

---

# Disability Services Adverse Events Policy

---

March 2007

---

## Context Statement

---

The Disability Services Adverse Events Policy have been developed to assist key stakeholders in understanding the linkages, roles and processes to enable the effective management of all adverse events. The effective management, reporting and monitoring of adverse events by disability service providers requires the commitment and involvement of all, including Disability Services Division (DSD), regional and disability service providers executives; managers; staff and people with a disability.

DSD is committed to an effective integrated approach to the management and reporting of adverse events involving people with a disability receiving services and supports from disability service providers. The Departmental Service Excellence Framework (SEF) reinforces that quality is a core Departmental value by putting into practice *continuous quality improvement of all service activities*.

This involves promoting a learning culture, and identifying needs and opportunities for improvement in a systematic and planned way. It involves progressively increasing value to clients and other stakeholders through changes designed to better meet their needs and preferences.<sup>1</sup> The SEF comprises eight categories, which reflect operational management in the DHS context, they are:

- Leadership
- Effective Communication
- Service Integration
- Client Outcomes
- Strategic Management
- Knowledge Management
- Workforce
- Partnerships<sup>2</sup>.

Within this context, DSD has a commitment to the management of adverse events within a quality framework and to use information on adverse events productively to improve the quality, safety and accessibility of disability services.

The Standards for Disability Services in Victoria are an integral part of the Adverse Events Policy, specifically *Freedom from Abuse & Neglect* and *Complaints & Disputes* Standards. This policy has been developed to assist key stakeholders in understanding the linkages, roles and processes to enable the effective management of adverse events.

It is important to note that effective management, reporting and monitoring of adverse events by disability service providers requires the commitment and involvement of all. Including

---

<sup>1</sup> KnowledgeNet Service Excellence Framework [http://intranet\\_2.csv.au/operations/serviceexcellence/](http://intranet_2.csv.au/operations/serviceexcellence/)

<sup>2</sup> The Service Excellence Framework (SEF), General Information. 'We always strive to do our best and improve the way we do things'

DSD, regional and disability service providers executives, managers, staff and people with a disability.

Please note this policy is complementary to DHS policies in relation to incidents, complaints and significant/serious events. It does not replace these processes.

---

## **Definitions**

---

### **Adverse Event**

Is an event that leads to negative consequences for individuals and/or groups directly or indirectly attributable to the service intervention. The apparent cause of an adverse event may be direct professional error or an alignment of service management issues<sup>3</sup>.

Adverse events information is collected from a variety of sources including Ombudsman and other Statutory bodies enquires or investigations, incident reports, notifications from the National Disability Abuse and Neglect Hotline and complaints.

### **Complaint**

A registered expression of dissatisfaction with any departmental service, which includes provided, funded or regulated services. It must relate to a specific occurrence or episode (including non-delivery of a service) that has had a significant impact on the individual complainant or a group.<sup>4</sup>

The complainant can be a person with a disability, family, friend, carer, staff member, an advocacy service or general member of the public.

### **Incident**

An unplanned event or near miss resulting in or having the potential for injury, damage or other loss to clients, staff or members of the public that occurs at a service or during service delivery<sup>5</sup>.

### **Notification**

Notification refers to information received from the National Disability Abuse and Neglect Hotline in the context of disability service provision.<sup>6</sup>

---

<sup>3</sup>Quality in Services Framework, Department of Human Services 2002.

<sup>4</sup> Glossary of Complaint Terms, Department of Human Services Portfolio Services, Corporate Complaints Unit 2006

<sup>5</sup> Australian Patient Safety Foundation cited in NSW Health Department. The Clinician's Toolkit for Improving Patient Care. 2001.

<sup>6</sup> Statement of Roles and Responsibilities, National Disability Services Abuse and Neglect Hotline and Disability Services Division, 2006.

## **Risk Management**

Risk management encompasses a set of processes for systematically identifying and evaluating risks that may impact on service delivery. This includes strategies to manage, monitor and review risk management strategies.<sup>7</sup>

## **Root Cause Analysis**

Is a systematic process whereby the factors that contributed to an incident/adverse event are identified to prevent reoccurrence.<sup>8</sup>

---

## **Application of Policy**

---

This policy has been developed by the Disability Services Division to promote quality outcomes and provide a useful framework to the disability services sector to inform the management of adverse events.

This policy integrates with other DHS policies and procedures for managing an adverse event. Departmental policies, procedures, legislation and standards override this policy where response requires legal and/or disciplinary action.

---

## **Objectives**

---

The objectives of this policy are to:

1. Provide a clear, just and accessible policy in which all staff assume responsibility for managing adverse events.
2. Recognise, promote, empower and protect the rights of people with a disability.
3. Ensure the appropriate response and management of adverse events occurs with the assistance of a risk management matrix. (Please refer to attachment 1)
4. Ensure that all staff are supported to adequately manage emerging risks and identify quality improvements using a risk management approach.
5. Improving the quality of service delivery through the collection of adverse events data.

---

## **Authority**

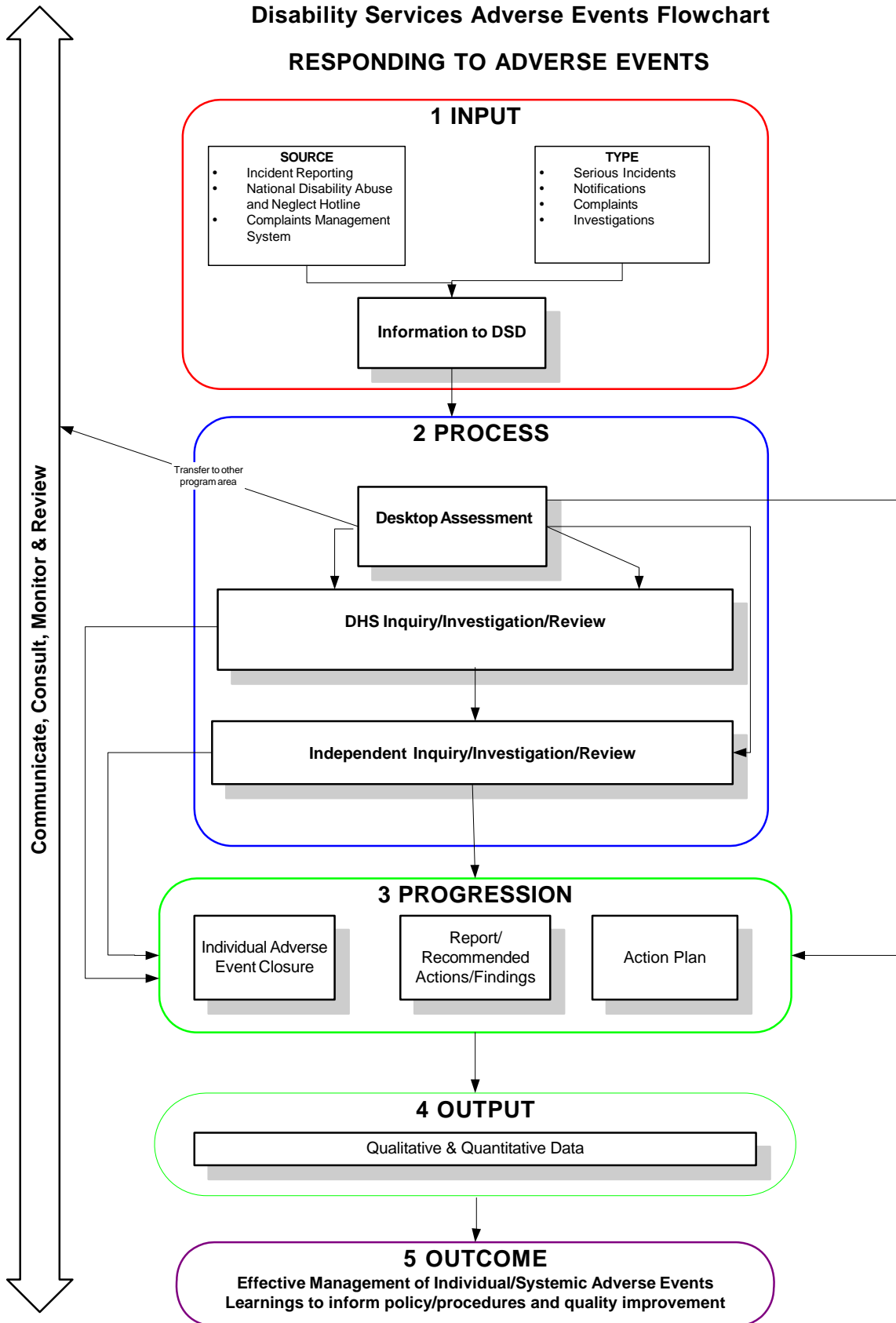
---

This policy statement is issued in accordance with the powers provided until July 2007 to the Secretary of DHS under the Intellectual Disability Persons Services Act 1986 (IDPSA) and the Disability Services Act 1991 (DSA). The Disability Act 2006 effective from July 2007 will replace the IDPSA and the DSA. This policy aligns with the Disability Act 2006 and will remain effective under this Act.

