CLINICAL INCIDENT MANAGEMENT

PROCEDURE ©

DOCUMENT SUMMARY/KEY POINTS

- This Procedure document outlines the processes and responsibilities for those involved in clinical incident management at Sydney Children's Hospital Network (SCHN).
- This document provides SCHN-specific information regarding clinical incident management. Staff should access the NSW Ministry of Health Incident Management (PD2020_047) policy for a complete description of the mandated process.
- All staff are responsible for identifying incidents and for taking immediate action to ensure the safety of patients, visitors and other staff, with the aim of reducing harm.
- Clinical incidents, including near misses, ***must*** be recorded in the Incident Management System (ims+) as soon as practically possible.
- Open disclosure must occur whenever a patient has been harmed, whether that harm is a result of an unplanned or unintended event or circumstance, or is an outcome of an illness or its treatment that has not met the patient's or the clinician's expectation for improvement or cure, as per the NSW Health Open Disclosure (PD2014_028) policy.
- SCHN must undertake a Preliminary Risk Assessment (PRA) within 72 hours for reportable incidents (clinical Harm Score 1 incidents). The Chief Executive (CE) may also direct that a PRA be completed for other clinical incidents (Harm Score 2–4) that may be due to a serious systemic problem.
- A serious adverse event review (SAER) must be undertaken following a clinical Harm Score 1 incident. The review is to identify any factors that caused or contributed to the incident, and any practices, processes or systems that could be reviewed for the purposes of a recommendations report. The CE may also direct a SAER be undertaken for other clinical incidents (Harm Score 2–4) which may be due to serious systemic problems. It must be submitted to the Ministry of Health within 60 calendar days of the incident notification in ims+.
- SCHN must monitor the implementation of recommendations arising from incident reviews, and have escalation processes in place for recommendations that cannot be progressed.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st December 2021	**Review Period**: 3 years
Team Leader:	Patient Safety Lead	**Area/Dept**: Clinical Governance Unit

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CHANGE SUMMARY

- This document is a revision of the previous document 'Incident Management' in ePolicy, following the update to the NSW Ministry of Health Incident Management (PD2020_047) policy in December 2020.
- This Procedure document does not include information regarding ims+ user information for notifiers and managers. Supplementary information and training resources can be located on the Clinical Excellence Commission (CEC) website, SCHN Clinical Governance intranet page, or via consultation with the Patient Safety team within the Clinical Governance Unit (CGU).
- This Procedure document only includes information regarding ***clinical*** incident management at SCHN. Information regarding corporate incident management (SCHN Work Health Safety Risk Management Procedure) and consumer feedback (SCHN Patient Complaints Management Procedure) is located on ePolicy.
- Appendix 2 includes a glossary of key terms and abbreviations that are used during clinical incident management.
- Title changed. Previous title - Incident Management (2006-8324 v5).

READ ACKNOWLEDGEMENT

- All staff working in clinical areas are required to read and acknowledge this Procedure and complete the ims+ Notifier Training module in My Health Learning.
- All managers working in clinical areas are required to read and acknowledge that they understand the contents of this Procedure, whilst additionally completing the ims+ Manager Training and Open Disclosure Training modules in My Health Learning
- All other staff throughout SCHN must be aware of this Procedure.

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Introduction

The purpose of this procedural document is to provide all SCHN staff with an outline of the processes and responsibilities for the reporting and management of clinical incidents at SCHN.

This document is an adaptation of the ***NSW Ministry of Health's Incident Management*** (PD2020_047) policy. This document relates the fundamentals described within the state policy to the processes applicable at SCHN. For more detailed information regarding clinical incident management, the state policy should be accessed.

Resources

Incident Management System (ims+)

- Accessed via the application window on the SCHN desktop, or remotely from any location – https://imsplus.private.aus-1.datixcloudiq.com. Staff must use their Stafflink ID and password to access ims+.

Patient Safety SCHN Intranet Pages

- ims+ Resources: How to relocate an incident in ims+, location owners, ims+ downtime processes/form.
- Patient Safety: Incident management resources, dedicated family contact (DFC) resources, Serious Adverse Event Review (SAER) and SCHN Case Review templates.
- Patient Safety Reporting: Archive of completed SCHN SAER and Case Review reports.
- How safe are we?: Refer to the 'Patient Safety Incident Dashboard' for a graphical representation of all clinical incidents entered into the Incident Management Systems at SCHN since 2017.

My Health Learning (HETI)

- Notifier training – *'ims+ How to Notify an Incident'* (Course Code: 259009870).
- Manager training – *'ims+ How to Manage and Review an Incident Record'* (Course Code: 266765062).
- Open disclosure training – *'Open Disclosure'* (Course Code: 47311513).

ims+ Information Website

- URL: https://imsplus.health.nsw.gov.au/
- Training tab – Quick reference guides, educational videos and other resources.

Clinical Excellence Commission (CEC) Website

- Incident management policy resources tab – Templates and toolkits.

SCHN Clinical Governance Unit (CGU)

- Patient Safety team email: SCHN-PatientSafety@health.nsw.gov.au
- CGU email: SCHN-CGU@health.nsw.gov.au; CGU Phone: 9845 3442

Clinical Incident Management Process

The purpose of clinical incident management is to understand and address system and process issues related to SCHN. The process involves a series of steps which are mandated by NSW Health policy and involve incident identification, ensuring the immediate safety of people and the environment, notification in ims+, escalation, review, action implementation and feedback to all involved. The overall aim of this process is to reduce patient harm. Refer to the NSW Ministry of Health's Incident Management (PD2020_047) policy for further details regarding the process for clinical incident management.

Responsibilities of SCHN Staff

Incident management is the responsibility of all staff members, at all levels, at SCHN.

Manager responsibilities within ims+ may be delegated to other senior staff members, where appropriate. For further guidance in this process, please contact the Patient Safety team: SCHN-PatientSafety@health.nsw.gov.au.

All Staff

- All staff ***must*** enter clinical incidents into the Incident Management System (ims+). Incidents should be notified on the same day as they occurred, or as soon as practicable.
- Staff ***must*** contemporaneously document the nature of the incident, inclusive of the incident identification number (Incident ID) generated by ims+, in the patient's electronic medical record. If staff were not responsible for entering the incident record in ims+ but were still involved in the event, the nature of involvement should be recorded in the patient's electronic medical record (where appropriate).
- When notifying any incident, adverse event or near miss involving ***clinical*** care, the notifier should select "Patient" or "No Person" under the drop-down heading *Who or What Was Most Affected?* to ensure it is recorded as a clinical incident.
- Staff should ensure that the incident details are communicated with their manager in a timely manner (verbal and written).

Ward & Department Managers (i.e. Staff Responsible for Managing Incidents in ims+)

- Managers of departments and wards (or an appropriate delegate) are required to manage all incidents under their area of responsibility.
- Managers should review all incidents in a timely fashion. The incident status in ims+ must be updated to "Under Investigation", with the Harm Score confirmed:
  - Within 24 hours for Harm Score 1 incidents
  - Within 5 calendar days for Harm Score 2, 3 and 4 incidents
- A detailed review of the incident must continue. Once completed, the incident status in ims+ should be updated to "Investigation Complete", followed by "Finalised":
  - Within 60 calendar days of notification for Harm Score 1 incidents
  - Within 45 calendar days of notification for Harm Score 2, 3 and 4 incidents
- All incidents must have a confirmed Harm Score, a documented incident review and have all mandatory fields completed. This process is required regardless of further reviews of the incident being completed by CGU.
- It is the manager's responsibility to support and/or undertake open disclosure, provide feedback to staff involved in each incident, and ensure all peripheral departments impacted by the incident are informed and invited to be involved in the response.
- A ward/department manager may be invited to a Preliminary Risk Assessment (PRA) meeting if a significant incident requires further review under their area of responsibility.
- Managers are responsible for implementing recommendations from all Clinical Incident Reviews under their area of responsibility. The implementation of recommendations must be documented within ims+, and may require reporting in other forums.
- If professional misconduct, impairment or unsatisfactory professional performance is identified as a potential contributing factor to the outcome of a clinical incident, this should be reviewed, managed and/or escalated as per usual management procedures.
- All managers are responsible for promoting a sound safety and reporting culture.

Patient Safety Team

- The Patient Safety team are responsible for providing expert advice and support to all staff within SCHN regarding clinical incident management.
- The Patient Safety team review all clinical incidents entered into ims+ to analyse the nature of the incident, the level of harm associated, and ensure significant incidents are reviewed and escalated appropriately for further action.
- A summary report of all clinical incidents entered into ims+ is circulated each working day to all applicable staff members prior to the site-based Hospital Team Talk.
- The Patient Safety team escalate significant clinical incidents that warrant further action through Reportable Incident Briefs (RIB), PRAs and other briefings to Senior Executive staff and the NSW Ministry of Health.

- The CGU is responsible for leading SAERs, supporting Case Reviews and other locally-led incident reviews.
- The Patient Safety team monitors trends and patterns from clinical incidents reported throughout SCHN. Matters that require special reviews and working parties are referred to the Director of Safety, Quality & Governance. Data reports related to incidents and reviews are also generated by the Patient Safety team for Executive staff, clinical leads and relevant Committees throughout SCHN upon request. Graphical clinical incident data can also be accessed via the Patient Safety Incident Dashboard, which can be found on the 'How Safe Are We?' dashboard page on the SCHN intranet.

Clinical Program Directors (Tier 3 Management)

- Clinical Program Directors (CPD) are responsible for supporting managers with clinical incident management, particularly those associated with significant harm, aggregate incidents of a similar nature, and those that may represent an organisational risk. Incidents of significant harm/risk should be communicated to CGU for assistance.
- A CPD may be required to support managers where an incident is highlighted by a complaint raised by patients, families, carers and/or staff.
- A CPD should support managers if professional misconduct, impairment or unsatisfactory professional performance is identified as a potential contributing factor to the outcome of a clinical incident.
- All CPDs have a standing appointment for all PRA teams, as endorsed by the Chief Executive (CE). A CPD will be invited to attend a PRA meeting by the Patient Safety team when their corresponding area of responsibility has been implicated or affected.
- A CPD is responsible for nominating and briefing selected staff prior to a SAER or Case Review, and support staff throughout the Clinical Incident Review process to ensure they have the capacity to maintain quality of work in their assigned role.
- Interdepartmental collaboration should be encouraged, including the review of clinical incidents during Morbidity & Mortality meetings and other quality/safety meetings.
- A CPD are required to disseminate the key findings, recommendations and shared learnings from Clinical Incident Reviews to all staff within their Program.
- It is a requirement that the implementation of recommendations from Clinical Incident Reviews are overseen and/or appropriately delegated, documented in ims+ and other appropriate forums, and regular completion updates fed back to CGU.

Senior Executive Staff (Tier 2 Management)

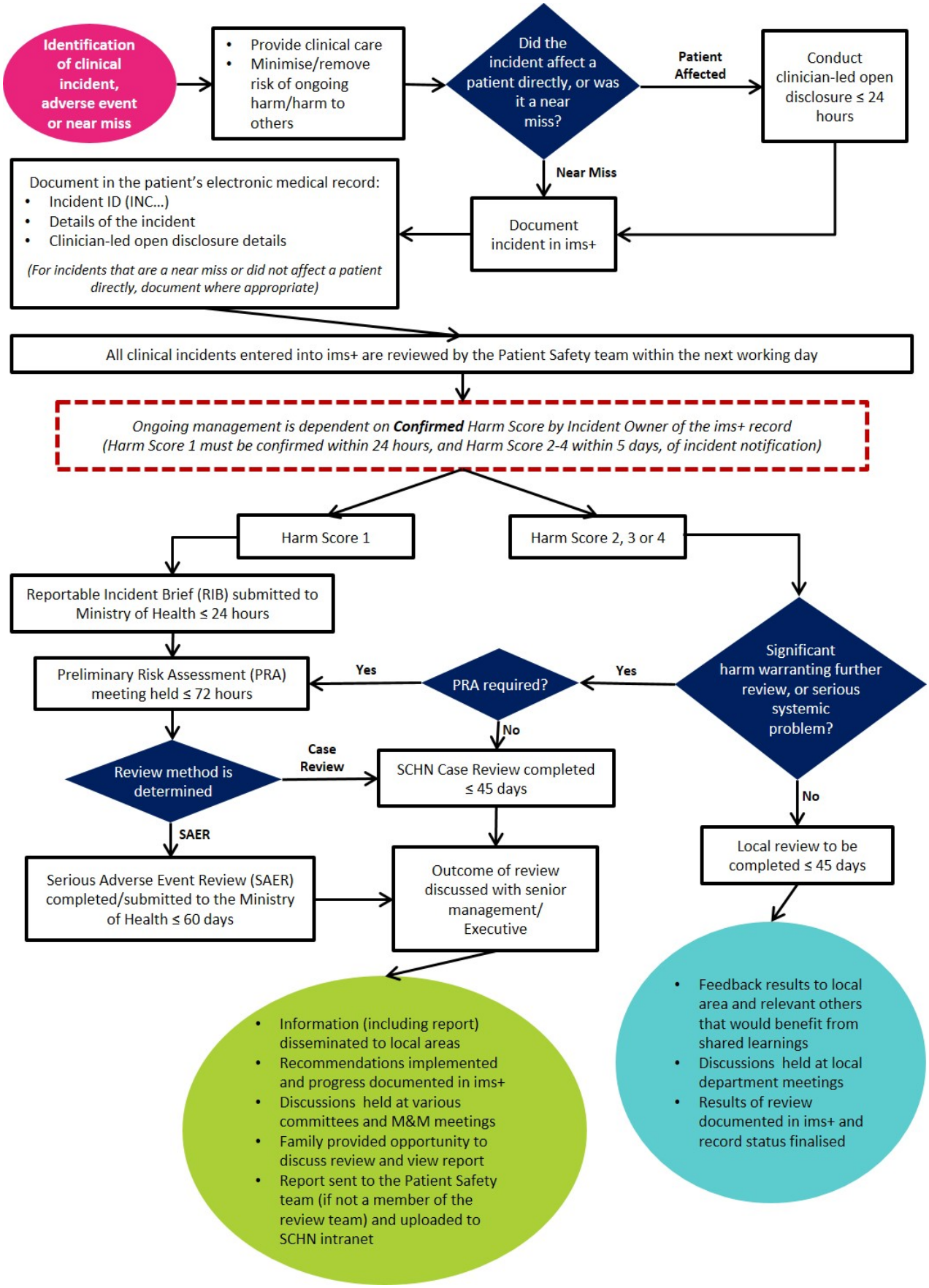
- Executive staff are responsible for supporting CPDs and managers with clinical incident management, particularly those associated with significant harm, aggregate incidents of a similar nature, and those that may represent an organisational risk. Should a significant problem be identified that warrants further attention and/or has the potential for media interest, the CE should be briefed.

