Vermont Psychiatric Care Hospital Policy and Procedure		
Event Reporting		
Effective: February 2020	Revised: January 2023	Due to Review: January 2025

POLICY

The Vermont Psychiatric Care Hospital (VPCH) maintains a readily accessible internal reporting system aimed at identifying and addressing actual or potential hazards or safety events. VPCH will collect, aggregate, and analyze data for the purpose of developing and implementing strategies aiming to eliminate specific adverse events. Reports of adverse events will be made to external agencies in accordance with event-specific reporting requirements.

DEFINITIONS:

Adverse Event: Any untoward incident, therapeutic misadventure, iatrogenic injury, or other undesirable occurrence directly associated with care or services provided by a health care provider or health care facility.

Causal Analysis: A formal root cause analysis, similar analytic methodologies, or any similarly effective, but simplified processes that use a systematic approach to identify the basic or causal factors that underlie the occurrence or possible occurrence of a reportable adverse event, adverse event, or near miss.

Intentional Unsafe Act: An adverse event or near miss that results from

- a criminal act
- a purposefully unsafe act
- alcohol or substance abuse; or
- Abuse of a hospitalized person

Near Miss: Any process variation that did not affect the outcome, but for which a recurrence carries a chance of an adverse outcome.

Serious Bodily Injury: means bodily injury that creates a substantial risk of death or that causes substantial loss or impairment of the function of any bodily member or organ or substantial impairment of health or substantial disfigurement.

Serious Reportable Event: Adverse events which require VPCH to report to external agencies.

PROCEDURE

Personnel who identify or otherwise become aware of an actual or potential adverse event or near miss shall:

1. When possible, take immediate action to address the situation, and address any injuries or other negative outcomes that may have resulted from the hazard/event.
2. Notify their immediate supervisor of the hazard/event as soon as reasonably possible and

inform them of any action taken.

3. If the event involved hospitalized individual(s), document in the respective medical record(s) the facts of the event in a progress note. Submission of an internal event form shall not be referenced in the medical record.
4. Complete the applicable internal event reporting form, which are available to access, complete, and print from the VPCH SharePoint site. Please note the *Guidelines for Internal Event Reporting* (Appendix A) outlines the specific types of event reports and provides guidance for when each report should be completed.
5. Completed internal event reporting forms shall be submitted in accordance with routing instructions provided on the form. Actual and potential events shall be reported in writing as soon as reasonably possible, but no later than the end of the shift on which it occurred/was observed. While it can be helpful for a reporter to include identifying information on the event report, reports can be made anonymously.
6. Personnel shall receive required education on event reporting and event disclosure in orientation and then periodically.

Department managers, supervisors, or designees of these positions, who become aware of an adverse event or near miss shall:

1. When possible, take immediate action to address the situation, and address any injuries or other negative outcomes that may have resulted from the hazard/event.
2. Reference applicable VPCH policy/procedure to determine subsequent action steps.
3. Aid in completing the applicable internal event report and review to confirm relevant and necessary information has been included.
4. Department managers, supervisors, or their designees overseeing the area in which the event occurred are expected to complete an initial review of adverse events. This review shall consist of a cursory exploration of the event to identify the fundamental reasons the incident occurred, processes and risk areas that may have contributed to the event, and a plan to address the event.
   Note: Depending on the nature and severity of the incident, initial investigation may include preservation of evidence and interviewing witnesses. If during this initial review, there becomes reason to believe that misconduct may have occurred and witness information is not needed for immediate safety, managers/supervisors should consult Human Resources prior to engaging in further witness discussions.
5. Provide notification to the Chief Nursing Executive and the Chief Executive Officer (CEO) or their designees as soon as reasonably possible for events requiring such notification, including:
   - Events that result in an injury requiring outside medical attention
   - Events that did, or that have imminent potential to, compromise the provision of care services and/or threaten the hospital environment
   - Events that require response from law enforcement, fire, or other emergency service
   - Intentional unsafe acts and/or potential criminal acts (including physical/sexual assault on hospital grounds)
   - *Serious Reportable Events* (SRE) that may require a report to an outside regulatory authority such as the Department of Licensing and Protection, Centers for Medicare and Medicaid Services, the Joint Commission, etc.

The VPCH Quality department will provide ongoing surveillance of internal event reports. In collaboration with hospital leadership, the Quality department will determine the level of analysis and response using Appendix B: Levels of Patient Event Severity and Response (modified from the NCC MERP, Comprehensive Harm Level Index). The Quality team is responsible for:

6. Identifying patterns and trends through compilation and analysis of event report data and identifying areas for improvement
7. Routinely sharing event report data and analysis with hospital leadership
8. Collaborating with hospital leadership and other identified stakeholders, including Human Resources if misconduct is suspected, to develop and implement corrective action plans that address trends identified as contributing to actual or potential adverse events
9. Tracking the progress/effectiveness of corrective/performance initiative(s) and reporting this to hospital leadership and other identified stakeholders
10. Promptly identifying and tracking SREs
11. Leading causal analysis and corrective action planning and monitoring for SREs.
12. Completing the proper external reports in a timely manner

Serious Reportable Events

1. The VPCH Quality Department shall be responsible for the completion of a causal analysis in response to each serious reportable event (see Appendix C: Guide to Externally Reportable Events). A causal analysis shall include:
    - Interdisciplinary participation including individuals closely involved in the processes and systems review. (Human Resources shall be consulted if misconduct is suspected).
    - A detailed description of the SRE including date, day of week, time, location, services involved, and chronology of events.
    - A primary focus on systems and processes rather than individual performance.
    - A systemic and comprehensive assessment of factors contributing to the serious reportable event.
    - Consideration of literature/evidentiary support relevant to the serious reportable event.
2. The VPCH Quality Department is responsible for developing and monitoring the implementation of a corrective action plan in response to each SRE. This shall include:
    - Specific actions to correct the identified causes of the event to prevent a similar event from reoccurring.
    - Identified measurable outcome(s).
    - A specific implementation plan, including completion dates and provisions for education of and communication with appropriate personnel and a description of how the corrective action plan will be assessed and evaluated.
    - A designated person(s) responsible for ongoing plan maintenance and evaluation.

Information reported through the VPCH event reporting system and information related to root cause analysis is peer review protected and is considered confidential and privileged pursuant to 26 V.S.A. § 1441-1443 and 18 V.S.A. §1917.

Serious Reportable Event Disclosure

In the unfortunate event of a SRE, VPCH shall disclose to hospitalized individuals and any surrogate decision maker(s), or, in the case of a death, an adult member of the individual's immediate family, any adverse events that cause death or serious bodily injury, including those resulting from intentional unsafe acts. Disclosures shall be made by trained, professional personnel and shall be done in such a way as to minimize trauma and protect the confidentiality and emotional health of all involved parties to the extent possible. At a minimum, any disclosure shall comply with the following:

- Disclosures will most often be led by the attending Psychiatrist along with a member of the VPCH Quality Department. Other members of the VPCH Executive Leadership team or the involved individual's treatment team may be included as recommended by the Psychiatrist and/or VPCH legal counsel. It is important to have a second individual present during the disclosure conversation to aid in the documentation.
- Disclosures shall be done as soon as possible after the hospital becomes aware of the serious reportable event and its sequalae.
- Disclosures will be made to the hospitalized individual and any surrogate decision maker(s) or, in the case of death, to an adult member of the individual's immediate family. Disclosures may also be made to a health care agent or guardian if applicable and appropriate and/or to any other person as requested by the hospitalized individual. It should be asked if any additional support person(s) should be included.
- Disclosures shall consist of full factual accounting of the circumstances. The facts that are known at the time of the disclosure should be presented in an honest, objective, non-judgmental manner. The focus should remain on the hospitalized individual's condition and what will be done to mitigate/minimize harm.
- Disclosures shall occur in a private, confidential location at a time convenient to the hospitalized individual and/or surrogate decision maker.
- Disclosures shall offer assurance that events that may be related to a deviation from the standard of care are reviewed through the hospital's review processes to identify opportunities to prevent reoccurrence.
- Participants shall be offered an opportunity to ask questions and shall be kept informed of information obtained after the disclosure as appropriate and shall be provided with a name and contact information for whom they can contact should they have further questions.
- Disclosures shall be documented in the medical record including at a minimum: the date and time of the disclosure, a summary of the conversation, identification of everyone present, and any responses or requests made by participants.
- Resources, including periodic disclosure training as well as just in time trainings, and Employee Assistance Programs, will be available to assist and support individual(s) responsible for disclosures. Personnel can connect with their direct supervisor for additional information.

The VPCH Quality department shall retain internal report documents and data relating to the causal analysis of any adverse event, near miss, or intentional unsafe act for a period of at least seven (7) years.

References (if applicable):

- Patient Safety Surveillance and Improvement System Rule Procedure Manual, found here.
- The National Quality Forum's *List of Serious Reportable Events*, found here.
- The National Quality Forum's Serious Reportable Events 2011 Report, found here.
- Occupational Safety and Health Administration Severe Injury Guidelines, found here.
- Joint Commission Sentinel Event Reporting Guidelines, found here.
- NCC MERP Comprehensive Harm Level Index, found here.
- Guidelines for Disclosure Conversations, found here.

