ARE YOU JUST REPORTING INCIDENTS?

OR ARE INCIDENTS AN INTEGRAL PART OF YOUR GOVERNANCE, RISK MANAGEMENT, SAFETY AND CONTINUOUS IMPROVEMENT SYSTEMS?

Incident management underpins clinical governance and overall organisational governance, and is an essential part of continuous improvement strategies.

The Aged Care Quality and Safety Commission defines an incident as 'any acts, omissions, events or circumstances that occur in connection with the provision of care to a consumer and have (or could reasonably have been expected to have) caused harm to a consumer or another person (such as a staff member or visitor to the service)'.

Most organisations also include incidents that negatively disturb operations and impact the organisation (e.g. theft, property damage) to support a comprehensive system that limits the different forms that need to be completed and therefore increase the likelihood that incidents will be reported.

Incident reporting does not end there. It is about identifying areas of concern or areas for improvement, determining what you are trying to prevent or improve, and developing a measurable plan of action.

Incident management is constantly evolving, and should be happening on a regular basis, as a pre-emptive tool for quality improvement.

So, what makes an effective incident management system?

1. **Establish clear policies.** Provide simple policies, procedures, flowcharts and work instructions that guide organisational practices, designed in a way that encourages them to be followed.
2. **Keep IT user-friendly.** If using an IT system, it needs to support ease of use and access so that all staff can log incidents, otherwise incidents can get missed or not be reported in a timely manner. Your team shouldn't need to be tech savvy to use the system. It's hard enough to find good employees; don't create another hurdle to the recruitment and retention process.
3. **Provide training.** Training is crucial for effective governance. It needs to be a simple and comprehensive part of orientation and induction, and there should be ongoing training. A system that isn't used, just isn't any good.
4. **Document everything.** Document how open disclosure principles were applied, by whom and with whom; this is an ongoing process. Who has been notified, when, how and by whom? What happened from these notifications?
5. **Communicate.** Decide in advance how staff and other stakeholders will be notified, while maintaining privacy of those involved as appropriate to the incident and notification.
6. **Investigate.** Investigation of individual incidents and completion of a root cause analysis will help inform future practices. Construct a chronology of what happened, including what may have contributed to the incident, clearly identifying immediate factors.
7. **Develop a plan.** This may be reviewing the consumer's care plan, a performance improvement plan for staff, or adding items to a preventive maintenance schedule. To do this, firstly develop a problem statement, that is, be clear about what are you trying to prevent. There are a variety of problem solving tools you can use to help you do this, and asking the following questions can help:
   - What is the realistic outcome you want? (In relation to individual and organisational risks.)
   - What are the barriers to reaching the outcome?
   - Is remedial action required? (Could the incident have been prevented or the harm minimised?)

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8. **Make it measurable.** The individual plan is about what can be done or put in place to overcome the barriers to achieving the desired outcome, and is measurable. The plan needs to be closely monitored and adjusted according to how effective it is.
9. **Analyse and report.** Report incidents to the appropriate governance committee, and analyse them to identify trends.
10. **Continuously improve.** Develop measurable plans for addressing trends and reporting on the progress and effectiveness of the actions taken to the governance committee.

So, next time you're looking at incident reports, keep in mind why the system is in place and what you want to achieve.

Ultimately, there are enormous benefits for the individuals involved, for the systems and outcomes of the business, and for the quality of care and services provided.

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