Appendix F: Patient Safety Incident Reporting Form

**Section A:** (notification) - to be completed by the staff who witnessed the incident that occurred. Submit section A and B to next level for notification for SAC 1 incidents.

**Section B:** (Account of the event by patient, staff or other witnesses) – to be completed by staff, patients or other that were directly involved while the incident took place.

**Section C:** (investigation) - to be completed by investigator(s) of the incident, in most cases this would be the manager(s) of section where the incident took place.

**SECTION A – Notification of event**

**Ref no:**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Date PSI identified**
 |  | 1. **Time PSI identified**
 |  |
| 1. **Event identified by**
 | Reported by health professional | Research studies | Patient experience of care surveys | Inpatient medical review | Review of record on follow-up | External sources | Safety walk rounds | Focused teams | Use of data |
| Complaints | Media | Public |
| 1. **Provide a short overview of the Patient Safety Incident**
 |
| What happened/went wrong? |
|  |
| What is the initial outcome or harm? |
|  |
| 1. **Describe immediate actions taken to minimise harm**
 |
| What action was taken to minimise harm? |
|  |
| Who led that action? |
|  |
| What was the outcome of the minimising action? |
|  |
| 1. **Provide a description of communication and escalation (initial disclosure)**
 |
| What and how was the incident communicated with patient? (if appropriate) |
|  |
| What and how was the incident communicated with patient’s family? (if appropriate) |
|  |
| What and how was the incident escalated to management within the facility? (if appropriate) |
|  |
| **7. Type of patient safety incident (PSI): Mark with an X (review this once the investigation has been finalised)** |
| No harm | Near miss | Harmful (Adverse Event) |
| **8. SAC rating: Mark with an X** | **1 Serious** | **2****Moderate** | **3 Minor** | **4** **None** | **9. Date SAC 1 reported to next level** |  | **11. No of days to report PSI with SAC = 1**  |  |
| **10. Time SAC 1 reported to next level** |  |
| 1. **Patient and ward information**
 | 1. **Staff witnesses**
 |
| Patient name and surname |  | Name and surname | Contact detail | Department |
| Patient file number |  |  |  |  |
| Patient Id number |  |  |  |  |
| Location (department/ward) |  |  |  |  |
| Age |  |  |  |  |
| Gender |  |  |  |  |
| Final diagnosis  |  |  |  |  |
| Number of patients in the ward/head count |  |  |  |  |
| Name of facility patient was referred from (where applicable) |  |  |  |  |
| Name of facility patient was down referred to (where applicable)  |  | **14. Number of staff on duty** |  |
| **Compiled by: Designation: Signature: Date:** |

**SECTION B- Account of the event by patient, staff or other witnesses**

|  |
| --- |
| 1. **Account by staff, patient or significant other: (Add sections for additional statements and information as needed)**
 |
| **Account 1:**  |
|  |
|  |
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|  |
| **Account 2:** |
|  |
|  |
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| **Compiled by: Designation: Signature: Date:** |

