Incident Identification and Notifications in Aging Services

A SYSTEMS THINKING APPROACH

Written by
Victor Lane Rose, MBA, NHA, FCPP, CPASRM, Director, Aging Services
Scott R. Lucas, PhD, PE, Director, Accident and Forensic Investigation
Josi Wergin, CPHRM, CPASRM, ELS, Risk Management Analyst
When an incident occurs in aging services, the very first steps taken—including identifying the incident, caring for the people affected, making an initial determination of severity, and conducting internal and external notifications—are critical. But incident management plans often do not adequately account for these steps and the myriad challenges that can arise in both routine and unusual circumstances.

For example, failure to promptly identify that an incident has happened and notify appropriate people, internally and externally, may exacerbate harm to individuals or damage to objects or property affected by the initial incident, lead to injury of others if hazards are not quickly addressed, and hinder fact collection and device sequestration (when applicable), potentially impeding investigation and analysis or abrogating legal protections. Similarly, having inadequate protocols and readily available supplies to provide immediate care for affected individuals, including staff and visitors, can worsen injuries and outcomes.

The following hypothetical scenarios illustrate the harm that can result when these seemingly simple tasks are missed or inadequately performed:

- **A stylist slips and falls while working in a community’s salon.** She glances at the floor but sees nothing amiss, concluding that her slippery shoes were to blame. She feels a bruise coming on but is otherwise unhurt, so she doesn’t report the incident. A few hours later, a resident slips and falls in the same spot, breaking his hip. A closer look reveals a small amount of hair product on the floor.

- **On a Friday afternoon, staff discover that a resident has signs of influenza-like illness but do not notify the supervisor.** The resident continues to eat meals in the dining room, and the resident’s physician is not contacted until Monday. Other residents begin to show signs of respiratory illness, some mild and some severe. As the care needs of the resident population increase because of the outbreak, fewer staff are available to provide care as they fall ill, too.

- **A resident goes missing but is found and taken to the hospital.** A nurse fills out an electronic incident report but waits to verify certain facts before clicking “Submit.” Although the system would automatically notify administrative personnel on submission, the nurse forgets to submit the report. The resident dies at the hospital. As the day shift arrives the next morning, a local TV news crew is set up outside the building, talking about the resident’s death and asking employees about the incident.

When these errors in process occur, residents, families, and the surrounding community may view the resulting problems as stemming from lack of care about persons served and an inability to fulfill duty-of-care obligations. By contrast, the ability to quickly identify an incident, make an initial determination of its severity, conduct timely notifications, and implement the appropriate response shows the level of importance the organization places on the safety of all persons served, those who provide care and services, and visitors.

This white paper provides guidance from a systems thinking perspective for operationalizing practices to identify incidents and conduct internal and external notifications.
What Is Systems Thinking?

The systemic approach to management, also called a systems thinking approach, focuses on two fundamental concepts. The first concept is that “a whole is more than the sum of its parts.” The interactions between the things that make up a system are just as important as the individual parts in fulfilling an organization’s mission and purpose. It also suggests that the whole possesses characteristics that none of the parts individually possess. It has everything to do with organization design: individual positions to teams to departments, the processes that connect them, and the alignment of systems inside and outside the organization. This means that all parts are important to fulfilling a system’s purpose. It also means that removed from the system, a part loses its purpose and the system behaves differently.

The second concept is the development ethic. This concept says that every individual in the system should be encouraged to develop and use his or her fullest positive potential for the benefit of the person and the organization. “The inputs required to do this are a reasonable salary, access to required and desired learning, a managerial system that treats them fairly and encourages development, and a work environment that does not hamper their efforts.” (Roth)

Organizations that incorporate a systems thinking approach share four key characteristics:

1. **True participation.** All employees affected by a decision have some level of input into that decision.
2. **Full integration.** This characteristic recognizes the reality of the whole; therefore, activities are coordinated on all levels and between all levels.
3. **Ongoing learning.** The organization’s activities and processes support and reward continual learning for all employees, which also contributes to the ongoing learning of the system.
4. **Ongoing feedback and continuous improvement.** The organization has processes that allow it to adapt fluidly to changing internal and external environments.

