



EVENT REPORTING FORM

Person completing: _____

Date/time of incident: _____

Department: _____

Date/time of report: _____

Patient/s affected: _____

TYPE OF EVENT:

- Medication error
- Medication near miss
- Patient grievance
- Equipment malfunction
- Needle stick
- Fall/injury on property
- Other:

SEVERITY CATEGORY:

- Unsafe or unsatisfactory conditions – No harm
- Event – No harm (did not reach patient/staff/visitor or did reach with no evidence of harm)
- Event – Harm (reached patient/staff/visitor resulting in temporary or permanent injury, harm, or death)
- Undetermined – cannot assess at this time

INCIDENT (Include a detailed summary of events leading up to and following the incident – see list on back):

OUTCOME (Give a detailed summary, including both patient and staff outcomes):

PLAN (How could this event have been avoided/what can we do for the future?):

REPORTED TO:	NAME	SIGNATURE	DATE	TIME
Patient (<input type="checkbox"/> Check here if no report to patient)		N/A		
Supervisor				
Compliance Manager				
Department Director				
Employee completing form	Does patient require medical care follow up? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Explain:			
Date reviewed by QI committee:				

EVENT REPORTING PROCEDURES: REPORTING TIMELINE

STEPS	TIMELINE
Report all events at the time they are discovered to an immediate supervisor and/or the compliance manager	Immediately
Complete the Event Reporting Form	ASAP or at least within 24 hrs.
Notify Department Director and Executive Director of any events causing harm to staff/patient/visitor	ASAP or at least within 24 hrs.
QI Committee/Compliance Manager completes Event Follow Up Form if needed	Within 7 days
QI Committee/Compliance Manager completes Root-Cause Analysis for events that cause harm	Within 30 days
*Notify patient as needed (in cases of harm, potential clinical significance or in some case of event reaching patient with no harm)	Determined based on situation and outcome

NOTES ON FORM COMPLETION:

- This form shall not be filed in the patient's medical record.
- Form should be completed objectively, accurately, and without conclusions, criticisms, or placement of blame.

REPORT TO INCLUDE THE FOLLOWING:

- Location of the event
- Identification of people affected (e.g., patient, visitor, employee)
- Names of people witnessing the event
- Name of the physician to whom the event was reported (if applicable) and the physician's response (e.g., orders given)
- Brief, factual description of the event
- Key observations of the event scene (e.g., if the event was a fall, was there water on the floor or ice on the sidewalk, or were bed siderails raised?)
- Manufacturer, model, and lot (or batch) number of any medical device involved
- Condition of the people affected (including any complaints of injury, observed injuries, and a brief comment on any follow-up care)