INDIANA SCHOOL FOR THE BLIND AND VISUALLY IMPAIRED

Reportable Patient/Student Events

Policy O-56

Policy: It is the policy of the Indiana School for the Blind and Visually Impaired (ISBVI) to encourage and promote a philosophy of continual performance improvement and to assure that its health care practices meet student/patient safety requirements, by: 1) identifying and categorizing all Reportable Patient Events; 2) conducting appropriate investigations and analyses of such events; 3) creating and implementing necessary and appropriate corrective actions to improve the quality of patient care.

The Health Care Center of the ISBVI is charged with maintaining and improving the health and well-being of students and staff. One aspect of this mission is the administration of medications. This policy is designed to reach a broad objective of creating a non-punitive, systems-based approach to reduce medication adverse events and errors. The goals are to raise awareness of error-prone processes in the medication delivery process, to maximize appropriate application of system redundancies and build awareness of the medication error issue.

There are three distinct and different medication administration processes currently used by nurses of the Health Centers. The first is the administration of the medication for immediate consumption, the second is the transportation of the medication supplies to and from home, and third, the distribution of medications to the ISBVI staff accompanying students on trips off campus. This policy applies to all current and future medication administration processes.

Process:

1. ISBVI will establish a Health Care Quality Assurance Committee (HCQAC), who will be responsible to review all medication events and reportable patient events, to determine the root cause.
2. Members of HCQAC will be assigned in writing by the Superintendent, with the following suggestions:
    a. Director of Nursing Services
    b. Safety Officer
    c. Physical Therapist
    d. Occupational Therapist
    e. Audiologist

In the event of either a “near miss” in medication administration, the person who first becomes aware of the event will submit a Reportable Patient Event form. The completed form will be submitted to the Director of Nursing Services (DNS), who will review the submission, and notify the HCQAC members and set a date and time for a meeting to review the report.

In the event of a medication administration error, the individual involved or the individual who discovered the error will contact the ISBVI Nurse Practitioner, and a pharmacist, to determine if other immediate actions are warranted. At a minimum the individual will provide the Nurse Practitioner and pharmacist with the medication given, other medications taken by the student and if the student who received the medication has any allergies. Once any immediate corrective action has been taken, the DNS will be notified, who in turn will contact the superintendent and the student's family.

3. The HCQAC will investigate the event, and determine the root cause; reporting options are human error, systems error, distribution error, or other. Each finding will result in one of the following:
    a. **Human Error** events will be reviewed by the DNS with the individual involved to discuss how the event could have been avoided, and a Letter of Counseling or Discipline may be generated, with both parties signing the form. Additional human error incidents may subject the individual to additional disciplinary action.
    b. **Systems Error** events will be reviewed by the Safety Officer and in collaboration with the Superintendent, the director of the affected system and the DNS, will make corrective measures to prevent future occurrences.
    c. **Distribution Error** events will be submitted to the Superintendent with suggestions for corrective actions.
    d. **Other** root causes will be addressed by the committee and corrective measures will be submitted to the Safety Officer and Superintendent for implementation.
4. At the completion of determining the root cause, both the incident report and subsequent actions will be submitted to the Superintendent for review and approval.
5. Additionally the HCQAC may be requested to review or investigate other incident reports that result in student injuries. The location and incident type will be mapped by the safety officer for subsequent action.

Definitions:

- **Near Miss** – an event where a medication administration error was in progress, but was identified and stopped prior to the administration/distribution of the medication.
- **Distribution Error** – an event where the incorrect medication was sent either to the student's home or sent with a staff member for an off campus trip.
- **Medication Error** – this is an event in which the student/patient received and consumed a medication that was either, the wrong medication, the wrong dosage, or the wrong route.
- **Human Error** –is a medication event in which the person administering the medication made an error that could not be contributed to the current system or failed to follow accepted medication administration practices.
- **Reportable Patient Events** – events in which the student/patient could be injured such as falls, or walking into objects, are addressed in other ISBVI policies.

The ISBVI Board directs the ISBVI Superintendent to ensure ISBVI staff, contractors, and volunteers, compliance with this policy by:

1) Providing ISBVI staff, contractors, and volunteers written notice and documenting their awareness and receipt of these documents by obtaining their signatures;

2) Affording initial and periodic on-going training to ISBVI staff, contractors, and volunteers on the ISBVI Board Policy on Reportable Patient/Student Events and accompanying ISBVI Administrative Directives and Procedures.

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Adopted by ISBVI Board: 10/21/13

Reviewed and Approved: 10/22/18