North Carolina Department of Public Safety
Prisons

SECTION: Administrative-Performance Improvement & Risk Management

POLICY # AD II-14

SUBJECT: Health Services Electronic Event Reporting System (HSE)

EFFECTIVE DATE: October 2017
SUPERCEDES DATE: New

References:
Related ACA Standard **4th Edition Standards for Adult Correctional Institutions 4-4410**

PURPOSE

To provide a means to monitor, analyze, investigate, evaluate and manage Health Services events involving patients/offenders that may impose liability and legal implications/risks and/or indicate system issues that merit further evaluation and possible improvements in policy, procedure, and overall work product for the North Carolina Department of Public Safety (NCDPS) Division of Adult Correction (DAC) Prisons. Event Reports are an important and integral part of Health Services' Performance Improvement. This policy applies to all Health Services staff.

POLICY

- Event Reports are considered internal management reports as directed by Health Services Continuous Quality Improvement (CQI) Committee.
- Event Reports are for NCDPS, DAC, Prisons Health Services use only as outlined in N.C.G.S. 131E – 95 and NC G.S. 90 – 21.22A.
- Event Reports are privileged and confidential for the express use of Risk Management/CQI in the Peer Review/Performance Improvement Process.
- Event Reports are to be completed by the Health Services staff member that observe and/or discover the event.
- Event Reports are not to be printed, copied or filed in patient's healthcare records.
- Event Reports are not to be shared with patients, family, or any other non-employee except by court order.
- Any requests for these documents shall be directed to the Health Services Risk Manager.
- The Health Services Risk Manager/designee will review the event reports to identify patterns and/or trends as part of the overall Performance Improvement Plan of the NCDPS DAC Prisons Health Services. This data will be provided to Health Care Administration leadership and the CQI Committee members at least quarterly.

DEFINITIONS

1. **Event/Error**

   - An unexpected, unanticipated or unintended event/act, including unintended or unnecessary harm or suffering arising from any aspect of health care management, either problems of omission or commission that has an impact on our patient's physical or emotional well-being and/or implications of risk for the NCDPS.
   - The failure of a planned action to be completed as intended.
   - The failure of an unplanned action that should have been completed (omission).

2. **Medication Error/Event**

   - Is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional or patient.

3. **Serious/Adverse Event**
   - An unexpected occurrence that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient. The duration of the physical or psychological damage is two (2) weeks or less.

4. **Sentinel Event**
   - An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof (potential). Serious injury specifically includes loss of limb or function. "Or risk thereof (potential)" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
   - These events are not related to the natural course of an individual's illness or underlying condition.
   - These events need to be reviewed immediately by the region and/or facility health services leadership.
   - Of note – a sentinel event and an error are not used interchangeably; not all sentinel events occur due to an error and not are errors are sentinel events.

5. **Good Catch (Near Miss)**
   - An error of commission or omission that could have harmed the patient, but serious harm did not occur as a result of:

- Chance – the patient received a contraindicated drug but did not experience an adverse drug reaction;
- Prevention – a potentially lethal overdose was prescribed, but the nurse identified the error before administering the medication;
- Mitigation – a lethal drug overdose was administered but discovered early and countered with an antidote.

- Any process variation which did not affect the outcome but for which a recurrence carries a significant chance of a serious outcome.

6. **Hazardous Condition**
   - Any set of circumstances; exclusive of the disease or condition for which the patient is being treated; which significantly increases the likelihood of a serious adverse outcome.

7. **Patient Safety**
   - To ensure the health, safety and welfare of the individual and the prevention of harm caused by errors of commission and omission.

8. **Categories of events**
   - ACTUAL events – example: wrong medication is given to an offender with a similar name;
   - POTENTIAL events – example: inhalant medications have similar packaging and are stored in the same area;
   - "GOOD CATCH" events (Near misses) – example: medication is prepared for administration, but just before giving the medication, you realize the dose is incorrect. The dose is corrected prior to giving the medication to the patient.

PROCEDURE

Notification needs to be made prior to the end of shift by the individual that discovered the event or Nurse Manager/Lead Nurse to Health Services Risk Management section by telephone at (984) 255 – 6124, or email at DPS_AC_Admin_HealthSvcs_RiskMgmt, if any of the following occurs:

- Death – Unanticipated and Anticipated
- Event that contributed to or resulted in the patient's death
- Event that required intervention to sustain the patient's life
- Self-Injurious Behavior
- Suicide attempts

- Any activities that reasonably could be considered life-threatening
- Event that may have contributed to or resulted in temporary harm to the patient and/or required an Emergency Room visit or hospitalization
- Event that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm.

I. Reporting of Events

1. A full account of the event, including the immediate interventions and outcomes, must be documented in the patient's healthcare record as soon as possible following the event. Do not document in the patient's healthcare record "an event report has been submitted."
2. If several patients/offenders are involved in an event, a separate event form must be completed for each patient/offender. Examples would be physical altercations, fire, bus accident, etc.
3. The Nurse Supervisor will review the Health Services Electronic Event Report within forty-eight (48) hours/two (2) business days and document their outcomes to include additional information gathered, if applicable.
4. The CP/CPHC and NCCIW Risk Managers will review the Health Services Electronic Event Report within seventy-two hours/ (3) business days and document their outcomes to include additional information gathered, if applicable.
5. The Risk Management section will review the Health Services Electronic Event Report after five (5) days.

Terri L. Catlett 10/30/2017

Terri Catlett, Deputy Director of Health Services Date

SOR: Risk Manager