

October 27, 1987

DM&S Supplement to Part I, VA Manual MP-1, "General Administrative," is changed as indicated below:

1. Transmitted is a revision of DM&S Supplement MP-1, part I, chapter 2, Investigation, Security, and Law Enforcement Policy.
2. The primary purpose of this revision is to incorporate into DM&S Supplement the following:
 - a. The reporting requirements contained in 38 CFR 17.508, Patient Injury control, to ensure that this supplement is in agreement with agency regulations in 38 CFR 17.500 - 17.540.
 - b. To include the requirements in MP-5, part I, chapter 297.
 - c. Additional categories to be contained in the "Summary of Special Incidents Involving Beneficiaries," RCS 10-0073.
 - d. A statement of the DM&S policy that the patient and/or the patient's family will be informed of the circumstances surrounding a therapeutic misadventure which results in the injury of a patient.
 - e. Provide definitions for the various reporting categories of the Patient Injury Control Program.
 - f. Additional reporting requirements.
 - g. Minor editorial changes.

FILING INSTRUCTIONS:

Page 2-i: Remove this page and substitute pages 2-i through 2- Insert page # attached.

Page 2A-1 through 2A-4: Remove these pages and substitute pages 2A-1 through 2A- Insert pg # attached.

Add Appendixes D and E attached.

RESCISSIONS: Change 41, dated August 20, 1985, to DM&S Supplement MP-1, Part I.

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CHAPTER 2. INVESTIGATION, SECURITY, AND LAW ENFORCEMENT POLICY

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CHAPTER 2. INVESTIGATION, SECURITY, AND LAW ENFORCEMENT POLICY

SECTION A. INVESTIGATIONS

1. POLICY

a. Notification of the appropriate officials in VA Central Office will be accomplished in the following manner:

(1) Emergency matters involving the incidents described in MP-1, part I, paragraph 208.02a, will be reported immediately by telephone or teletype to the appropriate Regional Director (10BA__), who will transmit the information to the Office of the Medical Inspector (10A6). Consistent with VA disclosure laws, serious criminal incidents also will be reported without delay to the appropriate Federal or State law enforcement agency and the VA District Counsel as described in section B, paragraph 14a(7) and the Director, Security Service (132). The Office of the Medical Inspector will notify the Inspector General.

(2) Other incidents, as indicated in 38 CFR 17.508 and Appendix E, will be reported immediately by telephone or teletype to the appropriate Regional Director (10BA__), who will transmit the information to the Office of the Medical Inspector (10A6). This information will be followed by two copies of the completed VA Form 10-2633 within 10 working days. If an investigation is required, the Report of Investigation will be submitted to VA Central Office within 30 calendar days. Other incidents which the Director believes should be brought to the attention of VA Central Office should be reported in the same manner.

b. If the incident does not come within the purview of paragraph a.(1) or (2) or require an investigation, the Medical Center Director will take such action as may be indicated within the delegated authority. The Medical Center Director will record on VA Form 10-2633, or on an appendix thereto, the action which has been taken and will place the completed form in a file established so designated for this purpose in the office of the Medical Center Director.

2. INITIATION OF VA FORM 10-2633, REPORT OF SPECIAL INCIDENT INVOLVING A BENEFICIARY

a. The VA Form 10-2633, Report of Special Incident Involving a Beneficiary, will be initiated without delay by the employee first becoming aware of the incident in all instances where a beneficiary is involved in an incident that either has harmed or has the potential of causing harm. After completion of Section 1 of the VAF 10-2633, the form will be delivered

promptly to the physician in charge of the area concerned. In any case, the nurse and physician in charge of the ward on which the individual is a patient or the clinic the patient is attending or the Domiciliary Officer will be notified within 12 hours.

b. This reporting requirement applies to both inpatients and outpatients. The report will include a description of the event, its location, and pertinent physical factors such as diagnosis, age, mental status, medication taken within 12 hours and a medical evaluation. Only facts should be recorded on the VAF 10-2633. The same information should be documented in the patient's medical record.

c. The physician receiving the VA Form 10-2633 will record a brief statement of the findings in Section 2 of the form. The form will then be delivered within 1 working day through the Chief of Staff who will indicate whether, in their opinion, the incident comes under the scope of paragraph 1.b. above to the Medical Center Director. If the Medical Center Director concurs that the incident is covered by paragraph 1.b. above, the Director will make the appropriate notification and proceed to further develop the facts in the case and/or appoint a Board of Investigation.

3. INVESTIGATIONS, QUALITY ASSURANCE AND ADMINISTRATIVE, AND MORTALITY AND MORBIDITY REVIEWS FOR SUICIDES AND SUICIDE ATTEMPTS

a. In accordance with Appendix E, when an investigation is required, the Medical Center Director will determine whether an Administrative or a 38 U.S.C. 3305 protected QA (Quality Assurance) investigation is to be performed. If it is determined that a QA investigation is to be conducted, this fact must be indicated in the memorandum establishing the Board of Investigation by using the following language prescribed in 38 CFR 17.508(c)(2):

"In accordance with the provisions of 38 CFR 17.508(c)(2), I hereby direct that a Quality Assurance Investigation be conducted regarding (describe incident). All documents, memoranda, reports and other records generated by and included in this investigation will be strictly confidential and will only be disclosable as permitted by 38 U.S.C. 3305."

Failure to use the prescribed language will mean that the report and any records generated in the investigation are not protected by 38 U.S.C. 3305. For both Administrative and QA Investigations, the Medical Center Director will appoint a board (a minimum of three people) having appropriate professional representation to develop the facts and furnish a complete report, to include recommendations. Appropriate professional representation means that if Nursing Service personnel are an integral part of the incident, then a Registered Nurse should be on the Board of

Investigation; if a physician is an integral part of the incident, then a physician should be on the board; if a Domiciliary patient is an integral part of the incident, then the Chief of Domiciliary Operations or other representative from Domiciliary Operations should be on the board. Complete testimony will be obtained, the testimony transcribed, reviewed, and corrected, if necessary, and signed by the person being interviewed and then forwarded as part of the investigation to VA Central Office.

When an investigation, administrative or QA or a suicide Mortality and Morbidity Review is conducted on an incident which involves suicidal or assaultive behavior, the Chairperson of the Board will complete VAF 10-0046, Report of Suicidal or Assaultive Behavior, and submit it with the investigation/review. Testimony will be taken under oath. The Report of the Board of Investigation will be prepared in the following format:

Authority:

Purpose:

Scope:

Exhibits:

Findings:

Conclusions:

Recommendations:

b. In Administrative Investigations, any interviews or formal testimony of bargaining unit employees must be conducted in accordance with rights to union and other representation that may arise under statute or collective bargaining agreement, local or national, of any union contract.

c. Before making the determination to initiate a Quality Assurance Investigation, the following criteria should be considered:

- (1) The incident has a substantial impact on the quality of patient care;
- (2) The incident is indicative of a trend or pattern and not an unique event;
- (3) No allegations of VA employee unacceptable performance has been made;
- (4) The expected outcome of the investigation is not likely to find the conduct, performance or competency of a VA employee was a significant contributory factor in the incident and that disciplinary action, resignation, or restriction, suspension, or revocation of clinical privileges will result from the investigation; and

(5) The purpose of the investigation is the improvement of patient care through peer analysis, intervention, resolution of the problem, and follow up to ensure corrective action was effective.

d. In a Quality Assurance Investigation, the information obtained is confidential and protected by 38 U.S.C. 3305. Therefore, this information cannot be used as a basis for disciplinary action. An employee who is being interviewed in a QA Investigation is under no threat of disciplinary action and thus is not entitled to have representation nor is there a need for such representation.

e. The facility copy of these reports will be placed in a file established for this purpose in the Office of the Medical Center Director. Those reports will not be filed in such a manner that would allow them to be retrieved by personal identifier. Those investigations designated Quality Assurance Investigations in accordance with the regulation implementing 38 U.S.C. 3305, Confidentiality of Medical Quality Assurance Records, will be confidential and all safeguards appropriate to that law will be followed. See 38 CFR 17.00 - 540, for guidance.

f. The Medical Center Director will forward the original and three completed copies of VA Form 10-2633 and an original and three copies of the report of the investigation to the appropriate Regional Director (10BA___), including the Medical Center Director's comments, recommendations, action(s) taken, exhibits, photographs, documents, transcripts, and all other documents concerning the investigation. In addition, in the case of suicides or suicide attempts, the completed VA Form 10-0046 will be submitted.

g. When an incident such as described above occurs at a non-VA facility involving a beneficiary who is being examined and/or treated under VA authorization, such as Sharing Agreements and Contract Nursing Homes, the VA facility having appropriate jurisdiction will submit a preliminary report of findings, comments, and recommended action to the appropriate Regional Director (10BA___).

h. If a beneficiary, while absent, with or without permission, or en route between facilities, becomes involved in any incident as described in Appendix E, a report will be sent by each facility to the appropriate Regional Director (10BA___) containing all the information which is available. The appropriate Regional Director (10BA___) will transmit the reports covered by this paragraph to the Office of the Medical Inspector (10A6).

i. A M&M (Mortality and Morbidity) Review (often termed a psychological autopsy) will be conducted whenever there is a suicide or suicide attempt. Such a review is protected by 38 U.S.C. 3305 and thus is confidential. If an investigation is conducted, a M&M is not mandatory. If an investigation is not conducted, the Chief of Service responsible for the patient's care at the time of the incident (e.g., Psychiatry, Medicine, Nursing Home Care Unit, etc) will see that the review is conducted and that a report of the review is forwarded through the Chief of Staff to the Medical Center Director. The report will then be

forwarded to the Medical Inspector (10A6) through the appropriate Regional Director (10BA__). If a non-fatal incident occurred on a service other than Psychiatry, the service chief will ensure that a psychiatry consultation is immediately obtained. The results of this consultation will assist in determining if the incident meets the criteria for a M&M. These requirements apply to both inpatients and outpatients. Guidelines for conducting a M&M for suicides and suicide attempts may be obtained from the Mental Health and Behavioral Sciences Service (116), VA Central Office.

4. ALLEGATIONS OF PATIENT ABUSE

a. Allegations of patient abuse must be investigated by an Administrative Board of Investigation. Whenever possible, the patient should be interviewed as part of this process. Exceptions to the requirement for an Administrative Investigation are when the patient is known by the treatment team to use allegations of this nature or the threat of making such allegations to manipulate staff and when the condition of the patient making the allegation is such that the patient could not possibly have been aware of what was, in reality, occurring. In these exceptions, in addition to filling out a VA Form 10-2633, a fact-finding review will be instituted and the results of that review, together with a short clinical history, will be submitted to VA Central Office in the same manner as an investigation.

b. Patient abuse includes mental, physical, sexual, and verbal abuse such as the following:

- (1) Any action or behavior that conflicts with patient's rights, identified in VA regulations 38 CFR S 17.34a.
- (2) Intentional omission of care;
- (3) Willful violations of a patient's privacy;
- (4) Intimidation, harassment, or ridicule of a patient; or
- (5) Willful physical injury.

c. It should be remembered that one does not have to intend to abuse a patient to commit patient abuse.

d. Although it is not feasible to educate all employees in handling self-destructive or assaultive patients, a concerted effort will be made to provide this education and training to those employees who have routine and frequent contact with these types of patients. Since some incidents of patient abuse may result from insufficient employee education or understanding of patient behavior, continuing education should assist in the prevention of patient abuse.

5. SURGICAL COMPLICATIONS

The Medical Center Director will submit the monthly report on VA Form 10-7396a, Complications of Surgical Procedures, in accordance with M-2, part XIV, chapter 5, to the Director, Surgical Service (112) in Central Office, through the appropriate Regional Director (10BA__), and through the Medical Inspector (10A6). In all cases where a death has occurred in the OR (Operating Room), in the Recovery Room, or within 24 hours of surgery, a copy of the Discharge Summary, the OR Report, the Autopsy Report, if an autopsy was done, and the Surgical Service Morbidity and Mortality Review will be attached. It is recognized that, on occasion, the Medical Center Director may wish to authorize an investigation and, in those cases, the procedures for investigations will be followed.

6. VA CENTRAL OFFICE REVIEW

a. The Office of the Medical Inspector (10A6) will circulate the investigation to the pertinent elements within Central Office for their review. Their comments will be forwarded to the Office of the Medical Inspector within 10 working days. A copy of all investigations will be transmitted by the Medical Inspector to the Inspector General (51) for review as part of the oversight function of that office.

b. The Office of the Medical Inspector (10A6) will notify the field facility, through the appropriate Regional Director (10BA__), when the case has been closed.

7. SUMMARY OF SPECIAL INCIDENTS INVOLVING BENEFICIARIES, RCS 10-0073

Semiannually, each facility will develop a report, Summary of Special Incidents Involving Beneficiaries, RCS 10-0073. This report will consist of a count of all VA Forms 10-2633, Report of Special Incident Involving a Beneficiary, that have been completed since the last reporting date. The count should be broken down by quarter and subdivided into the following categories:

- (1) Suicide Gesture
 - (a) Outpatient
 - (b) Inpatient
- (2) Attempted Suicide
 - (a) Outpatient
 - (b) Inpatient
- (3) Suicide
 - (a) Outpatient
 - (b) Inpatient
- (4) Alleged Patient Abuse
- (5) Sustained Patient Abuse
- (6) Falls

- (7) Transfusion Errors
- (8) Medication Errors
- (9) Patient Injury Other Than Falls
- (10) Unexpected Deaths Related to Surgery
- (11) Unexpected Deaths--Other Than Those Related to Surgery
- (12) Patients Involved in Fires
- (13) Patient on Patient Assaults
- (14) Patient on Staff Assaults
- (15) Other--Define.

b. The reporting periods will be October 1 through March 31 with the report due in Central Office on the last working day of April and April 1 through September 30 with the report due in VA Central Office on the last working day of October. The report will be submitted to the Office of the Medical Inspector (10A6) through the appropriate Regional Director (10BA__).

8. TORT CLAIMS

At the time a medical center is notified by the District Counsel that a Standard Form 95, Claim For Damage, Injury, Or Death, involving that facility and dealing with clinical issues has been filed, the medical center will submit to the Medical Inspector (10A6), through the appropriate Regional Director (10BA__), the name of the patient involved, the allegations, and a copy of the Discharge Summary dealing with the episode of care during which the alleged incident occurred, a clinical description of the incident and the names of the primary providers involved in the care that is in question.

9. THERAPEUTIC MISADVENTURES

The term "therapeutic misadventure" is defined as any adverse event which has occurred as part of the patient's diagnosis, care, and treatment while an inpatient or outpatient in the Veterans Administration, which has caused, will cause, or has the potential of causing the patient significant harm, discomfort, disability, or death. When a "therapeutic misadventure" occurs, the patient or the patient's family, where appropriate, should be informed as promptly as possible. The information provided should include a brief summary of the incident, its effect on the patient's prognosis, and the proposed plan for dealing with sequelae and/or minimizing complications/further disability. This discussion and the information provided should be documented in the patient's medical record. Examples of a "therapeutic misadventure" are giving the patient the wrong unit of blood, leaving a surgical sponge in the patient, etc.

10. DISCLOSURE TO STATE LICENSING BOARDS

a. It is the policy of the Department of Medicine and Surgery to report to State Licensing Boards, on its own initiative, those separated licensed appointees who so significantly failed to conform to generally accepted standards of clinical professional practice as to raise reasonable concern for the safety of patients. Should the Agency be conducting an investigation into the clinical practice of an individual when the employee resigns, the investigation should be completed so that the determination can be made as to whether the former employee meets the reporting requirements of MP-5, part I, chapter 297.

b. It is also the policy of the Department of Medicine and Surgery to disclose appropriate information to State Licensing Boards inquiring about the clinical professional practice or other activities germane to licensure or registration of licensed appointees and former licensed employees.

c. Under no circumstances should an agreement be entered into with an employee which would prohibit the reporting of this individual to the appropriate State Licensing Board and/or other license monitoring or issuing organizations or would prohibit the Veterans Administration from responding honestly to inquires concerning the employment and termination of an employee.

