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	Document Title:	LABORATORY INCIDENT REPORTING

PURPOSE:

To report, record and investigate all work-related injuries or illnesses, accidents, near miss or dangerous occurrence on the premises, or any significant incident that happened during duty or working hours.

LEVEL:

All Laboratory Personnel

DEFINITION OF TERMS:

Incident report form- is a form that is filled out in order to record details of an unusual event that occurs at the facility, such as an injury to a patient.


Incident report- is defined as any unusual event occurring to a consumer/specimen that needs to be recorded and investigated for risk management or quality improvement purposes or unusual event occurring to a staff member during the course of his/her work schedule

Example: mislabeled samples pose a threat to patient safety due to delays in sample processing, re-draws, and the possibility that results may be reported on the wrong patients.

Root cause analysis is a process tool for analyzing an event in order to determine the "root" cause of the event and implement specific action(s) to prevent recurrence.


POLICY:

1. All accidents, incidents or reported injuries shall be reported to establish a written record of factors causing the event, along with near misses for prompt investigation and to support corrective actions.
 - 1.1. Incident report is not tantamount to blaming a fellow employee for the problem. It shall be made clear that filing an incident report is not an admission

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of negligence but rather, it is to help facilitate the improvement or development of reporting systems that receive information that can be used to improve patient safety.

2. The report must be accurate, factual, complete, graphic and valid.
3. Incident report shall be written using the assigned template.
 - 3.1. For Staff Nurse (Incident Report)
 - 3.2. For Head Nurse/Nurse Supervisor(Anecdotal)
4. Incident Report shall be completed as soon as possible after the occurrence, but not later than 24hrs after the incident occurred.
5. Incident reports must be submitted with an Anecdotal Report prepared by the immediate head/supervisor.
 - 5.1. Details of the incident shall include the complete name of the person and staff, date and time the incident happened, and what were the initial remedial measures and actions taken, with date and time that the incident was elevated and referred to the immediate supervisor.
 - 5.2. Date and time indicated in the report must be in a chronological order.
6. Incident Reports are considered confidential and must be endorsed to the authorized person only. Any incident with legal implications must be referred to the Client Relation Officer.
7. In response to a sentinel event occurrence, the administrative team shall conduct root cause analysis. The objectives of the root cause analysis are:
 - 7.1. To identify those causative issues,
 - 7.2. To identify systems or processes that represent core reasons for occurrence of the event;
 - 7.3. To develop an action plan that will prevent recurrence of the event;
 - 7.4. To implement the action plan,

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- 7.5. To monitor the plan's effectiveness periodically,
- 7.6. To assure the event will not be repeated.

DOCUMENTATION:

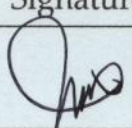
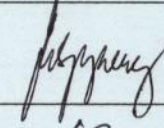


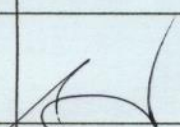
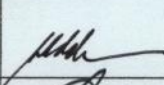
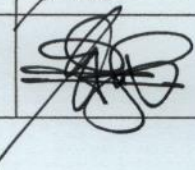
New Policy


DISSEMINATION:

Policies and Procedure Manual
Orientations

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	MELANIE ROSE B. ZERRUDO, MD, FPSP Chair, Department of Pathology		07-29-22
Reviewed:	DENNIS C. ESCALONA, MN, FPCHA, FPSQua Quality Assurance Supervisor		08-30-2022
Recommending Approval:	RONEL G. SARIO, MD, FPCP Medical Director- Una Konsulta		8/10/22
	SOCORRO VICTORIA L. DE LEON, CPA, MBA, PhD, FPCHA Vice President- Chief Operating Officer		09/01/22
Approved:	GENESIS GOLDI D. GOLINGAN President and CEO		9/11/22

	Document Code:	DPOTMH-L-100-P10-S01
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PURPOSE:

To provide a process for reported incidents/accidents for assessment, investigation and monitoring of planned corrective actions for the prevention and reduction of the risk of occurrence of these incidents/accident.

SCOPE:


Applies to all Laboratory Unit staff of Una Konsulta

PERSON RESPONSIBLE:


Una Konsulta Manager, Medical Technologists, Laboratory Personnel, Unit Head, Quality Assurance Supervisor, Human Resource Division Personnel

PROCEDURES:

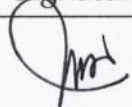
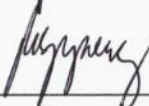




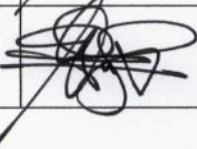
1. The staff must complete an incident report within 24 hour period upon occurrence of the incident.
 - 1.1. The Incident report form is available in the e-library of the Hospital Communicator. Laboratory personnel are encouraged to include in the report "near misses" as they are considered a precursor to actual incidents.
2. The staff must immediately submit the incident report to the Unit Head.
3. The Unit Head shall send a copy to:
 - 3.1. the Laboratory Director
 - 3.2. Head Pathologist for reference and confidential filing
 - 3.3. Quality Assurance Section of the Total Quality Division
4. An investigation and a Root Cause Analysis of the incident and "near misses" will be conducted by the Quality Assurance Supervisor. Concerns and Corrective actions will be addressed accordingly by the unit.
5. If incident is caused by faulty machines/equipment/software program a copy of Root Cause Analysis must be given to the concerned department (Maintenance and Engineering Department/MIS and etc.) for immediate action.


