

PATIENT SAFETY SENTINEL EVENT REPORTING FORM

(May 2007)

1. FACILITY INFORMATION

_____	_____
Name of Facility	Telephone
_____	_____
Person Reporting	Title

Email	

2. PATIENT INFORMATION

Patient DOB: _____ **Age** _____ **Gender:** F ___ M ___

Principal Admitting Diagnoses _____ **Date of Admission** _____

ICD Code	Narrative Descriptions
(if known)	
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Principal Discharge Diagnoses: (possibly preloaded)

(ICD and CPT codes if known)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. EVENT INFORMATION

_____	_____	_____
Date of Event	Time	Date of Determination

- Death
 - Major permanent loss of function
 - Other (Please describe) _____
- _____
- _____
- _____

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Narrative Description (to give context)

Patient's Cognitive Status prior to event: (Check one)

- | | |
|--------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Alert/Oriented | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Comatose |
| <input type="checkbox"/> Mentally Retarded | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Other |

Location of Patient when event occurred: (Check one)

- | | |
|----------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Patient Room | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Recovery Room | <input type="checkbox"/> Lobby/Waiting |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Hallway |
| <input type="checkbox"/> Operating Room | <input type="checkbox"/> Home |
| <input type="checkbox"/> ICU/CCU | <input type="checkbox"/> Facility Campus |
| <input type="checkbox"/> Radiology | |
| <input type="checkbox"/> Procedure Room (Cath, Endo, GI) | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Labor/Delivery | _____ |

Type of Occurrence: (Check one)

Death or Major Permanent Loss of Function arising from:

Surgery and/or Procedure:

- Performed on wrong body part.
- Performed on wrong patient.
- Incorrect surgery and/or procedure performed on a patient.
- Retention of a foreign object in a patient after surgery or other procedure except:
 - o Objects intentionally implanted;
 - o Objects present prior to surgery and left in place; and
 - o Broken micro-needles.
- Intraoperative or immediately post-operative death in an ASA Class I patient within 24 hours of surgery.
- Other _____

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Product or Device Event:

- Arising from the use of contaminated drugs, devices, or biologics provided by the healthcare facility.
- Associated with the use or function of a device in patient care in which the device is used for an off-label use except pursuant to informed consent.
- Associated with intravascular air embolism that occurs while being cared for in a healthcare facility except when associated with neurosurgical procedures.
- Other _____

Patient Protection Event:

- Infant discharged to the wrong person.
- Patient death or major permanent loss of function arising from patient elopement.
- Patient suicide or attempted suicide while being cared for in a healthcare facility or within 72 hours of discharge.
- Other _____

Care Management Event:

- Arising from a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
- Arising from a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products.
- Arising from labor and/or delivery of a low-risk pregnancy while being cared for in a health care facility
 - Except deaths from pulmonary or amniotic fluid embolism;
 - Acute fatty liver of pregnancy;
 - Cardiomyopathy
- Unanticipated death of a full-term infant.
- Arising from hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.
- Kernicterus associated with failure to identify and treat hyperbilirubinemia and/or bilirubin greater than 30 milligrams per deciliter in neonates.
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility:
 - Except those that progress from stage 2 to stage 3 if the stage 2 ulcer was documented upon admission.
- Due to spinal manipulative therapy.
- Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field.
- Radiotherapy to the wrong body region
- Radiotherapy greater than 25% above the planned radiotherapy.
- Related to a healthcare acquired infection.
- Other _____

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Environmental Event:

- Arising from an electric shock while being cared for in a healthcare facility:
 - Excluding emergency defibrillation in ventricular fibrillation and electroconvulsive therapies.
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.
- Arising from a burn incurred from any source while being cared for in a healthcare facility.
- Associated with the use of restraints or bedrails while being cared for in a healthcare facility.
- Arising from a fall while being cared for in a healthcare facility including fractures and/or head injuries with intracranial hemorrhage.
- Other _____

Criminal Event:

- Any care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- Abduction of a patient of any age.
- Nonconsensual sexual contact on a patient, staff member or visitor by another patient, staff member or unknown perpetrator while on the premises of the healthcare facility.
- Criminal assault or battery that occurs on the premises of the healthcare facility.
- Other _____

Other (please specify):

- _____

If a Facility suspects that a patient safety sentinel event may have occurred to a patient who was transferred from another facility, the receiving facility shall report the suspected patient safety event to the facility that initiated the transfer.

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4. ROOT CAUSE ANALYSIS AND CORRECTIVE ACTION *(To be submitted 60 days following the determination of event and after the conduction of an RCA)*

Type of Harm/Outcome: (Check all that apply):

- | | |
|-------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Burn | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Confinement | <input type="checkbox"/> Laceration |
| <input type="checkbox"/> Decline in Condition | <input type="checkbox"/> Spinal Injury |
| <input type="checkbox"/> Decubitus Pressure Ulcer | <input type="checkbox"/> Unwelcome Sexual Contact/Advance |
| <input type="checkbox"/> Dislocation | |
| <input type="checkbox"/> Emotional Harm/Upset | |
| <input type="checkbox"/> Other (Please specify) _____ | |
| _____ | |

Contributing Factors: (Check all that apply)

- | | |
|-----------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Availability of Info | <input type="checkbox"/> Lack of Monitoring |
| <input type="checkbox"/> Care Planning | <input type="checkbox"/> Organization Culture |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Orientation/Competency/ Training |
| <input type="checkbox"/> Continuum of Care | <input type="checkbox"/> Patient Assessment |
| <input type="checkbox"/> Device Breakdowns | <input type="checkbox"/> Procedural Compliance |
| <input type="checkbox"/> Environ. Safety/ Security | <input type="checkbox"/> Process Breakdowns |
| <input type="checkbox"/> Equipment - List Equipment used: _____ | <input type="checkbox"/> Staffing |
| <input type="checkbox"/> Failure to recognize changes | <input type="checkbox"/> Other (Please specify): _____ |
| <input type="checkbox"/> Human Factors _____ | _____ |
| <input type="checkbox"/> Leadership | _____ |

Actions Taken: (Check all that apply)

- Documentation Changes – (please specify): _____
- Documentation Changes – Charting Tool
- Documentation Changes – Checklist
- Documentation Changes – Form
- Education
- Equipment taken out of service
- Information System Change
- Policy & Procedure Addition/Revision
- Staffing Changes
- Work Flow Process Redesign
- Other: (Please specify) _____

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Any other comments or narrative explanations: