Safety Intelligence (SI) Downtime Form

Privileged & Confidential as provided for under the NJ Patient Safety Act: NJSA 26:2H-12.25(g) et. Seq. Ref. NJAC 8:43E-10 et. Seq.

Frontline Reporter-Patient Event

This document illustrates the flow of complete set of questions for the Frontline Reporter in the Patient Safety Net® (PSN). These forms incorporate the questions outlined in the AHRQ Common Formats. PSN organizations can customize the display of the detail questions to the frontline reporter (e.g., hide a question or set it to required), so the set of questions that appear in your Patient Safety Net® tool may be different than those in this document.

START

***Date of Patient Admission**
***Or* Ambulatory Encounter**

Date (mm/dd/yyyy) _____ /_____ /_____
❑Unknown

***Medical Record *or* Patient Account Number:**

_____

Patient Last Name:

Patient First Name:

***Date of Birth:**

Date (mm/dd/yyyy): _____ /_____ /_____
❑Unknown

***Gender:**

❍ Male
❍ Female
❍ Unknown

Race:

❍ American Indian or Alaskan Native
❍ Asian
❍ Black or African American
❍ Native Hawaiian or other Pacific Islander
❍ White
❍ More than one race
❍ Unknown

Event Basics

***Event Type**

Select ONE event type:

❍ Adverse reaction
❍ Anesthesia event
❍ Behavioral event
❍ Care coordination/communication
❍ Complication of surgery or anesthesia
❍ Complications of care (unanticipated, non-surgical)
❍ Equipment/devices
❍ Event relating to surgery or invasive procedure
❍ Fall
❍ Food/nutrition
❍ Healthcare-associated infection (HAI)
❍ Laboratory test
❍ Liver/transplant complications
❍ Maternal
❍ Medical records/patient identification
❍ Medication related
❍ Neonatal
❍ Omission/errors in assessment, diagnosis, monitoring
❍ Other/miscellaneous
❍ Radiology/imaging test
❍ Respiratory care
❍ Skin integrity
❍ Supplies
❍ Transfusion

Safety Intelligence (SI) Downtime Form

Privileged & Confidential as provided for under the NJ Patient Safety Act: NJSA 26:2H-12.25(g) et. Seq. Ref. NJAC 8:43E-10 et. Seq.

Frontline Reporter-Patient Event

***Event Discovery Date and Time (military):**

Date (mm/dd/yyyy) _____/ _____ /_____
❑Unknown

Time (military): _____:_____
❑Unknown

***Event Occurrence Date and Time (military):**

Date (mm/dd/yyyy) _____/ _____ /_____
❑Unknown

Time (military): _____:_____
❑Unknown

Was the event related to handover/handoff?

❍ Yes
❍ No
❍ Unknown

How did you learn about the event? (Check all that apply)

❑ Assessment after event
❑ Report by another staff member
❑ Report by family or visitors
❑ Report by patient
❑ Review of record or chart
❑ Witnessed / Involved
❑ Other

Event Location

***Primary Location where event occurred:**

_____

Other Location or Service (if applicable):

_____

Clinical/Hospital Service:

_____

Event Detail

DO NOT include names of individuals. Instead, use terms like "patient", "nurse". Stick to the facts.

SITUATION:

BACKGROUND:

ASSESSMENT:

RECOMMENDATION:

Describe any factors contributing to the event, lessons learned, and/or recommendations to prevent recurrence:

Harm Score

***Extent of harm:**

Harm:

- ❍ 9 Death
- ❍ 8 Severe permanent harm
- ❍ 7 Permanent harm
- ❍ 6 Temporary harm

Reached the Patient:

- ❍ 5 Additional treatment
- ❍ 4 Emotional distress or inconvenience
- ❍ 3 No harm evident, physical or otherwise

Near Miss:

- ❍ 2 Near miss
- ❍ 1 Unsafe condition

***What prevented the near miss from reaching the patient?**

- ❍ Fail-safe designed into the process and/or a safeguard worked effectively
- ❍ Practitioner or staff who made the error noticed and recovered from the error (avoiding any possibility of it reaching the patient)
- ❍ Spontaneous action by a practitioner or staff member (other than person making the error) prevented the event from reaching the patient
- ❍ Action by the patient or patient's family member prevented the event from reaching the patient
- ❍ Unknown
- ❍ Other

How long after the incident was harm assessed (approx)?

- ❍ Within 24 hours
- ❍ After 24 hours but before 3 days
- ❍ 3 days or later
- ❍ Unknown

Was any intervention attempted to prevent, reverse or halt the progression of harm?

❍ Yes

❍ No

❍ Unknown

Which of these interventions (rescues) were performed? (Check all that apply):

- ❑ Transfer, including transfer to a higher level of care area within facility, or transfer to another facility, or hospital admission (from outpatient)
- ❑ Monitoring, including observation, physiological examination, laboratory testing, phlebotomy, and/or imaging studies
- ❑ Medication therapy, including administration of antidote, change in pre-incident dose or route
- ❑ Surgical intervention
- ❑ Respiratory support (e.g., ventilation, tracheotomy)
- ❑ Blood transfusion
- ❑ Counseling or psychotherapy
- ❑ Unknown
- ❑ Other intervention (specify)**:**

Nature of Injury:

- ❍ Abrasion
- ❍ Allergic Reaction
- ❍ Aspiration
- ❍ Bite
- ❍ Blister
- ❍ Bruise
- ❍ Thermal Burn
- ❍ Electrosurgical Burn
- ❍ Cellulitis
- ❍ Compartment Syndrome
- ❍ Contusion
- ❍ Dental Injury
- ❍ Dislocation
- ❍ Edema
- ❍ Extravasation
- ❍ Fracture
- ❍ Hematoma
- ❍ Hemorrhage
- ❍ Infection
- ❍ Infiltration
- ❍ Laceration
- ❍ Pain
- ❍ Phlebitis
- ❍ Pulmonary Embolism
- ❍ Punctured
- ❍ Rash
- ❍ Retained Foreign Body
- ❍ Scratch
- ❍ Skin Tear
- ❍ Ulcer
- ❍ No Injury
- ❍ Other

Misc. Info

Who was notified? (Check all that apply)

❍ Covering Physician

Date notified (mm/dd/yyyy) _____/ _____ /_____

❑ Check here if date is unknown

Time notified (military): _____:_____

❑ Check here if time is unknown

❍ Patient or Family
Date notified (mm/dd/yyyy) _____/ _____ /_____
❑ Check here if date is unknown

Time notified (military): _____:_____
❑ Check here if time is unknown

❍ Other designated contact
Date notified (mm/dd/yyyy) _____/ _____ /_____
❑ Check here if date is unknown

Time notified (military): _____:_____
❑ Check here if time is unknown

Others notified (check all that apply):
- ❑ Employee Health
- ❑ Human Resources
- ❑ Nurse
- ❑ Manager/Supervisor
- ❑ Risk Management (by phone)
- ❑ Security/Police
- ❑ Other (specify):

Who else was involved (e.g. patient, staff, visitor)?

Last Name	First Name	Phone or email	Dept

Reporter Info *(leave this section blank if you prefer to remain anonymous)*

Reporter Role:

- ❍ Registered Nurse
- ❍ Charge Nurse
- ❍ Float nursing staff
- ❍ Nurse's Aide
- ❍ Nurse Practitioner
- ❍ Nursing Student
- ❍ LPN
- ❍ CRNA
- ❍ Pharmacist
- ❍ Pharmacy resident
- ❍ Pharmacy student
- ❍ Pharmacy technician
- ❍ Physician – attending/staff
- ❍ Physician – resident/intern/fellow
- ❍ Physician Assistant
- ❍ Medical Assistant
- ❍ Medical student
- ❍ Midwife
- ❍ Respiratory therapist
- ❍ Radiation Therapist
- ❍ Technologist/Technician (lab, X-ray, etc)
- ❍ Security
- ❍ Volunteer
- ❍ Care Tech
- ❍ Unit secretary/Clerk
- ❍ Manager
- ❍ Lab/Radiology Tech
- ❍ Laboratory Coordinator/Supervisor
- ❍ Specimen/pathology Coordinator
- ❍ Phlebotomist
- ❍ Mental Health Counselor
- ❍ Clinic Director
- ❍ LCSW
- ❍ Dietician/dietary aide
- ❍ Paramedic/EMT
- ❍ Patient Relations/representative
- ❍ Social worker
- ❍ Chaplain
- ❍ PT/OT
- ❍ Infection Control Practitioner
- ❍ Anonymous
- ❍ Other (specify)

Reporter Last Name: _____

Reporter First Name: _____

Reporter Contact Information:

Phone: _____

Email: _____

❑ Check here if you would like feedback from your manager and confirmation of report submission by email

Forward this completed paper form to Patient Safety via hard copy, fax or email:

IN PERSON:
Patient Safety Office, UH B261, 8 am to 4 pm

VIA FAX:
973-972-1567

VIA EMAIL:
patientsafety@uhnj.org

Thank you for your work in keeping our patients safe.