

Informing best practice in workplace health and safety incident review and system improvement processes

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Executive Summary

Background

The current Workplace Health and Safety (WHS) incident management processes at Monash Health are being reviewed. The Centre for Clinical Effectiveness (CCE) was requested to conduct a review of the literature to provide information around processes relating WHS incident management to inform the development of best practice at Monash Health.

Objective

To identify information relating to WHS incident management processes after incidents are reported, including incident review and system improvements resulting from an incident.

Methods

Searches were performed in Google and Google Scholar to identify grey literature as well as published peer reviewed literature on the topic using the terms “workplace health safety incident management systems” and “effective incident management systems”. Documents were included and information extracted according to the inclusion criteria.

Results

The search identified nine sources [1-9] of information across six industries; education, health, aviation, sport, engineering and utilities.

The following table outlines the key concepts relevant to WHS incident management processes which include incident review and system improvement. Both these key concepts involve various activities which are also outlined in the table and detailed in the Full Report.

WHS Incident Review	WHS System Improvement resulting from an incident
<p>Investigation</p> <ul style="list-style-type: none"> Description of the purpose of investigation Details for carrying out an investigation Description of responsibilities in the investigation process <p>Analysis</p> <ul style="list-style-type: none"> Analysis and types of analysis reported <p>Documentation of investigations</p> <ul style="list-style-type: none"> Details of the investigation report, final report and statutory notification record Appropriate timeframes for investigation 	<p>Development of corrective actions and recommendations</p> <ul style="list-style-type: none"> Guidelines and recommendations for corrective actions <p>Implementation of action plan</p> <ul style="list-style-type: none"> Recommendations for the action plan that is to be implemented <p>Organisation-wide monitoring and review of outcomes</p> <ul style="list-style-type: none"> Description of the review and monitoring of outcomes Key performance indicators Responsibilities and endorsements of corrective actions Timeframe for corrective actions <p>Post-event actions</p> <ul style="list-style-type: none"> Counselling, debriefing, communication and support

Conclusions

The grey literature evidence collated from across six industries (education, health, aviation, sport, engineering and utilities) has highlighted common concepts in workplace health and safety incident review and system improvements from incidents incurred. These key concepts have been described in detail and can inform the development of best practice at Monash Health.

Implications for practice

Successful workplace health and safety incident reviews and system improvement processes relay a clear purpose, have allocated responsibilities within each step of either the investigation or improvement process, suggest relevant analysis tools, provide standard templates and procedures for reporting outcomes, and provide mechanisms to ensure that actions and outcomes of incident investigations and improvements are disseminated, without disclosing personal details, to persons who are directly or indirectly affected by either the incident or improvements made as a direct outcome of the incident.

Background

The current Workplace Health and Safety (WHS) incident management processes at Monash Health are being reviewed. The Centre for Clinical Effectiveness (CCE) was requested to conduct a review of the literature to provide information around processes relating WHS incident management to inform the development of best practice at Monash Health.

Objectives

To identify information relating to WHS incident management processes after incidents are reported, including incident review and system improvements resulting from an incident.

Methods

Scope and definitions

For the purpose of this review, an incident is defined as an event or circumstance including near misses that could have resulted or did result in harm, injury or damage to visitors or staff. Due to the broad scope of the review to include non-healthcare industries, we excluded incident management processes related to natural disasters. The term 'workplace health and safety' was used to define all nomenclature relating to occupational or corporate health and/or safety.

Inclusion Criteria

Setting	Include: Healthcare and non-healthcare industries in Australia
Context	Include: Incident management processes that include WHS incident review and WHS systems improvement
Concept	Include: Incident review (investigation, analysis, documentation) Systems improvements (Development of corrective actions and recommendations, Implementation of action plans, Organisation-wide monitoring and review of outcomes, Post-event actions) Exclude: Incident reporting processes; documents that did not provide a clear description or adequate details of the incident management process. Anything reporting the management of only patient/clinical incidents or any information unclear in defining the type of incidents managed.
Types of information	Include: White papers, reports, policy and procedures Exclude: Blogs, web pages, online articles
Limits	Database: Google, Google Scholar Date: 1 Jan 2011 – 14 Sept 2016 Language: Publications in English

Search strategy

Searches were performed in Google and Google Scholar to identify grey literature as well as published peer reviewed literature on the topic using the terms "workplace health safety incident management systems" and "effective incident management systems". Documents were included and information extracted according to the concepts listed above.

Results

Summary of findings

The search identified nine sources [1-9] of information across six industries; education, health, aviation, sport, engineering and utilities. Only grey literature sources (Google) adequately detailed WHS incident management processes.

Table 2a & b, highlights the key concepts of WHS incident review and system improvement found within the documents identified. Table 3a & b provides the descriptive detail of these key concepts. These tables are included in Appendix 1.

WHS incident review

The following describes WHS incident review and the various activities which are involved in this process.

Investigation

Purpose

The purpose of the investigation should be clear from the outset. This helps to determine the causes of the hazard or incident and identifies actions to prevent, control and correct the problem from reoccurring [1, 2, 5, 7, 8]. Organisations' relevant policies should inform the level and nature of the investigation [3].

Investigation checklist

An investigation checklist outlines appropriate steps in the process. A range of steps were documented which included: collection of information [1-5, 7-9], classification of incidents to determine type and method of investigation [2], how to plan the investigation [2, 3], identification of suitable control measures [1, 5, 7], identification of barriers to prevent or mitigate the problem [3], incorporation of policies and procedures that promote a positive safety reporting culture [2, 3], assigning appropriate levels of responsibility and resources [2, 3], support staff involvement in investigations for assistance with identifying suitable training programs [3, 5], respecting privacy policies [7-9].

Responsibilities in the investigation process

Responsibilities at all levels of the investigation process are outlined in both health and non-healthcare settings. We identified different levels of responsibilities across the following steps in the investigation process: assessing the incident [4-6, 8, 9], commissioning the formal investigation [6], conducting the investigation [1, 3, 7, 9], completing the investigation report [3, 6, 7], initiation of further investigation [1, 7], endorsing the report [1-3], and coordinating external investigations [2, 5, 6, 8].

Analysis

Analysis was seen to take place at a number of different levels within the investigation process including the level at which the incident occurred [3]. Three types of analysis that are conducted within the incident review process were identified, these include, Reason model analysis [2], Root Cause Analysis [3, 5, 6, 8], and Trend analysis [1, 3, 8, 9]

Documentation and timelines of investigations

Outlines are provided by different organisation for types of reports [2, 3] and statutory notifications required as part of the review process [6].

The timeframes in which investigations should occur varied greatly. Suggestions were that they should be conducted promptly [1, 4, 5] however definitions varied from 24 hours [9] to 45 days [3]. For incidents that required further investigation up to three months was considered appropriate [7]. Investigation timeframes seemed to be whatever was deemed appropriate within particular settings.

WHS system improvement

The following describes WHS system improvement and the various activities which are involved.

Development of corrective actions and recommendations

Guidelines for raising corrective actions

The implementation of appropriate corrective actions is critical to the success of reducing the risk of hazards in the workplace [8] and the development of better systems to ensure improved practice [3].

Guidelines for raising corrective actions include: listing necessary corrective actions, identifying responsibility for taking action and ensuring action is completed, assigning a timeframe for completion of corrective action, identification of a management system reference to allow status tracking of actions and identification of any statutory reporting requirements [2].

Formation of corrective actions

Recommended corrective actions should be **Specific, Measurable, Achievable, Realistic, Timely, Effective and Reviewed (SMARTER)** [2, 8]. They should be determined in consultation with workers who will be directly involved or

affected by the corrective action [1, 5, 6, 8], should be implemented in a timely manner, be appropriate for the root cause [2], aimed at implementing the highest practical level of risk control [2, 6, 8], not introduce any new hazards or risks [2, 6, 8], address system deficiencies [5, 8], include interim or temporary recommendations for immediate corrective actions [2, 8], and be appropriately assigned to relevant management for accountability in implementation and monitoring of the actions [3].

