Department of Health

# Using this Form

Health Service Establishments Licensing

*Health Service Establishments Regulations 2011 (Tas), Schedule 1, Part 4, Clause 10*

HSE 2014-18

**Reporting: Injuries, Transfers, Deaths and Other Sentinel Events**

This form should be used to record and report an incident to the Secretary, Department of Health (DoH) under Schedule 1, Part 4, Clause 10 of the *Health Service Establishments Regulations 2011* (Clause 10).

# Important Information and Instructions for Completion

## Part 1: What to record

### Clause 10 requires that you record the following incidents using Part 1 of this form:

1. **any injury requiring medical attention** that is sustained by a patient as a **result of any accident** at a private hospital or day-procedure centre; and
2. the transfer of a patient to another hospital **as a result of an injury or iatrogenic condition;** and
3. the **death of any patient** at a private hospital or day-procedure centre; and

### (iv) any incident classified as a **sentinel event** by the Australian Commission on Safety and Quality in Healthcare.

As soon as practicable after any such incident, details of the incident must be **recorded on this form and placed on the patient’s clinical record.**

### Details of the incident must also be reported to the director of nursing, and to the patient’s medical practitioner. These are requirements of the Regulations.

***Part 2: What to record***

The incident must then be investigated by the **medical advisory committee.** The results of the investigation must be entered in Part 2 of the incident form, and **placed on the patient’s clinical record.**

***Reporting: When do I need to provide this form to the DoH?***

Please follow the ***Reporting: Injuries, Transfers, Deaths and Other Sentinel Events Flow Chart*** illustrating the incidents that are reportable to the Department and the timeframes for completion.

Regulation and Licensing Contact Details

|  |  |  |
| --- | --- | --- |
| Website | Enquiries | Email |
| [www.dhhs.tas.gov.au/privatehealthregulation](http://www.dhhs.tas.gov.au/privatehealthregulation) | (03) 6166 3856 | hselicensing@health.tas.gov.au |

Submit this form electronically to DoH Regulation Unit at **hselicensing@health.tas.gov.au**

### Oral notifications can be made by contacting the Department on **(03) 6166 3856**

*Please remove this page prior to submission of the form.*

Part 1: Details of the Incident *(submit this form to DoH Regulation Unit within* ***3 days*** *of incident)*

|  |
| --- |
| **1. Details of Health Service Establishment** |
| Name of Health Service Establishment (HSE)*(include campus if applicable)* |
| Name of Health Service Establishment (HSE) |

|  |
| --- |
| **2. Details of Patient** |
| UR / Patient Number | Date of Birth | Admission Diagnosis |
| UR / Patient Number | 01/01/1901 | Admission Diagnosis |

|  |
| --- |
| **3. Details of Incident** *(please tick all applicable)* |
| Date and Time of Incident |
| Date: 01/01/1901 | Time: 00 : 00  (please indicate am/pm) |
| 1. Patient sustained an **injury** requiring medical attention as a result of an accident that occurred at the health service establishment. [ ]  Yes [ ]  No
2. Patient was **transferred** to another hospital as a result of an injury or iatrogenic condition arising within the health service establishment (if yes, please provide details of the transfer below). [ ]  Yes [ ]  No
3. Patient **died** at the health service establishment. [ ]  Yes [ ]  No
 |
| **SENTINEL EVENTS** | 1. A procedure involving the **wrong patient or body part** occurred, resulting in death or major permanent loss of function. [ ]  Yes [ ]  No
2. The patient committed **suicide** in an inpatient unit of the facility. [ ]  Yes [ ]  No
3. **Retained instruments** or other materials were identified after the patient’s surgery, requiring re-operation or further surgical procedure. [ ]  Yes [ ]  No
4. The patient experienced an **intravascular gas embolism**, resulting in death or neurological damage [ ]  Yes [ ]  No
5. The patient experienced a haemolytic **blood transfusion reaction**, resulting from ABO (blood group) incompatibility. [ ]  Yes [ ]  No
6. A **medication error** occurred, leading to the death of a patient which was reasonably believedto be due to the incorrect administration of drugs. [ ]  Yes [ ]  No
7. **Maternal death or serious morbidity** occurred related to labour/delivery. [ ]  Yes [ ]  No
8. An **infant** was discharged to the wrong family. [ ]  Yes [ ]  No
 |
| Description of Incident*(please include a detailed account of the incident and if needed include an attachment)* |
| Description of Incident (please include a detailed account of the incident and if needed include an attachment) |
| Details of Transfer*(if applicable)* |
| Details of Transfer (if applicable) |

|  |
| --- |
| **4. Details of Reporting** |
| Date of Report to Director of Nursing | Date of Report to Patient’s Practitioner |
| Date: 01/01/1901 | Date: 01/01/1901 |
| Date of Open Disclosure | Date of Oral Report to Secretary *(if applicable)* |
| Date: 01/01/1901 | Date: 01/01/1901 |
| Anticipated Date of MAC Investigation*(if unknown, please provide estimate)* | Date of Coronial Notification *(if applicable)* |
| Date: 01/01/1901 | Date: 01/01/1901 |

|  |  |  |  |
| --- | --- | --- | --- |
| Name:       | Position:       | Signed:       | Date: 01/01/1901 |

Part 2: Details of Medical Advisory Committee Investigation

#### (investigation to be completed within **70 days** of date of incident)

|  |  |  |
| --- | --- | --- |
| UR / Patient Number | Date of Birth | Admission Diagnosis |
| UR / Patient Number | 01/01/1901 | Admission Diagnosis |
| Date and Time of Incident |
| Date: 01/01/1901 | Time: 00 : 00 (please indicate am/pm) |

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| --- |
| **5. Details of Medical Advisory Committee (MAC) Investigation** |
| Date of MAC Investigation: 01/01/1901 |
| Findings to include the following: |
| Patient OutcomePlease complete |
| System Review/Investigation* *This section to include full analysis of incident and any contributory factors; and*
* *Consideration from internal/external persons (ie internal clinical review committees and/or external reviews).*

Please complete |
| Recommended Changes to Practice* *This section to include future risk mitigation strategies; and*
* *Quality Improvement/action plans including appropriate timeframe for implementation*

Please complete |
| Will a coronial inquest occur? [ ]  Yes [ ]  No |

**Note:**

A referral to the coroner does not obviate the need to notify the Department and conduct a MAC investigation.

|  |  |  |
| --- | --- | --- |
| Dated this       | day of       | 20   |
| Name:       | Position:       | Signed:       |