INCIDENTS and SERIOUS EVENTS

CHART

EVENT REPORT FORM

Patient Safety/Risk Management Only
□ **Serious Event***
□ **Incident**
□ **Infrastructure Failure* (use other form)**
□ **Other**
PA-PSRS# _____

***Confirmation date:** _____/____/____

Name, MR# and Date of Birth of person involved

DIAGNOSIS AND/OR PROCEDURE AT TIME OF EVENT _____

Attending Physician: _____ **Advised** ☐Yes ☐No **Date of event** ___/___/___ **Time (military)** _____

Dept/Unit: _____ **Location of event:** _____

Age: _____**Years** **Gender:** _____ **Type of Outcome/Injury:** _____

_____**Months** (*if under 2 years*) **Status:** ☐Inpatient ☐Outpatient ☐Clinic Patient ☐ED patient ☐Swing Bed ☐Visitor

_____**Days** (*if under 1 month*) ☐Location/Person Not Applicable ☐Other (specify) _____

How was this event discovered? (Check all that apply)**:**

☐Assessment after event ☐Report by family or visitor ☐Report by patient ☐Report by resident, fellow, or student
☐Report by staff member ☐Review of record or chart ☐Witnessed/Involved

HARM SCORE: ☐**N/A**

Incident (No Harm):
☐A Circumstances that could cause adverse event
☐B-1 No harm: did not reach pt. because of chance alone
☐B-2 No harm: did not reach pt. because of active recovery
☐C No harm: reached patient
☐D Monitoring required to confirm no harm

Serious Event (Harm or Death):
☐E Temporary harm requiring treatment or intervention
☐F Temporary harm requiring increased LOS
☐G Permanent harm
☐H Near-death event
☐I Death

BRIEF FACTUAL DESCRIPTION OF EVENT (*Facts, no opinions*)**:** _____

Did event result in new orders for treatment by physician? ☐Yes ☐No. **If yes, describe patient's treatment:** _____

Individual preparing report: (*print name*) _____ **Dept** _____ **Date of report** ___/___/_____

Did Health IT cause or contribute to this event? ☐Yes ☐No ☐Unknown

Which Health IT Systems Cause or Contributed to the Event? (See page 2 of the Infrastructure Failure form for options)
Administrative/Billing or Practice Management System: _____
Electronic health record (EHR) or component of EHR: _____
Miscellaneous: _____

HIT Contributing Factors: (See page 2 of the Infrastructure Failure form for options)
Equipment/Device function: _____
Ergonomics, including human/device interface issue: _____
Miscellaneous: _____

Device Identifier(s):
Device/Application Name: _____ **Manufacturer:** _____

COMPLICATION OF PROC/TX/TEST

□ **Anesthesia event**
◊ Aspiration
◊ Cardiopulmonary arrest
◊ Death
◊ Intubation trauma
◊ Myocardial infarction
◊ Stroke
◊ Use of reversal agents (Not neuromuscular blockers)
◊ Other (specify)_____
□ **Cardiopulmonary arrest outside ICU**
□ **Catheter or tube problem**
□ **Complication following spinal manipulative therapy**
□ **Complication following surgery or invasive procedure**
◊ Acute renal failure
◊ Cardiopulmonary arrest
◊ Death
◊ Deep venous thrombosis (DVT)
◊ Intravascular air embolism
◊ Myocardial infarction
◊ Pneumothorax
◊ Pulmonary embolism (PE)
◊ Removal of tube or other medical device by patient
◊ Stroke or other neurologic deficit
◊ Unplanned return to OR
◊ Unplanned transfer to ICU
◊ Wound dehiscence
◊ Other (specify)_____
□ **Emergency Department**
◊ Discrepancy between ED interpretation of X-ray/EKG and final reading
◊ Left before visit completed
◊ Left without being seen
◊ Patient in 302 process eloped with injury
◊ Unplanned return to ED within 48 hours requiring admission
◊ Other (specify)_____

