Coroner Paresa Spanos
Coroners Court of Victoria
65 Kavanagh St
Southbank
Melbourne 3050

NorthWestern Mental Health

Level 1 North
Main Block
The Royal Melbourne Hospital
Grattan Street
Parkville Vic 3050
Tel 61 3 9342 7705
Fax 61 3 9342 8216

Provider of mental health services to:

Melbourne Health
The Royal Melbourne Hospital

Western Health
Sunshine Hospital
Western Hospital

Northern Health
The Northern Hospital
Broadmeadows Health Service
Bundoora Extended Care Centre

MELBOURNE HEALTH

North Western Mental Health is part of Melbourne Health Service

www.mh.org.au
ABN 73 802 706 972

Thursday, 12 May 2016

Re: Inquest Finding. [redacted] Court Reference: 2009 / 4252

Dear Coroner Spanos,

I am writing in response to a finding handed down by you on 7th March 2016 following an inquest into the death of [redacted] at Western Hospital on 31st August 2009. Four recommendations were made by you, two of which apply to Orygen Youth Health / Melbourne Health…*"I recommend that Orygen Youth Health / Melbourne Health develop a procedure that addresses the need for scene preservation and / or recording, in circumstances where a serious suicide attempt has taken place in an inpatient facility, in anticipation of a foreseeable coronial investigation. Such a procedure could also assist the mental health services to undertake its own root cause analysis (whether mandated or otherwise) and to comply more broadly, with their duty of care obligations. I further recommend that such a procedure identify roles and responsibilities as clearly as possible, in particular as regards the completion of a Riskman report of the incident or any other tool or software being used from time to time in the health service to manage risk."*

NorthWestern Health (NWMH) has undertaken the following actions.

1. The attached NWMH Memorandum in regard to scene preservation has been amended to include (a) a direct reference to the possibility of a foreseeable coronial investigation and (b) inclusion of dot point 5 which now references the relevant Melbourne Health policy and procedure

2. The attached Melbourne Health policy and procedure *MH19.02 Incident Reporting* is in the process of being amended however this process will not be completed within the 90 day response timeframe as required by the Court. I have included with this response the suggested wording to be included in the revised policy and this has been highlighted in the track changed word document. I expect that the amended policy will be approved by the relevant Melbourne Health committee and ready for posting by 1 July 2016.

3. I have written to Acorn Engineering Company, City of Industry, California, Ca 91744-0527, United States of America, to alert the company to the potential ligature hazard associated with the placement of the Acorn Brand clothing/towel hook in circumstances when (a) two hooks are placed side by side and (b) the hooks are placed on the inside of an ensuite bathroom door such that a ligature may be wrapped around the hook fittings as an attachment point and then thrown over the top of the ensuite door as described in this tragic case. I have taken this step because the product information supplied by Acorn Engineering makes no reference to the possibility of the clothing / towel hooks being used in this manner.

NorthWestern Mental Health

Level 1 North
Main Block
The Royal Melbourne Hospital
Grattan Street
Parkville Vic 3050
Tel 61 3 9342 7705
Fax 61 3 9342 8216

Provider of mental health services to:

Melbourne Health
The Royal Melbourne Hospital

Western Health
Sunshine Hospital
Western Hospital

Northern Health
The Northern Hospital
Broadmeadows Health Service
Bundoora Extended Care Centre

MELBOURNE HEALTH

North Western Mental Health is part of Melbourne Health Service

www.mh.org.au
ABN 73 802 706 972

4. I will provide a copy of the letter sent to Acorn Engineering to the Capital Management Branch, Department of Health and Human Services (DHHS) and I will request an opportunity to discuss this at the DHHS convened meeting of Directors of Clinical Services and Area Managers to minimize the risk of such an event occurring in the future.

Yours sincerely,

Peter Kelly
Director Operations

NorthWestern Mental Health

Attachments:

1. NWMH Memorandum re Scene Preservation
2. Melbourne Health policy and procedure MH19.02

Memorandum

NorthWestern Mental Health

To	NWMH Nurse Unit Managers
From	Peter Kelly Director Operations NWMH
cc	NWMH Area Managers
Date	9th May 2016
Subject	Liaison with Victoria Police in the event of an attempted suicide in an IPU

1. In the event that a suicide attempt occurs in an Inpatient Unit (IPU), and the consumer is successfully resuscitated and is subsequently transferred to a general acute facility, but where there is a high probability that the consumer will ultimately not survive the suicide attempt – and in anticipation of a foreseeable coronial investigation - Nurse Unit Managers, or their delegates are required to do the following;
    - Secure the room or space pending a scene examination by Victoria Police.
    - Notify Victoria Police of the event and provide police with an opportunity to attend on site and collect exhibits and photograph the room or space.
    - Document in the Riskman report the name of the police station that was contacted and the name of the police officer and the badge number of the police officer who is informed of the attempted suicide.

2. Typically, these events may involve an attempted suicide by hanging, followed by a Code Blue response, followed by an admission to an Intensive Care Unit bed with a diagnosis of 'hypoxic brain injury'.

3. If police choose not to attend the scene after being informed of an attempted suicide please document this in the Riskman report and in the medical record.

4. If police do choose to attend the scene, but do not attend in a reasonable timeframe and, if there is pressing need to use the secured room or space, please escalate to your Area Manager or on-call Manager as appropriate.

5. This memo is consistent with guidance provided to staff in Melbourne Health policy *MH19.02 Incident Reporting*.

Peter Kelly. Director Operations NWMH

DRAFT

DEPARTMENT	Melbourne Health
NAME OF DOCUMENT	Incident Reporting
NUMBER	MH19.02
SPONSOR	Executive Director, Clinical Governance and Medical Services
FUNCTIONAL GROUPS	Transformation and Quality Director, Director Clinical Governance North Western Mental Health (NWMH), Risk and Patient Safety Manager, Quality and Patient Safety Consultants, Quality Programs and Standards Manager, Evaluation and Service Improvement Coordinators; Divisional Director(s), Director(s) of Nursing and Operations; Nurse Unit Managers; Fellow in Medical Management; Occupational Health Safety and Wellbeing Consultants, Director, Occupational Health and Wellbeing
IMPLEMENTATION STRATEGY	E-mail update; Policy of the Week. Good Catch Award for reporting near misses. Communication via Clinical Governance and Improvement Committee, Service level Quality and Improvement, Patient Safety Committees, NWMH Clinical Risk Management Committee, Adverse Events and Health Outcomes Committee, Clinical and Quality Executive.
EVALUATION STRATEGY	• Trended data on the number of completed formal incident investigations; • Root Cause Analysis (RCA) investigations completed and endorsed within 60 days; • In-Depth Case Reviews (IDCR) completed and endorsed within 60 days; • IDCR involving falls completed and endorsed within 30 days; • Number of completed OHS investigations for all ISR 2 incidents; and • Number of recommendations from RCAs and IDCRs implemented within the specified timeframes.
ACCREDITATION NSQHS Standards ACSAA Accreditation Standards National Standards for Mental Health Services Department of Health standards	Standard 1: *Governance for Safety and Quality in Health Service Organisations.* Expected Outcomes: 3.1, 3.2, 3.3, 3.4. Standard 8. Governance, Leadership and Management. Criterion 8.8; 8.10; 8.11. Corporate - Risk Management
VERSION SUMMARY	~~This procedure outlines in detail the actions to be undertaken by staff of Melbourne Health in order to ensure effective and timely management of clinical, and Occupational Health and Safety (OH&S) incidents. This includes the immediate response to the incident, notification processes, investigation and the implementation of risk reduction action plans.~~ Summarise changes to this version

EXECUTIVE SUMMARY

1. When an incident is identified immediate action is necessary to reduce the risk to the patient/staff or any person involved.
2. Incidents are to be reported to the Line Manager/Area Manager as soon possible after the

DRAFT

incident occurs and reported on the RiskMan system.

~~2.~~3. 3-5 major points that employees should be aware of.

1. ASSOCIATED MELBOURNE HEALTH POLICY

MH19 Risk Management Policy

2. PURPOSE AND SCOPE

This procedure outlines processes to be followed at Melbourne Health for reporting and management of incidents and near misses through the on-line incident reporting system (RiskMan) also known as Victorian Health Incident Management System (VHIMS). The purpose is to:

- Ensure a consistent and appropriate response to incident reporting, investigation, management and implementation of risk reduction plans arising from reviews and investigations.
- Provide an environment where consumers, carers, staff and managers feel supported when things go wrong.
- Ensure a robust system of notification with open and honest communication of adverse events.
- Foster a culture where investigative processes bring real and necessary changes based on lessons learned.

3. DEFINITIONS [1], [2], [3]

Adverse Event	An incident that resulted in harm to a person (patient/client) receiving care.
Area Manager	Manager responsible for the local area: ward, facility, department or service.
Clinical Governance	The system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers, patients or residents.
Clinical Incident	An event or circumstance that could have, or did, lead to unintended and/or unnecessary harm to a person (patient/client) receiving care. Clinical incidents include adverse events, near misses and hazards in the environment that pose a clinical risk.
Closing Incident	Incident has been reviewed and there is an agreed plan in place to address issues identified from the incident, or there is no need to initiate a mitigation plan.
Dangerous Occurrence	A dangerous occurrence is defined by the *Occupational Health and Safety Act 2004* (Vic) as being one of the following: • The collapse, overturning, failure or malfunction of, or damage to any plant that the regulations prescribe must not be used unless the plant is licensed or registered; or • The collapse or failure of an excavation or of any shoring supporting an excavation; or • The collapse or partial collapse of any part of a building or structure; or • An implosion, explosion or fire; or • The escape, spillage or leakage of any plant, substance or object; or

[1] Australian Commission on Safety and Quality in Health Care
[2] Victorian Health Incident Management policy (2011) Department of Health, State Government of Victoria
[3] Victorian Health Incident Management Policy Guide (2011) Department of Health, State Government of Victoria

