DEFINITIONS

"Adverse event" means any unintended event, accident, malfunction or injury that occurs at the hospital including, but not limited to patient events, employee events and environmental events.

"Near miss" means any process variation that did not affect the outcome, but for which a recurrence carries a significant chance of an adverse outcome.

"Reportable adverse events" are the most serious adverse events and/or unexpected occurrences involving death or serious physical or psychological injury, or risk thereof including, but not limited to: untimely or unexpected patient death, an event that results in death or serious disability, rape, elopement that results in injury, intentional unsafe acts. Reportable adverse events include the list, as amended from time to time, of serious "never" events compiled by the National Quality Forum (NQF) and available on their website at www.qualityforum.org. Reportable adverse events are required to be reported to Patient Safety Surveillance and Improvement System (PSSIS) of the Vermont Department of Health and may be required to be reported to other authorities.

"VPCH **event reporting system"** means the system, paper or electronic, for reporting all adverse events at VPCH.

CONSIDERATIONS/REQUIRED STEPS:

Responsibilities following the identification of an adverse event:

a. **Employee responsibilities.** Any employee that identifies or otherwise becomes aware of an adverse event or near miss shall:
   i. **ACTION.** When possible, take immediate action to correct the situation, and address any injuries or other negative outcomes that may have resulted from the event.
   ii. **NOTIFICATION.** Notify immediate supervisor of adverse event or near miss and actions taken.
   iii. **DOCUMENTATION IN THE MEDICAL RECORD.** If the event involved a patient(s), document in the patient(s) medical record that facts of the event: what happened, who was notified and what steps were taken to address the event. If the event involved an employee and an injury was sustained, take steps as indicated by the ***Employee Injury Procedure.***

   iv. **REPORT.** Report all adverse events or near misses in the VPCH event reporting system. Include all relevant and necessary information in the report.

PLEASE NOTE: The attached ***Appendix - Guidelines for Event Reports*** outlines the specific types of event reports and provides guidance for when each report should be completed.

b. Department Manager, Supervisor or Designee responsibility. Any department manager, supervisor or designee that becomes aware of an adverse event or near miss shall:

i. ACTION. When possible, take immediate action to ensure that action has been taken to correct the situation and address any injuries or other negative outcomes that may have resulted from the event

1. If the event involves a suspicion that any patient has been the subject of abuse, neglect or exploitation, take steps as indicated by the ***Mandatory Reporting Procedure.***
2. If the event involves a patient elopement, take steps as indicated by the ***Elopement and Late Return Procedure.***
3. If the event involves the death of a patient, take steps as indicated in the ***Patient Death Procedure.***
4. If the event involves suspected criminal activity of a patient, take steps as indicated by the ***Reporting Patient Criminal Activity to Law Enforcement Procedure.***
5. If the event involves an untimely patient death, patient serious injury or any suspected criminal act, take steps as indicated by the ***Securing the Scene Procedure.***

ii. NOTIFICATION.

1. Manager or supervisor shall notify the Director of Nursing, Associate Director of Nursing or designee of events of significant magnitude. Events requiring such notifications include:
   - **a.** reportable adverse events;
   - **b.** events that result in any injuries that require outside medical attention;
   - **c.** events that do or have imminent potential to compromise patient care services and/or threaten the hospital environment;
   - **d.** events that require police, fire or other emergency personnel response;
   - **e.** Events that result in a report to an outside regulatory authority (e.g. APS, DLP, CMS, JCAHO).
2. The Director of Nursing, Associate Director of Nursing or designee shall notify Chief Executive Officer or designee

iii. INVESTIGATE. When appropriate, conduct a sufficiently thorough initial investigation to identify the fundamental reasons the incident occurred, including both human errors and clinical and non-clinical systems, processes and risk areas that may have contributed to the event. Depending on the nature and severity of the incident, initial investigation

may include securing the scene (See ***Securing the Scene Procedure),*** preservation of evidence and interviewing witnesses.

iv. **REPORT.** Report, assist staff in reporting or ensure that a report of the event was made in the VPCH event reporting system and that all relevant and necessary information is included in the report.

v. **FOLLOW-UP.** Using VPCH event reporting system, follow up as appropriate on all events that have occurred in assigned area of responsibility.

c. **Confidentiality of reports made to the VPCH event reporting system.** All information reported through the VPCH event reporting system and information related to root cause analysis is peer review protected and considered confidential and privileged pursuant to 26 VSA §1441-1443 and 18 VSA §1917.

Approved by	**Signature**	**Date**
Frank Reed, Commissioner of DMH	Frank Reed	8/29/16

Appendix

Vermont Psychiatric Care Hospital	
Guidelines for Event Reports	Effective date: 8/26/2010

Type of Event Report	Form #	When to complete
Patient Event Form	NCF-31	Whenever you witness, discover, or have direct knowledge of an incident in which a patient: • was injured (by accident or deliberately) • experienced a "near miss/close call" without injury • was aggressor or victim in a patient-to-patient altercation • alleged abuse, neglect, and/or exploitation • attempted or completed suicide • eloped or attempted to elope • damaged property • set or attempted to set a fire • experienced a serious medical event or emergency • was involved in any other event that was potentially dangerous to self or others <u>In addition:</u> Any event that has been reported as a Patient Event Report should also be documented in a Progress Note in the patient's medical record.
Medication Event Form	NCF-19	Whenever you witness, discover, or have direct knowledge of a medication-related error or variance in any of the following categories: • prescription • transcription • administration • documentation • monitoring • dispensing • ordering • storage • medication security (includes variance in narcotic count)

Type of Event Report	Form #	When to complete
Potential Adverse Drug Reaction (ADR) Reporting Form	NCF-35	Whenever you witness, discover, or have direct knowledge of a patient's possible or suspected adverse reaction to one or more medications. An "adverse reaction" includes subjective discomfort ranging from mild to severe, as well as unwanted physical symptoms up to and including death.
Employee Event Form	NCF-9	Whenever an employee or staff member who witnesses, discovers, or has direct knowledge of injury, wound, or damage to the body resulting from an event at work, within 24 hours. <u>In addition:</u> Any injury to an employee that occurs as a result of an interaction with a patient, that has been documented on an Employee Event Form, should also be documented in a Progress Note in that patient's medical record.
Variance Reporting Form	NCF-7	To be completed by the employee discovers or witnesses an event or environmental hazard or other condition not involving a patient or employee injury and not related to an emergency involuntary procedure.