Appendix E

THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000 – 1661 PORTAGE AVENUE, WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
TOLL FREE (MB ONLY) 1-877-774-4344

ADVERSE EVENT REPORT FORM

Facility Information

Facility Name: _____

Medical Director: _____ Submission Date: _____

Mandatory Notification

The Medical Director shall notify the Deputy Registrar of The College of Physicians & Surgeons of Manitoba within 1 working day after the discovery of any of the following:

Please identify the type of event:

a. Deaths within the facility or within 10 days of the procedure ..... ☐
b. Transfers from the facility to a hospital regardless of whether or not the patient was admitted ..... ☐
c. Unexpected admission to hospital within 10 days of a procedure or anesthetic performed in the facility ..... ☐
d. Clusters of infections among patients treated in the facility ..... ☐
e. Procedure performed on wrong patient, side or site ..... ☐

Please note: Events such as needlestick, incomplete sterilization, breaks in technique, medication errors, etc., should be investigated and documented in the facility for inclusion in the annual report to the College and for accreditation purposes.

Deputy Registrar Contact Information

Phone 204-774-4344; Toll Free 877-774-4344
Fax 204-774-0750

Registrar Notified: _____

Documentation Required

Within two weeks, please submit via courier or fax (204-774-0750):

1. This form completed and signed by the physician most involved with the case describing the event, action taken and outcome (Part A) and the Medical Director (Part B).
2. A copy of the patient's **complete** clinical record from the facility.

The Deputy Registrar may review the circumstances with the Medical Director and may consult with other practitioners to determine the risk of harm to patients. If necessary, the Deputy Registrar may suspend the accreditation of any facility on a suspicion of continuing risk.

For College use only	
Report received by College _____	☐ More Information Required
Report reviewed with the Facility _____	☐ Reviewed by Program Review Committee
Decision communicated to Facility _____	☐ File Closed
Confirmation from Facility of Follow Up _____	

Part A – to be completed by the physician most involved with the event

Summary of Adverse Event

Report Completed By: _____ Phone: _____

Title: _____ Date of Event: _____

Procedure performed by Dr. _____

Anesthesia performed by: Dr. _____

Patient Identification Number: _____ ASA Classification: _____

Gender: Male ☐ Female ☐ Age: _____ Height: _____ Weight: _____

Procedure Proposed: _____

Procedure Performed: _____

Description of the Event (please type or print)

Describe **what** happened; details of the event

Description of the Event (continued)
Describe **where** it happened (describe the exact location in the facility, if appropriate)
What was the outcome of the transfer (e.g. diagnosis, length of stay, sequelae, etc.)?

History of the Event - describe factors contributing to the event
Patient (co-existing disease conditions, language barriers, compliance disclosures)
Personnel (e.g. number, training, experience, performance)
Equipment (list any equipment that may have played a role in the event)
Environment (e.g. noisy, crowded)

Reporting Physician
Signature _____ Date _____

Part B – to be completed by Medical Director

Facility Response to the Event
If this event had progressed without corrective action, what might the outcome have been for the patient?
What prevented this event from becoming more serious?
Was this adverse event predictable?
What steps have been taken to prevent future occurrences? (e.g. change to policy or procedures)
Additional Details (if applicable)

Medical Director
I have reviewed the content of this report. Signature _____ Date _____