ASHRM Patient Safety Tip Sheet: Value of Incident/Event Reporting

AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Situation:
The limitations of voluntary incident/event reporting systems are well documented. Incident/event reports are subject to selection bias due to their voluntary nature. When a medical record review and direct observation are completed, it was found that incident/event reports captured only a small percentage of incident/events and may not reliably identify serious events.[1]

Background:
Patient safety incident/event reporting systems are a backbone of efforts to detect patient safety events and opportunities for quality improvements. "Incident reporting is frequently used as a general term for all voluntary patient safety event reporting systems, which rely on those involved in events to provide detailed information. Initial reports often come from the frontline personnel directly involved in an event or the actions leading up to it (e.g., the nurse, pharmacist, or physician caring for a patient when a medication error occurred), rather than management or patient safety professionals."[2]

Assessment:
Incident/event reporting adds value to an organization's awareness. Incident/event reports document the details of an event or process that are typically not included in the medical record. Joint Commission and the Centers for Medicare and Medicaid Services (CMS) requires facilities to have a way to track adverse events; incident/event reporting process satisfies these requirements. Some states also have requirements related to incident/event reporting or adverse event reporting. Lastly, incident/event reporting systems provide a means for frontline personnel to report safety hazards.

Recommendations:
Important Concepts related to Incident/Event Reporting:

- Incident/event reports should be filed for any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Incident/Events include errors, adverse events, near misses and hazards.
- Incident/event reports are risk management tools to gather and trend data.
- Reports are escalated to leaders who assist in evaluating the processes and systems related to the reported event. Changes in processes to prevent similar errors or adverse events should be explored.
- Reporting systems that encourage residents and physicians to report incident/event and close calls provide value in the identification of processes needing evaluation.

Additional Resources:
Patient Safety Primer: Reporting Patient Safety Events found on the Agency for Healthcare Research and Quality website (updated September 2019).https://psnet.ahrq.gov/primer/reporting-patient-safety-events

Incident Reporting Systems - Adverse Events: Reporting and Prevention by Tom Inglesby (October, 2014) https://www.psqh.com/analysis/incident-reporting-systems-reporting-and-prevention/

1. Cullen DJ, Bates DW, Small SD, et al. Incident reporting system does not detect adverse drug events: a problem for quality improvement. The Joint Commission journal on quality improvement. 1995.

2. AHRQ: Patient Safety Network, Reporting Patient Safety Events, September 2019. Retrieved from: https://psnet.ahrq.gov/primer/reporting-patient-safety-events