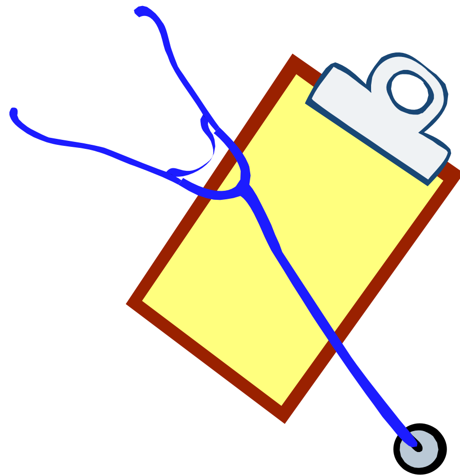
Nemours

How to Complete an Incident Report

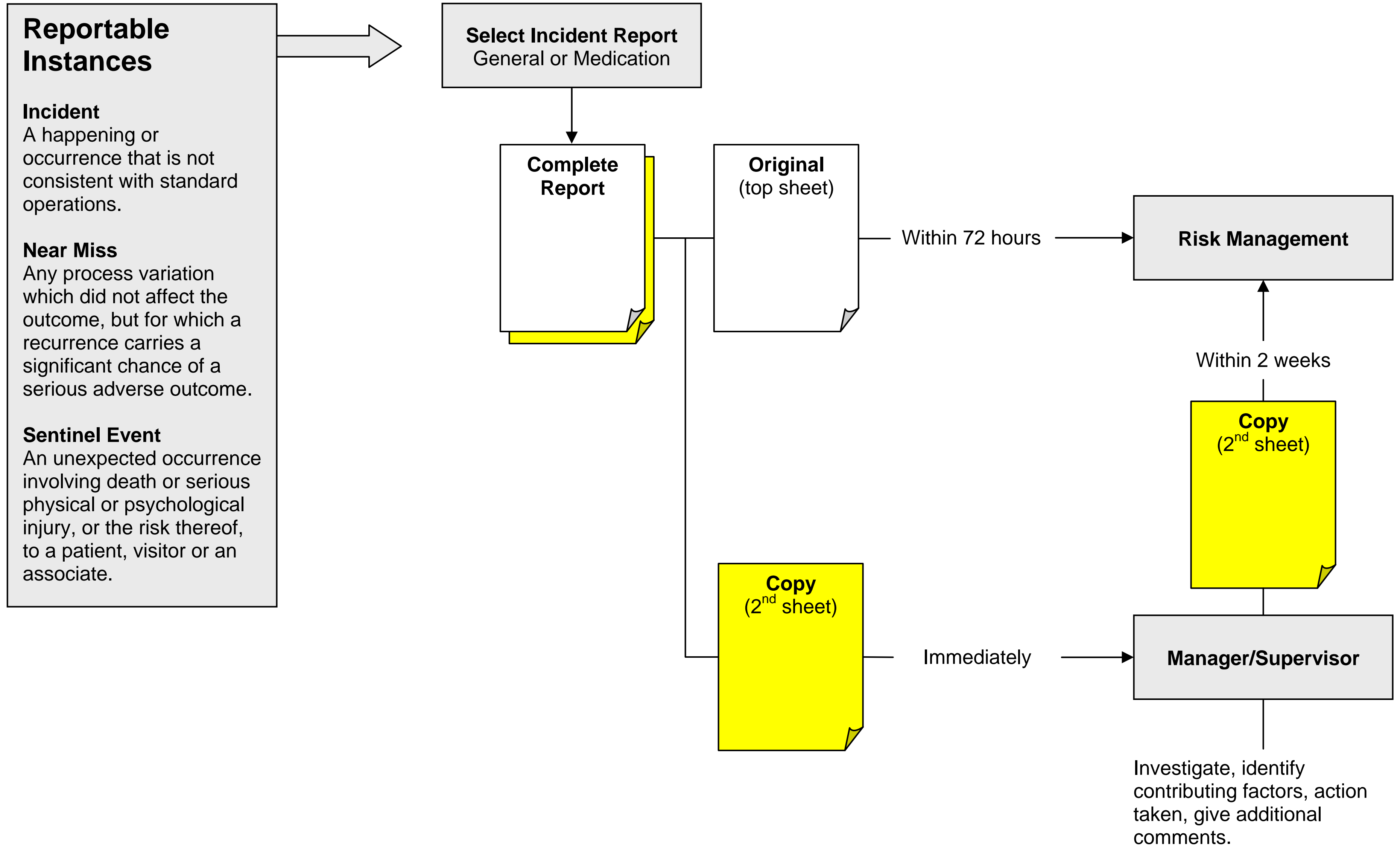
2005



The Reporting Process	1
Two Forms: Medication and General Reports	2
Steps	
First Section	3
Incident Types	4
Equipment / Device / Supply	5
Outcomes and Parameters	6
Last Section	7

© 2005 Nemours Risk Management

The Reporting Process



Nemours

© 2005 Nemours Risk Management

Two Forms: General and Medication Reports

General Incident Report

- Patient falls
- Procedure variance
- Safety and Security
- Blood Product
- Miscellaneous
- Documentation
- More . . .

THIS FORM SHOULD NOT BE COPIED OR INCLUDED IN THE MEDICAL RECORD

NEMOURS INCIDENT REPORT

Person Involved	Identification Status	
Last Name: ____	☐ Patient	☐ Facility
First Name: ____	☐ Contractor	☐ Vendor
Street Address: ____	☐ Equipment	☐ Volunteer
City/State/Zip: ____	☐ Student/Resident/Fellow	☐ Associate
Medical Record #: ____	☐ Other ____	

Date Time Location	Facility	Person Initiating Report
Date of Incident: ____	☐ Hospital	Name: ____
Time of Incident: ____	☐ Clinic ____	Title: ____
Report Date: ____	☐ Other ____	Department: ____
Location where incident occurred: ____		Phone #: ____

Brief Description of Incident (Include immediate action taken and outcome.)

INCIDENT TYPES BY CLASS - Check box next to appropriate incident

Blood Product	*Procedure/Test/Treatment*	*Procedure/Test/Treatment (cont'd)*
☐ Event r/t administration	☐ Break in sterile technique	☐ Other proc/test/tx related
☐ Event r/t dispensing	☐ Consent missing/inadequate	*Complication Procedure/Test/Tx)*
☐ Event r/t sample collection	☐ Consent other	☐ Aspiration
☐ Hemolytic reaction – **Florida only**	☐ Count incomplete/not done	☐ Catheter or tube problem

Medication Incident Report

- Drug reactions
- Contraindicated medication
- Incorrect dose
- Incorrect patient
- Overdose
- ANY medication-related event

THIS FORM SHOULD NOT BE COPIED OR INCLUDED IN THE MEDICAL RECORD

NEMOURS MEDICATION INCIDENT REPORT

Person Involved	Identification Status	
Last Name: ____	☐ **Patient**	☐ **Facility**
First Name: ____	☐ **Contractor**	☐ **Vendor**
Street Address: ____	☐ **Equipment**	☐ **Volunteer**
City/State/Zip: ____	☐ **Student/Resident/Fellow**	☐ **Associate**
Medical Record #: ____	☐ **Other** ____	

Date Time Location	Facility	Person Initiating Report
Date of Incident: ____	☐ **Hospital**	**Name:** ____
Time of Incident: ____	☐ **Clinic** ____	**Title:** ____
Report Date: ____	☐ **Other** ____	**Department:** ____
Location where incident occurred:		**Phone #:** ____

Brief Description of Incident (Include immediate action taken and outcome.)

INCIDENT TYPES BY CLASS - Check box next to appropriate incident

Medication	*Medication (con't)*	*Intravenous Fluids (con't)*
☐ Adverse Drug Reaction **Florida only**	☐ Therapeutic duplication	☐ Incorrect time

© 2005 Nemours Risk Management

Identification Status
Check one box. Specify what "other" is if checked.

Person Involved
Name of the person directly involved in or affected by the incident. Leave blank if it's a safety or security incident involving Nemours property.

Date Time Location
Fill in each space to include the exact time, (i.e. not "day shift") unless the event occurred over the entire shift.

Facility
If Clinic is checked, specify the name of the clinic. If "other," identify the location, such as "hospital grounds," "parking lot," etc.

Person Initiating Report
Legibly write or print your name, title (staff nurse, manager, dietitian, etc.), department, and phone number where you can be reached.

Description of Incident
- Print or write legibly.
- Briefly describe the event using facts only – no opinions.
- Document using quotes for visitors, etc., if the incident was not witnessed by staff.
- Document action taken and the result/outcome using only the facts as they happened and what you observed or know as fact.

1 2 3 4 5 6

THIS FORM SHOULD NOT BE COPIED OR INCLUDED IN THE MEDICAL RECORD

NEMOURS INCIDENT REPORT

Person Involved	Identification Status	
Last Name: ______	☐ Patient	☐ Facility
First Name: ______	☐ Contractor	☐ Vendor
Street Address: ______	☐ Equipment	☐ Volunteer
City/State/Zip: ______	☐ Student/Resident/Fellow	☐ Associate
Medical Record #: ______	☐ Other ______	

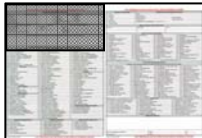
Date Time Location	Facility	Person Initiating Report
Date of Incident: ______	☐ Hospital	Name: ______
Time of Incident: ______	☐ Clinic ______	Title: ______
Report Date: ______	☐ Other ______	Department: ______
Location where incident occurred: ______		Phone #: ______

Brief Description of Incident (Include immediate action taken and outcome.)

INCIDENT TYPES BY CLASS - Check box next to appropriate incident

Blood Product	*Procedure/Test/Treatment*	*Procedure/Test/Treatment (cont'd)*
☐ Event r/t administration	☐ Break in sterile technique	☐ Other proc/test/tx related
☐ Event r/t dispensing	☐ Consent missing/inadequate	*Complication Procedure/Test/Tx)*
☐ Event r/t sample collection	☐ Consent other	☐ Aspiration
☐ Hemolytic reaction – **Florida only**	☐ Count incomplete/not done	☐ Catheter or tube problem

You Are Here



© 2005 Nemours Risk Management

★ **Use a separate incident report for each incident being reported.**

Select Class
Select the most appropriate class.

7

Select Type
Select only one type per report.

8

INCIDENT TYPES BY CLASS - Check box next to appropriate incident		
Blood Product	***Procedure/Test/Treatment***	***Procedure/Test/Treatment (cont'd)***
☐ Event r/t administration	☐ Break in sterile technique	☐ Other proc/test/tx related
☐ Event r/t dispensing	☐ Consent missing/inadequate	***Complication Procedure/Test/Tx)***
☐ Event r/t sample collection	☐ Consent other	☐ Aspiration
☐ Hemolytic reaction – **Florida only**	☐ Count incomplete/not done	☐ Catheter or tube problem
☐ Incorrect component dispensed	☐ Count incorrect-equip/device	☐ Expose-commun dis- **Florida only**
☐ Incorrect patient	☐ Count incorrect-needles	☐ ... acquire infect- **Florida only**
☐ Incorrect time	☐ Count incorrect-sponges	☐ Indwelling cath infect- **Florida only**
☐ Mismatched unit	☐ Delay-critical result reporting	☐ Intubation complication
☐ Non-hemolytic react – **Florida only**	☐ Delay in scheduling	☐ Removal tube/device by pt
Fall/Injury	☐ Delay in service	☐ Unintended intraop awareness
☐ Ambulating	☐ Film unavailable or inadequate	☐ Unintended lac/puncture
☐ Assisted sit	☐ Foreign body in pt-unplanned	☐ Wound dehiscence
☐ During exam/test/procedure	☐ ID band missing/incorrect	☐ Wound/surg site infec- **Florida only**
☐ Found on floor	☐ Incorrect patient	☐ Other comp proc/test/tx
☐ Lying in bed	☐ Incorrect procedure	***Nutrition***
☐ Sitting at side of bed	☐ Incorrect reading/interpretation	☐ Contaminated or exp nutrition
☐ Sitting in chair	☐ Incorrect result	☐ Contraindication-clinical
☐ Toileting	☐ Incorrect side (R vs. L)	☐ Contraindication-documented allergy
☐ Transferring	☐ Incorrect site	☐ Incorrect diet
☐ Other fall/injury related	☐ Incorrect test ordered	☐ Incorrect dose form
Skin Integrity	☐ Incorrect test performed	☐ Incorrect duration
☐ Pressure ulcer	☐ Medical gas problem	☐ Incorrect patient
☐ Trauma to healthy tissue	☐ Mislabeled specimen	☐ Incorrect rate
☐ Other skin integrity related	☐ Missed treatment	☐ Incorrect route
Miscellaneous	☐ MRI safety violation	☐ Incorrect strength/concentration
☐ Attempted/actual suicide	☐ Ordered, not done	☐ Incorrect time
☐ Breach of confidentiality	☐ Prep inadequate/incorrect	☐ Missing feeding or supplement

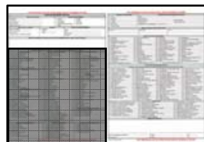
★ **Medication form only**

Medication(s) involved:	Was medication/IV given? ☐ yes ☐ no

Witness(es) Name and Phone Number

Form # 01002 (8-05) THIS FORM SHOULD NOT BE COPIED OR INCLUDED IN THE MEDICAL RECORD

You Are Here



© 2005 Nemours Risk Management

Equipment / Device / Supply – Form Page 2

Equipment Ownership
If equipment, a device, or supply is involved, complete the Equipment Ownership and Equipment Device/Supply Information section.

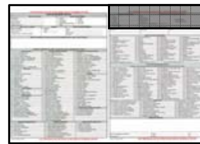
9

Equipment Ownership	Equipment/Device/Supply Information	
☐ Clinic	Name:	
☐ Hospital	Manufacturer:	
☐ Patient	Model Number:	Serial Number:
☐ Leased	Lot Number:	Inventory Number:
☐ Borrowed	MedWatch form completed: ☐ Yes ☐ No	
☐ Not specified		

10

Equipment/Device/ Supply
Fill out the Equipment/Device/ Supply Information section *completely* so that the equipment or device can be identified.

You Are Here



Witnesses – Form Page 2

★ **Provide the name and telephone number of all witnesses.**

- Two names can be written under each column.
- If there are more than two witnesses under any of the columns, document additional witnesses under the additional comments sections.

11

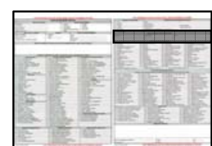
Physicians, Practitioners, ARNP, etc.

Employees

Volunteers, visitors, family, etc.

Witness(es) Name and Phone Number		
Physician	Employee	Other

You Are Here



© 2005 Nemours Risk Management

★ **An outcome shows the result of the action or non-action of a function or process.**

Select as many as apply.

12

Check box for physician notification, family notification, and documentation in the medical record.

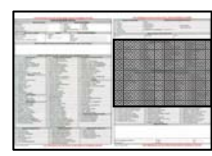
13

Outcomes (select all that apply)			
☐ Abrasion	☐ Ecchymosis/bruise	☐ Ischemia	☐ Perforation
☐ Abscess	☐ Edema	☐ Laceration	☐ Perm harm/injury/disability
☐ Aggravate pre-exist cond	☐ Emesis	☐ Law enforcement called	☐ Phlebitis
☐ Altered skin integrity	☐ Embolus	☐ Loss of consciousness	☐ Property damage/clinical
☐ Apnea	☐ Escorted from property	☐ Loss of limb	☐ Property damage/personal
☐ Arrhythmia/dysrhythmia	☐ Fainting	☐ Loss of limb function	☐ Respiratory arrest
☐ Brain injury	☐ Fistula	☐ Loss/impairment of organ	☐ Rupture
☐ Burn	☐ Fracture	☐ Mental status change	☐ Security called
☐ Cardiac arrest	☐ Head injury	☐ Necrosis	☐ Shock
☐ Damage to teeth	☐ Hematoma	☐ Neuro deficit	☐ Spinal cord injury
☐ Death	☐ Hemorrhage	☐ No additional tx or cost	☐ Strain or sprain
☐ Discomfort/inconvenience	☐ Hemo or pneumothorax	☐ No adverse outcome	☐ Surgery
☐ Dislocation	☐ Hyper/hypotension	☐ Obstruction	☐ Unplanned transf-higher care
☐ Dismissal from practice	☐ Increase length of stay	☐ Other condition/injury	☐ Visceral injury
☐ Dizziness	☐ Infection	☐ Pain	☐ Wound disrup/dehiscence
Attending Phys Notified ☐ yes ☐ no	Family Notified ☐ yes ☐ no	Documented in MR ☐ yes ☐ no	

