PATHOLOGY & LABORATORY MEDICINE SERVICE
VA Maine Health Care System
Department of Veterans Affairs
Augusta, Maine 04330

Event ID #:

BB ID #:

CONFIDENTIAL:

QUAL-FRMa-105.07

Quality Assurance FORM
Event Report

SECTION A: Reporter

DATE OF OCCURANCE	DATE DISCOVERED/ INVESTIGATED	DATE EVR PREPARED	REPORTER ID# or NAME
PATIENT(S) INVOLVED	**LAST 4 OF SSN**	**SECT/WARD/CLINIC**	**ORDERING PROVIDER**
INVOLVED STAFF	**INST/DEPT**	**SECT/WARD/CLINIC**	**PHONE NO / EXTENTION**

PROBLEM (What happened to warrant this Event Report?)

Patient ID Error Specimen Labeling/Requisition Error: Specimen Type / Quality / Quantity:

INCORRECT INFO: _____ _____

OTHER (Describe Below):
Brief Narrative of the Event: Order Number(s)/Accession Number (s):_____

ACTION Taken immediately to resolve the Event or Fix the problem (What was done immediately?)

☐ CORRECTED/TESTING COMPLETED ☐ REJECTED/TEST CANCELLED ☐ REJECTED/RECOLLECTED
BRIEF Narrative:

AFFIDAVIT STATEMENT

NOTE: If allowing correction of Name/SSN or Site/Source (for AP/CY ONLY), "Affidavit Statement" below ***MUST*** be completed.
*******CORRECTIONS IN NAME/SSN ARE NOT ALLOWED FOR ANY BLOOD BANK SAMPLE/WILL BE IMMEDIATLEY DESTROYED*******

CORRECT INFO: _____

By my signature, I attest that I am responsible for the **original labeling/requisition** of the item(s) described above. I attest that I can positively identify this specimen as belonging to the patient as stated above and/or as being from the site/source listed above and that an error occurred in the original labeling/requisition.

STAFF Printed Name: _____Signature: _____

Date correction made: _____

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SECTION B: QA Review

CATEGORIZATION	*Error RESULT* (as applicable)	*ORIGIN of Event/Error*
Patient ID Error: ☐ Lab Other		☐ Reference Lab _____
☐ Spec. Label Error: ☐ Lab ☐ Other	☐ Wrong Result Reported	☐ CBOC _____
☐ Handoff Communication	☐ Testing Delayed	☐ Ward/Clinic __
☐ Specimen Processing	☐ Test Not Performed	☐ Lab Section ____ ____
☐ Specimen Collection	☐ Incorrect Data Entry (details)	☐ LIM _____
☐ Clerical Error	☐ Patient Redrawn	☐ Other_____
☐ Safety Concern	☐_____	
☐ Procedural/Technical_____	_____	
☐ Other_____	_____	

SECTION C: Department Supervisor

ANALYSIS of the event/problem (What broke down/what went wrong?)

☐ Procedural Error?

☐ COPY to Facility Patient Safety Manger (MDP 00X)
☐ COPY to Other Service (Nurse Manager, Chief of Service, Etc.)

DATE RESOLVED:

OUTCOME/SOLUTION: How can we prevent this from happening again?
☐ Process Improvement/Change ☐ Section Training ☐ Employee **RE**training ☐ Other (describe)
BRIEF description of the specifics:

Employee Signature:_____ Date:_____

Employee Supervisor:_____ Date:_____

Department Supervisor:_____ Date:_____

P&LMS Lab Manager/QA/designee:_____ Date:_____

P&LMS Medical Director / designee:_____ Date:_____