Risk Management Remote Data Entry (RDE)

This session will focus on the use of the MIDAS+ Risk Management subsystem’s Remote Data Entry (RDE) function. RDE provides real-time risk event reporting for the entire hospital staff and, in doing so, greatly enhances response and improvement opportunities throughout your organization. Attendees will explore RDE implementation strategies, see how to manage event follow-up using SmarTrack Worklist Rules, and learn to measure program effectiveness using SmarTrack Indicators.

Presented by:

Natalie Pino, LHRM
Risk Manager – Baptist Health South Florida
Miami, Florida

Jane Holder
Implementation Consultant, ACS MIDAS+
Post-Symposium Availability

Shortly after the conclusion of this year’s Symposium, some General Session and all Breakout Session presentations will be available for downloading by licensed MIDAS+ clients from our Clients Only Web site.

The presentations will be available online in PDF format. Copies of presentations in native PowerPoint format are not generally available.

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Risk Management
Remote Data Entry (RDE)

Lessons Learned by a
Health Care System

Natalie Pino, LHRM
Risk Manager – Baptist Health South Florida
Miami, Florida

Baptist Health South Florida
Largest faith-based, not-for-profit healthcare organization in region

- 6 hospitals (soon to be 7) - 1,472 Beds
- Emergency Visits – 181,325
- Urgent Care (7) visits – 75,392
- Outpatient (21) visits - 138,250
- Home Health Agency visits – 30,420
- Admissions – 67,569
- Births - 10,144
- Employees – 11,615
- Physicians – 1,928
### Why Implement Remote Data Entry?

- Standardization including consistent data collection and consistent definitions
- Simplified data collection (forms)
- Capture comparative data
- Preservation of the original form
- Improved reporting (output)
- Improved communication across the health care system

### Our Previous Process

- Each Facility had their own forms
- Each coded incidents differently
- Each had varying Board Reports
- Each had 1 data entry person
- Each had 72 hours to receive incident (Florida statute requirement)
Our Time Line

- November 2003 started utilizing the Risk Module for data entry.
- January 2006 started to standardize across our health system
- July 2006 implemented Standards
- January 2007 started development of RDE process
- October 2007 Go-live on the Intranet
- November 2007 Go-live across the Health System
Lesson 1 – Getting Started with RDE

- RDE Team – included IT and Risk Management data entry staff
- Standardize incident types & class
- Create Standards
- Establish locations and departments
- Develop incident data flow chart
- Conduct off site visit

Lesson 2 – Forms

- Determine which fields will be required
- How many incident types on a form
- State requirements
- Keep it simple - BUT the more you have the better
Lesson 3 - Reports

- Daily e-mail summary reports
- Detailed reports (User Report Processing) - 56 reports
- SmarTrack reports - 66 reports
- Data Validation Report – report was created to ensure accuracy of standard data fields

Lesson 4 - Training

- Online training for front line staff
- Online training for managers/supervisors to do Follow-up/Action
- Downtime Form and Procedures Online
- Training Manual Online
- Quick Reference Guides - employees
- Quick Reference Guides were created for managers to complete follow-up/action
How to Keep it Rolling

- Quarterly meetings with the RDE group
- 1 point person concept (questions, concerns)
- Involve Staff – keep communication open
- Follow through on what’s been reported – share the data
- Reinforcement of reporting requirements
- Communication with manager/supervisors for Follow-up/Action commitment

QUESTIONS

- BHSF is available for site visit
- Contact information: Npino@baptisthealth.net

Baptist Health South Florida
RISK MANAGEMENT

Remote Data Entry: Security/Site Parameters & More

Jane Holder
Implementation Consultant
ACS-MIDAS+

RISK MANAGEMENT: RDE

- Incident = Event
- HIPAA Document
- RDE privacy Profile
- Site Parameters
- Worklist Security Restrictions
- File Attachments
- RDE in Kiosk Mode
RISK MANAGEMENT: RDE

INCIDENT = EVENT

HIPAA & RDE
HIPAA & RDE

People Making Technology Work

MIDAS+ RDE and HIPAA

The Remote Data Entry (RDE) application was designed at the request of clients to provide a mechanism for hospitals to securely and efficiently encode data through the hospital’s network. The application was designed with guidance from eight clients. This design allows access to the application to be secured with a password. It also provides for anonymity and that it stay within HIPAA guidelines.

The RDE application is a web-based form that can be launched from anywhere. It is each client’s responsibility to protect the launch point for RDE through appropriate network and institutional security practices.

Once an employee has gained access to the RDE application, the incident data is encrypted before patient lookup. The data restricts the number of patient encounters that are displayed to those encounters in which the incident could have occurred. The MIDAS+ Privacy Profile was created to allow a client to determine what information is necessary for an employee to look up a patient in RDE. Each client has the ability to define parameters matching patient lookup as follows:

1. Name: restrict the number of characters required in both the first and last name fields
2. Number: account number, medical record number, social security number or the patient’s universal identification number
3. Combination of both name and number

The Privacy Profile also allows the client to restrict the fields that display back to the user to verify that the correct patient encounter has been selected.

The RDE form is entry only. An employee who enters the incident report cannot obtain the report without authenticated access to the MIDAS+ system. Once an incident report has been submitted to the MIDAS+ System, it is available for reporting, viewing, or SmartTrack Whistleblower activation. A copy of the original submitted incident report is maintained indefinitely and can be posted if

RDE: Privacy Profile (Dict #558)

Note that the more encounters you block, the harder it is for users to distinguish between encounters (or even patients), if looking by name is permitted.
RDE: Privacy Profile continued

Unable to look up by name because it was blocked in the privacy profile dictionary
RDE: Privacy Profile continued

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Encouraged to block to prevent unauthorized access</td>
</tr>
<tr>
<td>Encounter Start Date</td>
<td>Encouraged to block to prevent unauthorized access</td>
</tr>
<tr>
<td>Encounter End Date</td>
<td>Encouraged to block to prevent unauthorized access</td>
</tr>
</tbody>
</table>

Date of Birth, Encounter Start Date and Encounter End Date blocked in Privacy Profile
RDE: Privacy Profile continued

1. RDE Encounter Post Incident Display Criteria

If an integer value is entered, encounters will be displayed that have start dates that many days after the date entered in RDE encounter lookup. If one or more encounter types are entered, only those types will qualify.
RDE: Site Parameters

2. RDE Ignore Discharge Date Encounter Types

Enter an encounter type to have the discharge date ignored by RDE patient lookup for that encounter type. If the outpatient encounter type is entered, RDE patient lookup will include outpatient encounters for which the discharge date precedes the RDE lookup date.

RDE: Site Parameters Screen Shot
Site Parameter Screen Shot

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Encounter Type</th>
<th>Inc. Start Date</th>
<th>Inc. Disch Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jones, Christopher</td>
<td>Inpatient Rehab</td>
<td>4/15/2008</td>
<td>4/15/2008</td>
<td></td>
</tr>
<tr>
<td>Jones, Christopher</td>
<td>Inpatient Rehab</td>
<td>6/1/2008</td>
<td>6/21/2008</td>
<td></td>
</tr>
<tr>
<td>Jones, Christopher</td>
<td>Inpatient Rehab</td>
<td>2/1/2008</td>
<td>2/11/2008</td>
<td></td>
</tr>
<tr>
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<td>Inpatient Rehab</td>
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<td>9/21/2008</td>
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17th Annual MIDAS+ User Symposium
Tucson, Arizona   June 2008
RDE: Kiosk Mode

- Prevents users from clicking BACK button which creates the PAGE EXPIRED message or locks accounts for up to 20 minutes

- Does not remove commands from the context menu
QUESTIONS
Midas Remote Data Entry - Online Incident Reporting

How Do I Report?

1. **What is an Incident?**

   Any occurrence, accident, or event that is not anticipated and has the potential to result in injury, has caused injury, or that is not consistent with the operation of department or facility.

   A happening not consistent with the routine care of a patient or routine operation of the hospital whether or not injury occurred.

2. **Why should I report?**

   a. To improve the opportunity to evaluate "near misses".
   b. Opportunity to implement corrective actions.
   c. Tracking and trending.
   d. Affirmative duty of all hospital employees.
   e. Mandated by Florida Law.

3. **Who should enter the report?**

   The person with the best knowledge of the situation when the event is discovered.

4. **What do I report?**

   Any happening which may range from potential to catastrophic that is a variation from the anticipated, usual or expected process of outcome of care and any happening that is inconsistent with routine operation of department or facility.

   (Examples: Falls, Medication occurrences, Surgical related occurrences, Procedure/Treatment occurrences, Blood occurrences, Adverse drug reactions, IV infiltrations).

5. **When do I report?**

   Immediately after event is discovered & before the end of shift. It is never wrong to report a patient event. The information obtained from reporting events contributes to creating a safer environment of care for Baptist Health patients, visitors, and employees.

6. **How much information should I report in the comments area (Describe what happened)?**

   A complete description of the event, only the FACTS of the event and any pertinent patient/family quotations.

Using Midas to Report Incidents:

1. **Where do I find Midas?**

   Login to the Baptist Health Sun Page using your network user ID and password, click on Online Resources and you will find Risk Management - Online Incident Reporting.

2. **If I do not have time to complete the form and save it, can I go back and make changes?**

   No, you are not able to go back into the event you reported, but your clinical manager can pull up the event and add any information that was left incomplete.
Risk Management Incident Reporting is going On-Line

Effective October 1, 2007 all incidents will be reported on line through the Intra-Net Sun Page

On-Line training sessions will be announced in September and will be mandatory. The Risk Management Midas Champions will be available to assist with unit training if necessary. Please contact your Risk Management Department
Go to the Baptist Health Sun Page. Select Online Resources and then select Risk Management Online Incident Reporting. Click on Risk and select the incident form you desire: Falls, Med Errors, Procedural, Patient Care (see back for a list of the incident forms). Complete the initial information regarding facility (BHM, SMH, HH, DH, MH, MASC, BOS) type of patient, incident date, time of incident and complete remaining fields as noted below. The following entry screen appears:

The SAVE is to SUBMIT the entry to Risk Management
The X button is to return to the SUN PAGE
The CANCEL is to return to the Previous Screen
THANK YOU FOR REPORTING THIS INCIDENT

When you have completed the form, click SAVE. If you need to discard the form without saving, click CANCEL. Do not use the BACK button or X out of the form. If you need to go back and start over, click CANCEL. Once you complete the form you cannot access it again.

The Risk Management Form will automatically be sent to the Risk Management Department. If there is any additional information that you may have regarding the incident after the report has been sent, please advise your manager/supervisor as they will have an opportunity to complete any Follow-up/Action that is required or necessary regarding the event after it has been sent to Risk Management.
• Advanced Directives/Patient Rights (examples: DNR Issue, Guardianship, Allegations of Sexual Misconduct)
• Adverse Drug Reaction
• AMA – Against Medical Advice
• Blood Occurrences (examples: delay, improper blood ID band, mislabeled blood)
• Consent Occurrences
• Communication Occurrences (examples: failure to provide report to caregiver, failure to report values)
• Documentation/Medical Record Occurrences (examples: documentation incomplete/illegible/missing)
• ED/Outpatient Fall
• Environment of Care Occurrences (examples: electrical problem, maintenance issues-elevators)
• Equipment Occurrences (examples: malfunction/breakage/defective, unplanned disconnection of equipment)
• Infection Control Occurrences (examples: needle stick, break in sterile technique, phlebitis, infections of lines/tubes)
• Inpatient Fall (includes NDNQI)
• Medication Error Occurrences (examples: IV infiltrates, omission, wrong dose, wrong medication, labeling error)
• Minor Injury/Trauma Occurrences (examples: struck by object, electrical current, hot substance)
• OB & Labor/Delivery Occurrences
• Patient Care Occurrences (examples: codes, transfer, ID bands, Pressure Ulcers, Deaths, disengaged IV lines/tubes)
• Patient/Family Grievances (examples: clinical communication w/nursing or medical staff, HIPAA, missing items)
• Pediatric Fall (inpatient/outpatient & ED)
• Physician Care/Behavior Occurrences (examples: consults, delay in care, disruptive, documentation, failure to return call)
• Procedure/Treatment Occurrences (examples: delay, cancellation, error in ordering, incorrect results reported, return to OR, specimen issues, surgical count, undesired effect, laceration/perforation/tear/puncture). Use for lab, surgical, radiology, diagnostic.
• Security Occurrences
• Visitor Fall

Note: We have listed examples for your reference, these are not all inclusive of incidents that are to be reported. This is a quick reference guide to help assist you in selecting the appropriate form for the event that occurred. You can also reference the training manual for a more detailed list of incidents. Please remember that an incident is “an unusual event that has caused or has the potential to cause injury to a patient, visitor or employee”.
Risk Management Online Incident Reporting
A Quick Reference Guide

Go to the Baptist Health Sun Page. Select Online Resources and then select Risk Management Online Incident Reporting. Click on Risk and select the incident form you desire: Falls, Med Errors, Procedural, Patient Care etc. Complete the initial information regarding facility (BHM, SMH, HH, DH, MH, MASC, BOS) type of patient, incident date, time of incident and complete remaining fields as noted below. The following entry screen appears:

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Form #4229  Rev. 9/07
<table>
<thead>
<tr>
<th>Advanced Directives/Patient Rights</th>
<th>Environment of Care Occurrences</th>
<th>Physician/Behavior Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Directives/DNR issues</td>
<td>Electrical Problem</td>
<td>Change of Physician</td>
</tr>
<tr>
<td>Alleged Abuse</td>
<td>Elevator Failure/Malfunction</td>
<td>Consult Not Done/Unfilled/Refused</td>
</tr>
<tr>
<td>Allegations of Sexual Misconduct</td>
<td>Hazardous Material Spill Exposure</td>
<td>Unable to Obtain</td>
</tr>
<tr>
<td>Ethical Issues</td>
<td>(CODE WHITE)</td>
<td>Delay in Care</td>
</tr>
<tr>
<td>Guardianship/Proxy/Surrogate Issues</td>
<td>Maintenance Issues</td>
<td>Disruptive Physician</td>
</tr>
<tr>
<td>HIPAA Breach of Confidentiality</td>
<td>Parking Hazards</td>
<td>Failure to do H &amp; P</td>
</tr>
<tr>
<td>Organ Donation Issue</td>
<td>Plant Safety/Environmental Issues</td>
<td>Failure to arrive at appointed time</td>
</tr>
<tr>
<td>Adverse Drug Reaction</td>
<td>Infection Control Occurrences</td>
<td>Failure to document Daily Progress Notes</td>
</tr>
<tr>
<td>MMA/Left without being seen</td>
<td>Break in Sterile Technique</td>
<td>Failure to provide Admitting/Discharge Orders</td>
</tr>
<tr>
<td></td>
<td>Contacts with Sharps/Needlestick Exposition to Body Fluids</td>
<td>Failure to respond to call or page</td>
</tr>
<tr>
<td></td>
<td>Failure to appropriately dispose of Sharps/Biomed</td>
<td>Failure to secure appropriate coverage</td>
</tr>
<tr>
<td></td>
<td>Failure to Maintain appropriate Temp/Humidity</td>
<td>Impaired Practitioner</td>
</tr>
<tr>
<td></td>
<td>Failure to maintain isolation</td>
<td>Physician leaves during Surgery/Procedure</td>
</tr>
<tr>
<td></td>
<td>Protocols</td>
<td>Possible failure to provide appropriate treatment</td>
</tr>
<tr>
<td></td>
<td>Nosocomial Infections/Infection</td>
<td>Refusal to take Call assignment</td>
</tr>
<tr>
<td></td>
<td>Phlebitis</td>
<td>Patient Care/Nutrition Occurrences</td>
</tr>
<tr>
<td></td>
<td>Presence of Vermin/Vector</td>
<td>Code Blue XCardiac Arrest/Adults</td>
</tr>
</tbody>
</table>
|                                  | Suspect infection of Lines/Tubes/ Drains/Implant Device | Code Purple (Ped)
|                                  | Drainage Device                  | Code Resusc (Patient Clinical Deterioration) |
| Blood Occurrences                | Minor Injury/Trauma Occurrences  | Delay Admission/Discharge |
| Blood Infiltrate                 | Injury/Trauma (due to)           | Celeration of Physical/Mental Condition |
| Cancellation of Blood Administration | Wrong Amount Transfused         | EMIT/LACOBRA Issues           |
| Delay in Transfusion             | Wrong Blood Type sent            | Failure to appropriately transfer admitted patient |
| Failure to assign correct blood type | Wrong Blood Type transfused     | Failure to follow Policy/Procedures (medication reconciliation)
| Improper Blood ID on patient    | Consent Occurrences              | Inappropriate discharge of patient/infant/child |
| Mislabeled Blood                 | Failure to Obtain Consent        | IDA/Allergy Brand issues |
| Transfused to wrong patient      | Incomplete/Incorrect/Improper Consent | Incorrect Information, No ID Band |
| Transfused and wrong product     | Deviation from Consented Procedure | IV, Lines, Tubes &/or Catheters |
| Transfusion not given            | Communication Occurrences        | Disengaged Non-Compliant Patient |
| Undesired Effect (Transfusion Reaction) | Wrong Amount Transfused | Non-Compliance with Discharge Policy Procedures |
| Wrong amount transfused          | Failure to Delay/To Provide/Receive report to Caregiver | Nutrition Issues |
| Wrong Blood Type sent            | Failure to notify Physician of patient issue | Wrong diet, omission, food cold |
| Wrong Blood Type transfused      | Failure to Notify Physician of abnormal Values/Results | Patient Assessment omitted/delayed |
| Consent Occurrences              | Inaccurate Information given to Physician/Caregiver | Pressure Uterus on Admit |
| Failure to Obtain Consent        | Incorrect Information given to Physician/Caregiver | Stage 1, 2, 3, 4, Unstageable |
| Incomplete/Incorrect/Improper Consent | Deviation from Consented Procedure | Stage 1, 2, 3, 4, Unstageable |
| Deviation from Consented Procedure | Communication Occurrences        | Suicide Attempt or Ideation |
| Documentation/Medical Record Occurrences | OB & Labor/Delivery Occurrences | Transfer Issues |
| Documentation Incomplete/Illegible/ Missing | Congenital Anomalies in Newborn Delivery by Other MD | Tubing & Catheter Misconnections |
| Documentation Altered/Defaced Fraudulent | Maternal Anomalies, Mispresentation, Shoulder Dystocia | Death, Unexpected Death during Admission (Unknown patient) |
| Inaccurate use of documentation in the Medical Record | Maternal/Fetal Complication | Restraints in use |
| Incorrect Info Data entry        | Newborn Identification Issues    | Unexpected Return to Hospital |
| Incorrect Information in Medical Record | Precipitous or Unattended Delivery | Unplanned/Unexpected Transfer to Higher Level of Care |
| Equipment Occurrences            | Medication Error Occurrences     | Procedure/Treatment Occurrences |
| Equipment/Implant issues         | Contrast Extravasation Delay     | Additional Unplanned Procedure Cancellation |
| (outed/not available/storage)    | Excess Contrast                   | Delay of Procedure/Treatment |
| Failure to label equipment correctly | Extra/Incorrect Dose             | Error in ordering |
| Improper use/storage of equipment | Inaccurate Documentation         | Procedure/Treatment Extended PACU Stay |
| Misfunction/Breakage/Removal/    | Illegible IV Infused Caustic Agent | Failure to Establish Time Out |
| Defective (with/without intervention) | IV Infusion In Intricate         | Inappropriate Procedure Ending |
| Missing/Damaged equipment        | Labeling Error                   | Procedure/Treatment Done, Not Ordered |
| Tampering/Operator not qualified | Narcotic Count                   | Procedure/Treatment Ordered, Not Done |
| Unplanned Disconnection of       | Not Documented                   | Procedure/Treatment performed at Bedside |
| equipment                      | Omission                        | Procedure performed on Wrong Site |
| Wrong/Unapproved Equipment/     | Patient/Family self medicated    | Procedure performed Wrong/Site |
| Implant used                   | Pyxis Overdose                   | Incorrect Results Reported/Sent |
| Falls                         | Unapproved Abbreviation          | Surgical Count Varied |
|                               | Wrong Chart                     | Needle, Instrument, Sponge |
|                               | Wrong Dosage                    | UNDESIRE EFFECT |
|                               | Wrong Frequency                 |                           |
|                               | Wrong Med/Drug                  |                           |
|                               | Wrong Med in Pyxis              |                           |
|                               | Wrong Patient                   |                           |
|                               | Wrong Rate                      |                           |
|                               | Wrong Route                     |                           |
|                               | Wrong Time                      |                           |

**Note:** The text above is a list of medical occurrences and events, categorized under Advanced Directives/Patient Rights, Environment of Care Occurrences, and Physician/Behavior Occurrences. Each category contains specific examples of occurrences such as electrical problems, infection control issues, and minor injury/trauma. The text is structured in a table format, with columns for each category and rows for each subcategory, providing a detailed overview of various medical occurrences and their descriptions.
Welcome to the Online training for employees.

This training will take you through the steps of completing an Incident Report Online.

You can get to the Baptist Health South Florida Sun Page either by clicking on the Internet icon:

Or you may have a computer that already has the Sun Page, in this case click on Online Resources and this will advance you to the Online Incident Reporting screen.
Now, select Online Incident Reporting Entry. This will advance you into the Online Reporting System.

This screen gives you the list of Incident Report Forms to choose from. To help in your selection click on a form and examples of reportable incidents will be displayed.

Once you have chosen your form, the system will take you to the next Screen where you will select your facility and start the Remote Data Entry process.
Select your Facility by using the drop down button.

Always select the patient button for Inpatient & Outpatient care incidents.

Non-Patient button is used for visitor incidents Falls, Disruptive family.

Once you have completed the above fields, click on the Next button.

Select patient by using the patient’s account number button and then enter the account number in this field.

Once you have finished entering the account number, select the Next Button. This will take you to the Patient Lookup screen.
Here you will click on the patient’s name and correct encounter start date (admission date), which will advance you to the Risk Incident Form.

All fields that have an asterisk (*) are required fields and must be completed in order for the Incident form to be SAVED and sent to Risk Management. As you can see some of the fields will be automatically populated and others will require you to select the information from a look-up field. You can also refer to the Help Screen for a description of that field or helpful hints.
This is a required free text field to explain the incident, include information that you feel is important about the event. Be sure that your entry is factual and as accurate as possible.

Contributing Factors are additional information that supplements the incident type. These are selected by clicking on the Lookup button, which will display those factors associated to the incident type.

Note: You MUST use the SAVE Button for the Incident entry to reach Risk Management.

Once you click on SAVE you will be taken back to the Risk Function screen, which will allow you to enter another incident or EXIT from the system using the X button.
Risk Managers and RDE Champions

• BHM – Risk Managers
  – Lynne Thompson
  – Jayne Dohre
  – Natalie Pino
• BOS – Risk Managers
  – Helen Mule
  – Aileen Vasquez
• Doctors – Risk Managers
  – Pat Blanco
  – Lauranne Quinn
• Homestead – Risk Managers
  – Christine Kinik
  – Susan Bunting
• Mariners – Risk Manager
  – Carol Welsh
• South Miami – Risk Managers
  – Vivien Knight
  – Maribe Gongora

• BHM – RDE Champions
  – Natalie Pino
  – Sandra Rodriguez
• BOS – RDE Champions
  – Helen Mule
  – Aileen Vasquez
• Doctors – RDE Champions
  – Linette Cabado
• Homestead – RDE Champions
  – Susan Bunting
  – Susan Pegan
• Mariners – RDE Champion
  – Carol Welsh
• South Miami – RDE Champions
  – Maribe Gongora
  – Wanda Morales
Welcome to the Online training for managers and supervisors. This training will take you through the steps of completing the Follow-up/Action part of the Online Incident Reporting system.

This is the daily e-mail notification that managers and supervisors will see in the morning when RDE Incidents are generated.

Once you print your report and if you are ready to do your Follow-up/Action you can click on the above link and you will be taken directly to the Midas+ Care Management where you’ll be able to enter the Risk Module (example of screen on next slide).

There are two ways to get to the Midas+ Care Management & Risk Module. You can follow the above link or follow the next steps to enter Midas using the Baptist Health Sun Page.
Double Click on Midas+ Care Management to enter the Risk Module.

This is the format of the report you will receive on a daily basis. The report will be sent via e-mail. You will need this report, which contains the incident number in order to complete any Follow-up/Action taken on incidents that are reported through your staff.
Click on Applications

- Home
- Baptist Health Community
- Baptist Learning Network
- Corporate Compliance
- Departments
- Directories
- Human Resources
- Applications
- Medical Library
- Policies and Procedures
- Wellness Advantage

Click on Midas 7.0 to Begin the logon process for Midas+ Care Management.
Click on Midas+ Care Management to enter the Risk Module.

This is the screen that you will use to log in (click on the OK button) to the Risk Module and begin the process of completing the Follow-up/Action fields.
The first time you enter a Follow-up/Action you will need to click on the Function button, Select Risk Management and then Risk Incident Report Entry, which will take you to the Patient lookup screen.

After your first Follow-up/Action entry the next time you go into Midas+ Care Management you will see the Smart Buttons screen which will eliminate the above step. You will select Risk Incident Report Entry and this will take you directly to the Patient lookup screen (presented on the next slide).

2. Click on the Lookup button, which brings you into the Risk General Tab.

1. Using the Incident Number from your Report enter the number in the Incident No: field (Example: 07-1234).
Click on the User Fields button, which will take you to the Extended User Field Screen. Here you will find the Follow-up/Action fields.

This is the Extended User Field Screen that will be used for: Follow-up/Action.

Select Action taken from the multi select look up field. You will also find that some fields are free text (i.e. Summary of findings) which gives you an opportunity to include information that you or your staff feel are important.

Once you have completed your Follow-up/Action you will need to click on the OK button, which will take you back to the General Tab.
Now that you've completed the Follow-up/Action section, you must click on the SAVE button shown on this screen in order for your information to be saved and reviewed by Risk Management.

Once the SAVE button is clicked you will be taken to the next screen, which is how you will exit from Midas+ or continue to another incident that may need Follow-up/Action.

If you have completed all Follow-up/Action, enter the Incident number in the Incident No: field and follow the same steps presented earlier.

If you need to do additional Follow-up/Action, enter the Incident number in the Incident No: field and follow the same steps presented earlier.

If you have completed all Follow-up/Action you will click on the CANCEL button, which will take you to the screen below.

This is the screen you will use to exit the Risk Module. In order to exit this program you will need to click on the X Button which will take you back to the Midas+ Care Management Screen in which you will click on the X button again and that will completely EXIT you out of the Midas+ System.
Risk Managers and RDE Champions

- BHM – Risk Managers
  - Lynne Thompson
  - Jayne Dohre
  - Natalie Pino
- BOS – Risk Managers
  - Helen Mule
  - Aileen Vasquez
- Doctors – Risk Managers
  - Pat Blanco
  - Lauranne Quinn
- Homestead – Risk Managers
  - Christine Kinik
  - Susan Bunting
- Mariners – Risk Manager
  - Carol Welsh
- South Miami – Risk Managers
  - Vivien Knight
  - Maribe Gongora

- BHM – RDE Champions
  - Natalie Pino
  - Sandra Rodriguez
- BOS – RDE Champions
  - Helen Mule
  - Aileen Vasquez
- Doctors – RDE Champions
  - Linette Cabado
- Homestead – RDE Champions
  - Susan Bunting
  - Susan Pegan
- Mariners – RDE Champion
  - Carol Welsh
- South Miami – RDE Champions
  - Maribe Gongora
  - Wanda Morales
Managers/Supervisors Follow-up/Action
A Quick Reference Guide

You can complete the follow-up/action by following the link within the daily e-mail or by utilizing the BHSF Sun Page. Select Applications, Midas 7.0, double click on the Midas+ Care Management to enter the Risk Module. You will be prompted to sign into the Risk System in order to do follow-up/action.

The first time you enter a Follow-up/Action you will need to click on the Function button, Select Risk Management and then Risk Incident Report Entry, which will take you to the Patient lookup screen.

After your first Follow-up/Action entry the next time you go into Midas+ Care Management you will see the Smart Buttons screen which will eliminate the above step. You will select Risk Incident Report Entry and this will take you directly to the Patient lookup screen (presented on the next slide).
This is a sample of your daily report where you can find the incident number.

Remember that you must have the incident number in order to complete any follow-up/action. It’s important that you keep reports in a safe confidential area. Once you have completed your follow-up/action you will shred the report. As managers/supervisors you will receive a monthly report from Risk Management containing all incidents that were reported on your unit. Please remember that all information contained in the report or incident is Privileged and Confidential. The reports are not to be copied or maintained on your unit.
System Downtime Procedures for Incident Reporting

The following procedures are to be implemented if the Baptist Health Sun Page is not available for incidents to be completed through the Online reporting system.

Complete the Risk Management Downtime Incident Form and send to Risk Management within 3 business days.

Guidelines:

1. Obtain a blank form from your manager (Form # 4219).

2. Fill out the form completely (only one person completes!).
   - Leave no blanks.
   - OK to use NA for not applicable.
   - Select an incident type that is closest to the event that occurred.

3. Write legibly.
   - Correct mistakes with a single line.
   - No correction fluid.

4. Describe the incident carefully.
   - Explain the incident, include information that you feel is important about the event.
   - Document any injury or lack of injury.
   - Avoid finger pointing, signs of anger or frustration, opinions or accusations.
   - Be sure that your information is factual and as accurate as possible.

5. Report any action taken and outcome, if known.

6. Include information of witnesses or others directly involved.

7. Please make sure you sign, date and include your title.

8. Forward incident report to Risk Management within three business days. Risk Management will then be responsible for entering the data.

9. DO NOT MAKE COPIES OR PLACE IN THE MEDICAL RECORD.
### DOWNTIME INCIDENT FORM

**PATIENT NAME / ROOM #**

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>Time of Incident</th>
<th>Location of Incident</th>
<th>Shift</th>
<th>☐ Day ☐ Eve</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Room No.</th>
<th>Account Number</th>
<th>Age</th>
<th>Sex</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date Admitted</th>
<th>Admitting Diagnosis</th>
<th>Physician Contacted About Incident</th>
<th>Yes / No</th>
<th>Physician Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Orders Received:</th>
<th>Yes / NO</th>
<th>Description of Orders / Comments:</th>
</tr>
</thead>
</table>

### Advanced Directives/Patient Rights
- ☐ Advanced Directives/DNR Issues
- ☐ Alleged Abuse
- ☐ Allegations of Sexual Misconduct
- ☐ Ethical Issues
- ☐ Guardianship/Proxy/Surrogate Issues
- ☐ HIPAA/Breach of Confidentiality
- ☐ Organ Donation Issue

### Adverse Drug Reaction
- ☐ Adverse Drug Reaction
- Name of Drug: _______________________

### AMA/Left without being seen
- ☐ ATP: Informed Refusal/Withdrawal from Program
- ☐ Elopement/AMA From Unit
- ☐ Left AMA
- ☐ Left AMA Refused Admission
- ☐ Left AMA refused Treatment/Test/Procedure
- ☐ Left ED without being Treated/Seen
- ☐ Unauthorized Absence from Patient Care Unit

### Blood Occurrences
- ☐ Blood Infiltrate
- ☐ Cancellation of Blood Administration
- ☐ Delay in Transfusion
- ☐ Failure to assign correct blood type
- ☐ Improper Blood ID on patient
- ☐ Mislabelled Blood
- ☐ Transfused to wrong patient
- ☐ Transfused wrong product
- ☐ Transfusion not given
- ☐ Undesired Effect (Transfusion Reaction)
- ☐ Wrong amount transfused
- ☐ Wrong Blood Type sent
- ☐ Wrong Blood Type transfused

### Consent Occurrences
- ☐ Failure to obtain Consent
- ☐ Incorrect/Incomplete/Improper Consent
- ☐ Deviation from Consented Procedure

### Communication Occurrences
- ☐ Failure/Delay to Provide/Receive report to Caregiver
- ☐ Failure to Notify Physician of patient issues
- ☐ Failure to Notify Physician of Abnormal/Critical Values/Results
- ☐ Incorrect Information given to Physician/Caregiver
- ☐ Incorrect Physician Called

### Documentation/Medical Record Occurrences
- ☐ Documentation Incomplete/Illegible/Missing
- ☐ Documentation Altered/Defaced Fraudulent
- ☐ Inappropriate use of documentation in the Medical Record
- ☐ Incorrect/No Data entry
- ☐ Incorrect Information in Medical Record

### Environment of Care Occurrences
- ☐ Electrical Problem
- ☐ Elevator Failure/Malfunction
- ☐ Hazardous Material Split/Exposure (CODE WHITE)
- ☐ Maintenance Issues
- ☐ Parking Hazards
- ☐ Plant Safety/Environmental Issues

### Equipment Occurrences
- ☐ Equipment/Implant Issues
  - (outdated/not available/storage)
- ☐ Failure to label equipment correctly
- ☐ Improper use/storage of equipment
- ☐ Malfunction/Breakage/Removal/Defective (with/without Intervention)
- ☐ Missing/Damaged equipment
- ☐ Tampering/Operator not qualified
- ☐ Unplanned Disconnection of equipment
- ☐ Wrong/Unapproved Equipment/Implant used

### Infection Control Occurrences
- ☐ Break in Sterile Technique
- ☐ Contacts with Sharps/Needles/Used Equipment
- ☐ Contamination/Isolation Issues
- ☐ Exposure to Body Fluids
- ☐ Failure to appropriately dispose of Sharps/Biomedical Waste
- ☐ Failure to maintain appropriate Temp/Humidity
- ☐ Injury/Trauma (due to)
- ☐ Malpresentation, Malposition, Shoulder Dystocia
- ☐ Maternal/Fetal Complication
- ☐ Newborn Identification issues
- ☐ Precipitous or Unattended Delivery (CODE ORANGE)
- ☐ Pregnancy Issue
- ☐ Shoulder Dystocia
- ☐ Unexpected Respiratory/Cardiac Distress in Infant (CODE PINK)
- ☐ Vacuum/Forceps delivery issues

<table>
<thead>
<tr>
<th>Inpatient/ED/Pediatric Falls</th>
<th>Injury/Trauma Occurrences</th>
<th>Minor Injury/Trauma Occurrences</th>
<th>OB &amp; Labor/Delivery Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alleged Fall</td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Infancy (due to)</td>
<td>☐ Congenital Anomalies in Newborn</td>
</tr>
<tr>
<td>☐ Fall</td>
<td>☐ Chemical/caustic substances</td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Delivery by Other MD</td>
</tr>
<tr>
<td>☐ Found on the floor</td>
<td>☐ Contact with electrical current</td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Malpresentation, Malposition, Shoulder Dystocia</td>
</tr>
<tr>
<td>☐ Was there an injury?</td>
<td>☐ Contact with adhesive tape</td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Maternal/Fetal Complication</td>
</tr>
<tr>
<td>☐ F1 - No Injury</td>
<td>☐ Contact with hot substance/liquid</td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Newborn Identification issues</td>
</tr>
<tr>
<td>☐ F2 - Minor (ice, cleaning wound, elevation or topical medication)</td>
<td>☐ Contact with sharp object</td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Precipitous or Unattended Delivery (CODE ORANGE)</td>
</tr>
<tr>
<td>☐ F3 - Moderate (suturing, stenstrips, fracture)</td>
<td>☐ Struck by object</td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Termination of Pregnancy Issue</td>
</tr>
<tr>
<td>☐ F4 - Major (surgery, casting, consultation for neurological injury)</td>
<td></td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Transfer of Neonate to Other facility</td>
</tr>
<tr>
<td>☐ F5 - Death (patient died as a result of the fall)</td>
<td></td>
<td>☐ Acquired from being caught between objects</td>
<td>☐ Traumatic delivery resulting in:</td>
</tr>
</tbody>
</table>

