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BUNDABERG HEALTH SERVICE DISTRICT

POSITION DESCRIPTION

POSITION TITLE	Quality Coordinator
VACANCY REFERENCE NO.	BB02/05/6
LATTICE POSITION NO.	022150
LOCATION	Quality Management Unit – Bundaberg Base Hospital
CLASSIFICATION LEVEL	A06
REPORTS TO	District Manager
AWARD	District Health Services Employees' Award - State
REVIEW DATE	May 2002

PURPOSE OF POSITION

- Ensure the planning, development and coordination of a Quality Management program for the Bundaberg Health Service District
- Develop and maintain a continuous quality improvement strategy, which is outcome oriented, including the identification and evaluation of annual priorities and targets.
- Train staff in use of quality management tools and processes
- Develop and maintain a comprehensive risk management strategy for the District and undertake a regular evaluation of outcomes

ROLE OF DEPARTMENT

- To establish a culture of continuous quality improvement throughout the District and to manage organisational change
- To encourage and advance the application of evidence based practice.
- To work closely with managers/supervisors to develop and implement a Quality Management program, which involves the integration of quality processes throughout Bundaberg Health service District to promote and maintain accreditation through the appropriate bodies
- To educate all employees about quality standards, quality work practices and business improvement.

ORGANISATIONAL ENVIRONMENT

The Bundaberg Health Service District provides comprehensive Hospital and Community based health care. The District consists of Bundaberg City and surrounding coastal towns from Burnett Heads to Woodgate, the towns of Childers, Gin Gin and Mount Perry. There are Hospitals at Bundaberg, Childers and Gin Gin and a Community Health Centre at Mount Perry.

The Bundaberg Hospital campus is a 140-bed facility. The Hospital provides medical, surgical, paediatrics, emergency, intensive/coronary care, day surgery, renal, orthopaedics, diabetes, gynaecology/obstetrics, medical oncology, rehabilitation, allied health and mental health services for the District population.

Community Health Services provided by the District comprises Community Mental Health, Alcohol and Drug, Child & Youth Mental Health, Child Health, BreastScreen, Oral Health and Indigenous Health.

Bundaberg Health Service District has approximately 850 employees.

REPORTING RELATIONSHIPS

- An Administrative Office (A02) supports this position.

SPECIFIC DELEGATIONS/ACCOUNTABILITIES

- Accountable for preparing the organization to undertake accreditation
- Responsible for ensuring that the workforce is appropriately trained to understand and apply quality concepts and tools
- Responsible for ensuring that managers and supervisors are skilled in quality management processes in order for unit-based quality management plans to be prepared within the overall Quality Management program
- Accountable for the development of a comprehensive organisation wide risk management strategy and evaluation of outcomes
- Accountable for the Quality Management cost centre expenditures and budget

SKILLS

- Ability to work unsupervised and with a reasonable degree of independence
- High level of communication, consultation, negotiation and interpersonal skills
- Ability to deliver training programs based on adult learning principles
- Ability to manage issues relating to quality management practices and to prepare policies and procedures within the overall Quality Management Program.
- Ability to coordinate and oversee the achievement and maintenance of accreditation
- Ability to develop research methodology for managers and supervisors to progress quality management plans and practices
- Ability to conceptualise systems/processes where required, and facilitate their development and initiation within a team environment
- Ability to undertake research, develop databases and prepare comprehensive reports for the District Manager and others as appropriate.
- Possession of a tertiary qualification in a relevant field is desirable

KNOWLEDGE

- Sound knowledge of contemporary management processes and practices for the development of quality management plans and an overall Quality Management Program.
- Knowledge of clinical processes, particularly in relation to utilisation reviews, clinical indicator programs and clinical review activities
- Knowledge of quality management processes from the planning and development phase through to evaluation and review.

PRIMARY DUTIES/RESPONSIBILITIES

- Ensure compliance with the ACHS EQuIP program and any other accreditation programs, including IOS 9000, NATA, BreastScreen National Accreditation, and coordinate any relevant assessments and ensure data is reported to the relevant body.
- Manage and coordinate the development and review of Bundaberg Health Service District policies and procedures to ensure workplace standards and reflect best practice
- Provide expert advice to District Manager, District Executive and senior management on current trends in accreditation and certification systems
- Assist and support the District Executive to achieve quality objectives as defined in the Corporate Service Level Agreement
- Provide high level advice and assistance on quality management and accreditation issues to all departments within the Bundaberg Health Service District to ensure performance improvement

- Educate District staff in quality management and best practice to ensure the continuum of care is enhanced
- Instil a culture of evidence based practice through the use of evidence databases and journals, appropriate data collection, analysis and application
- Provide expert direction, support and training in implementing continuous quality improvement concepts, tools and processes across the District
- Provide expert direction, support and training in the implementation of risk management processes across the District
- Ensure coordination, collation and analysis of quality activities and associated documentation, and maintain effective, confidential reporting/recording systems throughout the District
- Establish and maintain systems and frameworks to continually monitor, review and evaluate quality activities
- Ensure that activities are integrated across disciplines, and promote a multidisciplinary team approach to problem solving within the organization
- Consult with and advise managers/supervisors on the processes by which unit-based quality management plans within the Quality Management program can achieve and maintain quality improvement and accreditation
- Promote and support the development of the quality management program across all Bundaberg Health Service District agencies
- Provide expert advice, support and training for implementation and monitoring of District systems and frameworks for managing change and risks
- Maintain the Bundaberg Health Service District QHEPS Home page, and ensure timely and appropriate publishing of relevant documents.
- Manage Complaints system and report trends bi-monthly to the District Manager
- Facilitate and promote consumer participation in the development and evaluation of health services
- Promote a culture where there is sharing of results and innovation and where learning from mistakes is a priority rather than assigning blame
- Facilitate and provide expert advice to meetings of the District Improving Performance Committee
- Monitor and evaluate performance and provide feedback to quality improvement teams and committees
- Participate in the Performance, Appraisal and Development process
- Actively participate in a working environment supporting quality human resource management practices, including workplace health and safety, employment equity, anti-discrimination, and ethical behaviour

ADDITIONAL INFORMATION

Queensland Health is a "smoke free" employer. Smoking is not permitted in any Queensland Health facility except where specifically defined.

The Bundaberg Health Service District requires all employees to adopt appropriate and recognised measures to minimise the risk of infection and workplace injury to themselves, other staff and clients and to adhere to the Districts Infection Control Policy Manual and Workplace Health and Safety policies and practices.

A Bundaberg Health Service District *Confidential Agreement* is to be signed upon appointment.

POLICY FOR THE MANGEMENT OF HUMAN IMMUNODEFICIENCY VIRUS, HEPATITIS B VIRUS AND HEPATITIS C VIRUS

It is important for all employees to be aware of Queensland Health's Policy for the Management of Human Immunodeficiency Virus, Hepatitis B Virus and Hepatitis C Virus.

An extract from the policy document states that:

(a) "Queensland Health care workers whose occupation poses a potential risk of exposure to blood or body fluids must be immunised against Hepatitis B according to NHMRC and the Queensland Health Care workers who have direct patient contact (e.g. medical officers, nurses and allied health staff) as well as those staff who in the course of their work may be exposed to blood or body fluids such as (but not confined to) plumbers and gardeners who may be exposed to contaminated sharps. It is expected that the administration of institutions will apply this policy within reasonable boundaries, keeping the staff member's welfare in mind. The requirements for vaccination is not retrospective, although health care workers who care currently employed are encouraged to be vaccinated".

"Hepatitis B immunisation is a condition of employment as a Queensland Health care worker".

Therefore, each health care worker must be immunised against Hepatitis B or be willing to undertake Hepatitis B vaccination on commencement of duties. Persons who are non-seroconverters to Hepatitis B immunisation are assured that this will not affect their employment opportunities.

(b) "Health care workers who are Hepatitis C antibody and PCR positive; Hepatitis B antigen or HBV DNA positive; or HIV antibody positive (as determined by laboratory tests performed on two separate occasions) **must not perform exposure prone procedures."**

Definition of a Health Care Worker
Persons (including students) involved in the delivery of health services in health facilities (particularly where those persons have regular contact with patients or any contact with blood or body substances from patients

CENTRAL ZONE MANAGEMENT

Clinical Services Networks (CSNs) are being developed in the Zone in a range of medical specialities as the vehicle of efficient and equitable service delivery, quality improvement, education and professional accreditation. The appointee will be required to provide services to the Bundaberg Health Service District and may be asked to provide services in other hospitals within Central Zone as part of CSNs at times and places to be specified.

Applicants must address each selection criterion.

SELECTION CRITERIA

SC1

Demonstrated current knowledge of quality management concepts and practices

SC2

Demonstrated ability to contribute towards the development and implementation of organisational strategic and operational plans.

SC3

Demonstrated ability to train staff in quality principles and the use of continuous quality improvement tools and processes

SC4

Demonstrated conceptual and analytical skills particularly in relation to the development, monitoring and evaluation of quality activities

SC5

Demonstrated high level of interpersonal skills including communication, negotiation and problem solving, with capacity to interact effectively with a broad range of staff.

SC6

Demonstrated ability to initiate, implement and manage change and to provide leadership through change.

SC7

Demonstrated ability to actively participate in a working environment supporting quality human resource management practices, including employment equity, anti-discrimination, workplace health and safety, and ethical behaviour.

ORGANISATIONAL CHART

- As per attachment.

The Bundaberg Health Service District is an Equal Employment Opportunity Employer

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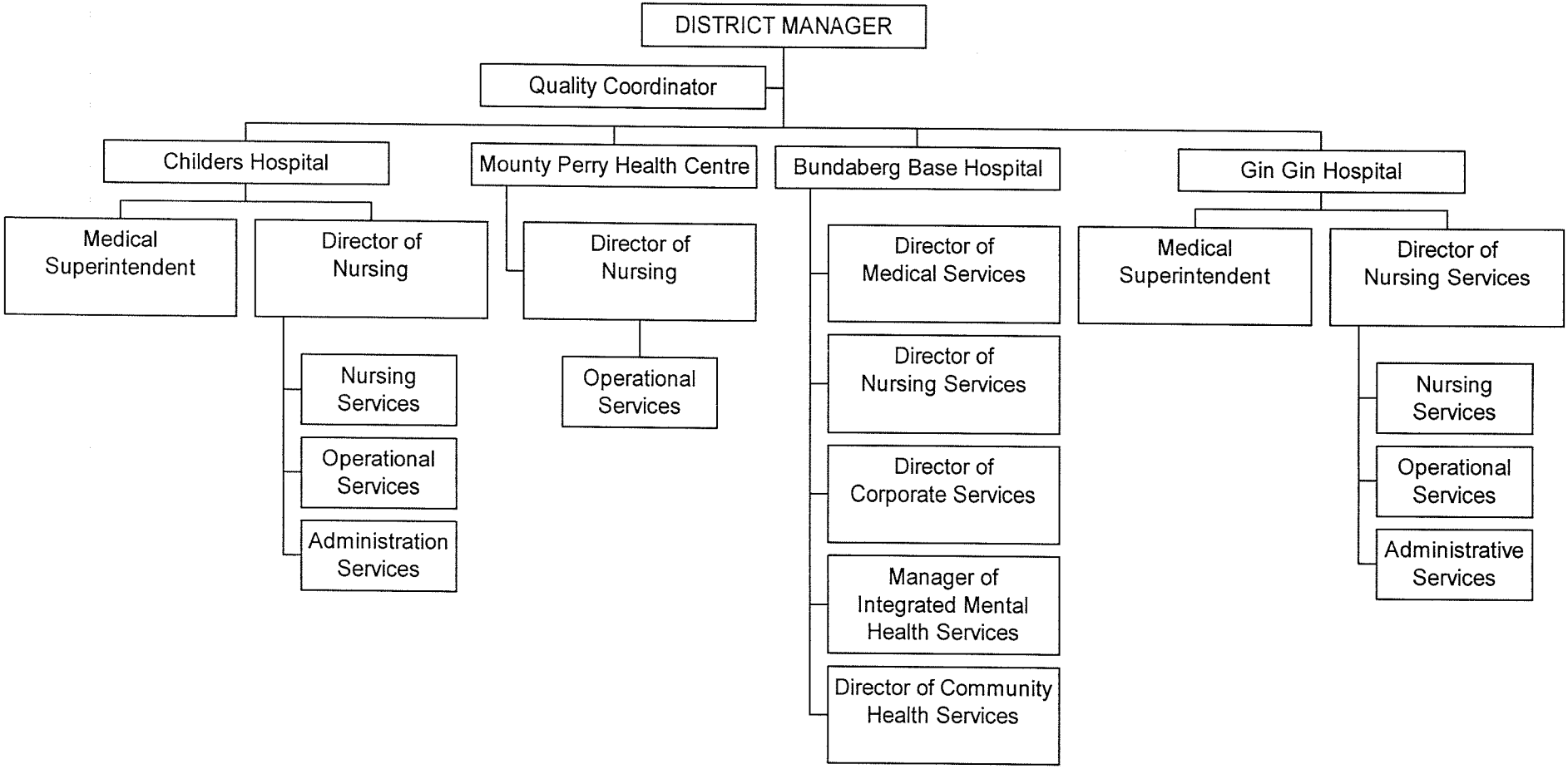
Organisational Chart

Bundaberg Health Service District



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Policy & Procedure Manual

Version No:	2	Manual No:	2
Originally Developed:	MAR2000	Section:	Leadership and Management
Review Dates:	MAY2001	Document No:	2-11
Replacement For:	2-2-11	Name of Manual:	Bundaberg Health Service District

TITLE: **Complaints Management System**

DESCRIPTION: The process by which all complaints to the Bundaberg Health Service District will be addressed.

TARGET AUDIENCE: **All Staff**

AUTHORISED BY DISTRICT MANAGER

Name: _____ Date:

(District Manager)

STANDARD
ACHS EQuIP Standard: Leadership and Management 2.1.

The Complaints Handling Process of the Bundaberg Health Service District is consistent with the Australian Health Agreement 1998-2003 and the Queensland Public Patients' Health Service Charter 1999, *"Making the most of a visit to your healthcare service"*.

OUTCOME
All complaints will be dealt with appropriately within 35 days of receipt to achieve resolution.

PURPOSE

- To establish a formal process for complaints handling
- To assist continuous improvement within the organisation.
- To establish a framework to pro-actively manage risk
- To develop a culture of openness and a willingness to learn from mistakes, and to optimise the quality of health services provided
- To provide an easily accessible, responsive and fair complaints procedure for all consumers
- To ensure that the complaints management process is documented
- To investigate, review, document and resolve all complaints within 35 days.
- All staff are expected to demonstrate commitment to effective and fair resolution of complaints and be aware of the guidelines of the acceptance and investigation of complaints.

POLICY

- All complaints will be seen as opportunities to review and improve the services provided by the Bundaberg Health Service District and not as an attempt to place or apportion blame.
- The timely resolution of complaints is encouraged by early identification and intervention by the relevant Head of Department at the time of the complaint.
- All complaints from patients shall be reported to the appropriate Health Service personnel within 24 hours. All complaints will be investigated.
- The Complaints Coordinator (Quality Coordinator) will provide education on procedures for complaint handling to all staff of the Bundaberg Health Service District.
- The Bundaberg Health Service District has a formal mechanism for recording the process, investigation and outcome of any particular complaint.
- The complaints handling process with be subject to quality auditing. The Complaints Management process will be monitored to improve organisational performance and quality of care.
- The Executive Offices will be the central filing location of complaints for document management and retrieval. The Complaints Coordinator will hold a record of such information as is required to effectively monitor and trend the complaint management process, and to provide reports to the Leadership and Management Committee.
- Fundamental to the consideration and resolution of patient/client complaints is the principle that all complaints, whenever possible, should be resolved at the point at which they originate.
- Members of the Health Service Executive will be responsible for coordinating the investigation of a complaint in their area of authority.
- All staff will be informed of the Complaints Handling Process through Orientation and the Bundaberg Health Service District Policy and Procedure Manual.

Strategies to improve access to the complaints/compliments process

- Signage is located in all patient waiting areas and lounge rooms, outpatients department, emergency department, and the front foyer of all buildings to provide information about complaints management, including the contact number to call if there is a need to make a complaint or compliment.
- The corporate brochure "Making the most of a visit to your health-care service" is provided within admission and waiting areas.
- The Queensland Public Patients Hospital Charter will be available for all patients upon entering the hospital.

PROCEDURE

Definitions

Consumer: The term consumer is used to refer to users of Queensland public healthcare services and may include:

- Patients
- Clients
- Relatives
- Friends
- Carers
- Visitors

The term consumer may also be used to reflect a group of the above consumers or patient advocacy groups such as the Queensland Mental Health Association and Breastfeeding Mothers Association.

Complaint: A complaint is any expression of dissatisfaction or concern by or on behalf of an individual consumer or group of consumers regarding care and treatment, administrative practices, other aspects of service, or an expression of dissatisfaction about staff, client, or patient-staff activity.

A complaint may refer to consumer's rights and/or responsibilities in relation to: (See Complaints Data Collection)

- Access
- Communication
- Corporate Services
- Privacy/Discrimination (Rights)
- Consent
- Costs
- Professional Conduct
- Grievances
- Treatment

Handling of Consumer Complaints

Verbal Complaints

In person:

If a patient makes a complaint or a person presents at the organisation to make a complaint:

- The relevant Head of Department should make every attempt to resolve the complaint at the point of contact. The process for appropriate complaints handling is outlined below.
- If the Head of Department is unable to resolve the complaint to the complainant's satisfaction, the relevant Director should be contacted.
- The Complaints Coordinator can be invited by the relevant Director to assist with resolution of the complaint.
- After hours the Nurse Manager or other appropriate member of staff will be paged.

Telephone

If the switchboard operator or any person who receives a phone call that they recognise as a complaint, they must:

- Refer the complaint to the relevant Department Head.
- If the Department Head cannot be contacted, or cannot resolve the complaint, the phone call should be forwarded to the relevant Executive Director.
- After hours the Nurse Manager or other appropriate member of staff will be paged

Process

- Identify yourself, listen and record details and determine what the complaint is about and what the complainant wants
- Confirm the details received
- Record the name and contact information for the individual making the complaint
- Record the time and date that the complaint was made
- Determine the nature of the complaint
- Explain the courses of action available
- Do not attempt to lay blame or be defensive
- Resolve the complaint if possible or commit to doing something immediately, irrespective of who will ultimately handle the complaint
- Ensure that the complainant is informed that the complaint is receiving attention, without creating false expectations
- Check whether the consumer is satisfied with the proposed action and if not, advise alternative courses of action
- Provide acknowledgment eg. Thank you letter, phone call
- Follow-up as appropriate and monitor to ensure the customer remains satisfied as well as receives feedback

Complaints received in writing

In principle, this is the same as processing telephone or verbal complaints. However, in this situation, a response should be provided promptly (within 3 days) in writing. An initial response can be to advise the complainant that the complaint has been received and is being investigated. A final reply should be forwarded within 35 days of receipt of complaint.

Most letters of complaint will be received by the District Manager or by an Executive member.

All written complaints should be advised to the relevant Executive Director. The Executive Director will ensure that a registration form is sent to the Complaint's Coordinator at the completion of the process.

Complaints Management Process

- All complainants will receive acknowledgment of the receipt of their complaint within 3 working days.
- All complainants will be informed of the progress of the investigation into their complaint within 21 calendar days of receiving the complaint
- The outcome of all complaints will be finalised within 35 calendar days
- Patients will not to be discriminated against or victimised if they lodge a formal complaint
- No record of the complaint will be kept in the patients record
- All efforts should be made to try and resolve the complaint at the point of service. The Head of Department or the most senior person on duty at that particular time shall be deemed responsible for following the complaint up.
- Staff members that are able to resolve complaints to the satisfaction of all concerned (patient/ consumer/staff) at the point of service will complete a Complaints Registration form and forward it to the Complaints Coordinator for data collection. (Complaints that are very trivial in nature, and can be resolved very easily, may not need to be registered on the Complaints database).
- If a complaint cannot be resolved at the point of service, the relevant Executive Director should be contacted for further action in relation to the complaint. The complaint is then formalised and registered the complaint on the database.

Assessment	Examples	Action Plan
Minor	Complaint minor in nature and resolved easily	• Resolve at point of service • Forward completed Complaints Registration Form to Complaints Coordinator
Routine	Legitimate consumer complaint but causing no lasting detriment	• Acknowledge receipt of complaint within 3 working days • Inform complainant of progress within 21 calendar days • Resolve complaint within 35 calendar days • Where possible the Head of Department should attempt to resolve the complaint to the complainant's satisfaction. If this is unsuccessful, the Executive Director should be contacted • Forward completed Complaint Registration form and send to the Complaints Coordinator
Substantial	Significant issues regarding standards, unlawful actions, denial of rights, complaints which clearly impact on the quality of care or service delivery	• These complaints are covered by statutory reporting obligations and involve allegations of assault, abuse etc. Mandatory reporting requirements of sexual and physical assault must be followed in these instances. • Forward the complaint to the relevant Executive Director, who will immediately inform the District Manager

Any complaint in the above categories may be additionally graded as sensitive:

- **A political issue**
- **An issue being investigated by the media**
- **An issue that has the potential to lead to litigation**

All sensitive complaints must be immediately reported to the DISTRICT MANAGER.

- The investigation process is to be coordinated by the nominated work unit line manager or executive member.
- Following the investigation process the line manager is to identify the cause of the complaint, isolate contributing factors and identify opportunities for improvement that prevent the circumstances of the complaint recurring. All quality improvement activities undertaken as a result of the complaint investigation process are to be registered with the Quality Management Unit, and forwarded to the Improving Performance committee as appropriate
- When the complaint is resolved, all relevant documentation (or copies, where appropriate) be returned to the Complaints Coordinator for completion of data registration.
- The Complaints Coordinator will compile all complaints into a Complaints Register for quality improvement purposes. This will include date complaint received, name of complainant, service area involved, the source of the complaint, the nature of the complaint, and the adherence to specified time frames for resolution.
- The Complaints Coordinator will provide a bimonthly report to the Leadership and Management Committee. Ongoing trends will be reported with recommendations on how the hospital can improve the service area identified.
- In the event of a complaint against a service that the Bundaberg Health Service District is not directly responsible eg private practitioner, the complainant in the first instance should be encouraged to speak directly to the health professional concerned. If this is unsuccessful, then alternatives to the complainant should be provided. These will include lodging the complaint with the:
    - Health Rights Commission
    - Minister's Office
    - Registering authority responsible for that professional discipline.

BIBLIOGRAPHY

COMPLAINT CATEGORIES AND DESCRIPTIONS

1. Access to Services	Refers to availability of services in terms of location, waiting lists and other constraints that limit the use of the service

Subcategory	Definition
Attendance	Provider fails to keep an agreed appointment; or failure to attend to give emergency treatment
Delay in Admission or Treatment	Delays in treatment, admission or any other delay, including delay in provider attending. For example, long waits in the emergency department or waiting rooms. (Excludes 'Unreasonable wait for elective surgery'. See 'Waiting Lists')
Discharge or Transfer Arrangements	Premature, unsuitable or delayed discharge or transfer; inadequate discharge planning; or refusal to discharge
Referral	Refusal to refer or inappropriate referral
Refusal to Admit or Treat	Refusal by an institution or health provider to accept a person as a client. Refusal to provide a service where a service is available.
Service Unavailable	Service or resources unavailable within reasonable proximity to the consumer
Transport	Ambulance and patient transit problems including inter-hospital transfers
Waiting Lists	Unreasonable wait for elective surgery or further postponement after a date has been set. (Excludes 'Delay in Admission or Treatment')

2. Communication	Refers to appropriateness, completeness and reliability of information; the way information is communicated, or special communication needs.
Attitude	Provider's manner is rude; discourteous; negative; lacks sensitivity; or is patronising or overbearing. (Excludes 'Discrimination')
Information Inadequate	Information is inadequate; incomprehensible; difficult to understand; or is incomplete. (Excludes 'Interpreter/Special Needs Services')
Information Wrong/Misleading	Information is wrong; incorrect; misleading; or conflicting. (Excludes 'Consent not informed/Failure to warn' and 'Information on Costs')
Interpreter/Special Needs Services	Failure to provide interpretative or special needs services for consumer to assist in communication eg. Spoken language, sign language, and disability support.

3. Consent	Refers to consumer's right to be involved in decision-making and to be given sufficient information on which to base their consent to treatment or service.
Consent Invalid	Consent considered invalid when the patient was not competent to consent; did not understand information; was coerced; or consent was not specific to the treatment performed.
Consent not informed/ Failure to warn	Not enough information was given for the consumer to make an informed choice regarding treatment options. (Excludes 'Inadequate Information')
Consent not obtained	Treatment provided or action taken without the current consent of the consumer or consumer's legal representative.
Failure to consent consumer	Failure to involve the consumer in decision-making in relation to any aspect of treatment or care.
Involuntary admission	The admission or treatment of a patient when not agreed to. Also detained, scheduled under a mental health act.

4. Corporate Services	Refers to support services such as hotel services, administrative procedures and the standard of facilities including hygiene and safety. (Excludes 'Billing Practices')
Administrative Services	Administrative processes such as clerical; reception; administrative record keeping; and bookings/admissions.
Hotel Services	Services and physical environment provided during a patient's visit or stay. Includes car parking; cleaning; catering; grounds; laundry; maintenance; security and accommodation. (Excludes 'Hygiene and Environmental Standards')
Hygiene/ Environmental Standards	Hazards in physical environment; unsanitary conditions; unsafe storage of sharps; inadequate or substandard conditions in relation to fire safety; way finding; noise and lighting. (Excludes 'Infection Control')
5. Cost	Refers to fees; discrepancies between advertised and actual costs; charges and rebates; and information about costs and fees.
Billing Practices	Unfair/unsatisfactory billing practices including item numbers used to disadvantage; insufficient or wrong information on bill; extra fees for services normally included in global fee; unreasonable penalties for late payment; refusal to consider financial circumstances; etc. (Excludes 'Overcharging')
Government Subsidies	Government subsidies for treatment or services are unavailable or inadequate. For example schedule fee, availability of drugs under PBS, travel subsidy.
Information on costs	Information about costs was not offered prior to treatment; or the information was partial; misleading or incorrect.
Overcharging	Fee or account is too high including unnecessary provision of services.
Private Health Insurance	Complaints about Private Health Insurance and claim handling if the respondent is the fund.
Public/Private Election	Patient classified as private rather than public (or vice versa); failure of a hospital to explain options for choice of status; or confusion between fee-for-service and public status.
6. Grievances	Refers to action taken by a provider in response to a complaint.
Inadequate/No response to complaint	Inadequate or non-existent response to a complaint made directly to a service provider by a consumer.
Reprisal/ Retaliation	Any direct or indirect action or threat of action against a consumer, or detrimental change in treatment or care as a result of the complaint; or disadvantage in employment for staff who lodge a complaint or report or who give information about a complaint.
7. Privacy/ Discrimination	Refers to breaches of consumer rights or acts of discrimination in relation to service provision; or breaches of privacy.
Access to Records	Restriction or refusal of access to information in any personal health record.
Discrimination	Claims that a consumer receives less favourable health treatment or refusal of treatment on once of the civil (race, sex, age, religion, colour, disability) grounds in anti-discrimination law or covenant. (Excludes 'Attitude' and 'Refusal to Admit or Treat')
Discrimination Public/Private	Public patient treated less favourably than private patient (or vice versa); or pressure to accept private treatment or service.
Inconsiderate Service	Failure to treat with respect, dignity and consideration. (Excludes 'Attitude')
Privacy/ Confidentiality	Failure to ensure personal privacy or confidentiality; or breach of privacy principles.

8. Professional Conduct	Refers to unethical and illegal practices as well as issues of competence. (Excludes 'Negligent Treatment' and 'Referral')
Accuracy/ Inadequacy of Records	Failure to create and maintain adequate, accurate, complete and up-to-date health records.
Assault	Physical aggressive or violent actions against a consumer. (Excludes 'Consent not obtained'. For assaults of a sexual nature see "Sexual Misconduct')
Certificates/Reports	Failure to provide a correct certificate or report; deliberate falsification of certificate or report; or provision of an incorrect; biased or misleading report.
Competence	Failure to meet a standard of practice because of lack of or failure to use clinical knowledge, skills, judgement or care.
Financial Fraud	Claims that a provider has tried to make a profit dishonestly; gain an unjust financial advantage; become beneficiary of a vulnerable person's will; or commit Medicare fraud.
Illegal Practices	Alleged breaches of trade practices law, deceptive claims; assuming bogus qualifications; extortion; criminal actions; fraudulent claims of curative properties; or dishonesty. (Excludes 'Financial Fraud')
Impairment	Failure to meet a standard of practice due to mental or physical condition related to drug or alcohol addiction; mental illness; physical impairment; or illness to a degree where it impinges on a provider's ability to practice safely.
Sexual Misconduct	Any touching of a sexual nature or any sexual relationship with a consumer whether or not initiated by the consumer; or behaviour such as gestures or comments that are sexually demeaning to a consumer.

