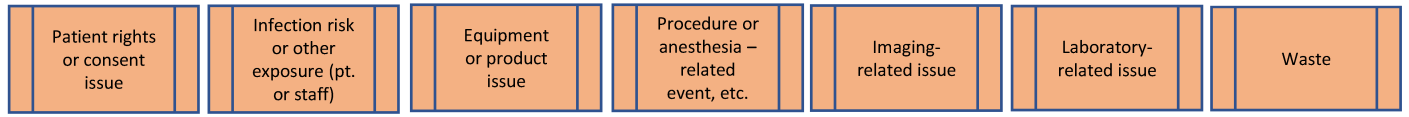
Coding Instructions

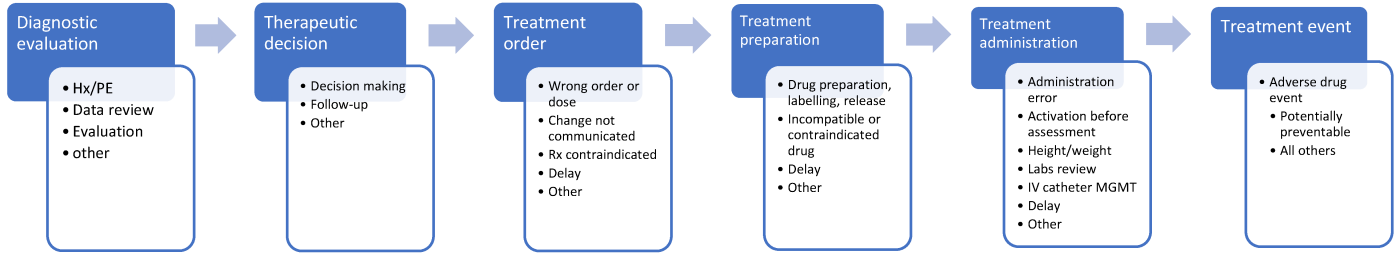
Step 1: Does incident fit into one of these specialized categories? If not proceed to step 2

Start Here



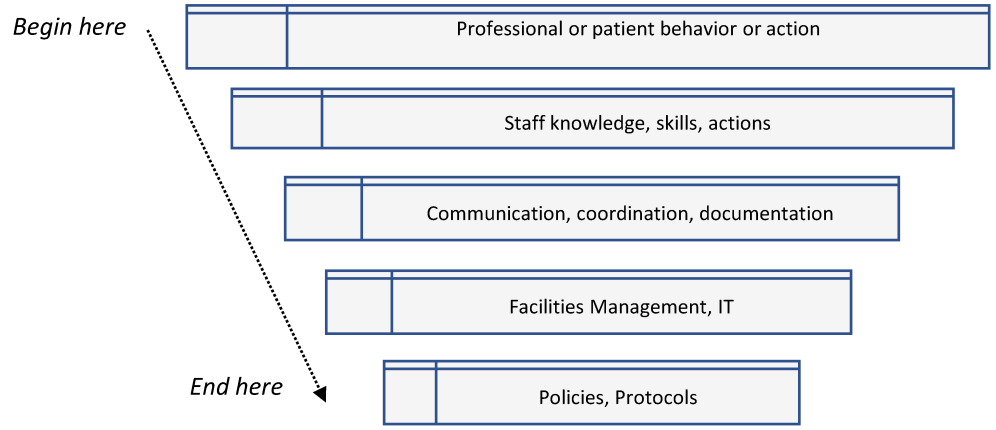
Step 2: Does incident fit into a diagnostic or therapeutic category? If not proceed to step 3

Here Next



Step 3: If incident doesn't fit above, select the **uppermost** category that describes the occurrence best. If none fit, select "Event category not otherwise specified" or "No Event"

End Here



Incident Assignment Process (page 1)

