Clinical Governance & Incident Management Checklist

This checklist will help you review your clinical governance approach and how you use incident management. The first set of questions are reflective questions for Boards. The second and third set provide some example actions that you may want to consider, should you answer No to any of the questions below. This is not an exhaustive list, but focussed on ensuring incident management is used as a learning tool to drive changes in practice to prevent incident reoccurrence.

Date _____

Address _____

Inspector _____

REFLECTIVE QUESTIONS FOR BOARDS ABOUT CLINICAL GOVERNANCE		
	Enter your response here	If follow up actions are required – list here
How do we know we have a ***safety culture?***		
How do we know our governance frameworks and procedures translate to daily practice?		
How do we know our care is ***consumer-centred?***		
How do we know our ***people are capable*** to deliver safe care?		
How do we know we are measuring, monitoring and reporting ***key clinical risks?***		
How do we use incident management to improve care and enhance risk controls?		
How do we know our care is ***safe and effective?***		

INCIDENT MANAGEMENT

	Yes	No	NA	Potential actions if answered No	Who	By When
Do staff know how to document an incident – and what constitutes an incident?	☐	☐	☐	e.g. Conduct training with staff to ensure they understand how to document incidents.		
Is incident management person-dependent?	☐	☐	☐	e.g. In cases where a small number of staff manage the investigation and documentation of ncidents, ensure there are enough staff trained to do so, should key staff leave the organisation.		
Do staff document near misses?	☐	☐	☐	e.g. Encourage reporting of near misses and engage staff in discussions about what they did hat prevented an incident, so that future incidents might also be prevented. e.g. Start a “nice save” or “good catch” award, celebrating and rewarding active interventions that revented harm.		
Do you use shift handover to raise near misses or incidents that occurred during the shift or service?	☐	☐	☐	e.g. Consider including questions about incidents and near misses during handover and discuss riefly actions to prevent reoccurrence.		
Do you use manual paper incident reporting?	☐	☐	☐	e.g. For larger, multi-site organisations, consider an electronic system to record incidents and ear misses.		
Are the incidents aligned with known risks?	☐	☐	☐	e.g. If there is an aligned risk – check the risk controls are being applied and consider eassessing the risk likelihood or consequence.		
Do incidents keep re-occurring?	☐	☐	☐	e.g. Review the effectiveness of controls put in place to prevent a repeat incident. Work with lient to agree appropriate solutions or alternatives.		

CLINICAL GOVERNANCE COMMITTEE AND INCIDENT MANAGEMENT

	Yes	No	NA	Suggested actions if No	Who	By When
Based on the number and complexity of clients you provide services for, do you think incidents are being reported?	☐	☐	☐	e.g. Conduct a review of the volume of incidents over the last 2 years (monthly data) and see if here are any major changes in volume. Large increases are likely about better reporting rather han more incidents occurring.		
Does the clinical governance committee receive trend data for incidents?	☐	☐	☐	e.g. Conduct trend analysis of data to understand occurrence, site and types of incidents to nform training and audit. If patterns emerge, identify priority actions to minimise risk for clients.		
Do you conduct root cause analysis (RCA) of incidents result in changes in practice?	☐	☐	☐	e.g. Add root cause analysis to your review of incidents. See the link below from NSW Clinical Excellence Meeting about RCA may be useful1.		
For incidents that result in procedural change, do you revisit this 3 months later to ensure the change has been sustained?	☐	☐	☐	Conduct observational audits to validate adherence to new practice. e.g. Include major practice changes into staff training and refreshers to help ensure sustainability of new procedures and practice.		

[1]NSW Clinical Excellence Commission, posted 11/12/2020 Root Cause Analysis [Online video] Available at: https://www.youtube.com/watch?v=JHtUIXZ_Y08 Accessed 29/07/2021

CLINICAL GOVERNANCE COMMITTEE AND INCIDENT MANAGEMENT - CONTINUED						
	Yes	No	NA	Suggested actions if No	Who	By When
Are reportable incidents re-occurring?	☐	☐	☐	e.g. Review the effectiveness of controls put in place to prevent a repeat incident. Work with lient to agree appropriate solutions or alternatives.		
Does the volume of incident data reflect the likelihood of risks on your clinical risk register?	☐	☐	☐	e.g. Revisit risk rating for likelihood and consequence for high frequency risks and determine if current ontrols minimise harm.		
Do you periodically consider issues in your sector (ie relevant issues in the media, coroners reports etc) and ask "Could this happen to us?"	☐	☐	☐	e.g. Try doing a scan once or twice a year for major incidents in your sector and consider what safeguards you have in place to ensure it could not happen in your organisation.		

If you would like to speak to someone about clinical governance or incident management, call our email us at info@ansvarrisk.com.au