UC Riverside, School of Medicine Policies and Procedures
Policy Title: Incident Reporting
Policy Number: 950-03-021

Responsible Officer:	Chief Medical Officer
Responsible Office:	Clinical Affairs
Origination Date:	February 25, 2022
Date of Revision:	September 2022
Scope:	Applies to all Providers and Staff at UCR Health

I. Policy Summary

This policy sets guidelines for UCR Health incident reporting.

II. Policy

It is the policy of UCR Health to create and maintain an environment of safety for our patients, visitors and personnel, as well as to protect the organization assets. This is done through the development and maintenance of an early warning system. RL Solutions is the web-based, incident reporting system used by UC Riverside Health. An incident includes an unusual occurrence and includes near misses where there was a deviation from standards of practice.

Confidentiality is expected in the handling of all individual incident reports.

A. Accountability

Clinicians and staff are accountable for their practice. Consequently, professional competence issues may be identified through this process and interventions may occur, such as coaching or focused training. A commitment is expected to correct individual deficiencies in practice related to a lack of judgment, knowledge and/or skill. Clinicians and staff are required to participate in the detection and reporting of events, the identification of potential causes, and the implementation of improvements to reduce events. Event reports will only be submitted in good faith, based on the reporter's honest and reasonable observations of the facts

B. Privileged and Confidential

The incidents that are recorded in individual incident reports may result in litigation against UCR Health. Incidents may require physician peer review by appropriate medical staff committees. Individual incident reports are confidential records prepared by UCR Health employees and physicians, as an integral part of the UC Riverside Health Risk Management Plan, which operates under the direction of the UC Legal Department and the UC Self Insurance Trust. The UC Riverside Health intends the content of each individual event report to be treated as confidential communication under the attorney client privilege, attorney work product doctrine and, where appropriate, to be protected under CA Evidence Code Section 1157. UC Riverside Health internal reporting of de-identified aggregate trends in event reports is not to be construed as a waiver of the applicable privileges which are intended to shield the confidentiality of the content of individual report.

III. Procedure

A. Care of the Patient and Documentation:

1. The priority of the clinicians, staff, fellows and residents is to provide for the care and

safety of the patient. The attending/treating physician should be notified of incident resulting in patient harm to obtain orders for treatment if applicable.

2**.** A factual description of the incident, the patient status, the treatment provided and the patient's response to treatment will be documented in the patient's medical record. Do not reference the event report in the medical record.

B. Reporting an Incident

Any employee, physician, fellow or resident reporting an incident will complete an incident report promptly after the incident (preferably within twenty-four [24] hours) by accessing the RL Solutions system via the link on the UC Riverside Health Intranet. The reporter selects the most appropriate incident type and answers the questions as completely and accurately as possible. The report will include a detailed and objective description of the incident, including post-event patient status.

C. Incident Response and Follow-up

1. Completed incident reports are stored in the system's database and designated managers receive report notification.
2. The manager or supervisor/designee of the area will conduct the investigation, achieve resolution, and implement corrective action as needed. Managers from other affected departments will be involved in evaluating actual incident and identifying potential contributing factors and will be sent a copy of relevant incident reports by the manager of the department in which the incident has occurred, if not automatically routed by the system. The manager (or Supervisor/designee) of the department involved in an event:
   - 2.1 Provides immediate support to staff involved in significant events. Individuals involved or affected by an incident will be offered support and assistance. Examples, Employee Assistance Program.
   - 2.2 Takes necessary action when hazardous conditions exist that could result in injury to patients, visitors, clinicians or staff or damage to equipment or facilities
   - 2.3 Reviews event reports and initiates investigations within seven (7) days of occurrence. This includes identification of contributing factors, determination of patient outcome, and development and timely implementation of corrective actions. The contents of incident reports are considered preliminary information and event details are subject to investigation.
   - 2.4 Provides feedback on individual incident to the appropriate employee/s. Managers' feedback should include a review of safety rules, risks associated with failure to follow safety rules, strategies to reduce the risk of recurrence, and responsibility to make safe decisions. Feedback may also include how the event was resolved.
   - 2.5 Shares aggregate incident reports data with their staff. Staff discussion of aggregate incident data will be for the purpose of analyzing department efforts to improve patient safety.
3. UCR Health Risk Department oversee the grouping of incident reports to monitor for trends and/or systems issues and direct global performance improvement. The UCR Health Risk Department will follow-up with the manager of the area to ensure timely and appropriate resolution. The UCR Health Risk Department will assure that all appropriate

individuals and departments have been involved in evaluation of the actual event. The UCR Health Risk Department reviews incident reports to determine that sufficient investigation has been completed and patient outcomes reported so that accurate severity ranking can be assigned.

4. Incident involving practitioner (physician, allied health) performance are referred to leadership and/or Quality Improvement Representatives (QIR's) for follow-up. Incident are forwarded as appropriate to the Medical Staff Department Committees for evaluation and possible follow-up through departmental performance improvement initiatives.

D. Severity Ranking

1. The Clinic/ Department Managers will review the incident report, evaluate the resolution, and assign the severity rank the event report by the end of the following month. Severity level options include the following:
    a. No harm, reached patient –incident occurred that reached the patient, but no harm was evident.
    b. No harm, did not reach patient –incident occurred that did not reach the patient and therefore did not result in harm.
    c. Mild harm, reached patient –incident caused minimal symptoms or loss of function, or injury limited to additional treatment, monitoring and/or increased length of stay.
    d. Mild harm potential, did not reach patient - incident could have caused minimal symptoms or temporary loss of function, or injury limited to additional treatment, monitoring and/or increased length of stay.
    e. Moderate harm, reached patient - incident caused injury adversely affecting functional ability or quality of life, but not at the level of severe harm.
    f. Moderate harm potential, did not reach patient - incident could have caused injury adversely affecting functional ability or quality of life, but not at the level of severe harm.
    g. Severe harm, reached patient - incident caused injury (including pain or disfigurement) that interferes substantially with functional ability or quality of life.
    h. Severe harm potential, did not reach patient - incident could have caused injury (including pain or disfigurement) that interferes substantially with functional ability or quality of life.
    i. Death, progression of illness - death was a result of the progression of illness.
    j. Death, unexpected - death was unexpected and not a result of the progression of illness.
    k. Unable to determine.
    l. Non-event.

E. Notification of Events that Result in Patient Harm

1. Any occurrence resulting in patient harm shall immediately be reported to the appropriate Chain of Command.
2. The patient's attending physician will be designated as the spokesperson for the patient and family to assure coordinated communication. The Chief Medical officer and as well

as Risk Management department will serve as consultation resources on disclosure to the attending staff and other providers.

F. Performance Improvement and Risk Reduction

1. The Patient Safety Committee will evaluate trend analysis reports to determine appropriate organizational responses related to systems issues that impact patient safety.

IV. Responsibilities

UCR Health Clinical Faculty, staff, clinicians, fellows and residents.

V. Revision History

N/A

Approvals:

COMPLIANCE COMMITTEE (10/25/2022)

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Addendum One: List of adverse incidents (July 2022)

Types of adverse incidents:

A. An incident in which care resulted in an undesirable clinical outcome. An outcome not caused by underlying disease that prolonged the patient care, caused serious and/or permanent patient harm, required life-saving intervention, or contributed to death.[i]

B. Any breach in medical care, such as the following:
1. A deviation from administrative procedures,
2. A deviation from an informed consent,
3. Any other event resulting in an outcome not normally associated with the standard of care.

C. Any incident trigging a reporting obligation on the part of the School of Medicine, including but not limited to licensing boards, the Title IX Office; Office of Compliance; Office of Diversity, Equity, and Inclusion.

D. Additional adverse incidents as defined below [ii]
1. Surgery or invasive procedure events
   a. Surgery or other invasive procedure performed on the wrong site.
   b. Surgery or other invasive procedure performed on the wrong patient
   c. Wrong surgical or other invasive procedure performed on a patient
   d. Unintended retention of a foreign object in a patient after surgery or other invasive procedure

2. Product or device events
   a. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
   b. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
   c. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.

3. Patient protection events
   a. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.

4. Care management events
   a. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
   b. Patient death or serious injury associated with a fall while being cared for in a healthcare setting.
   c. Artificial insemination with the wrong donor sperm or wrong egg.
   d. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
   e. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.

5. Environmental events

a. Patient or staff death or serious injury associated with an electric shock during a patient care process in a healthcare setting.
b. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances.
c. Patient or staff death or serious injury associated with a burn incurred from any source during a patient care process in a healthcare setting.

6. Radiologic events
   a. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.

7. Potential criminal events
   a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
   b. Abduction of a patient/resident of any age.
   c. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting.
   d. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

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[i] Office of Inspector General: Adverse events (Internet), US Department of Health and Human services, 2022 June 16 (cited 2022, July 15). Available from: https://oig.hhs.gov/reports-and-publications/featured-topics/adverse-events/#:~:text=Adverse%20Event%20%2D%20An%20event%20in,intervention%2C%20or%20contributed%20to%20death.

[ii] National Quality Forum (NQF), Serious Reportable Events in Healthcare, 2011 Update: A Consensus Report, Washington, DC: NQF; 2011.