Reportable Quality Improvement Event Policy

I. Purpose:
Adfinitas endorses and supports a culture of safety and views event reporting as a means of improving systems and processes in providing healthcare services to all residents. In a continuing effort to promote a safe environment for patient and residents, Adfinitas will conduct a systematic program of quality improvement event reporting. Quality Improvement event reporting is nonpunitive and all employees are encouraged to report all resident and visitor events, whether involving themselves or another colleague.

Adfinitas encourages open and honest reporting of actual or potential injuries or hazards to residents, visitors, and employees at all sites and service lines and at all levels of care throughout the organization. In the event a report is filed involving a colleague, every effort to maintaining the reporter's confidentiality will be undertaken.

Adfinitas strives to facilitate education and problem resolution through forthright disclosure of process failure and/or human error.

The purpose of this policy is to outline the reporting requirements and follow-up of Reportable Quality Improvement Events.

II. Policy:
A Reportable Quality Improvement Event is defined as an unexpected quality improvement occurrence involving death or serious physical or psychological injury, or the risk thereof. The phrase "the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. This is also referred to as a "near miss". The fundamental objective of this Reportable Quality Improvement Event Policy is corrective in nature and the identification of appropriate actions to prevent recurrence.

Quality Improvement Event reporting is considered part of the performance and quality improvement process. The circumstances surrounding an Quality Improvement Event, all information contained in the quality improvement event report, and any follow-up reports are strictly confidential. All Quality Improvement Event Reports and related work-product and activities are protected by the federal Patient Safety Work-product privilege. Quality Improvement Event Reports, and related materials, may not be copied or otherwise disseminated.

A. Criteria
The policy is applicable to serious, unexpected patient occurrences (or near misses), including those that result in an unanticipated death, major permanent loss of limb or function, or serious injury of a non-permanent nature. It is not intended to include illness or injury related to the natural course of a patient's illness or underlying condition.

It includes but is not limited to the following:

- ❑ Unexpected death

- ❑ Birth-related injuries (for example, maternal/fetal death, anesthesia related injuries, cerebral palsy or shoulder dystocia)
- ❑ Brain damage, neurological impairment

- ❑ Paralysis
- ❑ Loss of hearing or sight
- ❑ Injury due to fall, lifting or repositioning
- ❑ Pressure ulcer leading to bad outcome
- ❑ Complications from improper medication, route, or dosage
- ❑ Severe burns
- ❑ Internal injury
- ❑ Reproductive organ loss or impairment
- ❑ Total or partial disability
- ❑ Disfigurement
- ❑ Severe scarring
- ❑ Delay in diagnosis of malignancy or other serious medical condition
- ❑ Delayed finding on an x-ray, lab report, or other study which was not disclosed to a patient or family
- ❑ Missed radiological study (including, but not limited to a plain film, mammogram, CT, MRI, or CTA) which resulted in a negative outcome or an overread of a film or radiological study which altered a patient's outcome.
- ❑ All identified cases of unanticipated death or major permanent loss of function associated with a hospital-acquired infection
- ❑ Any "near miss" involving any of the above
- ❑ Abduction of any patient receiving care, treatment, and services
- ❑ Discharge of an infant to the wrong family
- ❑ Rape of a patient by another patient, visitor or staff member

B. Reporting

All Quality Improvement events are to be reported to the Risk Manager via the Quality Improvement Form.

The matter will be referred to the appropriate member of the Risk Management Committee to conduct and coordinate appropriate follow-up including root cause analysis, assessment of any deviation from standard of care, identifying appropriate remediation and process improvement.

III. Procedure:

A. Quality Improvement Form received at qualityimprovementevent@adfinitashealth.com

B. Matter assigned to Risk Management Committee member for processing and analysis

C. Site leadership is informed and involved (as deemed appropriate by the Risk Management Committee)

D. Root Cause Analysis performed and Report written

E. If applicable, a Plan of Improvement/Remediation Developed and Implemented

F. Report and results reported to Risk Management Committee

G. Report and supporting documentation filed with ECRI (Patient Safety Organization)

H. If applicable, report to medical malpractice insurance carrier

I. Follow-up with site leadership 30 days after implementation of remediation to confirm utility and improvement.