Appalachian State University
Beaver College of Health Sciences
Nursing Department
Clinical Event Form

This document is a student education record protected as confidential under the Family Educational Rights and Privacy Act.

This report is to be completed legibly, in detail and with factual information by student and faculty member. Please use back of form or additional paper if needed. Completed form should be given to the Nursing Department Chair within 24 hours of the event. Due to the nature of the information in the report, copies/scans of the form should not be made. This document is to be used only for the purpose of education of involved parties within the Department of Nursing.

Initial Data:		
Date:	**Time:** □ AM □ PM	**Facility Name and Address:**
Exact location of event:		
Type of Event: Patient □ Student □ Faculty □ Staff □ Other □ (specify) _____ Witnessed □ Not Witnessed □		
Name:		**DOB:**
Address:		**Phone Numbers:**
Student Name:		**Faculty Name:**
Witness(es): use back of form if needed		
Name:		Contact Info:
Name:		Contact Info:
Provider(s): use back of form if needed		
Name:	Notified: Yes □ No □	Date: Time:
Name:	Notified: Yes □ No □	Date: Time:
Description of the Event: (WHO, WHAT, WHEN, WHERE, WHY, HOW) (use additional paper if needed)		

Medication Event: Yes □ No □	**Check all that apply below**	
Wrong Drug- Yes □ No □	Wrong Dose- Yes □ No □	Wrong Route- Yes □ No □
Wrong Time- Yes □ No □	Wrong Patient- Yes □ No □	New Medication Order- Yes □ No □
High Alert Med- Yes □ No □	Misread Order (student)- Yes □ No □	Misread Order (faculty)- Yes □ No □
Transcription Error- Yes □ No □	Abbreviation Error- Yes □ No □	Barcoding Error- Yes □ No □
MAR Misinterpretation- Yes □ No □	Look/Sound Alike Med- Yes □ No □	Crowded med prep area- Yes □ No □
Multiple meds simultaneous prepared- Yes □ No □	Omitted Required Assessment Prior to Administration- Yes □ No □	
Faculty present when med prepared- Yes □ No □	Faculty present when med given- Yes □ No □	

Two unique patient identifiers used- Yes □ No □	Three safety checks omitted- Yes □ No □
Student competency verified- Yes □ No □	Documentation- Yes □ No □
OTHER:	

Treatment Management Event: Yes □ No □ Check all that apply below		
Wrong treatment- Yes □ No □	Wrong Patient- Yes □ No □	Wrong Time- Yes □ No □
Treatment order verified- Yes □ No □	Treatment order difficult to read- Yes □ No □	
Crowded prep area- Yes □ No □	Wrong supplies/equipment used- Yes □ No □	
Omitted/Incorrect Assessment Prior to Treatment- Yes □ No □	Omitted/Incorrect Assessment Following Treatment- Yes □ No □	
Competency to perform verified- Yes □ No □	First time student performed treatment- Yes □ No □	
Discrepancy between facility policy/procedure and Nursing programs teaching of skill- Yes □ No □		
OTHER:		

Patient Fall Event: Yes □ No □ Check all that apply below		
Floor conditions- Clean and smooth □ Slippery or wet □ Other □- describe-		
Identified as at risk for fall- Yes □ No □	Frame of Bed- High □ Low □	Night light- Yes □ No □
Ambulation privilege- □ Unlimited □Limited with assistance □ Complete bedrest □ Other-		
Status of bed rails- □ No □ 1 up □ 2 up □ 3 up □ 4 up	Patient left in bathroom □ on bedpan □ bedside commode □ in any type of chair □	
Unlocked wheels on Bed □ Stretcher □ Wheelchair □		
Other restraints (type and extent)		
Were narcotics, analgesics, hypnotics, sedatives, diuretics, antihypertensives or anticonvulsants given during last 4 hours? Yes □ No □ Drug(s) Dose(s)- Time(s)-		
Other contributing factors:		

Other Safety Management Event: Yes □ No □ Check all that apply below
Patient/Site Identification compromised- Yes □ No □ **Two unique patient identifiers used- Yes □ No □** Describe:
Patient Hand-off compromised- Yes □ No □ Describe:
Bloodborne Pathogens Protocol compromised- Yes □ No □ Describe:
Infection Control compromised- Yes □ No □ Describe:
Confidentiality/HIPAA breached- Yes □ No □ Describe:
Other type event- Yes □ No □ Describe:
Persons notified other than physician: include name, date and time notified
Nurse Manager:
Risk Manager:
Department Chair:
Director of Compliance and Student Support:

Additional info from faculty perspective:	**Additional info from student perspective:**
Evaluation/Follow-up: Please circle appropriate category(s) and document action/plan below:	
□Staff discussion □Policy and procedure review □Equipment change □Counseling □Re-education and return demonstration □Disciplinary process □Other_____	
Printed Name and Signature of Faculty Completing Report	**Date:**
Printed Name and Signature of Student	**Date:**