Incident Report

Instructions: *Use this form to report any unexpected patient incidents related to patient care or treatment, even if there is no adverse patient outcome (this includes errors, safety hazards, injuries and sentinel events). After completion, please return this form to Administrator within 24 hours of the incident.*

Details of where the incident was discovered	
Person affected by incident:	**Location:**
Name:____________________	Address:____________________
Date of Birth:____________________	Caregiver Present? ☐ Yes ☐ No
Date and Time of Incident:____________________	Name of Caregiver:____________________

Staff Involved:

Name(s) and Title(s):____

____

Witness(es):____

Nature of Incident [check appropriate box(es)]

☐ Malfunction Equipment/Monitors
☐ Lack of Equipment/Monitors
☐ User error of Equipment/Monitors
☐ Medication Prescription Error
☐ Medication Dispensing Error
☐ Medication Administration Error
☐ Extravasation
☐ Infection Control Issue
☐ Breach of Policies/Protocol
☐ Poor patient preparation
☐ Inappropriate request
☐ Inappropriate/no escort
☐ Breach in Confidentiality
☐ Patient documentation issue
☐ Patient positioning
☐ Consent
☐ Failure to perform investigation
☐ Delay in urgent investigation
☐ Failure to interrupt results
☐ Wrong dose radiation
☐ Wrong site
☐ Wrong patient
☐ Repeat dose unnecessarily
☐ Pregnancy not considered in radiation exposure

Patient Outcome [check appropriate box(es)]

☐ Death
☐ Critical condition
☐ Injury
☐ Ill Health
☐ Temporary deterioration of condition
☐ Transfer to higher level of care
☐ Pain/Prolonged pain
☐ Patient Distress
☐ Delay in treatment
☐ Change to treatment
☐ Prolonged stay in hospital
☐ Radiation over exposure
☐ Disruption to services
☐ Unable to assess outcome
☐ Near miss by chance
☐ Near miss by intervention
☐ No adverse effect

Injury-Nature of Injury [check appropriate box(es)]

☐ Contusion/crush
☐ Laceration/open wound
☐ Concussion
☐ Burn
☐ Superficial Injury
☐ Sprain/Strain
☐ Dislocation
☐ Foreign Body
☐ Fracture
☐ Amputation
☐ Internal Injury
☐ Dermatitis

Location of Injury [check appropriate box(es)]

☐ Head/face
☐ Hand/fingers
☐ Hip/leg
☐ Eye
☐ Shoulder/arms
☐Foot/toes
☐ Internal organs
☐ Trunk (other than back)
☐ Back
☐ Other:______________

Incident Report (cont.)

Medical Follow-Up:

Was Medical Attention Sought: ☐ Yes ☐ No Treatment Refused: ☐ Yes ☐ No

Physician Notified ☐ Yes ☐ No Physician Name: ______________________________ Date Notified: ______________

Physician Response: ____

Contributory factors [check appropriate box(es)]

☐ Knowledge and Training	☐ Poor communication	☐ Poor documentation
☐ Staffing Issues	☐ Distraction	☐ Poor Handwriting
☐ Lack of appropriate equipment	☐ Labeling	☐ Use of abbreviations/shorthand
☐ Breach of policy/procedure	☐ Supplies	☐ Storage

☐ Other :____

Worker Compensation first report sent: ☐ Yes ☐ No Date: ________________ OSHA 300 Log #: ___________________

Permission for blood to be tested for HIV (known to cause AIDS), HBV and HCV given: ☐ Yes ☐ No

Summary of Incident (please state facts only and not opinion—attach separate sheet if needed):

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**Ensure that all necessary steps have been taken to support and treat anyone injured and prevent injury to others. Ensure medical records are factual and up to date. **

Supervisor Notified: ☐ No ☐ Yes Date:_______________________ Time: ________________________

Actions Taken by Staff Members:

____

____

____

Employee Acknowledgement:

I acknowledge that the facts and circumstances reported above are true and accurate to the best of my knowledge.

Employee Name:____ Title/Position:______________________________

Employee Signature:____ **Date:**__________________________

INTERNAL USE ONLY

Action Taken as a Result of Incident: (please give brief details -attach separate sheet if necessary):

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Office Representative: ____ **Date:**____________________