---

<sup>7</sup> Risk Management Framework, Department of Human Services August 2004; 1

### Disability Services Adverse Events Flowchart RESPONDING TO ADVERSE EVENTS



---

## Key Procedural Elements

---

The first priority when an adverse event is identified is an assessment of the severity and impact of the event on individual/s involved. It may be necessary to take prompt and appropriate action to ensure that harm is minimized to the person involved or to prevent further harm. Please refer to the relevant DHS documents such as the Incident Reporting: Departmental instructions September 2005; Responding to allegations of physical or sexual assault: Departmental instructions August 2005 and so on.

An adverse event may be identified by:

- A person affected by the event
- A staff member at the time or post the event
- When an unexpected outcome has taken place
- When there is expressed dissatisfaction with the service/care provided
- Through the incident reporting system
- As the result of detection by carers, family, advocates, friends or visitors to the service.<sup>9</sup>

The procedures to be applied for adverse events consists of the following key elements:

- 1. Input - Management and reporting of individual adverse event.**
- 2. Process - Desktop assessment, investigation or review of adverse event.**
- 3. Progression - Report, Findings, Action, Closure.**
- 4. Output – Qualitative and quantitative data analysis.**
- 5. Outcome – Quality improvement.**

*Refer to flowchart for overview of process.*

### **1. INPUT - MANAGEMENT & REPORTING OF INDIVIDUAL ADVERSE EVENTS**

The input is the referral source (Incident Report, Notification, Complaint, Ombudsman, Coroner or other statutory body) and the type of event that has occurred. The input information is to be coordinated at a state-wide level by the Quality and Sector Development branch (QSD) DSD.

---

<sup>8</sup> Victorian Government Health Information, Clinical Risk Management, Quality and Safety Branch, Rural and Regional Health & Aged Care Services Division, <http://www.health.vic.gov.au/clinrisk/sentinel/rca.htm>

<sup>9</sup> Australian Council for Safety and Quality in Health Care, Open Disclosure Standard: A national standard for open communication in public and private hospitals, following an adverse event in health care. July 2003; 16

## **2. PROCESS**

### **2.1 Desktop assessment of an Adverse Event**

Adverse events are assessed:

- To determine the seriousness using departmental instructions, policies and tools such as the Risk Management Matrix
- To guide the response and management of the current event
- Against historical information such as previous management/frequency of adverse events.

The responses to, and the management of, an adverse event will be based on Departmental policies and practice instructions consistent with the Department's duty of care and the obligations associated with the provision of quality services for people with a disability.

DSD staff have a role in reviewing reoccurring, significant and/or severe, intractable and systemic issues contributing to an adverse event, to ensure that appropriate follow up takes place.

### **2.2 Investigation or Review of Adverse Event**

The level of investigation or review is guided by the risk assessment and the desktop assessment. For internal services a briefing or email response is sought. The initial contact includes an action or investigation plan. This response should identify any proposed or implemented actions, timelines for completion, evidence to support the response where available and nominated contact person (and where appropriate the individual / group affected by / concerned in the adverse event) for further information.

### **2.3 Contracted and/or External Investigation**

Subsequent to a desktop assessment or as a result of a preliminary investigation, a contracted investigator may be commissioned. A contracted investigator is an organisation/individual engaged by DHS to carry out an impartial and independent investigation within a quality assurance framework.

The Director, Quality and Sector Development Branch, Disability Services (QSD) or Regional Disability Services Manager and/or the region will be guided in the decision to engage a contracted investigator. This decision will be made based on the significance, severity, and/or reoccurrences of the issue/incident or where potential for corrective action has not been or will not be deemed successful.

### **3. PROGRESSION - REPORTS, FINDINGS, ACTION PLAN, CLOSURE**

Individual events can be closed when management and/or external statutory agency are satisfied that all reasonable steps have been taken to finalise the matter, prevent recurrence, or an appropriate root cause analysis has taken place and the issue has been rectified.

Once the investigation is complete a final report or briefing is undertaken (refer to the Incident Reporting: Departmental Instruction September 2005) identifying the findings and any ongoing issues. Once the parties or party involved with the adverse events are satisfied that and outcome/resolution has occurred or avenues for rectification have been exhausted the matter can be closed.

