Health Service Establishments Licensing

*Health Service Establishments Regulations 2021 (Tas), Schedule 1, Part 4, Clause 10*

HSE 2023-18

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

# Using this Form

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 2021* (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
4. 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.

***Please refer to the Form 18 User Information Guide for assistance***

***with completion of Part 1 and Part 2 of this form.***

# Regulation and Licensing Contact Details

|  |  |  |
| --- | --- | --- |
| Website | Enquiries | Email |
| [www.health.tas.gov.au/about/private-health-regulation-unit](http://www.health.tas.gov.au/about/private-health-regulation-unit)  | (03) 6166 3856 | hselicensing@health.tas.gov.au |

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

Verbal notifications (including on weekends) can be made by contacting the Department on: **(03) 6166 3856**

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

Department of Health

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

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

|  |
| --- |
| **2. Details of Patient** |
| Surname |  | Forenames |  |
| UR / Patient Number | Date of Birth | Admission Diagnosis |
|  |  |  |

|  |  |
| --- | --- |
|  | **3. Details of Incident** *(please tick all applicable)* |
| Date and Time of Incident |
| Date:  | Time: (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 |
| 1. 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 |
| 1. 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 |
| 1. The patient committed **suicide** in an inpatient unit of the facility.
 | [ ]  Yes | [ ]  No |
| 1. **Retained instruments** or other materials were identified after the patient’s surgery requiring re-operation or further surgical procedure.
 | [ ]  Yes | [ ]  No |
| 1. The patient experienced an **intravascular gas embolism**, resulting in death or neurological damage
 | [ ]  Yes | [ ]  No |
| 1. The patient experienced a haemolytic **blood transfusion reaction**, resulting from ABO (blood group) incompatibility.
 | [ ]  Yes | [ ]  No |
| 1. A **medication error** occurred, leading to the death of a patient which was reasonably believed to be due to the incorrect administration of drugs.
 | [ ]  Yes | [ ]  No |
| 1. **Maternal death or serious morbidity** occurred related to labor/delivery.
 | [ ]  Yes | [ ]  No |
| 1. An **infant** was discharged to the wrong family.
 | [ ]  Yes | [ ]  No |
| 1. Use of **physical or mechanical restraint** on an inpatient resulting in serious harm or death.
 | [ ]  Yes | [ ]  No |
| 1. Use of **incorrectly positioned oro or nasogastric tube** resulting in serious harm or death.
 | [ ]  Yes | [ ]  No |
|  | Description of Incident *(please include a detailed account of the incident and if needed include an attachment)* |
|  |
| Details of Transfer *(include mode and destination) – if applicable* |
|   |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Position: | Signed: | Date:  |

# 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 |
|  |  |  |
| Date and Time of Incident | Date of MAC Investigation  |
| Date: Time:  |  |

|  |
| --- |
| **5. Patient Outcome** |
| *If transferred to higher-level care did patient return to the health service? Y / N* *If the patient required inpatient stay at higher-level care, please provide information including procedures, investigations, diagnosis and outcome* |
| **6. System Review / Investigation:** |
| *This section to include full analysis of incident, any contributing factors, and findings.**Please attach copy of Incident Investigation/ System Review/ any report relevant to the incident Paperclip with solid fill**Was the incident referred to any other committee or person (provide details if YES): Y / N*  |
| **7. Recommended Changes to Practice:** |
| Were there Recommended Changes to Practice? No □ Yes □ If yes, please provide details below |
| *Please attach Quality Improvement/action plans including appropriate timeframe for implementation. Paperclip with solid fill* |
| **Have the recommended changes to practice been actioned?** Yes □ No □ If no, projected date for completion:  |
| **8. Medical Advisory Committee Review**  |
| *Please provide details of MAC review and discussion regarding incident* |
| Will a coronial inquest occur? Y / N |  *A referral to the coroner does not remove the need to notify the Department and conduct a MAC investigation.* |
| **Medical Advisory Committee Endorsement** |
| MAC Chair Name:  | Signature: |
| Dated this | Day of | 20 |