NQIP

New Zealand Incident Management System

A NATIONAL APPROACH TO THE MANAGEMENT OF HEALTHCARE INCIDENTS

Issue 3 September/October 2008

IN THIS ISSUE

- Recent activity
- Sector feedback
- Consumer feedback
- Working draft
- National central agency
- NZIMS Training programme
- Training content

Launch CD
Launch CDs including presentations by Dr Jim Bagian and the Hon. David Cunliffe, Minister of Health at the project launch in June will soon be available. Please contact Melanie MacFarlane if you would like a copy.

I.S. Consultation
Register your interest in being involved in the consultation of the draft specifications later this year or early 2009 via the project website.

CONTACT US

For more information about any aspect of the NZ Incident Management System please visit our website via:

http://nzsip.communiogroup.com

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RECENT ACTIVITY

Welcome to Issue 3 of the **New Zealand Incident Management System** newsletter.
Recent activity has focused on:

- Analysis of feedback received on the draft national policy
- Development of the Policy Feedback Report
- Revision of the national policy
- Arranging pre-training visits and training sessions in DHBs
- Finalisation of the training programme

SECTOR FEEDBACK

Eighty-plus submissions were received on the draft incident management policy via an online survey, in written form and through face to face or telephone meetings. All feedback was analysed and discussed in the ***Policy Feedback Report***, available on the homepage of the project website.

Based on the feedback received, the NZIMS Steering Committee made key decisions which were considered in the revision of the policy. It was noted there was **strong support for the introduction of a national approach** to the management of healthcare incidents and that major amendments to the policy were not required. The policy would clearly identify that it is written for **application in all health and disability services** across the country and there would be an enhanced **focus on systems** and **not individuals**. It was agreed to increase the focus on **consumers** and **open disclosure** and the Health and Disability Commissioner's ***Guidance on Open Disclosure Policies*** (March 2007) would be a key reference for the policy. **Language** used would better reflect the broader scope of the policy and a section included on the required **culture change needed** to achieve a national approach. All health and disability service providers must have **one policy** for incident management and open disclosure. It was agreed that Root Cause Analyses (RCA) should **not be delayed** to accommodate HDC, Coroners or ACC investigations and the agreed time for completing RCAs would remain at **70 calendar days**. Neither the health practitioner(s) nor the consumer(s) involved in an incident would be on the team that investigates that incident. The timeframe for reporting Severity Assessment Code (SAC) 1 and SAC 2 incidents to the national central agency via a **Reportable Events Brief (REB)** will be **five working days**. Changes will be made to the Likelihood table in the **SAC matrix** to be more consistent with the risk matrix previously agreed by DHB Quality and Risk Managers. Changes will be made to Consequence table in the SAC matrix that relate to **mental health incidents**. Once an incident has been identified, staff members have a **responsibility** to report an incident and incident reports should allow for both **identification** and **non-identification** of the notifier. Consumers must be **enabled to report** an incident by some means. Definitions used will be international and preferably from the **World Health Organisation**.

CONSUMER FEEDBACK

To ensure additional consumer input into the draft policy, the Health and Disability Commission held a consumer forum, for which the NZIMS project team is grateful. Participants supported the need for a greater focus on the **consumer** and for **rapid and open disclosure** of

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incidents to consumers. The importance of acknowledging the **pain and difficulty** experienced by consumers when dealing with an event as well as making a complaint was highlighted. Consumers wanted to contribute to **systems learning** to prevent reccurrence of similar incidents and save other consumers and their families unnecessary anguish and harm. It was felt this could be facilitated by consumers being able to **trigger incident reports,** provide **information for an investigation** of an incident they were involved with or if suitably trained, to be considered for **inclusion in an RCA team** provided they were not involved with the incident being investigated.

WORKING DRAFT

In response to concerns from the sector that the policy would be finalised too quickly, it will be recommended to the Ministry of Health that the policy be issued as a 'working draft' to allow for improvements that may be identified during the initial implementation phase in DHBs. When complete, the revised 'working draft' policy will be forwarded for approval to the NZIMS Steering Committee followed by the National Steering Group. It is expected that by early October the policy will be delivered to the Ministry of Health for approval and subsequent issue to the health and disability sector.

NATIONAL CENTRAL AGENCY

The establishment of a national reporting and learning agency for clinical and consumer safety to facilitate national learning from incidents and systems improvement is an essential part of the whole NZ Incident Management System. A paper outlining options for this was provided to the Ministry with the preferred option being the establishment of an independent national central agency.

The role of the proposed agency will be to **receive reports** from health and disability providers; provide **quality assurance** of REBs, the RCA process and final RCA reports; identify immediate recognisable hazards and **issue alerts** as required; analyse data and information received from **the HDC, the Coroner, the ACC** and all health and disability services; identify **strategies for improvement** nationally; provide ongoing training for providers; undertake **independent investigations** of serious clinical incidents as required; **report to the community** on healthcare safety; undertake **research** into consumer safety and quality in healthcare and **publish** the results of that research; and form **cooperative relationships** with international patient safety agencies.

NZIMS TRAINING PROGRAMME

With initial implementation occurring in DHBs, the NZIMS training programme aims to build on existing work undertaken to assist in the development of a culture and environment within which incidents can be identified, reported, investigated and acted upon to prevent recurrence and to support clinicians and managers to ensure rapid and open disclosure to consumers.

The aim is to raise awareness with as many people as possible within the DHB. The training targets the Board, the executive group, senior managers and clinicians, staff with a responsibility for quality and risk and anyone else with an interest in incident management and patient safety. DHBs are to provide places for staff from neighbouring DHBs and primary care if they are able and choose to do so.

TRAINING CONTENT

DAY ONE EVENING SESSION

This 4-hour session provides an overview of the NZIMS, beginning at 5.00pm and includes dinner. Content:

- The role of **senior management leadership** in supporting a safe culture of incident reporting and open disclosure.
- Theory of **human factors**, errors and systems thinking.
- Models of **accident causation**.
- **Error** types and error-related behaviour patterns.
- Use of the **Severity Assessment Code**.
- **Question-time** and overview of following two days.

DAYS TWO AND THREE

The following two days combine lecture-style teaching methods with group work as people work in mock RCA teams to investigate an incident. Content:

- Nine steps for **incident management** - recognising, reporting, prioritising, reviewing, analysing and acting on incidents to achieve improvement.
- Learning how to undertake a **Root Cause Analysis** investigation.
- Identification of **effective strategies** to address the causes of incidents and adverse events.
- **Interview** techniques and **writing** credible reports.
- Providing open and transparent **disclosure** to consumers.