### **4. OUTPUT – QUALITATIVE & QUANTITATIVE DATA**

The aim of collecting data is to inform the direction of and measure the impact of quality improvement initiatives across disability services. Any system improvement and/or changes recommended should be monitored and tracked for the effectiveness in preventing recurrence<sup>10</sup>.

### **5. OUTCOME – QUALITY IMPROVEMENT**

Data will assist to provide reliable status reports on adverse events to the relevant stakeholders and to cross check with regional data through a sustainable quality improvement cycle. This will incorporate the analysis and feedback on adverse events at program, regional and service provider levels, and consider cross program and systemic issues. This report will influence the ongoing development and review of the current operational processes and practices, as a response to and management of individual or systemic adverse events.

The DHS has an obligation to participate in ongoing monitoring and review of the remedial strategy or action plan to ensure quality outcomes for people with a disability. Please refer to the Incident reporting: Departmental instructions (September 2005). It is the responsibility of the region to ensure that the appropriate monitoring and corrective action is implemented (if applicable). The recording, management and root cause analysis of adverse events will provide information that will be utilised to inform policy/procedure/practice improvements.

It is the responsibility of the QSD to monitor the implementation of corrective action stemming from high and critical events deemed of systemic or statewide relevance.

---

<sup>10</sup> Australian Council for Safety and Quality in Health Care, Open Disclosure Standard: A national standard for open communication in public and private hospitals, following an adverse event in health care. July 2003; 28

## **ADVERSE EVENT MANAGEMENT FOR COMMUNITY SERVICE ORGANISATIONS**

In relation to Community Service Organisations (CSOs), the *'Monitoring framework for the health, housing and community service sector': Guidelines for departmental staff August 2005* provide appropriate assurances for the department on an organisation's performance and sustainability by:

- Working jointly with organisations to improve performance where necessary
- Formalising monitoring requirements
- Improving monitoring consistency and communication across the department's regions and divisions
- Using risk management principles for early detection of potential problems.

The desktop assessment for CSOs is to be managed according to Section 6 (Desktop Review) of the framework<sup>11</sup>. Such a review should be activated outside of the annual review cycle in circumstances where there are significant concerns regarding the management/frequency or severity of adverse events. A Regional Disability Services Manager can recommend the review, outside of the annual cycle.

---

### **Roles and responsibilities**

---

It is the responsibility of all staff to recognise, protect and promote the rights of people with a disability.

#### **Region:**

- Encourage an environment of efficient, fair and accessible complaints handling
- To have and maintain a complaints handling system
- To have information available and accessible on complaints and external complaints handling body.

#### **Disability Services Division:**

- Provide a single point of contact – Quality and Sector Development Branch
- Ensure the proper process for managing complaints is followed.

---

### **Delegations**

---

Adverse events should be managed at the local level according to the organisational/regional management structure and escalated to QSD, DSD when an issue cannot be resolved or is systemic in nature.

---

<sup>11</sup> Monitoring framework for the health, housing and community services sector, Department of Human Services, August 2005.

---

## **Related Legislation, Standards, Policies and Procedures**

---

The related policies, procedures and legislation for adverse events include:

### **RELATED LEGISLATION AND STANDARDS**

- Disability Services Act 2006 (operational July 2007)
- Intellectual Disability Persons Services Act 1986 (IDPSA) (To be repealed July 2007)
- Disability Services Act 1991 (DSA) (To be repealed July 2007)
- Victorian Managed Insurance Authority (VMIA) Act (1995)
- Information Privacy Act 2000
- AS/NZS 4360 – 2004, Risk Management
- AS ISO 10002 –2004, Australian Standard – Customer satisfaction – Guidelines for complaints handling in organisations. (ISO 1002:2004, MOD)
- ISO 10002 –2004, Quality management – Customer satisfaction – Guidelines for complaints handling in organisations
- Whistleblowers Protection Act 2001
- Service Agreement, Department of Human Services
- Health Information Act 2001.

### **RELATED DHS POLICIES AND PROCEDURES**

- DHS Duty of Care, Legal Services, January 2006
- DHS Incident Reporting Departmental Instruction, September 2005
- DHS Policy Responding to Physical and Sexual Assault, August 2005
- DHS Risk Management Framework (DHS only) February 2004
- DHS Complaints Handling Principles, June 2006
- DHS Services Quality Framework 2005
- Code of Conduct for the Victorian Public Sector, August 2003
- DHS Privacy Policy, June 2002
- DHS Monitoring Framework for the health, housing and community service sector. October 2005.

