UMHHC Policy 03-07-001
Patient Safety Reporting (formerly Incident Reporting)

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I. POLICY STATEMENT, PURPOSE AND SCOPE

It is the policy of the University of Michigan Hospitals and Health Centers (UMHS) that all patient adverse events and incidents are reported as soon as known, and within 48 hours, by entering a patient safety report into the PSRS for quality, clinical risk, and patient safety management.

The purpose of the policy is to provide a mechanism for documenting and reporting patient safety events occurring at UMHS. The policy is utilized for quality, clinical risk, and patient safety improvements and is applicable to all patients within UMHS.

The documentation and reporting of patient safety events and incidents is a quality improvement effort. Reporting of events aids efforts to improve the culture of safety for patients and all UMHS staff. Analysis of quality improvement efforts and promoting a culture of safety identify ways to mitigate risk and facilitate clinical quality care improvements.

II. DEFINITIONS

Patient Safety Events - Events that may have resulted in patient injury, which can be physical or psychological. These events may result from acts of commission or omission. Patient safety events also include an event that was caught and/or prevented from reaching the patient, either by chance or timely intervention, thereby avoiding patient harm. Such incidents have also been referred to as "close calls" or "near misses". An example of a near miss would be when a surgical or other procedure is almost performed on the wrong patient due to lapses in verification of patient identification, but caught by chance at the last minute. Near misses are opportunities for learning and afford the opportunity to develop preventive strategies and actions.

All patient safety events require reporting in the Patient Safety Reporting System. **Harm does not have to occur for a report to be filed**.

Examples of reportable events include but are not limited to:

- Physical harm to a patient or visitor
- Unauthorized leave by a patient
- Accidents in which patients or visitors are injured or die
- Medication errors/variances
- Foreign bodies unintentionally left in patients
- Burns
- Nerve damage
- Mistaken identity
- Surgery on wrong part of the body
- Injury to or removal of the wrong party of the body
- Falls or other mishaps, e.g., lacerations, bruises
- Transfusion issues (This excludes routine untoward reactions, i.e., 5% chills, fever, etc.)
- Patient leaving the hospital Against Medical Advice (AMA)
- Complications from IV administration (extravasation, fluid overload, etc.) resulting in harm to patient
- Pressure sores, burns, or other skin injuries
- Procedure breakdowns involving a patient: for example, consent form not signed, incorrect identification band, wrong patient transported for diagnostic or therapeutic procedure, incorrect sponge and/or instrument counts in O.R., unavailability of transport for patient
- Suicide attempts by patients while in the hospital, or within 72 hours of discharge

Intentional unsafe acts must be reported to Patient Relations & Clinical Risk or the Office of Clinical Affairs immediately. See UMHHC Policy 03-07-004 Safety Events including Sentinel Events and UMHS Policy 04-06-036 Drug-Free Workplace.

PSRS - Patient Safety Reporting System, UMHS online incident reporting system. The link is available on the Clinical Home Page and the Internal Home Page.

RM Pro - Risk Monitor Pro (another name for the PSRS).

Reviewable Adverse Events - See UMHHC Policy 03-07-004 Safety Events including Sentinel Events.

III. POLICY STANDARDS

A. Every safety event, including near misses (i.e., events that occur without harm) and events resulting in harm, are reported through the online reporting system (PSRS). Patient events with serious harm (> E3) should be reported immediately to Patient Relations and Clinical Risk either by telephone at 734-763-5456 or through the paging operator (to contact the Clinical Risk Staff on Call).

B. Disclosure and apology to the patients/families will occur. See UMHHC Policy 03-07-011 Disclosure of Unanticipated Patient Outcomes.

C. UMHS shall maintain the PSRS database for analysis of aggregate trends throughout UMHS.

D. Reporting of patient safety events shall not, in and of itself, subject staff to punitive or disciplinary actions.

E. PSRS reports or Patient Relations & Clinical Risk contacts should not be included or referenced in the patient's medical record. Record objective facts in the medical record as appropriate to the patient's treatment and diagnosis. Discussion of the facts surrounding the patient safety event shall be discussed with the patient by designated treating staff. See UMHHC Policy 03-07-011 Disclosure of Unanticipated Outcomes.

F. PSRS reports are confidential and non-discoverable to the extent provided by law for quality improvement efforts under the Michigan Public Health Code. PSRS reports shall not be copied, photocopied, retained by individuals, or given to patients.

G. Institutional departments and committees use reported patient safety events data for quality improvement purposes. These include Patient Relations & Clinical Risk, the Office of Patient Safety, the Patient Safety Event Team, the Patient Safety Committee, Office of Clinical Affairs, Clinical Quality Committee (CQC) and other aggregate review committees assigned a quality improvement purpose.

IV. PROCEDURES/ACTIONS

Responsible Person	Action
All Employees/Students/Volunteers when observing **or** discovering a potentially injurious patient safety event.	1. Assess the patient to assure the safety and well-being of involved person or patient. 2. Notify the patient's physician(s) and/or area manager/supervisor. 3. Provide follow-up treatment as prescribed. If serious harm (>E3; refer to scoring system) has occurred, call Patient Relations & Clinical Risk at 734-763-5456 or through the paging operator (to contact the Clinical Risk Staff on Call). 4. If medical equipment/product is involved in the incident, page Clinical Engineering immediately through the Paging Operator 24 hours/day, 7 days/week. Do not unplug or turn off equipment unless it poses a danger to the patient. (Unplugging and/or turning off devices can cause the loss of important and/or useful stored data.) Save all equipment and devices including disposable items and packaging, e.g., catheters, IV, tubing, etc., and give to Clinical Engineering. 5. Document objective facts of the incident in the medical record. Do not reference "incident report", "Patient Safety Report Form", or "Patient Relations & Clinical Risk" in the medical record. 6. Complete a PSRS Form (online patient safety report). 7. Coordinate with the patient's attending physician and/or area manager regarding disclosure (see UMHHC Policy 03-07-011 Disclosure of Unanticipated Patient Outcomes.)

Supervisor, Managers, or Designees	Event review and analysis: 1. Address immediate health/safety/operational issues as applicable to a patient safety event. Complete a debrief with involved individuals. 2. Using the PSRS manager tool, perform initial review of incident within 72 hours. Complete the review within one week. 3. Record any review/follow-up that occurred on the Follow-up page. 4. On the Review/Resolution (Outcome) Page, enter the date and the manager review. In the Outcome Details section, enter a short description of the outcome action steps taken since the event. 5. Analyze area's incident data for trends and opportunities for patient safety improvement. 6. Assume responsibility for instituting appropriate policy and procedural changes to address quality of care issues. 7. Within the PSRS report function for managers, use the templates in the Shared folder of PSRS or Risk Monitor Pro or Report Producer. Provide Education and Training: 1. Training materials for reporting and review for managers and staff 2. Orient employees, students, and volunteers to the online location of the PSRS form, located as a link on the Internal Home Page and the Clinical Home Page. 3. Orient employees, students, and volunteers to policy and procedure for reporting patient safety events. 4. Attend PRCR training classes to learn event review documentation and analysis of trends in areas of patient care responsibilties.
Hospital Committees	1. Hospital Committees and leadership groups perform individual and aggregate reviews of appropriate patient safety reports. 2. These Committees/Groups review individual events and identify trends and opportunities for patient safety improvement efforts. 3. They may also initiate multidisciplinary improvement efforts and refer Peer Review concerns to the Office of Clinical Affairs.
Patient Relations & Clinical Risk	1. Coordinate, identify, and investigate patient harm > E3. Reports activities with the Office of Clinical Affairs, Patient Safety Event Team, Safety Officers, Pharmacy, Nursing, Clinical Engineering, Infection Control, Office of General Counsel, and other appropriate departments. 2. Review of patient safety events with harm >E3 should be completed as soon as possible, preferably within 72 hours. 3. Disclosure to the patients and families will occur (see UMHHC Policy 03-07-011 Disclosure of Unanticipated Patient Outcomes) with initial acknowledgement of the event, holding of directly related billing, and mitigation of damages.

Office of Patient Safety	Reporting of Sentinel Events to the Joint Commission and generation of an Action Plan post Root Cause Analysis (RCA) will be performed (see UMHHC Policy 03-07-004 Safety Events including Sentinel Events).

VI. REFERENCES

National Quality Forum. NQF Releases Updated Serious Reportable Events

Centers for Medicare and Medicaid Services: Fact Sheets: Details for Eliminating Serious, Preventable and Costly Medical Errors. Released May 18, 2006. Accessed November 9, 2012.

Michigan Compiled Laws, Annotated, Sections 333.20175, 333.21515, 333.2631 - 2 - Public Act 368, 1978.

The Joint Commission Accreditation Manual for Hospitals (2012). Standards: LD. 04.04.03; IM 02.01.01; II. 03.01.01; MS 05.01.03 & 05.01.03

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Approved by:

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