

## Incident reports: A safety tool

Nurses tend to cringe when they think about completing an incident report. Reasons for this reaction include the distress that occurs when something untoward has happened, anticipated loss of precious time to complete the report (particularly if the organization's reporting system is cumbersome), and fear of being blamed for the incident or becoming embroiled in a court case. In this situation, it's easy to forget that incident reports are a valuable resource for keeping patients safe. They also can keep employees safe by identifying system-wide problems such as insufficient staffing or equipment to move patients, which often contributes to staff injuries.

So that patients and employees can benefit from an incident report, nurses need to understand their use. They also need to know how to complete and file a report correctly to protect themselves and their organization from the report being used as part of legal action in a lawsuit brought by a patient.

### A safety tool

Incident reports provide a record of an unexpected occurrence, such as a fall or administration of a wrong medication dose, that involved a patient, a family member, or an employee. These reports can be used to identify areas of safety improvement and to educate others about how to avoid similar events in the future.

Nurses should think of the incident report as a safety tool, not a method of assigning blame. Organizations should view these reports through the lens of a culture of safety, which The Joint Commission defines as "the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety." One tenet of a just culture is to take a nonpunitive approach to reporting and learning from adverse events.

### When to file

Nurses should check their organization's policy and procedure related to when to file an incident report. In general, a report should be filed when something unexpected occurs that results in harm. Sometimes nurses may be unsure whether an event warrants reporting. In this case, it's best to go ahead and complete a report. Even if the event did not result in harm (for example, the patient did not suffer ill effects after receiving a wrong medication), it's still important to have a record of the event so that the organization can learn from the event and the risk of a similar event can be reduced.

Typically, a licensed professional, such as a nurse or nurse practitioner, who was part of or witnessed the event completes the form. However, nonlicensed clinicians should report events and provide information as needed for the report. If the event wasn't witnessed (e.g., the patient fell out of bed when alone in the room), generally the first licensed person who becomes aware of the event should file the report.

Reports should be completed as soon as possible after the event (and within 24 hours) and submitted to the designated person/department. Many organizations now allow employees to file reports online, with the risk management department and the appropriate manager receiving notification. Hospitals, clinics, and other healthcare organizations should make reporting as easy as possible to encourage staff participation.

Traditionally, incident reports have focused on situations where harm occurred, but many organizations now also encourage employees to file reports about "near misses" or "close calls"—events that could have resulted in harm but did not because someone became aware of the problem. An example of a near miss is the nurse who misreads a label on a medication mixed by the pharmacy department and almost administers an incorrect dose. These reports can be reviewed by risk managers and clinicians to determine changes that can be made to avoid future harm. In the case of the medication label, for instance, it might mean making

the print on the label larger, so it is easier to read. The Joint Commission calls on organizations to recognize employees for reporting both adverse events and close calls, so lessons can be learned and shared.

### **Incident reports and legal action**

In general, incident reports, which should not be part of a patient's health record, cannot be used in legal action. Support for this comes from the Patient Safety and Quality Improvement Act of 2005, which established a voluntary reporting system designed to encourage data sharing so that healthcare quality could be improved. The act "provides Federal privilege and confidentiality protections for patient safety information, called patient safety work product." (To be eligible for these protections, hospitals establish a patient safety evaluation system that provides data to a patient safety organization.)

However, if the report is not completed correctly, it may end up in court. For example, in a Michigan case, the hospital was arguing that it didn't know the cause of the injury, but a report contained an opinion about how an injury occurred (even though opinions should not be included in incident reports). The report was allowed to be included in the case, and the court issued sanctions against the hospital and its counsel for raising defenses "not well-grounded in fact."

In addition, a few state rulings have noted that incident reports are not always exempt from use in legal action. For instance, an Illinois court ruled that a "quality-related event report" was not privileged and that a patient suing the hospital should have access to it.

Nurses can lessen the likelihood of an incident report being part of a lawsuit by correctly completing it (see sidebar). If the report ends up in court, an accurate document can help provide evidence that the nurse and organization were not at fault for what occurred.

### **Completing the report**

The report should include a detailed description of what happened. Most organizations have a standard form designed to capture key information such as date, time, and location of the event; name of the person who was affected; names of witnesses to the event; names of those who were notified (e.g., the patient's physician); the condition of the person affected (e.g., any visible breaks in the skin after a fall); and actions taken in response (e.g., radiograph obtained, malfunctioning equipment sent to biomedical engineering).

Objectivity is key. Any relevant statements made by the person affected by the event or witnesses should be recorded verbatim. It's also important to note who assessed the patient and the results of that assessment.

Although the incident report is not part of the patient's health record, nurses should still objectively document the event, including what happened, assessment results, interventions, and follow-up (such as physician notification), in the record.

### **A helpful tool**

Incident reports are often seen as something to be avoided. However, if completed properly, they can provide useful information that can help keep patients and staff safe.

## How to complete an incident report

Here are some do's and don'ts for completing an incident report:

### Do...

- complete the report as soon as possible after the event (but after the safety of the person affected has been ensured and immediate necessary follow-up is completed).
- state only the objective facts that you witnessed or know for certain. For example: "The patient was found on the floor next to his bed." (NOT "The patient fell out of bed." This is an assumption.)
- include a clear, detailed (but concise) description of what happened.
- include relevant direct quotes (use quotation marks) from witnesses and those affected by the event. For example, a family member may have said, "He didn't want to wear his non-skid slippers and slipped on the floor."
- note interventions done in response to protect the person affected by the incident.
- provide a timeline for the event and responses.

### Don't...

- include subjective information such as assumptions, opinions, or suggestions for how similar events can be avoided in the future.
- document in a patient's health record that an incident report was completed.
- use abbreviations that aren't readily understood. For example, instead of COPD, spell out chronic obstructive pulmonary disease.

Article by: Cynthia Saver, MS, RN, is president of CLS Development, Inc., in Columbia, Md.

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