	• The fall or release from a height of any plant, substance or object.
Finalise Incident	The investigation is complete and the incident is no longer required to be viewed in the '*Entered Incidents*' list in VHIMS, or the incident no longer requires input from the employee who has access to view the incident.
Harm	Harm includes disease, suffering, impairment (disability) and death: • Disease - a psychological or physiological dysfunction; • Injury – damage to tissues caused by an agent or circumstance; • Suffering - experiencing anything subjectively unpleasant. This may include pain, malaise, nausea, vomiting, loss (any negative consequence, including financial) depression, agitation, alarm, fear or grief; or • Disability - any type of impairment of body structure or function, activity limitation and/or restriction of participation in society, associated with a past or present harm.
Health Service	Collectively refers to public health services and public hospitals as defined under the *Health Services Act 1988* (Vic).
Incident	An event or circumstance that could have, or did lead to unintended and or unnecessary harm (ACSQHC).
Incident Severity Rating (ISR)	An incident score of 1, 2, 3 or 4 which indicates the severity of the impact caused to the person affected by an incident. ISR 1 indicating the highest or most severe and ISR 4 indicating no harm/near miss. The ISR is derived from a response to three consequence descriptor category questions relating to: • Degree of impact; • Level of care; and • Treatment required.
In-Depth Case Review (IDCR)	Risk managers and other health care personnel use root cause analysis (RCA) methods to investigate clinical incidents, to identify the underlying causes and to guide risk reduction plans to address safety system failures.
Line Manager	Manager responsible for employee.
Near Miss (or Good Catch)	An event that had the potential to cause harm although no harm was sustained due to a timely intervention and/or luck and/or chance.
Never Events	Based on international best practice, Melbourne Health has developed a list of 'Never Events' which are the kind of mistakes which should never happen. These adverse events are serious, generally preventable and of concern to Melbourne Health and the Victorian community. A 'Never Event' is defined as unambiguous (clearly identifiable and measurable), serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by health care providers. Never Events have the potential to seriously harm patients, are preventable, widely distributed national guidance; and are measurable (see Appendix 1 for complete list).
Notifiable Incidents	Notifiable incidents are those events that lead to death or serious injury, or expose a person to an immediate health and safety risk and are required by legislation to be reported to WorkSafe Victoria. Definition of Serious Injury below.
Notifiable Death	A notifiable death under the Mental Health Act 1986 is a death of an involuntary consumer or the unexpected death of a registered user of a Mental Health Service.
OHS and	The system by which the manager, staff and health and safety representatives

Wellbeing Governance	(HSRs) share responsibility and accountability for safety and wellbeing, continuously improving, minimising risks, and fostering an environment of excellence in safety.
OHS and Wellbeing incident (staff, visitors, contractors)	An event or circumstance that could have, or did, lead to unintended and/or unnecessary harm to a staff. OHS incidents include events, near misses and hazards in the environment that pose a risk.
Open Disclosure	The process of open communication with patients/clients/residents and their families following an incident.
Patient	The term 'patient' is inclusive of the terms, 'consumer', 'client', and 'resident'.
Preliminary Investigation	Investigation undertaken to verify facts and ensure completeness of information in order to determine if formal investigation is required.
RiskMan	RiskMan is an Enterprise Risk Management software system which the Department of Health (DH) requires health services to use for the management of incidents and feedback.
RiskMan Q	RiskMan Q is the quality activity module of the RiskMan system, used to manage quality activities. All recommendations of IDCR and RCAs are recorded in RiskMan Q.
Root Cause Analysis (RCA)	RCA is a process analysis method which can be used to identify the system and other possible factors that cause incidents or near misses. The RCA process is a critical feature of any safety management system because it enables answers to be found to the questions what happened, why it occurred, and what can be done to prevent it from happening again.
Sentinel Event	Defined by the Department of Health (Vic) (2012/13) as: *'...relatively infrequent, clear-cut events that occur independently of a patient's condition, may be linked to hospital systems and process deficiencies and may result in adverse outcomes for patients. This includes near miss or close call events that have the potential to result in adverse outcomes for patients.'* All health services and agencies that identify an incident that reflects a national sentinel event definition are required to report the incident to the Department of Health (Vic). The reporting categories are: – Procedures involving the wrong patient or body part resulting in death or major permanent loss of function; – Suicide in an inpatient unit; – Retained instruments or other material after surgery requiring re-operation or further surgical procedure; – Intravascular gas embolism resulting in death or neurological damage; – Haemolytic blood transfusion reaction resulting from ABO incompatibility; – Medication error leading to the death of patient reasonably believed to be due to incorrect administration of drugs; – Maternal death or serious morbidity associate with labour or delivery; – Infant discharged to wrong family; – ISR 1 clinical incident.
Serious Injury	A Serious injury is defined in accordance with the *Occupational Health and Safety Act 2004* as being: • A person requiring medical treatment within 48 hours of exposure to a

	substance; or • A person requiring immediate treatment as an in-patient in a hospital; • A person requiring immediate medical treatment for: o The amputation of any part of his or her body; o A serious head injury; o A serious eye injury; o The separation of his or her skin from an underlying tissue (such as de-gloving or scalping); o Electric shock; o A spinal injury; o The loss of bodily function; or o Serious lacerations. • Any other injury to a person or other consequences prescribed by the regulations.
Team Based Review	A local investigation of a clinical incident to identify the underlying causes and to guide risk reduction plans to address safety system failures undertaken by the service.
Victorian Health Incident Management System (VHIMS)	The Victorian Health Incident Management System (VHIMS) is the statewide footprint established with RiskMan to enable all Victorian public health services to report in the same way. The VHIMS data specification is a comprehensive data set that provides health services with a standardised framework for collecting and classifying clinical incidents, occupational health and safety incidents, and consumer feedback information. VHIMS is an incident reporting data set and taxonomy for use across publicly funded health services. By ensuring each health service and agency uses the same data set at a local level, there will be an ability to collect statewide incident data.

~~4. RESPONSIBILITIES~~

4. RESPONSIBILITIES

4.1. Employees are required to report all incidents and near miss events.

4.2. An incident does not include:

a Performance management and supervision issues; or

b Employee rostering issues.

4.3. All employees can report incidents via RiskMan (VHIMS) which is accessible via the Melbourne Health intranet page using their network login and password.

4.4. Specific employee responsibilities

a Employee reporting incidents:

i Notify the person in charge / manager of incident to as soon as is practicable.

ii Report the incident on RiskMan as soon as practicable and/or before the end of the day (see Appendix 2 for the elements of a good incident report).

iii Document the incident in the patient's medical history (clinical events).

4.5. Line Managers/Areas Managers

a Undertake any immediate actions to prevent a similar incident recurring.

b If required, ensure that employees involved in the incident are supported by provision of peer support incident debriefing sessions or the employee assistance program.

c Review all incidents (ISR 1, 2, 3 and 4) by next business day or when practicable to ensure:

i accuracy and completeness of information;

ii accuracy of the ISR, adjusting if necessary;

iii de-identification of summary field information;

iv ensuring patient/client/employee outcome is accurate;

v all relevant stakeholders have been notified, altering the distribution list where necessary; and

vi selecting the most relevant National Standard for the incident reported.

d In consultation with Quality and Patient Safety Consultant (QPSC), Evaluation and Service Improvement Coordinator (ESIC) or Occupational Health, Safety and Wellbeing (OHS&W), undertake a preliminary investigation of incidents rated ISR 1 and 2 and where appropriate participate in formal investigations.

e Undertake, or delegate the responsibility for a Team Based Review of all incidents rated ISR 3 and 4.

f Notify both the treating medical team and Director of Nursing and Operations/Divisional Director/Director of Clinical Services Manager/Medical Service Director if harm resulted to the patient (ISR 1 or 2) and inform them of patient outcomes and actions taken. Ensure that outcomes of any investigations carried out and findings are entered into RiskMan.

g Ensure that Open Disclosure has been undertaken by the relevant senior clinicians and that it has been documented in RiskMan and the medical record.

h Document relevant actions taken in the 'Incident Follow-up' (investigations and findings) section of RiskMan (VHIMS) as relevant information is obtained.

i Ensure that when going on a period of planned leave, responsibility for reviewing incidents has been delegated in RiskMan (VHIMS).

j Ensure that employees involved in the incident and the reporter are provided with feedback regarding the incident outcome.

k Where responsibility for implementing risk reduction action plans arising from incident investigations is assigned, ensure that actions are implemented in the timeframes indicated and update RiskMan to reflect status (date of completion and outcome).

l Notify the Occupational Health and Wellbeing Department of Notifiable Incidents.

4.6. Quality and Patient Safety Consultants and Evaluation and Service Improvement Coordinators

a Review incidents rated ISR 1 and 2 and verify the information with Line Manager/Area Manager.

b Where appropriate, refer incidents (non ISR 1 and 2s) for formal investigation to the Risk and Patient Safety Manager/Team.

c Ensure that ISR 1 and 2 incidents are distributed to all appropriate employees.

d In consultation with the Line Manager/Area Manager commence a preliminary investigation of incidents rated ISR 1 and 2 and ensure completion within five working days of incident occurring, recording information in RiskMan.

e Confirm ISR 1 and 2 incidents believed to require formal investigation with the Risk and Patient Safety Manager/Team prior to the Weekly Quality, Risk, Medico Legal and Consumer Liaison Operations Meeting.

f Ensure that the formal investigations are complete and final reports are endorsed within:

i 60 days for IDCR and RCA.

ii 30 days for IDCR involving patient falls.

g Send draft report to investigation team involved for feedback.

h For QPSC working with Royal Melbourne Health (RMH) Divisions:

i Forward completed draft IDCR / RCA reports to the Risk and Patient Safety Manager/Team for review and feedback (which will be provided within one week).

ii Incorporate feedback and prepare final report and endorsement sheet (with list of employees interviewed and those who have endorsed the report) to the Divisional Director, Divisional Director of Nursing/Operations and Service Director for endorsement.

iii Once endorsed, forward completed report to the Risk and Patient Safety Manager/Team to coordinate Executive Director endorsement.

iv Ensure a summary report from the final investigation is provided to team involved in incident.

v Set up RiskMan Q template, entering the RiskMan Q reference number to the RCA/IDCR log saved under S:\MH Incident & Event reviews\1. Incident Logs.

vi Update RiskMan Q to reflect the investigation is complete (including date complete), enter risk reduction plans and attach final investigation report and endorsement sheet to RiskMan Q.

i For ESIC working with NWMH:

i Incorporate feedback and prepare final report.

ii Present final report for endorsement to local Clinical Risk Monitoring Committee.

iii Ensure a summary report from the final investigation is provided to team involved in incident.

iv Set up RiskMan Q template, then enter the RiskMan Q reference number to the RCA/IDCR log saved under S:\MH Incident & Event reviews\1. Incident Logs.

v Update RiskMan Q to reflect the investigation is complete (including date complete), enter risk reduction plan actions and attach final investigation report and endorsement sheet to RiskMan Q.

j For falls with harm IDCR, the findings must also be entered into the Falls Trending Tool to enable review of the trends associated with falls.

k Support the monitoring for the implementation of risk reduction plans for RCAs and IDCR and escalate overdue actions to Divisional Directors/Divisional Directors of Nursing and Operations /Program Managers.

4.7. Occupational Health and Safety Consultants

a OH&S Consultants are responsible for the monitoring and statistical analysis of OH&S (staff) incidents and reporting this data to various committees.

b Provide assistance/advice regarding injury prevention and occupational risk management

c Liaise with staff and management representatives in relation to occupational health, safety and wellbeing.

