Patient Safety Incident Report Form

This form is not meant to be a substitute to the health region's incident reporting.

The purpose of this form is to assist with the identification and management of adverse events and near misses; and minimize risks and potential injury to clients and residents. Subsequently, recommendations will be developed for quality improvement and risk management. This form will not be used for student evaluation.

This form is not meant to be a substitute to the health region's incident reporting.
Patient Safety Incidents may occur when professional nursing students provide direct patient care. This form is designed to identify and manage Patient Safety Incidents (formerly referred to as adverse events, sentinel event, near miss, close call, no harm incident and critical incidents), and to minimize risks and potential injuries to patients/clients/residents and students. We want to identify what happened, how and why it happened, what can be done to reduce the risk of recurrence and make care safer, and share what was learned (CIACP, 2012). The form should be completed (anonymously) by College of Nursing students and faculty, or Health Region Partners, upon recognition of a Patient Safety Incident.

DEFINITIONS:

Adverse Event "any adverse outcome for a patient, including an injury or complication directly associated with the care or services provided to a patient" (The Canadian Patient Safety Dictionary, 2003).

This can be physical, emotional, psychological, and cultural. For example an adverse event is when a wrong medication is given to a client or a client receives wrong information that causes them to become depressed (i.e. a nurse mistakenly tells a client that their mother died but it never happened).

Near Miss "an event that could have adverse consequences, but did not" (Institute of Medicine, 2004). For example, a student is about to give an insulin injection but finds out from another individual that they were about to give it to the wrong person. The insulin mistake was caught in time.

Critical Incident "an incident resulting in serious harm (loss of life, limb or vital organ); there is a need for immediate investigation and response" (The Canadian Patient Safety Dictionary, 2003)

1. **Program Name**
   - ◯ BSN
   - ◯ PDBSN
2. **Program Site:** _____
3. **Health Care Agency:** _____
4. **Date of Event:** _____
5. **Date of Report:** _____
6. **Course:** _____
7. **Individual Reporting:**
   - ◯ Faculty
   - ◯ Student
8. **Year in Program**
   - ◯ 2nd
   - ◯ 3rd
   - ◯ 4th
   - ◯ Other:(specify)_____
9. **Term / Semester**
   - ◯ 1st /Fall
   - ◯ 2nd /Winter
   - ◯ 3rd /Spring
   - ◯ 4th /Summer
10. **Describe incident in detail:**

11. Describe immediate action taken to prevent further harm (if known):

12. How would you categorize this event?

- ○ No Harm Incident
- ○ Near Miss or Close Call
- ○ Adverse Event
- ○ Critical Incident

13. The event involved a(n)?

- ○ Fall.
- ○ Medication.
- ○ Intravenous / Injection.
- ○ Procedure.
- ○ Other: _____

14. Identify at what time during the term the event occurred.

- ○ Beginning
- ○ Middle
- ○ End

15. Identify the time of day the event occurred.

- ○ Morning (0700 - 1200 hours)
- ○ Afternoon (1200 – 1900 hours)
- ○ Evening (1900 – 2400 hours)
- ○ Night (2400 – 0700 hours)

16. Identify the clinical area the event occurred.

- ○ Long-Term Care
- ○ Medicine
- ○ Surgery
- ○ Mental Health
- ○ Pediatrics
- ○ Obstetrics
- ○ Community
- ○ Other: _____

17. Miscommunication between:

- ○ Student and client
- ○ Student and health team member
- ○ Student and faculty
- ○ Student and preceptor
- ○ Student and other department(s)
- ○ Other: _____

18. Resources:

- ☐ Inadequate information
- ☐ Staff or faculty not available; staff shortage
- ☐ Written resources unavailable
- ☐ Current and credible information unavailable
- ☐ Inadequate policies and procedures
- ☐ Other: _____

19. Medical Device:

- ☐ Malfunction
- ☐ Lack of availability
- ☐ Product labeling confusion
- ☐ Other: _____

20. Individual:

- ☐ Felt pressured to perform task quickly
- ☐ Did not feel adequately prepared to manage the care or skill
- ☐ Fatigued
- ☐ Other: _____

21. Environment:

- ☐ Work area layout problematic
- ☐ Need for rapid care management decisions
- ☐ Environment prone to distractions and interruptions
- ☐ Other: _____

22. Client:

- ☐ Confused
- ☐ Unsteady or weak
- ☐ Other: _____

23. How might this situation be prevented in the future (a systems solution)?

24. Describe follow-up with student:

25. Describe follow-up with health region, including details of disclosure (if known):

26. Describe preliminary investigation (what happened, how and why it happened, and to develop and manage recommended actions):

27. Who was notified:

28. Is further action required:

- ◯ **No**
- ◯ **Yes. Describe** _____

29. Recommendations to reduce risk of recurrence:

30. Was this incident reviewed during College of Nursing Aggregate Review:

- ◯ **No**
- ◯ **Yes. Describe** _____

31. How should student learning be improved to prevent future occurrence

32. Implementation Plan:

33. Evaluation Plan:

Privileged and confidential for quality improvement purposes.
Return this form as outlined by your program.