### **RELATED DISABILITY SERVICES POLICIES AND PROCEDURES**

- Victorian State Disability Plan 2002-2012
- Disability Services Ombudsman Procedures October 2006
- Standards for Disability Services in Victoria 2007.

### **RELATED COMMONWEALTH GOVERNMENT POLICIES AND PROCEDURES**

- Abuse Prevention Strategies in Specialist Disability Services, Final Report, National Disability Administrators January 2002
- DHS and National Disability Abuse and Neglect Hotline Roles and Responsibility Statement May 2006.

---

## **Contacts**

---

Should there be any questions regarding this policy:

DHS staff please contact -

Director, Quality and Sector Development Branch, Disability Services on 9096 7508.

CSO staff please contact -

The agency assigned Regional Program and Service Advisers.

---

## **Approved**

---

Executive Director, Disability Services Division:

Date:

## Risk Management Framework

For further information please refer to the *DHS Risk Management Framework 2004* for the Department of Human Services. The departmental framework has been developed from the Australian Standard AS/NZS 4360 – 2004.

Please note it is departmental policy to apply a consistent and comprehensive framework to the management of risk.

Provided below is a broad overview of the Risk Management Framework.

---

### Key Definitions

---

#### Likelihood-

- Used as a general description of probability or frequency.

#### Consequence-

- Outcome or impact of an event.

#### The decision making process

- 1 Collect all immediately available information about an adverse event to undertake a desktop review.
- 2 Use the likelihood table to assess how often this event is likely to occur or recur.
- 3 Use the consequence table to assess the seriousness of any loss or potential loss.
- 4 Use these values to determine the risk exposure related to the adverse events, which will determine type of reporting required (for example Incident Reporting, referral to Police, Victorian Managed Insurance Authority).

**Table 1: Likelihood of Risk<sup>12</sup>**

Level	Description
Almost certain	Is expected to occur in most circumstance
Likely	Will probably occur in most circumstance
Possible	Should occur at some time
Unlikely	May occur at some time
Rare	May occur in exceptional circumstance

---

<sup>12</sup> Table adopted from the Likelihood of Risk Table 2, Risk management framework for the Department of Human Services (2004) page 20.

**Table 2: Risk exposure matrix<sup>13</sup>**

		Consequences				
		Negligible	Low	Moderate	Major	Extreme
Likelihood	Almost certain	High Risk	High Risk	Critical Risk	Critical Risk	Critical Risk
	Likely	Medium Risk	Medium Risk	High Risk	Critical Risk	Critical Risk
	Possible	Low Risk	Medium Risk	High Risk	Critical Risk	Critical Risk
	Unlikely	Low Risk	Low Risk	Medium Risk	High Risk	Critical Risk
	Rare	Low Risk	Low Risk	Medium Risk	High Risk	High Risk

### Critical Risk

- Immediate action required, Regional root cause analysis and review should be commenced
- Immediately consider possible practice implications
- Central Office involvement and leadership in root cause analysis and review
- Consider input to quality management processes
- Consider independent review
- Consider briefing requirements as necessary
  - Minister, Community Services
  - Executive Director, Disability Services
  - Regional Director
  - Executive Director, Operations
- Consider involvement of other statutory bodies/jurisdictions (eg Police, Coroner, Ombudsman, Courts).

### High Risk

- Senior management (*at Region or Central Office*) to determine extent, methods and timeframes for root cause analysis, investigation or review
- Central Office may advise root cause analysis and review
- Consider input to quality management processes
- Consider independent review
- Consider briefing requirements as necessary
  - Executive Director, Disability Services
  - Regional Director
- Immediately consider possible practice implications
- Consider involvement of other statutory bodies/jurisdictions (eg Police, Coroner, Ombudsman, Courts).

<sup>13</sup> Table adopted from the Likelihood of Risk Table 2, Risk management framework for the Department of Human Services (2004) page 20.

### Medium Risk

- Local Management (*at Regional Office*) to determine extent and timeframes for root cause analysis, investigation or review
- Consider input to quality management processes
- Consider briefing requirements as necessary
  - Executive Director, Disability Services
  - Regional Director
  - Regional Management

### Low Risk

- Manage through routine procedures
- Review through quality management processes
- Consider briefing requirements as necessary
  - Regional Management