COMPLICATION OF PROC/TX/TEST

□ **Extravasation of drug or radiologic contrast** Medication_____
□ **Healthcare Acquired Infection**
◊ Antibiotic-associated diarrhea
◊ Antibiotic resistant organism
◊ Intravascular catheter infection
◊ Healthcare-associated pneumonia
◊ Sepsis 48 hours post-admission
◊ Urinary tract infection (UTI)
◊ Wound or surgical site infection
◊ Other (specify)_____
□ **IV site complication** (phlebitis, bruising, infiltration)
□ **Maternal complication**
◊ Death
◊ DVT (Deep Venous Thrombosis)
◊ Infection
◊ Intrapartum fetal death
◊ PE (Pulmonary Embolism)
◊ Seizure
◊ Unanticipated blood transfusion
◊ Unplanned transfer to ICU
◊ Uterine rupture
◊ Other (specify)_____
□ **Neonatal complication**
◊ Apgar < 5 at 5 minutes
◊ Birth injury or trauma
◊ Neonatal death
◊ Undiagnosed or untreated hyperbilirubinemia
◊ Unplanned transfer to NICU
◊ Other (specify)_____
□ **Onset of hypoglycemia during care**
□ **Other (specify)**_____

ERROR REL. TO PROC/TX/TEST

□ **Dietary**
◊ Foreign body in food
◊ Incorrect diet
◊ NPO patient given food
◊ Patient allergy to diet
◊ Other (specify)_____

ERROR REL. TO PROC/TX/TEST

□ **Laboratory test problem**
◊ Mislabeled specimen
◊ Result missing or delayed
◊ Specimen delivery problem
◊ Specimen label incomplete/missing
◊ Specimen quality problem
◊ Test ordered, not performed
◊ Test not ordered
◊ Wrong patient
◊ Wrong result
◊ Wrong test ordered
◊ Wrong test performed
◊ Other (specify)_____
□ **Radiology/imaging test problem**
◊ Delay in scheduling
◊ Film unavailable/inadequate
◊ Incorrect reading
◊ MRI safety violation
◊ Not completed
◊ Not ordered
◊ Ordered, not performed
◊ Report unavailable/delayed
◊ Unanticipated radiation exposure
◊ Wrong patient
◊ Wrong procedure
◊ Wrong side (L vs. R)
◊ Wrong site
◊ Other (specify)_____
□ **Referral/consult problem**
◊ Delay in scheduling
◊ Delay in service
◊ Report unavailable/delayed
◊ Other (specify)_____
□ **Respiratory care**
◊ Medical gas problem
◊ Missed treatment
◊ Self/unplanned extubation
◊ Unplanned/emergent intubation following procedure/treatment/test
◊ Ventilator alarms inaudible
◊ Ventilator alarms not set properly
◊ Ventilator settings wrong/changed without authorization
◊ Other (specify)_____

ERROR REL. TO PROC/TX/TEST

□ **Surgery/invasive procedure problem**
◊ Break in sterile technique
◊ Consent missing/inadequate
◊ Count incomplete/not performed
◊ Count incorrect – Equipment
◊ Count incorrect – Needles
◊ Count incorrect – Sponges
◊ Foreign body in patient
◊ ID missing/incorrect
◊ Preparation inadequate/wrong
◊ Procedure cancelled/not perform
◊ Procedure delayed
◊ Procedure not completed
◊ Procedure not ordered
◊ Unintended laceration or puncture
◊ Wrong patient
◊ Wrong procedure
◊ Wrong side (L vs. R)
◊ Wrong site
◊ Other (specify)_____
□ **Other (specify)**_____

