UC DAVIS HEALTH

Incident Reporting and Follow Up
2023

Objectives

- Understand the following:
  - Basic process of incident reporting
  - When and how to submit an incident report
  - SBAR format
  - How to investigate an incident: 5 Why's
  - How to respond to an incident in RL
- Best Practices

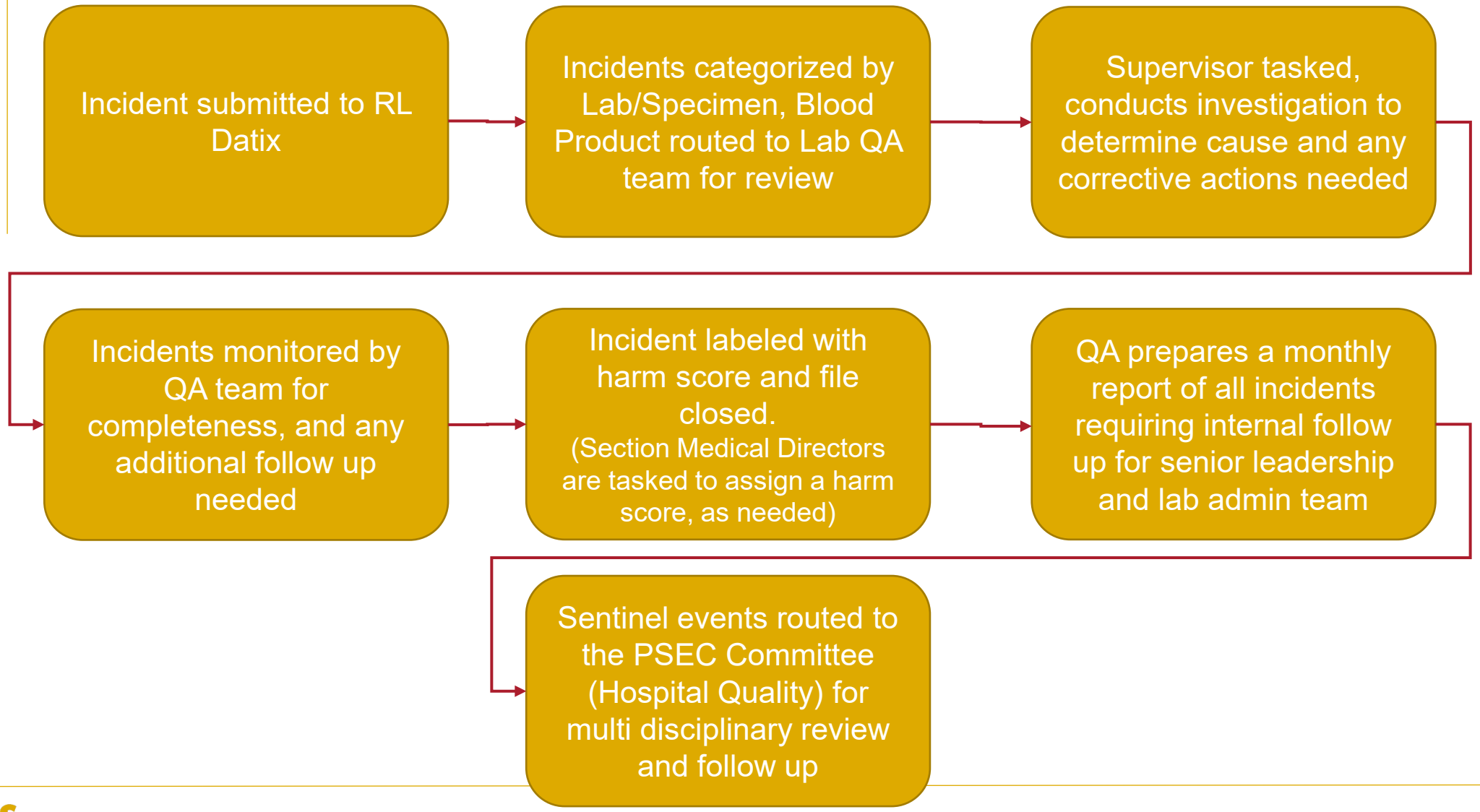
RL Datix vs. PET

- RL Datix
  - Hospital reporting system that is utilized to report any occurrence or near miss that may potentially or actually result in harm. The incident report is not to be used as a disciplinary tool. An IR copy shall not be placed in a staff member's personnel file

    Examples: Specimen mislabel, specimens collection errors resulting in redraw, specimen acceptability criteria not met, etc.
- Pathology Error Tracker (PET)
  - Application to track internal errors that do not necessarily require an incident to be submitted to RL Datix.

    Examples: Requisitioning errors that did not reach the patient, internal communication issues, etc.

Lifecycle of an Incident



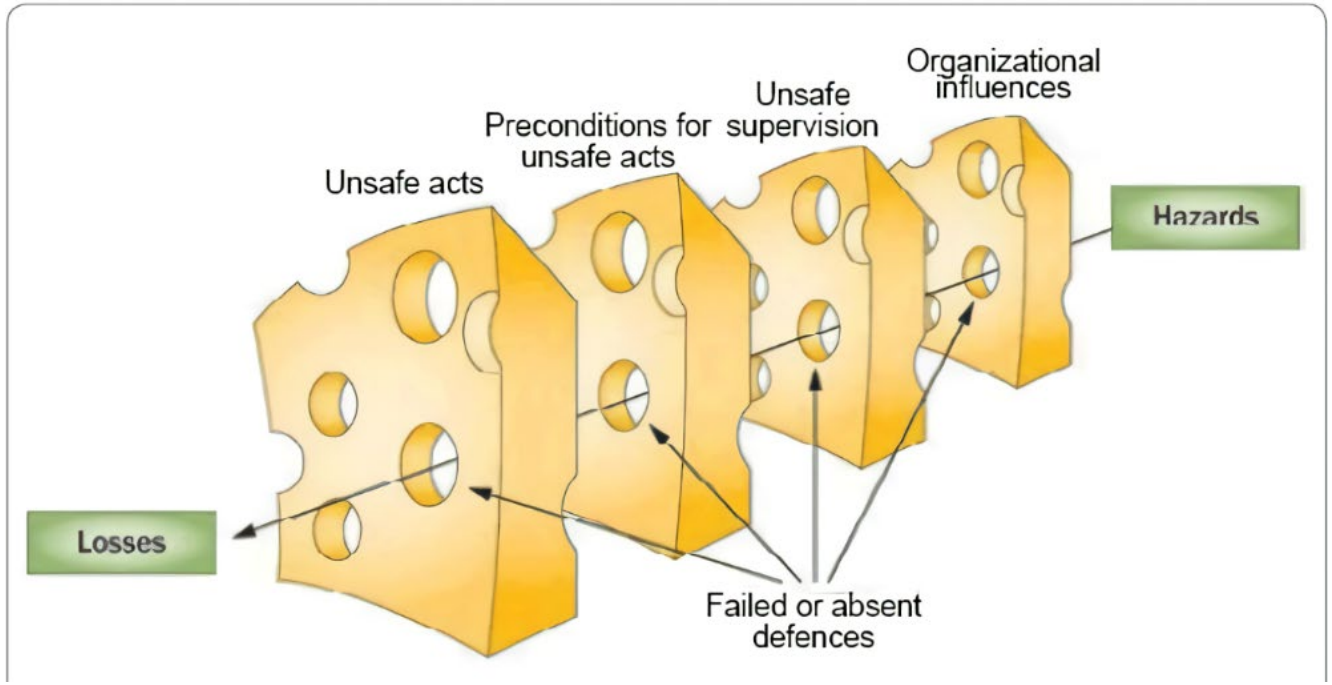
Harm Scores

RL SOLUTIONS – SEVERITY LEVEL (ACTUAL)

