Health Care Consumers' Association Inc
100 Maitland Street
HACKETT ACT 2602
Phone: 02 6230 7800
Fax: 02 6230 7833
Email: adminofficer@hcca.org.au
ABN: 59 698 548 902

Sharon Swain
Risk and Incident Management Team Leader
Quality and Safety Unit
ACT Health Directorate
sharon.swain@act.gov.au

20 April 2012

Dear Ms Swain

Re: Draft Significant Incident Reporting policy documents

The Health Care Consumers' Association of the ACT (HCCA) welcomes the opportunity to comment on the revised Significant Incident Reporting policy documents.

HCCA was formed over 30 years ago to provide a voice for consumers on local health issues and now provides opportunities for health care consumers in the ACT to participate in all levels of health service planning, policy development and decision making.

Overall, the documents are strong policy tools and HCCA welcomes the commitment to open disclosure that these policies and Standard Operating Procedures (SOPS) contain. However, there are several changes that could be made in order to enhance the effectiveness and appropriateness of the documents.

Language

The policies and SOPS must be accessible and clearly understandable for front-line staff dealing with these incidents. The language should be in plain English so as to facilitate the easy adoption of the policy. On page 4 of the draft Significant Incident Reporting Policy, HCCA suggests that the definition of a dangerous incident be changed to "[a]n incident in relation to a workplace that exposes a worker or any other person to a serious risk to a person's health or safety *as a result of*" (emphasis added) the following list of circumstances". On the same page, the use of word "plant" is confusing and requires clarification. Furthermore, it is unclear where consumers awaiting treatment/medical attention fit in. There was also some inconsistency in the use of definitions within the documents – some definitions were

listed in an appendix while others were included in the body of the policy. For the sake of uniformity, one approach to defining key terms should be adopted. Page 8 identifies "service is degraded" as a result of a major incident in the Business Process & Systems of the Health Directorate –it would be helpful to explain this in more detail. In the section on Sentinel Events in the draft Significant Incident Reporting Policy, it is important to include consequences of serious incidents apart from death; for example, the Policy should recognise other adverse effects suffered by consumers through medication and procedural errors. The Policy recognises that these outcomes are "unnecessary" but must also acknowledge that they are highly undesirable – for both consumers and health service providers.

Omissions

In the section within the policy on related policies and legislation, HCCA feels that it is very important to include references to the Human Rights Act, the Consumer Feedback Management Policy and the Charter of Health Care Rights which are all key pieces of legislation and governance and have strong links to the work outlined in these draft policies. In particular, there appears to be little integration with the established consumer feedback process and it remains unclear how the Significant Incident Reporting mechanism relates to the work of the Consumer Feedback and Engagement Team. In addition, the relevant Key Performance Indicator references in the section on evaluation should be discussed earlier in the document so that the connections with the evaluation strategy are made clear. While the policy demonstrates a commitment to open disclosure and the issuing of an "expression of regret", the term "apology" is lacking. HCCA understands the potential implications of this term, but if a culture of open disclosure is to be truly fostered, the taboo around this word in the delivery of health services needs to be removed. The process of open disclosure would also be enhanced by the provision of the current *and* future consequences of the significant incident.

Reporting

While the document requires that reporting of incidents be "objective" and free from "causal statements", HCCA suggests that it would also be appropriate to include that reports be free of value judgements, in order to ensure the highest possible level of front-line staff comprehension. The timeframes for reporting during the investigation of incidents raised some concerns with consumers. The 45-day gap between the initial report and the "by exception only" interim report is a long period without official communication. While 100 days is noted as the timeframe for the delivery of the final report, some guidance on the average timeframe might enhance understanding in this section. For example, some information regarding whether most final reports are issued before an interim report is even required, i.e. before 45, would be useful to readers of the policy. Interaction between different agencies with regard to reporting and providing responses to those affected by significant incidents was not fully explained. When appropriate, interagency coordination is important in order to develop the most comprehensive response to the incident. If there is a specific policy governing this, it would be useful for it to be mentioned within this policy document.

I strongly encourage you to take on board this consumer feedback to ensure that these policies are as effective as possible.

Yours sincerely

Darlene Cox
Executive Director
Health Care Consumers' Association