UPMC Staff Education
Initial Incident/Event Reporting

How We Improve the Health and Safety of Our Patients
Pennsylvania Act 13 established May 2002

- Known as the Mcare Act
- Established the Patient Safety Authority
- Reduction and elimination of medical errors
- Created role of Patient Safety Officer
- Requires hospitals to have a Patient Safety Plan
- Established guidelines for event reporting
Benefits of Event Reporting

• Problem solving begins
• Tracking and trending can occur
• Enhanced communication
• Process improvement opportunities
• Clinical practice habits for patient safety
• Meet regulatory requirements
Everyone Has Accountability

- A nurse who questions the type of diet ordered for a patient,
- An administrator who plans for services,
- A housekeeper who cleans up a spill in a patient room,
- A physician who prescribes medication,
- A therapist who informs the team of a change in a patient’s status

Every staff member does many things each day that helps to keep our patients safe.
What to Report

• Any occurrences /events that are not consistent with the:
  – Routine Care of Patient (Actual or Potential to harm)
  – Routine Service of a Department
  – Routine Operation of the Physical Plant
Near Misses

• A near miss as an error that happened but did not reach the patient.
• These errors are captured and corrected before reaching the patient, either through chance or purposefully designed system controls that have been put in place.
• Thus, reporting near misses can help to evaluate whether policies or procedures are functioning poorly— and to capture opportunities
**Incident**: an event, occurrence or situation involving the clinical care of a patient in a hospital which could have injured the patient but did not cause an unanticipated injury and/or require the delivery of additional services to the patient.

- A patient falls but is not injured
- An IV infiltration where treatment is compresses and elevation
- Medication given to the wrong patient with no harm to the patient
Reportable Events – Serious Events

**Serious Event:** an event, occurrence or situation involving the clinical care of a patient in a hospital that results in death or compromises patient safety and results in an *unanticipated* injury requiring additional health care services to the patient.

- A patient falls, fractures his arm and requires a cast
- An IV infiltration that requires the administration of a medication to reverse damage to the skin and tissue
- A medication error that results in the death of a patient

Reportable to the PA Department of Health via PA-PSRS within 24 hours of occurrence or confirmation of occurrence.
Infrastructure Failure: an undesirable or unintended event, occurrence or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety.

- An area of the hospital floods, requiring patient evacuation
- Patient elopement
- Activation of the Emergency Response Plan
- Patient death while in restraints or for prior 24 hours

Reportable to the PA Department of Health via PA-PSRS within 24 hours of occurrence or confirmation of occurrence
Reporting a Patient Safety Concern

Inform your supervisor
- Voice to voice – not in a message
- Always needs to know
- Sometimes needs to act
  • Nurse supervisor notification
  • Activation of internal emergency response
  • PA-PSRS reporting

Enter an Initial Incident Event Report (IIER) in Riskmaster
Consequences of Not Reporting an Event

• The circumstances leading to an event occurrence cannot be reviewed, evaluated, or revised for a safer practice.

• Under Pennsylvania law, the Hospital has an obligation to notify the appropriate State licensing board if a licensed health care provider providing services in the Hospital fails to report a Serious Event in accordance with this policy. An employee who knowingly fails to report a Serious Event may be subject to disciplinary or corrective action.
Where Reports Go

- Department Director
- Patient Safety Officer/Risk Manager
- Pennsylvania Patient Safety Authority
- Department of Health
- Hospital Patient Safety Committee
- The Joint Commission
Foster Patient Safety and Diminish Risk

• Listen to patients and their families
• Understand that errors can and do happen
• Ask questions
• Improve work processes and double-check
• Participate in Root Cause Analysis
• Follow Plan of Correction
• Report, Report, Report!!!
• **PA Whistleblower Law** – No adverse action or retaliation against staff for reporting.
• Healthcare workers who fail to report can be subject to professional board disciplinary action.

• The Joint Commission
  • 1-800-994-6610 or complaint@jointcommission.org

• The Pennsylvania Department of Health
  • 1-800-254-5164 (hospitals and ambulatory surgical facilities)

• The Pennsylvania Safety Authority
  • Serious Event Anonymous Report form via www.papsrs.state.pa.us

• Bureau of Professional and Occupational Affairs
  • 1-800-822-2113 (licensed medical professionals)
Submitting an Initial Incident/Event Report (IIER) into Riskmaster
• Access the UPMC Infonet- sign in with your e-mail (minus the @upmc.edu) and password if prompted. Click on Clinical Tools.
Risk Master

• Then click on Compliance and Risk Management. Choose the Risk Master: Incident Reporting that is in blue.
Choose Jameson then click on Login.