Severity Level (Actual)	Description (Hover)
Near Miss-Low Risk	Near Miss-Low Risk - Did NOT Reach Person Affected (Near Miss/Close Call)
Near Miss-High Risk	Near Miss-High Risk - Potential Severe Harm: Event Could Have Caused Injury (including Pain or Disfigurement) that Interferes Substantially with Functional Ability or Quality of Life
No Harm Event Reached Person Affected	No Harm: Event Occurred that Reached the Person Affected, but no Harm Evident
Mild Harm Event Reached Person Affected	Mild Harm: Event Caused Minimal Symptoms or Loss of Function, or Injury Limited to Additional Treatment, Monitoring, and/or Increased Length of Stay
Moderate Harm Event Reached Person Affected	Moderate Harm: Event Caused Injury Adversely Affecting Functional Ability or Quality of Life, but not at the Level of Severe Harm
Severe Harm Event Reached Person Affected	Severe Harm: Event Caused Injury (including Pain or Disfigurement) that Interferes Substantially with Functional Ability or Quality of Life
Death, Progression of Illness	Death was a Result of the Progression of Illness
Death, Unexpected	Death was Unexpected and NOT a Result of the Progression of Illness
Unsafe Condition	Unsafe Condition: Circumstances that Increase the Probability of an Adverse Event, (e.g. *unattended wet floor/trip or fall hazard*, broken elevator, equipment failure)
Prior Event	Prior Event: Events that Occur Outside or Prior to Our Care
Non Event	Non Event
Not Rankable	Not Rankable
Unable to Determine	Unable to Determine: Event Occurred that Reached the Person Affected but Cannot Identify Level of Harm or Impact at Time of Review

When and How to Submit an Incident

- When: Any incident that causes harm or has the **potential** to cause harm
  - Harm includes having to undergo another procedure (ie, phlebotomy draw), any potential that the patient was or could be mistreated based on laboratory results, patient safety (needlestick), etc.
- How: Any staff member can submit incident to RL Datix. PET is currently limited to Supervisors and Specialists
- Refer to Policy 775.A for details and step-by-step instructions



SBAR

- Situation:
  Brief fact-based statement on the current issue
- Background:
  Description of current process in place, policies, etc.
- Assessment:
  In depth description of issue, timeline, staff involved, any potential gaps in the process, corrective actions, etc.
- Recommendations:
  Any process improvements that can be implemented based on assessment

SBAR Example

Situation

Goofy entered the Building and slipped and fell after stepping off floor mat at entrance door.

Background

Goofy is a night shift employee at Mickey Mouse Clubhouse

Event occurred on Friday 4/1/2019 at approximately 7:58 pm at Mickey Mouse Clubhouse, East building entrance, outside room 007.

Assessment

The weather on 4/1/2019 was rainy and windy. Goofy stepped from the floor mat at the entrance to the floor outside room 1301 Goofy slipped and fell. It has been stated that the floor mat was saturated with water.

At approximately 8:30pm, Donald Duck, night shift supervisor of the clubhouse was notified of the injury by Goofy.

Recommendations

Risk assessment should be performed to determine if floor mat is adequate

Wet Floor signs should be set out during storms to alert employees/patients of possible slippery floors

Incident Response/Corrective Action

Supervisor provided Employee with the address to Urgent Care Med. Clinic (3000 Q St, Sacramento/CA) and the numbers for the Injury Analysis Team (EH&S) (762-0513 and 916-287-3719) as well as the number for the after-hours Workers' Compensation Line (4-8789).

Supervisor also faxed a copy of the Departmental Injury/Illness Worksheet (DIIW) for Employee to fill out and fax to Workers' Compensation.

Saturated floor mat was immediately removed and replaced with dry mat

Communication went out to all staff to be cautious when entering and exiting building

Incident was escalated to Managers Daisy, Minnie and Mickey by Donald via email

Risk assessment scheduled and wet floor signs have been ordered

Assessment: 5 Why's

- Ask yourself "Why?" until you find the root cause of the issue, **AT LEAST** 5 times
- Example: Specimen mislabel
  - Why was specimen mislabeled?
    Because CPT put wrong labels on patient tube
  - Why did CPT put wrong labels on patient tube?
    Because CPT didn't confirm two patient identifiers
  - Why didn't CPT confirm two patient identifiers?
    Because CPT pre-printed labels outside of draw area
  - Why did CPT pre-print labels outside of draw area?
    Because label printer wasn't working
  - Why was label printer not working?
    Because staff didn't know how to submit a ServiceNow ticket
  - **Root Cause**: Staff didn't know how to submit a ServiceNow ticket to get the printer fixed, resulting in a specimen mislabel

5 Why's

The 5 why's typically refers to the practice of asking, five times, why the failure has occurred in order to get to the root cause/causes of the problem. There can be more than one cause to a problem as well. In an organizational context, generally root cause analysis is carried out by a team of persons related to the problem. No special technique is required.

An example is in order:
You are on your way home from work and your car stops:

- Why did your car stop? Because it ran out of gas.
- Why did it run out of gas? Because I didn't buy any gas on my way to work.
- Why didn't you buy any gas this morning? Because I didn't have any money.
- Why didn't you have any money? Because I lost it all last night in a poker game.

I hope you don't mind the silly example but it should illustrate the importance of digging down beneath the most proximate cause of the problem. Failure to determine the root cause assures that you will be treating the symptoms of the problem instead of its cause, in which case, the disease will return, that is, you will continue to have the same problems over and over again.

Also note that the actual numbers of why's is not important as long as you get to the root cause. One might well ask why did you lose all your money in the poker game last night?

_____

Here's another example. I learned the example using the Washington Monument used when demonstrating the use of the 5 Whys.

The Washington Monument was disintegrating
Why? Use of harsh chemicals
Why? To clean pigeon poop
Why so many pigeons? They eat spiders and there are a lot of spiders at monument
Why so many spiders? They eat gnats and lots of gnats at monument
Why so many gnats? They are attracted to the light at dusk.
Solution: Turn on the lights at a later time.

Assessment: Additional Questions

- Is there a lab policy addressing this issue?
- Is there a hospital policy addressing this issue?
- Did staff follow the policy?
- Is readership documented for policy?
- Do we have documented training for staff?
- Were issues escalated appropriately by staff?
- Does staff have access to appropriate materials (policies, documents, equipment, resources, etc.) to ensure incident doesn't happen again?

If any of these answers are "No" supervisor next steps should be to make it a "Yes"

- Conduct retraining
- Document policy readership
- Update policies, as needed
- Ensure staff have access to appropriate resources

Recommendations/Response

Look for actual or potential:

- Deviations from proper workflow/policies
- Communication/Customer Service issues
- Education or equipment needs/issues
- Gaps in process or policies
- Any compromise in patient safety
- Any compromise in facility's license or accreditation
- Focus on systems, not people (ie, provide retraining for all staff at a location vs. one-on-one)

Recommendations/Response

- Why was specimen mislabeled?
  - *Because CPT put wrong labels on patient tube?*
- Why did CPT put wrong labels on patient tube?
  - *Because CPT didn't confirm two patient identifiers*
- Why didn't CPT confirm two patient identifiers?
  - *Because CPT pre-printed labels outside draw room*
- Why did CPT pre-print labels outside of draw area?
  - *Because label printer wasn't working*
- Why was label printer not working?
  - *Because staff didn't know how to submit a ServiceNow ticket*
- **Root Cause:** Staff didn't know how to submit a ServiceNow ticket to get the printer fixed, resulting in a specimen mislabel

- Is there a lab policy addressing this issue? **YES**
- Is there a hospital policy addressing this issue? **YES**
- Did staff follow the policy? **NO**
- Is readership documented for policy? **YES**
- Do we have documented training for staff? **YES**
- Were issues escalated appropriately by staff? **NO**
- Does staff have access to appropriate materials (policies, documents, equipment, resources, etc.) to ensure incident doesn't happen again? **NO**

Recommendations/Response

- Assign Good Documentation Practices module to all staff.
- Assign readership of labeling policies.
- Document training of staff on how to report IT issues via help desk(4-HELP) or ServiceNow ticket.
- Update access/permissions for staff in MediaLab, as necessary, and perform 1:1 training.
- Implement a process for staff to escalate issues quickly so problems don’t carry over from shift to shift.
- Monitor incidents for any trends regarding mislabels, or staff not following up for equipment issues.

