2018

Incident Management Framework

Care | Compassion | Trust | Learning

Building a Better Health Service | Seirbhís Sláinte Níos Fearr á Forbairt

Briefing Session

Changes as a result of Melissa's Story

- Guidelines for the management of early pregnancy complications developed by the HSE Clinical Programme for Obs & Gynae
- All Maternity units have a dedicated Early Pregnancy Assessment Unit
- 2nd ultrasound required to confirm a diagnosis of miscarriage
- MDT training for all staff involved in early pregnancy care available
- Each unit required to develop a policy and a service for supporting women who have suffered a miscarriage
- Metric on Irish Maternity Information System (IMIS) reported monthly

Context for Change

- Learning from the management to high profile serious incidents
- National Policy for Open Disclosure
- National Standards for the Conduct of Patient Safety Incident Reviews
- Civil Liability (Amendment) Act 2017 Part 4 Open Disclosure of Patient Safety Incidents
- Forthcoming Health Information Bill – Mandatory Reportable Events

Before we started, we listened

- **To service users and families**
- **To frontline staff**
- **To QPS Advisors**
- **To managers at all levels**
- **To key stakeholder groups**

What they said….

Patients and Families

- Adequacy of response
  - Compassion and care
  - Information (immediate and on-going)
  - Involvement and support with investigations
  - Length of time investigations take
  - Complexity of reports
  - That many reports do not address the concerns or questions they have

What they said…

Frontline Staff

- Adequacy of response
  - Support in the aftermath of an incident
  - Investigation process can be very stressful
  - Length of time investigations take
  - Outcome of investigation
  - Changes as a result of investigation

What they said…

Managers and QPS Staff

- Timeframes for decision making in the aftermath of an incident i.e. within 24 hours
- Decisions in relation to alternate pathways for reviews/investigations
- Complexity of investigation process
- Quality of recommendations made was variable
- Time taken to complete the process versus the KPI of 120 days

What we learnt …

- Importance of the period immediately following identification of an incident
- Need for a graduated and proportionate approach to review
- Need for a compassionate, timely and supportive response to families and staff
- Review must balance the **technical analysis** of the incident with the **needs of those affected**
- Quality of recommendations in many reports are poor and often difficult to implement

Developing the Incident Management Framework

- Establishment of Co-Design Group
- Visit to Healthcare Improvement Scotland
- Visit to NHS Tayside
- Blank page development of each step
- Reality testing of each step throughout the process
- Consultation with approx 500 individuals and groups
- Support from Patients for Patient Safety Ireland
- Consultation with the NJC Policies and Procedures Sub-group
- Review and sign-off by HSE Leadership Team

When to use the Framework?

- Not everything reported on an incident report form is an incident
- Incidents may also be reported through alternate routes
- Need to adopt a ‘no wrong door’ approach
- Need to ensure that any issue reported through any route is correctly located for review

Incident Management Framework Documents

Incident Management Framework Documents

Who does the Incident Management Framework apply to?

The IMF applies to all incidents occurring in publicly funded health and social care services provided in Ireland including but not limited to:

- Hospital Groups
- Community Health Organisations
- National Ambulance Service
- National Services e.g. National Screening Services, National Transport Medicine Programme
- HSE Funded Care e.g. Section 38/39 agencies

Principles upon which the Incident Management Framework is based

- Person Centred
- Fair and Just
- Openness and Transparency
- Responsive
- Improvement Focused
- Learning

Care Compassion Trust Learning

HSE Values in Action

Keep people informed – explain the now and the next

Nowhere are the **HSE Values** tested more than in the aftermath of an incident

Use my name and your name

Do an extra, kind thing

Incident Management – Six Step Process

1. Prevention through supporting a culture where safety is a priority
2. Identification and immediate actions required (for persons directly affected and to minimise risk of further harm to others)
3. Initial reporting and notification
4. Assessment and categorisation
5. Review and analysis
6. Improvement planning and monitoring

Step1. Prevention through supporting a culture where safety is a priority.

Key messages

1. Clear leadership at all levels to support a culture of quality and safety
2. Anticipate and manage risk which may lead to incidents
3. Define structures and processes for incident management
4. Integrate your quality and safety information to enhance its effectiveness

Step1. Prevention through supporting a culture where safety is a priority.