SKIN INTEGRITY

□ **Abrasion**
□ **Blister**
□ **Burn** (electrical, chemical, thermal)
□ **Laceration/cut**
□ **Pressure Injury (PI)**
How many pressure injuries? ____
Assessed for PI risk prior to developed:
□*Yes* □*No* □*Unknown*
Were PI interventions implemented?
□*Yes* □*No* □*Unknown*
Progression: hospital acquired PI?
□*Yes* □*No* □*Unknown*
Progression: PI present on admit?
□*Yes* □*No* □*Unknown*
Stage: □*1* □*2* □*3* □*4*
□Unstageable □Deep Tissue
□ **Rash/hives**
□ **Skin tear**
□ **Venous stasis ulcer**
□ **Other (specify)**_____

_____ _____
Signature: Department Director/Supervisor (indicates review) ***Date***

Please forward to Risk Management or Patient Safety Officer (per Hospital Procedure) when complete.

DO NOT COPY – NOT A PART OF MEDICAL RECORD

INCIDENTS and SERIOUS EVENTS

FALLS

Type of fall:
□ **Ambulating**
□ **Assisted sit / fall**
□ **Found on floor**
□ **From stretcher**
□ **Grounds of facility**
□ **Hallways of facility**
□ **In Exam Room / from exam table**
□ **Lying in bed**
□ **Sitting at side of bed**
□ **Sitting in chair / wheelchair**
□ **Toileting**
□ **Transferring**
□ **Other (specify)**_____

***Witnessed*?**
□Yes □No □Unknown
Witness name:_____

***Patient lost consciousness*?**
□Yes □No □Unknown

***Altered mental status*?**
□Yes □No □Unknown

***Patient requires assistance to rise from chair*?**
□Yes □No □Unknown

***Altered elimination*?**
□Yes □No □Unknown

***Dizziness or vertigo*?**
□Yes □No □Unknown

***Patient depressed*?**
□Yes □No □Unknown

***Fall precaution/protocol in place*?**
□Yes □No □Unknown

***Identify precaution/protocol*:**
□Patient risk identifiers
□Patient and family education
□Hourly (or more frequent) comfort and toileting rounds
□Nurse call system
□Alarms present: bed exit, or chair
□Appropriate footwear/clothing
□Equipment used: bedrails up, high-low beds, fall mats
□Other (specify)_____

***Restraints in place*?**
□Yes □No □Unknown
If Yes, Type:_____

***Sitter in place*:**
□Yes □No □Unknown

***Drug induced/contributed to*?**
□Yes □No □Unknown

***Medications received prior to fall*?**
□Anticoagulants
□Anti-seizure medications
□Antipsychotic
□Benzodiazepines(e.g.Valium, Ativan)
□Cardiac/hypertensive meds
□Diuretics
□Laxatives
□Pain medications/opiates
□Other (specify)_____

***Fall risk Assessment completed*?**
□Yes □No □Unknown

***At time of last assessment, was patient determined at risk*?**
□Yes □No □Unknown

***Level of injury as a result of the fall (check one)*:**
□No injury □Minor □Moderate
□Major □Death

***Does patient have recent history of visual impairment*?**
□Yes □No □Unknown

***Does patient have recent history of hearing impairment*?**
□Yes □No □Unknown

***Does patient have prior history of falls*?**
□Yes □No □Unknown

Additional Safety Precautions:

