Review of Root Cause Analysis Legislation

Hospital and Health Boards Act 2011 (Part 6)

Ambulance Service Act 1991 (Part 4A)

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Summary of Recommendations

It is recommended that the following areas be considered for **legislative amendment**:

1. Maintain the current enabling legislation approach to RCA.

2. Treat the Chain of Events documentation as part of the RCA Report and subject to the same disclosure and release provisions. The Chain of Events documentation should remain inadmissible in legal and disciplinary proceedings.

3. Include a decision of an RCA team member to report 'public risk notifiable conduct' to the Australian Health Practitioner Regulation Agency (AHPRA)* as an explicit ground for stopping an RCA.

4. Require RCA teams to notify the Commissioning Authority of the grounds for stopping an RCA and the information that forms the basis for that ground.

5. Expand the scope of the legislation to include non-government organisations prescribed under regulation.

* Note: The function of receiving mandatory reporting notifications will transfer from AHPRA to the Health Ombudsman in 2014 upon commencement of the *Health Ombudsman Act 2013*.

The following areas have been referred to the areas responsible for policy for the development of further **guidance and education** on provisions in the existing legislation:

1. Perceived restrictions on the ability to consult outside the RCA team in formulating recommendations.

2. Perceived restrictions on the ability for an RCA report to be shared with staff, and persons involved in the adverse event.

3. Uncertainty about when to stop an RCA on the grounds of reasonable belief of a 'blameworthy act'.

4. Uncertainty about a health practitioner's mandatory reporting obligations to AHPRA when they are acting as an RCA team member.

5. A Chief Executive's perceived lack of power to delegate the role of Commissioning Authority to more than one person or position.

1 Introduction

In 2008, legislation was introduced to provide a statutory framework in both the *Health Services Act 1991* and the *Ambulance Service Act 1991* for the conduct of Root Cause Analysis (RCA), focussed on improving safety in public and private health services and the Queensland Ambulance Service.

The introduction of a statutory framework for the conduct of RCA gave effect to a recommendation of the Queensland Health Systems Review Final Report 2005 (The Forster Review), concerning the development of legislation encouraging and protecting good quality and safety assurance analysis within health services. It also gave effect to a State Government commitment in the Action Plan – Building a Better Health Service for Queensland 2005 to generate a clinical culture which recognises the importance of timely and accurate incident reporting and investigation, clinical audit, benchmarking and clinical pathways variance analysis.

Section 38ZL of the *Health Services Act 1991* and section 36ZC of the *Ambulance Service Act 1991* state:

> '(1) The Minister must, before the second anniversary of the commencement of section 38K{36E}, start a review of this part to ensure it is adequately meeting community expectations and its provisions remain appropriate.
>
> '(2) The Minister must, as soon as practicable after the review is finished, cause a report of the outcome of the review to be laid before the Legislative Assembly'.

Planning for the review commenced in late 2009 between Queensland Health and the Department of Community Safety. Given that the legislative provisions and affected stakeholders were largely the same for both Queensland Health and the Queensland Ambulance Service, it was decided that there would be a concurrent review process. This approach was approved by the then-Deputy Premier and Minister for Health, and the then-Minister for Police, Corrective Services and Emergency Services.

The review was commenced on 3 March 2010.

The review panel comprised members from:

- Queensland Health Patient Safety and Quality Improvement Service (PSQ)
- Queensland Health Legislative Policy Unit
- Queensland Ambulance Service (QAS)
- Strategic Policy and Legislative Reform, Department of Community Safety

The review was jointly sponsored by Dr John Wakefield, Executive Director, PSQ, and Dr Stephen Rashford, Medical Director, QAS.

Stakeholder consultation was undertaken from 12 April 2010 to 17 January 2011. Key stakeholders were identified and invited to attend face-to-face meetings. All stakeholders were invited to provide written feedback on their perspective and usefulness of the RCA legislation. Details of the review were also published on the Queensland Health website and included a request for submissions from the public.

Face-to-face interviews were held with 15 stakeholders and written feedback was received from 27 stakeholders (see Annexure 2).

Prior to finalization of the review report the *Hospital and Health Boards Act 2011* was introduced to give effect to reform of the delivery of public sector health services in Queensland, repealing the *Health Services Act 1991*. The RCA provisions of the *Health Services Act 1991* are substantially replicated in the *Hospital and Health Boards Act 2011* and remain substantially the same as those continuing in the *Ambulance Service Act 1991*. For ease of reference, where it is necessary to refer to a particular section of the RCA legislation this report will refer to the provisions of the *Hospital and Health Boards Act 2011*. A table cross-referencing the section numbers for RCA provisions in each Act is provided as Appendix 1.

2 The role of RCA in improving patient safety

2.1 What is RCA?

RCA is an internationally recognised approach to the analysis of serious clinical incidents associated with the provision of healthcare, such as those resulting in unexpected death or serious injury. It involves the use of a multidisciplinary team to retrospectively analyse the sequence of events, identify any contributory factors, and make recommendations for how to prevent similar events occurring in the future. It is a core component of clinical incident management.

