SOURCE: Ministry of Health	POLICY TITLE: Incident/Accident Reporting
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REPLACESPOLICY DATED:	REVISION DATE(s):

Ministry of Health employs a number of systems to ensure quality patient care delivery. This policy is developed to provide notification of incidents or events that have occurred involving patients, staff, visitors, equipment and services and by no means replaces the Ministry of Public Service Disciplinary Manual. It also focuses on continuous improvement systems that foster a culture of team spirit and transparency. In an effort to improve overall services, health care providers and other employees are required to complete and submit an incident report.

Purpose and Applicability:

1. To provide a safe working environment for users of the facility.
2. To promote a fair and just culture where staff are supported in reporting adverse incidents.
3. Ensure a transparent and structured incident management system.
4. To promote a system-centered approach rather than a person-centered approach to problem resolution.
5. To identify trends at unit/department/section as well as hospital-wide for complaints, claims and adverse incidents.
6. To ensure that opportunities for improvement are identified and maximized.

Applies to all employees of Ministry of Health as well as students, interns and voluntary workers

Policy Statements:

All full time and part time employees, students, interns, voluntary workers, visitors and contractors shall report to Their Respective supervisor/manager on appropriate Incident Report Form, any *adverse incident*, *risks*, *harm or hazard* associated with their work.

All staff employed by the Ministry of Health is committed to the accurate and timely reporting of incidents/accidents that occurred during the performance of his/her duties.

All incidents/accidents must be acted upon within 24 hours of its occurrence.

Ministry of Health Officials must be informed of , in writing of all incidents/accidents involving media issue.

An "***Incident Report File***" must be maintained by Hospital Administrator or his/her designee.

Hospital Administrator must ensure that family members/legal guardian of patients involved in incidents/accidents are invited to a meeting where activities leading up to the incident/accidents are communicated with them.

Definitions:

- **Adverse Incident** – an event or circumstance arising during care that have lead to unintended or unexpected harm, loss, or damage.
- **Risk** – the chance that something happening will have an impact or expected outcome. It is usually measured in terms of consequence and likelihood.
- **Harm** – injury (physical or psychological), disease, suffering, disability or death. It can be considered to be unexpected if it is not related to the natural cause of the patient's illness or underlying condition.
- **Hazard** – anything that can cause harm.

Procedure:

When to Report:

- Reporting of an adverse incident should be done immediately, if this is impractical then not later than 24 hours after the incident.

- Any significant incident should be reported immediately.

What to report:

Clinical Incident – a situation when a patient is involved in an event or near miss which had a potential or actual adverse outcome, which would not be expected to occur in the routine course of events. This should include: medication incidents such as prescribing, dispensing, administration errors and incidents involving medical devices. (See Annex 1)

Equipment Incident – a situation when equipment is involved in an event or near miss which had a potential or adverse outcome.

Personal Incident – any incident which affected an individual not directly related to clinical treatment. Incidents involving exposures to blood and body fluids, or other hazards associated with work.

Violence, abuse or harassment – any incident involving verbal abuse, unsociable behavior, racial or sexual harassment or physical assault whether or not injury results.

Fire Incident – any incident, no matter how small, involving fire or fire warning systems (including false alarms).

Security Incident – any untoward incident involving theft, loss or damage to personal or the organisations' property, intrusions, false alarms (not fire alarms).

Vehicle Incident – any incident involving a vehicle e.g. road traffic accident, excluding vandalism or theft which would be considered as a security incident.

Any incident, which may lead to publicity, litigation or loss of public confidence.

NB: Please note that this reporting system will not replace other existing reporting systems; e.g., maintenance requests.

How to report:

Incidents should be reported using the Hospital's Incident Report Forms.

- When more than one person or department is involved:
  In the case of incidents involving more than one person a form should be completed for each person.
- Where one incident occurs affecting more than one department each department should rate and record the event according to the impact on their department.

Other ways an incident may be identified:

Incident reporting is one of a number of mechanisms for detecting adverse events. Other methods which may detect an event includes the following:

- ***Medical Record Review***
- ***Post discharge reporting*** – some events related to treatment in hospital only become evident after discharge.
- ***Policy auditing*** – events can be detected shortly after they occur. Each approved policy must have a check list developed for auditing the effectiveness of the policy. Any variation from policy statement can be reported promptly to the unit/section/department head, who should complete an incident report and submit to Hospital Administrator for review, analysis and action.
- ***Patient satisfaction/complaints***: - events from the patient's perspective are detected from patient satisfaction surveys, patient complaints formal and informal. Though concerns may be expressed that patient's are not able to adequately judge the quality of clinical services, information from patients provides valuable data for improving health care systems.

Procedure for managing incidents:

1. The injured person or damaged property should be assessed immediately, to ascertain the extent of injuries and identify emergency or urgent treatment.

2. Appropriate treatment/actions should be taken to minimize the extent of injury or damage.
   - 2.1 For patient errors, contact the relevant medical team in order to make an assessment of the situation.
   - 2.2 Refer as appropriate for medical/other opinion.

3. The patient and/or their relative must be informed as soon as possible of the incident and any treatment that may be necessary and before the media are involved if there is a likelihood of media interest.

4. Any equipment/device involved in the incident should be reported and clearly labeled *DO NOT USE* until appropriate checks can be carried out. The following procedures should be followed:

4.1 Ensure patient is safe and complete an incident form.
4.2 Keep the device involved in the incident, including the packaging.
4.3 If it is a machine, try to leave all switches and controls as they were at the time of the incident.
4.4 Return the device to Medical Supplies Unit or equipment to Maintenance Department for a Bio-medical Technician to evaluate and repair.
4.5 If the item is a part of a batch, check the remaining stock and ask if the defect has risen out of faulty storage. The entire batch might need to be withdrawn.

