

PATIENT – VISITOR INCIDENT REPORT



NOT PART OF MEDICAL RECORD

Edition 9/01

NAME/ADDRESS OF PERSON INVOLVED						
IF VISITOR, PHONE NUMBER		SEX		AGE		
DIAGNOSIS						
INCIDENT DATE	INCIDENT TIME AM/PM	PRIOR INCIDENT	REPORT DATE	SHIFT <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
EXACT LOCATION						
PRIOR CONDITION	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Sedated	Other (describe)		
<input type="checkbox"/> Alert	<input type="checkbox"/> Confused	<input type="checkbox"/> Requires Assistance				
MEDICATION (Past 12 Hours)			VITAL SIGNS			
FALLS <input type="checkbox"/> Fall/Slip <input type="checkbox"/> To/From Bed <input type="checkbox"/> From Chair or Equip. <input type="checkbox"/> While Ambulating <input type="checkbox"/> While Being Assisted <input type="checkbox"/> In Bathroom <input type="checkbox"/> Dizzy/Faint <input type="checkbox"/> Eased to Floor <input type="checkbox"/> Other (describe)	MEDICATION <input type="checkbox"/> Wrong Patient <input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Wrong Drug <input type="checkbox"/> Duplication <input type="checkbox"/> Wrong Time/Day <input type="checkbox"/> IV-Related <input type="checkbox"/> Wrong Route <input type="checkbox"/> Unordered <input type="checkbox"/> Wrong Dosage <input type="checkbox"/> Transcription <input type="checkbox"/> Omissions <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other (describe) _____		OTHER <input type="checkbox"/> Struck Object <input type="checkbox"/> Equipment Malfunction <input type="checkbox"/> Infection <input type="checkbox"/> Altercation/Violence <input type="checkbox"/> Wanderer/Elopement <input type="checkbox"/> Order not Executed <input type="checkbox"/> Self Inflicted Injury <input type="checkbox"/> Decubitus <input type="checkbox"/> Lab Related <input type="checkbox"/> Loss of Personal Prop <input type="checkbox"/> Treatment Related <input type="checkbox"/> Phys. Therapy <input type="checkbox"/> Smoking Related <input type="checkbox"/> Delayed Communication <input type="checkbox"/> Burns <input type="checkbox"/> Oxygen Related <input type="checkbox"/> Misdiagnosis <input type="checkbox"/> Suspected Abuse <input type="checkbox"/> Alleged Theft Other _____			
SAFETY DEVICES Bed Position <input type="checkbox"/> High <input type="checkbox"/> Low Side Rails <input type="checkbox"/> Up <input type="checkbox"/> Down Number _____	ACTIVITY LEVEL <input type="checkbox"/> Bed rest Only <input type="checkbox"/> Up Ad Lib <input type="checkbox"/> Up W/Assistance <input type="checkbox"/> BR Privileges <input type="checkbox"/> Other (describe) _____	NATURE OF INJURY RESULTING FROM ACCIDENT <input type="checkbox"/> No apparent injury <input type="checkbox"/> Fracture/Dislocation <input type="checkbox"/> Decubitus <input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Abrasion/Laceration/Skin Tear <input type="checkbox"/> Contusions <input type="checkbox"/> Burn/Scald <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> Sprain/Strain		INDICATE INJURY		
Brief Objective Description of Incident in Addition to Above:						
Equipment Involved		Manufacturer		Serial Number		
Witness' Name	Address	Phone Number	Patient	Employee	Visitor	
1						
2						
MEDICAL INFORMATION	FAMILY NOTIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO	TIME NOTIFIED AM/PM	BY WHOM			
	NAME OF PHYSICIAN NOTIFIED			TIME NOTIFIED AM/PM	TIME EXAMINED AM/PM	
	X-RAYS ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO		RESULTS			
	LAB WORK ORDERED <input type="checkbox"/> YES <input type="checkbox"/> NO		RESULTS			
Report of Examining Physician:						
PERSON COMPLETING REPORT			REVIEW BY SUPERVISOR/MANAGEMENT			
NAME:	DATE:	SIGNATURE:	SIGNATURE:	DATE:		

INCIDENT INVESTIGATION REPORT



Confidential Report to Attorney
To Be Completed At Time of Incident

Edition 9/01

DATE OF OCCURRENCE:	<input type="checkbox"/> Patient <input type="checkbox"/> Visitor	LOCATION:
ADMISSION DATE:	PRIOR INCIDENTS <input type="checkbox"/> Yes <input type="checkbox"/> No	DATES:

Briefly Describe Incident: _____

	A. Contributing Factors – Select as many as appropriate		
	<p align="center">Patient Falls</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> Failure to raise side rails 2. <input type="checkbox"/> Failure to respond to call bell 3. <input type="checkbox"/> Call bell not within reach 4. <input type="checkbox"/> Objects not within reach 5. <input type="checkbox"/> Failure to restrain (properly) 6. <input type="checkbox"/> Failure to orient patient 7. <input type="checkbox"/> Failure to prescribe activity level 8. <input type="checkbox"/> Wet/slippery floor 9. <input type="checkbox"/> Patient unattended 10. <input type="checkbox"/> Patient failed to request assistance as instructed 11. <input type="checkbox"/> Patient removed restraints/side rails 12. <input type="checkbox"/> Family left patient in unsafe manner 	<p align="center">Medications</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> Improper identification 2. <input type="checkbox"/> Transcription error 3. <input type="checkbox"/> Misread 4. <input type="checkbox"/> Failure to check orders 5. <input type="checkbox"/> Mislabeled/pharmacy error 6. <input type="checkbox"/> Miscommunication/misunderstood 7. <input type="checkbox"/> Documentation failure 	<p align="center">Other</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> Malfunctioning equipment 2. <input type="checkbox"/> Mislabeled specimen 3. <input type="checkbox"/> Incorrect results reported 4. <input type="checkbox"/> Failure to notify physician 5. <input type="checkbox"/> Failure to respond 6. <input type="checkbox"/> Failure to regulate temperature 7. <input type="checkbox"/> Failure to follow orders 8. <input type="checkbox"/> Wrong treatment 9. <input type="checkbox"/> Miscommunication 10. <input type="checkbox"/> Improper infection control Practices 11. <input type="checkbox"/> Patient uncooperative 12. <input type="checkbox"/> Suspected Abuse 13. <input type="checkbox"/> _____

	B. Fundamental Reasons for Occurrence – Select as many as appropriate		
	<p align="center">Personal Job</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> Lack of knowledge/skill 2. <input type="checkbox"/> Physically incapable 3. <input type="checkbox"/> Trying to save time 4. <input type="checkbox"/> Failure to request assistance 5. <input type="checkbox"/> Inadequate protocol 6. <input type="checkbox"/> Inadequate equipment/supplies 7. <input type="checkbox"/> Inadequate training 	<p align="center">Conditions</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> Inadequate illumination 2. <input type="checkbox"/> Inadequate ventilation 3. <input type="checkbox"/> Poor housekeeping 4. <input type="checkbox"/> Unsafe equipment 5. <input type="checkbox"/> Inadequate safety devices 6. <input type="checkbox"/> Hazardous walkway/surfaces 7. <input type="checkbox"/> Poor maintenance 8. <input type="checkbox"/> Improper equipment 	<p align="center">Actions</p> <ol style="list-style-type: none"> 1. <input type="checkbox"/> Exceeding authority 2. <input type="checkbox"/> Failure to follow procedures 3. <input type="checkbox"/> Use of unsafe equipment 4. <input type="checkbox"/> Failure to clean up spills 5. <input type="checkbox"/> Failure to monitor patient 6. <input type="checkbox"/> Failure to correct know Hazard
	Comments: _____ _____		

	C. Corrective Action to Prevent Recurrence		
	<ol style="list-style-type: none"> 1. <input type="checkbox"/> Counseled Staff 2. <input type="checkbox"/> Reviewed protocol 3. <input type="checkbox"/> Changed protocol 4. <input type="checkbox"/> In-service training 5. <input type="checkbox"/> Restricted duties 6. <input type="checkbox"/> Reassigned 	<ol style="list-style-type: none"> 7. <input type="checkbox"/> Increase supervision 8. <input type="checkbox"/> Suspended 9. <input type="checkbox"/> Terminated 10. <input type="checkbox"/> Repaired/replaced equipment 11. <input type="checkbox"/> Patient/family consultations 	<ol style="list-style-type: none"> 12. <input type="checkbox"/> Other (describe) _____ _____ _____

Done: _____	Target Date: _____	Follow-up: _____
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INVESTIGATED BY:	DATE:
REVIEWED BY MANAGEMENT:	DATE: