

Office for the Community Sector

**Quality and Safety Standards  
Framework for Tasmania's  
Community Sector**

**A Proposed Way Forward**

**Consultation Paper  
September 2008**

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## 1.0 Background

The non-government community sector in Tasmania has been recognised for its large and growing role in service delivery to meet the needs of Tasmanians. Currently, 10% of the total Department of Health and Human Services (DHHS) budget is invested in the delivery of services by the community sector. This amounts to approximately \$150 million annually.

Current organisational changes in the DHHS and the consequent decision to increase investment in the community sector to deliver quality services on behalf of government has highlighted the need for a more strategic and coordinated focus on the community sector. The establishment of the Office for the Community Sector was announced in March 2008 as the dedicated vehicle to provide strategic leadership, work across government and non-government organisations, develop policies, systems and processes, and provide advice regarding community sector reform and the enhancement of services needed in the community.

Quality and Safety is one of three key strategies of the Office for the Community Sector. The goal of the Quality and Safety Unit is to work in partnership with the community sector to establish an integrated, standardised, effective, efficient and sustainable Quality and Safety Standards Framework for Tasmania's community sector.

This consultation paper describes a proposed model for introducing;

1. **Nationally recognised standards to underpin a quality improvement program for all DHHS funded community sector organisations; and**
2. **A preferred model for the implementation of the program (the "vehicle" for delivery).**

## 2.0 Tasmania's Community Sector ... At a Glance

- There are 240 community sector organisations with DHHS service agreements.
- Organisations are dispersed state-wide from St Helens to Zeehan to Bruny Island
- They vary between one and multiple service delivery sites state-wide
- There are over 450 funded services
- Funding received by organisations ranges from \$1220 to \$12,100,000
- Approximately 50% of organisations have multiple service agreements
- Over eighty service types are specified in Agreements.
- Qualities of diversity and complexity of size and service type
- Approximately 8,500 staff and 15,000 volunteers work in the community sector
  - 60% of staff are part-time
  - 50% are older than 45 years
  - 17% are older than 55 years
- \$150 million dollars investment in the 2007-08 financial year
- A limited number of organisations are engaged in an accreditation process
- Organisations who are engaged in accreditation process use variety of national frameworks (Quality Improvement Council, The Australian Council of Healthcare Standards,, International Standards Organisation); some with service specialist standards frameworks (i.e. National Standards for Disability Services, National Standards for Mental Health Services)
- Most organisations are not undertaking any formal quality improvement program

### **3.0 Principles for establishing and implementing a quality and safety standards framework**

#### **The quality and safety standards framework will:**

- Be consumer focussed
- Focus on continuous quality improvement
- Be based on nationally recognised standards – generic and service specialist
- Minimise additional regulatory burden on organisations
- Be evidence based, efficient, outcomes focussed, effective and sustainable
- Integrate existing processes and templates as much as possible
- Align the quality requirements of each organisation with its service volume, resources and service type
- Foster a culture of partnership through processes and systems that enhance working relationships and a commitment to transparency and accountability.

#### **Funded organisations will:**

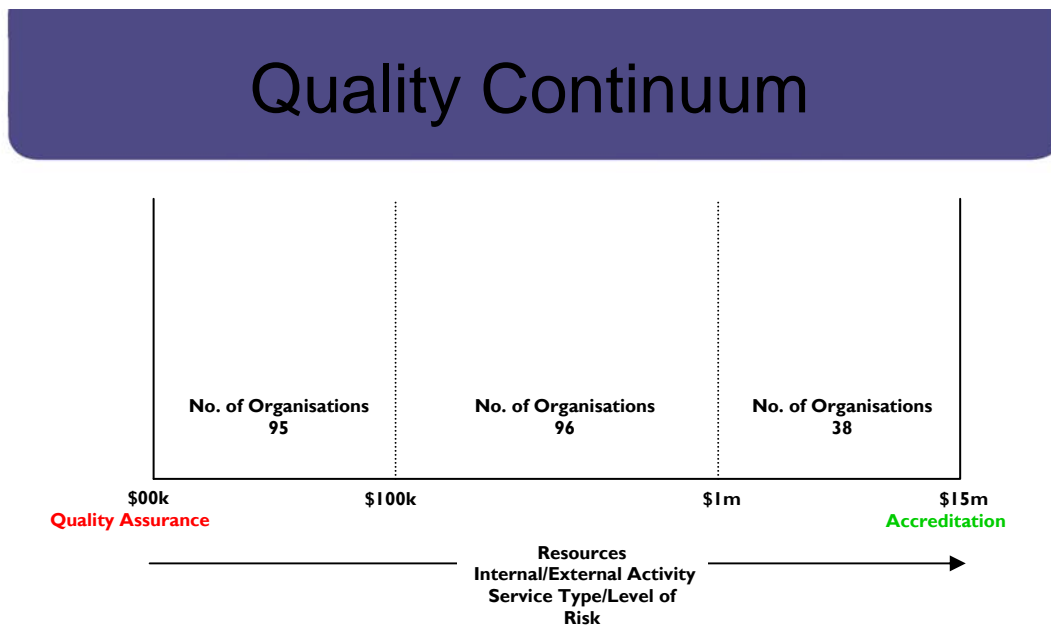
- Be required to engage in a quality improvement plan based on nationally recognised generic and service specialist standards
- Undergo monitoring, review and evaluation of their contractual requirements, including those relating to quality, safety and quality improvement
- Continue with their current accreditation framework or select an appropriate national standards framework if seeking accreditation

## 4.0 A standards framework for Community Sector Organisations

Every DHHS funded community sector organisation will be located somewhere along the quality continuum according to an equation of *service volume* and *resources*. Low service delivery volume and low resources will be located to the left of the continuum; high service delivery volume and high resources to the right.

A third part of the equation for locating an organisation along the continuum will be *service type/risk*.

Organisations already engaged in an accreditation process will be located to the right of the continuum.



*(This diagram illustrates the quality continuum in relation to DHHS investment and the quality improvement activity that it likely to be required to engage all funded organisations in a quality improvement program along the quality continuum).*

Depending on the location along the quality continuum, all organisations will have nationally recognised standards (where available) assigned to their organisation and included in their service agreement. Generally it can be expected that as we move along the continuum from left to right, the number of standards, the number of assessment criteria, and the level/depth of evidence required will increase, in line with the equation of service volume and investment. Consequently, increasing levels of evidence required to prove appropriate engagement and commitment to quality improvement will be expected. Exceptions to this approach may relate to high investment – high risk activities for a small number of services.

## 4.1 Generic Standards

All community sector organisations, regardless of their place along the continuum will be assigned a set of “generic standards” which may include:

- Governance, strategic and organisational planning
- Organisational legal status.
- Financial accountability requirements.
- Asset register.
- Service performance reporting and delivery.
- Fire risk management.
- Incident reporting and management.
- Pre-employment/pre-placement checks and screening.
- Complaints management.
- Consumer satisfaction
- Safe environment for staff, clients and visitors
- Improvement against the organisation’s “core standards set” (generic standards and service specialist standards)

All community sector organisations will be required to show that the organisation is engaged in planning processes and activities to continually improve their performance in relation to the generic standards.

## 4.2 Service Specialist Standards

Many organisations are of a service type for which there are national service specialist standards. Some examples are the National Standards for Mental Health, the National Standards for Disability Services, Home and Community Care Standards. These national specialist standards are a range of standards additional to generic standards that are specific to the practices and qualities of the particular service type. For example, standards relating to infection control, documentation hand-over processes, food handling or safe rostering may apply to a respite disability service, but not to a service providing desktop health-related information to the public from an information booth in a mall.

Organisations that are of a service type covered by a set of nationally recognised service specialist standards will have a selection of those standards included in their service agreements. As discussed in relation to generic standards, generally the location of the organisation along the quality continuum will determine the number of standards and the level/depth to which they will be required to evidence the organisations engagement in planning processes and activities to continually improve their performance against the standards.

Service Specialist Standards will be selected through discussions between community service organisations and the operational units. Standards selected will be relevant to the service/s provided by the organisation.

The combination of generic standards and service specialist standards for each organisation will be known as the organisations “core standards set”.

### 4.3 Accreditation

Some organisations are already engaged in processes to seek accreditation with national standards bodies such as the Quality Improvement Council (QIC), the Australian Council for Health Standards (ACHS), and the Industry Standards Office (ISO). In line with the principles outlined on Page 5, these organisations are encouraged to continue with their chosen/existing standards accreditation framework.

Organisations that are required by DHHS to seek accreditation in the future will be invited to choose an appropriate nationally recognised framework.

The products arising from an accreditation process, such as review reports, review recommendations, and improvement plans will be regarded as significant evidence of continuous quality improvement for the purposes of DHHS quality improvement requirements. Recommendations for improvement from accreditation processes will be included in the organisations next service agreement and will be monitored by DHHS.

Organisations will not be required to report twice on standards. This means that if organisations are already reporting on standards to satisfy another funder (for example Australian Government funding), they will not be required to report a second time to DHHS required standards. A copy of the report provided to the other funder will be sufficient to meet DHHS evidence requirements.

A survey of community sector organisations will be required to establish the number of organisations currently engaged in an ongoing accreditation process, and the standards framework/s with which they are engaged.

It is clear, however, through internal research and community forum discussion with the community sector, that there are relatively few of the 240 community sector organisations in Tasmania currently being accredited or engaged in a formal quality improvement program. Those organisations that are seeking accreditation are at the high end of the investment continuum. Feedback suggests that services at the other end of the continuum may be small in size and activity, and include those run by volunteers. While this does not mean that organisations are not providing a quality service, it does indicate that there may not be any formal, identifiable or measurable quality framework implemented. Therefore, the vast majority of organisations will require attention from DHHS to engage in a standards-based quality improvement program.

The set of generic standards will be included in all community sector organisations' service agreements as agreed and implemented through the development of the proposed model. Where service specialist standards (such as Disability) are required, the Operational Units will negotiate the standards to be included in service agreement with the community sector organisation. Where service specialist standards are required and there is no national framework specific to the service type available (i.e. Child Protection) the Office for the Community will assist the operational units to author standards that will map to appropriate and relevant (other) national standards frameworks.

## 5.0 Introducing a monitoring framework to strengthen accountability arrangements

Given the complexity of Tasmania's community sector, and the range of factors identified to implement an efficient, effective and sustainable quality improvement model in Tasmania, several monitoring frameworks for monitoring and reviewing service agreements and standards have been considered, including those of Queensland, NSW, Victoria and South Australia.

The proposed monitoring framework will be part of Tasmanian's DHHS structure for:

- the development of collaborative relationships with the community sector;
- monitoring performance and adherence to departmental program and policy guidelines;
- monitoring service agreement requirements;
- attending to service development needs;
- funds allocation; and
- using risk management principles for early detection and potential problems.

Tasmania will adopt a team approach to administering the monitoring framework. The team will include relevant DHHS Operational Unit staff, the Office for the Community Sector and the relevant community sector organisation.

Essentially, the monitoring framework has three key elements:

1. Core Monitoring
2. Desktop review
3. Service Review and routine accreditation reviews

## 5.1 How does the Monitoring Framework Operate

### 5.1.1 Element One: Core Monitoring

Core monitoring is undertaken with every organisation, regardless of the location of the organisation on the quality continuum, and including organisations seeking accreditation.

Core monitoring requires every organisation to provide a self-report regarding their performance against the “core standards set” every six months. Organisations seeking accreditation will provide evidence according to their national accreditation process when an organisational self-report and/or organisational survey, etc. is undertaken.

The Office the Community Sector Quality and Safety Unit will be responsible for assisting operational units and assessing performance of the organisation against the organisations generic and specialist service standards.

The process will engage the Finance and Performance Unit of the Office for the Community Sector in relation to funding status and financial reporting requirements contained as part of the Core Monitoring Self Report.

Features of Core Monitoring are:

- Core Monitoring occurs on a six monthly basis.
- Office for the Community Sector and relevant operational units will monitor the financial sustainability of the organisation, service delivery, and client safety and well-being including:
  - Governance, strategic and organisational planning
  - Organisational legal status.
  - Financial accountability requirements.
  - Asset register.
  - Service performance reporting and delivery.
  - Fire risk management.
  - Incident reporting and management.
  - Pre-employment/pre-placement checks and screening.
  - Complaints management.
  - Consumer satisfaction
  - Safe environment for staff, clients and visitors
  - Improvement against the organisation’s “core standards set” (generic standards and service specialist standards)

The Office for the Community Sector will develop templates to assist with the self reporting requirements.

## 5.1.2 Element Two: Desktop Review

A desktop review is an internal process conducted by the Office for the Community Sector and relevant stakeholders for every organisation regardless of where the organisation is located on the quality continuum. This review does not require a report or input from the community sector organisation. However, it does not exclude their participation if requested by either party. The desktop review aims to highlight a range of issues from identifying innovative practice to share with other service providers to identifying developing trends which may be of concern (e.g. a pattern of complaints). Early identification of such trends provides an opportunity to address these before they become a major issue.

Desktop reviews are led by the Office for the Community Sector Quality and Safety Unit. A desktop review:

- Occurs once every three months.
- Includes and collates all information gathered during Core Monitoring and will include feedback from the community sector organisation, consumers/clients, feedback from the Finance and Performance Unit, operational units and any other relevant information.
- Does not necessarily involve, but does not exclude, the community sector organisation and is completed by DHHS staff, thus reducing burden on the community sector organisation.
- Engages all departmental staff involved in monitoring.
- Focuses on risk factors, including:
  - Highly vulnerable or statutory client groups.
  - Service complexity.
  - Management and frequency of complaints and incidents.
  - Service performance and reporting (throughout monitoring and accreditation processes).
  - Financial sustainability and reporting.
  - Consumer feedback.
- Identifies service innovation and consumer satisfaction.

