Appendix

Appendix 1: Results of process audit of incident reviews

DIMENSION	N	%
IMMEDIATE RESPONSE		
1. Was Clinician Disclosure offered?	17	89.5%
2. Did Clinician Disclosure occur?	15	78.9%
3. Clinician Disclosure occurred how long after the identification of the incident? (of n=15)		
a) same day	3	20.0%
b) 1 – 2 days after incident	5	33.3%
c) 3 – 6 days after incident	2	13.4%
d) 7 days or more	2	13.3%
e) unknown	3	20.0%
4. Was Clinician Disclosure was documented in CIMHA? (of n=15)	11	73.3%
5. Was Clinician Disclosure was documented in RiskMan? (of n=15)	9	60.0%
6. Were staff provided with support following the recognition of the incident?	19	100.0%
REVIEW PROCESS		
7. The review team included:		
a) Relevant members of clinical team / team delivering care to the consumer		
b) Multidisciplinary representation	19	100.0%
c) Staff from relevant services or teams where care requirements carried across teams	19	100.0%
d) Specific expertise from clinical governance, and/or patient safety	15	78.9%
e) MHSS trained facilitator	18	94.7%
f) MHSS Peer Clinical expert	17	89.5%
g) Clinicians identified as expert in their field & relevant to the incident	19	100.0%
h) Representatives from external service providers	2	10.5%
8. Is the method for analysis specified within the incident report?	19	100.0%
9. Was input sought from all professional/operational streams of staff relevant to the incident?	19	100.0%
10. Were content experts relevant to the incident consulted?	19	100.0%
11. Was input to the review process sought from consumer/family/carer?	11	57.9%
12. Did the consumer/family/carer agree to provide information to the review process?	11	57.9%
13. Was the feedback from the consumer/family/carer considered by the review team?	11	57.9%
14. Was there an opportunity for Leadership team (service/division Executive as appropriate) to be involved in the review process?	19	100.0%
RECONSTRUCTION		
15. Is the reader of the review report able to adequately comprehend the incident and associated events from the description of events?	19	100.0%
ANALYSIS		
16. Were the relevant care processes specifically identified?	19	100.0%
17. Is there evidence that the review team has rigorously sought to identify the underlying causes/contributing factors of the incident?		
a) Chain of event/sequence of events	19	100.0%
b) Diagramming methodology (Constellation diagram / bow tie / fishbone diagram	11	57.9%

	c) Process mapping	19	100.0%
	d) Human factors methodology applied	19	100.0%
18.	Is there evidence that scientific literature and grey literature from other jurisdictions was searched?	6	31.6%
19.	Is there evidence that guidelines/protocols applicable to care processes relevant to the incident were identified?	14	73.7%
20.	Was adherence to or variation in care processes from applicable guidelines/protocols identified?	19	100.0%
21.	Does the report state whether the clinical indication for the provided care was correct and in line with evidence-based practice?	14	73.7%
CONCLUSIONS			
22.	Does the report identify root causes?	0	0.0%
23.	Does the report identify other learnings that can lead to enhancement of the care provided in the service?	19	100.0%
24.	Do the findings fit the description of the events?	18	94.7%
25.	Are contributing factors considered and/or identified?	13	68.4%
26.	Is there account taken of current service development / quality assurance activity / prior attempts to address the issues identified?	18	94.7%
27.	Are contributing factors not under the control of the hospital considered and/or identified?	19	100.0%
28.	Does the report identify any examples of high-quality care?	17	89.5%
RECOMMENDATIONS			
29.	Are there recommendations (however named)?	19	100.0%
30.	Are the recommendations written for ready implementation? (e.g., Specific, Measurable, Allocated, Realistic and Time-Sensitive (SMART))	19	100.0%
FOLLOW THROUGH			
31.	Was the incident review completed within the appropriate time frame?	9	47.4%
32.	Has feedback on the incident review been provided to the consumer/family/carer?	8	42.1%
33.	If yes, was this via the Formal Open Disclosure process? (of N=8)	8	100.0%