Health
South Eastern Sydney
Local Health District

MENTAL HEALTH SERVICE BUSINESS RULE SESLHDBR/008

Name	Enterprise Risk Management System (ERMS) Process – Mental Health		
What it is	It is a business rule that outlines for SESLHD Mental Health Service (MHS) managers the use of the ERMS risk register, indicating specific individual and committee responsibilities in regard to the entry and management of risks in this system.		
Risk Rating	Medium	**Review Date**	April 2025
What it is not	It is not a substitute, or replacement, for overarching NSW and SESLHD risk management policies/procedures.		
Who it applies to	This business rule applies to the SESLHD MHS Executive, Clinical Council Members, Service Directors, Clinical Operations Managers, Patient Safety and Clinical Quality Managers, Nurse Managers, Nursing Unit Managers, Department Managers and Line Managers.		
When to use it	This business rule is to be used when: • Determining the correct risk reporting/escalation procedure. • Identifying who has responsibility for each part of updating and maintaining the ERMS.		
Why the rule is necessary	This business rule is necessary to inform staff members of the correct escalation path, ongoing management, and review, of clinical and corporate risks across SESLHD MHS.		
Background	NSW Health Policy Directive PD2015_043 Risk Management – Enterprise-Wide Policy and Framework and SESLHD Procedure SESLHDPR/304 Enterprise-wide Risk Management Procedure are the overarching documents for risk management across SESLHD MHS, and contain details of the identification, assessment, treatment, escalation, evaluation and ongoing monitoring of any risk.		
Definitions	**Hazard:** A hazard is anything that can cause harm (e.g. work materials, equipment, work methods and practices). **Harm:** A negative safety and health consequence (e.g. injury or ill health). **Risk:** The chance of something happening that will have an impact on objectives; measured in terms of impact and likelihood. **Incident:** An unplanned event resulting in, or with the potential for, injury, damage or other loss.		

SESLHD MHS Risk Responsibility and delegations and escalation Matrix (as per NSW Health Risk Matrix)

Risk Rating	Action Required	Timeframe (working days)	Delegation to Accept Risk
Extreme	Escalate to Chief Executive	One (1)	Chief Executive*
Extreme	District Executive can action if mitigations and controls can be immediately applied to reduce the risk rating from extreme. Advise CE.	One (1)	District Executive [T2]
High	Escalate to Senior Management. A detailed action plan must be implemented to reduce the risk rating.	Two (2)	District Executive [T2] General Manager [T3]
Medium	Specify Management Accountability & Responsibility. Monitor trends and put in place improvement plans.	Five (5)	Senior Manager [T3], [T4]
Low	Manage by routine procedure. Monitor trends.	Ten (10)	Line Manager

*** Escalate to Ministry of Health**

Role and Risk Accountability/ Responsibility

Refer to Appendix A: SESLHD MHS Risk Procedure diagram:

All Staff/Visitors/Contractors

- Identify, assess, report and mitigate hazards, risks, and/or incidents according to level of competency.

Nursing Unit Managers and Team Leaders

- Identify, assess, document, report, manage, mitigate and escalate hazards, risks, and/or incidents according to level of competency, and within delegated responsibility.

Inpatient and Community Services Managers

HAZARDS

- Ensure hazards are reported in IMS+ or Facilities and Maintenance systems (BEIMS, MAXIMO etc) and escalated to appropriate organisational committees, i.e. Work Health and Safety Committee, or equivalent.

RISKS:

- Ensure appropriate risk assessment documentation and assessment occurs for each risk and escalated to appropriate organisational committees, ie site IMS meetings or site Clinical Governance Committee meetings (or equivalent).

INCIDENTS:

- Ensure incidents are reported in IMS+ and escalated to appropriate organisational committees, i.e. site IMS meetings or site Clinical Governance Committee or equivalent.
- Identify, manage and escalate hazards, risks and incidents appropriately, within delegated responsibility.

