DWK 48

Queensland Government
Queensland Health

Policy Identifier:
23360

QUEENSLAND HEALTH POLICY STATEMENT:
Incident Management Policy

10 June 2004

Policy Title	**Queensland Health Incident Management Policy**
Policy Statement	All incidents, clinical and non-clinical, shall be managed within Queensland Health's Integrated Risk Management Framework for Clinical and Corporate Services (2002), according to this statewide policy and instruction. Queensland Health Districts, Statewide Services and Corporate Office are required to adopt and implement this statewide incident management policy. This policy requires managers to establish and maintain governance and management structures and accountabilities that manage, report, investigate and analyse incidents and near misses. It is mandatory to report and manage sentinel events and events with very high and extreme risk rating according to this policy. All employees of Queensland Health must be aware of and comply with this policy and instruction.
Policy scope	This policy covers all incidents, clinical and non-clinical, including "workplace incidents" as defined in the *Workplace Health and Safety Act 1995.* This policy focuses on potential and actual incidents that have or are likely to have very high or extreme risk rating.
Aims	To improve safety To reduce risk To learn from underlying causes of incidents and near misses and to implement systems to reduce the likelihood of recurrence
Principles	The following principles underpin the Queensland Health Incident Management Policy and shall be reflected in managing incidents at all levels. ***1. Duty of care*** Queensland Health and its staff have a duty to take reasonable care to avoid causing harm to patients, visitors, employees and contractors.

Sponsor: Deputy Director-General, Policy and Outcomes
Issued by: Health Strategy and Funding Branch
Incident Management Policy
10 Jun 2004

98

Principle 4 of Queensland Health's Code of Conduct (2002) requires *employees to take reasonable care to avoid causing harm to themselves or other people.*

Clinicians and managers have an ethical responsibility to maintain honest communication with patients and their support person, even when things go wrong. The Open Disclosure Standard procedures are to be followed[1].

2.Focus on system improvement
Most incidents and near misses are caused by a chain of events and system failures, not by an individual. Analysis and investigations are to focus on improving systems of care and shall be reviewed for their effectiveness.

3.Part of integrated risk management framework
Investigation of clinical and non-clinical incidents is to be conducted through processes that focus on the management of risk according to Queensland Health's Integrated Risk Management Policy.

4. Effective governance and management
Incident management is an essential part of good governance. It is a management tool and relies on a system of accountability.

Managers authorise, establish and actively maintain the incident management structure and system. Managers resource, support and encourage staff participation.

5. Consistent with Queensland Health's legal obligations
Incidents are reported, investigated and analysed according to statutory obligations and requirements (*see Legislation and Associated documentation p 4),* procedural fairness and natural justice.

Reporting and investigation of certain incidents is a legal obligation for executives and managers in Queensland Health.

If incident management systems fail due to reasonable fear of adverse consequences of disclosure of information, one option is to pursue statutory protection or qualified privilege for a committee, under s31 of the *Health Services Act* (see p15).

6. Matches service capability
The incident management model is flexible to meet the different service configurations/capability around the State and local circumstances.

[1] *Open Disclosure Standard – a national standard for open communication in public and private hospitals, following an adverse event in healthcare* Australian Council for Safety and Quality in Health Care, July 2003

Queensland Government
Queensland Health

QUEENSLAND HEALTH INSTRUCTION
To Policy Statement 23360

Policy Title	**Queensland Health Incident Management Policy**
Scope and Application	All Queensland Health employees (permanent, temporary and casual), its agents, Visiting Medical Officers and other partners in care, contractors, consultants and volunteers.
Effective date	
Supersedes	New policy
Compliance	Incident Management is applicable to all Queensland Health services including Health Service Districts, Statewide Services and Corporate Office. All services are required to adopt and implement the endorsed systematic approach to risk management including incident management.
Review Cycle and Responsibilities	The Integrated Risk Management Program will review this policy within 12 months from the date of issue.

