RISK MANAGEMENT MEDICAL SERVICES INCIDENT REPORT

OMB - RISK MANAGEMENT DIVISION

SFN 53601 (9-2011)

Department Location Code				

☐ Incident
☐ Near Miss
☐ Claim Form Requested

Name:	ID Number:	☐ Client ☐ Outpatient ☐ Inpatient ☐ Employee ☐ Visitor ☐ Volunteer			
Address:		City:	State:	ZIP Code:	
Date of Incident:	Time of Incident:	Sex: ☐ Female ☐ Male	Date of Birth:	Telephone Number:	
Service Area:	Ward:	Notification: ☐ Medical ☐ Family	Workers Compensation Filed: ☐ Yes ☐ No		
Witness:	Telephone Number:	Address:			
City:	State:	ZIP Code:	Date Reviewed by Loss Control:	Property DMG. ☐ State ☐ Other What: _____	

OCCURRENCE CATEGORY: (Select one only)

MEDICATION
- ☐ Incorrect Day/Time
- ☐ Incorrect Dose
- ☐ Incorrect Medication
- ☐ Wrong Patient
- ☐ Incorrect Route
- ☐ Omitted
- ☐ Refusal
- ☐ Self-Med
- ☐ Given Without Order
- ☐ Other: _____

FALLS
- ☐ To/From Bed
- ☐ To/From Chair/Equipment
- ☐ Fall While Walking ☐ Assist ☐ Unassist
- ☐ Ice Fall
- ☐ Elevated Fall
- ☐ Other: _____

TREATMENT/PROCEDURE
- ☐ Infection-Related
- ☐ Surgery
- ☐ Testing-Related
- ☐ Treatment-Related
- ☐ Other: _____

TRAUMA
- ☐ Altercation/Hostility
- ☐ Burn
- ☐ Caught by Object
- ☐ Self Abuse
- ☐ Recreation Injury
- ☐ Scratched
- ☐ Struck
- ☐ Struck An Object
- ☐ Struck By Object
- ☐ Suicide/Attempted
- ☐ Swallowed Inedible
- ☐ Other: _____

MISCELLANEOUS
- ☐ Altercation/Hostility
- ☐ Complaint
- ☐ Confidentiality Breach
- ☐ Elopement/Leave without Notification
- ☐ Improper Clt/Clt Contact
- ☐ Improper Emp/Clt Contact
- ☐ Med. Record/Doc.
- ☐ Property Damage
- ☐ Equipment/Product Related
- ☐ Computer Security
- ☐ Unknown

PART OF BODY INJURED:

Body Part Injured ☐ Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Right ☐ Unknown ☐ Upper

TYPE OF BODILY INJURY:
- ☐ Abrasion/Scrapes
- ☐ Amputation
- ☐ Anoxia/Resp Distress
- ☐ Bite ☐ Intact Skin ☐ Broken Skin
- ☐ Blister
- ☐ Burns ☐ 1st ☐ 2nd ☐ 3rd
- ☐ Contusion/Bruise
- ☐ Damaged Teeth
- ☐ Death
- ☐ Decubitis Ulcer
- ☐ Edema/Swelling
- ☐ Nosebleed
- ☐ Fracture/Dislocation
- ☐ Infection
- ☐ Laceration ☐ Major ☐ Minor
- ☐ None Evident
- ☐ Reddened
- ☐ Rash
- ☐ Sprain/Strain
- ☐ Wound Disruption
- ☐ Other: _____

AREA OF OCCURRENCE:
- ☐ Administration Area
- ☐ Bathroom/Shower
- ☐ Bedroom
- ☐ Dining Area
- ☐ Exam Room
- ☐ Grounds
- ☐ Hallway/Waiting Room
- ☐ Kitchen
- ☐ Lab
- ☐ Living Area
- ☐ Med. Room
- ☐ Medical Records
- ☐ Nursing Station
- ☐ Off Premises
- ☐ Pharmacy
- ☐ Parking Area
- ☐ Recreational Facility
- ☐ Seclusion
- ☐ Stairs
- ☐ Surgery
- ☐ Tunnel
- ☐ Storage
- ☐ Vehicle
- ☐ Voc Program
- ☐ Unknown
- ☐ X ray
- ☐ Other: _____

PROCESS:
- ☐ Bathroom
- ☐ Behavior
- ☐ Day Program
- ☐ Exam
- ☐ Home Visit
- ☐ Household Duties
- ☐ Hygiene/Grooming
- ☐ Interpersonal Altercation
- ☐ Job/Work
- ☐ Leisure
- ☐ Left Premises Unattended
- ☐ Lifting Client
- ☐ Lifting Object
- ☐ Meal/Snack
- ☐ Med. Administration
- ☐ Other Daily Cares
- ☐ Rest/Sleep
- ☐ Scheduled Appointment
- ☐ Trauma by: Patient # ☐ Client/Patient ☐ Self ☐ Staff ☐ Other ☐ Seizure ☐ Seclusion/Restraint ☐ Stress Test
- ☐ Surgery
- ☐ Therapeutic Intervention
- ☐ Therapeutic Outing
- ☐ Transporting
- ☐ X ray
- ☐ Other: _____

Description of Incident:

Individual Preparing Report: (Name and Title)	Date:	Additional Sign-Off:	Date:
Department Head/Supervisor: (Name and Title)	Date:	Risk Management Review:	Date:

* Pursuant to N.D.C.C. Sec. 32-12.2-11, this report is privileged and exempt from the open records law as long as disclosure could prejudice any pending or reasonably predictable claim.

TO BE COMPLETED BY DEPARTMENT HEAD/SUPERVISOR

Describe policies and procedures in effect that relate to this incident.
Were policies and procedures followed? ☐ Yes ☐ No - Explain

List all causes of the incident (equipment, procedure, environment, behavior)

Action Taken

a. Has corrective action been initiated? ☐ Yes ☐ No
If yes, what corrective action is being taken?
If no, when will corrective action be taken?

b. Work Order Submitted ☐ Yes ☐ No

c. What safety equipment/training could have prevented this injury?

Comments and/or Diagram

GENERAL INSTRUCTIONS

1. Use ink. Place a bold "X" or "Check Mark" where necessary.
2. The employee who discovers the incident or to whom the incident is reported, shall complete the form. As you complete this form:
   a. Be objective and factual.
   b. Make appropriate notes in the patient/client record, but do not refer to incident report.
   c. Use complete record number for patient/client (ID number section). For others, print name, address, city, state, zip, and telephone number in designated section.
   d. Note the time of the incident (not the time of reporting).
   e. Witness: List the witness name, address, and telephone number, and indicate whether the witness is an employee. List additional witnesses on a separate piece of paper. Attach to Incident Report.
3. If an individual with Developmental Disabilities is involved in an accident, please complete notification box. The family must be notified if the incident involves the client's serious illness, serious accident or death, in order to comply with AC requirements.
4. The complete report is forwarded to the Risk Management designee, within 24 hours of the incident.

ANY INCOMPLETE REPORTS WILL BE RETURNED FOR COMPLETION