



Internal Event Reporting:
An Essential Tool for Risk Management and Patient Safety
May 19 & 20, 2010

- **Quality improvement and care management organization**
- **Founded in 1985; headquartered in Harrisburg, PA**
- **Works with HRSA on Medical Malpractice Claims Reviews and Risk Management Services under a contract initiated in 2004.**
- **Provides risk management and patient safety technical assistance to section 330 FTCA deemed Health Centers and Free Clinics.**

About ECRI Institute

- ▶ Independent, not-for-profit applied research institute focused on patient safety, healthcare quality, risk management
- ▶ Web site for HRSA grantees. Log in with user id and password at: www.ecri.org/clinical_RM_program
- ▶ **Have not activated your User ID yet? E-mail us at: clinical_RM_program@ecri.org.**
- ▶ 40-year history, 320 person staff
 - AHRQ Evidence-Based Practice Center
 - WHO Collaborating Center
 - Federally designated Patient Safety Organization

Objectives

- ▶ Identify reasons for having an effective internal event reporting system in health centers and clinics
- ▶ Recognize approaches for implementing an internal event reporting system as part of a health center or clinic risk management and patient safety plan
- ▶ Recall options for the flow of information for communication and action for reported events and near-misses
- ▶ Recognize strategies for implementing solutions to problems identified through event reporting systems for risk prevention and patient safety improvement

Why report events and near misses?



“You cannot manage what you do not know about...”



Why report events and near misses?

- ▶ Risk identification and loss reduction
- ▶ Prevention and improvement
- ▶ Education and learning
- ▶ Meet accreditation standards
 - National Patient Safety Goals
<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/>



Key Definitions

- ▶ **adverse event:** an undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.
- ▶ **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
- ▶ **sentinel event:** an unexpected occurrence involving death or serious physical or psychological injury, ...serious injury specifically includes loss of limb or function.

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MODEL INTERNAL EVENT-REPORTING POLICY

This model policy is intended as guidance to be adopted or adapted consistent with the internal needs of your organization. This policy is not to be viewed as required by ECRI Institute, KePRO, or HRSA.

SUBJECT: Adverse-Event and Near-Miss Reporting

ADOPTION AND REVIEW DATES:

RESPONSIBLE DEPARTMENT: Risk Management

PHILOSOPHY AND PURPOSE:

- ▶ [Organization name] endorses and supports a culture of safety and views adverse-event reporting as a means of improving systems and processes in providing healthcare services to all patients. In a continuing effort to promote a safe environment for patients, [organization name] will conduct a systematic program of adverse-event reporting. Reporting is nonpunitive, and all providers, employees, and volunteers are encouraged to report all patient and visitor events.

Supporting Toolkit Documents

Right click and choose "Save as" to save the files to your computer.

 Model Internal Event-Reporting Policy

 Event Reporting Barriers and Suggested Strategies

 Event Summary Tool

 Flow of Information Diagram

 Sample Action Plan Template

 Sample Data Collection Form

 Sample Event Report Narrative

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Barriers to Event Reporting	Strategies for Overcoming Barriers
Belief that someone else reported the event	Reporting systems should be able to identify duplications.
Lack of time to complete event report form	Design event report forms for ease of completion.
Lack of understanding of importance of reporting	Provide education about event reporting at orientation and annually thereafter; establish reporting as a performance expectation in job descriptions.