Sponsor: Deputy Director-General, Policy and Outcomes
Issued by: Health Strategy and Funding Branch
Incident Management Policy
10 Jun 2004

Legislation and Associated Documentation	*Queensland Acts* Child Protection Act 1999 Civil Liability Act 2003 Crime & Misconduct Act 2001 Coroners Act 2003 Electrical Safety Act 2002 Dangerous Goods Safety Management Act 2001 Freedom of Information Act 1992 Health Act 1937 Health Services Act 1991 Mental Health Act 2000 Personal Injuries Proceedings Act 2002 Public Safety Preservation Act 1986 Public Sector Ethics Act 1994 Public Service Act 1996 Whistleblowers Protection Act 1994 Workplace Health and Safety Act 1995 Workers Compensation and Rehabilitation Act 2003 *Policy and standards (Queensland Health)* including: Code of Conduct 2000 Complaints Management 2002 (Policy number 15184) Information Standard No 42A Information Privacy for Queensland Department of Health 2001 Informed Consent for Invasive Procedures 2002 (Policy number 14025) Integrated Risk Management for Clinical and Corporate Services Program – Guidance Document 2002 Integrated Risk Management 2002 (Policy number 13355) Policy Statement and Guidelines on the Treatment and Management of Abuse and Neglect of Children and Young People (0-18years) 2003 Public Patients Charter 2003 (*Your Rights and Responsibilities* - Making the most of a visit to your health service) Queensland Health Disaster Plan 2002 Queensland Health WorkCover Claims Management Guidelines 2002 IRM 3.1-2 Workplace Harassment – Standards of Appropriate and Ethical Behaviour in the Workplace IRM 3.1-4 Policy and Procedures for the management of public interest disclosure in accordance with the WPA 1994: 2000 IRM 3.1-5 Official Misconduct – requirements and process for reporting 2002 IRM 3.2-1 Workplace Health and Safety Policy 2000 (outlines systems for the management of incidents related to health and safety events) and Workplace Health and Safety Management Plan 1999 IRM 3.8-3 January 2003 Indemnity for Employees and Other Persons (Excluding Medication Practitioners) – Health Service Districts IRM 3.8-4 December 2002 Indemnity for Queensland Health and Other Approved Medical Practitioners *Other* Open Disclosure Standard – a national standard for open communication in public and private hospitals, following an adverse event in healthcare Australian Council for Safety and Quality in Health Care, July 2003
Corporate Office file	1236-0355-007
Further	Contact the Principal Project Officer Incident Management, Integrated Risk

Sponsor: Deputy Director-General, Policy and Outcomes
Issued by: Health Strategy and Funding Branch
Incident Management Policy
10 Jun 2004

information	Management Program, phone (07) 3234 1724

CONTENTS

Incident categories

In this policy, an incident is defined as *an event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person or the organisation, and/ or a complaint, loss or damage.*

Incidents include those also defined in legislation including:

The *Workplace Health and Safety Act 1995* defines "workplace incident" as

- *an incident resulting in a person suffering a work injury; or*
- *a work caused illness; or*
- *a dangerous event; or*
- *another matter decided by the Minister to be a workplace incident.*

The *Personal Injuries Proceedings Act 2002* defines "incident" *in relation to personal injury, means the accident, or other act, omission or circumstance, alleged to have caused all or part of the personal injury.*

Two (2) categories of incidents are identified in this policy:

1. Potential – that is a hazardous situation that is detected prior to the patient, customer, client, consumer or staff being harmed this could include near misses
2. Actual – including adverse and serious adverse incidents

Incidents can be risk evaluated and rated by considering likelihood of occurrence and severity of consequences. **This policy focuses on potential and actual incidents that have or are likely to have very high or extreme risk rating (see Appendix 1).**

A sentinel event is an event that signals that something serious or sentinel has occurred and warrants in depth investigation.

Sentinel event list

Where a sentinel event occurs, it must be immediately reported, then investigated, actioned and communicated in accordance with the incident management model contained in this policy.

