INFRASTRUCTURE FAILURE

CHART

EVENT REPORT FORM

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

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

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)

TYPE OF INFRASTRUCTURE FAILURE (Select One)

☐**Administration/Management**
- ◊ Care ordered/provided by one impersonating a licensed HCW
- ◊ Discharge of pt. to wrong family
- ◊ Elopement/AWOL - no injury
- ◊ Error in patient billing/records
- ◊ Failure to report Health Department reportable diseases
- ◊ Incomplete/incorrect order entry information
- ◊ Missing or incorrect patient ID
- ◊ Receipt of a strike notice
- ◊ Other (specify)_____

☐**Capacity**
- ◊ Boarding patient > 6 hours after discharge order
- ◊ Boarding patients after transfer orders received
- ◊ Patient receiving care in area not designated for care
- ◊ Use of unlicensed beds for patient care
- ◊ Other (specify)_____

Where are patients receiving care?(e.g. ED, PACU, hallway):_____

Number of patients affected?_____

☐**Criminal/Potentially Criminal or Illegal activity**
- ◊ Consensual sexual activity
- ◊ Disappearance of child from pediatrics
- ◊ Disappearance of infant from nursery
- ◊ Drug diversion/theft
- ◊ Lost/damaged patient property
- ◊ Misappropriation of pt./res property
- ◊ Narcotics discrepancy - Solved
- ◊ Narcotics discrepancy - Unsolved
- ◊ Theft of patient/visitor property
- ◊ Violence/Abuse/Neglect
  - ⌂ Assault by patient
  - ⌂ Assault by staff
  - ⌂ Assault by visitor
  - ⌂ Confrontational behavior
  - ⌂ Malnutrition or dehydration
  - ⌂ Patient/resident neglect
  - ⌂ Sexual assault/rape
  - ⌂ Suicide attempt - no injury
  - ⌂ Threat by patient
  - ⌂ Verbal abuse
  - ⌂ Other (specify)_____
- ◊ Other (specify)_____

☐**Emergency Services/Response**
- ◊ Activation of Internal or External Emergency Plan
- ◊ EMTALA violation
- ◊ Hospital in divert status
- ◊ Other (specify)_____

☐**Physical Plant/Utilities/Service Disruption**
- ◊ Disruption due to adverse manmade conditions or disaster
- ◊ Disruption due to adverse natural conditions or disaster
- ◊ Fire Safety
  - ⌂ Activation of fire response plan
  - ⌂ Fire alarm or sprinkler system out of service 4 hours or more
  - ⌂ Fire on facility grounds
- ◊ Interruption of utility service/unplanned power failure
- ◊ Interruption or termination of any clinical service
- ◊ Unplanned EMR downtime
- ◊ Other (specify)_____

_____ _____

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

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