Government of **Western Australia**
Department of **Health**

SAC 1 clinical incident investigations

Roles and responsibilities

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Contents

Introduction

The purpose of investigating clinical incidents is to establish the factors that may have contributed to the incident occurring, and to identify actions that can be taken to reduce the possibility of the incident occurring again thereby preventing harm to other patients.

In WA, the Clinical Incident Management Policy[1] (MP 0122/19; CIM Policy) requires all clinical incidents classified as Severity Assessment Code 1 (SAC 1) to be investigated using Root Cause Analysis (RCA) or another technique that has a similar rigorous methodology to identify the contributing factors via a systems-based approach. These investigations are required to be completed within 28 working days of the SAC 1 clinical incident being notified to the Patient Safety Surveillance Unit (PSSU).

Further information about some of these investigation methods can be found in section 4.1 of the Clinical Incident Management Toolkit.[2] Throughout this document the generic term 'SAC 1 investigation' is used to refer to all investigations into SAC 1 clinical incidents, irrespective of the specific approach or methodology that is employed.

The purpose of this document is to provide core information and guidance that Health Service Providers (HSPs) can tailor to their local context to assist staff involved in SAC 1 incidents and investigations about the attributes of effective clinical incident investigation processes, and their roles and responsibilities within the process. This document should be used in conjunction with the CIM Policy, Guideline and Toolkit, and the Guideline for the Investigation of Multi-Site clinical incidents.

SAC 1 investigation principles

The intent of all SAC 1 investigations can be broadly summarised as seeking to identify what happened, why it happened, and what can be done to prevent it happening again. In order to be effective in delivering sustainable improvements in the delivery of health services, all SAC 1 investigations should follow the principles for clinical incident management set out in section 1 of the Clinical Incident Management Guideline.[3]

Of particular importance are the principles of:

- **Patient centred care:** The patient and their family who are associated with the incident are asked to contribute to the CIM process as appropriate, particularly during the investigation. Outcomes of an investigation are shared and communicated openly.
- **Transparency:** Full and open communication occurs as part of clinical incident management. As appropriate, patients, staff and visitors notifying clinical incidents will receive feedback on findings of any investigation and preventative actions carried out.
- **Open 'just' culture:** The analysis and investigation of clinical incidents focuses on identifying and correcting underlying system problems rather than individual actions. The workforce is supported when systems break down and errors occur.
- **Probity/Fairness:** Staff and patients involved in clinical incidents will be entitled to fair treatment. Analysis of an incident focuses on what happened, why it happened and how it can be prevented from happening again.

It is also important that staff understand they have a duty to take reasonable care to avoid harm to patients, staff and visitors, and that the individuals involved in a clinical incident understand that should an investigation identify professional performance concerns that these will be considered outside of the incident investigation process. The investigation of SAC 1 clinical incidents must not be used as a method to investigate staff misconduct. If an element of misconduct is suspected the SAC 1 investigation team should refer the matter to the relevant area so it can be addressed using the appropriate management and governance processes. The SAC 1 investigation should continue separately to any misconduct processes unless the SAC 1 investigation team is advised to cease the investigation, including in circumstances where suspected criminal activity is identified.

Staff involved in or investigating SAC 1 clinical incidents should also be mindful that while the investigation process should be treated as confidential by the organisation, there is no privilege associated with the investigation process and information related to SAC 1 investigations may be subject to release under the *Freedom of Information Act 1992*[4] (FOI Act). Information related to SAC 1 clinical incidents where the patient died may also be provided to the State Coroner under the provisions of the *Coroners Act 1996*.[5] In summary the incident investigation is not protected by qualified privilege and may be subject to Freedom of Information, legal discoverability or may be accessible to the Coroner.

The principles of patient centred care and transparency are also fundamental to the Open Disclosure[6] process, and staff should expect that the details of a SAC 1 incident, and the findings of SAC 1 investigations will be shared with the patient and/or their family.

The SAC 1 investigation team

When a SAC 1 clinical incident occurs, the investigation into the incident should commence as soon as possible. Having staff trained in the organisation's SAC 1 investigation processes and able to participate at short notice will ensure that the SAC 1 investigation team can be formed, and the investigation begun in a timely manner. The SAC 1 investigation team may also be referred to as a 'panel' within some organisations.

The National Patient Safety Foundation[7] (NPSF; USA) recommends that the investigation team should be limited in size to 4-6 members, as larger teams will use more person-hours to complete the investigation, increase the difficulty of scheduling meetings, and reduce the nimbleness of the investigation process.

The SAC 1 investigation team should be assigned by the organisation's senior leadership and include members that collectively have the skills and experience to understand the event process being reviewed and follow the organisation's process for SAC 1 investigations. If available, a staff member with knowledge of human factors in health care should be involved in the investigation.

It is possible that one staff member may have multiple skills/experiences relevant to the investigation being undertaken. It may also be necessary to draw staff from outside the area where the incident occurred, or outside of the organisation, to allow a comprehensive investigation to occur.

When investigating multi-site SAC 1 clinical incidents, each health care organisation that provided care related to the incident should be represented on the SAC 1 investigation team. Please refer to the Guideline for the Investigation of Multi-Site clinical incidents[8] for further information about this.

The SAC 1 investigation team may also include members that can understand and address cultural considerations for Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities.

Staff members appointed to SAC 1 investigation teams must be able to commit to the investigation process including reviewing documentation, attending meetings and providing feedback on the investigation report. Where necessary, members of SAC 1 investigation teams may need to be released from some or all of their regular duties to enable their full participation in investigation meetings and other parts of the process.

Consideration should also be given to including a consumer representative on the SAC 1 investigation team in order to provide a consumer's perspective on the incident and investigation. However, the consumer representative should not represent the patient or family involved in the incident. The patient and their family may instead be interviewed (if willing) as an important part of the SAC 1 investigation process.

Staff directly involved in the incident and their immediate line-managers are not recommended to be included on the SAC 1 investigation team, but it is vital they are interviewed to understand what happened, and to gain their views on potential actions that may help avoid the incident happening again. The NPSF notes that the inclusion of managers/supervisors on the SAC 1 investigation team may lead to staff censoring themselves, thus inhibiting free and open communication.[7]

See Appendix 1 for a table summarising the suggested composition of SAC 1 investigation teams and people that should be interviewed as part of the investigation process.

There are multiple roles within the SAC 1 investigation team. It is important that all team members understand their roles and responsibilities before the first investigation meeting and have received an appropriate level of induction and/or training about the organisation's SAC 1 investigation process. The roles of Chair and Facilitator should be filled by different people.

Chair

The Chair is responsible for ensuring that the SAC 1 investigation process is followed and the work is completed on schedule. The Chair needs to be knowledgeable about the type of incident that has occurred and have a high level of credibility within the organisation. Ideally the Chair will have received training in systems-based investigation methodologies. Good problem solving and communication skills will assist the Chair in delivering an effective SAC 1 investigation.

See Appendix 2 for a more detailed set of roles and responsibilities for the Chair of the SAC 1 investigation team.

Facilitator

The Facilitator should be knowledgeable and experienced in the organisation's SAC 1 incident investigation process and should have been trained in systems-based investigation methods. The Facilitator does not need to have a detailed knowledge of the care processes involved in the incident. They will coordinate and document meetings of the investigation team, and may be responsible for drafting the investigation report. Facilitators are often members of the local clinical risk and/or quality and safety team.

See Appendix 3 for a more detailed set of roles and responsibilities for the Facilitator of the SAC 1 investigation team.

Team members

Members of the SAC 1 investigation team will ideally have received prior training and be experienced in systems-based investigation methods and will provide information relevant to the investigation based on their knowledge and experience. They are often involved in gathering information relevant to the incident (e.g. by interviewing staff or the patient involved) and will help identify the factors that contributed to the event and potential actions for improvement. These tasks may be undertaken with the assistance of the facilitator in some organisations.

Team members may need to be drawn from outside the area where the incident occurred, or outside of the organisation, to provide the team with the knowledge and experience necessary to effectively investigate the incident. If all the expertise required for the investigation cannot be provided by team members, it may be necessary to obtain this via interviewing the relevant experts instead.

See Appendix 4 for a more detailed set of roles and responsibilities for members of SAC 1 investigation teams.

SAC 1 investigation team members that are responsible for conducting interviews with staff, managers, patients and family members should refer to Appendix 5 for tips on conducting effective interviews as part of SAC 1 investigations.

Consumer representative

Including a consumer representative as a member of the SAC 1 investigation team can broaden the perspective on how to improve health services. This may be particularly important when there are indications that cultural issues may be identified as factors, including where Aboriginal and Torres Strait Islander persons or other culturally and linguistically diverse health consumers

and their families have been affected by a SAC 1 clinical incident. The consumer representative may be a member of the organisation's patient advisory council (or equivalent) or selected specifically for the investigation.

A consumer representative included on the SAC 1 investigation team should not be related to or represent the patient involved in the incident or their family members. They must have received education regarding the purpose of SAC 1 investigations and the organisation's investigation process, be supported throughout the investigation process, and should complete a confidentiality form before becoming involved. Failure to adequately induct and support consumer representatives in the SAC 1 investigation team is likely to hinder rather than enhance the investigation process.

Who should be interviewed during a SAC 1 investigation

The SAC 1 investigation team will usually need to conduct interviews with people involved in the event and/or subject matter experts as part of the process to gather information relevant to the investigation. The roles of some of these parties are summarised below.

Staff members involved in the incident

The staff involved in a SAC 1 clinical incident are vital to the investigation as they can provide a factual account of what happened and may have good insight into why the incident occurred (including any problems they observed) and what could be done in the future to prevent it happening again.

While it is critical that the staff involved in a SAC 1 clinical incident are interviewed to gain their account of events and insights, it is also important to remember that staff may be emotionally upset or at risk of assuming blame, particularly where the patient has been seriously harmed or has died following the incident.

It is vital that the staff involved in a SAC 1 clinical incident are supported to minimise the risk of them becoming 'second victims'[9] of the event. This support should be extended to the interview process, which must be conducted in a timely but sensitive manner.

Appendix 6 is an information sheet intended for staff involved in a SAC 1 investigation which covers the investigation and interview processes, as well as a reflective tool that may help them to document their recollection of events.

Other staff present at the time of the incident but not directly involved may also be interviewed as witnesses or requested to provide a statement of events to assist with the investigation. While this is encouraged, care must be taken to limit this to those staff necessary for the completeness of the investigation.

Subject matter experts

Line-managers in the area where the incident occurred are not recommended to be included on the investigation team but should be interviewed as they can often provide valuable insight into systemic issues that could have had an impact on care delivery at the time (e.g. staffing levels, workload and workplace culture).

Line-managers and directors have key roles in implementing and evaluating the effectiveness of the actions recommended in response to SAC 1 clinical incidents and should be considered in the development of the recommendations to address the contributory factors that are identified by the investigation team.

Other subject matter experts with knowledge or experience relevant to the investigation should also be interviewed if they are not members of the SAC 1 investigation team. An example of this may be interviewing a representative of a company that supplies a medical device that was involved in an incident to understand its correct method of use.

Patient involved/family/representative

The patient and their family are central to healthcare delivery and may have valuable insights into what happened when care does not go to plan. If the patient and/or family members are willing and able, they should be interviewed to gather their unique perspectives and insights into what happened and why. Considering the patient's and/or families' account of a SAC 1 incident may offer opportunities to develop additional strategies to reduce recurrence.

As is the case when interviewing staff involved in a SAC 1 clinical incident, the patient and their family may be emotionally distressed and may not wish to participate in the investigation process. While the patient and/or their family should be encouraged to participate in the investigation, their right to refuse to participate must always be respected.

Information to help explain the SAC 1 investigation process to patients and families, including its objectives and expected outcomes, is currently in development.

The role of senior leadership/Executive and Health Service Boards

While senior leaders and Health Service Boards may not be directly involved in SAC 1 investigations, they have vital roles in supporting the incident management process and the staff and patient/family involved. Leaders should drive safety culture by example, e.g. effective SAC 1 investigation processes require an appropriate investment in resources and training, which should be supported by senior leaders.

A key role for senior leaders and Health Service Boards is to ensure that their organisation is prepared to respond to SAC 1 clinical incidents when they occur, including the development of a crisis management plan before it needs to be used. Further information about organisational preparedness and crisis management can be found in the Institute for Healthcare Improvement's (IHI; USA) white paper Respectful Management of Serious Clinical Adverse Events.[10]

All actions recommended in response to SAC 1 clinical incidents should be reviewed and endorsed or approved by the highest levels of leadership within the organisation. If recommendations are not approved/endorsed, this should be communicated back to the investigation team to explore alternate actions to address the contributing factors. This may require exploration of organisational constraints not readily apparent to the SAC 1 investigation team. Senior leaders should also ensure that the approved actions are implemented, and their effectiveness is evaluated to allow for ongoing refinement of system improvements. For further information about the development of recommendations in response to clinical incidents see Section 5.6 of the CIM Guideline.[3]

The findings of investigations into SAC 1 incidents with patient outcomes of serious harm or death, including the recommendations and plan for their implementation, should be presented to Health Service Boards for review and comment. The visible involvement of senior leadership and the Health Service Boards demonstrates to staff that the SAC 1 investigation process is important to the organisation.

Senior leadership and Health Service Boards should also regularly review their organisation's clinical incident management program (including SAC 1 investigations) for effectiveness and opportunities for continued improvement.

Appendices

Appendix 1 – Suggested SAC 1 investigation team membership and involvement

Adapted from the National Patient Safety Foundation[7]

Note: An individual may serve in multiple capacities	Include as a member of the SAC 1 investigation team?	Interview as part of the investigation process?
Subject matter expert(s) on the incident process being investigated	Yes	Yes (if not on investigation team)
Individual familiar with the organisation's investigation process and methodology	Yes[a]	No
Leader well versed in the investigation process	Yes	No
Staff directly involved in the incident and their immediate managers	No	Yes
Other front-line staff working in the area/familiar with the process being investigated	Yes	Yes
Patient involved in the incident	No	Yes
Family of patient involved in the incident	No	Yes
Consumer representative	Yes[b]	Yes

Notes:

[a] This will often be the Facilitator, who does not need to have a detailed knowledge of the care processes involved in the incident but must be knowledgeable and experienced in the organisation's SAC 1 incident investigation process.

[b] Where a consumer representative is included in the SAC 1 investigation team they should not be related to or represent the patient involved in the incident or their family members.

Appendix 2 - Roles and responsibilities of the Chair of a SAC 1 investigation

The Chair (with the assistance of the Facilitator) is responsible for ensuring that the organisation's SAC 1 investigation process is followed, and the work is completed on schedule. The Chair needs to be knowledgeable about the type of incident that has occurred and have a high level of credibility within the organisation. Ideally the Chair will have received training in systems-based investigation methodologies. Good problem solving and communication skills will assist the Chair in delivering an effective SAC 1 investigation.

The Chair of a SAC 1 investigation team is usually appointed by senior leaders within the organisation.

The role of the Chair of the SAC 1 investigation team includes:

- Providing leadership to the SAC 1 investigation team to deliver an effective investigation.
- Bringing their extensive clinical skills and knowledge of the subject area to the investigation.
- Being the point of contact between senior leaders in the organisation and the investigation team.

The responsibilities of the Chair of the SAC 1 investigation team include:

- Ensuring that all organisational processes for the analysis and investigation are followed.
- Liaising with senior leaders in the organisation and the Facilitator to agree on the composition of the investigation team, including relevant senior staff and clinical experts.
- Leading the discussion during meetings of the investigation team and creating an environment where constructive dialogue between team members can occur.
- In consultation with the Facilitator, determining which team members should interview staff involved in the incident and/or the patient/family concerned.
- Ensuring that the views of all members of the investigation team are encompassed in the discussions and decisions about the incident.
- Guiding the team in their analysis and to remain focussed on the event and the system factors that may have contributed rather than the performance of individual staff members.
- Removing barriers faced by team members.
- Providing support for patient safety cultural change within the organisation.
- Reviewing and approving the final investigation report.
- Presenting the findings and the report to senior leaders, Executive and/or the Health Service Board, as required by the organisation.
- Ensuring that processes to inform relevant parties of the findings and actions arising from the investigation are commenced, including:
    - Owners of actions arising from the investigation understand the actions to be taken and the timeframe.
    - Incident notifiers are informed of the findings and actions arising from the investigation.
    - The patient and/or their family are informed of the findings and actions arising from the investigation.
- Referring any concerns identified that fall outside the scope of the SAC 1 investigation to the relevant area so they can be addressed using the appropriate management and governance processes.

Appendix 3 - Roles and responsibilities of the Facilitator of a SAC 1 investigation

The Facilitator for a SAC 1 investigation needs to be knowledgeable and experienced in the organisation's SAC 1 incident investigation process and have been trained in systems-based investigation methods and human factors. The Facilitator does not need to have a detailed knowledge of the care processes involved in the incident. The Facilitator should not also be the Chair of the SAC 1 investigation team.

Effective Facilitators will have expertise in analytical methods and techniques, and be skilled in managing group dynamics, delegation, and consensus building. Facilitators are often members of the local clinical risk and/or quality and safety team.

They will coordinate and document meetings of the investigation team, and may be responsible for drafting the investigation report.

The role of the Facilitator of the SAC 1 investigation team includes:

- Bringing their extensive knowledge of analytical techniques and the organisation's process and expectations for SAC 1 investigations to the team.
- Helping the Chair to ensure that the relevant processes are followed, and timeframes adhered to.
- Sourcing additional information relevant to the investigation, for example instructions for the use of a particular device, organisational policies and procedures, staffing at the time of the event compared to normal, or details of other relevant clinical incidents that have occurred and/or been investigated.
- In partnership with the Chair, facilitating a team culture that ensures the investigation stays focussed on the system-based factors that contributed to the event, and actions that may prevent recurrence.
- When requested, drafting of the investigation report.

The responsibilities of the Facilitator of the SAC 1 investigation team include:

- Ensuring that all team members are aware of the organisational processes for the analysis and investigation that must be followed.
- Ensuring that a timeline of events and a copy of the medical record has been provided and is available for discussion by the investigation team.
- Coordinating meetings of the investigation team.
- Keeping the team focussed on the event, and the system factors that may have contributed rather than the performance of individual staff members.
- Facilitating a constructive dialogue between team members.
- Documenting the discussion of the case by the investigation team, including the sequence of events and obtaining agreement on contributing factors and corrective actions.
- When requested, helping to arrange interviews with the staff involved in the incident and/or the patient/family concerned.
- When requested by the Chair, drafting the investigation report and sending it to investigation team members for review and comment.
- Finalising the investigation report in conjunction with the Chair.

Appendix 4 - Roles and responsibilities of SAC 1 investigation team members

Members of a SAC 1 investigation team are chosen as they have extensive knowledge relevant to the area in which the clinical incident occurred and may be able to add insight to the investigation. The goal of the SAC 1 investigation is to find out what happened, why it happened, and what can be done to prevent it from happening again.

The investigation will focus on what happened and why, rather than who was involved, to understand the system-level factors that may have contributed to the incident. This type of investigation is vital for making ongoing improvements in the delivery of health services and building the culture of safety throughout the WA health system.

The role of members of the SAC 1 investigation team includes:

- Bringing their extensive knowledge of the subject area to the investigation.
- Gathering additional information relevant to the investigation (e.g. identifying and interviewing staff involved in the incident, local policies/procedures in place).
- Working with the other members of the investigation team to identify the system-based factors that contributed to the event, and actions that may prevent recurrence.
- Reviewing the draft investigation report and providing feedback as appropriate.

The responsibilities of members of the SAC 1 investigation team include:

- Understanding the roles of the Chair and Facilitator and following their direction as appropriate.
- Maintaining the confidentiality and integrity of the investigation process.
- Prioritising attendance at SAC1 investigation meetings, and if unable to attend contacting the Chair and Facilitator to discuss.
- Reviewing the patient journey timeline and other relevant information (e.g. policies and procedures) provided by the Facilitator prior to discussion at meetings.
- Providing information relevant to the steps involved in the incident and the usual and/or best-practice processes that should have been followed.
- Determining the staff that were involved in the incident and should be interviewed as part of the investigation – staff present at the time but not involved in the incident may be able to provide a statement of events rather than being interviewed.
- When requested by the Chair, interviewing staff members and/or the patient/family involved – team members responsible for interviewing staff and/or patients/families should familiarise themselves with the information contained in Appendices 5 and 6.
- Actively and collaboratively participating in the discussion to find out what happened, why it happened, and what can be done to prevent it happening again.
- Maintaining a focus on systems and processes, not the performance of (or assigning blame to) individual staff members.
- Assisting with the identification of contributing factors and causal statements.
- Assisting with the development of recommendations, outcome measures, implementation evidence and evaluation methods, and identifying appropriate action owners.
- Providing input into the drafting of the investigation report, and feedback on the draft report to the Facilitator in a timely manner.

Your participation as a member of the investigation team is greatly appreciated. Our leaders support your involvement, and your manager has been asked to release you from your regular duties if needed to allow your full participation in investigation meetings and other parts of the process.

Appendix 5 - Tips for interviewers and interviews

Adapted from the National Patient Safety Foundation[7]

The goal of the interview process is to discover information about what happened and why that will lead to the identification of system issues and ultimately to effective and sustainable corrective actions. An important part of this process is to look deeper than where people went wrong and to understand why their actions made sense to them at the time. To answer questions like these and to achieve the goal of the interview process requires effective interviewing skills.

After a SAC 1 clinical incident, staff should be asked not to discuss the event among themselves, in order to promote the integrity and objectivity of the investigation process. Staff involved in the incident should be encouraged to use a reflective tool (such as the example in Appendix 6) as soon as possible to record the sequence of events from their perspective and assist their recount of events during an interview.

The following tips are intended to help interviewers to deliver effective interviews of staff, patients and families involved in SAC 1 clinical incidents.

Interviewing staff involved in a SAC 1 incident

- Not all staff present at the time of the incident may need to be interviewed. While the staff directly involved in the incident should be interviewed, those present but not involved may be able to provide a statement of events instead.
- Interviews should be conducted as soon as the SAC 1 investigation team has identified the interviewees and interview questions. Interviewers should aim to gather all information required in one session to minimise the impact on staff.
- Interview only one staff member at a time, which will permit information to be compared and weighed. Expect differences between descriptions given by different staff when they describe what happened, and use additional information gathered by the team to support the final conclusions. Remember that some sources of information, such as closed-circuit television (CCTV) may have limitations like a lack of sound or a different point of view to the staff that were involved in the incident.
- Conduct interviews in person wherever possible. Videoconferencing may be used where necessary. Conducting interviews via telephone should only be considered where the interviewer(s) and interviewee know and trust each other and agree this is an acceptable way to conduct the interview.
- Notify the staff member's immediate supervisor/manager that they will be needed for an interview so that coverage can be arranged. Supervisors/managers should not be present during the interview as this may affect the staff member's participation.
- Interviews should be conducted by only one or two members of the SAC 1 investigation team. Placing the staff member in front of a larger team may increase the stress associated with recounting the incident and be counter-productive.
- Conduct the interview in the staff member's area or in an area that may help them relax. Avoid the appearance of summoning them to a hearing or administrative review.
- Explain the purpose of the interview and that the SAC 1 investigation team is seeking to identify system issues and not to assign blame to any individuals. Request permission to take notes and/or record the interview and explain how the notes will be used. After the interview the staff member may wish to review the interviewers' notes to confirm their views have been accurately documented and request any inaccuracies be corrected.
- Be sensitive to the stress that staff involved in a SAC 1 clinical incident may be feeling. Let them know that no one is judging them and that the interview is being conducted to

identify and implement system-level sustainable corrective actions, so a similar event does not happen again.

- Staff members involved in the incident may wish to have a support person or representative present during the interview. The organisation should set the ground rules for such participation, including that representatives are made aware that they are not permitted to talk about what was discussed during the interview with anyone other than the staff member and the SAC 1 investigation team members.
- Effective interview skills will help make fact finding easier and the staff involved more comfortable with the process. Start with broad, open-ended questions and then move to more specific questions to clarify your understanding of what has been shared. The process should not feel like an inquisition, and it is essential that staff members are made to feel as safe as possible.
- Use active listening and reflect what is being said. Build confidence by restating and summarising what has been said. Keep an open body posture, good eye contact, and nod appropriately. Demonstrate empathy and be patient. Do not prejudge, lay blame, or interrupt.
- If the staff member is having difficulty remembering the details of the incident, ask them to describe what they normally do when completing the task/procedure that was involved. Drawing a sketch of the process or work area may also trigger their memory.
- Thank the staff member at the conclusion of the interview, provide your contact information in case they have additional information that they remember, and if you sense they need emotional support, be aware of what resources are available to them.

