POLICY AND PROCEDURE

Function:	**Performance Improvement**	**Policy Number:**	**TH 276** **Combines TMH GA 25.0 and SFH 1000.00**
Subject:	**Occurrence Reporting**	**Distribution:**	**Thomas Health System-wide**
Prepared By:	**Risk Management;** **Chief Quality Officer (CQO)**	**Effective Date:** **Last Review** **Revision Date:**	**February, 2017** **May, 2018** **August, 2020**
Approved By:	**Vice President-General Council;** **Quality Council**	**Approved By:**	**President/CEO**

I. PURPOSE

The Hospital Notification System (Occurrence Reporting) is a positive tool that enhances patient care, improves employee-working conditions and protects the hospital's assets.

II. SCOPE & RESPONSIBILITY

The notification system is a hospital-wide program that provides a mechanism to communicate important information to the personnel responsible for risk management. The system is designed as a risk identification and evaluation system. The system is utilized to capture data and communications necessary for supporting the risk management functions of the facility, including those functions relative to peer review. The system is used as a component of the Hospital's Quality Improvement Program in the identification and analysis of patient care issues. All employees of every inpatient/outpatient and provider-based outpatient department are expected to utilize the reporting system as delineated in the policy.

III. PROCEDURE

A. The hospital employee who is first involved in or is witness to an occurrence, or receives information regarding an incident or event, is responsible for assuring that the hospital notification (occurrence report) is completed and that his/her department leader or supervisor is notified via the appropriate system in a timely fashion. In situations where in patient care or optimal patient outcome is jeopardized, it is the reporting employee's responsibility to immediately notify their direct report supervisor and/or Risk Management.

B. The person completing the report shall make no judgment or statement assuming hospital liability. All information should be factual. All fields and/or blanks on the form are to be completed as fully and accurately as possible based on the investigation of the incident. The document is privileged and confidential and is for facility internal use only. No photocopying or printing of the electronic report is permitted.

C. Occurrence Reports are computer generated and each department has access to the reporting system. Manual form reporting is used for downtime procedure only. Manual forms are available from Material Management and should only be used as outlined above. It is the expectation that all clinical and ancillary departments will report through the electronic system unless there is a downtime of the electronic system The Department manager is responsible for entering the manual (downtime) form into the electronic system and for securing the paper form for delivery to the Risk Management Office. Destruction of the paper form will be done upon approval of hospital counsel.

D. The department leader in the department in which the incident occurred or their designee, is responsible for assuring accuracy of the occurrence and for completion of the investigation section of the report.

E. The Occurrence Report must be entered and forwarded to risk management within ***24 hours*** of event or discovery of the occurrence.

F. The Department leader or their designee must complete the investigation section of the report as soon as possible (24-48 hours) or as soon as reasonably possible based on the nature of the event and investigation process.

G. In the case of an injury-related occurrence (patient, visitor or employee), a telephone call should be made as soon as possible to the Risk Manager by the department leader or designee. During non-working hours, Nursing Supervision shall notify the administrator-on-call and (if possible) the Risk Manager of any event resulting in serious injury. Nursing supervision will notify employee health of any employee injury that requires treatment or is admitted. Other injuries may be reported the next working day.

H. **Reporting Procedures**

1. Employee Reporting Procedure. In case of an employee work related injury or illness, the employee completes the appropriate sections of the **occurrence report**. Employee health will complete the investigation/notes section of the report. The report is to be entered into the to the EHR Risk Management module within 24 hours. The Nursing Supervisor will be notified of all work related illnesses/injuries and a determination made as to treatment needs. Employee health will be notified of all work related illnesses/injuries and will complete the appropriate follow up. Blood Borne Pathogen exposure follow-up is to be completed by Employee Health within 48 hours of exposure.

2. Patient Reporting Procedure. Although patient occurrences are documented on the patient's chart, the occurrence report provides the mechanism to notify personnel involved in risk management. The Occurrence Report is not to be made part of a patient's medical record, and the progress notes and/or nursing documentation should not state that one has been completed. Under no circumstances should any hospital employee provide information regarding the occurrence to any person other than a hospital Administrative Official, Risk Manager or other authorized representative. ***In the event of a medical error, which results in harm to a patient and requires a change in physician orders, the Hospital Patient Notification of Medical Error policy will be immediately implemented. (Please refer to Policy #New number)***

IV. REVIEW AND DISPOSITION OF HOSPITAL NOTIFICATION FORM

A. The Risk Manager will review and trend all occurrence reports. Report will be made to Safety Committee bimonthly and to Quality Council, Medical Executive Committee and Board of Trustees, quarterly. Patient Safety Committee and/or Safety Committee will implement additional investigation when necessary.

B. The Human Resource administrator, with the assistance of the Employee Health, will maintain employee records and reports for the OSHA program.

C. The Occurrence Report is prepared for legal counsel in anticipation of possible litigation and is considered attorney- client privileged/confidential; and/or completed for trending of potential professional performance issues which are required under the Medical Staff peer review process and therefore are considered confidential and privileges information in accordance with WV Code 30-3C-1.

D. Following is a general list of categories that have been widely accepted as a reportable hospital occurrence:

1. Physical impairments, both permanent and temporary, arising out of the health care management of the patient.

2. Occurrences that <u>are not</u> consistent with routine patient care when compared to accepted standards.

3. Violation of established policies and procedures that involve patient care, or whenever, the Chain of Command policy is initiated.

