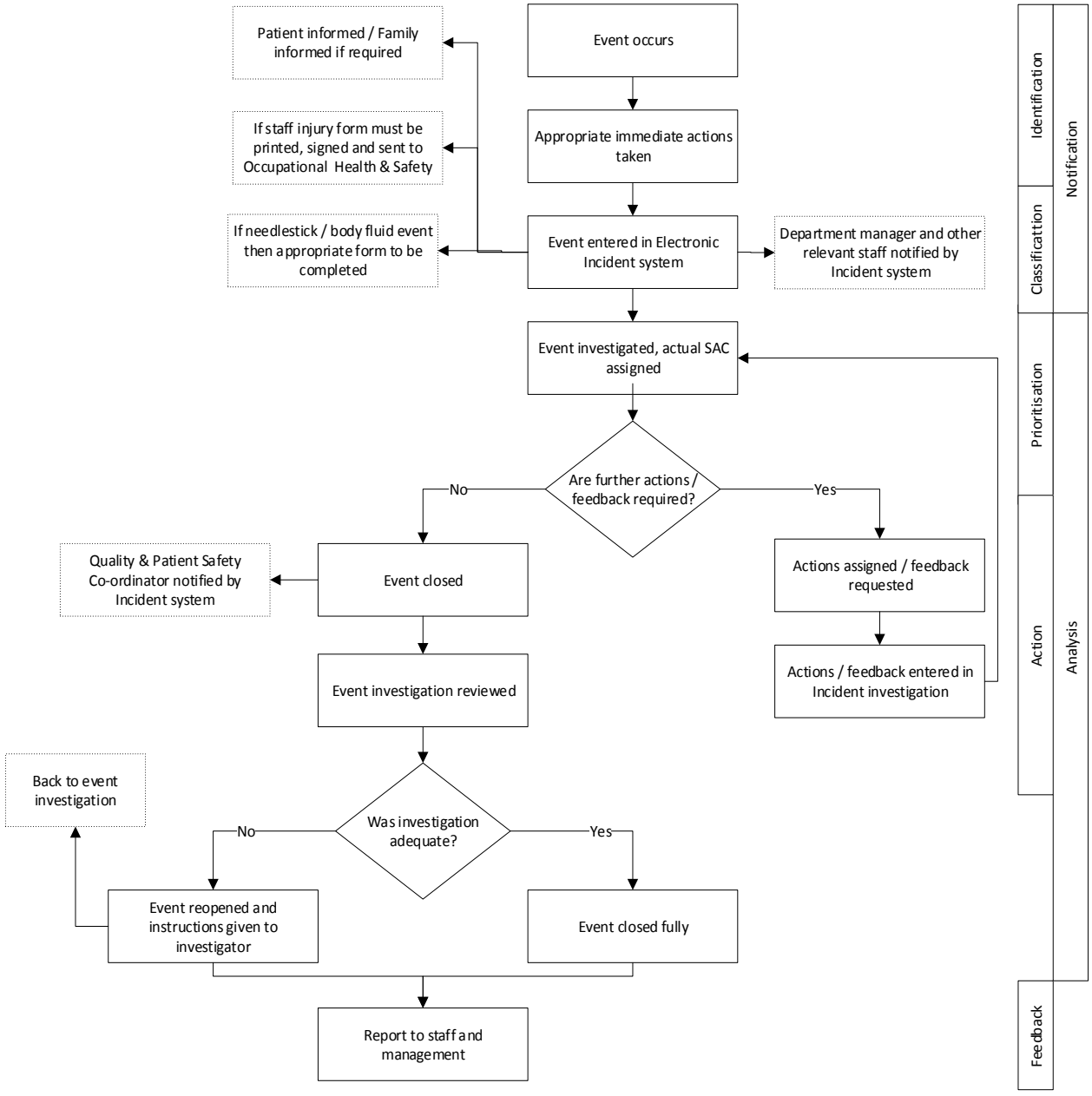

Response based on SAC Score	
SAC 1	Extreme risk – immediate action required – A Root Cause Analysis (RCA) investigation or Systems Analysis of Clinical Incident investigation (the London Protocol) must be completed within 70 calendar days. Reportable Event Brief (REB) must be forwarded to the national central repository
SAC 2	High risk – senior management attention needed – Notification to the national central repository and a detailed investigation must be completed within 70 calendar days
SAC 3 / 4	Medium risk – All incident forms to be reviewed, review in common incident types may be most appropriate to develop a common action plan. Responsibility for management of these incidents must be assigned
SAC 4	Low risk – manage through team level review and improvement procedures

STANDARD

1. SAC 1 and 2

All SAC 1 and 2 incidents require immediate reporting and escalation, notification via REB (Reportable Event Brief) to a central repository, detailed investigation and monitoring of trend aggregated data.

a) Notification

i) When an incident occurs it must be reported to the line manager and an electronic incident form is to be completed.

ii) The Quality and Patient Safety Manager will receive automatic notification once an incident form is completed however to ensure timely escalation and response, notification should be also be made by phone or email.

iii) The Quality and Patient Safety Manager will notify the Patient Safety Intensive Review Group and the Chief Executive Officer's (CEO) office, this does not preclude notifications been made through line managers.

iv) The Quality and Patient Safety Manager will make notification to the national central repository, via a REB within 15 working days (unless required earlier by legislation) of notification within the DHB.

v) The department who was responsible at the time of the incident will make notifications required under legislation e.g. Coroner, Department of Labour.

vi) Patients and or their family / whanau will be advised (using guidelines for open disclosure) as soon as practicable of any incident. The health professional with overall responsibility for the consumer's care should disclose the incident unless this is contraindicated.

b) Decision-Making

i) Having received notification and confirmed the incident is a SAC 1 or 2, the Quality and Patient Safety Manager confirms the type of investigation required. Most incidents will be investigated using Root Cause Analysis (RCA) or The London Protocol (Mental Health & Addiction Services) focusing on system issues however where the incident is one of the following other processes e.g. performance management will be used