11. INVESTIGATIONS CONCERNING LOSS OR DAMAGE OF BENEFICIARY'S PERSONAL PROPERTY, FUNDS, OR VALUABLES NOT TO BE REPORTED ON VA FORM 10-2633.

a. When loss or damage of the personal property, funds, or valuable of a patient or examinee is alleged, the Director will ensure that preliminary inquiries are conducted by medical center police or an investigator, as appropriate, depending on the amount and/or circumstances surrounding the loss. In Administrative Investigations, any interviews of bargaining unit employees must be conducted in accordance with rights to union and other representation that may arise under statute or collective bargaining agreement.

b. The report, with recommendations on the propriety of reimbursement and the placing of responsibility, will be reviewed by the Director who will endeavor to dispose of the matter locally. If the Director is unable to make such a disposition, the report will be referred to the District Counsel for comment and recommendations, including a determination of the applicability of the Federal Tort Claims Act (28 U.S.C. 2671 - 2680).

PATIENT INJURY CONTROL DEFINITIONS

<u>INCIDENT</u>	<u>DEFINITION</u>
Suicide Gesture	Suicidal behavior which does not meet the definition for suicide attempt.
Suicide Attempt	<p>Suicidal behavior which is either medically serious or psychiatrically serious.</p> <p>Examples of medically serious incidents are those which result in permanent disability or disfigurement and acts which would have been lethal were it not for the intervention of another party. This would include acts that require life-saving medical interventions. A suicidal act will be considered psychiatrically serious if the patient's psychiatric condition was such that any suicidal behavior has serious implications for the patient's future care. Examples of psychiatric seriousness currently suggested by psychiatric experts include: any suicidal behavior by a patient meeting the full DSM-III-R criteria for Major Affective Disorder; suicidal behavior in a substance abusing patient with recent or impending major life disruption (e.g., marital separation, death of a loved one); any suicidal behavior in a schizophrenic patient characterized by feelings of hopelessness, secondary depression, or a history of previous suicidal behavior.</p>

Medication
Errors

A medication error is broadly defined as a dose of medication that deviates from the physician's order as written in the patient's chart or as written on an outpatient prescription or from standard medical center procedures. Except for errors of omission, the medication dose must actually reach the patient; a wrong dose that is detected and corrected before administration to the patient is not a medication error.

The categories of medication errors are:

- Omission Errors
- Unauthorized Drug Error
- Wrong Dose Error
- Wrong Route Error
- Wrong Rate Error
- Wrong Dosage Form Error
- Wrong Time Error
- Wrong Preparation of a Dose
- Incorrect Administration Technique

The outpatient prescription dispensing program is included in this reporting system. Incorrect medications dispensed to the patient will be considered medication errors.

It is a medication error when individual or specialized inpatient or outpatient prescriptions, including intravenous admixtures compounded by Pharmacy Service, do not meet all labeling requirements as provided in the DM&S Clinical Services Manual, M-2, Part VII, Pharmacy Service. In these cases, the medication does not have to be administered to the patient for it to be considered a medication error.

It is considered a medication error when the additive to the IV mixture is incorrect, be it type of medication or dosage.

Serious Allergic
Reaction to
Anesthesia
or Drugs

Anaphylaxis or other adverse reactions
seriously affecting the well-being of
patient.

