Health
Sydney
Local Health District

SLHD Policy Compliance Procedure

Serious Incident Management	
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Policy Reference No.	SLHD_PCP2021_024
Related MOH Policy	Incident Management Policy PD2020_047
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Applies to	All SLHD Staff
Clinical Stream(s)	All Clinical Streams
Tier 2 Sign-off	Executive Director Medical Services, Clinical Governance and Risk SLHD
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Serious Incident Management

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Serious Incident Management

1. Introduction

This Policy Compliance Procedure (PCP) has been developed to ensure a coordinated approach in the management of serious incidents in Sydney Local Health District (SLHD) e.g. Harm Score (HS) 1 and/or other HS where there may be system issues particularly when multiple departments are involved or the incident is also associated with a complaint.

This PCP operationalises the requirements of the NSW Health Incident Management Policy (PD2020_047) which establishes the requirement for:

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.

SLHD acknowledges the work of Hunter New England Local Health District's (HNELHD) Clinical Governance Unit in developing the source document on which this PCP has been informed. SLHD is not responsible for updating the HNELHD source document.

2. The Aims / Expected Outcome of this PCP

The objectives of this PCP are to ensure:

- A coordinated approach to key elements of incident management processes, including the:
  - Reportable Incident Brief (RIB)
  - Preliminary Risk Assessment (PRA)
  - Designated Family Contact (DFC)
  - Serious Adverse Event Report (SAER)
  - Open Disclosure
- The appropriate method of investigation is used as per the MOH Incident Management Policy PD2020_047.
- Immediate risks related to critical incidents are identified and managed.
- Staff, patients, carers and families are kept informed and supported throughout the process.
- All procedures are completed and all stakeholders are aware of the outcome.

3. Risk Statement

SLHD Enterprise Risk Management System (ERMS) Risk #1 - Unwarranted deviation from standards of clinical care. This PCP outlines the SLHD mechanisms established to mitigate risks related to serious incidence by:

- Identifying immediate risks and ensure a coordinated approach in the management of critical incidents (i.e. Clinical and Corporate HS 1 and other serious incidents at the request of the Chief Executive);
- Establishing empathetic and timely communication to support patients and / or their family and staff.

- Managing immediate risks appropriately and ensure effective action is taken to improve the systems of care in order to prevent the recurrence of such an incident.

4. Scope

This PCP applies to all SLHD Clinical Governance Units, Patient Safety and Quality Units, Workforce Services and all Managers who review incidents. The procedure explains the steps to review clinical and corporate incidents.

5. Resources

Local resources for serious incident management are available on the SLHD Clinical Incident Management intranet page. Tools and templates used during serious investigations are to be used from the Serious Adverse Event Review Resources page.

The Clinical Excellence Commission have developed a suite of resources to support the implementation of the NSW Health Policy including fact sheets, training, templates and toolkits.

Education resources accessible via My Health Learning (MHL) include:

- Open Disclosure. A 15-30 minutes eLearning module supporting the clinical workforce in identifying when open disclosure is required and understanding the open disclosure process.
- Clinician Disclosure. A 2 hours eLearning module with six lessons designed to develop the skills and understanding required to perform Clinician Disclosure with patients or family members immediately following a patient safety incident.

6. Implementation

This PCP is supported by a dedicated project plan which supports implementation of the NSW Health Incident Management Policy.

Additional implementation resources are available at the:

- SLHD Clinical Governance Clinical Incident Management Intranet
- The Clinical Excellence Commission (CEC Website).

7. Key Performance Indicators and Service Measures

- 100% of Part A - RIB submitted to the MoH within 24 hours of the incident being notified.
- 100% Part B - RIB and PRA submitted to the MoH within 72 hours of the incident being notified.
- 100% Completion of SAER and submission to MoH within 60 calendar days from when the incident was notified.
- DFC is appointed in all HS1 RIBs.
- 80% of Clinical Safety Checks and Corporate Safety Checks are submitted to SLHD Clinical Governance Unit within twenty-one (21) calendar days of the incident being notified; 100% are submitted within forty-five (45) calendar days.