By using a systems thinking approach, leaders can better understand behaviors of the organization and increase their effectiveness in achieving the organization’s goals and fulfilling its purpose. This includes recognizing older adults as stakeholders. By thinking in terms of parts, processes, and alignment, organizations can create shift-by-shift care environments that promote safety and quality of life for all involved, including the organization itself, and fluidly adapt and improve.


Immediate Response and Notifications in Context

Immediate identification, severity determination, response, and notifications are time-sensitive and critical because they set everything else in motion. Figure 1. Overall Postincident Response Process illustrates the many elements of postincident response in three phases. Immediate identification, severity determination, response, and notifications—the topics addressed in this white paper—occur in Phase I.

Postincident response is both ongoing and complex. Depending on the incident, the total process can occur over a long period of time. It comprises a series of identifications, evaluations, decisions, internal and external notifications and reports, communications, analyses, monitoring, and ultimately changes to care, delivery, and systems. Postincident response activities do not always occur sequentially—one step might not be completed before the next begins—and several tasks and activities can occur at the same time. Figure 2. Postincident Response Algorithm maps the events and processes that make up the postincident response, including but not limited to elements that are important to conduct during Phase I. The algorithm in Figure 2 is an example; individual organizations’ algorithms will look and behave differently
Incident Identification and Notification of Supervisor

Incident identification refers to gaining awareness that an event has occurred and that the event meets the definition of an incident type within the organization. A strong culture of safety helps staff develop a sense of watching for incidents and feeling responsible for taking immediate action. The ability to identify occurrences that are incidents and to know whom to notify in a timely manner requires continuous communication, training, and retraining.

The individual who witnesses or discovers the incident should attend to the resident to the extent their licensure and training allow, make the initial notification to a supervisor, and later contribute to the internal incident report. Giving frontline staff responsibility and accountability for resident safety is empowering (Sankaranarayanan et al.). All employees, nonemployed professional staff, volunteers, visitors, and residents should be encouraged to report incidents and near misses. For organizations with multiple locations, organizational notification and reporting responsibilities extend to off-site facilities and treatment locations (e.g., home health agencies, hospices).

It is important to avoid confusing the timely notification of a direct supervisor regarding an incident with the more extensive process of internal and external notification. An organization’s postincident response practices must address both.

The first elements of postincident response include several crucial tasks, many of which often overlap in practice:

- Identify an incident.
- Address immediate care and safety needs of those involved.
- Immediately notify the appropriate direct supervisor that an incident has occurred.
- Gather and verify basic facts about the incident (e.g., names of those affected, injuries and condition, time and location of the incident, time the incident was identified, how the incident was identified, witnesses).
- Complete, sign, and submit an internal incident report.
- Make an initial determination of the severity of the incident.
**Figure 2. Postincident Response Algorithm**

- Notification within 24 hours

---

**Immediate notification**

- Report initiated by individual who discovers, witnesses, or is notified of event
- Review report and severity determination
- Review initial investigation findings
- Report to insurer, if applicable
- Report to local legal counsel, if applicable
- Track and trend with corporate data

---

**Supervisor, department head**

- Participate in root-cause analysis/system redesign
- Implement organization-wide performance improvement recommendations
- Communicate lessons learned throughout organization
- Manage ongoing claims

---

**Risk/quality management (campus)**

- Review and analyze incident report
- Review initial investigation findings
- Verify or modify severity determination
- Facilitate ongoing internal notifications
- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications
  - Departmental supervisor and administrator
  - Risk manager
  - Other departmental managers as necessary
- Conduct immediate external notifications
  - Attending physician
  - Family or responsible party
  - Authorities or agencies as applicable
- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications
- Conduct immediate external notifications
- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications

---

**Corporate risk management**

- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications
- Conduct immediate external notifications
- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications
- Conduct immediate external notifications
- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications

---

- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications
- Conduct immediate external notifications
- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications
- Conduct immediate external notifications
- Attend to care, safety, and well-being of those involved
- Conduct immediate internal notifications

---

*Serious events reported immediately to supervisor and risk manager*
Incident Identification and Notifications in Aging Services

RISK TIP

Make the initial severity determination carefully. Initially under- or overestimating severity can adversely affect all subsequent postincident response steps and undermine trust with residents, families, staff, authorities, the public, and others.

Initial Determination of Severity

Based on predetermined factors, the direct supervisor or department supervisor must make an initial determination of the severity of the incident. When creating policies and guidelines, severity should be used as a primary factor to determine the degree and scope of ongoing postincident response. To help staff develop an initial determination of severity, answers to the following questions often help:

— Was there injury or death? Did the incident have potential to cause injury or death?
— How many people were adversely affected by the incident?
— Was there need for transfer to another provider for further assessment or treatment?
— Does the incident necessitate reporting to regulatory agencies?
— Does the incident necessitate reporting to authorities?
— Did the incident involve other nonroutine factors, such as the involvement of media?

The sample tool Internal Adverse Event Reporting Policy, available to Continuing Care Risk Management (CCRM) members on the CCRM member website, includes an example set of severity categories that organizations can use or adapt. Including certain thresholds of severity that are fairly concrete and easy to ascertain early on in postincident response can clarify incident notification requirements within the organization.

External notification or reporting requirements may be based on severity as defined by the entity requiring notification or reporting, which may or may not align with severity criteria as defined in internal policies. Alternatively, external requirements may be based on factors such as incident type (e.g., suspected crime) rather than severity. Any incident that requires external notification or reporting, even if it does not otherwise meet severity criteria as outlined in internal policies, should also trigger internal notifications at the facility and corporate level.

Internal and External Notification

Supervisors and frontline managers must decide the appropriate levels of internal and external notification. Factors that may affect this determination include the nature of an incident, the severity including the degree of actual or potential harm, the potential for other negative outcomes, and external requirements. Within the organization, notification about an incident should go up the chain of command. External notification means providing notification to appropriate parties about the incident, including emergency services personnel, primary care physicians, police or other indicated authorities, families, and regulatory agencies as needed or required.

The internal and external notification process differs from completing an incident report and from ongoing communication. Notifications, whether conducted in person or by phone, email, or automated process, inform appropriate individuals that an incident has occurred. They also provide basic facts about the incident to drive ongoing response and about the status and well-being of people involved in the incident. By contrast, incident reports collect, record, and communicate information about the incident, and ongoing communication provides continual updates to vested parties throughout the postincident process.

Timing of notifications is care-critical. Even if all appropriate individuals, groups, and agencies are notified and in the proper order, delays in timing can contribute to negative outcomes. The order of notification is also important. Notification should occur in a sequence that focuses first on the well-being of those affected by the incident and prevention of additional harm. This includes preventing harm to others by implementing interim actions to prevent the incident from immediately recurring.

The organization should document the times notifications are made. For example, it is critical to record the time the organization notified the state agency. This can help show that the organization met notification deadlines. Well-documented
notification times may also support a defense argument showing that the organization took timely steps to address a situation. In addition, when notifying or reporting to families or other external entities, explaining which initial steps for well-being and safety were taken, and which individuals were contacted (e.g., primary care physician, risk manager, administration), can convey a strong sense of reassurance and transparency about the incident, helping to protect trust. Anticipating questions and preparing accurate answers for the people being notified is another important part of the process, which helps to convey a sense of reassurance and confidence.

Failures to complete notifications in a timely manner can prevent or delay necessary organizational response from others, increasing harm for all involved. Notification failures can:

— Allow further harm to those affected by the incident due to delay in treatment
— Allow others to be harmed in a similar manner
— Delay engagement of quality assurance and performance improvement processes, potentially eroding protections against discovery
— Introduce doubt about the integrity of the organization’s postincident response practices
— Open the organization to a variety of regulatory deficiencies and even reputational harm

Finally, it is important to acknowledge that the initial steps of postincident response, including initial internal and external notifications, are often managed by one person initially—typically the supervisor on duty who receives first notification about the incident. In addition to postincident responsibilities, this person often has other care-critical supervisory and care-coordination duties. Effective notification intends to activate appropriate organizational response to assist those persons on duty in the right measure and at the right time.

**Immediate Internal Notifications**

Internal notifications are those that occur within an organization as part of an organization’s postincident response process. Based on the severity of the incident, internal notifications should be communicated to the appropriate positions to facilitate decision-making and action for postincident response. For an example of how failures in immediate internal notification contributed to escalation of an incident and resident harm, see “Resident-to-Resident Attack Escalates as Internal Notifications Fail.”

