

Department of Health

# Using this Form

Health Service Establishments Licensing

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

HSE 2022-18

**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 2021* (Clause 10).

# Important Information and Instructions for Completion

## Part 1: What to record

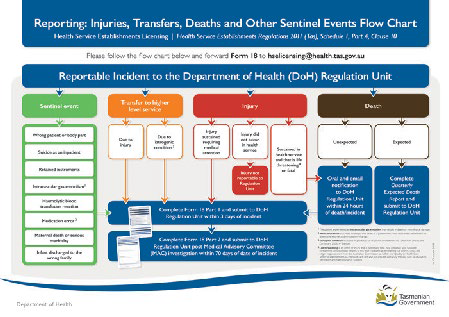
Clause 10 requires that you record the following incidents using Part 1 of this form:

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.

# 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](mailto:hselicensing@health.tas.gov.au) |

Submit this form electronically to DoH Regulation Unit at [**hselicensing@health.tas.gov.au**](mailto:hselicensing@health.tas.gov.au)**.**

Oral 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.*

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 of Open Disclosure | Date of Oral Report to Secretary *(if applicable)* |
|  |  |
| Anticipated Date of MAC Investigation  *(if unknown, please provide estimate)* | Date of Coronial Notification *(if applicable)* |
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|  |  |  |  |
| --- | --- | --- | --- |
| 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 | | |
|  | | Time: (please indicate am/pm) |

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| --- |
| **5. Details of Medical Advisory Committee (MAC) Investigation** |
| Date of MAC Investigation: |
| Investigation team: |
| *Was the incident referred to any other committee or person?*  Not applicable |
| Findings to include the following: |
| Patient Outcome as applicable:  Discharge to home  provide relevant details:  Remains an inpatient at this facility  provide details of current status:  Transferred to another facility  provide facility name and contact details:  Death  provide details of cause and date RIP: |
|  |
| *Did the patient return to the health service?*  If NO - Include details of patient’s current status: |
|  |
| System Review/Investigation *(To include full analysis of incident and any contributory factors or provision of the review report).* |
| Were there Recommended Changes to Practice? No  Yes  If yes, please provide details below |
| *Please include Quality Improvement/action plans including appropriate timeframe for implementation.* |
| Have the recommended changes to practice been actioned?  Yes  No  If no, projected date for completion: |
| Will a coronial inquest occur? Yes  No |

**Note:**

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

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