Event Summary Tool

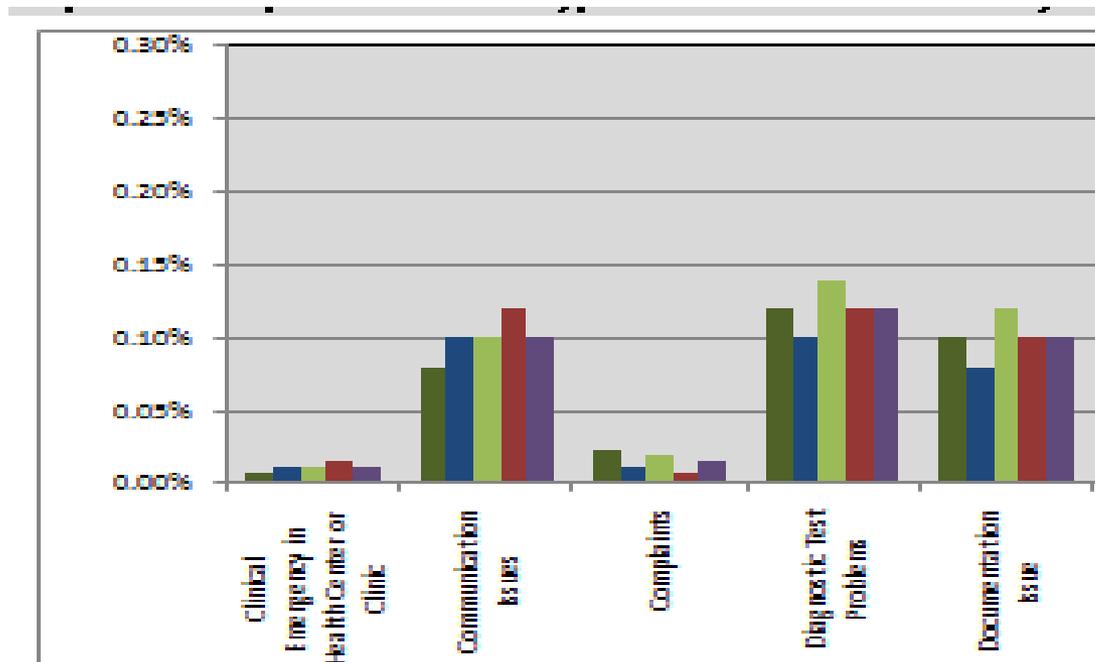
Health Center/Clinic Annual Report of Events 2010

1st Quarter

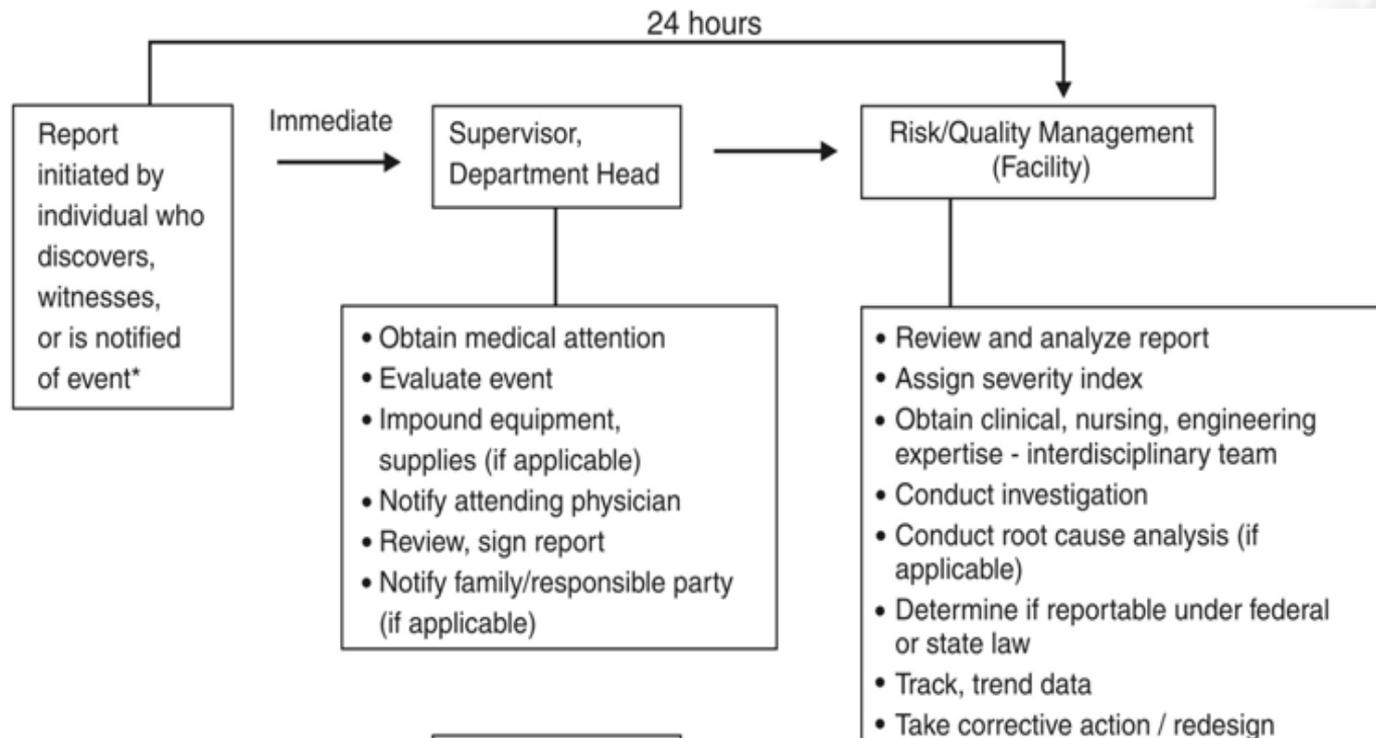
Event Type	Number of Events	Patient Encounters	%
Clinical Emergency in Health Center or Clinic	2	25000	0.01%
Communication Issues	20	25000	0.08%
Complaints	6	25000	0.02%
Diagnostic Test Problems	30	25000	0.12%
Documentation Issue	25	25000	0.10%
Falls	3	25000	0.01%
Handoff or Referral Problem	50	25000	0.20%
Incorrect Patient or procedure	1	25000	0.00%
Medication Errors	50	25000	0.20%

