Patient Safety Work Product Privileged Document

QUALITY IMPROVEMENT REPORT

Upon completion, please email this form to:

- **The Quality Improvement Event inbox (qualityimprovementevent@adfinitashealth.com)**

PURPOSE: To ensure timely reporting of all patient incidents for tracking, root cause analysis and reporting purposes.

Are you reporting yourself or another provider?: Self ☐ Another provider ☐

REPORTING PROVIDER INFORMATION	Name:	Title:	Date Reported:
	Email:		Phone:
ADDITIONAL PROVIDER INFORMATION	If more than one Provider was involved, please list their names and titles below:		
	Name:	Name:	Name:
	Title:	Title:	Title:

PATIENT INFORMATION	Patient Name:	DOB:
	Did Incident Result in Serious Injury or Death to Patient: Yes ☐ No ☐ Unknown ☐	MRN:

EVENT INFORMATION

Date(s) of Event:

Hospital ☐ or Post-Acute ☐ Name of Facility:

Family Member or Patient Complaint? Yes ☐ No ☐

Please identify type of Event: ☐ or Near Miss : ☐

❑ Unexpected death	❑ Severe burns	❑ Missed radiological study which resulted in a negative outcome
❑ Birth-related injuries	❑ Internal injury	❑ Abduction of any patient receiving care, treatment, and services
❑ Brain damage, neurological impairment	❑ Reproductive organ loss or impairment	❑ Discharge of an infant to the wrong family
❑ Paralysis	❑ Total or partial disability	❑ Other
❑ Loss of hearing or sight	❑ Disfigurement or severe scarring	
❑ Injury due to fall, lifting or repositioning	❑ Delayed finding on an x-ray, lab report, or other study which was not disclosed to a patient or family	
❑ Pressure ulcer leading to bad outcome	❑ Delayed in diagnosis of malignancy or other serious medical condition	
❑ Complications from improper medication or dosage	❑ Illness or injury associated with a hospital-acquired infection	

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Please provide a factual summary describing the incident: