

ALASKA PIONEER HOME		P&P No: 09.05
Title: Incident Report		Approval: D. COTE
Key Words: Unusual Occurrence, UOR, QAT, Sentinel Event, Medication Error		
Team: All Employees	Effective Date: 8/1/12	Page: 1 of 8

PURPOSE

To provide guidelines for responding, reporting, and following up on incidents that occur in the Alaska Pioneer Homes (AKPH).

POLICY

The Pioneer Homes assist older Alaskans to have a high quality of life by providing assisted living in a safe home setting which promotes positive relationships, meaningful activities, and physical, emotional, and spiritual growth (mission statement).

When an incident occurs, AKPH staff completes the Quality Assurance Tool (QAT) form and enters data into the Risk Plus program, which are parts of the quality assurance program.

Sentinel events are identified and analyzed to develop preventive measures and avoid undesirable trends.

DEFINITIONS

Quality assurance (QA) is the monitoring and evaluating of a service or facility to ensure that the highest standards of quality are being achieved.

Incident or unusual occurrence is an untoward event, condition, or situation which is not consistent with the routine safe operation of the Home. It is an unexpected consequence of routine resident care or clinical procedures.

Sentinel event is an unanticipated event in a health care setting, resulting in death or serious physical or psychological injury to a resident, not related to the natural course of the resident's illness. Sentinel event specifically includes loss of limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome.

Psychological injury is harm to the intellectual function or emotional state of a resident as evidenced by a reduction in the ability to function, perform, or behave within that resident's customary range. Psychological impairments and disabilities may arise from physical and/or mental injuries attributed to negligent actions.

Medication error is an event of inappropriate medication administration or omission.

PROCEDURE**I. Incident Report/Unusual Occurrence Report (UOR)**

- A. An incident or unusual occurrence report (UOR) is a legal document protected under State statute, and is an internal, confidential document.
1. Data from the UOR is reported to and evaluated by the risk manager.
 2. When a UOR involves a resident, the *occurrence* is recorded in the medical record, but the *report* is not placed in the resident's medical record.
 3. All AKPH staff is required to respond to and report incidents in the Homes.
- B. Types of incidents
1. Unusual occurrence
 2. Sentinel event
 3. Medication error
- C. Incidents
1. Incidents are reported using the Quality Assurance Tool (QAT form).
 2. Incidents in the Home apply to residents, staff, students, visitors, and volunteers.
 3. An incident in the Home:
 - a. Could result in bodily injury, illness, or death.
 - b. Could result in the use of a restraint.
 - c. Deviates from the physician's or nurse practitioner's prescribed treatment for the resident and results in errors, accidents, or omissions.
 - d. Occurs while on the Home property or off the Home grounds and involves on duty staff, residents, students, or volunteers.
 - e. Is loss or damage to personal property of residents, staff, students, visitors, or volunteers.
 - f. Is loss or damage to Home property as a result of accident, theft, or vandalism.
 - g. Disrupts the Home and its normal operations.
 - h. Involves a missing or eloped resident.
 - i. Poses an imminent threat to Home safety.
- D. Sentinel event
1. Sentinel events require additional reporting and follow up.
 2. Sentinel events signal the need for immediate investigation and response.
 3. Sentinel events are reported to the Home administrator and to the AKPH director in the Central Office in Juneau by telephone as soon as possible and *no later than 24 hours after the incident.*

Title: Incident Report

- a. Central Office works with the Home to determine additional investigation, analysis, or follow up actions to be taken.
 4. Report of harm caused by equipment or medical devices is completed according to the Safe Medical Devices Act.
 - a. The Home administrator contacts the AKPH Central Office as soon as possible.
 - b. The federal Safe Medical Devices Act requires that reports are completed.
 - c. The Home administrator and the nurse consultant work together to complete and send the required reports to the device manufacturer and the Food and Drug Administration.
 5. Sentinel events are reported to assisted living licensing.
 - a. The QA form is faxed to the coordinator (fax#907-269-3646) within 24 hours of the event.
 6. Sentinel events are reported and reviewed if they result in:
 - a. Unanticipated death.
 - b. Serious physical injury, such as the permanent loss of limb or function.
 - c. Psychological injury.
 7. Each Home tracks and reports a sentinel event, or the risk of an event, to maximize risk prevention and improve safety.
- E. Medication errors
1. Types of medication error
 - a. **Omission error** occurs when a dose is not administered by the time that the next dose is due. This does *not* include resident refusal or presence of contraindications, if this is *documented* in the MAR.
 - b. **Resident error** occurs when an ordered dose is given to the wrong resident.
 - c. **Drug error** occurs when a dose is given to a resident without a corresponding medication order; this error includes a discontinued medication.
 - d. **Dose error** occurs when the amount of the dose is greater or less than the amount ordered by the prescriber; includes an extra dose.
 - e. **Time error** occurs when a dose is given earlier or later than one hour from the prescribed time, unless a reason is documented in the MAR. There is a 2-hour period to give a dose at the correct time. The correct time is important when giving antibiotics for an infection.
 - f. **Route or site error** occurs when the dose is given to the resident by a route or to a site other than what is ordered by the prescriber. Routes include oral, sublingual, topical, transdermal, intramuscular, subcutaneous,

Title: Incident Report

vaginal, rectal, eye and ear drops, inhalant, intranasal, gastric, and intravenous.

- g. **Documentation or day error** occurs when a dose is given but the administration record is not signed; includes signing the record when a dose is not given or given on the wrong day.
 - h. **Drug missing** includes an empty blister pack or bottle.
 - i. **Transcription error** occurs when the prescribed order is incorrectly transcribed manually onto a paper record or electronically into the computer.
 - j. **Other error** include an incorrect dosage form, administration technique, storage, dispensing, monitoring, order due to contraindications, and giving an expired medication.
2. If a resident refuse to take an offered medication or chooses to take it at a different time of day, it is not considered a medication error. The residents retain the right to make decisions about their care.
 3. Medication errors are reported using the QAT.
- F. AKPH staff responds to an incident
1. Staff takes immediate action to assist the affected resident, and assistance is within the ability of the staff member.
 2. Reports the situation as soon as possible to the nurse working in the Home neighborhood in which the error or incident occurs or the resident lives.
 3. Completes the first section of the QAT form.
- G. AKPH nurse responds to incident report
1. The nurse immediately assesses the situation and possible resident injury.
 2. The nurse evaluates the resident's condition and determines if emergency medical assistance is needed.
 3. If emergency or urgent medical treatment is needed, the nurse:
 - a. Stays with the resident.
 - b. Provides basic first aid.
 - c. Directs another staff member to dial 911 and summon paramedics.
 - d. Notifies resident's representative, physician, and Home administrator of the incident and transport, once the resident is transported to the hospital.
 4. If non-emergency medical treatment is indicated, the nurse notifies the supervisor and Home administrator, and the resident's physician and representative; treatment is arranged.
 5. If the resident does not require emergency medical assistance but there is a possibility that the resident could have an injury or experience a change in

Title: Incident Report

condition, perform physical assessment of the resident and document in progress notes. Examples include falls, skin integrity changes, medications errors, and equipment failure.

6. If no medical treatment is indicated, the nurse notifies the resident's representative of the incident.
7. The nurse provides feedback to the staff to ensure:
 - a. Staff is aware of the incident or error.
 - b. The affected resident's care is appropriately modified.
 - c. Errors in care practices are corrected.
8. The nurse documents in the resident's chart:
 - a. The physical assessment of the resident.
 - b. Medical and nursing care received and interventions to be taken.
 - c. Follow-up actions.
9. The nurse completes section two of the QAT form by the end of shift during which the incident occurred.
10. The supervisor completes section three of the QAT form by the end of shift during which the incident occurred. The supervisor:
 - a. Reads the first and second parts of the QAT form and progress notes pertaining to the incident; ensures that documentation is complete.
 - b. Reviews actions taken during the incident, and determines if further action is warranted, such as education, counsel, or further investigation.
 - c. Documents on QAT form as soon as possible based on the type and severity of the incident, within one week after the incident occurred.
 - d. The QAT form is then sent to the risk manager.
11. The risk manager reviews the QAT form.
 - a. Assures the information is complete.
 - b. Reviews the actions taken during the incident.
 - c. Determines if additional follow up is indicated.
 - d. Enters data from the QAT form into the Risk Plus computer program.
 - e. Files a hard copy of the QAT form.
12. The risk manager provides the Home administrator with a summary report of unusual occurrences and medication errors each month.
13. AKPH staff injured while on duty must immediately complete a Worker's Compensation Form and submit it to the supervisor.

II. Instructions for Completing the QAT Form

- A. Section 1, general information and description.
 1. Section 1 is completed by the first staff member to discover the incident, and includes:
 - a. Date and time the report was started.

Title: Incident Report

- b. Resident identification.
 - c. Level of care and resident's neighborhood.
 - d. Witnesses to the incident.
 - 1) Print the names and phone numbers of persons who witnessed the incident or error.
 - 2) Attach written statements from staff and non-staff witnesses to the QAT.
 - e. Date and time of incident, a best estimate of when the incident happened.
 - f. Exact location of incident.
 - 1) N/A for medication error.
 - g. Observer's description of incident; the facts of what occurred.
 - 1) Include additional facts not mentioned which contributed to the incident.
2. The observer signs and dates section 1.
- B. Section 2, nurse's report and actions taken.
1. Nurse's description of incident.
 - a. Further description is optional depending on the accuracy and thoroughness of the observer's description.
 - b. Briefly write the facts that contributed to the incident.
 - c. Do not make subjective, opinionated statements.
 2. Type of incident (N/A for medication error).
 - a. Select the box that best describes the type of incident.
 - b. If no selection closely matches the type of incident, choose *Other* and write type of incident.
 3. Medication order as written.
 - a. This portion of the QAT applies only to a medication error.
 - b. Print the correct information for the drug that was to be administered, from the order, package label, or MAR (medication administration record).
 - 1) Print the name of the drug, dosage, amount, route of administration, and frequency.
 4. Person involved in the incident.
 - a. Indicate types of staff members who were involved in the incident or error.
 5. Physical condition of resident, including a brief summary about:
 - a. The findings of the nursing assessment.
 - b. Any interventions and treatment performed.
 - c. Follow up actions taken.
 6. Nature of injury (N/A for medication error).
 7. Disposition of resident.

Title: Incident Report

- a. Indicate the type of care the resident required within 24 hours after the incident or error.
 8. Persons notified.
 - a. Print the person's name on the line after the check box.
 - b. Include the date and time the persons were notified about the incident by the nurse.
 9. The nurse then signs and dates section 2.
- C. Section 3, supervisor review.
1. Review of incident.
 2. Intervention to correct situation and prevent incident/error from recurring.
 3. Follow up actions taken.
 4. The supervisor then signs section 3.

III. Instruction for the Risk Manager to Enter Data into the Risk Plus Program

- A. Statistical records
1. The risk manager inputs statistical information regarding each unusual occurrence incident, sentinel event, risk of sentinel event, and medication error into the Risk Plus program.
 2. Reports are generated for the Homes' internal risk managers to observe and analyze incidents for QA purposes.
 3. Reports are generated for external review of sentinel events and medication errors on a quarterly basis.
 4. Incident recording:
 - a. The risk manager determines the incident definition after receiving the completed QAT form and investigating the incident.
 - b. The risk manager records the incident as *non-applicable* for external reporting if the incident is not an actual sentinel event.
 - c. The risk manager records the incident as *applicable* for external reporting if the incident is a sentinel event.
 5. Medication error reporting.
 - a. All medication errors are reportable and *applicable* for statistical tracking.
 - b. The risk manager determines the type of medication error after receipt of the QAT form.
 - c. The types of medication errors are listed in this policy under section I., Incident Report.

AKPH P&P No. 09.05	Effective Date: 8/1/12	Page: 8 of 8
Title: Incident Report		

HISTORY OF REVISIONS

New: 1/1/12
Revised: 1/27/12; 3/18/12; 7/20/12
Reviewed: 1/27/12; 3/18/12

ATTACHMENTS

Quality Assurance Tool (QAT) form for AKPH

REFERENCES

HCBS SOP, 7 AAC 130.215