- a criminal act,
- a deliberately unsafe act,
- substance abuse by the provider (includes alcohol)
- deliberate patient harm or abuse

ii) Where an RCA is appropriate the Quality and Patient Safety Manager will convene an RCA Team within 72 hours.

iii) Members of the RCA team will be identified dependent on the situation but will always be multidisciplinary and have no more than five (5) members.

iv) Team members must not have been involved in the incident and are chosen for either their specific expertise or experience in RCA.

v) A team leader is identified. This person must be someone with experience in the RCA process and will be responsible the overall investigation. This includes:

- Co-ordination of meetings
- Keeping the team focused
- Managing timelines
- Ensuring RCA process is followed
- Participating in information gathering
- Completing the final report

c) Investigation

i) All SAC 1 incidents will be investigated using root cause analysis. SAC 2 must have a detailed investigation. This should take the form of RCA; however other appropriate and effective investigation methods may be used (e.g. The London Protocol).
ii) The investigation team will use the RCA process to identify system vulnerabilities that allowed the incident to occur and identify actions and recommendations to prevent a similar recurrence.
iii) The full investigation and required reporting will be completed within 70 days if the incident.
iv) The RCA should be finalised within one (1) to three (3) meetings.
v) Training and support will be provided to assist the investigation team through the Quality and Patient Safety Manager.
vi) Should there be any indication during the investigation reflecting significant poor professional practice requiring attention, the information will be extracted from the process and brought to the attention of the relevant General Manager (GM) and Human Resources.
vii) Any staff requested to provide information for the investigation must give exclusive priority to the request and timeframe deliverable.

Meeting One

- Plan process and expected timing and sequence of events.
- Using a simple flow diagram establish chronology of events which will form a basis for the investigation.
- Review relevant information incident form, medical record etc)
- Identify key questions and people to be interviewed.

Meeting Two

- Team member's present information gathered.
- Develop the final detailed flow diagram
- Identify relevant actions and / or inactions at each point of the detailed flow diagram
- Determine the most significant points where barriers might interrupt the flow of events.
- Identify root causes.

Meeting Three

- Select the significant root causes
- Describe the *causal chain* as a statement from the root cause to the problem.
- Make recommendations and develop a corrective action plan.

d) Reporting and Follow-Up

i) The draft report will be submitted to the intensive review subcommittee for review and endorsement.
ii) The final report will be signed by all members of the RCA team and submitted to the Chief Executive Officer (CEO) for final sign off.
iii) The final report will be logged in the Quality and Risk Management System (DATIX) and progress with follow up actions will be monitored through this by the Quality and Patient Safety team.
iv) Using the principle of open disclosure the findings are fed back to those affected by the incident e.g. patient and / or their family / whānau.

v) Recommended actions and solutions must be communicated to employees so that:
- The recommended actions are evaluated for their potential impact on other units or operational practices.
- Duplication of efforts to resolve closely related problems is prevented.
- All of the expertise that needs to be involved in addressing the problem is obtained.
- Learning can occur.

vi) Examples of feedback forums may include: quality improvement groups, patient care review groups, Audit Finance and Risk Management Committee, Health and Safety Committee, Infection Control Committee, Pharmacy and Therapeutics Committee, Combined Medicines Review Committee, Theatre Management Group N.B. this list is not exhaustive.

vii) Where a causative / contributory factor is identified, and its resolution requires organisation wide changes, it must be referred to the appropriate forum.

viii) Wherever possible, staff should be made aware of support services that are available should they choose to use these.

2. SAC 3 and 4

a) **Notification**

i) Any staff member who identifies an incident completes an incident form.

ii) The investigator will be automatically identified and will receive the report in their account for action and / or investigation.

b) **Decision-Making**

i) The line manager decides on the level of investigation required. This may only require a review to ensure all the controls were in place i.e. falls.

c) **Investigation**

i) Each incident form will be investigated by the nominated investigator.

ii) The investigator will decide whether the incident requires further investigation or it can be investigated as part of a common incident type.

iii) All investigations will be completed within 28 calendar days.

d) **Reporting and Follow-Up**

i) All incidents will be reviewed by the Quality & Patient Safety Co-ordinator for each service and forwarded to the Clinical Leader, where appropriate. Additional reviews are undertaken as appropriate by the Pharmacy Manager (for medication related events), service leaders, Director of Nursing and Medical Director.

ii) Ongoing monitoring of aggregated incident data will be used to identify and prioritise improvement projects.

REFERENCES

- New Zealand Health and Disability Services. National Reportable Events Policy. March 2012
- Reportable Event Brief Form 2012
- Guidelines on Open Disclosure Policies, Health and Disability Commissioner, Revised December 2009
- Health and Safety at Work Act 2015 and Regulations 2016
- Health Privacy Information Act Code 1994

- Health and Disability Commission 'Code of Rights'
- New Zealand Incident management System: A national approach to the management of healthcare incident – Training Manual
- Systems Analysis of Clinical Incidents: The London Protocol
- Reporting And Reviewing Serious & Sentinel Mental Health Incidents

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 2.1.4 Incident Management
- Bay of Plenty District Health Board policy 2.1.4 protocol 1 Incident Management - Standards and Severity Assessment Codes (SACs)
- Bay of Plenty District Health Board policy 2.1.4 protocol 3 Open Disclosures – Principles and Process
- Bay of Plenty District Health Board policy 2.5.1 Health Information Privacy
- Bay of Plenty District Health Board policy 5.3.1 Employee Health and Safety
- Bay of Plenty District Health Board policy 1.3.1 Complaints Management
- Bay of Plenty District Health Board policy 3.50.05 Protected Disclosures
- Bay of Plenty District Health Board policy 6.6.1 Death of a Patient
- Bay of Plenty District Health Board policy 1.4.4 Cultural Safety - Maori
- Bay of Plenty District Health Board Incident form