



# REPORTING OF INCIDENTS

NEIGHBORHOOD HOME  
HEALTH SERVICES, INC.



# PURPOSE

- To promote patient safety by identifying and reducing the risk of sentinel events.
- To measure, assess and improve Neighborhood Home Health Services, Inc.'s performance in the delivery of patient care, treatment and/or services.
- To identify, track, trend, respond to sentinel and adverse events that occur while a patient is receiving care, treatment and/or services from Neighborhood Home Health Services, Inc.
- To implement a proactive process to minimize or prevent the occurrence of sentinel events.
- To comply with the CHAP standards and any other applicable laws, regulations and standards



# POLICY

- Neighborhood Home Health Services, Inc. chooses to monitor, analyze and restructure/redesign, if necessary, to minimize the potential of negatively impacting patient safety.
- Unexpected events or occurrences involving death or serious physical or psychological injury, or the risk thereof (i.e., sentinel events) are to be reported to the Director of Operations/Administrator immediately upon identification.
- Any sentinel event requires immediate action to examine, in depth, the event to determine why the incident occurred and to identify interventions with the greatest likelihood of reducing recurrence.



# INCIDENTS INCLUDE

- ADVERSE EVENTS
- SENTINEL EVENTS



# ADVERSE EVENTS

- Adverse Event: adverse events fall into two main categories: (a) an event or occurrence which results in significant patient injury or impairment, or the risk thereof and (b) any unusual occurrences involving a patient, employee or family member which is not consistent with regular routine, regardless of whether or not there was an apparent injury or other damage, including all occurrences of significant patient complaint or criticism, together with complaints from a patient's relative or friend, should be the subject of an Incident Report (#7033).



# ADVERSE EVENTS EXAMPLES

- All serious drug events resulting in a significant condition change in the patient
- All hospital admissions/discharges
- Abusive Behavior from Patient or Family Members
- Cardiopulmonary Arrest
- Employee Injuries
- Patient Injuries
- Falls Employee/Patient
- Patient property missing or damaged
- Employee property missing or damaged
- Family member or Friends Complaints
- All medication errors, whether or not there is a resultant adverse impact on the patient's condition
- Any occurrence having an adverse effect on the patient
- Any occurrence causing injury or permanent loss of function to a patient
- An occurrence capable of precipitating a lawsuit or potentially undermining public confidence in the Agency
- Any product malfunction
- Any process variation which does not negatively impact patient outcomes or safety, but for which a recurrence carries significant risk of resulting in a serious adverse outcome or event. These process variations are often referred to as "near misses".



# SENTINEL EVENTS

- \* Sentinel Event: Unexpected adverse occurrence involving death or serious injury or psychological injury or the risk thereof. Serious injury specifically includes the loss of limb or function. A sentinel event is an adverse event of a severe and urgent nature that can result in an unexpected and undesirable patient outcome. The phrase “the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.



# SENTINEL EVENTS CONTD'

A sentinel event:

- Potentially involves a continuing threat to patient care or safety
- Has significant potential for being reflective of serious underlying systems problems within an organization
- Potentially undermines public confidence in the organization





# SENTINEL EVENTS EXAMPLES

- Death of a patient caused by an employee
- Death of or permanent injury to a patient due to an IV or blood transfusion error
- Patient fall
- Medication errors or the potential thereof
- Patient suicide



# PROCEDURE

- \* Each and every worker at NHHS is responsible to report any and all potential or actual sentinel and/or adverse events to their immediate Supervisor immediately upon identification of the event.



# INCIDENT REPORTING

- When an event occurs, an Incident Report is completed by personnel aware of the occurrence.
- The form is completed in its entirety.
- The narrative portion of the Incident Report form should NOT contain opinions or conclusions, but rather, consist of facts, direct observations and witnesses' statements.
- No photocopies of the Incident Report are to be made at any time.
- If the occurrence involves a patient, document precisely the necessary information on the patient's medical record. **Do not chart that an "error" or "mistake," etc. was made or that an Incident Report was completed.**



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- **The employee completing the report form will immediately forward the report to his/her Supervisor for review and countersignature. Thereafter, the form is to be forwarded to the Director of Operations for review and follow-up. The information obtained from the reports will be categorized in a "patterns over time" manner and submitted to the appropriate committees and departments.**