

INCIDENT REPORTING

Incident reports serve many purposes, such as quality improvement, event documentation, and liability monitoring. They serve as documentation of workplace illnesses, injuries, near misses and accidents, and as such, can be a positive management tool. Encouraging employees to complete an incident report provides management with the necessary information to improve the quality of services, track trends, and perhaps limit the possibility of repeat occurrences.

This bulletin provides best practices for incident reporting in the healthcare setting.

INCIDENT REPORTING SYSTEM

Every organization should define the purpose of their incident reporting system. The incident reporting system may serve to:

- Improve the management of patient care by assuring appropriate and immediate intervention occurs and corrective measures are implemented to prevent future recurrences.
- Provide a factual record of the event by the employee and/or volunteer who was a witness to and has information of the incident.
- Provide a database for the organization's Quality Assurance/Performance Improvement (QAPI) activities to ensure quality of care and services are properly evaluated for future quality improvement initiatives.
- Alert Risk Management/Administration of an occurrence that could result in a claim, so that loss control measures can be implemented.



Analyzing Incident Report Data

The designated individuals who review and sign off on individual incident reports should consider whether the information documented is adequate to establish a clear picture of the event. A root cause analysis may be needed to identify whether procedures were followed or to identify a probable cause.

In addition to identifying single events that require immediate intervention, incident report data can be a source of information to help reduce potential compensable events as well as further risk mitigation. The statistical information to be analyzed should include:

- Types of occurrences, severity of injury, and frequency, to establish priorities for loss-prevention activities.

- Event patterns to show a particular location, time of day or day of week.
- Patient demographics, such as age and gender.
- Staff characteristics, such as employee or agency.
- Incident trending, to show changes in the frequency over time.
- Effectiveness of corrective measures on the types of incidents being reported.

Incident reports alone cannot provide a conclusive picture of an organization's activities and potential exposures. Other sources of data such as quality improvement statistics, safety and security reports, utilization review data, patient/family satisfaction, complaint reports, and results from internal

and external surveys, etc., should be included in the review. Only then can an organization hope to have a thorough view of potential loss exposures.

Incident Reporting Guidelines

Establish guidelines to provide staff direction as to what incidents are reportable. Written policy should also identify events that are considered a sentinel, which require a more extensive follow up, such as a root cause analysis.

The following is a list of reportable events, and, while not all inclusive, should be considered as a guideline for a hospice or home care organization:

- Falls (both patient and visitor)
- Burns
- Medication errors/near misses
- Adverse or allergic drug reaction
- Refusal of treatment
- Unplanned absence of caregiver
- Patient elopement
- Failure of patient and/or caregiver to perform procedure as taught
- Mishaps due to faulty equipment
- Mishaps due to misuse of equipment (user error)
- All patient or family complaints, including alleged theft
- Failure of patient/family to use on-call emergency plan

- Failure of staff to report accident-causing hazard in home
- Unplanned return to an inpatient setting
- Breakage or damage to personal property of patient or family
- Abuse/neglect/exploitation of patient or allegations of sexual misconduct
- Failure to respond in a timely fashion to patient or family request for assistance, information or treatment
- Theft of organization equipment, such as laptops and cell phones
- Security breach incidents
- Motor vehicle accidents

It is important for an organization to periodically review and evaluate its incident reporting procedures. The belief that everything is fine because the reported incident numbers are low is probably not as accurate as one might think. It is more likely that staff are not reporting all incidents or near misses that occur.

Incident Reporting Policy and Procedure Checklist:

Ensure the following:

- There is a written policy/procedure for incident reporting.
- The policy/procedure includes a clear definition of what is reportable.

- The policy/procedure defines responsibility for reporting incidents and emphasizes participation of all staff in all departments.
- The policy/procedure clearly identifies reporting channels.
- The policy/procedure requires reporting and routing of all incident reports in a timely fashion.
- There is a non-punitive approach to incident reporting.
- Each individual report is reviewed by a designated quality, risk or safety person in the organization to evaluate for causative and preventable factors.
- Reports are trended and analyzed on a monthly and quarterly basis.
- Incident reports and trends are reported to appropriate committees, such as QAPI or Safety Committees, as well as the Board. The committee(s) play a role in identifying causative factors, evaluating severity, developing an action plan, and recommending further action if necessary.
- Staff receives feedback on the results of an investigation and problem resolution.

SUMMARY

Incident reporting helps organizations identify safety hazards and develop interventions to mitigate the exposures and reduce potential harm. Any incident that is not consistent with the routine care of a patient, or is not consistent with the daily operations of the healthcare organization should be reported and documented, and the data analyzed to help the organization's risk management efforts.