**QUALITY ASSURANCE REVIEW FORM**

Patient Initials: \_\_\_\_\_\_\_\_\_\_ MRN: \_\_\_\_\_\_\_\_\_\_ AGE: \_\_\_\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_\_\_\_\_

Date of Occurrence: \_\_\_\_\_\_\_\_\_\_ Location of Event: \_\_\_\_\_\_\_\_\_\_

Description of Event/Timeline:

1. What happened?

2. Why did it happen (focus on systems and processes)?

3. Is there a specific hospital policy that relates to the event? If so, which one?

Did any harm come to the patient?

[ ] HARM – Death

[ ] HARM – Severe permanent harm (interferes with functional ability or quality of life)

[ ] HARM – Permanent (bodily or psychological)

[ ] HARM – Temporary (bodily or psychological)

[ ] HARM – Additional treatment (including need for admission or increased LOS)

[ ] HARM – Emotional distress/inconvenience (mild transient pain or anxiety)

[ ] NO HARM – Event reached patient but no harm evident

[ ] UNKNOWN – Unknown at time of assessment

Was the standard of care met?

[ ] SOC Met – no further action

[ ] SOC Met – room for improvement

[ ] SOC Not Met – due to systems

[ ] SOC Not Met – due to practitioner

Department improvement plan to reduce risk of recurrence of system/process breakdown or practitioner error.

A. Due date for completion: \_\_\_\_\_\_\_\_\_\_

B. Person accountable for completion of plan: \_\_\_\_\_\_\_\_\_\_

C. How will improvement be monitored/measured?