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Queensland Government
Queensland Health

Bundaberg Health Service District
Policy & Procedure Document

QHEPS No. 21906

Title:	Adverse Events Management
Manual Name & No:	No 2 - Leadership & Management
Section:	Section 2 – Risk Management
Policy Number: Manual/Section/Number	2.2.A1

Applicable to: All Staff

Effective Date: 01 June 2004

Last Review Date: New Policy

Next Review Date: 01 June 2007

Initiator: District Quality Coordinator

Authorised: Original signed by Peter Leck
District Manager

Ratified: Original signed by Dr. Darren Keating
Director of Medical Services

Originals kept in the District Quality and Decision Support Unit

Replaces: New Policy

References:
- QH Incident Management Policy (Draft)
- West Moreton HSD Management of all Clinical Adverse Events Policy
- Hunter Area Health Service Management of Clinical Adverse Events Policy
- ACSQH – Open Disclosure Standard 2003

Description:

Outlines the process for reporting, investigating and documenting adverse events at the Bundaberg Health Service District

Definitions

Incident: 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.

Open Disclosure: The processes of open discussion of adverse events that result in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement.

Root Cause Analysis: Root Cause is the most basic reason for an undesirable outcome, and Root Cause Analysis is a tool that enables us to learn as much as possible about what happened, why it happened and what can be done to prevent the same thing recurring in the future.

Policy

Improved patient care, outcomes and safety are key objectives of the Bundaberg Health Service District. All clinical adverse events and near misses are to be reported and evaluated in a consistent manner that considers all contributing factors, with an emphasis on prevention of recurrence and on communication with all affected parties in a context of open disclosure.

Fundamental principles of this policy include:

- Avoidance of further harm to those affected
- Support for clinicians who are involved
- Focus on prevention of recurrence
- Evaluation of all contributing factors in a systematic, objective, non-punitive and just way
- Open disclosure, with providers to acknowledge and apologize when an incident occurs, avoiding the appearance of being evasive or defensive. Note: a narrow exception to open disclosure exists where the disclosure would in itself cause physical and mental harm to the patient and/or the family
- Promotion of consumer confidence in the openness and accuracy of information
- Reassurance to patients and their families that lessons learned will help prevent recurrence
- Confidentiality with all investigations of adverse events being conducted in a confidential manner, that is on a needs to know basis
- Reassurance to providers that medico-legal risks are addressed
- Notification of management and detailed feedback of relevant lessons learned to all levels of the health service.

Overview of process

This policy operates under the philosophy that reporting and investigation 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 and learning
- Prompt feedback

Outcome

All adverse events will be reported to the relevant Director and the District Quality and Decision Support Unit, Where indicated, an investigating officer appointed by the Director shall conduct an investigation. The investigation/analysis shall focus on identifying and rectifying system causes that underlie any adverse event. Outcomes from all investigations shall be registered with the DQDSU who will provide trend reports to identified groups on a regular basis.

Evaluation Method

Adverse events/adverse events will be monitored and trended by the DQDSU and an annual evaluation of the reporting system will be undertaken.

Procedure

All adverse events, whether involving patients, staff or visitors are to be reported on the Adverse event Report Form

When an adverse event occurs: (See flow chart attached)