***Surface conditions*:**
□Wet □Dry □Unknown

***Bed Position*:**
□High □Low □Unknown

***Call Light on*:**
□Yes □No □Unknown

***Side rails up*?**
□Yes □No □Unknown
□ 1 □ 2 □ 3 □ 4
□Upper □Lower□Full

***Bed alarm on*?**
□Yes □No □Unknown

***Other factors*:**
□Footwear □Lighting
□Obstacles □Unknown

MEDICATION ERROR

Type of Medication Error:
□ **Dose omission**
□ **Extra dose**
□ **Inadequate pain management**
□ **Medication list incorrect**
□ **Med reconciliation issue at admission**
□ **Med reconciliation issue at discharge**
□ **Monitoring error (includes contraindicated drugs)**
◊ Clinical (lab value, vital sign)
◊ Contaminated drug/biologic
◊ Deteriorated drug/biologic
◊ Documented allergy
◊ Drug-disease interaction
◊ Drug-drug interaction
◊ Drug-food/nutrient interaction
◊ Other (specify)_____
□ **Prescription/refill delayed**
□ **Unauthorized drug**
□ **Wrong**
◊ Drug
◊ Dosage form
◊ Dose/over dosage
◊ Dose/under dosage
◊ Duration
◊ Patient
◊ Rate (IV)
◊ Route
◊ Strength/concentration
◊ Technique
◊ Time
□ **Other (specify)**_____

***Stage in medication process where event occurred*:**
□ Administration
□ Monitoring
□ Preparation/dispensing
□ Prescribing
□ Transcription/order processing
□ Other (specify)_____

****Complete TYPE OF MEDICATION****

***Was the medication administered the same as prescribed*?**
□Yes □ No □N/A

***If No, Medication Prescribed*:**
Name_____
Dose_____ Route_____
If IV: □Push □Piggyback □Cont.
Frequency_____
Strength/Conc._____
Medication Class_____

***Number of doses affected*:**_____

***Appropriate for Patient*?**
□Yes □No □Unknown □N/A

***Order Type*:**
□Computer-based provider order entry
□First dose
□One-time dose
□PRN (as needed)
□Scheduled dose
□Verbal order
□Written order

***Patient Weight*:**_____□kg. □lbs.

***Source Of Medication (check all that apply)*:**
□ Another patient's supply
□ Automated Dispensing Machine (e.g., Pyxis, Omnicell)
□ Central inpatient pharmacy
□ Central outpatient pharmacy
□ Central Supply
□ Code tray
□ Delivery bin
□ Floor stock
□ Investigational medication
□ IV Room
□ Medication cart
□ Medication from home
□ Oncology clinic pharmacy
□ OR pharmacy
□ Other automated system (filling, bar coding, etc.)
□ Other satellite pharmacy
□ Outsourced/Contract Pharmacy
□ Sample medication
□ Other/Unknown

***Cause Of Medication Error*:**
_____
_____
_____

TYPE OF MEDICATION

***Medication Administered*:**
Name_____
Dose_____ Route_____
If IV: □ Push □ Piggyback □ Cont.
Frequency_____
Strength/Conc._____
Medication Class_____

***High Alert Medication*:**
□ Benzodiazepine
□ Cardioplegic solutions
□ Chemotherapeutic agent
□ Chloral hydrate
□ Colchicine injection
□ Dialysis solutions
□ Epidural or intrathecal medications
□ General anesthetic agents, inhaled and IV (e.g., propofol)
□ Glycoprotein IIb/IIIa inhibitors (e.g., eptifibatide)
□ Hypertonic dextrose (dextrose > or = to 20%)
□ Hypertonic sodium chloride (Sodium Chloride > 0.9%)
□ Insulin
□ IV adrenergic agonists (e.g., epinephrine)
□ IV adrenergic antagonists (e.g., propranolol)
□ IV amiodarone
□ IV Calcium
□ IV inotropic medications (e.g., digoxin, milrinone)
□ IV Magnesium Sulfate
□ IV moderate sedation agents (e.g., midazolam)
□ IV Potassium
□ IV radiocontrast agents
□ IV Theophylline
□ IV thrombolytics/fibrinolytics (e.g., tenecteplase)
□ IV unfractionated heparin
□ Lidocaine, local anesthetics in large vials
□ Liposomal forms of drugs (e.g., liposomal amphotericin B)
□ Low molecular weight heparin injection
□ Neuromuscular blocking agents
□ Nesiritide
□ Nitroprusside sodium for injection
□ Opiates/Narcotics
□ Oral methotrexate, non-oncologic use
□ Oral hypoglycemic
□ Total parenteral nutrition solutions
□ Warfarin