9. Treatment	Refers to quality or appropriateness of treatment
Diagnosis	Missed, wrong or inadequate diagnosis; or failure to investigate adequately.
Infection Control	Inadequate measures taken to control sources of infection; sterilise equipment; or to adhere to standard (universal) precautions.
Medication	Failure to prescribe; over or under prescribing; wrong or incorrect prescribing; or inappropriate use of medication. Also incorrect dosage administered.
Treatment Coordination	Uncertainty about who is managing the patient; no one taking overall responsibility for the patient, conflicting decisions; or poor communication between providers about treatment or care.
Treatment Rough/ Painful	Rough treatment or unnecessary pain inflicted during an examination or treatment.
Treatment Withdrawn/ Denied	Removal of treatment; or denial of additional treatment or service perceived to have a therapeutic benefit. (Excludes 'Refusal to Treat')
Treatment Wrong/Inappropriate	The incorrect or inappropriate choice of therapy has been made but not where proper therapies are performed wrongly.
Treatment Negligent	Explicit allegations of legal liability under tort law. (Distinct from 'Competence')

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NOTIFICATION OF COMPLAINT

This form is to be completed by either a staff member or the person lodging the complaint.

Date:_____ **Time:**_____

Name of Facility: ☐ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

Complainant: ☐ Patient ☐ Visitor ☐ Other (please state)_____

Name:_____ **UR Number:**_____

Address:_____

_____

_____ **Phone:**_____

Details of Complaint (attach additional information if necessary):

Signature: _____ **Date:**_____ **Designation:** _____
(of person documenting the complaint) (If staff member)

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COMPLAINT REGISTRATION FORM

This form is to be completed the staff member who is registering the complaint.

Complaint Identifier: _____
Office Use Only

Type of Complaint: ☐ Written ☐ Verbal ☐ Telephone

Name of person handling complaint: _____
Name and Designation of Staff handling the complaint

Facility:	Bundaberg	Childers	Gin Gin	Mt. Perry

Source of Complaint	☐ Patient/Client	☐ Relative/Carer	☐ Friend/Advocate
	☐ Staff Member	☐ Volunteer	☐ Anonymous
	☐ Other – Please specify		

Complainant Details	Name:		UR:
	Election Status:		Admission Status:
	Gender:	DOB:	Post Code:
	Complainant Name If different to above:		

Complaint referred by: If from an external source	☐ Ministerial	☐ Local MLA	☐ Other QH Department
	☐ HRC	☐ MP	☐ Staff Referral
	☐ Response to Survey	☐ Other	☐ Not Known

Complaint Handling Details Please provide the date each action was completed	Complaint submitted:	Complaint registered:
	Acknowledgment:	First progress report:
	Date of Resolution/Closure:	

Complaint Issue See Complaint Categories and Description	**Category**	**Description**
	1. Access to Services 2. Communication 3. Consent 4. Corporate Services 5. Cost 6. Grievances 7. Privacy/discrimination 8. Professional Conduct 9. Treatment	
Service Type	Location of Incident:	
Staff Category	Staff involved in the complaint:	

Severity of Complaint		
		Level One: Trivial, misconceived, subject matter not warranting acceptance for investigation
		Level Two: Complainant could have resolved complaint easily with support from staff involved
		Level Three: Legitimate consumer complaints, especially about communication or practice management, but no lasting detriment
		Level Four: Significant issues of standards, quality of care, or denial of rights, complaints with clear quality assurance implications
		Level Five: Long-term or severe damage, including death, serious adverse outcome, professional misconduct

Complainant Objective What does the complainant want to happen?	❒ Register concern	❒ Receive explanation	❒ Obtain apology
	❒ Obtain refund	❒ Access service	❒ Change procedure
	❒ Change policy	❒ Compensation	❒ Disciplinary action
	Please provide details:		

Resolution Mechanism/ Outcome By what means was the complaint resolved?	❒ Concern registered	❒ Explanation given	❒ Apology provided
	❒ Costs refunded	❒ Services provided	❒ Procedure/practice change
	❒ Policy change	❒ Compensation received	❒ Disciplinary action taken
	❒ No action taken		
	Please provide details:		

Recommendation/ Action taken What action has been taken as a result of this complaint?	❒ Staff member/contractor counselled	❒ Training/education of staff provided
	❒ Duties changed	❒ Dismissal/ termination of contract
	❒ Quality improvement activity initiated	❒ No action taken
	Please provide details:	

Adverse Outcome	

Narrative	Please provide a brief summary of the complaint

Office Use Only **Performance indicators**	Acknowledgment letter – 3 days	Progress report – 21 days	Resolution – 35 days
Reported in trends analysis	Date		

LTR3

Queensland Government Queensland Health	**Bundaberg Health Service District** **Policy & Procedure Document**	**QHEPS No. 17108**

Title:	Risk Management Process
Manual Name & No:	No. 2 - Leadership and Management
Section:	Section 2 – Risk Management
Policy Number: Manual/Section/Number	2.2.R1

Applicable to: All Staff

Effective Date: 01 December 2002

Last Review Date: New Policy

Next Review Date: 01 December 2004

Initiator: Quality Coordinator

Authorised:

District Manager

Ratified:

Director of Medical Services

Originals kept in the District Quality and Decision Support Unit

Replaces: New Policy

References:
Queensland Health *Integrated Risk Management for Clinical and Corporate Services Guidance Document* 2002.

Queensland Health *Integrated Risk Management Framework for Clinical and Corporate Services* 2002

Description:
Application of the Integrated Risk Management Framework at the Bundaberg Health Service District, and the processes utilised in this District to effectively manage all clinical and non-clinical risks.

Definitions:
Queensland Health Integrated Risk Management Guidance Document includes a Glossary of terms which may be found at:

http://qheps.health.qld.gov.au/Hssb/risk/Adobe/glossary.pdf

Policy Statement

The Bundaberg Health Service District is committed to the systematic application of the risk management process in all activities undertaken. The Risk Management Process is consistent with the requirements of the Queensland Health Integrated Risk Management Policy.

Link to Integrated QH Integrated Risk Management policy
http://qheps.health.qld.gov.au/Hssb/risk/Adobe/13355.PDF

Outcome

A systematic and rigorous process for identifying risks and opportunities in all activities undertaken will be implemented and maintained. The Risk Management process will be used to assist decision-making and to ensure that the Bundaberg Health Service District achieves its objectives.

Link to QH IRM Guidance Document Section One
http://qheps.health.qld.gov.au/Hssb/risk/Adobe/section_one.pdf

Link to QH Integrated Risk Management Framework:
http://qheps.health.qld.gov.au/Hssb/risk/Adobe/15232.pdf

Evaluation Method

- ❒ Risks reported quarterly to the Improving Performance Committee from each of the risk registers
- ❒ Reporting requirements to Corporate Office met

Procedure

Link to QH IRM Guidance Document Section Two
http://qheps.health.qld.gov.au/Hssb/risk/Adobe/section_two.pdf

All staff are required to apply risk management practices as a way of improving individual and organisational performance, while ensuring that legislative requirements are met and good quality service is achieved.

Improving Performance Committee

- The Improving Performance Committee will establish and maintain the Central Risk Register for the District. The risk register will be reviewed and monitored quarterly during regular meetings, and the effectiveness of treatment plans evaluated. unless risk is very high/extreme wit monitoring required on treatment plan.
- , Risks may be forwarded to the Improving Performance Committee via the Quality Coordinator
- The Improving Performance Committee may delegate responsibility for the treatment and monitoring of risks to the relevant committees as follows: (including but not limited to)

Continuum of Care Committee	• Clinical adverse events • Consumer satisfaction • Medical management • Patient care
Leadership & Management Committee	• Business continuity • Community expectations • Complaints management • Funding allocations • Medico-legal liabilities • Planning – strategic, business, operational • Policy development • Project management
Human Resource Management	• Human resource management • Induction and training • Workforce issues
Information Management	• Information management • Information systems management • Records management
Safe Practice and Environment	• Assess management • Building maintenance • Contract and control of contractors • Emergency preparedness • Environmental management • Infection management • Natural disasters • Security • Transport • Waste management • Workplace health and safety issues

- The Improving Performance Committee will be responsible for ensuring that electronic file transfer of the risk register is provided to the QH Integrated Risk Management Coordinator on a quarterly basis, or more frequently as required.

Clinical Service Forums

- Each Clinical Service Forum (CSF) will establish and maintain a Risk Register for risks related to each of the departments that participate in the forum.

- Risks are systematically identified on the Risk Notification form and forwarded to the Clinical Service Forum for inclusion on the risk register, and where necessary, the development of action plans.
- Risk Registers will be updated on a monthly basis during regular meetings. Risk Management will appear as a standing agenda item for all CSF's. The effectiveness of risk treatments shall also be monitored and reviewed during these meetings
- CSF's may make changes to clinical practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.

Clinical Service Forum/Departments

- ASPIC – Anaesthetics, Surgical Ward, Pre-admission Clinic, Operating Theatre, Intensive Care Unit
- DEM CSF – Department of Emergency Medicine, Department of Ambulatory Services
- Medical CSF – Medical Ward, Renal Unit, Rehabilitation Unit, Coronary Care (ICU)
- Paediatric CSF – Paediatric Unit
- Family Unit CSF – Bundaberg Family Unit, including Special Care Nursery, Ante-natal Clinic
- IMHS CSF – Acute Services, Community Mental Health, Child & Youth Mental Health

Allied Health Head of Department meeting

- The Allied Health Head of Department meeting will establish and maintain a Risk Register for risks related to each of the allied health departments.
- Risks are systematically identified on the Risk Notification form and forwarded to the Allied Health HOD for inclusion on the risk register, and where necessary, the development of action plans.
- Risk Registers will be updated on a monthly basis during regular meetings. Risk Management will appear as a standing agenda item. The effectiveness of risk treatments shall also be monitored and reviewed during these meetings
- Allied Health HOD is may make changes to clinical practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.

Community Health Head of Department meeting

- The Community Health Head of Department meeting will establish and maintain a Risk Register for risks related to each of the community health departments.
- Risks are systematically identified on the Risk Notification form and forwarded to the Community Health HOD for inclusion on the risk register, and where necessary, the development of action plans.
- Risk Registers will be updated on a monthly basis during regular meetings. Risk Management will appear as a standing agenda item. The effectiveness of risk treatments shall also be monitored and reviewed during these meetings
- Community Health HOD is may make changes to clinical practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.

Corporate Services Meeting

- The Corporate Services meeting will establish and maintain a Risk Register for risks related to each of the corporate services departments
- Risks are systematically identified on the Risk Notification form and forwarded to the Corporate Services HOD for inclusion on the risk register, and where necessary, the development of action plans.

- Risk Registers will be updated on a monthly basis during regular meetings. Risk Management will appear as a standing agenda item. The effectiveness of risk treatments shall also be monitored and reviewed during these meetings
- Corporate Services HOD is may make changes to practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.

Rural Facilities

- Each rural facility (Childers Hospital, Gin Gin Hospital and Mt. Perry Health Centre) will establish and maintain a Risk Register for risks related to their area.
- Risks are systematically identified on the Risk Notification form and forwarded to the Director of Nursing for inclusion on the risk register, and where necessary, the development of action plans.
- Risk Registers will be updated on a monthly basis during appropriate regular meetings as identified by each facility. Risk Management will appear as a standing agenda item. The effectiveness of risk treatments shall also be monitored and reviewed during these meetings.
- Rural facilities may make changes to clinical practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.
- Identified risks that are unable to be treated by the relevant facility, will be forwarded to the Improving Performance Committee for inclusion on the central risk register.

High, Very High and Extreme Risks must be reported immediately to the Improving Performance Committee

- All committees, meeting groups and rural facilities will provide a quarterly report to the Improving Performance Committee on the status of their risk registers, including the risks treated and improvements achieved.

Documentation

All risks are to be registered on the relevant Risk Register.

LTR 4

Queensland Government Queensland Health	**Bundaberg Health Service District** **Policy & Procedure Document**	**QHEPS No. 21906**

Title:	Adverse Events Management
Manual Name & No:	No 2 - Leadership & Management
Section:	Section 2 – Risk Management
Policy Number: Manual/Section/Number	2.2.A1

Applicable to: All Staff

Effective Date: 01 June 2004

Last Review Date: New Policy

Next Review Date: 01 June 2007

Initiator: District Quality Coordinator

Authorised:

District Manager

Ratified:

Director of Medical Services

Originals kept in the District Quality and Decision Support Unit

Replaces: New Policy

References:

- QH Incident Management Policy (Draft)
- West Moreton HSD Management of all Clinical Adverse Events Policy
- Hunter Area Health Service Management of Clinical Adverse Events Policy
- ACSQH – Open Disclosure Standard 2003

Description:

Outlines the process for reporting, investigating and documenting adverse events at the Bundaberg Health Service District

Definitions

Incident: An event or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage

Near Miss: An adverse event or close call that did not lead to harm, but could have.

Open Disclosure: The processes of open discussion of adverse events that result in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement.

Root Cause Analysis: Root Cause is the most basic reason for an undesirable outcome, and Root Cause Analysis is a tool that enables us to learn as much as possible about what happened, why it happened and what can be done to prevent the same thing recurring in the future.

Policy

Improved patient care, outcomes and safety are key objectives of the Bundaberg Health Service District. All clinical adverse events and near misses are to be reported and evaluated in a consistent manner that considers all contributing factors, with an emphasis on prevention of recurrence and on communication with all affected parties in a context of open disclosure.

Fundamental principles of this policy include:

- Avoidance of further harm to those affected
- Support for clinicians who are involved
- Focus on prevention of recurrence
- Evaluation of all contributing factors in a systematic, objective, non-punitive and just way
- Open disclosure, with providers to acknowledge and apologize when an incident occurs, avoiding the appearance of being evasive or defensive. Note: a narrow exception to open disclosure exists where the disclosure would in itself cause physical and mental harm to the patient and/or the family
- Promotion of consumer confidence in the openness and accuracy of information
- Reassurance to patients and their families that lessons learned will help prevent recurrence
- Confidentiality with all investigations of adverse events being conducted in a confidential manner, that is on a needs to know basis
- Reassurance to providers that medico-legal risks are addressed
- Notification of management and detailed feedback of relevant lessons learned to all levels of the health service.

Overview of process

This policy operates under the philosophy that reporting and investigation of adverse events is encouraged by:

- Learning, not accountability as being the key
- Reporting being confidential and non-punitive
- Emphasis on the importance of near misses
- Review teams being multidisciplinary
- Investigation being about identification and learning
- Prompt feedback

Outcome

All adverse events will be reported to the relevant Director and the District Quality and Decision Support Unit, Where indicated, an investigating officer appointed by the Director shall conduct an investigation. The investigation/analysis shall focus on identifying and rectifying system causes that underlie any adverse event. Outcomes from all investigations shall be registered with the DQDSU who will provide trend reports to identified groups on a regular basis.

Evaluation Method

Adverse events/adverse events will be monitored and trended by the DQDSU and an annual evaluation of the reporting system will be undertaken.

Procedure

All adverse events, whether involving patients, staff or visitors are to be reported on the Adverse event Report Form

When an adverse event occurs: (See flow chart attached)

1) Following the identification of an adverse event, the first priority is to ensure the safety of the patient and/or staff member and put steps in place to minimise harm
2) The staff member who was involved or discovered the adverse event completes the relevant section of the Adverse event Report Form (Appendix A)
3) If the adverse event relates to a fall, pressure area or occupational exposure, the relevant Minimum Data Set form must also be completed and attached to the adverse event form (Appendix B)
4) Where a Medical Officer has been called to examine the subject, the Medical Officer completes the relevant section of the Adverse event Report Form
5) The Adverse event Report Form is given to the Shift Supervisor or Cost Centre Manger who completes the Shift Supervisors report and ensures that the adverse event has been documented in the patients chart
6) The adverse event and the medical response should be factually recorded as soon as possible in the patient's record. Plans for further follow-up if indicated, should also be documented. Prior documentation must not be altered nor should back dated information be inserted. While addenda to the record can be made, the medical record should not be used to speculate or air grievances about other care providers, equipment, or administrative processes, and should only be used to provide information that is relevant to the care of the patient.
7) Staff involved in an adverse event should be offered appropriate support
8) All units will have in place a mechanism for alerting the relevant Director and/or other management staff of the occurrence of a significant or serious adverse event. This alert should occur as soon as practicable.
9) The completed Adverse event Report form is then forwarded to the District Quality and Decision Support Unit where each adverse event will be registered and risk rated
    a) Adverse events with a low or medium level of risk are registered and included in the relevant trend report
    b) Adverse events with a high, very high or extreme level of risk are reported to the relevant Director
        i) Patient adverse events are sent to the relevant Director who will nominate an appropriate investigation officer to investigate the adverse event and provide the adverse event analysis report (Appendix C) to the DQDSU
        ii) Staff adverse events are sent to the Workplace Health and Safety Officer who shall investigate the adverse event, enter details on WIMS and provide a report to the DQDSU
10) Adverse events of a serious nature may also require a root cause analysis to be undertaken. Recommendation for this to occur may come from the District Manager, relevant Director or DQDSU.
11) The DQDSU will provide feedback to the staff involved in the adverse event related to action taken and outcomes
12) The DQDSU shall generate quarterly trend reports and provide these to the relevant committees, including Executive Council, Leadership & Management Committee, Clinical Services Forums and Heads of Department Meeting

13) A Safety Climate Survey (See Appendix D) will be conducted annually and results distributed by DQDSU, and will focus on measuring improvements in:
    a) Safety Climate Scores and,
    b) Percentage of respondents reporting a Positive Safety Climate
14) An annual evaluation of the Adverse event Management System and shall be undertaken at the end of each financial year to:
    a) Monitor achievement of Key Performance Indicators of the reporting system
    b) Identify and communicate improvements that have been achieved in safety and quality of care
    c) Identify areas requiring further improvement and establish goals for the following year

Open Disclosure

The patient and/or their family should be given:

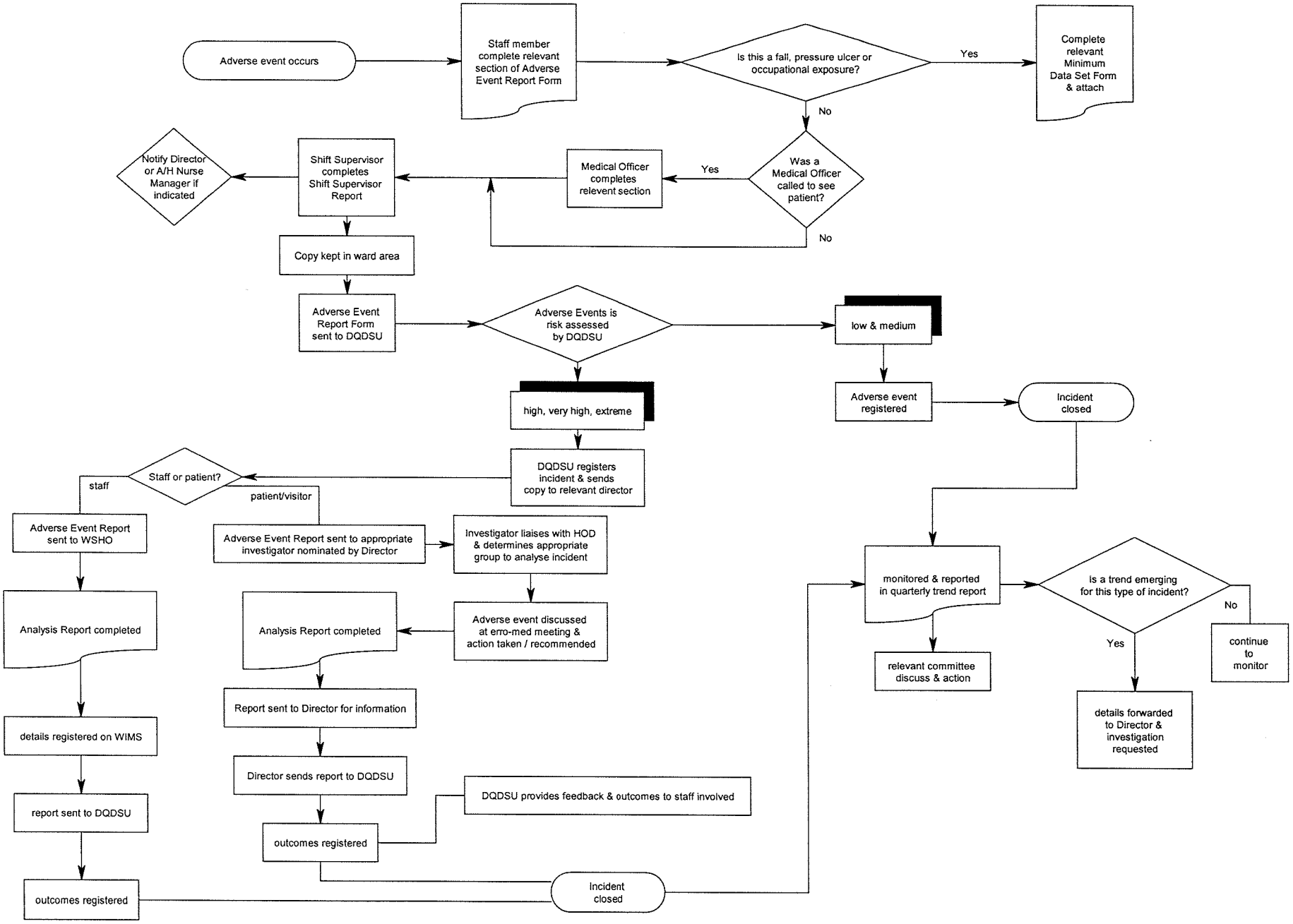
1) A factual and understandable explanation of what happened
2) An outline of the potential consequences
3) An outline of steps being taken to manage the event as soon as practicable after the event. This should entail reassurance that the adverse event is regarded seriously and that there are effective mechanisms of review to examine why the adverse event happened, in order to minimise recurrence.
4) **The safety and quality aspect of the review process should be emphasized so that the patient and/or their family understand that it is about making care safer, not about finding someone to blame.**
5) An expression of regret (without admitting liability)
6) Confirmation that someone will always be available to provide further information or clarification
7) Information on how to make a formal complaint
8) Information on support services provided by social workers and/or other trained support workers who can provide further information
9) Documentation about the open disclosure process and should be included in the medical record.

See Open Disclosure Policy for full details

Documentation

- Adverse Event Report Form
- Adverse Event Analysis Report
- Falls Minimum Data Set form (where required)
- Pressure Ulcer Minimum Data Set form (where required)
- Occupational Exposure Follow Up Questionnaire (where required)
- Safety Climate Survey

ADVERSE EVENT



Appendix A

Queensland Government
Queensland Health

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and treat this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only				
Registration No.		Date Registered		Date Received
Risk Assessment	Consequence	Likelihood	Risk Rating	
Risk Level				
Assessed by				
Action required				

Please print clearly using a **black** pen **(Attach extra sheets if required)**

Site	☐ Bundaberg	☐ Childers	☐ Gin Gin	☐ Mt. Perry

Patient/Visitor Adverse Event Enter details in this column			
Full Name	Or affix Patient Label		
UR Number			
Visitor Contact Details			
DOB/Age			
Department			
Sex of subject	Male	Female	Not stated
Subject is	Patient	Visitor	Other
IMHS Clients	Involuntary	Voluntary	Unknown
Reporters Details	**Name**		
	Contact No.		
Reporters Classification	Please specify		
1st Witness	Name & Contact No.		
2nd Witness	Name & Contact No.		
Place of Adverse event			
Date of Adverse event		Time	
Current patient diagnosis/problems			
Adverse Event Type			
Next of kin notified?	Yes No N/A	Name:	
Medical officer notified?	Yes No N/A	Name:	

Staff Adverse Event Enter details in this column				
Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event		Time		
Shift time	From	To		
Position title				
Supervisor's Details	**Name**			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment details	**Including Asset Number**			
1st Witness				
2nd Witness				
Medical officer notified?	Yes No N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

If relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

Medical Officer's Signature:		**Date & Time:**	
Open Disclosure process initiated?	Yes No N/A	Name:	

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened, including who was involved

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Impact or Outcome - What has been the outcome of this adverse event?

Minimisation of Outcomes - What factors minimised the outcome, or if this was a near miss, what stopped the event from occurring?

Prevention - How could this adverse event have been prevented?

Signature		**Date**	

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor /Management Report

Comment on action taken or action needed to be taken to prevent recurrence

Has the adverse event been documented in the medical record?	Yes	No	If not, why not?
Name:	**Signature:**		

Please forward this form to the District Quality and Decision Support Unit

Director's Comment (Where required)

WHSO Comment (Staff Adverse Event Only)

DQDSU Comment

Appendix B (i)

Queensland Government
Queensland Health

Bundaberg Health Service District

Falls Minimum Data Set Form

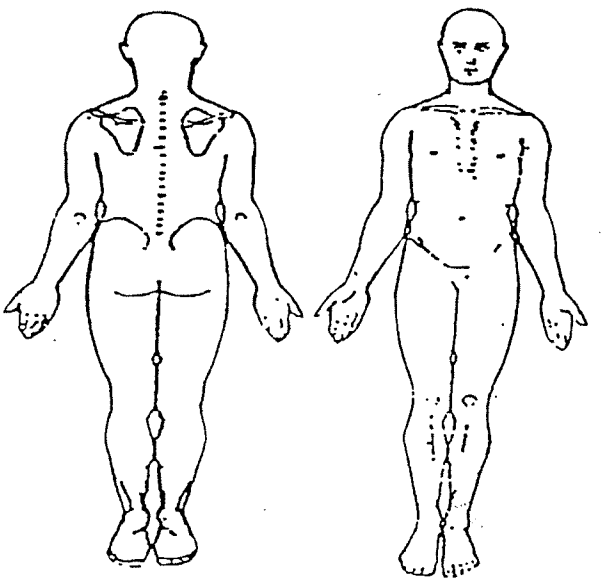
Please complete this form and attach to the relevant Adverse Event Report Form

Patient Name				**Date of Fall**		
Previous Falls Risk Assessment	☐ High Risk	☐ Medium Risk	☐ Low Risk	☐ Not attended		
How was this fall identified:	☐ Fall observed	☐ Patient informed staff	☐ Fall Suspected (Eg. Found lying on floor)			
Mobility at time of fall	☐ Independent	☐ Supervised	☐ Dependant on staff			
Mobility aids in use	☐ Crutches	☐ Walking Stick	☐ Hopper Frame	☐ Wheeled Walker	☐ Rollator	☐ None
Activity at time of fall	☐ Transfer to/from bed	☐ Transfer to/from chair	☐ Toileting	☐ Other transfer (eg. Wheelchair)		
	☐ Ambulating	☐ Bedfast	☐ Showering	☐ Other bathroom activity		
Did this fall occur post-operatively?	☐ Yes	☐ No	If so, how long after surgery?			
Did this fall occur due to faint/fit?	☐ Yes	☐ No	Comment:			

If flagged High or Medium Risk, please complete the following section:

Preventative measures in place	☐ Falls risk score recorded on care path ☐ Colour coded arm band in place ☐ Bed lowered to bottom position ☐ Use of walk belt ☐ Physiotherapy review ☐ Dietician review ☐ Pharmacy review ☐ Occupational Therapy review	☐ Incontinence managed ☐ Current individual environment checklist completed ☐ Client orientated to ward ☐ Mobility aid appropriate and accessible ☐ Hearing/visual aids working ☐ Hearing/visual aids being reviewed ☐ Footwear Checked ☐ Restraints chemical/physical (specify)

Safety devices in use	Bed rails up	☐ Yes	☐ No	Assistive device – please specify:
	Brakes on bed	☐ Yes	☐ No	
	Brakes on wheelchair	☐ Yes	☐ No	
	Call bell within reach	☐ Yes	☐ No	
	Wet floor signs in use	☐ Yes	☐ No	

Part of Body injured	☐ **Head**	☐ **Neck**		
	☐ **Face**	☐ **Back**		
	☐ **Nose/Mouth**	☐ **Trunk**		
		Left	**Right**	
	Eyes	☐	☐	
	Ears	☐	☐	
	Shoulder	☐	☐	
	Arm	☐	☐	
	Hands	☐	☐	
	Finger	☐	☐	
	Leg	☐	☐	
	Knee	☐	☐	
	Feet	☐	☐	
	Toes	☐	☐	
	Multiple locations Specify			

Appendix B (ii)

Queensland Government
Queensland Health

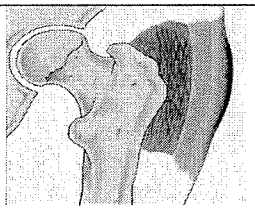
Bundaberg Health Service District

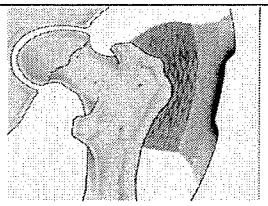
Pressure Ulcer Minimum Data Set Form

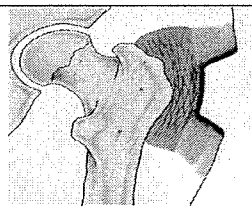
Please complete this form and attach to the relevant Adverse Event Report Form

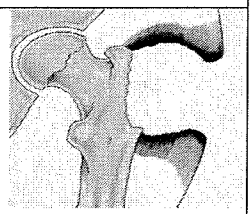
Patient Name		**Date of Event**	
Pressure ulcer present on admission?	☐ Yes If yes, date of admission	☐ No	☐ Unknown
Transferred from another unit/hospital?	☐ Yes If yes, please specify	☐ No	☐ Unknown

Staging


STAGE 1 ☐


STAGE 2 ☐


STAGE 3 ☐


STAGE 4 ☐

Location of Ulcer Please circle

1	Occiput	5	Scapula	9	Iliac Crest	13	Pretibial Crest
2	Ear	6	Spinous Process	10	Ischium	14	Malleolus
3	Nose	7	Elbow	11	Trochanter	15	Heel
4	Chin	8	Sacrum	12	Knee	16	Other

