# Clinic Event Reporting Examples

*This resource provides examples of reportable patient safety issues but is not considered an all-inclusive list.*

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| **Device or Medical/Surgical Supply** | | | |
| Broken or malfunctioning medical or surgical equipment or device | Incorrect use of medical or surgical device/supply | Expired medical or surgical supplies (including implants) | EHR downtime |
| **Medication** | | | |
| Incorrect drug or vaccine prescribed or administered | Incorrect dosage prescribed or administered | Incorrect route of administration (including patient self-administration) | Incorrect duration or course of medication therapy |
| Expired drug or vaccine in-stock or administered | Vaccine received too early or too late in the vaccination schedule | Incorrect drug storage | Adverse drug reactions |
| **Code/Emergency** | | | |
| Patient loss of consciousness | Transfer to a higher level of care | Respiratory issues requiring oxygen | Cardiac Arrest |
| **Delay in Treatment** | | | |
| Ordered treatment not received within appropriate timeframe (medication, lab) | Patient's voicemail or EHR message for nurse not followed-up on in timely manner | Delayed processing of critical diagnostic report | Other breakdowns in communication that impact timely care |
| **Environmental** | | | |
| Broken waiting room furniture | Frayed electrical cords or exposed outlets | Rooms not cleaned between patients | Power outage |
| **Failed to Order Intervention** | | | |
| Failed to order therapy (Speech, OT, PT) | Failure to order durable medical equipment | Failed to order specialist referral | Failed to order home health services |
| **Patient Behavioral Health Issues** | | | |
| Inappropriate language to other patients or staff | Aggressive behaviors toward other patients or staff | Suicidal actions or self-harm | |
| **Other** | | | |
| Scheduling errors | Miscoding a procedure/visit | Patient incorrectly billed for services | |

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| **Specimen** | | | |
| No order submitted | Specimen obtained on incorrect patient | Mislabeled specimen container | Failed to transport/store specimen in timely manner |
| Incorrect collection technique | Lab testing equipment issue | Results posted to wrong patient record | Failure to report critical results |
| **Fall** | | | |
| Fall attributed to environmental considerations (slips/trips) | Falls attributable to physiological factors (fainting, hypotension, gait instability) | Suspected intentional falls (attention-seeking or drug-seeking) | |
| **Communication** | | | |
| No interpreter available for patient | Failed to send appointment reminder - patient no show | Telehealth connection issues | Transition of care issues |
| **Complications after Hospitalization or Procedure** | | | |
| Uncontrolled pain following procedure | Infection at recent procedure site | Urinary tract infection (UTI) following hospitalization with urinary catheterization | Pneumonia diagnosis following recent hospitalization |
| **Diagnostic Error** | | | |
| Incorrect diagnostic test ordered or performed leads to delayed diagnosis | Key clinical information is missed resulting in failure to diagnose. | Abnormal findings not communicated or available to provider leads to missed diagnosis | Misinterpreted test results lead to wrong diagnosis |
| **Office Procedures** | | | |
| Wrong procedure performed | Procedure performed on wrong site | Lack of informed consent | Failure to discontinue procedural IV access before patient leaves clinic |
| **Patient ID** | | | |
| Failure to verify patient identity | Incorrect patient name or birthdate documented on chart | Assessment documented on incorrect patient chart (same/similar patient names) | |
| **Security** | | | |
| Disruptive patients or visitors | Unrestricted access to computers with patient information | Patient/visitors gaining access to secured areas | Missing valuables |