

# Electronic Patient Incident Reporting at STVHCS

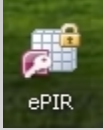
Guide to e-PIR

(Electronic Patient Incident Reporting)

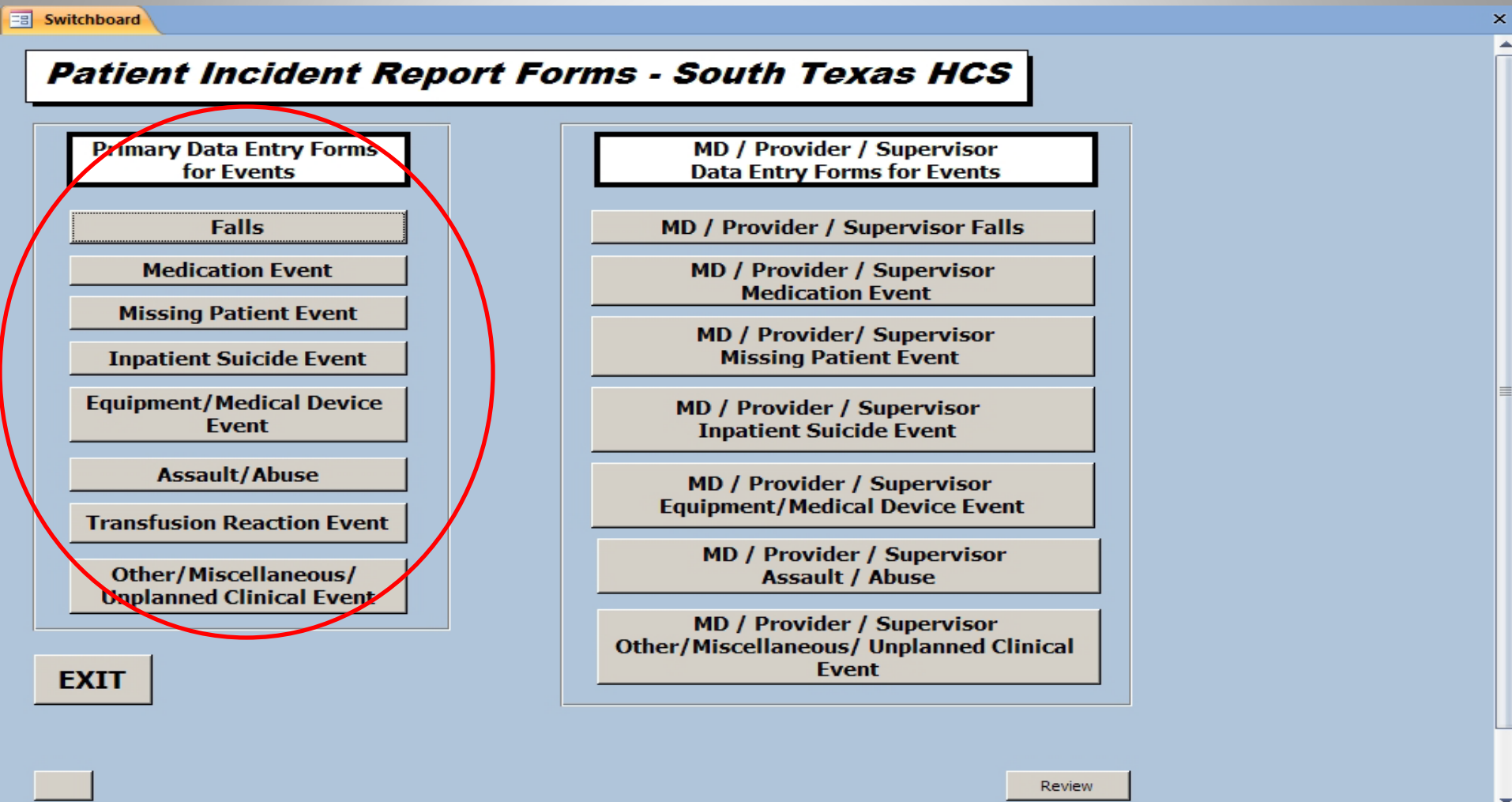
South Texas Veterans Health Care System

October 2012

# Data Flow

Clicking on the e-PIR icon  opens the Menu.

You then have access to the forms and a review option of the ePIR report.



The screenshot shows a software interface titled "Switchboard" and "Patient Incident Report Forms - South Texas HCS". The interface is divided into two main columns of buttons. The left column, titled "Primary Data Entry Forms for Events", lists various incident types: Falls, Medication Event, Missing Patient Event, Inpatient Suicide Event, Equipment/Medical Device Event, Assault/Abuse, Transfusion Reaction Event, and Other/Miscellaneous/Unplanned Clinical Event. This entire column is circled in red. The right column, titled "MD / Provider / Supervisor Data Entry Forms for Events", lists corresponding forms for each incident type: MD / Provider / Supervisor Falls, MD / Provider / Supervisor Medication Event, MD / Provider / Supervisor Missing Patient Event, MD / Provider / Supervisor Inpatient Suicide Event, MD / Provider / Supervisor Equipment/Medical Device Event, MD / Provider / Supervisor Assault / Abuse, and MD / Provider / Supervisor Other/Miscellaneous/ Unplanned Clinical Event. At the bottom left is an "EXIT" button, and at the bottom right is a "Review" button.

**Primary Data Entry Forms for Events**

- Falls
- Medication Event
- Missing Patient Event
- Inpatient Suicide Event
- Equipment/Medical Device Event
- Assault/Abuse
- Transfusion Reaction Event
- Other/Miscellaneous/Unplanned Clinical Event

**MD / Provider / Supervisor Data Entry Forms for Events**

- MD / Provider / Supervisor Falls
- MD / Provider / Supervisor Medication Event
- MD / Provider / Supervisor Missing Patient Event
- MD / Provider / Supervisor Inpatient Suicide Event
- MD / Provider / Supervisor Equipment/Medical Device Event
- MD / Provider / Supervisor Assault / Abuse
- MD / Provider / Supervisor Other/Miscellaneous/ Unplanned Clinical Event

**EXIT**

**Review**

Clicking on a tab ( **Falls** ) will open the report form.

ePIR : Database (Access 2007) (Read-Only) - Microsoft Access

Read-Only This database has been opened read-only. You can only change data in linked tables. To make design changes, save a copy of the database. Save As ...

Switchboard FallsDataForm

## Falls Event Reporting Form

Event Number: (New) Event Type: Falls Date of Report: 19-Aug-10

### Patient Information

*The information in this document is confidential and protected for quality improvement purposes under 38 U.S.C. 5705 and per VHA Directive 2004-051.*

**\*Last Name of Patient Involved in Fall:** N/A

**\*SSN:** 000-00-0000

**Gender:** Male

**Age:** 0

**Status:** N/A

**Service Pt belongs to:** N/A

**\*Unit/Area:** Enter unit/area

**Admission Date:**

**DATE FORMAT: DD - Mmm -YY**  
**(Example: 01-Jan-06)**

**Admission Diagnosis:** N/A

### Event Information

**Event Location:** N/A

**Other (if applicable):** N/A

**Event Date:** 19-Aug-10

**Day of Week:** N/A

**Time of Event:** 0 : 00 AM

**Event was an Actual Fall:** Yes

**Event was a Near Fall:** No

**Event was witnessed by staff:** No

**Activity at time of the fall:** N/A

**Family contacted re: event:** N/A

**Patient is on an inpatient unit but fall occurred off the unit:** No

**Patient fell off VA premises or outside of home (HBPC) and is receiving VA care for the event:** No

### Summary of Events

(Describe in detail the events concerning the fall)

N/A

Last name of the patient involved with the fall Num Lock

Complete all the sections with information known at the time of the report using the scroll bar to help move down the page.

NOTE: The “SUMMARY OF EVENTS” is the same as the narrative portion on the old paper incident report (VA Form 10-2633). This is free-text in memo form so provide as much of the incident as you can, especially that information not described elsewhere in the report.  
(See next slide for location of summary box)

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Save As ...

Switchboard FallsDataForm

# Falls Event Reporting Form

Event Number: (New) Event Type: Falls Date of Report: 19-Aug-10

## Patient Information

The information in this document is confidential and protected for quality improvement purposes under 38 U.S.C. 5705 and per VHA Directive 2004-051.

\*Last Name of Patient Involved in Fall:

N/A

Items with an \* and in RED are mandatory and must be filled out.

\*SSN:

000-00-0000

Gender:

Male

Age:

0

Status:

N/A

Service Pt belongs to:

N/A

\*Unit/Area:

Enter unit/area

Admission Date:

DATE FORMAT: DD - Mmm -YY  
(Example: 01-Jan-06)

Admission Diagnosis:

N/A

## Event Information

Event Location:

N/A

Other (if applicable):

N/A

Event Date:

19-Aug-10

Day of Week:

N/A

Time of Event:

0 : 00 AM

Event was an Actual Fall:

Yes

Patient is on an inpatient unit but fall occurred off the unit:

No

Event was a Near Fall:

No

Patient fell off VA premises or outside of home (HBPC) and is receiving VA care for the event:

No

Event was witnessed by staff:

No

Activity at time of the fall:

N/A

Family contacted re: event

N/A

## Summary of Events

(Describe in detail the events concerning the fall)

N/A

When finished entering the information, write down the event number, type your name in the marked box, and then save record and close form. (see below)

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Switchboard FallsDataForm

Protective Devices     Obstacles     Lighting  
 Footwear     Reaching for Needed Item(s)    Other:  
 Bed Side Rails     Patient/Family Education   

**Communication** (Check any area of communication that may have contributed to the fall)

Staff to Staff Communications     Staff to Patient Communications     Staff to Family/Other Communications

**Medications** (Check any type of medication patient was on at the time of the fall)

Anticonvulsants     Hypoglycemics     Antiarrhythmics     Muscle Relaxers  
 Antidepressants     Hypnotics     Anticholinergics     Non-steroidal anti-inflammatory drugs  
 Antihypertensives     Narcotics     Anti-emetics  
 Anticoagulants     PreOp Medications     Antihistamines     Sedatives  
 Diuretics     Psychotropics     AntiParkinsons

Progress Note has been written on patient re: Fall Event

Witness (Last Name):  Status:  Staff  Patient  Visitor

Witness (Last Name):  Status:  Staff  Patient  Visitor

\*Last Name of Person Making Out Report :

Remember this number!!

Event Number:  (N/A)

Click button to save this report and return to menu .

Save Record and Close Form

Thank you for submitting this Incident Report.

Last name of the patient involved with the fall

Num Lock

Each form is accessed the same way, filled in, number saved, signed and closed. Notify your Supervisor verbally of the incident providing the event number.

The next step is for either the MD, Provider or Supervisor to fill out. This will complete the initial reporting process.

# MD/PROVIDER/SUPERVISOR

PORTION of e-PIR process.

Switchboard

## Patient Incident Report Forms - South Texas HCS

**Primary Data Entry Forms for Events**

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- MD / Provider / Supervisor Assault / Abuse
- MD / Provider / Supervisor Other/Miscellaneous/ Unplanned Clinical Event

EXIT

Review

The MD/PROVIDER/SUPERVISOR must follow up on the incident and complete their portion on the specific incident. To open their portion of the report, they click on the correct tab corresponding to the initial report. **REMEMBER THAT THEY WILL NEED THE EVENT NUMBER.**



By clicking on this tab ( **MD / Provider / Supervisor Falls** ) it open this form for their entries. Fill out as complete as possible.

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Switchboard MD Falls Data Form

### MD/Provider/Supervisor Falls Data Entry Form

**Falls Reference List** (Click on 'Drop Down' Menu and select the event number, event date, and MD name to link report with original.)

Event Number	Event Date	MD Name

Event Number:  *The information in this document is confidential and protected for quality improvement purposes under 38 U.S.C. 5705 and per VHA Directive 2004-051.*

Level of Injury:    
 0 - None  
 1 - Minor  
 2 - Major  
 3 - Death

Treatment Refused:

Family Notified:

Type of Injury: (Check all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Sprain	<input type="checkbox"/> Burn
<input type="checkbox"/> Possible Fracture	<input type="checkbox"/> Laceration	<input type="checkbox"/> Allergic Reaction
<input type="checkbox"/> Fracture	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Change in Vital Signs
<input type="checkbox"/> Possible Dislocation	<input type="checkbox"/> Bruise	<input type="checkbox"/> Change in Mental Status
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Puncture	<input type="checkbox"/> Cardiac/Respiratory Arrest
	<input type="checkbox"/> Edema	<input type="checkbox"/> Ingestion/Overdose

Comments: (Narrative of event(s), findings, and treatments)

N/A

Determines level of injury

Num Lock

Type event number here

Enter findings here

Again the report must be signed by individual writing it, save the record and close it.

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Switchboard MD Falls Data Form

<input type="checkbox"/> Fracture	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Change in Vital Signs
<input type="checkbox"/> Possible Dislocation	<input type="checkbox"/> Bruise	<input type="checkbox"/> Change in Mental Status
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Puncture	<input type="checkbox"/> Cardiac/Respiratory Arrest
	<input type="checkbox"/> Edema	<input type="checkbox"/> Ingestion/Overdose

Comments: (Narrative of event(s), findings, and treatments)

N/A

Proposed Plan for dealing with sequelae and/or minimizing complications: (Check all that apply)

<input type="checkbox"/> Examined and Treated	<input type="checkbox"/> Refer for Consultation	<input type="checkbox"/> Admit
<input type="checkbox"/> Continued Observation	<input type="checkbox"/> Refer for XRay	<input type="checkbox"/> Discharge
<input type="checkbox"/> Modified Medication Plan	<input type="checkbox"/> Refer for CT Scan	<input type="checkbox"/> No Treatment
<input type="checkbox"/> Modified Treatment Plan	<input type="checkbox"/> Transfer	

A note was entered on this event in CPRS.

This event is a disclosable event.

Name of MD / Provider / Supervisor:  ← **HERE**

(Last Name, First Name/Initial) Date of Report: 19-Aug-10

Time of Report: 0 : 00 AM

1.  ← 2.  ← **HERE**

**HERE**

Narrative of the event based on MD observations Num Lock