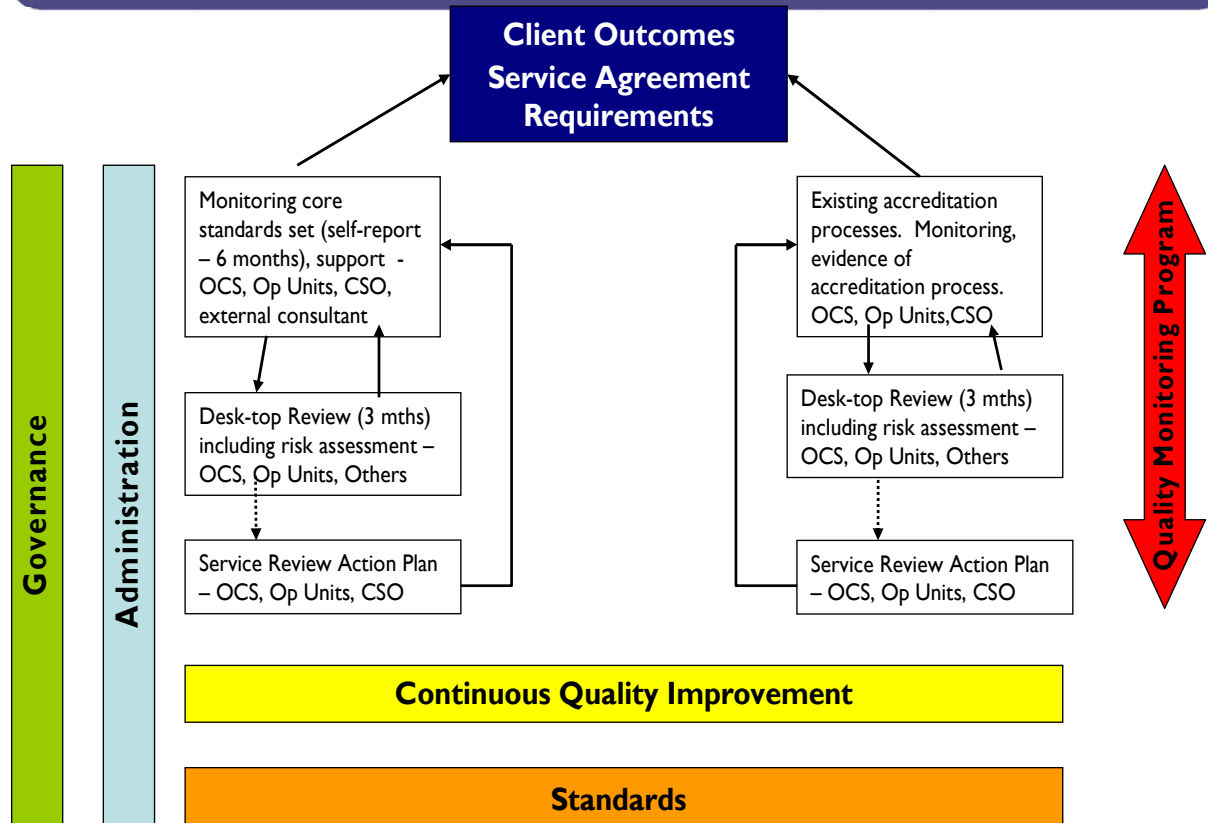
### 5.1.3 Element Three: Service Review

Service reviews will be undertaken where on-going concerns or serious risk is identified through a desktop review.

Service reviews will be led by the Office for the Community Sector Quality and Safety Unit and involve the organisation, operational unit staff, staff of the Finance and Performance Unit, Office for the Community Sector, and any other stakeholder groups / individuals as required.

- Accredited organisations or those seeking accreditation will routinely undertake an internal self assessment or external service review as part of the accreditation. However, subsequent to a desktop review, there may be occasions when the Office for the Community Sector will lead a service review further to routine accreditation requirements.
- A service review will be a collaborative process involving DHHS, the community sector organisation operational staff and any other stakeholder groups / individuals as required. The purpose is solution focussed and will be:
  - undertaken within the principles of partnership;
  - solution focussed;
  - quality focussed; and
  - related to the areas of service delivery, organisational management and financial management (when identified as an issue in the desktop review).

# Monitoring Model



The diagram above illustrates that organisations to the left of the continuum will provide a self-report to the Office for the Community Sector every 6 months. Organisations to the far right of the continuum, specifically those undertaking accreditation, will provide evidence (copy) of self-assessment reports and routine service review reports undertaken as part of the accreditation process.

## **6.0 Data system/functions for incident/complaints management with the Quality and Safety Standards Framework**

Data collection, incident or adverse event surveillance and analysis provides the opportunity to review actual or potential incidents, highlighting the opportunity for systems improvement. As such, it is a critical element of the Quality and Safety Standards framework.

The Electronic Incident Monitoring System (EIMS) is a guided electronic incident reporting system currently used by most clinical operational units within DHHS.

It is proposed that EIMS will be adopted as the system for monitoring incidents and complaints relating to community sector organisations.

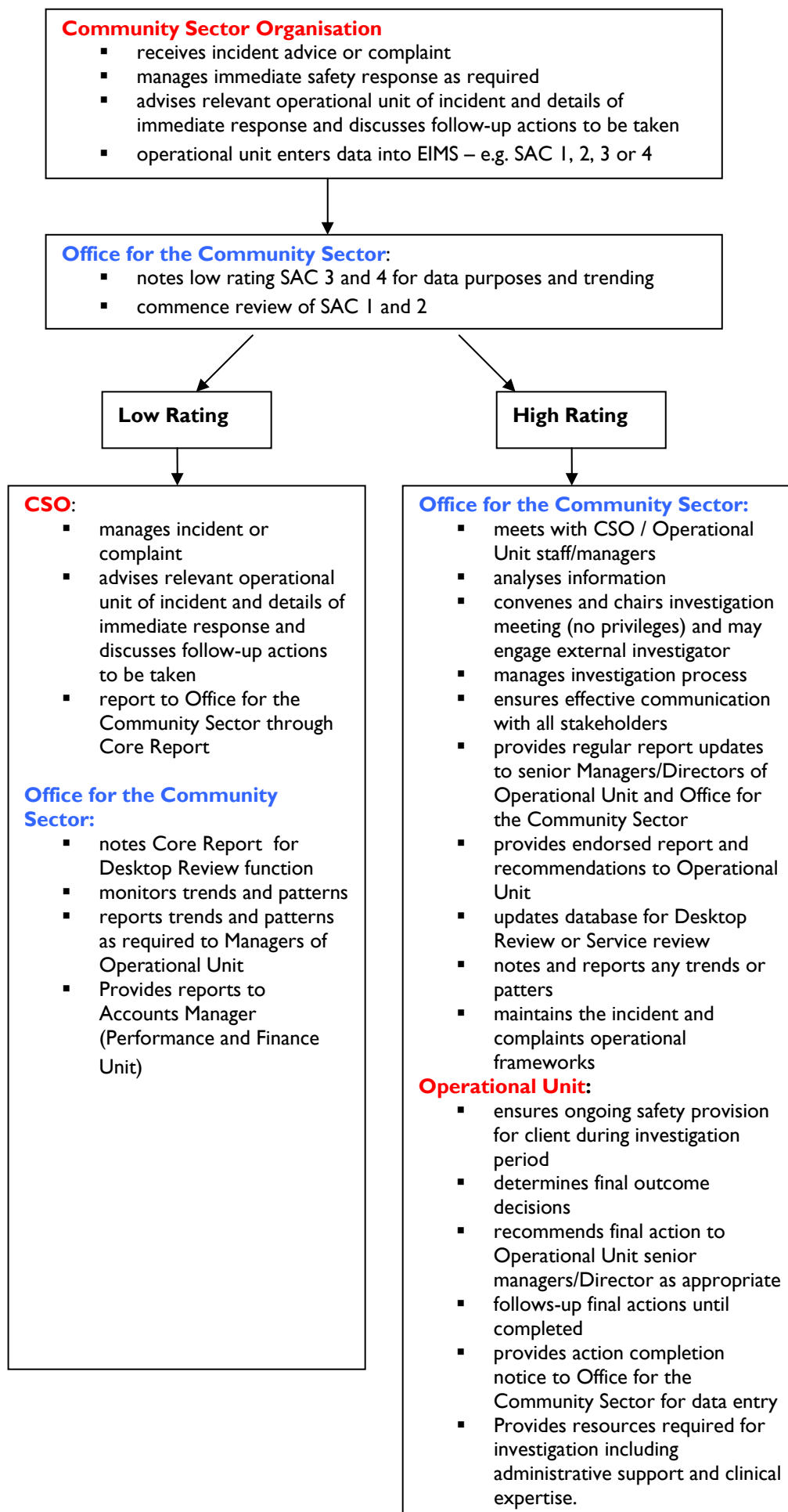
Features of EIMS:

- Has the ability to capture incidents, near misses, complaints and compliments and consumer feedback.
- Allows for an incident to be reported by any staff member with access to the web-based data base
- Monitors the entire process; from initial electronic report to identification of areas for quality improvement activity.
- Assists the staff member entering the incident data to assign the incident a Severity Assessment Code (SAC); reviewed by the manager with responsibility for incident/complaint review.
- Can have a variety of time-lines and responsible persons allocated to the management of incidents, thus improving accountability, incident analysis and outcomes.

In the interim it is proposed that community sector organisations will advise the Office for the Community Sector of incidents or complaints assessed at a Severity Assessment Code (SAC) 1 & 2 incidents within 24 hours and provide a report on SAC 3 & 4 incidents through their routine Core Reports.

Roles and responsibilities regarding incident / complaint monitoring and management are illustrated in the following diagram.

## 6.1 Incident and Complaint Data Management System

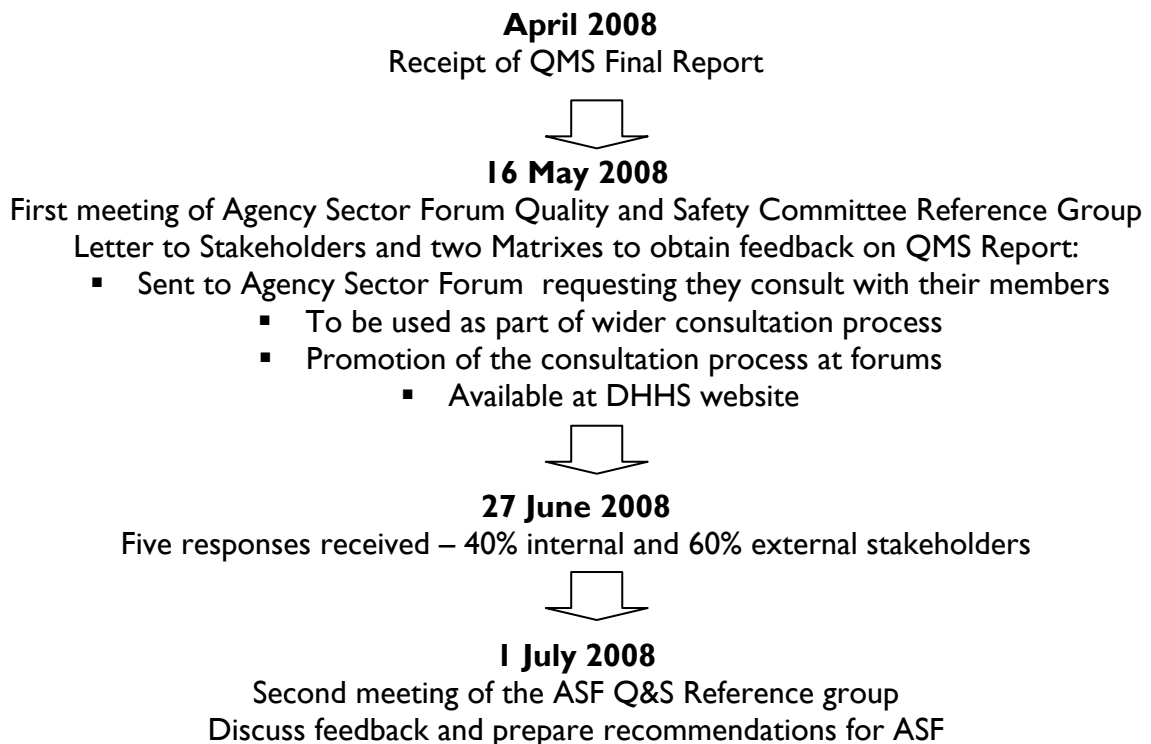


## 7.0 Evaluation of a Quality and Safety Standards Framework for Tasmania's Community Sector

The Office for the Community Sector is committed to ensuring that the quality and safety framework implemented in the Tasmanian community sector is evaluated to ensure continuous improvement. To this end, the Office for the Community Sector is in the early stages of developing an evaluation process for the Quality and Safety Standards Framework.

It is anticipated that the first evaluation will occur within 12-18 months of the Framework's implementation. The process will seek input from a range of stakeholders including clients / consumers, community sector organisations, operational unit staff, and other relevant parties.

## 8.0 Consultation Process as at September 2008



**Feedback** – as discussed at the ASF Q&S Reference group Meeting in 1 July 2008:

General acceptance of QMS Recommendations with qualification on:

- **Resourcing** – Significant costs (human and financial) associated with continuous quality improvement regardless of whether accreditation or non-accreditation requirements are implemented
- **Skill-set** – Important to ensure that the relevant skill-set and knowledge base feed into quality management processes.

ASF Q&S Reference Group agreed that the next stage was to develop possible quality and safety models for the Tasmanian DHHS and Community Sector environment.



**8 July 2008**

ASF Meeting

Endorsement to continue further investigation into options, in particular the Victorian Monitoring model



**13 August 2008**

Workshop DHHS



**22 August 2008**

ASF Quality and Safety Reference Group



**September 2008**

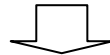
Consultation Paper distributed

The paper “*A Quality and Safety Standards Framework for Tasmania’s Community Sector – a Proposed Way Forward*” distributed to community sector organisations and the DHHS Human Services Group



**September 2008**

Presentations of proposed Quality and Safety Standards Framework to DHHS Directors and business units



**15, 16 and 22 October 2008**

Planned dates for state-wide consultation forums regarding “*A Quality and Safety Standards Framework for Tasmania’s Community Sector – a Proposed Way Forward*” with community sector organisations

## Appendix I

### Electronic Incident Monitoring System (EIMS).

- EIMS is a tool for reporting when things go wrong so that a review and update of the system can occur.
- EIMS categorises incidents using the Severity Incident Code (SAC); SAC 1 and 2 representing high severity outcomes such as death or serious physical injury resulting in permanent impairment; SAC 3 and 4 representing minor incidents and complaints that do not produce outcomes seriously detrimental to the client, service or property.
- It is comprised of two modules: Risk MonitorPro (for reporting incidents) and Feedback MonitorPro (for reporting compliments, comments and complaints).
- Operational units will enter incidents on EIMS and manage those categorised as SAC (Severity Incident Code) level 3 & 4. The OCS will lead responses to SAC 1 & 2.
- EIMS provides a matrix to assist in the accurate classification of incidents. Classification of an incident will be undertaken initially by the CSO or operational unit but may be changed during a review or investigation process or if additional information becomes available.

### What will EIMS do?

EIMS involves a systematic approach to enhancing the safety and quality of our services through:

- ⇒ online entry of incidents, near misses and feedback/complaint data;
- ⇒ assigning of tasks required for the resolution of the incident/complaint;
- ⇒ automatic alerts for particular types or large numbers of incidents;
- ⇒ email notification to those who need to know about the incident;
- ⇒ ready access to information to follow up on incidents that have been reported; and
- ⇒ assistance to managers in producing both basic and more detailed up to date reports easily.

### What data does EIMS capture?

- EIMS has the ability to capture incidents, near misses, complaints and compliments.
- The scope of EIMS is continually being revised. However, at this time EIMS is **NOT** used to report Occupational Health and Safety issues.

## What is EIMS expected to achieve?

It is expected that through the continuous use and improvement of EIMS the following outcomes will be achieved:

- ⇒ improved patient safety and quality of services;
- ⇒ enhanced open disclosure culture in a blame free environment;
- ⇒ improved data collection and quality improvement processes where incidents are investigated and analysed to find out what can be done to prevent recurrence;
- ⇒ increased consistency in the approach to incident reporting and monitoring at local and state-wide levels;
- ⇒ increased efficiency in incident reporting processes including timely reporting and action at local and state-wide levels; and
- ⇒ improved accountability for incident management at local and state-wide levels.

## Possible model for Implementation of EIMS:

*(Please note that the implementation of EIMS has not been finalised and may be subject to further changes)*

- Anticipated that there will be approximately 12 SAC1&2 cases per year.
- OCS to lead and HSG operational units to support
- Community sector organisations and HSG Operational units to manage SAC 3 & 4 and provide data to OCS
- HSG Operational units will enter all SAC 3 and 4 incidents into EIMS
- Community sector organisations will advise OCS of all SAC 1 & 2 incidents within 24 hours
- Community Sector Organisations will provide a report to OCS on SAC 3 & 4 as part of their Core Reports

The following matrix of <sup>1</sup>*the Severity Incident Code Guidelines* is utilised to classify the assessment as a SAC 1, 2 3 or 4. This is an assessment tool that will be considered and is attached for your information.

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<sup>1</sup> Severity Incident Code Guidelines utilised in DHHS Electronic Incident Monitoring System.