Best Practices: Reporting and Responding to Incident

- QA review incidents daily and task appropriate supervisor.
- Responses should be received within 7 days of task.
- Do's
  - Always use courteous, professional language
  - Use only factual statements
  - Respond to incident using 5 Why's
  - Get feedback from staff involved
  - Review our policies before entering response to ensure staff followed internal/hospital policies
  - Include corrective actions that address root cause (ie, retraining needs, updates to equipment or policies, etc.)
- Don'ts
  - Blame other sections or departments
  - Use shoulds (RNs should have….Chemistry should have… etc.)
  - Use "I" statements
  - Assume
- Keep in mind responses are visible to Lab leadership, Quality leadership, as well as outside departments' leadership.

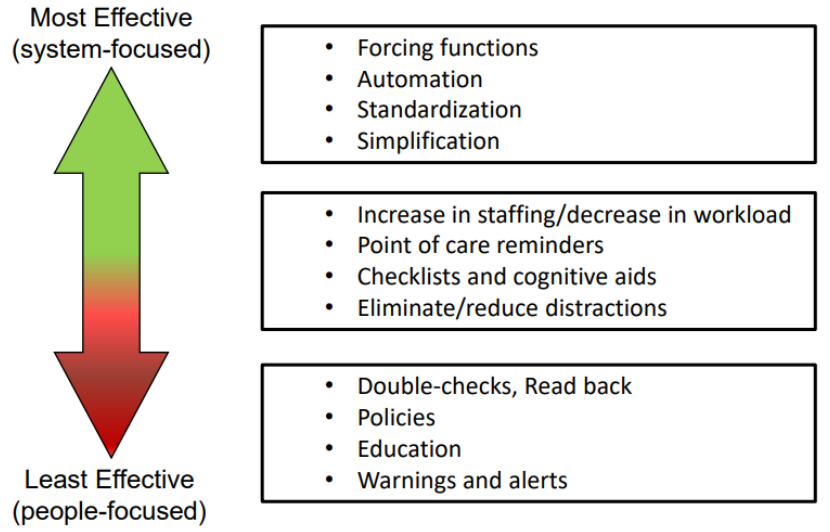
Best Practices: Reporting and Responding to Incident

- Create a template for entering RL incidents and/or responses
- Type incident/response in Word to perform spelling and grammar checks and copy/paste to RL
- Use terms like “employee” or “staff” or employee initials rather than full names. Employee names can be linked as Person Involved
- Review departmental and hospital policies before responding to ensure response aligns with and speaks to policies in place
- Corrective Actions:
  - Review CAP checklists and CLSI guidelines for best practices
  - Think about the Hierarchy of Interventions when implementing corrective action
- Escalate any issue that involves patient safety, patient complaint, or risk to accreditation to lab leadership before responding in RL

Issue: Incorrect container

On 5/12/23, the Micro Lab received a urine specimen for culture in an incorrect container. Specimen # 23S-132MI0238 was 58 mL of urine in a sterile cup. Urine specimens must be placed in preservative (gray top urine tube) for appropriate specimen preservation. The lab is unable to process non-preserved urine specimens for culture because of overgrowth of bacteria. Any specimens that are greater than 4 mL total volume should be aliquoted into a gray top urine tube to the fill-line for proper specimen preservation. Only specimens that are less than 4 mL total volume are acceptable to be transported to the lab in a sterile container on ice. This test was canceled due to improper specimen preservation.

