New Hanover Regional Medical Center

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Owner:	*LAURA FESTA: Dir Risk Management*
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Risk Management Variance Reporting

PURPOSE/SUPPORTING INFORMATION

Risk Management Event/Variance Reports provide a mechanism for reporting situations within New Hanover Regional Medical Center involving patients and visitors or property. This report should be a factual account of the event/variance. Event/variance report data is analyzed for trends to identify actual or potential exposures and risk reduction strategies. Event/variance reporting is the responsibility of all staff and volunteers. Data from the Event/Variance Reports may be submitted to Patient Safety Organizations as Patient Safety Work Product.

QUALIFICATIONS/SCOPE

NHRMC staff, volunteers, and physicians may submit event/variance reports.

EQUIPMENT

Downtime Forms:

On-line event/variance reports are submitted via the Intranet. During downtime procedures, paper variance Forms, Patient AD-045, and Non-Patient AD-044, will be used.

PROCEDURE

A. An event/variance is defined as any happening that is not consistent with the routine care of a patient or an event that is not consistent with normal operations. For example, events/variances may include patient or visitor falls, medication errors, property loss or damage, equipment malfunction, unexpected death, organ injury/ perforation, violation of patient rights, or violent behavior.

B. The event/variance report should be completed and submitted through the Intra-net by the end of the shift in which the event/variance was discovered. The on-line event/variance report will be automatically sent to the appropriate management staff. Managers or their designee will be responsible for the initial investigation of the circumstances surrounding the event/variance

C. During downtime procedures (>8 hours of computer downtime), the paper event/variance form will be used. (Patient: AD-045, Non-Patient: AD-044. Send this form to Risk Management within 36 hours of notification of the event/variance.

D. Reporting to Risk Management is confidential. Do not reference the event/variance report in the medical record.

E. Any employee/physician/staff person/volunteer can initiate a report. The person involved in the variance, who witnessed it, or to whom it was reported should complete the report.

F. Do not print the computer screens or make copies of the variance report.

G. Equipment involved in an event/variance should be tagged with an orange tag and removed from service. (Also see Environment of Care Medical Equipment Failure and/or Recall Response Plan.)

H. The following events/variances warrant an immediate call to Risk Management.

1. **Surgical or Invasive Procedure:**
    a. Wrong site/wrong patient (surgery or procedure)
    b. Unintended retention of a foreign object
    c. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient
2. **Product or Device:**
    a. Death/serious injury associated with use of contaminated drugs, devices or biologics
    b. Death/serious injury associated with intravascular air embolism
3. **Patient Protection Events:**
    a. Discharge/release of a patient (any age) unable to make decisions, to other than authorized person
    b. Death/serious injury associated with patient elopement
4. **Care Management Events:**
    a. Death/serious injury associated with medication error
    b. Death/serious injury associated with administration of blood products
    c. Maternal death/serious injury associated with labor or delivery in a low risk pregnancy
    d. Death/serious injury of a neonate associated with labor or delivery in a low risk pregnancy
    e. Death/serious injury associated with a fall within the facility
    f. Stage 3 or 4 pressure ulcer acquired after admission
    g. Artificial insemination with the wrong donor sperm or wrong egg
    h. Death/serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
    i. Death/serious injury resulting from failure to follow up or communicate laboratory, pathology or radiology test results
5. **Environmental Events:**
    a. Death/serious injury of patient or staff associated with electrical shock in course of a patient care process
    b. Incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances
    c. Death/serious injury to patient or staff associated with a burn incurred from any source in the course of patient care process
    d. Death/serious injury associated with use of or bed rails
6. **Radiologic Events:**

a. Death/serious injury to patient or staff associated with the introduction of a metallic object into the MRI area

7. **Potential Criminal Events:**
    a. Care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed provider
    b. Abduction of any patient receiving care, treatment and services
    c. Sexual abuse/assault on a patient or staff within or on facility grounds
    d. Death/serious injury of a patient or staff resulting from physical assault within or on facility grounds

l. Special Police will be responsible for completing the event/variance report for variances that occur in common areas.

REFERENCES

Environment of Care Medical Equipment Failure and/or Recall Response Plan

Environment of Care Workplace Violence Annex

Serious Reportable Events Policy

All revision dates: 12/2017, 12/2017, 01/2017, 04/2014, 04/2011, 01/2009, 10/2003, 03/1999, 12/1992

Attachments:

Verge Downtime Form - Non Patient AD-044.pdf
Verge Downtime Form - Patient AD-045.pdf

Approval Signatures

Step Description	Approver	Date
	Lori FEEZOR: VP Legal Affairs	12/2017
	LAURA FESTA: Dir Risk Management	12/2017

Applicability

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