### Auxiliary Information
- Form #4219
- New 9/2007
<table>
<thead>
<tr>
<th>Medication Error Occurrences</th>
<th>Patient Care/Nutrition Occurrences</th>
<th>Physician/Behavior Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Contrast Extravasation</td>
<td>☐ Code Blue (Cardiac Arrest-Adults)</td>
<td>☐ Change of Physician</td>
</tr>
<tr>
<td>☐ Delay</td>
<td>☐ Code Purple (Pediatric)</td>
<td>☐ Consult Not Done/Untimely/Refused</td>
</tr>
<tr>
<td>☐ Excess Contrast</td>
<td>☐ Code Rescue (Patient Clinical)</td>
<td>☐ Unable to Obtain</td>
</tr>
<tr>
<td>☐ Extra/Duplicate Dose</td>
<td>☐ Deterioration</td>
<td>☐ Delay in Care</td>
</tr>
<tr>
<td>☐ Inaccurate Documentation</td>
<td>☐ Delay Admission/Discharge</td>
<td>☐ Disruptive Physician</td>
</tr>
<tr>
<td>☐ Illegible</td>
<td>☐ Deterioration of Physical/Mental Condition</td>
<td>☐ Failure/Delay to do H &amp; P</td>
</tr>
<tr>
<td>☐ IV Inflicted Caustic Agent</td>
<td>☐ EMTALA/COBRA issues</td>
<td>☐ Failure to arrive at appointed time</td>
</tr>
<tr>
<td>☐ IV Infusion Infrate</td>
<td>☐ Failure to appropriately transfer monitored patient</td>
<td>☐ Failure to document Daily Progress Notes</td>
</tr>
<tr>
<td>☐ Labeling Error</td>
<td>☐ Failure to follow Policy/Procedures (medication reconciliation)</td>
<td>☐ Failure to provide Admitting/Discharge Orders</td>
</tr>
<tr>
<td>☐ Narcotic Count</td>
<td>☐ Inappropriate discharge of patient/infant/child</td>
<td>☐ Failure to respond to call or page</td>
</tr>
<tr>
<td>☐ Not Documented</td>
<td>☐ ID/Allergy Band Issues</td>
<td>☐ Failure to secure appropriate coverage</td>
</tr>
<tr>
<td>☐ Omission</td>
<td>☐ Incorrect information, No ID Band</td>
<td>☐ Impaired Practitioner</td>
</tr>
<tr>
<td>☐ Patient/Family self medicated</td>
<td>☐ IV, Lines, Tubes &amp;/or Catheters Disengaged</td>
<td>☐ Physician leaves during Surgery/Procedure</td>
</tr>
<tr>
<td>☐ Pyxis Overide</td>
<td>☐ Non-Compliant Patient</td>
<td>☐ Possible failure to provide appropriate treatment</td>
</tr>
<tr>
<td>☐ Unapproved Abbreviation</td>
<td>☐ Non Compliance w/discharge Policy/Procedures</td>
<td>☐ Refusal to take Call assignment</td>
</tr>
<tr>
<td>☐ Wrong Chart</td>
<td>☐ Nutrition Issues</td>
<td>Name of Physician: ____________________________</td>
</tr>
<tr>
<td>☐ Wrong Dosage</td>
<td>☐ wrong diet, omission, food cold</td>
<td>Patient/Family Grievance Occurrences</td>
</tr>
<tr>
<td>☐ Wrong Frequency</td>
<td>☐ Patient Assessment omitted/delay</td>
<td>☐ Change of Physician</td>
</tr>
<tr>
<td>☐ Wrong Med/Drug</td>
<td>☐ Pressure Ulcer on Admit</td>
<td>☐ Consult Not Done/Untimely/Refused</td>
</tr>
<tr>
<td>☐ Wrong Med in Pyxis</td>
<td>☐ Stage: 1, 2, 3, 4, Unstageable</td>
<td>☐ Unable to Obtain</td>
</tr>
<tr>
<td>☐ Wrong Patient</td>
<td>☐ Pressure Ulcer After Admit</td>
<td>☐ Delay in Care</td>
</tr>
<tr>
<td>☐ Wrong Rate</td>
<td>☐ Stage: 1, 2, 3, 4, Unstageable</td>
<td>☐ Disruptive Physician</td>
</tr>
<tr>
<td>☐ Wrong Route</td>
<td>☐ Suicide Attempt or Ideation</td>
<td>☐ Failure/Delay to do H &amp; P</td>
</tr>
<tr>
<td>☐ Wrong Time</td>
<td>☐ Transfer Issues</td>
<td>☐ Failure to arrive at appointed time</td>
</tr>
<tr>
<td>☐ Administration</td>
<td>☐ Tubing &amp; Catheter Misconnections</td>
<td>☐ Failure to document Daily Progress Notes</td>
</tr>
<tr>
<td>☐ Ordering</td>
<td>☐ Death, Unexpected Death during Admission (unstratified patient)</td>
<td>☐ Failure to provide Admitting/Discharge Orders</td>
</tr>
<tr>
<td>☐ Transcribing</td>
<td>☐ Restraints in use</td>
<td>☐ Failure to respond to call or page</td>
</tr>
<tr>
<td>☐ Prep/Dispensing</td>
<td>☐ Unexpected Return to Hospital</td>
<td>☐ Failure to secure appropriate coverage</td>
</tr>
<tr>
<td>☐ PO</td>
<td>☐ Unplanned/Unexpected Transfer to Higher Level of Care</td>
<td>☐ Impaired Practitioner</td>
</tr>
<tr>
<td>☐ IV</td>
<td>☐ HIPAA Issues</td>
<td>☐ Physician leaves during Surgery/Procedure</td>
</tr>
<tr>
<td>☐ IM</td>
<td>☐ Missing/Damaged Issues</td>
<td>☐ Possible failure to provide appropriate treatment</td>
</tr>
<tr>
<td>☐ SQ</td>
<td>☐ Inappropriate discharge of specimen</td>
<td>☐ Refusal to take Call assignment</td>
</tr>
<tr>
<td>☐ Rectal</td>
<td>☐ Clinical/Communication Medical Issues</td>
<td>Name of Physician: ____________________________</td>
</tr>
<tr>
<td>☐ Non-Marking of Site</td>
<td>☐ Complaint/Comfort needs not met</td>
<td>Patient/Family Grievance Occurrences</td>
</tr>
<tr>
<td>☐ NPO Status Violated</td>
<td>☐ HIPAA Issues</td>
<td>☐ Clinical/Communication Medical Issues</td>
</tr>
<tr>
<td>☐ Omission</td>
<td>☐ Missing/Damaged Issues</td>
<td>☐ Complaint/Comfort needs not met</td>
</tr>
<tr>
<td>☐ Patient refused</td>
<td>☐ Inappropriate discharge of specimen</td>
<td>☐ HIPAA Issues</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Clinical/Communication</td>
<td>☐ Missing/Damaged Issues</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Medical Issues</td>
<td>☐ Inappropriate discharge of specimen</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Refusal to take Call assignment</td>
<td>☐ Clinical/Communication Medical Issues</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Threat of Litigation</td>
<td>☐ Medical Issues</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Change of Physician</td>
<td>☐ Medical Issues</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Consult Not Done/Untimely/Refused</td>
<td>☐ Medical Issues</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Unable to Obtain</td>
<td>☐ Patient/Family Grievance Occurrences</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Delay in Care</td>
<td>☐ Consulting Provider Not Done/Unintimely/Refused</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Disruptive Physician</td>
<td>☐ Unable to Obtain</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Failure/Delay to do H &amp; P</td>
<td>☐ Delay in Care</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Failure to arrive at appointed time</td>
<td>☐ Disruptive Physician</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Failure to document Daily Progress Notes</td>
<td>☐ Failure to provide Admitting/Discharge Orders</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Failure to respond to call or page</td>
<td>☐ Failure to secure appropriate coverage</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Failure to provide appropriate treatment</td>
<td>☐ Impaired Practitioner</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Refusal to take Call assignment</td>
<td>☐ Physician leaves during Surgery/Procedure</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Threat of Litigation</td>
<td>☐ Possible failure to provide appropriate treatment</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Change of Physician</td>
<td>☐ Refusal to take Call assignment</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Consult Not Done/Untimely/Refused</td>
<td>☐ Physician leaves during Surgery/Procedure</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Unable to Obtain</td>
<td>☐ Possible failure to provide appropriate treatment</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Delay in Care</td>
<td>☐ Refusal to take Call assignment</td>
</tr>
<tr>
<td>☐ Procedure/Treatment</td>
<td>☐ Disruptive Physician</td>
<td>☐ Physician leaves during Surgery/Procedure</td>
</tr>
</tbody>
</table>

