MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: PATIENT AND VISITOR EVENT REPORTING

DEPARTMENT OVERSIGHT AND MAINTENANCE: Administrative

POLICY:

1. Any patient or visitor incident not consistent with normal operations or which results in an unexpected outcome or bodily harm, or creates the potential risk of such, including near misses, will be reported via the Event Reporting System.

2. The individual directly involved in, observing, or discovering the incident is responsible for initiating report in the Event Reporting System. The report must be submitted into the Event Reporting System prior to the end of the individual's shift.

3. The department manager and director must review any assigned incidents within **5 business days** of receipt.

   *Higher level severity incidents as scored by the individual entering the incident at 5 or above must be reviewed within **72 hours**.*

   The department manager and director must complete investigation of the incident within **10 business days** of the event.

4. When an incident involves actual or suspected serious harm or injury the department manager and Patient Safety Risk Officer are to be verbally notified and the notification documented in the incident report.

5. The department manager is required to verbally escalate the incident involving actual or suspected serious harm or injury to a member of the site executive team defined as the Chief Operating Officer, Chief Nursing Officer and Chief Medical Officer, to document the verbal escalation in the incident report follow up as well as task the incident via the Event Reporting System to the member of the executive team.

6. When an incident involves serious or suspected harm or injury related to a practitioner's practice and/or medical decision-making, the Patient Safety Risk Officer will verbally notify the Chief Medical Officer, document the verbal escalation in the incident report as well as task to the Chief Medical Officers the incident via the Event Reporting System.

7. Incident reports are used to track and trend events to prevent recurrence or to proactively change processes within the organization.

DEFINITIONS:

Incident: Any event or outcome that is inconsistent with normal operations or expected outcome. Actual injury need not occur for an event to be considered an incident. The potential for injury is sufficient for an event to be considered an incident. An Incident may take place in the hospital or in areas under the management or control of Mount Carmel Health System.

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Near Miss: Any event that is inconsistent with normal operations, policy or procedure that was caught or detected before it could reach the patient.

Reported Severity: A harm score initially assigned to an incident. This score is assigned by the individual entering the incident into the Event Reporting System.

Actual Severity: A harm score assigned to an incident in Event Reporting System by the Patient Safety Risk Officer.

Harm: Death, temporary, or permanent impairment of body function or structure which requires an intervention. Intervention includes but is not limited to: monitoring, extended hospitalization, a change in the level of care, change in therapy, medical and surgical treatment. Severity of harm is scored in Event Reporting System as follows:

0 – N/A or Unknown
1 – Event has capacity to cause error
2 – Event did not reach patient
3 – Event reached patient, caused no harm
4 – Patient monitored/treated to preclude harm
5 – Temporary harm to patient
5a – Event caused emotional harm to patient
5b – Event required patient transfer to another facility
6 – Event caused temporary harm/prolonged hospitalization
7 – Event contributed to permanent harm
8 – Event required intervention to sustain patient life
9 – Event contributed to patient death

Event Reporting System: Electronic reporting system for incidents, concerns, and events involving patients, visitors, students, and vendors, i.e. VOICE.

PROCEDURE FOR RESPONDING TO PATIENT INCIDENT:

1. The patient's physician is to be notified as soon as possible, and not later than the end of an individual's shift for all incidents that impact patient outcome, or for which there is any risk for harm. The individual identifying the event or providing direct care for the patient is responsible for this notification. The patient's physician must be notified immediately of any medication errors, adverse drug reactions, or drug incompatibilities.

2. The department manager and the Patient Safety Risk Officer shall be verbally notified as soon as possible when an incident occurs involving serious or suspected patient injury or harm. During off shifts, the administrative supervisor should be notified. If unsure if an event caused serious patient injury, contact the Patient Safety Risk Officer.

SUBJECT: PATIENT AND VISITOR EVENT REPORTING

3. If any equipment or a device is believed to be involved in the event, retain and remove equipment and device from service. Contact Clinical Engineering and tag the equipment for repair.

4. If a piece of equipment is believed to be involved in an event of serious or suspected patient injury or harm, refer to the Safe Medical Device Reporting and Recall Management Policy.

5. The individual directly involved in, observing, or discovering the incident is responsible for initiating an Event Reporting System report of the event. The Event Reporting System report must be submitted prior to the end of the individual's shift.
   a. Reporter identification is optional.
   b. The event report is not part of the medical record and is privileged, confidential, and protected from discovery by Ohio Revised Code 2305.24, 2305.25, 2305.252, 2305.253.
   c. Document the event within the medical record using factual statements and opinions.
   d. Do not mention in the medical record that an incident report or any other type of incident report has been completed.

6. Security is to be notified for issues of alleged abuse, criminal events, property damage/loss, or suspicious activities immediately. Refer to Administrative Policy: *Abuse – Investigation of Alleged Abuse or Alleged Criminal Activity by Associate, Volunteer, Physician.*

7. Any requests for an incident report should be referred to the Patient Safety Risk Management department.

PROCEDURE FOR RESPONDING TO VISITOR INCIDENT:

1. Hospital Sites: notify Security and House Supervisor. Emergency Department services may be offered to an injured visitor; however, no commitment should be made regarding payment for treatment services.

2. Hospital Off-Sites: Notify your departmental manager. Emergency Department services may be offered to an injured visitor; however, no commitment should be made regarding payment for treatment services.

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: PATIENT AND VISITOR EVENT REPORTING

REFERENCES

Centers of Medicare/Medicaid Services: Conditions of Participation, A-0508, 482.25 (b)(6), December 1, 2015
MCHS Safety Management Plan
Administrative Policy: "Serious Safety Event, *Sentinel Event, Serious Reportable Event*"
Administrative Policy: "*Abuse – Investigation of Alleged Abuse or Alleged Criminal Activity by Associate, Volunteer, Physician".*
Administrative Policy: *"Safe Medical Device Reporting & Recall Management"*
The Joint Commission Standards: Performance Improvement
Trinity Health EVENT REPORTING SYSTEM Training Guide Revised 5/2/18

DEVELOPED BY: Patient Safety-Risk Management

ORIGINAL ISSUE DATE: MCSA 7/84; MCW 4/87; MCE 3/90

REVIEW/REVISION DATES: MCSA – 6/93, 5/97; MCW – 5/88, 10/89; MCE – 3/91, 9/92, 3/93; 3/98* (combination of 2 facility policies); 2/00, 1/02, 1/04, 10/05, 1/06, 12/07, 11/09, 10/11, 12/13, 7/16, 5/18, 1/19, 12/20

REPLACES: Administrative P/P "VOICE: Incident or Occurrence Reporting"

REVIEWED BY: Administrative Policy Team 1/05/21

Holly Reardon 1/08/21
Vice President Date

APPROVAL FOR IMPLEMENTATION BY: Accreditation Council
DATE: via email vote 1/14/21

SUBJECT: PATIENT AND VISITOR EVENT REPORTING

APPENDIX A: EVENT REPORTING SYSTEM INCIDENT REPORTING

ANESTHESIA/SEDATION (ANES/SED)

ANES/SED-Cancellation
ANES/SED-Consent missing / inadequate
ANES/SED-Dental Damage
ANES/SED-Intubation Issue
ANES/SED-Lightening / Awakening / Awareness
ANES/SED-Other, specify in comments
ANES/SED-Over sedation
ANES/SED-Pre/Post OP assessment
ANES/SED-Reaction
ANES/SED-Unexpected adverse outcome
ANES/SED-Use of Reversal Agent

EQUIPMENT/SUPPLIES/DEVICE (EQP/SUP/DEV)

EQP/SUPP/DEV-Inadequate Sterilization/ Cleaning
EQP/SUPP/DEV-Clinical Alarm Issue
EQP/SUPP/DEV-Disconnected
EQP/SUPP/DEV-Equipment/ Supplies Not Available
EQP/SUPP/DEV-Failure/ malfunction
EQP/SUPP/DEV-Leakage
EQP/SUPP/DEV-Missing
EQP/SUPP/DEV-Other, specify in comments
EQP/SUPP/DEV-Patient owned equipment issue
EQP/SUPP/DEV-Unauthorized equipment/ device/ supply
EQP/SUPP/DEV-User Error
EQP/SUPP/DEV-Wrong Equipment/Device/Supplies

IDENTIFICATION (ID)

ID-Discharge to wrong caregiver
ID-Discharge/follow up instruction/prescription given to wrong person
ID-Documentation in wrong patient chart
ID-Duplicate record created
ID-Error in patient transfer / transport
ID-Gender Identity issue
ID-HIPAA/ Confidentiality
ID-ID Incorrect
ID-ID Missing
ID-ID Specimen Mismatch
ID-Identity Absent
ID-Identity Illegible
ID-Identity Theft
ID-Information from prior encounter not updated
ID-Monitoring Issue
ID-Not Verified
ID-Other, specify in comments
ID-Patient associated with another patient's record
ID-Patient identity not verified
ID-Referral/ consult on wrong patient
ID-RFID misapplied/ malfunction
ID-Specimen, label v. requisition
ID-Specimen, unlabeled
ID-Unlabeled
ID-Wristband identifiers incorrect
ID-Wristband illegible/ unreadable
ID-Wristband missing/ not applies
ID-Wrong demographics
ID-Wrong MRN or CPI
ID-Wrong name or spelling of name
ID-Wrong patient/ resident registered

NON-PATIENT/VISITOR (NON-PT-VIS)

NON-PT/VIS-Needle Stick (non-colleague)
NON-PT/VIS-Other, specify in comments
NON-PT/VIS-Visitor Accident / Injury
NON-PT/VIS-Visitor Fall

SKIN INTEGRITY (SKIN))

SKIN-Abrasion/ Skin Tear
SKIN-Blister
SKIN-Bruise Contusions
SKIN-Burn
SKIN-Deep Tissue Injury (DTI)
SKIN-Incontinent Dermatisis
SKIN-Ischemic Skin Event
SKIN-Laceration
SKIN-Moisture Associated Skin Damage (MASD)
SKIN-Other, specify in comments
SKIN-Pressure Injury Stage 1
SKIN-Pressure Injury Stage 2
SKIN-Pressure Injury Stage 3
SKIN-Pressure Injury Stage 4
SKIN-Pressure Injury to be staged
SKIN-Pressure Injury Unstageable
SKIN-Rash/ Hives (Non ADR)

TRANSFUSION (TRANS)

TRANS-ABO Blood Complication
TRANS-Adverse Reaction
TRANS-Availability
TRANS-Blood Band Missing
TRANS-Consent Issue
TRANS-Cross Match Issue
TRANS-Omitted
TRANS-Other, specify in comments
TRANS-Patient-Incorrectly Collected
TRANS-Patient-Wrong Transfused
TRANS-Patient-Wrong Requested
TRANS-Process Dispensing/ Distribution Issue
TRANS-Process-Event Related Blood Product Administration
TRANS-Process-Wrong Patient Requested
TRANS-Product-Expired
TRANS-Product-Unused not returned
TRANS-Product-Wasted
TRANS-Product-Wrong Component Issued
TRANS-Product-Wrong Component Requested
TRANS-Special Product needed not requested
TRANS-Special Product needed not issued
TRANS-Storage incorrect
TRANS-Transfusion not completed within policy timeframe
TRANS-Transfusion not started when product received
TRANS-Transfusion not started within Policy timeframe
TRANS-Transfusion Reaction
TRANS-Unit Mismatched

COMMUNICATION / DOCUMENTATION (COMM/DOC)

COMM/DOC-Critical Value Issue
COMM/DOC-Delay No response (provider/ caregiver delay)
COMM/DOC-DNR Designation issue
COMM/DOC-Documentation altered
COMM/DOC-Documentation done on wrong chart
COMM/DOC-Documentation inadequate
COMM/DOC-Guardianship Issue
COMM/DOC-Hand Off/ Transfer Issue
COMM/DOC-Medical Record Missing
COMM/DOC-Medical Record missing page (s)
COMM/DOC-Other, specify in comments
COMM/DOC-Restraints-No Order
COMM/DOC-Results reported on wrong patient
COMM/DOC-Wrong chart retrieved/ accessed
COMM/DOC-Wrong patient records in chart/ no pt. information

SUBJECT: PATIENT AND VISITOR EVENT REPORTING

APPENDIX A: EVENT REPORTING SYSTEM INCIDENT REPORTING

PATIENT FALL (PT FALL)

FALL-Ambulating/ Walking
FALL-During Patient Transfer
FALL-Employee assisted patient to floor
FALL-Found on floor (not toileting related)
FALL-From Bed
FALL-From Chair/ Gerichair/ Stool
FALL-From Crib
FALL-From Equipment
FALL-From Go Cart/ Push Cart
FALL-From OR/ Procedure/ Exam Table
FALL-From Play Equipment
FALL-From Standing Position
FALL-From Stretcher/ Gurney
FALL-From Wheelchair
FALL-Infant Fall
FALL-Other, specify in comments
FALL-Reported by Pt/ Family/ Representative
FALL-Suspected Intentional Fall
FALL-Toileting
FALL-While Playing
FALL-While Showering

PATIENT CARE PROCESS (PT CARE)

PT.CARE-Administrative Discharge
PT.CARE-Airway Management Issue
PT.CARE-Airway-Unplanned self extubation
PT.CARE-Alleged Abuse
PT.CARE-AMA-Pt. left against medical advise
PT.CARE-Dislodgement/ self removal
PT.CARE-ED-Potential EMTALA Violation
PT.CARE-ED-Return to ED requiring admission w/same complaint w/i 48 hrs
PT.CARE-ED-X-Ray/ EKG final read discrepancy
PT.CARE-Elopement involving involuntary patient
PT.CARE-Elopement-Leaving w/out notice
PT.CARE-Exposure-Body Fluid
PT.CARE-Failure to follow chain of command
PT.CARE-Failure to follow hand hygiene protocol
PT.CARE-Failure to isolate patient
PT.CARE-Food tray-delivered to a pt. who is NPO
PT.CARE-Food tray-metal utensils on a tray for a suicidal pt.
PT.CARE-Food tray-with item a pt. is allergic to
PT.CARE-Food tray-wrong tray delivered
PT.CARE-Hospital acquired DVT
PT.CARE-Hospital acquired Pulmonary Embolism
PT.CARE-Mismatch between patient and monitoring assignment
PT.CARE-Monitoring Inadequate/Lacking
PT.CARE-Other, specify in comments
PT.CARE-Refusal of treatment/test/procedure/medication/discharge
PT.CARE-Restraints used w/in past week and contributed to death
PT.CARE-Restraints-Death or injury associated with restraints
PT.CARE-Restraints-Death or injury-pt in restraints w/in previous 24 hrs.
PT.CARE-Transfer to Emergency Department
PT.CARE-Unexpected transfer to another facility
PT.CARE-Ventilator setting wrong/changed without authorization

MATERNAL / CHILDBIRTH (MAT/CHILD)

MAT/CHILD-Abduction
MAT/CHILD-Active 2nd Stage Labor Delay >4 hrs.
MAT/CHILD-Antenatal Screen Test Misdiagnosis
MAT/CHILD-Attempted or successful VBAC with complication
MAT/CHILD-Birth Trauma/ Complication Fetal
MAT/CHILD-Birth Trauma/ Complication Maternal
MAT/CHILD-Delayed C-Section
MAT/CHILD-Infant Death
MAT/CHILD-Infant discharged to wrong family
MAT/CHILD-Infant Fall
MAT/CHILD-Intrapartum Fetal Death
MAT/CHILD-Low Apgar
MAT/CHILD-Maternal Death
MAT/CHILD-Other, specify in comments
MAT/CHILD-Post-partum Hemorrhage
MAT/CHILD-Post-partum Hemorrhage Vaginal Delivery >500 ml
MAT/CHILD-Post-partum Hemorrhage Vaginal Delivery >1000 ml
MAT/CHILD-Retained Placenta
MAT/CHILD-Unattended Delivery
MAT/CHILD-Undiagnosed/ untreated Hyperbilirubinemia
MAT/CHILD-Unplanned Transfer-Infant
MAT/CHILD-Unplanned Transfer-Mother

SURGERY / PROCEDURE (SURG/PROC)

SURG/PROC-Break in Sterile technique
SURG/PROC-Break Sterile Field
SURG/PROC-Cardiac arrest during procedure
SURG/PROC-Count Incomplete
SURG/PROC-Count Incorrect, Needle
SURG/PROC-Count Incorrect, Sponge
SURG/PROC-Count Incorrect, Instrument
SURG/PROC-Count not performed
SURG/PROC-Death following/ during Surg/ invasive procedure
SURG/PROC-Other, specify in comments
SURG/PROC-Procedure Canceled/ not performed
SURG/PROC-Procedure Delay
SURG/PROC-Retained Foreign Body-Intentional
SURG/PROC-Retained Foreign Body-POA Present on admission
SURG/PROC-Retained Foreign Body-Unintentional
SURG/PROC-Surgical Burn
SURG/PROC-Surgical Fire
SURG/PROC-Transplantation of organs to unintended recipients
SURG/PROC-Unexpected complications intra-operative
SURG/PROC-Unexpected complications-post surgery/procedure
SURG/PROC-Unexpected transmission of infectious disease to a recipient
SURG/PROC-Unexpected transplant of organs of mismatched blood types
SURG/PROC-Universal Protocol not followed
SURG/PROC-Unordered procedure performed
SURG/PROC-Unplanned return to OR
SURG/PROC-Wrong Procedure
SURG/PROC-Wrong Site

SUBJECT: PATIENT AND VISITOR EVENT REPORTING

APPENDIX A: EVENT REPORTING SYSTEM INCIDENT REPORTING

DISRUPTIVE BEHAVIOR (DB)

DB-Assaultive Behavior
DB-Criminal-Alleged
DB-Family/ Visitor causing disruption
DB-Physical Aggression
DB-Property Damage
DB-Sexual Behavior
DB-Verbal Behavior Issue

HEALTH INFORMATION TECHNOLOGY (HIT)

HIT-Administrative/practice management/registration /appointment scheduling system
HIT-Clinical Decision support system
HIT-Clinical Documentation-Incorrect Entry
HIT-Computerized Prescriber Order Entry
HIT-Electronic medication administration record (eMAR)
HIT-Emergency Department Information System
HIT-Human interface device (e.g. hardware, keyboard, mouse, touchscreen
HIT-Incorrect entry resulting in human harm
HIT-Laboratory Information System (LIS) including pathology and microbiology systems
HIT-Information System
HIT-Operating Room Information System
HIT-Other, specify in comments
HIT-Pharmacy System
HIT-Radiology Information System (RIS) including picture archiving and comm. system (PACS)

MEDICATION / IV EVENT (MED/IV)

MED/IV-Adverse Drug Reaction
MED/IV-Automated dispensing machine issue
MED/IV-Barcode Issue
MED/IV-Contraindicated-Drug-Disease
MED/IV-Contraindicated-Drug-Drug
MED/IV-Contraindicated-Drug-Food
MED/IV-Contraindicated-Known Allergy
MED/IV-Controlled Substance Discrepancy
MED/IV-Delay in Medication Administration
MED/IV-Duplicate Therapy
MED/IV-Expired Product
MED/IV-Extra Dose
MED/IV-Home Medication Issue
MED/IV-IV-Dislodgment/Self removal
MED/IV-IV-Incorrect Flow Rate
MED/IV-IV-Infiltration/Extravasation/Pain/Phlebitis
MED/IV-IV-Outdated Site
MED/IV-Lack of availability of medication
MED/IV-Medication Labeling Issue
MED/IV-Medication Reconciliation Issue
MED/IV-Omitted/Not given
MED/IV-Medication Shortage
MED/IV-Other, specify in comments
MED/IV-Overdose
MED/IV-Prescribing Error
MED/IV-Prescription(s) not given on discharge
MED/IV-Refused
MED/IV-Strength/Concentration Issue
MED/IV-Unordered
MED/IV-Wrong administration technique
MED/IV-Wrong dosage form
MED/IV-Wrong Dose
MED/IV-Wrong Frequency
MED/IV-Wrong Medication
MED/IV-Wrong Medication Preparation
MED/IV-Wrong Patient
MED/IV-Wrong Route
MED/IV-Wrong Time

SAFETY/SECURITY/ENVIRONMENT (SAF/SEC/ENV)

SAF/SEC/ENV-Bomb Threat
SAF/SEC/ENV-Construction Related
SAF/SEC/ENV-Contraband/Drug/Paraphenalia
SAF/SEC/ENV-Electrical Related
SAF/SEC/ENV-Elevator/Escalator/Revolving Door Related
SAF/SEC/ENV-Exposure-Airborn/Chemical/ Contamination/Poisoning
SAF/SEC/ENV-Fire
SAF/SEC/ENV-Hazardous Spill
SAF/SEC/ENV-Improper Storage-Chemical
SAF/SEC/ENV-Improper Storage-Equipment
SAF/SEC/ENV-Lighting of Facility/Parking Areas
SAF/SEC/ENV-Natural Disaster
SAF/SEC/ENV-Other, specify in comments
SAF/SEC/ENV-Parking Lot Related
SAF/SEC/ENV-Property Damage/Lost/Stolen
SAF/SEC/ENV-Security Issue
SAF/SEC/ENV-Smoking on Hospital Property
SAF/SEC/ENV-Suspicious Package
SAF/SEC/ENV-Theft
SAF/SEC/ENV-Unauthorized Access/Trespassing
SAF/SEC/ENV-Water leak/Flood
SAF/SEC/ENV-Weapon

TEST / TREATMENT (TST/TRTMENT)

TST/TRTMENT-Contrast Reaction
TST/TRTMENT-Critical Value Issue
TST/TRTMENT-Delay in Treatment/Testing
TST/TRTMENT-Missed Treatment
TST/TRTMENT-MRI Safety Issues
TST/TRTMENT-Other, specify in comments
TST/TRTMENT-Radiation Exposure
TST/TRTMENT-Radiation Misadministration
TST/TRTMENT-Reported results missing identifiers
TST/TRTMENT-Result Delayed
TST/TRTMENT-Result Missing
TST/TRTMENT-Specimen Quality Event
TST/TRTMENT-Specimen, Lost
TST/TRTMENT-Test/Treatment-not ordered
TST/TRTMENT-Test/Treatment ordered-not performed
TST/TRTMENT-Wrong Patient
TST/TRTMENT-Wrong Patient Specimen
TST/TRTMENT-Wrong Site
TST/TRTMENT-Wrong Test Performed

SUBJECT: PATIENT AND VISITOR EVENT REPORTING

APPENDIX B: INITIATING AN EVENT

How to Initiate an Incident Report in the Event Reporting System (VOICE)

Enter a report on any patient or visitor, on any event not consistent with normal operations or resulting in an unexpected outcome or harm to the patient or potential risk of such including near misses. The individual directly involved in, observing, or discovering the incident is responsible for entering the event report.

- Location- open the VOICE application @ MC
- Choose "submit as myself" which will bring up a login for your Network ID and Password or choose "anonymously"
- Any Colleagues, Physicians, Residents may submit events
- Find a form- second icon on the left tool bar will bring up your icon wall
- Select an icon from the wall by hovering over the icon that is most representative of the event:

New File – Icon Wall

- Then proceed to fill out the file submission
- Classification of person affected- Drop box usually inpatient, outpatient, or visitor
- Then fill out all mandatory fields indicated by green asterisk*

File Submission

Person Affected

SUBJECT: PATIENT AND VISITOR EVENT REPORTING

APPENDIX B: INITIATING AN EVENT

- Reported severity level is based on what you know at the time of the event. Examples below:

    - 0 – NA or Unknown
      A patient leaves AMA (Against Medical Advice)
    - 1 – Event has capacity to cause error
      Patient transferred to the floor without hand off of care
    - 2 – Event did not reach patient
      Patient specimen mislabeled and staff notified lab prior to any results posting in the EMR
    - 3 – Event reached patient no harm
      Delay in procedure due to unavailability of transport staff
    - 4 – Patient monitored/treated to preclude harm
      Patient fell and bumped their arm on the side of the bed. X-ray of arm negative for fracture
    - 5 – Temporary harm to patient
      Patient's IV infiltrated during infusion of fluid causing swelling
    - 5a – Event caused emotional harm to patient
    - 5b – Event required patient transfer to other facility
      Delay in recognition of a pre-hospital fall requiring transport of patient to a trauma center
    - 6 – Event caused temporary harm/prolonged hospitalization
      Patient was not mobilized according to order resulting in increased weakness which delayed discharge for physical therapy
    - 7 – Event contributed to permanent harm
      Insufficient dry time of skin prep in the OR where the bovie caused a significant burn leading to scarring
    - 8 – Event required intervention to sustain life
      Patient in the OR for elective knee surgery, bradycardia noted on the monitor during induction of anesthesia and patient went into cardiac arrest. Resuscitative measures initiated and patient transferred to ICU
    - 9 – Event caused/contributed to death
      Patient fell, hit head and CT showed subdural hematoma leading to patient's death

- The details of the event include a brief factual description of what you know about the event: who, why and how the event happened and patient outcome, if known.
- The department is the location unit or area where the event or error happened
- Remember to click on the green submit button on the right lower corner of the report and submit

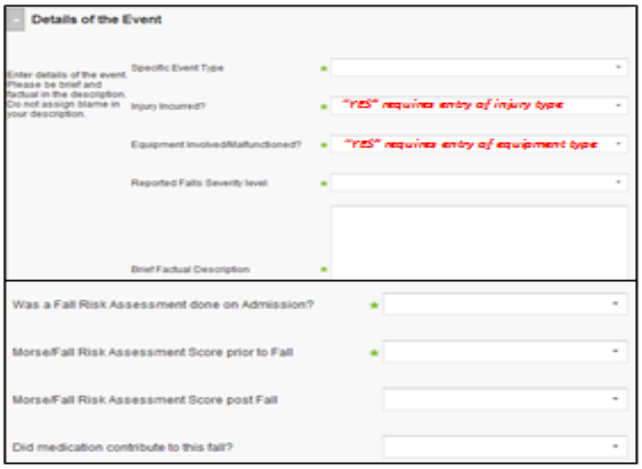
SUBJECT: PATIENT AND VISITOR EVENT REPORTING

APPENDIX B: INITIATING AN EVENT

- Please avoid use of e-mails about event reports as they are discoverable, enter any additional details or timelines to the event report.

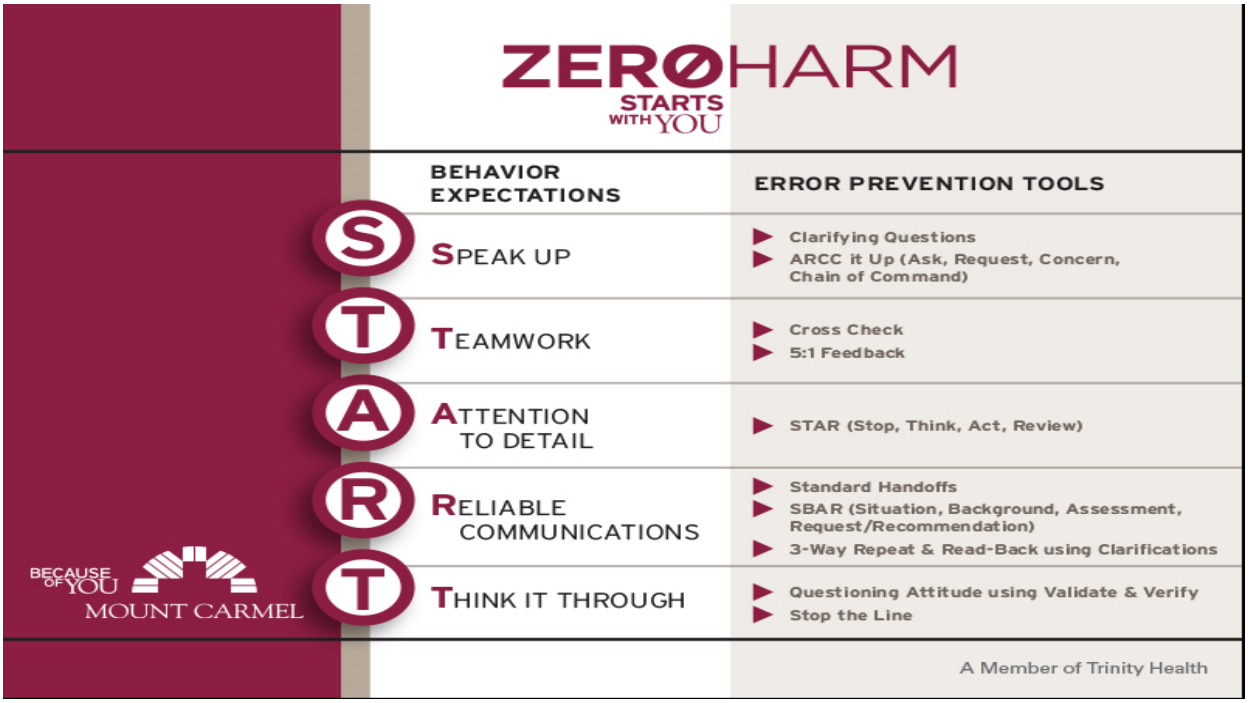
File Submission - Please remember employee injury goes into 'THEIR'.

Details of the Event



Department is the unit where the event or error happened

The location fields must be completed in order (descending).



SUBJECT: PATIENT AND VISITOR EVENT REPORTING
APPENDIX C: INVESTIGATION INTO INCIDENT REPORT

Expectations for Investigation into an Incident Report

Incident reports are used to track and trend events to prevent recurrence or to proactively change processes within the organization.
Important reminders regarding patient events:

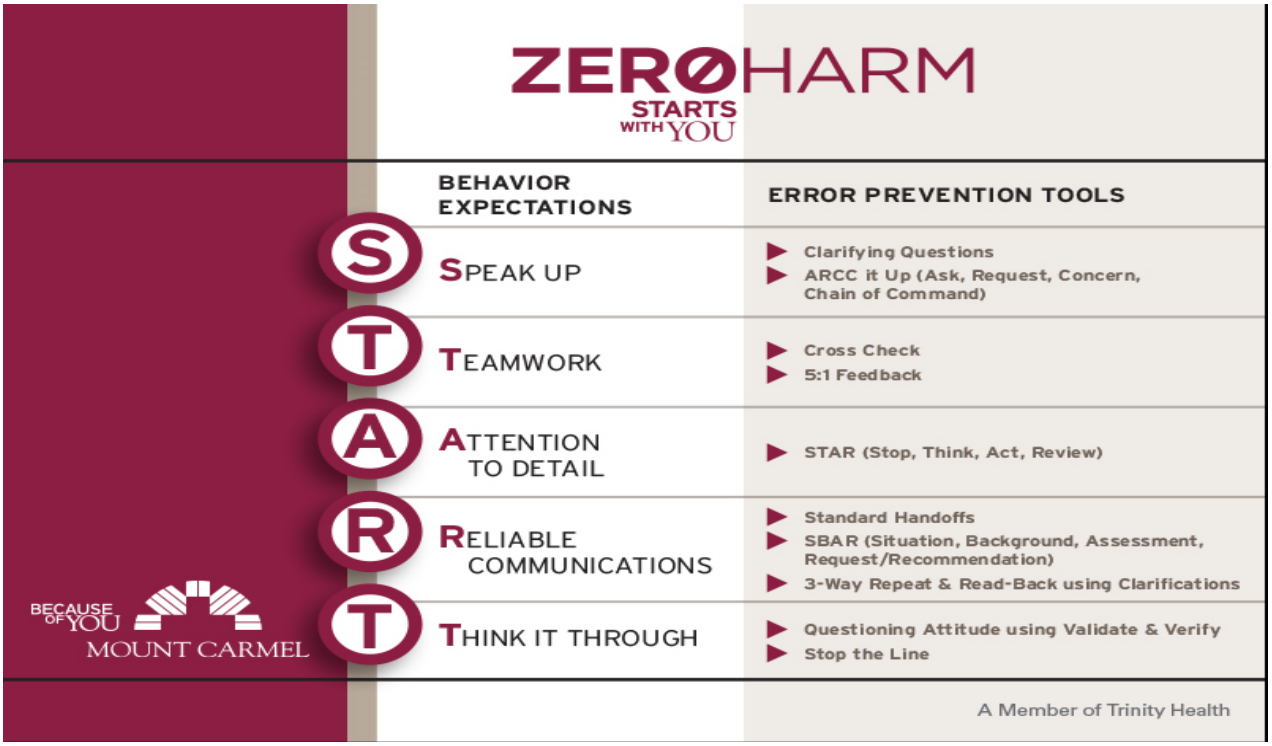
- If equipment or a device is believed to be involved in the event, retain and remove the item from service and contact Clinical Engineering.
- Department Managers/Directors review any tasks or VOICE files that are assigned to them **within 5 business days** of receiving the event. Events with a reported severity level of 5 or above will be reviewed **within 72 hours**
- Department Managers/Directors must complete their investigation, including resolution, into the event within **10 business days** of receiving the event and input findings into the VOICE system
- When an incident involves actual or suspected serious harm or injury the department manager and Patient Safety Risk Officer are to be **verbally** notified. The department manager is required to **verbally** escalate to a member or the site executive team defined as the COO, CNO, VPMA. The notification must be documented in the incident report.
- When an incident involves serious or suspected harm or injury related to a practitioner's practice and/or medical decision-making, the Patient Safety Risk Officer will **verbally** notify the Chief Medical Officers, document the verbal escalation in the incident report as well as task to the Chief Medical Officers the incident via the Event Reporting System.

The investigation into an event should include:

1. Any further details about what happened and the patient outcome.
2. What was done immediately to stabilize the situation if necessary?
3. What contributed to the event and why did it happen?
    - What normally happens? What does the procedure/process/policy require? Was that followed? Was the person involved aware of requirements?
4. What preventative actions have been put into place to prevent reoccurrence?
5. What ZeroHarm behavior expectations and subsequent error prevention tool(s) may have prevented the event?

Apparent Cause Analysis is a tool that provides a framework for investigation into an event, resolution, and actions to prevent recurrence. An Apparent Cause Analysis will be performed by the Manager/Director if requested by the Executive Leadership Team or if requested by the Patient Safety Risk Officer. Any Manager/Director may also initiate and complete an Apparent Cause Analysis. **If an Apparent Cause Analysis is completed on an incident in Event Reporting System, it can be attached to the report as the investigation.**

SUBJECT: PATIENT AND VISITOR EVENT REPORTING
APPENDIX C: INVESTIGATION INTO INCIDENT REPORT



Example:

Arterial blood gases were drawn from a patient's right arm who was on limb precautions with the appropriate band in place. The patient's nurse informed the respiratory therapist that the patient's right arm cannot be used for needle sticks.