- Support may be required for CPDs and managers where an incident is highlighted by a complaint raised by patients, families, carers and/or staff.
- Executive staff should support managers if professional misconduct, impairment or unsatisfactory professional performance is identified as a potential contributing factor to the outcome of a clinical incident.
- Executive staff have a standing appointment for all PRA teams, as endorsed by the CE. Attendance at all PRA meetings should be prioritised.
- The Director of Medical Services & Clinical Governance is responsible for endorsing a RIB, before sending to the CE for approval.
- Executive staff are responsible for supporting the work of SAER teams. Once SAER reports are completed, Executive staff are required to provide their advice and endorsement prior to escalation of the report to the CE.
- For completed SCHN Case Reviews and other reviews that involve multiple Clinical Programs, the site-based Director of Clinical Operations is required to provide their advice and endorsement prior to finalisation of the report.
- It is a requirement that the implementation of recommendations from Clinical Incident Reviews are overseen and/or appropriately delegated, documented in ims+ and other appropriate forums, and regular completion updates fed back to CGU.

Chief Executive (Tier 1 Management)

- The Chief Executive (CE) is responsible for endorsing RIBs and other clinical incident briefings that have been escalated for concern.
- For all clinical incidents with possible state-wide implications, the potential to become a matter of public interest, potential for the loss of public confidence, or involving contentious issues; the CE must immediately contact the Ministry of Health and the Clinical Excellence Commission.
- The CE, following appropriate briefing, is responsible for authorising the initiation of a PRA, staff members required to attend the PRA meeting, and endorse selected outcomes that may arise from a PRA meeting.
- Should a SAER be recommended as the method for review of a serious clinical incident by the PRA team, the CE must first provide their endorsement of the SAER and the staff nominated to be a part of the SAER team prior to any further review of the incident commencing.
- Once SAER reports are completed and endorsed by Senior Executive staff, the CE must provide their advice and endorsement prior to submission to the Ministry of Health. Once endorsed by the CE, the report can be shared with any member of the public, including patients, families, all staff and external to the organisation.
- The CE or appropriate delegate is responsible for reporting trended incident data, including outcomes of SAERs, to peak safety and quality committees, the Board and relevant groups within the broader Health Service.

SCHN Clinical Incident Management Flowchart



Incident Severity Classification: Harm Scores

Clinical incidents notified in ims+ are allocated a Harm Score, which quantifies the severity of an incident and broadly directs the level of review and action required for an event. In ims+, the Harm Score is automatically determined based on the incident outcome and the additional care and/or resources required as a result of the incident.

Confirmed Harm Scores are used by the Patient Safety team as a finalised severity of clinical incidents, and is a factor that guides further review. Managers are responsible for this task, which is expanded under 'Responsibilities of SCHN Staff' above.

A Harm Score can also be updated after the initial or confirmed Harm Score has been assigned. This typically occurs for serious incidents, where a patient's clinical status may change in the extended period of time following an incident (but the change must be directly related to the incident in question). A Harm Score may also be updated at the discretion of the Director of Medical Services & Clinical Governance based on hospital priorities and aggregate incidents of a similar nature with high potential for harm.

For more information regarding Harm Scores and incident severity classification, please refer to the NSW Ministry of Health's Incident Management (PD2020_047) policy or contact the SCHN Patient Safety team.

