



SUBMISSION

Canberra Health
Services:
**Clinical Incident
Management Policy
and Procedure**

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Health Care Consumers' Association

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Background

The **Health Care Consumers' Association (HCCA)** is a health promotion agency and the peak consumer advocacy organisation in the Canberra region. HCCA provides a voice for consumers on local health issues and provides opportunities for health care consumers to participate in all levels of health service planning, policy development and decision making.

HCCA involves consumers through:

- consumer representation and consumer and community consultations;
- training in health rights and navigating the health system;
- community forums and information sessions about health services; and
- research into consumer experience of human services.

We shared the CHS Clinical Incident Management Policy and Procedure documents with our members through HCCA's Quality and Safety Consumer Reference Group (QSCRG), and our Health Policy and Research Advisory Committee (HPRAC). Both these groups have a keen interest in this important area of health care. We have drawn on the input from both HPRAC and QSCRG in preparing this submission.

We appreciated the presentation and discussion on this work from Heather Needham and Shayne Brown, from the Consumer Participation and Incident Management team at Canberra Health Services (CHS), who joined us for our recent QSCRG meeting on 30 March 2021.

We have looked primarily at the Clinical Incident Management Policy in detail, over a detailed examination of the Procedure, as we feel having the right policy in place should lead to the development and implementation of suitable procedures.

1. Summary

HCCA and CHS want the clinical incident management system in our health services to support a culture of reporting and accountability for patient care. The National Safety and Quality Health Service (NSQHS) Standards outline in Action 1.11 that:

Incident reporting can improve safety (especially when it is based on a cycle of quality improvement), improve care processes, change the way clinicians think about risk and raise awareness of good practice. The nature of the risks faced by organisations varies according to the type of organisation and the context of service delivery. This highlights the importance of evaluating the effectiveness of incident management and investigation systems at the local level.

It is vital that clinical incident management systems form part of continuous quality improvement processes across CHS. Key elements of practice include:

- A supportive culture for the reporting of incidents and near misses. There needs to be capacity developed for consumers to also report incidents (perhaps to be encompassed in the review of RiskMan currently underway).
- Informed consent procedures that support consumers and carers in shared decision makingⁱⁱ.
- Open Disclosure carried out as a matter of course. This is a key part of continuous quality improvement processes, and we want to see commitment to greater openness, broader application of actions, and public release of recommendations and actions, that will help us move together towards a safer health care system.
- Support for consumers, carers and family that recognises the need for safety in the aftermath of clinical incidents or near misses. This includes support of physical, psychological and emotional well-being, as well as working through more formal processes of Open Disclosure where this is needed.
- In-depth training for staff around clinical incident management that is interactive, perhaps including “Speaking up for Safety”ⁱⁱⁱ. We suggest that the current e-learning package may not meet these needs, given the feedback from consumers about clinical incident management in practice across CHS.

2. General comments

Contextually, HCCA has been advised that this review of clinical incident review management helps align the CHS policy more with the approach in NSW, who are moving away from the concept of “root cause analysis” (RCA). This recognises that there are often a range of causes or multiple areas that need improvement following a clinical incident. We support this view that there are many clinical incidents that have multiple causes. However, we remain supportive of the use of RCA methodology.

(a) Openness and sharing of information around clinical incidents

The experience of HCCA is that the systems currently in place across CHS are very closed, preventing openness and sharing of information for the purposes of improvement and safety. Factors influencing these closed systems include legislation, culture and leadership, and low rates of Open Disclosure. These issues need to be addressed to foster and embed a culture of continuous quality improvement in CHS. To assist with this, it is important that the culture supports transparent process that fosters accountability, ensuring that any recommendations are communicated broadly and not isolated to staff only within the areas where an

incident occurred. The recommendations and actions from an incident can help everyone to learn and improve safety across the organisation. We will all benefit from such an approach.

(b) Culture of fear and under-reporting of incidents

HCCA consumer representatives report a reluctance by staff at committee meetings in CHS to share information around incidents. Consumer are concerned about a culture of fear from staff around incidents and reporting. Yet we know that the:

...fundamental role of patient safety reporting systems is to enhance patient safety by learning from failures of the health care system. We know that most problems are not just a series of random, unconnected one-off events. We know that health-care errors are provoked by weak systems and often have common root causes which can be generalized and corrected. Although each event is unique, there are likely to be similarities and patterns in sources of risk which may otherwise go unnoticed if incidents are not reported and analysed^{iv}.

A culture of fear may lead to under-reporting, including under-reporting of near misses. This is not consistent with a culture of continuous quality improvement.

We agree that it is sensible to move to HARM scoring of incidents, as reflected in the policy, which avoids the use of an 'insignificant' rating for clinical incidents. This supports the reporting of clinical incidents, even if they are a near miss or relatively minor incident, as part of learning and improvement.

(c) Open Disclosure

The management of clinical incidents is inextricably linked with the practice of Open Disclosure. However, we know that the rates of open disclosure in CHS are low (as indicated in the OurCare dashboard). The Australian Commission on Safety and Quality in Health Care (ACSQHC) describes Open Disclosure as:

An open discussion with a patient about an incident(s) that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence.

Open disclosure is a discussion and an exchange of information that may take place over several meetings^v.

To help develop the right recommendations and actions following a clinical incident, Open Disclosure provides the opportunity to understand the perspective of everyone involved, including consumers, carers and family. It also provides a chance to understand the consequences, outcomes or impact of that incident on those involved. HCCA supports the idea expressed in the policy statement (p1) that the CHS clinical management system reflects the NSQHS Standards, relevant legislation and is consistent with best practice nationally and internationally, but this cannot be the case without Open Disclosure in place.

The issue of Open Disclosure has been raised by HCCA and consumer representatives in a number of forums. As we understand the situation, if Open Disclosure in the ACT, under the Health Act (1993)^{vi}, relies on data gathered through the Clinical Review/Quality Assurance Committee, then it is difficult to achieve without legislative change. Currently the Health Act (1993) allows for protected information (ie. information gathered through incident investigation processes), but not sensitive information (ie. information that identifies or would allow for the identification of patient/informants etc.) to be shared as part of the execution of the duties of the Act but no more. To fix this problem, the legislation would need a provision under the Quality Assurance Committee (QAC) section stating something to the effect that Open Disclosure is part of the duties of the QAC, for example “protected information may be shared to meet Open Disclosure obligations under the Open Disclosure framework”.

The need for changes to this legislation was identified years ago and we have a level of frustration at the slow action taken in this area. It is important that these legislative changes are prioritised.

(d) Support for consumers

Related to open disclosure, we also hold concerns about the safety and wellbeing of both consumers and carers in the aftermath of clinical incidents or near misses. This includes support in a physical, psychological and emotional sense, as well as working through processes of open disclosure. This should be covered, or at least referenced in this work.

(e) Consumer and carer reporting of incidents

HCCA would also like to see consumers and carers be given the opportunity to make incident or near miss reports. Developing this capacity would see consumers and carers as true ‘patient safety partners’. ‘Patient safety partners’ is a term coined by patient safety advocate Don Berwick, where patients and their carers should be present, powerful and involved at all levels of healthcare organisations^{vii}. This recognises the value in involving consumers both in their own safety and in the wider delivery of healthcare.

This is also supported by research on the contribution of carers to patient safety in hospital. Merner et.al. (2019)^{viii} found that carers contribute to protecting patients from health care-associated harm by engaging in patient safety actions at a range of different levels, depending on the conditions faced during hospitalisation. Recommendations for policy from this research include “promoting carers as safety partners, [and ensuring they] are supported by practical measures to help staff recognize the value of carers to safety and facilitate different carers to contribute in different ways”^{ix}.

(f) Informed consent

Informed consent from consumers is a concept missing from this policy. To provide informed consent, consumers need to be involved in shared decision making and a clear understanding what could happen during a particular health care journey. This may include. For example, being clear about processes around seclusion in mental health services.

