For Privileged and confidential report for use by legal counsel and in accordance with risk management/quality assurance and peer review activities

CNA nso nurses service organization HPSO Healthcare Providers Service Organization

PRIVILEGED AND CONFIDENTIAL REPORT FOR USE BY LEGAL COUNSEL AND IN ACCORDANCE WITH RM/QA PEER REVIEW ACTIVITIES. THIS REPORT SHOULD NOT BE INCLUDED IN THE MEDICAL RECORD.

NAME OF INDIVIDUAL AFFECTED

INDIVIDUAL'S ADDRESS

NAME OF HEALTH CARE FACILITY

INDIVIDUAL'S DATE OF BIRTH (MM/DD/YYYY)

MEDICAL RECORD NO. (USE ADDRESSOGRAPH WHEN AVAILABLE)

NAME OF REFERRING PROVIDER NOTIFIED:

PRIMARY DIAGNOSIS

PRE-EVENT STATUS OF INDIVIDUAL

- ☐ Oriented
- ☐ Disoriented

EVENT DATE (MM/DD/YYYY)

TIME ____:____

- ☐ AM
- ☐ PM

INDIVIDUAL AFFECTED

- ☐ Inpatient
- ☐ Outpatient
- ☐ Visitor
- ☐ Staff
- ☐ Other (Specify)

SEX

- ☐ Male
- ☐ Female

DESCRIPTION OF INCIDENT (RECORD FACT ONLY, NOT OPINION. DESCRIBE THE EVENT AND CONTEXT IN WHICH IT OCCURRED)

INCIDENT TYPE

- ☐ Near Miss
- ☐ Actual Harm
- ☐ Other (Specify)

WAS NEXT OF KIN NOTIFIED?

- ☐ Yes
- ☐ No
- ☐ If No, Why Not?

WITNESS (LIST ALL INDIVIUALS THAT WITNESSED THE EVENT)

WITNESS NAME & PHONE NUMBER

WITNESS ADDRESS

LOCATION OF EVENT

- ☐ Treatment Room
- ☐ Bathroom
- ☐ Corridor
- ☐ Waiting Room
- ☐ Sidewalk/ Parking Lot
- ☐ Other (specify)

MEDICATION ADMINSTRATION

- ☐ Dosage
- ☐ IV Flow Rate
- ☐ Labeling
- ☐ Omission
- ☐ Patient Identification
- ☐ Reaction
- ☐ Wrong Medication
- ☐ Wrong IV Solution
- ☐ Other (Specify)

FALL / FOUND ON FLOOR

- ☐ Alleged Fall
- ☐ Found on Floor/Sidewalk
- ☐ History of Falls
- ☐ Staff Lowered Patient to Floor
- ☐ Other (Specify)

CONDITIONS AT TIME OF FALL (CHECK ALL THAT APPLY)

- ☐ Wet Floor
- ☐ Dry Floor
- ☐ Obstructed/Cluttered
- ☐ Poor lighting
- ☐ Other (Specify)

PATIENT'S RIGHTS

- ☐ Alleged Molestation/Rape
- ☐ Assault by Staff Member
- ☐ Assault by Other
- ☐ Dentures Damaged/Lost
- ☐ Improper Consent
- ☐ No Consent
- ☐ Property Damaged/Lost
- ☐ Patient Instructions
- ☐ Transfer
- ☐ Verbal/Written Complaint
- ☐ Other (Specify)

PATIENT BEHAVIOR

- ☐ AMA
- ☐ Attempted Suicide
- ☐ Self-Inflicted Injury
- ☐ Elopement
- ☐ Refused Treatment
- ☐ Other (Specify)

DIAGNOSIS RELATED

- ☐ Delay in Diagnosis
- ☐ Improper Test Performed
- ☐ Physician Not Available/Delayed
- ☐ Specimen Lost
- ☐ Test Ordered & Not Performed
- ☐ Other (Specify)

OTHER EVENTS

- ☐ Beverage Spill
- ☐ Fire
- ☐ Incorrect Diet
- ☐ Other (Specify)

EQUIPMENT/INSTRUMENT

- ☐ Availability
- ☐ Defective
- ☐ Improper Use By:
  - ○ Staff
  - ○ Patient
- ☐ Other (Specify)

Type: _____

Mfr. Name:_____

Model #:_____

Control#: _____

Removed From Service:

- ☐ Yes
- ☐ No

Date Removed (MM/DD/YYYY): _____

WARNING: If the event involves an equipment malfunction, DO NOT RELEASE THIS EQUIPMENT from your supervision without approval from the Risk Manager / Administrator.

ASSESSMENT (CHECK ALL THAT APPLY AND ILLUSTRATE ON THE DIAGRAM BELOW POSITION OR PLACE OF INJURY, IF ANY)

- ☐ No Apparent Injury
- ☐ Abrasion/Contusion
- ☐ Anaphylaxis
- ☐ Burn (If yes, complete section titled "Burns")
- ☐ Concussion
- ☐ Death
- ☐ Extravasation/Infiltration
- ☐ Foreign Body
- ☐ Fracture
- ☐ Hearing/Visual Impairment
- ☐ Hematoma
- ☐ Hemorrhage
- ☐ Infection
- ☐ Injury to/Loss of Organ Infiltration
- ☐ Laceration
- ☐ Loss of Consciousness
- ☐ Loss of Limb
- ☐ Perforation
- ☐ Pneumothorax
- ☐ Rash/Hives
- ☐ Spinal-Cord Injury
- ☐ Other (Specify)

FOLLOW-UP

EXAMING PHYSICIAN'S NAME, SPECIALITY DATE OF EXAMINATION (MM/DD/YYYY)

X-RAY

- ☐ Yes
- ☐ No
- ☐ Refused

If Yes, Specify X-ray Type and Pertinent Findings

BURNS

Is the patient able to perceive temperature?

- ☐ Yes
- ☐ No

Was patient's skin assessed prior, during and after treatment?

- ☐ Yes
- ☐ No

Was heat/cold properly padded and timed?

- ☐ Yes
- ☐ No

Did patient complain of burning or pain sensation during treatment?

- ☐ Yes
- ☐ No

TREATMENT

- ☐ Yes
- ☐ No
- ☐ Refused

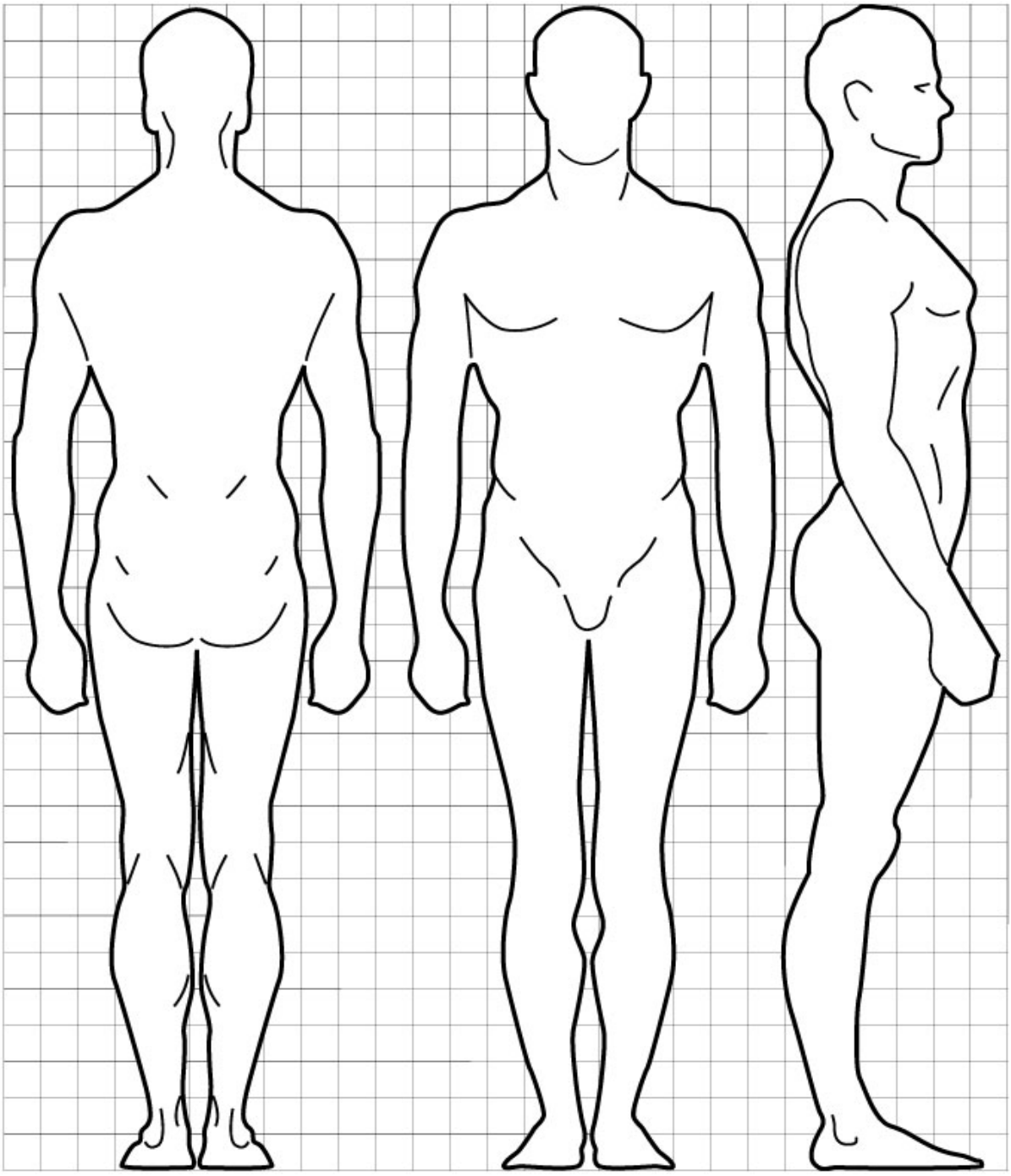
If Yes, Describe Treatment

ED REFERRAL / TRANSFER

- ☐ Yes
- ☐ No
- ☐ Refused

If Yes, Indicate Destination and Method of Transfer

PERSON COMPLETING REPORT (PRINT NAME AND TITLE)	SIGNATURE AND REPORT DATE (MM/DD/YYYY)



ADDITIONAL DOCUMENTATION

Complete a Report of Event Form within 24 hours whenever there is an unusual or unexpected occurrence that is not consistent with the routine operation of the health care facility or the routine care of the patient. Examples of when a form should be completed are listed below.	**Any staff member** who discovers or is involved in an occurrence should complete the form and forward it to the administrative department responsible for risk management within 24 hours.
• Anesthesia/Obstetrics Maloccurrence • Burn / Scald from Food or Hot Beverage • Delay or Complication in Diagnosis or Treatment • Elopement from the Health Care Facility • Equipment or Instrument Malfunction • Fall or Person Found on the Floor • Foreign Body Retained or Missing from an Operative Site • Lack of Consent or Inadequate Informed Consent • Lost Belonging(s) • Occurrence Involving Medication • Self-Inflicted Injury • Suicide/Attempted Suicide • Problem with Transfer • Violation of Patient's Rights **This list is not meant to be all-inclusive. Consult a risk manager/supervisor/administrator if you have any questions about when to complete this form.**	**When completing the form** 1. Use an addressograph when available 2. Write clearly using a ball-point pen 3. Be brief and objective 4. Be sure to clearly indicate the following: a. Facility Name b. Patient Name c. Time of Event d. Date of Event e. Type of Event f. Assessment 5. Provide specific information when the other category is checked. **Notify a supervisor/administrator/physician immediately of any injury and/or life-threatening event.**

DETAILED PROCEDURE FOR COMPLETING THE RM/QA REPORT OF EVENT FORM

Name of Health Care Facility – Print the name and address of the health care facility.

Patient's Name – Use an addressograph or print the name and address of the person involved in the event.

Identification Status – Check the box indicating the status of the person involved in the event.

Sex – Check the box indicating the sex of the person involved in the event.

Date of Birth – Provide data as indicated using digits only.

Event Date – Provide the date the event occurred. **This field cannot be left blank.**

Time – Indicate the time when the event occurred.

Pre-Event Status – Indicate the person's mental status before the occurrence.

Physician – Indicate the name of the primary treating physician.

Primary Diagnosis – Indicate the principle diagnosis.

Service – Specify the medical service the person was assigned, e.g., pediatrics, orthopedics.

Description of Event – Write a brief and objective description of the event. Include pertinent comments made by the person involved. **Do not write "see attached."**

Witness – Provide the complete name and address of the witness.

Location of Event

- Department or Service – Indicate the specific department or service where the patient was located at the time of the event, e.g., Medical Unit, Radiology, O.R., Physical Therapy.
- Specific Area – Check the box which describes the location where the event occurred.

Type of Event – Check **one** box that best describes the event. **For conditions of fall, check all that apply.**

Assessment – Check the box which best describes the injury sustained. **These findings should be reflected in the person's medical record.**

Follow-up

- Indicate the date the person was examined by a physician. Include the name and specialty of the physician.
- X-ray – Check the appropriate box. If yes, specify the x-ray study performed and include the pertinent findings.
- Treatment – Check the appropriate box. If yes, describe the treatment rendered and indicate the outcome.
- ED Referral/Transfer – Check the appropriate box. If yes, specify the ED chart number, indicate the outcome and the method of transportation, e.g., wheelchair, stretcher, ambulance, helicopter.

Person Completing Report – Print name and title, sign the report and include the date the report was prepared in the space provided.

Report Review – The person responsible for reviewing the report must sign the report and indicate the date it was reviewed.