Implementation of action plans

The Aviation industry [2] provides recommendations for action plans that are to be implemented. They outline that to maximise the effectiveness of the investigation report, its findings and conclusions should be distributed as widely as practicable both internally and externally to relevant industry bodies. A formal presentation to the responsible manager for implementation should be made. Where corrective actions have not been fully implemented, ongoing monitoring should be maintained until implementation is complete. The effectiveness of the corrective actions should be evaluated by a review of safety performance and through an audit within six months. Finally, investigative data and reports should be archived in accordance with organisation specific procedures [2].

Organisation-wide monitoring and review of outcomes

Review of outcomes

Review of outcomes are conducted in order to plan health and safety programs and initiatives, monitor the effectiveness of corrective or preventative actions, produce reports of hazards and incident statistics and trends for management, and to disseminate information relating to hazards and incidents to relevant sections of the organisation [7]. It is important that the corrective action plan is constantly monitored, reviewed and adjusted where necessary in order to ensure that changing circumstances do not alter priorities. [2] The ongoing monitoring of trended aggregated incident data also helps identify and prioritise issues that may require a practice improvement project. [3]

Organisation-wide monitoring

Organisation-wide monitoring for change should include the following nine areas: Knowledge (where new factors or information are included); Stakeholders (new stakeholders are included over time); Consultation (where all relevant stakeholders are consulted); Communication (using high quality and appropriate methods); Risks (risk treatments are implemented, new risks identified, addressed and managed appropriately); Common understanding (maintained by all participants); Quality of decisions; Changes in legislation, regulation and market factors; and Effectiveness of the implementation plan [2, 3].

Performance indicators

The key performance indicator in the NSW health service policy for corporate incidents is the submission of final Root Cause Analysis (RCA) Report (where relevant) to the Ministry of Health within 70 calendar days of incident notification in the incident management system [3].

The Clinical Excellence Commission of NSW list the following performance indicators to be included in the incident management framework for corporate incidents [3]:

- Submission of a Reportable Incident Brief to the Ministry of Health, concerning extreme risk corporate incidents within 24 hours of notification in the incident management system.
- Proportion of obligatory external notifications made within required timeframes.
- Proportion of high risk incident investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.
- Proportion of low to medium risk investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.
- Proportion of extreme risk incidents notified where incident status = new in ≤ 24 hrs of incident occurring.
- Proportion of low to high risk incidents notified where incident status = new in ≤ 5 days of incident occurring.
- Proportion of all actual low to high risk incidents where incident status = complete in ≤ 45 days of incident occurring.
- Proportion of RCA recommendations completed within stated timeframe.
- Proportion of incidents notified which have recommendations for action.
- Proportion of incidents notified where recommendations have been completed.

Responsibilities and endorsements for system improvements

Responsibilities are given to specific hierarchical positions within organisations to ensure that the recommendations [2, 5, 7], implementation [7, 8], review of actions [5, 8, 9], endorsement [2, 5] and improvements [9] within the system improvement cycle.

Prioritisation and completion of corrective actions are outlined by the University of Wollongong [8], recommending high risk incidents within 24 hours, medium risk within 14 days and low risk incidents within 28 days.

Post event actions

Post event actions should include the following: *counselling* to any affected persons [7]; *debriefing* by a supervisor or safety officer to explain the outcome of the hazard or incident, outcome of the investigation and any corrective/preventative measures that have been or will be taken [7]; *communication* of alerts of incidents rated as high or extreme risk [6]; and *support* to the persons involved including medical treatment, rehabilitation, health management resources and referral to an Employee Assistance Program as required [4, 9].

Discussion

As well as identifying key concepts for workplace health and safety incident review and system improvement the grey literature discusses the importance of the processes that occur once hazards and incidents have been reported in standardised reporting systems. Aviation and Health industry documents appear to be the most comprehensive in providing specific details for steps in the process of reviewing and improving practices post incident.

It is made clear that the purpose of internal investigations is to find systemic causes and not to blame individuals. The investigation should be comprehensive and attempt to address the factors that contributed to an event, rather than simply focusing on the event itself [2]. For this to occur a positive safety reporting culture and organisational policies to support this should be in place and reference throughout the investigation and improvement processes [2]. It has been reported that “the effort expended on investigations is proportional to the perceived benefit in terms of potential for identifying systemic hazards and risks to organisations” [2].

