HEALTH CARE INCIDENTS CHECKLIST
(JAGMAN A-2-x)

NOTE: INVESTIGATIONS UNDER JAGMAN A-2-x ARE SEPARATE FROM ANY QUALITY ASSURANCE INVESTIGATION CONDUCTED BY THE STAFF OF A MILITARY TREATMENT FACILITY SOLELY FOR QUALITY ASSURANCE PURPOSES.

___ Comprehensive chronology and description of all relevant facts.

___ Identification of all involved health care providers, including:

- ___ Credentials (education, training, and experience).
- ___ Status (trainee or staff; Government employee or contractor).
- ___ Role (attending, consulting, supervision).

___ Full identification of the staff physician responsible for the patient's care at the time of the incident.

___ If maintenance of equipment or training of personnel is involved, identify the individual(s) responsible for the maintenance or training at issue.

___ Patient information.

- ___ Name, date of birth, age, sex, address, phone number, marital status, dependents, occupation.
- ___ Medical history.
- ___ Condition immediately prior to incident.
- ___ Current condition.

___ Nature and extent of injuries alleged to have occurred.

- ___ Additional treatment required.
- ___ Prognosis.
- ___ Degree of disability.

____ Loss of chance of recovery.

____ Names and addresses of subsequent treating physicians or health care providers.

____ A copy of the claim and any other documents or correspondence which shed light on the claimant's or potential claimant's contentions concerning the matter.

____ Secure all of the medical records, inpatient, outpatient, and special studies (x-rays, tissue slides, EKG tapes, fetal monitoring strips, etc.).

____ Indicate the date and person who secured those items and the current location and custodian of each.

____ Complete copy of the medical record. Entries must be reviewed to ensure handwriting is legible and, if illegible, typed transcripts should be attached to the investigation.

____ All special studies must be retrospectively reviewed to assess whether the original interpretations were accurate.

____ Retrospective reviews must be structured as "blind" reviews, e.g., the reviewer should not be aware of the previous interpretation.

____ A summary containing the name and credentials of the person conducting the retrospective review and that person's findings must be included with the investigation. The summary should not be signed by the reviewer.

____ Copies of all relevant documents.

____ MTF staff bylaws.

____ MTF policies, procedures, and protocols (clinical/surgical, nursing, and ancillary services such as the laboratory or pharmacy, and health care administrative policies) in effect at the time of the incident.

____ All relevant logbook entries pertaining to the patient maintained by labs/clinics/offices (e.g., emergency room logs reflecting arrival/departure times, ambulance log book/trip sheets/rescue service reports, and centralized appointment registers/printouts or pharmacy history printouts.

____ All patient information pamphlets, brochures, or sheets which were provided to the patient.

____ In cases involving contract providers, a copy of the contract.

____ In cases involving possible equipment/device failure.

____ Photographs of equipment/devices taken before the equipment/device is moved, used again, altered, tested, or repaired. Photographs must be annotated to reflect the time, date and identity of the person who took the photograph.

____ The date, location, and names of the persons involved in the evaluation of the equipment/device and the findings thereof. Equipment/devices must be removed from service and secured until examined by appropriate technical representatives. Equipment/devices must not be used, altered, tested, or repaired until properly evaluated.

____ Copies of maintenance reports and any protocols.

____ Review of the staffing levels (physician, nursing, corpsman, and ancillary) at the time of the incident.

____ "Currency" of members to perform their duties at the time of the incident.

____ "Orientation" to perform the duties assigned at the time of the incident.

____ The standard of care for any practices, procedures, policies, protocols, or systems involved in the incident and the basis which establishes that standard of care (provide a copy of relevant medical literature, text, treatises, articles, policy, practices, or procedures).

____ This refers to clinical/surgical procedures, nursing procedures, ancillary services such as the medical laboratory or pharmacy procedures, and health care administrative policies. The source and date of documents relevant to the standard of care must be provided.

____ Summaries of expert reviews of the care documented by the investigation.

____ Identify the reviewer and the reviewer's credentials.

____ Evaluation (e.g., expert opinion) describing the duty that was owed the patient (standard of care).

____ Manner in which the duty was either met or not met.

____ In instances where the duty was not met, an opinion on whether the act or omission resulted in harm to the patient and, if so, a description of the harm, including an explanation of how the harm may affect the patient in the future.

____ Where there has been a deviation from the standard of care, an opinion regarding the cause(s) or contributing factors for any deviation from the standard, the name(s) of persons responsible for the deviation, and a description of corrective action, if required, in terms of personnel, equipment, or policy.

____ Each provider whose actions are at issue must be provided an opportunity to make a statement for inclusion in the investigation. The IO should summarize the results of the interview using care to be as accurate and complete as possible. Summaries of interviews with providers shall not be signed, instead authenticated by the IO's signature.