HARRISHEALTH SYSTEM

Policy No: 3.63
Page Number: 1 of 5

Effective Date: 3/2015
Board Motion No.:

TITLE: **INCIDENT REPORTING**

PURPOSE: To provide guidance regarding the reporting of Incidents involving patients, visitors, or Workforce members, which are inconsistent with the standard of care, and/or the routine operations of Harris Health System.

POLICY STATEMENT:

All injuries and hazards involving patients, visitors, and Workforce members shall be reported using the Harris Health System (Harris Health) electronic incident reporting system (eIRS). Harris Health does not tolerate retaliation against Workforce members who report Incidents.

ELABORATION:

I. DEFINITIONS:

A. **ADVERSE EVENT:** A patient care event that is unfavorable, undesirable, and usually unanticipated that causes death or serious injury, or the risk thereof. Adverse events may result from unintentional acts or omissions. Adverse Events may include, but are not limited to:

1. Patient falls;
2. Medication errors;
3. Procedural errors/complications;
4. Completed or attempted suicides;
5. Iatrogenic injuries, i.e., injuries due to medical treatment or procedure;
6. Failure to make a timely diagnosis;
7. Untimely implementation of appropriate therapeutic intervention; and
8. Missing patient events.

B. **INCIDENT:** An accident or injury that occurs within Harris Health staffed locations that is inconsistent with the standard of care of a patient or routine operations of Harris Health which may result in an unanticipated harm or injury to patients, visitors, affiliates, employees, and others. "Incident" shall include, but is not limited to events that are:

1. Inconsistent with any Harris Health policy or procedures; or
2. Non-anticipated and non-routine patient, employee, affiliate, contractor, visitor, volunteer or other injuries resulting from accidents or errors.

C. **NEAR MISS:** An event or situation that could have resulted in an accident, injury, or illness, but did not, either by chance or through timely intervention. An example of a Near Miss would be a surgical or other procedure almost performed on the wrong patient due to lapses in verification of patient identification but caught at the last minute by chance. Near Misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near Misses will receive the same level of scrutiny as Incidents that result in actual injury.

D. **SENTINEL EVENT:** An incident involving a serious adverse outcome error including death, serious physical or psychological injury or the risk thereof, or other resulting from any process variation for which a recurrence would carry a significant risk of a serious adverse outcome error. Serious injury specifically includes loss of limb or function. Events qualifying as sentinel events include, but are not limited to:

1. Unanticipated death;
2. Major, permanent loss of function;
3. Suicide;
4. Infant abduction;
5. Infant discharged to the wrong family;
6. Rape;
7. Hemolytic transfusion reaction involving major blood group incompatibilities;
8. Surgery on the wrong patient or wrong body part;
9. Prolonged fluoroscopy;
10. Death of a full term infant;
11. Severe neonatal hyperbilirubinemia;
12. Intrapartum maternal death;
13. Elopement (See Harris Health Policy 4205 Absences from Nursing Unit: Against Medical Advice (AMA), Elopement, Requests to Leave the Unit); or
14. Unintentional retention of a foreign body.

E. **WORKFORCE:** Employees (permanent or temporary), Board of Managers, volunteers, trainees, and other persons whose conduct, in the performance of work for Harris Health, is under the direct control of Harris Health, whether or not they are paid by Harris Health.

II. GENERAL PROVISIONS:

A. The Workforce member who discovers an Incident involving a patient shall immediately notify the patient's care team.

B. All Incidents involving patients, visitors or Workforce members shall be documented in the eIRS system or using downtime forms when the eIRS is not available.

C. An objective description of the Incident should be written in the medical record by both the medical and nursing staff along with any observations, diagnostic studies and results, and/or related treatment; however, the reporter should **not** write in the medical record that the Incident was reported in eIRS.

D. Workforce members are accountable for ensuring all Incidents are documented in the eIRS.

III. EXAMPLES OF INCIDENTS THAT MUST BE REPORTED:

A. All Incidents, Sentinel Events, Adverse Events, and Near Misses;

B. Patient identification issues (incorrect medical record number, mislabeled or wrong lab/diagnostic results reported, etc.);

C. Blood product administration errors;

D. Procedural errors;

E. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than two hundred and fifty (250) grams;

F. A patient death or serious injury associated with the use or function of a device designed for patient care that is used for or functions other than as intended (See Harris Health Policy 7503 Safe Medical Device Reporting Program); and

G. Major high-risk issues and/or critical incidents shall be reported and preceded with a telephone call to the Harris Health Risk Management Administrative Director.

H. Falls for any reason, with or without injuries;

I. Medication errors;

J. Needle sticks punctures and/or occupational exposures;

K. Diagnostic/therapeutic procedures performed on wrong patients;

L. Burns resulting from devices used in patient care;

M. Any faulty/defective equipment;

N. The existence of hazardous conditions within Harris Health staffed locations;

O. Vocal or written expressions of dissatisfaction from a patient or a patient's family concerning professional and non-professional services and/or treatment received within a Harris Health staffed location (Refer to Harris Health Grievance Policy 4200);

P. Patients exhibiting threatening or aggressive behavior that requires assistance by Security or law enforcement; or

Q. Patient or visitor's lost, stolen, or damaged property, claimed or actual.

REFERENCES/BIBLIOGRAPHY:

Centers for Medicare and Medicaid .Services: Conditions of Participation: Quality Assessment and Performance Improvement Program. § 482.21(iii) (2).

DNV-NIAHO Accreditation Requirements QM.8. Patient Safety System.

Harris Health System Policy and Procedure 4205 Elopement**.**

Harris Health System Policy and Procedure 4200 The Patient Complaint/Grievance Policy.

Harris Health System Policy and Procedure 7503 Safe Medical Device Reporting Program.

Texas Title-25: §133.48.02 Patient Safety Program.

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Risk Management Department

REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review or Revision Date (Indicate Reviewed or Revised)	Reviewed or Approved by: (Directors, Committees, Managers, and Stakeholders etc.)
	1.0	Expedited Approval 02/10/2015	Operations Policy Committee
		Expedited Approval 02/10/2015	Interdisciplinary Clinical Committee
03/26/2015		Approved 03/26/2015	Harris Health System Board of Managers