Adverse Event Reporting Instructions

Establishing a culture of safety, where people are able to report both adverse events and close calls without fear of punishment, is the key to creating patient safety

Joint Commission for Accreditation of Healthcare Organizations
Australian Council for Safety and Quality in Health Care

Do:

- ☑ Complete all appropriate sections
- ☑ Be factual
- ☑ Complete the form in a timely manner
- ☑ Forward the form to your supervisor as soon as possible
- ☑ Report near-misses (help us all to learn form your good fortune this time)
- ☑ Try to establish the sequence of events that led up to the adverse event
- ☑ Look at the different systems that were involved in allowing the adverse event to occur
- ☑ Describe what actually happened – be specific
- ☑ Identify what you did as a result of the incident
- ☑ Use the Adverse Event report form for all adverse events, including patients, visitors and staff

Don't:

- ☒ Use the adverse event report as a gripe session
- ☒ Blame individuals
- ☒ Forget to fill in the department and date (commonly left off report forms)
- ☒ Use the adverse event reports for performance issues
- ☒ Forget to complete minimum data set forms for falls and pressure areas
- ☒ Forget to complete the Occupational Exposure Follow-up Questionnaire for occupational exposures
- ☒ Forget to complete the Security Report form where required (Porterage and Security Staff only)
- ☒ Feel that you can't make a difference

Adverse Event Reporting and Monitoring

Responsibility

All staff have a legal and ethical responsibility to report adverse events, sentinel events and near misses to their supervisor within specified timeframes.

Definitions

For the purposes of adverse event reporting and monitoring the following definitions apply:

- **Adverse Event Monitoring** – A system for identifying, processing, analysing and reporting adverse events with a view to preventing their recurrence
- **Adverse event**: An event or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage
- **Near Miss**: An adverse event or close call that did not lead to harm, but could have.
- **Sentinel Event:** An unexpected occurrence involving death or serious physical or psychological injury or risk thereof

The list of defined Sentinel Events for Queensland Health is as follows:

1. Procedures involving the wrong patient or the wrong body part
2. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
3. Haemolytic blood transfusion reaction resulting from ABO incompatibility
4. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
5. Infant discharge to wrong family
6. Maternal death or serious morbidity associated with labour or delivery
7. Intravascular gas embolism resulting in death or neurological damage
8. Suicide of a patient in an in-patient unit
9. Any serious and rare event

Adverse event monitoring at the Bundaberg Health Service District operates under the philosophy that reporting and analysis of adverse events is encouraged by

- Learning, not accountability as being the key
- Reporting being confidential and non-punitive
- Emphasis on the importance of near misses
- Review teams being multidisciplinary
- Investigation being about identification
- Prompt feedback

The Adverse Event Report form is to be used to report all adverse events, including patient, visitors and staff.

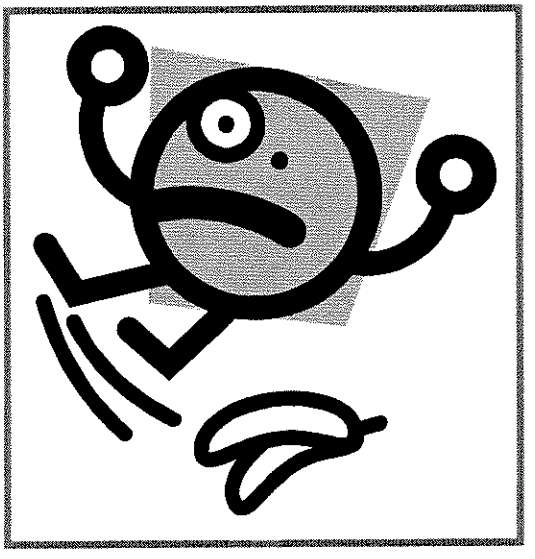
Creating a Culture of Safety

It has been reported in the medical literature that many deaths occur each year due to errors in medical care, many of which are preventable. In order to takes actions that will improve this situation, it is necessary to have a clear picture of what is actually happening so that appropriate steps can be taken to prevent such occurrences. Only by viewing the health care continuum as a system can truly meaningful improvements be made. A systems approach that emphasises **prevention, not punishment** is the best method to accomplish this goal. Other high risk industries such as airlines have used this approach to accomplish safety.

