7.2.5 Corporate HS1 review report sign off

Once finalised, the report is to be progressed to sign off. This may include a formal sign off meeting with the team leader or delegate and key stakeholders.

- The final corporate HS1 review report is submitted within ims+ to the CE
- The CE reviews the report and:
    - Endorses the recommendations; or
    - Does not agree with one or more recommendations, documents reason/s and proposes alternate recommendation/s which are attached to the report.
- The CE can clarify the rationale for any recommendation with the team and/or consult with other staff about the team's recommendations

The report is to be submitted to the Ministry of Health at MOH-Quality@health.nsw.gov.au and the CE is to ensure final notifications are completed as required by legislation and/or relevant policies, including the *Service Check Register for NSW Health* (PD2013_036).

7.2.6 Document storage – corporate HS1 review

Documents for storage include meeting notes, interviews, interviewee letters, confirmation emails approving findings and recommendations, email discussions within the team, and internal working documents (e.g. butchers paper and post-it notes).

Documents are to be stored securely in a physical location or electronic system with permission controls e.g. ims+, secure electronic filing system or eHealth SharePoint.

Team members must return paperwork to the team leader for confidential disposal.

7.3 Beyond the scope of corporate HS1 review teams

7.3.1 Issues with individuals

Corporate HS1 reviews conducted under this Policy must not attempt to assess an individual. Where a question of individual negligence or misconduct arises, it is managed via the performance management system and/or NSW Health Policy *Managing Complaints and Concerns about Clinicians* (PD2018_032), with support from Human Resources, as required.

Corporate HS1 review teams can use decision trees to help determine individual versus systemic issues (see Resources).

7.3.2 When to discontinue a corporate HS1 review

A corporate HS1 review is discontinued when:

- the review team believe issues with an individual may be responsible with no potential system issues, and
- the CE considers the incident was substantially caused by issues with an individual and that the team is not likely to identify other root causes, contributory factors or system improvements.

The Health Service notifies the Ministry of Health stating the reason/s for discontinuing and submits the completed front page of the report to MOH-Quality@health.nsw.gov.au.

7.4 When more than one organisation is involved - corporate

- Oversight responsibility is with the lead Chief Executive (CE) or delegate
- Each Health Service may be involved in open disclosure
- Each Health Service is represented on the safety check and corporate HS1 review teams
- Each CE signs off the corporate HS1 review report
- The CE with agreed primary responsibility oversees the corporate HS1 review and informs the other Health Service of their staff's involvement
- ims+ is the preferred document storage location for cross boundary incident reviews.

7.5 Implement and monitor actions

Managers are responsible for implementing report recommendations arising from an incident review.

Health Services are to:

- Monitor the implementation of recommendations
- Have local escalation processes for recommendations that cannot be progressed
- Report to relevant peak Health Services committees, Executive team and Board.

7.6 Feedback – corporate HS1 incidents

Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and their recommendations.

Health Services are to feedback lessons learned and proposed changes to a broader group of clinicians and managers e.g. at service or unit meetings.

The Health Service is to inform families of the outcome of a corporate HS1 review staff death or suspected suicide (s7.1.4).

8 CORPORATE HARM SCORE 2 INCIDENTS

A corporate HS2 incident involves major harm to a worker or visitor, or major loss or disruption of service.

8.1 Escalate corporate HS2 incidents

- Staff escalate as per Harm Score 3 and 4 incidents (s9.1)
- Managers notify senior management
- Health Services complete a RIB as required (s3.1.2 and s3.1.3)
- Health Services undertake a safety check if needed.

8.2 Review of corporate HS2 incidents

When reviewing corporate HS2 incidents, Health Services are to:

- Specify management responsibility
- Undertake formal open disclosure as needed for WHS incidents

- Identify relevant NSW Health Policy requirements
- Engage with other agencies where indicated
- Appoint a review team to undertake an incident review
- Consider members from relevant departments for the review team
- Include worker representation on review teams for WHS incidents
- Undertake aggregate reviews of similar Harm Score 2 incidents as needed
- Identify, plan, implement and evaluate organisational QI activities.