(g) Education and training

Consumers also noted that the current training around managing clinical incidents, conducted via e-learning, does not give staff enough depth of knowledge around incidents and management. They highlighted that there needs to be a face-to-face component to the training to help bridge this gap and help develop practical incident management skills. One possibility could include leveraging the “Speaking up for Safety” training designed by the Cognitive Institute. This program has been implemented across a range of health services across Australia, as part of helping to build a culture of safety through by empowering staff to support each other and raise concerns to prevent unintended patient harm^x.

3. Specific Issues – by section of the policy document

(a) Policy Statement

HCCA commends the statement in this section that the CHS clinical incident management system support a culture of reporting and accountability for patient care. However, we are unsure as to what is meant by ‘consumer and carer partners’ (paragraph 2) – whether this refers to consumer and carer stakeholder partners, or individual consumers and carers as partners in care, such as those involved in shared decision making.

Paragraph 3 mentions ‘being consistent with best practice’. We suggest that this is unnecessary as it is already covered off by legislation and ACSQHC standards.

In paragraph 4, a consumer told us that:

This is a clear statement but there needs to be something about acknowledging the impact on consumers and carers in clinical incidents. We can have a strong emotional response to this too and [these events can] undermine our trust in our treating team and the service.

Paragraph 6 states that ‘incident management processes *should* occur in accordance with relevant legislation, standards and policies’. We suggest that this can be strengthened as the use of ‘should’ suggests these processes are optional when they are not.

(b) Purpose

HCCA agrees with statements made about the purpose of the policy, but suggest that first and foremost should be a focus on consumer outcomes. Using continuous quality improvement towards reducing clinical incidents and harm to consumers across the health service.

Additionally, a consumer questioned why the purpose statement is not the first element of the policy document (recognising that this is the standard template where the purpose of the policy appears as the second section).

(c) Scope

A definition is provided here of what is included and excluded from the definition of a clinical incident. We suggest it would be wise to include here a reference to the definition on which this has been developed, to ensure this is a best practice definition.

(d) Roles and Responsibilities

We support the principle outlined in this section of “championing a positive safety culture and open communication between staff and with consumers and carers”. This appears under the responsibilities of Executive Directors, but we believe this should be broader responsibility across a range of staff levels.

HCCA also support staff access to incident management education and training. Consumers wondered whether this includes training in open disclosure, or whether this needed to be addressed in an additional dot point in this section.

We are concerned here that quality improvements resulting from an incident need to be applied broadly across a range of clinical areas, not just in the location where the incident occurred. For example, it could be across one Division, or broadly across all/most Divisions. Current arrangements appear to largely prevent much sharing of information about incidents and recommendations, and we suggest this is an impediment to quality improvement that must be overcome to help prevent future similar incidents in other areas.

Consumers also raised that while all staff have the responsibility for identifying and notifying incidents when they occur to their immediate supervisor, and that Directors/Supervisors/Managers have responsibility for ensuring the safety and support for patient/clients/consumers following an incident, there is a gap. The gap is around whose responsibility it is to communicate with consumers and/or carers about the incident itself. It is important that this role/responsibility is made clear.

Finally, we suggest considering the *All Staff* instructions be moved from the end of this section to appear instead as the first part of this section of the document. This will help ensure that staff reading the document do not miss the roles and responsibilities that are relevant to all staff.

(e) Evaluation

HCCA suggests that the evaluation component of this policy needs more work. The evaluation must relate to the purpose of the policy, outlined earlier in this document. It is not clear:

- What is meant by “the document is easily accessible” and how will this accessibility be measured? Does this mean that the document is available on the website and intranet? Has it been assessed to ensure an appropriate level of readability?
- If staff understand and comply with the process and responsibilities – how will this be measured? How will we know that this is happening?
- How the quality of open disclosure, when it is occurring, is assessed? Is there a separate policy and procedure for open disclosure where this is evaluated in greater detail? We note that there is a related procedure mentioned in the next section of this document, but no partnering policy. If the clinical incident management policy governs open disclosure, then this should be a more prominent feature.
- Why consumer experience is not part of the measurable outcomes for evaluation? We suggest adding something in the ‘Outcomes’ section along the lines of “Consumers and carers have clinical incidents explained to them in a way they can understand, and receive appropriate care and support following a clinical incident”. We also suggest that the ‘Measures’ section should include consumer experience.