To make the prevention effort effective, we use methods of gathering and analysing data from the field that allow the formation of the most accurate picture possible. Staff on the frontline are usually in the best position to identify issues and solutions. This is really the core of what we mean by building a *culture of safety.* This kind of cultural change does not happen overnight. It can only happen as a result of effort on everyone's part to take a different approach to the way we look at things. We must constantly question if we can do things in a better, more efficient, and safer manner.

We don't believe that people come to work to do a bad job or make and error, but given the right set of circumstances, any of us can make a mistake. We must force ourselves to look past the easy answer that it was someone's fault – to answer the tougher question as to why the error occurred. It is seldom a single reason.

Through understanding the real underlying cause we can better position ourselves to prevent future occurrences. "Experience is the best teacher" but is also one of the most expensive teachers. One of the best ways to reduce the expense is to take advantage of lessons present in **near misses**, where things almost go wrong, but no harm is done.



COMPLETING THE ADVERSE EVENT REPORT FORM

Queensland Government
Queensland Health

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and treat this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No.		Date Registered		Date Received
Risk Assessment	Consequence	Likelihood	Risk Rating	
Risk Level	This section is completed by the DQDSU when the report is received – just leave this blank			
Assessed by				
Action required				

Please print clearly using a black pen. **(Attach extra sheets if required)**

Site ☑ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

Patient Adverse Event Enter details in this column			
Surname:	Presley		
First Name:	Elvis		
UR Number	999999		
DOB/Age:	08/01/1935		
Department:	Surgical Ward		
Sex of subject:	(Male)	Female	Not stated
Subject is:	(Patient)	Visitor	Other
IMHS Clients:	Involuntary	Voluntary	Unknown
Reporters Details	Name Leonie Raven		
	Contact No. 41502026		
Reporters Classification:	Please specify Administrative Officer		
1st Witness:	Name & Contact No. Gail Aylmer ext 2273		
2nd Witness:	Name & Contact No. No second witness		
Place of event	Bathroom in room 2		
Date of event	02/03/2004	Time	1430
Current diagnosis	Right Inguinal Hernia Repair		
Adverse Event Type	Injury - Skin Tear		
Next of kin notified?	(Yes) No N/A	Name:	Priscilla Presley
MO notified?	Yes No (N/A)	Name:	

Staff Adverse Event Enter details in this column				
Surname				
First Name				
Employee No				
Employ't Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event			Time	
Shift time	From		To	
Stream				
Department				
Supervisor	Name & Contact			
Task	What were you doing at the time of the adverse event?			
Experience in task				years
Place of event				
Cause of injury				
Equip't details	Including Asset Number			
1st Witness				
2nd Witness				
MO notified?	Yes No N/A	Name:		

Medical Officer's examination (This section to be completed for patient or staff adverse event where relevant)

If relevant, please describe the assessment of the subject's condition and list treatments/investigations ordered. Ensure the medical record is complete.

Medical Officer's Signature:				**Date & Time:**	
Open Disclosure Process Initiated?	Yes	No	N/A	Name:	

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened, including who was involved

Patient calle3d for assistance and was found in bathroom with small skin tear to left forearm. States he had been showering and slipped slightly on wet floor, scraping his arm on a sharp edge of the door frame. Patient has been mobilising independently and did not require supervision with personal hygiene.

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

Wet floor in bathroom caused patient to slip against door frame.

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Skin tear cleaned and dressed with opsite

Impact or Outcome - What has been the outcome of this adverse event?

Minor discomfort to patient with minimal additional treatment required.

- Prevention - What factors minimised the outcome, or if this was a near miss, what prevented the event from occurring?

Ensure sufficient supply of floor mats to prevent patients slipping on wet floor.

Signature	Leonie Raven	**Date**	02/03/20004

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor /Management Report

Comment on action taken or action needed to be taken to prevent recurrence

Maintenance request sent to have sharp edge of door frame fixed

Has the adverse event been documented in the medical record?	(Yes)	No	If not, why not?
Name: Di Jenkin	**Signature:** Di Jenkin		

Please forward this form to the District Quality and Decision Support Unit

Director's Comment (Where required)

WHSO Comment (Staff Adverse Event Only)

DQDSU Comment

THE SHIFT SUPERVISOR THEN SIGNS THE FORM, OBTAINS A PHOTOCOPY TO BE KEPT IN THE DEPARTMENT AND FORWARDS THE ORIGINAL TO THE DISTRICT QUALITY AND DECISION SUPPORT UNIT.

WHAT WE DO WITH THE FORM WHEN WE RECEIVE IT IN THE DQDSU

When the Adverse Event Report form arrives in DQDSU it is registered, given a registration number, and then risk assessed. Based on the risk rating of the event the following will occur:

Low and Medium Risk events

- In most instances, these events will not be analysed further, however this will be determined on a case-by-case basis.
- The details of the event will be registered and included in the quarterly trend reports
- The DQDSU monitors for emerging trends on an ongoing basis, and should it become apparent that a particular type of event is occurring frequently, a request to conduct an analysis of these events will be sent to the relevant Executive Director
- Individual departments may choose to conduct an "in-house" analysis of low and medium risk events, and the adverse event analysis form will be available for this purpose, by contacting the DQDSU
- The Department Head will be notified by email of the registration number (so that the event can be easily tracked if further information is required) and the outcome of the risk assessment. The Department Head will be expected to provide this feedback to the staff member/s who were involved in and/or reported the event.

High, Very High and Extreme Risks

- Details of these adverse events will be provided to the relevant Executive Director, who will appoint an appropriate staff member to lead the analysis of the adverse event
- The appointed "Analysis Officer" will coordinate a multidisciplinary team to conduct the analysis. This may be conducted through the relevant Clinical Service Forum or Department Head meeting, or may be a team of appropriate people convened for the purpose of analyzing the event.
- The team will analyse the event to determine
    - the major causes of the event (remembering that there is rarely one single cause)
    - the potential or actual solutions to overcome the problem
    - the action taken as a result of the analysis or recommendations to the Leadership and Management Committee for action to be taken
- The event may then be entered on the relevant risk register where indicated
- The analysis should be completed within 10 working days
- The final analysis report is sent to the DQDSU where the details will be entered onto the register, and feedback to staff provided

Sentinel Events

Sentinel events will be analysed in the same manner, however reporting times for sentinel events differ to routine adverse events. The District Manager, Director of Medical Services and other relevant member of the Executive, must be notified of any sentinel event within 12 hours, and the report forwarded to the DQDSU within 24 hours.

The following is the list of reportable sentinel events for the Bundaberg Health Service District:

- Procedures involving the wrong patient or wrong body part
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- Haemolytic blood transfusion reaction resulting from ABO incompatibility
- Medication error leading to death of a patient reasonably believed to be due to incorrect administration of drugs
- Infant discharge to the wrong family
- Maternal death or serious morbidity associated with labour or delivery
- Intravascular gas embolism resulting in death or neurological damage

- Suicide of a patient in an in-patient unit
- Any serious and rare event

Categories of Adverse Events

There range of adverse events that should be reported extends far beyond the typical falls, skin tears, sprains, medication errors etc. The following categories and elements are provided to assist staff in determining the range of adverse events that should be reported. This list provides examples, but should not be viewed as a definitive list – there may be other events which require reporting that are not list here.

Admission /Access – Delays in the Admission Process (including but not limited to)

☑ Bookings/appointment cancellations	☑ Waiting time - admission	☑ Reluctance to admit
☑ Refusal to accept transfer to ward	☑ Inappropriate delay to accept admission	☑ Excessive patient waiting time

Admission /Access – Bed availability issues (including but not limited to)

☑ No beds	☑ Outlier issues	☑ Patient special requirements
☑ Unable to provide staff	☑ Op list changes not notified to staff	☑ Incomplete patient assessment
☑ Patient not notified of cancellations	☑ Incorrect advice to patient re admission	☑ DEM not informed of patient arrival
☑ Staff communication issues	☑ Incomplete documentation on admission	☑ Patient admitted to wrong ward

Behavioural (including but not limited to)

☑ Inappropriate patient behaviour	☑ Absconding	☑ Physical/verbal aggression
☑ Intended self harm	☑ Confused /wandering	☑ Smoking in hospital buildings
☑ Witnessed substance abuse	☑ Inappropriate sexual behaviour	☑ Inappropriate staff behaviour
☑ Staff breach of Code of Conduct	☑ Staff breach of legislation	☑ Unprofessional staff behaviour
☑ Physical aggression - visitor	☑ Verbal aggression - visitor	☑ Supply of illicit substance to patient

Documentation (including but not limited to)

☑ Incorrect information recorded	☑ Illegible writing	☑ Wrong health record used
☑ Patient ID incorrect/absent	☑ Ambiguous documentation	☑ Inappropriate abbreviations
☑ Results filed in wrong health record	☑ Documentation missing	☑ Subjective judgments written

Equipment/Therapeutic device (including but not limited to)

☑ Damaged equipment	☑ Equipment failure/malfunction	☑ Maintenance problem
☑ Misuse of equipment	☑ Incorrect equipment type	

Falls (including but not limited to)

☑ Bed/chair/wheelchair	☑ Fall over equipment	☑ Fall in toilet/shower
☑ Fall using equipment	☑ Mobility aids indicated but not used	☑ Mobility aids ordered but not used

Injury (including but not limited to)

☑ Abrasion	☑ Burn/Scald	☑ Bruise
☑ Cut/ Skin Tear/ Laceration	☑ Strain/Sprain/Fracture	☑ Unintended injury during procedure

Investigations/Diagnostic (including but not limited to)

☑ Incorrect investigation request	☑ Inadequate information	☑ Allergies not noted
☑ Patient reaction to investigation	☑ Wrong labeling of specimen	☑ Specimen not obtained
☑ Tests results unavailable	☑ Test results system failure	☑ Delay in processing
☑ Collection of specimens delayed	☑ Wrong delivery of specimens	☑ Patient escort delays

Medication Prescribing errors (including but not limited to)

☑ Ambiguous order	☑ Incomplete/no patient ID	☑ No doctor signature
☑ No dose prescribed	☑ No start date	☑ Not ceased - expired
☑ Inappropriate drugs prescribed together	☑ Illegible prescription	☑ Verbal/phone order not documented
☑ Ordered despite documented allergy	☑ Error in calculation	☑ Overdose prescribed and given

☑ Overdose prescribed but not given ☑ Under dose prescribed and given ☑ Under dose prescribed but not given

Medication - Incorrect Doses(including but not limited to)

☑ Calculation error ☑ Equipment programming overdose ☑ Equipment programming underdose
☑ Drug given twice ☑ Six rights ☑ Oxygen therapy error
☑ IV fluids overdose ☑ Wrong drug dilution ☑ Incorrect infusion

Medication – Drug count (including but not limited to)

☑ Not done ☑ Incorrect ☑ Keys not available

Medication Administration (including but not limited to)

☑ Not given ☑ Not signed ☑ Times not recorded
☑ Left with patient – not taken ☑ Given after cease order ☑ Incorrect drugs given on discharge
☑ Patient interference with drugs ☑ Patient self medicating without staff knowledge

Medication – Pharmacy issues (including but not limited to)

☑ Drug not available ☑ Dispensing error ☑ Pharmacist error
☑ Drugs inadequately labeled ☑ Expired drugs in stock ☑ Ward stocks not maintained

Medication – Intravenous Infusions (including but not limited to)

☑ Incorrect solution ☑ Incorrect rate ☑ Incorrect volume
☑ IV site infection ☑ IV site extravasations ☑ IV re-site delay
☑ Epidural infusion issues ☑ IV equipment issues ☑ Chemotherapy issues

Patient Care (including but not limited to)

☑ Patient treatment not given ☑ Observations/monitoring not carried out ☑ Inappropriate care delivered
☑ Delay/interruption in care continuity ☑ Patient interference/ non compliance ☑ Care not given as per orders

Property (including but not limited to)

☑ Items presumed stolen ☑ Items damaged ☑ Items lost

Security/Safety (including but not limited to)

☑ Contamination ☑ Environmental Hazard ☑ Patient/ staff security compromised
☑ Substance possession/use

Transfer/Discharge (including but not limited to)

☑ Inappropriate patient transfer ☑ Inadequate documentation on transfer ☑ Incorrect discharge procedures
☑ Patient self-discharge ☑ Community liaison issues ☑ Inadequate patient education
☑ Incorrect patient information ☑ Delayed patient discharge ☑ Communication issues