POLICY TITLE: Incident Reporting

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SUMMARY & PURPOSE: To establish a standardized process for incident reporting for the Herbert Wertheim College of Medicine (HWCOM). These reporting requirements are set forth to utilize data to improve patient outcomes and enhance patient safety, to minimize exposure to potential risk and liability by instituting process improvement activities, to prevent re-occurrences and to promote a culture of quality and patient safety. HWCOM faculty, staff and students will complete an incident report regarding patient care situations that involve a deviation from the standard of care and that may have harmed or could have the potential of causing harm to a patient or visitor whether an injury has occurred. The early identification of an actual, potential or near miss report will improve patient outcomes through investigation, analysis, tracking and trending by the HWCOM Clinical Risk Manager.

SCOPE/APPLICABILITY: This policy applies to all the HWCOM Clinical Locations and, affiliated institutions where faculty, students and/or staff provide care to patients. The HWCOM clinical locations are: FIU Health Modesto Maidique (“MMC”), Green Family Foundation NeighborhoodHELP Mobile Health Centers and Household visits and the Linda Fenner 3D Mobile Mammography Center.

POLICY: Every faculty, student and/or staff working in a clinical setting is responsible for reporting adverse incidents and near misses to the HWCOM Clinical Risk Manager. Each incident should be reviewed and discussed promptly to identify the cause and safeguard that the problems are immediately addressed. Incidents should be reported as soon as possible from the moment they are recognized, within 24 hours of occurrence and no later than three (3) business days after the incident. Any patient, visitor, or employee injury or condition that could cause a serious event must be reported immediately to the Clinical Risk Manager by contacting the Risk Management Department directly at 305-348-9174.
DEFINITIONS:

Adverse Incident: An event that causes, or has the potential to cause, an unexpected or unwanted effect involving the safety of a patient whether an injury has occurred. Adverse events vary in severity from minor to extremely serious.

Examples of adverse incidents where an incident report would be completed.
Included but are not limited to:

a. Failure to obtain appropriate consent (incomplete, incorrect, improper)
b. Medication errors (expired, wrong dose, wrong route, wrong medication)
c. Angry patients or family members
d. Any medical device causing patient harm
e. Patient or visitor fall
f. Any event causing injury/harm
g. Adverse Drug Reactions
h. Allegations of Sexual Misconduct
i. Threats of Litigation
j. Transfers by ambulance to other healthcare facilities for higher level of care
k. Needle stick injuries
l. Baker Act
m. Any additional event deemed appropriate by the reporter

Serious Adverse Incident: Should be reported directly and immediately to the Clinical Risk Manager. Examples of a serious adverse incident include but are not limited to: unexpected death, procedure on the wrong patient, misdiagnosis, mammography mis-reading, IUD uterine perforation, allegation from either patient or a family that an injury or harm has occurred, or any clinical situation that a faculty, student or staff members feels is serious and has affected patient safety.

Near Miss: An unplanned event that did not result in injury, illness, or damage – but has the potential to do so and a fortunate break in the chain of events prevented a serious injury, or fatality; in other words, a near miss is a close call. Near miss reporting helps identify trends, root causes, and weaknesses in the system. Example: During the preparation of a medication that is being administered intramuscularly, you notice that the physician order states medication is to be administered orally. You noted the error and intercepted this error before the medication was administered incorrectly, thus rendering this a near miss.

QIPSC: Quality Improvement Patient Safety Committee
PROCEDURE:
How to Complete an Incident Report

1. All clinical sites have the Clarity icon located on the desktop for ease of navigation.

   Clarity Icon

   Note: If you do not have the icon on your desktop, please reach out to Information Technology Department to have the icon deployed to your desktop.

2. Complete the fields in the link. The required items (noted by the symbol*) must be completed. Once complete, click save.

3. **Who completes the incident report?** The person with the most knowledge of the incident should complete the report. If the person with the most knowledge is unable to complete the incident report, someone else familiar with the incident should complete the incident report. All others present during the incident are listed as witnesses and are considered a vital part of the investigation. Please list all the witnesses with complete first and last names in the witness section. If there were many witnesses, only one report is required, listing all witnesses.

4. **How is the incident report completed?** It is written in a clear, factual, and objective manner free of unbiased personal opinions and judgements. Explain the who, what, when and where. Be specific, so that the Clinical Risk Manager understands factually what happened.

5. **What happens to the incident report once you click save?** Once the incident report is submitted, and saved the report is routed to the unit leader, Medical Director, and Clinical Risk Manager. The Clinical Risk Manager investigates the incident and determines if further steps are taken to address the concern. Tracking and trending of recurrent incidents is followed by the Clinical Risk Manager and reported to the Director of Quality as needed and the data is reported at a very high level at QIPSC.

6. **Specific to Patient / Visitor Falls:** What details should be included in the incident report when a fall occurs in our clinical settings? The details of the report should include precise location of the fall, any visible injuries caused by the fall, patient/visitor complaints in quotes, type of shoes worn, a description of the environmental factors: (lighting, water, clutter, or anything that may have contributed to this fall). Was the patient transferred to a higher level of care and did the patient/visitor refuse the transfer?

   *Please Note:* If you are unsure whether to complete an incident report, please complete one!

Use of Incident reports:

a. Incident reports are never a part of the medical record. Do not document that an incident report was completed or that Risk Management was notified or provide the name of the Clinical Risk Manager in the medical record.
b. Incident reports are never released to anyone, including patients. They are the property of Herbert Wertheim College of Medicine Clinical Risk Management Department, and are considered Privileged and Confidential, Patient Safety Work Product.
c. Incident reports are never printed or saved in departmental share drives or in binders
d. Incident reports are never utilized in the disciplinary process of HWCOM faculty, staff and/or students

**FIU Employee injuries:**
If you have any questions regarding an employee injury, please contact the division of Human Resources, at 305-348-7960. Email: cruzma@fiu.edu
Please refer to the *Workers Compensation Guideline* approved 6/2022. This guideline is only applicable to FIU Health MMC.

**SUPPORTING/REFERENCE DOCUMENTATION:**
- Joint Commission definition of Near Miss JC CAMH Update 2, January 2016
- National Safety Council definition of Near Miss, 2013
- Florida Statute 458.351 Reports of adverse incidents in office practice setting, 2016
- *Workers Compensation Guideline*. Approved 6/2022

**RELATED POLICIES, PROCEDURES, AND ASSOCIATED FORMS:**