# To Code or Not to Code (15)

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## Adverse Incident Reporting

The term “adverse incident” means an event over which health care personnel could exercise **control** and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which results in one of the following injuries:

## Code 15 Reporting

- Death
- Brain or spinal damage
- The performance of a surgical procedure on the wrong patient
- The performance of a wrong surgical procedure
- The performance of a wrong-site surgical procedure
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition



## Code 15 Reporting, continued

- The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient **and** documented through the informed-consent process
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure

# Annual Report

Code 15 Reports **PLUS**

- Permanent disfigurement
- Fracture or dislocation of bones or joints
- A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility
- Any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent
- Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident



# Reporting

Within 15 calendar days (Code 15):

"Any of the above incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported by the facility to the agency within 15 calendar days after its occurrence."

Annual reporting:

After December 31 and by April 1

# Case 1

- Block of ankle
  - Patient to have block prior to surgery
  - Site marked by anesthesiologist
  - Anesthesiologist went to medication room to draw medication
  - Anesthesiologist returned and inserted needle. Patient said, “Why are you injecting my right ankle?”
  - Anesthesiologist realized wrong ankle.
  - No medication injected.



# Case 2

- Patient and husband came into lobby and walked to registration. Patient signed in and staff member said something about patient returning for second surgery. Husband said, “Yes, maybe the doctor will do the correct side this time.”
- Registration staff informed administrator of comment.
- Discussed with surgeon who said, based on image on the date of the previous surgery and patient’s comments in pre-op, he decided left instead of right side was needed that previous admission.

# Case 2, continued

- What was written on the consent form? Was consent changed to do other side? No. Why not?
- What is documented in the medical record regarding patient assessment?
- Were films taken the day of previous injection prior to time of procedure?
- Did operating room staff know during that first surgery that site was not as scheduled or consented? Why not?
- What role does the nurse and radiology tech have in correct site for injection?
- Does the site get marked in pre-operative area? If not, when does it occur?



# Case 3

- Patient had a plan of care that listed the procedures the physician planned to perform. This was part of the H&P and went to the surgery center via electronic transmission.
- The pain practice scheduler went online to ASCs scheduling system and scheduled procedure #3.
- The patient was admitted. The circulator confirmed the procedure by asking the patient, so did the anesthesia provider.
- The doctor did the surgery that was written on the consent, the white board of the OR, and verified by circulator and anesthesia provider.

# Case 3, continued

- Patient went to doctor for follow up and that is when doctor noted he had performed procedure #3 when he had ordered procedure #2.
- What processes were involved?
  - Scheduling
  - Review of H&P by ASC staff. H&P and plan said procedure #2 to occur
  - Clarity with patient about procedure and site
  - Persons involved in time out in operating room
  - Memory re-call, previous steps or fresh look at documentation?
- Since #3 was also planned later, was this a wrong procedure?



# Case 4

- Patient was nearly blind before surgery.
- At end of surgery day, RN reports that a lens in the OR is “extra” and should have been removed from the O.R. when 5$^{th}$ case cancelled.
- 23.5 diopter planned for patient # 6. Diopter of 22.0 implanted was for patient # 5.
- Staff alerts physician who has already left for the day.
- Next day, patient returns to doctor’s office. Is delighted that vision is great. Patient DID NOT NEED to return to surgery for replacement lens.

# Case 5

- Patient had cataract surgery.
- At follow up visit next day, patient vision much worse than expected.
- Office records show 25.0 diopter. Office assistant wrote 20.5 on the lens sheet that goes to the ASC.
- ASC pulled 20.5 and doctor implanted 20.5
- Physician did not replace lens. Patient fitted for glasses to correct vision. Why?



# Case 6

- Early afternoon, tech tells RN manager that scope washer repairman arrived. Huh? What for?
- 16 lower GI cases performed that morning.
- From 4th case onward, processing not performed correctly. 4th patient was Hepatitis C positive.
- CDC: "If symptoms occur, the average time is 6–7 weeks after exposure, but this can range from 2 weeks to 6 months. However, many people infected with the Hepatitis C virus do not develop symptoms."
- Called med mal carrier and held discussions.
- Patients 5 – 16 were contacted. ASC paid for testing immediately, at 2 weeks, at 8 weeks, at 6 months, at one year. No patients were Hep C positive.

## Case 7

- Patient is terminal cancer patient with renal failure and many other co-morbidities.
- Patient has pain procedure.
- Patient admitted to hospital within 30 hours after procedure.
- Patient expires.



## Case 8

- Patient has pain procedure.
- Day after, patient has kidney dialysis.
- Two days after dialysis patient dies.

## Case 9

- Patient (33-years-old) had abdominoplasty and breast implants.
- Two days after surgery, boyfriend goes to awaken her and finds her unresponsive in bed.
- EMS transports to hospital emergency department where she is pronounced dead.
- ER record: patient had aspirated. Awaiting toxicology.
- Boyfriend's statements: Patient had lots of pain. He left bed to sleep on sofa due to her snoring. She had taken meds from medicine cabinet in addition to pain meds prescribed by surgeon.



## Case 10

- 24-year-old male had hand surgery to repair crushed bones
- Codes on the OR table. 911 called.
- Transported to hospital – less than 15 minutes away.
- Resuscitation unsuccessful.
- History of illegal drug use. At hospital, patient's friend said he had used drugs prior to arriving at ASC.

## Documenting the Event

- Record only the direct medical care. Write only the facts.
- Do not write conclusions, opinions, admissions or accusations.
- Not part of the medical record and nothing in medical record that states an incident report was completed.
- No copies made of the incident report



## Analysis of the Event

- Record analysis separate from the incident report facts.
- Make review part of quality and peer review process.
- Attempt to determine and understand the cause
- Perform Root Cause Analysis
- Blame free environment to encourage reporting and thoughtful, open-minded analysis
- “Over which healthcare could exercise control”

## Root Cause Analysis or Roots of Causes

- System or process approach – not a blame game
- Determination of human and other factors
- Determination of related processes and systems
- Analysis of underlying cause and effect systems through a series of ***why*** questions
- Identification of risks and their potential contributions
- Determination of potential improvement in processes or systems



## Action

- Action plan for improvement or correction for each root cause or contributing factor.
- At minimum, a suggested corrective action, a date of implementation, a team appointed to carry out the action, how and when each action will be evaluated, and the date of evaluation.
- Did the action fix the problem? (QAPI)

# AHCA Reporting

- AHCA asks for root cause analysis? Are your required to submit RCA?
- Do you file report when you are not sure of cause or if there was control over it?
- Do you file report when you learn of an event that occurred weeks or months ago?
- How can AHCA know of an event?



# Resources

- Patientsafety.va.gov
  - FMEA example
- AHRQ.gov: Agency for Health Care Quality
- Joint Commission
  - Universal protocol
  - Root cause analysis and template
- ASHRM

# Questions

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