Wound Description

Waterlow Score

Build/weight for height		**Mobility**		**Continence**		**Appetite**		**Sex**	
0	Average	0	Fully mobile	0	Complete/catheterised	0	Average	1	Male
1	Above Average	1	Restless, agitated	1	Urine incontinence	1	Poor	2	Female
2	Obese	2	Apathetic	2	Faecal incontinence	2	NGT/Fluids	**Age**	
3	Below Average	3	Restricted	3	Faecal & Urinary incontinence	3	NBM	1	14-49
		4	Bed bound			3	Anorexic	2	50-64
		5	Chair bound					3	65-74
								4	75-80
								5	81+

Skin Type Visual Risk		**Special Risks**					
		Medication		**Tissue Malnutrition**		**Neurological Deficit**	
0	Healthy	4	Cytotoxics	8	Terminal Cachexia	4-6	Diabetes, MS, CVA, Motor /sensory paraplegia (maximum of 6)
1	Tissue Paper		**Steroids**	5	Multiple Organ failure		
1	Dry		Anti-inflammatory	5	Cardiac failure		
1	Oedematous			5	PVD	**Major Surgery or Trauma**	
1	Clammy, pyrexia		Anti-coagulant (maximum 4)	2	Anaemia (Hb<8)	5	Orthopaedic/Spinal
2	Discoloured Stage 1			1	Smoking	5	On table>2 hours (in past 48hours)
3	Pressure Ulcer Stage 2-4						

Waterlow Score	**Current Score:**		**Score on Admission**
	10+ At Risk	**15+ High Risk**	**20+ Very High Risk**

Pressure Device in use		
	☐ Foam replacement mattress or overlay	☐ Alternating pressure overlay
	☐ Gel filled pads	☐ Low air loss bed
	☐ Fibre-filled overlay e.g. Spenco	☐ Alternating pressure mattress
	☐ Non-powered air filled mattress	☐ Comforter e.g. Sheepskin, pillows
	☐ Low air loss mattress	☐ Nil
	☐ Other	

Risk Factors				
☐ Trauma	☐ Para/Quadriplegia	☐ Obesity	☐ Bed/Chair bound	☐ Impaired cognitive state
☐ Disease	☐ Hemiplegia	☐ Pain	☐ Spinal injury	☐ Extended length of surgery
☐ Anaesthetics	☐ Fractures	☐ Burns	☐ ↓ conscious state	☐ Other

Interventional strategies		
☐ Pressure device implemented/continued		☐ Altered skin care e.g. Soap to sorbelene
☐ Turning regime implemented/continued		☐ Continence Management
☐ Wound treatment Regime	☐ Education	☐ Other

Appendix B (iii)

Queensland Government
Queensland Health

Bundaberg Health Service District

Occupational Exposure Follow up Questionnaire

Please complete this form and attach to the relevant Adverse Event Report Form. The DQDSU will forward this form to the Infection Control Coordinator

Name		Payroll Number		Work Area	
Designation		**Date of Incident**		Time of Incident	hours

INFORMATION ABOUT THE EXPOSURE INCIDENT

Where did the exposure occur?	Eg. Pathology, ICU, Laundry etc
What type of activity was in progress?	Eg. Waste Disposal, surgery, cleaning, routine patient care, CPR, autopsy etc
Were you wearing personal protective equipment?	Eg. Gloves etc
What substances or body fluids were you exposed to?	Eg. Wound exudate, after IM/SC injection etc
	If body fluid, was it visibly blood stained? ☐ Yes ☐ No

INJURY RELATED TO A SHARP DEVICE (Please go to next section if this incident was not caused by a sharp device)

What type of sharp device caused the injury?	Eg .Gloves, hollow bore needle, scalpel blade, scissors, razor, etc	Needle Gauge (if applicable)
For what purpose was the sharp used?	Eg. SC injection, suturing etc	
.t what point during use, did the injury occur?	Eg. During use, after disposal, cleaning etc	
	Were you the original user of the sharp? ☐ Yes ☐ No	
How deep was the injury?	☐ Superficial (surface scratch) ☐ Moderate (penetrated skin)	
	☐ Deep (puncture or wound) ☐ Actual injection of blood or body fluid	
Location of Injury?	Eg. Thumb etc	

NON-PERCUTANEOUS INJURY - SPLASH WITH BLOOD OR BODY FLUID

How did the exposure or splash occur?	Eg. Tube leak, vomit, soiled drapes, R/O IV etc			
What volume of blood/body fluid were you exposed to?	☐ <5mls	☐ 5-50mls	☐ >50mls	☐ Unknown
For how long was the exposure?	☐ Brief – <5mins	☐ Prolonged - >5mins	☐ Unknown	
Which body surfaces were involved?	☐ Eye/s	☐ Nose	☐ Mouth	
	☐ Non-intact skin	☐ Intact skin	☐ Other	Specify:

GENERAL INFORMATION

How much time was lost due to this injury?	Days	Hours	Minutes
⊣ow would you avoid such ı injury in the future?	Please Comment		
Are you satisfied with your injury management so far?	Please Comment		
☐ Yes ☐ No			

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE
PLEASE ATTACH TO RELEVANT INCIDENT FORM AND FORWARD TO DQDSU AS SOON AS POSSIBLE

Office Use Only

HCW notified of results	☐ Initial time	☐ 6 weeks	☐ 3 months	☐ 6 months
HCW follow0up letter sent	☐ 6 weeks	☐ 3 months	☐ 6 months	
Source Results	☐ Yes	☐ No	Comment	
Heb B Immunoglobulin	☐ Yes	☐ No	Comment	
Hep B vaccine post exposure	☐ Yes	☐ No	Comment	
Serum drawn within 7 days	☐ Yes	☐ No	Comment	
Anti-HIV prophylaxis	☐ Yes	☐ No	If so, how soon after exposure?	

Appendix C

District Quality and Decision Support Unit Use Only					
Registration Number		Date report received (P.I. 1)	Benchmark – 90% within 2/7	Acknowledgement sent to HOD	Date:

Risk Assessment	1 = Negligible	2 = Minor	3 = Moderate	4 = Major	5 = Extreme
Patients	Event ran to completion but no harm caused	Extra observations and monitoring/ no treatment required	Moderate harm ⇧ LOS or ⇧ level of care, investigations	⇩function- sensory, motor, physiologic, intellectual	Death or major permanent loss of function
Visitors	Event ran to completion but no harm caused	Evaluated but no treatment required/refused	Evaluation and treatment required (up to 3 visitors)	Evaluation, treatment and admission required	Death or major permanent loss of function
Staff	Event ran to completion but no harm caused	No lost time or restricted duty injuries/illnesses	<3 days lost time or restricted duty injuries	>3 days lost time or restricted duty injuries	Death or major permanent loss of function
Equipment	No damage/cost	Damage < $5000	Damage >$5000 but < $10,000	Damage >$10,000 but <$100,000	Damage >$100,000

Likelihood	
Rare = 1	The event may occur only in exceptional circumstances (may happen sometime in 5-30years)
Unlikely = 2	The event might occur at some time, but is not to be expected (may happen sometime in 2-5years)
Possible = 3	The event could occur at least once (capable of happening/foreseeable)
Likely = 4	The event is expected to occur occasionally (may happen several times in 2years)
Almost Certain=5	The event is expected to occur frequently or in most circumstances (may happen several times in 1 year)

RISK MATRIX	1 = Negligible	2 = Minor	3 = Moderate	4 = Major	5 = Extreme
Rare	Low (1)	Low (2)	Low (3)	Medium (4)	Medium (5)
Unlikely	Low (2)	Medium (4)	Medium (6)	High (8)	High (10)
Possible	Low (3)	Medium (6)	High (9)	Very High (12)	Very High (15)
likely	Medium (4)	High (8)	Very High (12)	Very High (16)	Extreme (20)
Almost Certain	Medium (5)	High (10)	Very High (15)	Extreme (20)	Extreme (25)

RISK ASSESSMENT	Factor of Consequence		X Likelihood		Risk Rating	
Patient Adverse event sent to:	☐ ADON	☐ Director	Date Sent		Reply due by:	
Staff Adverse event sent to:	☐ WHSO	☐ Director	Date Sent		Reply due by:	

Feedback (DQDSU only)				
Adverse event report received	☐ Investigating Officer:	☐ WHSO	☐ Executive Director	Date
P.I -3 High, Very High & Extreme	Time to investigation complete (No. of days)		Benchmark – 90% investigations complete within 10 working days	
				Signed
Feedback sent to:	☐ Head of Department	Date		
	☐ Staff member reporting	Date		
	☐ Subject involved in adverse event	Date		
Reported in Trend Report:	☐ Leadership & Management	Date		
	☐ Executive Council	Date		
	☐ District Rural Executive Forum	Date		
	☐ Heads of Department	Date		
Adverse event closed on: (P.I.3)		No. of days	Benchmark – ()% closed within 28 days	
Performance Indicators	P.I.1 – Adverse event Report Form received by DQDSU within 2 working days			
	P.I. 2 – High, Very High & Extreme adverse events investigation completed within 10 working days			
	P.I.3 – All adverse events closed within 28 days			
Additional Information – where relevant				

ANALYSIS/ INVESTIGATION REPORT			
Investigation completed by:	Name:		
Please complete the following information for all adverse events with a risk rating of High, Very High or Extreme			
Investigation Process	☐ Patient Record	☐ Personal interview	☐ Other: (Please specify)
Findings What was found to be the major/ immediate causes of this adverse event?	Any substandard conditions, substandard practices, system failures or human error which directly resulted in the adverse event		
Solutions What potential/actual solutions were identified to overcome the problem?	Details of action/s either proposed or taken to correct and/or prevent this adverse event occurring again		
Action What action has been taken as a result of this investigation?	Detail action/ preventative action either proposed or taken		
Action undertaken by:		Completion date	
Report provided to: Where has this analysis been reported?	Committee/meeting	Date reported:	
Risk entered onto the Risk Register: (please tick, where relevant)	☐ ASPIC ☐ IMHS CSF ☐ Allied Health HOD ☐ Childers ☐ District Central Risk Register	☐ DEM CSF ☐ Medical CSF ☐ Community Health HOD ☐ Gin Gin ☐ Other: (Please Specify)	☐ Family CSF ☐ Paediatric CSF ☐ Corporate Services HOD ☐ Mt. Perry
Please add any additional comments/information that you feel may be relevant:			

Please return this completed form to the District Quality and Decision Support Unit

Appendix D

BUNDABERG HEALTH SERVICE DISTRICT

SAFETY CLIMATE SURVEY

Date: ..... Unit/Department: .....

Please answer the following items with respect to your specific unit or clinical area. Choose your responses using the scale below:

	A Disagree Strongly	B Disagree Slightly	C Neutral	D Agree Slightly	E Agree Strongly	X N/A
1. The culture of this clinical area makes it easy to learn from the mistakes of others.						
2. Medical errors are handled appropriately in this clinical area.						
3. The senior leaders in my hospital listen to me and care about my concerns.						
4. The physician and nurse leaders in my areas listen to me and care about my concerns.						
5. Leadership is driving us to be a safety-centred institution.						
6. My suggestions about safety would be acted upon if I expressed them to management.						
7. Management/leadership does not knowingly compromise safety concerns for productivity.						
8. I am encouraged by my colleagues to report any safety concerns I may have.						
9. I know the proper channels to direct questions regarding patient safety.						
10. I receive appropriate feedback about my performance.						
11. I would feel safe being treated here as a patient.						
12. Briefing personnel before the start of a shift (i.e. to plan for possible contingencies) is an important part of safety.						
13. Briefings are common here.						
14. I am satisfied with the availability of clinical leadership (please respond to all three):						
Medical Officer						
Nursing						
Pharmacy						
15. This hospital is doing more for patient safety now, than it did one year ago.						
16. I believe that most adverse events occur as a result of multiple system failures, & are not attributable to one individual's actions.						
17. The personnel in this clinical area take responsibility for patient safety.						
18. Personnel frequently disregard rules or guidelines that are established for this clinical area.						
19. Patient safety is constantly reinforced as the priority in this clinical area.						

Have you ever completed this survey before? ○ Yes ○ No ○ Don't Know

Job Position: (mark only one)

○ Director
○ Senior Medical Officer
○ Principal House Officer
○ Junior House Officer
○ Senior Medical Officer
○ Nurse Unit Manager
○ Clinical Nurse
○ Registered Nurse
○ Enrolled Nurse
○ Allied Health Professional
○ Administration Officer
○ Operational Services

Other: _____

Thank you for completing the survey. Your time and participation are greatly appreciated.
Please return this survey to Leonie Raven in the District Quality and Decision Support Unit

Risk Matrix

	Type	Consequences				
		Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
	Adverse Clinical Incident (C)	No injury or harm caused, minor adjustment to operational routine	Minimal harm caused, minor interruption to routine	Loss of function, major harm caused	Loss of life	Multiple deaths
	Outrage/Damage to reputation (O)	**Minimal adverse local publicity**	Significant adverse local publicity	Significant adverse statewide publicity	Significant and sustained statewide adverse publicity	Sustain national adverse publicity, QH reputation significantly damaged
	Litigation (L)	Minimum exposure to Qld Health	Significant exposure to Qld Health	Exposure will result in single claim	Claims >$500,000 or multiple claims resulting from single exposure	Claims >$1M or multiple claims resulting from multiple similar exposures
	Security (S)	Event noted by local staff, no changes to routine required	Monitored by local staff, some effect on routine operations	Reportable event some threat to program/service requires investigation & review	Significant event threatens program/service across the organisation	Extreme event affecting organisations ability to continue program/service
	Staff Morale (SM)	Staff dissatisfaction within local unit. No effect on services or programs	Alteration to routine practice required at local are or district	Disruption spreads across services or programs	Disruption spreads to routine practice statewide	Statewide cessation of service or programs
	Workplace Health and Safety (H)	Incident or injury, no lost time	Injury/illness lost time of less than 4 days	Serious injury/ illness event notifiable, more than 4 days lost time	Fatality	Multiple fatalities
	Environment Impact (E)	No lasting detrimental effect on the environment	Local detrimental effect on the environment	Short term local detrimental effect	Long term detrimental environmental effect	Extensive detrimental long term effect on the environment
	Workforce Issues (W)	No effect on services or programs	Some effect on specific service or program – alterations to routine practice required	Restrictions to service or program availability within a location/district, possible flow on to other locations	Cessation of service or program of a location or district, other locations of districts are affected	State wide cessation of a program or multiple programs
	Operational Management (OM)	No impact on local operations	Minor impact local operations	Moderate to long-term impact on wider operations	Major impact across other areas of organisation	Cessation of some operations
	Disruption to established routines/ operational delivery (D)	No interruption to service	Some disruption manageable by altered operational routine	Disruption to a number of areas within a location or district & possible flow on to other locations	All operational areas of a location/district compromised, other locations/districts affected	Total system dysfunction and / or total shutdown of operations
	Corporate Management (M)	Local management review	Management review on broader basis	Local Executive management review	Zonal / Branch / whole services review	Statewide Management review
	Financial	~ 1% of monthly / project budget	~ 2% of monthly / project budget	~ 5% of monthly / project budget	~ 10% of monthly / project budget	~ 15% of monthly / project budget
Likelihood	**Rare** May occur in exceptional circumstances	**Low**	**Low**	**Low**	**Medium**	**High**
	Unlikely Might occur at some time (not to be expected)	**Low**	**Medium**	**Medium**	**High**	**Very High**
	Possible Could occur at least once (capable of happening)	**Low**	**Medium**	**High**	**Very High**	**Very High**
	Likely Is expected to occur occasionally (to be expected)	**Medium**	**High**	**Very High**	**Very High**	**Extreme**
	Almost Certain Is expected to occur frequently (in most circumstances)	**Medium**	**Very High**	**Very High**	**Extreme**	**Extreme**

LTR6

Queensland Government Queensland Health	**Bundaberg Health Service District** **Policy & Procedure Document**	**QHEPS No. 21907**

Title:	Sentinel Events and Root Cause Analysis
Manual Name & No:	No. 2 - Leadership and Management
Section:	Section 2 – Risk Management
Policy Number: Manual/Section/Number	2.2.S1

Applicable to: All Staff

Effective Date: 01 June 2004

Last Review Date: New Policy

Next Review Date: 01 June 2007

Initiator: Director of Medical Services

Authorised:

_____
District Manager

Ratified:

_____
Director of Medical Services

Originals kept in the District Quality and Decision Support Unit

Replaces: New Policy

References:
- Department of Veterans Affairs, Veterans Affairs National Centre for Patient Safety Michigan, USA, February 2002
- The Clinicians Toolkit – for Improving Health Care – NSW Health 2001
- Sentinel Event Discussion Paper – QH Dec 2002
- QH Incident Management Policy – Draft – Oct 2003

Description

The identification, investigation and monitoring of sentinel events together with the health care facility's response is an important tool in developing safe, patient care and improving the safety of health care for consumers.