Hierarchy of Interventions

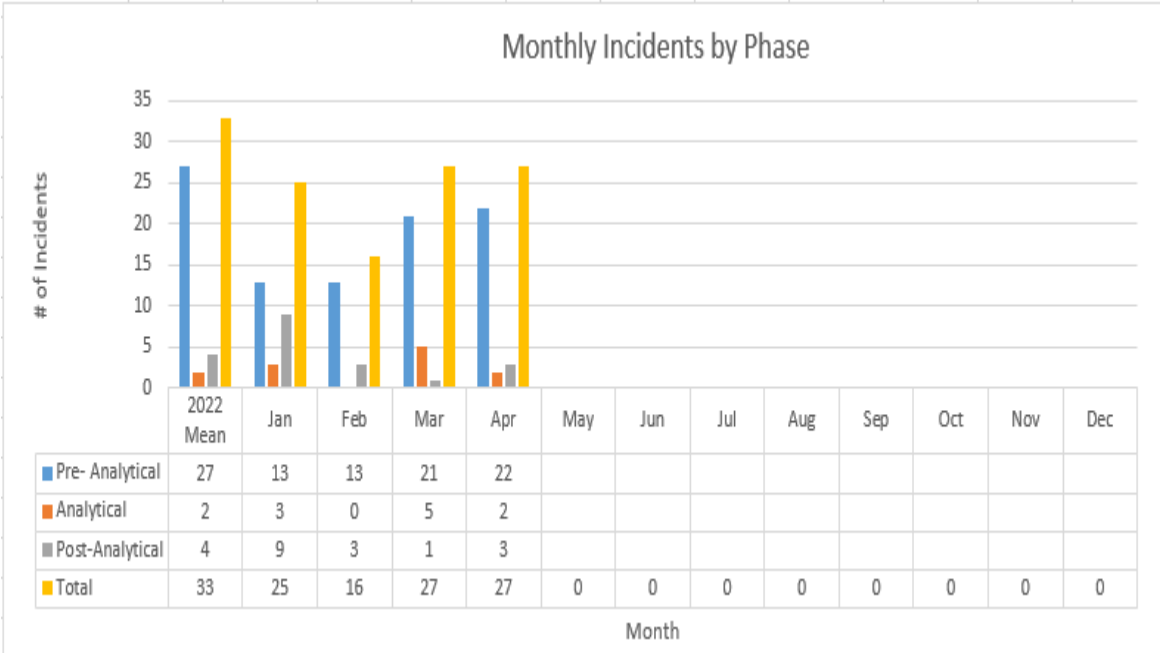


Root Cause Analysis

- Root Cause Analysis is performed on sentinel or other serious events
- Sentinel Event: Unexpected occurrence involving death, serious physical or psychological injury, or risk thereof, that may result in similar events in the future
- Involves bringing together all stakeholders and thoroughly examining all processes associated with incident
- Generally, involves significant follow up from stakeholders and ongoing meetings to ensure any gaps have been properly addressed
- Patient Safety Events Committee (PSEC)
  - Incidents that are submitted for PSEC review involve all stakeholders performing an internal RCA which is presented to the Chief Quality Officer and PSEC Committee
  - Action items are assigned, and department must respond to the Chief Quality Officer/PSEC Committee with all resolutions

Monthly Incident Report

- Sent monthly to senior leadership for awareness of all incidents which required internal follow up from laboratory
- Review for:
  - What patterns are seen? (increases or decreases in type, frequency or severity)
  - What trends are seen compared to prior periods of time?
  - Which incident types have been reported multiple times?
    - For these incident types was an SBAR/RCA conducted?
  - When were corrective actions completed? How does this compare to the timing of the incidents?
  - Does the data support resolution of issues discovered?
  - Was there an effect on patient safety?



	2022 Mean	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Pre- Analytical	27	13	13	21	22								
Analytical	2	3	0	5	2								
Post-Analytical	4	9	3	1	3								
Total	33	25	16	27	27	0	0	0	0	0	0	0	0

- Keep in mind: 50-75% of all errors occur in pre-analytical phase of testing
- UCD
  - 2022: ~80% of incidents were pre-analytical
  - 2023 YTD: ~74% of incidents are pre-analytical

Resources

- UC Davis Health Risk Management
  - Risk Management (ucdavis.edu)
- UC Davis Health Quality and Safety
  - Quality & Safety | Homepage (ucdavis.edu)
- Policy 775.A Incident Reporting (MediaLab)
- Policy 790.A Sentinel Events (MediaLab)
- Policy 1466 Incident Reports (Ellucid)
- QMS11_2015 Nonconforming Event Management
- Analytical Skills Development Certificate Series
  - Human Resources - Analytical Skills Development Certificate Series (ucdavis.edu)
- CAP Focus on Compliance Webinar: Root Cause Analysis