Metric Anesthesia Consultants

FOR CLINICIANS | PATIENT SAFETY | PRINT ONLY

Clinical Incident Report

Anesthesia Patient Safety Event Report for Metric CRNAs and Clinical Staff

Metric Anesthesia Consultants, PLLC | 102 Wiltshire Avenue, Louisville, KY 40207 | 502-640-8349 | chad@metricanesthesia.com

INSTRUCTIONS: PRINT ONLY: PAPER REPORTS DELIVERED IN PERSON

1. Print this form and complete it by hand in blue or black ink. Print clearly.
2. **Do NOT email, fax, text, photograph, scan, or upload this form or any part of it, completed or partially completed.**
3. Place the completed form in a sealed envelope marked CONFIDENTIAL.
4. Hand-deliver it to Chad Riddle, CRNA, or the designated Metric representative within 24 hours of the event.
5. **Serious events (death, cardiac or respiratory arrest, malignant hyperthermia, wrong site or wrong patient, serious harm, or suspected drug diversion) must ALSO be reported by phone to Chad Riddle immediately at 502-640-8349.**

Use this form to report any anesthesia-related adverse event, near miss, or unsafe condition at a Metric-covered facility. Reporting is expected, non-punitive for good-faith reports, and helps us protect patients and colleagues. Also complete the facility's own incident report as required by facility policy.

PHI WARNING: Minimum necessary information only. Do NOT enter patient names, dates of birth, addresses, phone numbers, Social Security numbers, photographs, or other full protected health information (PHI). Identify the patient by facility MRN or initials only. Describe events factually without additional identifiers.

1. Reporter

REPORTER NAME

CREDENTIALS (E.G., CRNA, MD, RN)

PHONE

EMAIL

ROLE

☐ CRNA ☐ Anesthesiologist ☐ SRNA ☐ RN ☐ Surgeon ☐ Other

2. Facility, date, time, and location

☐ Perry County Memorial Hospital (Tell City, IN)
☐ Livingston Hospital (Salem, KY)
☐ Advanced Surgical Institute of New Albany (ASINA)
☐ Other

IF OTHER, FACILITY NAME AND CITY

EVENT DATE (MM/DD/YYYY)

EVENT TIME (24 HR)

TIME OF REPORT

ROOM / UNIT

LOCATION

☐ Pre-op / holding ☐ Operating room ☐ PACU ☐ L&D / OB ☐ Procedure area ☐ Other

3. Patient identifier (minimum necessary only)

Facility MRN or patient initials only. No names, dates of birth, or other identifiers.

FACILITY MRN OR INITIALS

AGE RANGE

PROCEDURE (GENERAL DESCRIPTION)

4. Event type (check all that apply)

- ☐ Airway (difficult airway, reintubation)
- ☐ Malignant hyperthermia
- ☐ Dental injury
- ☐ Equipment failure
- ☐ Needlestick or staff injury
- ☐ Death
- ☐ Medication error
- ☐ Cardiac or respiratory arrest
- ☐ Nerve or positioning injury
- ☐ Wrong site, procedure, or patient
- ☐ Local anesthetic systemic toxicity (LAST)
- ☐ Near miss (did not reach patient)
- ☐ Adverse drug reaction or anaphylaxis
- ☐ Aspiration
- ☐ Awareness under anesthesia
- ☐ Fall
- ☐ Unplanned ICU admission or transfer
- ☐ Other

IF OTHER, DESCRIBE EVENT TYPE

5. ASA class and anesthesia type

ASA PHYSICAL STATUS

☐ I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐ E (emergency)

ANESTHESIA TYPE (CHECK ALL THAT APPLY)

- ☐ General (ETT)
- ☐ General (LMA / SGA)
- ☐ MAC / sedation
- ☐ Spinal
- ☐ Epidural / CSE
- ☐ Peripheral nerve block
- ☐ Local / other

6. Description of event

Factual, chronological account: what happened, when, and how it was recognized. Avoid opinions, blame, and patient identifiers.

DESCRIPTION

7. Immediate actions taken

INTERVENTIONS, TREATMENTS, AND RESOURCES CALLED (E.G., MH CART, LIPID EMULSION, CODE TEAM)

8. Outcome and harm severity

OUTCOME

- ☐ Event resolved, case completed
- ☐ Case delayed or cancelled
- ☐ Admitted or prolonged stay
- ☐ Transferred to higher level of care
- ☐ Outcome unknown at time of report

HARM SEVERITY (SELECT ONE; ADAPTED FROM THE AHRQ COMMON FORMATS HARM SCALE)

- ☐ No harm: did not reach patient — Near miss or unsafe condition
- ☐ No harm: reached patient — No injury or monitoring only
- ☐ Mild harm — Minimal intervention, little or no impact
- ☐ Moderate harm — Intervention required, short-term harm
- ☐ Severe harm — Life-threatening or permanent harm, major intervention
- ☐ Death — Death caused or contributed to by the event

PATIENT CONDITION AT TIME OF REPORT

9. Notified parties

PARTY	NAME	DATE	TIME
☐ Surgeon / proceduralist			
☐ Facility risk management			
☐ Patient or family			
☐ Chad Riddle, CRNA (Metric)			
☐ Supervising / collaborating physician			
☐ Pharmacy or charge nurse			

10. Equipment, medications, and lot numbers

DEVICE / EQUIPMENT (MAKE, MODEL, SERIAL OR ASSET #)

MEDICATION(S), DOSE, LOT # AND EXPIRATION

- ☐ Equipment sequestered and tagged
- ☐ Biomed / manufacturer notified
- ☐ Not applicable

11. Witnesses

WITNESS NAME AND ROLE | **CONTACT**

WITNESS NAME AND ROLE | **CONTACT**

12. Contributing factors (check all that apply)

- ☐ Patient condition / comorbidity
- ☐ Communication or handoff
- ☐ Staffing or fatigue
- ☐ Equipment or supplies
- ☐ Medication labeling or look-alike
- ☐ Policy or process
- ☐ Training or experience
- ☐ Environment or time pressure
- ☐ Unknown
- ☐ Other

COMMENTS ON CONTRIBUTING FACTORS

13. Follow-up

- ☐ Facility incident report filed
- ☐ Peer review requested
- ☐ Equipment sequestered
- ☐ Pharmacy / FDA MedWatch report
- ☐ Debrief held with team
- ☐ Disclosure conversation planned
- ☐ Malpractice carrier notified
- ☐ Other

FOLLOW-UP PLAN, OWNER, AND DUE DATE

14. Attestation and signature

I attest that this report is accurate and complete to the best of my knowledge, was prepared for patient safety and peer review purposes, and contains only the minimum necessary patient information.

- ☐ I agree to the attestation above

SIGNATURE | PRINTED NAME AND CREDENTIALS | DATE

15. For Metric use only

RECEIVED BY | DATE / TIME RECEIVED | FACILITY REPORT # | PEER REVIEW CASE #

- ☐ Severity confirmed
- ☐ Peer review assigned
- ☐ Counsel consulted
- ☐ External reporting reviewed
- ☐ Closed

Privacy notice: To protect patient privacy, incident reports are accepted only on paper and in person. Reports are used only for Metric's patient safety, quality improvement, and peer review activities, are shared only with those who need them for those purposes, including the involved facility, and are intended to be maintained as confidential patient safety and peer review documents to the extent permitted by Kentucky and Indiana law. Do not use this form for emergencies; follow facility emergency procedures first.

Draft for review with healthcare counsel, including Kentucky and Indiana peer review privilege and HIPAA requirements. Completed forms are stored in a locked location with access limited to authorized Metric personnel and are not scanned into email, messaging, or shared drives.

16. Hand-delivery record

DELIVERED BY (PRINT NAME) | RECEIVED BY (CHAD RIDDLE OR DESIGNATED METRIC REPRESENTATIVE)

DATE DELIVERED | TIME DELIVERED | SEALED, MARKED CONFIDENTIAL (INITIALS) | RECIPIENT INITIALS