**SECTION C – Investigation including classification**

|  |
| --- |
| 1. **Classification according to incident type – mark appropriate one with an X**
 |
| **1.Clinical administration** | **3. Healthcare-associated infections** | **5. Blood and blood products** | **8. Patient accidents and self-inflicted injury** |
| Medical procedure performed without valid consent | Central line associated Blood Stream Infection | Acute transfusion reactions | Falls – Bedside |
| Falls – Toilet/bathroom |
| Communication/ confidentiality | Non-device related (Primary) blood line blood infection | Delayed transfusion reactions/ events (including Transfusion Transmitted Infections) | Falls – Stretcher |
| Falls – Therapeutic equipment |
| Patient incorrectly identified and recorded | Peripheral line blood infection | Errors- wrong blood/ blood products | Patient injury |
| Missing patient record | Surgical site infection | **6. Medical device/equipment** | Self-inflicted injury |
| Unclear/ ambiguous/ illegible/ incomplete information in patient record | Hospital acquired pneumonia | Not available  | Suicide  |
| Ventilator associated pneumonia | Failure / malfunction | Attempted suicide |
| Catheter associated urinary tract infection | Not used correctly | **9. Pressure ulcers acquired during/after admission** |
| Communicable diseases |
| **2. Clinical process/ procedure** | **4. Medication / IV fluids** | Incorrect medical device/ equipment used | Grade I |
| Not performed when indicated | Incorrect dispensing | **7. Behaviour** | Grade II |
| Performed on wrong patient | Omitted medicine or dose | Sexual assault by staff member | Grade III |
| Clinical procedure errors | Medicine not available | Sexual assault by fellow patient or visitor | Grade IV |
| Surgical procedure errors | Adverse drug reaction | Physical assault by staff member | **10. Infrastructure/ Buildings/ Fixtures** |
| Clinical treatment error (incorrect clinical management) | Incorrect medicine | Physical assault by fellow patient or visitor | Damaged/ faulty/ poor maintenance |
| Incorrect dose/ strength administered | Non-existent |
| Clinical assessment error (Missed, delayed, wrong) | Incorrect patient | Exploitation, verbal abuse, aggression, neglect or degrading treatment by fellow patient or visitor | Inadequate/inappropriate |
| Incorrect frequency | Back-up electricity not functional/available |
| Incorrect route | Back-up water supply not available |
| Failure to act on test results or report | Prescription error | Exploitation, verbal abuse, aggression, neglect or degrading treatment by staff member | 1. **Laboratory / Pathology**
 |
| Performed on wrong body part/ site/ side | Incorrect dispensing label | Delayed laboratory results |
| Retention of foreign object during surgery  | Medicine expired | Patient abscond | Processing error by laboratory |
| Incorrect technique  | Missing patient Abscond while under 72-hour observation | Incorrect labelling of results |
| Inappropriate polypharmacy | **12. Other** |
|  | Any other incident that does not fit into categories 1 to 11 |
| 1. **Framework for root cause analysis and implementation of action plans**
 |
| * 1. **Contributing factors – Mark with an X**
 |
| **1. Staff**  | Lack of knowledge of clinical processes/ guidelines/ protocols | Human error- clinical  | Human error - Admin | Risky/reckless behaviour | Communication Factors | Condition/ disease related factor | Social factors | Leadership |
| **2. Patient**  | Behaviour | Communication factor | Condition/ disease related factor | Social factors |
| **3. Work/ environment** | Physical environmental / infrastructure | Remote/ long distance from service | Equipment (faulty due to no maintenance) | Consumables | Environmental risk  | Current Code/ specifications/ regulations | Security/safety |
| **4. Organisational/ service**  | Clinical Protocols/ policies/ procedures not available/ up to date/ approved | Non - Clinical Protocols/ policies/ procedures not available/ up to date/ approved | Organisational management/ decisions/culture | Organisation of teams | Staffing | Political unrest | Package of service  | Bed utilisation  |
| **5. External** | Natural event or disaster | Equipment, products malfunctioning due to manufacturer’s fault | Services, systems and policies of external providers | Delays in emergency medical services transport |
| **6. Other** | Not specified in classification 1 to 5 |
| * 1. **Root cause analysis -** These are the most fundamental underlying factors contributing to the incident that can be addressed
 |
| **Contributing factor** | **Describe the factor that contributed to the event**  | **Describe the action plan to rectify the identified problem** | **Person responsible for implementing the action plan** | **Date for implementation** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| 1. **Findings and recommendations of the investigation**
 |
| What were the key findings (why did the incident occur)? |
|  |
| What are the key recommendations? (Note: Recommendations should address all the root causes and lessons learned, be designed to significantly reduce the likelihood of recurrence and/or severity of outcome; be clear and concise and kept to a minimum wherever possible; be Specific, Measurable, Achievable, Realistic and Timed (SMART) so that changes and improvements can be evaluated; be prioritised wherever possible; be categorised as: those **specific** to the area where the incident happened; those that are **common** only to; the organisation involved; those that are **universal** to all and, as such, have provincial/district significance.) |
|   |
|  |
| 1. **Type of behaviour according to Just Culture: mark with a X**
 | **No error** | **Human error** | **At–risk behaviour** | **Reckless behaviour** |
| 1. **Provide a description of final communication to patient/family (final disclosure)**
 |
| What and how was the incident communicated with patient? (if appropriate) |
|  |
| What and how was the incident communicated with patient’s family? (if appropriate) |
|  |
|  |
| 1. **Date of closure of PSI case**
 |  | 1. **No days to close PSI case**
 |  | 1. **Type of closure: mark with an X**
 | **PSI case concluded**  | **Litigation** | **Referred to labour relations** |
| 1. **Patient outcome according to degree of harm: Mark with an X**
 | No harm  | Mild | Moderate | Severe | Neonatal trauma | Obstetric trauma | No longer classified as a PSI after investigation |
| Child death under 5 years | Child death 5 years and above | Adult death | Neonatal death | Maternal death | Still birth | Deaths due to hospital associated venous thromboembolism | Deaths due to health care associated sepsis | Perioperative death (30 days after surgery) |
| 1. **Organisational outcome: Mark with an X**
 | Property damage  | Increased length of stay | Admission to special care area (e.g., high care or ICU) | Additional treatment/tests | Additional staff required | Additional equipment required | Media attention |
| Formal complaint | Damaged reputation | Legal ramifications | None | Other | No longer classified as a PSI after investigation |
| Compiled by: Designation: Signature: Date: |