Sample Adverse Event Report Form

This privileged and confidential incident report is intended for use by legal counsel, in accordance with risk management/quality assurance and peer review activities. This report should not be included in the patient healthcare information record.

Instructions

Complete an adverse event report form within 24 hours of any unusual or unexpected occurrence that is not consistent with the routine operation of the practice or the routine care of the patient. Examples of when a form should be completed include, but are not limited to:

- Delay or complication in diagnosis or treatment.
- Equipment or instrument malfunction.
- Patient fall observed.
- Foreign body retained or missing from an operative site.
- Lack of consent or inadequate informed consent.
- Lost belongings.
- Adverse medication reaction.
- Self-inflicted injury.
- Problem with transfer.
- Violation of patient's rights.

Consult a risk manager/supervisor/administrator if you have questions regarding when or how to complete this form.

Any staff member who discovers or is involved in an adverse event should complete the form and forward it to the administrative department responsible for risk management within 24 hours.

When completing the form:

1. Write clearly, using a ballpoint pen.
2. Clearly indicate the following:
    a. Facility name.
    b. Patient name.
    c. Time of event.
    d. Date of event.
    e. Type of event.
    f. Assessment.
    g. Other requested information.
3. Provide specific information when the "other" category is checked.
4. Be brief and objective.

Immediately notify a supervisor/administrator/physician of any injury and/or life-threatening adverse event.

Background information

Name of healthcare facility: _____

Individual affected: _____

☐ Inpatient ☐ Outpatient ☐ Visitor ☐ Staff ☐ Other (specify) _____

Individual's address: _____

Individual's date of birth (mm/dd/yyyy): _____/_____/_____ Sex: ☐ Male ☐ Female

If individual is a patient:

Healthcare information record number: _____

Attending physician: _____

Primary diagnosis: _____

Service: _____

Referring provider notified (if individual is not a patient): _____

Was next of kin notified? ☐ Yes ☐ No If no, why not? _____

Date and time of event

Date (mm/dd/yyyy): _____/_____/_____ Time: _____:_____ ☐ AM ☐ PM

Location of event

☐ Treatment room ☐ Bathroom ☐ Corridor ☐ Waiting room ☐ Sidewalk/parking lot

☐ Other (i.e., floor, unit, ward, etc.) _____

Type of event

Event type: ☐ Near miss ☐ Actual harm ☐ Other (specify) _____

Medication administration: ☐ Dosage ☐ IV flow rate ☐ Labeling ☐ Omission ☐ Patient misidentification ☐ 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 space ☐ Poor lighting

☐ Other (specify) _____

Patient rights: ☐ Alleged molestation/rape ☐ Assault by staff member ☐ Assault by other ☐ Improper consent

☐ No consent ☐ Property damaged/lost ☐ Dentures damaged/lost ☐ Patient instructions ☐ Transfer

☐ Verbal/written complaint ☐ Other (specify) _____

Patient behavior: ☐ Against medical advice (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

☐ Unavailable ☐ Defective ☐ Improper use by: ☐ Staff ☐ Patient ☐ Other (specify) _____

Type: _____

Manufacturer's name: _____

Model number: _____

Control number: _____

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.

Burns (if applicable)

