CLINICAL INCIDENT REPORTING REQUIREMENTS FOR COMMISSIONED PROVIDERS

Procedure

Purpose

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

Background

Murray PHN are committed to ensuring robust and accessible procedures are in place for commissioned service providers to report clinical incidents. Commissioned providers are required to escalate and report notifiable clinical 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), reporting requirements.

Victorian Public Health and Community Services (and those services under their governance structures) are in scope to report through VHIMS, including bush nursing services and public-sector residential aged care facilities.

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, managed through the Southern Local Health District.

Scope

This procedure applies to all Murray PHN commissioned service providers, who are required to act on and report notifiable clinical incidents to Murray PHN.

Notifiable clinical incidents 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 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.

1. Incident Severity Rating 1 and 2 Incidents

Commissioned providers obligated to report notifiable ISR 1 and 2 incidents through the VHIMS system are also required to report to Murray PHN.

Table 1 - Incident Severity Rating 1 and 2 Incidents

ISR	Degree of Impact	Report to PHN
1	***Severe***	***Yes***
2	***Moderate***	***Yes***
3	***Mild***	***No***
4	***No Harm/Near Miss***	***No***

2. Major Impact Incidents

Commissioned providers obligated to report notifiable clinical incidents of Major Impact through the CIMS system are also required to report to Murray PHN.

Table 2 – Major Impact Incidents

Category	Degree of Impact	Report to PHN
Major Impact Incident	Unanticipated consumer death severe physical, emotional, or psychological injury or suffering which is likely to cause on-going trauma.	***Yes***
Non-major Incident	Incidents causing physical, emotional, or psychological injury or suffering, without resulting in a major impact	***No***

3. Clinical Harm Score 1 incidents

Table 3 – Clinical Harm Score 1 Incidents

Harm Score	Incident Type	Report to PHN
Clinical Harm Score 1	Clinical incidents that relate to unexpected death or are an Australian Sentinel Event.	***Yes***
Clinical Harm Score 2	Clinical incident where Major Harm to the consumer is indicated	***Yes***
Clinical Harm Score 3 and 4	***Mild***	***No***

Procedure

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

1. Immediate Incident Management

- Following the identification of the incident, initiate internal clinical incident assessment and management procedures.

2. Incident Notification

- Make notification to relevant Victorian or New South Wales Government and other authorities as per notifiable incident reporting requirements
- The relevant Program Manager notifies Murray PHN about the incident via the online ***Report An Incident Form***, located on Murray PHN website (hyperlink) within the following timeframes:
    - ISR1, Major Impact or HS1 incidents within ***24 hours*** of the incident occurring or the organisation becoming aware of incident.
    - ISR 2 and HS2 incidents, incidents involving professional misconduct or malpractice, and/or incidents requiring mandatory notification to state, AHPRA, or other regulatory body, within ***48 hours*** of the incident occurring or the organisation becoming aware of incident.
- The relevant Program Manager notifies the Murray PHN Contract Manager for the commissioned service via telephone to provide information regarding the incident. If that person is unavailable, an email with incident details (ensuring compliance with privacy and confidentiality requirements) must be sent.

3. Open Disclosure

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

4. Incident Investigation

- Commence an internal incident investigation in accordance with relevant state government and Murray PHN incident reporting investigation requirements outlined below:
    - ISR1, Major Impact incidents or Clinical Harm Score 1 Incidents require a ***Root Cause Analysis*** (RCA) investigation.
    - ISR2, HS 2 incidents, incidents involving professional misconduct or malpractice, and/or requiring mandatory reporting/notification to state, AHPRA, or other regulatory body incidents require an ***In-Depth Review*** investigation.
    - Links to the relevant incident investigation tools are available within the section in this procedure on Related Documents and Forms.

5. Incident Investigation Reporting

- A summary of your In-depth Review Report with recommendations (de-identified of client and staff information) must be ***submitted via the link in your email notification from Murray PHN*** within ***70 days*** of the incident being reported to Murray PHN.
- A summary of your Root Cause Analysis (RCA) with recommendations (de-identified of client and staff information) must be ***submitted via the link in your email notification from Murray PHN*** within ***90 days*** of the incident being reported to Murray PHN.

6. Review of Incident

- Murray PHN will review the findings from the investigation and make recommendations for further actions into the incident or incident closure.

Exceptions to Procedures Flow

Clinical Incidents of *ISR 3 and ISR4*, *Non-Major Impact* incidents and those categorised as *Harm Score 3 and 4* are excluded from this process as these incidents are managed locally by each service provider as articulated in their contract.

Definitions

Term	Definition
Adverse Event	An adverse event is an incident that results in harm to a patient.
Clinical Incident	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 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

Term	Definition
	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.
Incident Reporting	The process by which clinical incident 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 Incidents	Are clinical incidents requiring notification (reporting) to Murray PHN, because of the severity of their impact. Incidents notifiable to Murray PHN are also notifiable through the relevant Victorian and NSW government incident reporting systems. Notifiable incident categories that must be reported to Murray PHN are: ISR 1 and ISR 2 incidents Major Impact Incidents Clinical Harm Score 1 and Harm Score 2 incidents
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
Sentinel Event	
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

Date	Author	Modification	Version
September 2021	Tessa Moriarty, Consultant	Procedure developed	Draft
November 2021	Janice Radrekusa, Director of Operations Ian Johansen, Director Mental Health and Wellbeing Janine Holland, Chief Operations Officer	Reviewed and revised	1

Procedure Flowchart