Health Service Directive Patient Safety

Guideline for Clinical Incident Management

1. Purpose

This Guideline provides recommendations regarding best practice for clinical incident management.

2. Scope

This Guideline applies to all Hospital and Health Service employees and all Department of Health employees working in or for Hospital and Health Services. This Guideline also applies to all organisations and individuals acting as an agent for Hospital and Health Services (including Visiting Medical Officers and other partners, contractors, consultants and volunteers).

3. Guideline for Clinical Incident Management

Clinical incidents can and do occur in the course of providing healthcare. By recording, analysing and learning from these clinical incidents, both at the Hospital and Health Service level and at the state-wide level, future incidents and patient harm may be minimised.

The Patient Safety Unit reviews clinical incident data and clinical incident analysis reports from both the Queensland public health system and from the coronial system. Trends relating to patient safety issues are analysed and the results are shared with Hospital and Health Services to help reduce the potential for preventable patient harm.

3.1 Incident Reporting

3.1.1 Hospital and Health Services should have an established local documented process for identifying, managing and reporting any clinical incident which has resulted in actual or potential patient harm.

3.1.2 This process should include specific roles and responsibilities for recording all clinical incidents in PRIME Clinical Incidents (CI) database as soon as practicable after the incident has occurred. At a minimum, and in accordance with the Patient Safety Health Service Directive, Severity Assessment Code
3.1.3 The local clinical incident processes should also include, or link to, a process for identifying and managing patient safety issues/risks (refer: Guideline for Patient Safety Notification System QH-HSDGDL-032-3).

3.1.4 Hospital and Health Services should have a local process for directly notifying any significant incident to the Director-General. If there is any question about whether or not to notify the Director-General, this should be discussed with the Senior Departmental Liaison Officer on telephone 3234 1570.

3.2 Incident Analysis

3.2.1 Hospital and Health Services should have an established local documented process for incident analysis and should include incidents that will be subject to analysis, the method of analysis and the roles and responsibilities for those involved with the incident analysis process.

3.2.2 This process should include timeframes for the completion of incident analysis. At a minimum, and as required by the Patient Safety Health Service Directive, SAC1 incidents should undergo incident analysis within 90 calendar days of the incident being reported.

3.2.3 The process should include a specific role responsibility to submit the SAC1 analysis report to the Patient Safety Unit. As required by the Patient Safety Health Service Directive, the SAC1 analysis report should be submitted within 90 calendar days of the incident being reported. Where a SAC1 analysis report cannot be submitted within 90 calendar days of the incident being reported, an email should be sent to the Patient Safety Unit advising the reason for the delay and the anticipated completion date.

3.2.4 A SAC1 analysis report must contain:
- A factual description of the event
- The factors identified as having contributed to the event
- Recommendations to prevent or reduce the likelihood of a similar event happening again.

PSU contact details for SAC1 incident analysis reports:
Phone: 3646 3849
Email: PSQ-SAC1DOCUMENTS@health.qld.gov.au

3.3 Coronial Recommendation Management

3.3.1 Hospital and Health Services should have an established local process for recording and actioning any recommendations made by a Coroner to the Hospital and Health Service following a coronial inquest.
3.3.2 There is no requirement for a Hospital and Health Service to accept and implement a coronial recommendation. However, there is a requirement to contribute to whole-of-government public reporting on any government response to a coronial recommendation.

3.3.3 The process should include a documented process for decision-making about all recommendations. If recommendations are accepted, a plan for implementing and monitoring those recommendations should also be documented.

3.3.4 The process should also include a specific role responsibility for submitting a preliminary response to coronial recommendations to the Patient Safety Unit, as required by the Patient Safety Health Service Directive. This response should be submitted by email on the Coronial Response Template within 30 calendar days of the inquest findings being delivered. Updates should continue to be provided every 60 calendar days until the implementation of any accepted recommendations has been completed.

3.3.5 The Coronial Response Template is available on QHEPS.

**PSU contact details for coronial management:**
Phone: 3646 3848
Email: psccoronal@health.qld.gov.au

4. Supporting and related documents

**Authorising Health Service Directive**
- Patient Safety (QH_HSD_032:2013)

**Related Guidelines**
- Guideline for Patient Safety Notification System (QH-HSDGDL-032-3)

**Legislation**
- Hospital and Health Boards Act 2011
- Hospital and Health Boards Regulation 2012

**Forms and Templates**
- Draft Guide to Best Practice Clinical Incident Management
- Coronial Response Template
- PRIME handbook, information sheets, forms, templates and training tools
5. Definition of Terms

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<tr>
<th>Term</th>
<th>Definition / Explanation / Details</th>
<th>Source</th>
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<tbody>
<tr>
<td>Clinical incident</td>
<td>Any event or circumstance which has actually or could potentially lead to unintended and/or unnecessary mental or physical harm to a patient</td>
<td>Clinical Incident Management Guideline</td>
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<tr>
<td>SAC</td>
<td>Severity Assessment Code, the measurement of consequences to a patient associated with a clinical incident. The SAC score (1, 2 or 3) is used to determine the appropriate level of analysis, action and escalation for clinical incidents.</td>
<td>Clinical Incident Management Guideline</td>
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<tr>
<td>SAC 1</td>
<td>Death or likely permanent harm which is not reasonable expected as an outcome of healthcare.</td>
<td>Clinical Incident Management Guideline</td>
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6. Approval and Implementation

Guideline Custodian
Kirstine Sketcher-Baker, Senior Director, Patient Safety Unit, Health Services Innovation Branch, Health Service and Clinical Innovation Division

Appointing Officer:
Kirstine Sketcher-Baker, Senior Director, Patient Safety Unit, Health Services Innovation Branch, Health Service and Clinical Innovation Division

Approval date: 01/08/2013
Effective from: 01/08/2013

7. Version Control

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