

Occurrence Reporting: Frequently Asked Questions

Why should I enter an occurrence report?

In 1999, the Institute of Medicine (IOM) published a landmark study on preventable medical error. In that paper, they estimated that there were nearly 100,000 avoidable hospital deaths per year as a result these types of mistakes. The IOM's 2015 follow up indicates that not only is this type of harm is still frequent, but that the previous estimates may actually be an underestimate. The IOM urges healthcare organizations to create an environment that encourages the identification and reporting of occurrences, evaluations of causes, and initiation of appropriate actions to prevent future errors from occurring.

The system that the University of Colorado Hospital uses to enter and respond to occurrences is RL Datix.

What types of events should I enter?

Per the hospital's *Patient Occurrence Reporting Process* policy, you should enter **any** event that could result in **actual or potential injury** to a patient as soon as it is witnessed or discovered. Your report is confidential. It provides immediate notification to all pertinent safety teams in order to allow them to review circumstances surrounding the event and determine an appropriate course of action.

You are encouraged to enter **any** event, whether an actual or near miss. Examples include:

- Allergic reactions
- AMA discharges
- Falls
- Lab specimen or test errors
- Lack of informed consent
- Medication errors
- Unexpected cardiac or respiratory arrests
- Unintended retention of a foreign object
- Unexpected surgical or anesthesia outcomes

You **must** enter an event **AND** call Patient Safety (720-848-9427) immediately if you witness or discover any events involving:

- Alleged patient neglect or abuse
- AWOL patients
- Burn injuries
- Death related to restraint or seclusion
- Drug diversion
- Equipment malfunction
- Event resulting in brain or spinal cord injury
- Falls resulting in loss of consciousness
- Infant abduction or discharge to the wrong parent
- Life threatening anesthesia or transfusion complication
- Major permanent loss of function unrelated to the patient's illness
- Suicide
- Surgery or procedures on the wrong patient or body part
- Transfusion reaction
- Unexpected death or death due to suspicious circumstances

Do not file or reference the RL occurrence report in the patient's medical record.

How do I enter an event? A training module outlining how to report an event in RL can be reached using the QR Code to the right and takes approximately 10 minutes to complete. You can also refer to the reverse side of this sheet.

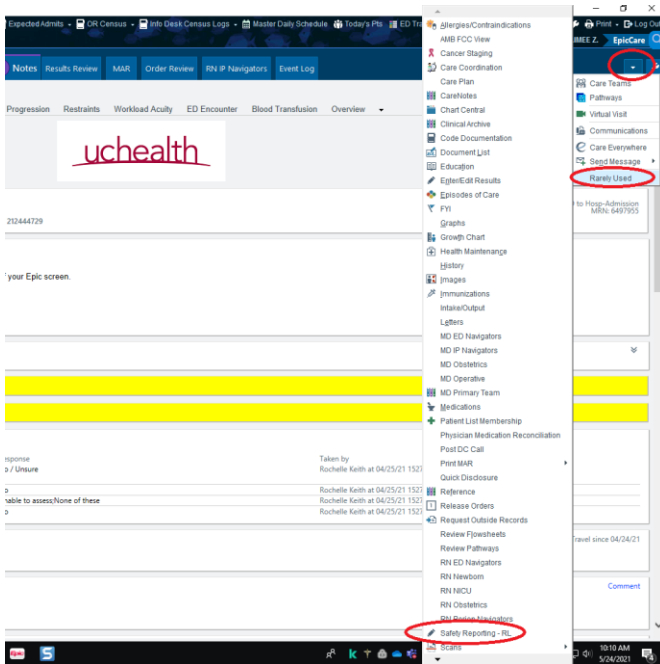


Occurrence Reporting: How to Enter an Event

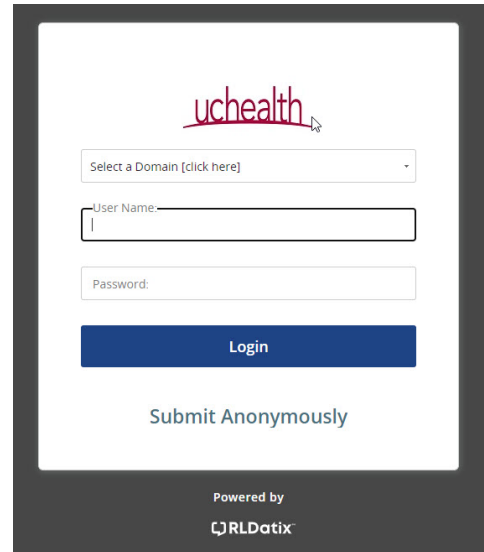
How do I enter an event?

Launching RL from within the patient record in Epic allows the MRN, patient name, birthdate, and other demographics to auto-populate the occurrence report.

1. Within the patient's chart, click More activities and find *Safety Occurrence - RL Launcher* to open the application.
 - o **TIP:** You can add this as a favorite by clicking the star, so you don't have to search for it each time.



2. Select your Domain from the drop down menu.



3. Enter your network/Epic username and password, then click LOGIN
4. Continue using the RL site to document the patient event
5. NOTE: Verify that the patient information populated into RL is correct.

You can also access RL Risk via the Source:

