

Patient / Visitor Incident Report

Please review each of the applicable categories and check as many items that apply. Obtain supervisor's signature. Forward completed form to SMC Corporate Office..

DO NOT COPY OR FAX FOR ANY REASON

<p>PATIENT LABEL, or NAME: FULL ADDRESS: AGE: SEX: CHART #: PHONE #: PT. DIAGNOSIS AND/OR SURGICAL PROCEDURE:</p>	<p>CATH LAB NAME DATE OF OCCURRENCE: SHIFT: AREA OR UNIT: PT. IDENTIFICATION (check one): <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Visitor <input type="checkbox"/> Other</p>
<p>CATH LAB LOCATION TIME OF OCCURRENCE: ROOM #:</p>	
<p>NATURE OF OCCURRENCE</p> <p> <input type="checkbox"/> Adverse Outcome/Complication <input type="checkbox"/> Delayed a) Procedure b) Tx <input type="checkbox"/> Last / Damaged Property <input type="checkbox"/> Surgical Procedure Complication <input type="checkbox"/> Break in Sterile Field <input type="checkbox"/> Disruptive Behavior <input type="checkbox"/> Management Issue <input type="checkbox"/> Transfusion Reaction <input type="checkbox"/> Burn / Skin Lesion <input type="checkbox"/> Equipment / Device Failure <input type="checkbox"/> Omitted a) Procedure b) Tx <input type="checkbox"/> Wasted Blood or Blood Product <input type="checkbox"/> Cancelled a) Procedure b) Tx <input type="checkbox"/> Equipment Unavailable <input type="checkbox"/> PL Care / Tx Related <input type="checkbox"/> Wrong Blood <input type="checkbox"/> Complaints <input type="checkbox"/> Exposure Issue <input type="checkbox"/> Return to Hospital / Unexpected <input type="checkbox"/> Wrong Patient <input type="checkbox"/> Consent Issue <input type="checkbox"/> Fall / Accident <input type="checkbox"/> Restraints Issue <input type="checkbox"/> Wrong a) Procedure b) Tx c) Equipment <input type="checkbox"/> Contrast Media Reaction <input type="checkbox"/> Infiltration <input type="checkbox"/> Return to OR, same admission <input type="checkbox"/> Other _____ <input type="checkbox"/> Count Incorrect <input type="checkbox"/> LWBS / AMA <input type="checkbox"/> Security Issue _____</p>	
<p>PATIENT FACTORS</p> <p> <input type="checkbox"/> Call Light Not Used <input type="checkbox"/> Mental Status – Rational <input type="checkbox"/> Unexpected Movement <input type="checkbox"/> Other _____ <input type="checkbox"/> Climbed Over Rail / Foot of Bed <input type="checkbox"/> Mental Status – Under Sedation <input type="checkbox"/> Unwilling to Follow Orders _____ <input type="checkbox"/> Footwear <input type="checkbox"/> Pt Gave Inaccurate/Incorrect Info <input type="checkbox"/> Visitor Assisting Patient _____ <input type="checkbox"/> Incontinent <input type="checkbox"/> Seeking Attention <input type="checkbox"/> Visual or Hearing Impaired _____ <input type="checkbox"/> Mental Status - Combative <input type="checkbox"/> Unable to Follow Orders <input type="checkbox"/> Weakness, Seizure, Fainting _____</p>	
<p>EQUIPMENT FACTORS</p> <p> Bed Rails <input type="checkbox"/> Up <input type="checkbox"/> x1 <input type="checkbox"/> x2 <input type="checkbox"/> x3 <input type="checkbox"/> x4 <input type="checkbox"/> Down <input type="checkbox"/> Absent Bed Position <input type="checkbox"/> High <input type="checkbox"/> Low Length of Bed Rails <input type="checkbox"/> ½ <input type="checkbox"/> ¾ <input type="checkbox"/> Full Signal Cord Within Reach <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	<p>ACTIVITY LEVEL:</p> <p> <input type="checkbox"/> Ambulatory <input type="checkbox"/> Up With Assistance <input type="checkbox"/> Bedrest <input type="checkbox"/> _____</p>
<p>RESTRAINTS</p> <p> Restraints In Place: <input type="checkbox"/> Prior to Occurrence <input type="checkbox"/> After Occurrence <input type="checkbox"/> N/A Type Used: <input type="checkbox"/> Posey <input type="checkbox"/> Wrist(s) <input type="checkbox"/> Ankle(s) <input type="checkbox"/> None <input type="checkbox"/> N/A <input type="checkbox"/> Other _____</p>	
<p>NATURE AND SITE OF INJURY (Example: Skin tear to left elbow. 3 cm laceration to left upper thigh.)</p>	
<p>WITNESSES (Give full name and address of witnesses.)</p>	
<p>DESCRIBE EVENTS LEADING TO OCCURRENCE (Include any statements made by patient, family, visitor, etc.)</p>	
<p>HARM TO PATIENT / VISITOR (Please indicate applicable item.)</p> <p> CAT 1: Near miss. Circumstances with potential for error. CAT 6: Potential permanent harm to patient. CAT 2: Event reached the patient, but patient was not harmed. CAT 7: Possible patient death. CAT 3: Minor harm to patient. Increased monitoring or first aid required. UNK: Unable to determine impact on patient. CAT 4: Temporary harm to patient. Treatment or intervention required. N/A: Not applicable. CAT 5: Temporary harm to patient. Initial or prolonged hospitalization.</p>	
<p>TREATMENT</p> <p> Referred for Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Treatment Rendered By: <input type="checkbox"/> Physician <input type="checkbox"/> Emergency Room <input type="checkbox"/> Other Healthcare Provider <input type="checkbox"/> Other</p>	
<p>PHYSICIAN'S COMMENTS / ORDERS (Including treatments given.)</p>	
<p>PERSON COMPLETING REPORT SIGNATURE</p>	<p>DATE / TIME COMPLETED</p>
<p>SUPERVISOR / DIRECTOR SIGNATURE</p>	<p>DATE RECEIVED BY RISK MANAGEMENT</p>
<p>PHYSICIAN'S NAME</p>	<p>DATE / TIME PHYSICIAN NOTIFIED</p>