NORTHERN
HEALTH REGION

Occurrence Reporting Quick Tips

June 2014

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Introduction

Risk management is the identification of the organization's risks, assessment of the importance of each risk, and the action to prevent or manage these risks. A solid occurrence reporting process is the cornerstone to effectively identifying the risks within the NRHA.

Who should complete an Occurrence Report?

You! All staff, physicians or volunteers are responsible for completing an Occurrence Report if they identify an event that meets the below definition for a near miss, occurrence, critical Incident or critical occurrence.

What is an occurrence?

It is an event and/or circumstance that resulted in or could have resulted in an unintended or undesired outcome. It may result in:

- injury to an individual
- damage to equipment or property
- loss of equipment or property

When do I complete an Occurrence Report?

Whenever a situation presents itself that meets the above definition. A report should be completed for an:

- Occurrence – preferably before the end of your shift (but definitely **within 24 hours** of the occurrence)
- Critical Incident & Critical Occurrence – **Immediately**

Why should I complete an Occurrence Report?

We cannot fix what we don't know about. The Occurrence Report 'brings to light' the risks. We need to be diligent about completing occurrence reports and encourage our co-workers to report occurrences so that we can discuss them, learn from them and change the way we configure our work.

Reasons to report:

- I can make the care and services we provide safer for the people we serve
- I can make our work environments safer for our co-workers and ourselves
- I can minimize organizational risk
- I have an important part to play in making our environment safe. It is my responsibility to report.
- I can make a difference.

Where and how do I obtain Occurrence Reports?

Each program or department should have forms readily accessible and available for staff reporting. Additional forms can be ordered in packages of up to 60 copies through Purchasing.

Quick Tips for Completing an Occurrence Report

Demographics

Please fill out this section as completely as you can. Fill out the time and date. Use the addressograph, the name of the person who perpetrated the event or the name of the person most affected by the occurrence.

Occurrence Involved:

This section requires the information of the person affected by the occurrence. If it involved:

- A patient/client/resident: an addressograph or label can be applied to this section of the form. Information can also be written in with pen.
- A agency personnel, staff member, physician, student and visitor

Site/Facility:

- Is the name of the building the occurrence took place in. e.g. St. Paul's, St. Anthony's, PHC-FF, TGH, Northern Spirit Manor, FFGH, etc.

Program/Department:

- Provide the name of the program within the building where the occurrence took place. E.g. Emergency Department, Psych. Unit, Home Care

Location:

- Provide the location of where the incident took place e.g. clients bathroom, laundry ,med room

Narrative:

- What happened? Facts Only please.

Degree of Injury

Minor:

- an event occurred that resulted in the need for treatment and/or intervention and/or monitoring and caused temporary harm.

Major:

- an event occurred that resulted in admission to hospital, or a prolonged hospital stay and which was not the result of the client's health status
- an event occurred that resulted in disability or permanent patient harm or near death event such as anaphylaxis

Unknown:

- select this option when you do not know the degree of injury.

None Apparent:

- an event occurred but the patient/client/resident was not harmed.

- an event occurred that resulted in the need for increased patient/client/resident assessments but no change in vital signs and no harm resulted.
- an event occurred resulting in no apparent injury to employees, physicians, volunteers, students visitors

Recommendations

In your opinion what could be different to prevent similar occurrence

Reporter

Name, title, department and date reported

Witness

Other than the reporter

Contributing Factors

Check all that apply

Contributing Factor: (Multiple options can be selected)	**Check this 'Contributing Factor' when the possible cause is related to….**
Body mechanics	- improper use of body mechanics. E.g. not bending knees to lift a heavy object
Client behavior/mental status	- when the client's behavior or actions contributed to the occurrence. E.g. spontaneous actions, aggression, confusion - the person involved in the occurrence had a physical or mental condition that contributed to the occurrence. E.g. a client has a self-inflicted injury in part due to the client's mental condition
Client education concern	- when the reason for the fall was related to the client's behavior/mental. E.g. confused or disoriented - e.g. lack of information, non-compliance, miscommunication related to language barrier
Client information missing	- information pertaining to the client/patient/resident that is missing from the documentation e.g. weight, allergies, diagnosis
Client interference	- when a task or procedure is interrupted by a client. - client's lack of cooperation or difficulty with assisting. - e.g. Injured when trying to transfer a resident who was combative during the process.

Contributing Factor: (Multiple options can be selected)	**Check this 'Contributing Factor' when the possible cause is related to….**
Client not available	- e.g. client away from the nursing unit or away on a day pass.
Client physical condition	- when the reason for the fall was related to the client's physical condition. E.g. the client was not strong enough to climb stairs and fell, recently had a medication change or experienced a cardiac arrest.
Client self-medication	- client/patient/resident is taking the prescribed medication and or other medications including herbal supplements on a schedule other than that prescribed by the physician/pharmacist. Client/patient/resident is taking other medications including herbal supplements without having checked the drug interactions or contraindication.
Clothing or footwear	- when the reason for the fall was related to the clothing or footwear worn by the person. E.g. Slippers/shoes with smooth soles or soles lifting away from the shoes, pant legs that caught under the toes
Do Not Use abbreviation	- an abbreviation from the Do Not Use List was documented in the client health record.
Drug name, label, packaging problem	- e.g. look/sound-alike names, look-alike packaging, unclear/absent labeling
Drug storage or delivery problem	- e.g. slow turnaround time, inaccurate delivery, missing supplies, placed in wrong bin or container/location
Environmental conditions	- e.g. poor lighting, noise levels, clutter, interruptions - when the reason for the fall was related to deficiencies in the surrounding where the fall occurred. E.g. poor lighting, ice or snow
Error calculating dose	- the dose was not calculated correctly prior to administering or dispensing
Failure to check chart/assignment	Not checking scheduled duties for the shift. E.g. client missing related to not checking chart for need to complete 15 minute checks E.g. Staff did not review work assignments
Fainted/seizures	When the reason for the fall was related to the persons fainting or having a seizure

Contributing Factor: (Multiple options can be selected)	**Check this 'Contributing Factor' when the possible cause is related to….**
Faulty device/equipment problem	a problem related to the equipment or device used. E.g. A surgery was cancelled because of equipment failure. A medication was not provided because of computer failure. The rate of flow was incorrect because the pump malfunctioned. Equipment not available when required. When the reason for the fall was related to an equipment failure. E.g. A lift broke, wheelchair brake released
Gait	When the reason for the fall was related to a particular way or manner the person moves his/her feet.
Illegible handwriting	Any handwritten order that a health care practitioner cannot read.
Incontinent	When the reason for the fall was related to client incontinence.
Infusion pump training not up to date	When the staff involved have not renewed their training on use of infusion pumps
Interruption of work flow	E.g. While in the process of preparing medication for administration the nurse interrupted
Lack of security	The reporter believes the occurrence would not have happened if security were present.
Medication not checked properly	E.g. during medication administration or distribution the staff member did not perform all the medication rights
Miscommunication of information	E.g. there is misunderstanding of information given during report that is not clarified before the reporter left
Miscommunication of order	E.g. illegible, ambiguous, incomplete, misheard, or misunderstood
Misunderstanding of communication/or information	The person involved in the occurrence misunderstood the directions. E.g. Protective equipment not worn when using a chemical because the user misunderstood the instructions or need for the same.
Order information missing	When necessary information about an order was missing E.g. missing date, time, priority level or the clients age, weight, allergies, lab values, pregnancy, patient identity, location, renal/liver impairment, diagnosis was not available or not included when required