Is the patient able to perceive temperature? ☐ Yes ☐ No

Was patient's skin assessed prior to, during and after treatment? ☐ Yes ☐ No

Was heat/cold source properly padded and timed? ☐ Yes ☐ No

Did patient complain of burning sensation or pain during treatment? ☐ Yes ☐ No

Assessment

Pre-event status of individual: ☐ Oriented ☐ Disoriented

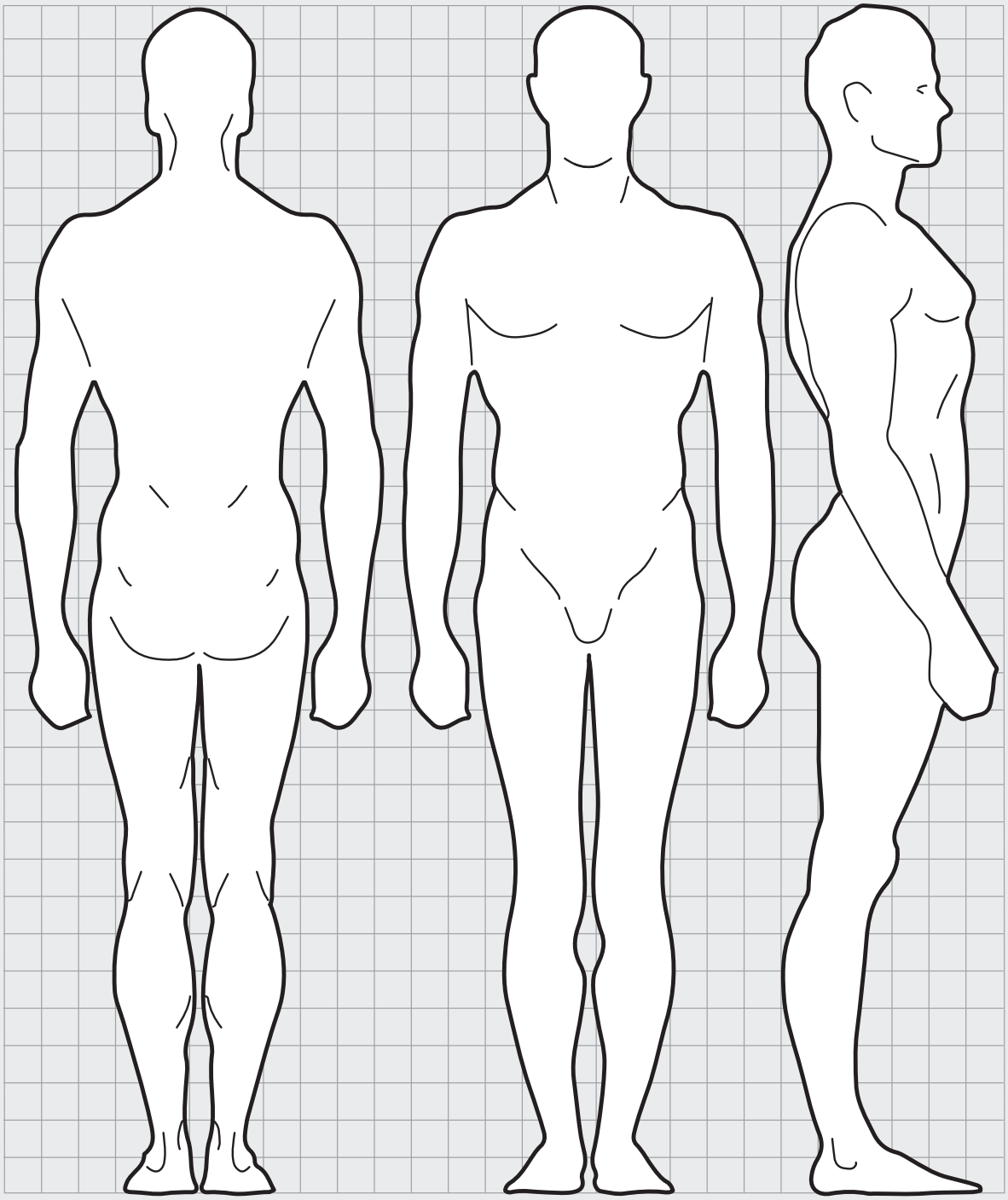
Check all that apply, illustrating on the diagram the position/place of injury, if any:

☐ No apparent injury ☐ Abrasion/contusion ☐ Anaphylaxis ☐ Burn

☐ 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)



Description of event

Describe the event and context in which it occurred. Record facts only, not opinions.

_____

_____

_____

Follow-up

Examining physician's name: _____

Specialty: _____ Date of examination (mm/dd/yyyy): _____/_____/_____

X-ray: ☐ Yes ☐ No ☐ Refused

If yes, specify X-ray type and pertinent findings. _____

Treatment: ☐ Yes ☐ No ☐ Refused

If yes, describe treatment. _____

Emergency department referral/transfer: ☐ Yes ☐ No ☐ Refused

If yes, indicate destination and method of transfer (e.g., wheelchair, stretcher, ambulance, helicopter, etc.).____

Report completed by

Name (print): _____ Title: _____

Signature: _____ Report date (mm/dd/yyyy): _____/_____/_____

Report reviewed by

Name (print): _____ Title: _____

Signature: _____ Review date (mm/dd/yyyy): _____/_____/_____

Witnesses

List the individuals who witnessed the event.

Name: _____ Phone number: _____

Address: _____

Name: _____ Phone number: _____

Address: _____

This sample form is for illustrative purposes only. As each practice presents unique situations, and statutes may vary by state, it is recommended that you consult with your attorney prior to use of this or similar forms in your practice.