



Incident Reporting V. 2.0

User Manual

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Date	Description (Patch # if applic.)	Project Manager	Technical Writer
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Introduction

NOTE:

The Incident Reporting package is being replaced by Joint Patient Safety Reporting (JPSR). Patch, QAN*2.0*34, sets all editing functions to “Disabled-USE Joint Patient Safety Reporting-JPSR”. Only options for printing reports and querying data are left active.

The Incident Reporting package is a component of the Quality Management sub-system. It deals with the gathering and manipulation of data for such incidents as follows.

- Suicide
- Suicide Attempt
- Sexual Assault
- Homicide
- Patient Abuse
 - Alleged
 - Proven
- Fall
- Transfusion Error
- Medication Error
- Injury Not Otherwise Listed
- Fire, Patient Involved in
- Assault, Patient to Patient
- Assault, Patient/Staff
- Death
 - Operating Room
 - Recovery Room
 - During Induction of Anesthesia
 - Within 48 Hours of Surgery
 - Conjunction with a Procedure
 - Cases accepted by the M.E.
 - Equipment Malfunction
 - On Medical Center Grounds
 - Failure to Diagnose or Treat
 - Other
- Missing Patient
- Informed Consent, Failure To Obtain

It is important for the user to understand that this package is driven by the incident rather than the patient. This was done to allow for the entry of more than one patient associated with a single incident as may occur with fires or patient to patient assaults. When entering a new incident, the software always asks for the type of incident first and then the name(s) of the patient(s). However, when editing an incident, it may be pulled up by the patient name.

The software is designed to accomplish the following tasks.

- Track information on all nationally defined incidents.
- Allow for the manipulation and reporting of the data via the Ad Hoc Reporting mechanism.
- Automate the completion and transmittal of the "Special Incidents Involving a Beneficiary" quarterly report.

Patient Safety Improvement Program

Patient Safety Improvement is a strategy aimed at (1) preventing injuries to patients, visitors, and personnel and (2) managing those injuries that do occur to minimize the negative consequences to the injured individuals and the VHA.

Orientation

How To Use This Manual

The Incident Reporting User Manual is provided in Adobe Acrobat PDF (portable document format). The Acrobat Reader is used to view the document. If you do not have the Acrobat Reader loaded, it is available from the VistA HSD&D Home Page, Technical Resources, Viewers Directory.

Once you open the file, click on the “Bookmarks” tab if it is not already open. You may then click on the desired entry name to go to that entry in the document. You may print any or all pages of the file. Click on the “Print” icon and select the desired pages. Then click “OK”.

On-line Help

When the format of a response is specific, there usually is a HELP message provided for that prompt.

Typing in a <?> at most prompts will display any on-line help available. Help messages provide lists of acceptable responses or format requirements which provide instruction on how to respond. Anytime choices appear with numbers, the system will usually accept the number or the name. As many as three question marks <??> may be entered to get varying degrees of help.

Date Range Selection

One of the features of the Incident Reporting package is the flexibility provided in selecting dates to be used for inquiry and printouts. The date range prompts in Incident Reporting follow a specific pattern throughout the package. Common date prompts are used in all instances where a range is desired. The basic prompt that will appear for date range selection is as follows.

Monthly, Quarterly, Semi-Annual, Yearly, Fiscal Yearly, User Selectable
Select date range:

Range	Format
Monthly	January 1998 would be entered as 1-98, 1/98, or 1 98
Quarterly	2nd quarter 1988 would be entered as 2-98, 2/98, or 2 98
Semi-Annual	Enter quarter and year you want semi-annual range to end with. Format same as quarterly.
Yearly	1998 would be entered as 1998 or 98
Fiscal Yearly	Fiscal year 1997 would be entered as 1997 or 97
User Selectable	Enter beginning and ending dates for the desired time period in usual date format

Division Prompt

When the division prompt appears in the Incident Reporting Package software, it pertains to those sites that have been integrated through the National Database Integration (NDBI) project and share one database. It is not intended to be used for those sites which are considered multi-divisional due to settings such as domiciliaries or satellite clinics.

Package Operation

Site Parameters Enter/Edit

The Site Parameters Enter/Edit option is used to enter/edit the following Incident Reporting site parameters.

MAILGROUP (QAN)

Mail group which will be notified when new incidents are entered into the program via the Brief Incident Enter/Edit option.

BULLETIN SENT (QAN)

Will send bulletin to specified mail group if set to YES.

RESPONSIBLE PERSON SWITCH

Enter whether or not the RESPONSIBLE PERSON field should be asked when entering incident information. 0 or OFF; 1 or ON.

QA TIME FRAME

This field holds the number of days (maximum of 10) the user wishes to wait before the system warns the user of the deadline in filing VAF 10-2633, Report Of Special Incident Involving A Beneficiary. This is only for incident events that do not require immediate notification to the VISN.

IR HOSPITAL DIVISION

This field is used by integrated sites (sites that have been integrated through the NDBI integration process and share one database) to enter the member hospitals in the integrated group. This prompt displays only if the site has been set up as an integrated site.

Edit Status Incident Reporting Record

This option marks the entire record (including any patient data associated with it) as *open*, *closed*, or *deleted*. Using this option is also a quicker way to close records than using the Full Incident Edit option.

Data from deleted records will not appear on any of the outputs. Deleted records will appear when a patient's Incident History file is accessed through the Full Incident Edit option, but the Incident Status will be shown as deleted.

Patient Information Enter/Edit

This option allows the user to delete the patient name for those records where incorrect names have been entered for the incident. Deleting a name also deletes the incident data if the name deleted is the only name associated with the incident.

Incident Reporting Main Menu

Full Incident Edit

This option is used to enter a new incident or to edit an existing incident. You may only edit open incidents.

Sites that have been integrated through the National Database Integration (NDBI) project and share one database will be prompted for the applicable division.

Any incident entered via the Brief Incident Enter/Edit option or the Quick Incident Entry option can be accessed through this option for completion.

The “Fall Assessment Score” prompt only appears for the incident type Fall. If your site doesn’t use a fall assessment scale, bypass this prompt.

For many incidents, severity level defines whether or not an incident is reported on the Beneficiary Report.

If you answer YES to the “Is this the final incident type?” prompt, that incident will be added to the Special Incidents Involving a Beneficiary report. That means records that are not closed would be reported on the quarterly report if this prompt was answered YES for those records.

If you have completed the record, you may close it locally by entering YES at the “Do you wish to close this particular incident?” prompt. When a reportable incident is closed locally, the completed data will be sent to the National Database server in a daily batch by use of the tasked option, [QAN AUTO E-MAIL BRIEF] or [QAN AUTO E-MAIL FULL].

Incident Reporting Main Menu
Incident Reports Main Menu
Ad Hoc Report

This option allows you to produce reports tailored to specific needs. You are allowed to choose up to four sort fields and seven print fields. Refer to the QM Integration Module User Manual for instructions covering the expanded functionality of the Ad Hoc reporting mechanism, if necessary.

Sort fields allow the user to limit the sort to one specific type (i.e., within Service you may ask for just those incidents with Medication Errors; within Incident, you may ask for just Medication Errors). It is important to note that if you want your data for a specified date range, you must make Date of Incident one of your sort fields. If you want to limit your cases to either *open* or *closed*, then you must choose Incident Case Status as a sort field. Valid sort fields are fields which are numbered.

The Division field has been added to this report as a sort field. Only those sites that have been integrated through the National Database Integration (NDBI) project and share one database will be prompted for the applicable division.

This option provides the ability to update sort and print macros. If the Ad Hoc Report menu has changed since the macro was created, a message will be displayed, once the macro is loaded, informing you the macro is not current. The macro can then be reviewed and if it still reflects the desired report, it can be updated. If the macro is no longer valid, you are given the opportunity to reenter the macro.

Incident Reporting Main Menu
Incident Reports Main Menu
Ad Hoc Report

Notice how each chosen field is starred in the next selection.

===== Ad Hoc Report Generator =====

1	Patient	14	Level of Review
2	Patient Id	15	Date of Incident
3	Date of Admission	16	Incident Case Status
4	Patient Type	17	Severity Level
5	Ward/Clinic	18	National Case Status
6	Treating Specialty		Fall Assessment Score
7	Service		Person Reporting the Incident
8	Responsible Service		Patient Diagnosis
9	Medication Errors		Medical Center Action
	Case Number		Incident Description
11	Incident		Pertinent Information
12	Incident Location	25	Division
13	Type of Death		

Sort selection # 1: **11** Incident

Sort from: BEGINNING// **FALL**

Sort to: ENDING// **FALL**

===== Ad Hoc Report Generator =====

1	Patient	14	Level of Review
2	Patient Id	15	Date of Incident
3	Date of Admission	16	Incident Case Status
4	Patient Type	17	Severity Level
5	Ward/Clinic	18	National Case Status
6	Treating Specialty		Fall Assessment Score
7	Service		Person Reporting the Incident
8	Responsible Service		Patient Diagnosis
9	Medication Errors		Medical Center Action
	Case Number		Incident Description
11	* Incident		Pertinent Information
12	Incident Location	25	Division
13	Type of Death		

Sort selection # 2: **15** Date of Incident

Sort from: BEGINNING// **1/1/98** (JAN 01, 1998)

Sort to: ENDING// **T** (APR 03, 1998)

Incident Reporting Main Menu
Incident Reports Main Menu
Ad Hoc Report

===== Ad Hoc Report Generator =====

1	Patient	14	Level of Review
2	Patient Id	15 *	Date of Incident
3	Date of Admission	16	Incident Case Status
4	Patient Type	17	Severity Level
5	Ward/Clinic	18	National Case Status
6	Treating Specialty		Fall Assessment Score
7	Service		Person Reporting the Incident
8	Responsible Service		Patient Diagnosis
9	Medication Errors		Medical Center Action
	Case Number		Incident Description
11 *	Incident		Pertinent Information
12	Incident Location	25	Division
13	Type of Death		

Sort selection # 3: **16** Incident Case Status

Select one of the following:

0	CLOSED
1	OPEN
2	DELETED

Sort from: BEGINNING//: **0** CLOSED

Select one of the following:

0	CLOSED
1	OPEN
2	DELETED

Sort to: ENDING//: **1** OPEN

Incident Reporting Main Menu
Incident Reports Main Menu
Ad Hoc Report

===== Ad Hoc Report Generator =====

1	Patient	14	Level of Review
2	Patient Id	15	* Date of Incident
3	Date of Admission	16	* Incident Case Status
4	Patient Type	17	Severity Level
5	Ward/Clinic	18	National Case Status
6	Treating Specialty		Fall Assessment Score
7	Service		Person Reporting the Incident
8	Responsible Service		Patient Diagnosis
9	Medication Errors		Medical Center Action
	Case Number		Incident Description
11	* Incident		Pertinent Information
12	Incident Location	25	Division
13	Type of Death		

Sort selection # 4: <RET>

===== Ad Hoc Report Generator =====

1	Patient	14	Level of Review
2	Patient Id	15	Date of Incident
3	Date of Admission	16	Incident Case Status
4	Patient Type	17	Severity Level
5	Ward/Clinic	18	National Case Status
6	Treating Specialty	19	Fall Assessment Score
7	Service	20	Person Reporting the Incident
8	Responsible Service	21	Patient Diagnosis
9	Medication Errors	22	Medical Center Action
10	Case Number	23	Incident Description
11	Incident	24	Pertinent Information
12	Incident Location	25	Division
13	Type of Death		

Print selection # 1: **1** Patient

The above chart will be redisplayed before each additional print selection with the previous selections starred.

Print selection # 2: **17** Severity Level

Print selection # 3: **5** Ward/Clinic

Print selection # 4: <RET>

Incident Reporting Main Menu

Incident Reports Main Menu

Ad Hoc Report

Do you want the report to include 'deleted' records? No// <RET> (No)

Enter special report header, if desired (maximum of 60 characters).

FALLS 1/1/98-4/3/98

DEVICE: **DEV2**

```
1 DEV2$PRT  EF Printer, in Hall by A413
2 DEV2$PRT-A138-10/6/UP  Development HP5 Si
3 DEV2$PRT-A138-16/6/UP  Development HP5 Si
Choose 1-3> 2  DEV2$PRT-A138-10/6/UP  Development HP5 Si
```

The first output separates the incidents by showing each *date* and *case status*. The second output is easier to read. It is the same report but with the @ sign being used when selecting those two sort fields shown in italics above. The user would type @15 for the date and @16 for the Incident Case Status at the “Sort Selection” prompt. This suppresses the printed date and status.

First Output

FALLS 1/1/98-4/3/98		MAY 12,1998 10:04	PAGE 1
Patient	Severity Level	Ward/Clinic	

Incident: Fall			
Date of Incident: JAN 25,1998 22:35			
Incident Case Status: OPEN			
IRPATIENT, ONE	MAJOR	12A	
Date of Incident: FEB 10,1998 08:00			
Incident Case Status: CLOSED			
IRPATIENT, TWO	MINOR	8B	
Date of Incident: MAR 24,1998 09:00			
Incident Case Status: QUICK			
IRPATIENT, THREE	MAJOR	9C	
Date of Incident: APR 2,1998 02:00			
Incident Case Status: CLOSED			
IRPATIENT, FOUR	MAJOR	NHCU	

Incident Reporting Main Menu
Incident Reports Main Menu
Ad Hoc Report

Second Output

FALLS 1/1/98-4/3/98		MAY 12, 1998 10:11	PAGE 1
Patient	Severity Level	Ward/Clinic	

Incident: Fall		
IRPATIENT, ONE	MAJOR	12A
IRPATIENT, TWO	MINOR	8B
IRPATIENT, THREE	MAJOR	9C
IRPATIENT, FOUR	MAJOR	NHCU

Incident Reporting Main Menu
Incident Reports Main Menu
Incident per Ward Report

The Incident per Ward Report generates a report showing the number of particular incident(s) on selected wards or that occurred in selected incident locations. Only incidents involving inpatients appear on this output.

Information provided on the report may include ward, incident location, incident type, and number of incidents.

Sites that have been integrated through the National Database Integration (NDBI) project and share one database will be prompted for division. You may select a single division or all divisions. If all is selected, the report will be sorted by division.

Incident Reporting Main Menu
Incident Reports Main Menu
Outpatient Incident Reporting

The Outpatient Incident Reporting option is used to obtain a summary of incidents for outpatients. The only prompts are for date range and device. Information provided on the output includes incident type, the number of each incident type which occurred, and the total number of outpatient incidents.

Sites that have been integrated through the National Database Integration (NDBI) project and share one database will be prompted for division. You may select a single division or all divisions. If all is selected, the report will be sorted by division.

Incident Reporting Main Menu
Incident Reports Main Menu
Beneficiary Report

The Beneficiary Report option is used to generate VAF 10-0139B, Special Incidents Involving A Beneficiary Report, for the date range specified by the user. You may choose to include only *open* cases, only *closed* cases, or both *open* and *closed* cases. You may also choose from a wide selection of different ward types.

Information provided may include incident type, severity level, total number of incidents for each type and the number that resulted in investigation. Locally defined incidents do not appear on the Beneficiary Report.

Sites that have been integrated through the National Database Integration (NDBI) project and share one database will be prompted for division. You may select a single division or all divisions. If all is selected, the report will be sorted by division.

Incident Reporting Main Menu
Incident Reports Main Menu
Pseudo 10-2633 Incident Worksheet

This option is used to print the pseudo VAF 10-2633 - Patient Incident Worksheet. VA Form 10-2633 is Report of Special Incident Involving a Beneficiary. You may print worksheets for both *open* and *closed* incidents.

Information provided on the worksheet may include details of the particular incident, physician's examination findings/actions, service level findings/actions, recommendations for further follow-up, director's review, chief of staff review, and action taken by the medical center.