- 80% of detailed investigations (eg: clinical investigation report) for harm score 2, 3 and 4 incidents are submitted to the SLHD Clinical Governance Unit within forty-five (45) calendar days of the incident being notified and 100% within 90 calendar days
- 100% of harm score 2, 3 and 4 incidents are changed from new to investigate within five (5) calendar days of the incident being notified.
- 80% of harm score 2, 3 and 4 incidents are changed from under investigation to finalised within forty-five (45) calendar days of the incident being notified.

8. Roles and Responsibilities

8.1 Chief Executive

The *Health Administration Act 1982* outlines duties that are delegable by the Chief Executive, some duties are non-delegable.

8.1.1 Non-delegable

- Approval of PRA Team (same as existing procedure).
- Direction on methodology of SAER (currently limited and referred to as RCA or root cause analysis).
- Appointment of SAER team members.
- Appointment of additional SAER team members to prepare recommendations.

8.1.2 Delegable

- RIB approval (same as existing procedure).
- Approval of PRA findings for sharing with families.
- Directing whether recommendations report is to be prepared.
- Approval of recommendations.

8.2 SLHD Executive – Tier 2

The SLHD Tier 2 Executive is responsible for:

- Ensuring successful implementation of this procedure within the organisation;
- Assigning responsibility and resources to promote this procedure;
- Promoting a culture which values transparency and consumer participation;
- Setting the example by acting on issues raised through the process.

8.3 SLHD Executive Director Medical Services, Clinical Governance and Risk

The SLHD Executive Director Medical Services, Clinical Governance and Risk/or Delegate, in collaboration with Chief Executive and Executive Director of Operations, are responsible for:

- Approval of RIBs
- Collaboration with the facilities/services Clinical Governance Units or equivalent, to ensure the PRA meeting is coordinated and obtain documentation approval. The facilities/services Clinical Governance Units or equivalent are delegated the responsibility for organising PRA meetings.
- Approval of the PRA attendees from the Standing team and additional PRA members, which the Chief Executive must approve.

- Approval of the PRA minutes and actions.
- Email and hard copy of the approved PRA report is sent to the SLHD Chief Executive.

8.4 General Managers and Head of Departments (HoD)

General Managers or delegate, working with HoD as appropriate, are responsible for the processes of the incident review. This includes the engagement of key stakeholders at each stage. Specific responsibilities:

- Briefing the SLHD Executive on call, including the Chief Executive, to assist in notifying the relevant NSW Health Deputy Secretary, if appropriate;
- Involved in the review phase (for non-SAERs);
- Ensure Open Disclosure occurs;
- Ensure that a Dedicated Family Contact is assigned, where appropriate;
- Ensure the outcomes of the PRA meeting are achieved as set out in this procedure and follow-up on actions;
- Ensure the investigation of the clinical or corporate critical incident is progressed to completion within established timeframes.

8.5 Health Service Managers/Nurse or Midwifery Managers/Department Managers

Health Service Managers/ Nurse or Midwifery Managers and Department Managers are responsible for participating in the process including:

- Responding to any immediate risk after the incident has occurred;
- Completing actions as agreed to by the PRA (i.e. managing immediate risks, feedback to staff);
- Ensuring that actions are completed within the specified time;
- Feedback to staff about the outcome of the incident investigation;Ensure the outcomes of the meeting are achieved as set out in this procedure and follow-up on actions.

8.6 Facility Clinical Governance Units (or equivalent)

- Providing a description of the incident from clinical records.
- Use the PRA to document the incident description, actions and persons responsible.
- Seek endorsement of the PRA agenda, report and action log from the PRA attendees.
- A copy of the endorsed PRA is provided to the District Patient Safety Manager for escalation of approval by the Executive Director Medical Services, Clinical Governance and Risk/or delegate.
- Distributing the approved PRA via email to the meeting attendees and the facility standing members within one working day of the meeting, ensuring the appropriate disclaimer regarding the confidential, privileged nature of the document is utilised (see Appendix 1).

