

|  |
| --- |
| Client incident management system (CIMS)Self-paced learning moduleModule 4: Reviewing client incidentsJuly 2020 |
|  |

|  |
| --- |
| To receive this publication in an accessible format phone 1300 024 863, using the National Relay Service 13 36 77 if required, or email the client incident management system team <CIMS@dhhs.vic.gov.au>.Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Department of Health and Human Services, July 2020.Available at [client incident management system](https://providers.dhhs.vic.gov.au/cims) <https://providers.dhhs.vic.gov.au/cims> |
|  |

Contents

[Module 4: Reviewing client incidents 4](#_Toc498943801)

[Learning objectives 4](#_Toc498943802)

[Introduction to the client incident management system 7](#_Toc498943803)

[Learning 4.1: What is the purpose of a client incident review? 8](#_Toc498943804)

[Learning 4.2: When to conduct a client incident review, and roles and responsibilities 9](#_Toc498943805)

[Learning 4.3: Best practice in client incident reviews 12](#_Toc498943806)

[Learning 4.4: The two different types of client incident reviews in the CIMS 13](#_Toc498943807)

[Learning 4.5: How to conduct a case review 14](#_Toc498943808)

[Learning 4.6: How to decide when an RCA review is required 17](#_Toc498943809)

[Learning 4.7: A summary of the RCA review process and methodology 18](#_Toc498943810)

[Sector application 22](#_Toc498943811)

[Case study 1: Homeless sector 22](#_Toc498943812)

[Case study 2: Child protection sector 24](#_Toc498943813)

[Case study 3: Community mental health sector 26](#_Toc498943814)

[Case study 4: Disability sector 28](#_Toc498943815)

[Summary 30](#_Toc498943816)

[Module 4: Reviewing client incidents 30](#_Toc498943817)

[Self-check 32](#_Toc498943818)

[Tasks – expected responses 32](#_Toc498943819)

[Case studies – expected responses 35](#_Toc498943820)

[Evaluation form 39](#_Toc498943821)

# Module 4: Reviewing client incidents

## Learning objectives

Module 4: Reviewing client incidents focuses on incident reviews as required under the Department of Health and Human Services (the department) client incident management system (CIMS). It provides an overall picture of what incident reviews are and how they are undertaken.

The CIMS is designed to foster continuous improvement in service delivery to clients. Reviewing client incidents plays an important role in understanding how an incident has occurred, and ensuring that key learnings from incidents are captured to prevent them from happening again.

There are two types of incident reviews required under the client incident management system (CIMS) in response to a major impact incident – case reviews and root case analysis (RCA) reviews.

It is expected that the majority of reviews conducted under CIMS will be a case review, which will be the primary focus of this module. A case review will generally involve a desktop review of available information and speaking with client(s) and relevant staff members to explore what might have caused an incident. The lessons and actions are then documented to reduce the risk of the same type of incident occurring again in future.

An RCA is only required for highly complex incidents where there appear to be major systemic or process issues underpinning the incident, with multiple cause(s) and potential contributing factors suspected that warrant a more detailed analysis.

While case reviews and RCA reviews share some commonalities, conducting an RCA review is a deeper exploration into an incident. When an RCA review is required, it should be conducted by a person who has undertaken specialised training and/or has the appropriate skills and experience.

In this module, the two types of reviews are explained, but the main focus is on how to conduct a case review. A high level overview of RCA is provided in this module. When participants complete this module they will have an understanding of:

* the purpose of client incident reviews
* how to determine whether to conduct an incident review, and roles and responsibilities in the review process
* best practice in reviewing client incidents
* the two different types of incident reviews in the CIMS – case reviews and RCA reviews
* how to decide when an RCA review is required rather than a case review
* processes for
	+ conducting a case review
	+ an RCA review (overview only).

This is the final of four self-paced learning modules to support participants’ understanding of the CIMS, as outlined in detail in the CIMS policy document, the Client incident management guide. It is not necessary for participants to read the Client incident management guide in order to complete the modules. The first two self-paced learning modules are relevant to any staff member working for an in‑scope service provider to gain an overview of the CIMS, and the requirements for responding to and reporting client incidents.

This self-paced learning module, Reviewing client incidents, is also relevant to any staff member wanting to get a broad overview of CIMS requirements. However, it is more relevant for and targeted towards service provider staff who will have to undertake incident reviews in their organisations.

Table 4.1 outlines the four self-paced learning modules and what they cover.

Table 4.1: CIMS self-paced modules

|  |  |
| --- | --- |
| Self-paced learning Module 1**The CIMS end-to-end model** | Module 1 is a self-paced module that introduces the aims, objectives and principles of the CIMS, along with the five stages of the CIMS as outlined in the *Client incident management guide*. |
| Self-paced learning Module 2**Responding to and reporting client incidents** | Module 2 is a self-paced module that focuses in more detail on CIMS stages 1 and 2, responding to and reporting client incidents. This module describes how to respond to a client incident and what information is required to complete an incident report. |
| Self-paced learning Module 3**Investigating client incidents** | Module 3 is a self-paced module on CIMS incident investigations. It describes what incident types require an investigation to be undertaken and the requirements for conducting an incident investigation. |
| Self-paced learning Module 4**Reviewing client incidents** | Module 4 is a self-paced module on CIMS incident reviews. It provides an overall picture of what incident reviews are and how they are undertaken. |

The four CIMS self-paced learning modules are available at [client incident management system](https://providers.dhhs.vic.gov.au/cims) <https://providers.dhhs.vic.gov.au/cims>.

Participants will have a better understanding of the requirements of the CIMS once the four self-paced learning modules are completed.

Each of the self-paced modules (1–4) will take one to two hours to complete. The modules do not have to be completed in one sitting.

## Introduction to the client incident management system

Welcome to the Department of Health and Human Services (the department) client incident management system (CIMS) self-paced learning module.

The CIMS has clear requirements for responding to, reporting and managing client incidents. The main aim of the CIMS is to support the safety and wellbeing of clients. The objectives of the CIMS are to ensure:

* timely and effective responses to client incidents
* effective and appropriate investigations of client incidents
* effective and appropriate review of client incidents
* learnings are used to reduce the risk of harm to clients and improve the quality of the service system
* accountability of service providers to clients.

The CIMS includes the five stages outlined in Figure 4.1.

