



PATIENT – EMPLOYEE SAFETY MONITORING FORM

DATE: _____

CORE INDICATORS	6AM– 2PM	2PM– 10PM	10PM– 6AM	STATION & NAME OF PERSONNEL
FALL INJURY				
MEDICATION ERROR				
HOSPITAL ACQUIRED PRESSURE INJURY				
IV EXTRAVASATION				
NEEDLESTICK INJURY				
OTHER PROCEDURAL ERROR (PLS. INDICATE)				
OTHER WORK-RELATED INJURY (PLS. INDICATE)				
NAME & SIGNATURE OF ROTATING SUPERVISOR:				

** If an event occurs, please obtain an incident report from the personnel involved within 24hours.*

Noted by: _____

FM-NS-PS-003

Revision: 0

Effectivity Date: July 01, 2025



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