Interviewing the patient and/or family

- Conduct interviews of patients and/or family members at a location that is acceptable to them. Patients may have family and/or a support person present during the interview.
- When needed, use interpreters during the interview to help ensure that patients/family members from Aboriginal and Torres Strait Islander and other culturally and linguistically diverse backgrounds can communicate effectively with the interviewers.
- In accordance with Open Disclosure principles, express to the patient and/or any family present that you are sorry the event occurred.
- Explain that the investigation into the incident is being conducted to identify system issues and implement sustainable and effective corrective actions, and that the team is not seeking to assign blame to individuals involved in the event.
- If the patient and/or family members raise questions that fall outside of the scope of the investigation, ensure these are documented and referred to the appropriate areas of the organisation for response.
- Use active listening and reflect what is being said. Build confidence by restating and summarising what has been said. Keep an open body posture, good eye contact, and nod appropriately. Demonstrate empathy and be patient.
- Explain the next steps – how and when the patient and/or family will be informed of the outcomes of the investigation and the actions that are planned to be taken.
- Thank the patient and/or family at the conclusion of the interview, provide your contact information in case they have additional information that they remember, and if you sense they need further support, be aware of what resources are available to them.

Appendix 6 - Information for staff involved in a SAC 1 incident and/or investigation

A comprehensive investigation of a SAC 1 clinical incident has been commenced, and you have been identified as someone who may be able to add important information and insights about the circumstances of the event. The goal of the investigation is to find out what happened, why it happened, and what can be done to prevent it from happening again.

The investigation will focus on what happened rather than who was involved, to understand the system-level factors that may have contributed to the incident and make recommendations for how this type of incident may be prevented in the future. This type of investigation is vital for making ongoing improvements in the delivery of health services and building the culture of safety throughout the WA health system.

The incident investigation will:

- be multidisciplinary, involving experts from frontline services
- seek input from those who are most familiar with the situation
- look beyond the surface of what happened to understand the system factors that may have influenced the decisions taken
- identify changes that could be made to the improve the systems and processes in the which staff work
- be objective and impartial in its review of the incident.

Your assistance in meeting with a member of the investigation team would be greatly appreciated.

Who will be involved?

One or two members of the team appointed to investigate this incident will meet with you. If you would like to have a colleague or union/other representative attend as a support for you, please let the team member know when the meeting is arranged.

What will be discussed?

You will be asked about:

- Your understanding of the circumstances and sequence of events leading up to the incident.
- Your role in the situation.
- Any issues, problems or difficulties you observed.
- Factors that may have contributed to the issues, problems or difficulties observed. These contributory factors may include:
    - communication between staff and with the patient/family
    - knowledge, skills and competence of staff
    - the environment, work conditions and scheduling
    - equipment and technology
    - policies, procedures and guidelines
    - safety mechanisms
    - patient factors.
- Any other comments you wish to make.

Please ensure that the information you provide is factual and does not blame staff associated with the clinical incident.

Using the reflective tool overleaf as soon as possible after a clinical incident may assist you in documenting the circumstances surrounding the incident while they are fresh in your mind and help you to think about why things may have not gone as planned. It may also serve as a useful

reference for you during the interview, and you are welcome to refer to it or any other notes relevant to the event that you have made.

What will be recorded?

The investigation team members will take notes to help them remember your comments for analysis along with the other information collected in relation to this incident. Your comments do not represent a formal statement however may be subject to access under the *Freedom of Information Act 1992* (FOI Act).

You may request a copy of the notes from your interview to allow you to review and verify that the facts have been documented correctly. If you believe there are any errors in the notes you should raise this with the investigation team as soon as possible. The investigation team members may ask if they can record your interview to help them make accurate notes, however, will only record the interview with your permission.

How will the information be used?

Your comments and views will be analysed along with information from other interviews, the patient health record and other relevant documents to help identify the contributory factors most relevant to the incident and actions that are likely to reduce the likelihood of incidents like this happening again. While the role/designation of staff involved in the incident will be included in the investigation report the names of staff will not be included.

