資料３【海外の報告制度】

- Home (/)
- Patient safety (https://www.england.nhs.uk/patient-safety/)
- Report a patient safety incident

Report a patient safety incident

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe.

Contents

Both healthcare staff and the general public are encouraged to report any incidents, whether they result in harm or not, to our national services for recording patient safety events.

Find out more about how we use these reports to improve patient safety on our Using patient safety events to keep patients safe (https://www.england.nhs.uk/patient-safety/using-patient-safety-events-data-to-keep-patients-safe/how-we-acted-on-patient-safety-issues-you-recorded/) web pages.

For the general public

Members of the public should record patient safety incidents directly to the National Reporting and Learning System (NRLS) using the patient and public eform via the link below:

- Report a patient safety incident using the patient and public eform (https://www.eforms.nrls.nhs.uk/eformPP/)

Please note: these reports are only used to support national learning. We do not investigate individual reports and you will not receive a reply. Details of how to make a complaint about an NHS service can be found on the NHS.uk web (http://www.nhs.uk/chq/pages/1084.aspx?categoryid=68).

Important notice: by completing one of our e-forms you confirm you have read and accept the NRLS acceptance note, and give NHS Improvement permission to process the information you provide to learn about patient safety.

For healthcare staff

Healthcare staff are encouraged where possible to record all patient safety incidents on their organisation's local risk management systems (LRMS). These reports will then be routinely uploaded to our systems to support national learning.

Smaller organisations, such as general practice, independent dental surgeries, community pharmacies and opticians, may not have their own LRMS. In these organisations, staff can now record patient safety events directly to the new Learn from patient safety events service (LFPSE), which is currently being rolled out to replace the existing National Reporting and Learning System (NRLS).

- Report an incident to LFPSE (https://record.learn-from-patient-safety-events.nhs.uk/)

Further information can be found on our LFPSE primary care webpage (https://www.england.nhs.uk/patient-safety/patient-safety-incident-management-system/primary-care-information-on-the-new-national-learn-from-patient-safety-events-service/).

NRLS acceptance note

If using the NRLS public eform, it is important that you acknowledge, understand and accept the following before submitting your report:

1. The NRLS is managed and operated by NHS England and NHS Improvement as part of our statutory duty to collect patient safety incident reports. Healthcare organisations, staff and the general public can report incidents either directly to the NRLS using the links above or via an organisation's own local risk management system. These reports support improvements to patient safety by enabling us to understand and learn from what goes wrong in healthcare.
2. We do not investigate individual incidents. We use this information to improve safety by clinically reviewing reports to identify new or under-recognised patient safety risks so appropriate action can be taken across

the NHS to protect patients from harm. We also share data to support other organisations' work to prevent the more common and persistent types of patient safety incidents.

3. We do not require the identity of the reporter, patients, healthcare staff or other individuals involved in the incident. Please refrain from providing any information that could potentially enable the identification of an individual, ie the names of individuals, patient date of birth, NHS hospital numbers or ward name. Personal identifiable information when found by automated or manual processes is removed wherever possible before the incident report is added to our database.
4. As mentioned above, we frequently share patient safety incident reports with other relevant organisations working to improve patient safety. These include CQC, MHRA, commissioners, providers, academia and others such as the Academic Health Science Networks (AHSNs) and UK Health Security Agency.
5. NHS England and NHS Improvement will only retain information for as long as necessary. Patient safety reports will remain accessible for a long period of time to continue to support the understanding of contributing factors to under-recognised risks and enable trends to be monitored over time.

Related content

- Using patient safety events to keep patients safe (https://www.england.nhs.uk/patient-safety/using-patient-safety-events-data-to-keep-patients-safe/how-we-acted-on-patient-safety-issues-you-recorded/)
- Learn from patient safety events service (LFPSE) (https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/)

Legal Services Commission South Australia

Legal Help for all South Australians

Aged Care Quality and Safety Commission

Complaints against Commonwealth-funded aged care services can be made to the Aged Care Quality and Safety Commission (the Commission). The Commission was established under the Aged Care Quality and Safety Commission Act 2018 (Cth) and the Aged Care Quality and Safety Commission Rules 2018 (Cth). The Act and Rules apply to both approved providers of residential aged care or home-care services, and Commonwealth-funded aged care service providers.

Since 1 January 2019, the Aged Care Quality and Safety Commission replaced the former Aged Care Complaints Commissioner and the former Australian Aged Care Quality Agency, combining the functions of the two former agencies into a single service that oversees aged care compliance monitoring, complaints, and customer service.

From January 2020, the Commission has responsibility over the Commonwealth Department of Health's aged care compliance responsibilities.

The **Serious Incident *Response* Scheme 'SIRS'** part commenced on 1 April 2021 (full commencement on 1 October 2021) and requires aged care providers to have an effective incident management system in place and to identify, record, manage, resolve and report all serious incidents that occur, or are *alleged* or suspected to have occurred.

There are eight types of ***reportable incidents*** under the SIRS: unreasonable use of force, neglect of a consumer, psychological or emotional abuse, unexpected death, stealing or financial coercion by a staff member, inappropriate use of restrictive practices, and unexplained absence from care. Under the SIRS, an allegation, suspicion, or *witness* account of any of the above serious incidents must be reported to the Commission.

From 1 July 2021, approved providers have updated and specific responsibilities under the Aged Care Act 1997 (Cth) and the Quality of Care Principles 2014 relating to the use of any **restrictive practice** in residential aged care or short-term restorative care in a residential care setting. A **restrictive practice** in relation to a care recipient is any practice or intervention that has the effect of restricting the rights or freedom of movement of the person.

From 1 September 2021, it is a requirement for all residential aged care providers to have **Behaviour Support Plans ('BSP')** in place for care recipients that need them. A BSP forms part of an existing Care and Services Plan and are required for any person:

- that needs behaviour support
- where the use of a restrictive practice has been assessed as necessary, and
- where a restrictive practice is being used.

The Commission's role includes:

- overseeing the approval, accreditation and assessment of Commonwealth-funded aged care providers;

- providing a complaints resolution process for complaints relating to Commonwealth-funded aged care providers;
- overseeing the monitoring and compliance processes of Commonwealth-funded aged care providers, including home care investigations
- administering the Serious Incidents Response Scheme, through receiving and assessing reportable incident notices from residential aged care providers, including regulatory action and issuing compliance notices where appropriate
- reducing the use of restrictive practices

Aged care service providers subsidised by the Australian Government must meet the responsibilities and standards of care set out in the Aged Care Act 1997 (Cth). They are also required to comply with the Aged Care Quality Standards (from 1 July 2019). Information on the Aged Care Quality Standards can be accessed via the **Aged Care Quality and Safety Commission website.**

A person who has a concern or complaint about a service provider's responsibilities under the Aged Care Act 1997 (Cth) should attempt to raise any concerns with the aged care service provider in the first instance. If they are unable to do this or the provider is unable to resolve their concern, they should then contact the Aged Care Quality and Safety Commission online via the **Commission's website**, or by telephoning 1800 951 822. Complaints can be made confidentially or anonymously and all complaints are taken seriously. Any person can raise a complaint or concern with the Commission.

The Commission may be able to assist with a concern or complaint relating to:

- residential care or residential respite care;
- home care packages;
- the Commonwealth Home Support program;
- Flexible Care, including Transition Care and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program;
- Commonwealth-funded aged care providers.

A complaint or concern may relate to wide range of matters including the health care or personal care assistance that a consumer is receiving, their living environment, or a concern that their personal choices or preferences are not being followed. It may relate to concerns about a staff member's role or actions, the communication of information to the consumer, or to certain fees and charges contained in care agreements.

Complaints may be resolved using one or more of the following methods:

- the provider's processes for complaint resolution;
- conciliation;
- mediation;
- investigation.

For more information on the process of aged care complaints, see the **Aged Care Complaints Process** on the **Aged Care Quality and Safety Commission website**or contact the Commission 1800 951 822.

for legal advice. See Disclaimer for details. For free and confidential legal advice in South Australia call 1300 366 424.

We embrace diversity and welcome all people, irrespective of culture, faith, sexual orientation and gender identity.

Legal Services acknowledges Aboriginal people as the Traditional Owners and ongoing occupants of the lands and waters in South Australia and we respect their spiritual, cultural and heritage beliefs. We recognise their continuing connection to land, water and community and pay our deep respect to Elders past and present.

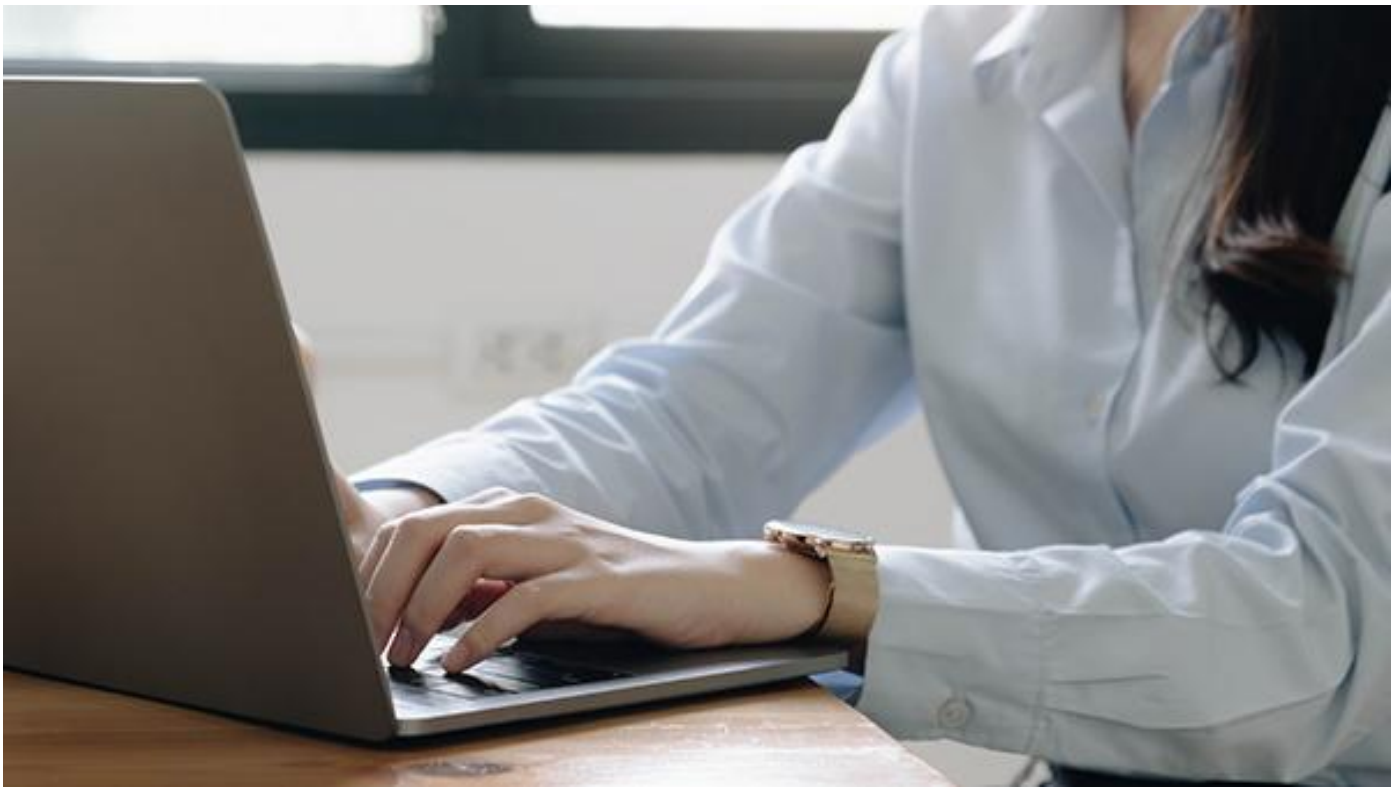
Connect with us

Serious Incident Response Scheme

Introduction to the SIRS

SIRS in residential aged care

SIRS in home services



SIRS decision support tool

Resources for providers

Incident management

Frequently asked questions

Your role in the SIRS

SIRS forms

Changed: Thursday, 11 May 2023 - 3:06pm

Was this page useful?

Yes No

Primers

Reporting Patient Safety Events

September 7, 2019

Background

Patient safety event reporting systems are ubiquitous in hospitals and are a mainstay of efforts to detect patient safety events and quality problems. *Incident reporting* is frequently used as a general term for all voluntary patient safety event reporting systems, which rely on those involved in events to provide detailed information. Initial reports often come from the frontline personnel directly involved in an event or the actions leading up to it (e.g., the nurse, pharmacist, or physician caring for a patient when a medication error occurred), rather than management or patient safety professionals. Voluntary event reporting is therefore a *passive* form of surveillance for near misses or unsafe conditions, in contrast to more *active* methods of surveillance such as direct observation of providers or chart review using trigger tools. The Patient Safety Primer Detection of Safety Hazards provides a detailed discussion of other methods of identifying errors and latent safety problems.

Characteristics of Incident Reporting Systems

An effective event reporting system should have four key attributes:

Box. Key Components of an Effective Event Reporting System

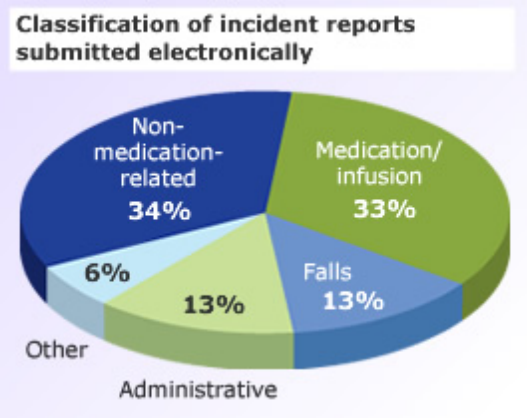
- Institution must have a supportive environment for event reporting that protects the privacy of staff who report occurrences.
- Reports should be received from a broad range of personnel.
- Summaries of reported events must be disseminated in a timely fashion.
- A structured mechanism must be in place for reviewing reports and developing action plans.

While traditional event reporting systems have been paper based, technological enhancements have allowed the development of Web-based systems and systems that can receive information from electronic medical records. Specialized systems have also been developed for specific settings, such as the Intensive Care Unit Safety Reporting System and systems for reporting surgical and anesthesia-related errors.

Voluntary event reporting systems need not be confined to a single hospital or organization. The United Kingdom's National Patient Safety Agency maintains the National Reporting and Learning System, a nationwide voluntary event reporting system, and the MEDMARX voluntary medication error reporting system in the U.S. has led to much valuable research.

The advantages of voluntary event reporting systems include their relative acceptability and the involvement of frontline personnel in identifying safety hazards for the organization. Because event reports usually are submitted by personnel involved in the events themselves, these caregivers may have legitimate concerns about the effects reporting will have on their performance records. Voluntary event reporting systems are generally confidential, in that the identity of the reporter is known, but legal protection is provided unless professional misconduct or criminal acts took place. Some systems, such as the ICU Safety Reporting System, are entirely anonymous–neither the patient nor the reporter can be identified.

Studies of electronic hospital event reporting systems generally show that medication errors and patient falls are among the most frequently reported events.

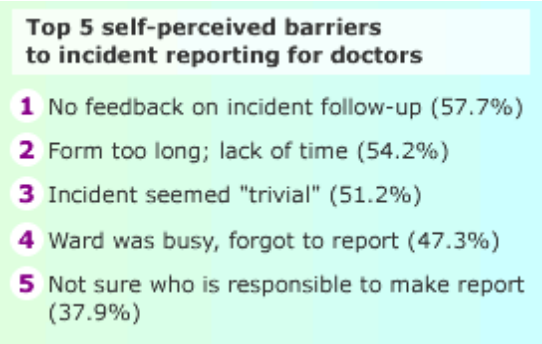


Source: Milch CE, Salem DN, Pauker SG, Lundquist TG, Kumar S, Chen J. Voluntary electronic reporting of medical errors and adverse events. J Gen Intern Med. 2006;21:165-170. [go to PubMed]

Limitations of Event Reporting

The limitations of voluntary event reporting systems have been well documented. Event reports are subject to selection bias due to their voluntary nature. Compared with medical record review and direct observation, event reports capture only a fraction of events and may not reliably identify serious events. The spectrum of

reported events is limited, in part due to the fact that physicians generally do not utilize voluntary event reporting systems.



Source: Evans SM, Berry JG, Smith BJ, et al. Attitudes and barriers to incident reporting: a collaborative hospital study. Qual Saf Health Care. 2006;15:39-43. [go to PubMed]

A 2008 study of over 1600 U.S. hospitals evaluated their event reporting systems using the criteria above (Box) and concluded that according to these standards, most hospitals do not maintain effective event reporting systems. In addition to lack of physician reporting, most hospitals surveyed did not have robust processes for analyzing and acting upon aggregated event reports. Failure to receive feedback after reporting an event is a commonly cited barrier to event reporting by both physicians and allied health professionals.

While event reports may highlight specific concerns that are worthy of attention, they do not provide insights into the epidemiology of safety problems. In a sense, event reports supply the *numerator* (the number of events of a particular type–and even here, this number only reflects a fraction of all such events) but do not supply the *denominator* (the number of patients vulnerable to such an event) or the number of "near misses." Event reports therefore provide a snapshot of safety issues, but on their own, cannot place the reported problems into the appropriate institutional context. One way to appreciate this issue is to observe that some institutions celebrate an increase in event reports as a reflection of a "reporting culture," while others celebrate a reduction in event reports, assuming that such a reduction is due to fewer events.

Using Event Reports to Improve Safety

A 2016 article contrasted event reporting in health care with event reporting in other high-risk industries (such as aviation), pointing out that event reporting systems in health care have placed too much emphasis on collecting reports instead of learning from the events that have been reported. Event reporting systems are best used as a way of identifying issues that require further, more detailed investigation. While event reporting utilization can be a marker of a positive safety culture within an organization, organizations should resist the temptation to encourage event reporting

without a concrete plan for following up on reported events. A PSNet perspective described a framework for incorporating voluntary event reports into a cohesive plan for improving safety. The framework emphasizes analysis of the events and documenting process improvements arising from event analysis, rather than encouraging event reporting for its own sake.

Current Context

At the national level, regulations implementing the Patient Safety and Quality Improvement Act became effective on January 19, 2009. The legislation provides confidentiality and privilege protections for patient safety information when health care providers work with new expert entities known as Patient Safety Organizations (PSOs). Health care providers may choose to work with a PSO and specify the scope and volume of patient safety information to share with a PSO. Because health care providers can set limits on the ability of PSOs to use and share their information, this system does not follow the pattern of traditional voluntary reporting systems. However, health care providers and PSOs may aggregate patient safety event information on a voluntary basis, and AHRQ will establish a network of patient safety databases that can receive and aggregate nonidentifiable data that are submitted voluntarily. AHRQ has also developed Common Formats—standardized definitions and reporting formats for patient safety events—in order to facilitate aggregation of patient safety information. Since their initial release in 2009, the Common Formats have been updated and expanded to cover a broad range of safety events.

As all hospitals are required to maintain a confidential event reporting system, existing voluntary reporting systems have a shared interest in developing ways to compare and benchmark safety data. AHRQ will encourage use of the initial set of Common Formats by hospitals in their internal event reporting systems and encourage other voluntary reporting systems to consider adopting the Common Formats as well. Future Common Formats will address other sites of care and other stages of the improvement process (such as forms for reporting root cause analyses).

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Mass.gov

Incident reporting for Assisted Living Residences

Learn more about reporting incidents that occur at your Assisted Living Residence (ALR).

TABLE OF CONTENTS

Filing system

Any report required under 651 CMR 12.04(11)(c) must be filed with the Assisted Living Certification Unit **within 24 hours** after the occurrence of the incident or accident via EOEA's online filing system (QuickBase).

In the event the online filing system is unavailable, the Residence must submit a temporary report by fax or email, and telephone and formally submit the official report via the online filing system as soon as the service becomes accessible.

The information submitted in the incident report must be accurate and include all details associated with the incident. This requirement is in addition to the requirements of M.G.L. c. 19A, § 15, and of any other applicable law.

Reporting facility wide situations

If any emergency or facility wide situations displaces Residences from their Units for 8 hours or more, the manager of the Residence or his or her designee must immediately submit a report to the EOEA Assisted Living Residence Certification Unit. This report should include at least:

1. The name and location of the Residence;
2. The nature of the problem;
3. The number of Residents displaced;
4. The number of Units rendered unusable due to the occurrence, and the anticipated length of time before the Residents may return to them;

5. Remedial action taken by the Residence; and
6. Other State or local agencies notified about the problem.

Reporting resident-specific emergencies

A Residence must report to EOEA the occurrence of an incident or accident that arises within a Residence or its property, that has or may have a **Significant Negative Effect** (/info-details/incident-reporting-for-assisted-living-residences#what-is-significant-negative-effect?-) on a resident's health, safety or welfare, as defined by 651 CMR 12.02.

A Significant Negative Effect is assumed whenever, as a result of an incident or accident, any unplanned or unscheduled visit to a hospital or medical treatment is necessary.

What is Significant Negative Effect?

Significant Negative Effect is the consequence of a situation in which a Resident experienced a significant risk of death or serious physical or emotional harm.

The consequences of such situations include, but are not limited to:

- accidental injury
- Unanticipated Death
- suicide or suicide attempt
- a physical or sexual assault by or against a Resident
- a complaint of Resident abuse, suspected Resident abuse, or referral of a complaint of Resident abuse to a local or state authority
- a medication error requiring medical attention
- SAMM or LMA error with an adverse effect requiring medical attention
- elopement with an absence of greater than 30 minutes
- misuse of a Resident's funds by the Residence or its staff
- an outbreak of a serious communicable disease that is listed in **105 CMR 300.100: Diseases Reportable to Local Boards of Health** (/regulations/105-CMR-30000-reportable-diseases-surveillance-and-isolation-and-quarantine)
- pest infestation
- food poisoning as defined in **105 CMR 300.020: Definitions** (/regulations/105-CMR-30000-reportable-diseases-surveillance-and-isolation-and-quarantine)
- fire or structural damage to the Residence

Please refer to the **Assisted Living Regulations** (https://www.mass.gov/regulations/651-CMR-12-certification-procedures-and-standards-for-assisted-living-residences) for further details.

RELATED

How to report incidents at your ALR (/how-to/report-incidents-at-your-assisted-living-residence-alr)

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(/)

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Public Records Requests (/topics/public-records-requests)

- Home (/)
- Patient safety (https://www.england.nhs.uk/patient-safety/)
- Monthly data on patient safety incident reports

Monthly data on patient safety incident reports

Rolling data updated monthly, to show the number of patient safety incidents reported to the National Reporting and Learning System (NRLS) in the last 12 months.

Our publication provides timely organisational data on reporting to the NRLS, promotes data transparency, encourages more consistency in NRLS reporting patterns, and supports organisations to monitor potential under-reporting of incidents.

The data is based on the date each incident report was submitted to the NRLS and not the date the incident was said to have occurred. It represents the current position at the time data was extracted from the NRLS and is subject to change, should any reports be updated as further information becomes available.

The data is broken down by each month reported and degree of harm, and is refreshed and updated on a monthly basis.

- NRLS monthly report England April 2022 to March 2023 (https://www.england.nhs.uk/publication/nrls-monthly-report-england/) – Data by organisation on incidents reported to the NRLS by each English NHS trust and foundation trust, and regularly reporting social enterprise organisation.*

Note: some trusts are now reporting incidents to the new Learn from Patient Safety Events (LFPSE) service (https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/), and are no longer reporting to the NRLS. As a result they are showing as reporting no reports in the NRLS monthly data report. We plan to start publishing data on patient safety events recorded on LFPSE soon, when more organisations have made the transition from reporting to the NRLS.

We are currently reviewing the format of the information we publish in our monthly NRLS data reports. We would welcome feedback from users on how they find the current excel spreadsheets and any improvements they would like to see. To send us your feedback please email nrls.datarequests@nhs.net (mailto:nrls.datarequests@nhs.net)

> For Welsh monthly NRLS data please refer to the Welsh Government (https://gov.wales/patient-safety) website. Our regular NRLS reports based on the date the incident occurred will continue to be published every six months.

How NRLS data should be used

We want to help all users of NRLS data to understand and use it appropriately. This is important not only for accurate interpretation, but to ensure we continue to encourage improvements in identifying and sharing information about patient safety incidents.

If you use NRLS data, then you should follow our data principles (https://www.england.nhs.uk/wp-content/uploads/2020/08/NRLS_data_principles_December_2016_v2_1.pdf).

Learning from patient safety incidents

Find out how we learn from patient safety incidents (https://webarchive.nationalarchives.gov.uk/20200706210038/https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/) reported to the NRLS to support improvements in patient safety and p patients from harm. You can also read our Patient safety review and response report

(https://webarchive.nationalarchives.gov.uk/20200706221508/https://improvement.nhs.uk/resources/patient-safety-review-and-response-april-september-2016/) to find examples of the action we take in direct response to incidents reported to us via the NRLS and other sources.

*The threshold for including social enterprise organisations is those that report over 100 incidents a year.

Related content

- Patient safety alerts (https://www.england.nhs.uk/patient-safety/patient-safety-alerts/)
- Organisation patient safety incident reports (https://www.england.nhs.uk/patient-safety/organisation-patient-safety-incident-reports/)
- National quarterly data on patient safety incident reports (https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/)