Definitions

Sentinel event: An incident in which serious harm resulted to a person receiving healthcare.

Root Cause Analysis: Root Cause is the most basic reason for an undesirable outcome, and Root Cause Analysis is a tool that enables us to learn as much as possible about what happened, why it happened and what can be done to prevent the same thing recurring in the future.

Policy Statement

Sentinel events are rare and serious events that signal the need for prompt multidisciplinary investigation and action. All sentinel events will be subject to a root cause analysis, conducted in an environment of support and learning to ensure that the appropriate actions are taken to prevent future recurrence.

When a sentinel event occurs in a health care facility of Bundaberg Health Service District, it is necessary that the District Manager, Director of Medical Services and the Director of Nursing Services and relevant Director are made aware of the event. The event must be investigated and the cause(s) that initiated the event understood; and changes made in the organisational systems and process to reduce the probability of such an event occurring in the future.

Outcome

- A positive impact in improving patient care.
- Focus attention of facility that experienced sentinel event on understanding the causes underlying the event, and on making changes in the care delivery systems and processes to reduce the probability of such an event in the future.
- Improve safety of health care for consumers and maintain the confidence of the public in the care provided.

Evaluation Method

- Sentinel Event Risk Register maintained by the District Quality and Decision Support Unit
- A six monthly report on trends and analysis to the Leadership & Management Committee; which is then made available to Heads of Department.
- Policies & procedures changed due to investigation of sentinel events on an annual basis.

Procedure

The following events are defined as sentinel events in the Bundaberg Health Service District (as per Australian Council for Safety and Quality in Health Care).

1. Procedures involving the wrong patient or the wrong body part
2. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
3. Haemolytic blood transfusion reaction resulting from ABO incompatibility
4. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
5. Infant discharge to wrong family
6. Maternal death or serious morbidity associated with labour or delivery
7. Intravascular gas embolism resulting in death or neurological damage
8. Suicide of a patient in an in-patient unit
9. Any serious and rare event

Upon identification of one of these events, immediate notification to one of the DM, DMS or DON must occur, preferably by the senior staff member involved in the incident. A verbal report should be received within 12hrs and a written notification within 48 hrs (see attachment A).

After this notification, immediate handling of the event is required. The designated executive member will be responsible for liaison with patient, family and staff in order to facilitate ongoing care; identify possible complaints and concerns and provide explanation of the investigation process. Liaison and notification of CZMU and Corporate Office Queensland Health will be required. Legal advice may also be required. (See Open Disclosure Policy 2.2.O1 for further information)

Upon notification of the sentinel event, an investigation and root cause analysis will be conducted. This investigation will be conducted by a team, headed by one of the executives noted above or by a senior staff member so duly appointed. The investigation will focus on systems and processes, not individual performance. It should encompass special causes in clinical process to common causes in organisational

process. The analysis should identify potential improvements in process or systems in order to decrease the likelihood of such events in the future. An action plan should be developed which identifies responsibility for implementation, mechanisms for oversight, time lines and strategies for measuring the effectiveness of the actions.

The report will be passed to the Leadership & Management Committee, in order that it undertakes the actions required in the facility to ensure the risk of a repeat event is reduced.

Goals of Root Cause Analysis

Root Cause

A root cause is the most fundamental reason an event has occurred

Contributing Factor

Contributing factors are additional reasons, not necessarily the most basic reason that an event has occurred

Root Cause Analysis (RCA)

Root Cause Analysis is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls. RCAs have the following characteristics:

- The review is interdisciplinary in nature with involvement of those closest to the process.
- The analysis focuses primarily on systems and processes rather than individual performance.
- The analysis digs deeper by asking *what* and *why* until all aspects of the process are reviewed and all contributing factors are identified (progressing from looking at special causes to common causes).
- The analysis identifies changes that could be made in systems and processes through either redesign or development of new processes or systems that would improve performance and reduce the risk of event or close call recurrence.

The goal of a **Root Cause Analysis** is to find out

- ***What happened?***
- ***Why did it happen?***
- ***What do you do to prevent it from happening again?***

By addressing the immediate causes at a unit or clinical level, you will reduce the likelihood that the same incident will occur again. However, by addressing the underlying causes (i.e. root causes) this will reduce the likelihood of a similar incident occurring throughout the organisation.

Root Cause Analysis is a *tool* for identifying prevention strategies. It is a process that is part of the effort to build a *culture of safety* and move beyond the culture of blame.

In **Root Cause Analysis**, basic and contributing causes are discovered in a process similar to diagnosis of disease - with the goal always in mind of preventing recurrence.

Root Cause Analysis is

1. inter-disciplinary, involving experts from the frontline services
2. involving of those who are the most familiar with the situation
3. continually digging deeper by asking why, why, why at each level of cause and effect.
4. a process that identifies changes that need to be made to systems
5. a process that is as impartial as possible

To be thorough, a Root Cause Analysis must include:

1. determination of human & other factors,
2. determination of related processes and systems,
3. analysis of underlying cause and effect systems through a series of ***why*** questions,
4. identification of risks & their potential contributions, and
5. determination of potential improvement in processes or systems.

To be credible a Root Cause Analysis must:

1. include participation by the leadership of the organisation & those most closely involved in the processes & systems,
2. be internally consistent, and
3. include consideration of relevant literature.

Documentation

Sentinel Event Report Form (Appendix A)
Root Cause Analysis Report (Appendix B)

Appendix A

Queensland Government
Queensland Health

Bundaberg Health Service District

Sentinel Event Report Form

Sentinel events are rare and serious events that require prompt and in-depth investigation
Sentinel events must be reported verbally to the District Manager, Director of Medical Services, Director of Nursing and other relevant Director within 12 hours.
This written report forwarded to DQDSU within 48 hours

Please print clearly using a **black** pen

Site	☐ Bundaberg	☐ Childers	☐ Gin Gin	☐ Mt. Perry

Details of the subject of the sentinel event (fill in applicable details)

Last Name:	Or affix Patient Label	Sex of Patient:	☐ Male ☐ Female ☐ Not stated
First Name:		IMHS Clients:	☐ Voluntary ☐ Involuntary ☐ Unknown
UR Number:		Unit	Inpatient Unit
DOB/Age:			Unit where event occurred
Reporters Details	**Name:**	**Signature**	
	Contact No.	**Date**	
Reporters Classification:	☐ Nurse ☐ Medical Officer ☐ Allied Health Professional ☐ Other - specify		

Sentinel Event

Please indicate which Sentinel Event has occurred:

- ☐ Procedures involving the wrong patient or the wrong body part
- ☐ Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- ☐ Haemolytic blood transfusion reaction resulting from ABO incompatibility
- ☐ Medication error leading to death of a patient reasonably believed to be due to incorrect administration of drugs
- ☐ Infant discharge to wrong family
- ☐ Maternal death or serious morbidity associated with labour or delivery
- ☐ Intravascular gas embolism resulting in death or neurological damage
- ☐ Suicide of a patient in an in-patient unit
- ☐ Any serious and rare event

ıte of Event				Time of Event	**hours**
Reported to:	☐ DM	☐ DMS	☐ DON	Time reported	**hours**
Also reported to:	☐ DCAHS	☐ DCS	☐ Service Director IMHS	Time reported	

Narrative
Provide details of how this event occurred, including people involved, outcomes etc
Attach additional sheets if insufficient space

Appendix B

TRIGGERING QUESTIONS

(Adapted from the VA National Centre for Patient Safety Triage Questions)

Human Factors – Communication In this section address all questions	Yes	No
Was the patient correctly identified?	☐	☐
Was information from various patient assessments shared and used by members of the treatment team on a timely basis?	☐	☐
If "No" -- This could be a Root Cause/Contributing Factor		
Did existing documentation provide a clear picture of the work-up, the treatment plan and the patient's response to treatment?	☐	☐
Assessments & Consultations	☐	☐
Orders & Treatment team notes	☐	☐
Progress notes	☐	☐
Medication administration record	☐	☐
X-ray & Pathology reports	☐	☐
If "No" -- This could be a Root Cause/Contributing Factor		
Was communication between management/supervisors and front line staff adequate? Was it:	☐	☐
Accurate & Complete	☐	☐
Using standard vocabulary and no jargon & Unambiguous	☐	☐
If "No" -- Describe how management/supervisors and front line communications are not adequate.		
Was communication between front line team members adequate?	☐	☐
If "No" -- Describe how communications between team members were not adequate		
Were policies and procedures communicated adequately?	☐	☐
If "No" -- Describe how policies and procedures were not communicated adequately.		
If this is an issue, see the questions.		
Was the correct technical information adequately communicated 24 hours a day to the people who needed it?	☐	☐
If "No" -- Describe how communication about technical information is not adequate.		
Were there methods for monitoring adequacy of staff communication? Were there methods for:	☐	☐
Confirmation messages, Debriefs etc	☐	☐
If "No" -- This could be a Root Cause/Contributing Factor.		
Was the communication of potential risk factors free from obstacles?	☐	☐
If "No" -- This could be a Root Cause/Contributing Factor.		
Was there manufacturer's recall/alert/bulletin on file for equipment, medication, or transfusion related elements at the time of the event or close call?	☐	☐

Human Factors – Communication In this section address all questions	Yes	No
If this is an issue, consider ***questions***		
Were relevant staff members aware of the recall/alert/bulletin?	☐	☐
If relevant, were the patient and their family/significant others actively included in the assessment and treatment planning?	☐	☐
Did management establish adequate methods to provide information to employees who needed it in a manner that was easy to access/use, and timely?	☐	☐
If "No" -- This could be a Root Cause/ Contributing Factor.		
Did the overall culture of the facility encourage or welcome observations, suggestions, or "early warnings" from staff about risky situations and risk reduction?	☐	☐
Also, has this happened before and was anything done to prevent it from happening again?	☐	☐
Did adequate communication across organizational boundaries occur?	☐	☐

Notes/Additional Information

Human Factors – Training In this section, address all questions	Yes	No
Was there a program to identify what is actually needed for training of staff?	☐	☐
If "No" -- This could be a Root Cause/Contributing Factor.		
Was training provided prior to the start of the work process?	☐	☐
If "No" -- This could be a Root Cause/Contributing Factor		
Were the results of training monitored over time?	☐	☐
If "No" -- This could be a Root Cause/Contributing Factor		
Was the training adequate? If not, consider the following factors:	☐	☐
Supervisory responsibility	☐	☐
Procedure omission	☐	☐
Flawed training	☐	☐
Flawed rules, policy, or procedure -	☐	☐
If yes, go to the questions.		
Were training programs for staff designed up-front with the intent of helping staff perform their tasks without errors?	☐	☐
If "No" -- This could be a Root Cause/Contributing Factor		
Had procedures and equipment been reviewed to ensure that there was a good match between people and the tasks they did; or people and the equipment they used?	☐	☐
If procedures were not followed as intended, see the questions		
Were all staff trained in the use of relevant barriers and controls?	☐	☐
If yes, see the questions		
If equipment was involved, did it work smoothly in the context of:	☐	☐
Staff needs and experience	☐	☐
Existing procedures, requirements, and workload	☐	☐
Physical space and location	☐	☐
If equipment was involved, see the questions		

Notes/Additional Information

Human Factors – Fatigue and Scheduling	Yes	No
Were the levels of vibration, noise, or other environmental conditions appropriate?	☐	☐
If applicable, were environmental stressors properly anticipated?	☐	☐
If stressors were anticipated, see the questions. ***If stressors were not anticipated, why weren't they anticipated?***		
Did personnel have adequate sleep?	☐	☐
Did scheduling allow personnel adequate sleep?	☐	☐
Was fatigue properly anticipated?	☐	☐
Was the environment free of distractions?	☐	☐
Was there sufficient staff on-hand for the workload at the time? (i.e., Workload is too high, too low, or wrong mix of staff.) ***If yes, see the questions***	☐	☐
Was the level of automation appropriate? i.e. Neither too much nor not enough ***f yes, see the questions***	☐	☐
Notes/Additional Information		

Environment and Equipment In this section, address all questions	Yes	No

Environment		
Was the work area/environment designed to support the function it was being used for?	☐	☐
Had there been an environmental risk assessment (i.e., safety audit) of the area? *If no, consider reviewing the and questions.*	☐	☐
Were the work environment stress levels (either physical or psychological) appropriate? (e.g. Temperature, space, noise, intra-facility transfers, construction projects.) *If yes, go to the questions.)*	☐	☐
Had appropriate safety evaluations and disaster drills been conducted?	☐	☐
Did the work area/environment meet current codes, specifications, and regulations?	☐	☐
Equipment (If training was an issue go to .)		
Was equipment designed to properly accomplish its intended purpose?	☐	☐
Did the equipment involved meet current codes, specifications, and regulations?	☐	☐
Was there a documented safety review performed on the equipment involved?	☐	☐
If relevant, were recommendations for service/recall/maintenance completed in a timely manner?	☐	☐
Was there a maintenance program in place to maintain the equipment involved? If no, go to .	☐	☐
If there was a maintenance program, did the most recent previous inspections indicate that the equipment was working properly?	☐	☐
If previous inspections pointed to equipment problems, what corrective actions were implemented and were they effective?	☐	☐
Were adequate time and resources allowed for physical plant and equipment upgrades, if problems were identified?	☐	☐
Was there adequate equipment to perform the work processes?	☐	☐
Were emergency provisions and back-up systems available in case of equipment failure?	☐	☐
Had this type of equipment worked correctly and been used appropriately in the past?		
Was the equipment designed such that usage mistakes would be unlikely to happen?		
Was the design specification adhered to? If yes, go to the questions.		
Was the equipment produced to specifications and operated in a manner that the design was intended to satisfy?	☐	☐
Were personnel trained appropriately, to operate the equipment involved in the adverse event/close call? If no, see the questions.	☐	☐
Did the design of the equipment enable detection of problems and make them obvious to the operator in a timely manner?	☐	☐
Was the equipment designed so that corrective actions could be accomplished in a manner that minimized/eliminated any undesirable outcome?	☐	☐
Were equipment displays and controls working properly and interpreted correctly?	☐	☐
Was the medical equipment or device intended to be reused (e.g. not a Single Use Device)?	☐	☐
Notes/Additional Information		
Rules Policies and Procedures In this section, address all questions	Yes	No

Was there an overall management plan for addressing risk and assigning responsibility for risk?	☐	☐
Did management have an audit or quality control system to inform them how key processes related to the adverse event are functioning?	☐	☐
Had a previous audit been done for a similar event, were the causes identified, and were effective interventions developed and implemented on a timely basis?	☐	☐
Would this problem have gone unidentified or uncorrected after an audit/review?	☐	☐
Was required care for the patient within the scope of the facility's mission, staff-expertise and availability, technical and support service resources?	☐	☐
Was the staff, involved in the adverse event or close call, properly qualified and trained to perform their functions?	☐	☐
Were all involved staff oriented to the job, facility, and unit policies regarding: safety, security, hazardous material management, emergency preparedness, life-safety-management, medical equipment, and utilities management?	☐	☐
Were there written up-to-date policies and procedures that addressed the work processes related to the adverse event or close call?	☐	☐
Were these policies/procedures consistent with relevant federal and VHA policies, standards, and regulations?	☐	☐
Were relevant policies/procedures clear, understandable, and readily available to all staff?	☐	☐
If no, go to the questions.		
Were the relevant policies and procedures actually used on a day-to-day basis?	☐	☐
If the policies and procedures were not used, what got in the way of their usefulness to the staff?	☐	☐
If policies and procedures were not used, what positive and negative incentives were absent?	☐	☐

Notes/Additional Information

What barriers and controls were involved in this adverse event or close call?	☐	☐
Were these barriers designed to protect patients, staff, equipment, or environment?	☐	☐
Was patient risk considered when designing these barriers and controls?	☐	☐
Were these barriers and controls in place before the event happened?	☐	☐
Had these barriers and controls been evaluated for reliability?	☐	☐
Were there other barriers and controls for work processes?	☐	☐
Was the concept of "fault tolerance" applied in system design?	☐	☐
Were the relevant barriers and controls maintained and checked on a routine basis by designated staff?	☐	☐
If no, go to the questions.		
Would the adverse event have been prevented if the existing barriers and controls had functioned correctly?	☐	☐
Were the systems or processes tested before they were implemented?	☐	☐
Did the audits/reviews related to barriers include evaluation of plans, designs, installation, maintenance, and process changes?	☐	☐
If yes, go to the questions.		
Did management have a method for identifying what the results of the system changes would be before implementation?	☐	☐
If yes, go to the questions.		
Notes/Additional Information		

LTR 7

Queensland Government Queensland Health	**Bundaberg Health Service District** **Policy & Procedure Document**	

Title:	Incident Management – Clinical and Non-Clinical
Manual Name & No:	No 2 - Leadership & Management
Section:	Section 2 – Risk Management
Policy Number:	2-2-I1 Manual/Section/Number

Applicable to: All Staff

Effective Date: 01 November 2004

Last Review Date: 01 November 2004

Next Review Date: 01 November 2005

Initiator: District Quality Coordinator

Authorised:

District Manager

Ratified:

Director of Medical Services

Originals kept in the District Quality and Decision Support Unit

Replaces: 2-2-A1

References:

- Queensland Health Incident Management Policy 23360

Description

Management of all actual and potential clinical and non-clinical incidents at the Bundaberg Health Service District

Definitions

Actual Incident – An event or circumstance that did lead to unintended and/or unnecessary harm to a person or the organisation, and/or a complaint, loss or damage

Potential Incident – A hazardous situation that is detected prior to the patient, consumer, client, customer or staff being harmed (near miss, near hit, close call)

Queensland Health Policy Supported

http://qheps.health.qld.gov.au/hssb/risk/im/adobe/incident_mgt_policy.pdf

Policy Statement

Improved patient care, outcomes and safety are key objectives of the Bundaberg Health Service District. All actual and potential incidents are to be reported and evaluated in a consistent manner that considers all contributing factors, with an emphasis on prevention of recurrence and on communication with all affected parties in a context of open disclosure.

The Incident Management system for the BHSD is consistent with the requirements as identified in the Queensland Health Incident Management Policy.

Outcome

All incidents will be received and acknowledged in an impartial environment and viewed as opportunities to review and improve care and services provided by the Bundaberg Health Service District.

All actual and potential incidents are monitored and appropriate action taken to improve safety, reduce risk and to learn from underlying causes to implement systems to reduce the likelihood of recurrence.

Evaluation Method

Incidents will be monitored and trended by the District Quality and Decision Support Unit and an annual evaluation of the reporting system will be undertaken.

Procedure

See Flowcharts attached

All staff

1. Identify and acknowledge any incident – either actual or potential
2. Take immediate action to prevent further harm, rectify or contain the situation
3. Document the incident as fully as possible ensuring that all sections of the incident form is completed
    a. Patient Incidents – enter *patient details* in the left hand column on the incident form
    b. Staff Incidents – enter *staff details* the right hand column
4. Medical Officer's section is completed by the attending Medical Officer where relevant
5. All sections on page 2 of the incident form are to be completed for both patient and staff incidents- *Please see Guidelines for further information*
6. If the incident is a fall, pressure area or occupational exposure, the relevant Minimum Data Set form must also be completed and attached to the incident form
7. If the incident is related to security and a security officer has been called, the security officer completes the Security Notification form and forwards it to the Operational Services Manager
8. The Shift Supervisor is notified that an incident has occurred and is responsible for ensuring that the incident is recorded in the patient's record.
9. The incident and the medical response should be factually recorded as soon as possible in the patient's record. Plans for further follow up if indicated, should also be documented. Prior documentation must not be altered nor should back dated information be inserted. While addenda to the record can be made, the medical record should not be used to speculate or air grievances about other care providers, equipment, or administrative processes, and should only be used to provide information that is relevant to the care of the patient.
10. Staff involved in an incident should be offered appropriate support.

Cost Centre Manager

11. The incident form remains in the department until it has been reviewed by the Cost Centre Manager who completes the "Cost Centre Manager's Section"
12. The Cost Centre Manager is responsible for ensuring that all sections of the form are complete, and then forwards the incident form to the District Quality and Decision Support Unit as soon as practicable.

13. The District Quality and Decision Support Unit registers and risk assesses each incident:
    a. Incidents with a low or medium level of risk are registered and included in the relevant trend report
    b. Incidents with a high, very high or extreme level of risk are reported to the relevant Director
        i. Patient incidents are sent to the relevant Director who, where required, will nominate an appropriate officer to conduct an analysis of the incident and provide a report, including recommendations for improvement back to the Director within the agreed timeframe. A copy of this report is forwarded to the DQDSU after it has been reviewed and actioned by the relevant Director and/or the Leadership & Management Committee
        ii. Staff incidents are sent to the Workplace Health and Safety Officer who shall follow up the incident and enter details on IMS
    c. The DQDSU will provide feedback to the Cost Centre Manager (via email) of outcome of the risk assessment and the planned action.
    d. Where an analysis has been undertaken, the relevant Director or the officer appointed to conduct the analysis will provide feedback to the Cost Centre Manager in relation to the outcome of the analysis via a copy of the final report.
14. The DQDSU shall generate quarterly trend reports and provide these to the relevant committees, including Executive Council, Leadership & Management Committee, Clinical Services Forums and Heads of Department Meeting
15. An annual evaluation of the Incident Management System and shall be undertaken at the end of each financial year to:
    a. Monitor achievement of Key Performance Indicators of the reporting system
    b. Identify and communicate improvements that have been achieved in safety and quality of care
    c. Identify areas requiring further improvement and establish goals for the following year

Documentation

- Incident Report Form
- Falls Minimum Data Set form (where required)
- Pressure Ulcer Minimum Data Set form (where required)
- Occupational Exposure Follow Up Questionnaire (where required)
- Porterage/Security Report (where required)

Queensland Government Queensland Health	**Bundaberg Health Service District** **Policy & Procedure Document**	

Title:	Incident Analysis
Manual Name & No:	No 2 - Leadership & Management
Section:	Section 2 – Risk Management
Policy Number:	2-2-I2 Manual/Section/Number

Applicable to: All Staff	**Description** Process for conducting and reporting of incident analysis
Effective Date: 01 November 2004	
Last Review Date: NA	
Next Review Date: 01 November 2005	
Initiator: District Quality Coordinator	
Authorised: _____ District Manager	
Ratified: _____ Director of Medical Services	**Definitions**
Originals kept in the District Quality and Decision Support Unit	
Replaces: New Policy	
References: Queensland Health Incident Management Policy	

Policy Statement

Incidents will be investigated and analysed according to their potential/ actual risk rating, level of harm caused and within the available resources.

Outcome

Risk of incidents occurring again is reduced by learning from our mistakes and implementing corrective action.

Evaluation Method

Trend reports reviewed to identify reductions in the number and type of incidents that recur

Overview of process

This policy operates under the philosophy that reporting and investigation of incidents is encouraged by:

- Learning, not accountability as being the key
- Reporting being confidential and non-punitive
- Emphasis on the importance of near misses
- Review teams being multidisciplinary
- Investigation being about identification and learning
- Prompt feedback

Procedure

Incident Analysis is a *tool* for identifying prevention strategies. It is a process that is part of the effort to build a *culture of safety* and move beyond the culture of blame.

In **Incident Analysis**, basic and contributing causes are discovered in a process similar to diagnosis of disease - with the goal always in mind of preventing recurrence.

Incident Analysis is

1. Inter-disciplinary, involving experts from the frontline services
2. Involving of those who are the most familiar with the situation
3. Continually digging deeper by asking why, why, why at each level of cause and effect.
4. A process that identifies changes that need to be made to systems
5. A process that is as impartial as possible

To be thorough Incident Analysis must include:

1. Determination of human & other factors
2. Determination of related processes and systems
3. Analysis of underlying cause and effect systems through a series of ***why*** questions
4. Identification of risks & their potential contributions
5. Determination of potential improvement in processes or systems

To be Credible Incident Analysis must:

1. Include participation by the leadership of the organization & those most closely involved in the processes & systems
2. Be internally consistent
3. Include consideration of relevant literature

In general, the incident analysis process includes

- Commissioning of a team, including external agencies if a statutory requirement.
- Review of the incident report/s and other information at hand.
- Use of tools to determine the sequence of events, contributory factors, probable causes and risk identification.
- Analysis of risk using the Integrated Risk Management Guidance Document
- Identification of corrective action.
- Identification of timelines and person/s responsible for corrective actions.
- Preparation of a report including a corrective action plan.
- Authorisation of recommended corrective actions by the Leadership & Management Committee

Incident Analysis Guidelines may be useful when undertaking the analysis process.

Queensland Government Queensland Health	**Bundaberg Health Service District** **Policy & Procedure Document**	

Title:	Sentinel Events and In-depth Analysis
Manual Name & No:	No. 2 - Leadership and Management
Section:	Section 2 – Risk Management
Policy Number:	2.2.S1v2 Manual/Section/Number

Applicable to: All Staff

Effective Date: 01 November 2004

Last Review Date: 01 November 2004

Next Review Date: 01 November 2005

Initiator: District Quality Coordinator

Authorised:

District Manager

Ratified:

Director of Medical Services

Originals kept in the District Quality and Decision Support Unit

Replaces: 2-2-S1

References:
Queensland Health Incident Management Policy 23360

Description

The identification, investigation and monitoring of sentinel events together with the health care facility's response is an important tool in developing safe, patient care and improving the safety of health care for consumers.

Definitions

Sentinel event: An incident in which serious harm resulted to a person receiving healthcare.

In-depth Analysis: Comprehensive analysis of a sentinel event to determine the most basic reason for an undesirable outcome. This analysis enables us to learn as much as possible about what happened, why it happened and what can be done to prevent the same thing recurring in the future.

Queensland Health Policy Supported

http://qheps.health.qld.gov.au/hssb/risk/im/adobe/incident_mgt_policy.pdf

Policy Statement

Sentinel events are rare and serious events that signal the need for prompt multidisciplinary investigation and action. All sentinel events will be subject to in-depth analysis, conducted in an environment of support and learning to ensure that the appropriate actions are taken to prevent future recurrence.

This policy is consistent with the requirement for reporting sentinel events as set out in the Queensland Health Incident Management Policy.

Outcome

- A positive impact in improving patient care.
- Focus attention of facility that experienced sentinel event on understanding the causes underlying the event, and on making changes in the care delivery systems and processes to reduce the probability of such an event in the future.
- Improve safety of health care for consumers and maintain the confidence of the public in the care provided.

Evaluation Method

- Sentinel Event Risk Register maintained by the District Quality and Decision Support Unit
- A six monthly report on trends and analysis to the Leadership & Management Committee; which is then made available to Heads of Department.
- Policies & procedures changed due to investigation of sentinel events on an annual basis.

Queensland Health has deemed the following actual incidents as sentinel events:

1. Surgery/procedure on the wrong patient/wrong body part
2. Deaths including
    (a) Suicide of a patient
    (b) Death of a patient as a direct and immediate result of medication error
    (c) Death of a patient during inter-hospital transfer
    (d) Direct maternal death
    (e) Sudden and unexpected death of an infant associated with labour or delivery
    (f) Death of a patient during surgery
    (g) "Unexpected" death of a patient

3. Haemolytic blood transfusion reaction resulting from ABO incompatibility
4. Instrument or other materials inadvertently left in body cavity or operation wound following a procedure
5. Intravascular gas embolism resulting in death or neurological damage
6. Infant discharged to wrong family
7. Death of an employee during the course of their duties

Mental health specific:

8. Suicide or unexpected death in respect of:
    • Any patient (inpatient or community) of a mental health service.
    • Any person who has been in contact with a mental health service or emergency department within the 7 days preceding the incident.
9. Death of any person through shooting by the Queensland Police Service where the deceased had, or is reasonably suspected to have had, a serious mental illness
10. Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness.