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Increased emphasis on linking Risk and Incident Management

Managing Risk in your area of responsibility

- Anticipate
- Vigilance
- Respond
- Learn and Improve

https://www.hse.ie/eng/about/QAVD/riskmanagement/risk-management-documentation

Step 2 - Identification and immediate actions

Key Messages

1. Minimise impact of the incident on person harmed
2. Take any actions immediately required to prevent the risk of recurrence to others.
3. Identify and support the needs of persons affected
4. Initiate Open Disclosure process
5. Factually document incident and care provided in service user healthcare record.
6. Appoint service user/family and staff liaison persons

Step 2 - Identification and immediate actions

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Increased emphasis on supporting those affected

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Appoint service user/family and staff liaison persons

Supporting those who are affected – e.g. Service Users and Families

Role of Line Manager critical in maintaining trust and restoring confidence

- Ensure all immediate care required is provided
- Providing a caring and compassionate response
- Open Disclosure
- Listening to their concerns and queries
- Ensuring a named Liaison person is identified to keep them informed throughout the process

Supporting those who are affected – Staff

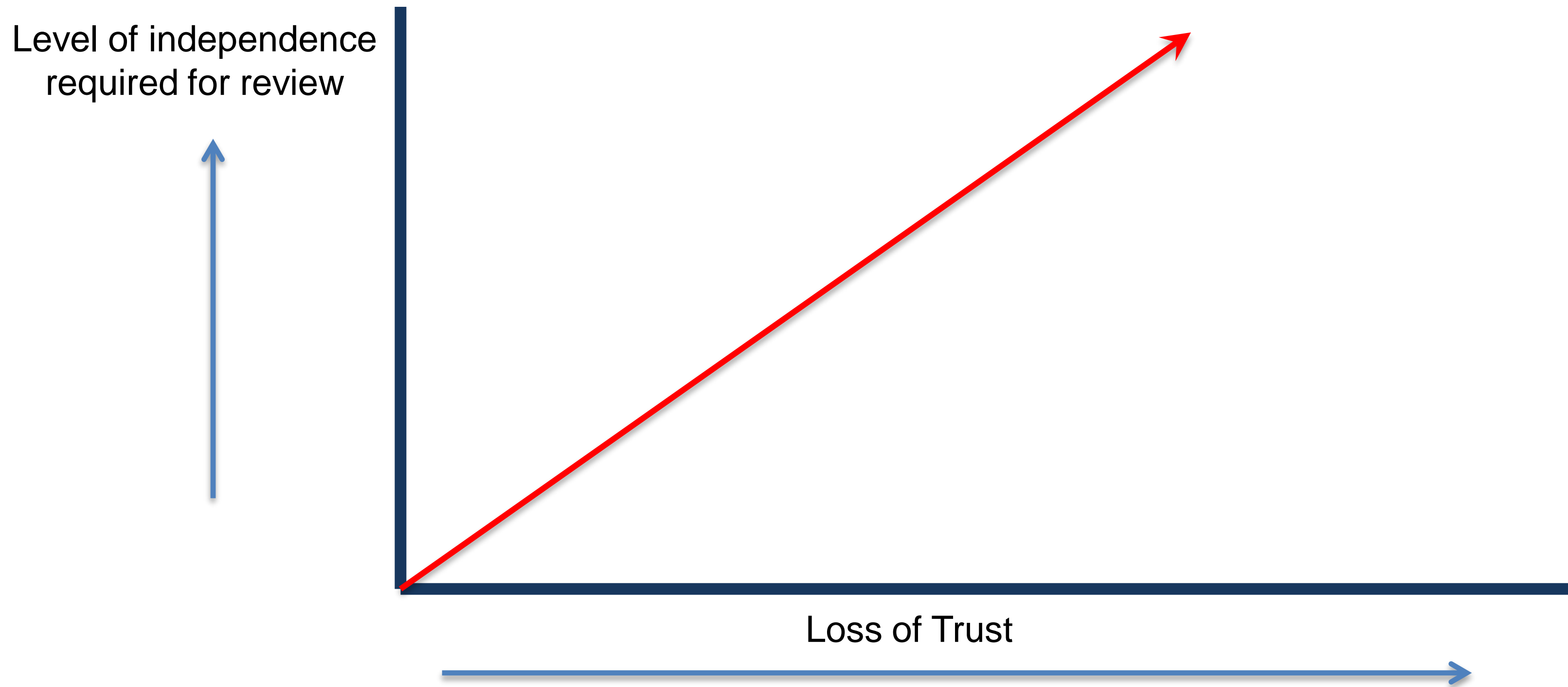
Staff are the ‘second victims’ and can suffer guilt, shame and a sense of isolation. They need line manages to provide;

