Adverse Event Documentation

Question

An adverse event has occurred with resident injury: **what should be documented in the medical record and what information should be documented on other business documents?**

Definition

The Institute of Healthcare Improvement defines an **adverse event** as an "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death."[1]

Issues to Consider

1. **Medical Record Documentation** – Document accurate information about the event, including assessment, monitoring, interventions, actions, communications, and resident response. Include relevant comments from the resident and family regarding the event (e.g., "My family brought my new glasses yesterday. I have been having balance issues since I started wearing my new glasses").

   Document the timeline of care and treatment during and after a significant adverse event including vital signs, neuro checks (e.g., for witnessed and unwitnessed reports of head injury), acute symptom management (e.g., complaints of shortness of breath or difficulty breathing after a fall), and pain management. Document the transition of care if the resident is transferred to the emergency room or an acute care facility, including hand-off report to the accepting nurse.

   Ensure that documentation regarding the adverse event is factual, concise, and complete. Avoid assumptions, opinions, or accusations about the care and treatment. Do not blame or criticize the resident, family, other care team members, the facility, or other healthcare organizations.

   Clearly document communication with the primary care physician, the resident (as appropriate), and the family (as appropriate). Assign responsibility for post-event follow-up communication with the resident and family.

   Case Example: (This case example does not represent an actual legal or medical case. The names and story example were created for illustration purposes only.)

   A certified medication aide informs the Director of Nursing that she has just given a resident the wrong medications. The medication aide is very emotional and upset but is able to confirm that she gave Mrs. Mary Jones the medications intended for Ms. Thelma Peterson. Mary Jones is a frail resident that weighs less than 90 pounds. Mary received her medications this morning which

included an anti-hypertensive, an oral hypoglycemic, and a diuretic. Thelma Peterson is on several medications which include an anti-hypertensive, an anti-coagulant, a hypoglycemic medication, and a pain medication.
Mary Jones is monitored closely over the next 60 minutes and shows progressive changes in her vital signs and cognition. She is transferred to the emergency room and admitted to ICU.
Mary Jones is hospitalized for several days with a noticeable decline in her physical condition.

What to Document: Documentation must be complete and accurate and reflect the care that was provided but does not have to draw attention to the adverse event by labeling with such terms as medication error or wrong medications administered. At a minimum, documentation should include the name of the medication(s), dosage, route, physician notification, resident monitoring, and resident response.

A good practice is the "Mother Standard." What would you expect staff members to document and communicate regarding a medication error that was given to your mother?

2. Incident Report – Document brief, factual information about the event. Clinical information included in the incident report must also be noted in the medical record to ensure a complete record of clinical care provided. Do not note in the medical record that an incident report was completed.

   Ensure incident reports are marked as "Confidential" documents. Consult with facility legal counsel for specific statutory protection language.

   Quality Follow-Up – Quality assurance/performance improvement follow-up should be noted on a separate quality document that is marked as "Confidential". Consult with facility legal counsel for specific statutory protection language. Quality follow-up documents should not be attached to the incident report.

   The quality document provides an opportunity to review the details of the event and ask pertinent questions. Some examples include:
   - Were facility policies and procedures followed? Are policy and procedure modifications needed to provide clarity to workflow processes?
   - Were administrative and engineering controls in place and functioning properly? Were any administrative or engineering controls over-ridden or silenced?
   - Has employee training and competency validation been provided related to this adverse event?
   - Was the resident care plan being followed? Was the resident care plan appropriately modified to reflect current resident needs and risk of injury?
   - Was this adverse event related to resident non-compliance?
   - Was appropriate care and treatment provided post-event?
   - Was appropriate communication provided post-event?

3. Investigative Notes – Ensure that administrative and risk management investigative notes are completed as either a quality document or a document created under Attorney-Client privilege in anticipation of litigation. Consult with your insurance carrier and facility legal counsel for specific recommendations.

Document the date and time of communications with your insurance carrier and state and federal agencies with mandated reporting requirements. Document the name, title, and contact information of the person(s) with whom you are in contact. Document the details of the conversation.

4. **Disclosure of Error Conversation and Documentation –** Document that the resident (as appropriate) and the family (as appropriate) were provided information about the event and the resident plan of care post-event.

   When communicating information about the adverse event, provide known facts. Do not guess about probable causes. Avoid assumptions, opinions, or accusations about the care and treatment. Do not blame or criticize the resident, family, other care team members, the facility, or other healthcare organizations. Provide follow-up information, as appropriate, when additional details are known.

   Most, if not all, families want to know that you take adverse events seriously and are committed to improving any identified quality issues.

5. **Employee Personnel File –** Incident reports **should not** be placed in Employee Personnel Files. Incident reports must be maintained as confidential business documents.

Source

1. Agency for Healthcare Research and Quality. Adverse Events, Near Misses, and Errors. [Updated September 2019]. https://psnet.ahrq.gov/primer/adverse-events-near-misses-and-errors

Resources

Vaaler Senior Resource Center – Policies and Procedures

- Incident Management SNF
- Incident Management ALF
- Disclosure ALF
- Disclosure SNF