The option also provides the ability to print a blank VA Form 10-2633.

Incident Reporting Main Menu
Patient/Incident View

This option allows the user to view/print the Patient/Incident Data Inquiry Report. This report contains the information entered for a particular incident. Examples of the data elements which may be provided include case number, patient type, severity level, national case status, level of review, ward/clinic, etc.

Incident Reporting Main Menu

View Open Incident(s)

This option is used to generate the *open* Incidents and the Associated Patient(s) Report. Information provided may include case number, type of incident, date of incident, and patient(s) associated with the incident.

Sites that have been integrated through the National Database Integration (NDBI) project and share one database will be prompted for division. You may select a single division or all divisions. If all is selected, the report will be sorted by division.

Incident Status Enter/Edit

This option allows the user to enter/edit site-defined incident categories. You will be prompted for the following fields for the selected incident type.

Select Incident Type

Enter a new or existing incident type. Entering <??> will display a list of existing incident types.

QA Incidents Incident Number

Will only appear when entering new incident category. Must be 3-6 numbers in length, greater than or equal to 200, with or without two decimal places.

VA Form 10-2633

Indicates whether VA Form 10-2633 is required for this incident.

Choose from: 1 - YES; 2 - POSSIBLE

Investigation of the Incident

Indicates whether the incident requires an investigation.

Choose from: 1 - YES; 2 - POSSIBLE

Select Other QA Report Forms

Enter other applicable report forms.

Incident Status: Local//

Enter I for Inactive, L for Local.

Incident Location Enter/Edit

This option allows the user to enter/edit site-defined incident locations. You will be prompted for the following fields.

Select an Incident Location

Enter a new or existing incident location. Entering <?> will display existing locations and whether or not they are active.

QA Incident Location Incident Location Number

Will only appear when entering new incident location. Must be 3-6 numbers in length, greater than or equal to 200, with or without two decimal places.

Incident Location Status

Indicates whether location is currently valid. Enter 1 if active.

Quick Incident Entry

This option can be used to enter the basic incident information. Data entered here will appear in the Full Incident Edit option, if accessed, for entry of follow-up information concerning the incident.

Note that multiple patients may be entered for a single incident.

Brief Incident Enter/Edit

This option is used to enter basic information on an incident that just occurred. It was designed to be used at those sites where incidents can be entered via any terminal. At the end of the session, the information is displayed and may be edited if not correct.

A mail message is triggered to those individuals at the site who are responsible for the entry of the follow-up information on the incident and for notifying the VISN of any reportable incidents.

Sites that have been integrated through the National Database Integration (NDBI) project and share one database will be prompted for the applicable division.

Note that multiple patients may be entered for a single incident.

Incident Summary to Site

This option accumulates incident/patient data for a quarter. It then rolls the data up to site file, QA INCIDENT SUMMARY (#742.6).

If you want to recompile the summary data, enter YES at the “Enter Yes or No” prompt. The Quarterly Summary Data will be deleted, rebuilt, and resent to File #742.6. If you do not want to recompile the summary, enter NO. If you enter YES, you will then be given the opportunity to generate a report which compiles Incident Event data for a given quarter.

Incident Reporting Database Integrity Checker

This allows the user to look at the links between the patient and incident. This option checks cross references and other required information such as, patient name, patient SSN, incident, and case number.

The only prompt is for device.

Edit Existing Brief Incident (Stand-alone Option)

This option allows editing of the fields in the Brief Incident Report as long as the report is still “open”.

The option is not distributed as part of any existing menu. It can be added locally to the menu created at sites for use by service-level users.

ADPAC Guide

This guide has been designed as an educational and resource manual to support the Quality Management Automated Data Processing Application Coordinator (ADPAC) with installation, testing, training, use, and maintenance of the Incident Reporting V. 2.0 software.

Changes from Incident Reporting V. 1.0 to V. 2.0

- Version 2.0 provides for quicker input of data and fewer output choices. Many of the extraneous and mandatory fields have been eliminated. The only mandatory entries are for the Incident Type, Date/Time, and Patient Name.
- The Ad Hoc reporting mechanism allows the user to sort by a single item or selected items.
- The software allows the user to add additional incident types or to define site-specific types of incidents via the Incident Status Enter/Edit option. It also allows for tracking of these incidents.
- The site has the choice of giving the Brief Incident Enter/Edit option to selected employees so that basic information can be entered on an incident and a message sent to the persons responsible for follow up of the incident.
- There is a worksheet available that can be used as the VAF 10-2633, Report of Special Incident Involving a Beneficiary. Information previously entered on an incident will appear on this worksheet.
- More than one patient may be linked with an incident, such as may happen in a fire. The software is driven by the incident, not by the patient.
- A list of incident locations used by the software can be defined by the site.

Functional Flow

The incident reporting process probably is not the same at every site. The following information is provided to show you how the software may be used and to help you determine menu option assignment.

Brief Incident Enter/Edit

This option can be used to enter incidents into VistA directly from the area where the incident took place, such as the patient's ward. The user would enter the incident type, the date/time of the incident, description of the incident, where it took place, whether or not it was witnessed, and the involved patient name(s). When an incident is entered through this option, a mail message is sent to the local mail group assigned to the package to alert the group members of the new incident entry.

