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 COVD-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:

2. 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