D H E C

PROMOTE PROTECT PROSPER

C. Earl Hunter, Commissioner

Promoting and protecting the health of the public and the environment.

September 14, 2006

MEMORANDUM

TO: Administrators of Licensed Health Care Facilities or Activities

FROM: Dennis L. Gibbs, Director
Division of Health Licensing

SUBJECT: Accidents/Incidents That Must Be Reported to Health Licensing

Standards established in South Carolina regulations require facilities or activities to notify us in the event certain types of accidents or incidents occur. Attachment (1) to this memorandum identifies the sections of the regulations that may apply to your facility. Reporting requirements for each type of facility or activity may vary.

Attachment (2) is a sample form for reporting accidents or incidents and is provided as a model. Use of this form is at the discretion of the facility or activity. It is not intended to replace forms that you are currently using.

Regardless of the format used, reports must include at least the following information:

Facility/Activity Name	Extent/Type of Injury and How Treated, e.g. hospitalization
Client Age and Sex	Identified Cause of Accidents/Incidents
Date of Accidents/Incidents	Internal Investigation Results if Cause Unknown
Location of Accidents/Incidents	Identity of Other Agencies Notified of Accidents/Incidents
Witness Names	Date of the Report

This document supersedes the previous memorandum dated November 11, 1996.

Should you have any questions or concerns, please contact our office at (803) 545-4319.

DG/JR/jr

Attachments: (2)

Attachment 1

Accident/Incident Reporting Requirements
Regulation Licensing Standards

R61-13, Standards for Licensing Habilitation Centers For The Mentally Retarded Or Persons With Related Conditions –

Section B.(7):

(a) Accidents/Incident Reports: A record of each accident and/or incident, involving clients, staff or visitors, occurring in the facility or on the facility grounds shall be retained. Accidents/Incidents resulting in death or serious injury shall be reported in writing to the Division of Health Licensing within 10 days of the occurrence.

(b) Serious injuries shall be considered as, but not limited to fractures of major limbs or joints, severe burns, severe lacerations, severe hematomas, and suspected abuse.

All accidents/incidents shall be reviewed, investigated if necessary and evaluated in accordance with facility policy.

R61-16, Standards for Licensing Hospitals and Institutional General Infirmaries –

Section 206.2. Accident and/or Incident Report: A record of each accident and/or incident occurring in the facility, including medication errors and adverse drug reactions, shall be retained. Incidents resulting in death or serious injury, e.g., a broken limb, shall be reported, in writing, to the Division of Health Licensing within ten days of the occurrence.

R61-17, Standards for Licensing Nursing Homes –

Section B.(7):

(a) Accidents/Incident Reports: A record of each accident and/or incident, involving residents, staff or visitors, occurring in the facility or on the facility grounds shall be retained. Accidents/Incidents resulting in death or serious injury shall be reported in writing to the Division of Health Licensing within 10 days of the occurrence.

(b) Serious injuries shall be considered as, but not limited to fractures of major limbs or joints, severe burns, severe lacerations, severe hematomas, and suspected abuse.

(c) All accidents/incidents shall be reviewed, investigated if necessary and evaluated in accordance with facility policy.

R61-24, Standards for Licensing Midwives –

Section P.4. Reporting Requirements

b. Special Reports. When any of the emergency measures listed in Section N. are utilized, a special report must be filed with the quarterly report to the Department, describing in detail the emergency situation, the measure(s) taken, and the outcome.

Section N. Emergency Measures.

The midwife must be able to carry out emergency measures in the absence of medical help. S/he must be trained to deal effectively with those life-threatening complications most likely to arise in the course of childbirth.

1. Examples of emergency situations are:
    a. Respiratory or circulatory failure in mother or infant;
    b. Postpartum hemorrhage;
    c. Cord prolapse;
    d. Tight nuchal cord;
    e. Multiple births and malpresentations;
    f. Shoulder dystocia;
    g. Gross prematurity or intra-uterine growth retardation;
    h. Serious congenital anomalies.

2. Examples of emergency measures are:
    a. Episiotomy;
    b. Intramuscular administration of Pitocin for the control of postpartum hemorrhage.

R61-75, <u>Standards for Licensing Day Care Facilities for Adults</u> –

Section F.3.(d) Incident and Accident Reports: A record of each accident or incident occurring in the facility shall be prepared immediately. Accidents resulting in serious injury or death shall be reported, in writing, to the Department within 10 days of the occurrence.

R61-78, <u>Standards for Licensing Hospices</u> –

Section 601.

A. A record of each incident and/or accident, including the use of mechanical / physical restraints, and medication errors involving patients or staff members/volunteers, in the hospice facility or on the hospice facility grounds, shall be prepared and retained.

    1. Incidents/Accidents resulting in unexpected death or inpatient hospitalization shall be reported via telephone to the next-of-kin or responsible party immediately and in writing to the Department's Division of Health Licensing within 10 days of the occurrence.
    2. Incidents/Accidents shall be considered as, but not limited to: fractures of major limbs and joints, severe burns, severe lacerations, severe hematomas, and actual/suspected abuse/neglect/exploitation if patients.

B. Reports shall contain at a minimum: hospice name, patient age and sex, date of incident/accident, location, witness names, extent/type of injury and how treated, (e.g., hospitalization), identified cause of incident/accident, internal investigation results if cause unknown, and the date of the report.

C. Incidents where patients have left the premises of the hospice facility without notice to staff members/volunteers of intent to leave and have not returned within 24 hours shall be reported to the next-of-kin or responsible party and to local law enforcement immediately. When patients who are cognitively impaired leave the premises without notice to staff members/volunteers law enforcement, and next-of-kin shall be contacted immediately upon discovery of the patient's absence. The Division of Health Licensing shall be notified not later than 10 days of the occurrence.

D. Medication errors and adverse medication reactions shall be reported immediately to the next-of-kin or responsible party, prescriber, emergency contact, and other personnel as required by agency policy.

R61-84, <u>Standards for Licensing Community Residential Care Facilities</u> –

Section 601.A.:

A. A record of each incident and/or accident, including usage of mechanical/physical restraints, involving residents or staff members/volunteers, occurring in the facility or on the facility grounds, shall be retained.

1. Incidents/accidents and/or serious medical conditions as defined below and any illness resulting in death or inpatient hospitalization shall be reported via telephone to the next-of-kin or responsible party immediately and the sponsoring agency at the earliest practical hour, but not to exceed 12 hours of the occurrence, and in writing to the Department's Division of Health Licensing (DHL) within 10 days of the occurrence.

2. Serious medical conditions shall be considered as, but not limited to: fractures of major limbs or joints, severe burns, severe lacerations, severe hematomas, and actual/suspected abuse/neglect/exploitation of residents.

B. Reports shall contain at a minimum: facility name, resident age and sex, date of incident/accident, location, witness names, extent/type of injury and how treated, (e.g., hospitalization), identified cause of incident/accident, internal investigation results if cause unknown, identity of other agencies notified of incident/accident and the date of the report.

C. Incidents where residents have left the premises without notice to staff members/volunteers of intent to leave and have not returned to the facility within 24 hours, shall be reported to the next-of-kin, sponsoring agency or any agency providing services to the resident and local law enforcement immediately. When residents who are cognitively impaired leave the premises without notice to staff members/volunteers, regardless of the time-period of departure, law enforcement, next-of-kin, and sponsoring agency shall be contacted immediately. DHL shall be notified not later than 10 days of the occurrence.

D. Medication errors and adverse medication reactions shall be reported immediately to the next-of kin or responsible party, prescriber, supervising staff member, and administrator, and no later than 12 hours, as applicable, to the sponsoring agency, and recorded in the resident record.

E. Changes in the resident's condition, to the extent that serious health concerns, e.g., heart attack, are evident, shall be reported immediately to the attending physician and the next-of-kin/responsible party, and no later than 12 hours afterwards to the administrator and the sponsor. (I)

R61-91, Standards for Licensing Ambulatory Surgical Facilities –

Section 601:

A. A record of each accident and/or incident, involving patients or staff members, occurring in the facility or on the facility grounds, shall be retained.

1. Serious incidents/accidents and/or medical conditions as defined below and any illness resulting in death or inpatient hospitalization shall be reported via telephone to the next-of-kin or responsible party immediately and in writing to the Department's Division of Health Licensing within 10 days of the occurrence.
2. Serious medical conditions shall be considered as, but not limited to: major permanent loss of function, hemolytic transfusion reaction involving administration of blood or blood products, surgery on the wrong patient or wrong body part, fractures of major limbs or joints, severe burns, lacerations, or hematomas, and actual or suspected abuse or mistreatment of patients.

B. Reports made to the Division of Health Licensing shall contain at a minimum: facility name, patient age and sex, date of incident/accident, location, extent/type of injury, and how treated, e.g., hospitalization.

C. Significant medication errors and significant adverse medication reactions that require intervention shall be reported immediately to the patient or next-of-kin or responsible party, prescriber, supervising staff member, and administrator. Significant medication errors and significant adverse medication reactions shall be considered as: unintended, undesirable, and unexpected effects of prescribed medications, or of medication errors that require discontinuing a medication or modifying the dose; require hospitalization; result in disability; require treatment with a prescription medication; result in cognitive deterioration or impairment; are life-threatening; or result in death.

D. Changes in the patient's condition, to the extent that serious health concerns are evident, e.g., heart attack, shall be reported immediately to the attending physician, the next-of-kin or responsible party, and the administrator. (I)

R61-93, Standards for Licensing Facilities That Treat Individuals For Psychoactive Substance Abuse or Dependence –

Section 601.:

A. A record of each accident and/or incident, including usage of physical restraints, involving clients or staff/volunteers, occurring in the facility or on the facility grounds shall be retained.

1. Incidents/accidents and/or serious medical conditions as defined below and any illness resulting in death or inpatient hospitalization shall be

reported via telephone to the next-of-kin or responsible party at the earliest practicable hour, but not to exceed 24 hours of the occurrence, and in writing to the Department's Division of Health Licensing (DHL) within 10 days of the occurrence.

2. Serious medical conditions shall be considered as, but not limited to: fractures of major limbs or joints, severe burns, severe lacerations, severe hematomas, and actual/suspected abuse/neglect/exploitation of clients.

B. Reports shall contain at a minimum: facility/program name, client age and sex, date of incident/accident, location, witness names, extent/type of injury and how treated, e.g., hospitalization, identified cause of incident/accident, internal investigation results of cause unknown, identity of other agencies notified of incident, and the date of the report.

C. Medication errors and adverse medication reactions shall be reported immediately, as applicable, to the prescriber, supervising nurse, pharmacist, and administrator and recorded in the client record.

D. In medical detoxification facilities only, incidents where clients have left the premises without notice to staff/volunteers of intent to leave and have not returned to the facility within 24 hours, shall be reported to DHL, next-of-kin, responsible person, and, if there is evidence that the client may be a danger to himself or others, local law enforcement.

E. In 24-hour facilities, changes in the client's condition to the extent that serious health concerns, e.g., heart attack, are evident, shall be reported immediately to the attending physician, and no later than 12 hours to the next-of-kin/responsible person and administrator.

F. In NTP facilities, premature or stillborn births to clients shall be reported in writing to DHL within 10 working days.

R61-97, <u>Standards for Licensing Renal Dialysis Facilities</u> –

Section 310. A record of each accident or incident occurring in the facility, including medication errors and adverse drug reactions shall be prepared immediately. Accidents resulting in serious injury or death shall be reported, in writing, to the licensing agency within 10 days of the occurrence.

Accidents or incidents that must be recorded include but are not limited to:

1. Those leading to hospitalization;
2. Those leading to death;
3. Use of wrong dialyzer on patient;
4. Blood spills of more than 75 ml;
5. Hemolytic transfusion reactions;
6. Reactions to dialyzers.

R61-102, Standards for Licensing Birthing Centers For Deliveries By Midwives –

Section C.4. Administrative Records: The following essential documents and references shall be on file in the administrative office of the facility:

h. A record of each accident or incident occurring in the facility.

R61-103, Standards For Licensing Residential Treatment Facilities For Children And Adolescents –

Section C.(4) Administrative Records: The following essential documents and references shall be on file in the administrative office of the facility:

(h) a record of each accident or incident occurring in the facility, including medication errors and drug reactions. Incidents resulting in hospitalization or death shall be reported in writing to the Department within 10 days.

R61-109, Standards for Permitting Body Piercing Facilities –

Section 601

A. A record of each accident and incident involving clients or technicians occurring in the facility shall be retained. Incidents or accidents resulting in serious medical conditions, *e.g.*, lacerations, hematomas, actual or suspected abuse of clients by technicians, *etc.*, in which the client is hospitalized, shall be reported via telephone to the next-of-kin or responsible person at the earliest practicable hour, but not to exceed 24 hours of the occurrence, and in writing to the Department's Division of Health Licensing (DHL) within 10 days of the occurrence.

B. Reports shall contain at a minimum: facility name, technician name, client age and sex, date of incident or accident, location, witness names, identified cause of incident or accident, extent and type of injury and how treated, *e.g.*, hospitalization, and the date of the report.

R61-111, Standards for Licensing Tattoo Facilities –

Section 701.:

A. A record of each accident and incident involving clients, or staff occurring in the facility shall be retained. Incidents or accidents resulting in serious medical conditions, *e.g.*, lacerations, hematomas, actual or suspected abuse of clients by staff, in which the client is hospitalized, shall be reported via telephone to the next-of-kin or responsible person at the earliest practicable hour, but not to exceed 24 hours of the occurrence, and in writing to the Department's Division of Health Licensing within 10 days of the occurrence.

B. Reports shall contain at a minimum: facility name, staff member name, client age and sex, date of incident or accident, location, witness names, identified cause of incident or accident, extent and type of injury and how treated, *e.g.*, hospitalization, and the date of the report.

Attachment 2

ACCIDENT/INCIDENT REPORT
(Attach additional pages if necessary to provide full report)

Facility/Program Name: _____

Individual's Age: ____ Sex: _____ Date and Time of the Incident: _____

Specific location of the incident: _____

Incident witnessed by staff ____ other client/patient/resident _____ visitor _____

Names of Witnesses: _____
_____
_____

Describe the incident and injury: _____
_____
_____
_____
_____
_____

What caused the incident? If undetermined, summarize action to determine cause and investigative conclusions: _____
_____
_____
_____
_____
_____

At the time of this report, the investigation has not been concluded; investigative results will be forwarded: _____ (Check if applicable)

Was the responsible party notified? _____ Date/Time _____

Was the individual hospitalized? _____

Was the incident reported to other agencies with oversight of the facility/program such as law enforcement, Ombudsman, etc.? _____ Date/Time: _____

_____ _____
Signature and Title of Person Making Report Date