NOTIFIABLE EVENT - CLINICAL REPORTING

Policy

Purpose

This policy outlines Murray PHN's commissioned service providers' responsibilities and requirements for Notifiable Event (clinical) monitoring, reporting and management. This policy fosters consistency in Notifiable Event reporting across all Murray PHN's programs, including where the programs are delivered via a digital health platform.

This policy will outline the Murray PHN system that facilitates and supports the identification, reporting, management, and evaluation of Notifiable Events (clinical), in a timely and effective manner, and in accordance with the State and Commonwealth funded services notifiable event/incident (clinical) reporting requirements (where applicable). This policy enables alignment with legislation, mitigation of future risk, supports the safe delivery of commissioned services, and promotes a culture of continuous quality improvement.

A Notifiable Event (clinical) is also referred to as a notifiable clinical incident. Murray PHN uses the term event to mean incident.

Scope

This policy applies to Murray PHN and commissioned service providers, including all employees, sub-contractors, and consultants, whether permanent, temporary, fulltime, part time, or casual. Notifiable Events (clinical) must be reported to Murray PHN. Please refer to relevant sections of this policy and the accompanying procedure on Notifiable Event (clinical) Reporting for Commissioned Service Providers, for further information and reporting requirement details.

It is not the role of Murray PHN, or its staff, to manage notifiable events that occur in commissioned services. Murray PHN requires commissioned service providers to have event (incident) management systems, and relevant policies and procedures in place, to identify, report and manage those events. Murray PHN does require that commissioned service providers notify Murray PHN of serious and major events, therefore this policy sets out the requirements associated with events. These requirements are included in the contracts and agreements executed between Murray PHN and commissioned service providers.

Background

Notifiable Event (clinical) management is the responsibly of everyone within an organisation's healthcare team. Murray PHN's Enterprise-wide Risk Management Framework applies a whole-of-organisation approach with clear points of accountability for reporting and feedback at all levels of the organisation. Effective clinical event management by commissioned service providers requires a similar approach.

Commissioned service providers are required to escalate notifiable clinical events within the mandatory reporting requirements of the Victorian Government Victorian Health Incident

Management System (VHIMS) or the Client Incident Management System (CIMS) and the NSW Incident Management System (IMS).

Victorian Public Health and Community Services – and all services under their governance structures – are required to report through VHIMS.

Victorian services in scope to report through CIMS include:

- Health services providing mental health community support services (youth and adult residential, individualised support packages, accommodation, respite, and community support);
- Alcohol and Other Drug (AOD) treatment services.
- Home and Community Care (HACC) services.
- Aged Care and carers support.
- Community palliative care.
- Department delivered or funded disability services.
- Children, youth, and family services; and
- Housing and specialist homelessness and community services.

New South Wales services in scope to report through IMS include hospital and community-based services, supported, and managed through the Southern Local Health District.

Mandatory Reporting Requirements

Reporting of Health Professionals

Health practitioners registered with the Australian Health Practitioner Regulatory Agency (AHPRA), Australian Association of Social Workers or other like registration bodies and their employers must make mandatory notifications in some circumstances. This is a legal requirement under the National Law to protect the public from the risk of harm.

There are four concerns that may trigger a mandatory notification, depending on the risk of harm to the public:

- impairment
- intoxication while practising
- significant departure from accepted professional standards, and
- sexual misconduct.

Please refer to the AHPRA Mandatory notifications about registered health practitioners, March 2020, for further details.

Reporting of Child Abuse

Mandatory reporting is the legal requirement for certain professional groups to report a reasonable belief of child physical or sexual abuse to child protection authorities. In Victoria, under the *Children, Youth and Families Act 2005*, mandatory reporters must make a report to child protection, if while practising their profession or carrying out duties of their office, position, or employment; they form a belief on reasonable grounds that a child needs protection from physical injury or sexual abuse. Please refer to the current Victorian reporting requirements for further details.

In NSW, mandatory reporting is regulated by the *Children and Young Persons (Care and Protection) Act 1998 (the Care Act)* and mandatory reporters are guided by the NSW Mandatory Reporter Guide. Mandatory reporters, where they have reasonable grounds to suspect that a child (under 16 years of age) is at risk of significant harm, must report to NSW Department of Communities and Justice

(previously FACS) as soon as practicable, the name, or a description of the child, and the grounds for suspecting that the child is at risk of significant harm.

Mandatory Standards and Frameworks

Child Safety Laws

Organisations commissioned by Murray PHN to provide services to children are obliged to comply with the *Child Wellbeing Being and Safety Act (Vic) 2005, Children Youth and Families Act (Vic) 2005, the Children's Services Act (Vic) 1996* (or the New South Wales equivalent legislation) and any other applicable State or Commonwealth laws that in any way relate to child safety (Child Safety Laws), must comply with all state and commonwealth government Child Safety Laws and relevant standards. Please refer to the Commission for Young People Child Safe standard information for further information (CCYP | Child Safe Standards). New South Wales service providers engaged or funded by Murray PHN must comply with new South Wales equivalent legislation such as the *Children and Young Persons (Care and Protection) Act (NSW) 1998*, *Children's Guardian Act (NSW) 2019* and the *Child Protection (Working with Children) Act (NSW) 2012*. For further information, please refer to Implementing the Child Safe Standards | Office of the Children's Guardian (nsw.gov.au).

Family Violence Protection

Many organisations commissioned by Murray PHN will be considered a Framework Organisation or an Agency that must comply with the *Family Violence Protection Act (Vic) 2008 (FVP Act).* Framework Organisations or Agencies must effectively incorporate the four pillars of the Multi-Agency Risk Assessment and Management Framework (MARAM) into existing policies, procedures, practice guidance and tools, as appropriate to their organisation's the roles and functions. Please refer to Overview of the MARAM Framework and resources | Victorian Government (www.vic.gov.au) for further information.

Policy Statement

All commissioned service providers are bound by their contractual obligations regarding clinical governance and incident management to report Notifiable Events (clinical) and those outlined below, to the appropriate authorities and directly to Murray PHN as per this policy.

Commissioned providers are required to report notifiable clinical events to Murray PHN, including:

- An adverse client outcome, categorized as a Major Impact incident (CIMS), ISR 1 and 2 Incidents (VHIMS), Harm Score 1 (HS 1, IMS) and Harm Score 2 (HS 2 IMS) clinical incidents.
- An event, incident or situation involving professional misconduct or malpractice;
- Requiring a mandatory notification to the Australian Health Practitioner Regulation Agency (AHPRA) or other regulatory body or authority, relevant to clinical practice (note, this does not include clinicians who are being reviewed by Professional Standards Review [PSR]);
- Requiring a mandatory notification of Child Abuse where the alleged perpetrator is a care professional delivering services or activity that is co-ordinated by or funded by Murray PHN; and/or
- An event where there has been a breach of any Mandatory Standards and Frameworks (Child Safety Laws and Family Violence Protection) caused by, or in any way connected with, the organisation (commissioned service provider), or its personnel, including sub-contractors.

Notifiable Event – clinical data is reported to the Murray PHN Board, Programs and Quality Committee, CEO, Executive and Senior Leadership teams, via regular Risk and Compliance and Operations reporting.

Murray PHN expects that as an element of the management of notifiable clinical events commissioned service providers will comply with the requirements of open disclosure in accordance with the Australian Open Disclosure Framework 2014.

Responsibilities

- **Murray PHN Board and Programs and Quality Committee:** Approval of Murray PHN Clinical Governance Framework, review of regular Operations and Risk and Compliance reporting including clinical event data submitted by commissioned service providers.
- **CEO, Executive and Senior Leadership team:** Review and maintain Clinical Governance Framework, review, and approve Notifiable (Clinical) Event Reporting Policy (this policy) and procedure.
- **Senior Leadership team:** Assurance of implementation of the policy and escalation of events and associated risk to the Executive and Board.
- **Responsible Managers, Activity Leads and Contract Managers:** Monitor commissioned service providers performance through contract management processes including assurance of reporting and escalation of notifiable clinical and other events as submitted to Murray PHN as required by this Policy.
- **Commissioned Service providers:** Report to Murray PHN notifiable clinical events as outlined in this Policy.

Relevant Legislation

Health Services Act 1988

Child Wellbeing and Safety Act 2005 (Vic)

Children, Youth and Families Act 2005 (Vic)

Family Violence Protection Act (Vic) 2008

Working with Children Act (Vic) 2005

Australian Open Disclosure Framework 2014

Definitions

Term	Definition
AHPRA	Australian Health Practitioner Regulation Agency.
Adverse Event	An adverse event is an event or incident that results in harm to a patient.
Clinical Event	Clinical event, incident or circumstance that could have, or did, lead to unintended and/or unnecessary harm.
CIMS	Client Incident Management System is the system utilised by Victorian services to report incidents to the Victorian Department of Families, Fairness and Housing (DFFH).
HS 1	**Clinical Harm Score 1**

	This clinical event category rating applies only to clinical events that relate to unexpected death or are an Australian Sentinel Event. Events that relate to an unexpected death include: 1. The **death** of a patient unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management; 2. **Suspected death by suicide** of a person (including an inpatient or community patient) who has received care or treatment for a mental illness from the relevant Health Services organisation where the death occurs within 7 days of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation; 3. **Suspected homicide** committed by a person who has received care or treatment for mental illness from the relevant Health Services organisation within six months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.
HS 2	**Clinical Harm Score 2** This clinical incident category rating applies when Major Harm is indicated where because of the incident, the consumer: • requires life-saving surgical or medical intervention that is unrelated to the natural course of the illness/injury and differing from the expected outcome of consumer's health care management, or • has shortened life expectancy that is unrelated to the natural course of the illness/injury and differing from the expected outcome of consumer's health care management, or • has experienced permanent or long-term loss or reduction of bodily functioning (sensory, motor, physiologic or intellectual) that is unrelated to the natural course of the illness/injury and differing from the expected outcome of consumer's health care management.
IMS	Incident Management System is the reporting system utilised by health services funded by the NSW Department of Health.
Event Reporting	The process by which clinical event data is sent directly to Murray PHN.
ISR	Incident Severity Rating is the category utilised within the VHIMS (see below), incident management system, to measure the severity of the impact caused to either a person or organisation following an incident.
ISR 1 and 2	ISR 1 incidents are those of a severe impact such as death. ISR 2 incidents are those of a moderate impact such as aggressive behavioural incidents.
Mandatory Reporting	Includes: 1. Reporting of health practitioners under National Law to the Australian Health Practitioner Regulation Agency (AHPRA). 2. Reporting to the relevant state government department, child abuse or any breaches of Child Safety Laws, defined under state law.
Murray PHN	Murray Primary Health Network

Major Impact Incidents	Major impact incidents are those utilised within CIMS to measure incidents such as unanticipated death, severe physical, emotional, or psychological injury or suffering which is likely to cause on-going trauma.
Notifiable Clinical Events	Are clinical events or incidents requiring notification (reporting) to Murray PHN, because of the severity of their impact. Events notifiable to Murray PHN are also notifiable through the relevant Victorian and NSW government incident reporting systems. Notifiable event categories that must be reported to Murray PHN are: ISR 1 and ISR 2 incidents Major Impact Incidents Clinical Harm Score 1 incidents • Please also refer to the definition of Notifiable Event outlined in the Notifiable Event (Non-clinical) Reporting Policy for a full definition of Notifiable Events, outside of those deemed clinical.
Open Disclosure	Open disclosure is the process of open discussion with a client, and/or their family/support person about any incident that results in harm to that client.
PSR	Professional Services Review
VHIMS	Victorian Health Incident Management System is the system utilised by Victorian services to report incidents to the Victorian Department of Health (DH).

Related Documents and Forms

Title	Location
National Clinical Governance Framework (2017)	https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf
VHIMS reporting requirements 2021	https://www.bettersafercare.vic.gov.au/notify-us/vhims
CIMS Summary Guide 2020	https://providers.dffh.vic.gov.au/client-incident-management-summary-guide-word
Murray PHN Clinical Governance Framework 2021	Murray Docs
Murray PHN Enterprise Wide Risk Management Framework 2021	Murray Docs
NSW Health Incident Management Policy 2020	https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_047.pdf
Australian Open Disclosure Framework 2014	https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.pdf
Murray PHN Notifiable Event Reporting Forms	New Forms Website Link

Document Control

Date	Author	Modification	Version
September 2021	Tessa Moriarty, Consultant	Original policy	1
October 2021	Janice Radrekusa – Director of Operations Ian Johansen – Director of Mental Health and Wellbeing	Review and modification	1
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