Incident Reporting

To every patient, every time, we will provide the care that we would want for our own loved ones.

Health, healing and hope.

Is Healthcare Safe?



- •1999 Institute of Medicine: Estimated between 44,000 and 98,000 incidents of harm **every year**.
- •That is equivalent to a jumbo jet crashing every day.

But, that was 1999.....Today

- •2010 The Office of Inspector General reports that patients continue to experience harm in our nation's hospitals.
 - oIn October 2008 alone, 134,000 experienced at least one adverse event.
 - •In 1.5% of hospitalized Medicare patients, a harm event contributes directly to the patient's death.
 - o''44% of the harm is clearly or likely preventable."
- •2012 The Office of Inspector General reports that most errors go unreported.
 - Medication errors
 - •Bed sores
 - Infections

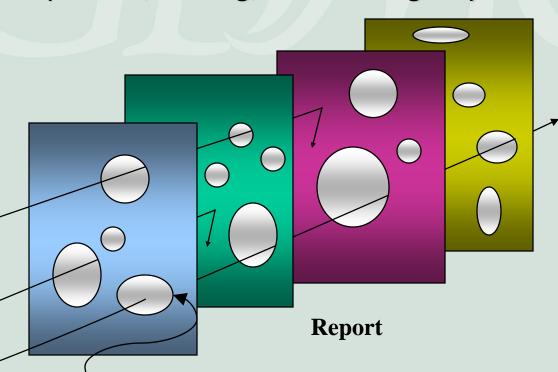
Why Do Events Happen? System Barriers to Stop Event

(Policies, Training, Self Checking etc.)

Significant Events or Injuries

Event Triggers

- •Human Errors,
- •Equipment Failures or
- External Events starts a chain of events



How many barriers failed if there is a significant event?...How many successful barriers to prevent an event?..

Based on Dr. James Reason, *Managing the Risks* of Organizational Accidents, 1997.

Reliability



What should happen, happens

What shouldn't happen, doesn't

We all make errors

- •Even experienced, professional people
- •Healthcare is a "high-risk" occupation
- •Seriousness of errors increases in Healthcare





When An Error Happens... We Need To Understand WHY

- •Human Error: an accident; a mistake, a slip or lapse -- "did not mean to do it"
- •At-Risk Behavior: A Choice when we don't "see the risk" or understand it or if we think it's okay "this time" or is "justified"
- •Reckless Behavior: Breaking the rules on purpose—making a choice with a conscious disregard to the outcome.

Questions To Ask To Foster Learning and Improve Systems

- •What happened?
- •What normally happens?
- •What's supposed to happen?



Examples of Learning @ GBMC

- •Incident Reporting: Using Quantros
- •**Team Huddles** Debrief/Update quickly every day
- •Storytelling A person/family was touched
- •Great Saves Wednesdays- An email blast highlighting a great save weekly

QUANTROS

What to report?

- •Anything that happens, that shouldn't happen involving the care of patients
- •Or any incidents involving injury or harm to visitors or patients

Examples Of What To Report

- •Falls
- •Pressure Ulcers
- Medication Errors
- Complications
- •Delays in care
- •Any injury to a patient
- •Medical equipment failure
- Visitor falls

NOTE: Employee related injuries are NOT entered into Quantros at this time. Employees should notify their supervisor who will complete the appropriate form.

Why Reporting Is So Important?

- •To continue to **learn** and improve
- •To **prevent** it from happening again
- •To <u>recognize</u> "good catches"
- •Most importantly, it's the **right thing** to do



Who Should Complete An Incident Report?

- •If you were **involved** in an incident
- •If you were **informed** of an incident
- •If you <u>discovered</u> the incident

<u>NOTE</u>: It is OKAY if more than one person submits an incident report on the same issue



When Should I Report?

•As soon as it is reasonably possible (after you have taken care of any patient issues)



ALWAYS before your shift is over

What Happens After I Report?

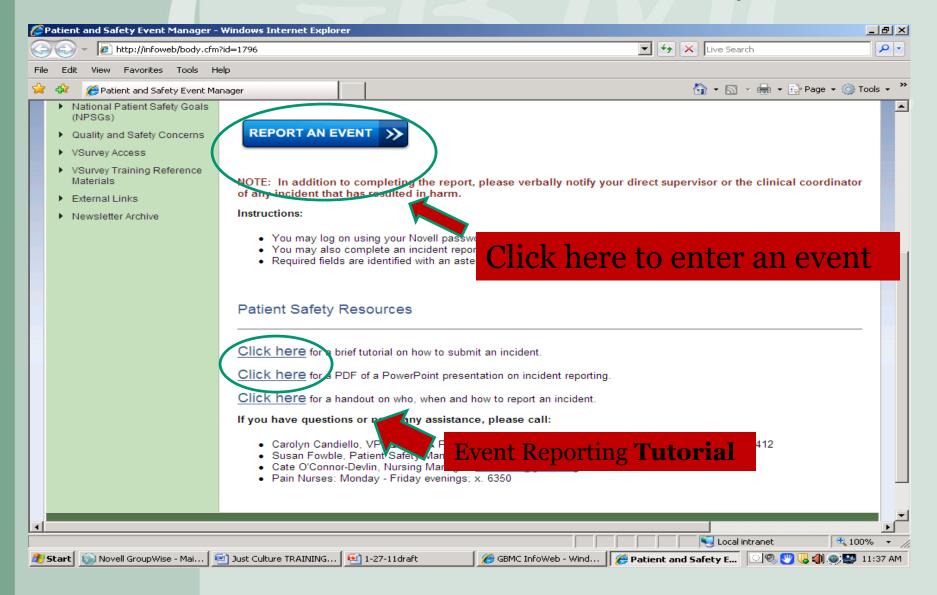
- •Quality and Safety Department receives and reviews each incident
- •The incident is reviewed by the department where incident occurred
- •Opportunities to improve are identified and shared

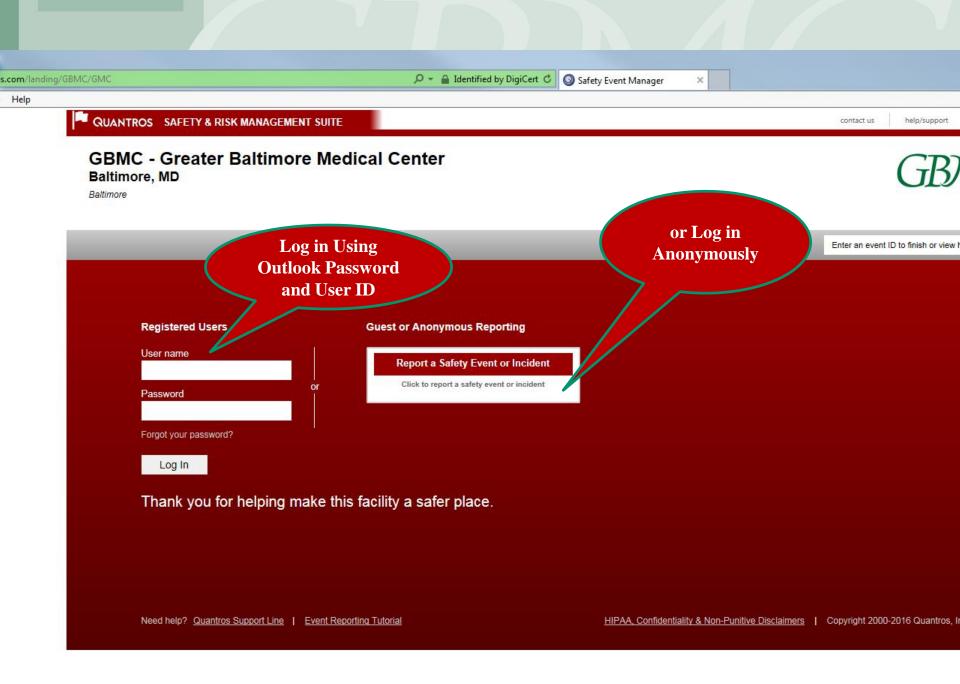


Where To Report - Infoweb



Quantros = User Friendly





Fill out as much as you can. Required fields are marked with an RED ASTERISK (*)

Reporting Recap

- •Tool is on the Infoweb
- •When in doubt, fill it out
- •It is easy and quick
- •The learning opportunity is **priceless**