# Step 1 Consequence

CORPORATE CONSEQUENCE

	Serious	Major	Moderate	Minor	Minimum
<b>Staff:</b> Death of staff member related to work incident or suicide, or hospitalisation of 3 or more staff	<b>Staff:</b> Permanent injury to staff member, hospitalisation of 2 staff, or lost time or restricted duty or illness for 3 or more staff or pending or actual WorkCover prosecution	<b>Staff:</b> Medical expenses, lost time or restricted duties or injury / illness for 2 or more staff	<b>Staff:</b> First aid treatment only with no lost time or restricted duties.	<b>Staff:</b> No injury or review required	
<b>Visitors:</b> Death of visitor or hospitalisation of 3 or more visitors	<b>Visitors:</b> Hospitalisation of up to 2 visitors related to the incident / injury or pending or actual WorkCover prosecution	<b>Visitors:</b> medical expenses incurred or treatment up to 2 visitors not requiring hospitalisation	<b>Visitors:</b> Evaluation and treatment with no expenses	<b>Visitors:</b> No treatment required or refused treatment	
<b>Services:</b> Complete loss of service or output	<b>Services:</b> Major loss of agency / service to users, including cancellation of booked surgery more than twice	<b>Services:</b> Disruption to users due to agency problems	<b>Services:</b> Reduced efficiency or disruption to agency working	<b>Services:</b> No loss of service	
<b>Financial:</b> loss of assets replacement value due to damage, fire etc > \$1M or loss of cash/investments/assets due to fraud, overpayment or theft >\$100K	<b>Financial:</b> loss of assets replacement value due to damage, fire etc \$100K-\$1M or loss of cash/investments /assets due to fraud, overpayment or theft \$10K-\$100K	<b>Financial:</b> loss of assets replacement value due to damage, fire etc \$50K to \$100K or loss of cash/investments /assets due to fraud, overpayment or theft to \$10K	<b>Financial:</b> loss of assets replacement value due to damage, fire etc to \$50K	<b>Financial:</b> No financial loss	
<b>Environmental:</b> Toxic release off-site with detrimental effect. Fire requiring evacuation	<b>Environmental:</b> Off-site release with no detrimental effects or fire that grows larger than an incipient stage	<b>Environmental:</b> Off-site release contained with outside assistance or fire incipient stage or less	<b>Environmental:</b> Off-site release contained without outside assistance	<b>Environmental:</b> Nuisance releases	
Patients with <b>Death</b> unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management <b>or any of the following:</b> <b>Sentinel Events reportable to Australian Council for Safety and Quality in Health Care</b> <ul style="list-style-type: none"> <li>Procedures involving the wrong patient or body part</li> <li>Suicide</li> <li>Retained instruments</li> <li>Unintended material requiring surgical removal</li> <li>Intravascular gas embolism resulting in death or neurological damage</li> <li>Haemolytic blood transfusion</li> <li>Medication error leading to death</li> <li>Maternal death or serious morbidity associated with labour or delivery</li> <li>Infant abduction or discharge to wrong family</li> <li>Requires notification under existing legislative reporting requirements</li> </ul>	Patients with <b>Major permanent loss of function (sensory, motor, physiologic or psychologic)</b> unrelated to the natural course of the illness and differing from the expected outcome of patient management <b>or any of the following:</b> <ul style="list-style-type: none"> <li>Disfigurement as a result of the incident</li> <li>Absconded involuntary mental health patient</li> <li>Threatened or actual physical or verbal assault of patient or staff requiring intervention</li> </ul>	Patients with <b>Permanent reduction in bodily functioning (sensory, motor, physiologic, or psychologic)</b> unrelated to the natural course of the illness and differing from the expected outcome of patient management <b>or any of the following:</b> <ul style="list-style-type: none"> <li>Increased length of stay as a result of the incident</li> <li>Surgical intervention required as a result of the incident</li> </ul>	Patients requiring <b>Increased level of care including:</b> <ul style="list-style-type: none"> <li>Review and evaluation</li> <li>Additional investigations</li> <li>Referral to another clinician</li> </ul>	Patients with <b>No injury or increased level of care or length of stay</b>	

CLINICAL CONSEQUENCE

## Step 3 Rating

Likelihood	Consequence				
	Serious	Major	Moderate	Minor	Minimum
Almost certain	1	1	2	3	3
Probable	1	1	2	3	3
Possible	1	2	2	3	4
Unlikely	1	2	3	4	4
Remote	2	3	3	4	4

## Step 2

	Likelihood	Definition	Possible (Occasional)	Unlikely (Uncommon)	Remote (Rare)
			Possibly will occur / reoccur at some time (may happen every 1 to 2 years)	Possibly could occur / reoccur at some time in 2 to 5 years	Unlikely to occur / reoccur – only in exceptional circumstances (may happen every 5 to 30 years)
<b>Almost certain (Frequent)</b>		Is expected to occur / reoccur either immediately or within a short period of time (likely to occur most weeks or months)			
<b>Probable (Likely to occur again)</b>		Will probably occur / reoccur in most circumstances (several times a year)			