Contributing Factor: (Multiple options can be selected)	**Check this 'Contributing Factor' when the possible cause is related to….**
Policy and procedure variance	The occurrence was caused by a deviation from an established policy and procedure. E.g. Fire in a client's room as the non-smoking policy not followed. When the reason for the fall was related to not following an existing policy or procedure. E.g. Fall prevention plan or restraint policy was not utilized. when an established medication, therapeutic or diagnostic policy/procedure was not followed in the care of a patient/client/resident and resulted in or could have resulted an unintended, undesired outcome. E.g. when there is a breakdown in the process of delivery or pick up of medication, therapeutic or diagnostic supplies or when a client is not monitored according to standards.
Restraint in use	When the reason for the fall was related to or involved the use of a restraint. E.g. A client falls out of bed when trying to maneuver over a bed rail.
Sedation	When the reason for the fall was related to the administration of a sedative or drug.
Side rail in use	When the reason for the fall was related to or involved the use of a side rail. E.g. A client falls out of bed when trying to maneuver over a bed rail.
Staffing or workflow	E.g. staffing mix, workload, inefficient workflow, short staffed
Transcription error	An order is transcribed incorrectly to a med. Admission sheets or lab requisitions etc.
Unexpected movement	When the reason for the occurrence was related to a movement that was not anticipated. E.g. Aggressive behavior or spontaneous client movement before transfer equipment was secured
Wet floor	When the reason for the occurrence was related to a wet floor. E.g. coffee spilled in the hallway caused a visitor to fall

Contributing Factor: (Multiple options can be selected)	**Check this 'Contributing Factor' when the possible cause is related to….**
Other	A contributing factor not listed above was involved in the occurrence. Please record the 'other' information in the space provided Any other reasons for the occurrence can be listed in this area. Please record the 'other' information in the space provided

Type of Occurrence

Select and complete **only one** of sections A-E

A. Staff/Workplace Injury

Type of Injury
Please record the type of injury if known. Options include:

- abrasion
- abuse (Physical)
- abuse (Verbal)
- amputation
- bang/bruise
- blood or body fluid exposure
- burn
- chemical burn
- cut
- electric shock
- fall
- fracture
- needle stick
- repetitive strain
- sprain/strain
- other: Please record the type of injury in the space provided

Fill out the section that asks for body part injured, time off work and did you see a Physician
All workplace injuries MUST be reported to a manager or designate immediately. The Manager or Designate will notify Human Resources within 24 hours or by the next business day

B. Falls

Fell From:	**Check this when….**
Bed or Crib	- When the fall originated from a bed or crib. E.g. The person fell while getting out of bed or rolled off of the bed.

Fell From:	**Check this when….**
Chair	- When the fall originated from a chair (excluding wheelchairs). E.g. The person fell while trying to stand up from a chair.
Exam table/stretcher	- When the fall originated from an exam table or stretcher. E.g. The person falls from an exam table during x-ray or surgical procedure.
Stairs	- When the fall was related to using stairs.
Toilet/commode	- When the fall originated from the toilet/commode
Tub/shower	- When the fall was related to the use of the tub/shower.
Wheelchair/scooter	- When the fall was related to the use of a wheelchair/scooter.
Other	- When the fall originated from any other means than those listed above. E.g. Falling from a vehicle. Please record the 'other' information in the space provided.
Unknown	- When you are unable to determine the origin of the fall E.g. the person is found on the floor and is not able to communicate how they fell.
Not applicable	- When the person did not fall from any specific object. E.g. Fell while walking.
Fell While:	**Check this when….**
Laying	- The person involved in the fall was lying down immediately before the fall.
Standing	- The person involved in the fall was standing immediately before the fall.
Transferring	- The person involved in the fall was transferring from one location to another. E.g. From the bed to a wheelchair.
Walking	- The person involved in the fall was walking immediately before the fall. E.g. Fell while walking up stairs, slipped on wet floor while walking
Status of Equipment or Restraint	- Please check the appropriate box that best describes the status of the equipment or restraint - Check n/a if the equipment or restraint was not applicable to this client.

C. Medication or Treatment, Test, Procedure Variance

For medication variance please ensure to document the name, frequency, dose and route of the medication that was ordered AND the medication that was given. Attach extra sheet to report if more space is needed.