**Procedure/Treatment Occurrences**

- Additional Unplanned Procedure
- Cancellation
- Delay of Procedure/Treatment
- Error in ordering Procedure/Treatment
- Extended PACU Stay
- Failure to Establish Time Out
- Inappropriate Position during Procedure/Treatment
- Incorrect Results Reported/Sent
- Laceration/Perforation/Tear or Puncture
- Non-Marking of Site
- NPO Status Violated
- Omission
- Patient refused Procedure/Treatment
- Performed on Wrong patient
- Procedure/Treatment Done, Not Ordered
- Procedure/Treatment Ordered, Not Done
- Procedure/Treatment performed at Bedside
- Procedure Performed on Wrong Site
- Procedure Performed Wrong/Incorrectly
- Prolonged Fluoroscopy
- Radiation Exposure during Procedure
- Results from Procedure Not Reported in Specified Time
- Return to Surgery/Procedure
- Retrieval of a Foreign Object/Material
- Specimen Issues (lost, mislabeled, contaminated)
- Surgical Count Variance (needle, instrument, sponge)
- UNDESIRED EFFECT

**Description of Incident:**

- Attending Physician Notified: ☐ Yes ☐ No
- Date: __________ Time: ________ By Whom: _______________
- Was patient examined by an M.D. regarding incident: ☐ Yes ☐ No
- Date: __________ Time: ______________ Name of MD: __________________________

**Follow up and/or Actions taken:**

- __________________________
- __________________________
- __________________________
- __________________________
- __________________________
- __________________________

- **Witnesses** - including employees: (List Name, Address, and Phone Number):

- __________________________
- __________________________
- __________________________

- **Name of Person Reporting:** __________________________
- **Title of Person Reporting:** __________________________
- **Date:** __________ Time: ______________
- **Name of Manager Reviewing:** __________________________
- **Date:** __________ Time: ______________

**Forward to Risk Management within 3 Business Days - DO NOT COPY**
**MIDAS+ RDE and HIPAA**

The Remote Data Entry (RDE) application was designed at the request of clients to provide a mechanism for the hospital-wide reporting of patient safety and patient relations incidents within the hospital. The application was designed with guidance from eight clients. The clients were adamant that the application could be accessed without a password, that it provide for anonymous entry, and that it stay within HIPAA guidelines.

The RDE application is a web-based form that can be launched from any browser. It is each client’s responsibility to protect the launch point for RDE through appropriate hospital network and workstation security practices.

Once an employee has gained access to the RDE application, the incident date is required before patient lookup begins. This date restricts the number of patient encounters that are displayed to those encounters in which the incident could have occurred. The MIDAS+ Privacy Profile was created to allow a client to determine what information is necessary for an employee to lookup a patient in RDE. Each client has the ability to define parameters restricting patient lookup as follows:

1. **Name**- restrict the number of characters required in both the first and last name fields
2. **Number**- account number, medical record number, social security number or the patient's universal identification number
3. **Combination** of both name and number

The Privacy Profile also allows the client to restrict the fields that display back to the user to verify that the correct patient encounter has been selected.

The RDE form is entry only. The employee who entered the incident report can not retrieve the report without authenticated access to the MIDAS+ system. Once an incident report has been submitted to the MIDAS+ System, it is available for reporting, viewing, or SmarTrack Worklist rule activation. A copy of the original submitted incident report is maintained indefinitely and can be printed if necessary

RDE has been designed to allow a client to restrict patient data viewing to that which is minimally necessary to identify the correct patient encounter in order to accurately report a risk or patient relations incident.

If the RDE model described above does not fit into a clients HIPAA compliance framework, the Risk Management Module and Patient Relations Modules in the MIDAS+ system can be utilized. This would require each user to authenticate to the MIDAS+ System and have appropriate rights to these modules.