Approved by	Signature	Date
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APPENDIX A: Guidelines for Internal Event Reporting

Type of Event Report	**When to Complete**	**Initial Reviewer**
Patient Event (NCF-31)	Whenever you witness, discover, or have direct knowledge of an actual or potential incident in which a hospitalized person: • Alleged abuse, neglect, or exploitation • Suicide attempt • Self-injury • Death • Was injured (accidently or purposefully) • Experienced a near miss/close call without injury • Was aggressor or victim in peer-peer altercation • Eloped or attempted to elope • Set or attempted to set a fire • Experienced a serious medical event or emergency Patient events, including injuries sustained by the individual or inflicted on others, should also be documented in the individual's medical record either in a Nursing Progress Note or High-Risk Note at Nurses' discretion.	Chief Nursing Executive or designee
Medication Event (NCF-19)	To be completed whenever you witness, discover, or have direct knowledge of an actual or potential medication-related incident involving: • Prescription • Transcription • Administration • Documentation • Monitoring • Dispensing • Ordering • Storage • Medication security (i.e. narcotic count)	Director of Pharmacy or designee
Adverse Drug Reaction (NCF-35)	To be completed whenever personnel witness, discover or have direct knowledge of an actual or suspected adverse reaction to one or more medications. An Adverse Reaction includes	Director of Pharmacy or designee

	response to a drug which is noxious and unintended or death.	
Employee Event (NCF-9)	To be completed whenever personnel witness, discover, or has direct knowledge of injury, wound, medical event, or damage to the body resulting from an event at work, or while at work.	Chief Executive Officer or designee
Patient Care Process and Procedure Variance (NCF-95)	To be completed whenever personnel discover or witness an actual or potential care delivery process or procedure deficiency that did or has the potential to adversely affect hospitalized individual(s) or other individuals.	Chief Nursing Executive or designee
Electronic Health Record & Computer Variance	To be completed whenever computers malfunction or connectivity is disrupted, applications fail, or if the electronic health record (CPSI/Evident) malfunctions.	Director of Hospital Operations or designee
Environmental Variance (NCF-7)	To be completed whenever personnel witness or discover an event or environmental hazard or other condition that did or has the potential to adversely affect hospitalized person(s) or other individuals.	Director of Hospital Operations or designee

APPENDIX B: Levels of Patient Event Severity and Response

	Severity Level	**Level of Review and Potential Actions**
Not Categorized	Near Miss	Department Level Review – track and trend
Category A	Circumstances exist with the capacity to cause event/error or variance in care	Department Level Review – track and trend
Category B	Event/error and/or omission occurred but did not reach patient	Department Level Review – track and trend
Category C	Event/error reached patient but caused no harm	Department and Multidisciplinary Level Review
Category D	Event/error increased need for treatment/intervention /monitoring and caused temporary harm	Department and Multidisciplinary Level Review Root Cause Analysis, Corrective Action Planning, Disclosure
Category E	Event/error resulted in temporary harm and required initial or prolonged hospitalization	Root Cause Analysis, Corrective Action Planning, Disclosure, Possible External Reporting
Category F – Serious Reportable Event	Event/error resulted in permanent harm and required initial or prolonged hospitalization	Root Cause Analysis, Corrective Action Planning, Disclosure, Possible External Reporting
Category G – Serious Reportable Event	Event/error required intervention necessary to sustain life	Root Cause Analysis, Corrective Action Planning, Disclosure, Possible External Reporting
Category H – Serious Reportable Event	Event/error resulted in unexpected death	Root Cause Analysis, Corrective Action Planning, Disclosure, Possible External Reporting
Not Known	Not enough information available to assign a severity category	Department Level Review

APPENDIX C: Guide to Externally Reporting Serious Reportable Events

	Possibly Required External Reports	**Responsible Department**
Patient Event Category E-H	• Joint Commission Sentinel Event Report • Centers for Medicare and Medicaid Services • Vermont Patient Safety Surveillance • Adult Protective Services • Vermont Division of Licensing and Protection	Quality
Employee Work-Related Injury	Events involving a work-related fatality hospitalization, amputation, or loss of an eye are considered *Serious Reportable Events.* • OSHA (24 hours – fatalities must reported within 8 hours) • Vermont Patient Safety Surveillance – Reportable Adverse Events Report	Quality
Intentional Unsafe Acts	• Vermont Patient Safety Surveillance (7 days) • Vermont Office of Professional Regulation • Law Enforcement • Vermont Patient Safety Surveillance – Reportable Adverse Events Report	Quality

Identifying and Reporting Intentional Unsafe Acts

VPCH provides care and services to individuals experiencing acute mental illness and as such understand that some may act violently as a symptom of their illness and, for this reason, VPCH does not interpret patient-perpetrated assaults as *potentially criminal* or report to law enforcement. VPCH does, however, offer guidance and support to hospitalized individuals and/or personnel who wish to report a physical assault to a law enforcement agency.