1) Following the identification of an adverse event, the first priority is to ensure the safety of the patient and/or staff member and put steps in place to minimise harm
2) The staff member who was involved or discovered the adverse event completes the relevant section of the Adverse event Report Form (Appendix A)
3) If the adverse event relates to a fall, pressure area or occupational exposure, the relevant Minimum Data Set form must also be completed and attached to the adverse event form (Appendix B)
4) Where a Medical Officer has been called to examine the subject, the Medical Officer completes the relevant section of the Adverse event Report Form
5) The Adverse event Report Form is given to the Shift Supervisor or Cost Centre Manger who completes the Shift Supervisors report and ensures that the adverse event has been documented in the patients chart
6) The adverse event and the medical response should be factually recorded as soon as possible in the patient's record. Plans for further follow-up if indicated, should also be documented. Prior documentation must not be altered nor should back dated information be inserted. While addenda to the record can be made, the medical record should not be used to speculate or air grievances about other care providers, equipment, or administrative processes, and should only be used to provide information that is relevant to the care of the patient.
7) Staff involved in an adverse event should be offered appropriate support
8) All units will have in place a mechanism for alerting the relevant Director and/or other management staff of the occurrence of a significant or serious adverse event. This alert should occur as soon as practicable.
9) The completed Adverse event Report form is then forwarded to the District Quality and Decision Support Unit where each adverse event will be registered and risk rated
    a) Adverse events with a low or medium level of risk are registered and included in the relevant trend report
    b) Adverse events with a high, very high or extreme level of risk are reported to the relevant Director
        i) Patient adverse events are sent to the relevant Director who will nominate an appropriate investigation officer to investigate the adverse event and provide the adverse event analysis report (Appendix C) to the DQDSU
        ii) Staff adverse events are sent to the Workplace Health and Safety Officer who shall investigate the adverse event, enter details on WIMS and provide a report to the DQDSU
10) Adverse events of a serious nature may also require a root cause analysis to be undertaken. Recommendation for this to occur may come from the District Manager, relevant Director or DQDSU.
11) The DQDSU will provide feedback to the staff involved in the adverse event related to action taken and outcomes
12) The DQDSU shall generate quarterly trend reports and provide these to the relevant committees, including Executive Council, Leadership & Management Committee, Clinical Services Forums and Heads of Department Meeting

13) A Safety Climate Survey (See Appendix D) will be conducted annually and results distributed by DQDSU, and will focus on measuring improvements in:
    a) Safety Climate Scores and,
    b) Percentage of respondents reporting a Positive Safety Climate
14) An annual evaluation of the Adverse event Management System and shall be undertaken at the end of each financial year to:
    a) Monitor achievement of Key Performance Indicators of the reporting system
    b) Identify and communicate improvements that have been achieved in safety and quality of care
    c) Identify areas requiring further improvement and establish goals for the following year

Open Disclosure

The patient and/or their family should be given:

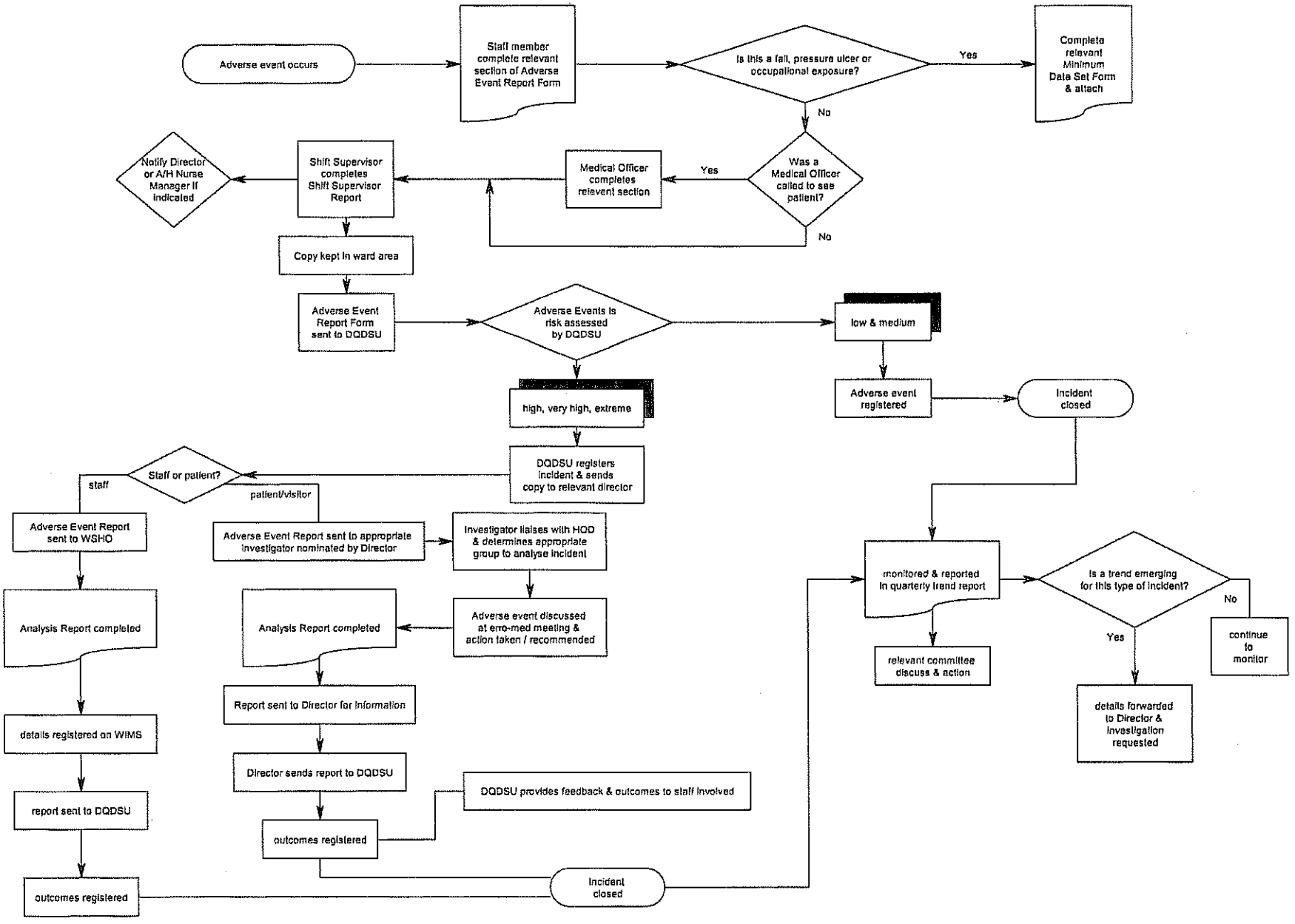
1) A factual and understandable explanation of what happened
2) An outline of the potential consequences
3) An outline of steps being taken to manage the event as soon as practicable after the event. This should entail reassurance that the adverse event is regarded seriously and that there are effective mechanisms of review to examine why the adverse event happened, in order to minimise recurrence.
4) **The safety and quality aspect of the review process should be emphasized so that the patient and/or their family understand that it is about making care safer, not about finding someone to blame.**
5) An expression of regret (without admitting liability)
6) Confirmation that someone will always be available to provide further information or clarification
7) Information on how to make a formal complaint
8) Information on support services provided by social workers and/or other trained support workers who can provide further information
9) Documentation about the open disclosure process and should be included in the medical record.

See Open Disclosure Policy for full details

Documentation

- Adverse Event Report Form
- Adverse Event Analysis Report
- Falls Minimum Data Set form (where required)
- Pressure Ulcer Minimum Data Set form (where required)
- Occupational Exposure Follow Up Questionnaire (where required)
- Safety Climate Survey

ADVERSE EVENT



Appendix A

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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				
Assessed by				
Action required				

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

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

Patient/Visitor Adverse Event
Enter details in this column

Full Name	Or affix Patient Label		
UR Number			
Visitor Contact Details			
DOB/Age			
Department			
Sex of subject	Male	Female	Not stated
Subject is	Patient	Visitor	Other
IMHS Clients	Involuntary	Voluntary	Unknown
Reporters Details	Name		
	Contact No.		
Reporters Classification	Please specify		
1st Witness	Name & Contact No.		
2nd Witness	Name & Contact No.		
Place of Adverse event			
Date of Adverse event		Time	
Current patient diagnosis/problems			
Adverse Event Type			
Next of kin notified?	Yes No N/A	Name:	
Medical officer notified?	Yes No N/A	Name:	

Staff Adverse Event
Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event		Time		
Shift time	From	To		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			
Experience in this task	years			
Place of adverse event				
Cause of injury				
Equipment details	Including Asset Number			
1st Witness				
2nd Witness				
Medical officer 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

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

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

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

Minimisation of Outcomes - What factors minimised the outcome, or if this was a near miss, what stopped the event from occurring?

Prevention - How could this adverse event have been prevented?

Signature		Date	

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

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

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

Appendix B (i)

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Bundaberg Health Service District

Falls Minimum Data Set Form

Please complete this form and attach to the relevant Adverse Event Report Form

Patient Name			**Date of Fall**	
Previous Falls Risk Assessment	☐ High Risk	☐ Medium Risk	☐ Low Risk	☐ Not attended
How was this fall identified:	☐ Fall observed	☐ Patient informed staff	☐ Fall Suspected (Eg. Found lying on floor)	
Mobility at time of fall	☐ Independent	☐ Supervised	☐ Dependant on staff	
Mobility aids in use	☐ Crutches	☐ Walking Stick	☐ Hopper Frame	☐ Wheeled Walker ☐ Rollator ☐ None
Activity at time of fall	☐ Transfer to/from bed	☐ Transfer to/from chair	☐ Toileting	☐ Other transfer (eg. Wheelchair)
	☐ Ambulating	☐ Bedfast	☐ Showering	☐ Other bathroom activity
Did this fall occur post-operatively?	☐ Yes ☐ No	If so, how long after surgery?		
Did this fall occur due to faint/fit?	☐ Yes ☐ No	Comment:		