8.7 Dedicated Family Contact

A Dedicated Family Contact (DFC) is assigned and responsible for:

- Contacting the family after a serious incident and establish an approach for ongoing communication.
- Ensure any concerns are directed to relevant health service staff.
- Maintain regular contact and establish agreed time intervals when communication with the family will be offered.
- Ensure appropriate support needs for the family are met e.g. Social Worker, Advocate, Interpreter.
- Help the family navigate the health system.
- Explain the review process including timelines, the steps involved and the scope of the review.
- Liaising with the review team and assist in facilitating open disclosure following review completion.

8.8 Workforce Services Representative

The Workforce Services Representative responsibilities include:

- The Director of Workforce and Corporate Operations or delegate will participate in the Safety Check (PRA) for all HS 1 **Corporate Incidents** with representation by a member of staff at the relevant facility/service.
- Supporting General Managers/or delegate with advice / input in relation to supporting staff involved in the incidents and identifying counselling opportunities.
- Providing General Managers (or delegate) with advice / input in relation to the completion of risk assessments of clinicians involved in the incident, including strategies to minimise / control risks identified.
- Supporting General Managers (or delegate) to identify and investigate risks or complaints or concerns about the clinician/s involved in the incident.

8.9 Director of Media Involvement

If the PRA team determine possible media implications from the review process, the Director of Media may be contacted for:

- Early assessment of possible reputational risk to the organisation associated with the incident.
- Considering potential media and social media interest, complaints management and government relations responsibilities, to ensure SLHD can address and manage reputational quickly and efficiently.
- Involving the wider Unit to provide support for other services in managing reputation risks associated with the incident, where necessary.
- The PRA team will allocate an action to a PRA member to be the principal contact with the Director of Media.

9. Procedure

9.1 Clinical Harm Score 1 Incidents

9.1.1 Unexpected death or Sentinel Event

A PRA is undertaken within 72 hours of incident notification to identify immediate risks for action and to guide the next steps. The changes also apply to clinical HS 2, 3 and 4 incidents that the Chief Executive determines may be due to serious systemic problems. The PRA is a mandated state-wide form and a minimum of three staff members, with a minimum of one independent staff member, must attend the PRA meeting.

At this time, a staff member is assigned as a Dedicated Family Contact (DFC). The DFC is the primary point of contact for the family and maintains regular communication. The DFC should not participate in the PRA.

A SAER is undertaken with separate findings and recommendations stages. The Findings Report and Recommendations Report can be shared with the family following Chief Executive approval. The Chief Executive can appoint additional SAER team members to help prepare the Recommendations Report. Refer to the SLHD Incident Management Flowchart in Appendix 2.

The Chief Executive approves the SAER methodology which is generally recommended to be RCA. Other methodologies are available and can be used if the Chief Executive, lead investigator, Clinical Governance Unit or Patient Safety Manager determines that it will strengthen the investigation.

9.2 Corporate Harm Score 1 Incidents

A Corporate HS 1 incident is the death of a staff member potential arising from the activities of the work place of that staff member (Work Health Safety) or complete loss of a service (corporate).

A Corporate Safety Check is undertaken within 72 hours of incident notification. The Corporate Safety Check process will follow a similar process as a PRA, as seen in Appendix 2. It is not a privileged process or document. Privilege does not apply to corporate incidents. At this time, a staff member is assigned as a DFC, this should be a Facility Executive or senior staff member.

Following this, a Corporate HS 1 review is undertaken. Findings and recommendations can be separate. There can be one report or separate findings and recommendations reports.

The Chief Executive can appoint additional review team members to help develop recommendations.

9.2.1 Stages of investigation for Clinical and Corporate Harm Score 1 Incidents

There are three phases in the coordination of a critical incident. They are the:

- PRA process/Corporate Safety Check
- Investigation phase
- Final disclosure phase

9.3 Clinical Harm Score 2

In line with pre-existing practice, the Chief Executive has determined that all incidents recorded as **HS 2 (previously SAC 2)** will require a Clinical Safety Check.

