Intentional Unsafe Act Report

Submit no later than (7) seven calendar days
following a good faith belief that intentional unsafe act occurred

Please complete all sections of this form by printing or typing the required information. The form must be submitted to the Patient Safety Surveillance & Improvement System via secure email, fax or mail. **See last page of form for contact information.**

1. Facility Identification

Facility name:
Facility address:
(Street) (City) (State) (Zip)

Name and title of person submitting report:
Telephone number: Email address:

2. Employee Information

Full name of staff person involved with unsafe act:

3. Patient Information

Patient name: ______________________________
If a child, parent name(s): ______________________________
Address: ______________________________
____

Date of birth: ___________ Gender: ____________________
Primary diagnosis: ____
Secondary diagnosis: ____

If more than one patient was involved, complete the following. If additional patients were involved, attach a separate page with the patient information included.

Patient name: ______________________________
If a child, parent name(s): ______________________________
Address: ______________________________
____

Date of birth: Gender: ____________________
Primary diagnosis: ____
Secondary diagnosis: ____

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4. Incident Information

Incident date: ______________ Time: ___________

Date you became aware of event: ____________ Time: ___________

Date reported to Vermont Department of Health: _____________

Where was the patient when event occurred? (*Check only one*)

- ☐ Unit Medical
  - ☐ Surgical
  - ☐ ICU
  - ☐ Obstetrics/Gynecology
  - ☐ NICU
  - ☐ Nursery
  - ☐ Pediatric
  - ☐ Other
- ☐ Diagnostic services – specify:
- ☐ Dialysis
- ☐ Emergency Department
- ☐ Labor and Delivery
- ☐ Operating Room
- ☐ Recovery Room
- ☐ Rehabilitative Services – specify:
- ☐ Outpatient Services – specify:
- ☐ Hallway or other common area
- ☐ Other

5. Understanding of event

6. How was event discovered? (*check all that apply*)

- ☐ Reported by staff
  - ☐ Nurse Physician
  - ☐ Unlicensed staff
  - ☐ Other

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- ☐ Assessment of patient after event
- ☐ Report by family/visitor
- ☐ Review of chart/record
- ☐ Report by patient
- ☐ Other:

7. **Outcome of event** (*check only one*)
   - ☐ Death; date of death:
   - ☐ Serious bodily injury – bodily injury that creates substantial risk of death or that causes substantial loss or impairment of function of any bodily member or organ or substantial impairment of health or substantial disfigurement.
   - ☐ Temporary harm, higher level of care required.
   - ☐ Temporary harm, increased monitoring required.
   - ☐ No harm, increased monitoring of patient required.
   - ☐ No harm, no increased monitoring needed.
   - ☐ Near Miss – event could have caused an adverse event but did not harm patient.

8. **Patient/family disclosure:** ☐ Yes ☐ No
   Date of notification:
   If no disclosure, why?

9. **Categorization of event** (*check all that apply*)
   - ☐ Alleged criminal act
   - ☐ Alleged purposefully unsafe act
   - ☐ Alleged alcohol or substance abuse
   - ☐ Alleged patient abuse

10. Was the event reported to another agency?
    - ☐ Yes (*check all that apply*)
      - ☐ Adult Protective Services   Date reported:

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- ☐ Department for Children and Families — Date reported:
- ☐ Law Enforcement — Date reported:
- ☐ Medical Practice Board — Date reported:
- ☐ Office of Professional Regulation — Date reported:
- ☐ Other, specify: — Date reported:

☐ No

11. Is this event also reportable adverse event?

☐ Yes – Complete Reportable Adverse Event initial report form
☐ No

<u>You may email, fax or mail the completed form to the Patient Safety Program.</u>

Email form to: sre@vpqhc.org

Fax form to: Vermont Program for Quality in Health Care, Inc.
802-262-1307
Attention: Patient Safety Program

Mail form to: Vermont Program for Quality in Health Care, Inc
Attention: Patient Safety Program
132 Main Street
Montpelier, VT 05602