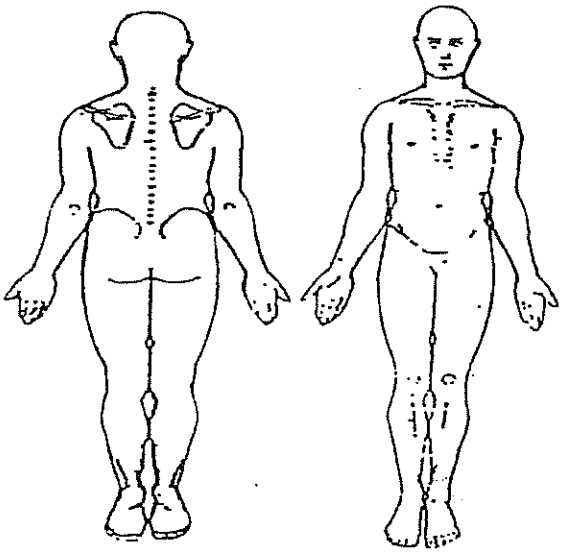
If flagged High or Medium Risk, please complete the following section:

Preventative measures in lace	☐ Falls risk score recorded on care path ☐ Colour coded arm band in place ☐ Bed lowered to bottom position ☐ Use of walk belt ☐ Physiotherapy review ☐ Dietician review ☐ Pharmacy review ☐ Occupational Therapy review	☐ Incontinence managed ☐ Current individual environment checklist completed ☐ Client orientated to ward ☐ Mobility aid appropriate and accessible ☐ Hearing/visual aids working ☐ Hearing/visual aids being reviewed ☐ Footwear Checked ☐ Restraints chemical/physical (specify)

Safety devices in use	Bed rails up	☐ Yes	☐ No
	Brakes on bed	☐ Yes	☐ No
	Brakes on wheelchair	☐ Yes	☐ No
	Call bell within reach	☐ Yes	☐ No
	Wet floor signs in use	☐ Yes	☐ No

Assistive device – please specify:

Part of Body injured	☐ **Head**	☐ **Neck**	
	☐ **Face**	☐ **Back**	
	☐ **Nose/Mouth**	☐ **Trunk**	
		Left	**Right**
	Eyes	☐	☐
	Ears	☐	☐
	Shoulder	☐	☐
	Arm	☐	☐
	Hands	☐	☐
	Finger	☐	☐
	Leg	☐	☐
	Knee	☐	☐
	Feet	☐	☐
	Toes	☐	☐
	Multiple locations Specify		



Appendix B (ii)

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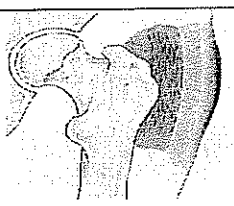
Bundaberg Health Service District

Pressure Ulcer Minimum Data Set Form

Please complete this form and attach to the relevant Adverse Event Report Form

Patient Name		**Date of Event**	
Pressure ulcer present on admission?	☐ Yes If yes, date of admission	☐ No	☐ Unknown
Transferred from another unit/hospital?	☐ Yes If yes, please specify	☐ No	☐ Unknown

Staging



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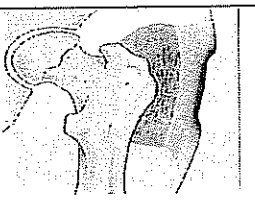

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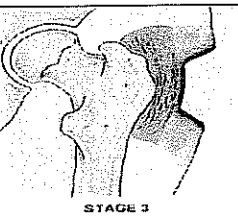

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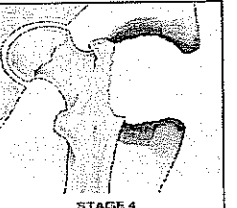