Figure 4.1: The five stages of the CIMS



## Learning 4.1: What is the purpose of a client incident review?

The purpose of client incident reviews, as required under the CIMS, is to foster continuous improvement to ensure that client safety and wellbeing are maintained, and that key learnings from major impact incidents are captured to prevent the same type of incident from happening again.

This module focuses on undertaking an incident review when a major impact incident does not meet the threshold for an investigation (see Module 3: Investigating client incidents to learn more about incident investigations).

|  |
| --- |
| **What is a client incident review, and what is its purpose?**A client incident review is a professional practice framework to generate insight into why an incident happened and to capture the key learnings from that incident. It is intended to support continuous improvement by reflecting on the incident, exploring what might have caused it (human, process and system errors), and documenting the lessons and actions the service provider will take to reduce the risk of the same type of incident happening again.The purpose of an incident review is to answer the following questions:* What are the key learnings from the incident?
	+ Why did the incident happen, and what can be changed to reduce the likelihood of similar or related incidents happening again? (Focus on continuous improvement.)
* Did the service provider respond with appropriate actions to manage the incident? (Focus on quality assurance, accountability and client outcomes.)
 |

## Learning 4.2: When to conduct a client incident review, and roles and responsibilities

Module 1: The CIMS end-to-end model and Module 2: Responding to and reporting client incidents covered the process for deciding whether a client incident has occurred during service delivery and if so, whether it is a major impact or non-major impact incident. *Module 3: Investigating client incidents* covered the types of incidents that need to be investigated and the process for conducting these investigations.

We will now explore the steps involved in determining whether an incident review is required in response to a major impact incident, and the roles and responsibilities in relation to doing so.

### Major impact incident follow-up requirements

#### Client incident review or incident investigation?

Following all major impact incidents, the service provider is required to undertake the appropriate follow-up action. This role is allocated to a senior staff member in the service provider who must ensure the following happens:

* Any major impact incident involving the alleged abuse of a client, sexual exploitation, poor quality of care or unexplained injury are investigated
* If the incident does not meet the threshold for an incident investigation (see Module 3: Investigating client incidents), then an incident review must be conducted.
	+ Every major impact incident must be subject to **either** an incident review or an incident investigation.

The follow-up recommendation must then be submitted by the service provider to the divisional office for endorsement at the same time as the incident report.

The follow-up recommendation will also include:

* The type of review to be undertaken (root cause analysis or case review)
* the service provider’s recommendation about who should manage the incident review

the rationale and proposed approach for the review type recommended

|  |
| --- |
| **How do I determine whether a client incident review is required?**There are specific thresholds for an incident investigation to be conducted and if the incident does not meet these thresholds, the service provider must then proceed with an incident review instead.It is expected that in the majority of incidents the recommendation will be to conduct a case review, as opposed to a root cause analysis review. |

#### Who will manage the client incident review?

In the majority of cases, it is the service provider’s responsibility to manage the incident review. The service provider will assess whether it is able to manage the review internally or whether it needs to outsource the review to an external expert. This is particularly relevant when recommending an RCA review. The service provider should consider whether it has:

* the required experience and skill set to conduct the review internally

the appropriate level of objectivity to conduct the review internally.

In exceptional circumstances, the incident review may be managed jointly with the service provider and the divisional office, or wholly by the department.

The decision to jointly review an incident will be based on a consideration of the service provider’s capability and capacity to manage the review to the standards required under the CIMS.

The service provider is required to nominate a senior staff member to conduct the review. This person is known as the **review manager**. The service provider must consider any actual or perceived conflict of interest when appointing a review manager. It is very important to manage any perceived conflict of interest to ensure the credibility of the review.

#### Follow-up recommendation rationale for client incident reviews

The follow-up recommendation for a major impact incident must be submitted to the divisional office within three business days of the incident occurring or from when the service provider became aware of the incident. This timeframe reflects the serious nature of the incident and ensures that a review commences in a timely manner.

In this period, the service provider will assess, based on the information available and using its professional judgement, whether a case review or an RCA review is the most appropriate review method.

The rationale for the recommendation must outline how the service provider has come to its recommended course of action. It is important that the rationale contains all relevant information. Making the decision as to whether to conduct a case review or an RCA review is explained further in [Learning 4.6: How to decide when an RCA review is required instead of a case review](#_Learning_4.6:_How).

|  |
| --- |
| **What is required for the follow-up recommendation for a client incident review?**As part of the major impact incident follow-up recommendation, which must be submitted to the divisional office **within three business days** of becoming aware of the incident, the service provider must decide what kind of incident review is required: a case review or an RCA review, and ensure the rationale for recommending the particular review type is clear. |

### Other investigative and review processes

Incident reviews in the CIMS are distinguished from incident investigations, which have a focus on whether abuse or neglect of a client by a staff member (including a volunteer) or another client can be substantiated. Further details on investigation can be found in Module 3: Investigating client incidents and in the Client incident management guide, Chapter 4: Investigating allegations of abuse or poor quality of care.

Where an incident investigation is carried out, there is no requirement for the service provider to undertake an incident review, so long as the investigation covers any relevant issues of quality assurance and continuous improvement that would otherwise be considered by a review of that incident.

If the service provider decides that an incident review is appropriate once an investigation has been completed (for example, because the investigation did not provide adequate information about quality assurance and accountability or opportunities for continuous improvement), the review should not occur until the investigation has been completed, and it should avoid unnecessary duplication of evidence-gathering processes.

Methods to avoid duplication include:

* collecting evidence in such a way that it can be used for both investigative and continuous improvement purposes (for example, witness interviews should occur with both purposes in mind, and witness statements should be prepared accordingly)
* the review being conducted by the same person who carried out the investigation, where possible and appropriate.

Client incident reviews are also distinguished from:

* other types of reviews with a broader scope than individual incidents, such as service reviews and functional efficiency reviews
* reviews carried out by external oversight bodies, including those pursuant to legislative processes.

|  |
| --- |
| **How is an incident review distinguished from an incident investigation in the CIMS?**Incident reviews in the CIMS have a focus on determining or substantiating whether there has been abuse or neglect of a client by a staff member, carer or another client.Where an incident investigation is carried out, there is no requirement to undertake an incident review; however, in some circumstances the service provider may decide it is appropriate to do so. In this case, the review should not occur until the investigation has been completed, and it should avoid unnecessary duplication of evidence-gathering processes. |

### Non-major impact incidents do not require incident reviews

Incident reviews are not required for non-major impact incidents.

However, as discussed in Module 2: Responding to and reporting client incidents, incident details for non-major impact incidents must be recorded on the client file and in the organisation’s client incident register.

### Task 4.2.1: What is a client incident review?

For each statement below, indicate whether it is correct with a ‘Yes’, or incorrect with a ‘No’.

Responses can be reviewed against the [self-check](#_Self-check) guide at the end of the module.

| What is a client incident review? | Yes/No |
| --- | --- |
| 1. A client incident review is designed to determine why the incident happened, and what can be changed to reduce the likelihood of similar or related incidents occurring in the future.
 |  |
| 1. A client incident review is the same as an incident investigation, only quicker.
 |  |
| 1. A client incident review is designed to determine whether the service provider responded with appropriate actions to manage the incident, and how any such response could be improved in the future.
 |  |
| 1. An RCA review is always conducted once a case review has been conducted.
 |  |

## Learning 4.3: Best practice in client incident reviews

The following key principles apply when undertaking a client incident review. Service providers need to consider these principles throughout the planning, review, reporting and action phases of the process.

### Person-centred approach

A person-centred approach means that the interests and needs of the client are the most important consideration. The way the system responds to the person is individualised, taking into account their age, gender, language, culture, abilities and support needs. In a person-centred approach, what the person has to say is taken seriously; people listen to the individual and take their perspective into account. Even where the person’s account of an incident might differ from the account of others, their self-reported experience and the impact of the incident on them should be acknowledged and validated.

### Rights-based approach

A rights-based approach means that the incident review process must be respectful and take into account the client’s legal, civil and human rights. Responses must consider the client’s preferences, needs and values, including gender issues, and cultural considerations and customs. The approach taken when conducting an incident review must be guided by the client’s wishes, while being informed by their capacity to exercise self-determination (for example, their age, life experience or cognitive capacity), and ultimately support the client’s safety and wellbeing.

### Providing support

Clients should get the support they need to participate in the incident review process. This might mean involving a person they know well, and whom they trust, such as a guardian, family member or independent advocate. It might mean involving a person who speaks their language (including sign language). It might mean getting advice from a professional such as a psychologist, speech pathologist or social worker. The client might need support to obtain a lawyer.

|  |
| --- |
| **Best practice in client incident reviews**Best practice when undertaking incident reviews, much the same as with the incident response, is about putting yourself in the client’s shoes and being sensitive to their needs and empathetic in your approach.Key principles that should be applied when undertaking an incident review include a **person-centred approach**, considering the interests and needs of the client; a **rights-based approach**, respecting and taking into account the client’s legal, civil and human rights; and ensuring **clients get the support they need to participate** in the incident review process. |

## Learning 4.4: The two different types of client incident reviews in the CIMS

As discussed earlier in this module, there are two different ways to conduct an incident review in the CIMS: a case review and an RCA review.

A case review is primarily based on a desktop review of available information and may also require speaking with client(s) and relevant staff members to explore what might have caused the incident, and documenting the lessons and the actions the service provider will take to reduce the risk of the same type of incident occurring again.

|  |
| --- |
| **What is a case review?**A case review is led by the service provider following a major impact incident. It is designed to identify what happened, and provide a framework to harness the learnings and any actions to implement to improve client safety and wellbeing based on that incident.A case review is not conducted for complex incidents where major systemic or process issues with multiple causes and potential contributing factors are suspected. For these incidents, an RCA review should be conducted by someone with the appropriate training, skills and experience. |

A case review must commence **immediately** once receiving confirmation from the divisional office that the incident report has been endorsed, and then it must be completed **within 21 working days**.

Reviewing an incident using RCA methodology applies only to highly complex incidents where there appear to be major systemic or process issues underpinning the incident, with multiple causes and potential contributing factors suspected, warranting a more thorough and detailed analysis. A case review is a very important but more straightforward professional practice mechanism for reviewing less complex incidents.

The decision-making process for deciding whether RCA is the appropriate methodology to be used for an incident review is explored in greater detail in [Learning 4.6: How to decide when an RCA review is required instead of a case review](#_Learning_4.6:_How).

Under the CIMS, it is expected that most client incidents referred for review will result in a case review. Given this, Module 4 will focus on how to conduct this type of review, while providing an overview of RCA reviews.

## Learning 4.5: How to conduct a case review

This section explains how to conduct a case review. In the majority of circumstances, a case review will be the appropriate method for undertaking an incident review.

A case review is primarily based on a desktop review of available information and may also require speaking with client(s) and relevant staff members to explore what might have caused the incident, and documenting the lessons and the actions the service provider will take to reduce the risk of the same type of incident occurring again.

|  |
| --- |
| **How is a case review conducted?**Upon receiving endorsement from the divisional office, the review manager should prepare and document in a case review plan an outline of the key activities that will be undertaken as part of the process. This may include reviewing documentation such as incident reports and client file notes, and speaking to client(s), staff and decision-makers/managers.The case review assessment report should clearly outline how the incident happened, whether the immediate safety needs of the client were met, how the client was supported following the incident, the key learnings and an action plan in response to the incident.The service provider’s chief executive officer (CEO) or senior delegate must then review and approve the case review report. |

### What are the steps required in undertaking a case review?

Case reviews must be initiated **once** receiving endorsement of the incident report from the divisional office, that it is the appropriate review action. Service providers must complete the case review **within 21 working days**.

Service providers are required to submit case review reports to the divisional office upon completion but they are not subject to endorsement by the division office.

A case review seeks to answer the following questions:

* Why did the incident happen, and what can be changed to reduce the likelihood of similar or related incidents occurring in the future? (Focus on continuous improvement.)
* Did the service provider respond with appropriate actions to manage the incident? (Focus on quality assurance, accountability and client outcomes.)

Case review planning and report templates are available from the [Client incident management system page](file:///%5C%5Cn171%5Cgroup%5CCommunity%20Services%20Branch%5CQuality%20%26%20Oversight%20Unit%5CCIMS%5CIMPLEMENTATION%5CL%26D%5CDevel%20CIMS%20L%26D%20modules%5CDeliverables%5CModules%201%20to%205%5CM4%20Rev%5CClient%20incident%20management%20system%20page) <https://providers.dhhs.vic.gov.au/cims>.