The Clinical Safety Check comprises an internal process for quality and safety improvement purposes Facilities will be responsible for the coordination of Clinical Safety Check for clinical HS 2 incidents, including the appointment of the Clinical Safety Check team.

The Clinical Safety Check is to guide and document immediate steps required post incident management, and is not intended to be an incident investigation report or be provided to a patient and/or family. Where an incident also involves a complaint, the written response should be provided in a detailed letter and/or on a clinical investigation report template.

9.3.1 Clinical Safety check KPI and approval

The Clinical Safety Check is to be completed by the facility Clinical Governance Unit within twenty-one (21) calendar days of the reported date. The incident description in the Clinical Safety Check is to be succinct and only include analysis that relates to determining whether the care provided was to standard (and not preventable) or it represents a system learning opportunity.

Clinical Safety Check reports are approved by the General Manager, tabled at the relevant committee(s) and sent to SLHD CGU for thematic analysis. Approved Clinical Safety Check reports are attached as a document in ims+ by the facility Clinical Governance Unit.

9.3.2 Clinical Investigation

A more detailed investigation, such as a Clinical Investigation, will also be required for incidents where a system improvement opportunity is identified, and/or are potentially preventable OR as requested by the SLHD Clinical Governance Unit. Detailed investigation formats include the SLHD Clinical Investigation template, Falls Investigation Template or aggregated review template, which can be provided by contacting SLHD Clinical Governance Unit.

Detailed investigations, including Clinical Investigations are due for review to the SLHD Clinical Governance Unit within forty-five (45) calendar days of the incident reported date; and are approved by the facility/service GM with final sign off by the Executive Director Medical Services, Clinical Governance and Risk.

The facility Clinical Governance Unit will inform the SLHD Clinical Governance Unit of the completed Clinical Safety Checks and decision to proceed/not proceed to a Clinical Investigation.

9.3.3 Extensions

A maximum of five (5) calendar days can be granted for Clinical Safety Check extension and forty-five (45) calendar days for detailed investigation reports. Requests for extensions should be directed for approval to SLHD-imsplus@health.nsw.gov.au

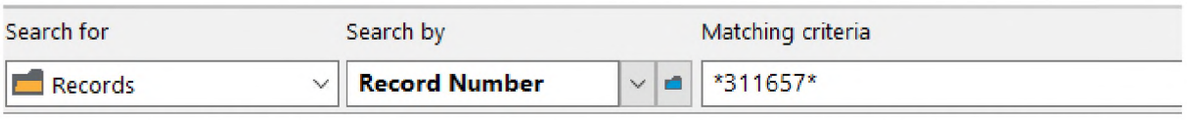
Any further extensions will require approval by the Executive Director Medical Services, Clinical Governance and Risk.

9.3.4 TRIM

SLHD CGU create an incident management (IM) folder in the electronic and records management system, "Trim" for all incidents requiring a SAER, Clinical Safety Check and/or Clinical Investigation.

The IM folder naming convention is: IM year of incident / INC number eg: IM21/236734.

Search for an IM folder using wildcards * and the incident number eg: *311657*.



IM folders for incidents in the previous incident monitoring system (IIMS) have the same naming convention, using the first 7 digits, without the -20. Eg: incident 2731481-20 will be searched using *2731481*

A security group from the relevant facility will be given access to their facility's IM folders.

GM approved Clinical Safety Checks and recommendation evidence as described in 9.3.5 should be saved to this folder.

Access to Trim is obtained by completing the *Trim User Form,* available on the intranet Click on Forms, then search for Trim.

9.3.5 Clinical Investigation and Clinical Safety Check compliance monitoring

All incidents identified as requiring a Clinical Safety Check or Clinical Investigation are logged on the SharePoint spreadsheet by the facility or SLHD CGU. Access to the SharePoint spreadsheet is provided by SLHD CGU.

Compliance status with clinical investigation/clinical safety check completion is provided monthly by email to the facilities by SLHD CGU.

9.4 Corporate Harm Score 2

The Chief Executive SLHD has determined that all **corporate incidents** recorded as **HS 2** will require a Corporate Safety Check. The Corporate Safety Check comprises an internal process for work health and safety and staff wellbeing. Work Health Safety Coordinators will be responsible for the coordination of Corporate Safety Checks and are required to be completed within twenty-one (21) calendar days. In the instance where a corporate incident involves patient clinical care or clinical issues, such as aggressive behaviour, then Clinical Governance Units must be involved.

The Director Workforce and Corporate Operations SLHD will have overarching responsibility for Corporate HS2 events, in particular: leadership immediately following the incident; appointment of the investigation team; and, sign-off on the final report before submission to the SLHD Chief Executive.

Compliance with Corporate Safety Checks are monitored by the SLHD Clinical Governance Unit and provided monthly to facility Clinical Governance Units and General Managers.

9.5 Clinical Harm Score 3 or 4 Incidents

The Chief Executive or Executive Director Medical Services, Clinical Governance and Risk may request a PRA is completed for any of these incidents.

The SLHD or facility Clinical Governance Unit may request that a Clinical Safety Check be completed for any of these incidents which is due twenty-one (21) calendar days from the date requested and otherwise according to the process in 9.2.

9.6 Corporate Harm Score 3 or 4 Incidents

The SLHD Chief Executive or Director of Workforce and Corporate Operations in consultation with the SLHD Clinical Governance Unit may request that a Corporate Safety Check be completed. Work Health Safety Coordinators will be responsible for the coordination of Corporate Safety Checks and are required to be completed within forty-five (45) calendar days from the date requested according to 9.3.

10. PRA process

The Executive Director Medical Services, Clinical Governance and Risk/delegate, the facilities services Clinical Governance Units or equivalent is delegated to organise the meeting for all incidents that are deemed for review using the PRA. The PRA document is to identify the facts as to what has occurred and determine the best way forward in managing the event. Reference is to be made to the NSW Health Policies for Incident Management, Open Disclosure and Managing a Complaint or Concern about a Clinician.

The PRA meeting is convened within 72 hours of identifying the incident. The PRA may consist of but is not limited to the following positions:

- Executive Director Medical Services, Clinical Governance and Risk (Chair) (or delegate);
- Executive Director Operations (or delegate);
- General Managers where the incident occurred (or delegate);
- District Patient Safety Manager;
- Facility Director Clinical Governance/ equivalent (or delegate);
- Facility Patient Safety Manager/Officer;
- Facility Director Medical Services (or delegate) / Medical Director;
- Facility Director of Nursing and Midwifery (or delegate);
- Facility Health Service Manager, Nurse/Midwifery Manager, Department Manager or Senior clinicians with knowledge of the case but not directly involved.

A representative from the Clinical Stream may be requested by member/ members of the PRA to participate in the commissioning meeting, or to provide clinical leadership and support to the process.

The role of the PRA is to:

- Assess the immediate situation and clarify the facts.
- Ensure immediate risks are managed.
- Ensure initial open disclosure has been undertaken.
- Assign a Dedicated Family Contact from the facility where the incident occurred.

- Agree on the HS and ensure the decision making for this is documented in the PRA meeting minutes.
- Specify the type of investigation that is required and recommended methodology (Privileged SAER or Incident Review).
- Identify if any issues or complaints have arisen from the patient or family and determine the most appropriate method for these issues to be investigated (e.g. the SAER/Investigation, Senior Management or Complaints Management System) and refer the issues to the most appropriate person for review.
- Recommend members for the SAER team or investigation team.
- Provide or facilitate appropriate support to any affected individuals.
- Determine if there is a need for risk assessment for staff/s involved in the incidents and if so allocate responsibility for completion of an employee risk assessment/s. The risk assessment require revision at least every thirty (30) calendar days, when an ongoing risk is identified and on implementation of measures to minimize risks.
- Determine if external agencies require notification (e.g. Coroner – NSW Health Coronial Checklist, Treasury Managed Funds – TMF Notification and SafeWork NSW.
- Assess if a RIB is required and allocate responsibility for completing the RIB.
- Assess, identify, and manage reputational risks associated with the incident.
- Assess if a SAER needs to be completed.
- Following the PRA meeting, any immediate actions identified are to be completed within the agreed timeframes.

After Hours: Should an incident occur after-hours the Facility Executive on-call will escalate as per the SLHD Policy On-call Escalation Process SLHD_PD2019_036. Where possible, the PRA team will convene during business hours to ensure all aspects of the procedure have been completed.

On occasions a PRA meeting may need to occur outside business hours. This should occur when the KPI of completing a PRA in 72 hours cannot be met during business hours. The Facility Executive on-call is responsible for managing the out-of-hours PRA meeting and required documents.

11. SAER process

The review phase will be conducted during the SAER process:

- The review team will conduct the investigation according to the NSW Health Policy: Incident Management PD2020_047 in conjunction with the SAER toolkit for SAER team leaders.
- There will be ongoing liaison between the family and Designated Family Contact as required. The Designated Family Contact will identify any concerns the family may raise, and refer them to the most appropriate person for review (SAER team, investigation team, Senior Management).

12. Privilege

The PRA and SAER documents are privileged for clinical incidents. Statutory privilege applies from the time a SAER team is appointed. SAER team members are required to

maintain privilege by not disclosing any information, written or verbal, obtained during the investigation for the dominant purpose of the SAER.

A PRA completed for a clinical HS 1 incident is legally privileged. The PRA report cannot be disseminated to any person outside of the PRA team, including SAER team members, without the approval of the Chief Executive. Any clinical review requested by the Chief Executive will be privileged.

The Dedicated Family Contact must not discuss PRA findings or review findings or recommendations to the family to maintain privilege.

13. Recommendation Monitoring

13.1 SAER Recommendations

Recommendations arising from SAERs are logged by SLHD CGU on the *SAER Recommendation Monitoring* excel spreadsheet maintained by SLHD CGU.

Facility CGUs send recommendation evidence to SLHD-CGURecommendations@health.nsw.gov.au

Evidence is submitted on the *SAER-RCA Recommendations and SI Submissions Report* template found on the SLHD Clinical Governance Unit Clinical Incident Management tab.

Compliance with recommendation completion is monitored quarterly by SLHD CGU via email to the Facility/Service Clinical Governance Unit and General Manager.

13.2 Clinical Investigation Recommendations

Recommendations/actions arising from Clinical Investigations are logged by the facility or SLHD CGU on the SharePoint *Clinical Investigations Recommendations Monitoring* spreadsheet.

Once the recommendation evidence is received by the facility CGU, the facility updates SharePoint accordingly and saves the evidence to the IM folder (refer to Section 9.3.4: Trim).

Access to the SharePoint spreadsheet is provided by contacting SLHD CGU.

Compliance with recommendation completion is monitored by the facility CGU and tabled regularly (eg: 6 monthly) at the Facility Clinical Quality Council or equivalent committee and the meeting minutes provided to SLHD CGU.

14. Conflict of Interest and Confidentiality

Team members appointed to PRA, SAER and Clinical Investigations are required to complete a SLHD Conflict of Interest Declaration (AMR805.051) and SLHD Confidentiality Agreement (AMR805.050). The PDF forms are emailed as a PDF for the team member to sign and return. The forms are found on the SLHD Clinical Governance Unit intranet page.

PRA standing team appointees complete these once, PRA additional team member completes these for each PRA they are appointed to

The investigation team leader is responsible for obtaining the completed forms from the team member and providing these when the final draft report is submitted to SLHD CGU.

15. Definitions

Clinical Safety Check Report and Action Log	Clinical Safety Check is an internal process for Clinical HS 2 events and requested HS 3 or 4 incidents. The Clinical Safety Check is performed to provide advice and guidance to the facility, SLHD Clinical Governance and Executive Director Medical Services, Clinical Governance and Risk to guide the incident response and subsequent review.
Dedicated Family Contact	A dedicated family contact is a staff member assigned to a patient, carer or family following a serious incident of a patient. A dedicated family contact (DFC) is a consistent point of contact for families during the review process, establishes rapport and trust with the family and coordinates communication with the health service during the incident review.
Harm Score	Harm score replaces the "Serious Adverse Event (SAC)" Matrix which guides how an investigation should occur and the seriousness of the event. 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' of PD2020_047 • 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.
Incident	Any event resulting in, or with the potential for, injury, damage or other loss.
Open Disclosure	The process of providing an open, consistent approach to communicating with the patient and their support person following the completion of a serious incident investigation.
Preliminary Risk Assessment	Preliminary Risk Assessment (PRA). PRA is required for all HS 1 incidents and any other clinical incidents the Chief Executive believes may be due to serious systemic problems. The PRA is privileged and all documents and discussions that take place must not be shared with other people.
Privilege	The work of PRA assessors and SAER teams convened by the Chief Executive for reportable incidents attracts statutory privilege. The privilege is described under Part 2A of the *Health Administration Act*

	1982. Privilege supports people who feel concern for their confidentiality when asked for their recollections of an incident.
Root Cause Analysis	Root Cause Analysis (RCA) – a methodology used to identify the cause of incidents and develop recommendations to prevent recurrence or inform quality improvement activity.
Reportable Incident Brief	An initial summary of why the serious incident is being reported.
Serious Adverse Event Review	A serious adverse event review (SAER) is performed to find out what happened, why it happened and how to prevent a similar incident happening again.
Support person	May be any individual identified by the patient as a nominated recipient of information regarding their care.

16. Consultation

A/Clinical Audit and ims+ Manager SLHD

A/Executive Director Clinical Governance and Risk SLHD

A/Director Accreditation, Patient Safety and Quality RPAH

Director Clinical Governance, Concord Hospital

Director Clinical Governance, Mental Health Services

Patient Safety and Incident Manager SLHD

Patient Safety Manager SLHD

SLHD Centre for Education and Workforce Development Policy Committee

Work Health Safety Coordinator, SLHD

17. Links and Tools

The Clinical Excellence Commission (CEC Website) – Incident Management

18. References

NSQHS Standard 1: Clinical Governance Standard

Health Administration Act 1982 No 135

NSW Health Policy Documents:

- PD2020_047 IncidentManagement
- PD2020-013 Complaint Management Policy
- GL2020-008 Complaint Management Guidelines
- PD2014_028 Open Disclosure Policy
- PD2018_032 Managing Complaints and Concerns about Clinicians
- PD2018_031 ManagingMisconduct
- PD2010_054 Coroners Cases and the Coroners Act 2009

- IB2010_058 Coronial Checklist
- *Health Administration Act 1982 No 135*

19. National Safety and Quality Standard/s, 2nd ed


Clinical Governance Standard


Partnering with Consumers Standard


Communicating for Safety Standard

20. Appendices

20.1 Appendix 1: Confidentiality Templates

These templates are to be used when sending emails related to serious incident management investigations and reports.

SAER:

*****Under SAER legislation this email and any associated attachments is confidential and privileged and cannot be circulated to or discussed with any person outside of the commissioned SAER team***** If you have any queries in relation to confidentiality aspects of SAER processes, please seek clarification from the SAER team leader or the Director of Clinical Governance/ or Equivalent

RIB:

Clinical incident RIBs and any other documents created for or by the Clinical Governance Unit are created for the purpose of authorised investigation and research and are privileged under the NSW Health Administration Act 1982. The copying or distribution of the document or any information it may contain without express permission of the A/Executive Director of Clinical Governance and Risk is prohibited

PRA:

*****Under legislation this email and any associated attachments is confidential and privileged and cannot be circulated to or discussed with any person outside of the commissioned team. If you have any queries in relation to confidentiality aspects of PRA processes, please seek clarification from the Executive Director Medical Services/ Clinical Governance & Risk*****

20.2 Appendix 2: SLHD Incident Management Flowchart from 14/12/20