SESLHD PROCEDURE COVER SHEET

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EXECUTIVE SPONSOR	Director, Clinical Governance and Medical Services
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FUNCTIONAL GROUP(S)	Clinical Governance
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SUMMARY	This procedure outlines the process for reporting and escalating HS 1 and HS 2 incidents, including the approval process for revising/ downgrading the Harm Score (HS) of incidents initially reported as HS 1 or HS 2 where the outcome did not indicate this.

1. POLICY STATEMENT

This procedure outlines the immediate steps to be undertaken by SESLHD personnel following notification of Clinical and Corporate Harm Score (HS) 1 or HS 2 incidents, and the reporting requirements to the Chief Executive (CE). It also outlines the approval process for the revision of the HS of incidents initially reported as a HS 1 or HS 2 requiring downgrade to a different HS, as well as the steps to be undertaken for the analysis and escalation of clinical risk.

2. BACKGROUND

Following identification of any incident, it is necessary to take immediate action to mitigate any potential or actual harmful consequences of the incident.

NSW Health Policy Directive PD2020_047 – Incident Management outlines the mandated response to serious incidents.

A HS is allocated within the incident management system (ims+) system depending on the outcome for the effected person. An incorrect HS can sometimes be allocated by the notifier or the HS may be determined inappropriate if new information is obtained following notification.

The NSW Ministry of Health (MoH) has mandated that where it is determined that an initial HS 1 rating requires downgrading, the Director Clinical Governance and the Chief Executive must give final approval before the HS 1 rating is downgraded.

3. RESPONSIBILITIES

3.1 Employees will:

- Immediately report HS 1 and HS 2 incidents to their Line Manager.
- Notify any identified incident (both clinical and corporate) in the incident management system (ims+), as outlined in the NSW Health Incident Management Policy Directive PD2020_047.

3.2 Line Managers/ Service Managers will:

- Ensure immediate action is undertaken in accordance with the NSW Health Incident Management Policy Directive PD2020_047.
- Review the incident notification and confirm the HS rating in line with the ims+ categories.
- If the rating is a HS 1, the Line Manager/ Service Manager must immediately report the incident to the General Manager/ Service Director/ After-Hours Manager and the Site/ Service Clinical Practice Improvement Unit (CPIU).
- If the HS 1 rating is incorrect and requires revision, inform relevant staff from CPIU as per local procedures and obtain approval for downgrade from the General Manager.
- If the rating is a HS 2, the Line Manager/ Service Manager must immediately report the incident to the CPIU as per local procedures.

3.3 CPIU staff will:

- Review all new incident notifications in the ims+ on a daily basis (business days) and ensure incidents have been assigned appropriate HS's.
- Consult with the Line Managers/ Service Managers to confirm HS for incidents initially reported as HS 1 and HS 2 incidents.
- Notify the General Manager/ Service Director and District Clinical Governance Unit of HS 1 and HS 2 incidents, and the need to downgrade a HS 1 score when the initial rating is incorrect. Ensure General Manager approval to downgrade an incident incorrectly notified as HS 1 is provided to District Clinical Governance Unit.
- Facilitate Preliminary Risk Assessment (PRA) meetings and/ or Clinical Incident Review meetings as per the NSW Health Incident Management Policy Directive PD2020_047.

3.4 General Managers and Service Directors will:

- Ensure that all HS 1 incidents are notified to the Deputy Director Clinical Governance and Medical Services within 24 hours.
- If a HS 1 is incorrect and requires downgrade, notify the District Clinical Governance Unit for approval.
- Ensure that all confirmed HS 2 incidents are notified to the District Clinical Governance Unit within 24 hours of local confirmation (72 hours on weekends and public holidays).
- Ensure that the Director Clinical Governance and Medical Services is informed of any staff performance issues or risks to the organisation in relation to serious incidents.
- Ensure there are processes in place for the trending and analysis of incidents and identification of clinical risk e.g. reoccurring incidents in particular services.

3.5 The Deputy Director Clinical Governance and Medical Services will:

- Ensure that all HS 1 Incidents are notified to the Chief Executive within 24 hours, with RIB submitted to the MoH within mandated timeframe.
- Confirm if appropriate to downgrade a HS 1 incident and seek approval from the Chief Executive.
- Ensure that all confirmed HS 2 incidents are notified to the Chief Executive within seven days or sooner if required (based on risk).
- Ensure that the Chief Executive is informed of any staff performance issues or risks to the organisation, in relation to HS 1 and HS 2 incidents, within 24 hours.
- Provide trended reports of all serious incidents to the SESLHD Clinical and Quality Council.

4. PROCEDURE

4.1 Harm Score 1 Incidents

- All staff will report clinical and corporate incidents and complaints in the ims+, and immediately report HS 1 incidents to their Line Manager.
- The Line Manager will confirm the HS 1 rating and report the incident to the Service Manager.