Type: (only one type can be selected)	**Check this 'Type' when….**
Adverse reaction	- when a patient/client/resident experiences a harmful and/or unintended clinical response caused by a drug or other product - E.g. of adverse reactions include everything from a rash to severe difficulty breathing Health Canada March 2004: Adverse reactions are undesirable effects to health products. Health products include drugs, medical devices and natural health products. Drugs include both prescription and non-prescription pharmaceuticals; biologically-derived products such as vaccines, serums, and blood derived products; cells, tissues and organs; disinfectants; and radiopharmaceuticals. Reactions may occur under normal use conditions of the product. Reactions may occur within minutes or years after exposure to the product and may range from minor reactions like a skin rash to serious and life-threatening events such as a blood disorders or liver damage.
Blood type/product	- an error in ordering, obtaining or administering blood or blood product.
Break in sterile or isolation technique	- when procedures are not followed during the preparation or use of sterile products. The break in technique increases the chance of introducing microorganisms; or - when infection control practices were not followed. E.g. not wearing the required protective attire when entering isolation areas or reuse of a lancet.
Cancellation	- when there is a cancellation of a treatment, test or procedure
Consent issue	- when consent was not obtained for a treatment, test or procedure when it should have been obtained. E.g. a surgical procedure was preformed without written consent. - when a patient/client/resident denies giving consent for a treatment, test or procedure. E.g. Parent denies giving consent to have child immunized

Type: (only one type can be selected)	**Check this 'Type' when….**
Delay in Treatment/Test/Procedure	- when there is a delay in a treatment, test or procedure.
Delivery/pickup problem	- when a sample, test etc. is not delivered or picked up according to the usual procedure.
Discontinued	- when a client/patient/resident discontinues use of a prescribed drug, therapy or treatment.
Do NOT use abbreviation usage	- when an abbreviation from the Do Not Use abbreviation list appears in any part of a client's health record.
Duplication	- when a medication, treatment, test or procedure is inadvertently repeated in error. E.g. Flu vaccine is administered to a patient twice - when multiple drugs are ordered in the same class E.g. two beta blockers ordered for the same patient when only one is required
Foreign body left in client	- when a surgical sponge, needle or instrument is left in the patient/client/resident in error
Inappropriate results	- when results for treatments, test or procedures are incorrect. E.g. an equipment malfunction resulted in inaccurate test results
Incomplete/omitted procedure	- when a procedure that should have been completed for a client that was not performed or not completely performed.
Incorrect client	- when a med/therapeutic or diagnostic procedure was ordered for or provided to the wrong patient/client/resident - e.g. when an x-ray was performed on a Mr. Jones (bed A) that should have been performed for Mr. Smith (bed B).
Incorrect dose	- when the correct drug was provided but in the wrong amount. E.g. Cipro 250 mg ordered but Cipro 500mg was provided.

Type: (only one type can be selected)	**Check this 'Type' when….**
Incorrect medication administered /consumed	- when the patient/client/resident consumed a medication without a doctor's order or not on the standing orders; or - when and IV solution administered was incorrect. For example order for 5%D ½ NS with 20 mEq KCl was provided instead of 5% D N/S with 20 mEq KCl; or - the patient received the wrong type of medication. E.g. the client receives ceptaz instead of ceftaz.
Incorrect medication dispensed	- when a medication was dispensed by Pharmacy for a client or taken from the night cart or ward stock without a corresponding doctors order. - when medication was stored in the incorrect storage device. E.g. Pyxis drawer, pill bottle, blister package mix-up - **Note**: The patient/resident/client did not consume the medication - when a medication was prepared/portioned/pulled incorrectly (prior to the medication being administration to the client). This type captures occurrences that take place after the medication was dispensed but before the medication was administered to the patient.
Incorrect narcotic count	- when there is a discrepancy between the documented amounts of narcotics versus the actual amount of narcotics available. E.g. 10 tablets of codeine are documented as being available, but only 6 are physically present. - **Note:** It is essential to notify the Pharmacy Director and Manager Safety Services immediately when and incorrect narcotic count is identified.
Incorrect order	- when an order is written incorrectly. E.G. an order is written in a patient's chart that was intended for a different patient. - when an order is written in the wrong rate or units. - when an order is written with prohibited abbreviations. E.g. 'U' is written instead of writing out the word 'Units'.
Incorrect procedure/service	- when the wrong procedure was performed on a client. E.g. an x-ray or surgery on the left limb instead of the right limb or a client is transferred without the required equipment.

