

Private Health Facilities Amendment (Reportable Incidents) Regulation 2021

under the

Private Health Facilities Act 2007

Her Excellency the Governor, with the advice of the Executive Council, has made the following Regulation under the *Private Health Facilities Act 2007*.

BRAD HAZZARD, MP Minister for Health and Medical Research

Explanatory note

The object of this Regulation is to amend Private Health Facilities Regulation 2017 (the Regulation) to—

- (a) update references in the Regulation as a consequence of amendments made by the *Health Legislation Amendment Act (No 3) 2018*, Schedule 6, and
- (b) prescribe a type of review that is a serious adverse event review and a type of incident that is a reportable incident for the purposes of the *Private Health Facilities Act 2007* by reference to documents adopted by the Regulation, and
- (c) prescribe the manner in which a relevant health services organisation may disclose advice of an assessor or information obtained from the advice for the purposes of the *Private Health Facilities Act 2007*, and
- (d) allow the licensee of a facility to notify, or exchange information with, other facilities or relevant health services organisations required to exercise functions under the *Private Health Facilities Act* 2007, Part 4 or the *Health Administration Act* 1982, Part 2A.

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1 Name of Regulation

This Regulation is the *Private Health Facilities Amendment (Reportable Incidents)* Regulation 2021.

2 Commencement

This Regulation commences on 1 July 2021 and is required to be published on the NSW legislation website.

Schedule 1 Amendment of Private Health Facilities Regulation 2017

[1] Clause 3 Definitions

Insert in alphabetical order in clause 3(1)—

relevant health services organisation has the same meaning it has in the Health Administration Act 1982, Part 2A.

[2] Part 5, heading

Omit "Root cause analysis". Insert instead "Serious adverse event review".

[3] Clause 17 Reportable incident

Omit clause 17(1). Insert instead—

(1) For the purposes of the Act, section 41, definition of *reportable incident*, a reportable incident means an incident of a type set out in Appendix D of the *Incident Management Policy* published in the Government Gazette No 292 on 30 October 2020.

[4] Clause 17(3)

Omit "A root cause analysis team". Insert instead "A serious adverse event review team".

[5] Clause 17(3)

Omit "section 42 of the Act". Insert instead "the Act, section 46".

[6] Clause 17(3)

Omit "section 44 of the Act". Insert instead "the Act, section 47".

[7] Clauses 18-18D

Omit clause 18. Insert instead—

18 Serious adverse event review

For the purposes of the Act, section 41, definition of *serious adverse event review*, the following types of review are prescribed—

- (a) NSW Health Concise Incident Analysis set out in Appendix E of the *Incident Management Policy* published in the Government Gazette No 292 on 30 October 2020,
- (b) NSW Health Comprehensive Incident Analysis set out in Appendix F of the *Incident Management Policy* published in the Government Gazette No 292 on 30 October 2020,
- (c) Systems Analysis of Clinical Incidents: The London Protocol, published in August 2004 by Imperial College London.

18A Disclosure of information—assessor advice

For the purposes of the Act, section 45(1)(e), the following prescribe the manner in which advice or information may be disclosed—

- (a) to obtain legal advice,
- (b) to obtain legal representation,
- (c) to notify an insurer of an incident and to provide information in relation to an insurance claim.

18B Disclosure of information—incident reviewers

- (1) For the purposes of the Act, section 49D, a person who is or was an incident reviewer may divulge or communicate information acquired by the person in the person's capacity as an incident reviewer if the information is divulged or communicated to a committee for the purposes of any research or investigation the committee is authorised to conduct under the *Health Administration Act* 1982, section 23(1).
- (2) In this clause—

committee means a council, committee or advisory body appointed under the *Health Administration Act 1982*, section 20 and includes the following—

- (a) Special Committee Investigating Deaths Under Anaesthesia (SCIDUA),
- (b) Collaborating Hospitals Audit of Surgical Mortality Committee (CHASM),
- (c) the NSW Maternal and Perinatal Mortality Review Committee.

18C Notification of incidents—the Act, s 49H(g)

- (1) A licensee of a private health facility (the *original licensee*) may notify another licensee of a private health facility about an incident if the original licensee is of the opinion the notification may assist the other licensee to perform a function under the Act, Part 4.
- (2) A licensee of a private health facility may notify a relevant health services organisation about an incident if the licensee is of the opinion the notification may assist the relevant health services organisation to perform a function under the *Health Administration Act 1982*, Part 2A.

18D Exchange of information—the Act, s 49H(h)

- (1) A licensee of a private health facility (the *original licensee*) may exchange information with another licensee of a private facility if the original licensee is of the opinion the exchange of information may assist the other licensee to perform a function under the Act, Part 4.
- (2) A licensee of a private health facility may exchange information with a relevant health services organisation of an incident if the licensee is of the opinion the exchange of information may assist the relevant health services organisation to perform a function under the *Health Administration Act 1982*, Part 2A.