Queensland Health has deemed the following actual incidents as sentinel events:

1. Surgery/procedure on the wrong patient/wrong body part

	2. Deaths including[2]: (a) suicide of a patient (b) death of a patient as a direct and immediate result of medication error (c) death of a patient during inter-hospital transfer (d) direct maternal death (e) sudden and unexpected death of an infant associated with labour or delivery (f) death of a patient during surgery (g) "unexpected" death of a patient 3. Haemolytic blood transfusion reaction resulting from ABO incompatibility 4. Instrument or other materials inadvertently left in body cavity or operation wound following a procedure 5. Intravascular gas embolism resulting in death or neurological damage 6. Infant discharged to wrong family 7. Death of an employee during the course of their duties **Mental health specific:** 8. Suicide or unexpected death in respect of: • Any patient (inpatient or community) of a mental health service. • Any person who has been in contact with a mental health service or emergency department within the 7 days preceding the incident. 9. Death of any person through shooting by the Queensland Police Service where the deceased had, or is reasonably suspected to have had, a serious mental illness 10. Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness.
Incident management model	Queensland Health's model for incident management includes nine (9) elements: • Prevention • Incident identification • Classification/ prioritisation • Reporting and recording • Patient and staff care/ management • Analysis/investigation • Action • Feedback • Communication **PREVENTION** Managers shall develop and maintain a strong safety culture in every service/ facility. Examples of a safety-first culture include: • Clinical guidelines & use of evidence-based practice • Credentials and clinical privileges

[2] Note a number of these sentinel events are also "reportable deaths" under the *Coroners Act 2003 s8(3)*.

- Emergency procedures
- Falls prevention
- Fire safety procedures
- Healthcare associated infection management
- Informed consent
- Medication management system
- Occupational violence management
- Patient and staff safe safety handling programs
- Patient identification systems and procedures
- Pressure ulcer and wound prevention
- Risk reporting
- Staff training in understanding human error and patient safety
- Workplace health and safety committee, representatives and officers.

INCIDENT IDENTIFICATION

Incidents are identified in many ways, for example:

- Audit and peer review activities/reports
- Complaints
- Coroners' reports
- Death audits
- Equipment failure reports
- Food poisoning reports
- Hazard identification reports
- Health Rights Commission Annual Reports and Investigation Reports to service providers
- Infection rates
- Information security breach
- Loss of property
- Medication chart review
- Medico-legal requests and/or notifications of potential liability
- Self reporting (staff)
- WorkCover Claims
- Workplace Health and Safety checklist reports
- Workplace Health and Safety incident reporting

CLASSIFICATION/ PRIORITISATION

Incidents are prioritised according to their risk rating: severity of consequences and likelihood of reoccurring (see Appendix 1). This determines the urgency of response.

Incidents are classified by type e.g. similar events such as falls, medication error.

The first priority in dealing with an incident is to respond by taking immediate action to prevent further harm, rectify or contain the situation, and to assess the risk.

The severity of an incident should be assessed for the level of risk being faced at that time. This is done by the first person to detect the incident, by

[3] Non-accidental injury of a serious and permanent nature to the patient or another person caused by the patient
[4] Expected to be available after July 2004

asking:

- How much harm has been caused?
- What are the consequences of that harm?
- What is the likelihood of the risk continuing and causing harm or further harm?

Assessment of the incident should be discussed with the line manager/ supervisor.

Full risk analysis should be conducted during the investigation phase.

In carrying out this assessment, reference can be made to the Integrated Risk Management Guidance Document and the Risk Matrix and consequences and likelihood table (Appendix 1).

REPORTING AND RECORDING

Locally, there should be a formal, documented process to guide how an incident will be reported. This information must be readily available to all employees and agents in a user-friendly format.

All incidents must be reported. These should be reported locally, according to the procedures established by managers at the local level.

Incidents with a very high and extreme risk rating should be reported to the appropriate line management.

The requirements of this policy do not remove Queensland Health staff's duty to meet statutory reporting requirements, for example obligations contained in the *Coroners Act*, *Crime and Misconduct Act* and IRM 3.1.5 and the *Workplace Health and Safety Act.*

Reporting sentinel events
The line manager must report sentinel events to the District Manager, State Manager, relevant Corporate Office Branch Executive or Director of Mental Health **immediately.**

The District Manager, State Manager or relevant Corporate Office Branch Executive is required to notify the Director-General via the Secretariat, Risk Management Advisory Group **immediately,** using the Sentinel Event Notification Report template (see Appendix 2).

See Appendix 3 for a flow chart of the high level management of sentinel events.

