



Reportable events reporting

When a root cause analysis (RCA) is conducted in Queensland a copy of the RCA report must be sent to the Office of the Health Ombudsman (OHO).

Reporting root cause analysis events to the Health Ombudsman

When a health service provider conducts an RCA in Queensland, a copy of the report must also be sent to the OHO.

This applies to all public and private health service providers, including the Queensland Ambulance Service (see Section 110 of the *Hospital and Health Boards Act 2011* and Section 360 of the *Ambulance Service Act 1991*).

Private health facilities also have the option of giving authority to the chief health officer to forward copies of their RCA reports to the OHO on their behalf.

What information needs to be provided?

RCA reports should include the following information:

- where the event happened
- the type of reportable event
- a description of the event
- the factors that contributed to the event
- any recommendations that might help prevent the same type of event happening again
- 'chain of events' documentation.

When to send RCA reports to the OHO

RCA reports should be sent to the OHO as soon as possible after completion and approval from the RCA commissioning authority.

What about events reviewed using a non-RCA method?

Effective from 1 November 2015, non-RCA reports do not have to be sent to the OHO.

However, if the OHO requires a non-RCA report in order to assess or further investigate a matter, it may request it from the health service provider by way of a formal notice.

Please submit RCA reports to:

Email: reporting@oho.qld.gov.au



What are reportable events?

For public and private health service facilities, a reportable event is defined in the Hospital and Health Boards Regulation 2012 (section 29) as:

- maternal death or serious maternal morbidity associated with labour or delivery
- the death of a person associated with the incorrect management of the person's medication
- the death of a person, or neurological damage suffered by a person, associated with an intravascular gas embolism
- the wrong procedure being performed on a person, or a procedure being performed on the wrong part of a person's body, resulting in the death of the person or an injury being suffered by the person
- the retention of an instrument, or other material, in a person's body during surgery that requires further surgery to remedy the retention
- the death of a person, or an injury suffered by a person, associated with a haemolytic blood transfusion reaction resulting from the wrong blood type being used for the person during a blood transfusion
- the suspected suicide of a person receiving inpatient healthcare
- the suspected suicide of a person with a mental illness who is under the care of a provider of mental health services while residing in the community
- any other death of a person, or an injury suffered by a person, that was not reasonably expected to be an outcome of the health service provided to the person.

Reporting requirements for the Queensland Ambulance Service

For the Queensland Ambulance Service, a reportable event is defined in the *Ambulance Service Act 1991* (section 36A) as any of the following events happening while an ambulance service is being provided to a person:

- the death of the person, or permanent injury suffered by the person, while giving birth
- the death of the person caused by the incorrect management of the person's medication
- the death of the person, or neurological damage suffered by the person, caused by an intravascular gas embolism
- the death of the person, or permanent loss of function suffered by the person, unrelated to the natural course of the person's medical condition for which he or she was receiving the ambulance service
- the death of the person, or permanent injury suffered by the person, contributed to by an unreasonable delay in the provision of the ambulance service or a failure to meet recognised standards for providing the ambulance service
- the wrong procedure being performed on the person or a procedure being performed on the wrong part of the person's body.

For more information on the Office of the Health Ombudsman visit our website:
www.oho.qld.gov.au