The Edit Existing Brief Incident option [QAN BRIEF EDIT] can be used to edit these Brief Incident Reports if the report is still open.

After entering the information through the Brief Incident Enter/Edit option, the user then accesses the Pseudo 10-2633 Incident Worksheet option and prints a copy of the worksheet.

The Pseudo 10-2633 Incident Worksheet can be signed by the reporting person, used by the examining physician for entry of the examination findings, and can then be sent to all other required reviewing managers for completion and signatures.

Finally the information from the worksheet is entered into the Full Incident Edit option and the record is closed when entry is complete.

Full Incident Edit

The Full Incident Edit is the only option that contains all the edit fields for an incident. It can be used in the same way as the Brief Incident Enter/Edit option depending on the site, end users, and available equipment. The first portion looks just like the Brief Incident Enter/Edit option. It is generally expected that this menu option would be given to selected users who would obtain the information from the completed VAF 10-2633 and enter it into the program.

The Pseudo 10-2633 Incident Worksheet can also be used with this option at any time to print the data that has been entered into the system. To use this form as the 10-2633, you will need to add signatures, findings, and reviewing comments to make it complete.

Functional Flow

Quick Incident Entry

This option should only be given to a few select individuals as it is meant to be used to quickly enter data on reportable incidents. The data entered through this option is the minimal data needed for sending an automatic transmission to the National Database and includes the following.

Incident Type

For deaths, also the type of death

Severity level

Patient(s) name

Date/Time of incident

Reportable incidents can also be entered via the Full Incident Edit option. Just remember to fully define the incident with the type of death or the severity level.

Data entered through this option will also appear within the Full Incident Edit option.

Implementation Check List

Virgin Installations

- ❑ 1. Read over the Introduction and Orientation sections of the User Manual to acquaint yourself with the software. Thoroughly cover the contents of the ADPAC Guide.
- ❑ 2. Discuss with the QM staff the probability of other services (Nursing, MAS, etc.) being involved in data input. What will the equipment and support requirements be? How will access be managed? How will training be handled? Discuss the possibilities with your IRM staff and come to a decision as to what can be done.
- ❑ 3. Discuss the time frame for setting up a training account, training staff, and going live with the software with both the IRM staff and the QM staff and any other services such as Nursing and MAS that might be involved in the use of the software.
- ❑ 4. Have those services that will be using the software define a list of users and come to a decision about what menu options will be assigned to the different types of users. You will want to review the Functional Flow section in this guide and the Package Operation portion of the User Manual covering the options for Brief Incident Enter/Edit, Quick Incident Entry, and Full Incident Edit.
- ❑ 5. Discuss required external files (see Technical Manual) and software with your IRM staff to make sure they are in place.
 - ❑ New Person File #200
 - ❑ Quality Assurance Site Parameters File #740
 - ❑ QA Audit File #740.5
 - ❑ MAS V. 5.0 or better
 - ❑ Kernel V. 6.5
- ❑ 6. Ask the QM staff to define a list of locations that they would like to have incorporated in the software. This list is not the same as the patient's assigned ward, but a list that shows where incidents happen. The exported contents of the Incident Location file (#742.5) can be found in the Contents of Exported Files section of this guide.

Implementation Check List

Virgin Installations

- ❑ 7. Ask the QM staff or other interested users if there will be a need for any site-defined incidents that they would like to track through use of the software. Suggestions include patient concerns and surgical misadventures.
- ❑ 8. Ask the QM staff to define the members of a mail group that will receive notification of new incidents entered through the Brief Incident Enter/Edit option. Entry of a mail group is required in the Site Parameters file even if your site does not use the Brief Incident Enter/Edit option.
- ❑ 9. Set up a test/training account under the direction of IRM.
- ❑ 10. Populate or edit the files you will need to use the package. Use the Package Operation section of the User Manual for direction.

Required file:

- ❑ Site Parameters Enter/Edit

Optional files for editing:

- ❑ Incident Location Enter/Edit
- ❑ Incident Status Enter/Edit

- ❑ 11. Review the User Manual, specifically the Package Operation section. Thoroughly review the instructions for the reports
- ❑ 12. Learn to use the program so you can teach other people who will be using it.
 - ❑ Use the exercises provided within this guide to get acquainted with the software and understand how it functions.
 - ❑ Use any options not covered by the exercises.
- ❑ 13. Test the outputs for accuracy while in the test account.
- ❑ 14. Give the users' list, with the menu options they will need, to your IRM support person so that the menu options can be assigned to each user.
- ❑ 15. When you are satisfied that you have mastered the program, show the users how the package works and let them practice in the test account area. Allow plenty of time to do this if the user group is large.

Implementation Check List

Virgin Installations

- ❑ 16. Discuss the time frame for going to a live account with both the QM and IRM staff, allowing yourself sufficient time to populate the files you will need (#10 a, b, c) and to test the outputs.
- ❑ 17. Populate the files (#10 a, b, and c) and check the outputs before letting the users access the software. If you are using the Brief Incident Enter/Edit option, check the mail function to determine whether or not incidents entered via that option produce a mail message to the mail group. Make sure your mail group members understand how to access this mail. If you find a problem with the outputs or the mail, review the Data Validation and Trouble Shooting section in this guide to see if you can diagnose and correct the problem. If not, discuss the problem with your IRM support staff.
- ❑ 18. Once the users begin entering data, check the outputs daily for two or three weeks to see if the data entered is showing up on the reports. If not, you will want to review how the data is entered by each user.
- ❑ 19. Check with the VISN the day following the transmittal of a reportable incident to make sure the report reached their mail group. You may want to set up the transmittal of a test incident, transmit it manually (first informing the VISN of your intention), see if the message is received, and then delete the incident. Check with the VISN to see that they also received a message that the incident was deleted.
- ❑ 20. Set up a routine maintenance schedule to check the outputs. Whenever new users are added to the system, check the reports for correct information.

Conversion Installations

There are no special tasks to be completed for converting the old data in V. 1.0 to the new format in Incident Reporting V. 2.0. You will want to review the section in this guide on the changes between the two versions and then follow the installation check list for implementation.

Adding Locally Defined Incident Types

Overview

Some sites may wish to track events that were not exported with the original files. This package offers a mechanism to enter data for such events and to print out summaries of that data via the Ad Hoc reporting mechanism, the Incident Per Ward Report, or through Outpatient Incident Reporting. These locally defined incidents do not appear on the beneficiary report.

Incident Status Enter/Edit

When there are similar events that can be grouped (patient concerns, hospital acquired decubiti, etc.), define a name for the group and enter that as the Incident Type through the Incident Status Enter/Edit option. There are other events that do not fit into any particular group. For those events, you may want to use a name such as "Additional Types". It would be best to not use the term "Other" as it is used to define a particular set of incidents that fall into the "Other" category on the quarterly beneficiary report and may confuse the user.

Give each of your defined groups a number of 200 or greater and then bypass all other fields except the last field in the option, Screen Status. Activate the screen by entering it as L(ocal).

All locally-defined incident types will appear in the look-up list along with the nationally-defined incidents.

Menu Option Assignment

It is suggested that this option be available to limited users to control the incident types entered. This will help prevent duplication and provide more control over data integrity.

Making Changes to the Incident Location File

Incident Location Enter/Edit

File #742.5 can be edited through the Incident Location Enter/Edit option or it can be left as it was exported with the software. If you intend to edit the file, be sure to do so on implementation of the software so there is some consistency with the data.

Be sure to confine the contents of this file to descriptive areas other than those listed in your site's Ward Location file (which are specific). Think of incident location as an area where the incident took place, which may not be where the patient resides (Ward/Clinic from the Ward Location file).

Menu Option Assignment

It is suggested that only the ADPAC and a back-up be given this option to prevent duplication and to control data integrity.

Division Prompt

When the division prompt appears in the Incident Reporting Package software, it pertains to those sites that have been integrated through the National Database Integration (NDBI) project and share one database. It is not intended to be used for those sites which are considered multi-divisional due to settings such as domiciliaries or satellite clinics.

Making Changes to an Incident Record

Full Incident Edit

Within the Full Incident Edit option, the user can edit all fields, even the mandatory entry fields of incident, date/time, and patient name. The record must be *open* to be retrieved for editing.

Edit Status Incident Reporting Record

This option provides a quick edit for opening, closing, and deleting records. It marks the entire record (including all patient data) as *open*, *closed*, or *deleted*. To look up a record in this option, use the internal number since patient names are not provided in the look-up list of incidents.

This was done because more than one patient could be associated with the incident.

Records marked as *deleted* will not appear in any of the outputs.

Once a record has been marked as *closed* or *deleted*, the only way to view the entire record is by reopening it and using the Full Incident Edit option to view its contents. The Ad Hoc Report option also provides the user access to data in closed records. The user can pull up all incidents for a patient through the Ad Hoc Report option and print seven selected fields for those incidents. A Pseudo 10-2633 can be printed on any closed record.

Patient Information Enter/Edit

This option lets the user quickly edit a patient name. You can delete the name; however, it will also delete the incident record if no other patient name is attached to the record.

Menu Option Assignment

It is suggested that these options be available to all QA and/or other staff that enter incident information.

Using the Summary Reports Options

Ad Hoc Report

This option can be used to print information on both nationally and/or locally defined incident types. The incident date must fall within the date range chosen. The selected sort and print data must be available. This report displays both inpatient and outpatient incidents unless Patient Type is a sort selection and the sort is limited to either inpatient or outpatient. The chosen sort fields do not automatically show on the report, so your output may be confusing unless you also print those same fields. The record must match the selected type of record - *open*, *closed*, or *both*.

Incident per Ward Report

This option prints data on nationally and/or locally defined incident types. The incident date must fall within the chosen date range. The incident type and the incident location and/or ward must be available for those incidents you want the report to capture. This report allows the user to print by patient ward/clinic or incident location. The phrase "ward/clinic" is misleading as only inpatients appear in this report. They consist of *open* and *closed* records. The report can be printed for one or more types of incidents.

- You can print the report by Ward/Clinic. Ward/clinic is where the patient was residing (ward) on the date of the incident. This data is obtained from your site's Ward Location file.
- You can print the report by Location. Incident location is where the incident took place. The Incident Location file is exported with the software but may be edited by your site through the Incident Location Enter/Edit option.

Outpatient Incident Reporting

This option prints data on nationally and/or locally defined incident types. The incident date must fall within the date range chosen. It lists only outpatients with incidents. The report includes both *open* and *closed* records.

Using the Summary Reports Options

Beneficiary Report

Only nationally defined incident types are printed in this report. The incident must fall within the date range chosen. The severity level field must be completed. The prompt “Is this the final incident type? NO//” must be answered as YES. The report includes *open* and *closed* records.