4.8. Divisional Director, Director of Nursing and Operations/Clinical Services Manager/Medical Service Director and Service Directors

a Ensure that appropriate review of all incidents rated ISR 1 and 2 is being undertaken.

b Where appropriate, refer clinical incidents (ISR 3 and 4s) for formal investigation to the Risk and Patient Safety Manager/Team.

c Provide support as required to Line Manager/Area Manager in undertaking preliminary investigations.

d Ensure that Open Disclosure has been undertaken where relevant and documented in RiskMan and the medical record.

e Review RCAs and IDCR reports and provide feedback regarding adequacy/feasibility of risk reduction action plans prior to final approval of the report.

f Oversee and monitor the implementation of risk reduction action plans arising from formal incident investigations.

g Ensure that risk reduction action plans arising from RCAs and IDCR are included in Service Business Plans and discussed within established governance structures to enable effective monitoring and timely implementation.

h Table outcomes of RCA and IDCR at appropriate Service level Quality and Patient Safety Committee meetings/Clinical Risk Management Meetings.

i Ensure that when going on a period of planned leave, responsibility for reviewing incidents has been delegated in RiskMan.

4.9. Treating Medical Officer

a Provide appropriate clinical care and take immediate action to minimise further harm to patient.

b After notification from Manager, or person in charge of area where the incident occurred, notify Head of Unit regarding any adverse event resulting in harm to the patient.

c Undertake Open Disclosure when incidents have resulted in harm, or potential harm, to the patient. Document that Open Disclosure has been conducted in patient's medical history and in RiskMan.

d In consultation with Line Manager/Area Manager, liaise with the patient regarding follow-up of the incident investigation.

4.10. Head of Unit

a Review incidents rated ISR 1 and 2.

b Ensure that when going on a period of planned leave, responsibility for reviewing incidents has been delegated in RiskMan.

c Review RCA and IDCR reports and provide feedback regarding adequacy/feasibility of recommendations prior to final approval of risk reduction action plan.

d Support the implementation of risk reduction action plans arising from formal incident investigations.

4.11. Risk and Patient Safety Manager/Team

a Review all incidents rated ISR 1 and 2 (in addition to any other incidents which are referred to the team which pose a significant risk), referring to QPSC or ESIC for clarification and information from the preliminary investigation.

b Confirm the level of investigation required for all incidents rated ISR 1 and 2 at the weekly Quality, Risk, Medico Legal and Consumer Liaison Operations Meeting.

c Notify relevant QPSC or ESIC to initiate a formal investigation (RCA or IDCR).

d Notify DH of Sentinel Events within three working days of incident occurring.

e Notify the relevant Divisional Directors, Directors of Nursing/Operations, Medical Service Director and Manager of the area if a formal investigation is to be undertaken.

f Ensure adequate training of staff undertaking incident investigation and provide expert advice and support to staff conducting incident investigations.

g Arrange for review and sign-off of RCA reports before submitting to DH.

h Ensure appropriate notification to insurer by reporting cases involving any patient whose clinical outcomes were impacted upon by treatment received in the health service.

i Provide reports on the status of RCAs and IDCR and the progress towards completion of risk reduction action plans arising from incident investigation to key Clinical Governance and Quality committees.

4.12. Melbourne Health Occupational Health, Safety and Wellbeing Director

a Ensure that legislative obligations under the Occupational Health and Safety Act 2004 and the Occupational Health and Safety Regulations 2007 are appropriately managed.

b Assist Department Managers and Executive Team in relation to OH&S compliance.

c Ensure WorkSafe Victoria is notified following any Notifiable Incident.

d Liaise with all relevant parties.

4.13. NorthWestern Mental Health

a RCAs and IDCR are reviewed by the Director of Clinical Services (DCS) and then presented at the local Area Mental Health Service (AMHS) Clinical Risk Management Committee.

b RCAs are forwarded to the NWMH Director of Clinical Governance for review and sign off before being submitted to Melbourne Health's Executive Director Clinical Governance and Medical Services.

4.14. Executive Director (Clinical Governance and Medical Services)

a Review and sign-off on RCAs prior to submission to DH.

b Chair weekly Quality, Risk, Medico Legal and Consumer Liaison Operations Meeting.

c Ensure that incidents are escalated and reported to the Board through reporting pathways.

4.15. Executive Director (Royal Melbourne Hospital)

a Review and sign off of all RMH IDCR and RCAs.

4.16. Chief Executive

a Review and sign off of all RCAs prior to reporting Events to DH.

DRAFT

5. PROCEDURE

5.1. Incident management process

a Immediate Action: When an incident is identified immediate action is necessary to reduce the risk to the patient/staff or any person involved. This action may include:

i Seeking appropriate clinical assistance and initiating an emergency response if required.

ii Providing immediate care to the patient/consumer or employee involved in the incident; and

iii Making the surroundings safe to prevent a recurrence of the incident.

b If the incident results in harm or potential harm, a Medical Officer should review the person and document the event in the medical record.

c Where a patient has or may have suffered unintended harm, discussion with the patient and/or family must be undertaken in accordance with the Melbourne Health Open Disclosure Procedure.

d Where the incident involves a Notifiable Incident, preservation of the scene ~~of the accident~~ must occur.

