

Complication record

Form | PRO-FRM-004

Document type	Form
Title	Complication record
Document ID	{{facility.code}}-PRO-FRM-004
Version and status	1.0 Issued for use. Pending ASF Expert Committee ratification
Prepared by	{{roles.quality_lead.name}}, Quality lead
Reviewed by	{{roles.clinical_director.name}}, Clinical director Date: _____
Approver and signature	{{roles.clinical_director.name}}, Clinical director Signature: _____ Date: _____
Effective date	{{document.effective_date}}
Next review	{{document.review_date}} (12 months, or sooner after any incident or change)
Replaces	None (new document)
Standards and criteria supported	Standard 11 (Procedure Units), criterion 11.5, 11.9
Evidence basis	E-006, E-009
Status of this document	Recommended best-practice model. A hospital may adopt, adapt or replace it with an equivalent that meets the same criteria.

Use this form when

Records each complication, its treatment, any transfer and its review.

1. How to complete

- Record each complication at once.
- Record the treatment and any transfer.
- Record the review.

2. Items to check

#	Item	Standard or evidence	Yes	No	N/A	Action if No
1	Procedure and patient ID	Yes	☐	☐	☐	Action and who to tell
2	Complication and time	Yes	☐	☐	☐	Action and who to tell
3	Treatment given	Yes	☐	☐	☐	Action and who to tell
4	Transferred to hospital (yes or no) and time	Yes	☐	☐	☐	Action and who to tell
5	Named contact used	Yes	☐	☐	☐	Action and who to tell
6	Reviewed (date) and action	Yes	☐	☐	☐	Action and who to tell

Completed by (name and role): _____ Date/time: _____ Signature: _____

3. Evidence

ID	Source and status
E-009	Based on the ASF Expert Committee consensus and the WHO Guidelines for Safe Surgical Care and Safe Procedures (2009).
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

EC = ASF Expert Committee consensus.

4. Change history

Version	Date	What changed	Approver and signature
1.0	{{document.effective_date}}	First version	Pending Expert Committee approval