"Other" refers to all the nationally defined incidents that do not fall into the categories listed above it.

Pseudo 10-2633 Incident Worksheet

This option prints a worksheet on nationally and/or locally defined incident types. Only the required fields must be completed in order to print out a worksheet. These fields are incident, date/time, and patient name.

Menu Option Assignment

It is suggested that the reports options be available to all QA staff and to those in Nursing Service and Administration that are responsible for tracking incidents. The Pseudo 10-2633 Incident Worksheet could be given to any staff that use the Brief Incident Enter/Edit option such as clerical staff, ward nursing staff, etc.

Understanding Automatic Transmission of Data

For Incident Reports

The National Database is updated daily with information about an incident. The updates are batched when the user successfully utilizes the Brief Incident Enter/Edit or Quick Incident Entry options.

Notification messages are sent to the local mail group after the Brief or Quick Edit options are utilized.

Special Incidents Involving a Beneficiary

There is an automatic quarterly roll-up of the data for the Beneficiary Report. The Severity Level field must be completed and the prompt “Is this the final incident type? NO//” within the Full Incident Edit option must be answered YES for the incident to appear on the report. The record can be either *open* or *closed*. The date of the incident must fall within the reporting period.

Reportable Incidents

When an Incident Report is closed locally, any additional data that can be used by the centralized system will be sent daily to the National Database. Here is an example of a full message with an explanation of each line.

```
14000.910001^INCD^Suicide^2910861.0835^ADMINISTRATIVE INVESTIGATION^
14000.910001^DESC^THIS IS A WORD PROCESSING FIELD^
14000.910001^DESC^THAT MAY BE MORE THAN ONE LINE^
14000.910001^PAT^ONE, IRPATIENT^123456789^DEATH^
14000.910001^RESP^ONE, IRPATIENT^PSYCHIATRY^
14000.910001^ADV^4
```

The case number reads as follows.

14000 = site number

91 = year

0001 = the local case number

Case number^(INCD) Incident data^Type of incident^Date^Level of review^Level of review (LR) initiated^Level of review (LR) completed

Case number^(DESC) Description^This is a description of the incident^
(*Because this is a word processing field, it may take up more than one line as in the example above.*)

Case number^(PAT) Patient data^Patient name^SSN^Severity level^
(*Type of death if applicable*)

Case number^(RESP) Responsible service data^Patient name^
(*Responsible service(s)*)

Understanding Automatic Transmission of Data

Deleted Incidents

This automatic transmission looks for any record that has been transmitted to the VISN and has then been deleted. A new message is sent notifying the VISN of the deletion.

Trouble Shooting

There is no simple method of finding out whether the transmission took place unless the VISN or Headquarters informs you that no data has been received. The Beneficiary Report will have to be requeued by IRM.

Be sure you have entered the destinations correctly through VA FileMan.

Field /Prompt

EWS MAIL GROUP / SERVER:
EWS DOMAIN:
NQADB MAIL GROUP / SERVER:
NQADB DOMAIN:

User Input

G.EWSMAIL
{Domain to be used for the early warning messages]
S.A4BVNQADBSERVER
REDACTED

Data Validation and Problem Solving

When Should Data Validation Be Done?

1. Data validation should be done while in test or in the instructional environment before going to a live environment. Test all outputs. Show the users how to routinely test whether or not their input is showing up properly on all the outputs. This means running a report prior to entering new data and rerunning the report following the data entry to see if it appears on the report.
2. Immediately after going to a live account, test the outputs again.
3. Determine a routine schedule for checking the outputs and stick by it.
4. Always validate data whenever there has been a patch to the Incident Reporting software. Join the mail groups on Forum that will alert you to new patches. Keep in touch with IRM to know when new patches are installed.
5. Validate the data whenever a new QM package has been installed at your site. One package may affect the function of another as shared routines are often shipped with each package. QAQ routines are shared between most of the QM packages and generally are shipped with each software package to the site. While there is care taken that each QAQ version shipped will not adversely affect another QM package, it is still wise to take precautions by validating your data.
6. Always validate data whenever a new user comes onto the system.

Data Validation and Problem Solving

Problem Solving

1. Save any printouts/reports that are associated with the problem.
2. Print the screen, (if possible) where the problem occurred, slave a printer to the CRT, and repeat the process that resulted in the problem. This will save you from having to remember later just what you or the user did that resulted in the problem showing up.
3. Find out if the same problem has ever occurred before, if it is peculiar to one user or several users. Get the user's opinion as to what happened.
4. Ask whether it happens only when certain equipment is used.
5. Find out when the problem was first noticed. Was it since the addition of patches or new versions? New installations most likely to affect QM software are other QM packages, MAS software, VA FileMan, and Kernel.

Exercises

Instruction

Mandatory entry fields (those fields that the user cannot bypass without an entry) are Incident Type, Date, and Patient Name.

Those fields that enhance the outputs but are not mandatory are the following:

- Incident Location
- Fall Assessment Score (only seen when entering a fall)
- Medication Error specific types (only seen when entering a medication error)
- Ward/Clinic
- Treating Specialty (automatic capture for inpatients)
- Service (this does not include the field for Responsible Service)
- Patient Diagnosis
- Pertinent Information (word processing field)

This information is provided so the user can be more discerning in the use of the software, however it is recommended that all fields be completed and that all users be taught to complete every field so data that is required is not missed.

