



Why should I report?

Improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality.

What should I report?

Incidents: patient safety events that reached the patient, whether or not there was harm involved.

Near misses (or close calls): patient safety events that did not reach the patient.

Unsafe conditions: circumstances that increase the probability of a patient safety event occurring.

What happens to my report?

All safety reports are reviewed by patient safety specialists at each institution. The reports are then evaluated for potential for harm and if further steps need to be taken to prevent harm in the future.

Will I get in trouble if I report?

NO. The Patient Safety and Quality Improvement Act of 2005 is a federal law that provides legal protection of information voluntarily reported.

Safety Reporting - Resources

CLICK HERE TO SUBMIT A PATIENT SAFETY REPORT



http://a-rl6.uhealth.org/RL6_Production/Homecenter/Client/Login.aspx?ReturnUrl=/RL6_Production/

Contact:

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https://rl6.childrenscolorado.org/RL6_Prod/

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<http://psipsi/datix/live/index.php>

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<https://patientsafety.csd.disa.mil/>

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NOTE: these can only be accessed on-site on the intranet, and may also be accessible from the desktop and/or EMR.



<https://psnet.ahrq.gov/primers/primer/13/reporting-patient-safety-events>