The report of the investigation will be shared with senior leaders so that they are aware of the challenges facing staff and the actions that are proposed to improve the systems and processes in which they work. This will also allow the senior leadership to provide information about the investigation and its findings to the staff working in the area where the incident occurred.

The findings of the investigation and the actions being taken will be accessible to the person that originally notified the incident (via the incident management system) and may also be shared with the patient and/or their family in a supported manner so that they can gain an understanding of what is being done to make the health system safer.

While the team investigating the incident will maintain your confidentiality during the investigation, please be aware that the investigation findings, recommendations and report may also be subject to access under the FOI Act, and may be requested by the Coroner in cases where the patient has died.

If you have questions about the incident investigation process, please contact:

Name:	Telephone:
Position:	Email:

What other support is available?

Further support for staff following a SAC 1 clinical incident is available from your organisation's Employee Assistance Program (EAP). Discussions between a staff member and the EAP are confidential and will not be provided to the team investigating the incident.

For further information about the EAP contact/see/phone

<Insert local EAP details here>

Reflective tool for staff involved in clinical incidents

Adapted from the NSW Clinical Excellence Commission[11]

This tool is designed to help you to reflect on a clinical incident and consider any factors that may have contributed. It will help to clarify your role, the role of others, and how these interacted.

It is recommended that you complete your reflection as soon as possible after an incident, while the events are fresh in your mind. This reflection is personal and private; however, you may use it to help in your discussion with the team investigating the incident, or during any contact you have with the Employee Assistance Program. You are not required to provide a copy of this reflective tool to the team investigating the clinical incident.

Describe the incident and sequence of events. What happened and how were you involved?

What were you thinking and feeling at the time of the event, or when you first learned of it?

What was good (desirable features or points in favour), and what was bad or undesirable about what happened? Consider this from:

- **Your viewpoint or position**
- **The patient's and/or family's point of view**
- **Your hospital's/organisation's point of view**.

What sense can you make of the situation? Why did things happen the way they did? Consider if any of the following factors may have contributed:

- **Yourself or your state of mind**
- **Expectations and assumptions of staff and the patient/family**
- **Communication between staff and with the patient/family**
- **Issues with equipment and technology**
- **The work environment and conditions**
- **Policies, procedures and guidelines (e.g. normal procedure not followed)**
- **System and cultural factors**
- **Patient factors**

What else might you have done? Could you/others be better prepared in future to influence any of the above factors?

If a similar situation arose again, what would you differently?

References and resources

1. WA Department of Health. Clinical Incident Management Policy. 2019. Available at: https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Clinical-Incident-Management-Policy

2. WA Department of Health. Clinical Incident Management Toolkit. 2019.Available at: https://ww2.health.wa.gov.au/~/media/Files/Corporate/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Policy/Clinical-Incident-Management-Policy-2019/Supporting/Clinical-Incident-Management-Toolkit-2019.pdf

3. WA Department of Health. Clinical Incident Management Guideline. 2019. Available at: https://ww2.health.wa.gov.au/~/media/Files/Corporate/Policy-Frameworks/Clinical-Governance-Safety-and-Quality/Policy/Clinical-Incident-Management-Policy-2019/Supporting/Clinical-Incident-Management-Guideline-2019.pdf

4. Government of Western Australia. Freedom of Information Act 1992. 2020. Available at: https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_353_homepage.html

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6. WA Department of Health. Open disclosure web page https://ww2.health.wa.gov.au/Articles/N_R/Open-disclosure

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8. WA Department of Health. Guideline for the Investigation of Multi-Site clinical incidents. 2019. Available at: https://ww2.health.wa.gov.au/~/media/Files/Corporate/general-documents/patient-safety/PDF/Guideline-for-the-investigation-of-multi-site-clinical-incidents.pdf

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10. Conway J, Federico F, Stewart K, Campbell M. Respectful Management of Serious Clinical Adverse Events (Second Edition). IHI Innovation Series white paper. Institute for Healthcare Improvement. 2011. Available at: http://www.ihi.org/resources/Pages/IHIWhitePapers/RespectfulManagementSeriousClinicalAEsWhitePaper.aspx

11. NSW Clinical Excellence Commission. Serious adverse event review: Information for staff affected by a serious incident. 2020. Available at: https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0019/622027/SAER-information-for-staff.pdf

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