MONTANA STATE PRISON
OPERATIONAL PROCEDURE

Procedure:	**MSP HS B-08.0 PATIENT SAFETY AND CLINICAL ERROR REPORTING SYSTEM**
Effective Date:	11/01/2010 Page 1 of 2
Revision Date(s):	10/01/2020; 10/01/2021; 06/30/2026
Public Safety Chief Signature:	/s/ John Schaffer, Public Safety Chief
Medical Director Signature:	/s/ Dr. Paul Rees, MD
Health Services Bureau Chief Signature:	/s/ Cynthia McGillis-Hiner, RN, MSN

I. PURPOSE

Promptly document and report all adverse or near-miss clinical events that may affect or jeopardize the safety of patients and cause potential harm. Reduce risk and promote patient safety in a non-punitive, professional, and supportive environment.

II. DEFINITIONS (see Glossary)

III. REQUIREMENTS

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 they believe may affect patient safety by completing an incident report in the offender management system.
   a. Clinical errors resulting from improper medication administration (for example, wrong dose, wrong patient, wrong medication) will be documented on an *HSB Medication Error Report.*
3. Incidents requiring documentation include but are not limited to clinical errors and whether the error occurs by omission or by commission.
4. 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:
   a. determine the routing and distribution of each report, including necessary precautions to protect confidentiality; and
   b. ensure copies of the report are distributed accordingly.

3. The MSP Health Services Manager will analyze each adverse or near miss event in order to drive changes or adjustments to the current process.
4. In most cases, the affected patient will be informed when an adverse event has occurred.
   a. 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 the CQI committee.

IV. CLOSING

Questions about this procedure should be directed to the Medical Health Services Manager.