South Carolina Department of Labor, Licensing and Regulation
Office of Investigations and Enforcement
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Board of Nursing
EMPLOYER SUPPLEMENTAL COMPLAINT FORM

License Name: _____

License Contact Information: _____

License: ☐ APRN ☐ RN ☐ LPN

Facility Information

Contact: (Address, telephone) _____

Start date and termination/resignation date: (If applicable) _____

As a result of incident(s), what action has been taken:

☐ Retained Individual ☐ Accepted Resignation
☐ Accepted Resignation In Lieu of Termination ☐ Terminated Individual

Were multiple patients involved? ☐ Yes ☐ No (If yes, complete this form for the specific incident that triggered the report to the Board or the patient who suffered the most harm.)

Date of Incident(s): _____

Time of Incident(s): _____

Location of Incident(s): (Include what part/hall/wing of facility) _____

_____

Type of Facility:

☐ Ambulatory Care
☐ Assisted Living
☐ Behavioral Health
☐ Critical Access Hospital
☐ Home Health Care
☐ Hospital
☐ Long Term Care
☐ Office-Based Surgery
☐ Physician/Provider Office or Clinic
☐ Other: _____

Type of Shift: ☐ 8-hour ☐ 10-hour ☐ 12-hour ☐ On-Call ☐ Other: _____

Shift Start Time: _____ Shift End Time: _____

Number of days licensee worked in a row at the time of the incident: _____

Type of Assignment at the time of incident:

☐ Direct Patient Care, Team Leader ☐ Charge ☐ Nurse Manager/Supervisor
☐ Combination Patient Care/Leadership

Number of assigned direct care patients at the time of the incident: _____

Number of staff responsible for supervising at the time of the incident: _____

Number of patients responsible, including direct care and supervising patients at the time of the incidents: _____

What was the nurse-to-patient staffing ratio at the time of the incident: _____

Were there any policies or procedures in place if incident involved clinical event or procedure or patient condition?
☐ Yes (Please include copies with this form)

Previous discipline history by employer(s), including current employer, for practice issues?
☐ Yes (Please include copies with this form)

Respondent Factors

Identify factors that contributed to the practice breakdown. Check all that apply:

- ☐ Language Barriers
- ☐ High Work Volume/Stress
- ☐ Drug/Alcohol/Impairment/Substance Abuse
- ☐ Inexperience (with clinical event, procedure, or patient condition)
- ☐ Lack of Orientation/Training
- ☐ Lack of Team Support
- ☐ Conflict with Team Members
- ☐ Lack of Adequate Staff
- ☐ Cognitive Impairment
- ☐ Fatigue/Lack of Sleep
- ☐ Functional Ability Deficit
- ☐ No Rest Breaks or Meal Breaks
- ☐ Overwhelming Assignment
- ☐ Mental Health Issues
- ☐ Nurse's Personal Pain Management
- ☐ None
- ☐ Other: (Please specify) _____

Did licensee receive any training directly relating to clinical event or procedure or patient condition involved in the incident? ☐ Yes ☐ No

Patient Demographics

Were specific patient care issues identified? ☐ Yes ☐ No (If **No**, then skip this section)

Patient Name: _____

Patient DOB: _____

Patient Gender: ☐ Female ☐ Male

Were the patient's friends and family present at the time of the incident? ☐ Yes ☐ No

Pertinent patient characteristics at the time of the incident. Check all that apply:

- ☐ Agitation/Combativeness
- ☐ Altered Level of Consciousness
- ☐ Cognitive Impairment
- ☐ Communication/Language Difficulty
- ☐ Depression/Anxiety
- ☐ Incontinence
- ☐ Inadequate Coping/Stress Management
- ☐ Insomnia
- ☐ Sensory Deficits (hearing/vision/touch)
- ☐ Pain
- ☐ None
- ☐ Unknown

Patient's two primary diagnoses: (1) _____ (2) _____

What happened to the patient? Check all that apply:

- ☐ Abuse/Neglect
- ☐ Allergic/Anaphylaxis/Transfusion Reaction
- ☐ Medication Error
- ☐ Equipment Failure
- ☐ Death
- ☐ Nosocomial (hospital-acquired) Infection
- ☐ Treatment Error/Omission
- ☐ Patient Fell
- ☐ Suicide
- ☐ Other: (Please specify) _____
- ☐ Unknown

Patient outcome as a result of incident:

- ☐ No Harm – An error occurred, but with no harm to the patient
- ☐ Harm – An error occurred which caused a minor negative change in the patient's condition
- ☐ Significant Harm – Involves serious physical or psychological injury, specifically including loss of function or limb
- ☐ Patient Death – An error occurred that may have contributed to or resulted in patient death

Were other patients involved? If so, please list their names, DOB, and gender:

Practice Breakdown Categories

Identify which of the following where a factor in the practice breakdown (check all that apply):

Medication Error: What was the medication order? _____

- ☐ Wrong Dosage
- ☐ Wrong Time
- ☐ Extra Dose
- ☐ Wrong Patient
- ☐ Wrong Medication
- ☐ Unauthorized Medication
- ☐ Wrong Route
- ☐ Wrong Reason
- ☐ Mislabeled
- ☐ Wrong Administration Technique
- ☐ Omission
- ☐ Other – *provide example*

Documentation Error

- ☐ Pre-Charting/Untimely
- ☐ Incomplete or Lack of Charting
- ☐ Charting Incorrect Information
- ☐ Charting on Wrong Patient Record
- ☐ Other – *provide example*

Attentiveness/Surveillance

- ☐ Patient not observed for an unsafe period of time

Clinical Reasoning

- ☐ Clinical implications of patient signs, symptoms, and/or response to interventions not recognized
- ☐ Clinical implications of patient signs, symptoms, and/or intervention misinterpreted
- ☐ Following orders, routine (rote system) without considering specific patient condition
- ☐ Poor judgment in delegation and the supervision of staff members
- ☐ Inappropriate acceptance of assignment or accepting a delegated action beyond the nurse's knowledge and skills
- ☐ Lack of Knowledge

Interpretation of Authorized Provider's Orders

- ☐ Did not follow standard protocol/order
- ☐ Unauthorized Intervention
- ☐ Misinterpreted telephone or verbal order
- ☐ Missed authorized provider's order
- ☐ Misinterpreted authorized provider's handwriting
- ☐ Undetected authorized provider error resulting in execution of inappropriate order

Professional Responsibility/Patient Advocacy

- ☐ Nurse fails to advocate for patient safety and clinical stability
- ☐ Nurse did not recognize limits of own knowledge and experience
- ☐ Nurse does not refer patient to additional services as needed
- ☐ Specific patient requests or concerns unattended
- ☐ Lack of respect for patient/family concerns and dignity
- ☐ Patient Abandonment
- ☐ Boundary Crossings/Violation
- ☐ Breach of Confidentiality
- ☐ Nurse attributes responsibility to others

Statement of Alleged Nurse Practice Act Violation(s)

Provide a statement describing the alleged practice breakdown and the implications to the health, safety, and welfare:

Checklist for Accompanying Documents

- ☐ Witness Statements
- ☐ Facility policies and procedure related to the alleged incident
- ☐ Internal Investigation Documents
- ☐ MAR
- ☐ Nurse/physician/provider progress notes
- ☐ Nurse Flow Sheet
- ☐ Controlled Substance Logs
- ☐ Employee Personnel Record
- ☐ Facility Policy
- ☐ Photographs
- ☐ Duty roster, time cards, assignment sheets
- ☐ Facility incident/occurrence reports
- ☐ Toxicology
- ☐ Other
- ☐ Drug Screens
- ☐ Facility Incident Reports

Witness Information

Name, home address, home/cell phone number, email.

- Witness 1: _____
- Witness 2: _____
- Witness 3: _____
- Witness 4: _____
- Witness 5: _____
- Witness 6: _____

Name and position of person making the report: _____

Name, title, address, phone number, and email of person who accepts subpoenas for your facility:

_____