Reporting potential and actual incidents that have or are likely to have very high or extreme risk rating
Potential or actual incidents rated as very high to extreme must be reported to the District Manager, State Manager or relevant Corporate Office Branch Executive **within 24 hours.**

Mental Health Specific Incidents
In addition to reporting suicides and unexpected deaths of patients of mental health services the following mental health incidents must also be **reported to the Director of Mental Health (DMH) within 24 hours:**

Non-accidental injury of a serious and permanent nature[3] in respect of:

- Any patient (inpatient or community) of a mental health service.
- Any person who has been in contact with a mental health service or emergency department within the 7 days preceding the incident.

Absence without approval or other serious adverse incident in relation to the following patients:

- Persons of Special Notification.
- Classified Patients.
- All inpatients within a medium and high secure setting.
- High risk patients.

S530 of the *Mental Health Act* provides Queensland Health staff with the authority to give this information to the DMH without breaching the confidentiality provisions of s63 *Health Services Act.*

Reporting requirements – local

Incidents shall be reported by staff when they first become aware of the incident e.g. from a complaint or informal communication. It is important to note all staff are required to report an incident even if they believe the incident has been previously reported by another staff member.

All incidents shall be reported on an incident report form using the agreed Queensland Health data definitions and data elements[4].

Each District Manager, State Manager or relevant Corporate Office Executive shall maintain a comprehensive register of all reported incidents in their accountability area.

See p.11 for requirements about providing feedback to those who have reported an incident.

The Secretariat, Risk Management Advisory Committee, shall maintain the statewide Register of Notified Sentinel Events and a register of Annual Reports received on incidents and incoming aggregated data.

The following information must be included in an incident report:

- a description of the incident
- date and time of incident
- name of the person involved in the incident
- patient's UR number (where applicable)
- severity (see pp.7-8)
- type (see pp.7-8)
- immediate action taken to prevent further harm, rectify or to contain the situation

The name and details of the person reporting the event is mandatory for the following incidents:

- involving staff (i.e. a staff member is injured)
- that may lead to litigation where indemnity may be sought by staff involved in the incident (see Industrial Relations Manuals 3.8-3 and 3.8-4)
- which relate to research or clinical trials
- that are reportable in law (such as reportable to the Coroner).

For other incidents, anonymous reporting is a local management decision.

Reporting requirements – state (see p.12 Communication)

PATIENT AND STAFF CARE/MANAGEMENT

The first priority is prompt care and support of the people involved, removal of danger and prevention of further harm. This is called immediate action.

The reporting person and where possible the line manager/ supervisor are responsible for immediate action that assists to bring the situation under control.

Patients, their carers and involved staff may need considerable support after experiencing an adverse event. A care plan is also required. The Open Disclosure Standard and procedures are to be followed (see p.15).

When harm has occurred, an expression of regret should be provided to the patient following the Open Disclosure Standard and consistent with the *Civil Liability Act* (CLA) statutory requirements.

Secondary action (medium term) and longer-term management of the incident occur during the investigation and action phases.

INCIDENT ANALYSIS/ INVESTIGATION

Locally, there should be a formal, documented process to guide how an incident will be managed and the level of analysis/ investigation required.

Incidents should be investigated and analysed according to their potential/ actual risk rating, level of harm caused and within the available resources.

The line manager should determine the appropriate investigation agency and process. Investigation of certain incidents must meet the relevant statutory requirements including the *Coroners Act, Crime and Misconduct Act, Workplace Health and Safety Act,* and the *Health Services Act.* For example, if initial analysis/ investigation of the incident points to an intentionally unsafe act, the investigation/ analysis should cease and be reported to the District Manager, State Manager or Corporate Office Branch Executive in accordance with IRM 3.1-5 for appropriate administrative action.

In general, the incident analysis process includes

- Commissioning of a team, including external agencies if a statutory requirement
- Review of the incident report/s and other information at hand
- Use of tools to determine the sequence of events, contributory factors, probable causes and risk identification
- Analysis of risk using the Integrated Risk Management Guidance Document and the example risk classification and prioritisation table (Appendix 1)
- Identification of corrective action
- Identification of timelines and person/s responsible for corrective actions
- Preparation of a report including a corrective action plan
- Authorisation of recommended corrective actions by the District Manager, State Manager or relevant Corporate Office Branch Executive

The following mandatory requirements are to be used for investigating sentinel events:

- Use of a team, independent of the incident
- Analysis, commencing within seven (7) working days after the incident
- The root cause analysis investigation tool must be used
- Teams should be commissioned by the District Manager, State Manager or relevant Corporate Office Branch Executive
- At least one member of the team must be trained in using the root cause analysis tool and process
- A report must be provided to the District Manager, State Manager or relevant Corporate Office Branch Executive within 45 days of commencement of investigation

See Appendix 3 for a flow chart of the management of sentinel events.

ACTION

Actions are identified through investigating the underlying causes of incidents and near misses and are documented in a report for the District Manager, State Manager or Corporate Office Branch Executive.

The District Manager, State Manager or Corporate Office Branch Executive shall nominate a person, unit or committee to receive investigation reports and authorise and resource this entity to implement authorised actions.

Corrective actions for potential or actual incidents rated as very high to extreme, including sentinel events, must be endorsed by the District Manager, State Manager or relevant Corporate Office Branch Executive. Actions should be limited to a maximum of three, aiming for two strong and one intermediate action (see p.13).

The corrective action plan should be included for priority implementation within the service/ quality improvement plan/ cycle.

FEEDBACK

Feedback about immediate actions already taken, the investigation and actions to be taken, must be provided to those harmed by incidents and those involved in incident response and management in a timely manner. The person responsible for providing feedback is identified through local procedures.

The Open Disclosure Standard must be used as the framework for communication with the patient and their support person/s and with involved staff. Sections 10.3-10.5 of the Standard provide guidance on the timing of disclosure as well as who will make the disclosure and what will be disclosed.

Feedback must meet the relevant statutory requirements for example relating to the *Coroners Act, Crime and Misconduct Act* and *Workplace Health and Safety Act.*

Local incident management information should be aggregated and reviewed by the District Manager, State Manager and Corporate Office Branch Executive. Actions aimed at preventing similar incidents from occurring will be implemented, monitored and reviewed through the service/ quality improvement plan/ cycle.

	Identified risks from analysing incidents and near misses must be recorded and reported on the local Risk Register according to the Integrated Risk Management Policy and Guidance Document. The District Manager, State Manager or relevant Corporate Office Branch Executive is responsible for reviewing local implementation of this policy and reporting compliance as required. **COMMUNICATION** Lessons learned locally from incident management, especially those incidents with very high to extreme risk rating, are to be communicated throughout Queensland Health, to reduce the likelihood of recurrence and monitor trends. Communication must meet the relevant statutory requirements for example relating to the *Coroners Act, Crime and Misconduct Act, Workplace Health and Safety Act, Health Act* and the *Mental Health Act.* The District Manager, State Manager or Corporate Office Branch Executive shall provide an annual report to the Director-General via the Secretariat, Risk Management Advisory Committee by 30 June on: • Actions implemented regarding previously notified sentinel events • Actions implemented regarding potential and actual incidents that have or are likely to have very high or extreme risk rating. The Committee may request reports on a more urgent basis.

RESPONSIBILITIES AND ACCOUNTABILITIES

Incident management is the responsibility of everyone in the organisation. Employees shall be trained in and supported to apply this policy in their workplace.

Director-General	Provides leadership, strategic direction and ensures alignment with Whole-of-Government priorities. Accountable for providing leadership and ensuring that systems are in place that support good governance structures and enable efficient and effective management of the health care system and provide assurance that public confidence is maintained. Responsible for the operation of the Department that includes the establishment and maintenance of suitable systems of internal control and risk management.
Deputy Director-General, Policy and Outcomes	Provides leadership and strategic oversight in the development of policy and planning, information and business management reforms and capital programs. Responsible for the overall development and implementation of the Integrated Risk Management Policy and Framework and related policies and standards including the Queensland Health Incident Management Policy. Monitors and reviews statewide implementation of this policy.
General Manager, Health Services	Provides leadership and strategic oversight in relation to the delivery of statewide health services.

	Responsible for the overall implementation of risk management strategies including the Queensland Health Incident Management Policy within the Health Services Division and ensures that line management accountability is effective and that reporting across the Division occurs as part of core business.
Chief Health Officer	Provides high level medical advice to the Minister and the Director-General on health issues, especially on standards, quality, ethics and research issues.
Risk Management Coordinator	Responsible for providing the Secretariat to the Risk Management Advisory Committee. Responsible for maintaining the statewide Sentinel Event Notification Register and a register of Annual Reports received on incidents and incoming aggregated data.
Risk Management Advisory Committee	Responsible for receiving, analysing and monitoring notifications of Sentinel Events and trending of incidents in Queensland Health. Responsible for reporting incidents, trends and risks to the Director-General or delegate.
Director, Audit and Operational Review Branch	Responsible for Queensland Health's statewide Crime and Misconduct Commission liaison role and the investigation of alleged official misconduct. Maintains an investigations and whistleblowers database and monitors and reports on systemic issues and trends.
Zonal Managers	Responsible for monitoring the implementation of the incident management policy in Districts within the Zone. Responsible for monitoring compliance with mandatory incident reporting requirements.
District Managers, State Managers of Public Health Services, Pathology and Scientific Services, Statewide and non-Government Services, Information Services, Corporate Office, Branch Executives	Responsible for implementation of the incident management policy within their area of responsibility. This includes to: ▪ Establish, endorse and maintain an effective local governance framework and system of accountability ▪ Ensure incident reporting meets statutory requirements ▪ Ensure staff training and compliance ▪ Ensure adequate resourcing to implement corrective actions ▪ Ensure corrective actions address very high and extreme risks and are implemented in a timely manner ▪ Provide mandatory reports ▪ Maintain risk and incident registers ▪ Provide information on request and report trends at least annually ▪ Monitor and review policy implementation within their area of responsibility ▪ Contribute to communication about risks and lessons learnt through Queensland Health
Managers/ supervisors	Responsible for implementation of the incident management policy within their area of responsibility. This includes to: • Ensure staff are aware of and comply with this policy • Develop local procedures for the reporting, investigation and management of incidents according to the local governance framework and system of accountability • Ensure that the immediate management of all incidents is appropriate, complies with the Open Disclosure Standard and aimed at reducing impact and ensuring containment • Ensure that incidents are reported and graded according to the

	Integrated Risk Management Analysis Matrix and that incidents are subjected to an appropriate level of analysis and review commensurate with the level of risk • Ensure that improvement strategies are developed and implemented within timeframes agreed by local management • Ensure that all improvement strategies are monitored and reviewed for efficiency, effectiveness and appropriateness • Ensure feedback and communication between the local designated area of responsibility for incident monitoring and analysis and those providing direct patient care
Contact officer	Each Health Service District, Statewide Service and Corporate Office Branch Executive has a nominated contact officer to receive information regarding this policy and distribute to relevant staff in their area
Employees/ agents	Employees and agents are required to: • Be aware of and comply with this policy • Report incidents including near misses to a designated person according to this policy and local endorsed procedures • Provide immediate patient and/or staff management according to this policy, including use of the Open Disclosure Standard where indicated • Assist with information gathering, investigation and analysis as requested • Implement required corrective actions

KEY TERMS

Actual (see Adverse Event)

Adverse event
An incident in which unintended harm resulted to a person receiving health care
An incident in which harm is caused to the organisation
In the context of this policy, *adverse event* means where minimal harm has been caused

Close call (see **Near Miss**)

Corrective Action
Corrective/remedial changes required to improve the system to address the root cause/s of the event. Actions can be strong, intermediate or weak. Examples of strong actions include architectural/physical plant changes; standardisation of equipment and processes. Intermediate actions include checklists and eliminating look and sound alikes. Weak actions include warnings and labels, new policies, procedures or directives and staff training.

Error
The failure to complete an action as intended, or the wrong use of or the wrong plan to achieve an aim. Errors may occur by doing the wrong thing (commission) or by failing to do the right thing (omission)

Event
An incident or situation, which occurs in a particular place during a particular interval or time

Expression of regret
An expression of regret made by an individual in relation to an incident alleged to give rise to an action for damages for personal injury is any oral

or written statement expressing regret for the incident to the extent that it does not contain an admission of liability (i.e. an admission of fault or negligence) on the part of the individual or someone else. (s69 & 71 *Civil Liability Act 2003)*
An expression of regret made by an individual in relation to an incident alleged to give rise to an action for damages for personal injury at any time before a civil proceeding is started in a court in relation to the incident is not admissable in the court proceeding (s72 *Civil Liability Act 2003*)

Governance
The manner in which Queensland Health is directed, controlled and accountable for the achievement of its strategic goals and operational objectives. This includes a framework, structures and processes.

