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:** _____/____/____

Is the Event Related to a Specific Patient? ☐Yes ☐No

Name, MR#, Date of Birth, and Zip Code of person involved

IF EVENT IS RELATED TO SPECIFIC PERSON, PLEASE COMPLETE THIS SECTION:

Patient Classification: ☐Inpatient ☐Outpatient ☐Clinic Patient ☐ED patient ☐Home Care ☐Resident ☐Swing Bed ☐Visitor

Sex Assigned at Birth or Gender/Sex from medical record: ☐Female ☐Male

Gender Identity: ☐Female ☐Male ☐Transgender ☐Non-binary or Genderqueer ☐Something else ☐Patient declined to answer ☐Not asked

Sexual Orientation: ☐Bisexual ☐Lesbian, gay or homosexual ☐Straight or heterosexual ☐Something else ☐Patient declined to answer ☐Not asked

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Other ☐Patient declined to answer ☐Not Asked

Ethnic Group: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other ☐Patient declined to answer ☐Not Asked

Date of Admission/Ambulatory Encounter: ___/___/___ **DIAGNOSIS AND/OR PROCEDURE AT TIME OF EVENT** _____

Patients Physician:_____ **Advised?** ☐Yes ☐No

TO BE COMPLETE FOR ALL EVENTS: Date of event ___/___/___ **Time (military)**_____

Location of event: Care Area Name:_____**Care Area Type:**_____

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

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

HARM SCORE: ☐**N/A**

Incident (No Harm): (If NOT related to a patient must be A)
☐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 No harm: Monitoring required to confirm no harm

Serious Event (Harm or Death): Event occurred that contributed to/resulted in
☐E Temporary harm and required treatment or intervention
☐F Temporary harm and required initial or prolonged hospitalization
☐G Permanent harm
☐H Near-death event (required ICU care or other life sustaining intervention)
☐I Death

Type of Outcome/Injury:_____

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:**_____

Did Health IT cause or contribute to this event? ☐Yes ☐No ☐Unknown (If yes complete Health IT/Telehealth Form)

Was this event related to a telehealth visit? ☐Yes ☐No (If yes complete Health IT/Telehealth Form)

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)_____