Conclusions

The grey literature evidence collated from across six industries (education, health, aviation, sport, engineering and utilities) has highlighted common key concepts in workplace health and safety incident review and system improvements from incidents incurred. These key concepts can inform the development of best practice at Monash Health.

Implications for practice

Successful workplace health and safety incident reviews and system improvement processes relay a clear purpose, have allocated responsibilities within each step of either the investigation or improvement process, suggest relevant analysis tools, provide standard templates and procedures for reporting outcomes, and ensure that actions and outcomes of incident investigations and improvements are disseminated, without disclosing personal details, to persons who are directly or indirectly affected by either the incident or improvements made as a direct outcome of the incident.

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Appendix 1

Table 2a: Key concepts of incident review by industry

Workplace health and safety incident review	Education			Health		Industry			
	[7]	[1]	[8]	[4]	[3]	[6]	[2]	[5]	[9]
Investigation									
Description of the purpose of investigation	X	X	X		X		X	X	
Details for carrying out an investigation	X	X	X	X	X		X	X	X
Description of responsibilities in the investigation process	X	X	X	X	X	X	X	X	X
Analysis									
Analysis and types of analysis reported		X	X		X	X	X	X	X
Documentation of investigations									
Details of the investigation report, final report and statutory notification record					X	X	X		
Timeframe for investigation	X	X		X	X			X	X

Table 2b: Key concepts of systems improvement by industry

Workplace health and safety systems improvement	Education			Health		Industry			
	[7]	[1]	[8]	[4]	[3]	[6]	[2]	[5]	[9]
Development of corrective actions and recommendations									
Guidelines and recommendations for corrective actions		X	X		X	X	X	X	
Implementation of action plan									
Recommendations for action plan that is to be implemented							X		
Organisation-wide monitoring and review of outcomes									
Description of the review and monitoring of outcomes	X		X		X	X	X		
Key performance indicators					X				
Responsibilities and endorsements of corrective actions	X		X	X			X	X	X
Timeframe for corrective actions			X						
Post-event actions									
Counselling, debriefing, communication and support	X			X		X			

Table 3a. Descriptive detail of key concepts involved in WHS incident review

Workplace health and safety incident review
Investigation
Purpose Determine causes of the hazard or incident [5, 7] and identify actions to: <ul style="list-style-type: none">- Prevent or control any incident that may result from the hazard. [5, 7]- Correct the problem and to prevent a recurrence of any incident. [1, 5, 7] The extent of the investigation depends on the actual and potential consequences of the event or hazard (as determined by an initial risk assessment) [2, 8] and relevant policy documents should inform the level and nature of the investigation [3]
Investigation checklist <ul style="list-style-type: none">• Collect information (i.e. who was involved including witnesses, time, location) [3, 5]. This includes identifying and assessing:<ul style="list-style-type: none">- Cause(s) of the incident (the ‘why’ and not just the ‘what’).[1, 2, 4, 8, 9]- Sequence of events that occurred prior, during and after the hazard or incident being identified. [7]- Hazards applicable. [1, 3, 7-9]- Contributing factors (process or organisational) to the incident. [2, 3, 7-9]- Nature of any injury or affliction that was sustained as a result of the incident [7].• Incidents are reviewed and classified [2-4] to determine which ones to be investigated and how. [2]• Plan the investigation – identify the scope, potential sources of information (through observations, interviews etc) and resources required. [2, 3]• Identify suitable controls measures in line with the hierarchy of controls. [1, 5, 7]• Identify the barriers that would most likely prevent or mitigate the problem – then determine appropriate recommendations.[3]• Where a positive safety reporting culture is in place, the policy and procedures for internal investigations are clearly referenced. [2, 3]• Assign appropriate levels of responsibility and resourcing for investigation and action. [3] Accountability for the management of investigations is documented in the organisation’s manual. [2]• The organisation should have appropriately trained staff to support staff involved in investigations and provide access to training programs for the investigation. [3, 5]• Privacy must be maintained throughout the incident reporting, investigation and escalation process according to organisation’s privacy policies. [7-9]
Responsibilities in the investigation process
1. Assess incident: Director, managers, supervisors, site senior persons or their equivalents shall review the details of the incident, identify possible contributing factors, provide a root cause of the incident, and assess the risk of the hazard using a risk assessment matrix. [4-6, 8, 9]
2. Commission formal investigation: The Business Unit Manager is responsible for commissioning a formal investigation, in accordance with the Root Cause Analysis Guide of high and extreme risk incidents, with the assistance of the Division Manager. [6]
3. Conduct investigation: The Safety Officer, and/or the immediate supervisor in charge of the area where the incident occurred, and WHS representative [1, 7] or an Investigation Team shall conduct the investigation. [3] The structure of the Investigation Team varies with the severity of the incident reported. [9] It generally consists of members with knowledge about the corporate processes in the area where the incident occurred, but not involved in the incident. [3] Or may also include an area manager, WHS advisor and coordinator, and a qualified lead investigator or an executive member for higher risk incidents. [3, 9] In areas remote from buildings, e.g. footpaths and car parks, or areas where responsibility is not clear, WHS unit shall carry out the investigation.[7]

4. Complete investigation report:

The Safety Officer, together with supervisor of the staff member and WHS representative [7] or the Investigation Team will prepare investigation report. [3] The WHS Manager will record incidents on a database to facilitate the analysis of trends and identification of problem areas. [6]

5. Initiate further investigation:

The Manager or Coordinator, WHS will monitor trends of incidents and initiate further investigation where: [1]

- A number of incidents are noted for similar situations.
- A workers compensation claim has been lodged.
- The manager has requested assistance to investigate an incident.
- A serious or major incident has occurred.
- Any situation that is deemed to require further investigation.

Where necessary, the Manager, WHS, in consultation with and approval by appropriate executive management, will determine the need for a committee of inquiry and the terms of reference of the inquiry. [7]

Structure of the Committee of inquiry [7]

- Chaired by a senior member of staff.
- Representation from WHS, the appropriate Health & Safety representative(s), technical experts, other staff and external experts as necessary.
- Experts from another academic/administrative unit can provide an essential element of the independent review.

6. Endorse report:

The Manager or coordinator, WHS [1] or the management of (business group and site) should formally review the investigation report for completeness, quality of the investigation and to endorse the recommended corrective actions. [2]

In the health service, the Chief Executive (CE) reviews, clarifies and endorses the recommendations before the Report is submitted to the Ministry and ensures all external notification requirements are met. Recommendations that are added or altered by the CE must be documented. [3]

The Clinical Governance Unit and/or Corporate Governance Unit (or its equivalent) provides appropriate oversight of the quality of investigation processes and outcomes [3]

7. Coordinating external investigation:

Higher risk incidents are categorised as being notifiable to appropriate statutory or authoritative body. [5, 8]

- WHS Manager, or safety manager, [2, 6] in conjunction with the Operations Manager, [5] shall be responsible for facilitating investigations conducted by statutory bodies and act as the organisation's point of contact/ coordinator for external investigations as a way of keeping informed as they progress. [2]

Analysis

Analysis takes place at a number of levels in the system: [3]

- At the level at which the incident occurred (for example the ward or the patient interface in a primary care setting).
- At the organisational level and at the State and National level. Different data are analysed and different is expected at these various levels. Groups of incidents may be analysed to identify trends or emerging themes.
- Health Services are responsible for analysis and action at the health organisation level.
- The Ministry of Health and the Clinical Excellence Commission (CEC) are responsible for analysis and action at the State level.

Analyses include:

- Reason model analysis. [2]
- Root cause analysis. [3, 5, 6, 8]
- Trend analysis. [1, 3, 8, 9]

Documentation of investigations

The **investigation report** should include: [2]

- The scope of investigation.
- Who will investigate, including specialist assistance if required

- Recording of investigations findings for follow-up trend analysis and who is responsible for follow-up.
- Timeframe for completion.

The **final** report should include: [3]

- A description of the reportable incident.
- The Incident ID from the incident management system.
- A causation statement/s that indicates the reasons why the Investigation Team consider the incident occurred.
- Recommendations for system changes to improve procedures or practices to minimise recurrence of the incident.

