Atal Bihari Vajpayee Institute of Medical Sciences and Dr Ram Manohar Lohia Hospital

Baba Kharak Singh Marg, New Delhi-110001

INCIDENT / ACCIDENT REPORTING FORM

S. No. _____

An incident is any happening which is not consistent with the routine operation of the hospital or the routine care of a particular patient. It includes occurrences within the hospital that could have led or did lead to an undesirable outcome. **Sentinel** event is an incident which leads to death or **major and enduring loss of function** for a recipient of Health care services. The impairment lasts for a minimum period of 2 weeks and is not related to any underlying condition.

INSTRUCTIONS :

1. Strike out entire sections that do no apply
2. Complete both sides and sign reports
3. The completed form should be submitted to Safety Committee within 48 hours of the incident for onward transmission to Quality Department.
4. **Tick mark appropriately** : Incident form has been filled earlier for the same person anytime after admission : **YES / NO**

UHID/CR No._____

MLC No. _____

Patient / Visitor Name / Incident related person -	Treating Doctor –
Age –	Date of admission –
Sex –	Diagnosis
MRD No –	Operation done (if any)
Location –	Date of incident – Time -
	Date of report – Time -

1. TYPE OF INCIDENT

A) Surgery or anesthesia related

- performed on wrong site/side
- performed on wrong patient
- Wrong surgical procedure performed on patient
- Retained instrument / material discovered post surgery
- Death during or immediately after surgery
- Anesthesia related adverse event
- Death / Disability due to spinal manipulative surgery (Tick mark)
- Patient landing up into a major surgery as a result of the complications of some minor procedure performed

B) Device / equipment related

- Use of contaminated drugs, devices or any other product
- Use and function of a device in a manner other than the device's intended use
- Intravascular air embolism
- Burn
- Injury due to restraint

C) Patient protection even

- Vulnerable patient discharged to wrong person
- Patient suicide / attempated suicide
- Patient absconding
- Wrong gas / gas contaminated by toxic substances delivered

D) Environment related

- Burn incurred from any source (other than device. Don't repeat if covered in point B)
- Patient slip / trip/fall
- Electric shock
- Bumped or struck by object
- Infrastructure failure / collapse

E) Care management event

- **Transfusion reaction related to an administration of incompatible blood/ blood product**
- **Medication error**
  - ☐ **Wrong drug**
  - ☐ **Wrong rate**
  - ☐ **Wrong route**
  - ☐ **Wrong patient**
  - ☐ **Wrong dose**
  - ☐ **Wrong time**
  - ☐ **Wrong administration technique**
  - ☐ **Omission error**
- **An avoidable delay in treatment or response to abnormal test results**

F) Criminal event

- **Physical assault**
- **Sexual assault**
- **Homicide**
- **Abduction of patient**
- **Care provided by an individual impersonating a clinical member / staff**

G) Any other (not listed above)

H) Death / disability due to any of above (B to G, as ascertained by doctor)

- **(Mention about it)** _____
- **Expected period of disability** _____

2. SEVERTY OF INJURY

- **Non apparent**
- **Slight - no treatment**
- **Moderate - first aid**

3. CONTRIBUTING FACTORS

- Language barrier
- Hearing aid
- Limited vision
- Obesity
- Seizures
- Intoxication
- Other

4. CONDITION OF PATIENT / ATTENDANT / EMPLOYEE

(before incident)

- Well oriented
- Confused
- Sedated
- Drowsy
- Hyperactive
- Uncooperative

Other _____

5. PERSONS NOTIFIED

- Consultant
  Sign. Time: Date:
  (Consultant are requested to fill incident form if death / disability happens to the patient due to this incident)
- RMC _____
- Nursing Incharge
- Others _____

6. PERSONS EXAMINING PATIENT AS ARESULT

- Consultant
- RMO
  Name _____
  Date _____
  Time _____
- Nurse
  Name
  Date _____
  Time _____

7. Narrative description of occurrence (Describe how incident happened. Be specific. Do not assume. **Write facts and not opinion.** Quotes should be used when not witnessed by reporter e.g. patient states "—")

8. **Designation of person completing this form** _____

Sign: **Name:** **Date:**

9. Action advised or comments by Nursing Incharge/ HOD/ Medical Superintendent/Safety Committee/Quality Committee

Tick mark appropriately : Incident is SENTINEL / NEAR MISS / MEDICATION ERROR

Sign: **Name:** **Date:**

10. Action advised or comments by Medical Superintendent/Safety Committee/Quality Committee : In case of Sentinel events or OTHERWISE

Tick mark appropriately : Incident is SENTINEL / NEAR MISS / MEDICATION ERROR

Sign: **Name:** **Date:**