ADVERSE DRUG REACTION

□ **Arrhythmia**
□ **Dizziness**
□ **Hematologic problem**
□ **Hypotension**
□ **Mental status changes**
□ **Nephrotoxicity**
□ **Skin reaction** (rash, blister, itching, hives)
□ **Other (specify)**_____

****Complete TYPE OF MEDICATION****

***Start Date*: ___/___/_____**
***Stop Date*: ___/___/_____**

***ADR abated after use stopped or reduced*?**
□Yes □No □Unknown □N/A

***ADR reappeared after reintroduction*?**
□Yes □No □Unknown □N/A

***Was drug involved in ADR appropriate for condition*?**
□Yes □No □Unknown □N/A

***Were appropriate therapeutic drug monitoring or other lab tests performed and results used*?**
□Yes □No □Unknown □N/A

***Toxic serum drug level documented*?**
□Yes □No □Unknown □N/A

***Previously documented history of allergy or reaction to drug*?**
□Yes □No □Unknown □N/A

***Drug-drug, drug-food or drug-lab interaction involved in ADR*?**
□Yes □No □Unknown □N/A
If Yes, interaction with what?
_____

***Poor compliance involved in ADR*?**
□Yes □No □Unknown □N/A

TRANSFUSION

□ **Apparent transfusion reaction**
□ **Consent missing/inadequate**
□ **Event related to blood product administration**
□ **Event related to blood product dispensing or distribution**
□ **Event related to blood product sample collection**
□ **Incomplete documentation on the transfusion record**
□ **Mismatched unit**
□ **Special product need not issued**
□ **Special product need not requested**
□ **Wrong component issued**
□ **Wrong component requested**
□ **Wrong patient requested**
□ **Wrong patient transfused**
□ **Other (specify)**_____

EQUIPMENT/SUPPLIES/DEVICE

□ **Disconnected**
□ **Electrical problem**
□ **Equipment/device malfunction**
□ **Equipment/device misuse**
□ **Equipment/device not available**
□ **Equipment safety situation**
◊ Failed test of standard procedure
◊ Preventive maintenance inadequate/not performed
◊ Other (specify)_____
□ **Equipment wrong or inadequate**
□ **Inadequate supplies**
□ **Medical device problem**
□ **Broken item(s)**
□ **Outdated item(s)**
□ **Sterilization problem**
□ **Other (specify)**_____

*****If equipment/device involved*****
Name of equipment/device:_____
_____
_____
_____
Bed Space #_____
Manufacturer_____
Model #_____
Serial #_____
Lot #_____
Biomedical Engineering #_____
Biomedical Asset #_____
***Removed from service*:**
□Yes □No □Unknown

OTHER

□ **Against Medical Advice (AMA)**
□ **Combative/violent behavior**
□ **Confidentiality**
□ **Consent problem**
□ **Contraband**
□ **Death or injury during inpatient elopement**
□ **Death or injury involving seclusion**
□ **Delay in service**
□ **Deviation from policy/procedure**
□ **Dissatisfied patient/family**
□ **Electric shock to patient**
□ **Identification of patient/site**
□ **Inappropriate discharge**
□ **Inappropriate physician conduct**
□ **Other unexpected death**
□ **Readmission within 24 hours d/c**
□ **Restraint/Seclusion**
◊ Death in restraints
◊ Within 24 hours of removal
◊ Within 1 week of removal
◊ Injury in restraints
□ **Patient Self-Harm**
◊ Anorexia/bulimia
◊ Ingestion of foreign object or substance
◊ Self-mutilation
◊ Suicide attempt - Injury
◊ Suicide - Death
◊ Other (specify)_____
□ **Unanticipated transfer to higher level of care**
◊ Intra-facility transfer to higher acuity unit
◊ Inter-facility transfer to higher acuity facility/unit
◊ Other (specify)_____
□ **Other (specify)**_____