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<th>CRAIG HOSPITAL POLICY/PROCEDURE</th>
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<td><strong>Approved:</strong> DD 11/06; SC, CIC, MEC, P&amp;P 1/07; CC, P&amp;P 6/07; 05/10; DD, MEC 09/11 P&amp;P 10/11, 09/12; EOC 06/13, P&amp;P 07/13; 10/14, 07/16; P&amp;P 03/17</td>
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<td><strong>Attachments:</strong></td>
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**SUBJECT:** EVENT REPORTS AND REPORTING TO THE COLORADO DEPARTMENT OF HEALTH

**RATIONALE:** To provide a reporting system for occurrences which are hazardous or potentially hazardous to patients, employees or visitors at Craig Hospital, and to promote a safe environment and system of care. To maintain a log of patient complaints for analyses and trending. To report events as required by law to the Colorado Department of Public Health and Environment (CDPHE) Health Facilities and Emergency Services Division (HFEMSD).

**SCOPE:** All Staff

**POLICY:**

I. **Criteria for Completion of Event Reports**
   A. Any occurrence that threatens the safety or well-being of patients or visitors, or which results in an injury to patients or visitors, must be reported in the hospital’s electronic event report system. Such incidents may involve falls, Code Blue, medications, lab, medical imaging, elopement, equipment/device, safety, privacy and other/miscellaneous.
   B. Any “near miss” event that would have constituted an unintended event in the system of care with potentially negative consequences to the patient but was intercepted at the point of patient care service before it actually reached the patient.
   C. Any significant deviation from policies and procedures or the normal routine of the hospital that could adversely affect quality of patient care.
   D. Any patient complaint that warranted follow-up by a department director will be entered into the hospital’s electronic event report system. Unresolved complaints are forwarded to the patient representative or hospital administration per policy RI 26 Patient Concerns or Complaints.
II. Certain incidents are required by law to be reported to the CDPHE/HFEMSD within one business day. These incidents are defined below and will be immediately reported to the Vice President of Clinical Services, Vice President of Patient Care Services, or Safety Officer to complete the report to the CDPHE/HFEMSD.

III. Any employee that has concerns about the safety or quality of care provided a patient in the hospital may report these concerns to the Joint Commission (1-800-994-6610), the CDPHE, or other agencies. Hospital employees have the right to speak out on behalf of a patient’s safety without fear of disciplinary action, retaliation, or loss of employment.

PROCEDURE:

I. Completion of the Event Report
   
   A. The staff member observing the incident/near miss will promptly complete all information in the electronic event reporting system on the Craig Intranet site within 24 hours (unless immediate notification is required see section II).
      1. If a patient is involved, the physician and nurse are notified as appropriate and the physician’s name is so indicated on the form.
      2. Provide a brief, factual description of the event, near miss or patient complaint. Do not include personal opinions, feelings or suspicions. Do not place blame.
      3. For patient complaints, summarize the follow-up activity.

   B. The event form will be submitted to designated staff members when the staff member reporting the event clicks the submit button.

   C. The physician, or his/her designee, informs the patient, or when appropriate, the patient’s family, about the outcomes of care, including unanticipated outcomes, as soon as reasonably possible.

II. In order to efficiently report specific occurrences (events) and data as required by regulations of the CDPHE, all hospital departments and staff need to communicate to the Patient Safety Officer, Vice President of Clinical Services, or Vice President of Patient Care Services immediately, and submit an electronic event report.