	Site Clinical Directors/Clinical Operations Managers • Ensure accountability of Department Heads/Inpatient Services Managers and Community Services Managers in reporting and managing risk, as per the NSW Health Risk Matrix. • Prioritise and focus on risk reduction and quality improvement strategies. SESLHD MHS WHS Committees and SESLHD MHS Performance Meeting • Table Risk Assessments via site committee reporting processes and escalate as per SESLHD MHS Committee Structures. • Review risk issues, and consider risk information, when planning/prioritising committee work plans and strategic priorities. SESLHD/Site MHS Clinical Governance Committees • Ensure risk management is incorporated into planning, reporting and evaluation strategies, as appropriate. • Discuss, accept, escalate and monitor risks reported, according to the Risk Matrix. • Reassign risk to more appropriate committees, as required. • Ensure appropriate structures and processes are in place within Departments/Programs to manage actual and potential risks at relevant levels. SESLHD MHS General Manager/site Service Directors • Ensure articulation of the principles of this business rule, which is a subset of NSW Health PD2015_043 Risk Management – Enterprise-Wide Policy and Framework. • Ensure there is a process in place for regular review of risk management processes and measurement of their effectiveness. • Ensure that all staff and SESLHD MHS and Site Clinical Governance Committees are accountable for their level of responsibility for risk management. • Ensure that appropriate resources are allocated to support risk reporting and risk mitigation. • Ensure extreme risks are escalated to the SESLHD Chief Executive, and that extreme risk management is monitored and reported through appropriate committees.
Delegation to Accept a Risk, and the Management Review Processes	• A new risk entered (Registered) in ERMS is considered a draft until an Approving Manager, with the necessary risk delegation, 'accepts' the risk. • In accordance with NSW Policy, if a risk or opportunity remains unaddressed by the reviewing Manager, the 'failure to make this decision means the risk has been accepted by default.' The decision to accept the risk or opportunity by "default" will be made by the ERMS Administrator after consideration of the risk detail as well as the consequence

	and likelihood. If a risk is rejected by the Approving Manager or determined as un-implementable the reason/s will be provided to the Risk Owner and Manager and documented in ERMS. • All 'extreme' and 'high' risks must have a nominated T2 Executive Sponsor for governance and reporting purposes. Any extreme or high risks identified as having soft or ineffective actions / mitigations / controls will require reassessment and will be returned to the Risk Owner as well as being escalated to the relevant Manager and Executive. • Entered risks or opportunities which identify one-off and / or recurrent funding requirements are not automatically allocated funding when a risk in 'accepted' by the Approving Manager. • **Risk Review:** Every 90 days ERMS will automatically generate an email to the Risk Owner and identified Manager to initiate the review. Risk Owners are expected to complete their own reviews and updates in ERMS. • **Risk Closure:** A risk can be closed when it has been eliminated, when the current risk rating reaches the target risk rating and/or the controls in place have been assessed as adequate for ongoing monitoring. Risk Owners must receive approval from all risk stakeholders including the Approving Manager, Executive Sponsor or Committee, before closing a risk. Refer to Appendix A: SESLHD MHS Risk Procedure diagram
Who enters Risks into ERMS and when are they entered?	**At the <u>Site/Service</u> level:** • Site ERMS documentation is maintained by the relevant Patient Safety and Clinical Quality Manager, reviewed at monthly, and updated at least three monthly. • The STG/TSH or ESMHS Clinical Governance Committee is accountable for the monthly review of any site ERMS risks, to ensure that these risks are updated, and that any new identified risks are entered on the ERMS Register, if appropriate. **At the <u>SESLHD MHS</u> level:** • The SESLHD MHS ERMS documentation is maintained by the SESLHD MHS Clinical Risk Manager and updated on a monthly basis. • The SESLHD MHS Clinical Governance Committee is accountable for the monthly review of the ERMS Register to ensure that risks and mitigation plans are updated, and that any new identified risks are entered on the ERMS Register, if appropriate.
Reporting Hazards, Incidents and Risks	• As explained in 'Definitions' above, risks, hazards and incidents have specific meanings. This means that hazards and incidents are reported in a different manner to risks. • All hazards are identified and managed through IMS+ or Facilities and Maintenance Systems (BEIMS, MAXIMO etc.)

