INTERPRETIVE GUIDELINES FOR REPORTABLE EVENTS

Revised July 2009

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INTRODUCTION

Effective May 27, 2009, the Health Data Reporting Act of 2002 was amended by Public Acts of 2009, Chapter 318. The new law provides that all licensed health care facilities are no longer required to report "unusual events" as the term was defined in the 2002 Act, but that each facility shall only report incidents of abuse, neglect, and misappropriation that occur at the facility to the Department. For state licensure purposes, the facility is required to make the report within seven (7) business days from the date that the facility identifies the incident. Federally certified nursing homes must, pursuant to federal rules under 42 CFR §483.13, continue to report abuse, neglect, misappropriation, and injuries to patients of an unknown origin to the Department within five (5) working days. The new law also removes the requirement that the facility shall submit a corrective action report to the Department. Although reporting requirements for facilities have been changed, the Department is still required to investigate the incidents of abuse, neglect, misappropriation, and injuries to patients of nursing homes of an unknown origin reported to the Department as complaints for federal Centers for Medicare and Medicaid Services (CMS) certification purposes.

The new law also did not change the requirements contained in the 2002 Act that require all licensed health care facilities to report the following to the Department:

- **strike by the staff at the facility;**
- **external disaster impacting the facility;**
- **disruption of any services vital to the continued safe operation of the facility or to the health and safety of its patients and personnel;**
- **fires at the facility that disrupt the provisions of patient care services or cause harm to the patients or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.**

These incidents must also be reported to the Department of Health within seven (7) business days after the facility becomes aware of the incident, except for federally certified nursing homes which must continue to report within five (5) business days.

While the new law removes the requirement to submit a corrective action report along with an event report, the optional "Framework for An Analysis in Response to a Reportable Event" form continues to be included for facility use in root cause analysis. This form may, but does not need to, be included with the facility's report.

General Information

Definitions:

- **"Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.**

- **"Misappropriation of patient property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.**

- **"Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.**

CMS Definitions also include:

- "Physical abuse" includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

- "Verbal abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

- "Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

SECTION A

SUMMARY OF REPORTABLE CODES

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Injury of Unknown Origin (Federally certified nursing homes only)	901.	All other reportable events or accidents occurring to a resident of a federally certified nursing homes warranting DOH notification, and not covered by other codes.	**Licensed-only nursing homes, and all other facility types.**

EXAMPLE:

- Definition of Reportable Incidents of Unknown Origin:

  A reportable incident of an unknown origin is an unexpected occurrence or accident of unknown origin resulting in death or injury to a nursing home patient in a federally certified nursing facility.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Strike by staff	931.	Strike by facility staff.	

Strike is defined as collective work stoppage by facility staff.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
External Disasters	932.	External disaster outside the control of the facility which affects facility operations.	932. Situations that are related to termination of service should be reported under 933.

NOTE:

Reporting under this occurrence code relates specifically to natural or catastrophic disasters.

EXAMPLE:

- Earthquakes
- Bioterrorism
- Bomb Threat

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Termination of Services	933.	Termination of any services vital to the continued safe operation of the facility or to the health and safety of its patients and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food, pharmacy, or contract services.	

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Fires	935.	Facility fire disrupting patient care or causing harm to patients or staff.	
	936.	All other fires.	

NOTE:

- This code should be used to identify any fires which result in cancellation or delay of any patient care services or result in any movement of patients.

CATEGORY	OCCURRENCE CODE	INCLUDES	EXCLUDES
Abuse	968. 969. 970.	Physical Abuse. Sexual Abuse. Verbal Abuse.	
Neglect	971.	Neglect or Self-Neglect.	
Misappropriation	972.	Misappropriation or Exploitation of Patient Funds or Property.	

EXAMPLE:

- Inappropriate contact (sexual) between patient and staff.

NOTE:

Nursing homes should also refer to specific definitions under Medicaid nursing home regulations and Linton Law for resident abuse, neglect, or misappropriation of funds.

