



Preparation for New Risk Managers and Peer Reviewers

Introduction to Incident Investigations

Part 1 of a 5-Part Series

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Preparation for New Risk Managers and Peer Reviewers

Part 1: Introduction to Incident Investigations

Part 2: Initiating an Incident Investigation

Part 3: Incident Investigation Documentation

Part 4: Determining the SOC within the KS State Risk Management Regulations

Part 5: Creating a Plan of Corrective Action for the Incident

Completing an Incident Report

Staff Guidance

- ☐ Patient Information – Complete
- ☐ Status, Shift, Department, and Location
- ☐ Primary Physician
 - Document the primary or attending physician's name in this area.
- ☐ Was the Patient Examined?
 - By Whom? Use the credential or job position not the person's name (i.e., Nurse, Doctor, PA, RN, APRN, etc.)
- ☐ Was the Primary Physician Informed?
- ☐ Were the Facts Documented in the Medical Record?
- ☐ Severity of Outcome (*Usually from a List*)
- ☐ Has the Family Been Notified?
- ☐ What is the Patient's or Family's Attitude?
- ☐ What Staff were Involved? (*Usually from a List*)
- ☐ Narrative
 - Document the **FACTS** of the event only.
 - No opinions on how it may have occurred.
 - Do not use staff or provider names in this area—use credential or job position only.

What Essentials Do I Need to Know or Have Access to?

Facility Policies and Procedures – ALL Departments

Medical Staff Bylaws or Rules and Regulations

Kansas Hospital Statutes and Regulations

CMS State Operations Manuals

- Appendix W – Critical Access Hospitals
- Appendix A – Acute Care Hospitals (Specific Department Requirements)
- Appendix V – Responsibilities of Medicare Participating Hospitals in Emergency Cases (EMTALA)
- Appendix Z – Emergency Preparedness for All Provider and Certified Supplier Types
- Appendix G – Rural Health Clinics

HHS/OCR Privacy, Security, and Breach Notification Rules (HIPAA, HITECH, & Cyber Security)

Kansas Risk Management Statutes and Regulations

- All corresponding and supplementary statutes and regulations.



Incident Investigation vs. Root Cause Analysis

A Comparison

Incident Investigation and Peer Review

- **Focus:** Individual Causes
- Statutory Protection
 - KSA 65-4922
- All Incident Reports

Root Cause Analysis (RCA)

- **Focus:** Systems or Process Causes
- Protection Dependent
 - Where Performed
- Commonly Sentinel or Serious Reportable Events (SREs)

Incident Report Generation

Events are in Real Time

- Personal Observation
- Charge/Manager Debriefing Tool*
 - Ensure patient needs and care are the priority
 - Address patient and family concerns
 - Support involved staff
 - Obtain facts from staff
 - Secure equipment involved
 - Document patient care in the record
 - Fill out an incident, variance, or occurrence report

*The Full Manager Debriefing Tool can be provided.



**Do Not Document the
Incident Report in the Chart.**

Incident Report Generation

Retroactive Reviews

- Occurrence Screens-QA
- Infection Control Reports
- Complication Reports
- Mortality or Death Reviews
- Blood Usage Reviews
- Tissue Reviews
- Patient Satisfaction Surveys
- Patient and Family Complaints
- Medical Record Reviews
- Pharmacy Reconciliation Reports



Introduction to Incident Investigations

Key Takeaways

- Complete incident reports will save time and decrease frustration for you and the peer reviewers.
- Know what resources are necessary and where the information is located.
- Incident reports can come from every department.
 - Promote incident reporting.
 - Be prepared to deep dive, especially on retroactive reviews.

Questions?

Feel Free to Reach Out

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Up Next

Part 2: Initiating an Incident Investigation