CHILDREN'S HOSPITALS AND CLINICS
OFFICE OF PATIENT SAFETY

SAFETY LEARNING REPORT

(revised 6/01)

The information you report is generated and maintained for quality improvement purposes under Minnesota Statute 145.61 et seq and is confidential under that statute.

ADDRESSOGRAPH OR NAME / MEDICAL RECORD # / DOB / ACCOUNT NUMBER

USE THIS FORM TO REPORT ANY:

ACCIDENT / NEAR MISS / SYSTEM BREAKDOWN /
GOOD CATCH / HOW SAFETY WAS CREATED /
HAZARDOUS SITUATION / ACCIDENT WAITING TO HAPPEN /
NORMALIZATION OF DEVIANCE

1 SITE (check one):

☐	MINNEAPOLIS	☐	ST. PAUL
☐	RIDGES	☐	WEST
☐	ROSEVILLE	☐	OTHER

2 TODAY'S DATE

3 MEDICATIONS INVOLVED:
(include med name, admin route)

4 EQUIPMENT INVOLVED:

5 EVENT DATE:

6 EVENT TIME:

7 HAPPENED TO:

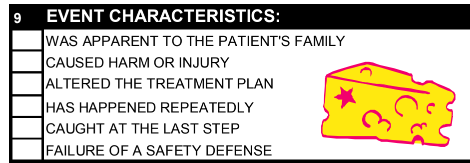
- ☐ INPATIENT
- ☐ OUTPATIENT
- ☐ STAFF
- ☐ STUDENT
- ☐ VISITOR
- ☐ VOLUNTEER
- ☐ OTHER

8 LOCATION:

EVENT LOCATION	
PATIENT DEPT	
OTHER DEPT INVOLVED	

9 EVENT CHARACTERISTICS:

- ☐ WAS APPARENT TO THE PATIENT'S FAMILY
- ☐ CAUSED HARM OR INJURY
- ☐ ALTERED THE TREATMENT PLAN
- ☐ HAS HAPPENED REPEATEDLY
- ☐ CAUGHT AT THE LAST STEP
- ☐ FAILURE OF A SAFETY DEFENSE



10 What happened?

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IF NOT INCLUDED ON THE PREVIOUS PAGE, PLEASE PROVIDE ADDITIONAL INFORMATION BY ANSWERING THE FOLLOWING QUESTIONS. ALTHOUGH OPTIONAL, EACH ANSWER CONTRIBUTES TO CREATING SAFETY AT CHILDREN'S.

How did it happen? What was the chain of events? How did the problem arise? How was it discovered? How was it corrected? At worst, what could have happened and how was harm prevented or reduced?

What were the contributing factors? What was the work environment like at the time of this situation? What were the personal or team factors effecting human performance in this situation (such as Inattention, Perceptions, Judgements, Decisions, Communication, Coordination)? Was there a breakdown in a safety defense? Please include what you believe really caused the problem.

Has this happened before? How frequently do you think there is the potential for this situation to occur? What increases the risk? What decreases the risk?

What could prevent future occurrence of this situation? What did you learn from this situation? Is there anything that you will do differently in the future? Who could help improve this situation? What could you see or measure that would show that Children's has reduced the risk of this situation occurring in the future?

11