

# INCIDENT REPORTING

Quality Unit  
HQE II  
MSQH 2023  
18/09/2023



# TALK OVERVIEW

- WHATS THE NEED FOR THIS TALK
- WHAT IS INCIDENT REPORTING
- AIM OF INCIDENT REPORTING
- ELEMENTS OF INCIDENT REPORTING
- NATIONAL / KKM STANDING ON INCIDENT REPORTING
- RCA
- WHAT INCIDENT TO BE REPORTED
- PRACTICAL AT HQE II



# WHATS THE NEED FOR THIS TALK

- Policies and Procedures were not adequately communicated to certain areas eg Incident Reporting; the Orientation program, Code Blue, and their implementation were not effectively addressed. **The Incident Report process is not well-informed to all departments.**
- **Latihan** bagi Incident Reporting perlu diadakan.
- **Incident report incomplete** - few forms available but no endorsement from unit kualiti **on next action and no outcome from report.** To get endorsement from unit kualiti. & follow up action on each report.
- **Aktiviti keselamatan melibatkan IR** dan kawalan infeksi kepada semua anggota hendaklah diberi perhatian.
- **Fail incident report** perlu dikemas kini

# WHAT IS INCIDENT REPORTING & LEARNING SYSTEM ?

- It is a **system of reporting** patient safety incidents that happen in healthcare, **investigate or review** why the incident happen, learn from the incident, take appropriate **action** to prevent similar incident from happening and **share** with others.



# Definitions of Patient Safety

- **Absence of preventable harm** to a patient during process of health care” (WHO)
- **Freedom** from **accidental injury**
- **Actions** undertaken by individuals and organizations **to protect health care recipients** from being **harmed** by the **effects of health care services.**

ABSENCE  
OF HARM

FREEDOM  
ACCIDENTAL  
INJURY

ACTIONS TO  
PROTECT

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# AIM OF INCIDENT REPORTING

- To **find weakness of the system** that can be improved & **reduce patient harm**.
- To find effective actions / solutions to **prevent similar incident** from happening.
- It involves “**holistic improvement of the system**” and not about “**finding an individual to be blamed**”

# ELEMENTS OF INCIDENT REPORTING

## WHAT ARE THE 3 MAIN ELEMENTS OF INCIDENT REPORTING?

“Report + Respond + Share = Incident Reporting & Learning System”

**Report** - when patient safety incident occur. Incident which result in “severe” patient outcome or “death” should not be left unreported.

**Respond** - this includes the following:

- Investigating the incident to find the weakness of the system
- Taking suitable action or control measures to improve the system. This may prevent similar incident from happening and also future incidents which have not happened

**Share** - with others about the lessons learnt from the incident to prevent similar incident from happening

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# NATIONAL KKM STANDING ON INCIDENT REPORTING

- HPIA 2023
- MPSG 2.0 (KPI 9)
- National Data Analysis E-IR
- MSQH 6<sup>th</sup> Edition





## TECHNICAL SPECIFICATIONS OF HOSPITAL PERFORMANCE INDICATORS FOR ACCOUNTABILITY (HPIA) 2023

<b>Indicator 9</b>	<b>Percentage of Morbidity and/ or Mortality meetings being conducted at the hospital level with documentation of the cases discussed</b>  <b>State &amp; Specialist Hospital: 12 times/ year</b> <b>Other Hospital: 6 times/ year</b>
<b>Element</b>	<b>Internal Business Process</b>
<b>Rationale</b>	The main purpose of the meeting is to improve patient's management and quality of care. Regular morbidity and mortality meetings serve to look at the weakness and the shortfall in the overall management of patients, hence it will be learnt, and the same mistake could be prevented and would not be repeated in the future.
<b>Definition of Terms</b>	<b>Morbidity:</b> A diseased state or symptom.  <b>Mortality:</b> The quality or state of being mortal.  <b>Morbidity Meeting:</b> Discussion of case management in regards to patient morbidity, incidence reporting, issue of patient safety, clinical audit (at the hospital level).  <b>Mortality Meeting:</b> Discussions related to the management of the case and cause of death of the patient. (e.g.: Clinical audit, POMR, MMR, Dengue Mortality, TB Mortality, Mortality under 5 years of age (MDG5), Perinatal Mortality Reviews (MDG4), Inquiries) (at the hospital level).  <b>Hospital level:</b> A meeting chaired by the Hospital Director or a person appointed by the Hospital Director with multidisciplinary involvement (preferably). For district hospital/ institution, multidisciplinary involvement is not necessary.  <b>Conduct:</b> Meeting can be led by the Hospital Director/ Head of Department/ Appointed Specialist/ Medical Officer/



# MALAYSIAN PATIENT SAFETY GOALS 2.0



MINISTRY OF HEALTH MALAYSIA

<b>GOAL 1</b>	<b>INFECTION PREVENTION AND CONTROL</b> <i>Applicable to Hospital / Medical Institution</i>	<b>GOAL 4</b>	<b>TRANSFUSION SAFETY</b> <i>Applicable to Hospital / Medical Institution</i>
 <p><b>KPI 1 :</b> Hand Hygiene Compliance Rate  <b>Target :</b> <math>\geq 75\%</math>  <i>6 monthly audit</i></p>	<p><b>KPI 2 :</b> Rate of Catheter Associated Blood Stream Infection  <b>Target :</b> <math>\leq 0.5</math> per 100 admissions  <i>Once / year (point prevalence survey)</i></p>		<p><b>KPI 6 :</b> Number of Incorrect Blood Component Transfused (IBCT)  <b>Target :</b> Zero Cases  <i>Monthly data collection</i></p>
<b>GOAL 2</b>	<b>SAFE SURGERY SAVES LIVES</b> <i>Applicable to Hospital / Medical Institution with OT</i>	<b>GOAL 5</b>	<b>FALL PREVENTION</b> <i>Applicable to Hospital / Medical Institution / Clinics</i>
 <p><b>KPI 3 :</b> No. of "Wrong Surgery Performed"  <b>Target :</b> Zero Cases  <i>Monthly data collection</i></p>	<p><b>KPI 4 :</b> No. Of "Unintended retained surgical item" (URSI)  <b>Target Zero Cases of Category 2 &amp; 3</b>  <i>Monthly data collection</i></p>		<p><b>KPI 7 :</b> Rate of Patient Fall  <b>Target :</b>  <b>Inpatient : <math>\leq 5</math> per 1000 patient-days</b>  <b>Outpatient &amp; Primary Healthcare Facilities : <math>\leq 5\%</math></b>  <i>Monthly data collection</i></p>
<b>GOAL 3</b>	<b>MEDICATION SAFETY</b> <i>Applicable to Hospital / Medical Institution / Clinics</i>	<b>GOAL 6</b>	<b>PATIENT IDENTIFICATION</b> <i>Applicable to Hospital / Medical Institution / Clinics</i>
 <p><b>KPI 5 :</b> Number of Medication Error Leading To Severe Harm Or Death  <b>Target :</b> Zero Cases  <i>Monthly data collection</i></p>			<p><b>KPI 8 :</b> Number of Patient Safety Incidents Caused by Wrong Patient Identification (Detected by incident reporting &amp; investigation)  <b>Target :</b> Zero Cases  <i>Monthly data collection</i></p>
<b>GOAL 7</b>	<b>INCIDENT REPORT AND LEARNING SYSTEM</b> <i>Applicable to Hospital / Medical Institution / Clinics</i>	 <p><b>KPI 9 :</b> Implementation of Patient Safety Incident Report and Learning System  <b>Target :</b> System Implemented  <i>Compiled monthly (No. of reports for additional information)</i></p>	



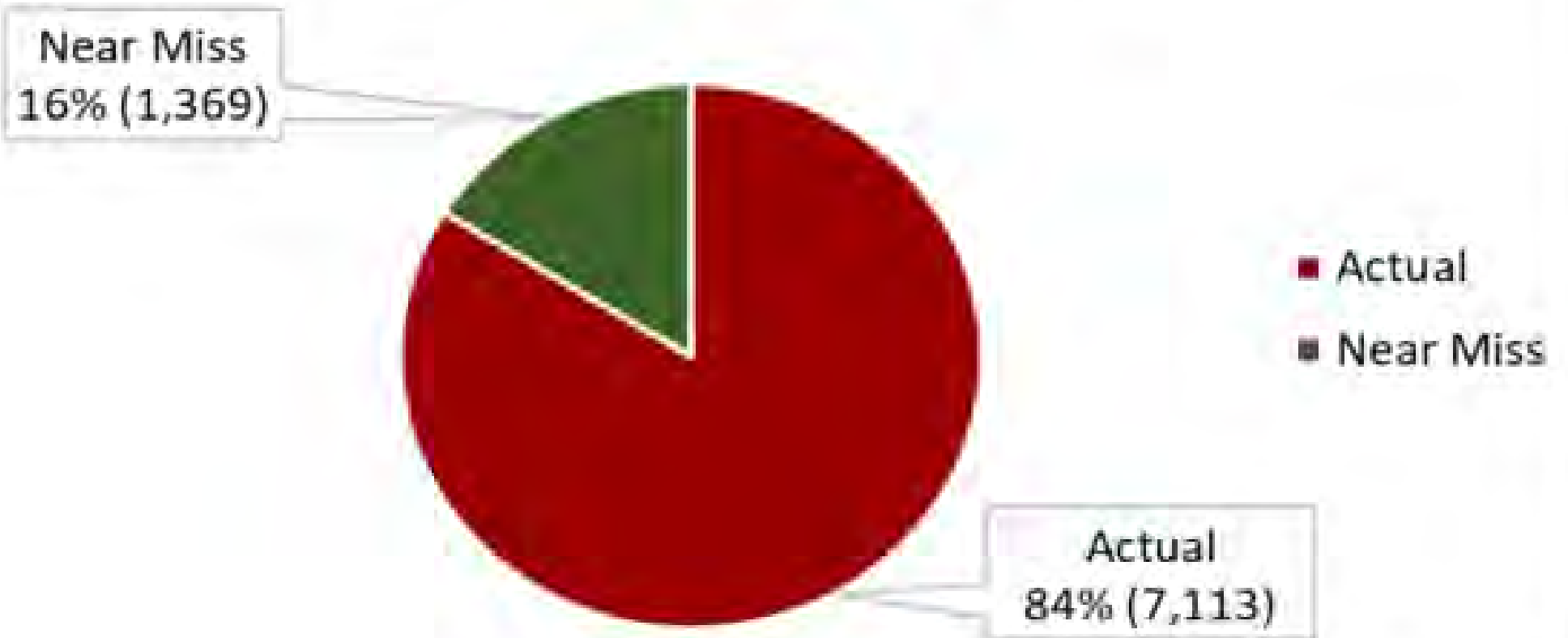
# **DATA ANALYSIS E-INCIDENT REPORTING IN MOH HOSPITALS 2022**

Patient Safety Unit  
Medical Care Quality Section  
Medical Development Division  
Ministry of Health, Malaysia

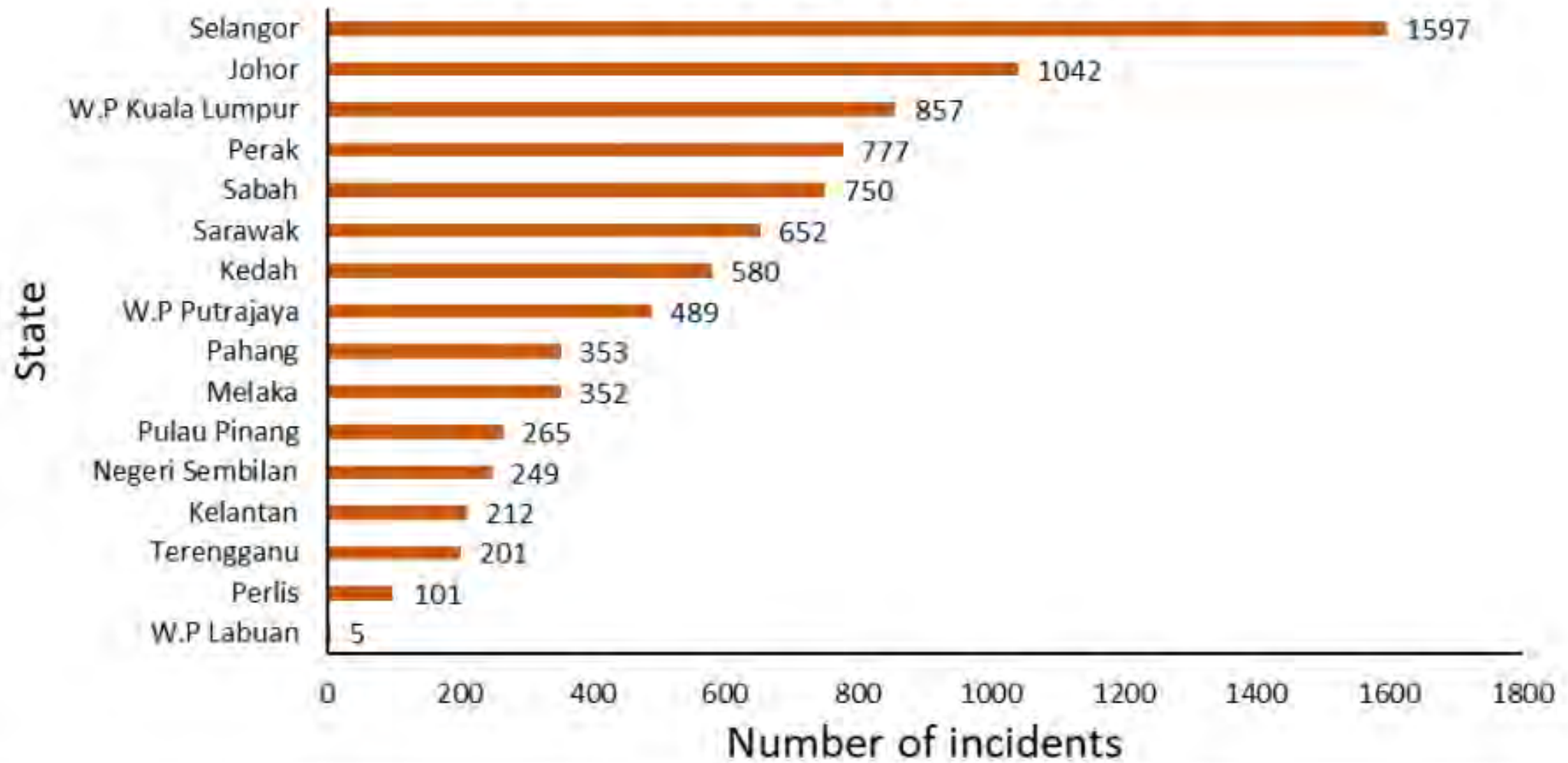
- Total number of patient safety incidents reported through e-Incident Reporting (e-IR) for 5 consecutive years 2018 - 2022 were 43 178.
- Total incident reported in 2022 were 8,482 and out of these, 7113 (84% were actual incidents and 1,369 (16%) incidents were near miss.



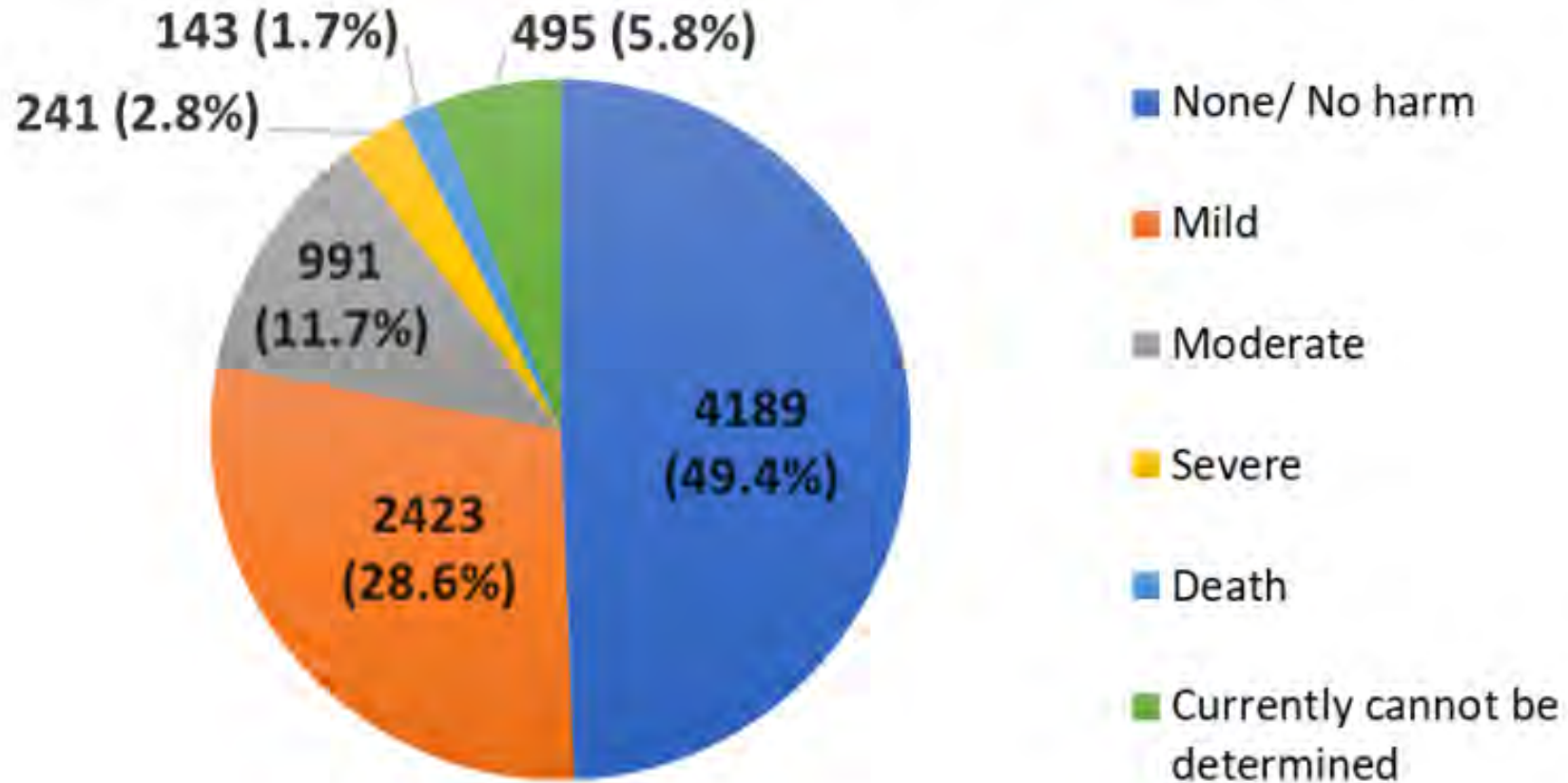
## Number of incidents by Type, 2022



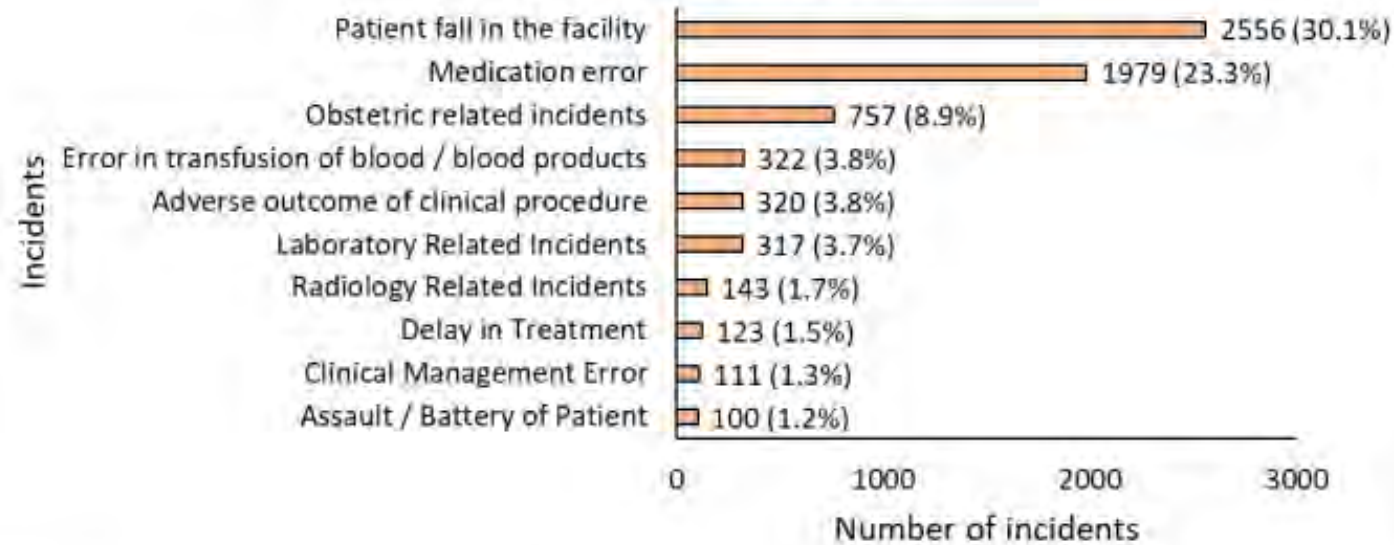
## Number of Reporting by State, 2022



## Number of incidents by Patient Outcome, 2022



## Top 10 incidents, 2022



## Top 10 incidents leads to Severe/ Death Outcome, 2022



## Number of incidents by Hour, 2022



# COMMON INCIDENTS BY AGE GROUP

## ≤ 12 years old

Incident	No. of Incident
Medication error	359
Patient fall in the facility	232
Obstetric related incidents	139
Laboratory Related Incidents	69
Adverse outcome of clinical procedure	61

## 13 -17 years old

Incident	No. of Incident
Medication error	30
Patient fall in the facility	29
Laboratory Related Incidents	7
Adverse outcome of clinical procedure	6
Improper / Incomplete Consent	6

## 18 - 45 years old

Incident	No. of Incident
Obstetric related incidents	610
Patient fall in the facility	541
Medication error	495
Error in transfusion of blood / blood products	149
Laboratory Related Incidents	99

## 46 - 64 years old

Incident	No. of Incident
Patient fall in the facility	715
Medication error	572
Adverse outcome of clinical procedure	78
Laboratory Related Incidents	69
Error in transfusion of blood / blood products	68

## ≥ 65 years old

Incident	No. of Incident
Patient fall in the facility	1034
Medication error	474
Adverse outcome of clinical procedure	79
Laboratory Related Incidents	63
Error in transfusion of blood / blood products	62

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RCA



## Root Cause Analysis & Action (RCA<sup>2</sup>)

Concept RCA<sup>2</sup> was introduced by National Patient Safety Foundation, USA in 2015 (traditional RCA has had inconsistent success)

Emphasize on the **“Action”** part with the ultimate objective to prevent future harm from the lessons learnt.

## Root Cause Analysis (RCA)

A **structured investigation that aims to identify the root cause** of the problem and actions necessary to eliminate it.

(risk management tool)

## Root Cause

Original cause for the failure / insufficiency of a process or the most **fundamental reason why an event has occurred.**



# RCA<sup>2</sup> - Root Cause Analysis & Action Report

## Incident Reporting & Learning System

PLEASE ATTACH THE IR 2.0 FORM THAT CORRELATES WITH THE INCIDENT AS THE FIRST PAGE.

1. HOSPITAL NAME: \_\_\_\_\_
2. PATIENT'S RN/ IDENTIFICATION NUMBER: \_\_\_\_\_
3. INCIDENT TYPE: \_\_\_\_\_

4. INVESTIGATION TEAM:

Name	Designation
Team Leader/ Coordinator	
Team Members	

**Reported By:**

Name: \_\_\_\_\_  
 Designation/ Stamp: \_\_\_\_\_  
 Date: \_\_\_\_\_

**Verified By:**

Name: \_\_\_\_\_  
 Designation/ Stamp: \_\_\_\_\_  
 Date: \_\_\_\_\_

This template need to be used together with "Guidelines on Implementation Incident Reporting & Learning System 2.0 for Ministry of Health Malaysia Hospitals"

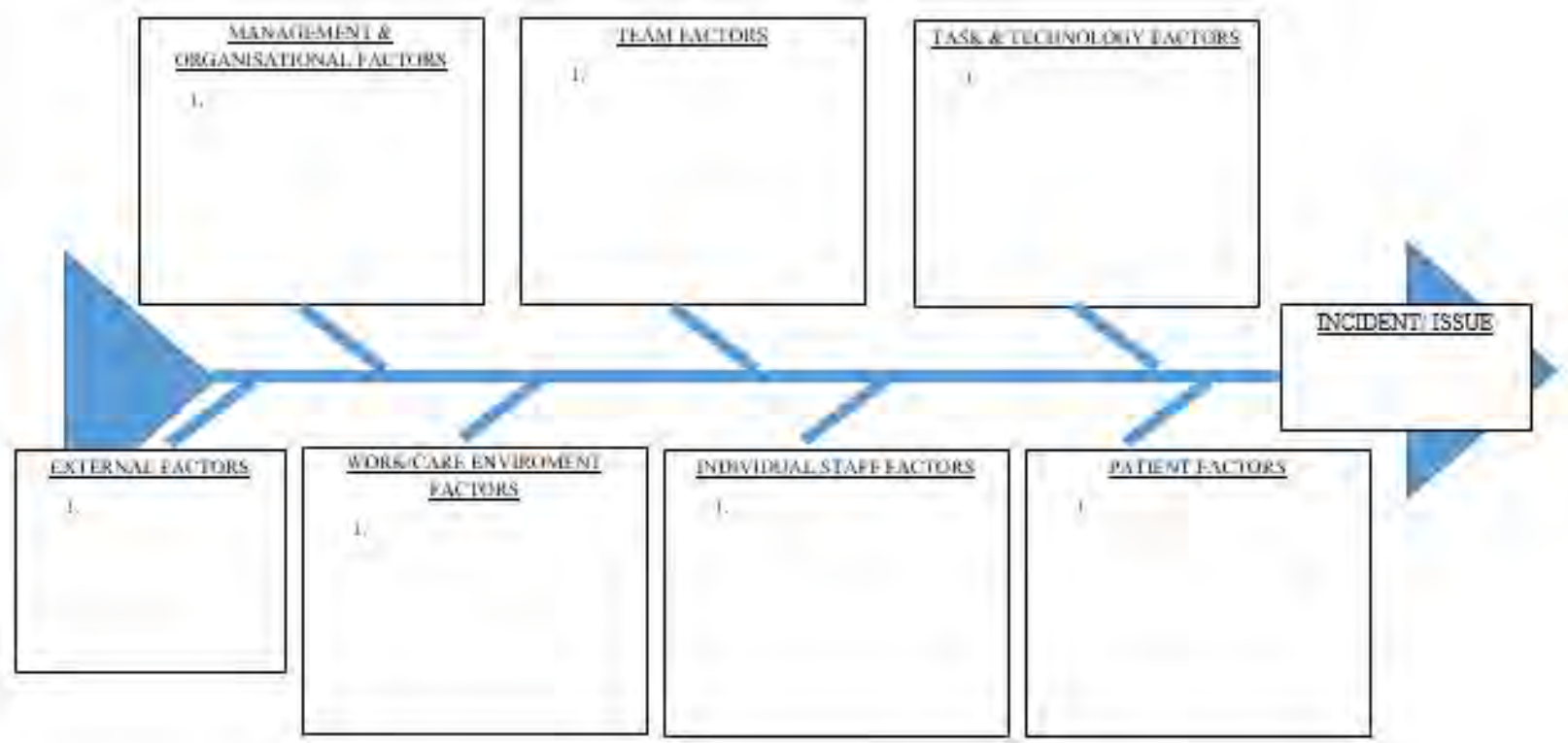
5. SUMMARY OF THE INCIDENT:

6. SEQUENCE OF EVENTS:

Please state **only the important information/events/steps** that lead to the incident:

Date	Time (24 hr)	Location	Event description	Key person involved (initial) & designation	Comments- please add in what event write in every sequence

7. FISH BONE DIAGRAM (REFER TO LONDON PROTOCOL FOR CATEGORISATION)



## 8. CONTRIBUTING FACTORS:

Please choose and tick at the relevant box the relevant contributing factors that lead to the incident & describe the factors. (can be more than one factor)

FACTORS THAT LEADS TO THE INCIDENT																						
1	TEAM FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Written communication issue</td></tr> <tr><td><input type="checkbox"/></td><td>Verbal communication issue</td></tr> <tr><td><input type="checkbox"/></td><td>Unclear roles and responsibility</td></tr> <tr><td><input type="checkbox"/></td><td>Lack of supervision/ monitoring</td></tr> <tr><td><input type="checkbox"/></td><td>Ineffective leadership/ responsibility</td></tr> <tr><td><input type="checkbox"/></td><td>Problem in seeking help</td></tr> <tr><td><input type="checkbox"/></td><td>Staff or colleague response/ support to help</td></tr> <tr><td><input type="checkbox"/></td><td>Others (specify):</td></tr> </table> <p>Description:</p>	<input type="checkbox"/>	Written communication issue	<input type="checkbox"/>	Verbal communication issue	<input type="checkbox"/>	Unclear roles and responsibility	<input type="checkbox"/>	Lack of supervision/ monitoring	<input type="checkbox"/>	Ineffective leadership/ responsibility	<input type="checkbox"/>	Problem in seeking help	<input type="checkbox"/>	Staff or colleague response/ support to help	<input type="checkbox"/>	Others (specify):				
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2	INDIVIDUAL STAFF FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Lack of knowledge/experience/ skill</td></tr> <tr><td><input type="checkbox"/></td><td>Distraction</td></tr> <tr><td><input type="checkbox"/></td><td>Fatigue/ stress</td></tr> <tr><td><input type="checkbox"/></td><td>Lapse of concentration</td></tr> <tr><td><input type="checkbox"/></td><td>Non compliance to protocol/ policy/ SOP</td></tr> <tr><td><input type="checkbox"/></td><td>Personal issue</td></tr> <tr><td><input type="checkbox"/></td><td>Unsafe behaviour – assuming, not asking clarification etc.</td></tr> <tr><td><input type="checkbox"/></td><td>Interpersonal issue</td></tr> <tr><td><input type="checkbox"/></td><td>Others (specify):</td></tr> </table> <p>Description:</p>	<input type="checkbox"/>	Lack of knowledge/experience/ skill	<input type="checkbox"/>	Distraction	<input type="checkbox"/>	Fatigue/ stress	<input type="checkbox"/>	Lapse of concentration	<input type="checkbox"/>	Non compliance to protocol/ policy/ SOP	<input type="checkbox"/>	Personal issue	<input type="checkbox"/>	Unsafe behaviour – assuming, not asking clarification etc.	<input type="checkbox"/>	Interpersonal issue	<input type="checkbox"/>	Others (specify):		
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4	TASK & TECHNOLOGY FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Availability and use of protocols/ SOP/ guidelines</td></tr> <tr><td><input type="checkbox"/></td><td>Availability and accuracy of health information</td></tr> <tr><td><input type="checkbox"/></td><td>Task design issue</td></tr> <tr><td><input type="checkbox"/></td><td>Information technology (e.g. malfunction, system design)</td></tr> <tr><td><input type="checkbox"/></td><td>Decision making aids</td></tr> <tr><td><input type="checkbox"/></td><td>Medication related issue (e.g. wrong prescription, similar packaging/ sounding names, complicated dosage design)</td></tr> <tr><td><input type="checkbox"/></td><td>Radiotherapy related issue (e.g. miscalculation of dose)</td></tr> <tr><td><input type="checkbox"/></td><td>Others (specify):</td></tr> </table> <p>Description:</p>	<input type="checkbox"/>	Availability and use of protocols/ SOP/ guidelines	<input type="checkbox"/>	Availability and accuracy of health information	<input type="checkbox"/>	Task design issue	<input type="checkbox"/>	Information technology (e.g. malfunction, system design)	<input type="checkbox"/>	Decision making aids	<input type="checkbox"/>	Medication related issue (e.g. wrong prescription, similar packaging/ sounding names, complicated dosage design)	<input type="checkbox"/>	Radiotherapy related issue (e.g. miscalculation of dose)	<input type="checkbox"/>	Others (specify):				
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<input type="checkbox"/>	Others (specify):																					
7	EXTERNAL FACTOR	Please specify:																				

9. List out the most important contributing factors/ root cause (s) that lead to the incident.

**The factors/ root cause (s) should be selected/written using 5 Rules of Causation**  
(Please refer to Appendix 3 of Guideline on Implementation of Incident Reporting & Learning System 2.0)

10. \*Root Cause (s):

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11. ACTION PLAN TABLE

Based on the contributing factors/root cause (s) listed above, identify the most effective action plan. The action plan should have at least 1 **strong/intermediate action plan**. "Weak" action can be implemented to support other action or while waiting for "stronger" or "intermediate" action to be implemented.

Fundamentally, RCA aims to establish:

√ **WHAT** happened

√ **HOW** it happened

√ **WHY** it happened  
(5 rules of causation)

**Contributing  
Factors**

The objective is to **identify all the causal factors** that contributed to the incident / issue – some of these will be identified as **root causes**.

The background of the slide is a vibrant sunset or sunrise. The sky transitions from a deep purple at the top to a bright orange and yellow near the horizon. On the right side, there is a dark silhouette of a tree with a wide, spreading canopy, set against the colorful sky. The overall mood is serene and contemplative.

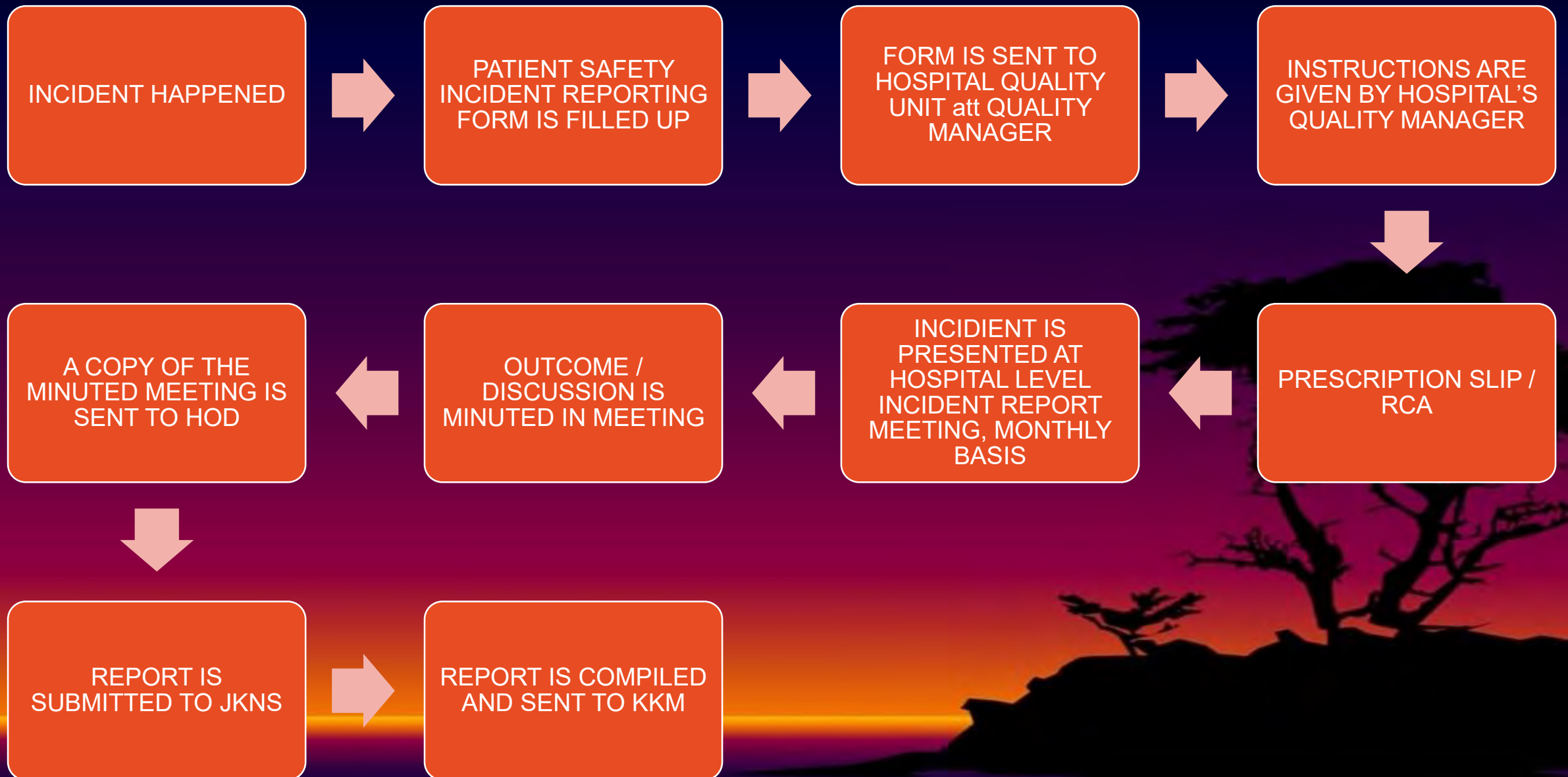
WHAT INCIDENT TO BE REPORTED??



# PRACTICAL AT HQE II



# WORK FLOW OF INCIDENT REPORTING



# I.R 2.0 FORM

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**I.R 2.0 FORM**

**SECTION A**

**SECTION B**

Within 48 hr

Filled up by the  
"person who report  
the incident"

Filled up by the "Risk  
Manager/ Quality  
Manager" of the hospital



DATE OF REPORTING: / /

\*Barang boleh diisi dalam Bahasa Malaysia

SECTION A: TO BE COMPLETED BY THE REPORTER OF THE INCIDENT

INCIDENT DESCRIPTION (Please fill in the blanks)

1. NAME OF FACILITY/ INSTITUTION	PATIENT'S NAME
2. DATE OF INCIDENT	IF UNCERTAIN APPROXIMATE DATE: / /
3. TIME OF INCIDENT	IF UNCERTAIN APPROXIMATE TIME: : AM/PM

4. PATIENT'S RN/ OTHER IDENTIFICATION NUMBER: \_\_\_\_\_ AGE: \_\_\_\_\_ ETHNIC: \_\_\_\_\_  
 GENDER: MALE / FEMALE / UNKNOWN (please circle) STATUS: ALIVE / DECEASED LANGUAGE BARRIER: YES / NO  
 DIAGNOSIS: \_\_\_\_\_

5. TYPE OF PATIENT (please tick one)

<input type="checkbox"/> INPATIENT	<input type="checkbox"/> DAY CARE
<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> OTHERS: SPECIFY _____
<input type="checkbox"/> A&E	

DEPARTMENT(S) INVOLVED (please tick)

<input type="checkbox"/> MEDICAL	<input type="checkbox"/> O&G	<input type="checkbox"/> ONCOLOGY
<input type="checkbox"/> SURGICAL	<input type="checkbox"/> PHARMACY	<input type="checkbox"/> GERIATRIC
<input type="checkbox"/> ORTHOPAEDIC	<input type="checkbox"/> RADIOLOGY & IMAGING	<input type="checkbox"/> REHABILITATION
<input type="checkbox"/> PAEDIATRIC	<input type="checkbox"/> A&E	<input type="checkbox"/> ICU/ CCU
<input type="checkbox"/> LABORATORY	<input type="checkbox"/> PSYCHIATRY	
<input type="checkbox"/> OTHERS: SPECIFY _____		

LOCATION/ WARD / CLINIC: \_\_\_\_\_

6. TYPE OF INCIDENT  Actual  Near Miss (please tick one)

Examples of incidents that need to be reported: (Note that this list is not exhaustive)

- i. Wrong surgery/procedure -wrong site, side or patient
- ii. Unintended retained foreign body in patient after an operation/procedure
- iii. Error in transfusion of blood/blood products
- iv. Medication error (please fill in MERS form as well)
- v. Patient fall in the facility
- vi. Obstetric related incidents
- vii. Adverse outcome of clinical procedure
- viii. Pre-hospital care and ambulance service related incident
- ix. Radiotherapy related incident
- x. Patient suicide / attempted suicide
- xi. Patient discharged to wrong family members / next-of-kin
- xii. Assault/ battery of patient
- xiii. Unanticipated Fire - Fire, flame, or unanticipated smoke, heat, or flashes occurring in the facility
- xiv. Others type of incident: \_\_\_\_\_

7. BRIEF DESCRIPTION OF WHAT HAPPENED (Please fill in the blanks)  
 The description should explain what happen prior and during the incident and how it occurred. Do include any additional information which you think may lead to the incident.

*(Empty space for handwritten description)*



DATE OF REPORTING: 2 / 6 / 2023

\*Barang boleh diisi dalam Bahasa Malaysia

SECTION A: TO BE COMPLETED BY THE REPORTER OF THE INCIDENT

INCIDENT DESCRIPTION (Please fill in the blanks)

1. NAME OF FACILITY/ INSTITUTION	PATIENT'S NAME
2. DATE OF INCIDENT	IF UNCERTAIN APPROXIMATE DATE: / /
3. TIME OF INCIDENT	IF UNCERTAIN APPROXIMATE TIME: : AM/PM

4. PATIENT'S RN/ OTHER IDENTIFICATION NUMBER: \_\_\_\_\_ AGE: \_\_\_\_\_ ETHNIC: \_\_\_\_\_  
 GENDER: MALE / FEMALE / UNKNOWN (please circle) STATUS: ALIVE / DECEASED LANGUAGE BARRIER: YES / NO  
 DIAGNOSIS: \_\_\_\_\_

5. TYPE OF PATIENT (please tick one)

<input type="checkbox"/> INPATIENT	<input type="checkbox"/> DAY CARE
<input type="checkbox"/> OUTPATIENT	<input type="checkbox"/> OTHERS: SPECIFY _____
<input checked="" type="checkbox"/> A&E	

DEPARTMENT(S) INVOLVED (please tick)

<input type="checkbox"/> MEDICAL	<input type="checkbox"/> O&G	<input type="checkbox"/> ONCOLOGY
<input type="checkbox"/> SURGICAL	<input type="checkbox"/> PHARMACY	<input type="checkbox"/> GERIATRIC
<input type="checkbox"/> ORTHOPAEDIC	<input type="checkbox"/> RADIOLOGY & IMAGING	<input type="checkbox"/> REHABILITATION
<input type="checkbox"/> PAEDIATRIC	<input type="checkbox"/> A&E	<input type="checkbox"/> ICU/ CCU
<input type="checkbox"/> LABORATORY	<input type="checkbox"/> PSYCHIATRY	
<input type="checkbox"/> OTHERS: SPECIFY _____		

LOCATION/ WARD / CLINIC: \_\_\_\_\_

6. TYPE OF INCIDENT  Actual  Near Miss (please tick one)

Examples of incidents that need to be reported: (Note that this list is not exhaustive)

- i. Wrong surgery/procedure -wrong site, side or patient
- ii. Unintended retained foreign body in patient after an operation/procedure
- iii. Error in transfusion of blood/blood products
- iv. Medication error (please fill in MERS form as well)
- v. Patient fall in the facility
- vi. Obstetric related incidents
- vii. Adverse outcome of clinical procedure
- viii. Pre-hospital care and ambulance service related incident
- ix. Radiotherapy related incident
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- xiv. Others type of incident: \_\_\_\_\_

7. BRIEF DESCRIPTION OF WHAT HAPPENED (Please fill in the blanks)  
 The description should explain what happen prior and during the incident and how it occurred. Do include any additional information which you think may lead to the incident.

At 10:00pm, 1/6/23.  
 Patient wanted to go to toilet, stand up from bed, however unable to control PU. allegedly pee on floor and step on it. fell backward due to slippery floor.  
 Post fall, no ~~actual~~ Head injury / vomiting / dizziness / stand up with aid, no deformity / external wounds. claim unable to move @ LU @ 8AM after pain @ C/shoulder. s/s: @ shoulder loss of control.  
 rom limited!

PATIENT OUTCOME [please tick one] & IMMEDIATE ACTION – ONLY FOR ACTUAL INCIDENT							
8. OUTCOME OF INCIDENT	<input type="checkbox"/> NONE						
	<input type="checkbox"/> MILD						
	<input type="checkbox"/> MODERATE						
	<input type="checkbox"/> SEVERE						
	<input type="checkbox"/> DEATH						
	<input type="checkbox"/> CURRENTLY CANNOT BE DETERMINED						
9. IMMEDIATE ACTION FOLLOWING INCIDENT							
REPORTED BY							
10. DESIGNATION: (please tick one)	SIGNATURE OF REPORTER:						
<table border="1"> <tr> <td><input type="checkbox"/> NURSE</td> <td><input type="checkbox"/> SPECIALIST</td> </tr> <tr> <td><input type="checkbox"/> HOUSE OFFICER</td> <td><input type="checkbox"/> PHARMACIST</td> </tr> <tr> <td><input type="checkbox"/> MEDICAL OFFICER</td> <td><input type="checkbox"/> OTHERS:</td> </tr> </table>	<input type="checkbox"/> NURSE	<input type="checkbox"/> SPECIALIST	<input type="checkbox"/> HOUSE OFFICER	<input type="checkbox"/> PHARMACIST	<input type="checkbox"/> MEDICAL OFFICER	<input type="checkbox"/> OTHERS:	NAME: DATE:
<input type="checkbox"/> NURSE	<input type="checkbox"/> SPECIALIST						
<input type="checkbox"/> HOUSE OFFICER	<input type="checkbox"/> PHARMACIST						
<input type="checkbox"/> MEDICAL OFFICER	<input type="checkbox"/> OTHERS:						
Note: As part of good leadership and clinical governance, please inform the incident to your Head of Department(s) immediately.							

SECTION B : TO BE COMPLETED BY THE RISK MANAGER/ QUALITY MANAGER OF HOSPITAL	
1. ACTION TAKEN:	(Please tick)
Mandatory Root Cause Analysis: 1) Incident with Severe or Death outcome 2) Other incident/near miss based on the Risk Manager/ Quality Manager assessment 3) Directive from State Health Department / Ministry.	<input type="checkbox"/> "PRESCRIPTION SLIP"
	<input type="checkbox"/> MONITOR THE TREND FIRST
	<input type="checkbox"/> RCA
	<input type="checkbox"/> MIRCA (Multi-incident Root Cause Analysis)
Additional comments :	
2. e-IR SUBMITTED?	Date of Submission: _____
Please submit to e-IR <b>within 5 days</b> from the date of the incident.	
3. RISK MANAGER/ QUALITY MANAGER OF HOSPITAL	(please fill in the blanks)
NAME: SIGNATURE: DESIGNATION: DATE:	

PATIENT OUTCOME [please tick one] & IMMEDIATE ACTION – ONLY FOR ACTUAL INCIDENT							
8. OUTCOME OF INCIDENT	<input checked="" type="checkbox"/> NONE						
	<input checked="" type="checkbox"/> MILD						
	<input type="checkbox"/> MODERATE						
	<input type="checkbox"/> SEVERE						
	<input type="checkbox"/> DEATH						
	<input type="checkbox"/> CURRENTLY CANNOT BE DETERMINED						
9. IMMEDIATE ACTION FOLLOWING INCIDENT	<i>URAY @ show Heny AP 1st 4 Nov.</i>						
REPORTED BY							
10. DESIGNATION: (please tick one)	SIGNATURE OF REPORTER:						
<table border="1"> <tr> <td><input checked="" type="checkbox"/> NURSE</td> <td><input type="checkbox"/> SPECIALIST</td> </tr> <tr> <td><input type="checkbox"/> HOUSE OFFICER</td> <td><input type="checkbox"/> PHARMACIST</td> </tr> <tr> <td><input type="checkbox"/> MEDICAL OFFICER</td> <td><input type="checkbox"/> OTHERS:</td> </tr> </table>	<input checked="" type="checkbox"/> NURSE	<input type="checkbox"/> SPECIALIST	<input type="checkbox"/> HOUSE OFFICER	<input type="checkbox"/> PHARMACIST	<input type="checkbox"/> MEDICAL OFFICER	<input type="checkbox"/> OTHERS:	NAME: <b>DR SWEE JIA WEI</b> DATE: <i>[Signature]</i> Pegawai Perubatan UD41 No. MAMC: 94120 Jabatan Kecemasan dan Trauma Hospital Queen Elizabeth II
<input checked="" type="checkbox"/> NURSE	<input type="checkbox"/> SPECIALIST						
<input type="checkbox"/> HOUSE OFFICER	<input type="checkbox"/> PHARMACIST						
<input type="checkbox"/> MEDICAL OFFICER	<input type="checkbox"/> OTHERS:						
Note: As part of good leadership and clinical governance, please inform the incident to your Head of Department(s) immediately.							
SECTION B : TO BE COMPLETED BY THE RISK MANAGER/ QUALITY MANAGER OF HOSPITAL							
1. ACTION TAKEN:	(Please tick)						
Mandatory Root Cause Analysis: 1) Incident with Severe or Death outcome 2) Other incident/near miss based on the Risk Manager/ Quality Manager assessment 3) Directive from State Health Department / Ministry.	<input checked="" type="checkbox"/> "PRESCRIPTION SLIP"						
	<input type="checkbox"/> MONITOR THE TREND FIRST						
	<input checked="" type="checkbox"/> RCA						
	<input type="checkbox"/> MIRCA (Multi-incident Root Cause Analysis)						
Additional comments :							
2. e-IR SUBMITTED?	Date of Submission: <i>13-7-2023</i>						
Please submit to e-IR <b>within 5 days</b> from the date of the incident.							
3. RISK MANAGER/ QUALITY MANAGER OF HOSPITAL	(please fill in the blanks)						
NAME: SIGNATURE: DESIGNATION: DATE:	<i>[Signature]</i> <b>DR AHMAD HUMAZI ZAKRI</b> MBBS (JUM) No. Pendaftaran Perub: 47875 Pegawai Perubatan Hospital Queen Elizabeth II <i>16/6/2023</i>						

# OUTCOME OF INCIDENT

## None

- Patient outcome is not symptomatic or no symptoms detected and no treatment is required e.g. Wrong dose of medication given but the patient did not suffer any harm

## Mild

- Patient outcome is symptomatic, symptoms are mild, loss of function or harm is minimal or intermediate but short term, and no or minimal intervention (e.g., extra observation, investigation, review or minor treatment) is required, **increase length of stay (up to 72 hrs)**

## Moderate

- Patient outcome is symptomatic, requiring intervention (e.g., additional operative procedure; additional therapeutic treatment), **increase length of stay (more than 72 hours to 7 days)**

## Severe

- Patient outcome is symptomatic, requiring life-saving intervention or major surgical/medical intervention, **increase length of stay (more than 7 days)**, shortening life expectancy or causing major permanent or long term harm or loss of function

## Death

- On balance of probabilities, death was caused or brought forward in the short term by the incident.

## Unsure

- The definite outcome is yet to be determined, cannot be certain during the time of reporting.

In Risk Assessment: When in doubt, select category of outcome which is "higher" (e.g: "severe" instead of "moderate")



Ministry of Health Malaysia  
Incident Reporting & Learning System "Prescription Slip"

Serial No.

Serial No. [Blank]

To: [Blank] Department / Ward: [Blank]

Issue(s)/Comment(s):

[Large empty text area for issue/comment]

- Please Take Note
- Please Take Necessary Action

Others : [Blank]

From [Blank]  
Name & Stamp: [Blank]  
Date: [Blank]



Ministry of Health Malaysia  
Incident Reporting & Learning System "Prescription Slip"

Serial No. 48/2023

Serial No. 48/2023

To: KETUA JABATAN / UNIT  
JABATAN KECEMASAN & TRAUMA

Department / Ward: ETD

Issue(s)/Comment(s):

Mohon melakukan penyiasatan dan membuat laporan berkaitan dengan insiden pesakit jatuh yang berlaku pada **01 JUN 2023, NO.RUJ: IR/HQE2/2023/JUNE/FALL/01.**

Mohon pihak tuan/puan mengemukakan maklumbalas siasatan kepada Penyelaras Laporan Insiden **dalam tempoh 14 hari bekerja** dari surat ini diterima. Bersama-sama ini disertakan salinan insiden tersebut untuk tindakan tuan/puan selanjutnya.

- Please Take Note
- Please Take Necessary Action

Others : [Blank]

From: *A*  
Name & Stamp: MAD HUMANI ZAKRI  
MBBS (IUM)  
No. Pendaftaran Perubatan : 47675  
Pegawai Perubatan  
Hospital Queen Elizabeth II  
Date: 16/6/2023

## BORANG MAKLUMBALAS PEMANTAUAN LAPORAN INSIDEN , HOSPITAL QUEEN ELIZABETH II.

Bil.	No.daftar IR (di isi oleh jawatankuasa IR)	Ringkasan Insiden (Diisi oleh wad/unit terlibat)	Maklumbalas tindakan segera dan cadangan penambahbaikan (diisi oleh wad/unit yang terlibat)	Pemantauan oleh jawatankuasa IR (2 minggu, 1 bulan, 6 bulan & 1 tahun)	Penilaian semula oleh jawatankuasa IR	Status insiden (selesai / belum selesai)
		Lokasi :  Tarikh & masa insiden:				

Nota : Sila kembalikan borang ini setelah selesai mengisi maklumbalas tindakan segera dan penambahbaikan kepada Penyelaras IR



# MEMO

JABATAN RADIOLOGI  
HOSPITAL QUEEN ELIZABETH II  
LORONG BERSATU, OFF JALAN DAMAI, LUYANG  
88300 KOTA KINABALU, SABAH



RUJUKAN KAMI : (11)RAD/HQE2/M/2023

TARIKH : 14 September 2023

<b>KEPADA</b>	Penyelaras Insiden Report, HQE II
<b>DARIPADA</b>	Ketua Jabatan Radiologi, HQE II
<b>TAJUK</b>	<b>MAKLUMBALAS INSIDEN REPORT ADVERSE OUTCOME OF CLINICAL PROCEDURE (EXTRAVASATION) SERIAL NO. 68/2023</b>

Tuan/puan,

Dengan segala hormatnya perkara di atas adalah dirujuk,

2. Disertakan bersama ini adalah maklumbalas insiden *report adverse outcome of clinical procedure (extravasation)* dari Jabatan Radiologi. Butiran lanjut mengenai maklumbalas insiden ini ada disertakan untuk makluman dan perhatian pihak tuan/puan selanjutnya.

3. Kerjasama dan perhatian dari pihak tuan/puan amatlah dihargai dan diucapkan ribuan terima kasih.

Sekian, terima kasih.

"MALAYSIA MADANI"

"BERKHIDMAT UNTUK NEGARA"

Saya yang menjalankan amanah;

  
DR WAN NAJWA ZAINI BT WAN MOHAMED  
(M.M.C. No. 95009)  
Ketua Jabatan & Pakar Radiologi,  
Jabatan Pengimejan Diagnostik,  
Hospital Queen Elizabeth II,  
Kota Kinabalu, Sabah.

(DR WAN NAJWA ZAINI BT WAN MOHAMED)  
Ketua Jabatan dan Pakar Radiologi Gred Khas Jusa "C",  
Jabatan Radiologi,  
Hospital Queen Elizabeth II  
Kota Kinabalu, SABAH

sk: - Fail Insiden Report Jab. Radiologi HQE II



## 5. SUMMARY OF THE INCIDENT:

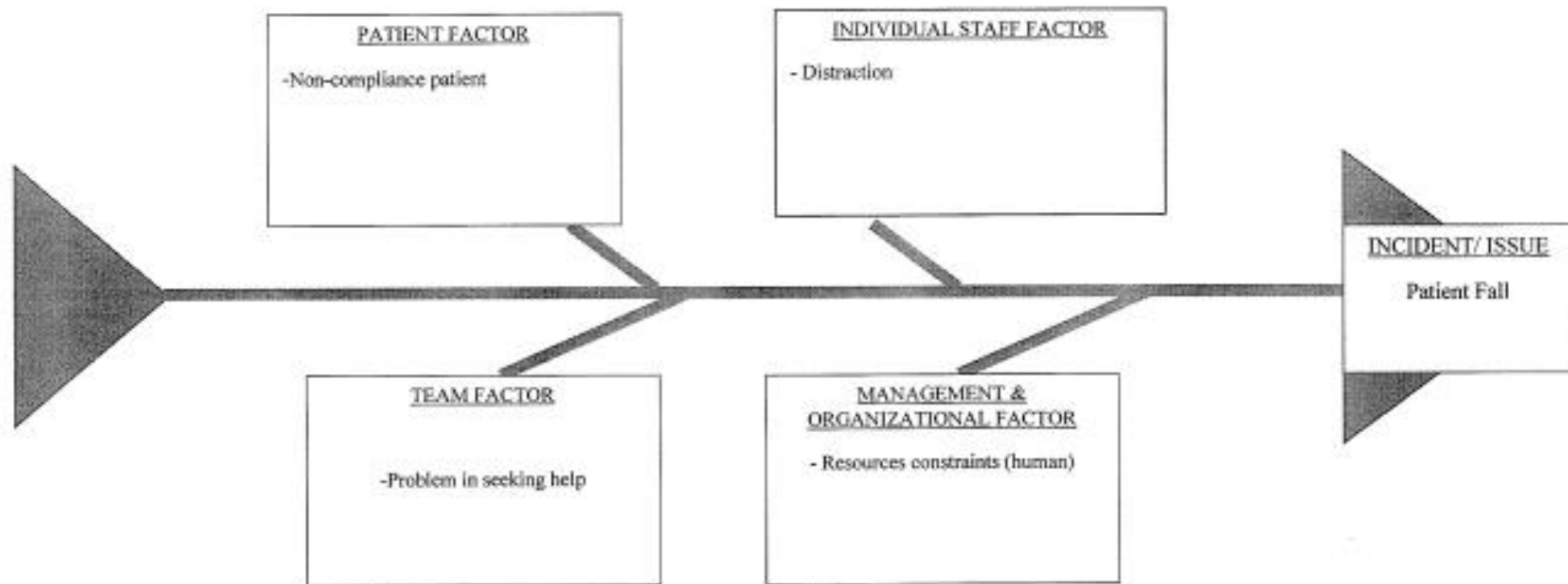
Mr W visited ETD on 30/05/23 at 08:47H for shortness of breath. He was being treated for Acute Decompensated Heart Failure secondary to De Novo Heart Failure and was planned for admission into the medical ward. On 01/06/23 at around 2200H, the patient was found lying on the floor while the staff went to take clean linen for the patient to change. The patient was attended stat by the Medical Officer and staff in charge. The patient had pain over the Left shoulder post fall which resolved, and the X-ray showed no fractures/dislocation.

6. SEQUENCE OF EVENTS:

Please state **only the important information/events/steps** that lead to the incident:

Date	Time (24 h)	Location	Event description	Key person involved(initial) & designation	Comments- please add in what went wrong in every sequence
30.05.2023	0847H	Triage Counter	Patient registered and was triaged to Red zone	AMO	
	0847H	RZ	Clerked by MO Blood investigation taken. ECG & CXR done. CBD inserted. Referred to Medical & Cardio.	MO SN	
	1400H	RZ	Seen by Medical MO planned to refer to Cardio for admission.	MO	
	1430H	RZ	Seen by Cardio MO planned to decongest in ETD for HDU & CCU ward full.	MO	
	2100H	RZ	Review by Cardio MO planned to continue decongestion in ETD for HDU & CCU ward still full.	MO	
	2330H	RZ	Seen by GA MO planned to continue decongestion in ETD, not for ICU admission.	MO	
31.05.2023	0845H	RZ	ETD AM Review, awaiting medical admission.	MO	
	0924H	RZ	Review by Medical MO planned for acute bed admission (GMW/MEW).	MO	
	1800H	YZ	ETD PM Review, awaiting medical admission.	MO	

7. FISH BONE DIAGRAM (REFER TO LONDON PROTOCOL FOR CATEGORISATION)



## 8. CONTRIBUTING FACTORS:

Please choose and tick at the relevant box the relevant contributing factors that lead to the incident & describe the factors. (Can be more than one factor)

FACTORS THAT LEADS TO THE INCIDENT																						
1	TEAM FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Written communication issue</td></tr> <tr><td><input type="checkbox"/></td><td>Verbal communication issue</td></tr> <tr><td><input type="checkbox"/></td><td>Unclear roles and responsibility</td></tr> <tr><td><input type="checkbox"/></td><td>Lack of supervision/ monitoring</td></tr> <tr><td><input type="checkbox"/></td><td>Ineffective leadership &amp; responsibility</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Problem in seeking help</td></tr> <tr><td><input type="checkbox"/></td><td>Staff or colleague response/ support to help</td></tr> <tr><td><input type="checkbox"/></td><td>Others (specify):</td></tr> </table> <p>Description: The staff didn't seek help from other colleagues.</p>	<input type="checkbox"/>	Written communication issue	<input type="checkbox"/>	Verbal communication issue	<input type="checkbox"/>	Unclear roles and responsibility	<input type="checkbox"/>	Lack of supervision/ monitoring	<input type="checkbox"/>	Ineffective leadership & responsibility	<input checked="" type="checkbox"/>	Problem in seeking help	<input type="checkbox"/>	Staff or colleague response/ support to help	<input type="checkbox"/>	Others (specify):				
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<input checked="" type="checkbox"/>	Problem in seeking help																					
<input type="checkbox"/>	Staff or colleague response/ support to help																					
<input type="checkbox"/>	Others (specify):																					
2	INDIVIDUAL STAFF FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Lack of knowledge/experience/ skill</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Distraction</td></tr> <tr><td><input type="checkbox"/></td><td>Fatigue/ stress</td></tr> <tr><td><input type="checkbox"/></td><td>Lapse of concentration</td></tr> <tr><td><input type="checkbox"/></td><td>Noncompliance to protocol/ policy/ SOP</td></tr> <tr><td><input type="checkbox"/></td><td>Personal issue</td></tr> <tr><td><input type="checkbox"/></td><td>Unsafe behaviour – assuming, not asking clarification etc.</td></tr> <tr><td><input type="checkbox"/></td><td>Interpersonal issue</td></tr> <tr><td><input type="checkbox"/></td><td>Others (specify):</td></tr> </table> <p>Description: The staff went to get new linen from the linen cabinet.</p>	<input type="checkbox"/>	Lack of knowledge/experience/ skill	<input checked="" type="checkbox"/>	Distraction	<input type="checkbox"/>	Fatigue/ stress	<input type="checkbox"/>	Lapse of concentration	<input type="checkbox"/>	Noncompliance to protocol/ policy/ SOP	<input type="checkbox"/>	Personal issue	<input type="checkbox"/>	Unsafe behaviour – assuming, not asking clarification etc.	<input type="checkbox"/>	Interpersonal issue	<input type="checkbox"/>	Others (specify):		
<input type="checkbox"/>	Lack of knowledge/experience/ skill																					
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<input type="checkbox"/>	Others (specify):																					
3	PATIENT FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Miscommunication between patient and staff</td></tr> <tr><td><input type="checkbox"/></td><td>Language barrier</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Non-compliance patient</td></tr> <tr><td><input type="checkbox"/></td><td>Social issue</td></tr> <tr><td><input type="checkbox"/></td><td>Patient-staff relationship issue</td></tr> <tr><td><input type="checkbox"/></td><td>Patient-patient relationship issue</td></tr> <tr><td><input type="checkbox"/></td><td>Complexity of clinical condition</td></tr> <tr><td><input type="checkbox"/></td><td>Pre-existing comorbid</td></tr> <tr><td><input type="checkbox"/></td><td>Known risk associated with treatment</td></tr> <tr><td><input type="checkbox"/></td><td>Others (specify):</td></tr> </table> <p>Description: The patient insisted to urinate in the toilet.</p>	<input type="checkbox"/>	Miscommunication between patient and staff	<input type="checkbox"/>	Language barrier	<input checked="" type="checkbox"/>	Non-compliance patient	<input type="checkbox"/>	Social issue	<input type="checkbox"/>	Patient-staff relationship issue	<input type="checkbox"/>	Patient-patient relationship issue	<input type="checkbox"/>	Complexity of clinical condition	<input type="checkbox"/>	Pre-existing comorbid	<input type="checkbox"/>	Known risk associated with treatment	<input type="checkbox"/>	Others (specify):
<input type="checkbox"/>	Miscommunication between patient and staff																					
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<input type="checkbox"/>	Known risk associated with treatment																					
<input type="checkbox"/>	Others (specify):																					

4	TASK & TECHNOLOGY FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Availability and use of protocols/ S.O.P/ guidelines</td></tr> <tr><td><input type="checkbox"/></td><td>Availability and accuracy of health information</td></tr> <tr><td><input type="checkbox"/></td><td>Task design issue</td></tr> <tr><td><input type="checkbox"/></td><td>Information technology (e.g malfunction, system design)</td></tr> <tr><td><input type="checkbox"/></td><td>Decision making aids</td></tr> <tr><td><input type="checkbox"/></td><td>Medication related issue (e.g wrong prescription, similar packaging/ sounding names, complicated dosage design)</td></tr> <tr><td><input type="checkbox"/></td><td>Radiotherapy related issue (e.g miscalculation of dose)</td></tr> <tr><td><input type="checkbox"/></td><td>Others (specify):</td></tr> </table> <p>Description:</p>	<input type="checkbox"/>	Availability and use of protocols/ S.O.P/ guidelines	<input type="checkbox"/>	Availability and accuracy of health information	<input type="checkbox"/>	Task design issue	<input type="checkbox"/>	Information technology (e.g malfunction, system design)	<input type="checkbox"/>	Decision making aids	<input type="checkbox"/>	Medication related issue (e.g wrong prescription, similar packaging/ sounding names, complicated dosage design)	<input type="checkbox"/>	Radiotherapy related issue (e.g miscalculation of dose)	<input type="checkbox"/>	Others (specify):				
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<input type="checkbox"/>	Others (specify):																					
5	MANAGEMENT & ORGANIZATIONAL FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Leadership and governance issue</td></tr> <tr><td><input type="checkbox"/></td><td>Organizational structure issue</td></tr> <tr><td><input type="checkbox"/></td><td>Objectives, policies and standard issue</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Resources constraints (human/ financial)</td></tr> <tr><td><input type="checkbox"/></td><td>Inadequate safety culture/ lack priorities in safety</td></tr> <tr><td><input checked="" type="checkbox"/></td><td>Others (specify): Pending Admission</td></tr> </table> <p>Description: The other staff was occupied with different tasks (admission to the ward and attending to other patient) The staffs need to handle new patients and pending admission patients at the same time.</p>	<input type="checkbox"/>	Leadership and governance issue	<input type="checkbox"/>	Organizational structure issue	<input type="checkbox"/>	Objectives, policies and standard issue	<input checked="" type="checkbox"/>	Resources constraints (human/ financial)	<input type="checkbox"/>	Inadequate safety culture/ lack priorities in safety	<input checked="" type="checkbox"/>	Others (specify): Pending Admission								
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<input checked="" type="checkbox"/>	Others (specify): Pending Admission																					
6	WORK & ENVIRONMENTAL FACTOR	<table border="1"> <tr><td><input type="checkbox"/></td><td>Building &amp; design related issues</td></tr> <tr><td><input type="checkbox"/></td><td>Physical environment issue (temperature, lighting, wet floor, holes, storage, housekeeping)</td></tr> <tr><td><input type="checkbox"/></td><td>Noisy, busy surrounding</td></tr> <tr><td><input type="checkbox"/></td><td>Malfunction/ failure of equipment/ maintenance of equipment, functionality, design</td></tr> <tr><td><input type="checkbox"/></td><td>Cluttered surrounding</td></tr> <tr><td><input type="checkbox"/></td><td>Unsafe surrounding</td></tr> <tr><td><input type="checkbox"/></td><td>Inappropriate allocation of staff (i.e not according to workload/ specialty)</td></tr> <tr><td><input type="checkbox"/></td><td>Heavy workload, inadequate break</td></tr> <tr><td><input type="checkbox"/></td><td>Service delivery- delay, missed, inappropriate</td></tr> <tr><td><input type="checkbox"/></td><td>Others (specify):</td></tr> </table> <p>Description:</p>	<input type="checkbox"/>	Building & design related issues	<input type="checkbox"/>	Physical environment issue (temperature, lighting, wet floor, holes, storage, housekeeping)	<input type="checkbox"/>	Noisy, busy surrounding	<input type="checkbox"/>	Malfunction/ failure of equipment/ maintenance of equipment, functionality, design	<input type="checkbox"/>	Cluttered surrounding	<input type="checkbox"/>	Unsafe surrounding	<input type="checkbox"/>	Inappropriate allocation of staff (i.e not according to workload/ specialty)	<input type="checkbox"/>	Heavy workload, inadequate break	<input type="checkbox"/>	Service delivery- delay, missed, inappropriate	<input type="checkbox"/>	Others (specify):
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<input type="checkbox"/>	Others (specify):																					
7	EXTERNAL FACTOR	Please specify:																				

9. List out the most important contributing factors/ root cause (s) that lead to the incident.

**The factors/ root cause (s) should be selected/written using 5 Rules of Causation**  
(Please refer to Appendix 3 of Guideline on Implementation of Incident Reporting & Learning System 2.0)

#### INDIVIDUAL STAFF FACTOR

Distraction and problem in seeking help lead to patient being left unattended and resulting in fall.

#### MANAGEMENT & ORGANIZATIONAL FACTOR

Pending admission leads to staff being occupied with different tasks (admission to the ward and attending to other pending patient/new patient) and increases the likelihood of patient fall.

## 10. \*Root Cause (s):

\*if the root cause(s) can be identified

This incident happens because staff is occupied with different tasks and distraction lead to the patient being left unattended and increases the likelihood of the patient fall.

## 11. ACTION PLAN TABLE

Based on the contributing factors/root cause (s) listed above, identify the most effective action plan. The action plan should have at least **1 strong/intermediate action plan**. "Weak" action can be implemented to support other action or while waiting for "stronger" or "intermediate" action to be implemented.

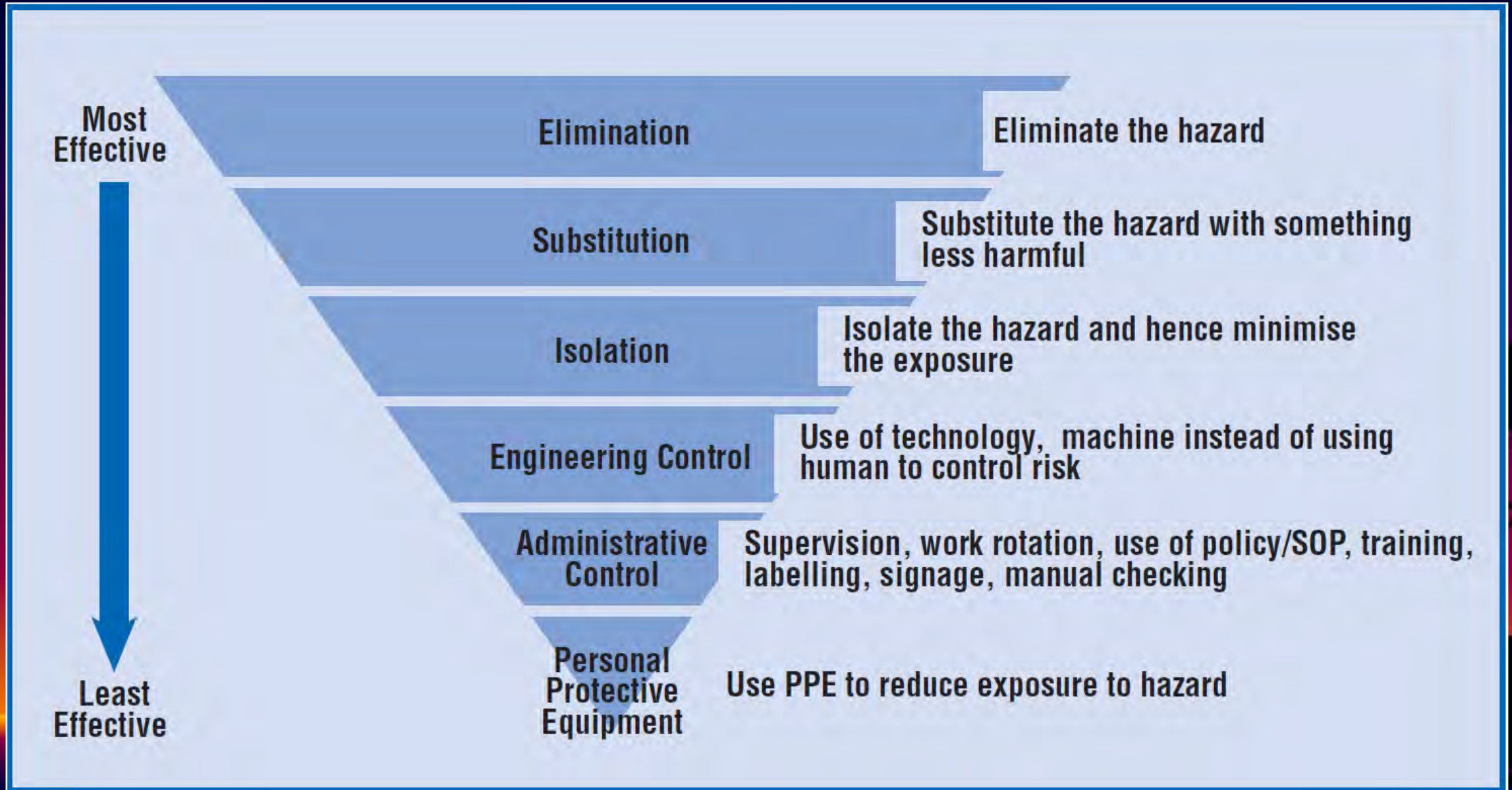
No.	Contributing Factors/ Root Causes	Description of Action Plan	Action Hierarchy (strong/ intermediate/ weak)	Person responsible (Name & designation)	Evidence of completion/ Progress	Expected Completion Date
1.	Inadequate attention to the high risk patients.	<ul style="list-style-type: none"><li>- Regular rounds by the shift supervisor to monitor staffs and patients' safety</li><li>- Reminder to all staffs to inform other staff when leaving the assigned zone</li><li>- Reinforce compliance to patient monitoring/ safety during Morning Prayer/CME/department meetings</li></ul>	Strong	All staff & supervisor		

# Formulate Action Plan & Risk Reduction Strategies

- To address the identified contributing factors & root causes
- Most important step in RCA<sup>2</sup> process
- Aim to **eliminate / reduce** the probability of harm occurring to patients, hence prevent recurrence of similar incidents



# Hierarchy of Risk Control



INCIDENT HAPPENED ✓



INCIDENT REPORTED ✓



INFORMED UNIT QUALITY ✓



RCA DONE ✓



AFTER RCA ??





KEMENTERIAN KESIHATAN MALAYSIA  
HOSPITAL QUEEN ELIZABETH II  
Lorong Bersatu  
Off Jalan Damai, Luyang  
88300 KOTA KINABALU  
SABAH

Tel : 088 - 324600  
Faks : 088 - 272454  
Laman Web : <https://hqe2.moh.gov.my/v2/>  
E-mel : [pengarah.hqe2@moh.gov.my](mailto:pengarah.hqe2@moh.gov.my)

Ruj.Kami : HQE2 (SB) 100-10/1 Jld.3(88)  
Tarikh : 01 SEPTEMBER 2023

Ketua Jabatan / Ketua Unit / Wad  
Hospital Queen Elizabeth II  
( Senarai Edaran seperti dalam lampiran A )

Tuan / Puan,

**MESYUARAT LAPORAN INSIDEN BIL. 07/2023, HOSPITAL QUEEN ELIZABETH II.**

Dengan segala hormatnya perkara diatas dirujuk.

2. Sukacita dimaklumkan bahawa Mesyuarat Laporan Insiden akan diadakan pada ketetapan berikut :

Tarikh : 05 September 2023 (Selasa)  
Masa : 8.30 pagi  
Tempat : Bilik Mesyuarat Pengarah  
Agenda :  
i. Perutusan Pengerusi  
ii. Pengesahan Minit Mesyuarat  
iii. Perkara-perkara berbangkit  
iv. Membincangkan Laporan Insiden bagi bulan Julai 2023.  
v. Pembentangan Medication Safety(Near Miss)  
vi. Hal-hal lain.

3. Kehadiran tuan / puan adalah diwajibkan. Sila hantar wakil sekiranya tidak dapat hadir ke mesyuarat ini. Kerjasama tuan / puan dalam perkara ini amatlah dihargai.

Sekian, terima kasih.

“MALAYSIA MADANI”

“BERKHIDMAT UNTUK NEGARA”

Saya yang menjalankan amanah,

(DR.FERRO FIRDAUS IBRAHIM)  
Pengarah,  
Hospital Queen Elizabeth II,  
KOTA KINABALU.



LAMPIRAN A

Senarai edaran:

1. Dr.Ferro Firdaus Ibrahim
2. Dr.Wan Sherhan Wan Ilias
3. Dr. Vivy Sudiana Sudeli
4. Dr.Chan Kien Loong
5. Dr.Lim Chee Hui
6. Dr.Wan Najwa Zaini Wan Mohammad
7. Dr.Shahnaz Irwani Sabri
8. Dr.Ahmad Humaizi Zakri
9. Dr.Parvin Rubon A/L Arangulavan
10. Dr.Anantha Kumar A/L Ramachandran
11. Dr.Emily Quek Ser Kay
12. Dr.Muhammad Nazif Md.Shah
13. Dr.Nur Fariza Idris
14. Dr.Wan Mohd Rashid bin Wan Mohd Nasir
15. Ir.Thomson Lai Teck Yong
16. Puan Siew Len
17. KPPPPK Andrew Suali
18. KPJH Hikmah Savitri Sunarto
19. PJ Yong Tshin Ngo
20. PJ Fatimah Salbat
21. PJ Noemi Maiton
22. PJ Choong Kam Yoke
23. PJ Helen John Chuan
24. PJ Ruth Matthew
25. PJ Mary Tan
26. PJ Mary Padtong
27. PJ Ida Gosibin
28. PJ Ainah Wallie
29. PJ Siti Asmeh Ahmad Miji
30. PJ Murikah Hj.Manap
31. PJ Roslina Jenang
32. JT Patsy Geoffrey
33. PPPP Ardan Hj. Mohd.Said
34. KPPPP Yap Yah Yun
35. KJ Helen Oris
36. PPPK Batus Saliun
37. KJ Fauziah Muldan
38. KJ Salmiah Duai
39. KJ Anisah@ Siti Noraisyah Saidi

- Pengarah  
Timbalan Pengarah (Klinikal)  
Tim.Pengarah (Sok.Klinikal) & UKI  
Jabatan Ortopedik  
Jabatan Anestesiologi & ICU  
Jabatan Radiologi  
Jabatan Perubatan Transfusi  
Penyelaras Laporan Insiden  
Unit Kualiti  
Unit Penjagaan Luka & Stoma  
Jabatan Patologi  
Unit Pengurusan Klinikal  
Unit Keselamatan & Kesihatan Pekerjaan  
Unit Kesihatan Awam  
Unit Kejuruteraan  
Jabatan Farmasi  
Unit PPP  
Unit Kejururawatan  
Jabatan Pembedahan Am & Ortopedik  
Jabatan Perubatan Am  
Jabatan Kardiotorasik & kardiologi  
Jabatan Anaesthesiologi & ICU  
Unit Kejururawatan  
Jabatan Kecemasan & Trauma  
Jabatan Perubatan Am  
Jabatan Perubatan Am  
Dewan Bedah  
Jabatan Pembedahan  
Jabatan Kardiologi  
Jabatan Neurosurgeri  
Unit Rawatan Rapi  
Dewan Bedah  
Jabatan Anestesiologi  
ETD  
ETD  
Klinik Ortopedik  
FOW  
MOW  
General Medical Clinic



### 3.4 DATA: IR/HQE2/2023/JUNE/FALL/01

DATE OF INCIDENT: 01.06.2023

4

WARD: ETD

DATE RECEIVED: 02.06.2023

TYPE OF INCIDENT: *Patient fall*

*Mr.W visited ETD on 30/5/2023 at 8.47H for SOB. He was being treated for Ac decompensated heart failure secondary to denovo heart failure and was planned for admission into the Medical ward. On 01/6/2023 at around 2200H, the patient was found lying on the floor while the staff went to take clean linen for the patient to change. The patient was attended stat by the MO and staff incharge. The patient had pain over the shoulder post fall which resolved, and the x-ray showed no fractures/dislocation.*

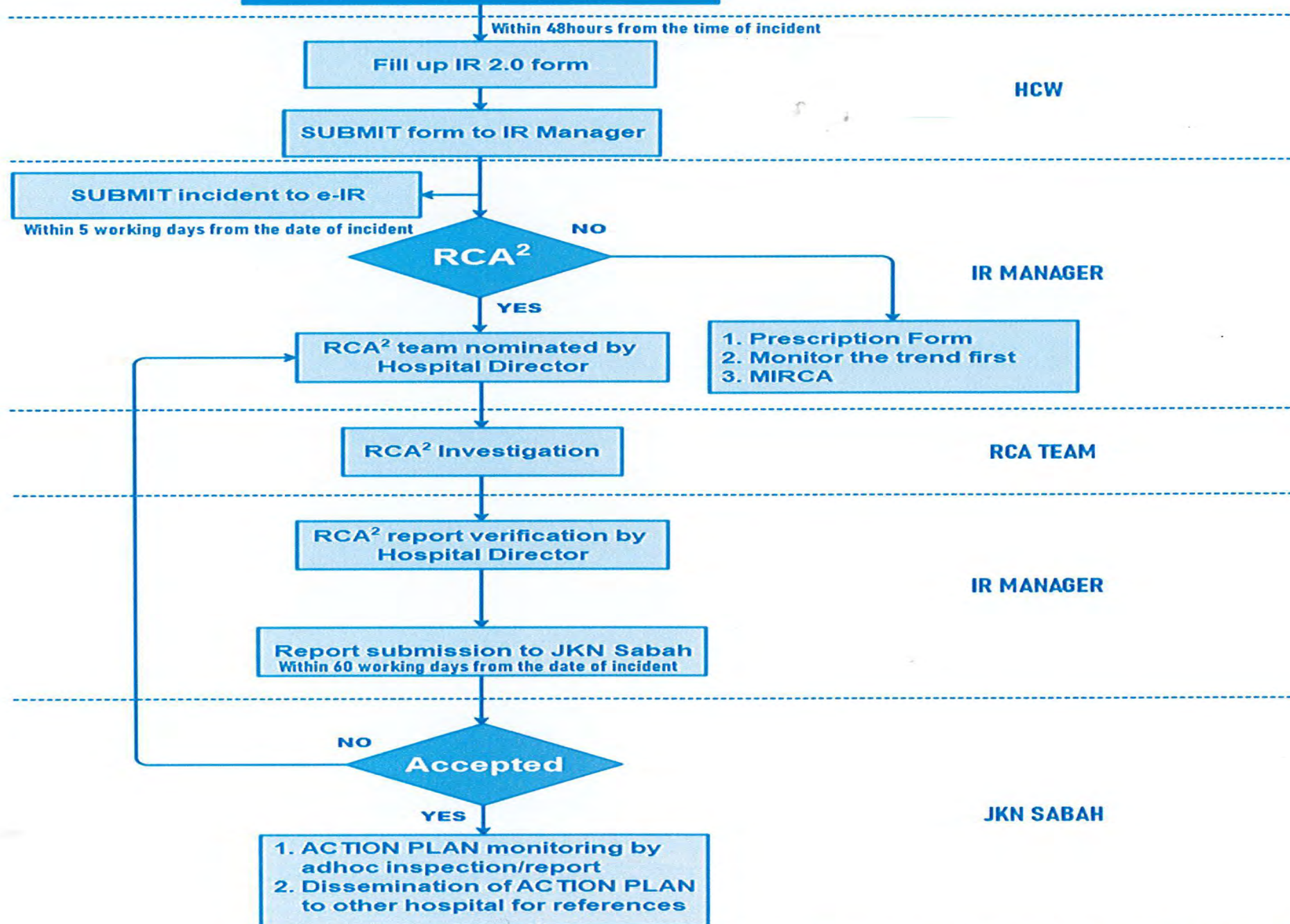
KPPP Yap telah menjelaskan insiden yang berlaku. Daripada *root cause analysis* yang dibuat antara faktor penyumbang adalah (i) Faktor individu iaitu staf yang terlibat tidak meminta bantuan dari rakan sekerja untuk menjaga pesakit sementara dia pergi mengambil linen bersih. (ii) *Management & Organizational factor* iaitu staf sibuk disebabkan ETD penuh dan *pending admission* yang banyak menyebabkan pesakit kurang diberi perhatian dan berpotensi untuk jatuh. Tindakan pembetulan dan penambahbaikan telah dibuat seperti yang dinyatakan dalam *root cause analysis*.

Pengerusi memaklumkan walaupun punca jatuh itu disebabkan oleh pesakit itu sendiri, sebagai anggota kesihatan kita tidak boleh mengelak dari memastikan kesihatan dan keselamatan pesakit terjaga. Pengerusi menasihatkan supaya Jabatan Kecemasan & Trauma melaksanakan tindakan penambahbaikan yang telah dirancang supaya insiden yang sama tidak berulang lagi.

Tindakan : Makluman

# Patient Safety Incident

## RESPONSIBILITY



**PREVENTION**

**IMPROVEMENT**

Internal event reporting programs include the comprehensive identification and reporting of hazardous conditions, near misses, adverse events, and sentinel events.

Internal reporting has four goals.

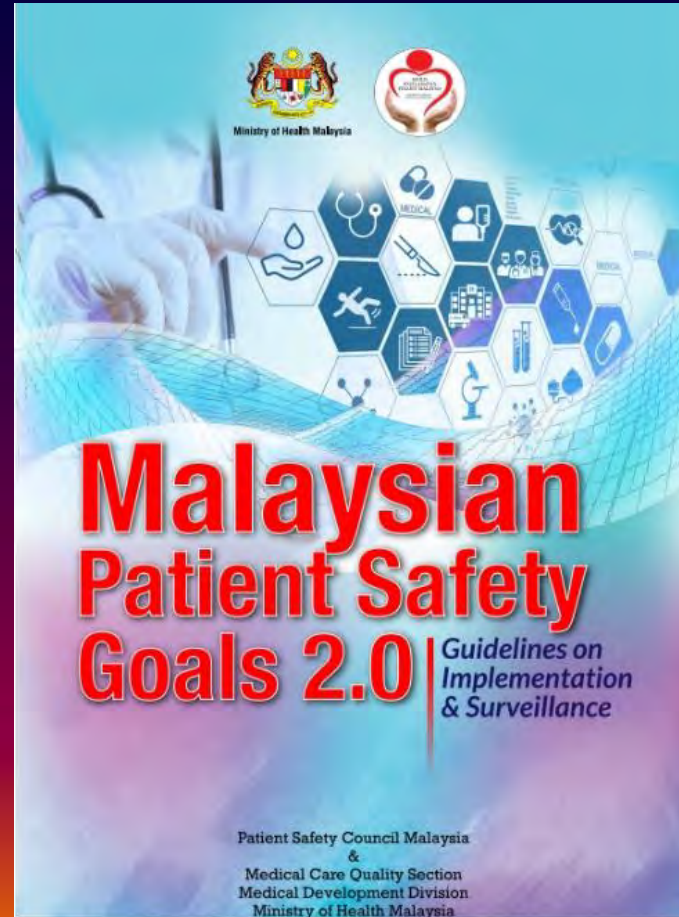
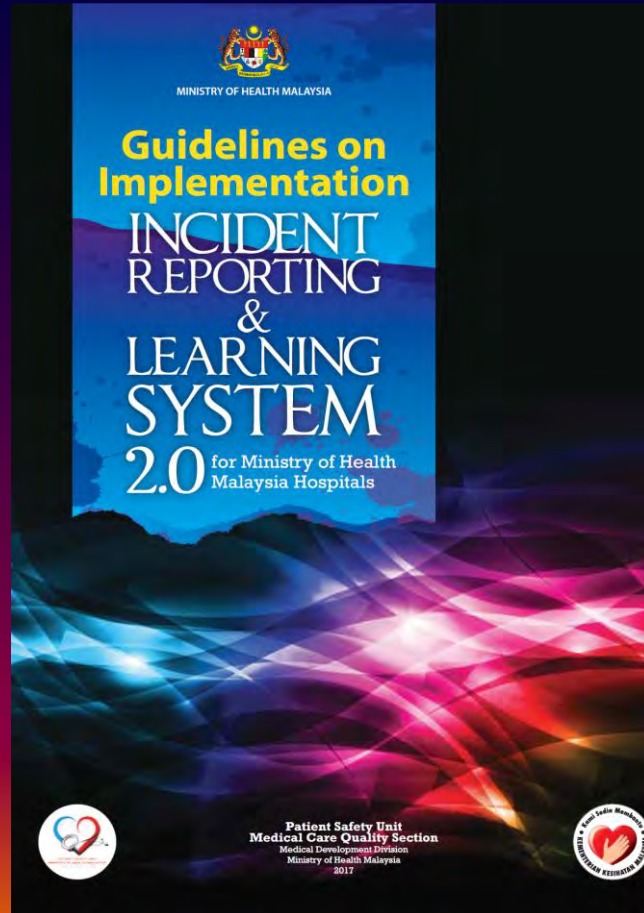
**LOSS REDUCTION**

**EDUCATION**

# Take away points

1. Wujudkan **budaya** dan **kesedaran** berkenaan kepentingan *Patient Safety* di kalangan kakitangan hospital keseluruhan.
2. Budaya pelaporan insiden yang **TELUS**. Kesemua insiden *Patient Safety* wajib dilaporkan.
3. Menggunakan **near misses** dan **RCA** bagi mencegah berulangnya insiden dan medicolegal.
4. **Tamatkan** budaya **BLAMING** dan cari punca insiden secara **SYSTEMIC**.
5. Langkah penambahbaikan yang berkesan dikongsi bersama wad/jabatan dan hospital lain. **REPORT RESPOND SHARE**

# REFERENCES





THANK YOU