Reportable Incident Brief (RIB)

The Reportable Incident Brief (RIB) system is designed for the reporting of specific health care incidents to the Ministry of Health. The RIB process is used for reporting both clinical and corporate incidents. Clinical incident RIBs are covered by statutory privilege.

A RIB is completed by a nominated member of the Patient Safety team at SCHN. Management staff linked to the location of the incident, or those involved, may be contacted by the Patient Safety team during this process.

For information regarding the types of clinical incidents which require mandatory reporting using a RIB, refer to the NSW Ministry of Health's Incident Management (PD2020_047) policy.

Preliminary Risk Assessment (PRA)

A Preliminary Risk Assessment (PRA) must be undertaken for all clinical Harm Score 1 incidents within 72 hours of incident notification, or sooner as directed by the CE or Ministry of Health. A PRA can also be completed for any Harm Score 2, 3 or 4 clinical incident as determined by the CE (or delegate) if further review of a clinical incident is required, or serious systemic problem is identified.

The purpose of a PRA is to ensure understanding about the incident, act immediately to keep the people and environment safe, identify and escalate any immediate risks, and guide subsequent review.

At SCHN, as endorsed by the CE, the following staff have standing appointments on a PRA team:

- All Executive staff

- All CPDs (selected to attend if their area of responsibility has been affected)
- CGU managers
- Patient Safety team members

Ward/department managers and selected clinical specialists may be appointed to a PRA team upon endorsement by the CE, as guided by the details of the incident.

The PRA team should consist of individuals who were not directly involved in the incident.

A PRA action log is used to support the actions that arise from a PRA.

For information regarding the SAER process, please refer to the NSW Ministry of Health's Incident Management (PD2020_047) policy. Resources and templates can be located on the Clinical Excellence Commission (CEC) Website under the Incident management policy resources tab.

Types of Clinical Incident Reviews

The review of a clinical incident is an important component of an effective incident management system. All incidents notified in ims+ are allocated a Harm Score to guide the level of investigation or review process required.

The effective review and management of a clinical incident requires a whole-of-organisation approach. Roles and responsibilities need to be clearly communicated and understood by all members involved.

There are three levels of review for clinical incidents:

1. Serious Adverse Event Review (SAER)

The purpose of a Serious Adverse Event Review (SAER) is to identify and address systemic issues within a healthcare system. All confirmed Harm Score 1 incidents require a SAER to be completed. Selected Harm Score 2 incidents and other clinical incidents associated with significant systemic issues may be reviewed using a SAER at the CE's discretion.

The SAER should be completed using the ims+ Investigation module, from team appointment through to reporting.

The SAER is undertaken in two stages; findings and recommendations. The Findings Report must be completed and endorsed by the CE (or delegate) prior to the Recommendations Report being compiled. The combined SAER Report (inclusive of findings and recommendations must be submitted to the Ministry of Health within 60 calendar days of incident notification.

The SAER comprises a team of subject-matter experts and is facilitated by a member of the Patient Safety team. It is a requirement that members selected for the SAER team did not have an active role in the incident being reviewed, either a participant in the clinical care provided nor a direct manager of the area involved, as all members must remain impartial throughout the review.

The approved methods for conducting a SAER are outlined in the below table.

Approved SAER Methods	Description
Root Cause Analysis (RCA)*	A method used to review and analyse incidents to identify the root causes and factors that contributed to an incident, and recommended actions.
London Protocol (LP)*	A method that seeks to identify care delivery problems and contributing factors. It was specifically designed for the acute healthcare setting by patient safety experts.
NSW Health Concise Incident Analysis*	A method that seeks to identify issues related to an incident and to consider those issues against categories of contributing factors. Typically uses a constellation diagram.
NSW Health Comprehensive Incident Analysis*	Similar to the NSW Health Concise Incident Analysis, except that it involves a more consideration of all nine IA domains and all guiding questions.

*Resource workbooks and templates for the above review methods are provided by the Clinical Excellence Commission, and are located on the SCHN intranet.

The SAER is focussed on system and process factors – should any professional misconduct, unsatisfactory professional conduct or impairment issues be identified during the investigation, the team must escalate to the CE in writing for further action.

Once the report has been endorsed by the CE, it can be shared throughout SCHN to allow feedback with involved parties and provide learning opportunities to all SCHN staff.

For information regarding the SAER process, please refer to the NSW Ministry of Health's Incident Management (PD2020_047) policy.

2. SCHN Case Review

A Case Review is an SCHN initiative designed to review a significant incident that would benefit from multidisciplinary analysis. Typically, this review method is used for an incident which has caused significant harm (usually Harm Score 2 or 3) that does not require the depth of the SAER process but still warrants further review. The decision to commence a Case Review may occur via one of the following channels:

- The Patient Safety Team identify an incident which has caused, or has the potential to cause, significant harm and escalates this to the SCHN Patient Safety Manager who coordinates the commencement of a Case Review
- Following the discussion of a serious incident at a PRA meeting, a collaborative decision is made for the incident to be analysed via a Case Review (at the direction of the SCHN Director of Medical Services & Clinical Governance)
- Any clinical department within SCHN can instigate a Case Review using an approved template in consultation with CGU

Each Case Review team involves a small group of clinical staff who examine the incident and make recommendations for improvement where appropriate, and is led by a clinician and may include support from a CGU staff member.

The Case Review team leader is responsible for:

- Organising team meetings
- Collating documents for review
- Drafting the report and
- Discussing the feasibility of recommendations with appropriate senior management

The NSW Health Concise Incident Analysis or NSW Health Comprehensive Incident Analysis are the preferred methods for the completion of a Case Review. Analysis of the incident typically involves a table-top review of the event chronology, may include interviews of involved staff, and review of policy and procedure documents related to the incident. The results of the review are to be documented using the SCHN Case Review templates designed by the Patient Safety team available on the SCHN intranet. The review should be completed within 45 days of incident notification, and the results should be fed back to all appropriate staff as per the clinical incident management framework.

Refer to Appendix 1 for a flowchart description of the SCHN Case Review process.

3. Local Management Review

Please refer to the 'Managers' section of the 'Responsibilities' heading for a description of the expectations of managers in reviewing clinical incidents in ims+. Managers are also encouraged to conduct local investigations of incidents which have a significant impact on their department, or represent an aspect of a larger safety issue within their area, using any methodology in line with management responsibilities.

Statutory Privilege

Under Section 23 of the Health Administration Act 1982, any research or investigation conducted for the purpose of review of a serious adverse event is deemed confidential, and any information collated through the process of review is unable to be produced outside of the review without legal ramifications. This ensures that when a reportable incident occurs, staff feel safe to speak openly about what happened and what they observed.

Statutory privilege applies to the PRA and SAER processes.

For more information regarding statutory privilege, the specific information that is covered by privilege, and the storage of privileged material, please refer to the NSW Ministry of Health's Incident Management (PD2020_047) policy.

Open Disclosure

As early as possible, the healthcare provider should share with the patient and their carers what is known about the event and what actions have been taken. This is known as clinician-led open disclosure, and ideally occurs within 24 hours of an incident. An expression of

apology should be extended at that time. For serious incidents such as those requiring a SAER, formal open disclosure should occur, in line with the NSW Health Open Disclosure (PD2014_028) policy. Open disclosure should be clearly documented in the patient's electronic medical record.

Dedicated Family Contact (DFC)

The dedicated family contact (DFC) is a primary staff contact selected during a PRA, whose role is to promote communication between the SAER team and the affected patient's family. The DFC usually has rapport, credibility and trust with the patient, carer and/or family, and is expected to understand the family's preferred mode of communication, liaise with the family to enable information to be relayed to the SAER team leader, explain incident management processes and timelines, and support the family from a practical and cultural standpoint during the process.

Any staff member can be selected as a DFC.

Resources to assist the DFC have been developed by the CEC, and are located on the SCHN intranet.

Implementation of Review Recommendations

Completed Clinical Incident Reviews are approved and disseminated by Executive staff to relevant clinical areas as part of the feedback process. Recommendations for improvement that arise from Clinical Incident Reviews should be prioritised and actioned within the appropriate timeframe stipulated in the report.