   A. The following occurrences are reportable to the CDPHE/HFEMSD: Any occurrence that results in the death of a patient or resident of the facility and is required to be reported to the coroner as arising from an unexplained cause or under suspicious circumstances;
      1. Any occurrence that results in any of the following serious injuries to a
patient or resident:

a. Brain or spinal cord injuries;
b. Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions;
c. Second or third degree burns involving 20% or more of the body surface area of an adult patient or resident or 15% or more of the body surface area of a child patient or resident;

2. Missing Person: Any time that a resident or patient of the facility cannot be located following a search of the facility, the facility grounds, and the area surrounding the facility and there are circumstances that place the resident’s health, safety, or welfare at risk or, regardless of whether such circumstances exist, the patient or resident has been missing for eight hours;

3. Any occurrence involving physical, sexual, or verbal abuse of a patient or resident by another patient, resident, or employee of the facility or a visitor to the facility; If the abuse meets the occurrence standard, it must also be reported to the police, also see RI 35 Victims of Abuse and Neglect for more specific procedures in this area;

4. Any occurrence involving neglect of patient or resident, also see RI 35 Victims of Abuse and Neglect for more specific procedures in this area;

5. Any occurrence involving misappropriation of a patient’s or resident’s property. For purposes of this policy, “misappropriation of a patient’s or resident’s property” means a pattern of or deliberately misplacing, exploiting, or wrongfully using, either temporarily or permanently, a patient’s or resident’s belongings or money without the patient’s or resident’s consent, also see RI 35 Victims of Abuse and Neglect for more specific procedures in this area;

6. Any occurrence in which drugs intended for use by patients or residents are diverted to use by other persons;

7. Any occurrence involving the malfunction or intentional or accidental misuse of patient or resident care equipment that occurs during treatment or diagnosis of a patient or resident and that significantly adversely affects or, if not averted, would have significantly adversely affected a patient or resident of the facility.

8. If a patient death is related to restraints then the hospital will report it to the Centers for Medicare and Medicaid Services no later than the close
of the next business day following knowledge of the patient’s death. Refer to RI 40 Restraints and Safety Devices.

B. The Safety Officer, Vice President of Clinical Services or Vice President of Patient Care Services or their designee is responsible for reporting to the CDPHE/HFEMSD Internet Portal www.cohfd-egov.com all above occurrences by the next business day after the occurrence or after the facility becomes aware of the occurrence.

C. If the internet portal is not available, the CDPHE/HFEMSD occurrence reporting line 303-692-2900 may be used. The occurrence report would then need to be submitted by internet once available.

III. Any report to the CDPHE/HFEMSD, law enforcement, community agencies, programs/or individuals will be recorded in the Disclosure Tracking Log Form (PR12F) and follow the procedures in policy PR 12 Release of Health Information that does not require a Patient Authorization – State and Federal Laws. A copy of the Disclosure Form will be sent to Health Information Management Department.

IV. Event Report Database

A. Access to the event report/near miss database will be provided as appropriate to directors, designated supervisors and administrative personnel.

B. Data will be entered into the database by staff reporting the event.

C. The event will be directed to selected management staff for each event category.

D. The manager of each event area will complete necessary follow-up and enter a summary in the outcome section of the database. They will also complete any follow-up screens as needed.

E. Monthly, quarterly and annual summary reports of the event categories will be provided and periodically reviewed in the Environment of Care Committee, Nurse Practice Council (Emergency Stat/Code Blue Patient Experience Committee (patient complaints) and Quality Council for trends and opportunities for improvement.
Event/Near Miss Occurs

Electronic event report completed by staff within 24 hours; MD notified as appropriate if patient is involved

Immediate notification of supervisor if incident/med error results in:
- Unexplained death
- Brain injury, SCI, life-threatening complications of anesthesia or transfusion errors, second or third degree burns to 20% or more of body
- Elopement over 8 hours
- Incidents of suspected violence, abuse or neglect
- Misappropriation of patient’s property;
- Drug diversion; or adverse outcome from equipment involved.

Physician (or his/her designee) informs patient (or patient’s family when appropriate) about significant, unanticipated outcomes of care

Supervisor/director completes follow-up in event database. Notifies any other departments involved.

CQI
Monthly, quarterly and annual summaries of trends and opportunities for improvement

Supervisor notifies Safety Officer, VP of Clinical Services and VP of Patient Care Services for CDPHE reports