Enter the unit/department where the event occurred.
Risk Master Initial Incident/Event Report Form
All underlined fields must be completed plus medical record number.
1. Incident Reports – are discoverable in a court of law
   - Write facts only - give as much detail as possible
   - **Exclude** opinions and references to personal feelings

2. Joint Commission reporting - such as sentinel events
   - Facts only
   - Prior to submitting documents
     - Review the following at Patient Safety Peer Review Committee
       - Approval to submit the content
       - Proposed submission
     - Include discussion in meeting minutes

3. Documents given to DOH surveyors that are taken out of the hospital
   - Discoverable
   - Limit to medical records and policies
Incident Reporting Tips

• If it is a medication or fall event – need to select the radio button for fall or medication event there is more information behind that is required for submission to state.

• If the event does not have anything to do with a exact patient or multiple patients you are able to type in first and last name none, choose not applicable for gender and then you are able to type the event and it will let you submit. This could be used for a power failure for example.
How to Complete an Initial Incident/Event Report

- Just the Facts
- Objective information – who, what, when, where, how
- Concise with enough detail to tell the story
- Timely – before the end of the shift when the event occurred
- An Initial Incident/Event Report (IIER) can be submitted Anonymously
Because what is reported matters.

*Initial Incident Event Reports to Process Improvement Opportunities.*

*Are you part of the solution?*
UPMC EVENT MANAGEMENT IN A JUST CULTURE

This tool applies to any event occurring at any UPMC-owned or leased facility involving employees, medical staff, students/trainees, contract personnel, volunteers, vendors, or any other individual providing services on behalf of UPMC.

Event requiring managerial intervention occurs

Is the event clinical or patient safety related?

TAKE ACTION:
1. Report this event in Risk Master
2. Investigate the event

Utilize the A Just Culture Decision Tree to determine issue category and appropriate response (Go to next page)

Please contact Human Resources for assistance with event investigation and response.
Analysis using the Decision Tree applies to any incident or event occurring at any UPMC-owned or leased facility involving:

- Employees
- Medical staff
- Students/trainees
- Contract personnel
- Volunteers
- Vendors
- Any other individual providing services on behalf of UPMC

Regardless of the people involved, the focus is on a consistent framework for analyzing why safety incidents/events occurred.
## Covered Instances: Examples

<table>
<thead>
<tr>
<th>A Just Culture Decision Tree applies to . . .</th>
<th>A Just Culture Decision Tree does not apply to . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medication errors</td>
<td>• Attendance issues</td>
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<tr>
<td>• Mislabeling blood specimens</td>
<td>• No-call/no-show incidents</td>
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<td>• Failure to follow:</td>
<td>• HIPAA violations/breaches of confidentiality</td>
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<tr>
<td>▪ patient identification protocols</td>
<td>• Harassment</td>
</tr>
<tr>
<td>▪ Patient Falls policy</td>
<td>• Theft</td>
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<tr>
<td>▪ protocol outlined in Prevention of</td>
<td>• Fraud</td>
</tr>
<tr>
<td>Wrong Site, Wrong Procedure and Wrong</td>
<td>• Inappropriate/unprofessional conduct</td>
</tr>
<tr>
<td>Person Surgery or Invasive Procedure</td>
<td>• Failure to comply with the Clean</td>
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<tr>
<td>policy</td>
<td>Air/Smoke- and Tobacco-Free Campus policy</td>
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<tr>
<td>▪ restraint/seclusion protocol</td>
<td></td>
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<tr>
<td>• Lack of compliance with infection</td>
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<tr>
<td>control practices when providing care</td>
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A JUST CULTURE: ACCOUNTABILITY FOR PATIENT SAFETY
DECISION TREE FOR STAFF

Ask four questions . . .

1. Malicious
   - Was there desire to cause harm?

2. Impaired
   - Does there appear to be evidence of impairment, i.e., ill health or substance abuse?

3. Departure from Procedure
   - Did the individual depart from agreed protocols, safe procedures, and/or standards of care?