The written record of a **statutory notification** should: [6]

- Be filed with incident report.
- Include file notes of conversations and emails.
- Show date, time and name of inspector spoken with.
- Summary of conversation.

Timeframe

Investigations should be conducted promptly, [1, 5] ideally **within 24 hours** (or **within five working days**) of receiving the incident notification, irrespective of its severity level. [9]

In a small organisation, the investigation report must be submitted within **48 hours**. [5]

In aged care facility, a comprehensive report to be submitted **within two weeks** of the incident.[4]

In a health service, the investigation should be completed within **45 days** of being notified in the incident management system or a progress report outlining the management plan with a revised completion date being submitted to the appropriate manager. [3] High risk incidents that require detailed investigation must be reported to the Ministry of Health within **70 days** from the notification of the incident in the incident management system. [3]

For incidents requiring further investigation, (i.e. committee of inquiry) the investigation report (or progress report for prolonged investigations) must be submitted within **three months** of the occurrence of the incident. [7]

Table 3b. Descriptive detail of key concepts involved in WHS system improvement

Workplace health and safety systems improvement

Development of corrective actions and recommendations

The implementation of appropriate corrective actions is critical to the success of reducing the risk of hazards in the workplace [8] and the development of better systems to ensure improved practice. [3]

Guidelines for raising corrective actions: [2]

1. List the corrective actions the investigations has shown to be necessary.
2. Identify who will responsible for taking action, who is responsible for ensuring the action is completed.
3. Set a date by which corrective action must be completed
4. Identify the management system reference to allow status tracking of the corrective actions.
5. Identify any statutory reporting requirements for the event.

Corrective actions that are recommended should be **Specific, Measureable, Achievable, Realistic, Timely** [2, 8] and **Effective, Reviewed** (SMARTER) [2]

They should:

- Be determined in consultation with workers who will be directly affected by the implementation of the corrective actions in the workplace. [1, 5, 6, 8]
- Be implemented in a timely manner as per the WHS Risk Management Guidelines, [8] within suitable timeframe. [3]
- Be appropriate for the root cause. [2]
- Control the hazard and residual risk to an acceptable level, [2, 8] aimed at implementing the highest practical level of risk control using the Hierarchy of Controls, [6] or reduce likelihood of the factor contributing to similar events in

future. [2]

- Not introduce or expose a new hazard or risk (or if they do, ensure this new hazard or risk is assessed). [2, 6, 8]
- Address system deficiencies in WHS management system. [5, 8]
- Also include interim or temporary recommendations for immediate corrective actions before long term corrective actions (i.e. those involving higher cost or more complex approvals) are implemented. [5, 8]
- Be appropriately assigned to relevant management for accountability in implementation and monitoring of the actions. [5]

Implementation of action plan

Recommendations for action plan that is to be implemented: [2]

1. *Distribution*

To maximise the effectiveness of the investigation report, its findings and conclusions should be distributed as widely as practicable internally within the organisation and externally to industry bodies.

2. *Implementation of corrective actions*

Corrective actions will be formally presented to the responsible manager for implementation. An action plan and time frame will be agreed and endorsed by the appropriate level of management.

3. *Implementation monitoring*

The completion of corrective actions must be documented and communicated by the responsible manager. Where corrective actions have not been fully implemented, ongoing monitoring should be maintained until implemented is complete.

4. *Analyse effectiveness*

The effectiveness of the corrective actions should be evaluated by a review of safety performance and through an audit within the next six months. A report will be prepared for management to detail compliance and progress achieved.

5. *Document archiving*

Investigative data and reports will be archived in accordance with procedures specified in relevant organisation's manual.

Organisation-wide monitoring and review of outcomes

Review of outcomes

WHS committee reviews the hazard and incident reports received in order to: [7]

- Plan health and safety programs and initiatives.
- Monitor the effectiveness of corrective/preventive actions.
- Produce quarterly reports on hazard and incident statistics and trends for management.
- Disseminate information relating to hazards and incidents and their prevention to relevant sections of the university.

