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Incident Reporting and Management

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1. Overview/procedure description

This procedure outlines the purpose of the incident reporting system at RCH, the **Victorian Health Incident Management System (VHIMS)**, the responsibilities of RCH staff in reporting incidents when they occur and the follow-up required.

2. Related Policy

Quality Improvement & Risk Management Policy

3. Definition of Terms

- **Incident**
  - **Clinical** - An event or circumstance which could have resulted, or did result, in unintended or

unnecessary harm to a person receiving care (Australian Commission on Safety and Quality in Healthcare, ACSQHC 2006).

- **Workplace Health and Safety** – an event or circumstance resulting in harm or potential harm to one or more staff members, contractors or visitors.
- **Corporate** – damage or potential damage to facilities, reputation or non-clinical or non-workplace health and safety incident A clinical incident can be an adverse event : An incident in which harm resulted to a person receiving health care (ACSQHC 2006).

- An incident can be an **adverse event** : An incident in which harm resulted to a person receiving health care (ACSQHC 2006), a staff member of RCH, a visitor or contractor or damage to buildings, reputation or RCH operations.
- An incident can be a **near miss** : An incident that did not cause harm (ACSQHC 2006) damage or interruption to RCH operations. Near misses encompass incidents that had potential to cause harm or interruption to operations but didn't, due to timely intervention and/or luck/chance.
- **Sentinel Events** are relatively infrequent, clear-cut events that occur independently of a patient's condition, commonly reflect hospital system and process deficiencies and result in unnecessary outcomes for patients.
- **Just culture** exists when staff feel comfortable disclosing errors, including their own, while maintaining professional accountability. A just culture recognises many individual or "active" errors represent predictable interactions between human operators and the systems in which they work. A just culture does not tolerate conscious disregard of clear risks to patients, staff or other operations or gross misconduct (Agency for Healthcare Research and Quality)
- **Open disclosure** refers to the process of open communication with patients and their families following an adverse event or an unexpected event that may or may not result in harm to the patient (Department of Health).

4. Procedure details

Adverse events are an important public health issue. Studies have estimated that adverse events occur in 3.5% to 16% of admissions to hospital. Incidents can result in significant impact in terms of harm to patients, staff, visitors and contractors or damage to buildings and infrastructure or disruption to operations

Risk management processes state that there should be identification of risk, analysis of events leading to a risk occurring and treatment of the risk to decrease the likelihood of recurrence. It is important for RCH to collect details about incidents, the response to the incident in terms of ensuring patient and staff safety, integrity of infrastructure and maintenance of operations and identifying actions taken to minimise the likelihood of an incident recurring. Monitoring incident trends in an area or across the organisation allows a greater understanding of issues. Reporting of incidents facilitates early reporting to the RCH insurers for those incidents with legal implications. At RCH VHIMS has been implemented to collect this data with the ultimate goal of improving safety and service continuity. RCH supports the fostering of a just culture, the incident reporting system is part of a series of quality systems implemented across the organisation to support improvements in the safety and quality of care and services provided.

VHIMS has been established by the Department of Health, Victorian health services and other key stakeholder groups, for collection and review of statewide incident information. All RCH staff are required to have a log-on to VHIMS. Staff can log-on to VHIMS via the front page of the intranet, then follow log-on instructions. When setting up a log-on staff must use their RCH email address. Staff must nominate their manager as part of the log-on process. Assistance is available from the Quality Support Officer on 6957.

When an incident occurs staff should ensure any harm as a result of the incident is minimised. Relevant staff should be informed that the incident has occurred, for example the nurse in charge of the shift or a Departmental Managers. If the incident is a clinical incident patients and families should be informed of the adverse event and any treatment required as a result, in keeping with the RCH Open Disclosure procedure.

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Once all appropriate steps have been taken in response to the incident an incident report should be completed on VHIMS. It is an RCH expectation that all incidents are reported within 24 hours of occurrence. Details should be provided in an objective manner.

Managers will be notified of all incidents reported by staff who have nominated them as their manager. Managers are required to review all incidents within two working days of receipt. As part of the incident management process managers should debrief staff involved in serious incidents and access support services, should these be required. For Workplace Health and Safety Incidents members of the RCH Workplace Health and Safety Department are also advised and will follow up with affected staff, visitors or contractors.

Managers need to investigate an incident, seeking to understand factors which contributed to the incident occurring and identifying system changes that will minimise the likelihood of the incident recurring. Managers are then required to complete the incident follow-up section of the VHIMS report:

- Investigation/Findings
- Investigated By
- How to prevent re-occurrence
- Specific details of controls/changes to made
- Internal Review

The incident follow up is to be completed by managers within 21 days of an incident occurring. The follow up of incidents will be reviewed by staff within the Strategy and Organisational Improvement, Risk and Information Management or Workplace Health and Safety Departments and incidents will be closed when no further action is required. Closure of incidents within 30 days is an organisational key performance indicator and reported to the Clinical Quality and Safety Committee or Corporate Quality and Risk Committee. Staff reporting incidents are encouraged to review the incident follow-up to ascertain actions taken in response to the incident occurring. Feedback about incidents should be provided to all unit or department meetings

Incidents which are rated as 1 (severe harm) or 2 (moderate harm) may require a critical incident review. This process is coordinated by staff within;

- Strategy and Organisational Improvement for clinical incidents
- Workplace Health and Safety for workplace health and safety incidents
- Risk and Information Management for all other incidents

Incidents are reported to the Patient Safety Committee, Workplace Health and Safety Committee or Corporate Quality and Risk, with the reporting line determined by the nature of the risk. Managers are required to assist with the review process; supporting staff, sourcing information, participating in analysis of the incident and assisting with determining appropriate recommendations for system change.

Incident data is analysed at a department, division and organisation level and used to identify risks and opportunities for improvement. Clinical incident data is reviewed monthly by the Clinical Quality & Safety Committee and Division Quality Committees.

Ongoing education about incident management and use of VHIMS is provided Strategy and Organisational Improvement

5. Reference

www.health.vic.gov.au/clinrisk/vhims/index.htm

6. Related procedures

Open Disclosure Procedure

Critical Incident Review Process (for staff) procedure

Policies and Procedures : Risk Management Procedure

Workplace Health and Safety Risk Management Procedure

7. Contacts

- Director of Quality Systems
- Director Risk and Information Management
- Director Workplace Health and Safety

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