Patient Safety Reporting System (PSRS) Report Form

IDENTIFICATION STRIP: *Please fill in all blanks. This section will be returned to you.*
NO RECORD WILL BE KEPT OF YOUR IDENTITY.

(SPACE BELOW RESERVED FOR PSRS REPORT RECEIPT STAMP)

TELEPHONE NUMBERS where we may reach you for further details of this occurrence:

HOME Area _____ No. _____ - _____ Hours _____

WORK Area _____ No. _____ - _____ Ext. _____ Hours _____

ADDRESS to which you want your confirmation of report receipt mailed:

NAME _____

ADDRESS / PO BOX _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PLEASE SUPPLY A BRIEF DESCRIPTION OF THE EVENT OR SITUATION YOU ARE REPORTING

_____

_____

DATE OF OCCURRENCE _____

LOCAL TIME (24 hr. clock) _____

INTENTIONALLY UNSAFE ACTS AND CRIMINAL ACTIVITY ARE NOT INCLUDED IN THE PSRS PROGRAM. YOUR NAME IS IMPORTANT SO YOUR ID STRIP CAN BE RETURNED TO YOU. ALL IDENTITIES CONTAINED IN THIS REPORT WILL BE REMOVED TO ASSURE COMPLETE REPORTER ANONYMITY.

PLEASE FILL IN SPACES AND CHECK BOXES BELOW THAT APPLY TO THIS EVENT OR SITUATION YOU ARE REPORTING.

REPORTER INFORMATION AND EVENT BACKGROUND

What is your current position?

- ☐ Administration (Director, QM, Patient Safety, etc.) (Position) _____
- ☐ Ancillary Care (Rehab, RT, OT, PT, RD, etc.) (Specify) _____
- ☐ Behavioral Medicine (Position) _____
- ☐ Environ / Engineering Services
- ☐ Laboratory (Specify) _____
- ☐ Nursing (RN, LVN, RNP, CRNA, etc.)
- ☐ Pharmacy (Specify) _____
- ☐ Physician (PA, Anesthesia, etc.) (Specify) _____
- ☐ Other: _____

How many years of health care experience do you have?

_____

How many years have you worked at your facility?

_____

How many years have you worked in your current position?

_____

Your participation in event:

- ☐ Involved
- ☐ Witnessed, not involved
- ☐ Not involved, heard of or advised of event

Type of facility:

- ☐ Hospital (including E.D.)
- ☐ Outpatient Facility
- ☐ Other: _____

What was your scheduled Shift?

- ☐ 8 hours
- ☐ 10 hours
- ☐ 12 hours
- ☐ 24 hours on
- ☐ 36 hours on
- ☐ 48 hours on
- ☐ Additional shift
- ☐ Other _____

This event occurred at:

- ☐ Hours into shift _____
- ☐ Change of shift?

EVENT LOCATION

(check all that apply)

Where did the event occur?

- ☐ Ancillary Services (Rehab, RT, OT, PT, Dietary, etc.)
- ☐ Behavioral / Mental Health
- ☐ Emergency Dept / Urgent Care
- ☐ Hallway or other Common Area
- ☐ ICU / CCU / TCU / NICU
- ☐ Laboratory / Pathology
- ☐ Maternal / Child
- ☐ Nurses Station / Med Room
- ☐ Patient Room
- ☐ Pediatrics
- ☐ Pharmacy
- ☐ Provider Office
- ☐ Radiology/Imaging
- ☐ Surgical Suite (OR / ASU / PACU)
- ☐ Treatment / Exam Room
- ☐ Women's Health
- ☐ Other: _____

OTHER FACTORS

Were there any environmental factors that may have contributed to the event (air quality, lighting, noise, etc.) ?

(Specify) _____

_____

Were there any IT hardware or software factors that may have contributed to the event (equipment malfunction, computer system down, etc.) ?

(Specify) _____

_____

EVENT DESCRIPTION — GO TO NEXT PAGE (2)

Using the Patient Safety Reporting System (PSRS) Report Form

The PSRS is a voluntary system for use by medical and support staff to report safety related events and situations that occur in medical settings. The purpose of the PSRS is to promote the improvement of safety for patients in medical facilities through the sharing of information.

Use the PSRS to report: Events or situations that could have resulted in accident, injury, or illness, but did not, either by chance or through timely intervention; unexpected serious occurrences that involved death, physical injury, or psychological injury of a patient or employee; lessons learned or safety ideas.

PSRS reports are de-identified by NASA and specific details that identify individuals, affiliations, or facilities are removed. NASA maintains a database of the de-identified PSRS safety information for analysis.

Several types of events are **not** included in the PSRS program. These may include the following intentionally unsafe acts: criminal acts; purposefully unsafe acts; alleged or suspected patient abuse.

Thank you for your contribution to patient safety!

Please fold both pages (and additional pages if required), enclose in a sealed, stamped envelope, and mail to:

PATIENT SAFETY REPORTING SYSTEM
POST OFFICE BOX 4
MOFFETT FIELD, CALIFORNIA 94035-0004

Keeping in mind the topics shown below, discuss those which you feel are relevant and anything else you feel is important. Include what you believe really **CAUSED** the problem, and what can be done to **PREVENT** a recurrence, or **CORRECT** the situation. (*Use additional paper, if needed.*)

(If you have more text to enter, stop here and continue on the next page)

CHAIN OF EVENTS		HUMAN PERFORMANCE FACTORS	
• How the problem arose	• Contributing factors	• Perceptions, judgments, decisions	• Actions or inactions
• How it was discovered	• Corrective actions	• Factors affecting the quality of human performance	

EVENT DESCRIPTION, continued...

CHAIN OF EVENTS		HUMAN PERFORMANCE FACTORS	
• How the problem arose	• Contributing factors	• Perceptions, judgments, decisions	• Actions or inactions
• How it was discovered	• Corrective actions	• Factors affecting the quality of human performance	