Type: (only one type can be selected)	**Check this 'Type' when….**
Incorrect rate of flow	- when an IV/TPN/Enteral feeding was not being administered at the correct rate. E.g. an enteral feeding running at 600 ml/hour instead of 60 ml/hour
Incorrect route/site	- when a medication was administered by a route/site different from the order. E.g. a medication was ordered IM but was delivered by IV
Incorrect time	- when a scheduled medication / therapeutic / diagnostic event was provided at the wrong time (and outside of a 30 minute window before or after the correct time). For example lab specimen that was to be obtained at 12:00pm was collected at 12:00am.
Infiltration	- when serious intravenous infiltration occurs with large volumes of product or meds that have the potential for tissue damage.
Injury to client	- when a client has become injured while in our care.
Lab specimen	- when there is any problem with a lab specimen.
Labeling problem	- when specimen, medication, test result, requisition is not labeled, is labeled incorrectly or is labeled with incomplete information
Medication Reconciliation not complete	- when the client does not have a complete medication reconciliation done within 48 hours of admission.
Misplaced medication	- when a medication that was found in a location where it should not be or cannot be found where it should be. - E.g. a medication is found in a clients night table, on the floor, on a meal tray returned to Nutrition Services
No MD in attendance	- when there is no physician in attendance.
Omitted dose	- when the administration of a medication was missed. - E.g. a medication was ordered qid but was only provided bid

Type: (only one type can be selected)	**Check this 'Type' when….**
Outdated product	- when a client care product intended to be used or was used was out of date e.g. medication, contrast media, blood/blood products, vaccine was provided or intended to be provided but it was past the items expiry date.
Surgical count	- when there is a discrepancy in the pre and post-surgical count for sponges, needles, and instruments.
Two Client Identifiers NOT Used	- when a medication was given or a treatment, test or procedure was done without first checking 2 client identifiers
Unordered drug	- A drug arrives on the unit that has not been ordered.
Other	- Any other event or circumstance related to a patient/client/resident's medication, therapeutic or diagnostic tests or procedures that resulted in or could have resulted in an unintended undesired outcome. Please record the 'other' information in the space provided

D. Abusive / Aggressive Behavior

Was a code white called? Please check Yes or No accordingly.

Form of Abuse:	**Check this 'Form of Abuse' when….**
Financial	Any action that results in monetary or personal gain E.g. borrowing from a client, misuse of another's money or using influence, pressure or coercion to obtain money or property
Emotional	Is the psychological/ emotional/ mental, neglect, and violation of human rights. It includes any act, which may diminish the sense of identity, dignity, or self-worth of those associated with the RHA. E.g. Confinement; physical and social isolation, verbal assault, harassment Humiliation, intimidation, or infanttilization; Denial of information, privacy, visitors, or religious worship; Coercion, compulsion by threat, or unlawful constraint to force a client to do some act that otherwise he/she would not have done. (Source: Protection for Persons in Care Part II Indicators of Abuse)

Form of Abuse:	**Check this 'Form of Abuse' when….**
Physical	Deliberate action or inaction that results in, or was intended to produce, bodily harm, pain or discomfort. E.g. Using force to physically make someone do something against their will.
Religious	Religious abuse is the crushing inner psychological, spiritual and emotional damage suffered by people of faith, belief or conviction whenever a person or group try to impose their faith, belief or conviction on another through unethical, cruel and damaging means.
Sexual	Sexual advances or inappropriate behavior of a sexual nature, such as harassment, failure to respect another person's right to privacy, exposure to sexually explicit material or other acts of a similar nature, with or without the individual's consent.
Verbal	Swearing at, or otherwise harassing, an individual through using language which would likely be perceived as derogatory, humiliating or insulting; or making threats of a serious nature against an individual.

E. Miscellaneous

Type:	**Check this 'Type' when….**
Breach of confidentiality	- when an event takes place that involves the unauthorized use of or disclosure of confidential information related to such things as an individual's salary, work history, performance (breach of Freedom of Information and Protection of Privacy Act - FIPPA) and any information of a medical or personal nature (breach of Personal Health Information Act - PHIA). - **Note:** The Privacy Officer requires notification of these occurrences (Policy #F.3.005).
Breach of information technology security	- when information technology policies and procedures are not followed and the security of information technology systems are at risk. E.g. Inappropriate use of VPN, internet or access to unauthorized systems.

Code Called	- any time a Code is called and the Emergency Response System is activated. Whether it is a drill/mock code or an actual event. - please document the code that was called.
Fire	- when a fire occurs.
Inappropriate disposal of sharps/biomedical supplies	- when a needle stick or sharp patient related object is not disposed of in the approved receptacles. E.g. a needle stick is found in the laundry with linens.
Left against medical advice	- when a client leaves the organization against medical advice.
Missing client	- when a client cannot be found within the facility. Note: Safety Services must be paged - a code Yellow should be called immediately to assist with a search for the client.
Property damaged	- when any property belonging to the organization or those associated with it is damaged. E.g. a facility window is broken or an employee's car is vandalized on RHA property, hearing aide or clients glasses broken
Property missing	- when property belonging to the organization or those associated with it is missing/lost. E.g. RHA equipment is missing or a client has lost their dentures while receiving RHA services.
Pressure Ulcer Risk Assessment Not Completed	- when a pressure ulcer risk assessment is not completed on admission.
Safe Surgical Checklist Not Completed	- when a safe surgical checklist is not completed prior to the commence of a surgical procedure.
Sterilizer Malfunction	- when there is any malfunction with a sterilizer
Unauthorized access	- when a person is found in an area they are not authorized to be in. E.g. A visitor or patient is found in the Pharmacy Department
Unauthorized Drugs or Equipment or Weapons	- when any person is found with unauthorized drugs, equipment or weapons in a facility or on the property
Unauthorized smoking	- when any person is found smoking in a facility or on the property

VTE Protocol Not Followed	- when there is any variance in the VTE policy and/or procedure

Equipment:

Damaged/defective:

- When a piece of equipment is damaged E.g. a piece of GI equipment is found to have a bite mark, the sling for a transfer device is worn/frayed.
- When a piece of equipment appears as it should but is not working properly. E.g. the roam alert system is not notifying staff when a resident leaves the building

Missing:

- When a piece of equipment is lost or missing. E.g. a resident's wheelchair cannot be located.

Taken out of service:

- Select this if a piece of equipment is removed from service because it is not safe to use or was involved in an occurrence that requires investigation

Locked away in a secure location:

- Always lock and label equipment involved in an occurrence away until an external investigator can examine the equipment to determine if the event was related to operator error or equipment failure. **Never return equipment involved in an occurrence to anywhere for repairs until the investigation is completed.**

Notification

Check off all sources notified of the occurrence including who reported it, the name of the person it was reported to, the date and the time, chart documentation etc.

Type of Event

- **Occurrence**: An unintended, undesired outcome. (Refer to NHR Policy AD-01-135)

- **Near Miss:** Has the potential to cause injury, unexpected death or property damage BUT DID NOT. (Refer to NHR AD-01-135)

- **Critical Occurrence**: Results in serious harm to staff or visitors; disruptions to the delivery of service and programs; an emergency or disaster; the potential to negatively affect public confidence, credibility and trust or attract media attention. (Refer to NHR Policy AD-06-55)

- **Critical Incident:** Harm has come to a client while receiving care. Such as death, disability, injury or harm, unplanned admission to hospital, stage 4 pressure ulcer development or unusual extension to hospital stay. (Refer to NHR Policy AD-06-60)

Initial Manger/Designate Follow-Up on Occurrence

- Record only the factual events that took place following the occurrence.
- Do not repeat the list of those notified on page 2.
- Document any feedback that was or will be provided to staff that were involved in or witness to the occurrence.

Investigation of Occurrences by Second Department

- Repeat process outlined in Part B above if more than one department is involved in the process.
- Check off if occurrence has been resolved