Policy and Procedure

Commissioning Incident Management

Purpose

The purpose of this policy is to provide direction for the consistent management of both clinical and corporate incidents to ensure South Western Sydney Primary Health Network (SWSPHN) and Commissioned Service Provider's (including sub-contractors) respond effectively to them.

Policy

Incidents occur even in the best organisations and a systematic process in managing incidents will reduce a repeat of similar incidents and promote service improvement.

There are four (4) steps to be undertaken in Incident Management:

1. Identification
2. Notification
3. Initial investigation and reporting
4. Investigation

The principles of open disclosure are to be followed throughout the Commissioning Incident Management process.

Failure to comply with this policy may result in disciplinary action as stipulated in the Commissioned Services Agreement (CSA). If there are any inconsistencies between any parts of the CSA and this Policy, the CSA takes precedence.

Applicability

Compliance with this Policy is mandatory for all SWSPHN and Commissioned Service Provider personnel, including sub-contractors (herein Service Provider).

This policy directive applies to incidents that occur in the delivery of services commissioned by SWSPHN or during the timespan a consumer is receiving services from a commissioned service provider. It provides guidance on the difference between clinical and corporate incidents, describes roles and responsibilities in the commissioning incident management process, articulates reporting requirements, as well as, defines timeframes within which incidents and the results of the investigation of these incidents are to be reported.

Service Providers will need to implement internal processes which facilitate the identification, investigation and reporting of notifiable incidents in a timely manner and these processes may be subject to an audit by SWSPHN.

Incident Management Process

Step 1 – Identification

SWSPHN or Service Provider personnel may identify incidents through several methods, including but not limited to, direct observation, consumer or support person disclosure, team discussion, complaints audits or chart reviews. Incidents may be identified at the time they occur or at any time after the event.

When an incident has been identified, it may be necessary to take immediate actions to mitigate harmful consequences of the incident. Such actions may include:

a) provide immediate care to individuals involved in the event (consumer, staff and/or visitors);
b) make the situation and scene safe to prevent immediate recurrence of the event;
c) remove malfunctioning equipment or supplies; and
d) notify police, other emergency services and/or security, as required.

Step 2 – Notification

General notification requirements

Service Providers must have in place a mechanism for consumers, their support persons or other services and stakeholders to report an incident and additionally a process for regularly checking that this information is well understood and implemented. The use of the Service Provider's complaints management process may be appropriate in some instances, however, the impacted persons should be able to notify the Service Provider that the incident has occurred without the need to register a complaint.

Notification to Impacted Persons

As early as possible after the incident, the Service Provider should share with the impacted persons and/or their nominated contact what is known about the incident and what actions have been taken to immediately mitigate or remediate the harm to the impacted persons.

Refer to the SWSPHN Open Disclosure Policy and Procedure for further guidance.

SWSPHN notification requirements

Incidents that are considered notifiable to SWSPHN are identified in Appendix 1: Incident Categories.

The Service Provider is required to report all **Category 1** and **Category 2** (Appendix 1) incidents to the SWSPHN Commissioning Administrator via an email sent to SWSPHN Contracts. Where possible, the Service Provider includes all details currently known about the incident at that time.

Timeframes for initial reporting of Category 1 and Category 2 incidents to SWSPHN are:

- **Category 1** – within 24 hours of the Service Provider becoming aware of the incident occurrence.
- **Category 2** – within three (3) business days of the Service Provider becoming aware of the incident occurrence

Step 3 – Initial investigation and reporting

Following initial notification, the Service Provider is to investigate the incident to gather sufficient information to complete the Incident Notification Form (refer to Attachment 1). This information includes:

- Details of incident
- Categorisation of incident
- Services being provided to consumer including what other service providers may be involved in the consumer's care and if they have been notified of the incident
- Any actions taken following identification of the incident
- Preliminary investigation findings
- Risks resulting from the incident

The Incident Notification Form is to be completed within ten (10) business days of the Service Provider becoming aware of the incident occurrence. The completed Incident Notification Form is to be signed by the Service Provider's senior management prior to sending to SWSPHN.

Upon receipt of the Incident Notification Form, SWSPHN will review and respond within three (3) business days. SWSPHN may contact the Service Provider to clarify issues and/or request additional information regarding the incident. It is expected the Service Provider will respond to this request within 48 hours. SWSPHN will also determine, based on the incident severity, details and information provided whether a Root Cause Analysis is required.

If the consumer was accessing services from more than one SWSPHN commissioned service provider, SWSPHN will determine if the other Service Provider is also required to complete a notification incident form or the form completed by the initial service notifying SWSPHN is sufficient. This will be dependent on the incident circumstances and the level of involvement of each service.

Step 4 – Detailed Investigation

A Root Cause Analysis investigation (refer to Attachment 2 – Root Cause Analysis) is to be conducted by the Service Provider in collaboration with the SWSPHN Program Coordinator and, if appropriate, a nominated SWSPHN commissioned service incident investigation officer (SWSPHN investigation officer) if specific expertise is required. The SWSPHN Investigation Officer is selected by the Executive from SWSPHN staff or an external entity not involved in the incident, for example, a representative from the SWSPHN Primary Care Advisory Panel (multidisciplinary). The purpose of an RCA is to identify contributing factors such as human, system and environmental with the purpose of improving care and prevent recurrence. Incidents that require an RCA must have the final RCA report completed and submitted to SWSPHN within thirty-five (35) calendar days from the initial notification of the incident to SWSPHN.

Completing an RCA

Detailed steps for completing an RCA are detailed in Attachment 2 – Root Cause Analysis.

The Service Provider's senior/executive management is responsible for appointing an individual/team (the lead) to undertake an RCA. The lead should have fundamental knowledge of the processes in the area where the incident occurred and must not have a conflict of interest such as being directly involved in the incident or in the care of the consumer. The Service Provider is expected to work collaboratively with the SWSPHN Program Coordinator and SWSPHN nominated investigation officer to investigate the incident thoroughly.

RCA investigating suspected death by suicide, homicides or serious crimes should include input from a senior clinician.

A suitable timeframe for the implementation of any recommendations must be documented in the RCA report. Monitoring the implementation of recommendations will form part of ongoing contract management by SWSPHN.

Feedback Following Investigation

Where relevant and appropriate, Information about Category 1 and Category 2 Clinical incidents should be offered to the impacted person and others involved in the incident within thirty (30) calendar days of the RCA report being released to SWSPHN. Consideration must also be given to their cultural and ethnic identity and first language, and the support needed.

Information for feedback should be derived from the RCA report. However, there may be circumstances during the investigation where communication with the impacted person is required.

It is also expected that Service Provider will have adequate resources in place to ensure involved staff are supported throughout this process. Internal and/or external supports available to staff may be subject to an audit by SWSPHN.

Associated Documents

Legislation and best practice guidelines:

- NSW Health Incident Management Policy
- NSW Patient Safety and Clinical Quality Program: Health Administration Act 1982

Internal policies and documents:

- Clinical Governance Framework
- Code of Engagement
- Commissioning Framework
- Commissioned Services Agreement
- Commissioning Incident Notification Form
- Commissioning Incident Root Cause Analysis (RCA) Report Template

- Consumer Identification Policy and Procedure
- Cyber Security Incident Response Plan
- Improvement and Corrective Actions Policy and Procedure
- Incident Register
- Mental Health Governance Policies and Procedures
- Open Disclosure Policy
- Stakeholder Satisfaction Policy and Procedure
- SWSPHN Organisational Chart
- Supplier Access and Security Policy

Roles and Responsibilities

Document Owner	Ensure that this document is published and implemented, progress is monitored and that it is reviewed according to the document control schedule outlined in the document. Ensure the Commissioning Incident Management Policy and procedures are aligned with broader organisation policy, clinical and corporate governance.
Executive Sponsor	Provide advice to the document owner, approve the final document, and present it to the Audit and Risk Management Committee, Clinical Council or Senior Leadership Meeting for approval.
CEO	Ensure Commissioning Incident Management process is in place at SWSPHN
Executive	Ensure implementation of the Commissioning Incident Management Policy and Procedure. Ensure there is education available for new and current staff about the Commissioning Incident Management Policy and Procedure. Initiate reviews of the Commissioning Incident Management Policy and Procedure. Ensure a regular review and feedback process is in place between SWSPHN and Service Providers as part of the clinical and corporate governance approach to ensure awareness, compliance, and best practice. Nominate an appropriate SWSPHN investigation officer from SWSPHN staff or an external entity not involved in the incident.
Management	Participate in the Commissioning Incident Management process. Support staff who are participating in the Commissioning Incident Management process. Ensure staff can access resources, training, and education regarding commissioning incident management. Ensure secure maintenance of records of Category 1 and Category 2 incidents. Report commissioning incidents to Executive as soon as practicable.
Contracts Staff	Ensure Service Provider incident management responsibilities are clearly communicated in contract documents. Periodically analyse and review individual and aggregate incident information to monitor and assess risk and identify opportunities to mitigate both clinical and corporate risk; and Work in partnership with the Program Coordinator, Management and Service Provider to reduce the likelihood of both clinical and corporate risk based on the outcomes of periodic reviews. This would also include regular audits of commissioned services.

	Ensure that Service Providers have an awareness of the Commissioning Incident Management Policies and Procedures.
Program Coordinator	Endorse submitted Incident Notification Form. Support review of aggregated incident information and work in partnership with the Contracts Staff, Management and Service Provider to reduce the likelihood of both clinical and corporate risk based on the outcomes of periodic reviews. Ensure that providers have an awareness of SWSPHN incident reporting policies and processes. Work collaboratively with the Service Provider and SWSPHN investigation officer to investigate incidents that require and RCA investigation. Where appropriate, ensure adequate supports are available to those impacted by Category 1 and Category 2 incidents.
SWSPHN Staff	Initiate and participate in the commissioning incident management process when an incident occurs. Report commissioning incidents to their Manager/Executive as soon as practicable. Participate in any relevant training.
Commissioned Service Provider and their subcontractors	Management of the incident the local service level per the Commissioning Incident Management Policy and procedure. Undertake Incident Management compliance checks against its internal incident Management Policy and procedures as well as against this document. Work collaboratively with the SWSPHN Program Coordinator and SWSPHN investigation officer to investigate incidents that require and RCA investigation. Ensure staff can access resources, training, and education regarding commissioning incident management. Ensure secure maintenance of records of Category 1 and Category 2 incidents

Definitions

Word/Term	Definition
Classification	The process for capturing relevant information about an incident to ensure the complete nature of the incident, including causative and contributory factors from a range of perspectives, is documented and understood.
Consumer	The recipient of the service/s
Clinician	A health practitioner or Health Service provider of any profession regardless of whether the person is a registered health practitioner.
Complaint	An expression of concern, dissatisfaction or frustration with the quality or delivery of services, a policy or procedure, or the conduct of another person.
Impacted Person	The person/people who have been directly impacted by the incident.
Incident	Any unplanned event resulting in, or with the potential for, injury, damage, or other loss. This includes a near miss.
Incident investigation	The management process by which underlying causes of the incident are uncovered.

