DOCTORS ON RICCARTON	

Policy for Incident Management

This practice recognises the importance of learning from events, incidents or accidents that have happened within the practice. It complements other systems that aim to minimise risks to patients and staff; these include policies for tracking laboratory and radiology results, advising patients of their results, triage of patients by reception staff, repeat prescribing, handling complaints and others.

Event Management will look at:

- Events that went well
- Incidents or potential incidents which have, or could have, produced an undesired result
- Accidents in workplace
- Sentinel events.

To oversee the process the practice has nominated the Practice Manager as the Events Reviewer for the medical centre. Depending on the seriousness of the event a review will be arranged either at the next scheduled meeting or sooner if required.

All events will be reported to the Reviewer. For accidents and sentinel events immediate action may be required to reduce, minimise or treat harm. An Event Register will be kept for all previous incidents that have been reviewed.

An event form will be completed by staff reporting the event with the Reviewer. This will detail when it happened, who is reporting it, who was involved and what happened. Any action that was required to be taken at the time will be detailed. The Reviewer will ensure that all staff involved should be included in the review process and who will be required to attend the meeting.

Contributory factors will be analysed; these include equipment, current policies in place by the practice, staff and the patient and the environment. Omissions and errors, poor communication or failure to comply with current policies will also need to be examined. Action that is to be taken, if any, is to be described and, where necessary, a review date is to be set.

Where the incident has resulted in harm to a patient, then consider keeping them informed of any actions that have been taken.

All completed forms should be stored (either on paper or electronically) for future reference.

CARMS Reporting
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Doctors on Riccarton

Incident Management Form

Date:	Time:	Person reporting:

Staff involved:

Description of event/incident:

Action taken at the time:

Analysis of event including contributory factors:

Action to be taken:

Further review required, if so when?

Doctors on Riccarton
Accident/Incident Report – Investigations and Recommendations

Manager/Investigator's name:	Work Location:	Date report received:

Severity of accident/ incident:
Type of incident ☐ Process/procedure error ☐ System failure ☐ Policy breach ☐ Complaint ☐ Other
How bad could it have been?
☐ Very Serious ☐ Serious ☐ Minor
What is the chance of it happening again?
☐ Minor ☐ Occasional ☐ Probable

Outcome of incident investigation (confirm details, list any additional information, identify contributing factors):

Recommendation to prevent similar incident:

Investigation Checklist:
☐ Talked to people involved ☐ Provided Feedback

Further actions required, if so when?

Does the hazard register need to be updated? (eg new hazard/risk identified or changes needed to hazard/risk control panel).	☐ No	☐ Yes
Does the training programme need to be updated? If so, review.	☐ No	☐ Yes
Did this incident cause Serious Harm, requiring notification to the relevant professional body or compliance board? (see SAC matrix/consequence table on the following page) If so, follow process and record who was notified and date/time of notification.	☐ No	☐ Yes

Manager Sign off		
Name:	Signature:	Date:

Consequence Table

Rate all adverse events on ACTUAL OUTCOME Rate all near misses on the most likely potential outcome Incidents with a high POTENTIAL SAC rating can be notified to the Central Repository (HQSC) via REB at the discretion of the organisation (http://www.hqsc.govt.nz)				
Severe	**Major**	**Moderate**	**Minor**	**Minimal**

Generic Consequences (applicable to all health and disability services)

Death or permanent severe loss of function that is related to the process of health care and differs from the expected outcome of that care.	**Permanent major or temporary severe loss of function** that is related to the process of health care and differs from the expected outcome of that care.	**Permanent moderate or temporary major loss of function** that is related to the process of health care and differs from the expected outcome of that care.	**Permanent minor or temporary moderate loss of function** that is related to the process of health care and differs from the expected outcome of that care.	**Temporary minor loss of function.**

Specific Incidents/Consequences

• Wrong consumer or wrong procedure with risk of or actual severe harm • Suicide as inpatient • Blood component given to wrong consumer • Retained item with delayed removal • Child/infant abduction or discharge to the wrong family • Failure of essential service with risk of severe consumer consequences	• Wrong consumer or wrong procedure with risk of or actual major harm • Retained item with immediate removal • Misadministration of radioactive materials • Unanticipated cardio-pulmonary resuscitation resulting from the process of health care • Community suicide by mental health consumer within 28 days of contact with service • Missing person with a risk of serious harm to self or others	• Wrong consumer or wrong procedure with risk of or actual moderate harm • Fall resulting in fracture Any of the following as a result of the incident: • Transfer to higher level of care, including hospitalisation • Increased length of stay (>one day) • Surgical or other significant intervention required	• Wrong consumer or wrong procedure with risk of or actual minor harm • Additional monitoring, investigations or minor interventions as a result of the incident	• Medication error with no harm

Likelihood Table

LIKELIHOOD CATEGORY	DEFINITION	CONSEQUENCE				
		Severe	Major	Moderate	Minor	Minimal
Almost Certain	Almost certain to occur at least once in next three months	1	1	2	3	4
Likely	Will probably occur at least once in the next four-12 months	1	1	2	3	4
Moderate	Is expected to occur within the next one to two years	1	2	2	3	4
Unlikely	Event may occur at some time in the next two to five years	1	2	3	4	4
Rare	Unlikely to recur – may occur only in exceptional circumstances ie >five years	1	2	3	4	4

Review Process	
SAC 1	• Complete REB Part 1 and send to HQSC within 15WD • Formal review using RCA methodology / London Protocol • Complete REB Part 2 and send to HQSC within 70WD
SAC 2	
SAC 3	• Review of incident within 30WD • May complete REB Part 1 and Part 2 and send to HQSC if considered relevant eg. Health sector issue or learning
SAC 4	

CARM Reporting
(reporting of patient's adverse reactions to medicine)

The Centre for Adverse Reactions Monitoring (CARM) in Dunedin is the national repository for adverse reaction reports. Reports to CARM help determine whether there is an association between an adverse reaction and a medicine, and the strength of any association.

How to report to CARM

In Medtech32 PMS software

- ➔ ERMS icon on toolbar
- ➔ Pharmacology tab
- ➔ Adverse Reaction Report – fill in details and hit "submit" button