WESTERN MICHIGAN UNIVERSITY SCHOOL OF MEDICINE (WMED)
EMPLOYEE/PATIENT/VISITOR OCCURRENCE FORM

CONFIDENTIAL REPORT IN CONTEMPLATION OF LITIGATION
Protected Under MCL 331.531, 331.532, 331.533, 333.20175, 333.21513, 333,21515, 333.22260, 333.20175
(Not Part of Medical or Personnel Record)

EMPLOYEE/PATIENT/VISITOR INFORMATION

Mandatory items are indicated in bold.

Facility:	O WMed Oakland Drive O Borgess Psychiatry office O Borgess Hospital O Bronson Hospital O Other _____
This incident is for a	O Patient O Visitor O Employee O Student O Other (Non-Employee) _____

Employee/Patient/Visitor/Student name (last, first, m):_____
Employee/Patient/Visitor/Student address (street, city, state, zip):
_____
Employee/Patient/Visitor/Student phone number:_____
Patient MRN:_____ Date of Birth:_____

DATE AND LOCATION OF OCCURRENCE

Incident Date (mm/dd/yyyy):_____Incident Time: _____O AM O PM

(Please indicate the department where the occurrence occurred. If it did not occur in a particular department, "No Dept" would be the correct choice.)

Department/Location:_____
Other description:_____
Please indicate where in the department the incident occurred below:

O Waiting Areas
O Offices
O Elevators
O Stairs
O Corridor
O Parking Lot
O Sidewalk
O Utility Room
O Equipment/Store Rm
O Cafeteria
O Other _____
O Clinic Patient Room
O Bathroom
O Treat/Procedure Room
O Front Lobby
O X-ray
O Laboratory
O Media Room
O Pharmacy
O Exterior Premises
O Store Room
O Hospital Location _____

Original Effective Date: 01/01/06
Revised Date(s): 04/09/12

GIVE A BRIEF DESCRIPTION OF THE OCCURRENCE/COMPLAINT

OCCURRENCE TYPE

O Occurrence	O Near Miss

Select an Occurrence or Complaint Type Below:

- O Fall – Attended
- O Fall – Unattended
- O Fainting/Seizure – Attended
- O Fainting/Seizure – Unattended
- O Exposure – Thermal
- O Exposure – Sharps
- O Exposure – Allergic Reaction
- O Exposure – Radiation
- O Exposure – Blood/Body Fluids
- O Exposure – Infectious Patient
- O Exposure – Respiratory
- O Self Inflicted Injury
- O Abduction
- O Abuse – Injury by another
- O Abuse – Threatened Injury
- O Abuse – Language
- O Abuse – Suicide
- O Abuse – Neglect
- O Spill – Chemical
- O Spill – Hazardous Materials
- O Spill – Radiation
- O Spill – Chemotherapy
- O Delay – Procedure
- O Delay – Transport
- O Delay – Treatment
- O Delay – Physician Notification
- O Delay – Physician Response
- O Delay – Lab Result
- O Identification – Mislabeled
- O Identification – Unlabeled
- O Suicide Attempt
- O Workplace Violence – Employee – Patient
- O Workplace Violence – Employee – Visitor
- O Workplace Violence – Employee – Employee
- O Workplace Violation – Patient – Visitor
- O Workplace Violence – Patient – Patient
- O Workplace Violence – Visitor – Visitor
- O Consent – Lack Of
- O Identification – Surgical Site
- O Equip/Prop – Inoperable
- O Equip/Prop – Damage
- O Equip/Prop – Malfunction
- O Equipment Theft/Loss
- O Equipment Unavailable
- O Equipment Contaminated
- O Property Theft/Loss
- O Confidentiality – Breach
- O Unanticipated Death
- O Unanticipated Surgery
- O Order Not Followed
- O Procedure Not Followed
- O Privacy Violation
- O Latex Allergy Event
- O Became Ill
- O Fire
- O Left before completion of visit
- O Patient in restricted area
- O Pt.'s property missing or damaged
- O Complaint – American Disabilities Act
- O Complaint – Clinical
- O Complaint – Communication
- O Complaint – Conflict of Care
- O Complaint – Dismissal
- O Complaint – Financial
- O Complaint – Patient Rights
- O Complaint – Privacy
- O Complaint – Quality of Care
- O Other_____

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PROCEDURE OR SURGERY

Was the occurrence related to a procedure or surgery? O Yes O No
If yes, complete the following:
Procedure/Surgery Date (mm/dd/yyyy):_____
Procedure/Surgery Type:_____
Staff involved in procedure:_____
Procedure/Surgery Comments:_____
_____
_____

EQUIPMENT INVOLVED

Equipment:_____
Manufacturer:_____
WMed Number:_____
Model Number:_____
Serial Number:_____
Lot Number:_____

OUTCOMES

Select an Outcome Below:

O No apparent effect
O Abnormal Labs
O Allergic Reaction
O Arrest Card/Resp
O Arrhythmia
O Blood Loss
O Blood React.
O Death
O Drug/IV React.
O Dyspnea
O Emotional Distr.
O Foreign Body
O Hyperglycemia
O Hypoglycemia
O Hypertension/ Hypotension
O Infection
O Injury – Abrasion
O Injury – Blister
O Injury – Burn
O Injury – Ecchymosis
O Injury – Contusion
O Injury – Dislocation
O Injury – Fracture
O Injury – Head
O Injury – Hematoma
O Injury – Hemorrhage
O Injury – Infection
O Injury – Laceration
O Injury – Nerve
O Injury – Puncture
O Injury – Phlebitis
O Injury – Sense-Sight
O Injury – Sense-Hearing
O Injury - Sense-Other
O Injury – Skin Tears
O Injury – Soft Tissue
O Injury – Strain/Sprain
O Loss of Consciousness
O Myocardial Infarction
O Neurological Impairment
O Pain
O Seizure
O Second Surgery
O Suicide
O Tooth – Broken
O Ulceration
O Vascular impairment
O Wound Disruption
O Not Applicable
O Other_____

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PHYSICIAN NOTIFIED

Was physician Notified?
O Yes O No
O NA O Unknown
How was the physician notified?
O Telephoned
O Present
O Other_____
Name of person notifying physician:_____

Physician Name:_____
Date of notification:_____
Time of notification:_____

SIGNATURE

Name of Person Preparing Report:_____
Date of Report:_____
Title of Person Preparing Report: O Physician O Resident O PA/NP
O RN O LPN O RMA/CMA
O Radiology personnel O Lab personnel
O Pharmacist O Pharmacy Resident Student
O Other_____

Manager Occurrence Reported to: _____Date of Report: _____

Thank for your submitting this occurrence report. We want to be aware of ways in which we can improve patient care and safety at WMed. The use of occurrence reports helps us to identify opportunities for improvement.

Please send completed report to the Director of Nursing and Clinical Support Services
Date received by Director of Nursing and Clinical Support Services: _____
Date received by Director of Facilities (if applicable): _____
Date received by OCC Health (if applicable): _____
Date received by Human Resources (if applicable): _____
Date received by Compliance Officer (if applicable): _____
Date received by Executive Medical Director: _____

To be completed by the Director of Nursing and Clinical Support Services/ or designee:

Date Logged: _____

Follow up by: _____ Date: _____

Date Resolved: _____

Preventable _____ Not Preventable _____

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Date:	Time:	Progress Notes/Action Taken

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Date:	**Time:**	**Resolution:**

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