SUNY DOWNSTATE MEDICAL CENTER
UNIVERSITY HOSPITAL OF BROOKLYN
POLICY AND PROCEDURE

No: RAD -53

Subject: INCIDENTS AND COMPLIANTS	**Original Issue Date:** 5/2001
Prepared by: Vincent Monte______	**Supersedes:** 3/2013
Reviewed by: Donna McKenzie, EMBA. Tina Riha, PT., DPT., MPA	**Effective Date:** 1/2016
	T.J.C. Standards: EC.02.01.01: The hospital manages safety and security risks. **LD.04.01.01:** The hospital complies with law and regulation. **PI.01.01.01:** The hospital collects data to monitor its performance hospital manages safety and security risks
Approved by: Hyman Schwarzberg, m.D. Harry Zinn, M.D.________________	**Related Policies No. (**RM-1) Incident/ Reporting
	Issued by: Radiology Department

I. PURPOSE

To ensure that there is immediate management of an incident when required and that every incident is appropriately prioritized, investigated and managed

II. DEFINITIONS

Incident: An incident is an event or circumstance which could have, or did result in unintended or unnecessary harm to a person, and or a loss or damage to property.

1. For the purposes of this policy incidents and complaints shall be treated in the same manner. Both shall be referred to as ***"incidents***"
2. Incidents are reported hospital-wide in accordance with UHB policy (RM-1 Incident Reporting)

III. POLICY

Incident and complaints will be reported, documented and maintain completeness of the records. All incidents will be processed, logged, investigated, and corrective action plans that are developed will be implemented

- All incidents must be referred to the supervisor of the division in which the incident occurred.

- The supervisor will investigate the circumstances surrounding the incident.

IV. RESPONSIBILITIES

Division supervisors Radiology Administrator

V. PROCEDURES/GUIDELINES

a. Incident will be recorded on the incident reporting form by the supervisor of the division in which the incident occurred.
   - Department- wide or interdivisional incidents will be referred to the Radiology Administrator.
   - Incidents regarding Radiologists will be referred to the chair of the Radiology Department
b. The patient's name Medical Record number (MR#), location where the incident occurred, the names of all employees involved in the incident and name of the person reporting the incident must be documented in the report.
c. The person filling the incident report will conduct a complete investigation of the incident
d. The action taken and the result of the action must be documented in the report.
e. The supervisor will send the completed Incident Report Form as soon as possible but no later than 48 hours to the Risk Management.
f. The Department of risk management will review the report and finalize the closure of the file
g. The department of Risk Management will maintain all incident reports in a database for reference as needed
h. Incident reporting is confidential and will be used for Peer Review Purposes
i. All incidents will be logged in the "Patient Incident LOG Book" located in each division
j. All incidents will be reported to the Radiology Performance Improvement Committee and recorded in the monthly P.I. Report.

VI. ATTACHMENT

Incident Report Form

VII. REFERENCE

Joint Commission Standard
UHB Policy (RM-1) Incident reporting *http://www.downstate.edu/regulatory/pdf/policies/RM-01.pdf*

Date Reviewed	Revision Required (Check One)		Responsible Staff Name and Title
5/2001	**Yes**		James , shanahan Administrator Radiology
3/2013		**(No)**	
1/2016	**(Yes)**	**No**	Vincent Monte, Associate Director , Radiology
	Yes	**No**	

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