e Notifiable Incident ~~until the WorkSafe inspector arrives to investigate.~~ The scene may be disturbed only to help someone who is injured, protect the health and safety of someone or to take essential action to make the site safe to prevent a further accident until the WorkSafe inspector arrives to investigate.

f In the event of a suicide attempt on an Inpatient Unit (IPU) where the consumer is successfully resuscitated and transferred to a general acute facility (Intensive Care Unit) but there is a high probability that the consumer will not survive (eg.diagnosis of "hypoxic brain injury") and in anticipation of a foreseeable coronial investigation, Nurse Unit Mmanagers, or their delegates are required to:

i secure the room or space pending a scene examination by Victoria Police.

ii Notify Victoria of the event and provide police with an opportunity to attend on site and collect exhibits and photograph the room or space.

iii Document in the Riskman report the name of the police station that was contacted and the name and badge number of the police officer who is informed of the attempted suicide.

iv If police do choose to attend the scene, but do not attend in a reasonable timeframe and, if there is pressing need to use the secured room or space, please escalate to your Area Manager or on-call Manager as appropriate.

v If police choose not to attend the scene after being informed of an attempted suicide please document this as part of the Riskman report.

~~d~~g

eh All employees should notify that an incident or near miss has occurred.

fi Incidents are to be reported to the Line Manager/Area Manager as soon possible after the incident occurs.

gj All incidents and near miss events are to be reported on the RiskMan, available to all employees on the Melbourne Health intranet. If an employee is unable to access RiskMan they should contact the RiskMan helpdesk.

hk To ensure accuracy of the event, a RiskMan report should be submitted as soon as practicable following the incident and prior to the conclusion of the shift.

il Clinical incidents must also be documented in the patient's medical record.

jm RiskMan will generate a notification to appropriate staff and notification is escalated according to the ISR see Table 1.

kn Clinical incidents rated ISR 1 and 2 are notified to the NWMH Quality and Innovations Manager and Transformation and Quality Service, and are presented for review at the weekly Quality, Risk, Medico Legal and Consumer Liaison Operations Meeting.

5.2. Prioritisation

a The employees who notifies the incident is required to undertake an initial assessment of the severity of the incident in RiskMan based on:

i Degree of impact;

ii Level of care; and

iii Treatment required.

b The combined selection of these three parameters will derive the ISR and guide the organisational response and level of investigation undertaken, as shown in Table 1. Incidents are rated on 4 levels of severity, from ISR 4 (no harm/ near miss) through to ISR1 (Severe/death).

Table 1 Incident Severity Rating Scale

Priority	Harm	Type of Investigation required#	Investigation Lead
ISR 1	Severe/death	Root Cause Analysis*	Quality and Patient Safety Consultant/ Evaluation and Service Improvement Coordinator or employee trained in RCA facilitation (clinical). Director Occupational Health, Safety & Wellbeing (Employee event).
ISR 2	Moderate	In-Depth Case Review*	Quality and Patient Safety Consultant/ Evaluation and Service Improvement Coordinator (clinical event) Falls related harm in collaboration with Nurse Unit Managers/ Program Manager. Coordinator in collaboration with the Line or Area Manager (clinical event). Line Manager

			(employee event)
ISR 3	Mild	Team Based Review	Line Manager/Area Manager (clinical or employee event).
ISR 4	No harm/near miss	Team Based Review	Line Manager (clinical or employee event).

ISR 3 and 4 can be investigated as an IDCR or RCA if it is determined that there are significant systems and process issues.
*Not required for all incidents – as determined by the weekly Quality, Risk, Medico Legal and Consumer Liaison Operations / or OHS&W steering committee

5.3. Preliminary Incident Investigation (ISR 1 and 2 incidents only)

a All incidents should be reviewed by the next working day.

b For RMH clinical incidents reported as ISR 1 and 2, a preliminary investigation is undertaken within five days of the incident occurring by the Quality and Patient Safety Consultant (QPSC), to acquire additional information and verify the facts.

c For NWMH clinical incidents reported as ISR 1 and 2 the Program Manager prepares an Executive Brief which is submitted to Area Manager and Director of Clinical Services.

d Journal entries in RiskMan are made to add further information and track progress of the preliminary investigation.

e For occupational health and safety (OH&S) incidents reported as ISR 1, the Occupational Health, Safety and Wellbeing Director will take a lead role in the incident investigation process.

Table 2 Procedure by ISR (details the notification, recording, investigation process for incidents)

	Sentinel Events, Notifiable Incidents and Incidents Rated ISR 1	Incidents Rated ISR 2	Incidents Rated ISR 3 and 4
Explanation	Not every ISR 1 clinical incident will require reporting as a Sentinel Event or involve an RCA. An IDCR may be deemed more appropriate. Where the initial incident investigation identifies that the major contributing factors to the incident were related to the patient's illness or management phase of chronic illness, then an RCA is not warranted.	Once identified as an ISR 2 through preliminary investigation, the QPSC or NWMH Manager Quality Planning and Innovation will brief the Risk and Patient Safety Team, who will table the incident for review at the Weekly Quality, Risk, Medico Legal and Consumer Liaison Operations Meeting.	Incidents rated ISR 3 and 4 are investigated and managed at the local level by Line Mangers/Area Managers. Where responsibility for the management of an incident is unclear, the Line Manager should clarify who will lead the investigation with the Area Manager.
Notification	If confirmed as a Sentinel Event, the Risk and Patient Safety Team will ensure that key stakeholders (relevant Executives, Service Directors, and Directors of Nursing) are notified. The Risk and Patient Safety Manager/Team will notify Sentinel Events to the DH (Vic) within three working days of the incident occurring or being identified. Where an employee incident reflects a Notifiable Incident, it should be reported immediately to the Director, Melbourne Health Occupational Health, Safety and Wellbeing (contacted via switchboard).	Following the Weekly Quality, Risk, Medico Legal and Consumer Liaison Operations Meeting, the Risk and Patient Safety Team will update RiskMan to indicate the outcome in a journal in RiskMan. Where an employee incident reflects a Notifiable Incident, it should be reported immediately to the Director, Melbourne Health Occupational Health, Safety and Wellbeing (contacted via switchboard).	Incidents rated ISR 3 or 4 may be escalated to the Divisional Director / Divisional Director of Nursing and Operations or Service Director for consideration and escalation to the Risk and Patient Safety Manager/Team.

