Adverse Event/Incident Report DO NOT PHOTOCOPY

Gramercy surgery center

Date of Occurrence:_____Time of Occurrence:_____Date of Report: _____

Incident Report By: Name: _____Title:_____Signature: _____

Patient:_____**Procedure:** _____

Location: ☐ Procedure Room ☐ OR #____ ☐ Pre-op ☐ Recovery Room ☐ Waiting Room ☐ Other _____

List of people in the room_____

_____

Nature of Incident:

1. **Falls:** ☐ Assisted to Floor ☐ Fall Alleged ☐ Fall Witnessed ☐ Found on Floor
   Related To: ☐ Ambulating ☐ Bathroom ☐ Bed ☐ Chair ☐ Other Person ☐ Stretcher/Table ☐ Unknown

2. **Skin:** ☐ Break/Tear/Scratch ☐ Burn ☐ Pressure Ulcer (Community) ☐ Pressure Ulcer (Newly Acquired)

3. **Lost/Damaged Property:** ☐ Articles/Clothing ☐ Cash ☐ Dentures ☐ Electronic Equipment ☐ Glasses/Lens ☐ Jewelry

4. **Institutional Conditions**: ☐ External Disaster Fire ☐ HAZMAT Disposal ☐ Poisoning ☐ Power Failure ☐ Service - Termination ☐ Spill/Leak

5. **Patient Associated Events:** ☐ AMA ☐ Assault ☐ Elopement ☐ Employee Actions ☐ Needlesticks ☐ Patient Actions ☐ Self-Injury ☐ Visitor Actions ☐ Anesthesia Related ☐ Cardiac Arrest ☐ Consent Issues ☐ Displacement/Break Implant ☐ Incorrect Instrument Count ☐ Incorrect Needle Count ☐ Incorrect Procedure ☐ Incorrect Sponge Count ☐ Injury to Patient ☐ Laparoscopic to Open Procedure ☐ New Onset Neuro Deficit ☐ Peripheral Neuro Deficit ☐ Retained Foreign Body ☐ Return to OR ☐ Surgical Complication ☐ Unanticipated Organ Removal ☐ Unanticipated Organ Repair ☐ Wrong Patient ☐ Wrong Site Surgery

6. **Instrument/Equipment**
Manufacturer: _____ **Serial #:** _____
Model #: _____ **Type:** _____
Problem: _____

7. **Medications Problem/Error: Type:** _____
☐ Documentation ☐ Dosage ☐ Infiltration ☐ Non-Prescribed ☐ Omission ☐ Patient ID ☐ Pharmacy ☐ Physician Orders ☐ Rate ☐ Reaction ☐ Route ☐ Self-Medication ☐ Technique ☐ Time

8. **Unexpected Event** – Non-Illness Related: ☐ Aspiration (Related to Conscious Sedation) ☐ CAC/Respirator Arrest ☐ Death ☐ Hospital Admission Following Surgery ☐ Impairment of Limb ☐ Loss/Impairment Body Function

Occurrence Description:
_____

Physician/PA Findings

☐No Changes in Condition	☐Ecchymosis	☐ Loss of Consciousness	☐ Pulmonary Edema
☐Abscess	☐Edema	☐ Necrosis	☐ Pulmonary Embolism
☐Anaphylaxis	☐Emotional	☐ Neurological Impairment	☐ Respiratory Arrest
☐Anastomotic Leak	☐Fluid Overload	☐ Pain	☐ Rupture
☐Burn	☐Fracture	☐ Perforation	☐ Seizure
☐Cardiac Arrest	☐Hematoma	☐ Peripheral/Neuro Impairment	☐ Shock
☐Contusion	☐Hemorrhage	☐ Peritonitis	☐ Sprains/Strain
☐Death	☐Infection	☐ Phlebitis	☐ Tooth Injury
☐Deep Vein Thrombosis	☐Inflammation	☐ Pneumonia	☐ Trauma
☐Dehiscence	☐Laceration	☐ Pneumothorax	☐ Unknown

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Corrective Plan of Action:

Physician/PA Name	ID Number	Signature	Date

Status: ☐ Surgeon ☐ Resident ☐ PA ☐ Anesthesiologist

Preventative Plan of Action:

Reviewed by Medical Director:

Name: _____ Title: _____ Signature: _____ Date: _____

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