

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
 DEPARTMENT OF HEALTH
 HEALTH REGULATION AND LICENSING ADMINISTRATION (HRLA)**

Board of Medicine

Mailing Address
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ADVERSE EVENT REPORTING FORM

DEMOGRAPHIC DATA – All Facilities

HEALTHCARE PROVIDER OR MEDICAL FACILITY INFORMATION:

<input type="checkbox"/> Health Clinic <input type="checkbox"/> General Hospital/Children's Hospital <input type="checkbox"/> Other* _____ (Specify)	<input type="checkbox"/> Physician or Healthcare Practitioner's Office <input type="checkbox"/> Long-Term Care Facility <input type="checkbox"/> Outpatient Surgical Facility <input type="checkbox"/> Nursing Facility
Facility Name and Address:	License Number:
	Sequential Report Number: **
Reporter's Name:	
Contact Person: Name: _____ Telephone Number: _____	

PATIENT INFORMATION:

Age _____	Date of Admission:
<input type="checkbox"/> M <input type="checkbox"/> F	Date and Time of Event: Date: _____ Time: _____
Date and Time Event First Known: Date: _____ Time: _____	
Date of Patient Death (if applicable):	
Admission Diagnosis:	

*The definition of who must report is very expansive. See definition at D.C. Official Code § 7-161

**The Medical Malpractice Amendment Act of 2006 requires that adverse events be reported with the patient being "de-identified and anonymous." Please use a report number which relates to the specific patient and event, so that if more information is needed the response will be appropriate to the patient and event.

DEPARTMENT OF HEALTH
ADVERSE EVENT REPORTING FORM

Sequential Report Number _____

DEMOGRAPHICS – Hospitals Only

<input type="checkbox"/> Inpatient <input type="checkbox"/> Hospital Based <input type="checkbox"/> Off Campus Satellite Site Name: _____ Address: _____	<input type="checkbox"/> Outpatient <input type="checkbox"/> Hospital Based <input type="checkbox"/> Off Campus Satellite Site Name: _____ Address: _____
LOCATION OF OCCURRENCE: <input type="checkbox"/> Medical Intensive Care <input type="checkbox"/> Neonatal/Pediatric Intensive Care <input type="checkbox"/> Surgical Intensive Care Unit <input type="checkbox"/> Adult Medical Adult <input type="checkbox"/> Surgical Ambulatory <input type="checkbox"/> Surgical Cardiac <input type="checkbox"/> Cath Lab Cardiac <input type="checkbox"/> Care <input type="checkbox"/> Dialysis <input type="checkbox"/> Emergency Department	<input type="checkbox"/> Obstetrical /Gynecological <input type="checkbox"/> Operating Room <input type="checkbox"/> Outpatient Services - Specify Type: _____ <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psychiatric <input type="checkbox"/> Diagnostic Services – Specify Type: _____ <input type="checkbox"/> Rehabilitative Services – Specify Type: _____ <input type="checkbox"/> Other: _____

NOTIFICATIONS:

PATIENT AND/OR AUTHORIZED REPRESENTATIVE NOTIFIED OF EVENT: Y ☐ Date notified _____ N ☐

DID THE PATIENT EXPIRE? Y ☐ N ☐

If yes:

MEDICAL EXAMINER NOTIFIED Y <input type="checkbox"/> N <input type="checkbox"/> CASE NUMBER (if applicable): _____	AUTOPSY PERFORMED (if applicable) Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/> LOCATION: _____
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At the time of this report, were any other entities known to have been notified of this event?

Check all that apply: <input type="checkbox"/> Centers for Medicare/Medicaid Services <input type="checkbox"/> Department of Children and Families <input type="checkbox"/> Food and Drug Administration <input type="checkbox"/> Joint Commission on the Accreditation of Health Care Organizations (JCAHO) <input type="checkbox"/> Product Manufacturer	<input type="checkbox"/> Local/State Police <input type="checkbox"/> District Fire Chief <input type="checkbox"/> Department of Social Services, Protective Services <input type="checkbox"/> Other _____ (Specify) <input type="checkbox"/> Unknown to reporter at time of report
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DEPARTMENT OF HEALTH
ADVERSE EVENT REPORTING FORM

Sequential Report Number

DESCRIPTION OF EVENT HERE FROM LIST FOLLOWING

Facts of Event and Status of Patient Condition Currently:

Describe immediate medical response at time adverse event discovered
and patient outcome.

