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මගේ අංකය / எனது இல / My Number: HQSA/MOH/02/2015
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දිනය / திகதி / Date: 13.06.2016

සුවසිරිපාය
சுவசிரிபாய
SUWASIRIPAYA

සෞඛ්‍ය පෝෂණ සහ දේශීය වෛද්‍ය අමාත්‍යාංශය
சுகாதார,போசணை மற்றும் சுதேசவைத்தியஅமைச்சு
Ministry of Health, Nutrition & Indigenous Medicine

චක්‍රලේඛ අංක : 01 - 38 /2016

සියලු සෞඛ්‍ය සේවා පළාත් අධ්‍යක්ෂවරු
සියලු සෞඛ්‍ය සේවා ප්‍රාදේශීය අධ්‍යක්ෂවරු
සියලු රෝහල් අධ්‍යක්ෂවරු/වෛද්‍ය අධිකාරිවරුන්

අසතුටුදායක සිදුවීම් වාර්තා කිරීම සහ රෝගීන් නැවත ඇතුළත් කිරීමේ ආකෘති පත්‍ර ක්‍රියාත්මක කිරීම

මෑත දශකය තුළ සෞඛ්‍ය සත්කාර සේවාවල අවශ්‍ය මූලික සංරචක ලෙස රෝගීන්ගේ සුරක්ෂිතතාව සහ ගුණාත්මක සත්කාර සේවය හඳුනාගෙන ඇත. ඒ අනුව, සෞඛ්‍ය පෝෂණ සහ දේශීය වෛද්‍ය අමාත්‍යාංශය, රෝගීන්ගේ සුරක්ෂිතතාව ප්‍රශස්ත අයුරින් සැලසීම සහ රෝගීන්ගේ සැලසුම් නොකළ නැවත ඇතුළත් කිරීම් සඳහා හේතු හඳුනාගැනීම සහ පිළියම් යෙදීම සඳහා අසතුටුදායක සිදුවීම් වාර්තා කිරීම සහ නැවත ඇතුළත් කිරීම් **(Reporting of Adverse Events & Readmissions)** ක්‍රියාත්මක කිරීමට තීරණය කර ඇත.

අදාළ සියලුම පාර්ශ්වකරුවන් සමග පැවති සාකච්ඡා මාලාවකින් පසුව සහ ජාත්‍යන්තර ප්‍රතිපත්තීන්ට අනුකූලව අදාළ ආකෘති පත්‍ර සහ මාර්ගෝපදේශ ගොඩ නගා ඇත. ඒ අනුව, පහත දැක්වෙන ආකෘතීන් ශ්‍රී ලංකාව තුළ ක්‍රියාත්මක කරනු ලැබේ.

- අසතුටුදායක සිදුවීම් වාර්තා කිරීම සහ නැවත ඇතුළත් කිරීමේ මාර්ගෝපදේශ
- අසතුටුදායක සිදුවීම් වාර්තා කිරීම සහ නැවත ඇතුළත් කිරීමේ ආකෘති පත්‍රය
- අසතුටුදායක සිදුවීම් විශ්ලේෂණය කිරීමේ ආකෘති පත්‍රය

මෙම චක්‍රලේඛයේ අන්තර්ගත කරුණු අනුව අසතුටුදායක සිදුවීම් වාර්තා කිරීම සහ රෝගීන් නැවත ඇතුළත් කිරීම් සඳහා වූ මෙම මුල පිරීම අදාළ ආයතනවල ක්‍රියාවට නංවන බවට එම ආයතන ප්‍රධානීන් විසින් සහතික කළ යුතු වේ.