- Acknowledgement of the impact of incidents on them
- Immediate support and reassurance
- Information about what happens next
- Identification of who to link for if they need to talk
- Continued support throughout review process including how to access formal support mechanisms e.g. EAP

"An adverse event does not necessarily break down trust between people involved in an incident and the service, rather it is the way a service responds to an incident which does"

Respectful Management of Serious Clinical Adverse Events (Institute for Healthcare Improvement)

Effect of Loss of Trust on the Review Process



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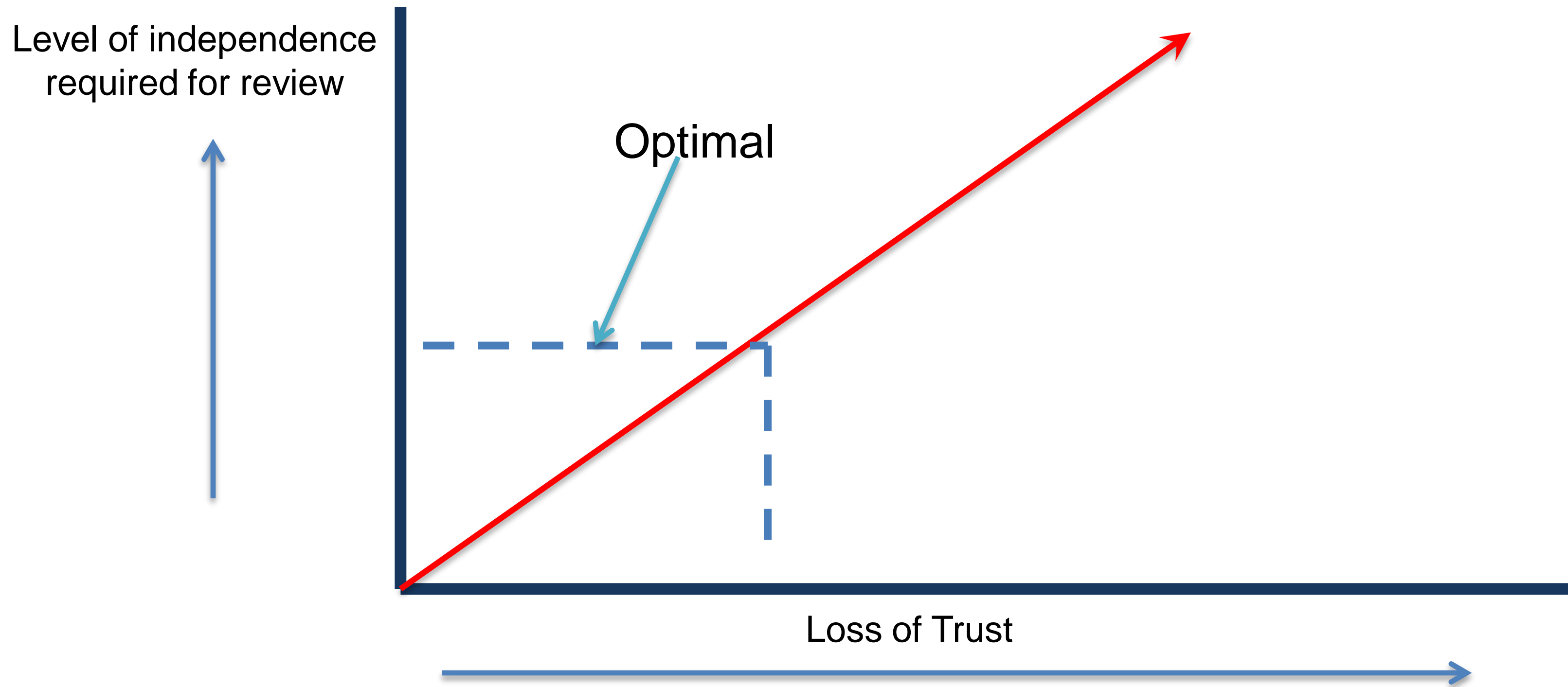

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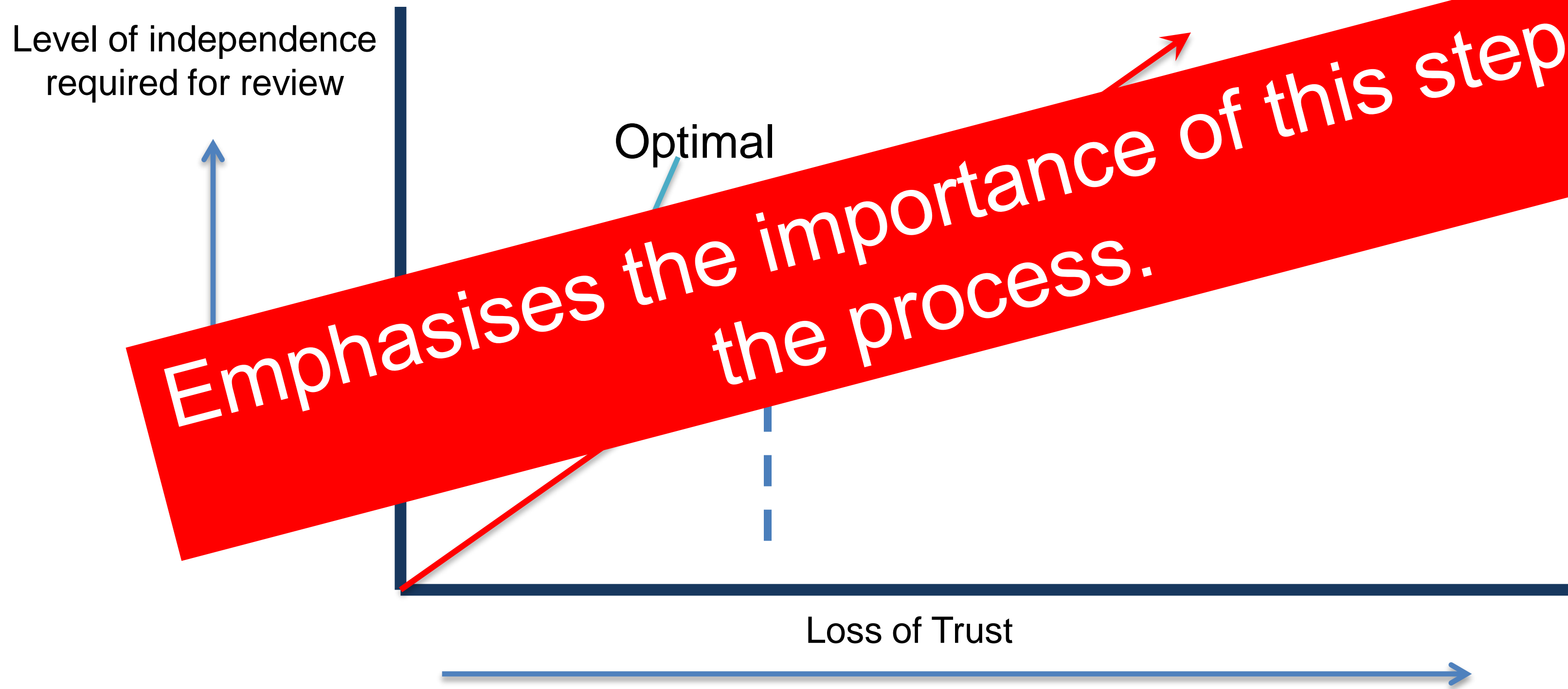

Step 3. Initial reporting and notification

Key Messages

1. Report incidents within 24 hours of their identification
2. Notification of Serious Incidents to the SAO within 24 hours of identification.
3. Report all incidents on the National Incident Management System (NIMS) as soon as possible (using NIRF forms).
4. Meet external reporting requirements within timeframes designated.

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Serious incidents require notification to the SAO within 24 hours of identification.

Step 4. Categorisation and Initial Assessment

Line manager confirms the level of harm relating to the outcome of the incident.

The level of harm informs the categorisation of the incident.

Incidents are categorised as follows:

1. **Category 1 Major/Extreme**
2. **Category 2 Moderate**
3. **Category 3 Minor/Negligible**

Step 4. Category 1 Incidents and SREs

• Category 1 Incidents

- Must be notified to the SAO within 24 hours
- Referral to SIMT for decision making in relation to review
- Governance of Category 1 incidents remains with SIMT until process complete
- All SIs require priority inputting on NIMS and if the SI is also an SRE this must be identified on NIMS .

• Serious Reportable Events

- Where an SRE results in a Category 1 outcome it follows the process of for Category 1 incidents.
- Where an SRE does not result in a Category 1 outcome it does not require referral to SIMT for decision making in relation to review but decisions not to review must be documented and ratified by the QPS Committee.
- All SRE's require identification on NIMS and priority inputting.

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- not result in a Category 1 it does not require referral to SIMT for decision making in relation to review but decisions not to review must be documented and ratified by the QPS Committee.
- All SRE's require identification on NIMS and priority inputting.

Decisions relating to the review of SREs which are not Category 1 incidents are generally made by the QPS Advisor in conjunction with the Local Manager

Decisions to be made by the SIMT

Based on information provided and discussions at the SIMT a decision is taken whether a review is required?

If it is decided that a review **is required** the following decisions are taken,

- Level of Review
- Approach to Review
- Level of Independence attaching to the Review process

If it is decided that a review **is not required** the decision must be ratified by the QPS Committee

SIMT decisions in relation to review must be communicated back to the service in which the incident occurred.

Levels and Approaches to Review

Level of Review	Approaches to Review
Comprehensive	1. Systems Analysis (Review Team Approach) 2. Systems Analysis (Review Panel Approach)
Concise	1. Systems Analysis (Facilitated Multi-Disciplinary Team Approach) 2. Systems Analysis (Desktop Approach) 3. Incident Specific Review Tool e.g. Falls and Pressure Ulcers 4. After Action Review
Aggregate	1. Systems Analysis (Aggregate Approach)

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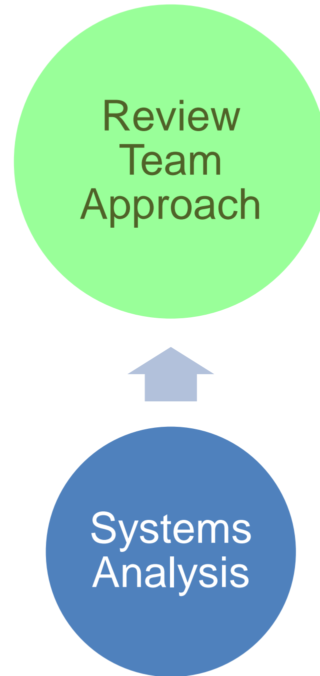
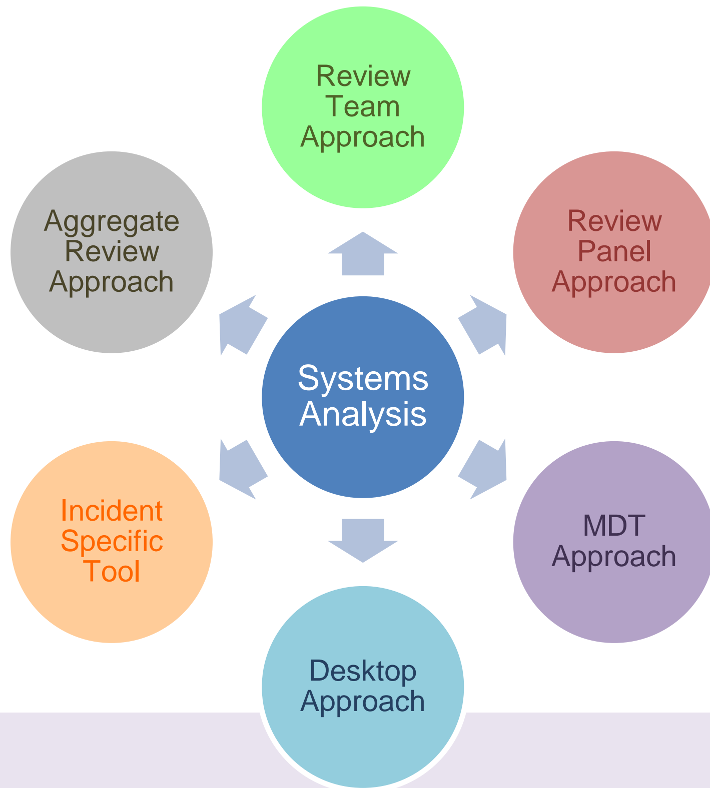
Concise	1. [illegible] Disciplinary Team Approach) [illegible]p Approach) [illegible] Review Tool e.g. Falls and Pressure Ulcers [illegible] Action Review
[illegible]	1. Systems Analysis (Aggregate Approach)

Introduction of Approaches to and Levels of Review allows for a more proportionate and timely response

Application of Systems Analysis – Prior to the Incident Management Framework



Application of Systems Analysis in the Incident Management Framework



All approaches are underpinned by systems thinking and a systems analysis approach