(f) Related Policies, Procedures, Guidelines and Legislation

HCCA is concerned that while the process of informed consent is important to this policy, this is not mentioned in the document.

Informed consent is a person's decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention. Ensuring informed consent is properly obtained is a legal, ethical and professional requirement on the part of all treating health professionals, supporting person-centred care and forming part of the NSQHS standards^{xi}.

CHS related policies and/or procedures on informed consent also need to be covered in this section.

Consumers also wondered why there was no mention of the Consumer Feedback Management Policy in the document, given this is also an integral policy related to Clinical Incident Management. We believe it is important to make this link.

We also noted that there is inconsistency in naming of the policies – some are labelled as CHS policies but not all. If the other are Territory-wide policies then it would be useful to make this clear.

4. Concluding remarks

We thank you for the opportunity to provide input to the consultation on the CHS Clinical Incident Management Policy and Procedure. HCCA views these documents, and their implementation, to be key pieces of work in ensuring high standards of safety and quality for consumers in public health services in the ACT.

HCCA is happy to be contacted to clarify any issues we have raised in our submission and looks forward to continuing to be involved in this work. Please do not hesitate to contact us if you wish to discuss our submission further.

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ⁱ ACSQHC National Safety and Quality in Health Services Standards (2nd ed. 2017) – Action 1.11 <https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-111#:~:text=incident%20reporting%20can%20improve%20safety,raise%20awareness%20of%20good%20practice> [accessed 9 April 2021]

ⁱⁱ ACSQHC Shared Decision Making (2019) <https://www.safetyandquality.gov.au/our-work/partnering-consumers/shared-decision-making> [accessed 12 April 2021]

ⁱⁱⁱ The Cognitive Institute “Speaking up for Safety” (2021) <https://www.cognitiveinstitute.org/courses/speaking-up-for-safety-programme/#:~:text=The%20Speaking%20Up%20for%20Safety,to%20prevent%20unintended%20patient%20harm>. [accessed 12 April 2021]

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- ^{iv} WHO Guidelines for Adverse Event Reporting and Learning Systems: from information to action (2005) <https://apps.who.int/iris/bitstream/handle/10665/69797/WHO-EIP-SPO-QPS-05.3-eng.pdf?sequence=1&isAllowed=y> [accessed 12 April 2021]
- ^v ACSQHC Australian Open Disclosure Framework (2013) <https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.pdf> [accessed 15 April 2021]
- ^{vi} Health Act (1993) <http://www.legislation.act.gov.au/a/1993-13/current/pdf/1993-13.pdf> [access 13 April 2021]
- ^{vii} National Health Service UK – Patients as partners in their own safety <https://improvement.nhs.uk/resources/patients-as-partners-own-safety/> [accessed 12 April 2021]
- ^{viii} Merner, B., Hill, S. and Taylor, M. (2019) “*I’m Trying to Stop Things Before They Happen*”: Carers’ Contributions to Patient Safety in Hospitals”. *Qualitative Health Research*. 29(10) 1508-1518. <https://journals.sagepub.com/doi/full/10.1177/1049732319841021> [accessed 16 April 2021]
- ^{ix} Ibid. Merner et.al. (2019) p1517.
- ^x The Cognitive Institute “Speaking up for Safety” (2021) <https://www.cognitiveinstitute.org/courses/speaking-up-for-safety-programme/#:~:text=The%20Speaking%20Up%20for%20Safety,to%20prevent%20unintended%20patient%20harm.> [accessed 12 April 2021]
- ^{xi} Under the NSQHS Standards - ‘Partnering with patients in their own care’, Action 2.4 (2017) <https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard/partnering-patients-their-own-care/action-24>