NEBRASKA COALITION FOR PATIENT SAFETY Event Questionnaire

Organization/Facility _____ ***Reporter*** _____

Date of Event: _____ **Date RCA Completed**: _____ **RCA Not Applicable (Harm less than E)**_____

Date of this Report: _____ Patient Age (if younger than 90) _____ Patient Gender: ☐ M

Patient Age 90 or older check here: ☐ ☐ F

Check the location of the event:

- ☐ Emergency Department
- ☐ Intensive care unit
- ☐ Laboratory
- ☐ Medical/surgical ward
- ☐ Outpatient/Ambulatory services
- ☐ Operating Room/Surgical Suite
- ☐ Pharmacy
- ☐ Post Anesthesia Care Unit
- ☐ Procedure Room
- ☐ Outside area
- ☐ Radiology/Imaging Suite
- ☐ Rehabilitation Unit
- ☐ OB/LDR
- ☐ Other _____

Check the ONE category that describes the SEVERITY of the EVENT based on harm to the patient.
The coalition requires that you report any events of harm level E or greater. You are encouraged to share any de-identified event that may have educational value for other Nebraska hospitals.

	NO EVENT	**NO HARM**
☐	Category A	Circumstances or actions that have the capacity to cause an adverse safety event
	EVENT	**NO HARM**
☐	Category B	Event occurred but it did not reach patient
☐	Category C	Event occurred that reached the patient, but did not cause harm (includes errors of omission)
☐	Category D	Event occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to prevent harm
	EVENT	**HARM**
☐	Category E	Event occurred that may have contributed to, or resulted in, temporary harm to the patient of unknown duration and required intervention
☐	Category F	Event occurred that may have contributed to, or resulted in, temporary harm to the patient and required initial or prolonged hospitalization
☐	Category G	Event occurred that may have contributed to, or resulted in, permanent harm to patient
☐	Ctegory H	Event occurred that required intervention necessary to sustain life
	EVENT	**DEATH**
☐	Category I	Event occurred that may have contributed to, or resulted in, patient death

DESCRIBE THE EVENT, how it occurred, how it was discovered (a narrative may be attached):

_____

_____

_____

_____

_____

_____

_____

_____

Check the ONE category that describes the TYPE of the REPORTABLE EVENT. "Serious injury" is defined as a disease, inaction or injury that changes the patient's risk status for life, requiring monitoring or treatment that was previously not needed before the event.

SURGICAL EVENTS

- ☐ Surgery or other invasive procedure performed on the wrong site
- ☐ Surgery or other invasive procedure performed on the wrong patient
- ☐ Wrong surgical or other invasive procedure performed on a patient
- ☐ Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- ☐ Intraoperative or immediately postoperative/post procedure (first 24 hrs) death in an ASA Class I patient
- ☐ Surgical or other invasive procedure event not otherwise specified

PRODUCT OR DEVICE EVENTS

- ☐ Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
- ☐ Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than intended
- ☐ Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
- ☐ Product or device event not otherwise specified

PATIENT PROTECTION EVENTS

- ☐ Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
- ☐ Patient death or serious injury associated with patient elopement (disappearance)
- ☐ Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting or suicide within 72 hours of discharge
- ☐ Patient protection event not otherwise specified

CARE MANAGEMENT EVENTS

- ☐ Patient death or serious injury associated with 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)
- ☐ Medication error not otherwise specified
- ☐ Patient death or serious injury associated with unsafe administration of blood products
- ☐ Maternal death or serious injury associated with labor or delivery in a low risk pregnancy while being cared for in a healthcare setting
- ☐ Death or serious injury of a neonate associated with labor or delivery in a low risk pregnancy while being cared for in a healthcare setting
- ☐ Death or serious injury (kernicterus) associated with the failure to identify and treat hyperbilirubinemia (bilirubin greater than 30 milligrams/deciliter) in neonates
- ☐ Patient death or serious injury associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- ☐ Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- ☐ Patient fall not otherwise specified
- ☐ Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
- ☐ Healthcare acquired infection in a low risk patient (e.g. non-immunocompromised, etc.)
- ☐ Artificial insemination with the wrong donor sperm or wrong egg
- ☐ Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
- ☐ Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
- ☐ Unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition
- ☐ Failure/delayed response to change in patient's condition
- ☐ Care management event not otherwise specified

ENVIRONMENTAL EVENTS

- ☐ Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
- ☐ Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances
- ☐ Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- ☐ Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
- ☐ Environmental event not otherwise specified

RADIOLOGIC EVENTS

- ☐ Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
- ☐ Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field or any delivery of radiotherapy to the wrong region or greater than 25% above the planned dose
- ☐ Radiologic event not otherwise specified.

POTENTIAL CRIMINAL EVENTS

- ☐ Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- ☐ Abduction of a patient/resident of any age
- ☐ Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
- ☐ Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

OTHER

- ☐ Other (please describe) *Include events that are not listed here but have educational value for other health care facilities

Check factors that contributed to the event:

- ☐ A contributing factor not determined
- ☐ Barcode, missing
- ☐ Barcode, non-readable
- ☐ Barcode, system non-functional
- ☐ Code situation
- ☐ Computer system/network down
- ☐ Cross coverage
- ☐ Distractions
- ☐ Emergency situation
- ☐ Fatigue
- ☐ Imprint, identification failure
- ☐ Language, barrier
- ☐ No 24-hour pharmacy
- ☐ No access to patient info
- ☐ Patient names similar/same
- ☐ Patient transfer
- ☐ Poor lighting
- ☐ Range orders
- ☐ Shift change
- ☐ Staff, agency/ temporary
- ☐ Staff, floating
- ☐ Staff, inexperienced
- ☐ Staffing, alternative hours
- ☐ Staffing, insufficient
- ☐ Workload increase
- ☐ Other:_____
- ☐ Other:_____

Check known immediate or proximal cause(s) of the event:

Documentation

- ☐ Abbreviations (including leading zero missing and trailing zero present)
- ☐ Blanket orders
- ☐ Documentation inaccurate /omitted/ illegible/ confusing
- ☐ Non-metric units used
- ☐ Order confusing/incomplete
- ☐ Prefix/suffix misinterpreted
- ☐ Pre-printed order forms
- ☐ Other: _____

Electronic Medical Record

- ☐ Computer screen display unclear/confusing
- ☐ Computer prescriber order entry
- ☐ Computer entry
- ☐ Computer software
- ☐ Information mgmt. system
- ☐ Barcode-inaccurate, missing
- ☐ Other: _____

Environment

- ☐ Physical environment condition
- ☐ Workflow disruption
- ☐ Other: _____

Equipment:

- ☐ Equipment design confusing/inadequate
- ☐ Equipment failure/malfunction
- ☐ Equipment-improperly operated
- ☐ Equipment maintenance
- ☐ Fax/scanner involved
- ☐ Dispensing device involved
- ☐ Override warnings
- ☐ Other: _____

Human Performance

- ☐ Handoff Communication
- ☐ Did not communicate concern up the chain of command
- ☐ Knowledge deficit/training insufficient
- ☐ Language Barrier
- ☐ Patient disregarded instruction
- ☐ Patient identification failure
- ☐ Performance (human) deficit
- ☐ Shift Change
- ☐ Other: _____

Management System

- ☐ Measuring device inaccurate/inappropriate
- ☐ Monitoring inadequate/lacking
- ☐ Information mgt. system
- ☐ Reference material confusing/inaccurate
- ☐ Procedure/Protocol not followed
- ☐ Staffing issues
- ☐ System safeguards inadequate
- ☐ Other: _____

Supplies

- ☐ Barcode unavailable
- ☐ Label (manufacturer's) design
- ☐ Label (your facility's) design
- ☐ Labeling process
- ☐ Similar Packaging/container design
- ☐ Repackaging by your facility
- ☐ Repackaging by other facility
- ☐ Similar products
- ☐ Storage proximity
- ☐ Unlabeled syringe/container
- ☐ Other: _____

Medication

- ☐ Contraindicated, drug allergy
- ☐ Contraindicated, drug/ drug
- ☐ Contraindicated, drug/ food
- ☐ Contraindicated in disease
- ☐ Contraindicated in pregnancy/breastfeeding
- ☐ Decimal point
- ☐ Diluent wrong
- ☐ Dispensing device involved
- ☐ Dosage form confusion
- ☐ Drug distribution system
- ☐ Drug unavailable
- ☐ Incorrect medication activation
- ☐ Look alike/sound alike medications
- ☐ MAR variance
- ☐ Non-formulary drug
- ☐ Reconciliation-admission
- ☐ Reconciliation-discharge
- ☐ Reconciliation-transition
- ☐ Storage proximity
- ☐ Other: _____

Please attach a summary of the causal statements from your root cause analysis.

Recall that causal statements must follow five rules:

RCA Not Applicable (Harm less than E)_____

1. Clearly show cause and effect relationships
2. Use specific and accurate descriptions
3. Identify the system cause of the error
4. Identify preceding cause of policy or procedure violation
5. Acknowledge that a failure to act is only causal when there is a preceding duty to act

Please check the categories of causal statements discovered in your root cause analysis:

- ☐ Environment/Equipment/Software
- ☐ Human Factors/Communication
- ☐ Human Factors/Fatigue/Scheduling
- ☐ Human Factors/Training
- ☐ Organizational Factors
- ☐ Patient Management Factors
- ☐ Patient/Family Factors
- ☐ Rules/Policies/Procedures

ACTION PLAN

Please attach a summary of your action plan, which includes the following information

1. **Date(s) for completion of action plan(s):** _____
2. **Individual(s) accountable for implementing your action plan(s):** _____
3. **Measures of the effectiveness of your action plan(s).**
4. **Specific changes implemented to reduce the risk of the event recurring.**

   _____

   _____

   _____

   _____
5. **Was this event reported to the patient/family? Yes___ No___ If no, why not?** _____

Check actions taken to avoid future events:

- ☐ Communication process improved
- ☐ Education/ training provided
- ☐ Environment modified
- ☐ Equipment/ software modified
- ☐ Formulary changed
- ☐ Informed patient/ caregiver of error
- ☐ Policy/ procedure changed
- ☐ Policy/ procedure instituted
- ☐ Staffing practice/ policy modified

As outlined in Nebraska Statute and in your contract with the Coalition, for each reportable event, you are to **complete a root cause analysis (RCA) within 45 days of the event**. Use this form and necessary attachments to **report a summary of the RCA to the Coalition within 30 days of its completion**. Please email an electronic copy of this form and any supporting documents to ncps@unmc.edu - please ensure the email you are sending is encrypted! If you would like to test your email's encryption software, please send a test email with "Encryption Test" in the subject, along with any other keywords your organization requires to encrypt the email (e.g. 'Confidential', '4Private', etc.), to ncps@unmc.edu and we will be happy to work with you.