FOR HRLA USE ONLY

Date Report Received - Emergent	
Date Report Received	
Date Corrective Action Plan Received	

DEPARTMENT OF HEALTH
ADVERSE EVENT REPORTING FORM

CORRECTIVE ACTION PLAN (CAP)

Sequential Report Number

Facility:	Sequential Report Number for which this plan is being submitted:
	Date CAP Submitted:
Event being addressed:	
Findings:	
Corrective Action Plan to prevent reoccurrence:	
Does JCAHO require a root cause analysis for this event? Y <input type="checkbox"/> N <input type="checkbox"/>	
Timeline for implementation:	Completion date for CAP:
Identification of staff member, by title, who has been designated the responsibility for monitoring CAP implementation:	
Submitted by:	Date:

DEPARTMENT OF HEALTH
ADVERSE EVENT REPORTING FORM

Sequential Report Number

CHECK OFF THE ONE BELOW THAT APPLIES

EVENT	ADDITIONAL SPECIFICATIONS
1. SURGICAL EVENTS	
<input type="checkbox"/> 1A. Surgery performed on the wrong body part	<p>Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient.</p> <p>Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>
<input type="checkbox"/> 1B. Surgery performed on the wrong patient	<p>Defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>
<input type="checkbox"/> 1C. Wrong surgical procedure performed on a patient	<p>Defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient.</p> <p>Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>
<input type="checkbox"/> 1D. Retention of a foreign object in a patient after surgery or other procedure	<p>Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.</p>
<input type="checkbox"/> 1E. Intraoperative or immediate post-operative death in an ASA (American Society of Anesthesiology) Class I patient	<p>Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>Immediately post-operative means within 24 hours after induction of anesthesia (if surgery not completed), surgery, or other invasive procedure was completed.</p>

DEPARTMENT OF HEALTH
ADVERSE EVENT REPORTING FORM

Sequential Report Number _____

2. PRODUCT OR DEVICE EVENTS	
<input type="checkbox"/> 2A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility.	Includes generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.
<input type="checkbox"/> 2B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended.	Includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.
<input type="checkbox"/> 2C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.	Excludes deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
3. PATIENT PROTECTION EVENTS	
<input type="checkbox"/> 3A. Infant discharged to the wrong person.	
<input type="checkbox"/> 3B. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours.	Excludes events involving competent adults.
<input type="checkbox"/> 3C. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.	Defined as events that result from patient actions after admission to a healthcare facility. Excludes deaths resulting from self-inflicted injuries that were the reason for admission to the healthcare facility.
4. CARE MANAGEMENT EVENTS	
<input type="checkbox"/> 4A. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration).	Excludes reasonable differences in clinical judgment on drug selection and dose.
<input type="checkbox"/> 4B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.	
<input type="checkbox"/> 4C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility	Includes events that occur within 42 days post-delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.

DEPARTMENT OF HEALTH
ADVERSE EVENT REPORTING FORM

Sequential Report Number _____

<input type="checkbox"/> 4D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility.	
<input type="checkbox"/> 4E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates.	Hyperbilirubinemia is defined as bilirubin levels >30mg/dl. Neonates refers to the first 28 days of life.
<input type="checkbox"/> 4F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.	Excludes progression from Stage 2 to Stage 3, if Stage 2 was recognized upon admission.
<input type="checkbox"/> 4G. Patient death or serious disability due to spinal manipulative therapy.	
5. ENVIRONMENTAL EVENTS	
<input type="checkbox"/> 5A. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility.	Excludes events involving planned treatments such as electric countershock.
<input type="checkbox"/> 5B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.	
<input type="checkbox"/> 5C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.	
<input type="checkbox"/> 5D. Patient death associated with a fall while being cared for in a healthcare facility.	
<input type="checkbox"/> 5E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.	
6. CRIMINAL EVENTS	
<input type="checkbox"/> 6A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.	
<input type="checkbox"/> 6B. Abduction of a patient of any age.	
<input type="checkbox"/> 6C. Sexual assault on a patient within or on the grounds of a healthcare facility.	
<input type="checkbox"/> 6D. Death or significant injury of a patient or staff	

DEPARTMENT OF HEALTH
ADVERSE EVENT REPORTING FORM

Sequential Report Number _____

member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility	
7. DISTRICT OF COLUMBIA	
<input type="checkbox"/> Nosocomial infection defined as a central catheter associated laboratory confirmed primary bloodstream infection.	HAI data should be reported to the CDC through the National Healthcare Safety Network to be risk adjusted and reported to DC HRLA.

Additional Comments:

Person Submitting
Adverse Event Report

Print Name_____

Signature_____

Title_____

Phone_____

Date Submitted_____