

Supporting evidence

Supporting evidence may be useful to demonstrate to auditors that a rigorous and thorough investigation has been undertaken. Supporting evidence that the standard has been observed may include:

- a brief and factual description of the incident;
- a description of the composition of the team (job title sufficient);
- a statement indicating relevant staff have been interviewed;
- details of the recommendations related to each contributing factor (please note, this information cannot be disclosed if the investigation has been conducted under the qualified privilege afforded by the *Health Services (Quality Improvement) Act 1994*);
- details of the outcomes measures for each recommendation; and
- documents which indicate that the Chief Executive has agreed and has signed off on all recommendations to be implemented.

How Can You Get Involved?

- Register your interest in participation in Quality and Safety programs with those responsible for clinical governance in your area.
- Attend an RCA training workshop.
- Report incidents.

Further information is available from the Office of Safety and Quality in Health Care

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Delivering a **Healthy WA**



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Clinical Incident Investigation Standard

Office of Safety and Quality
in Health Care
Department of Health

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Overview

Serious clinical incidents such as those identified through the WA Incident Management System should be investigated where feasible. The goal of any investigation is to improve health care by reducing the likelihood that events will recur or reduce the consequences where a risk cannot be eliminated.

Rationale

Serious clinical incidents may signal a breakdown in health care systems. An investigation of these events will identify the root causes of these system breakdowns and other factors that may have contributed to these events. The recommendations arising from the investigation should contain strategies that can be implemented to minimise or eliminate the occurrence of similar events in the future.

Principles

Where there has been an incident that requires investigation, the initial primary responsibility is to ensure safety and care of patients and staff. The investigation should at all times respect the dignity of all persons involved.

An investigation into an incident will involve a comprehensive and systematic analysis of facts to identify root causes or contributing factors. There should not be any blame or fault apportioned to individuals involved.

A senior staff member who was not directly involved in the incident and who can maintain objectivity should facilitate the investigation process.

If there is suspected or alleged blameworthy behaviour or a purposeful unsafe act, a separate process should be followed to ensure these are managed appropriately.

A hospital will, consistent with its obligation to take reasonable care, advise patients of any serious adverse event which has caused harm or in which there is a potential for harm to arise.

Patients and families do not typically participate in investigations, however, they may, if relevant, be interviewed concerning the facts and circumstances of the events, and be informed of outcomes where possible (the exception being incidents undergoing investigation under the protection of the *Health Services (Quality Improvement) Act 1994*).

Types of investigations

There are a number of methodologies for investigating serious clinical incidents or near misses, including but not limited to:

- Root Cause Analysis;
- Clinical Review (internal and external);
- Mini Root Cause Analysis; and
- External Review.

Criteria

Whatever the methodology used to investigate the incident it is recommended that the following standards be applied:

- the investigation considers all relevant disciplines;
- the investigation committee should be fully composed of independent members who were not involved in the incident;

- the investigation considers all interpretations of the factors which may have led to the incident and is focussed on system issues;
- the investigation involves interviews or input from staff involved in the incident;
- the patient and/or their carer are interviewed if it is believed that their input can add to the information;
- that all major contributing factors are discovered/identified and relevant literature or other internal/ external evidence has been considered;
- recommendations are based on contributing factors;
- recommendations are achievable and measurable;
- where possible, the recommendations should consider the opportunities to eliminate, minimise or treat the risks;
- ongoing monitoring to ensure the recommendations are implemented and evaluated to determine whether the contributing factors have been addressed by the recommended action;
- where possible the recommendations and action are fed back to the patient and, with their permission, to their carer or relative (please note, this information cannot be disclosed if the investigation has been conducted under qualified privilege afforded by the *Health Services (Quality Improvement) Act 1994*); and
- after the investigation is completed all relevant staff and service providers should be informed of the investigation outcome and key lessons are learned.