★ **Identify things – parameters – that may have contributed to what you are reporting.**

Parameters (Contributing Factors) — Parameters are the things that may have contributed to or affected the reported event. Select all that apply.			
☐ Altered mental status	☐ Decimal error	☐ Inc or unclear written order	☐ Pain med w/in 4 hours
☐ Amb w/ walker/crutches	☐ Delay provider response	☐ Incontinent	☐ Sedation/diuretic w/in 4h
☐ Ambulatory w/ assist	☐ Delayed delivery	☐ Incorrect computer order entry	☐ Patient owned
	☐ Delivery to incorrect location	☐ Knowledge deficit	☐ Patient refused treatment
	☐ Device failure	☐ Knowledge deficit provider	☐ Patient unavailable
	☐ Difficult patient/family	☐ Knowledge deficit family/pt	☐ Pt/family non-compliance
	☐ Docum inaccurate/lacking	☐ Known drug allergy	☐ Policy/proc not followed
☐ Bed rails down	☐ Fax error	☐ Known drug intolerance	☐ Prevent maint not done
☐ Bed rails up	☐ High risk for falls	☐ Known drug sensitivity	☐ Reprocess single-use item
☐ Bed rest	☐ ID band missing/incorrect	☐ Medical record not avail	☐ Restraints in place
☐ Borrowed/loaned item	☐ Illegible fax of order	☐ Misinterp of order	☐ Running
☐ Calculation error	☐ Illegible handwriting	☐ Mislabeled	☐ System safeguard ignored
☐ Call light out of reach	☐ Improper footwear	☐ No policy or procedure	☐ Unapproved abbreviation
☐ Change in pt condition	☐ Inadeq isolation precaut	☐ Non-stock item	☐ Unsafe environ factor
☐ Communication	☐ Inadequate lab/dx test	☐ Not entered in computer	☐ Verbal order
☐ Criteria not met (VS, lab)	☐ Inadequate monitoring	☐ OOB ad lib	☐ VS not as ordered
☐ Comorbidity condition	☐ Inadeq/unavail staff	☐ OOB w/ assist	☐ Walking surface poor
	☐ Inappro unit of measure	☐ Order transcribed incorrectly	☐ Walking surface wet/slip

You Are Here



© 2005 Nemours Risk Management

Action Taken

- Completed by the manager/supervisor.
- Select as many as apply.

14

Additional Comments

- Completed by the manager/supervisor.
- Expanded information on outcome or action taken.

15

Action Taken

☐ Arrange for support of staff involved	☐ Enforce policy & procedure	☐ Referred to another dept
☐ Change in clinical duties/privileges	☐ Environment modified	☐ Referred to medical staff leadership
☐ Change in plan of care	☐ Equipment/device/supply change	☐ Referred to admin leadership
☐ Communication flow change	☐ Inventory change	☐ Removed equipment or supplies
☐ Competency/skill demonstration	☐ Item repaired or replaced	☐ Requested assist from QI
☐ Computer software modify/obtain	☐ Modified staff pattern or work flow	☐ Review/revise policy & procedure
☐ Corrective action plan	☐ No action necessary	☐ Staff orientation review/revise
☐ Develop policy or procedure	☐ Patient account adjusted	☐ Talk with patient/family
☐ Discussed with staff	☐ Preceptor/proctor assigned	

Additional Comments

Supervisor/Manager Signature: ____________________________ Div/Dept: __________ Date:_______

Forwarded to: Div/Dept: Date:

You Are Here

© 2005 Nemours Risk Management