- The Service Manager will immediately report the incident to the General Manager with involvement of the CPIU as per local processes.
- The General Manager or delegate will immediately notify the Deputy Director Clinical Governance and Medical Services.
- A PRA meeting will be arranged, as per the NSW Health Incident Management Policy Directive PD2020_047.
- Identify staff performance issues and if required, refer to the relevant manager for follow up as per the NSW Health Managing Complaints and Concerns about Clinicians Policy Directive PD2018_032.
- A Reportable Incident Brief (RIB) is completed by the Site/ Service and once approved by the General Manager is sent to the Deputy Director Clinical Governance and Medical Services via the ims+ for approval by the Chief Executive and submission to the MoH within 24 hours.
- A SAER team will be commissioned to investigate and report, as per the NSW Health Incident Management Policy Directive PD2020_047.
- Information regarding identified staff performance issues or risks to the organisation should be sent to the Deputy Director Clinical Governance and Medical Services with the RIB, for escalation to the Chief Executive.

4.2 Revising the harm score (HS) of incidents initially reported as a HS 1

- If it is identified that a HS 1 score may be incorrect, CPIU staff must confirm the clinical outcome of the patient incident and check the rating with the ims+ categories.
- If the score is incorrect, CPIU staff must seek approval from the General Manager and the Deputy Director Clinical Governance and Medical Services, who will seek approval from the Chief Executive to downgrade the HS.
- Once approved the SESLHD Clinical Governance Unit will revise the HS score in the ims+ and document the approval and rationale for the HS 1 downgrade in the progress notes section of the incident notification.
- Sites/ Services must table the HS 1 incidents that are downgraded at local Patient Safety and Clinical Quality meetings.
- CPIU staff are to provide feedback to notifiers and their managers.

4.3 HS 2 Incidents

- All staff will report clinical and corporate incidents and complaints in the ims+ and immediately report HS 2 incidents to their Line Manager.
- The Line Manager will confirm the HS 2 rating and report the incident to the Service Manager and the CPIU as per local processes.
- If the score is incorrect, CPIU staff must ensure the rationale for the HS 2 revision is documented in the progress notes section of the incident notification.
- The CPIU and Service Manager will ensure that Open Disclosure occurs.
- The Service Manager will immediately report any identified performance issues or organisational risks related to HS 2 incidents to the General Manager.
- The CPIU staff will notify the General Manager and Clinical Governance Unit within 24 hours (72 hours on weekends and public holidays) that a confirmed HS 2 incident has occurred.

- The Clinical Governance Unit will notify the Chief Executive and Director of Operations that a HS 2 incident has been reported, and if there are identified organisational risks or staff performance issues.

5. CLINICAL RISK

- All SESLHD Sites/ Services must ensure that a thematic analysis of all HS 2 incidents is conducted and reported to the Site/ Service Patient Safety and Clinical Quality Committee quarterly.
- The trended report should include monthly data over two years and include principle incident type (PIT), location, speciality, and further analysis to identify areas of concern.
- Emerging risks associated with reoccurring incidents in particular services should be addressed.
- The Clinical Governance Unit will provide a monthly trended HS 2 report to the SESLHD Clinical and Quality Council.
- The Clinical Governance Unit will provide an annual HS 1/ SAER thematic analysis to the SESLHD Clinical and Quality Council.

6. DOCUMENTATION

- Incident Management System
- Preliminary Risk Assessment
- Reportable Incident Brief
- Serious Adverse Event Review – Findings and Recommendations Reports

7. AUDIT

Monthly review by Clinical Governance Unit of Harm Score 1 and Harm Score 2 notifications from Facilities/ Services against incident management system (ims+) data to ensure compliance with procedure.

8. REFERENCES

- NSW Health Incident Management Policy Directive PD2020_047
- NSW Health Open Disclosure Policy Directive PD2023_034
- NSW Health Managing Complaints and Concerns about Clinicians Policy Directive PD2018_032

9. VERSION AND APPROVAL HISTORY

Date	Version	Version and approval notes
October 2016	1	Kim Brookes, Acting Director Clinical Governance
December 2016	1	Endorsed by DET
February 2019	2	Major review endorsed by Executive Sponsor – Kim Brookes, Director Clinical Governance
March 2019	2	Draft for comment period.

May 2019	2	Feedback incorporated and final version approved by Executive Sponsor. Formatted by Executive Services prior to tabling at June 2019 Clinical and Quality Council meeting for approval.
June 2019	2	Approved by Clinical and Quality Council
June 2021	3	Minor review by Patient Safety Manager. Changes to RCA/SAER terminology and ims+.
September 2021	3	Approved by Deputy Director of Clinical Governance and Medical Services Approved by Executive Sponsor.
17 July 2024	3.1	Minor review by District Patient Safety Lead to update name, hyperlinks, include additional key terms, and more explicitly detail documentation requirements for Harm Score 1 and 2 downgrades. Approved by Executive Sponsor.
17 July 2024	3.1.1	Title of document in header amended.