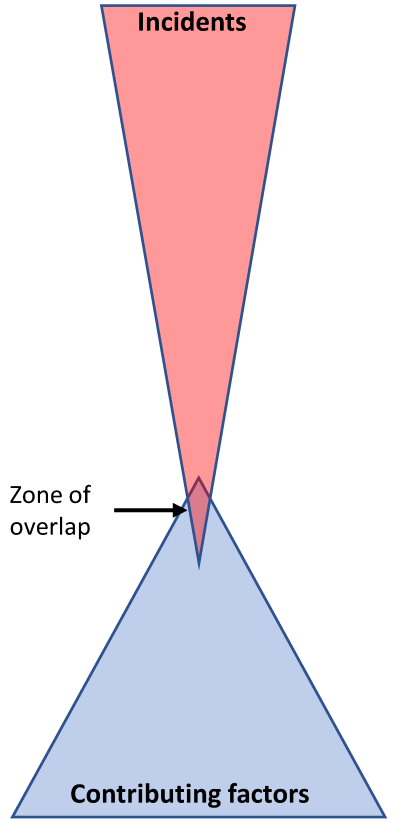
- Review the Incident Codebook to find the single best incident type that fits the scenario. Assign an incident type for each case unless the description does not identify a safety incident.
- Process (see Figure):
  - Step 1. Is the incident a *specialized* event (e.g., procedure complication, infection exposure)? If so, assign a category. If not, proceed to Step 2.
  - Step 2. Does the incident fit in one of the six diagnostic or therapeutic categories? If so, assign the best fit. If not proceed to Step 3.
  - Step 3. If incident doesn't fit above, select the uppermost category that describes the occurrence best. If not, assign the incident as "not otherwise specified" or as "no incident"
  - General principles:
    - When selecting an incident type, it is often useful to consider the personnel involved. Which group or individual had the most active role in the incident? Assigning the incident to specific personnel is not about assigning blame; it is about localizing the incident as accurately as possible. Other questions to ask: who was the decision maker?; where did incident originate?; what was the primary *action* that led to the incident?; why did the staff member enter the incident report?
    - Assign category based on the *incident*, not the *outcome*. For example, a chemotherapy order that resulted in a misadministration should be assigned to the provider (prescribing error) rather than as a medication misadministration error
    - Ignore whether the reported incident was completed or interrupted or whether harm occurred.

Incident Assignment Process (page 2)

- Assign a second incident if present. The second incident should be distinct from the first. It may be completely unrelated to the primary incident or a significant "downstream" event.
  - Example 1: A patient is kept waiting for two hours because of limited staffing in pharmacy. When treatment finally arrives, the infusion nurse (who is rushed and behind) behaves rudely to the patient. This is a downstream incident (unprofessional behavior), but it is separable from the first. Conclusion: two events (pharmacy delay and unprofessional behavior)
  - Example 2: A prescriber requires 3 calls to sign off on orders for a patient waiting in infusion. The orders are then signed but one of the drugs is omitted. Conclusion: These are two separable incidents involving the same provider (provider delay, prescribing error).
  - Example 3: A prescriber enters the wrong orders for treatment. The infusion nurse then administers the wrong drugs. Conclusion: This is NOT a second incident. The misadministration is the *outcome* of the initial incident.

Terminology

- Incident refers to an event occurring during patient care that has the potential to, or does cause injury or harm to the patient or staff. Incidents can involve errors and/or harm. Errors are defined as actions or omissions that may or may not lead to harm, including near misses or no harm events. Harm refers to a physical injury or a complication requiring further treatment, prolonged hospital stay, or morbidity or mortality as a result of the process of care delivery (modified from Howell, international recommendations for IRS)
- An incident is the reporter's impression of *what happened*.
- A contributing factor the reporter's impression of *how and/or why the incident occurred*. A contributing factor is something that enabled the incident.



In rare cases, it can be difficult to distinguish between an incident and a contributing factor. In general, the incident should identify the occurrence that led the staff member to generate a report.