Patient Injury
Examples:

Any injury to patient. Other Than Fall
Self-inflicted injury, etc,
(non-suicidal) involving:
Fracture
Multiple Sutures
Neurological Impairment
Requiring Transfer to ICU
Electrical Shock
Chemical Exposure
Equipment Caused
Injury Due to Treatment or Diagnostic
Procedure

Operating Room
Death

Includes:
In Operating Room
In Recovery Room
During Induction of Anesthesia
Death Within 48 Hours of Surgery

Unexpected Death

Death due to a procedure:
Cardiac Catheterization, etc
Biopsy
Radiological Procedure
Endoscopy
Cause of death unknown
Reportable to local Medical Examiner or Coroner
Death due to previously unknown problem or diagnosis
Misadventure such as respirator
malfunction, medication error, failure
to diagnose or failure to treat
appropriately

Death Within 24
Hours of
Admission

Any death within 24 hours of admission
(timed from 10-10 application)

Patient Involved In Fires	Patient: sets the fire is involved in a fire is burned is exposed in smoke of fire; i.e., smoke inhalation
Search for a Patient	Court appointed legal guardian for person exists, is a danger to himself or others, is legally committed, lacks cognitive ability to make decisions.
Failure to Obtain Informed Consent	All invasive procedures, research protocol participation, psychotropic or neuroleptic drugs, from guardian for legally incompetent patients.
Inaccurate Counts In Surgery	Needles, Sponges, Pads.
Rape/Attempted Rape	Sexual Assault with or without penetration
Homicide	Death of a patient or staff caused by a patient Death of patient caused by another individual
Patient on Staff Abuse	Physical injury Intentionally striking staff Permanent disability
Patient on Patient Abuse	Patient injured by another patient Patient assaulted by another patient
Surgical Complications	See M-2, Part XIV, Chapter 5

Idiosyncratic
Reaction to
Blood or Blood
Products

Reaction to blood or blood product that
has been properly typed/cross matched and
administered

Diagnostic Error

Failure to Diagnose a problem,
Failure to do proper diagnostic
procedures

Misdiagnosis

Incidents Which
Result or May
Result in
Disability/
Disfigurement

Permanent or requires extensive
corrective therapy/surgery

PATIENT INJURY CONTROL REPORTING

OTHER DATA TO BE	VA FORM	RCS	VACO NOTIFICATION	REQUIRED
<u>INCIDENT</u>		10-0073	AND	
<u>INVESTIGATION</u>			<u>10-2633</u>	<u>CATEGORY 10-2633 to VACO</u>
			<u>SUBMITTED TO VACO</u>	

Suicide Attempt X 2
X Suicide Mortality and Morbidity

Review to be done by Treatment

Team

Completed VAF 10-0046, "Report of

Suicidal or Assaultive Behavior"

Suicide X 3
X Suicide Mortality and Morbidity

Review to be done by Treatment

Team

Completed VAF 10-0046, "Report of

Suicidal or Assaultive Behavior"

PATIENT INJURY CONTROL REPORTING

	VA FORM	RCS 10-0073	VACO NOTIFICATION AND		REQUIRED
OTHER DATA TO BE					
<u>INCIDENT</u>			<u>10-2633</u>	<u>CATEGORY</u>	<u>10-2633 to VACO</u>
<u>INVESTIGATION</u>			<u>SUBMITTED TO VACO</u>		

Alleged Patient Abuse	X		X	4	X
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Note: If patient has a history

of making allegations as part of manipulation, no investigation need be done. However, a fact-finding review must be done and submitted to VACO.

If assaultive behavior involved, complete VAF 10-0046

Rape/Attempted Rape Suicidal or Assaultive Behavior"	X		X	4, 13,	X
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Completed VAF 10-0046, "Report of or 14

Homicide X Completed VAF 10-0046, "Report of Suicidal or Assaultive Behavior"	X	4, 14			X
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or 15

Falls Notification patient's treatment required.	X			6	VACO Status of only if serious
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injury.

