

Non-Hospital Medical Surgical Facilities
Adverse Patient Outcome

DOCUMENTATION REQUIRED:

Within two weeks of the event, please submit via Fax (204-774-0750) or email:

AccreditedFacilities@cpsm.mb.ca (documents that are emailed must be password protected and the password submitted in a separate email.)

- 1. This form must be completed by a regulated health care professional and must describe the event, any action(s) taken and the outcome. It must be signed by the person completing the form, the physician or surgeon most involved with the case and by the Medical Director of the Facility.
2. A copy of the patient’s complete clinical record from the facility.

The Assistant Registrar (or delegate) may review the event with the Medical Director and/or may consult with other practitioners. If necessary, the facility’s accreditation may be withdrawn.

MANDATORY NOTIFICATION

The Medical Director must notify the Assistant Registrar of the College of Physician and Surgeons of Manitoba within one working day and provide a report within two weeks of any of the following.

Please identify the type of event, check all that apply:

- a. Death that occurs 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 performed .....
d. Clusters of infections among patients treated in the facility.....
e. Procedure performed on wrong patient, side, or site or wrong procedure .....
f. Any other major adverse patient outcome.....

Please describe: \_\_\_\_\_

Assistant Registrar Contact Information:

Phone: 204-560-4227

Date Assistant Registrar Notified (DD-MMM-YYYY): \_\_\_\_\_

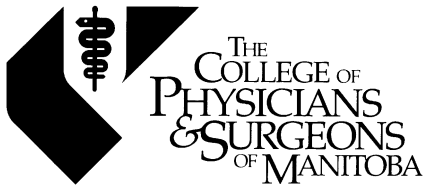
FACILITY INFORMATION (PLEASE PRINT)

Facility Name and Address:

\_\_\_\_\_
\_\_\_\_\_

Medical Director (Full Name): \_\_\_\_\_

Submission Date (DD-MMM-YYYY): \_\_\_\_\_



**GENERAL INFORMATION (PLEASE PRINT) (All dates must be DD-MMM-YYYY)**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PHIN or other unique identifier: \_\_\_\_\_

Gender: Male  Female  Gender Diverse

ASA Classification: I  II  III

Date of Procedure: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

Full name of the person the procedure was performed by: \_\_\_\_\_

Full name of the physician the procedure was overseen by: Dr. \_\_\_\_\_

Full name of the physician the anesthesia was performed by: Dr. \_\_\_\_\_

Procedure proposed: \_\_\_\_\_

Procedure performed: \_\_\_\_\_

**Anesthetic type:**

General anesthesia  Sedation (including oral)  Major Regional Block (including eye blocks)

Other : \_\_\_\_\_

Length of Procedure: \_\_\_\_\_ hours/mins

Surgical Safety Checklist Performed: Yes  No

**Description of Event (Please PRINT):**

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**Describe corrective action(s) that was/were taken (Please PRINT):**

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**Were the following given to the patient on discharge?**

Post-operative instructions given verbally.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Post-operative instructions given in writing .	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Facility contact information given in writing.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Emergency contact/access information given.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Additional Comments: \_\_\_\_\_

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**Required Documentation:**

Please confirm that the following **required** documentation is provided to CPSM:

- 1) A copy of the patient's full clinical record which includes the following:
  - a. Pre-operative patient history
  - b. Assessment on day of admission to Facility
  - c. Copies of any laboratory, diagnostic testing/imaging
  - d. Anesthesiologist's pre-operative assessment
  - e. Surgeon's pre-operative assessment
  - f. Nurse's pre-operative assessment
  - g. Description of procedure
  - h. Relevant information pertaining to complication(s)
  - i. Discharge documentation
  - j. Details of transfer to hospital, including name of hospital (if applicable)



2) Action taken by the facility to prevent future occurrences (e.g. ,policy changes, re-education, changes in procedure(s)). Please specify changes and attach any pertinent documents.

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**Medical Director Comments:**

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Regulated Health Care professional completing this form:

PRINT Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(DD-MMM-YYYY)

Health Care designation: \_\_\_\_\_

Physician most involved in the case: I have reviewed the content of this report:

PRINT Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(DD-MMM-YYYY)

Medical Director: I have reviewed the content of this report:

PRINT Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(DD-MMM-YYY)