CONFIDENTIAL

Adverse Patient Safety Event Report

Patient Name:_____ MR#:_____

Date of Event: _____Time:_____ Team: _____

Location of Event: ❑ Home ❑ LTC ❑ ALF ❑ IPU ❑ Other: _____

Staff Involved:_____

Event	Event Detail
Fall ❑ #1 ❑ #2 ❑ #3 ❑ #._____	❑ Witnessed ❑ Unwitnessed Name of witness:_____ Injury: ❑ None ❑ Minor ❑ Major ❑ Death Location of Injury: _____
Medication Error	❑ Wrong Pt ❑ Wrong Dose ❑ Wrong Time ❑ Wrong Medication ❑ Wrong Route ❑ Other:_____
Equipment Issue/Failure	Specify Equipment:_____ Specify Equipment:_____ Specify Equipment:_____
Other Adverse Event:	

Event Summary: (Who, what, why, how, include witness names and all details) _____

_____

_____

_____

_____

Immediate Actions Taken/Safety Measures Implemented: _____

_____

_____

_____

_____

Family Notified: ❑ Yes ❑ No Who:_____ Date/Time:_____

Physician notified: ❑ Yes ❑ No Attending:_____

Hospice Medical Director: ❑ Yes ❑ No _____

Report Submitted by: _____ Investigated by: _____

Management Reviewer Name/Signature: _____/_____

Form Review: April 2018 Completed form to be submitted to the Director of Clinical Operations

Lifesong Hospice and Palliative Care