### What should be included in a case review plan?

The review manager should prepare and document the following to be included in a case review plan:

* an outline of the key activities that will be undertaken as part of the case review process, which may include
	+ a review of relevant documentation such as incident reports, client file notes, medication chart records, professional reports previously prepared to inform the support of the client, occupational health and safety records, human resources records (for example, staff training records, formal complaint records and performance reviews)
	+ speaking to client(s)
	+ speaking to relevant staff
	+ speaking to decision-makers/managers.

It is not always necessary to speak to client(s), staff and others for a case review. The requirement to speak with relevant parties is assessed on a case-by-case basis. Speaking with staff to inform a case review does not need to be forensic in nature nor does it need to be as detailed as would be expected for an RCA review, for example.

The review manager should use their professional judgement to determine whether there is a ny relevant documentation to be reviewed and who they need to speak to in clarifying any aspects of the incident.

### What should be included in a case review assessment report?

A case review report should answer the following questions:

* How did the incident happen?
* Were the immediate safety needs of the client met after the incident occurred?
	+ What about from the client’s perspective?
	+ Do the views from the client and service provider perspectives about the response to the incident and how the client’s safety needs were met corroborate with each other? If not, why not?
* What actions have been taken or put in place by the service provider to support the client in the longer term?
* What are the key learnings from this incident?
	+ Was the incident managed appropriately?
	+ What could be done differently in future to avoid or reduce the likelihood of the same thing happening again?

An action plan should outline any specific actions to be implemented in response to the incident and who is responsible for each action (for example, a specific individual, all staff who work with the client, a memo to be sent to staff in the organisation sharing the lessons that emerged from the incident to bring it to the attention of a broader audience), and when these actions are to be implemented (ongoing or a specific date).

### Finalising a case review assessment report

When the case review is completed, the following steps are required:

* The service provider’s CEO or senior delegate must carefully consider the report and determine whether it meets the CIMS requirements.
* The service provider’s CEO or senior delegate approves the case review, and ensures that any changes relevant to the services provided to the client are recorded in the client’s file.
* The service provider must log any planned actions against the incident in the organisation’s client incident register, and when completed, record these actions in the client’s file.
* Service providers must communicate the findings of reviews to the people involved in the incident (including the client and their guardian, family member, key support person or case manager/planner).
* The service providers are required to submit each individual case review outcome report to the divisional office.
* Once any actions required as a follow-up to the review have been implemented, the service provider can close off the client incident.

### Task 4.5.1: Storyboard the case review process

You’ve now read about the process of undertaking and finalising a case review as required in the CIMS.

Now imagine you have to report back to a group of senior managers in your organisation about the process of undertaking a case review. You will need to step them through the process, and be prepared to answer any questions they have along the way.

| What happens? | Then what? | … and then? | … and then? |
| --- | --- | --- | --- |
| * A major impact incident occurs, and based on the incident type, it is determined that an incident review is the most appropriate action to undertake in response.
* The review manager is appointed to determine the most appropriate review type for the incident (case review or RCA review).
 |  |  |  |
| **Who is responsible?** | **Who is responsible?** | **Who is responsible?** | **Who is responsible?** |
|  |  |  |  |
|  |  |  |  |

Responses can be reviewed against the [self-check](#_Self-check) guide at the end of the module.

## Learning 4.6: How to decide when an RCA review is required

In the majority of circumstances where a client incident review has been recommended for a major impact incident, a case review will be the appropriate mechanism to capture the learnings from that incident.

This section explores what the review manager should take into account when trying to ascertain whether an RCA review should be recommended as the appropriate type of review.

### Making the decision to conduct an RCA review

An RCA review is recommended for highly complex, major impact incidents where it is suspected that major systemic or process issues underpin that incident. In other words, it appears that the incident is an indicator of broader systemic issues in the organisation that made it possible for the incident to occur in the first instance. As such, it is an incident that warrants taking a much closer look to identify the root cause or causes (there is often more than one cause discovered in RCA reviews) and contributing factors, in order to avoid the same incident happening again.

An RCA review is a ‘deep-dive analysis’ to get to the heart of the incident – to find out why and how it happened. This process also explores whether the causes identified, in relation to a particular incident, may also be causing (or at risk of causing) other client incidents and/or problems elsewhere within the system or service provider setting. RCA is a methodology intended to unveil system and process issues so they can be proactively addressed by the service provider.

|  |
| --- |
| **Making the decision to conduct an RCA review**An RCA review is a ‘deep-dive analysis’ recommended for highly complex, major impact incidents where it is suspected that major systemic or process issues underpin that incident. Review managers should use their professional judgement to make an assessment as to whether this type of review is the necessary and appropriate course of action for the incident that has occurred. |

In deciding whether to recommend an RCA review, the review manager should consider factors such as:

* Is it reasonably clear at this point how to determine what happened in the incident?
* Is it likely that this incident is a one-off?
* Is it reasonably clear at this point that the service provider will be able to determine whether the incident was managed appropriately?
* Is it reasonably clear at this point that the service provider will be able to identify the cause of the incident?
* Is it reasonably clear at this point how the service provider will determine the learnings from the incident?

Is it reasonably clear at this point how the service provider will determine what actions should arise from the review to reduce the risk of the same type of incident occurring again, and thereby reduce the risk of future harm?

If, after thoughtful consideration, the answers to these questions seem unclear, then it may be that an RCA review is required, and the review manager should recommend an RCA review.

If the answer to these questions, or most of these questions, is ‘Yes’, then a case review is likely to be the appropriate method for conducting the incident review rather than an RCA review.

It is expected that an RCA review will only be required in a small number of cases, including those involving the most complex incidents.

The incident review recommendation must be approved by the service provider’s CEO or senior delegate and submitted to the divisional office for endorsement.

## Learning 4.7: A summary of the RCA review process and methodology

As explained earlier in this module, an RCA review will be required for highly complex incidents where there appear to be major systemic or process issues underpinning the incident, with multiple causes and potential contributing factors suspected. This section covers the process requirements of the policy, including timeframes for completion, and summarises the RCA methodology.

For the purposes of the CIMS:

* A **cause** is defined as a condition that produces an effect; eliminating a cause(s) will eliminate the effect. (For example: The client used heroin, which caused them to overdose (the effect) and resulted in them being hospitalised.)

A **contributing factor** is defined as a condition that influences the effect, rather than being a cause in and of itself, by increasing its likelihood, accelerating the effect in time, affecting the severity of the consequences, and so on. Eliminating a contributing factor(s) won't necessarily eliminate the effect. (For example: The client had not used heroin for one month prior to that. Earlier in the day the client had an argument with another client, which caused them to feel highly anxious and increased their craving for heroin, and resulting in the client then proceeding to use it. The argument was a contributing factor of the resulting overdose (the effect) but was not the cause itself.)

Case reviews and RCA reviews do share some commonalities; however, conducting an RCA review is a deeper exploration of the incident.

### Who conducts the RCA review and when does it need to be completed by?

The service provider will assess whether it is able to manage the RCA review with internal resources or whether it needs to outsource the review to an external expert. This assessment should consider whether the service provider has:

* the experience and specific skill set required to conduct the RCA review internally

the appropriate level of objectivity to conduct the review internally.

An RCA review can be conducted by a service provider where they have appropriately trained and experienced staff to do so. Otherwise, a service provider might commission an external expert to either assist with or undertake the process.

Regardless of whether the RCA review is conducted by an external expert, the service provider is still responsible for identifying a review manager. It is expected that this role would be undertaken by a senior staff member within the service provider.

In exceptional circumstances, the RCA review may be managed jointly with the service provider and the divisional office, or wholly by the department.

The decision to jointly review a client incident will be based upon a consideration of the service provider’s capability and capacity to manage the review to the standards required under the CIMS.

An RCA review must be completed **within 60 working days** of receiving incident endorsement from the divisional office.

### What is typically involved in undertaking an RCA review?

An RCA review is a deep-dive analysis to get to the heart of the incident – to find out why and how it happened. This process also explores whether the causes uncovered, in relation to a particular incident, may also be causing (or at risk of causing) other client incidents and/or problems elsewhere within the system or service provider setting. RCA is a methodology intended to unveil system and process issues so they can be proactively addressed by the service provider to minimise the risk of the incident reoccurring.

An RCA review is a structured process for identifying the cause(s) and contributing factors of a client incident. It is a process designed to facilitate learning from a complex incident, and to provide the information needed to modify and improve policies, procedures and systems.

The root cause(s) are identified as the earliest point at which action could have been undertaken to minimise the likelihood of the incident occurring. This method enables answers to questions such as what happened, why did it occur, and what can be done to prevent or minimise the risk of the incident reoccurring.

#### Principles of RCA methodology

The five principles of RCA methodology are to:

1. focus on systems and processes, not individual performance
2. be fair, thorough and efficient
3. focus on problem-solving and not on assigning blame
4. use recognised analytical methods
5. use a scale of effectiveness to develop actions to eliminate or minimise risk.

#### What are the main steps in an RCA review?

* Step 1 – Verify the incident and define the problem:
	+ provide a clear understanding of the problem that is to be addressed
	+ confirm the scope of the RCA review
	+ identify the consequences of the incident for the individual client
* Step 2 – Map a timeline, including any known or assessed causal factors
* Step 3 – Identify critical events (a common tool used for this step is called a ‘critical event map’)
* Step 4 – Analyse critical events
* Step 5 – Identify root causes (a common tool used for this step is called a ‘cause and effect chart’, also known as a ‘fishbone chart’)
* Step 6 – Analyse root causes, supporting each one with evidence
* Step 7 – Identify and select the best solutions
* Step 8 – Develop recommendations
* Step 9 – Complete a written RCA review report and a risk reduction action plan.

#### Common tools used to conduct an RCA review

Some of the tools commonly used when undertaking an RCA review:

* **Critical event map** – An event map is used to identify specific activities that took place in sequence immediately prior to and following an incident. These events should be defined in terms of the time and place where they occurred, who was there, and what each person was doing.
Note: The timeline over which the event map runs might be a matter of minutes, hours or days.

**Cause and effect chart**, also known as a fishbone chart – A cause and effect chart is used to highlight the critical contributors to an incident. It recognises that there is rarely a single cause that gives rise to an incident. It also recognises that to avoid such incidents in the future, a range of measures needs to be identified and a variety of actions taken at different points in the system.

As the focus of this module is primarily on the process for conducting a high quality case review and it is only intended to provide a summary of the RCA process and methodology, these tools will not be explored further in this module but will be discussed in the targeted classroom-based training program.

#### What might be examined in an RCA review?

The objective of an RCA review is to analyse and review client incidents, and to aggregate information to identify lessons and practice implications and make recommendations for systemic improvement in the provision of services through policy or practice change.

Some common aspects that might be examined in an RCA review are:

* client case file history – including medical history, psychiatric and behaviour management, physical health and case management notes
* the service provider’s day book
* client incident reports
* interviews with staff who were on duty at the time of the incident and other relevant staff as required
* policies, protocols, instructions, guidelines and procedures specific to the incident review
* meetings with clients/residents, with an advocate present if appropriate
* meetings with family (if requested or considered appropriate)
* meetings with other persons as identified during the RCA review
* site visits as relevant or appropriate.

### What is required in an RCA review report?

The final report of an RCA review should include:

* a executive summary, giving an objective description of what has occurred, the conditions under which it occurred and the actions (or inactions) that contributed to its occurrence, the impact and the key actions recommended by way of follow-up (for example, changes in policy and practice)
* a Critical event map
* a Cause and effect chart
* conclusions and supporting evidence, with a focus on policies, procedures and systems

recommendations, including a risk reduction action plan.

RCA review reports must be submitted to the divisional office within 60 working days of receiving endorsement from the divisional office regarding the appropriate review action. This is part of the department’s quality assurance process.

The divisional office will review the RCA review report and might, as part of its ongoing monitoring and oversight:

* assess the outcomes and recommendations made to determine whether all appropriate actions have been identified based on the facts and findings of the RCA review

follow up with the service provider to determine whether the actions and outcomes identified have been implemented.

At an organisational level, RCA review reports will ordinarily be reviewed and the recommended actions endorsed by the service provider’s CEO or senior delegate. Given the serious nature of a client incident giving rise to the need for an RCA review, such reports would also ordinarily be drawn to the attention of, or made available to, an organisational board of management or the equivalent legally responsible governing body.