Word/Term	Definition
Incident Management	A systematic process for identifying, notifying, prioritising, investigation and managing the outcomes of an incident and steps taken to prevent similar occurrences.
Incident type	The core issues of the incident such as a fall or medication error. There can be more than one type of incident associated with each registered incident.
Nominated Contact	A person who has been formally nominated as the contact for matters relating to the incident.
Notifiable incident	Category 1 and Category 2 incidents as described in Appendix 1
Open Disclosure	The process of communicating with a consumer and/or their support person/nominated contact, and staff about a consumer related incident.
Root Cause Analysis (RCA)	A method used to investigate and analyse incidents to identify the root causes and factors that contributed to the incident. The process yields recommended actions directed at the prevention of a similar occurrence.
Stakeholders	GPs, Practice Nurses and Practice staff, allied health professionals, consumers, funders, NGOs, training providers, other health service providers or the community in general.
Support Person	A person responsible for providing support to the consumer during their care. This may include a family member, guardian, carer, support/peer worker or kin.
Unplanned Closure	Closure of service availability and/or service provision for 2 hours or more, with less than 48 hours notice. *Should unplanned closure be as a result of Sorry Business, only an email notification is required notifying of the closure, see Step 2 - Notification.*

Document Control

Document review every (choose most applicable) ☐ 1 year ☐ 2 years ☑ 3 years

Version	Date Commenced	Document Owner	Change Description	Review Date	Approver
V1.0	October 2016	Commissioning Manager	New policy	October 2019	Clinical Director
V2.0	February 2018	Commissioning Manager	Policy Review	February 2021	Director of Planning and Performance
V3.0	February 2021	Commissioning Manager	Policy Review Addition of Roles & Responsibilities	February 2024	Director of Planning and Performance
V3.1	March 2023	Commissioning Manager	Policy Review	March 2026	Director of Planning and Performance
V4.0	August 2026	Commissioning Manager	Policy Review	August 2029	Director of Planning and Performance

This document will remain in effect until replaced.

Appendix 1: Incident Categories

The table below identifies both clinical and corporate incidents which may occur in relation to Service Provider consumers, personnel or against the organisation itself.

Any incident which is identified as a Category 1 or Category 2 Incident is notifiable to SWSPHN and root cause analysis is to be conducted by the Service Provider against these two categories to minimise incident recurrence.

Clinical and Corporate Incident Categories: the examples listed below are not exhaustive.

		Notifiable Incidents	
		Catastrophic[1] – Category 1	**Major – Category 2**
CLINICAL CONSEQUENCE	**Consumer**	• Death on site or while providing/receiving services • Death of a consumer unrelated to the natural course of pre-existing illness & differing from the immediate expected outcome of consumer management. • Medical error with potential to cause physical or psychological harm to a consumer. • Suspected suicide attempt resulting in death[2] • Suspected homicide[3]	• Assaults on site • Hospitalisation because of suicidal ideation, attempt or acute mental health crisis.
CORPORATE CONSEQUENCE	**Staff**	• Death of staff member related to work incident or suicide.	• An injury occurring while on site, or while providing/receiving services for which a person attends and/or receives treatment by a medical practitioner.

	Service	• Complete loss of service or output. • An event which has the potential to subject the Service or SWSPHN to high levels of public or legal scrutiny. • Significant damage to site from natural disaster, fire, vandalism, or other event resulting in site or service closure. • Personal sensitive data compromised due to a cyber incident.	• Major loss of service to users, including unplanned closure of service for more than 2 hours with less than 48 hours' notice. • Non-personal data compromised due to a cyber incident.
	Financial	• Workcover claims involving serious injury or illness	• Workcover claims involving moderate injury or illness

[1] A catastrophic incident has a low likelihood of occurring, but the consequence is very high, for example, death unrelated to natural course, or a natural disaster. In comparison, a major incident has a slightly higher likelihood of occurrence, and the consequence is not as severe as a catastrophic incident. For example, permanent injury, temporary loss of service or Police intervention is required.

[2] Suspected suicide of a consumer where the death occurs within 3 months of the person's last contact with the Service Provider or where there are reasonable clinical grounds to suspect a connection between the death and the care/treatment provided by the Service Provider.

[3] Suspected homicide committed by a consumer within 6 months of the person's last contact with the Service Provider or where there are reasonable clinical grounds to suspect a connection between the death and the care/treatment provided by the Service Provide.