In the Add Follow up section, click Work Done on File to add free text.

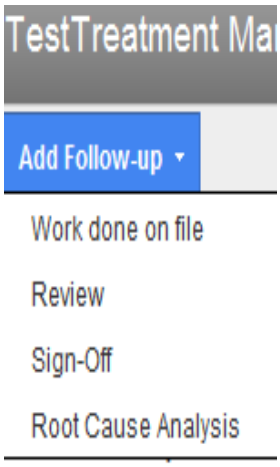
1. The patient had a history of breast cancer with surgery and related limb precautions. The patient had the appropriate wrist band on.
2. The RN informed the RT that the right arm could not be used for any lab draws or IV's.
3. The patient had a decreased level of consciousness and was unable to tell the RT not to use the arm which may have contributed. The RT was not familiar with this band or policy and did not take the time to determine what it meant.
4. The RT was educated on checking bands along with patient identification for any restrictions prior to drawing blood. This was also discussed in unit-based safety huddles for shared learning.
5. Attention to Detail along with STAR could have prevented this event.

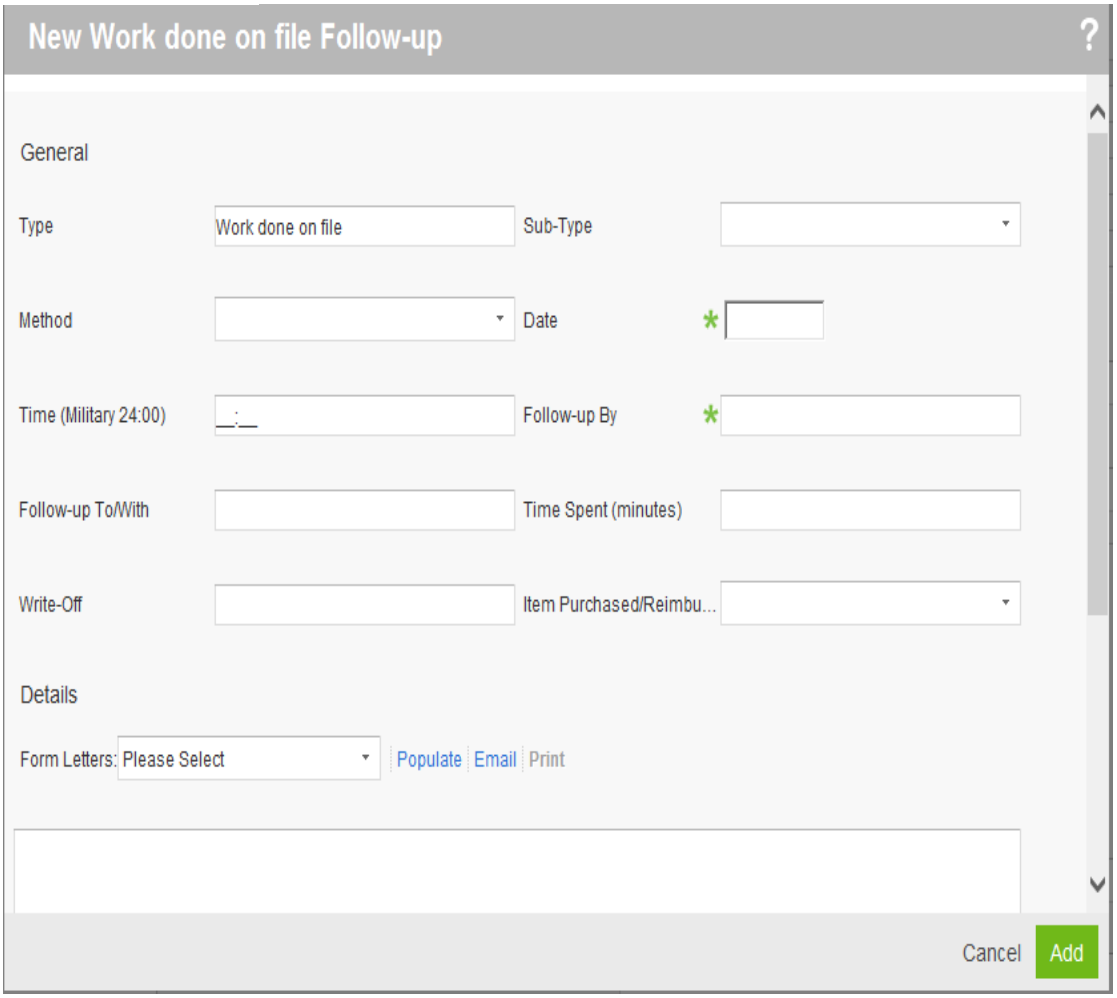
SUBJECT: PATIENT AND VISITOR EVENT REPORTING

APPENDIX C: INVESTIGATION INTO INCIDENT REPORT

MOUNT CARMEL
POLICY/PROCEDURE

SUBJECT: PATIENT AND VISITOR EVENT REPORTING





SUBJECT: PATIENT AND VISITOR EVENT REPORTING

Once this is completed, click on "Add follow-up" Sign-off and complete the form.