UC Riverside, School of Medicine Policies and Procedures
Policy Title: Addendum One: Adverse Incidents
Policy Number: 950-03-029

Responsible Officer:	Executive Director Clinical Operations
Responsible Office:	Clinical Operations
Origination Date:	07/15/2022
Date of Revision:	N/A
Scope:	UCR Health Faculty Practice Sites

I. Policy Summary

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.

II. Definitions

N/A

III. Policy Text

N/A

IV. Responsibilities

N/A

V. Procedures

Reporting process:

A. All adverse incidents must be immediately reported to the clinic manager.

B. An incident report of the adverse event/incident must be submitted in the School of Medicine's confidential incident reporting database.

VI. Forms/Instructions

N/A

VII. Related Information

N/A

VIII. Revision History

N/A

Approvals:

COMPLIANCE COMMITTEE (08/17/2022)

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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.