To ensure that changing circumstances do not alter priorities, the corrective action plan must be constantly monitored, reviewed and adjusted where necessary. [2]

Organisation-wide monitoring

The following should be monitored for change: [2]

1. Knowledge (new factors or information are included)
2. Stakeholders (new stakeholders included over time)
3. Consultation (all relevant stakeholders are consulted)
4. Communication (high quality and appropriate methods used)
5. Risks (risk treatments are implemented, new risks identified, addressed and managed appropriately)
6. Common understanding (maintained by all participants)
7. Quality of decisions
8. Changes in legislation, regulation and market factors
9. Effectiveness of the implementation plan

Ongoing monitoring of trended aggregated incident data may identify and prioritise issues requiring a practice improvement project. [3]

Performance indicators

The **key performance indicator** in the NSW health service policy for corporate incidents: [3]

- Submission of final Root Cause Analysis (RCA) Report (where relevant) to the Ministry of Health within 70 calendar days of incident notification in the incident management system.

The following **performance indicators** should be included in the incident management framework at a Health Service level for corporate incidents: [3]

- Submission of a Reportable Incident Brief to the Ministry of Health, concerning extreme risk corporate incidents within 24 hours of notification in the incident management system.
- Proportion of obligatory external notifications made within required timeframes.
- Proportion of high risk incident investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.
- Proportion of low to medium risk investigations completed within 45 days as monitored in the incident management system or have a progress report outlining the management plan with a revised completion date being submitted to the appropriate senior manager.
- Proportion of extreme risk incidents notified where incident status = new in ≤ 24 hrs of incident occurring.
- Proportion of low to high risk incidents notified where incident status = new in ≤ 5 days of incident occurring.
- Proportion of all actual low to high risk incidents where incident status = complete in ≤ 45 days of incident occurring.
- Proportion of RCA recommendations completed within stated timeframe.
- Proportion of incidents notified which have recommendations for action.
- Proportion of incidents notified where recommendations have been completed.

Responsibilities and endorsements

Recommendations

The event owner should sign to indicate they accept the report, including corrective actions and priorities, and enter relevant comments. [2] The WHS Committee, as advised by the Safety Officer [7], reviews the incidents and resultant corrective actions and makes recommendations where required. [5]

Implementation

The WHS Unit will consult with the event owner and workers and supervisor of the area(s) involved to ensure appropriate ownership of the corrective action. [8]

Appropriate Head of unit to take steps to implement the recommendations arising out of the investigation. [7]

Review of actions

The WHS supervisor or senior manager (or their equivalent) to ensure corrective actions as stated by the initial notification have been completed within the timeframe, and been effective in reducing the risk of injury. [5, 8, 9] Corrective actions which are not completed on time are reviewed by the WHS Unit on a monthly basis and escalated to the nominated supervisor to outline a plan for completion. [8]

Endorsement

CE and WHS Manager to review actions taken and sign off as satisfied with remedial action. [5]

The executive director, CE or management equivalent should sign to indicate they accept the final report, including actions and priorities, and enter relevant comments. [2]

System improvement

The executive management must show commitment and support for effective incident reporting management by implementing processes for the continual review and improvement of the WHS incident reporting system. [9]

Time frame

Depending on the classification of the hazard involved, the following time periods will be used as a guide for the prioritisation and completion of corrective actions: [8]

- High risk (within 24 hours)
- Medium risk (14 days)
- Low (28 days)

Post-event actions

1. **Counselling** must be offered for any affected person [7]

2. **Debriefing** [7]

Where a serious or significant hazard or incident has impacted on other people or has caused concern within an area, a debriefing must be offered by the supervisor or Safety officer to explain:

- The outcome of the hazard or incident.
- The outcome of the investigation.
- Any corrective/preventive measures that have been or will be taken.

3. **Communication** [6]

After becoming aware of an incident rated high or extreme risk, the WHS Manager shall issue an Alert. Managers and Site Senior Persons (or their equivalents) are responsible for ensuring all employees under their direction receive all Alerts via weekly toolbox meetings.

4. **Support** [4, 9]

Supervisors of the area where the incident occurred must ensure that any person involved is provided with the necessary level of support, including access to medical treatment, rehabilitation and health management resources and referral to the Employee Assistance Program as required.