RCA utilises quality improvement methodology. It neither seeks to, nor is capable of, determining liability or apportioning blame to individuals. Its purpose is to improve patient safety through the identification of, and elimination or mitigation of latent weaknesses in healthcare systems and processes. It is intended as an addition to, rather than a replacement for, existing systems of individual accountability such as those found in administrative, civil, professional/disciplinary or criminal proceedings.

2.2 What is the purpose of RCA?

The purpose of RCA is to address and prevent patient harm associated with healthcare.

It does this through two main mechanisms:

1. identification and implementation of improved health care processes designed to reduce the likelihood of similar adverse events occurring in the future, and

2. supporting Open Disclosure by providing information to help patients and their families get answers to the many questions that follow a serious adverse event.

2.3 Why is RCA needed?

Prior to the introduction of RCA in Queensland, there was no defined process for the internal investigation of serious adverse events. Without this, patients and their families frequently had to resort to legal proceedings to obtain any information to help explain what happened to themselves or their loved one. The timeframe for such processes is usually several years, which further contributed to unresolved grief and loss of trust in the healthcare system. The adversarial legal processes pursued by the small percentage of patients or relatives focused on apportioning blame and damages, and arguably contributed little to improving health care systems and processes.

RCA provides a mechanism by which information and opinion can be obtained in a timely way, and used to provide disclosure to patients, families and affected staff, as well as contributing to continued improvements in future patient safety.

2.4 What has RCA contributed to patient safety

The Queensland Health experience has been positive with regards to the aim of improved patient safety and reduction in preventable patient harm as a result of RCA recommendations. Such examples include:

- Targeted patient safety tools, interventions and program implementation, e.g. Clinical Handover, Recognition and Management of the Deteriorating Patient.

- Standardisation of systems across the organisation, e.g. World Health Organisation - Surgical Safety Checklist.

- Changes to equipment standards and manufacture, e.g. ventilator manufacture and bedside monitoring device standards.

- Enhanced governance of health service improvement, e.g. local governance accountability toward RCA recommendations and the accountabilities contained within the Department of Health Clinical Incident Management Policy.

- Queensland Health annual publication on clinical incident management – “Learning to Action”.

- Enhanced ability to share information with patients and family following adverse events and open disclosure transparency.

The introduction of RCA has also met key recommendations of the Forster Review relating to safety, quality & clinical governance and in particular, incident monitoring and analysis including:

- Appropriate training in the use of specific service improvement techniques such as incident investigation, clinical audit, benchmarking and clinical pathway variance analysis.
- Review and implement the incident management policy.
- Analyse serious and sentinel events at an area health service and state level (and contribute to national reporting) with a focus on preventing and minimising harm.
- Based on incident analysis develop and implement state-wide safety initiatives using clinician led networks.
- Provide an annual public report on sentinel events.
- Development of legislation encouraging and protecting good quality and safety assurance analysis should proceed and be submitted to the Health Minister to progress.

The Queensland Ambulance Service (QAS) utilises RCA as part of a broader clinical audit suite which facilitates review of patient care services in a significant number of cases on an ongoing basis. This review is instrumental in identifying systemic and process issues for improvement. Additionally, QAS participation in RCAs commissioned by Queensland Health is developing stronger links between the pre-hospital and hospital elements of patient care.

3 RCA Legislation

3.1 Why is it necessary to have legislation for RCA?

RCA depends upon the provision of information to the RCA team by staff who were directly involved in the care of the patient. It also depends on the voluntary participation of a team of health professionals to form the RCA team to undertake the analysis of the event.

If staff do not feel protected in a confidential and privileged environment, RCAs will not be conducted and the thorough analysis that can lead to patient safety improvement and more effective open disclosure may not occur. On the other hand, if complete protection and confidentiality is provided to participants and the information they provide, there will be no transparency of the process or output from the RCA team and no ability for others to learn from the lessons identified by the RCA team.

The current legislation aims to balance this tension between the need for transparency of processes and outcomes and the strongest assurance of confidentiality to enable willing and robust participation in incident analysis by both individuals involved in adverse events and RCA team members, without fear that their involvement will result in future repercussions or reprisals.

3.2 Key features of the current RCA legislation

RCA provisions are currently contained in Part 6 Division 2 of the *Hospital and Health Boards Act 2011* (previously Part 4B of the *Health Services Act 1991*) and Part 4A of the *Ambulance Service Act 1991*.

The current RCA legislative provisions seek to achieve the balance of confidentiality and transparency discussed above by restricting access to certain information obtained during the course of an RCA (such as that which could unreasonably be used against the person providing the information) but at the same time, requiring the RCA team to produce a report which can be used to aid open disclosure and contribute to safety improvements. In seeking to achieve this balance, the RCA provisions draw heavily on features of the Commonwealth *Transportation Safety Investigation Act 2003*, which have a similar purpose for investigating aircraft and other similar transportation accidents involving death or serious injury.

