

START

***Who was affected by the event:**

- Patient
- Staff
- Visitor
- Unsafe Condition

Only applicable to Patient/Staff/Visitor

***Type:**

- Patient
- Visitor
- Employee or member of staff

Last Name:

First Name:

Only applicable to Patient

***Medical Record Number:**

***Subtype (or Patient Status):**

- Inpatient
- Outpatient
- Unknown

***Date of Birth:**

***Gender:**

- Male
- Female
- Unknown

Date of Admission or Ambulatory Encounter:

Does patient have Hispanic or Latino ethnicity?

(Hidden by default)

- Yes
- No
- Unknown

Race: *(Hidden by default)*

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- More than one race
- Unknown

Encounter Number: *(Hidden by default)*

Patient's principal diagnosis code: (Enter ICD-9-CM Code) *(Hidden by default)*

Patient's principal procedure code: (Enter ICD-9-CM Code) *(Hidden by default)*

EVENT BASICS *(applicable to all)*

***Event Type/Category/Subcategory:**

***Event Discovery Date/Time:**

Event Occurrence Date/Time:

***Primary site/location where event occurred:**

Other site/location or service (if applicable):

Clinical Service:

Was the event related to handover/handoff?

- Yes
- No
- Unknown

Front Line Reporter Basics

Was health information technology (HIT) implicated in this event?

- Yes
- No
- Unknown

How did you learn about the event?

- Assessment after event
- Report by another staff member
- Report by family or visitors
- Report by patient
- Review of record chart
- Witnessed/Involved
- Other

Describe the event in your own words:

Describe any factors contributing to the event, lessons learned, and/or recommendations to prevent recurrence:

Extent of Harm:

Extent of Harm:

- Harm caused
- Reached the individual
- Near miss

Harm Score:

Harm caused

- 9 Death
- 8 Severe
- 7 Permanent harm
- 6 Temporary harm

Reached the individual

- 5 Additional treatment
- 4 Emotional distress or inconvenience
- 3 No harm evident, physical or otherwise

Near Miss

- 2 Near miss
- 1 Unsafe condition

*What prevented the near miss from reaching the patient?

- Fail-safe into the process and/or a safeguard worked effectively
- Practitioner or staff who made the error noticed and recovered from the error (avoiding any possibility of it reaching the patient)
- Spontaneous action by a practitioner or staff member (other than person making the error) prevented the event from reaching the patient
- Action by the patient or patient's family member prevented the event from reaching the patient
- Unknown
- Other

How long after the incident was harm assessed (approx.)?

- Within 24 hours
- After 24 hours but before 3 days
- 3 days or later
- Unknown

Was any intervention attempted to prevent, reverse or halt the progression of harm?

- Yes
- No
- Unknown

Which of these interventions (rescues) were performed? (Check all that apply):

- Transfer, including transfer to a higher level of care area within facility, or transfer to another facility, or hospital admission (from outpatient)
- Monitoring, including observation, physiological examination, laboratory testing, phlebotomy, and/or imaging studies
- Medication therapy, including administration of antidote, change in pre-incident dose or route
- Surgical intervention
- Respiratory support (e.g., ventilation, tracheotomy)
- Blood transfusion
- Counseling or psychotherapy
- Unknown
- Other intervention (specify):

Front Line Reporter Basics

Nature of Injury: (Hidden by default)

- | | | |
|---|--|--|
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Dental injury | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Allergic reaction | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Punctured |
| <input type="checkbox"/> Aspiration | <input type="checkbox"/> Edema | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Bite | <input type="checkbox"/> Extravasation | <input type="checkbox"/> Retained foreign body |
| <input type="checkbox"/> Blister | <input type="checkbox"/> Fracture | <input type="checkbox"/> Scratch |
| <input type="checkbox"/> Bruise | <input type="checkbox"/> Hematoma | <input type="checkbox"/> Skin tear |
| <input type="checkbox"/> Thermal burn | <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Electrosurgical Burn | <input type="checkbox"/> Infection | <input type="checkbox"/> No injury |
| <input type="checkbox"/> Cellulitis | <input type="checkbox"/> Infiltration | <input type="checkbox"/> Other |
| <input type="checkbox"/> Compartment Syndrome | <input type="checkbox"/> Laceration | |
| <input type="checkbox"/> Contusion | <input type="checkbox"/> Pain | |
| | <input type="checkbox"/> Phlebitis | |

EMSI INFO

Was anybody else involved in this event?

- Yes
 No

How was this person involved in the event?

- Claimant
 Complainant
 Employee/member of staff directly involved
 Investigation lead
 Perpetrator
 Person injured
 Witness
 Other

Type:

- Patient
 Visitor
 Employee or member of staff

MRN: (for Patient only)

Subtype: (for Patient/Staff only)

Last name:

First name:

DOB: (for Patient only)

Gender: (for Patient only)

Job Title: (for Staff only)

Contact phone number:

E-mail address: (for Staff only)

Who was notified (by the front line reporter)?

- Covering physician
 Date: / Time:
- Patient or family designated contact
 Date: / Time:
- Employee health
 Human resources
 Nurse
 Manager/supervisor
 Risk management (by phone)
 Security/police
 Other (specify)

REPORTER INFO

Reporter Role:

Registered Nurse	Security
Charge Nurse	Volunteer
Float Nursing Staff	Care Tech
Nurse's Aide	Unit Secretary Clerk
Nurse Practitioner	Manager
Nursing Student	Lab/radiology Tech
LPN	Laboratory Coordinator Supervisor
CRNA	Specimen pathology, Coordinator
Pharmacist	Phlebotomist
Pharmacy Resident	Mental Health Counselor
Pharmacy Student	Clinic Director
Pharmacy Technician	LCSW
Physician – attending staff	Dietician/dietary aide
Physician-resident intern/fellow	Paramedic/EMT
Physician Assistant	Patient relations representative
Medical Assistant	Social worker
Medical Student	Chaplain
Midwife	PT/OT
Respiratory Therapist	Infection Control practitioner
Radiation Therapist	Anonymous
Technologist/technician (lab x-ray, etc.)	Other (specify)

Last Name:

First Name:

Contact phone number:

Your email address (ensure this is completed if you would like to receive acknowledgement of report submission):

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