GME Curriculum

INCIDENT REPORTING

The GME Team
Incident Reporting

Who ?  Why ?

What ?  When ?

Where ?
What is an Incident Report?

- A reporting of any occurrence/incident that is not consistent with the routine care of...
  - Patients
  - Visitors
  - Employees
  - Physicians/Residents/Fellows
- Not an admission of negligence – it simply records the event
Type Of Events That Are Reported

- Sentinel events
- Never events
- Adverse events
- Close call/near misses
- Other
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

The terms “sentinel event” and “error” are not synonymous; not all sentinel events occur because of an error, and not all errors result in sentinel events.
Sentinel Event Examples

- surgery on the wrong patient or wrong body part
- unintended retention of a foreign object
- suicide of patient receiving care, services or treatment in a staffed 24 hour setting or within 72 hours of discharge
- if medication is prescribed or administered within the organization, any individual death, paralysis, coma, or other major permanent loss of function associated with a medication error
- any elopement, that is an unauthorized departure of an individual served from an around-the-clock care setting resulting in a related death (suicide, accidental death, or homicide) or major permanent loss of function
- a patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
- maternal death
Never Events

- **Surgical Events**
  - Intraoperative or immediately postoperative death in an American Society of Anesthesiologist Class 1 patient

- **Product or device events**
  - Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
  - Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used for functions other than as intended
  - Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
Never Events

- Patient protection events
  - Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
Never Events

- Care management events
  - Patient death or serious injury associated with a medication error
  - Patient death or serious injury associated with unsafe administration of blood products
  - Artificial insemination with the wrong donor sperm or wrong egg
Never Events

- Care management events (continued)
  - Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare facility
  - Patient death or serious disability resulting from irretrievable loss of an irreplaceable biological specimen
  - Patient death or serious injury resulting from failure to follow-up or communicate laboratory, pathology, or radiology results
Never Events

- **Environmental events**
  - Patient or staff death or serious disability associated with an electric shock in the course of a patient care process in a healthcare setting
  - Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances
  - Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
  - Patient death or serious injury associated with the use of restraints or bedrails
Never Events

- Radiologic events
  - Death or serious injury of a patient or staff associated with introduction of a metallic object into the MRI area
Never Events

- Criminal events
  - Instance of care ordered by or provided by someone impersonating a licensed healthcare provider
  - Abduction of a patient of any age
  - Sexual abuse/assault on a patient within or on the grounds
  - Death or significant injury of a patient or staff member resulting from a physical assault
Adverse Events

- Adverse event
  - one that causes an injury to a patient as the result of a medical intervention rather than the underlying medical condition. It represents an unintentional harm to a patient arising from any aspect of healthcare management.
Examples of Adverse Events

- Administration of the wrong medication
- Failure to make timely diagnosis
- Adverse reactions or negative outcomes of treatment
Close Calls/Near Misses

- Events that could have resulted in harm but did not, either by chance or through timely intervention
  - Close Calls/Near Misses provide opportunities for developing strategies of prevention and should receive the same level of scrutiny as events that caused actual harm.

“Studies estimate that one million serious error-related adverse events occur annually. If close calls/near misses were also reported, the total number of reportable events could be five million.”

(Leape, 2002)
Examples of Close Calls

- Wrong medication caught before given to a patient
- Blood mislabeled but detected before processing
- Wrong x-ray given to view – caught before providing wrong treatment to patient
Other patient safety incidents to be reported

- Staffing issues
- Supply issues
- Patient complaints
- Infection control issues
- No admission orders written
- Delay in care
- Mislabeling or no labeling of specimens
- Workplace violence
- IV infiltrations or extravasations that require intervention or treatment
- Unplanned return to the operating room
Who should report?

- All employees of the facility to include physicians, residents, and fellows
- If you do not have access – the risk management or quality office will be able to assist
Where do you report?

- UHS - RL Solutions (desktop)
  - For help call 358-1345
    - Emergency Contact after hours – 203-4802

- VA – ePIR (desktop)
  - For help call 617-5300 x13589
When do you report?

Immediately after the person involved has received the appropriate care.
Why do you report?

- To record the event as it happened
- To identify
  - The factors that contributed to the event
  - Ways of redesigning the care processes to reduce the likelihood of similar events in the future
- To promote quality improvement and patient safety
- To bring safety concerns to the attention of the organization
- To improve customer satisfaction
When in doubt, fill it out!
What NOT to do…

- An incident report does not replace charting in the Electronic Medical Record (EMR)
- Do not reference the incident report in the EMR or to the patient or family member
- Incident reports are not to be printed, copied or disseminated
# Yellow Cards

## Resident's Reporting Card

**Step 1:** your chain of command  
**Step 2:** appropriate section below or on back

### Patient Issues

*I have a concern about patient safety, harm, or potential for harm or wish to report a medical error, near miss, or unintended outcome:

- UHS .................. desktop: RL Solutions  
- UHS .................. 358-1345  
- VA .................. desktop: ePIR  
- VA .................. 617-5300 x 13589  
- SAMMC .................. desktop: PSR  
- Christus/CHOSA ... 704-2020

*I have a general suggestion:

- GME office ........ 567-4431  
- DIO .................. bready@uthscsa.edu  
- UHS CMO ............ bryan.alsip@uhs-sa.com  
- VA DEO ............ david.dooley2@va.gov  
- SAMMC  
  Dean ........ Woodson.S.Jones.Civ@mail.mil  
- UT System  
  Hotline ............ 877-507-7317

## Physician Wellness

### I have a concern about duty hours/fatigue:

- DIO's office (Dr. Bready)......567-4431  
- UT System Hotline ..........877-507-7317

### I have a concern about my mental health:

- 1-888-EAP-2400  
  "I work at UH"  
- www.deeroaks.com  
- TMA physician hotline ...800-880-1640

### I have a concern about mistreatment or accommodations:

- Ombuds (Dr. Blankmeyer) ....567-2691  
- DIO's office (Dr. Bready)......567-4431  
- UT System Hotline ..........877-507-7317

### I have a concern about potential workplace violence:

- C.A.R.E ...................567-2273

### I have contacted the other resources and still have concerns:

- ACGME Resident Services  
  ................... residentservices@acgme.org

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6/2013
Questions?
Next GME Curriculum

- April 9 @ 6:30 am 209L
- April 11 @ 11:00 am TBD
Incident Reporting

Please register your attendance using this QR code or by signing an attendance sheet.