The following table sets out the key features of the current legislative provisions. Section references in this table are to the *Hospital and Health Boards Act 2011*. Please see Appendix 1 for the equivalent provisions of the *Ambulance Service Act 1991* and the repealed *Health Services Act 1991*.

Section	**Feature**	**Rationale**
95	Defines RCA	RCA must be focused on what happened, how it happened and how it can be prevented in future. RCA is not suitable for investigating professional competence or to apportion blame for an adverse event.
93, 97	Sets out purpose and guiding principles for the conduct of RCA	RCA is a quality improvement technique, has a systems focus, and is about learning and improvement.
93	Enabling approach	RCA is not mandatory under the legislation, but allows health services to undertake RCA with confidentiality and privilege if the requirements of the Act are met.
98	Describes who may appoint RCA teams	RCA requires a senior accountable officer to be responsible for the appointment of RCA teams. In the case of the QAS, this officer is the Commissioner.
99	Minimum requirements for the RCA team	Undertaking an RCA requires specific knowledge and skill and the RCA team must be free from bias or conflict of interest (either actual or perceived).
100-101	Reporting	In order to be of value, an RCA must lead to a written report which can be used to facilitate open disclosure, as well as to inform relevant persons of what happened, any contributing factors, and actions that need to be taken to prevent recurrence.

Section	Feature	Rationale
102-103	Provides for an RCA to be stopped under certain circumstances	RCA is not an appropriate tool for examining individual accountability and must not be used if there is a reasonable belief that the adverse event involves a blameworthy act by an individual or if the capacity of a person who was involved in the adverse event was impaired by alcohol or drugs. RCA may not be appropriate if another authority (such as the police or a health practitioner registration board) is conducting an investigation into the event.
104-118	Specifies how, when and to whom information can be provided	Release of information arising from an RCA is subject to stringent conditions aimed at maximizing the potential benefit to affected patients and families and patient safety in the community; and minimizing the potential for unjustified adverse consequences to RCA team members and persons providing information to RCA teams. RCA team members cannot be compelled to give evidence in legal proceedings in relation to their role in an RCA. Persons providing information to RCA teams cannot be compelled to give evidence in legal proceedings about whether they provided information to an RCA team, and/or what information they gave to an RCA team.
116-122	Specifies protections for those involved in an RCA	Persons agreeing to serve as members of an RCA team and providers of information to an RCA team must be protected from liability and reprisal for their honest and reasonable actions in undertaking the RCA.
119	RCA report not admissible in evidence	RCA is a quality improvement methodology and does not afford procedural fairness. Further, strict confidentiality is critical to the effective functioning of RCAs, particularly for promoting clinician participation in RCAs. To preserve this confidentiality and ensure appropriate procedural fairness, RCA reports and information must not be used as evidence in any legal proceedings.

Part 6, Division 2 of the *Hospital and Health Boards Act 2011* is supported by Part 6 of the *Hospital and Health Boards Regulation 2012*, which re-enacts the provisions of the previous *Health Services Regulation 2002*.

The Regulation defines “reportable events” for which an RCA may be conducted and authorise a range of bodies with safety and quality functions within Queensland Health to receive RCA reports to be used for quality improvement purposes.

There is no equivalent regulation under the *Ambulance Service Act 1991* as these matters are addressed within the Act itself.

4 Use of RCA in Queensland

The majority of the RCAs conducted in Queensland to date have occurred in Queensland public hospitals and health facilities. Reasons for this include:

- Queensland Health , with over 60,000 full time staff across 166 public facilities, is the largest provider of health services in the state
- despite the legislation not mandating RCA, Queensland Health has had a policy position since 2004 that all clinical incidents resulting in unexpected death or likely permanent harm must undergo an RCA
- Queensland Health has invested significant resources into implementing and supporting clinical incident analysis through the establishment of the Patient Safety Centre (now the Patient Safety Unit) and the deployment of Patient Safety Officers across the state.

The table below provides a summary of the numbers of RCAs conducted since the legislation was proclaimed on 20 March 2008:

Health service sector	**Number of RCAs commissioned from 20 March 2008 to 31 December 2012**	**Comment**
Queensland Health	766	Use of RCA is mandated through policy for the most serious unexpected patient outcomes
Private Hospitals	71	Private hospitals and day surgery units are required to report serious adverse events and copies of RCA reports to the Private Health Regulatory Unit of the Department of Health.
Queensland Ambulance Service	2 commissioned independently by the QAS, with the majority as joint participants in hospital commissioned RCAs.	Reportable events in the RCA context occur significantly less often in the pre-hospital environment. Additionally, RCA is seen by QAS as only a small part of the overall clinical audit suite and thus should only be utilised in appropriate circumstances. The most appropriate review path is assessed by the Medical Director QAS in each instance.

5 Findings of the Review

5.1 Overview of consultation feedback

Most feedback acknowledged the positive contribution of RCA to the broader approach to patient safety improvement. No submissions were received requesting that the legislation be abolished.

Positive issues raised included:

- Robust nature of the RCA process
- Staff being treated more fairly after a serious adverse event
- Improved boundaries and confidentiality during RCA, preventing bias
- Facilitation of open disclosure with affected patients and families
- Focus on improvement rather than blame
- Protections for RCA team members support their participation
- Greater chance of change due to requirement for executive commissioning and response to RCAs.

Negative issues raised included:

- Perceived complexity of the legislative requirements
- Enabling nature of the legislation gives organisations the choice of whether or not to undertake RCAs
- Extent of privilege hinders sharing information from RCAs
- Lack of information available for consumers regarding the RCA process
- Private practitioners are not funded to participate
- Concerns that RCA teams cannot provide any information to assist a Commissioning Authority if they suspect a blameworthy act.

A significant number of submissions raised issues which were actually related to policy, practice and implementation of incident management and RCA, rather than the legislation itself. Examples included the timeframes set for completion of RCA reports, and the templates used to support the incident management process. These will not be considered further in this report, and have been referred to the areas responsible for policy.

5.2 Discussion of issues raised during the review

5.2.1 Enabling or mandating legislation

The current legislation does not mandate RCA; rather, organisations may benefit from the privileges and protections of the legislation if they decide to undertake an RCA for an adverse event that meets the definition in the legislation. Whether an RCA is undertaken for such an adverse event is currently a matter for organisational policy and is not prescribed by the legislation.

There are arguments for and against extending the scope of the legislation to mandate RCA for reportable events. A number of health consumers strongly advocated for extending the legislation in this way, citing the perceived benefit of improved accountability and openness for patients and their families. However, health service providers sought the flexibility that the current legislation allows, citing that RCA is resource intensive and is not always the best approach. Furthermore, health service providers perceive there is a risk that all available resources will be channelled into the more complex RCA methodology for incident analysis leaving less resources available to implement, monitor and evaluate corrective actions.

The Health Quality and Complaints Commission (HQCC) provided verbal feedback, particularly around process and policy however did not provide any submissions related to changing the legislation and the organisation supports the enabling provisions of the current Acts.

The Office of the State Coroner (OSC) had no requirements for amendments to the current legislation. The OSC regarded the availability of RCA reports as a positive experience and that in many cases the detail and depth of RCA reports was of assistance in managing cases. Coroners continue to review and provide valuable comment on the quality of individual RCA reports as they are relevant in coronial investigations.

All stakeholders recognised RCA as a quality improvement process that is reliant upon the culture and commitment of an organisation to learn and improve.

Submissions from colleges and professional associations supported the quality improvement process of RCA and did not indicate a shift away from the current enabling approach in the architecture of the current legislation was desired.

Voluntary RCA team involvement by senior clinicians is widely seen to enhance the quality activity intended.

Overall, the majority of submissions support the current enabling approach of the legislation to ensure effective clinical incident management and to facilitate explanations of what happened to patients and families. The alternate view expressed, to mandate the conduct of RCAs and the open sharing of RCAs reports, is aimed at improving openness and accountability for patients and families.

In considering the alternate view, it should be noted that while RCA reports are privileged in that they are protected from use in legal proceedings (except for coronial inquests), the current legislation does allow the results of an RCA to be openly shared with patients and families as part of the Open Disclosure process. Accountability is also provided through other incident analysis processes, such as formal investigations where issues of individual misconduct rather than systems issues are in question. RCA is just one tool in the array of tools for responding to clinical incidents.

It is considered that mandating RCA would not necessarily improve openness and accountability over and above existing processes and may in fact be detrimental given the positive outcomes already cited in support of the current enabling provisions. Therefore when considered with the majority of stakeholder feedback, continuation of the enabling legislative approach is supported.

Recommendation 1

Maintain the current enabling legislation approach to RCA.

5.2.2 Reporting and release of information from RCAs

A concern raised in most submissions was the degree to which the current legislation restricted the sharing of information to persons perceived as requiring it.

In considering this issue, it is necessary to briefly outline how the current legislation deals with information arising from RCAs. RCAs involve four main information components:

- Source documents – such as patient records, observation charts, incident reports. These attract no privilege and are fully discoverable.

- Working documents – created during the process of the RCA. These include notes of interviews with witnesses. These are fully privileged and cannot be disclosed to any person outside of the RCA team under penalty of law.

- RCA Report – produced by the RCA team and defined in the legislation to include a description of the event; a statement of the factors the RCA team considers contributed to the event happening; any recommendations about changes or improvements in a policy, procedure or practice relating to the provision of health services, to reduce the likelihood of, or prevent the same type of event happening again during the provision of health services. Access to this report is prescribed by the legislation and includes relevant safety and quality entities and any person deemed by the person responsible for commissioning the RCA (the 'Commissioning Authority') to have a personal or professional interest. The RCA report cannot be used as evidence in a civil, criminal or professional disciplinary proceeding

- Chain of Events document – produced to assist the RCA team to determine what happened and why. It usually includes a chronological flow chart of events leading up to the adverse event. It also usually includes a contributing factors diagram which reflects the error chain of contributing factors that the RCA team believe contributed to the event occurring. Chain of Events documents are also privileged and cannot be disclosed. Chain of Events documents can only be viewed by the Commissioning Authority and for authorised purposes by relevant safety and quality entities or the Medical Director QAS.

Access to the working documents from the RCA team

No submission requested that privilege be removed from information such as the notes taken by an RCA team of an interview with a witness. No change is proposed to the legislation in this regard and it is still seen as a critical component of ensuring staff can trust the confidentiality of the process to ensure ongoing participation by both RCA team members and by staff providing information to an RCA team.

Access to the RCA report

There was a perception in multiple submissions that the RCA report could not be shared with staff and persons involved in the adverse event. This perception is inconsistent with existing legislative authority for a Commissioning Authority to share the RCA report with any person with a sufficient personal or professional interest in the adverse event. A Commissioning Authority also has the authority under the existing legislation to provide a safety and quality report derived from the RCA report, to individuals or entities with responsibilities for patient safety initiatives and programs for the health service facility or QAS.

This misperception about the ability to share the RCA report highlights an area for further education rather than a need for legislative change and has been referred to the areas responsible for policy.

Access to the chain of events documents

Several submissions noted the importance of the Chain of Events documents for committees responsible for oversight of safety and quality, as well as for individuals who are allocated responsibility to implement recommendations arising from the RCA. It is argued that without access to these Chain of Events documents it is difficult to get a true understanding of the causative factors, how the recommendations were arrived at, and to achieve buy-in from staff needing to implement the recommendations.

As noted above, Chain of Events documents usually include a chronological flow chart of events leading up to the adverse event and a contributing factors diagram which reflects the error chain of contributing factors that the RCA team believe contributed to the event occurring.

When the legislation was initially introduced the reason for restricting access to these documents was to manage the perceived risk of individuals being identified through such working documents. However, with several years experience and improvements in the procedures and quality review of RCAs, this risk has been reduced substantially, such that the risks of continuing to maintain privilege may outweigh the benefits available from being able to more broadly share these Chain of Events documents to be read together with the RCA report.

Opening up access to the Chain of Events documents would provide the potential for more comprehensive information for patients and their families, as well as staff,

following analysis of a serious adverse event. It will also provide for a better understanding of how the RCA team arrived at their recommendations and thereby increase the likelihood of buy-in for their implementation. As the RCA report cannot be used as evidence in proceedings, it is not envisaged that including the Chain of Events documents within the RCA report definition will create any direct additional risks to protections and indemnities already provided. However, any perceptions of increased risk to staff may affect participation in RCAs, and this would need to be carefully monitored and assessed over time.

Recommendation 2

Treat the Chain of Events documentation as part of the RCA Report and subject to the same disclosure and release provisions. The Chain of Events documentation should remain inadmissible in legal and disciplinary proceedings.

5.2.3 Stopping an RCA

A number of concerns have been raised in submissions related to the stopping of RCAs.

Provisions in the current legislation to stop an RCA are designed to ensure that an RCA is not used or continued when an adverse event is suspected to be caused by a 'blameworthy act' (see definition below) or impaired capacity of a healthcare worker due to alcohol or drugs, as RCA is not a tool that is designed to investigate such matters. Queensland Health's experience with clinical incidents subject to RCA has been that almost all adverse events occur at the hands of well intentioned, well trained staff, doing their best to provide patient care. In practice, it has been rare that an RCA has been stopped by an RCA team under these legislative provisions. The total number of RCAs conducted during the period 20 March 2008 to 30 June 2013 was 766 and only 20 RCAs were stopped in that period.

A 'blameworthy act' is defined to mean:

(a) An intentionally unsafe act;
(b) Deliberate patient abuse (or deliberate abuse of a person receiving an ambulance service);
(c) Conduct that constitutes a criminal offence.

It was submitted that RCA teams have had some difficulties in interpreting this definition. It is appreciated that this is a difficult task in complex circumstances. It is not considered that further legislative amendment would make this task any easier and efforts should be made at the policy level to provide further education and guidance on this issue. This has been referred to the areas responsible for policy.

5.2.4 Mandatory Reporting Laws and RCA

The Health Practitioner Regulation National Law Act 2009 introduced mandatory reporting obligations upon all registered health practitioners to report to the Australian

Health Practitioner Regulation Agency (AHPRA)[*] if they reasonably believe that another practitioner has behaved in a way which presents a risk to the public.

While RCA is not intended as a tool to examine an individual practitioner's competence or conduct, registered health practitioners who are members of RCA teams may still find themselves in a position where they form a reasonable belief about the conduct of another practitioner that would trigger mandatory reporting obligations, in conflict with their confidentiality obligations under RCA legislation. Mandatory reporting obligations do not apply to RCA team members who are not registered health practitioners.

In order to resolve this conflict and to provide a balance between the need to report matters of public risk via mandatory reporting to AHPRA and providing the confidentiality that is essential to encouraging clinicians to participate in systems review and improvement via RCA, the RCA legislation was amended to effectively divide the usual mandatory reporting standard of "notifiable conduct" into two elements: 'public risk notifiable conduct' and 'excluded notifiable conduct'. Registered health practitioner RCA members are obliged to report 'public risk notifiable conduct' to AHPRA, that is, that another practitioner has:

(a) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or
(b) placed the public at risk of substantial harm because the practitioner has practiced the profession in a way that constitutes a significant departure from accepted professional standards.

Registered health practitioner RCA members are not obliged to report, and are in fact restricted by RCA confidentiality provisions from reporting, to AHPRA 'excluded notifiable conduct', that is, that another practitioner has:

(a) practiced the practitioner's profession while intoxicated by alcohol or drugs; or
(b) practiced the practitioner's profession in a way that constitutes a significant departure from accepted professional standards but not in a way that placed the public at risk of substantial harm; or
(c) engaged in sexual misconduct in connection with the practice of the practitioner's profession.

The combined effect of the Health Practitioner Regulation National Law and the RCA legislation has been reported as difficult to understand leading to some confusion about a health practitioner's obligations when they are acting as an RCA team member. This is an issue that can be addressed by better education and guidance, rather than further legislative amendment.

[*] The function of receiving mandatory reporting notifications will transfer from AHPRA to the Health Ombudsman in 2014 upon commencement of the *Health Ombudsman Act 2013*.

A further area of concern that remains, however, is whether a determination by a health practitioner RCA team member that there is 'public risk notifiable conduct' to be reported to AHPRA is also a ground to stop an RCA. It is difficult to conceive of conduct that meets the definition of 'public risk notifiable conduct' that would not also meet the current grounds for stopping an RCA, i.e a 'blameworthy act' or impaired capacity of a practitioner involved in the adverse event. However, to resolve any uncertainty, it is recommended that the RCA legislation be amended to explicitly include a decision to report 'public risk notifiable conduct' to AHPRA as a ground to stop an RCA.

Recommendation 3

Include a decision of an RCA team member to report 'public risk notifiable conduct' to the National Agency (AHPRA) as an explicit ground for stopping an RCA.

5.2.5 Disclosure of reasons for stopping an RCA

The current legislation provides that an RCA team member must not provide any information to the Commissioning Authority about why they have stopped conducting an RCA. This creates a situation where the Commissioning Authority as the officer accountable is placed in a difficult position without sufficient information to direct further investigation. For example, should a formal investigation be commissioned? If so, what would be the terms of reference and what are the allegations? What if the RCA team held a reasonable belief of a criminal act?

In such cases, there is a reported need to provide the Commissioning Authority with information about the RCA team's concern and the basis for stopping the RCA, without creating prejudice to any subsequent investigation or professional disciplinary proceeding, but allowing the Commissioning Authority to make a more informed decision about what further investigations or actions are required.

This is an area for future legislative amendment to increase transparency and ability to act further when an RCA team has reasonable grounds to decide to stop conducting an RCA.

Recommendation 4

Require RCA teams to notify the Commissioning Authority of the grounds for stopping an RCA and the information that forms the basis for that ground.

5.2.6 Disclosure of information - RCA team

Several submissions, mainly from public hospital service providers, suggested that current legislative provisions have the effect of precluding RCA team members from consulting with relevant parties, such as a local Safety and Quality Committee, in formulating appropriate recommendations that are likely to be both effective and workable.

A similar issue was raised in regard to ability of the RCA team to consult within the QAS, particularly with the Medical Director. Feedback indicated that, in circumstances where QAS staff participate as members of RCA teams commissioned by hospitals or other health facilities, there is limited ability for those officers to seek feedback within QAS to contribute to the RCA teams decisions on regarding appropriate and effective recommendations.

The perceptions about the ability to consult outside the RCA team in formulating recommendations are inconsistent with the provisions of the current legislation which provide exceptions to the RCA team's strict confidentiality obligations for purposes of the RCA team conducting an RCA and preparing an RCA report. This is a further policy area for better education and guidance to RCA teams and has been referred to the areas responsible for policy.

5.2.7 Delegation by chief executive

Several concerns were reported regarding the restrictive nature of the powers of delegation to allow a Chief Executive to delegate the role of Commissioning Authority to a health executive, or an appropriately qualified officer or employee of the health service. This power has been interpreted as allowing delegation to only one individual and this has proved challenging due to the size of health services, the number of RCAs and the local governance structures.

This concern appears to be a misunderstanding of the current legislation. While the legislation allows a Chief Executive to delegate to "an" appropriate qualified employee, the rules of statutory interpretation provide that words in the singular may be interpreted as words in the plural, and vice versa. This is a further identified area for better education and guidance as a matter of policy, rather than a need for legislative amendment, and has been referred to the areas responsible for policy.

Within QAS the role of Commissioning Authority rests with the Commissioner. This remains appropriate and no amendment is required in this regard.

5.2.8 Scope of the legislation

A submission was received from the Royal Flying Doctor Service Queensland, requesting that organisation's inclusion within the scope of the legislation to clearly enable participation in relevant hospital or health service RCAs as well as to commission their own RCAs with associated protections and privileges when appropriate for the health services they provide.

Other non-government, non-private organisations similarly provide health services to the Queensland public. Where agreements with the State for provision of health services exist there is potential for enhanced governance of health service improvement utilising RCA for reportable events and widening the scope of RCA legislation to encompass organisations who hold these agreements. In line with the obligations of existing organizations utilizing the RCA legislation, RCAs would not be able to be used for blameworthy acts or practitioners with impaired capacity.

Recommendation 5

Expand the scope of the legislation to include non-government organisations prescribed under regulation.

Appendix 1: RCA legislative provisions

Title of provision	Health Services Act 1991 (repealed)	Hospital and Health Boards Act 2011	Ambulance Service Act 1991
Purpose	38I	93	36C
Definitions	38G	94	36A
Meaning of Root Cause Analysis	38H	95	36B
Guiding principles	38J	97	36D
When is a health service provided	-	96	-
Appointment of RCA team	38K	98	36E
Requirements for appointment	38L	99	36F
RCA team's report and chain of events document	38M	100	36G
Reporting to commissioning authority	38N	101	36H
Definition for division	38O	94	36I
Stopping conduct of RCA of reportable event – RCA team	38P	102	36J
Stopping conduct of RCA of reportable event – commissioning authority	38Q	103	36K
Definition for division	38R	104	36L
Disclosure of information – RCA team member or relevant person	38S	105	36M
Disclosure of information – commissioning authority or relevant person	38T	106	36N
Information about excluded notifiable conduct	38TA	107	36NA
Release of information to Health Quality and Complaints Commission	38U	108	36O
Release of information to chief health officer	38V	109	-
Release of information by chief health officer to Health Quality and Complaints Commission	38W	110	-
Release of information to director of mental health	-	111	-

Title of provision	Health Services Act 1991 (repealed)	Hospital and Health Boards Act 2011	Ambulance Service Act 1991
Giving of copy of RCA report or chain of events document – medical director	-	-	36P
Giving of copy of RCA report or chain of events document – patient safety entity	38X	112	-
Giving of copy of RCA report or chain of events document – investigation under Coroners Act 2003	38Y	113	36Q
Giving of information to Minister or chief executive	38Z	114	36R
Giving of copy of, or information contained in, RCA report – person who has sufficient personal or professional interest	38ZA	115	38S
Information not to be given in evidence	38ZB	(119)	36T
RCA report not admissible in evidence	38ZK	(119)	36ZB
Protection for documents and information	-	119	-
Protection from liability	38ZD	116	36V
Giving of information protected	38ZE	117	36W
Information provider can not be compelled to give particular information in evidence	38ZC	118	36U
Reprisal and grounds for reprisal	38ZF	120	36X
Offence for taking reprisal	38ZG	121	36Y
Damages entitlement for reprisal	38ZH	122	36Z
Delegation by chief executive	38ZI	(46)	
Application of provisions of this part	38ZJ	123	36ZA
Review of part	38ZL	-	36ZC

Regulations:

Title of provision	Health Services Regulation 1991 (Repealed)	Hospital and Health Boards Regulation 2012
Reportable events	33B	29
Prescribed patient safety entities and authorised purposes	33C, 33D, 33E	30, Schedule 2

Appendix 2: Stakeholder Consultation

Stakeholders consulted in this review

Internal Public Health System:

1. Patient Safety Officers .
2. Patient Safety and Quality Improvement Service
3. Health Service District - District Chief Executive Officers
4. Executive Directors Medical Services
5. Directors Of Nursing
6. Office of the Director General
7. Chief Executive Officer Tony O'Connell – Centre for Health Care Improvement
8. Commissioning Authorities
9. Private Hospitals Licensing Unit (Division of Chief Health Officer)
10. Occupational Health and Safety
11. Mental Health Alcohol and Other Drugs Directorate
12. Central Clinical Governance Unit
13. Legal Unit - Peter Brockett, Senior Lawyer - Legal Unit
14. Consumer Representation:
15. Health Consumers Queensland – Director - Paige Armstrong,

Professional/Staff Representation:

1. Medical Board QLD
2. Australian Health Practitioners Regulation Agency
3. Australian Council of Ambulance Professionals
4. Australian College of Ambulance Professionals Mr. Ian Patrick ASM FACAP
5. Liquor, Hospitality and Miscellaneous Union Branch
6. Association of Salaried Medical Officers, Queensland
7. Australasian College of Dermatologists (Qld Faculty)
8. Australasian College for Emergency Medicine
9. Australasian College of Paediatric Surgeons
10. Australasian Day Surgery Association
11. Australian and New Zealand College of Anaesthetists
12. Australian College of Mental Health Nurses
13. Australian and New Zealand Society of Nuclear Medicine (Qld Branch)
14. Australian Association of Musculoskeletal Medicine
15. Australian Association of Occupational Therapists - Queensland
16. Australian College of Critical Care Nurses
17. Australian College of Health Service Managers
18. Australian College of Midwives, Qld Branch
19. Australian College of Operating Room Nurses (ACORN)
20. Perioperative Nurses Association of Queensland, Inc.
21. Australian Institute of Radiography (Qld Branch)
22. Australian Medical Association (Qld Branch)
23. Australian Neonatal Nurses Association – Qld
24. Australian Orthopaedic Association (Qld Branch)
25. Australian Physiotherapy Association - Queensland Branch
26. Australian Rural Nurses
27. Congress of Aboriginal and Torres Strait Islander Nurses

28. Council of Deans of Nursing and Midwifery (Australia and New Zealand)
29. Directors of Nursing Association Queensland (Inc) (queensland nursing council)
30. Fulltime Medical Specialists Association of Queensland
31. Infection Control Practitioners Association of Queensland
32. Medical Superintendents Association of Queensland
33. National Enrolled Nurse Association
34. Office of the Health Practitioner Registration Boards
35. The Pharmacy Guild of Australia - Queensland Branch
36. Queensland Public Sector Union
37. Queensland Nursing Council
38. Queensland Nurses Union
39. Royal Australian and New Zealand College of Obstetricians and Gynaecologists
40. Royal Australian and New Zealand College of Ophthalmologists
41. Royal Australian and New Zealand College of Psychiatrists
42. Royal Australian and New Zealand College of Psychiatrists RANZCP
43. Royal Australian and New Zealand College of Radiologists (Qld Branch)
44. The Royal Australian and New Zealand College of Radiologists
45. Royal Australasian College of Dental Surgeons Inc.
46. Royal Australasian College of Medical Administrators
47. Royal Australasian College of Physicians
48. Royal Australasian College of Surgeons
49. Royal Australian College of General Practitioners
50. Royal College of Nursing Australia
51. Royal College of Pathologists of Australasia
52. Rural Doctors Association of Queensland
53. The Society of Hospital Pharmacists of Australia

Private Sector:
1. Private Hospitals Association Queensland

Other Queensland Government:
1. Health Quality and Complaints Commission
2. Office of the State Coroner - Michael Barnes
3. Department of the Premier and Cabinet
4. Department of Justice and Attorney General
5. Deputy Premier and Minister for Health, Paul Lucas
6. Minister for Police, Corrective Services and Emergency Services

Department Community Safety (DCS) internal stakeholders
1. Office of the Director-General
2. Offices of the Commissioner and Deputy Commissioner, QAS (Queensland Ambulance Service);
3. Office of the Medical Director QAS;
4. Regional Assistant Commissioners, QAS;
5. Queensland Combined Emergency Services Academy;
6. Legal Services Unit.

Written submissions were received from the following stakeholders:
1. Patient Safety and Quality Improvement Service (PSQ), Queensland Health

2. Directors of Nursing and Midwifery Advisory Council (DONMAC) – Queensland Health
3. Mater Misericordiae
4. Australian College of Health Service Managers (ACHSM)
5. Australia & New Zealand College of Anaesthetists (ANZCA)
6. Family Representatives
7. Health Consumers Queensland
8. Dr. Helen Ward - Director of Safety and Quality The Prince Charles Hospital
9. Department of Premier and Cabinet - Queensland Government
10. Department of Justice and Attorney General (DJAG)
11. Mental Health Alcohol And Other Drugs Directorate, Queensland Health
12. Private Hospitals Association.
13. Patient Safety Officer Feedback: Michael Abbey.
14. Directors of Medical Services Advisory Committee (DOMSAC)
15. Feedback from a consumer - via Health Consumers Queensland (HCQ) notification.
16. Helena Lake Health Community Council.
17. Australian Day Hospital Association (ADHA).
18. Royal Australasian College of Surgeons.
19. Private Health Regulatory Unit – Queensland Health.
20. Director of Education, QAS.
21. Director, Legal Services, Department of Community Safety.
22. Assistant Commissioner, North Coast Region, QAS.
23. Assistant Commissioner, South Western Region, QAS.
24. Assistant Commissioner, Brisbane Region, QAS.
25. Patient Transport Reform Unit, Queensland Health.
26. Royal Flying Doctor Service.
27. Australian Medical Association -Qld Branch.

Face-to-face interviews were conducted with the following stakeholders:

1. Patient Safety Officers
2. Patient Safety and Quality Improvement Service (PSQ)
3. Dr. Helen Ward - Director of Safety and Quality The Prince Charles Hospital
4. DOMSAC
5. Australian Medical Association Queensland AMAQ
6. Department Premier and Cabinet - Queensland Government
7. DJAG - Queensland Government
8. DONMAC
9. Family Member Representatives
10. Open Disclosure Response
11. Consumer Representative
12. Mental Health Alcohol And Other Drugs Directorate
13. Health Quality and Complaints Commission (HQCC)
14. Office of the State Coroner
15. Private Hospitals Association