PATIENT INJURY CONTROL REPORTING

OTHER DATA TO BE	VA FORM	RCS 10-0073	VACO NOTIFICATION AND	REQUIRED
<u>INCIDENT</u>			<u>10-2633</u>	<u>CATEGORY</u>
<u>INVESTIGATION</u>			<u>SUBMITTED TO VACO</u>	<u>10-2633 to VACO</u>
Incidents Which Result or May Result in Disability/ Disfigurement			X	6 or 9 X
Transfusion Error	X		X	7 X
Medication serious Errors reaction or potential errors reaction should be reported on VAF 10-2633 whether or not the patient has an adverse reaction. This should be done by Pharmacy as well as Clinical Services.			All When serious patient medication or potential of	8 Only when patient reaction of serious
		serious reaction		

PATIENT INJURY CONTROL REPORTING

OTHER DATA TO BE <u>INCIDENT</u> <u>INVESTIGATION</u>	VA FORM RCS 10-0073	VACO NOTIFICATION AND <u>10-2633</u> <u>SUBMITTED TO VACO</u>	CATEGORY <u>10-2633 to VACO</u>	REQUIRED
Serious Allergic When there is a death or Reaction to potential for permanent Anesthesia disability or Drugs		X		8, 9, or 11 X
Patient Injury Short Clinical History Other Than Incident and Outcome Fall		X	9	Only if possible permanent damage/ disability to patient
Patient Injury X Due to Short Clinical History Procedure and Outcome		X		9 Procedure Report
Operating Room OR Report Death Discharge Summary Autopsy Surgical Mortality and Morbidity Review		X		10

PATIENT INJURY CONTROL REPORTING

OTHER DATA TO BE	VA FORM	RCS 10-0073	VACO NOTIFICATION AND	REQUIRED
<u>INCIDENT</u>			<u>10-2633</u>	<u>10-2633 to VACO</u>
<u>INVESTIGATION</u>			<u>SUBMITTED TO VACO</u>	
Death Within unexpected 24 Hours of Autopsy Report, if done Admission			X Discharge Summary	10, 11, Only if or 15
Unexpected Death Cause Unknown Discharge Summary Unidentified Autopsy Report, if done Problem			X	11 X
Misadventure X			X	11
X				
Procedure X			X Discharge Summary	11
Procedure Report Autopsy Report, if done				
Patient Involved Patient is burned in Fires Patient is seriously injured Fire in Security or			X	12 X

Seclusion Room

Patient on
possible
VAF 10-0046,
Patient
permanent injury
disability
Behavior"

X
Death or possible

13 Death or
If investigated -
permanent
Assaults
Assaultive or

"Report of Suicidal or

PATIENT INJURY CONTROL REPORTING

OTHER DATA TO BE	VA FORM	RCS 10-0073	VACO NOTIFICATION AND	REQUIRED
<u>INCIDENT</u>			<u>10-2633</u>	<u>CATEGORY</u>
<u>INVESTIGATION</u>			<u>SUBMITTED TO VACO</u>	<u>10-2633 to VACO</u>
Patient on Staff possible VAF 10-0046, Assaults permanent disability disability Behavior"			X Death or possible "Report of Suicidal or	14 Death or If investigated - permanent Assaultive
Search for a If patient is dead or Patient			X	15 If patient is not found, seriously seriously injured injured or died or is not found
Failure to Obtain Informed Consent			X	15
Inaccurate Counts in Surgery			X	15
Idiosyncratic Reaction to Blood or Blood Products			X	15

PATIENT INJURY CONTROL REPORTING

OTHER DATA TO BE	VA FORM	RCS	VACO NOTIFICATION	REQUIRED
<u>INCIDENT</u>		10-0073	AND	
<u>INVESTIGATION</u>			<u>10-2633</u>	<u>CATEGORY 10-2633 to VACO</u>
			<u>SUBMITTED TO VACO</u>	

Diagnostic Error

Failure to 2633 Diagnose Problem Failure to do proper procedures Misdiagnosis length of stay(2)		When See VAF 10-2633 possibility of permanent damage or disability(1) Significantly extends	15See VAF 10-
Death X		11	X

Surgical

VAF 10-7396a - "Complications of
Complications
Surgical Procedures"

In each case of death:

Discharge Summary
OR Report
Autopsy Report, if done
Surgical Mortality and
Morbidity Review