#### Recording and storage of RCA review reports

RCA review reports should remain under active consideration by the service provider, and be regularly reviewed until such time as all the agreed actions in the risk reduction action plan have been implemented and their effectiveness established. To assist with this process, service providers should maintain a risk reduction action plan register and tracking system.Once any actions required as a follow‑up to the incident have been implemented and found to be effective, the service provider can close off the incident file.

### Task 4.7.1: When should an incident review be undertaken?

Now that you’ve read about the two types of incident reviews in CIMS, for each statement below, indicate whether it is correct with a ‘Yes’, or incorrect with a ‘No’.

Responses can be reviewed against the [self-check](#_Self-check) guide at the end of the module.

| When should an incident review be undertaken? | Yes/No |
| --- | --- |
| 1. An incident review should be conducted for all non-major impact incidents
 |  |
| 1. An incident review is appropriate for major impact incidents, regardless of the type of incident, when the incident appears to have happened because the new staff member on duty at the time of the incident did not know what to do when the incident occurred.
 |  |
| 1. An incident review is required when there is an allegation of a staff member emotionally abusing a client.
 |  |
| 1. An incident review is appropriate when it is reasonably likely that the incident is a one‑off.
 |  |

# Sector application

The aim of this section is to apply learnings to the relevant sectors. A selection of case studies is provided. Responses may be reviewed against the [self-check](#_Self-check) section at the end of this module.

## Case study 1: Child protection sector

### Introducing Sarah

Sarah is 15 years old and lives in a four-bedroom residential care unit run by a department-funded organisation. Sarah came into care as a result of her mother’s inability to manage Sarah’s challenging behaviour and unwillingness to continue to care for Sarah. Sarah has a history of aggressive behaviour, significant marijuana use and undertaking dangerous activities, such as playing ‘chicken’ with cars when she is substance-affected, where she runs across busy roads without looking.

Sarah has a child protection case manager, with whom she usually has a good relationship. However, recently Sarah has refused to meet with her case manager and is often absent from the unit.

Over the past two weeks, Sarah’s absence from the residential unit has increased in regularity, although she has returned every couple of nights. Other clients have reported seeing Sarah playing ‘chicken’ with cars in the main street of the local area, to the point where she caused a car to run off the road and hit a fence in an attempt to avoid hitting her. Sarah immediately absconded after this incident and did not return to the unit for two days.

Residential staff, Sarah’s case manager and her care team are in regular contact with each other. Numerous attempts have been made to engage Sarah in other activities when she returns to the unit, but without success. Staff are concerned about the escalation of Sarah’s behaviour and worried about her safety.

### The incident

On Monday night, police return to the unit with Sarah. The police advise that Sarah caused a two-car collision when one car swerved to miss her and ran into another car. Sarah was very shaken by the incident but not physically hurt.

An incident report is submitted by the service provider as incident type ‘Dangerous actions’. The service provider assesses that due to the escalation in Sarah’s behaviour and the high risk of physical harm, the incident report should be submitted as a major impact incident. The service provider recommends that a review be undertaken in response to this major impact incident.

### Questions

Read through the statements below, which refer to Case study 2. Using your knowledge of the CIMS, indicate whether you agree or disagree with these statements.

Responses can be reviewed against the [self-check](#_Self-check) section at the end of the module.

|  |  |
| --- | --- |
| 1. This incident requires an incident review to: | Agree/Disagree |
| 1. Determine how the incident happened
 |  |
| 1. Identify whether the service provider responded appropriately to the incident
 |  |
| 1. Determine whether the client has been abused
 |  |

|  |  |
| --- | --- |
| 2. The review must: | Agree/Disagree |
| 1. Be undertaken jointly by the service provider and the divisional office, given that Sarah is a child protection client
 |  |
| 1. Be approved by the divisional office
 |  |
| 1. Commence within seven days of divisional office approval
 |  |

|  |  |
| --- | --- |
| 3. What type of review would you recommend? | Agree/Disagree |
| 1. Case review
 |  |
| 1. RCA review
 |  |

|  |
| --- |
| 4. Why have you chosen to undertaken the type of review listed above? |
|  |

|  |  |
| --- | --- |
| 5. This review should involve: | Agree/Disagree |
| 1. Appointment of a review manager
 |  |
| 1. Reviewing relevant documents
 |  |
| 1. Interviews with staff
 |  |
| 1. Interview with clients
 |  |
| 1. Reviewing the client’s entire case file
 |  |

## Case study 2: Community mental health sector

### Introducing Mark

Mark is a 42-year-old man who has a long history of mental health issues. He has limited contact with his extended family and separated from his wife two years ago, due to his aggressive behaviour. Mark has limited supports in the community but has a good relationship with his GP, who regularly monitors Mark’s medication.

Mark has a history of self-harm and suicide attempts. He is currently residing at Chapman Community Mental Health Service, where he is receiving support for paranoia and depression.

### The incident

Just before a meal time, Mark becomes distressed, advising staff that he is hearing voices telling him to hurt himself. Manny Zerosky, one of the support staff, approaches Mark to see what is going on. Mark becomes increasingly agitated and distressed, and starts to bang his head hard against the wall, causing immediate bruising to his forehead.

While another staff member intervenes to calm Mark, Manny contacts the local area mental health team, asking them to come to the facility and assess Mark as per the agreed risk plan. Manny and the other staff member stay with Mark until the mental health team arrives. This is the third time the mental health team has been called to visit Mark in the past 10 days.

After assessing Mark and administering a sedative to calm him, the mental health team speaks to the Program Manager, Mary Rogers, expressing concern that there has been deterioration in Mark’s mental health consistent with him not taking his medication. Part of Mark’s mental health management plan is that he goes to reception and is given his sealed Webster-packed medication just prior to meal times. The reception person has received training in medication management but has been on leave for the past two weeks. A casual worker, Tim Simons, has been filling in at reception.

Mary checks Mark’s medication record sheet, which has been signed by Tim each time Mark has taken his medication. Mary remembers that Tim attended a two-day external training session earlier in the week and could not have provided Mark with his medication. However, Tim’s signature is against each medication entry. When asked, Mark tells Mary that he hasn’t had his tablets for the past two days.

An incident report is submitted by the service provider as a ‘Medication error’. The service provider assesses that the incident report should be submitted as a major impact incident. The service provider recommends that a review be undertaken in response to this major impact incident.