After Action Review

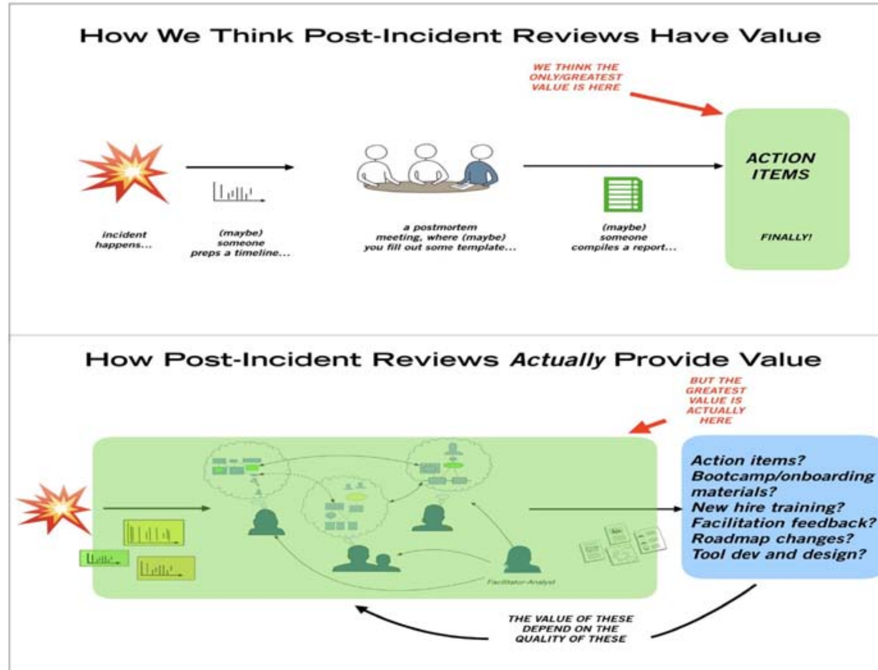
An After Action Review (AAR) is a structured, facilitated discussion of an event which focuses on 4 Questions

- What did you expect to happen?
- What actually happened?
- Why was there a difference?
- What have we learnt?

In the context of incident management it can be used to de-brief staff in the aftermath of a Category 1 incident or as a review approach in Category 2 & 3 incidents.

Simulation based training developed in collaboration with University College Hospital London and the Institute for Leadership RCSI.

Emphasis on a multidisciplinary involvement in the review process



MDT involvement a key feature of:

- Review Panel Approach
- Multidisciplinary Team Approach
- Incident Specific Review Tools
- After Action Review

Step 5. Review and Analysis

Failure to correct systems issues will result in them failing again.

- Safety management is underpinned by **learning** and **improvement**.
- Review must be undertaken in a **systematic** and **structured** way which looks beyond the particular incident.
- The process must be :
  - **Supportive**, **Open** and **Fair**
  - Follow the principles of **natural justice** and **fair procedures**.
- Review must identify **both** the things that could be improved with the areas of good performance.
- It should **not** be viewed as a **negative process**.

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Re-emphasis on the purpose of review i.e. providing those harmed with answers and learning for the service

Quality Assuring Review Reports prior to their Finalisation

The process seeks to ensure that

- The scope and process applied was in line with the terms of reference.
- The process conformed with the principles of fair procedures and natural justice.
- There are clear linkages between the findings and the recommendations made.
- The recommendations are SMART.

The purpose is one of assuring quality to enable closure and support the implementation of recommendations rather than to question the findings of the review.

Step 6. Improvement Planning and Monitoring

Key messages

1. An improvement plan should be developed to take account of the actions required to implement recommendations arising from a review

2. A 'master' improvement plan should be in place within a service to enable the effective monitoring of actions identified from a range of sources

3. Reports relating to thematic learning should be collated to assist and inform the wider service improvement programmes

Next steps

- Our commitment
  - Identify support needs by engaging through divisions
  - Tailor response
  - Develop training, guidance and tools

- What we need from you
  - Consistent and compassionate leadership
  - Reflect and discuss with your colleagues and teams
  - Consider changes that might be needed
  - Work with us on implementation plan

- Launch of service user falls and pressure ulcer review guides
- Revised systems analysis guidance
- Training – online / systems analysis / AAR
- Videos – staff and service user
- Engagement – service users, CHOs and hospital groups

Discussion