LOG # _____

Hospital

EVENT REPORT FORM

Forward Completed Form to Department Manager

For Risk Management/Quality Improvement Purposes Only

If event involved patient: Patient Name: _____

Age: _____ Sex: M F MR # _____

If event involved visitor: Visitor Name: _____

Address: _____

Phone No: _____

For Employee Injury, complete Employee Incident Report Form.

A. TYPE OF EVENT:

TREATMENT/PROCEDURE:

Blood:
- ___ Infiltration
- ___ Adverse Reaction
- ___ Wrong Patient
- ___ Dispensing Error

___ Patient Identification
___ Deviation from Established Procedure
___ Consent Problem
___ Dietary Problem
___ Omission
___ Delay
___ Unlabeled/Missing Specimen
Other (Explain)

Operating Room
- ___ Cancelled Procedure/Delay
- ___ Consent Missing
- ___ Break in Sterile Technique
- ___ Unanticipated Return to OR
- ___ Incorrect Sponge/Needle Count
- ___ Unanticipated patient injury (burn/lac/reaction)
- ___ Prep Problem
- ___ Other (Explain)

PATIENT ACTIVITIES:

- ___ Assault/Violence/Threat of
- ___ Dissatisfied Patient/Family
- ___ Patient Left Before Care Began
- ___ Patient Left After Care Began – No AMA Form
- ___ Patient Left – AMA Form Completed
- ___ Patient Refusal/Non-medication
- ___ Other (Explain)

PATIENT FALLS:

- ___ Bed
- ___ Bedside Commode
- ___ Chair/Stretcher/Table
- ___ Faint
- ___ Found on Floor
- ___ Rehabilitation Activity
- ___ While Ambulating
- ___ Other (Explain)

Previous Fall? ___ YES ___ NO
Patient attended? ___ YES ___ NO
Bed Position ___ HIGH ___ LOW
Siderails in use? ___ YES ___ NO
Full Rails? ___ YES ___ NO
Half Rails? ___ YES ___ NO
Surface Conditions ___ WET ___ DRY
Other Restraints? ___ YES ___ NO

PATIENT CONCERNS:

___ Billing ___ Service ___ Other

ENTER ADDITIONAL INFORMATION IN SECTIONS E AND F ON REVERSE SIDE OF THIS FORM.

COMMUNICATION/DOCUMENTATION:

- ___ Computer Order Error
- ___ Misfiled Chart/Form
- ___ Reporting of Test Results
- ___ Code of Conduct
- ___ Paging/Phoning
- ___ Other
- ___ Transcription

EQUIPMENT/PRODUCT/DEVICE:

- ___ Care/Maintenance
- ___ Disconnect/Dislodge
- ___ Other
- ___ Not Available
- ___ Tampered With
- ___ Malfunction/Defect
- ___ Improper Use

IF EVENT INVOLVED EQUIPMENT, COMPLETE SECTION J OF THIS FORM AS WELL.

LABORATORY SPECIMEN (For Lab Use Only)

- ___ Improper Labeling
- ___ Improper Specimen
- ___ Incomplete Orders
- ___ Lab Error
  - ___ Sample Mix-up
  - ___ Technical Error
  - ___ Transcription Error
- ___ Phlebotomy Complications
  - ___ Patient Injured (hematoma, etc)
  - ___ Patient Ill (fainting, etc)
- ___ Mislabeled Specimen
- ___ No Requisition
- ___ No Signature/No Date
- ___ No ID Band
- Other Patient ID Problem
- ___ Specimen Transport Problem
- ___ Unlabeled Specimen
- ___ Req/Spec. Mismatch
- ___ Time delay in processing
- ___ Result Reporting Problem

MISCELLANEOUS

___ Ambulating/Other Accident
___ Non-patient threat to staff safety
___ Property Damaged
___ Needle/Sharp Stick (non-employee)
___ Theft/Missing Property
___ Fire
___ Other

B. **IDENTIFICATION (circle one): 1) Inpatient 2) Outpatient 3) Visitor 4) Other**

C. **DATE OF EVENT**_____ **TIME OF EVENT** _____ **(Use military time)**

D. **LOCATION**_____

E. **Brief Objective Description (Factual information only. Note any apparent injuries):**

_____

_____

_____

_____

F. **Brief Subjective Description (PATIENT/VISITOR statement quoted):**

_____

_____

_____

_____

G. **Witness(es):**_____

_____

_____

H. **Immediate corrective action taken:**

_____

_____

_____

I. **Severity of Injury (circle one):**

1) **No apparent Injury** (no injury of any type is noted)
2) **Minor** (injury is temporary and does not cause further complications). Example: abrasion
3) **Major** (Injury is serious, causing considerable discomfort requiring extended treatment of or life threatening)
4) **Death** (use if the patient dies and this may be directly attributable to the incident)
5) **Not applicable**
6) **Unable to determine** (use if impossible to determine the extent of the injury related to the incident.

J. **Safety Devices** If the event involved equipment, write the equipment control/serial number and present location:

_____

Do not discard disposable equipment; save packaging if possible.

Was equipment tagged and removed from service? YES NO Date and time: _____

Was equipment in use on a patient at the time of failure? YES NO

K. **Factual Information of the Patient Event Recorded in Medical Record?** ___Yes ___No ___N/A

L. **Referred for Treatment?** ___Yes ___No ___Refused ___Not Indicated ___Not Applicable

M. **Name of Physician Notified (if applicable:** _____

N. **Date/Time:**_____

O. _____ _____

Signature of Person Reporting Incident **Date**

P. ***For Department Manager Use Only*** - **Briefly describe follow-up investigation :**_____

_____

_____

_____

_____

_____ _____

Department Manager Signature Date

Department Managers: Forward Completed Forms to Quality Management

CONFIDENTIAL – NOT A PART OF PATIENT MEDICAL RECORD

Name of Hospital

Safety Policy

Title: Patient/Visitor Event Reporting
Safety Manual Section I - 11

I. POLICY
It is the policy of Hospital to communicate information via the Event Reporting system to appropriate members of staff regarding unusual events involving patients or visitors that require investigation and/or resolution.

II. PURPOSE
The purpose of this policy is to define the procedure for reporting unusual events such as injuries, falls, procedure and/or treatment errors and equipment errors which affect patients or visitors.

III. DEFINITIONS
Event - a potentially significant incident or event which is inconsistent with the normal or expected operations of the hospital. The potential for injury is sufficient to be considered an event; actual injury need not occur, however.

IV. SCOPE
This policy applies to all staff on all shifts at all locations, including off-site facilities and treatment centers.

V. PROCEDURE
1. Events involving patients and/or visitors will be reported as soon as possible or within 24 hours by the person or persons most directly involved in the event, or by those who observed or discovered the event.

2. The event must be reported on the . Event Report (Attachment A). The information on this report is confidential and duplication of the report is prohibited. These forms are available in all departments, the Safety Manual, the Administrative Personnel Policies Manual and from Quality Management and/or Risk Management.

3. Employee/volunteer accidents/illnesses/injuries should be reported via the Employee Incident Report form (see Administrative Personnel Policy Manual Section VII #17). Employee incidents related to property loss will be reported to Facilities Services.

4. The employee or employees involved in, observing, or discovering the event is responsible for initiating the Event Report.

A. An event which is of a sensitive or urgent nature should be reported verbally to the employee's department manager who will communicate it to Quality Management.

B. Unusual events relating to patients or visitors will be reported using the Event Report form.

i. The report will be completed legibly and objectively, without extraneous comment, personal opinion or conjecture.

ii. Employees will refrain from discussing any event with or in the presence of employees, patients, visitors or others outside the hospital. Refer to the Confidentiality Policy (Administrative Personnel Policy Manual Section VII #28).

5. The department supervisor and/or manager will receive and review all Event Report forms generated by his/her staff.

6. Follow-up investigation taken by the department supervisor and/or manager at the time he/she first receives the Event Report form will be noted on the form.

7. After review and initial investigation by the department manager, forward all Event Reports to the Director of Quality Management. Forward all Event Reports received, regardless of apparent significance of patient outcome.

8. Further follow-up investigation, as deemed necessary, will be conducted by Quality Management and/or Risk Management in cooperation with unit/department management and staff.

9. As necessary and appropriate, significant findings, conclusions, actions and recommendations will be communicated to Hospital Administration and the Board of Directors through established mechanisms.

Approved: _____ _____

Presid