

University of Texas Medical Branch Center for Sleep Disorders Policy: Procedure for use of unusual occurrence report	Effective Date: January 30, 2013 Revised Date: January 18, 2019 Campus: Galveston and Webster
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PROCEDURE FOR USE OF UNUSUAL OCCURRENCE REPORT

PURPOSE

A tool utilized to facilitate an investigation of concerns or issues (perform a root cause analysis) that may arise at a sleep facility by collecting all data that will identify and/or verify opportunities for improvement in quality of service.

POLICY

The unusual occurrence report is a guide to walk through a thorough investigation for a root cause analysis. An unusual occurrence report is to be completed for all injuries/accidents or any situation/occurrence that could pose a safety risk to patients or staff. The unusual occurrence report process provides identification of areas for process or system improvement to prevent future events by identifying what happened, why it happened, and possible changes necessary to mitigate future events of the same nature.

Definitions

Concern: An issue, complaint or situation that occurs within the sleep facility that is reported/communicated to or by an employee or patient.

Unusual occurrence: Any **significant adverse event** that: 1) occurs during hours of operation; 2) results in injury or potential harm to the patient, patient's family, or staff member; 3) may be a Risk Management issue; and 4) includes but is not limited to: patient or staff death, permanent loss of function or of a body part by a patient or staff, hospitalization of a patient or staff, activation of an emergency medical response, sexual or physical assault of a patient or staff or allegations thereof, release of a minor or a patient lacking capacity or competency to an unauthorized individual, elopement of a patient, complications arising from the effects of hypnotics, and/or any event required to be reported to a government agency.

PROCEDURE

1.0 Form routing

- 1.1 The unusual occurrence report is to be completed as soon as possible but no later than 48 hours after event by the employee that identified/involved in the occurrence.
- 1.2 Completed unusual occurrence report is then routed to Manager for investigation and plan of correction/outcomes documentation.
- 1.3 Completed Form is then submitted to Medical Director, if appropriate.
- 1.4 Final outcome and form filed for record keeping purposes.

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Form completion instructions (root cause analysis):

1.5 Identify the event:

- 1.5.1 Complete the box at the top of the form indicating the type of event, and the Data Gathering Information Section to clearly identify the issue as a “concern” or “significant adverse event”, as defined on the form.

1.6 Narrative description: *describe what happened:*

- 1.6.1 A narrative description is to be completed by the employee initiating the report who is most involved in the event. This section describes what happened through the collection and organization of the data/facts surrounding the event to understand what occurred.

1.6.2 What to include in a well written narrative description:

1.6.2.1 Who was involved in the event/situation?

1.6.2.2 When did it happen? Specify time points if possible.

1.6.2.3 Where did it happen? Specify location (example: patient fell while getting out of shower after taking an Ambien).

1.6.2.4 Signature and title of employee writing the narrative description.

1.7 Investigative findings: *identify the contributing factors:*

- 1.7.1 The appropriate individual identified by the facility will complete this section; identify contributing factors, situations, circumstances or conditions that may have caused the event.

1.7.2 This individual may need to:

1.7.2.1 Contact appropriate individuals who may have additional information.

1.7.2.2 Perform patient clinical record review, if appropriate.

1.7.2.3 Meet with other management personnel who may add pertinent information related to the event or investigation.

- 1.7.3 *Identify the root cause:* analysis of the contributing factors identifies the process and/or system issues that caused the event.

1.8 Corrective plan of action/outcome

- 1.8.1 The appropriate designated individuals determine, design and implement changes to eliminate the cause of the event to prevent a similar event from occurring. This may include but is not limited to:

1.8.1.1 Changes in work flow/communication processes;

1.8.1.2 In-service education or conferencing;

1.8.1.3 Follow-up response to appropriate individuals;

1.8.1.4 Other appropriate actions.

- 1.8.2 Measure the success of the modifications: evaluate at a given time point.

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1.9 Risk management

- 1.9.1 Any event that may pose a potential liability safety risk as identified on the unusual occurrence report must be reviewed by senior management.
- 1.9.2 Submit a copy of the unusual occurrence report attached to the risk management form for record keeping purposes.