### Questions

Read through the statements below, which refer to Case study 3. Using your knowledge of the CIMS, indicate whether you agree or disagree with these statements.

Responses can be reviewed against the [self-check](#_Self-check) section at the end of the module.

|  |  |
| --- | --- |
| 1. This incident requires an incident review to: | Agree/Disagree |
| 1. Determine how the incident happened
 |  |
| 1. Identify whether the service provider responded appropriately to the incident
 |  |
| 1. Determine whether the client has been abused
 |  |

|  |  |
| --- | --- |
| 2. The review must: | Agree/Disagree |
| 1. Be undertaken jointly by the service provider and the divisional office
 |  |
| 1. Be approved by the divisional office
 |  |
| 1. Commence within seven days of divisional office approval
 |  |

|  |  |
| --- | --- |
| 3. What type of review would you recommend? | Agree/Disagree |
| 1. Case review
 |  |
| 1. RCA review
 |  |

|  |
| --- |
| 4. Why have you chosen to undertaken the type of review listed above? |
|  |

|  |  |
| --- | --- |
| 5. This review should involve: | Agree/Disagree |
| 1. Appointment of a review manager
 |  |
| 1. Reviewing relevant documents
 |  |
| 1. Interviews with staff
 |  |
| 1. Interview with clients
 |  |
| 1. Reviewing the client’s entire case file
 |  |

# Summary

## Module 4: Reviewing client incidents

**1. What is the purpose of a client incident review**

* 1. What is a client incident review, and what is its purpose?

A client incident review is a professional practice framework to generate insight into why an incident happened and to capture the key learnings from that incident. It is intended to support continuous improvement by reflecting on the incident, exploring what might have caused it (human, process and system errors), and documenting the lessons and actions the service provider will take to reduce the risk of the same type of incident happening again.

The purpose of an incident review is to answer the following questions:

* What are the key learnings from the incident?
	+ Why did the incident happen, and what can be changed to reduce the likelihood of similar or related incidents happening again? (Focus on continuous improvement.)
	+ Did the service provider respond with appropriate actions to manage the incident? (Focus on quality assurance, accountability and client outcomes.)

**2. When to conduct a client incident review, and roles and responsibilities**

* 1. How do I determine whether a client incident review is required

There are specific thresholds for an incident investigation to be conducted and if it has been determined that a major impact incident investigation is not required, the service provider must then proceed with an incident review instead.

It is expected that in the majority of cases the recommendation will be to conduct a case review, as opposed to a root cause analysis review.

* 1. What is required for the follow-up recommendation for a client incident review

As part of the major impact incident, which must be submitted to the divisional office **within three business days** of becoming aware of the incident, the service provider must decide what kind of incident review is required: a case review or an RCA review, and ensure the rationale for recommending the particular review type is clear.

* 1. How is an incident review distinguished from an incident investigation in the CIMS?

Incident reviews in the CIMS have a focus on determining or substantiating whether there has been abuse or neglect of a client by a staff member or another client.

Where an incident investigation is carried out, there is no requirement to undertake an incident review; however, in some circumstances the service provider may decide it is appropriate to do so. In this case, the review should not occur until the investigation has been completed, and it should avoid unnecessary duplication of evidence-gathering processes.

**3. Best practice in client incident reviews**

Best practice when undertaking incident reviews, much the same as with the incident response, is about putting yourself in the client’s shoes and being sensitive to their needs and empathetic in your approach.

Key principles that should be applied when undertaking an incident review include a **person-centred approach**, considering the interests and needs of the client; a **rights-based approach**, respecting and taking into account the client’s legal, civil and human rights; and ensuring **clients get the support they need to participate** in the incident review process.**4. The two different types of client incident reviews in CIMS**

A case review is led by the service provider following a major impact incident. It is designed to identify what happened, and provide a framework to harness the learnings and any actions to implement to improve client safety and wellbeing based on that incident.

A case review is not conducted for complex incidents where major systemic or process issues with multiple causes and potential contributing factors are suspected. For these incidents, an RCA review should be conducted by someone with the appropriate training, skills and experience.

**5. How to conduct a case review?**

Upon receiving incident endorsement from the divisional office, the review manager should prepare and document in a case review plan an outline of the key activities that will be undertaken as part of the process. This may include reviewing documentation such as incident reports and client file notes, and speaking to client(s), staff and decision-makers/managers.

The case review assessment report should clearly outline how the incident happened, whether the immediate safety needs of the client were met, how the client was supported following the incident, the key learnings and an action plan in response to the incident.

The service provider’s chief executive officer (CEO) or senior delegate must then review and approve the case review report.

**6. How to decide when an RCA review is required instead of a case review**

An RCA review is a ‘deep-dive analysis’ recommended for highly complex, major impact incidents where it is suspected that major systemic or process issues underpin that incident.

Review managers should use their professional judgement to make an assessment as to whether this type of review is the necessary and appropriate course of action for the incident that has occurred.

# Self-check

## Tasks – expected responses

Check your understanding of the tasks given during the module against the expected responses below. Refer back to the *Client incident management guide* and review the relevant sections.

### Task 4.2.1: What is a client incident review?

| What is a client incident review? | Yes/No |
| --- | --- |
| 1. A client incident review is designed to determine why the incident happened, and what can be changed to reduce the likelihood of similar or related incidents occurring in the future.

**Correct.** | **Yes** |
| 1. A client incident review is the same as an incident investigation, only quicker.

**Incorrect. Incident reviews are distinguished from incident investigations, which have a focus on determining whether there has been abuse or neglect of a client by a staff member (including a volunteer) or another client. An incident review is not an appropriate first response to an allegation of abuse or neglect of a client.** | **No** |
| 1. A client incident review is designed to determine whether the service provider responded with appropriate actions to manage the incident, and how any such response could be improved in the future.

**Correct.** | **Yes** |
| 1. An RCA review is always conducted once a case review has been conducted.

**Incorrect. An RCA review is only conducted for complex incidents where major systemic or process issues are suspected.** | **No** |

### Task 4.5.1: Storyboard the case review process

In Task 4.5.1 you were asked to imagine you are required to report back to a group of senior managers in your organisation about the process of undertaking a case review, and to step them through the process, and be prepared to answer any questions they have along the way.

| What happens? | Then what? | … and then? | … and then? |
| --- | --- | --- | --- |
| * A major impact incident occurs, and based on the incident type, it is determined that an incident review is the most appropriate action to undertake in response.
* The review manager is appointed to determine the most appropriate review type for the incident (case review or RCA review) and to make this recommendation during the incident submission within 3 business days of the incident occurring or becoming aware of the incident.
 | * **The review manager, using their professional judgement and making an assessment based on the information available to them about the incident, considers whether there appear to be major systemic or process issues underpinning the incident, and deeming this not to be the case, they submit a recommendation for a case review to be conducted.**
 | * **The review manager makes an assessment as to who should undertake the case review (it may be them), ensuring that that person has an appropriate level of independence from the incident and appropriate skills and experience to do so.**
 | * **The case review is undertaken, which may involve a desktop scan of available information, and speaking to relevant clients and staff members, to determine why the incident happened and what the key learnings are.**
* **An action plan is completed, documenting any specific actions to be implemented in response to the incident, who is responsible for each action, and associated dates for completion.**
 |
| Who is responsible? | Who is responsible? | Who is responsible? | Who is responsible? |
| **Service provider**  | **Review manager** | **Review manager**  | **Review manager** |
| **Review manager** |  |  | **Reviewer (if external)** |

### Task 4.7.1: When should an incident review be undertaken?

| When should an incident review be undertaken? | Yes/No |
| --- | --- |
| 1. An incident review should be conducted for all non-major impact incidents.

**Incorrect. Incident reviews are only conducted for major impact incidents in the CIMS.** | **No** |
| 1. A incident review is appropriate for major impact incidents, regardless of the type of incident, when the incident appears to have happened because the new staff member on duty at the time of the incident did not know what to do when the incident occurred.

**Incorrect. The decision to undertake either an incident investigation or an incident review is not based on the staff members response to the incident but rather the what type of incident occurred. Some major impact incident types must automatically proceed to an investigation and an incident review would therefore not be the appropriate first response.** **If it is deemed that an incident review is the appropriate follow up action to a major impact incident then the service provider must then make a decision to conduct either a Case Review or an RCA review if it appears that there may be major systemic or process issues underpinning the incident.**  | **No** |
| 1. A incident review is required when there is an allegation of a staff member emotionally abusing a client.

**Incorrect. All allegations of abuse of a client by a staff member must be subject to a CIMS investigation.**  | **No** |
| 1. An incident review is appropriate when it is reasonably likely that the incident is a one-off.

**Correct.** | **Yes** |

## Case studies – expected responses

Check your understanding of the case study you selected against the expected responses below. Refer back to the Client incident management guide and review the relevant sections.

### Case study 1: Child protection sector

### Answers

|  |  |
| --- | --- |
| 1. This incident requires an incident review to: | Agree/Disagree |
| 1. Determine how the incident happened
 | **Agree** |
| 1. Identify whether the service provider responded appropriately to the incident
 | **Agree** |
| 1. Determine whether the client has been abused
 | **Disagree** |

|  |  |
| --- | --- |
| 2. The review must: | Agree/Disagree |
| 1. Be undertaken jointly by the service provider and the divisional office, given that Sarah is a child protection client
 | **Disagree** |
| 1. Be approved by the divisional office
 | **Agree** |
| 1. Commence within seven days of divisional office approval
 | **Disagree** |

|  |  |
| --- | --- |
| 3. What type of review would you recommend? | Agree/Disagree |
| 1. Case review
 | **Agree** |
| 1. RCA review
 | **Disagree** |

|  |  |
| --- | --- |
| 5. This review will always involve: | Agree/Disagree |
| 1. Appointment of a review manager
 | **Agree** |
| 1. Reviewing relevant documents
 | **Agree** |
| 1. Interviews with staff
 | **Disagree** |
| 1. Interview with clients
 | **Disagree** |
| 1. Reviewing the client’s entire case file
 | **Disagree** |

### Case study 2: Community mental health sector

### Answers

|  |  |
| --- | --- |
| 1. This incident requires an incident review to: | Agree/Disagree |
| 1. Determine how the incident happened
 | **Agree** |
| 1. Identify whether the service provider responded appropriately to the incident
 | **Agree** |
| 1. Determine whether the client has been abused
 | **Disagree** |

|  |  |
| --- | --- |
| 2. The review must: | Agree/Disagree |
| 1. Be undertaken jointly by the service provider and the divisional office
 | **Disagree** |
| 1. Be approved by the divisional office
 | **Agree** |
| 1. Commence within seven days of divisional office approval
 | **Disagree** |

|  |  |
| --- | --- |
| 3. What type of review would you recommend? | Agree/Disagree |
| 1. Case review
 | **Agree** |
| 1. RCA review
 | **Disagree** |

|  |  |
| --- | --- |
| 5. This review will always involve: | Agree/Disagree |
| 1. Appointment of a review manager
 | **Agree** |
| 1. Reviewing relevant documents
 | **Agree** |
| 1. Interviews with staff
 | **Disagree** |
| 1. Interview with clients
 | **Disagree** |
| 1. Reviewing the client’s entire case file
 | **Disagree** |

# Evaluation form

**Module 4: Reviewing client incidents**

Please help us improve this self-paced learning module by responding candidly to the following statements, using a five‑point scale where:

1 = Strongly disagree; 2 = Disagree; 3 = Neither agree nor disagree; 4 = Agree; 5 = Strongly agree

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| By the end of this self-paced learning module I had a good foundational knowledge of the requirements for incident reviews under the CIMS  | 1 | 2 | 3 | 4 | 5 |
| The content was easy to understand, and the activities were useful and easy to follow | 1 | 2 | 3 | 4 | 5 |
| There was enough information about where I could find out more about the CIMS | 1 | 2 | 3 | 4 | 5 |
| Overall, the self-paced learning module was informative and provided a sufficient introduction and overview to CIMS client incident reviews | 1 | 2 | 3 | 4 | 5 |

What did you like most about this self-paced learning module?

|  |
| --- |
|  |

How can we improve this self-paced learning module?

|  |
| --- |
|  |

Any other comments:

|  |
| --- |
|  |

Please provide your contact details if you would like to discuss your response:

|  |  |  |
| --- | --- | --- |
| Name | Email | Telephone number |
|  |  |  |

Please send this form to CIMS Learning <CIMS.Learning@dhhs.vic.gov.au>.