**HOSPITAL SULTAN ABDUL AZIZ SHAH**
**UNIVERSITI PUTRA MALAYSIA**
**Document Code: HSAAS/UKPR/BR68**

# PATIENT SAFETY INCIDENT REPORTING (IR) FORM

* *Borang boleh diisi dalam* ***Bahasa Melayu***

**DATE OF REPORTING**: /_____/_____

**SECTION A: TO BE COMPLETED BY THE REPORTER OF THE INCIDENT**

**INCIDENT DESCRIPTION** (Please fill in the blanks)

| | | | | |
|---|---|---|---|---|
| **1.** | **NAME OF FACILITY/ INSTITUTION** | | **PATIENT'S NAME** | |
| **2.** | **DATE OF INCIDENT** | ☐☐ / ☐☐ / ☐☐☐☐ | **IF UNCERTAIN** APPROXIMATE DATE:_____/____/____ | |
| **3.** | **TIME OF INCIDENT** | ☐☐ : ☐☐ **AM/PM** | **IF UNCERTAIN** APPROXIMATE TIME:_____:_____AM /PM | |

**4.** **PATIENT'S MRN/ OTHER IDENTIFICATION NUMBER:**_____ **AGE**:_____ **ETHNIC**: _____
**GENDER:** MALE / FEMALE / UNKNOWN (Please circle) **STATUS:** ALIVE / DECEASED **DIAGNOSIS:** **LANGUAGE BARRIER**: YES / NO

**5.** **TYPE OF PATIENT** (Please tick one)

| | | | |
|---|---|---|---|
| ☐ | INPATIENT | ☐ | DAY CARE |
| ☐ | OUTPATIENT | ☐ | OTHERS: SPECIFY |
| ☐ | A&E | ☐ | ---------- |

**LOCATION/ WARD / CLINIC:**
_____

**DEPARTMENT(S) INVOLVED** (Please tick)

| | | | | | |
|---|---|---|---|---|---|
| ☐ | MEDICAL | ☐ | O&G | ☐ | ONCOLOGY |
| ☐ | SURGICAL | ☐ | PHARMACY | ☐ | GERIATRIC |
| ☐ | ORTHOPEDIC | ☐ | RADIOLOGY & IMAGING | ☐ | REHABILITATION |
| ☐ | PEDIATRIC | ☐ | A&E | ☐ | ICU/ CCU |
| ☐ | LABORATORY | ☐ | PSYCHIATRY | ☐ | |
| ☐ | OTHERS: SPECIFY | | | | |

**6. TYPE OF INCIDENT** ☐ **Actual** ☐ **Near Miss**
(Please tick one)

**Examples of incidents that need to be reported (Note that this list is not exhaustive):**

| | | |
|---|---|---|
| ☐ | i. | Wrong surgery/procedure –wrong site, side or patient |
| ☐ | ii. | Unintended retained foreign body in patient after an operation/procedure |
| ☐ | iii. | Error in transfusion of blood/blood products |
| ☐ | vi. | Medication error (please fill in MERS form as well) |
| ☐ | v. | Patient fall in the facility |
| ☐ | vi. | Obstetric related incidents |
| ☐ | vii. | Adverse outcome of clinical procedure |
| ☐ | viii. | Pre-hospital care and ambulance service related incident |
| ☐ | ix. | Radiotherapy related incident |
| ☐ | x. | Patient suicide / attempted suicide |
| ☐ | xi. | Patient discharged to wrong family members / next-of -kin |
| ☐ | xii. | Assault/ battery of patient |
| ☐ | xiii. | Unanticipated Fire – Fire, flame, or unanticipated smoke, heat, or flashes occurring in the facility |
| ☐ | xiv. | **Others type of incident**: |

**7. BRIEF DESCRIPTION OF WHAT HAPPENED** (Please fill in the blanks)

The description should explain what happen prior and during the incident and how it occurred. Do include any additional information which you think may lead to the incident.

**PATIENT OUTCOME** (Please tick one) **& IMMEDIATE ACTION – ONLY FOR ACTUAL INCIDENT**

**8. OUTCOME OF INCIDENT**

| | |
|---|---|
| | NONE |
| | MILD |
| | MODERATE |
| | SEVERE |
| | DEATH |
| | CURRENTLY CANNOT BE DETERMINED |

**9. IMMEDIATE ACTION FOLLOWING INCIDENT**

**REPORTED BY**

**10. DESIGNATION:**

| | | | |
|---|---|---|---|
| | NURSE | | SPECIALIST |
| | HOUSE OFFICER | | PHARMACIST |
| | MEDICAL OFFICER | | OTHERS: |

**(Please tick one)**

**SIGNATURE OF REPORTER:**

**NAME:**

**DATE:**

**VERIFIED BY**

**11. DESIGNATION:**

| | | | |
|---|---|---|---|
| | NURSE | | SPECIALIST |
| | HOUSE OFFICER | | PHARMACIST |
| | MEDICAL OFFICER | | OTHERS: |

**(Please tick one)**

**SIGNATURE:**

**NAME:**

**DATE:**

**Note: As part of good leadership and clinical governance, please inform the incident to your Head of Department(s) immediately.**

**SECTION B: TO BE COMPLETED BY THE RISK MANAGER/ QUALITY MANAGER OF HOSPITAL**

**1. ACTION TAKEN:**

*Mandatory Root Cause Analysis:*

*1) Incident with Severe or Death outcome*

*2) Other incident/near miss based on the Risk Manager/ Quality Manager assessment*

(Please tick)

| | |
|---|---|
| | PRESCRIPTION SLIP |
| | MONITOR THE TREND FIRST |
| | RCA |
| | MIRCA (Multi-incident Root Cause Analysis) |

Additional comments:

**2. RISK MANAGER/ QUALITY MANAGER OF HOSPITAL**

(Please fill in the blanks)

NAME:
SIGNATURE & STAMP:

DESIGNATION:
DATE: