Patient Safety Incident Report Form

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. Subsequently, recommendations will be developed for quality improvement and risk management. This form will not be used for NP student evaluation.

This form is not meant to be a substitute to the health region’s incident reporting. Patient Safety Incidents may occur when nurse practitioner (NP) 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 clients/preceptors 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 NP students and faculty, or Health Region/Agency 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)

During the pandemic – any transmission of a COVID-19 infection from a student to a client, preceptor, faculty member or another NP student will be considered a Critical Incident due to the potential for serious harm.
Patient Safety Incident Report Form

Section 1: To be completed by the NP student.

1. Program Name:
   ___ MN-NP
   ___ PGDSC- NP

2. Practicum Health Care Agency:

3. Employment Health Care Agency:

4. Date of Event:

5. Date Reported to FRP:

6. Date form completed:

7. Course:
   ___ NURS 884
   ___ NURS 875
   ___ NURS 880
   ___ NURS 888
   ___ NURS 878

8. Individual Completing Report:
   ___ Faculty
   ___ Student

9. Student Year in Program: ___ 2nd ___ 3rd ___ 4th ___ Other: (specify)

10. Term: ___ Term 1 Fall ___ Term 2nd Winter ___ Term 3/4 Spring/Summer

11. Describe incident in detail:

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

13. How would you categorize this event?
   ___ No Harm Incident
   ___ Near Miss or Close Call
   ___ Adverse Event
Critical Incident

14. The event involved a(n)?
   ____Fall.
   ____Medication.
   ____Injection/Immunization.
   ____Procedure.
   ____Minor Surgical Procedure
   Other: (Describe)

15. Identify at what time during the term the event occurred.
   ____Beginning    ____Middle    ____End

16. Identify the time of day the event occurred.
   ____Morning (0700 - 1200 hours)
   ____Afternoon (1200 – 1900 hours)
   ____Evening (1900 – 2400 hours)
   ____Night (2400 – 0700 hours)

17. Identify the clinical area the event occurred.
   ____ Primary Care Clinic
   ____Mental Health
   ____Long-Term Care
   ____Corrections
   ____Pharmacy
   ____Physiotherapy
   ____Specialist Office
   ____ER
   ____Other:
18. Miscommunication between:
   ___Student and client
   ___Student and health team member
   ___Student and faculty
   ___Student and preceptor
   ___Student and other department(s)
   ___Other: (Describe)

19. Resources:
   ___Inadequate information
   ___Staff or faculty not available;
   ___Staff shortage
   ___Written resources unavailable
   ___Current and credible information unavailable
   ___Inadequate policies and procedures
   ___Other: (Describe)

20. Medical Device:
   ___Malfunction
   ___Lack of availability
   ___Product labeling confusion
   ___Other: (Describe)

21. Individual:
   ___Felt pressured to perform task quickly
   ___Did not feel adequately prepared to manage the care or skill
   ___Fatigued
   ___Other: (Describe)
22. Environment:
___ Work area layout problematic
___ Need for rapid care management decisions
___ Environment prone to distractions and interruptions
___ Other: (Describe)

23. Client:
___ Confused
___ Unsteady or weak
___ Other: (Describe)

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

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Section 2: The following to be completed by Faculty/FRP:

1. Describe follow-up with student:

2. Describe follow-up with health region or clinical agency, including details of disclosure (if known):

3. Describe preliminary investigation (what happened, how and why it happened, and the development and management of recommended actions):

4. Who was notified:

5. Is further action required:
   ___ No
   ___ Yes. (Describe)
6. Recommendations to reduce risk of recurrence:

7. Was this incident reviewed during College of Nursing NP Program Aggregate Review:
   ___ No
   ___ Yes. (Describe)

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

9. Implementation Plan:

10. Evaluation Plan:

Privileged and confidential for quality improvement purposes.

Return form to the Director NP Programs