Event Summary Tool

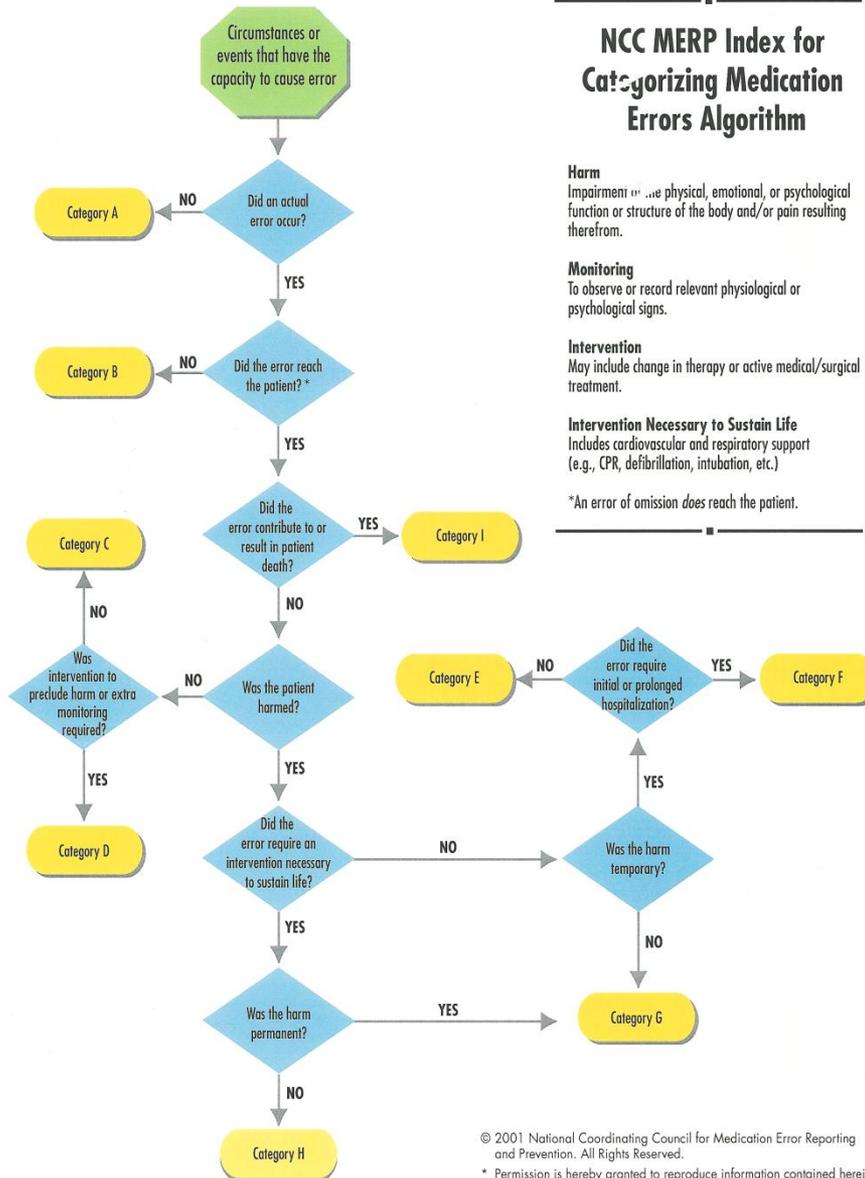
Tool generates a graph with your added data



