ADVERSE EVENT: DOCUMENTATION

Documentation of Adverse Event

Needham,Matthew J (BIDMC - Anesthesia Residents)
BIDMC Department of Anesthesia, Critical Care & Pain Medicine

Guide for Clinical Documentation of an Adverse Event

Why

Documentation of the adverse event is essential to;

- Enable planning of appropriate care
- Facilitate learning and reflection
- Provide an accurate record for future investigation

As well as clinical information it should also clearly, and separately, record any conversations that have taken place with the patient and their family.

Who

Documentation should be done by the most involved and knowledgeable member of the health care team who was involved in the incident. Notes in both the OMR and TALIS notes should be confirmed by the responsible attending.

Where

Separate to the RedCap/RL incident reporting process a clear, concise and contemporaneous record should be made either as a note in OMR or on the anesthetic record in TALIS. For deaths in the OR a record should always be made in the intra-operative record.

What to write

The record of the clinical event should include;

- Objective details of the event including date, time and place
- Patient's condition immediately before the event
- Action taken during and after the event
- The patient's response and their subsequent condition
- All other healthcare members notified of the event

What not to write

Any conversations with patient safety or risk management staff should not be included in the medical records. Additionally, the following should be avoided;

- Statements aiming to apportion blame
- Statements that are self-serving and defensive
- Derisive comments about other members of the healthcare team

References

1. BIDMC Safety Event Reporting Policy
2. Responding to adverse events. A consensus statement of the Harvard hospitals 2006
3. BIDMC Patient Death in the OR