5. An incident form should be completed as soon as possible, preferably by the staff member involved and passed to the relevant ward/section/department head.

6. Where appropriate, witness names and contact numbers and/or addresses should be recorded; witness statements may be required.

7. Any other agencies involved in the incident should be recorded.

8. The incident forms should be completed accurately and fully stating facts and not opinions.

9. Management actions and preventative measures taken must be recorded and fed back to the unit/section/department involved.

Management/Support of staff directly following an incident:

1. Ministry of Health recognizes that it has a responsibility to all staff to support them following incidents.

2. Staff involved must be kept informed of the progress of an investigation at all stages. Individuals who have been absent from work may require additional support and supervision to aid confidence when returning to work.

3. Individuals will need reassurance about management actions that may affect them immediately or in the longer term.

Incident Review:

- All incidents along with complaints and claims will be recorded and managed by the Hospital Administrator. This will allow management to monitor and analyze the types of incidents, complaints and claims occurring.

- Aggregate reviews of reported incidents can identify trends not noticeable from individual incident analysis and can provide additional valuable information for learning.

- Reviews will be carried out and reported using the following approach:

Frequency Analysis

A frequency analysis looks at the number of occurrences of one or more variables across the whole for a particular time period, or for an individual speciality or location, such as:

- Number of reported incidences
- Incident type (event, near miss etc.)
- Nature of harm (physical injury, psychological injury, disease, suffering, disability, death)
- Immediate causes (patient, individual, team, task, environment)
- Underlying causes
- Action taken/proposed
- Incident cost.

Implementing and monitoring improvement strategies

Ministry of Health aims to learn lessons from individual incidences, from reviews and from wider experiences, including feedback and benchmarking. Improvement strategies aimed at reducing risk for future patients will be implemented, monitored by Hospital Administration and where appropriate practice will be changed to improve the safety and quality of care for our patients.

Training

Training will be provided for all staff to ensure that everyone is aware of their responsibilities regarding the reporting of incidents and follow-up as required.

In-service training sessions will be organized jointly by Hospital Administration for cohort of staff based on problems identified from incident reports.

Records of training will be maintained and updated as necessary.

Forms:

1. MOH Incident/Accident Report Form

Responsibilities:

1. Staff member involved in the incident should complete the report.

2. If more than one staff member were involved, each staff member is responsible to complete an incident form.
3. In cases where radiological and/or laboratory services were required, the patient's physician should countersign the report verifying orders for these services.
4. If the incident involves a visitor, a member of the nursing team must escort the person to the Emergency Room and the Charge Nurse/ Department Head should complete the incident report form.
5. If the incident results in an injury that renders an employee unable to complete an injury form, the Ward/Department Heads should complete the form.
6. Wards/Department Heads should ensure that nurses under their Span of control adhere to the Incident Report Policy.
7. Hospital Administrator will identify, analyze and report on incidences coming out of medical record reviews, post discharge reporting, policy auditing and patient satisfaction surveys and complaints.
8. Hospital Administrator, in collaboration with members of the management team, will organize and implement training sessions for staff.
9. Hospital Administrator or his/her designee will conduct and report on frequency analysis.
10. Hospital Administrator/Deputy Regional Health Manager, in charge of Community Hospital's will be responsible to submit monthly summary reports of all incidents to Regional Health Manager.
11. Regional Health Manager will submit quarterly summary reports of all incidents to their respective Deputy Director of Health Services, at the Ministry of Health.
12. Any incident/accidents from health districts that involves media, should be acted upon immediately, verbal, in the first instance, followed by written report should be forwarded to the respective Deputy Director of Health Services and/or Director of Health Services, if DDHS is unavailable. No incident that is aired on media or rumored should be delayed.

Effective Date: This policy will be effected on the date of issuance.

Signatures:

Prepared by: _____ Date: _____

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Reviewed by: _____ Date: _____

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Approved by: _____ Date: _____

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Annex 1
Examples of reportable clinical and non-clinical incidents

General Cases
Delay in diagnosis, wrong diagnosis or incorrect patient assessment.
Health records not available during a consultation.
Communication problems between a patient and healthcare professional
Health care associated infection
Defective medical device

Catastrophic Events
Performance of a procedure on wrong body part (wrong-surgery-site)
Performance of a procedure (including radiological studies and higher end imaging) on a wrong patient
Infant abduction or discharge to wrong family.
Rape of a hospitalized patient.
Self-harm or suicide
Blood specimen obtained for cross matching from the wrong patient.
Blood transfusion administered to the wrong patient.

Risk Incidents
Unexpected or trauma related deaths
Any unplanned return to Operating Theatre
Critical care equipment problems
Infusion pump problems
Hospital incurred trauma
Wrong patient or wrong site surgery or radiology
Misdiagnosis
Swab/instrument count incorrect at the end of procedure
Absent medical notes
Unplanned readmission within 5 days of discharge

Procedural Breakdowns
Errors or unexpected complications related to the administration of drugs or transfusion
Discharge against medical advice (DMA)
Significant delays in diagnosis or diagnostic testing
Breach of confidentiality

Others
Untoward outcomes; unexpected deaths.
Significant infections
Absence of signed Informed Consent Forms
Lost of instrument in theatre
Patient absconsions
Infant Abductions
Inpatient Falls including fatal falls
Institutionally acquired pressure sores
Institutionally acquired burns (chemical or other)
Unavailability of health record

Occupational Health
Work related diseases, injuries and/or exposures

Non-Clinical Events
Theft, loss or damage to personal or organization's property
Intrusions
Risks affecting patient/public safety
Violence, abuse and/or harassment

Spills outside of patient care area