

Quality Assurance Review Form

Section I: General Information:

Department Performing QA Review: \_\_\_\_\_

Patient Initials: \_\_\_\_\_ MRN: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: ☐ Male ☐ Female

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

Section II: BRIEF Description / Timeline of Event:

1. What happened?

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\_\_\_\_\_

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\_\_\_\_\_

2. Why did it happen? Be specific as to system or process issues causal to the event.

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\_\_\_\_\_

a) if there is a specific policy / procedure related to event, please specify title and #:

**Section III: Harm Determination – Please use the following categories – Determination of Level is at time of assessment of patient:**

<u>Check As Applicable</u>	<u>Category – AHRQ Harm Scale</u>	<u>Guideline / Definition</u>
<input type="checkbox"/>	<b>HARM – Death</b>	Dead at time of assessment.
<input type="checkbox"/>	<b>HARM – Severe Permanent Harm</b>	Severe lifelong bodily or psychological injury or disfigurement that interferes significantly with functional ability or quality of life.
<input type="checkbox"/>	<b>HARM – Permanent Harm</b>	Lifelong bodily or psychological injury or increased susceptibility to disease.
<input type="checkbox"/>	<b>HARM – Temporary Harm</b>	Bodily or psychological injury, but likely not permanent.
<input type="checkbox"/>	<b>HARM – Additional Treatment</b>	Injury limited to additional intervention during admission or encounter and/or increased length of stay, but no other injury. Treatment since discovery, and/or expected treatment in future as a direct result of event.
<input type="checkbox"/>	<b>HARM – Emotional distress or inconvenience</b>	Mild and transient anxiety or pain or physical discomfort, but without the need for additional treatment other than monitoring. Distress / inconvenience since discovery, and/or expected in future as a direct result of event.
<input type="checkbox"/>	<b>NO HARM</b>	Event reached patient, but no harm evident.
<input type="checkbox"/>	<b>UNKNOWN</b>	Unknown at time of assessment.

**Section IV: Departmental Determination – Standard of Care (SOC):**

- ☐ SOC Met – no further action  
☐ SOC Met – room for improvement (please specify in Section IV)  
☐ SOC Not Met – due to systems (please specify in Section IV), AND  
☐ SOC Not Met – due to practitioner:

Name of practitioner: \_\_\_\_\_ Title: \_\_\_\_\_

**Section V: Departmental Improvement Plan to Reduce Risk of Recurrence of System/Process Breakdown or Practitioner Error. Please be specific and answer A-C below.**

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A. Due Date for Completion of Action Plan: \_\_\_\_\_

B. Staff Person Accountable for Completion of Plan:

▪ Name \_\_\_\_\_ Title: \_\_\_\_\_

C. Measure Of Effectiveness – How will improvement be measured:

- ☐ Observations of staff performance
- ☐ Medical Record documentation review
- ☐ Monitoring period: \_\_\_\_\_
- ☐ Sample size: \_\_\_\_\_
- ☐ Other (describe): \_\_\_\_\_  
\_\_\_\_\_

**Section VI: Disclosure:**

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- ☐ Yes; Disclosure made to: ☐ Patient ☐ Parent ☐ Health Care Agent ☐ Surrogate ☐ Family
  - Disclosure documented in the medical record? ☐ Yes Date documented: \_\_\_\_\_ ☐ No
- ☐ No; Disclosure not made; please indicate reason:  
\_\_\_\_\_
- ☐ N/A; No disclosure required; or patient/family aware