For an incident to appear on the Beneficiary Report, the user must answer YES to the “Is this the final incident type?” prompt. The incident must also be one of the nationally defined incidents and the severity level must also be entered.

Before beginning the exercises, make sure you have at least ten patients in your database. Some of them may be outpatients. You may use the same patient more than once.

Do a printout of each report for today by selecting “User Selectable” and entering "T" at the beginning and ending date prompts. For every incident you enter for these exercises, make the incident date T(oday) or N(ow).

Exercises

Exercise #1

Enter five medication errors of differing types (Procedure, Transcription, Other). Use one patient twice. Use the Quick Incident Entry and Brief Incident Enter/Edit options at least once to see how that data is picked up by the Full Incident Edit option.

1. Using the Ad Hoc reporting feature, print a report on transcription errors, with the patient's name, ward, responsible service, medication error, and pertinent information. Play with the Ad Hoc mechanism. How can you improve the output? What should you sort by?
2. Using the Incident Per Ward Report, print a report on medication errors by ward.
3. If you used outpatients, print an outpatient report using Outpatient Incident Reporting.
4. Print a Beneficiary Report.
5. Check the outputs for accuracy. Is all the data there for each of the reports you printed? If it isn't, why not? If there is data missing, review your data input on those records.

Exercise #2

Enter five more incidents, one of each of the following types.

- Death within 24 hours of admission
 - Fall, severity level of 1
 - Diagnostic Error with a severity level of 1
 - Fall, severity level of 2
 - Sexual Assault, choose your own severity level
1. Print out a Beneficiary Report. Do all your incidents appear correctly on the report, including the five medication errors? Which incidents fall under the "Other" category?
 2. Print a report that shows falls by incident location using the Incident Per Ward Report.
 3. Check the outputs for accuracy. Is all the data there. If not, why not?

Exercises

Exercise #3

Using the Incident Status Enter/Edit option, define a local type of incident. Enter a patient for the incident you defined through the Brief Incident Enter/Edit option.

1. Print out a Pseudo 10-2633 Incident Worksheet. What information is captured by the worksheet?
2. Complete the entry on the patient using the Full Incident Edit option and print out another Pseudo 10-2633 Incident Worksheet. What data is captured? What data isn't captured?
3. Use the Ad Hoc to print the most useful contents of this record.
4. Print out the other reports. Which report does not show data from this type of incident?
5. Check the outputs for accuracy. Is all the data there?. If not, why not?

Exercise #4

1. Use the Patient Information Enter/Edit option and change the patient's name for one of your records. Check the Full Incident Edit option. Is the new name now shown with the record?
2. Use the Edit Status Incident Reporting Record option and delete one of the records. Check your outputs. Has the record correctly disappeared from the outputs?

Contents of Exported Files

DEATH TYPE file (#742.14)

This file cannot be edited.

OPERATING ROOM
RECOVERY ROOM
DURING INDUCTION OF ANESTHESIA
WITHIN 48 HOURS OF SURGERY
CONJUNCTION WITH A PROCEDURE
CASES ACCEPTED BY M.E.
EQUIPMENT MALFUNCTION
WITHIN 24 HOURS OF ADMISSION (EX. DOAs and TERMINALs)
ON MEDICAL CENTER GROUNDS
FAILURE TO DIAGNOSE OR TREAT
OTHER

INCIDENT LOCATION file (#742.5)

This file can be edited.

BATHROOM
HALLWAY/STAIRS
NON-TREATMENT AREA
OPERATING RM
OTHER
OUTSIDE HOSPITAL-OFF GROUNDS
OUTSIDE HOSPITAL-ON GROUNDS
PATIENT'S ROOM
TREATMENT AREA

Glossary

Ad Hoc	A reporting mechanism that allows the user to determine, from a predefined list of fields, what fields the program should sort by and what data to print.
ADPAC	Automated Data Processing Application Coordinator
Case Number	A number assigned automatically to each incident. Appears in the format: XXXXX.YYZZZZ XXXXX = site number YY = year ZZZZ = incident number
Closed	Refers to local definition of case as being completed.
Fall Assessment Score	A one to four character value from a scale, defined by the site, that delineates a patient's probability of falling.
Iatrogenic Injury	Injury induced inadvertently by a physician or his treatment.
Level of Review	Incident examination type.
Location	Place where incident took place; not to be confused with ward on which patient resides. Location file can be edited by the site.
LR Date	Level of Review Date. Date on which the review was begun.
Patient Type	Term used as field in the Ad Hoc Report option; either outpatient or inpatient.
Person reporting the incident	Person who describes the incident for reporting purposes, not necessarily a witness to the incident.
QM	Quality Management
Responsible Service	The service(s) considered to have contributed in some manner to the incident.

Glossary

Sentinel Event	An adverse event that results in the loss of life or limb or permanent loss of function.
Severity Level	The actual or anticipated injury to the patient, ranging from no disability to death.
Unplanned Clinical Occurrence	<ol style="list-style-type: none">1. An adverse event that results in hospitalization or increased hospital stay for more than observation.2. An identified error that could (but by chance or through timely intervention did not) result in a sentinel event or an adverse event involving hospitalization or increased hospital stay for more than observation.
VISN	Veterans Integrated Service Network

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