8.2.1 Incident review teams

Review teams are to use a review method and tools set out in a NSW Health Policy, for example:

- WHS incidents, see *Work Health and Safety: Better Procedures* (PD2018_013)
- Security related incidents, see the *Protecting People and Property Manual*
- Suspected privacy breaches, see:
  - *Privacy Management Plan* (PD2015_036)
  - *NSW Health Privacy Internal Review Guidelines* (GL2019_015)
  - *Privacy Manual for Health Information*.

If no relevant NSW Health Policy exists, the review team uses a structured method and Health Service tools to analyse the incident and recommend actions to improve safety and reduce risk.

The review team engages relevant departments e.g. WHS, Human Resources, Engineering, Security. A report is to be written up with findings and recommendations, using a NSW Health Policy specified or Health Service report template.

8.3 Implement and monitor actions – corporate HS2 incidents

Managers are to implement report recommendations arising from an incident review.

Health Services are to:

- Monitor the implementation of recommendations
- Have local escalation processes for recommendations that cannot be progressed
- Report to relevant peak Health Services committees, Executive team and Board.

8.4 Feedback – corporate HS2 incidents

Health Services are to provide feedback to staff involved in an incident, so staff understand reviewers' conclusions and their recommendations.

Health Services are to also feedback lessons learned and proposed changes to a broader group of staff and managers e.g. at service or unit meetings.

The Health Services are to inform families or other people involved of outcomes and provide a corporate HS2 report or written summary to the family as appropriate.

9 CORPORATE HARM SCORE 3 AND 4 INCIDENTS

A corporate HS3 incident involves minor harm to a worker or visitor, or minor loss or disruption of service. No harm or a near miss is a corporate HS4 incident.

9.1 Escalate concerns to a manager – corporate incidents

Staff are to seek advice from a manager when:

- Another service/unit may need to be notified e.g. Biomedical engineering and HealthShare Procurement about a faulty device
- External discussion may be needed e.g. a supplier
- An external regulator may need to be notified e.g. SafeWork NSW, NSW Food Authority, NSW Environmental Protection Authority (EPA), Therapeutic Goods Administration (TGA)
- Police may need to be contacted e.g. suspected criminal activity
- You have any concerns.

9.2 Review of corporate HS3 and 4 incidents

Managers are to undertake service/unit reviews. They:

- Review the medical record and/or documentation
- If concerned after initial review, escalate to senior management
- Liaise with clinicians and teams as needed
- Assess the physical location of the incident if needed
- Refer to relevant NSW Health and Health Service policies e.g. *Medication Handling in NSW Public Health Facilities* (PD2013_043), *Work Health and Safety: Better Procedures* (PD2018_013), Protecting People and Property Manual
- Refer to guidelines and local procedures
- Analyse the review findings
- Inform patients, carers, families and notifiers of progress
- Devise solutions with staff and patients, carers or families where possible.

Managers can review similar incidents together to identify emerging issues and take action to reduce potential risks.

Managers review complaints according to the NSW Health *Complaint Management Policy* (PD2020_013) and the NSW Health *Complaint Management Guidelines* (GL2020_008), and review compliments for feedback to clinicians and teams. No Harm Score is allocated to complaints or compliments.

9.3 Implement and monitor actions – corporate HS3 and 4 incidents

Following review, managers are to:

- Develop and document action plans in ims+
- Engage the team to implement actions
- Monitor and adjust actions as needed
- Track progress over time (e.g. control charts) to ensure positive change.

9.4 Feedback – corporate HS 3 and 4 incidents

Managers are to:

- Inform families, other people involved and notifiers of outcomes
- Present incident data and review findings at unit/team meetings
- Share the evaluation of actions with staff and seek suggestions as needed.

10 APPENDIX LIST

Appendix A: Statutory health corporations and Affiliated health organisations

Appendix B: Incident management summary tables

Appendix C: Which clinical incident management elements are privileged and who can they be disclosed to?

Appendix D: Reportable Incident Definition

Appendix E: NSW Health Concise Incident Analysis

Appendix F: NSW Health Comprehensive Incident Analysis

Appendix A: Statutory health corporations and Affiliated health organisations

In addition to Local Health Districts, NSW Ambulance and divisions of the Health Administration Corporation that provide clinical services, such as NSW Health Pathology and HealthShare, the following organisations are defined as “relevant health services organisations” subject to the privilege provisions under the *Health Administration Act 1982*:

Statutory health corporations

- The Justice Health and Forensic Mental Health Network
- The Sydney Children’s Hospitals Network (Randwick and Westmead) (incorporating The Royal Alexandra Hospital for Children)

Affiliated health organisations

Name of organisation	Recognised establishment or service
Calvary Health Care (Newcastle) Limited	• Calvary Mater Newcastle
Calvary Health Care Sydney Limited	• Calvary Health Care Sydney
Catholic Healthcare Limited	• St Vincent's Health Service, Bathurst • Lourdes Hospital and Community Health Service *(other than Holy Spirit Dubbo)*
Hammondcare Health and Hospitals Limited	• Braeside Hospital, Prairiewood • Greenwich Hospital, Greenwich • Neringah Hospital, Wahroonga • Northern Beaches Palliative Care Service
Karitane	Child and Family Health Services at: • Carramar • Fairfield • Liverpool • Randwick
Mercy Hospitals NSW Ltd	• Mercy Care Centre, Young (excluding Mount St Joseph's Nursing Home) • Mercy Health, Albury
Royal Rehab	• General rehabilitation services • Brain injury rehabilitation services • Spinal injury rehabilitation services • Extended care services
Royal Society for the Welfare of Mothers and Babies	Tresillian Family Care Centres at: • Belmore • Broken Hill • Coffs Harbour • Dubbo • Lismore • Penrith • Queanbeyan • Taree • Willoughby • Wollstonecraft
St Vincent's Hospital Sydney Limited	• Sacred Heart Health Service • St Joseph's Hospital, Auburn • St Vincent's Hospital, Darlinghurst
The Uniting Church in Australia	• War Memorial Hospital, Waverley

Appendix B: Incident management summary tables

Table 1: Incident management steps for clinical Harm Score (HS) 1 to 4 incidents

CLINICAL	HS 1	HS 2	HS 3	HS 4
Incident description	Reportable incidents – Unexpected death or Australian Sentinel Event	Major harm	Minor harm	No harm or Near miss
Step 1: Identify incident				
Clinician disclosure (< 24 hours)	Yes	Yes	Yes	No harm – generally, yes Near miss – generally, no
Step 2: Ensure safety				
Immediate care to patients, staff or visitors involved	Yes	Yes	Yes	Yes
Make the environment safe	Yes	Yes	Yes	Yes
Support to patients, carers and families	Yes	Yes	Yes	Yes
Support to staff	Yes	Yes	Yes	Yes
Step 3: Notify incident				
Incident management system (<24 hours)	Yes	Yes	Yes	Yes
Step 4: Escalate incident				
Escalate as required	Staff to manager to senior manager	Staff to manager to senior manager	Staff to manager as needed	Staff to manager as needed
RIB: Part A – 24 hours Part B – 72 hours or sooner	Yes, always	Yes, some incidents – as per s3.1.1 & s3.1.3	Generally, no	Generally, no
PRA: 72 hours or sooner Dedicated family contact assigned	Yes	If directed by Chief Executive to undertake PRA	Generally, no	Generally, no

CLINICAL	HS 1	HS 2	HS 3	HS 4
Step 5: Review incidents				
Type of review	Serious adverse event review (SAER) by SAER team	Clinical HS2 review by review team	Service/unit level review by manager	Service/unit level review by manager
		If directed by Chief Executive, a SAER to be undertaken by SAER team for incident due to serious systemic problem.		
Report	Yes	Yes	No	No
Submission timeframe	Findings report to CE (<60 days) Findings report and recommendations report to MoH in 60 calendar days or sooner	45 calendar days to Clinical Governance	Not applicable	Not applicable
Potential for aggregate review	No	Yes	Yes	Yes
Step 6: Implement and monitor actions				
Implement	As per recommendations	As per recommendations	Yes	Yes
Monitoring oversight	Executive	Senior management	Manager (service/unit level)	Manager (service/unit level)
Step 7: Feedback to staff and patients, carers and families				
To staff	Yes	Yes	Yes	Yes
To patients, carers and families	Yes. Via open disclosure	Yes. Can be via open disclosure	Yes	No harm– generally, yes Near miss– generally, no
Feedback loop				

Table 2: Incident management steps for corporate Harm Score (HS) 1 to 4 incidents

CORPORATE	HS 1	HS 2	HS 3	HS 4
Incident description	**Death of worker or visitor or Complete loss of service**	**Major harm to worker or visitor OR Major loss or disruption**	**Minor harm to worker or visitor OR minor loss or disruption**	**No harm Near miss**
Step 1: Identify incident				
Clinician disclosure (< 24 hours)	Yes, for death of worker	No	No	No
Step 2: Ensure safety				
Immediate care to people involved	Yes	Yes	Yes	Yes
Make the environment safe	Yes	Yes	Yes	Yes
Support to patients, carers and families	Yes, for death of worker	No	No	No
Support to staff	Yes	Yes	Yes	Yes
Step 3: Notify incident				
Incident management system (<24 hours)	Yes	Yes	Yes	Yes
Step 4: Escalate incident				
Escalate as required	Staff to manager to senior manager	Staff to manager to senior manager	Staff to manager as needed	Staff to manager as needed
RIB: Part A – 24 hours Part B – 72 hours or sooner	Yes, always	Yes, if determined by CE (s3.1.2) or a mandatory matter (s3.1.3)	Generally, no	Generally, no
Safety check: 72 hours or sooner	Yes	As needed	Generally, no	Generally, no
Dedicated family contact assigned	Yes, for death of worker	No	No	No

CORPORATE	HS 1	HS 2	HS 3	HS 4
Step 5: Review incident				
Type of review	Corporate HS1 review by review team	Corporate HS2 review by review team	Service/unit level review by manager	Service/unit level review by manager
Report	Yes	Yes	No	No
Submission timeframe	Corporate HS1 report to MoH in 60 calendar days or sooner	45 calendar days to Corporate Governance or General Manager	Not applicable	Not applicable
Potential for aggregate review	No	Yes	Yes	Yes
Step 6: Implement and monitor actions				
Implement	As per recommendations	As per recommendations	Yes	Yes
Monitoring oversight	Executive	Senior management	Manager (service/unit level)	Manager (service/unit level)
Step 7: Feedback to staff and patients, carers and families				
To staff	Yes	Yes	Yes	Yes
To patients, carers and families	Yes, for death of worker	No	No	No
Feedback loop				

Appendix C: Which clinical incident management elements are privileged and who can they be disclosed to?

Privilege applies to reportable incidents, being clinical Harm Score (HS) 1 incidents. It also applies to clinical HS2, 3 and 4 incidents determined by the Chief Executive to be due to a potential serious systemic problem. Privilege **does not** apply to corporate incidents.

Element	Clinical Harm Score (HS) 1	Disclosure – What and Who	Clinical HS2, HS3 and HS4
Reportable Incident Brief (RIB)	Yes	RIB document to Clinical Risk Action Group (CRAG)	As per s3.1.1 and s3.1.3
Preliminary risk assessment (PRA)	Undertaking a PRA – Yes PRA advice/report – Yes PRA action log – No	PRA advice provided verbally to patient, carer or family via open disclosure process following Chief Executive (CE) or delegate approval. On request and following CE approval, PRA advice can be provided to people or bodies approved in the legislation or the Regulations.	As per HS1, if CE determines incident may be due to serious systemic problem.
Serious adverse event review (SAER)	Undertaking a SAER – Yes Working documents of SAER team – Yes Findings report – Yes – limited privilege (see next column) Recommendations report – Yes – limited privilege (see next column)	Findings verbally to patient, carer or family via open disclosure process following CE or delegate approval. The findings report and recommendations report can be disclosed to anyone, where appropriate, but cannot be admitted into evidence.	As per HS1, if CE determines incident may be due to serious systemic problem.

If in doubt, seek advice from the Ministry of Health Legal Branch.

Appendix D: Reportable Incident Definition

Under the provisions of Part 2A of the *Health Administration Act 1982* when a "reportable incident" involving a relevant Health Services organisation is reported to the Chief Executive of the organisation, the organisation is to undertake a preliminary risk assessment (PRA) and to appoint a serious adverse event review (SAER) team in relation to the reportable incident.

For the purposes of the *Health Administration Regulation 2020*, a "reportable incident" is defined as follows:

- The **death** of a patient unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management;
- **Suspected suicide** of a person (including an inpatient or community patient) who has received care or treatment for a mental illness from the relevant Health Services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;
- **Suspected homicide** committed by a person who has received care or treatment for mental illness from the relevant Health Services organisation within six months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;
- Unexpected intra-partum stillbirth;

OR

- An Australian Sentinel Event (**ASE**) (see below for definitions of expressions used to describe ASEs) being:
    - Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death.
    - Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death.
    - Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death.
    - Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death.
    - Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death.
    - Suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward.
    - Medication error resulting in serious harm or death.

- Use of physical or mechanical restraint resulting in serious harm or death.
- Discharge or release of a child to an unauthorised person.
- Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death.

ASE definitions

"discharge or release of a child to an unauthorised person"[11]	A **child** defined as any person under the age of 15. An **unauthorised person** is defined as a person who is not a parent or legal guardian of the infant or child, or is a person who is the subject of a legal order preventing access to the infant or child.
"suspected suicide of a patient within an acute psychiatric unit or acute psychiatric ward"[2]	An **acute psychiatric unit or acute psychiatric ward** is defined as a specialised unit or ward that is dedicated to the treatment and care of admitted patients with mental illness or mental disorder. This includes specialist psychiatric units or psychiatric wards within emergency departments. For the purposes of this sentinel event 'acute psychiatric unit' and 'acute psychiatric ward' refer to psychiatric units and wards where all three of the following criteria apply: The psychiatric unit or psychiatric ward is specifically designed with fixtures and fittings that minimise the opportunity for patient suicide The psychiatric unit or psychiatric ward is specifically designed to prevent any unauthorised ingress or egress Observation protocols are applied within the psychiatric unit or psychiatric ward.
"unintended retention of a foreign object in a patient after surgery or other invasive procedures resulting in serious harm or death"[2]	**Unintended** incidents are where any relevant objects retained in a patient after surgery or other invasive procedure were not intentionally retained. A foreign object may be intentionally left in the patient where further action to locate and/or retrieve the object would be more damaging than retention or impossible, for example where the patient is not yet clinically stable.
"use of physical or mechanical restraint resulting in serious harm or death"[2]	**Restraint** is defined as the restriction of an individual's freedom of movement by physical or mechanical means. **Physical restraint** means the bodily force that controls a person's freedom of movement. **Mechanical restraint** means a device that controls a person's freedom of movement.
"invasive procedure"[2]	An **invasive procedure** is defined as a medical procedure that enters the body, usually by cutting or puncturing the skin or by inserting a needle, tube, device or scope into the body.
"serious harm"[2]	**Serious harm** is indicated where, as a result of the incident, the patient: • requires life-saving surgical or medical intervention, or • has shortened life expectancy, or • has experienced permanent or long-term physical harm, or

[11] Australian Commission on Safety and Quality in Health Care. Australian sentinel events list (version 2) – Development and specifications https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-sentinel-events-list-version-2-development-and-specifications.

- has experienced permanent or long-term loss of function.

Psychological harm

Psychological harm is recognised as an important harm. In the context of the sentinel events list, psychological harm has not been included in the definition of serious harm given the inability to measure psychological harm in the way that physical harm can be measured.

Appendix E: NSW Health Concise Incident Analysis

A serious adverse event review (SAER) team is to gather available sources of information for review. It is recommended practice for the team to comprise a minimum of two team members, although the team can include only one member. The team is to supplement this information with targeted interviews, of up to 30 minutes each. The SAER team is to agree upon key stakeholders for interview. Interviewees may include family, staff or others.

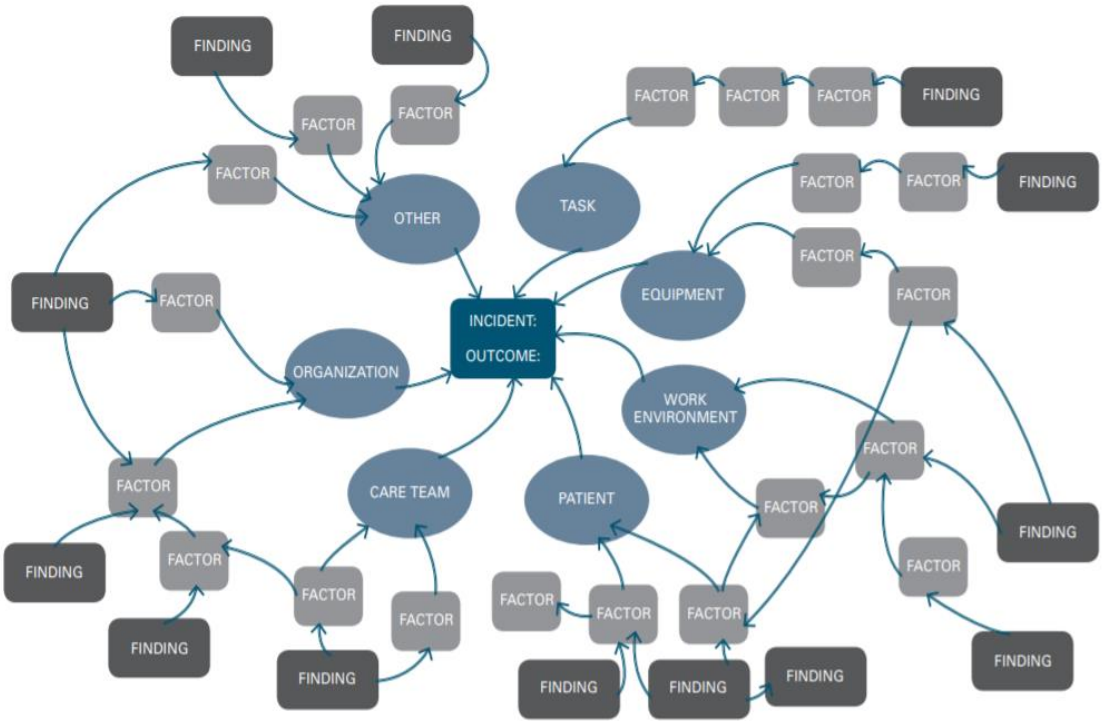
The SAER team is to construct a detailed incident chronology, which is to be a starting point for identifying system-based factors underlying the incident. There are up to nine domains that the SAER team may consider in a Concise Incident Analysis:

1. Patient(s) characteristics (in the context of how well the system identified, understood, and acted upon these factors)
2. Task (care/work process)
3. Care team – Caregiver(s)
4. Care team – Supporting team (all involved in care process)
5. Equipment (including materials, fixtures, information and communication systems)
6. Work environment
7. Organisation – Policies and priorities
8. Organisation – Culture
9. Organisation – Capacity (resources)

The SAER team are to determine which of the nine IA domains are relevant to the incident and review the *Guiding Questions* those domains. The Patient characteristics domain must not be the only domain to be considered by the team. Responses to the guiding questions are to be used to identify factors which caused or contributed to the incident.

The SAER team is to construct a constellation diagram (see example below) using these factors to analyse the interconnections between the factors.

Diagram 1: Example of a constellation diagram (reproduced from Canadian Incident Analysis Framework, 2012)



If, following their submission of a findings report, the SAER team is directed to prepare a recommendations report, the team must consider recommended actions for such a report. Prior to finalisation of the recommendations report, the SAER team is to assess the recommended actions against an effectiveness hierarchy. Such a hierarchy recognises that recommended actions have varying degrees of effectiveness. The SAER team is determine the most effective action or actions that are reasonable and/or practicable. Actions that are lower in an effectiveness hierarchy, such as policies and education, can be appropriate but are best when used in combination with more effective action categories. Stronger actions are ones which reduce the risk of human error by designing systems that have forcing functions and automation and rely less on decision making.

It is expected that a Concise IA is to be completed within approximately 30 days of incident notification.

Appendix F: NSW Health Comprehensive Incident Analysis

The NSW Health Comprehensive IA has five key differences to its Concise IA counterpart. It is recommended to be undertaken by a SAER team comprised of more team members (although the team may include one or more persons); interviewing must capture all relevant stakeholder perspectives; the team may undertake a simulation to aid their understanding of the incident; the team must consider all nine IA domains and all guiding questions; and it is expected that the entire review process will require up to 60 calendar days from incident notification.

A SAER team comprising three or more team members is to gather comprehensive sources of information for review. This is to include a site visit to the location where the incident occurred and may include an incident simulation. The team is to undertake detailed interviews with all relevant stakeholders, including family, staff or others.

The SAER team is to construct a detailed incident chronology, which is to be a starting point for identifying system-based factors underlying the incident. They review guiding questions against all of the nine IA domains, (being the same domains that apply to NSW Health Concise Incident Analysis in Appendix E). The Patient characteristics domain must not be the only domain to be considered by the team. Responses to the guiding questions are to be used to identify factors which contributed to the incident.

The SAER team is to construct a constellation diagram using these factors to analyse the interconnections between the factors.

If, following their submission of a findings report, the SAER team is directed to prepare a recommendations report, the SAER team must consider recommended actions for such a report. Prior to finalisation of the recommendations report, the SAER team is to assess the recommended actions against an effectiveness hierarchy. Such a hierarchy recognises that recommended actions have varying degrees of effectiveness. The SAER team is determine the most effective action or actions that are reasonable and/or practicable. Actions that are lower in an effectiveness hierarchy, such as policies and education, can be appropriate but are best when used in combination with more effective action categories. Stronger actions are ones which reduce the risk of human error by designing systems that have forcing functions and automation and rely less on decision making.

Guiding questions

Patient(s) characteristics: (Considered in the context of how well the system identified, understood, and acted upon these factors.)
Did the patient (s) have the information to assist in avoiding the incident?
If not, what would have supported the patient in assisting their care team?
Did factors like age, sex, medications, allergies, diagnosis, other medical conditions, contribute to the incident? How did they contribute?
Did any social or cultural factors contribute to the incident?
Was language a barrier?

Other?
Task (care/work process)
Were there previous or predicted failures for this task or process?
Were specialised skills required to perform the task?
Was a fixed process or sequence of steps required (e.g. order sets, checklists)?
If a fixed process existed, was it followed?
Was a protocol available, was it up-to-date, and was it followed in this case?
Were there constraints or pressures (e.g. time, resources) when performing the task?
Was the information required to make care decisions available and up-to-date (e.g. test results, documentation, patient identification)?
Was there a risk assessment/audit/quality control program and in place for the task/process?
Other?
Care team – Caregiver(s)
Were the education, experience, training and skill level appropriate?
Was fatigue, stressors, health or health factors an issue?
Was the workload appropriate?
Was appropriate and timely help or supervision available?
Other?
Care team – Supporting team (all involved in care process)
Was there a clear understanding of roles and responsibilities?
Was the quality and quantity of communication (verbal and/or written) between team members appropriate (clear, accurate, free of jargon, relevant, complete, and timely)?
Were there regular team briefings/debriefings about important care issues?
Was team morale good? Did team members support each other?
Were the communication channels available and appropriate to support the needs of the team (e.g., email, pager, and phone)?
Other?
Equipment (including materials, fixtures, information and communication systems)
Were the displays and controls understandable?
Did the equipment automatically detect and display problems?

Was the display functional?
Were the warning labels, reference guide, and safety mechanisms functional and readily visible/accessible?
Were the maintenance and upgrades up-to-date?
Was the equipment standardised?
Would the users describe this equipment as easy to use?
Were the communication systems (phone, pager, software, hardware, etc.) available and operational?
Other?
Organisation - Policies and priorities
Were the relevant policies and procedures available, known, and accessible, and did they meet the needs of users?
Were there workarounds to the documented policy/procedure?
Was there a mechanism in place to identify and resolve gaps between policy and practice?
Were the strategic priorities of the organisation clear to all?
Other?
Organisation – Culture
Was everyone (patients, clinicians, other staff) comfortable to speak-up about safety concerns?
Was there visible support from leadership and the board for safe patient care?
Was communication between staff and management supportive of day-to-day safe patient care?
Were incidents viewed as system failures with a mechanism/transparent process for fair and just review of actions by individuals where indicated?
Other?
Organisation – Capacity (resources)
Did scheduling influence the staffing level, or cause stress, or fatigue?
Was there sufficient capacity in the system to perform effectively (e.g., access to resources)?
Other?

Other – consider
Are there any factors that prevented this event from happening on a more regular basis?
Where there any factors or actions taken that mitigated the severity of the event?
Were there any local conditions or circumstances that may have influenced the incident and/or an outcome?
Were there any other contextual conditions or circumstances that may have influenced the incident and/or outcome?
Other?

PARENTS AND CITIZENS ASSOCIATIONS INCORPORATION ACT 1976

Section 21 (1) (d)

NOTICE OF CANCELLATION OF INCORPORATION OF PARENTS AND CITIZENS ASSOCIATION

The incorporation under the *Parents and Citizens Associations Incorporation Act 1976* of the following association is hereby cancelled:

1. Wadalba Community School

Sarah Mitchell
Minister for Education and Early Childhood Learning

Vocational Training Order under the *Apprenticeship and Traineeship Act 2001*

I, David Collins the Commissioner for Vocational Training, in pursuance of *section 5* of the *Apprenticeship and Traineeship Act 2001* make the following Order on:

30 October 2020

David Collins
Commissioner for Vocational Training

Vocational Training Order

Traineeship vocation designated:

- Business Services – Social Media Marketing

Commencement

This Order commences on 30 October 2020 the day on which it is published in the NSW Government Gazette and takes effect when published on the Training Services NSW website being the same day.

https://www.training.nsw.gov.au/cib_vto/index.html

Vocational Training Order under the *Apprenticeship and Traineeship Act 2001*

I, David Collins, the Commissioner for Vocational Training, in pursuance of *section 5* of the *Apprenticeship and Traineeship Act 2001* make the following Orders.

30 October 2020

David Collins, Commissioner for Vocational Training

1 Vocational Training Order

Apprenticeship Vocations designated:

- Engineering - Casting and Moulding Trade
- Engineering - Fixed and Mobile Plant Mechanic
- Engineering - Refrigeration and Air Conditioning
- Engineering - Toolmaking Trade

2 Commencement

This Order commences on 30 October 2020 when published in the NSW Government Gazette and takes effect when published on the Training Services NSW website being the same day.

https://www.training.nsw.gov.au/cib_vto/index.html