Many provider organizations are implementing internal electronic incident reporting systems that combine the submission of incident reports with automatic electronic notification of internal designees (e.g., director of nursing, administrator, risk manager). However, it is important to acknowledge that the notification process is separate from the incident reporting process. As illustrated in the example at the beginning of this white paper, a failure in electronic incident reporting can cause a failure in notification if the organization does not treat these steps as separate and have redundancies or backups in place.

**Immediate External Notifications**

Certain internal and external notifications often occur simultaneously after an incident. Should the incident warrant external notification, once the internal notification process has begun, the direct supervisor coordinating postincident response often begins making external notifications during the same period of time. Procedures or protocols should identify who may conduct each type of external notification, and these staff members should be trained in conducting such notifications.

Laws, insuring agreements, or other requirements may mandate reporting of certain circumstances, such as the following:

— Suspected elder abuse
— Suspected crimes
— State adverse event reporting requirements
— Medical device reporting
— Public health surveillance (e.g., infectious disease outbreaks)
— Worker illness and injury reporting
— Required reporting to accreditors
— Required reporting to insurers
— Required reporting to licensing boards or the National Practitioner Data Bank

Not all of these circumstances need to be reported immediately, and not all apply to aging services organizations themselves—for example, some may apply only to physicians or licensed healthcare personnel. However, aging services organizations should determine which reporting requirements apply to them, their medical directors, or their staff and the required timeframes for reporting. The organization should also determine timeframes for permissive reporting (e.g., to a
Resident-to-Resident Attack Escalates as Internal Notifications Fail

After a nursing home resident who was admitted after a psychiatric hospitalization attacked his roommate, the U.S. Department of Health and Human Services’ Departmental Appeals Board (DAB) upheld nearly $700,000 in penalties against the facility.

The resident had dementia, depression, and other behavioral concerns but was physically strong. He had been living in an assisted-living facility, then spent time in a geriatric psychiatric hospital unit before transfer to the nursing home. The roommate had severe cognitive impairment, was partially paralyzed and had muscle weakness, took anticoagulants, and had several other medical conditions.

On December 18, 2014, staff discovered bruising on the roommate’s shoulders and scratches on the resident’s neck. The facility reported the injuries to the state agency, stating that it could not determine the cause of the roommate’s bruising. Its report also stated that it examined all residents and found no other unexplained injuries, without mentioning the scratches on the attacking resident’s neck.

In the early morning hours of January 1, 2015, a certified nursing assistant (CNA) found the resident by the roommate’s bed, pulling on the privacy curtain and bed linens. When the CNA tried to persuade the resident to return to his bed, the resident scratched the CNA’s neck. The CNA left the residents alone in the room together, then told a licensed practical nurse (LPN) at the nurse’s station about the attack. The LPN told the CNA to tell his supervisor. The CNA found his supervisor, another LPN, smoking outside. While they both smoked on the porch, the LPN at the nurse’s station heard yelling and went to the residents’ room. She saw the resident leaning over the roommate and biting his neck and shoulders. The resident was naked, and his mouth was bloody. Staff separated the two and took the roommate to the hospital for treatment. The attacking resident stayed in the room and was discharged later that day. The supervising LPN completed an incident and investigation report, but the facility did not report this event to the state agency, reasoning that it did not need to do so because the resident was not capable of intentional abuse.

A complaint survey cited eight deficiencies at the immediate-jeopardy level related to the alleged attacks. The Centers for Medicare and Medicaid Services assessed civil monetary penalties totaling $687,350, including a penalty of $7,850 per day for 85 days of immediate jeopardy and $300 per day for 67 days for noncompliance below the immediate-jeopardy level. An administrative law judge upheld the sanctions. The facility appealed to DAB.

DAB upheld the citations and penalties, citing several reasons, including notification failures. For example, during the second incident, DAB noted that the supervising LPN left her post without telling the CNAs who reported to her or the LPN who remained at the nurse’s station where she would be. The CNA who was scratched left the resident and roommate alone together for a disputed but substantial time period while he smoked on the porch with his supervisor, and the LPN who was at the nurse’s station did not check on the residents or send anyone else to do so.

