

# RISK COMMUNIQUÉ

## ***Incident Reporting – An Important Risk Management Tool***

***What exactly is an incident? An incident is generally defined as any happening which is not consistent with the routine care of a particular patient, or an event that is not consistent with the routine operation of the organization.***

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Incident reports serve many purposes---quality improvement, event documentation and risk/safety monitoring. Organizations of all types have found that incident reports can be a positive management tool. Encouraging employees to complete a report when things do not go as planned provides management with the necessary information to improve the quality of services and perhaps limit the possibility of a repeat occurrence.

Hospice Medicare Conditions of Participation (COPs) state that “performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions.....” Joint Commission standards for home care and hospice organizations require a process for “internally reporting, investigating, and documenting” identified types of incidents including “injuries to patients, staff, or others within the organizations’ facilities.” In addition, most state licensing agencies require some type of incident reporting process, including maintenance of a log of patient incidents/events.

It is helpful for every organization to define the purpose of their incident reporting system. The purpose of incident reporting may include, but is not be limited to, the following:

- To improve the management of patient care and treatment by assuring that appropriate and immediate intervention occurs and corrective measures are implemented to prevent recurrences.
- To provide a factual record of the event by the employee or volunteer who was a witness to or had first hand information of the incident.
- To provide a database for the organization’s Quality Assurance/Performance Improvement (QAPI) activities so that care and services can be evaluated and changes can be made to improve quality.
- To 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***

Those individuals who review and sign off on individual incident reports should be considering whether the information documented is adequate to establish a clear picture of the event. The purpose of this review is to determine what happened, why it happened, and whether effective and appropriate corrective action can be taken to prevent a recurrence. This process is not an attempt to determine liability or legal blame.

Documentation should be of the facts only, with no additional comments, supposition or allegations. The incident report form should never be attached to, included in, or referenced in the patient record.

*This is a sample guideline furnished to you by Hospice and Community Care Insurance Services. Your organization should review it and make the necessary modifications to meet the needs of your organization. The intent of this guideline is to assist you in reducing risk exposure to personnel. For additional information on this topic, you may contact your Risk Control Representative at (800) 233-1957 or visit [www.hccis.com](http://www.hccis.com)*

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In addition to identifying single events that require immediate intervention to reduce patient risk and control a potentially compensable situation, incident report data should be tabulated and the statistical information analyzed to show:

- Types of occurrences, severity of injury and frequency to help establish priorities for loss-prevention activities;
- Event pattern to show a particular locations, time of day or day of week;
- Patient demographics, such as age and gender
- Staff characteristics, such as employee or agency
- Number of incidents over a period of time to show changes in the frequency;
- Effectiveness of corrective measures based on the number and type of a particular event being reported.

This analysis may be useful in getting at underlying causes of repetitive event types. Incident Report data alone cannot provide a comprehensive picture of an organizations activities and potential exposures. To achieve this other sources of data such as Quality Improvement statistics, Safety and Security reports, Utilization Review data, Patient/family satisfaction and complaint reports, and results from Internal and External Surveys, etc., also need to be reviewed. Only then can an organization hope to have a comprehensive view of potential loss exposures.

## ***Incident Reporting Guidelines***

The organization should have established guidelines to give staff some direction as to which types of events are reportable. (Sentence in here about sentinel events deleted)

The following list of reportable events, 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
- Adverse or allergic drug reaction
- Patient refusing 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)
- Patient or family complaints of 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 of patient, or allegations of sexual misconduct
- Failure to respond in a timely fashion to patient or family request for assistance, information, or treatment
- Patient/family complaints
- Thefts of organization equipment, such as laptops
- Oxygen use related incident
- Security Incidents
- Motor vehicle accidents

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It is important for an organization to periodically review and evaluate their incident reporting procedures. Consistency in reporting, processing and maintenance of reports is important. 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 is not reporting all incidents or near misses that occur.

**Incident Reporting Policy and Procedure Checklist:**

- There is a written incident reporting policy/procedure
- The procedure includes a clear definition of what is reportable
- The procedure defines responsibility for reporting incidents and emphasizes participation of all staff in all departments
- Incident reports include documentation of facts only, with no allegations or finger pointing due to the potential for discoverability in the event of a claim
- The procedure clearly identifies reporting channels
- The 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 factors and if event was preventable
- Reports are trended and analyzed on a monthly 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
- Incident reports are considered confidential work product. No copies are made and they are maintained in a secure location.

References: [www.cms.gov](http://www.cms.gov)  
[www.jointcommission.org](http://www.jointcommission.org)