4. Substitution Test
   - Based on Fact Finding*, has behaving in this way become part of your local culture (relevant to circumstances—hospital, department, unit, work group) so that 2 or 3 others have been/are engaging in the same behavior?

   - Were there any deficiencies in training, experience, or supervision?

   - Malicious Action
   - Fitness for Duty
   - Individual Human Error and/or System Failure
   - Risky Behavior and/or System Failure
   - Careless Behavior
   - System Failure

*Fact finding involves interviewing staff and/or reviewing prior incidents and events to establish local cultural norms. May consult HR to assist in this process.
Please note that the following Human Resources policies and LifeSolutions services apply to employed staff. When applying the A Just Culture Decision Tree in instances involving non-employed staff, such as contract personnel, volunteers, or vendors, please contact your Human Resources representative for assistance.

<table>
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<tr>
<th>Malicious Action</th>
<th>Unfit for Duty</th>
<th>Careless Behavior</th>
<th>Risky Behavior</th>
<th>Individual Human Error and/or System Failure</th>
</tr>
</thead>
</table>
| The staff member wanted to cause harm or engaged in a terminable offense as defined in policy. | The staff member’s performance may be impaired by illegal or legal substances, cognitive or physical impairments, or other health issues.  
• Consult Human Resources.  
• May result in discharge and/or legal proceedings.  
• Suspend duties immediately.  
• Report as appropriate to Legal Services and licensing board. | The staff member made an unsafe choice.  
• Consult Human Resources.  
• Progressive corrective action (minimum of written warning) is warranted.  
• Formal referral to LifeSolutions (EAP) is strongly recommended.  
• Address and fix applicable system issues.  
• Staff member may need intense retraining.  
• May teach lessons learned to others. | The staff member made a potentially unsafe choice.  
• Consult Human Resources.  
• Verbal counseling to remediate behavior is warranted.  
• Progressive corrective action may be warranted for repeat unsafe acts.  
• Encourage staff member to check in with LifeSolutions (EAP).  
• Formal referral to LifeSolutions (EAP) is strongly recommended if a serious patient event occurs.  
• Address and fix applicable system issues.  
• Staff member may need retraining.  
• May teach lessons learned to others. | Leaders are accountable to take initiative to fix the system to avoid future errors. Staff are accountable for assisting leaders in these initiatives and avoiding their own errors in the future.  
• Console staff member; coach staff member as applicable.  
• Performance Improvement Plan may be warranted for repeated human errors (performance issues); consult Human Resources.  
• Encourage staff member to check in with LifeSolutions (EAP).  
• Formal referral to LifeSolutions (EAP) is strongly recommended if a serious patient event occurs.  
• Address and fix applicable system issues.  
• Communicate system changes to staff members.  
• Staff member may need retraining.  
• May teach lessons learned to others. |

**Note:**
With Human Resources approval, managers retain the right to administer a mandatory referral to LifeSolutions (EAP) if the circumstances warrant, especially to ensure the staff member’s own safety and recovery from an event. A staff member given a mandatory referral to LifeSolutions who does not call for an appointment, does not show up for an appointment, or does not follow LifeSolutions’ recommendations will be considered suspended pending investigation or may be discharged.
Speaking Up for Patient Safety

“You Have My Permission”

June 2015
• Did you ever notice something unsafe that could harm a patient?

• Did you ever want to say something about safety but feel fearful or uncomfortable to speak up?
Why do errors occur in healthcare?

- Healthcare is complex
  - Handoffs and Transitions of Care
  - Evolving Science and New Procedures
  - Poor system design
- Fear of speaking up
- Working in silos
- Hierarchy rather than collaboration
- We are human!
  - Stressful Environments
  - Staff Burn Out
Our Goal

• Provide a safe environment for all of our patients, families, and employees throughout UPMC

• Prevent unsafe acts, conditions or near miss events by speaking up and reporting all issues that jeopardize the safety of our patients and associates
We Need Your Help

• Your participation and support is vital
  – Safety is everyone’s responsibility!
  – Patients and their families expect us to keep them safe
  – Feel empowered to express any concerns

• Don’t be afraid or uncomfortable to speak up
  – Be the patients’ voice
  – Nothing is more essential than safety!