Harm
Death, disease, injury and or disability experienced by a person
Destruction, damage or threat to the organisation, loss of or damage to property, or pollution of the environment.

Incident
An event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person or the organisation, and/or a complaint, loss or damage.

Incident monitoring
A system for identifying, processing, analysing and reporting incidents with a view to preventing their recurrence.

Intentionally unsafe acts
A criminal act; a purposefully unsafe act; an act related to alcohol or substance abuse by an impaired provider and/or staff; or events involving alleged or suspected patient abuse of any kind.

Liability
Responsible for an action in a legal sense.

Near hit (see **Near Miss)**

Near miss
An incident or close call that did not lead to harm, but could have.

Open Disclosure[5]
The process of open discussion of adverse incidents that resulted in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement.

Potential – A potential incident is a hazardous situation that is detected prior to the patient, customer, client, consumer or staff being harmed. This could include near misses. (see **Near Miss**)

Qualified privilege
Section 31 Health Services Act 1991 affords protection to members appointed to a committee which has been declared as an approved quality assurance committee under the Act. This means that the information which may be relevant to litigation and which there would normally be an obligation

[5] *Open Disclosure Standard* Australian Council for Safety and Quality in Health Care July 2003

112

	to provide, can be withheld from discovery in legal proceedings and is inadmissible as evidence in court proceedings. **Risk Management** The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects in order to improve the health and wellbeing of Queenslanders **Root cause** The most fundamental reason an event has occurred **Root cause analysis** A systematic process whereby the underlying factors which contributed to a sentinel event are identified **Safety** A state in which risk has been reduced to an acceptable level **Serious Adverse Event** An incident in which serious harm resulted to a person receiving health care and where the combined likelihood and consequence score (according to the Queensland Health Risk Matrix) is very high or extreme An incident in which serious harm resulted to the organisation and where the combined likelihood and consequence score is very high or extreme **Sentinel Event** An undesired event that signals that something serious or sentinel has occurred and warrants in-depth investigation (see Queensland Health list p.5) **Systems improvement** The changes made to dysfunctional operational methods, processes and infrastructure to ensure improved quality and safety **System failure** A fault, breakdown or dysfunction within an organisation's operational methods, processes or infrastructure

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URGENT MEMORANDUM

To: Director-General ATTENTION: Secretariat, Risk Management Advisory Group

Copies to: Click, enter CC's Name/s, Title/s

From: Click, enter Sender's Name and Title **Contact No:** Click, enter Sender's Tel No.

Fax No: Click, enter Sender's Tel No.

Subject: SENTINEL EVENT NOTIFICATION REPORT

File Ref: Click, enter Ref No.

I wish to advise that the following sentinel event has occurred in Click, enter location at Click, enter time and date:

TICK	LIST OF NOTIFIABLE SENTINEL EVENTS
	Surgery/procedure on the wrong patient/wrong body part
	Haemolytic blood transfusion reaction resulting from ABO incompatibility
	Instrument or other materials inadvertently left in body cavity or operation wound following a procedure
	Intravascular gas embolism resulting in death or neurological damage
	Infant discharged to wrong family
	Death of an employee during the course of their duties
	Suicide of a patient
	Death of a patient as a direct and immediate result of medication error
	Death of a patient during inter-hospital transfer
	Direct maternal death
	Sudden and unexpected death of an infant associated with labour or delivery
	Unexpected death of a patient during surgery
Mental Health specific	
	The suicide or unexpected death in respect of an inpatient, any patient under the *Mental Health Act 2000* or a patient who has been in contact with a mental health service or emergency department within seven (7) days preceding the incident
	Death of any person through shooting by the Queensland Police Service where the deceased had, or is reasonably suspected to have had, a serious mental illness
	Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness

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Incident Management Policy
10 Jun 2004

117

In compliance with Queensland Health's Incident Management Policy, I advise that due procedures are underway and an investigation using the root cause analysis tool will commence on Click, enter date (should be 7 days from event occurring).

<< to be signed>>

Click, enter name
Click, enter title
/ /

TO BE SIGNED AND FAXED IMMEDIATELY

FAX TO: 07 323 71691

APPENDIX 3: FLOW CHART OF SENTINEL EVENT INCIDENT MANAGEMENT PROCESS (high level)