WHAT IS A PATIENT SAFETY INCIDENT?

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A patient safety incident is any unplanned or unintended event or circumstance which could have resulted or did result in harm to a patient. This includes harm from an outcome of an illness or its treatment that did not meet the patient's or the clinician's expectation for improvement or cure.

Patient safety incidents may be classified as follows[5]:

A harmful incident:
A patient safety incident that resulted in harm to a patient, including harm resulting when a patient did not receive his/her planned or expected treatment. The term 'harmful incident' covers what used to be known as an 'adverse event' and/or a 'sentinel event.'
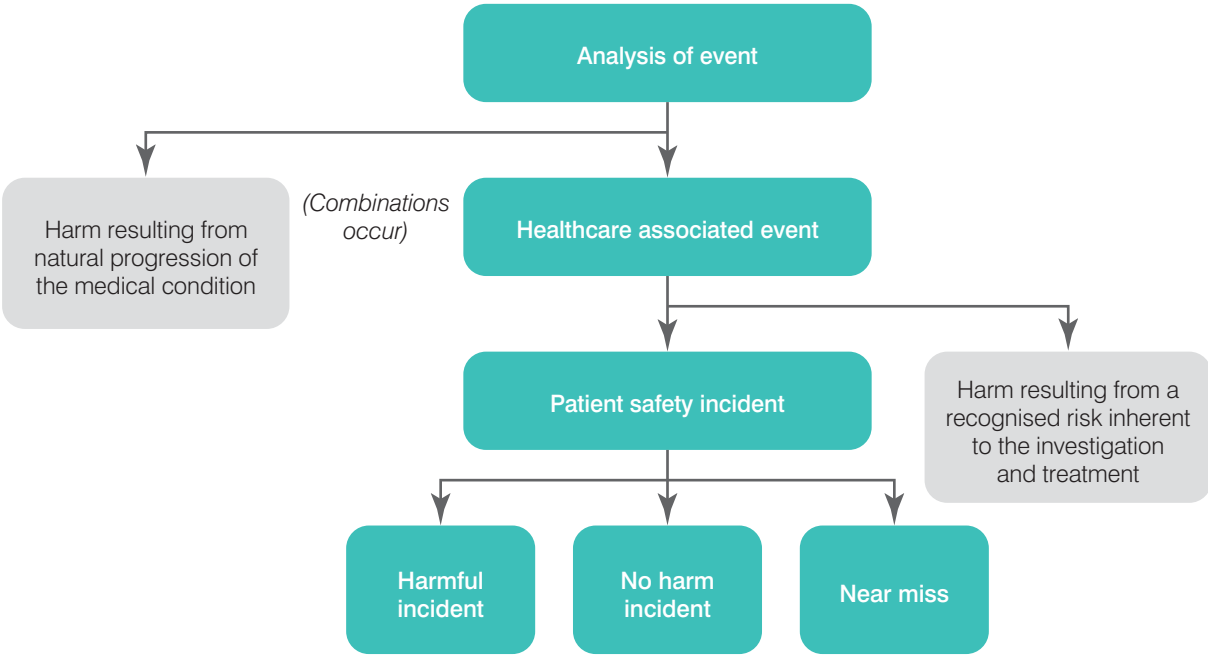
A no harm incident:
A patient safety incident occurs but does not result in patient harm – for example a blood transfusion being given to the wrong patient but the patient was unharmed because the blood was compatible.

A near miss:
A patient safety incident that did not cause harm but had the potential to do so – for example a unit of blood being connected to the wrong patient's intravenous line, but the error was detected before the transfusion started.

An incident may have been caused:

> because something has gone wrong during the patient's episode of care – an event has occurred that was unplanned or unintended

> because the outcome of the patient's illness or its treatment did not meet the patient's or his/her doctor's expectation for improvement or cure – for example a patient develops brain metastases from underlying lung cancer

> from a recognised risk inherent to an investigation or treatment – for example a patient's bowel is perforated during a routine colonoscopy

> because the patient did not receive his/her planned or expected treatment – for example he/she did not receive his/her medications as ordered.

5. World Health Organization *The Conceptual Framework for the International Classification for Patient Safety, Version 1.1 Final Technical Report Technical Annex 2,* WHO, Geneva, 2009.

The NSW Health Incident Management Policy PD2014_004 indicates that patient safety incidents may be identified by staff, patients and their support person(s) through a number of processes[6].

These may include:

> direct observation
> mortality and morbidity review meetings
> team discussion
> death review processes
> Coroner's reports
> chart reviews
> staff meetings
> clinical audits
> patient concerns or complaints

A patient safety incident may be identified at the time at which it occurs or at any time after the event.

Immediate action: supporting the patient and the clinician

Any person working in any capacity within NSW Health, including contractors, students and volunteers, who identifies that a patient safety incident has occurred has a duty to take action.

The initial response to a patient safety incident may be by the person who identified the incident, or a responsible person who was notified, and involves:

> ensuring personal safety
> providing immediate and appropriate clinical care to the patient and safeguarding against further harm
> notifying relevant people – for example, the unit/ department manager, the senior treating clinician and the patient and/or their support person(s)
> providing support for health care staff if required
> assessing the incident for severity of harm and the level of open disclosure response required.

The next steps

Once immediate support has been provided for the patient, their support person(s) and health care staff involved in the incident, the next steps are:

> gathering basic information about the incident from clinicians and other health care staff involved while the details are still fresh (ensuring confidentiality is maintained)
> gathering basic information about the incident from the patient and their support person(s), if able, while the details are still fresh (ensuring confidentiality is maintained)
> the initial open disclosure conversation – clinician disclosure.

The NSW Health Incident Management Policy outlines the steps for notifying and recording a patient safety incident. Reporting, investigating and analysing the causes of patient safety incidents should begin as soon as possible.

Staff members are required to record all patient safety incidents in the patient's health record and in the incident management system.

6. NSW Health Incident Management Policy PD2014_004 Section 2.3