	Sentinel Events, Notifiable Incidents and Incidents Rated ISR 1	Incidents Rated ISR 2	Incidents Rated ISR 3 and 4
Recording	Sentinel Events and associated RCA are recorded in the Activity Register (RiskMan Q).	IDCR are recorded in the Activity Register (RiskMan Q).	Findings and details of the Team Based Reviews should be documented in RiskMan under the incident follow up section.
Investigation	A Melbourne Health employee trained in RCA facilitation will lead the formal investigation. For occupational health and safety (OH&S) incidents reported as ISR 1, the Occupational Health, Safety and Wellbeing Director will take a lead role in the incident investigation process.	A Melbourne Health employee who is allocated responsibility for the incident investigation will undertake the formal investigation (In-depth Case Review) in collaboration with the responsible Line Manager/Area Manager. For occupational health and safety (OH&S) incidents reported as ISR 2, the Occupational Health, Safety and Wellbeing Director will take a lead role in the incident investigation process.	Team Based Reviews are undertaken by the treating clinical team, and review the clinical care provided along with the systems in place at the time of incident.
Timing	Sentinel event investigations (RCA) must be completed, endorsed and the final report submitted electronically to the DH within 60 days of notification.	An IDCR must be completed and endorsed within 60 days of notification (except those involving falls with harm which are due in 30 days).	A Team Based Review should be completed within 14 days of the incident being reported.
Other	At the discretion of the Weekly Quality, Risk, Medico Legal and Consumer Liaison Operations Meeting, an RCA may be undertaken for incidents not reportable as a Sentinel Event.		

5.4. Feedback and reporting following an incident

a For incidents reported as an ISR 1 or 2 resulting in an RCA or IDCR, the final investigation report will be provided to the relevant Service and presented at Quality and staff meetings.

b Reports must identify opportunities for improvement, the person responsible and an expected date of completion.

c For employee events, the Lead Investigator or Occupational Health and Wellbeing Consultant will distribute the final investigation report to the relevant Director of Nursing and Operations, Divisional Director.

d For incidents reported as ISR 3 and 4, managers are responsible for providing feedback to employees on incident outcomes and actions that result from any incident investigations.

e The employee reporting the incidents can view the progress of the investigation by logging into RiskMan (VHIMS) and viewing investigations and journal entries.

f Feedback in the form of aggregate data related to the completion of incident investigations and the implementation of recommendations is provided through monthly reports to Service / Divisional level quality committees and the Adverse Event and Health Outcomes Committee.

5.5. Implementing risk reduction action plans from formal investigations

a Following the completion of an RCA or IDCR the Lead Investigator will record the recommendations, the person responsible, and date for completion of risk reduction action plan, in RiskMan Q.

b The implementation of risk reduction action plan arising from incident investigations will be included as part of the Services' operational activities and progress will be overseen by the relevant Director of Nursing and Operations/Divisional Director/Director of Clinical Services Manager/Medical Service Director in which the incident occurred.

c The QPSC and ESICS will run fortnightly service RCA/IDCR risk reduction action plan reports via RiskMan Quality Activity reporting.

d These reports will be tabled by the QPSC at their fortnightly RMH Divisional/Nursing Director meetings and the implementation/progress of risk reduction action plans will be overseen and by the responsible Director of Nursing and Operations/Divisional Director (or delegate).

e These reports will be tabled by the ESIC at their Clinical Risk Management meetings and the implementation/progress of risk reduction action plans will be overseen and by the responsible Director of Clinical Services Manager/Program Manager (or delegate).

f Implementation of risk reduction action plans arising from incident investigations for Melbourne Health will be monitored and overseen Divisional Quality Committees, Clinical Risk Monitoring Committees or Occupational Health and Wellbeing Committee.