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6. A copy of the Root Cause Analysis is submitted to the Vice President for Medical Affairs for reference and confidential filing.
7. In cases of obvious negligence, dereliction of specified duties, it may be forwarded to the Human Resource Division (HRD).
8. The HRD then reviews and investigates the incident and if the employee is guilty of negligence, proper sanction/disciplinary action shall be given.


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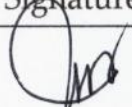
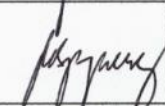
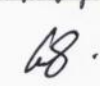



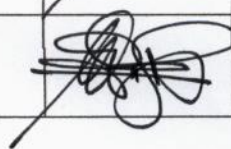
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KEY TASKS	PERSON RESPONSIBLE
1. Completes an incident report with in 24 hour period upon occurrence of the incident.	Laboratory Personnel/ Medical Technologist
2. Submits the incident report to the Unit Head	Laboratory Personnel/ Medical Technologist
3. Sends a copy of the incident report to the Laboratory Director, Head Pathologist and Quality Assurance Section	Unit Head
4. Investigates and conducts a Root Cause Analysis (RCA) of the incident and "near misses"	Quality Assurance Supervisor
5. Addresses the concerns and performs corrective actions	Unit Head/ Una Konsulta Manager
6. Sends a copy of the RCA to the concerned department if the incident is caused by faulty machines/equipment/software program	Unit Head/ Una Konsulta Manager
7. Forwards the incident report to the HRD in cases of obvious negligence or dereliction of specified duties	Unit Head/ Una Konsulta Manager
8. Reviews and investigates the incident and if the employee is guilty of negligence, proper sanction/disciplinary action shall be given	HRD Personnel

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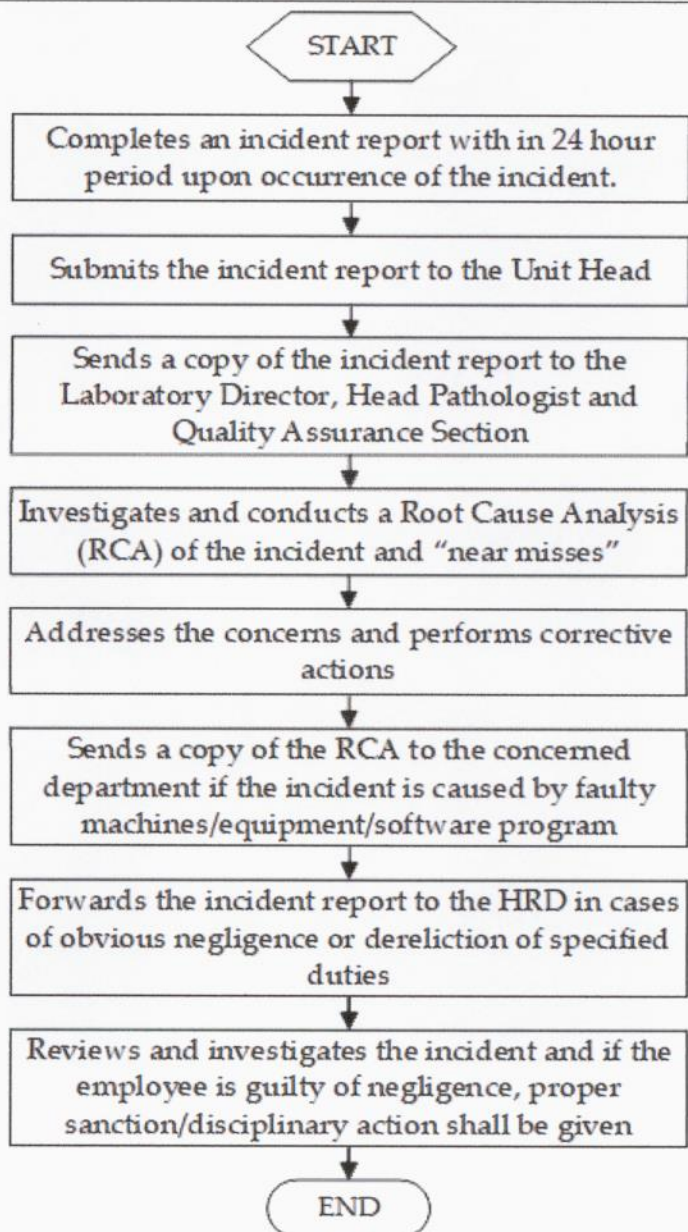
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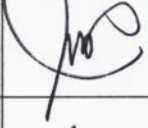




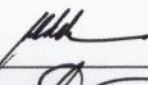
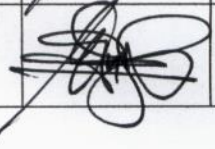
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FLOWCHART



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