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

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 If necessary, the facility's accreditation may be withdrawn.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): _____

Adapted from College of Physicians and Surgeons of Alberta
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V1 18 June 2021

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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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THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

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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: _____

_____

_____

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)

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☐ 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.

_____
_____
_____
_____
_____

Medical Director Comments:

_____
_____
_____
_____
_____

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)