වෛද්‍ය පී.ජී. මහීපාල
සෞඛ්‍ය සේවා අධ්‍යක්ෂ ජනරාල්
සෞඛ්‍ය පෝෂණ සහ දේශීය වෛද්‍ය අමාත්‍යාංශය

ඇමුණුම් :	අසතුටුදායක සිදුවීම් වාර්තා කිරීමේ මාර්ගෝපදේශ	(ඇමුණුම **I**)
	නැවත ඇතුළත් කිරීම් වාර්තා කිරීමේ මාර්ගෝපදේශ	(ඇමුණුම **II**)
	අසතුටුදායක සිදුවීම් වාර්තා කිරීමේ ආකෘති පත්‍රය	(ඇමුණුම **III**)
	අසතුටුදායක සිදුවීම් විශ්ලේෂණය කිරීමේ ආකෘති පත්‍රය	(ඇමුණුම **IV**)
	නැවත ඇතුළත් කිරීමේ ආකෘති පත්‍රය	(ඇමුණුම **V**)

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SUWASIRIPAYA

මගේ අංකය
எனது இல
My Number HQSA/MOH/02/2015

ඔබේ අංකය
உமது இல
Your Number

දිනය
திகதி
Date 13.06.2016

සෞඛ්‍ය පෝෂණ සහ දේශීය වෛද්‍ය අමාත්‍යාංශය
சுகாதார,போசணை மற்றும் சுதேசவைத்திய அமைச்சு
Ministry of Health, Nutrition & Indigenous Medicine

General Circular No: 01 - 38 / 2016

All Provincial Directors of Health Services
All Regional Directors of Health Services
All Hospital Directors/Medical Superintendents

Implementation of Adverse Event Reporting & Readmission Forms

Patient Safety & Quality of care have been identified as an essential and integral components of healthcare services during recent decades. Accordingly, Ministry of Health, Nutrition & Indigenous Medicine has decided to implement reporting of Adverse Events and Readmissions to optimize patient Safety, and to identify the causes & remedy unplanned readmissions.

The relevant forms and guidelines were developed after series of consultations with all relevant stakeholders and complying with international practices. Accordingly following formats will be implemented in Sri Lanka as follows:

- **Adverse Event Reporting & Readmission Guidelines**
- **Adverse Event Reporting & Readmission Form.**
- **Adverse Event Analysis form**

All Heads of Institutions are hereby requested to ensure the content of this circular this initiative is implemented for reporting of Adverse Events and Readmissions, in their respective Institutions.

Dr P.G.Mahipala
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine

Dr. P. G. Mahipala
Director General of Health Services
Ministry of Health, Nutrition & Indigenous Medicine
"Suwasiripaya",
385, Rev. Baddegama Wimalawansa Thero Mawatha,
Colombo 10

Attached: **Guidelines for Adverse Event/Incident Reporting (Annexure I)**
Guidelines for Reporting Readmissions (Annexure II)
Adverse Event Reporting Form (Annexure III)
Adverse Event Analysis form (Annexure IV)
Readmission Form (Annexure V)

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මගේ අංකය
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Your Number

දිනය
திகதி
Date
13 . 06 .2016

සෞඛ්‍ය පෝෂණ සහ දේශීය වෛද්‍ය අමාත්‍යාංශය
சுகாதார,போசணை மற்றும் சுதேச வைத்திய அமைச்சு
Ministry of Health, Nutrition & Indigenous Medicine

பொதுச் சுற்றுநிருப இல. 01 - 38 / 2016

சுகாதார சேவைகளின் அனைத்து மாகாணப் பணிப்பாளர்கள்

சுகாதார சேவைகளின் அனைத்து பிராந்திய பணிப்பாளர்கள்

அனைத்து வைத்தியசாலைப் பணிப்பாளர்கள்/ வைத்திய அதிகாரிகள்

<u>பாதக நிகழ்வுகளின் அறிக்கை மற்றும் மீள்அனுமதிப் படிவங்கள் அமுலாக்கம்</u>

நோயாளர்களின் பாதுகாப்பு மற்றும் பராமரிப்பின் தரம் என்பன அண்மித்த தசாப்தங்களில் சுகாதார பராமரிப்பு சேவைகளுடன் ஒருங்கிணைந்த அத்தியாவசியமான கூறுகளாக இனங்காணப்பட்டுள்ளன. அதன்பிரகாரம், நோயாளர்களின் பாதுகாப்பினைச் சாதகமாக்குவதற்காக பாதக நிகழ்வுகளின் அறிக்கை மற்றும் மீள்அனுமதிப் படிவங்கள் என்பனவற்றை அமுலாக்குவதற்கும், திட்டமிடப்படாத மீள்அனுமதிகளுக்கான காரணங்கள் மற்றும் பரிகாரங்களை இனங்காண்பதற்கும் சுகாதார, போசணை மற்றும் சுதேச வைத்திய அமைச்சு தீர்மானம் மேற்கொண்டுள்ளது.

பொருத்தமான அனைத்து பங்காளர்களுடனான ஆலோசனைகளின் பின்னர் சர்வதேச நடைமுறைகளுக்கு இசைவான வகையில் பொருத்தமான படிவங்கள் மற்றும் வழிகாட்டல்கள் விருத்தி செய்யப்பட்டுள்ளன. அதற்கமைய பின்வரும் வடிவமைப்புக்கள் இலங்கையில் அமுல்படுத்தப்படவுள்ளன.

- பாதக நிகழ்வுகளின் அறிக்கை மற்றும் மீள்அனுமதி வழிகாட்டல்கள்
- பாதக நிகழ்வுகளின் அறிக்கை மற்றும் மீள்அனுமதிப் படிவங்கள்
- பாதக நிகழ்வுகளின் பகுப்பாய்வுப் படிவங்கள்

இம் முன்னெடுப்பானது பாதக நிகழ்வுகள் மற்றும் மீள்அனுமதிகளை அறிக்கைப்படுத்துவதற்காக உரிய நிறுவனங்களில் அமுல்படுத்தப்படுகின்றது எனும் இச் சுற்று நிருபத்தின் உள்ளடக்கத்தினை உறுதிப்படுத்துமாறு அனைத்து நிறுவன தலைவர்களும் இத்தால் வேண்டப்படுகின்றார்கள்.

வைத்தியர். பி.ஜி. மஹிபால
சுகாதார சேவைகள் பணிப்பாளர் நாயகம்
சுகாதார, போசணை மற்றும் சுதேச வைத்திய அமைச்சு

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Colombo 10.

இணைக்கப்பட்டுள்ளவை:

பாதக நிகழ்வு/நிகழ்வு அறிக்கைக்கான வழிகாட்டல்கள் (இணைப்பு I)

மீள்அனுமதிகள் அறிக்கைக்கான வழிகாட்டல்கள் (இணைப்பு II)

பாதக நிகழ்வு அறிக்கைப் படிவம் (இணைப்பு III)

பாதக நிகழ்வு பகுப்பாய்வுப் படிவம் (இணைப்பு IV)

மீள் அனுமதிப் படிவம் (இணைப்பு V

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சுகாதார,போசணை மற்றும் சுதேச வைத்திய அமைச்சு

Ministry of Health, Nutrition & Indigenous Medicine

Guidelines for Adverse Event / Incident Reporting

Introduction

Patient safety is a major concern for all healthcare providers. It appears perverse that patients can suffer harm when they are being treated and cared for. However, healthcare is complex and its outcome is influenced by many factors. It is inevitable that within any healthcare system patients may be harmed, and in every encounter there is the potential for harm to occur. This has been recognized since the time of the physicians of Ancient Greece and Rome – 'First, do no harm.'

Safest place for patients is a Hospital. Are hospitals as safe as we think they are? Vast number of misconducts, negligence and adverse events are recorded from these patient care institutions. 'Patients are harmed from their health care either resulting in permanent injury, increased Length of Stay (LOS) in hospitals and even death. Adverse events occur not because bad people intentionally hurt patients but rather that the system of health care today is so complex that the successful treatment and outcome for each patient depends on a range of factors, not just the competence of an individual health-care provider' . There is no institution that can provide total patient safety. Risk that patients have to face is not homogeneous. It differs according to how sick the patient is, number of interventions he /she has to go through and duration of the stay. Unless substantial changes in the system are made, the vulnerable have to carry the burden of errors.

In Sri Lanka, there are many reported as well as unreported cases related to patient safety. Moreover, there are allegations that hospitals are covering up these incidents. Necessity of initiating patient safety culture in health care system and a compensation mechanism has been raised. It was found that medical staff lacks proper awareness on patient safety and its importance. Blame and shame leads to underreporting. In turn the organization lacks the opportunity to learn from its errors and prevent / mitigate future adverse events.

Patient safety is a new concept introduced to Sri Lankan health care system. "To Err is Human; Building a Safer Health System" was an eye opener which highlighted patient safety and patient safety culture. Health sector has learnt safety culture from other highly reliable organizations such as aviation, nuclear power industry etc. Similar to those organizations, the highly reliable health care providers have an inbuilt patient safety culture.

Purpose of Reporting

In seeking to improve safety, one of the most frustrating aspects for patients and professionals alike is the apparent failure of health-care systems to learn from their mistakes. Too often neither health-care providers nor health-care organizations advise others when a mishap occurs how to prevent from their experiences. Also they do not share what they have learned when an investigation has been carried out. As a consequence, the same mistakes occur repeatedly in many settings and patients continue to be harmed by preventable errors.

One solution to this problem is reporting: by the Consultant, Medical Officer, Nursing Sister, Nursing Officer or other provider within the hospital or health-care organization, and by the organization to a broader audience through a system-wide reporting system. Some believe that an effective reporting system is the cornerstone of safe practice and, within a hospital or other health-care organization, a measure of progress towards achieving a safety culture. At a minimum, reporting can help identify hazards and risks, and provide information as to where the system is breaking down. This can help target improvement efforts and systems changes to reduce the likelihood of injury to future patients.

Objective

The objective of this guideline to facilitate the improvement or development of reporting systems that receive information that can be used to improve patient safety. 85-90% of errors occur due to system failures and only 10-15% of errors due to individual failures. The reporting system mainly focuses on the system failures. This reporting system is not to punish or find fault with any healthcare personnel but to improve the systems for a safe healthcare delivery. Also this reporting allows learning through:

Reporting can lead to learning and improved safety through:

- **Generation of "alerts"** regarding significant new hazards, for example, complications of a new drug.
- **Dissemination of "lessons learnt"** by health-care organizations from investigating a serious event.

- **Analysis of many reports** can reveal **unrecognized trends and hazards** requiring attention, insights into underlying systems failures and generate recommendations for "best practices" for all to follow.

The ultimate success of a reporting system is whether the information from the reporting system is used appropriately to improve patient safety in the healthcare delivery.

A successful reporting and learning system to enhance patient safety should have the following characteristics:

- Reporting is safe (i.e. non-punitive) for the individuals who report. Also reporting should no focus on targeting or find fault with anyone;
- Reporting leads to a constructive response;
- Expertise, adequate resources and training are available to allow for meaningful analysis of reports;
- The reporting system must be capable of disseminating information on hazards and recommendations for changes.

The reporting of incidents is most effective when the data collected are analysed (at local, district as well as national levels with the professional colleges) and recommendations are disseminated and acted upon by those with the responsibility and mandate to act.

Definition of Terms

(WHO Draft Guidelines for Adverse Event Reporting & Learning Systems 2005)

No.	Term	Definition
i	**Safety**	Freedom from accidental injuries.
ii	**Incident (or adverse incident)**	Any deviation from usual medical care that causes an injury to the patient or posses a risk of harm. Includes errors, preventable adverse events, and hazards.
iii	**Adverse event**	An injury related to medical management, rather than the complications of disease. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable.
iv	**"Near-miss" or "close call"**	Serious error or mishap that has the potential to cause an adverse event but fails to do so because of chance or because it is intercepted. Also called potential adverse event.
v	**Hazard**	Any threat to safety, e.g. unsafe practices, conduct, equipment, labels, names.
vi	**System**	A set of interdependent elements (people, processes, equipment) that interact to achieve a common aim.

Guidelines of filling the Adverse Event / Incident Reporting Form (Please find the process of adverse event / incident reporting in Annexure I)

Part A

Part A can be filled by any health care worker in their own language. This may be different from a unit / ward where the patient received treatment. The adverse event / incident form must be completed immediately after the occurrence of the adverse event and the area and people are safe. For example, if a patient had a fall, it is important to attend the patient immediately and give appropriate treatment. Also to see the reason for fall, immediately remove the root cause of a fall (if the fall is due to wet floor, make arrangements to dry the floor area).

Then fill the form. The form should be filled within 24 hours. For the staff working in shift duties, they have to fill the form before they hand over to the staff of next duty shift.

Serious adverse events / incidents **MUST** be reported to the Head of the Institution and the relevant consultant as soon as possible.

All the adverse events related clinical management should be reported by the consultant, Senior Registrar, Registrar, Medical Officer or Intern House Officer. All such reports must be seen by the respective consultant or any other Senior Medical Officer assigned by the consultant.

The adverse events associated with the non-clinical management (such as fall) can be reported by the Nursing Sister or the Nursing Officer.
The nature of the adverse event must be mentioned briefly in the relevant cage. The immediate measures taken to manage the adverse event / incident should mention in the next cage in brief.

Part B

Part B should be filled by the head of the unit. It can be a Consultant, Medical officer, Nursing Sister/in charge nurse, Chief pharmacist, Chief MLT, Chief Radiographer, Officer in-charge of a unit etc.

Root causes and contributing factors relating to the adverse event should write after a brief discussion with relevant staff in the unit / ward. Based on the risk factors, root causes and contributing factors, preventive measures need to be taken or recommended.

The officer writing the form can write the category of staff member who is directly involved adverse event / incident which is optional. Then the outcome an also the type/types of the adverse event / incident should be ticked off. A list of types of adverse events and incident is provided at the other side of the form,

A copy of the form must be retained in the ward. Also s separate register must be maintained to record the details of all the adverse event forms filled and sent to the QMU.

Once the Adverse event/Incident report form is filled it should be sent to the Quality Management Unit (QMU). At the QMU, when the adverse event form is received it must be entered in a designated register. . When a form is received, date and time of the reception should be notified. It is then sent for the information and authorization to the head of the institution after notifying the date and time of notification.

Once it is received the categorization of the adverse event/incident based on the International Classification of Patient Safety should be filled by Quality Management Unit (QMU). It is recommended to consult Head of the Institution. The head of the institution should go through the form and provide his comments and authorize to carry out further root cause analysis if necessary. If Director has requested to further investigate on the adverse event / incident, the MO / QMU should analyze the incident with the relevant consultant and / or other stakeholders. There should not be any criticism or breach of confidentiality at any point of this process. Every attempt should be taken not to find fault with any individual unless there is a gross negligence. During the analysis quality improvement tools such as Why-Why Diagram, Fish-Bone Diagram or Problem Tree can be used.

Prevention action taken based on the adverse event / incident should be written in the form. If there are any other vital facts identified, it should be also mentioned in the form.

Category of Adverse Event / Incident (Adopted from ICPS)

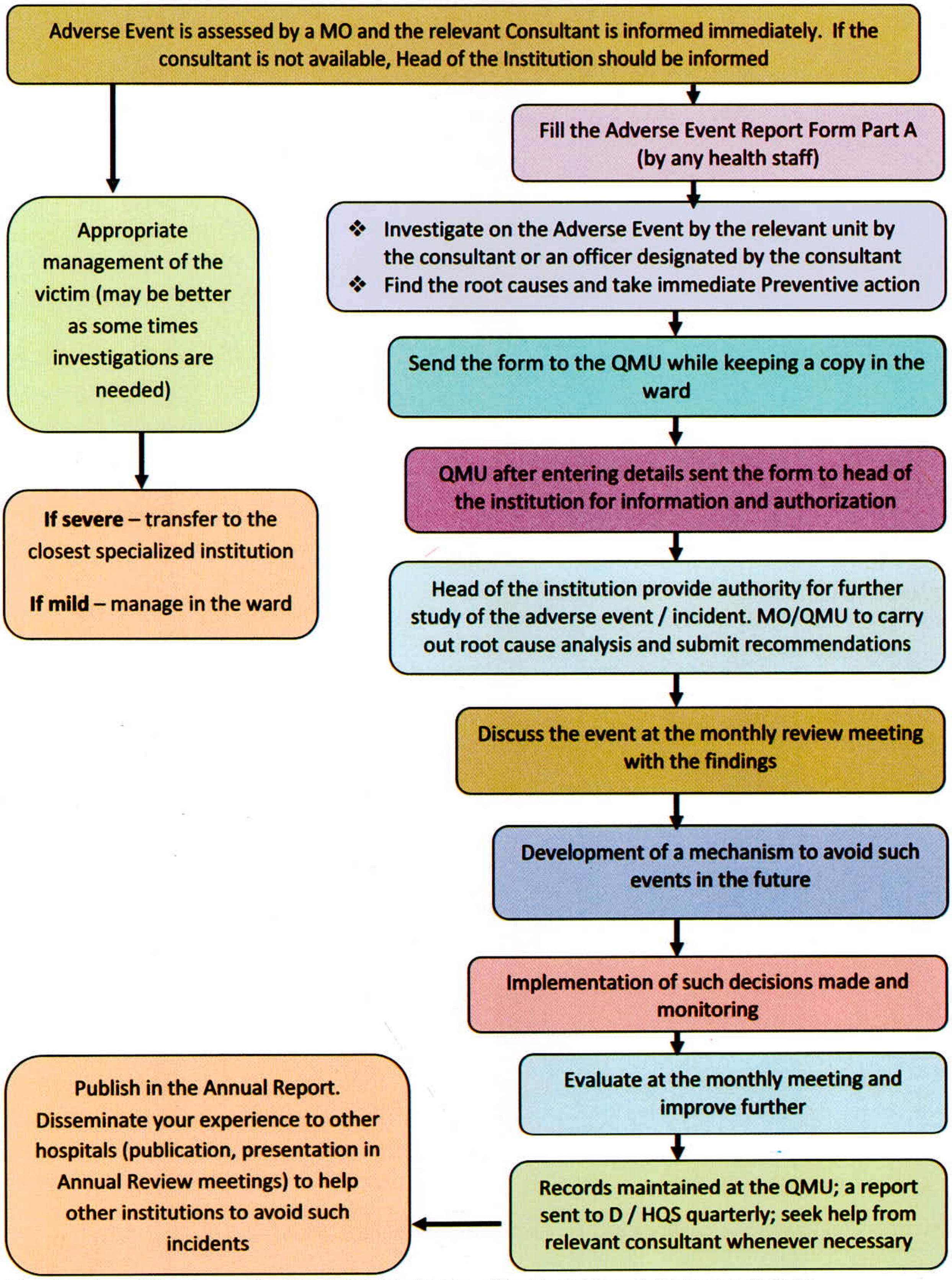
	Category	Example
1	Blood / Blood Products	Request for a blood product for the wrong patient; or blood with the wrong blood type was administered to a patient
2	Clinical Administration	Wrong document were filled out for admission; or a patient was treated by different doctor than previously discussed
3	Clinical Process / Procedure	A delay in treatment due to postponement of surgery; or a diagnosis is missed
4	Documentation	Patient chart was missing; or information on patient chart was incorrect or missing
5	Health care associated infection	Patient develops infection near the surgical site, due to a gauze that has been left behind in the wound
6	Infrastructure	Trolley does not fit into the lift, or a nurse slips on wet floor or a patient fall.
7	Medical / equipment	Computer malfunction or surgical tools that break or are unsterile
8	Medication fluids	Wrong drug is administered to the patient; or patient has not received medication
9	Nutrition	Wrong quantity or wrong sort of drip-feed is administered
10	Oxygen / gas / vapour	Patient returns from procedure and a nurse forgets to connect the oxygen
11	Patient accidents	patient has fallen out of bed; or patient that to connect the oxygen
12	Resources / organizational management	Understaffing or no available beds
13	Behaviour	Treatment of patients by staff was inconsiderate or rude

Certain serious adverse events / incidence can be discussed in the monthly clinical meetings. This is mainly to learn from experience and prevent such events in future in other wards / units. At any point of these meetings, no individual should be criticized.

Then after keeping of this form, a summary of the adverse event / incident should be sent to the Directorate / Healthcare Quality & Safety (D / HQS) of Ministry of Health quarterly. The name of the hospital, the unit and the health personnel involved in the incident need not to mention when sending to the D /HQS. D / HQS will analyze these events and discuss with the relevant professional colleges if there epidemiology or serious adverse events or if there a increasing trend of a particular event / incident.

Annexture I

PROCESS OF HANDLING ADVERSE EVENTS / INCIDENTS



Annexture II

Grading of Incident Severity (Adopted from Department of Health, Social Services and Public Safety in the Northern Ireland)

The initial assessment of an incident should be performed quickly, even when all facts may not be available. There is always scope to re-grade as facts and issues emerge over time and following investigation.

Actual Incident Severity (according to the facts available)

In determining the actual severity consider the outcome of the incident in terms of harm to people / resources / environment / reputation / quality.

Severity of incident   High Level Descriptors

	(see Impact Table for a more detailed list)
Catastrophic	Incident with widespread implications to services
Major	Significant disruption to service
Moderate	Short term disruption to services
Minor	No interruption to services
Insignificant evident	No adverse outcome but risk potential

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Ministry of Health, Nutrition & Indigenous Medicine

Strictly Confidential

Adverse Event / Incident Reporting Form

Hospital..

This form is not intended to penalize anyone. Reporting an incident will help us to prevent such events in the future

Part A:	මෙය ඕනෑම සෞඛ්‍ය සේවා වෘත්තිකයෙකුට සම්පූර්ණ කළ හැක; எந்தவொரு சுகாதார பணியாளராலும் நிரப்ப முடியும்; **Can be filled by any health care worker.**

Category of person affected: Patient ☐ Staff ☐ Visitor ☐

Name of affected person:	Place of occurrence of adverse event: ....
Age:	Reporting ward/unit: ....
Gender: Male ☐ Female ☐	BHT No. (If in patient): ....
Address (optional):	Date of adverse event/incident: dd/mm/yyyy...
	Time of adverse event/incident: ....

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Adverse event/incident (please describe in detail)

Elaborate (If necessary use a separate paper) Date and time of occurrence:

එම අවස්ථාවේ ඒ සම්බන්ධයෙන් ගත් ක්‍රියා මාර්ග; உடனடியாக எடுத்த நடவடிக்கை, **Immediate measures have been taken**

Directorate of Healthcare Quality & Safety, Ministry of Health, Nutrition & Indigenous Medicine

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Part B: To be filled by Head of the unit (Consultant, MO, Nursing Sister, Chief MLT, Chief Pharmacist, Chief Radiographer, in charges of units etc)

Describe the risk factors, root causes leading to the Adverse Event / Incident

Preventive measures recommended by the unit

Action recommended	Person responsible for remedial action	Target time period
		dd/mm/yyyy

Designation of the staff member involved in the adverse event

Consultant ☐ MO ☐ Nursing sister/NOIC ☐ Nurse ☐ Others:...

Outcome of the affected person (Can be more than one. Please tick the relevant outcome/outcomes):

a. Completely recovered ☐ Partially disabled ☐ Permanently disabled ☐

b. Needed hospitalization ☐ Extended hospitalization ☐ Death ☐

Reference list of adverse events/ Incidents (Please select relevant category/categories)

Fall/Safety issues		Treatment/diagnosis issues		Drugs/IV/Blood issues		Surgery/Anaesthesia issues	
Fall from bed/ chair/table		Orders/procedures carried out incorrectly		Omitted drug		Wrong patient identifier to call for surgery	
				Wrong drug		Wrong patient/side/site	
				Drug allergy			
Slip & fall		Orders/procedures on wrong patient		Patient/drug/dose/route /time		Left in patient – swab/ instrument	
Found on floor		Order not carried out/ delay		Dispensing error from pharmacy		Discrepancy in swab/ instrument count	
Climbed over bed rail		Plaster allergy/skin tear		Expired drug		Incorrect/no consent	
		Bed sore		Blood transfusion reaction		Diathermy burn	
Injury while transporting		Doctor not notified/ Doctor did not visit		IV site redness/Phlebitis		Equipment not available/ malfunction	
				Wrong diluents			
Laboratory reports		Medication delayed/ notavailable		**Miscellaneous issues**		Material not available	
Sample lost		Refusal of treatment by patient		Assault to patient/visitor/staff		No PAC	
Label lost		**Labour/Delivery issues**		Coroners' case		Others (Please specify)	
Wrong sample				Missed medical records			
Reports are not delivered on time		Traumatic birth		Therapeutic procedures			
		Forceps injury to infant		Theft			
Report lost		Laceration to neonate		Smoking/substance abuse in ward			
		Unattended delivery		Wrong drug prescribed, administered			

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Ministry of Health, Nutrition & Indigenous Medicine

Guidelines for Reporting of Readmission

Introduction

There are many challenges in precisely defining a readmission. Some of the readmissions may be unavoidable and in fact necessary and pre-decided between the physician and the patient. Others may be avoidable and arise due to possible lapses on the part of the patient or the physician. Finally there might also be cases wherein both the doctor and the patient performed all the required duties but it still resulted in a readmission. Time is another important factor. Usually readmission rates are calculated for 7, 15 and 30 days after the previous discharge. In many cases the patient may opt to get readmitted to a different hospital. Such cases would be technically readmissions but they would be difficult to track. Also it might be possible that the patient is affected by an illness totally unrelated to the initial ailment and had to get readmitted. All such factors need to be taken into account making calculation of readmission rates a complex and cumbersome process.

Tracking the number of patients who experience unplanned readmissions to a hospital after a previous hospital stay is one category of data used to evaluate the quality of hospital care. One example of an unplanned readmission would be someone who is readmitted to the hospital for a surgical wound infection that occurred after his or her initial hospital stay.

It's important to note that unplanned hospital readmissions may or may not be related to the previous visit, and some unplanned readmissions aren't preventable. However, unplanned hospital readmissions are a burden to the health sector.

A significant proportion of patients (3% - 11% in UK) return to hospital within 28 days because complications have arisen related to the condition at the time of admission, their operation, they have acquired an infection during their hospital stay, or rehabilitation has not progressed as planned. An April 2009 *New England Journal of Medicine* article by Stephen F. Jencks reports that 19.6% of Medicare fee for-service beneficiaries who had been discharged from a hospital were readmitted to the hospital within 30 days, 34.0% within 90 days, and more than half (56.1%) within one year of discharge. There is evidence that patients that are readmitted have a longer length of stay than for first admissions and that providers with lower than average lengths of stay for first admission have higher readmission rates. Reducing readmission rates can reduce average length of stay, whereas reducing average length of stay without tackling readmission rates may result in increase in readmission rates.

A ***readmission*** is defined as a unplanned subsequent hospital admission in the same or a different hospital within 30 days after discharge from hospital due to the same illness.

The ***readmission rate for a year is*** defined as:

$$\frac{\text{The number of readmissions in a given year}}{\text{The total number of hospital admission in a given year}} \times 100$$

Objectives of collecting readmission data

- To identify the causes for readmissions.
- To reduce readmissions.

Process of Collecting Readmissions

MO / OPD select readmissions on admission – Indicate it in the BHT by a rubber stamp

↓

Nursing Officer check every BHT and get it confirm it as readmission by a Medical Officer / House Officer and attach readmission form to the BHT by admitting ward Nursing Officer and enter in ward admissions register

↓

Part A should be filled by the Nursing Officer

↓

Part B should be filled by the MO / HO

↓

Duly filled forms should be sent by Nursing Officer in-charge to the Head of the Institution / QMU of the hospital on patient discharge

↓

Analysis of reported readmission by QMU

↓

Preparing a document / including in annual / quarterly reports and dissemination of findings. Quarterly reports should be sent to Directorate Healthcare Quality and Safety and RDHS (Only for Provincial Ministry Hospitals)
Discussing on important readmission findings in clinical meetings / review meetings

The Rubber seal format to be adopted **RE-ADMISSION**

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Ministry of Health, Nutrition & Indigenous Medicine

Readmission Form

Name of the patient... Age...................

Gender: Male ☐ Female ☐

Part A – Should be filled by a Nursing Officer

Details	**Readmission (Current admission)**	**Previous admission**
Name of the Institution		
Ward		
BHT No		
Date of Admission		
Date of Discharge		

Name of the Nursing officer...

Signature....................................... Date....../....../20...

Part B – Should be filled by a Medical Officer/House Officer

Details	**Readmission (Current admission)**	**Previous admission**
Mode of admission	Direct/Transfer/Referral	
Reason for admission		
Diagnosis		

Name of the Medical/House Officer..

Signature....................................... Date....../....../20.................

Directorate of Healthcare Quality & Safety, Ministry of Health, Nutrition & Indigenous Medicine

* Readmission : An unplanned admission to the same or different health institution within30 days of discharge, due to the same or sequelae of the illness.

* Completed form should be forwarded to Director/ Quality Management Unit by Nursing Officer Incharge.