MANITOBA QUALITY ASSURANCE PROGRAM (MANQAP)
1000 – 1661 Portage Avenue, Winnipeg, Manitoba R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
Toll Free within Manitoba 1-877-774-4344
WEBSITE: www.cpsm.mb.ca

Non-Hospital Medical Surgical Facilities
Adverse Patient Outcome

Submit via Fax (204-774-0750)
Within Two Weeks of the Event

Documentation Required:

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. A copy of the patient's complete clinical record from the facility must be included.

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 If necessary, the facility's accreditation may be withdrawn.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: _____
(day/month/year)

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Facility Information (please print):

Full Name of facility: _____

Address: _____
Street and/or Box No. City Postal Code

Name of Medical Director: Dr. _____

Submission Date: _____
(day/month/year)

General Information (please print):

Patient Name: _____

Date of Birth: _____
(day/month/year)

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: _____

Type of anesthesia:
General anesthesia ☐ Sedation (including oral) ☐ Major Regional Block (including eye blocks) ☐

Other: _____

Length of Procedure: _____
(hours/mins)

Surgical Safety Checklist Performed: Yes ☐ No ☐

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Description of Event (please print):

Describe Corrective Action(s) That Was/Were Taken (please print):

Were the Following Given to the Patient on Discharge?

Post-operative instructions given verbally	Yes ☐	No ☐
Post-operative instructions given in writing	Yes ☐	No ☐
Facility contact information given in writing	Yes ☐	No ☐
Emergency contact/access information given	Yes ☐	No ☐

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 the name of the hospital (if applicable) ☐
   k) Operative report ☐

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:

Full Name (print): _____

Signature: _____ Date: _____
(day/month/year)

Health Care designation: _____

Physician Most Involved in the Case, I have reviewed the content of this report:

Full Name (print): _____

Signature: _____ Date: _____
(day/month/year)

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

Full Name (print): _____

Signature: _____ Date: _____
(day/month/year)