Flow of Information - Event Reporting



NCC MERP Index for Categorizing Medication Errors Algorithm



Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

Intervention Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)

*An error of omission *does* reach the patient.

Algorithm: Categorizing Event Severity

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Sample Data Collection Report

CONFIDENTIAL EVENT REPORT (RM/QI Purposes only.)

SEX: N/A Female Male Unknown	AGE:	DAY OF WEEK: Sunday Monday Tuesday Wednesday	Thursday Friday Saturday Unknown	PATIENT MENTAL Oriented: Yes No Unidentif Sensory Impaired Yes No Unidentif
SELECT ONLY <i>ONE</i> CATEGORY:	Treatment/Procedure Equipment/Product	Environment Intravenous	Falls Blood	Business/Patient Medication
CHECK APPROPRIATE BOX IN DESIGNATED CATEGORY THAT BEST DESCRIBES THE EVENT				
TREATMENT/PROCEDURE Anesthesia Problem Application/Removal of Cast/Splint Aspiration Body Fluid Exposure	EQUIPMENT/PRODUCT Disconnected/Dislodged Electrical Problem Implant Improper Use	FALLS Assisted to Floor Chair Exam Table Faint	IV/BLOOD/MEDICATION Adverse Reaction Allergic Reaction Container not Child Proof Outdated Patient Identif Patient Refusc Phone Prescri	

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SAMPLE EVENT REPORT NARRATIVE

[Organization Name] Event Report (RM/QI purposes only – not part of patient medical record)

An **adverse event** or **incident** is defined, consistent with the [organization name] risk management as “an undesired outcome or occurrence, not expected within the normal course of care or the disease process, condition of the patient, or delivery of services.”

A **near miss** is defined as “an event or situation that could have resulted in an accident, injury, but did not, either by chance or through timely intervention (e.g., a procedure almost performed on wrong patient due to lapse in verification of patient identification but caught at the last minute chance).”

Patient Visitor Other Age _____ (days, months, years)

Female Male Date of this report (mm/dd/yyyy) _____

Last name, first name of patient or other individual involved in event _____

Event Report Information

- ▶ Date and time of the report
- ▶ Date and time of the event
- ▶ Location of the event
- ▶ Identification of people affected (e.g., patient, visitor, employee)
- ▶ Identity of people witnessing the event
- ▶ Identity of the physician to whom the event was reported (if applicable) and the physician's response (e.g., orders given)

Event Report Information (cont)

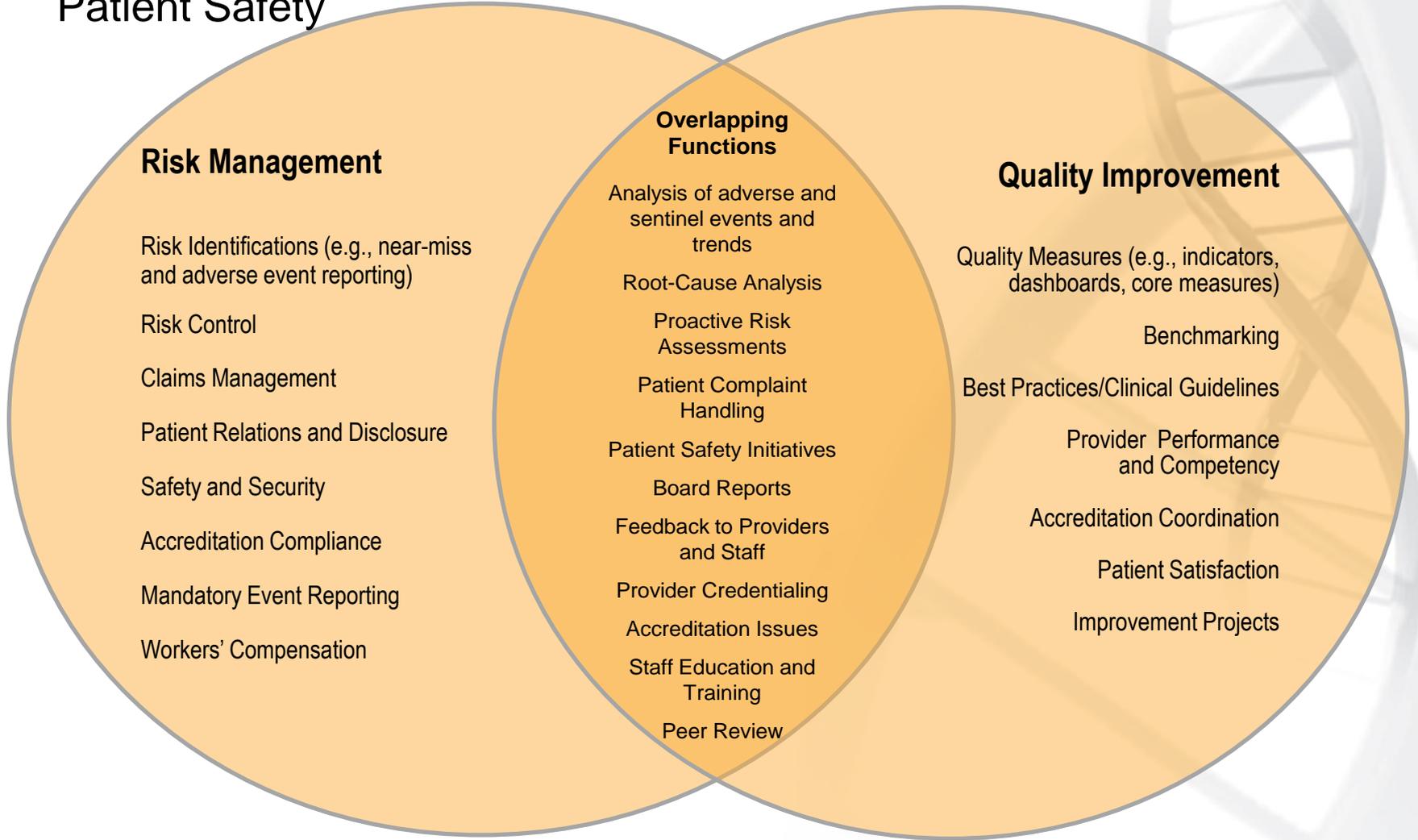
- ▶ Brief, factual description of the event
- ▶ Key observations about the event or at the scene
- ▶ Manufacturer, model, and lot number of any medical device or pharmaceutical involved
- ▶ Condition of the people affected (including any complaints of injury, observed injuries, and a brief comment on any follow-up care)

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4.0 Sample Response/Action Plan Template*

TOPIC	PROPOSED ACTION	RESPONSIBLE PERSON(S)	ACTION DUE DATE	PROGRESS	COMMENTS

Risk Management and Quality Improvement Functions Overlap in Patient Safety



Other ways of discovering events

- ▶ Clinic safety rounds
- ▶ Anonymous reporting
- ▶ Reports of complications
- ▶ Claims
- ▶ Complaints
- ▶ Chart reviews using trigger tools
- ▶ <http://www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/OutpatientAdverseEventTriggerTool.htm>

