MONTANA DEPARTMENT OF CORRECTIONS

MONTANA STATE PRISON
HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS B-08.0	Subject: **PATIENT SAFETY/CLINICAL ERROR REPORTING SYSTEM**
Reference: NCCHC Standard P-B-08, 2018. HS A-06.0, 2018 Continuous Quality Improvement Program	Page 1 of 2 and two attachments
Effective Date: November 1, 2010	Revised: October 1, 2020, October 1, 2021
Signature / Title: /s/ Cindy Heiner/Medical Bureau Chief	
Signature / Title: /s/ Paul Rees M.D./Medical Director	

I. PURPOSE

To promptly document and report all adverse or near-miss clinical events that may affect or jeopardize the safety of patient and cause potential harm. The intent is to reduce risk and promote patient safety in a non-punitive, professional, and supportive environment.

II. DEFINITIONS

Adverse clinical event – an injury or death caused by medical management rather than by the patients underlying disease or condition. Adverse clinical events occur by omission (failing to do something that is supposed to be done) or commission (doing something that is not supposed to be done).

Near-miss clinical event – an error in clinical activity without a consequential adverse patient outcome.

III. PROCEDURES

A. Documentation Requirements

1. Facility staff will implement patient safety systems to prevent adverse and near-miss clinical events.
2. All health staff must document any observed incident that they believe may affect patient safety by completing an Incident Report in OMIS 3.0. Clinical errors resulting from improper medication administration (i.e., wrong dose, wrong patient, wrong medication) will be documented on an *MSP Infirmary Medication Error Reporting Form.*
3. Incidents requiring documentation include, but are not limited to, clinical errors, whether the error occurs by omission or by commission. Staff must write incident reports in a clear, concise, legible, complete, and accurate manner.

B. Reporting Requirements

1. Health staff will submit completed incident reports to their immediate supervisor. The supervisor will review the report for adequacy, completeness, and clarity.
   a. Supervisors will return reports found lacking in these areas to the reporting staff member with instructions and appropriate guidance for correcting and re-submitting the report(s).
   b. The supervisor will sign adequate reports.
2. The immediate supervisor will determine the routing/distribution of each report, including necessary precautions to protect confidentiality issues, and ensure copies are distributed accordingly.
3. The Clinical Services Manager or designee will analyze each adverse or near miss event in order to drive changes or adjustments to the current operating system.

4. In most cases, the affected patient will be informed when an adverse event has occurred. Patient competency and the significance of the event may determine the appropriateness of disclosure.
5. Written incident reports will be maintained in a secure filing system.
6. Monitoring and evaluation of adverse clinical and near miss events will occur through CQI committee.

IV. CLOSING

Questions concerning this operational procedure will be directed to the Clinical Services Manager.

V. ATTACHMENTS

MSP Infirmary Medication Error Reporting Form New Medication Error Form 2015 revision 1.docx