Procedure

Where a sentinel event occurs, it must be immediately reported, then investigated, actioned and communicated in accordance with the incident management model contained in this policy.

Reporting sentinel events

- The line manager must report sentinel events to the District Manager, State Manager, relevant Corporate Office Branch Executive or Director of Mental Health **immediately**. (See Sentinel Event Report form – attached)
- The District Manager, State Manager or relevant Corporate Office Branch Executive is required to notify the Director-General via the Secretariat, Risk Management Advisory Group **immediately**, using the Sentinel Event Notification Report template (attached).

The following mandatory requirements are to be used for investigating sentinel events:

- • Use of a team, independent of the incident
- • Analysis, commencing within seven (7) working days after the incident
- • The root cause analysis investigation tool must be used
- • Teams should be commissioned by the District Manager, State Manager or relevant Corporate Office Branch Executive
- • At least one member of the team must be trained in using the root cause analysis tool and process
- • A report must be provided to the District Manager, State Manager or relevant Corporate Office Branch Executive within 45 days of commencement of investigation

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Sentinel Event Report Form

Sentinel events are rare and serious events that require prompt and in-depth investigation
Sentinel events must be reported verbally to the District Manager, Director of Medical Services, Director of Nursing and other relevant Director immediately

Please print clearly using a **black** pen

Site	☐ Bundaberg	☐ Childers	☐ Gin Gin	☐ Mt. Perry

Details of the subject of the sentinel event (fill in applicable details)

Last Name:	Or affix Patient Label	Sex of Patient:	☐ Male ☐ Female ☐ Not stated
First Name:		IMHS Clients:	☐ Voluntary ☐ Involuntary ☐ Unknown
UR Number:		Unit	Inpatient Unit
DOB/Age:			Unit where event occurred
Reporters Details	**Name:**	**Signature**	
	Contact No.	**Date**	
Reporters Classification:	☐ Nurse ☐ Medical Officer ☐ Allied Health Professional ☐ Other - specify		

Sentinel Event

- ☐ Surgery/procedure on the wrong patient/wrong body part
- ☐ Suicide of a patient
- ☐ Death of a patient as a direct and immediate result of medication error
- ☐ Death of a patient during inter-hospital transfer
- ☐ Direct maternal death
- ☐ Sudden and unexpected death of an infant associated with labour or delivery
- ☐ Death of a patient during surgery
- ☐ "Unexpected" death of a patient
- ☐ Haemolytic blood transfusion reaction resulting from ABO incompatibility
- ☐ Instrument or other materials inadvertently left in body cavity or operation wound following a procedure
- ☐ Intravascular gas embolism resulting in death or neurological damage
- ☐ Infant discharged to wrong family
- ☐ Death of an employee during the course of their duties

Mental Health specific:

- ☐ Suicide or unexpected death of any patient (inpatient or community) of a mental health service.
- ☐ Suicide or unexpected death of any person who has been in contact with a mental health service or emergency department within the 7 days preceding the incident.
- ☐ Death of any person through shooting by the Queensland Police Service where the deceased had, or is reasonably suspected to have had, a serious mental illness
- ☐ Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness.

Date of Event		Time of Event	**hours**

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Sentinel Event Report Form

Reported to:	☐ DM	☐ DMS	☐ DON	Time reported	hours
Also reported to:	☐ DCAHS	☐ DCS	☐ Service Director IMHS	Time reported	

Narrative
Provide details of how this event occurred, including people involved, outcomes etc
Attach additional sheets if insufficient space

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URGENT MEMORANDUM

To: Director-General ATTENTION: Secretariat, Risk Management Advisory Group

Copies to: Click, enter CC's Name/s, Title/s

From: Click, enter Sender's Name and Title **Contact No:** Sender's Tel Number
Fax No: Sender's Fax Number

Subject: **SENTINEL EVENT NOTIFICATION REPORT**

File Ref: Ref Number

I wish to advise that the following sentinel event has occurred in insert location, at insert date and time

TICK	LIST OF NOTIFIABLE SENTINEL EVENTS
	Surgery/ procedure on the wrong patient/wrong body part
	Haemolytic blood transfusion reaction resulting from ABO incompatibility
	Instrument or other materials inadvertently left in body cavity or operation wound following procedure
	Intravascular gas embolism resulting in death or neurological damage
	Infant discharge to wrong family
	Suicide of a patient
	Death of a patient as a direct and immediate result of medication error
	Death of a patient during inter-hospital transfer
	Direct maternal death
	Sudden and unexpected death of an infant associated with labour or delivery
	Death of a patient during surgery
	Unexpected death of a patient
	Death of an employee during the course of their duties
Mental Health Specific	
	The suicide or unexpected death in respect of an inpatient, any patient under the *Mental Health Act 2000* or a patient who has been in contact with a mental health service or emergency department within seven (7) days preceding the incident
	Death of any patient through shooting by the Queensland Police Service, where the deceased had, or is reasonably suspected to have had, a serious mental illness
	Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness

In compliance with Queensland Health's Incident Management Policy, I advise that due procedures are underway and an investigation using the root cause analysis tool will commence on enter date (should be within 7 days from event occurring)

Click, enter name
Click, enter title
/ /

TO BE SINGED AND FAXED IMMEDIATELY
FAX TO: 07 3237 1691

Queensland Government Queensland Health	**Bundaberg Health Service District** **Policy & Procedure Document**	

Title:	Risk Management Process
Manual Name & No:	No 2 - Leadership & Management
Section:	Section 2 – Risk Management
Policy Number:	2-2-R1v2 Manual/Section/Number

Applicable to: All staff	**Description**
Effective Date:	
Last Review Date: November 2004	
Next Review Date: November 2005	
Initiator: District Quality Coordinator	
Authorised: _____ District Manager	
Ratified: _____ Director of Medical Services	**Definitions**
Originals kept in the District Quality and Decision Support Unit	
Replaces: 2-2-R1	
References: Queensland Health Integrated Risk Management Policy 13355	

Policy Statement

The Bundaberg Health Service District is committed to the systematic application of the risk management process in all activities undertaken. The Risk Management Process is consistent with the requirements of the Queensland Health Integrated Risk Management Policy.

Link to Integrated QH Integrated Risk Management policy
http://qheps.health.qld.gov.au/Hssb/risk/Adobe/13355.PDF

Outcome

A systematic and rigorous process for identifying risks and opportunities in all activities undertaken will be implemented and maintained. The Risk Management process will be used to assist decision-making and to ensure that the Bundaberg Health Service District achieves its objectives.

Link to QH IRM Guidance Document Section One
http://qheps.health.qld.gov.au/Hssb/risk/Adobe/section_one.pdf

Link to QH Integrated Risk Management Framework:
http://qheps.health.qld.gov.au/Hssb/risk/Adobe/15232.pdf

Evaluation Method

- ❒ Risks reported quarterly to the Improving Performance Committee from each of the risk registers
- ❒ Reporting requirements to Corporate Office met

Procedure

Link to QH IRM Guidance Document Section Two
http://qheps.health.qld.gov.au/Hssb/risk/Adobe/section_two.pdf

All staff are required to apply risk management practices as a way of improving individual and organizational performance, while ensuring that legislative requirements are met and good quality service is achieved.

Improving Performance Committee

- The Improving Performance Committee will establish and maintain the Central Risk Register for the District. The risk register will be reviewed and monitored quarterly during regular meetings, and the effectiveness of action plans evaluated, unless the risk is very high/extreme with monitoring required on action plan.
- The Improving Performance Committee will develop an action plan for all high, very high and extreme risks.
- Risks may be forwarded to the Improving Performance Committee via the District Quality Coordinator
- The Improving Performance Committee may delegate responsibility for the treatment and monitoring of risks to the relevant committees as follows: (including but not limited to)

Continuum of Care Committee	• Consumer satisfaction • Patient Safety
Leadership & Management Committee	• Business continuity • Community expectations • Complaints management • Funding allocations • Medico-legal liabilities • Planning – strategic, business, operational • Policy development • Project management
Human Resource Management	• Human resource management • Induction and training • Workforce issues
Information Management	• Information management • Information systems management • Records management
Safe Practice and Environment	• Asset management • Building maintenance • Contract and control of contractors • Emergency preparedness • Environmental management • Infection management • Natural disasters • Security • Transport • Waste management • Workplace health and safety issues

- The Improving Performance Committee will be responsible for ensuring that electronic file transfer of the risk register is provided to the QH Integrated Risk Management Coordinator on a quarterly basis, or more frequently as required.

Clinical Service Forums

- Each Clinical Service Forum (CSF) will establish and maintain a Risk Register for risks related to each of the departments that participate in the forum.
- Risks are systematically identified and forwarded to the Clinical Service Forum for inclusion on the risk register.
- Risk Registers will be updated on a monthly basis during regular meetings. Risk Management will appear as a standing agenda item for all CSF's. The effectiveness of extra controls for risks shall also be monitored and reviewed during these meetings
- CSF's may make changes to clinical practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.

Clinical Service Forum/Departments

- ASPIC – Anaesthetics, Surgical Ward, Pre-admission Clinic, Operating Theatre, Intensive Care Unit
- DEM CSF – Department of Emergency Medicine, Department of Ambulatory Services
- Medical CSF – Medical Ward, Renal Unit, Rehabilitation Unit, Coronary Care (ICU)
- Paediatric CSF – Paediatric Unit
- Family Unit CSF – Bundaberg Family Unit, including Special Care Nursery, Ante-natal Clinic
- IMHS CSF – Acute Services, Community Mental Health, Child & Youth Mental Health

Allied Health Head of Department meeting

- The Allied Health Head of Department meeting will establish and maintain a Risk Register for risks related to each of the allied health departments.
- Risks are systematically identified and forwarded to the Allied Health HOD for inclusion on the risk register.
- Risk Registers will be updated on a monthly basis during regular meetings. Risk Management will appear as a standing agenda item. The effectiveness of extra controls for risk shall also be monitored and reviewed during these meetings
- Allied Health HOD is may make changes to clinical practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.

Community Health Head of Department meeting

- The Community Health Head of Department meeting will establish and maintain a Risk Register for risks related to each of the community health departments.
- Risks are systematically identified and forwarded to the Community Health HOD for inclusion on the risk register.
- Risk Registers will be updated on a monthly basis during regular meetings. Risk Management will appear as a standing agenda item. The effectiveness of extra controls for risks shall also be monitored and reviewed during these meetings
- Community Health HOD is may make changes to clinical practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.

Corporate Services Meeting

- The Corporate Services meeting will establish and maintain a Risk Register for risks related to each of the corporate services departments
- Risks are systematically identified on the Risk Notification form and forwarded to the Corporate Services HOD for inclusion on the risk register, and where necessary, the development of action plans.
- Risk Registers will be updated on a monthly basis during regular meetings. Risk Management will appear as a standing agenda item. The effectiveness of risk treatments shall also be monitored and reviewed during these meetings
- Corporate Services HOD is may make changes to practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.

Rural Facilities

- Each rural facility (Childers Hospital, Gin Gin Hospital and Mt. Perry Health Centre) will establish and maintain a Risk Register for risks related to their area.
- Risks are systematically identified and forwarded to the Director of Nursing for inclusion on the risk register.
- Risk Registers will be updated on a monthly basis during appropriate regular meetings as identified by each facility. Risk Management will appear as a standing agenda item. The effectiveness of risk treatments shall also be monitored and reviewed during these meetings.
- Rural facilities may make changes to clinical practice or protocols in order to manage "Low" and "Medium" level risks. Where the management of the risk requires expenditure of money, the request must be forwarded to the Leadership and Management Committee through the normal processes.
- Identified risks that are unable to be treated by the relevant facility, will be forwarded to the Improving Performance Committee for inclusion on the central risk register.

High, Very High and Extreme Risks must be reported immediately to the Improving Performance Committee

Reporting

- All committees, meeting groups and rural facilities will provide a quarterly report to the Improving Performance Committee on the status of their risk registers, including the risks treated and improvements achieved.
- Strategic Risks reported to Corporate Office by Improving Performance Committee as required

Completing the Forum Risk Registers

Each forum, HOD meeting and rural facility that is required to maintain a risk register should nominate a position or person who will be responsible for maintaining the register. This person will use the "Forums Risk Register" to enter and monitor risks that have been identified. The following sections need to be completed:

Accountability Area

- Select relevant forum from the drop-down list included in the register

Contact Person

- Name of the person who is responsible for maintaining the register

Risk Description

- A brief outline of the main components of the risk; that is what it is and how it can happen.

Consequence

- Identify all possible consequences using the risk matrix
- Consequence categories include:
    - Adverse Clinical Incident
    - Outrage/Damage to reputation
    - Litigation
    - Security
    - Staff Morale
    - Workplace Health and Safety
    - Environmental Impact
    - Workforce Issues
    - Operational Management
    - Disruption to established routines/operational delivery
    - Corporate Management
    - Financial

Likelihood

- The likelihood of the risk is selected from the drop down list included in the register

Rating

- The highest factor of consequence and the likelihood is used to determine the risk rating on the matrix

Current Controls

- The controls that are currently in place to minimise this risk are identified

Extra Controls

- Extra controls that are needed to further mitigate the risk are identified and listed

Responsibility

- The person who will be responsible for ensuring that the extra controls are implemented is identified

Timeframe

- The acceptable timeframe for the implementation of the extra controls is determined

Re-rated

- The risk rating process is repeated based on the implementation of the extra controls

Monitoring

- The data or activity that will be used to monitor the risk is recorded here. How often this data is reviewed is also recorded.

Central Risk Register

High, very high and extreme risks that are forwarded to the Improving Performance Committee will be included on the Central Risk Register. The Central Risk Register is maintained in an Excel Workbook, where High, Very High and Extreme risks are entered on separate sheets. The District Quality Coordinator will be responsible for maintaining the central risk register. Fields to be completed include:

Risk Number

- Used to identify when the risk was entered onto the register

Description

- A brief outline of the main components of the risk; that is what it is and how it can happen.

Area

- The area that the risk was received from is identified

Action Plan

- Strategies that are to be implemented in order to treat the risk, including any cost-benefit analysis are outlined here

Re-rating

- The risk rating process is repeated based on the implementation of the extra controls

Responsibility

- The person who will be responsible for ensuring that the extra controls are implemented is identified

Monitoring

- The data or activity that will be used to monitor the risk is recorded here. How often this data is reviewed is also recorded.

Outcome

- The outcome of the action plan is recorded following the implementation of treatments.

Documentation

Forums Risk Register – Attachment 1

Central Risk Register – Attachment 2

Attachment 1

Forums Risk Register

Accountability Area					Contact Person:				
Risk Description	Consequence	Likelihood	Rating	Current Controls	Extra Controls	Responsibility	Timeframe	Re-rated	Monitoring

Attachment 2

High Risks

Risk No.	Description	Area	Action Plan	Responsibility	Re-Rating	Monitoring	Outcome