5.6. Key Performance Indicators

Completion of preliminary initial investigation (ISR 1 and 2)	With five working days of incident.
Notification to DH of Sentinel Events	Within three working days of incident occurring.
Completion of RCA	Within 60 days of notification.
Completion of IDCR	Within 60 days of notification.
Completion of IDCR involving a patient fall with harm	Within 30 days of notification.
Open Disclosure	Within 24 hours of an incident occurring.
Closing of incidents in RiskMan (VHIMS)	Within 30 days of incident occurring.
Notifiable incidents reported	Immediate notification, and written notification within 48 hours

6. ASSOCIATED PROCEDURES

6.1. MH19.04 Open Disclosure

6.2. MH15 Occupational Health and Safety Policy

6.3. MH15.06 Occupational Health and Safety Issue Resolution

7. REFERENCES

7.1. Victorian Health Incident Management Policy 'Victorian health incident management policy' retrieved from the health.vic.gov.au document library

7.2. Victorian Health Incident Management Policy Guide http://docs.health.vic.gov.au/docs/doc/Victorian-health-incident-management-policy- guide

7.3. Australian Commission for Safety and Quality in Health Care http://www.safetyandquality.gov.au/

7.4. National Standards for Mental Health Services http://www.health.gov.au/internet/main/publishing.nsf

7.5. e Clinical Risk Management, Department of Health Clinical risk management - Department of Health, Victoria, Australia

7.6. Australian Standards – Risk Management (AS/NZS ISO 31000:2009)

7.7. WorkSafe Victoria

7.8. Occupational Health & Safety (incident notification) Regulations 2007

7.9. Occupational Health & Safety Act 2004

8. FURTHER INFORMATION

8.1. Transformation and Quality Service

8.2. Department of Health, Clinical Risk Management http://www.health.vic.gov.au/clinrisk/sentinel/

8.3. Department of Health – Office of the Chief Psychiatrist

8.4. Melbourne Health Risk and Patient Safety Manager

8.5. Occupational Health, Safety & Wellbeing Director

9. DOCUMENTATION

10. REVISION AND APPROVAL HISTORY

Date	Version	Author and approval
December 2007	1	T. Williamson, Risk Manager. Approved by the Delegations, Procedures and Organisational Policy Committee
November 2008	2	Gary Robertson, Gary Robertson, Occupational Health and Wellbeing Director; Samantha Reid, Risk Manager. Approved and authorised by the Corporate Policy Committee.
November 2011	3	Gary Robertson, Occupational Health & Wellbeing Director. R Riley Risk & Patient Safety Manager; Nic Thomas, Senior Legal Counsel. Approved and authorised by the Corporate Policy Committee.
October 2013	4	Quality and Patient Safety Consultants; NWMH Evaluation and Improvement Consultants; OH&S Director; The members of the weekly Quality, Risk, Medico Legal and Consumer Liaison Operations Meeting; A Divisional Director; A Divisional Director of Nursing and Operations; Nurse Unit Manager representative; Imaging Operations Manager. Approved and authorised by the Corporate Executive.

DRAFT

DRAFT		List all approvers by name and position prior to submission for approval.

Appendix 1 Never Events

The following list of Never Events has been developed by Melbourne Health staff. Despite the existence of processes and procedures designed to ensure these events never happen, some of these Never Events still occur.

Care management	▪ Hospital acquired stage 3 or 4 pressure injury ▪ Procedure involving the wrong patient or body part ▪ Resuscitation (bag/valve mask ventilation and/or cardiac compressions and/or defibrillation) of a patient with a known and completed Limitation of Medical Treatment Order - not for CPR ▪ Misidentification of a patient ▪ Haemolytic blood transfusion reaction resulting from ABO incompatibility ▪ Patient receiving a blood transfusion intended for another patient ▪ Patient death or serious disability associated with the onset of hypoglycaemia while an inpatient ▪ Unplanned transplantation of ABO or HLA-incompatible organs ▪ Intravascular gas embolism resulting in death or neurological damage ▪ Performing Electroconvulsive Therapy (ECT) on the wrong patient
Surgical	▪ Surgical procedure performed with an unsterile instrument/equipment ▪ Retained instruments or other material after surgery requiring re-operation or further surgical procedure ▪ Wrong implant/prosthesis ▪ Intra-operative or immediately postoperative (within 48 hours) death in a low risk patient ▪ Unrecognised high risk tissue surgical procedures performed on a returned CJD cohort patient
Medication safety	▪ Maladministration of potassium-containing solutions ▪ Use of any abbreviation for the word 'unit' when prescribing insulin; or failure to use a specific insulin device (e.g. insulin syringe or pen) to administer subcutaneous insulin ▪ Wrong route administration of medication ▪ Administration of a medication to which a patient has a documented previous anaphylactic reaction ▪ A medication prescribing, dispensing or administration error resulting in patient death or serious disability
Environmental	▪ Patient death or serious disability associated with a fall while an inpatient ▪ Patient death or serious disability associated with the use of restraints or bedrails while an inpatient ▪ Occupational exposures associated with the absence of a sharps container at the point of sharps use
Other	▪ Permanent disability or death of a employee or volunteer as a result of work activities ▪ Sexual assault or serious physical or psychological assault of a patient or employee at Melbourne Health

References: National Patients Safety Agency. Never Events Framework 2009/10. Process and action for Primary Care Trusts 2009/10. (2009)

DRAFT

Appendix 2 ELEMENTS OF A GOOD INCIDENT REPORT

A well-completed incident report will promote an effective incident management process. A good incident report will ensure questions relevant to who, what, when, where, how and why are completed, as well as being concise and objective. The use of names and identifying information in the free text section of the RiskMan incident report should be avoided.

Element	Questions to describe the incident
Completeness	Who is reporting the incident?
	Who was affected?
	What happened?
	What are the characteristics of the incident?
	What initial actions did you take?
	What is the severity rating at the time of the incident report?
	When did the incident occur?
	Where did the incident occur?
	Why and how did the incident occur and what factors contributed?
Concise	Ensure that all important points are included
Objective	Ensure factual information that can be provide or disproved. Avoid opinions and inferences
De-identified	Avoid using names and identifying information in the 'incident summary' and 'details' fields.