4. An accident to an employee, visitor, or patient with or without personal injury.

5. A hazardous material or waste incident spill or exposure.

6. Disturbance or unfavorable situation that could disrupt hospital functions, or damage the hospital's public reputation.

7. An event with injury that is considered a potential claim or lawsuit.

8. Mishaps due to faulty/defective equipment or environmental conditions.

9. Unexpected adverse results of professional care and treatment, which necessitates additional hospitalization or a dramatic change in patient treatment regimens.

10. Verbal and written expression of dissatisfaction from the patient and/or patient families regarding the professional and nonprofessional services.

11. Patient, visitor, or employee property loss or damage.

12. Violent acts are considered to be verbal, written, or physical acts of aggression; intimidating or harassing behaviors; threats, or abusive behavior toward authority.

E. In addition to the general categories of hospital occurrences, the following specific patient occurrences must be considered an occurrence that should be reported through the hospital reporting system. (*Please refer to Sentinel Event Policy)

1. Invasive diagnostic or surgical procedure performed on the wrong patient.
2. Absence of or an improper informed consent form.
3. Adverse results of anesthesia.
4. Intubation resulting in injury.
5. Wrong invasive diagnostic or surgical procedure performed on a patient.
6. Injury due to documented improper technique, personnel error, equipment failure or unexplained etiology.
7. Chemical or electrical burns from treatment regimen.
8. Laceration/tear or perforation/puncture of an organ or other body part as a result of invasive procedure.
9. Unanticipated death within 48 hours of admission or readmission to the facility.
10. Death occurring during restraint use.
11. Leaving against medical advice (AMA)/Left without being seen (LWBS) Left Prior to Medical Screen Evaluation (LPMSE), Elopement
12. Transfusion acquired hepatitis, transfusion reactions, and errors in identification of patients receiving transfusions and/or blood products or transfusion process failures.
13. Instrument breakage or malfunction resulting in injury.
14. Unexpected return to operating room during the same admission.
15. Surgery for removal of a foreign object left in operative site unintentionally.
16. Delay in calling code or responding to code.
17. Acute myocardial infarction during or up to 72 hours following surgery.
18. Sponge, needle, foreign object or other material left in operative site unintentionally or because of impossible retrieval.
19. Patient injured in any type of transport.
20. Unplanned removal, partial removal, or repair of a normal organ or body part during an operative procedure.
21. Unexpected post-operative nerve damage.
22. All patient and/or visitor falls with or without apparent injury. Serious injury or death related to a patient fall. (Please refer to the Sentinel Event Policy).

V. OCCURRENCE CLASSIFICATIONS

A. The following criteria shall be used to classify **Occurrences Notification Type:**

1. **Patient:** Any registered inpatient or outpatient which has a reported occurrence of any type

2. **Non-Patient:** Any non-registered patient, visitor, vendor, physician or other facility customer who has a reported occurrence of any type. This would also include personal property losses or non-work related employee incidents.

3. **Employee:** This includes only those incidents involving **employee illness or injury, which are work related.**

VI. SEVERITY CLASSIFICATION

A. Risk Management staff will classify occurrences according to severity.

1. All occurrence reports received by the Risk Management Department will be assigned a severity classification level in accordance with established criteria, Risk Management Guidelines and/or national standards.

2. The severity classification system will be utilized to track/trend significant incidents in an effort to identify issues needing further evaluation and/or action, i.e., Significant Medication Errors, Sentinel Events (Never Events).

3. The Risk Management Department shall review each occurrence report submitted for appropriate severity level assignment.
   a. It is the responsibility of the Risk Management Department to weigh all relevant facts when classifying incidents.
   b. This may constitute advice or consultation from the hospital's legal counsel.

VII. Tracking and Trending

A. The Risk Management Department shall see that all necessary parties are informed of the incidents regardless of severity classification assignment.

1. The mechanism used to accomplish this will be through trended reports and aggregated data. these reports shall be maintained by the Risk Management Department and shared with the appropriate department leaders. Each patient's confidentiality shall be protected and maintained throughout this process.

2. These reports shall be used as a tool to assist in tracking occurrences by department so that trends may be identified.

3. All information regarding occurrence reporting, trending, classifications, etc. is intended for internal risk management purposes. All information is considered **Confidential** and **Privileged** (and/or counsel work product) and should not be released or utilized for any other purpose.

VIII. Non-Punitive Self Reporting Versus Discipline

1. Punitive action is not associated with self reporting. However, opportunities for additional education, work improvement or mentoring may be utilized when appropriate. Additionally, disciplinary action up to and including termination may be taken when supported by the overall circumstances, including prior events involving the same employee. Any employee who intentionally avoids initiating/ completing an occurrence repot per policy requirements will also be subject to disciplinary action.

VIV. Confidentiality

All information relating to occurrence reporting, including trending, harm/ severity scores or other data, are intended for internal Risk/Quality and Peer Review purposes. Such information is considered Confidential and Privileged and should not be released or utilized for any other purposes. Anyone disclosing confidential and/or privileged information without express permission of the Legal Department shall be subject to disciplinary action.

Associated Form: CO 0051 - Downtime Occurrence Report Form (Saint Francis Hospital)
TH-244 - Downtime Occurrence Report Form (Thomas Memorial Hospital)

Reviewed/Revised Date: 8/20