	• All incidents are managed within IMS+ as per NSW Health PD2020_047 Incident Management • Once a risk has been identified, Managers are responsible for rating those risks using the NSW Health Risk Matrix, documenting the risk via a Risk Assessment and escalating responsibility to an appropriate level of management, via tabling at Site Clinical Governance Committee for decision on whether to assign a Risk Owner and for decision on whether to assign a Risk owner and enter into the ERMS.
Interface between ERMS and other corporate systems	As there is no electronic interface between ERMS, IMS+, MHS clinical information systems and performance and financial information systems, MHS Senior Executive Team and the SESLHD MHS Clinical Risk Manager are required to have monitoring systems in place to support risk reporting, escalation and risk mitigation.
Ministry of Health / SESLHD reference	**RISK:** • NSW Health Policy Directive PD2015_043 Risk Management – Enterprise-Wide Policy and Framework • SESLHDPR/304 Enterprise-wide Risk Management Procedure • NSW Health Risk Matrix • National Safety and Quality Health Standards (second edition): Standard 1 – Clinical Governance; Safety and Quality Systems: Risk Management • National Safety and Quality Health Standards (second edition): Standard 1 – Clinical Governance; Safe Environment **INCIDENT:** • NSW Health Policy Directive PD2020_047 Incident Management • SESLHDBR/009 Incident Processes for Harm Score (HS) 2, 3 and 4 Incidents required to be reported to the MHS General Manager • National Safety and Quality Health Standards (second edition): Standard 1 – Clinical Governance; Safety and Quality Systems: Incident Management • National Safety and Quality Health Standards (second edition): Standard 1 – Clinical Governance; Safe Environment **HAZARD:** • NSW Health Policy Directive PD2018_013 Work Health and Safety: Better Practice Procedures (Section 4.5 Risk Management) • ISO 45001:2018 – 6.1.2 Hazard Identification and assessment of risks and opportunities • National Safety and Quality Health Standards (second edition): Standard 1 – Clinical Governance; Safe Environment • National Safety and Quality Health Standards (second edition): Standard 3 – Infection Prevention and Control; 3.12 Maintaining and repairing Equipment, Building, Furnishing and

	Linen & 3.13 Clean and Safe Environment
Functional Group	Mental Health
Executive Sponsor	Sharon Carey A/General Manager, Mental Health Service
Author	Nicola DiMichiel, Clinical Risk Manager, Mental Health Service Emma Spiers, Clinical Quality Manager, Mental Health Service

Revision and Approval History

Date	Revision Number	Author and Approval
October 2012	0	Angela Karooz, SESLHD MHS Risk Manager. Approved by Mental Health Clinical Council.
August 2015	1	Scheduled review by MHS Policy Assistant Peter Baldas.
November 2015	1v2	Revised with input from Nikki DiMichiel, ESMHS Clinical Operations Manager, and David Tobin, STG MHS Inpatient Services Manager. Grammar edits and reference to committees, including Work Health and Safety, in escalation process. Endorsed by SESLHD MHS Clinical Council.
December 2018	2	Revised by Nicola DiMichiel, Clinical Risk Manager, SESLHD MHS.
January 2019	2	Consulted: Service Directors, Clinical Nurse Manager, Clinical Director, Clinical Operation Managers, Patient Safety and Clinical Quality Manager and Director of Clinical Governance.
February 2019	2	Endorsed by SESLHD MHS DDCC and SESLHD MHS Clinical Council
April 2019	2	Minor review, approved by Executive Sponsor and published by Executive Services.
February 2022	3.0	Reviewed and updated by Quality Manager. Appendix A added.
March 2022	3.1	Proposed modifications discussed at March 2022 Senior Executive Committee. Consensus for the MHS to align with the document to manage identified Risk. Circulated to DDCC for review/comment regarding proposed changes.
April 2022	3.2	Reviewed by DDCC. Minor amendments to changes proposed in v3.1 only. Endorsed for publication by Executive Sponsor.

Appendix A: Enterprise Risk Management System (ERMS) process