☐

Location of Ulcer Please circle

1	Occiput	5	Scapula	9	Iliac Crest	13	Pretibial Crest
2	Ear	6	Spinous Process	10	Ischium	14	Malleolus
3	Nose	7	Elbow	11	Trochanter	15	Heel
4	Chin	8	Sacrum	12	Knee	16	Other

Wound Description

Waterlow Score

Build/weight for height		Mobility		Continence		Appetite		Sex	
0	Average	0	Fully mobile	0	Complete/catheterised	0	Average	1	Male
1	Above Average	1	Restless, agitated	1	Urine incontinence	1	Poor	2	Female
2	Obese	2	Apathetic	2	Faecal incontinence	2	NGT/Fluids	**Age**	
3	Below Average	3	Restricted	3	Faecal & Urinary incontinence	3	NBM	1	14-49
		4	Bed bound			3	Anorexic	2	50-64
		5	Chair bound					3	65-74
								4	75-80
								5	81+

Skin Type Visual Risk		Special Risks					
		Medication		Tissue Malnutrition		Neurological Deficit	
0	Healthy	4	Cytotoxics **Steroids** Anti-inflammatory Anti-coagulant (maximum 4)	8	Terminal Cachexia	4-6	Diabetes, MS, CVA, Motor /sensory paraplegia (maximum of 6)
1	Tissue Paper			5	Multiple Organ failure		
1	Dry			5	Cardiac failure		
1	Oedematous			5	PVD	**Major Surgery or Trauma**	
1	Clammy, pyrexia			2	Anaemia (Hb<8)	5	Orthopaedic/Spinal
2	Discoloured Stage 1			1	Smoking	5	On table>2 hours (in past 48hours)
3	Pressure Ulcer Stage 2-4						

Waterlow Score

Current Score: | **Score on Admission**

10+ At Risk | **15+ High Risk** | **20+ Very High Risk**

Pressure Device in use

☐ Foam replacement mattress or overlay	☐ Alternating pressure overlay
☐ Gel filled pads	☐ Low air loss bed
☐ Fibre-filled overlay e.g. Spenco	☐ Alternating pressure mattress
☐ Non-powered air filled mattress	☐ Comforter e.g. Sheepskin, pillows
☐ Low air loss mattress	☐ Nil
☐ Other	

Risk Factors

☐ Trauma	☐ Para/Quadriplegia	☐ Obesity	☐ Bed/Chair bound	☐ Impaired cognitive state
☐ Disease	☐ Hemiplegia	☐ Pain	☐ Spinal injury	☐ Extended length of surgery
☐ Anaesthetics	☐ Fractures	☐ Burns	☐ ↓ conscious state	☐ Other

Interventional strategies

☐ Pressure device implemented/continued	☐ Altered skin care e.g. Soap to sorbelene
☐ Turning regime implemented/continued	☐ Continence Management
☐ Wound treatment Regime ☐ Education	☐ Other

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Appendix B (iii)

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Bundaberg Health Service District

Occupational Exposure Follow up Questionnaire

Please complete this form and attach to the relevant Adverse Event Report Form. The DQDSU will forward this form to the Infection Control Coordinator

Name		Payroll Number		Work Area	
Designation		Date of Incident		Time of Incident	hours

INFORMATION ABOUT THE EXPOSURE INCIDENT

Where did the exposure occur?	Eg. Pathology, ICU, Laundry etc
What type of activity was in progress?	Eg. Waste Disposal, surgery, cleaning, routine patient care, CPR, autopsy etc
Were you wearing personal protective equipment?	Eg. Gloves etc
What substances or body fluids were you exposed to?	Eg. Wound exudate, after IM/SC injection etc
	If body fluid, was it visibly blood stained? ☐ Yes ☐ No

INJURY RELATED TO A SHARP DEVICE (Please go to next section if this incident was not caused by a sharp device)

What type of sharp device caused the injury?	Eg .Gloves, hollow bore needle, scalpel blade, scissors, razor, etc	Needle Gauge (if applicable)
For what purpose was the sharp used?	Eg. SC injection, suturing etc	
\t what point during use, did the injury occur?	Eg. During use, after disposal, cleaning etc	
	Were you the original user of the sharp? ☐ Yes ☐ No	
How deep was the injury?	☐ Superficial (surface scratch)	☐ Moderate (penetrated skin)
	☐ Deep (puncture or wound)	☐ Actual injection of blood or body fluid
Location of Injury?	Eg. Thumb etc	