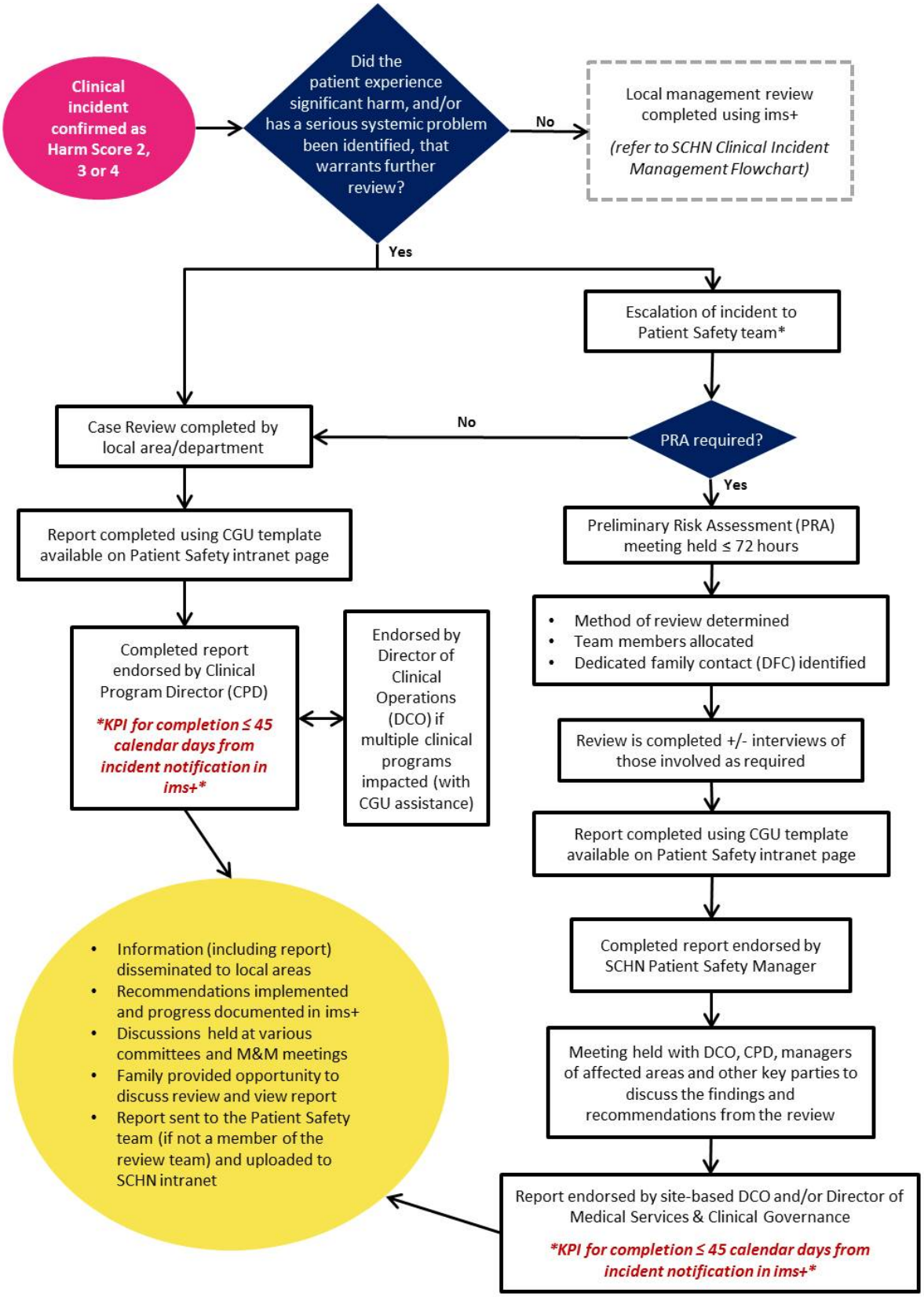
Managers are responsible for implementing recommendations arising from any review of a clinical incident, particularly those arising from a SAER or Case Review. CPDs are expected to monitor the implementation of recommendations, have processes to escalate recommendations that cannot be progressed, and report to peak Committees and Board members regarding the status of recommendations within their Clinical Program.

Appendices

Appendix 1 – SCHN Case Review Flowchart

Appendix 2 – Clinical Incident Management Terminology

Appendix 1: SCHN Case Review Flowchart



** Following consultation with the Patient Safety team, some incidents may be referred back to the local area for management should the harm/risk associated with the incident not require escalation (refer to SCHN Clinical Incident Management Flowchart)*

Appendix 2: Clinical Incident Management Terminology

Term	Abbreviation	Definition
Australian Sentinel Event	ASE	A wholly preventable patient safety incident resulting in death or serious patient harm. There are 10 categories of incidents defined by the Australian Commission on Safety and Quality in Health Care.
Case Review	-	An SCHN initiative for the review of incidents which caused significant harm and would benefit from multidisciplinary review. Incidents selected for these reviews are of Harm Score 2, 3 or 4.
Children & Young Person Sub-Committee	CYP	A committee of the Clinical Excellence Commission dedicated to the review of all clinical Serious Adverse Event Review (SAER) reports related to paediatric care. The committee consists of senior clinicians who review and classify the system issues identified in SAER reports.
Clinical Excellence Commission	CEC	One of the five pillars of the NSW Health system. Its role is to lead, support and promote improved safety and quality in clinical care through collaboration with clinicians, health consumers, other pillars and the NSW Ministry of Health.
Clinical Governance	-	The relationships and responsibilities set up by a health service to ensure good clinical outcomes. This is established in collaboration with NSW Health, SCHN Executive, clinicians, patients, families/carers and other stakeholders. Clinical governance ensures that systems are in place to deliver safe and high-quality care to every patient by continuously monitoring and improving services.
Clinical Governance Unit	CGU	A service that works across SCHN to support and encourage clinicians to make improvements in their day-to-day work and therefore improve the safety of patients and quality of care.
Clinician disclosure	-	Incident disclosure within 24 hours to a patient, carer or family by the treating clinician/team or staff member.
Collaborating Hospitals' Audit of Surgical Mortality	CHASM	An audit of the deaths of patients who were under the care of a surgeon within 30 days prior to their death, regardless of whether an operation was performed. This is overseen by a Committee appointed by the Secretary for NSW Health.

Term	Abbreviation	Definition
Dedicated Family Contact	DFC	A staff member who is the primary contact for the patient, carer or family for a Clinical Incident Review. They liaise between the patient, carer or family and the Review team.
Escalation	-	Process of advising a more senior person or an external body of concerns or risks.
Harm	-	Any unintended and unnecessary impairment resulting from, or contributed to, by health care. This can also include the absence of indicated medical treatment
Harm Score	HS	A score applied to clinical incidents based on the outcome and additional treatment and/or resources required (automatically calculated in ims+ based on cause and effect of the incident). Harm Score 1 – Unexpected death or ASE Harm Score 2 – Major harm Harm Score 3 – Minor harm Harm Score 4 – No harm or near miss
Incident	-	An incident is an unplanned event that results in, or has the potential for: injury, damage or loss, including near misses. An incident is also known as an 'adverse event'.
Incident category	-	Who or what was affected by the incident or near miss. To enter a clinical incident in ims+, the incident category that should be selected is 'Patient' or 'No Person'.
Incident management	-	Actions and processes for immediate and ongoing activities following an incident. Review is part of incident management.
Incident Management System	ims+	State-wide software application used for the recording of all clinical incidents, corporate incidents, near misses and consumer feedback.
Incident review	-	A structured process to identify what happened; how and why it happened; what could be done to reduce risk and make care safer; and what was learned.
London Protocol	LP	A method used to review and analyse clinical incidents to identify problems that may have occurred during the care delivery process, and any contributing factors present at the time of the incident.

Term	Abbreviation	Definition
Maternal & Perinatal Sub-Committee	MP	A committee of the Clinical Excellence Commission dedicated to the review of all clinical Serious Adverse Event Review (SAER) reports related to incidents involving maternity patients or neonates within the first 30 days of life. The committee consists of senior clinicians who review and classify the system issues identified in SAER reports.
Morbidity & Mortality Meeting	M&M Meeting	A meeting during which departments/specialties/facilities review the quality of the care that has been provided to their patients, and identify any opportunities for improvement.
Near miss	-	An incident that could have caused harm but did not, or an incident that was intercepted before causing harm.
Notification	-	The process of entering or documenting data about an incident or near miss into ims+ or other incident management systems.
Open disclosure	-	Ongoing communication process with a patient, carer or family about an incident and its management. Formal open disclosure involves multidisciplinary discussion/s with the patient, carer or family and senior clinical leaders and/or hospital Executive.
Patient Safety Incident Review Committee	PSIRC	A site-specific Committee consisting of Executive, managerial and clinical staff members dedicated to promoting and ensuring patient safety throughout the facility.
Preliminary Risk Assessment	PRA	A meeting to assist the Health Service to understand the events of an incident and identify immediate risks for action. These are undertaken following Harm Score 1 incidents and selected Harm Score 2, 3 or 4 incidents at the discretion of the Chief Executive or delegate.
Principal Incident Type	PIT	Classification system in ims+ used to group clinical incidents into major categories.
Recommendations	-	Actions aimed at preventing or mitigating any factors that caused or contributed to an incident and/or system improvements unrelated to an incident, which have been identified through the course of reviewing a clinical incident.

Term	Abbreviation	Definition
Reportable Incident Brief	RIB	The method for notifying and escalating serious clinical incidents to the Ministry of Health. These are mandated by state policy and are privileged in nature.
Root Cause Analysis	RCA	A method used to review and analyse incidents to identify the root causes and factors that contributed to an incident, and recommended actions. This methodology is typically used for a SAER.
Serious Adverse Event Review	SAER	A type of incident review defined in Part 2A of the *Health Administration Act 1982*. They are prescribed to be undertaken for a reportable incident (clinical Harm Score 1 incident) and selected clinical Harm Score 2, 3 or 4 incidents at the discretion of the Chief Executive or delegate.
Special Committee Investigating Deaths Under Anaesthesia	SCIDUA	A review of the deaths which occur while under, as a result of, or within 24 hours following the administration of anaesthesia or sedation for procedures of a medical, surgical, dental or investigative nature. This is overseen by a Committee appointed by the Secretary for NSW Health.