Implementing an Effective Event Reporting System

- ▶ Establish goals for system outcome
- ▶ Implement a “just culture”
- ▶ Assess existing systems
- ▶ Evaluate available systems
- ▶ Select and implement the system
- ▶ Monitor for effectiveness in identifying risks

Establish Goals

- ▶ The ultimate goal of an event reporting system is to identify events and problem areas so that:
 - The frequency of adverse events can be reduced
 - The impact of adverse events (and potential impact of near misses) on patient outcomes can be mitigated
 - The risk of liability claims can be reduced
 - The occurrence of adverse events can be prevented altogether

Implement a just culture

- ▶ Non-punitive, yet accountable
- ▶ Open communication
- ▶ Fair-minded treatment
- ▶ Meaningful feedback on positive change



OPEN

Assess existing systems

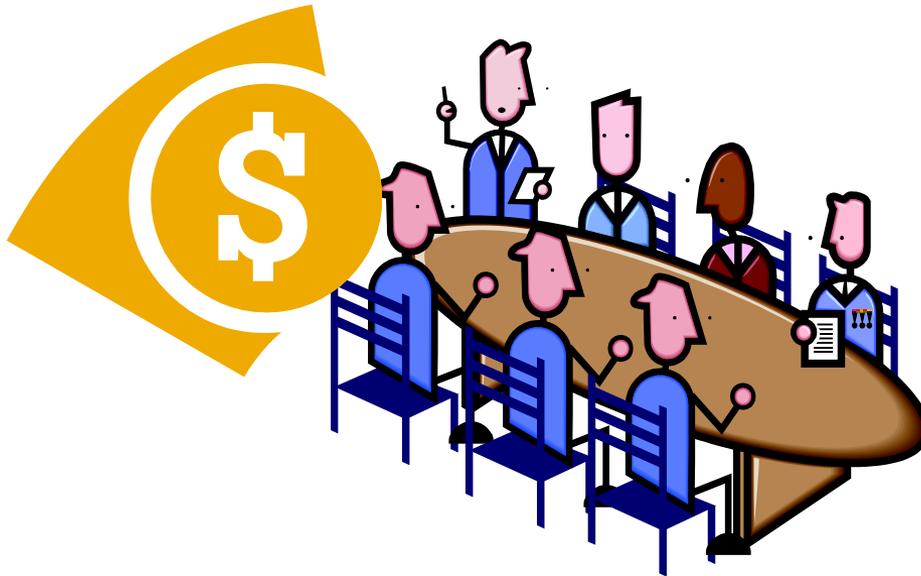
- ▶ Does the reporting system allow for ease of access and reporting by providers and staff?
- ▶ Does the report form include a listing of event types to prompt reporting of key events and near misses affecting patient safety?
- ▶ Does the system provide aggregate data for prioritization and trending information to evaluate systems and processes for safety and liability?

Evaluate available systems

- ▶ Use a task force
- ▶ Establish desired features
- ▶ Collect information on available systems
- ▶ Compare features, services, and costs
- ▶ Will it work in my health center or clinic?



Select, Implement, and Monitor



Getting the most from Internal Event Reporting Systems

- ▶ An effective event reporting system can enable the health center or clinic to:
 - Act on significant errors or events quickly in an attempt to prevent or minimize harm
 - Identify the cause of errors, near misses, and events so that recurrence can be prevented
 - Analyze trends so that systems and practices can be improved

Event Investigation

- ▶ Follow up information to “fill in” the gaps
- ▶ Helps identify contributing factors
- ▶ Investigation interview
 - Web resources: “Event Investigation Tips”
- ▶ Refer to quality improvement/peer review for action
- ▶ Report serious/sentinel event in anticipation of litigation

Medical Record Documentation of Event

- ▶ Date and time of the event
- ▶ A factual account of what happened
- ▶ Name of provider notified and time of notification (if applicable).
- ▶ Patient's condition after the event
- ▶ Any treatment or diagnostic tests rendered to the patient

Root Cause Analysis

- ▶ What exactly was the event or the chain of events that lead to the adverse event?
- ▶ What errors lead to it?
- ▶ What are the root causes?
- ▶ Did any errors relate to core system failures?
- ▶ Do they need redesign?
- ▶ What are lessons learned?
- ▶ Tools and Resources
- ▶ The Joint Commission
 - <http://www.jointcommission.org/SentinelEvents/Forms/>
- ▶ National Patient Safety Agency
 - <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847&>

Failure Mode and Effects Analysis

- ▶ Identify the process to be evaluated
- ▶ Construct a detailed diagram of the process – a functional block diagram and/or flowchart
- ▶ Evaluate each step in the process and identify all potential failure modes (errors) and effects using a systems approach
- ▶ List potential effects of each failure mode
- ▶ Prioritize for action
- ▶ Deploy redesign strategy

FMEA Resources

▶ IHI

- <http://www.ihl.org/ihl/workspace/tools/fmea/>

▶ American Society for Quality

- <http://www.asq.org/learn-about-quality/process-analysis-tools/overview/fmea.html>

Implementing solutions to identified problems

- ▶ Determine critical actions
- ▶ Resources needed
- ▶ Time frame for implementation
- ▶ Responsible individuals
- ▶ Potential impediments
- ▶ Countermeasures to impediments

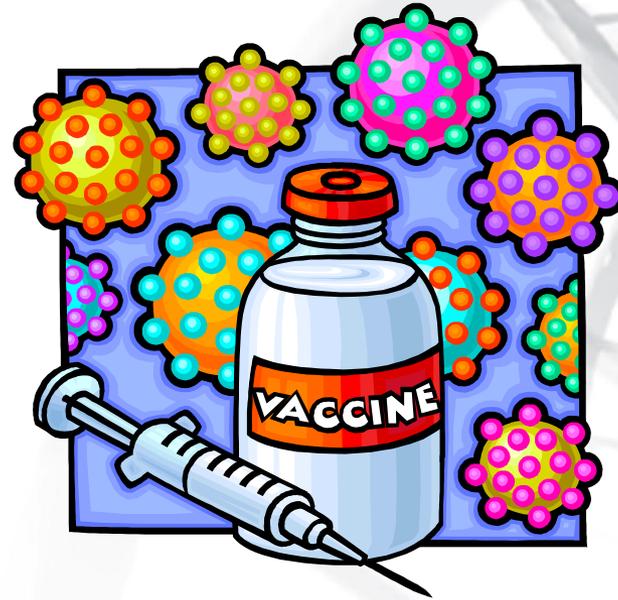
Implementing solutions to identified problems (cont)

- ▶ Develop/Disseminate
 - Education and lessons learned
 - Safety alerts
 - System modifications
 - Monitor effectiveness
 - Celebrate successes!
- ▶ Minnesota Adverse Event Measurement Guide
 - <http://www.stratishealth.org/news/20100415.html>



Success Story

- ▶ Reported vaccine mix-up
- ▶ Investigation of vials, cartons, and labels
- ▶ “Confirmation bias”
- ▶ Improved storage procedures
- ▶ Change in recording of lot numbers in vaccine log



Web Site Resources

Web site resources:

- CME courses in ECRI
Institute eLearn system
- Guidance articles
- Self Assessment
Questionnaire
- Standards and Guidelines



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Accessing your **ECRI Institute E-Learn** online course is easy as **1, 2, 3!**

1. Using your e-Learn course key code *, [register](#) and give yourself a user name and password. Watch this [Tutorial](#) if you need help registering.
2. [Check](#) your computer settings.
3. Login and take your courses!

User Name:

Password:



Challenges

Successes

Experiences

“Internal Event Reporting” program to be archived on Web site





Additional Questions?

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More info at:

www.ecri.org/clinical_RM_program

Thank You!