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**
□ **Delay in service**
□ **Deviation from policy/procedure**
□ **Dissatisfied patient/family**
□ **Electric shock to patient**
□ **Identification of patient/site**
□ **Inappropriate discharge**
□ **Other unexpected death**
□ **Restraint/Seclusion**
◊ Death in restraints
◊ Within 24 hours 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)**_____