DAB also found the facility’s response to the incidents deficient. The supervising LPN’s investigations of both incidents were inadequate and, in many respects, plainly false, DAB noted. The facility also entirely failed to report the second incident to the state agency. Thus, DAB upheld the citations and penalties.

Source: The Bridge at Rockwood, DAB No. 2954 (July 15, 2019)
Incident Identification and Notifications in Aging Services

Contacting a family or emergency contact person with basic and verified facts about the incident and communicating which initial actions have been taken can create a sense of confidence that the safety and well-being of persons involved in the incident are paramount. See “Example Notification of a Family Member” for an example. Conversely, if information turns out to be nonfactual or if important questions and concerns about a loved one or patient go unaddressed, it can lead to misconceptions about the organization, its processes, and its motivations.

The organization’s policies, guidelines, and training must consider many factors when establishing expectations and mapping the organization’s communication pathways for internal and external notification. Staff training and practice should provide guidance for making these decisions, often made difficult by the nature of what must be communicated. It is important to include back-up communication pathways and necessary redundancy, rather than rely solely on automatic electronic notification. If pathways are too sequential, initial or continued notification and response can stop if someone fails to receive notification. Notification should also include closed-loop communication, such as verification of receipt.

It is also imperative to account for federal, state, and local regulatory requirements and laws that address mandatory reporting such as the Elder Justice Act, which establish who must be notified about certain incidents as well as timeframes for notification or reporting. External notification requirements can drive not only what must be reported and when but also earlier steps in the process, such as the timing and content of initial notifications, decision making, and analytical and investigatory steps.

Effective and timely notification processes help to ensure that organizational response to an incident matches the severity of the incident, places appropriate persons on notice that the incident occurred, and mobilizes resources for response to ever-changing postincident circumstances. It can also convey a degree of competence about the organization’s care and services, helping to guard against suspicions about motives and the undermining of trust. Upon completion of necessary measures to protect the well-being and safety for those involved and making appropriate notifications, the assigned staff can then focus efforts on an initial investigation.

Example Notification of a Family Member

Following is an example of an initial notification of a family member—specifically, a phone call from a staff member:

“Hello, Mrs. Jones, this is the charge nurse on duty at XYZ retirement community. I am calling to notify you that your mother experienced a fall within the last 30 minutes. After assessing your mother’s condition and stabilizing her, I informed your mother’s doctor about the incident. At this time, we are concerned about potential injury to her left hip. The doctor has ordered a transfer to XYZ hospital emergency department for further evaluation and to rule out additional injuries. She is scheduled for transport via ambulance in the next 30 minutes, if you would like to meet your mother at the emergency department. In addition, we have notified our director of nursing and our risk manager. As more information is verified, we will continue to update you. I or another member of our nursing or administration team will provide an update by the end of the shift. Do you have any questions at this time? If you have additional questions after this conversation, please call (xxx) xxx-xxxx and ask for me.”
ECRI Resources

Continuing Care Risk Management

- Medical Device Reporting. https://www.ecri.org/components/CCRM/Pages/LegReg5.aspx
- Preventing Abuse, Neglect, and Exploitation of Older and Vulnerable Adults. https://www.ecri.org/components/CCRM/Pages/ResCare1.aspx

Healthcare Risk Control

- Hospital Relations with Police. https://www.ecri.org/components/HRC/Pages/AdSup3.aspx
- Elder Abuse Reporting. https://www.ecri.org/components/HRC/Pages/EmerCare3.aspx

References

- The Bridge at Rockwood, DAB No. 2954 (July 15, 2019).

*Contact clientservices@ecri.org for information on purchasing resources that are not part of your membership.
About ECRI
ECRI is an independent, nonprofit organization improving the safety, quality, and cost-effectiveness of care across all healthcare settings. With a focus on patient safety, evidence-based medicine, and health technology decision solutions, ECRI is the trusted expert for healthcare leaders and agencies worldwide. The Institute for Safe Medication Practices (ISMP) is an ECRI affiliate. Visit ecri.org and follow @ECRI_Org.

www.ecri.org/solutions/aging-risk-management