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- **"Misappropriation of patient property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's/resident's belongings or money without the patient's/resident's consent.**
- **"Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.**

CMS Definitions also include:

- "Physical abuse" includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.
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- "Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

SECTION B

FORMS

TENNESSEE DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LANDING, SUITE 501, HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243
TELEPHONE (615) 741-7221
FAX (615) 253-4356

REPORTABLE EVENT FORM

Facility Name: _____ License No: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail: _____

Fax: _____

☐ Not Patient Specific **Date of Occurrence:** _____ **Time:** _____ ___ AM ___ PM

Patient Information: Age: _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Race: ☐ 1 - American Indian or Alaska Native ☐ 2 – Asian ☐ 3 – Black or African-American ☐ 4 – Hispanic or Latino ☐ 5 - Native Hawaiian or Pacific Islander ☐ 6 – White ☐ UK – Unknown

MR # _____

Sex: ☐ Male ☐ Female

Occurrence Code: _____ _____ _____

Occurrence Codes:

901 - Injury of Unknown Origin (Federally certified nursing homes only)
931 - Strike by Staff
932 - External Disaster
933 - Termination of Services
935 - Fires with Disruption of Services or Patient Harm
936 - Other Fires

Occurrence Codes:

968 - Physical Abuse of Patient/Resident
969 - Sexual Abuse of Patient/Resident
970 - Verbal Abuse of Patient/Resident
971 - Neglect or Self-Neglect
972 - Misappropriation of Resident Funds/Property

Brief Summary of Incident: _____

Report Date: _____ Reporter: _____

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TELEPHONE (615) 741-7221
FAX (615) 741-7051

(Optional) **Framework for An Analysis In Response to a Reportable Event**

INSTRUCTIONS

For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date, title of responsible person for implementation and associated measure of effectiveness. If, after consideration of such a finding, a decision is made not to implement as associated strategy, indicate the rationale for not taking action.

Assure that the selected measure will provide data to assess effectiveness of the action.

Consider pilot testing of a planned improvement.

Improvement to reduce risk should be implemented in all areas where applicable, not just where the event occurred. Identify where the improvement will be implemented.

Root Cause Analysis	**Narrative Description**				**Action Plan**			
What happened? Adverse Occurrence What are the details of the event? (Brief description) Include date, day of week, time and the area/service involved.	(Write statement on attachment.)							
Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, including Root Cause(s)** Consider each aspect for analysis. Check yes or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. **YES**	**NO**		**Risk Reduction Strategies**	**Implemented YES**	**DATE**	**Measures of Effectiveness**
Policy or Process (System) in which the event occurred.	The system in place related to the event is effective.				Action:			Measure:
	The system in place related to the event was carried out as intended.							
	An effective policy is in writing.							
	The policy was effectively communicated.							
	An effective procedure is in place.							

(Optional) Framework for Root Cause Analysis and Action Plan In Response to a Reportable Event

Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, Including Root Cause(s)** Consider each aspect for analysis. Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement and measures to assess effectiveness of risk reduction strategies. YES / NO			**Risk Reduction Strategies**	Implemented YES	DATE	**Measures of Effectiveness**
Human Resources. (factors & issues)	Staff are properly qualified.				Action:			Measure:
	Staff are currently assessed as competent to carry out their responsibilities.							
	Staffing level plans were in place.							
	Staffing level plans were appropriate.							
	Staff level plans were implemented.							
	Staff performance in the relevant processes is evaluated.							
	Orientation & in-service training are in place							
	Human error did not contribute to the outcome.							
Environment of Care. (including equipment & other related factors)	The physical environment was appropriate for the processes/treatments being carried out.							
	A system is in place to identify environmental at risk.							
	Emergency and failure-mode responses have been planned.							
	Emergency and failure-mode responses have been tested.							
	Controllable equipment factors did not contribute to the event.							
	Controllable environmental factors did not contribute to the event.							
	Uncontrollable external factors, (natural disaster, power outages, etc.) were not a factor in this case.							

(Optional) Framework for Root Cause Analysis and Action Plan In Response to a Reportable Event

Why did it happen? What were the proximate causes? (special cause variation) What systems and processes underlie those proximate factors? (common cause variation)	**Aspects for Analysis**	**Findings, Including Root Cause(s)** Consider each aspect for analysis. Check yes, or true, as applicable. If no, or false, elaborate on root cause, develop plan for improvement, and measures to assess effectiveness of risk reduction strategies. **YES** **NO**			**Risk Reduction Strategies**	**Implemented** **YES**	**DATE**	**Measures of Effectiveness**
Environment of Care (Continued)	An emergency preparedness plan is in place.							
Information Management & Communication Issues	Necessary information was available.							
	Necessary information was accurate.							
	Necessary information was complete.							
	Necessary information was clear and unambiguous.							
	Communication among participants was effective.							
	No barriers to communication were identified.							
Standard of Care	The quality of care and services met generally accepted community standards.							
Leadership Corporate culture	Leadership is involved in the evaluation of adverse patient care occurrences..							
Other	Note other factors that influenced or contributed to this outcome? Note other areas of service impacted.							

Results of literature review (include key citation(s)):

Executive Summary of the Analysis (note critical findings):

- List titles of Root Cause Analysis participants i.e., Director of Nursing