CHART Event Reporting System

RL6:Risk

RLDatix™

Guide for Reporting Events

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Introduction

The purpose of the CHART Event Reporting System is to provide a mechanism for all members of the healthcare team, at all levels within the organization, to report events occurring in the hospital environment that harm, or have the potential to harm, an individual. The collection, aggregation, and analysis of these events are critical to continuously improve the quality and safety of the care we deliver. We ALL have a responsibility to ensure the safety of our patients, visitors and staff.

CHART strongly encourages and supports a culture of safety, empowering all members of the healthcare team to voluntarily report events, without fear of punishment or retaliation. All data and reports are considered confidential and are NOT part of a patient's medical record.

CHART has adopted a reporting taxonomy which encompasses nine event types pertaining to frequently occurring and/or serious patient safety events or near misses. The nine general event types are:

- Medication Event
- Adverse Drug Reaction
- Equipment/Supplies/Device Event
- Falls
- Error Related to Procedure/Treatment
- Skin Integrity Event
- Complication of Procedure/Treatment
- Transfusion Related Event
- Infrastructure Failure

There are also some optional general event types that can be activated for your site:

- Employee/Affiliate Issue
- Employee Accident/Injury/Illness
- Incidental Findings

Each general event type has further classification to "Specific Event Type" and detail. This Guide will define key terms to allow the healthcare team to collect and standardize information regarding reported events.

**Please note that the CHART Event Reporting System does NOT replace any current mandatory reporting system.*

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General Guidelines for Event Reporting

1. Report the event as soon as possible after its occurrence. You are more likely to recall the details of the event while it is still fresh in your mind.

2. Report ALL events, not just those causing harm. Valuable lessons can be learned from reports of unsafe conditions, "near misses" and/or "close calls".

3. Complete as much information on the event report form as you can. At a minimum, all mandatory fields (those marked with a green asterisk * in the electronic system) must be completed.

4. Provide a **factual** description of the event. Your report must be objective; do NOT include extraneous comments, personal opinions or derogatory notes.

5. Keep the information confidential and never make copies of any documentation related to the event.

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General Guidelines for Event Follow-Up

1. Complete the "Follow-Up Actions" sections in RL6:Risk as appropriate.
    - Potential Contributing Factors
    - Who Was Notified?
    - Follow-Up Actions
    - Risk Evaluation

2. Investigate the event as soon as possible. Consider the following: What happened? Why did it happen? What were the most proximate factors? What systems and processes underlie those proximate factors?

3. Develop an action plan to reduce risk and prevent the event from recurring. Include the following in your action plan for maximum benefit:
    - Individual(s) responsible for implementation and oversight
    - Pilot testing as appropriate
    - Time lines
    - Strategies for measuring the effectiveness of the actions

4. Implement the changes outlined in the action plan. Remember, your changes do not have to be major, permanent changes. It is often more valuable to implement easier, smaller changes that are likely to have a positive impact rather than big changes with unknown probability of success.

5. Monitor the effectiveness of the implemented changes and modify as necessary.

6. Report the event to external agencies as mandatory per regulatory requirements (e.g. state public health, CMS, Joint Commission, FDA, etc.).

7. If appropriate, submit information about the event to CHART as a potentially compensable event per Claims Department procedure.

8. If appropriate, submit the event to the PSO. Event reporting may be mandatory in certain States and is frequently protected by State law. Additional information regarding the event such as the details of the event investigation, however, may not be protected. The CHART Institute Patient Safety Organization can provide an extra layer of privilege and confidentiality and can accept event submissions directly from RL6:Risk. Contact CHART Institute's Director for further information.

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Definitions

Report Submission Types:	
Serious Event *(Harm Scores E – I)*	An event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient. The term does not include an incident.
Incident *(Harm Scores A – D)*	An event, occurrence or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. The term does not include a serious event.
Infrastructure Failure *(May be any Harm Score)*	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.

Harm Scores:	
Unsafe Condition	
A	Circumstances that could cause adverse events (e.g., look-alike medications, confusing equipment, etc.)
Event, No Harm	
B1	An event occurred but it did not reach the individual ("near miss" or "close call") because of chance alone.
B2	An event occurred but it did not reach the individual ("near miss" or "close call") because of active recovery efforts by caregivers.
C	An event occurred that reached the individual but did not cause harm and did not require increased monitoring (an error of omission such as a missed medication dose does reach the individual).
D	An event occurred that required monitoring to confirm that it resulted in no harm and/or required intervention to prevent harm.
Event, Harm	
E	An event occurred that contributed to or resulted in temporary harm and required treatment or intervention.
F	An event occurred that contributed to or resulted in temporary harm and required initial or prolonged hospitalization.
G	An event occurred that contributed to or resulted in permanent harm.
H	An event occurred that resulted in a near-death event (e.g., required ICU care or other intervention necessary to sustain life).
Event, Death	
I	An event occurred that contributed to or resulted in death.

Event Types:	
Medication Event 	An event involving medications, biological products, nutritional products, or medical gases. EXCLUSIONS: an adverse drug reaction with no apparent incorrect action; patient food
Adverse Drug Reaction 	An event involving any undesired or unexpected reaction to a drug, blood product or parenteral solution administered at normal dosage that requires discontinuing the product, modifying the dosage, prolonging hospitalization, or providing supportive treatment.
Equipment/Supplies/ Device Event 	An event involving any undesired or unexpected occurrence related to clinical or non-clinical equipment, supplies or devices. Includes defects, failures, incorrect uses, unavailability, outdated supplies, etc.
Fall 	An event involving a sudden, unintended, uncontrolled, downward displacement of a patient's body to the ground or other object. This definition includes an assisted fall – when patient begins to fall and is assisted to the ground by another person. EXCLUSIONS: a fall resulting from a purposeful action or violent blow; a near fall – loss of balance that does not result in a fall
Error Related to Procedure/Treatment/ Test 	An event involving any undesired or unexpected occurrence related to a procedure, treatment or medical test. This event type includes a variety of issues related to **laboratory** testing, **radiology/imaging** tests, **referral/consults**, **respiratory** care, **dietary** and/or **surgical/invasive** procedure issues. EXCLUSIONS: any event related to a procedure, treatment or test that results in a clinical complication
Complication of Procedure/Treatment/ Test 	An event involving any undesired or unexpected clinical complication related to a procedure, treatment or medical test. This category includes **anesthesia** events, complications following **surgery** or invasive procedures, **emergency department** issues, **maternal and neonatal** complications, healthcare acquired **infections**, **catheter or tube** problems, **IV site** complications, etc.

Skin Integrity 	An event involving any undesired or unexpected localized occurrence related to the skin integrity of a patient including abrasions, blisters, burns, lacerations, rashes and ulcers (pressure or venous stasis). This category includes **pressure injury** which are defined as localized injuries to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction which may be classified according to the following stages: **Deep Tissue:** Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, warmer or cooler as compared to adjacent tissue. **Stage I**: Localized, reddened area on intact skin that, when pressed, is "non-blanchable" (does not turn white). **Stage II:** Partial-thickness tissue loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. **Stage III:** Full-thickness tissue loss with damage to the tissue below the skin. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. **Stage IV:** Full-thickness tissue loss with exposed bone, tendon, or muscle. **Unstageable:** Full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed.
Transfusion 	A transfusion event or unsafe condition involving the processing, administration, dispensing/distribution, collection or documentation of blood or blood products.
Infrastructure 	An event involving any undesired or unexpected situation involving the hospital's infrastructure and processes of **administration/management**, **emergency services/response**, physical plant/**utilities**/service disruption, **medication safety**, and/or criminal/potentially **criminal** or illegal activity.

Other/Miscellaneous  *Please make sure that the event to be reported does not fall into one of the above categories before selecting "Other".	This category includes events deemed necessary to report but do not fall under any of the previously listed event types. **Please refrain from overuse of this event type.** It should only be used to report the following specific event types: • Against medical advice • Combative/violent behavior • Contraband • Deviation from policy/procedure • Electric shock to patient • Identification of patient/site • Inappropriate discharge • Other unexpected death • Restraint/seclusion • Patient Self-Harm • Unanticipated transfer to higher level of care