

New Jersey Department of Health and Senior Services
**REPORT OF SERIOUS PREVENTABLE ADVERSE EVENT
IN A NEW JERSEY LICENSED HEALTH CARE FACILITY**
Continued

NJDHSS INTERNAL USE ONLY

Report No.

SECTION B - EVENT DETAILS

5. TYPES OF SERIOUS PREVENTABLE ADVERSE EVENTS (Check only one)

A. CARE MANAGEMENT EVENTS in a Health Care Facility

- 1. Patient/resident death/harm due to a medication error
- 2. Patient/resident death/harm due to a hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- 3. Maternal death/harm due to labor/delivery in a low-risk pregnancy
- 4. Patient/resident death/harm due to hypoglycemia
- 5. Patient/resident death/harm due to failure to identify and treat hyperbilirubinemia in neonates
- 6. Stage 3 or 4 pressure ulcers acquired after admission
- 7. Patient/resident death/harm due to spinal manipulative therapy
- 8. Other event causing patient/resident death or harm that lasts seven days or is present at discharge

B. ENVIRONMENTAL EVENTS in a Health Care Facility

- 1. Patient/resident death/harm due to an electric shock
- 2. Any event in which a line designated for oxygen/other gas to be delivered to a patient/resident contains the wrong gas or is contaminated by toxic substances
- 3. Patient/resident death/harm due to a burn incurred from any source
- 4. Patient/resident death/harm due to a fall
- 5. Patient/resident death/harm due to the use of restraints or bedrails
- 6. Other event causing patient/resident death or harm that lasts seven days or is present at discharge

C. PRODUCT OR DEVICE EVENTS in a Health Care Facility

- 1. Patient/resident death/harm due to the use of contaminated drugs/devices/biologics
- 2. Patient/resident death/harm due to the use/function of a device in patient/resident care in which the device is used/functions other than as intended
- 3. Patient/resident death/harm due to intravascular air embolism
- 4. Patient/resident death/harm due to the use of a single-use device in which the device is used/functions other than as intended:
 - new single-use device
 - reprocessed single-use device
- 5. Other event causing patient/resident death or harm that lasts seven days or is present at discharge

D. SURGERY-RELATED EVENTS

- 1. Surgery performed on the wrong body part
- 2. Surgery performed on the wrong patient
- 3. Wrong surgical procedure performed on a patient
- 4. Retention of a foreign object in a patient after surgery or other procedure
- 5. Intraoperative or immediately post-operative coma or death in an ASA Class I inpatient or any ASA Class same day surgery patient or outpatient
- 6. Other event causing patient death or harm that lasts seven days or is present at discharge

E. PATIENT/RESIDENT PROTECTION EVENTS in a Health Care Facility

- 1. Infant discharged to the wrong person
- 2. Patient/resident death/harm due to patient elopement
- 3. Patient/resident suicide/attempted suicide
- 4. Other event causing patient/resident death or harm that lasts seven days or is present at discharge

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6. IF 5.A.1 WAS SELECTED, COMPLETE THIS SECTION:

What type of medication error occurred? (*Check all that apply*)

- Wrong Patient
- Wrong Drug
- Wrong Dose
- Wrong Route
- Wrong Frequency
- Wrong Time
- Omission
- Administration After Order Discontinued/Expired
- Wrong Diluent/Concentration/Dosage Form
- Monitoring Error

- Other: _____

Brand/Product Name (If Applicable): _____

Generic Name: _____

7. WHERE WAS THE PATIENT/RESIDENT WHEN THE EVENT OCCURRED? (*Check only one*)

- Patient/Resident Room
- Emergency Department
- Radiology
- Laboratory
- Operating Room
- Cardiac Catheterization Laboratory
- Labor and Delivery
- Nursery
- Recovery Room
- Rehabilitation Areas
- In Transit
- ICU / CCU / TCU
- Step Down Unit
- Telemetry Unit
- NICU
- Hallway or Other Common Area
- Other:

8. IMMEDIATE CORRECTIVE ACTION(S) TAKEN: