NOTIFIABLE EVENT- REPORTING REQUIREMENTS FOR COMMISSIONED SERVICE PROVIDERS

Procedure

Purpose

This procedure outlines the reporting requirements for commissioned service providers regarding notifiable events.

Background

Murray PHN are committed to ensuring robust and accessible procedures are in place for commissioned service providers to report Notifiable Events. Commissioned providers are required to escalate and report notifiable incidents within the mandatory Victorian state government Victorian Health Incident Management System (VHIMS) or the Client Incident Management System (CIMS) or the NSW Incident Management System (IMS), or WorkSafe Victoria, Safework Australia and the Australian Information Commissioner (OAIC), Australian Health Practitioners Regulation Agency (AHPRA), the Independent Broad-based Anti-Corruption Commission (IBAC) and all other statutory, and regulatory reporting requirements.

A notifiable event is also referred to as a notifiable incident. Murray PHN uses the term event to mean incident.

Scope

This procedure applies to all Murray PHN commissioned service providers, who are required to act on and report notifiable events to Murray PHN for all components of the **Services** or **Activity** providers have been commissioned to deliver. Notifiable Events are either clinical or non-clinical and include:

- An adverse client outcome categorised as Incident Severity Rating (ISR) 1 and 2 incidents, a Major Impact Incident, or Clinical Harm Score 1 (HS 1) and Harm Score 2 (HS 2) incidents.
- An event, incident or situation involving professional misconduct or malpractice; and/or requiring a mandatory notification to the Australian Health Practitioner Regulation Agency (AHPRA) or other regulatory body.
- A notifiable data breach of sensitive information, required to be reported a State or Commonwealth Privacy Commissioner, including breaches of privacy legislation.
- A serious data breach where there has been unauthorised access to data under your/your organisation's control (not related to privacy, health records or confidentiality).

- An incident which reasonably might give rise to a claim or investigation against you, including but not limited to breach of a public health direction, a public liability claim, professional negligence claim, child safety issue or occupational health and safety and including if applicable, whistle-blower claims or investigations.
- A change in control event, where there is a change to the controlling entity of your organisation, the structure, management, or operations which could reasonably be expected to have serious effect on governance.
- An event involving governance or personnel where there is an investigation of corruption, misappropriation, fraud, or other serious offence where this may adversely affect or has adversely affected the performance of the services.
- An event involving conflict of interest arising with you or Personnel in respect of personal interests or activities that influence or could appear to influence the ability to exercise judgement or make decisions in the best interests the funded services.

Procedure

When a notifiable event occurs, commissioned providers are required to conduct the following actions.

1. Immediate Event Management

Following the identification of the event, initiate internal event/incident assessment and management procedures.

2. Event Notification

- Make notification to relevant Victorian, New South Wales or Commonwealth Government authority and other authorities as per notifiable incident reporting requirements.
- In some programs, third parties involved with a program will impose additional reporting obligations concerning clinical incidents. Please check the agreement you have with Murray PHN as to whether this may apply to you, noting the timelines required in that agreement.
- The relevant Program Manager notifies Murray PHN about the incident via the online ***Report A Notifiable Event Form (Clinical and Non-clinical)***, located on Murray PHN website (hyperlink) within the following timeframes:
  - ISR1, Major Impact or HS1 clinical events and notifiable WorkSafe events within ***24 hours*** of the event occurring or the organisation becoming aware of it.
  - ISR 2, HS2 or incidents involving professional misconduct, malpractice, or events requiring mandatory reporting/notification to state, AHPRA, or other regulatory body within ***48 hours*** of it occurring/or becoming aware of it.
  - all other notifiable non-clinical events, within ***48 hours*** of it occurring/or becoming aware of it.
- The relevant Program Manager must also notify the Murray PHN Contract Manager for the commissioned service via telephone to provide information regarding the event and confirmation that an online report has been made via the Murray PHN website link. If that person is unavailable, an email confirming the event has occurred must be sent, but Identifiable event details must not be sent via email.

3. Open Disclosure

Where appropriate, undertake Open Disclosure, in accordance with requirements under the Australian Open Disclosure Framework 2014.

4. Event Investigation

Commence an internal event/incident investigation in accordance with relevant state government, or national statutory or regulatory authorities and Murray PHN notifiable event reporting investigation requirements. This will include the use of investigatory processes and tools required by the relevant government and/or authority, such as a ***Root Cause Analysis*** (RCA) investigation or an ***In-Depth Review*** investigation. It is important you refer to an comply with the government and/or authority investigatory requirements.

5. Event Investigation Reporting

A summary of your Event Investigation Report, with Recommendations (de-identified client and staff information) must be ***submitted via the link in your email notification from Murray PHN*** within:

- ***70 days*** of the event being reported to Murray PHN, for ISR 2 and HS2 clinical incidents, and all other notifiable non-clinical incidents as described in the ***Scope*** section of this procedure: or
- ***90 days*** of the event being reported to Murray PHN, for ISR1, Major Impact or HS1 clinical incidents and notifiable WorkSafe incidents as described in the ***Scope*** section of this procedure.

6. Review of Event

Murray PHN will review the findings within your Investigation Report and make recommendations for further actions into the event or event closure.

Definitions

Term	Definition
Clinical Event	Clinical event 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 incident category rating applies only to clinical incidents that relate to unexpected death or are an Australian Sentinel Event. Incidents 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

Term	Definition
	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 MPHN
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
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 Events	Are events requiring notification (reporting) to Murray PHN, because of the severity of their impact. Events notifiable to Murray PHN may also be notifiable through the relevant Victorian, NSW or Commonwealth government incident reporting systems and relevant statutory and regulatory authorities. Notifiable Events are defined in the contact or agreement you have with Murray PHN.
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
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
Clinical Incident Reporting Policy	Murray Docs
Australian Open Disclosure Framework 2014	https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-Open-Disclosure-Framework-Feb-2014.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
NSW Clinical Excellence Commission Incident Management Policy Resources	https://www.cec.health.nsw.gov.au/Review-incidents/incident-management-policy-resources
Safer Care Victoria Adverse Events Resource	https://www.bettersafercare.vic.gov.au/sites/default/files/2019-08/Policy%20-%20Adverse%20Patient%20Safety%20Events.pdf https://www.bettersafercare.vic.gov.au/support-and-training/review-and-response/reviewing-an-adverse-event https://www.bettersafercare.vic.gov.au/sites/default/files/2019-02/Incident%20review%20documentation%20-%20fact%20sheet.pdf
CIMS Tools and Resources	https://providers.dffh.vic.gov.au/incident-investigation-report-and-response-plan-cims-word https://providers.dffh.vic.gov.au/investigation-outcome-and-root-cause-analysis-rca-template-client-incident-management-system-cims

Document Control

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Date	Author	Modification	Version
	Ian Johansen, Director Mental Health and Wellbeing Michelle Allan, Corporate Counsel, Contracts and Commercial Lead Darryn Young, Governance Lead, Board Secretary Kristen Way, Quality & Risk Lead		

Procedure Flowchart