NON-PERCUTANEOUS INJURY - SPLASH WITH BLOOD OR BODY FLUID

How did the exposure or splash occur?	Eg. Tube leak, vomit, soiled drapes, R/O IV etc			
What volume of blood/body fluid were you exposed to?	☐ <5mls	☐ 5-50mls	☐ >50mls	☐ Unknown
For how long was the exposure?	☐ Brief – <5mins	☐ Prolonged - >5mins	☐ Unknown	
Which body surfaces were involved?	☐ Eye/s	☐ Nose	☐ Mouth	
	☐ Non-intact skin	☐ Intact skin	☐ Other	Specify:

GENERAL INFORMATION

How much time was lost due to this injury?	Days	Hours	Minutes
How would you avoid such a injury in the future?	Please Comment		
Are you satisfied with your injury management so far?	Please Comment		
☐ Yes ☐ No			

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE
PLEASE ATTACH TO RELEVANT INCIDENT FORM AND FORWARD TO DQDSU AS SOON AS POSSIBLE

Office Use Only

HCW notified of results	☐ Initial time	☐ 6 weeks	☐ 3 months	☐ 6 months
HCW follow0up letter sent	☐ 6 weeks	☐ 3 months	☐ 6 months	
Source Results	☐ Yes	☐ No	Comment	
Heb B Immunoglobulin	☐ Yes	☐ No	Comment	
Hep B vaccine post exposure	☐ Yes	☐ No	Comment	
Serum drawn within 7 days	☐ Yes	☐ No	Comment	
Anti-HIV prophylaxis	☐ Yes	☐ No	If so, how soon after exposure?	

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Appendix C

District Quality and Decision Support Unit Use Only					
Registration Number		Date report received (P.I. 1)	Benchmark – 90% within 2/7	Acknowledgement sent to HOD	Date:

Risk Assessment	1 = Negligible	2 = Minor	3 = Moderate	4 = Major	5 = Extreme
Patients	Event ran to completion but no harm caused	Extra observations and monitoring/ no treatment required	Moderate harm ⇧ LOS or ⇧ level of care, investigations	⇩function- sensory, motor, physiologic, intellectual	Death or major permanent loss of function
Visitors	Event ran to completion but no harm caused	Evaluated but no treatment required/refused	Evaluation and treatment required (up to 3 visitors)	Evaluation, treatment and admission required	Death or major permanent loss of function
Staff	Event ran to completion but no harm caused	No lost time or restricted duty injuries/illnesses	<3 days lost time or restricted duty injuries	>3 days lost time or restricted duty injuries	Death or major permanent loss of function
Equipment	No damage/cost	Damage < $5000	Damage >$5000 but < $10,000	Damage >$10,000 but <$100,000	Damage >$100,000

Likelihood	
Rare = 1	The event may occur only in exceptional circumstances (may happen sometime in 5-30years)
Unlikely = 2	The event might occur at some time, but is not to be expected (may happen sometime in 2-5years)
Possible = 3	The event could occur at least once (capable of happening/foreseeable)
Likely = 4	The event is expected to occur occasionally (may happen several times in 2years)
Almost Certain=5	The event is expected to occur frequently or in most circumstances (may happen several times in 1 year)

RISK MATRIX	1 = Negligible	2 = Minor	3 = Moderate	4 = Major	5 = Extreme
Rare	Low (1)	Low (2)	Low (3)	Medium (4)	Medium (5)
Unlikely	Low (2)	Medium (4)	Medium (6)	High (8)	High (10)
Possible	Low (3)	Medium (6)	High (9)	Very High (12)	Very High (15)
likely	Medium (4)	High (8)	Very High (12)	Very High (16)	Extreme (20)
Almost Certain	Medium (5)	High (10)	Very High (15)	Extreme (20)	Extreme (25)

RISK ASSESSMENT	Factor of Consequence		X Likelihood		Risk Rating	
Patient Adverse event sent to:	☐ ADON	☐ Director	Date Sent		Reply due by:	
Staff Adverse event sent to:	☐ WHSO	☐ Director	Date Sent		Reply due by:	

Feedback (DQDSU only)				
Adverse event report received	☐ Investigating Officer:	☐ WHSO	☐ Executive Director	Date
P.I -3 High, Very High & Extreme	Time to investigation complete (No. of days)	Benchmark – 90% investigations complete within 10 working days		Signed
Feedback sent to:	☐ Head of Department	Date		
	☐ Staff member reporting	Date		
	☐ Subject involved in adverse event	Date		
Reported in Trend Report:	☐ Leadership & Management	Date		
	☐ Executive Council	Date		
	☐ District Rural Executive Forum	Date		
	☐ Heads of Department	Date		
Adverse event closed on: (P.I.3)		No. of days	Benchmark – ()% closed within 28 days	
Performance Indicators	P.I.1 – Adverse event Report Form received by DQDSU within 2 working days			
	P.I. 2 – High, Very High & Extreme adverse events investigation completed within 10 working days			
	P.I.3 – All adverse events closed within 28 days			
Additional Information – where relevant				

ANALYSIS/ INVESTIGATION REPORT

Investigation completed by:	Name:

Please complete the following information for all adverse events with a risk rating of High, Very High or Extreme

Investigation Process	☐ Patient Record	☐ Personal interview	☐ Other: (Please specify)
Findings What was found to be the major/ immediate causes of this adverse event?	Any substandard conditions, substandard practices, system failures or human error which directly resulted in the adverse event		
Solutions What potential/actual solutions were identified to overcome the problem?	Details of action/s either proposed or taken to correct and/or prevent this adverse event occurring again		
Action What action has been taken as a result of this investigation?	Detail action/ preventative action either proposed or taken		
Action undertaken by:		Completion date	
Report provided to: Where has this analysis been reported?	Committee/meeting	Date reported:	

Risk entered onto the Risk Register: (please tick, where relevant)	☐ ASPIC	☐ DEM CSF	☐ Family CSF
	☐ IMHS CSF	☐ Medical CSF	☐ Paediatric CSF
	☐ Allied Health HOD	☐ Community Health HOD	☐ Corporate Services HOD
	☐ Childers	☐ Gin Gin	☐ Mt. Perry
	☐ District Central Risk Register	☐ Other: (Please Specify)	

Please add any additional comments/information that you feel may be relevant:

Please return this completed form to the District Quality and Decision Support Unit

Appendix D

BUNDABERG HEALTH SERVICE DISTRICT

SAFETY CLIMATE SURVEY

Date: ..... **Unit/Department:** .....

Please answer the following items with respect to your specific unit or clinical area. Choose your responses using the scale below:

	A Disagree Strongly	B Disagree Slightly	C Neutral	D Agree Slightly	E Agree Strongly	X N/A
1. The culture of this clinical area makes it easy to learn from the mistakes of others.						
2. Medical errors are handled appropriately in this clinical area.						
3. The senior leaders in my hospital listen to me and care about my concerns.						
4. The physician and nurse leaders in my areas listen to me and care about my concerns.						
5. Leadership is driving us to be a safety-centred institution.						
6. My suggestions about safety would be acted upon if I expressed them to management.						
7. Management/leadership does not knowingly compromise safety concerns for productivity.						
8. I am encouraged by my colleagues to report any safety concerns I may have.						
9. I know the proper channels to direct questions regarding patient safety.						
10. I receive appropriate feedback about my performance.						
11. I would feel safe being treated here as a patient.						
12. Briefing personnel before the start of a shift (i.e. to plan for possible contingencies) is an important part of safety.						
13. Briefings are common here.						
14. I am satisfied with the availability of clinical leadership (please respond to all three):						
Medical Officer						
Nursing						
Pharmacy						
15. This hospital is doing more for patient safety now, than it did one year ago.						
16. I believe that most adverse events occur as a result of multiple system failures, & are not attributable to one individual's actions.						
17. The personnel in this clinical area take responsibility for patient safety.						
18. Personnel frequently disregard rules or guidelines that are established for this clinical area.						
19. Patient safety is constantly reinforced as the priority in this clinical area.						

Have you ever completed this survey before? O Yes O No O Don't Know

Job Position: (mark only one)

- O Director
- O Senior Medical Officer
- O Principal House Officer
- O Junior House Officer
- O Senior Medical Officer
- O Nurse Unit Manager
- O Clinical Nurse
- O Registered Nurse
- O Enrolled Nurse
- O Allied Health Professional
- O Administration Officer
- O Operational Services

Other: _____

Thank you for completing the survey. Your time and participation are greatly appreciated.
Please return this survey to Leonie Raven in the District Quality and Decision Support Unit