Changes to serious incident management

Changes to the Health Act are designed to further strengthen patient safety. They relate to clinical Harm Score 1 incidents or any other clinical incidents determined by the Chief Executive (CE) to be due to potential serious systemic problems.

An updated Incident Management Policy will detail these key legislative changes and will specify similar requirements for corporate Harm Score 1 incidents.

1 Preliminary risk assessment (PRA)	A PRA is undertaken within 72 hours of incident notification to identify immediate risks for action and guide next steps. A small PRA team may visit the workplace where an incident occurred, review notes and speak with staff. A staff member is assigned to be a dedicated family contact (DFC). The DFC is the family's key point of contact and maintains regular communication.
2 Separation of findings and recommendations	During the review process, findings are separated from recommendations. The review team put together a findings report, and if directed by the CE, a recommendations report. Each report can be shared with the family following approval. Families do not have to wait for the recommendations to hear the review findings.
3 Engaging experts to assist with development of recommendations	The CE can appoint additional team members with relevant expertise to the review team to assist with developing recommendations.
4 Alternate review methods	There is more than one approved review method. 1. Root cause analysis (RCA) 2. Systems analysis of clinical incident – London Protocol 3. NSW Concise incident analysis 4. NSW Comprehensive incident analysis

For more information contact your Clinical Governance team or look out for updates on the Clinical Excellence Commission (CEC) website
https://www.cec.health.nsw.gov.au/