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:**

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| 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? | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What is the initial outcome or harm? | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Describe immediate actions taken to minimise harm** | | | | | | | | | | | | | | | | | | | | | | | | | |
| What action was taken to minimise harm? | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Who led that action? | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What was the outcome of the minimising action? | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Provide a description of communication and escalation (initial disclosure)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| What and how was the incident communicated with patient? (if appropriate) | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What and how was the incident communicated with patient’s family? (if appropriate) | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What and how was the incident escalated to management within the facility? (if appropriate) | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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**

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| 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**

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| 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** | | | | | | | | |
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| 1. **Findings and recommendations of the investigation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What were the key findings (why did the incident occur)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| What and how was the incident communicated with patient’s family? (if appropriate) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |