Institutional Handbook of Operating Procedures Policy 09.13.13	
Section: Clinical Policies	Responsible Vice President: Senior Vice President, Chief Medical & Clinical Innovation Officer
Subject: General Procedures	Responsible Entity: Quality & Patient Safety

I. Title

Event Reporting

II. Policy

A. The University of Texas Medical Branch at Galveston (UTMB) supports a just culture (balancing non-punitive reporting and accountability), to continue our efforts to improve quality of care and promote patient safety. It is the responsibility of all UTMB employees and contract workers to report events by using the Health System's designated event reporting tool, RL Datix.

This reporting process is used to increase awareness of patient, visitor, or employee safety concerns or unsafe conditions throughout the organization and to inform systemic change.

Information collected through the event reporting system is confidential, non-discoverable, and blame-free. **Note: If the event involves death or serious injury, or risk thereof, contact the Quality and Patient Safety Department immediately and refer to policy** IHOP - 09.13.16 - Sentinel Events.

B. Purpose - The purpose of the policy is to provide guidance and management on reporting of patient safety events, as well as employee and visitors safety events that result in harm. This includes both sentinel events and near miss events to prevent further occurrences.

C. Scope/Coverage - The event reporting tool, RL Datix, is accessible to all employees that have a UTMB user ID. It is the expectation that all employees use RL Datix to submit event reports that include harm or near misses involving patients, employees, visitors, vendors, or students.

III. Procedures

A. Confidentiality. Pursuant to Texas Health and Safety Code Chapter 161, and Texas Occupations Code Chapter 151/160, all event reporting data is confidential, privileged, and shall be maintained by the Department of Quality & Patient Safety for the use of UTMB's reporting structure and process(es).
To protect patient confidentiality and the privileged nature of this data, the following procedures must be followed:

- Event Reports should not be printed or copied.
- No reference should be made to the filing of an Event Report in a patient's medical records.
- Necessary information should be extracted and shared with other departments only as warranted.

Failure to follow these procedures may result in disciplinary action, up to and including termination.

B. **Reporting an Incident**

The event reporting tool is accessed by using the UTMB intranet home page. (See Patient Event Reporting System). Event reports should be completed within 24 hours by the person who is involved in, observed, or discovered the event. Any documentation of the event separate from the event report

must be requested from Quality & Healthcare Safety with authorization from the organization's safety oversight committee(s).

An objective description of the event should be documented in the medical records; however, it should **not** include details of the incident report being submitted.

Examples of events that *must* be reported include but not limited to:

- Near miss events
- Patient identification issues
- Procedural errors (miscount of sponge or instruments, wrong procedure, wrong site)
- Falls for any reason (patient, visitor, employee)
- Suicide attempts
- Reports of abuse, physical or sexual
- Medication errors or delays
- Delays in diagnosis or treatment
- Faulty equipment
- Employee events (on the job injuries, needle sticks)
- Workplace violence events
- All events that are considered a sentinel event (See Sentinel Event Policy)

C. Review Process

Managers assigned at the departmental level are responsible for reviewing events involving their areas within seven (7) business days of the date the incident is reported through the event reporting system.

Reviewing events may include, but are not limited to reading, verifying event type and harm score, discussing issues and proposed actions with their affiliated Medical Director, determining next steps, and initiating an investigation.

The Quality and Patient Safety Department will oversee and determine necessity for event report closure. The Quality and Patient Safety Department's participation is not mandatory for an investigation to be initiated by a manager. Events may also be forwarded to consultant department(s) for review. If consultant departments are collaborating with a manager on an investigation , the consultant reviewer should complete their investigation within seven (7) calendar days from receipt of the event.

Completing the event review process, to include moving to completed status, is to be recorded within fourteen (14) business days of notification of incident. Events with a higher harm scores assigned may require a more expedient review process. For extenuating circumstances that may require additional time beyond the fourteen (14) business day timeframe, the manager assigned to complete the event review will notify Quality and Patient Safety Department to request an extension and confer with their supervising manager.

Upon completion of an event action plan, involved staff and faculty are to be informed of outcome(s) by the manager and what changes, if any, are required.

Non-compliance with this review process is communicated to the appropriate member of Senior Leadership.

IV. Definitions

Adverse Event: an event that resulted in unintended harm to a patient by an act of commission or omission, rather than by the underlying disease or patient condition. An example of an adverse event would be a patient fall, iatrogenic injuries, delay in diagnosis or treatment, or medication errors.

Near Miss: an event or situation that could have resulted in injury, but it did not reach the patient, either by chance or through timely intervention.

Patient Safety Event: an event that is inconsistent with routine operations or standard care provided to a patient that did or did not result in harm.

Sentinel Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity or harm).

1. Permanent Harm: An event or condition that reaches the individual, resulting in injury that permanently alters and/or affects the individual's baseline health.

2. Severe Harm: An event or condition that reaches the individual, resulting in life threatening bodily injury that interferes with or results in loss of functional ability or quality of life.

Serious Reportable Events (SRE): Also known as 'Never Events', it was established by the National Quality Forum (NQF) and refers to events that should theoretically never happen, such as a wrong site surgery. There are currently seven categories with twenty-nine SREs NQF: List of SREs (qualityforum.org).

1. Surgical or procedural events
2. Product or device events
3. Patient protection events
4. Care management events
5. Environment events
6. Radiologic events
7. Criminal events

V. Relevant Federal and State Statutes

Texas Health and Safety Code §§ 161.031 – 161.033
Texas Occupations Code Chapter 151
Texas Occupations Code Chapter 160

VI. Relevant UTMB Policies and Procedures

IHOP – 08.01.04 – Workplace Violence
IHOP – 09.13.16 – Sentinel Events

VII. Additional Resources

Near Miss with Bedside Medications | PSNet (ahrq.gov)
Never Events | PSNet (ahrq.gov)

VIII. Dates Approved or Amended

Originated: 04/01/1994	
Reviewed with Changes	*Reviewed without Changes*

11/29/2014	09/07/2018
07/29/2014	
03/22/2017	
05/18/2020	
03/14/25	06/20/2023

IX. Contact Information

Quality and Patient Safety Department
(409) 772-8353