

# INCIDENT REPORT

Addressograph Impression

HOSPITAL/CENTER: \_\_\_\_\_

PATIENT/BUILDING/WARD: \_\_\_\_\_

PATIENT'S COMMITMENT STATUS: \_\_\_\_\_

INCIDENT/LOCATION: On grounds \_\_\_\_\_ specify \_\_\_\_\_ or Off grounds \_\_\_\_\_  
Building \_\_\_\_\_ Ward: \_\_\_\_\_ Room # \_\_\_\_\_

DATE OF INCIDENT: \_\_\_\_\_ Time: \_\_\_\_\_

DAY OF WEEK: 01 Sun 02 Mon 03 Tues 04 Wed 05 Thurs 06 Fri 07 Sat

WITNESS(S): 01 None 02 Staff 03 Patient(s) 04 Other  
Specify name(s) or patient(s) number(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

COMPLETED BY: \_\_\_\_\_  
TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

## NARRATIVE DESCRIPTION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

COMPLETE ITEM 1 THROUGH 5 FOR EACH INCIDENT. IF AN INCIDENT CATEGORY IS MARKED WITH #, COMPLETE THE OTHER ITEM INDICATED.

### 1. INCIDENT CATEGORY. Circle number(s) that apply. Not more than three.

- |                                 |                                    |                                   |                               |
|---------------------------------|------------------------------------|-----------------------------------|-------------------------------|
| 01 Accidental injury            | 08 Choking                         | 15 Medication error (# 7)         | 22 Theft                      |
| 02 Adverse drug reaction (7# C) | 09 Death (#10)                     | 16 Possession of contraband       | 23 Treatment/procedural error |
| 03 Alcohol use                  | 10 Destruction of property         | 17 Reported community disturbance | 24 Unauthorized absence (#12) |
| 04 Alleged patient abuse (#11)  | 11 Fall (#6)                       | 18 Seizure/convulsion             | 25 Other, specify _____       |
| 05 Alleged sexual assault       | 12 Fire setting                    | 19 Self-injurious behavior (#8)   |                               |
| 06 Allergic reaction            | 13 Illicit drug use                | 20 Sudden illness                 |                               |
| 07 Assault (#9)                 | 14 Infectious/communicable disease | 21 Terroristic threat             |                               |

### 2. INJURY. Circle the number(s) of all that apply.

- |                                         |                          |                              |                             |
|-----------------------------------------|--------------------------|------------------------------|-----------------------------|
| 01 None                                 | 09 Concussion            | 17 Hematoma                  | 25 Reopened old wound       |
| 02 Abrasion/scrape/scratch              | 10 Cut/laceration        | 18 Internal bleeding         | 26 R/O fracture             |
| 03 Amputation                           | 11 Damaged/lost tooth    | 19 Internal injury           | 27 Skin irritation/rash     |
| 04 Bite human/animal                    | 12 Dislocation           | 20 Knife/stab wound          | 28 Splinter                 |
| 05 Bite/sting insect                    | 13 Ear injury            | 21 Muscle pull/strain/sprain | 29 Strangulation            |
| 06 Bloody nose                          | 14 Edema                 | 22 Non-communicative         | 30 Unconscious/unresponsive |
| 07 Bruise/contusion/discoloration/swell | 15 Eye injury/irritation | 23 Pain                      | 31 Other, specify _____     |
| 08 Burn(s)                              | 16 Fracture/broken nose  | 24 Poisoned                  |                             |

### 3. SPECIFIC LOCATION. Circle one.

- |                          |                         |                    |                         |
|--------------------------|-------------------------|--------------------|-------------------------|
| 01 Activity/program area | 05 Canteen/vending area | 09 Lobby           | 13 Shower/tub           |
| 02 Bathroom              | 06 Courtyard            | 10 Medication room | 14 Visiting room/area   |
| 03 Bedroom/dormitory     | 07 Corridor/hallway     | 11 Nurse's station | 15 Other, specify _____ |
| 04 Cafeteria/dining room | 08 Day room/day hall    | 12 Porch           |                         |

### 4. PATIENT DISPOSITION. Circle all that apply.

- |                                      |                           |                            |                                       |
|--------------------------------------|---------------------------|----------------------------|---------------------------------------|
| 01 Admitted to general hospital      | 05 Placed on restrictions | 09 Placed on critical list | 13 Sent to emergency room             |
| 02 Autopsy requested/coroner ordered | 06 Placed in restraints   | 10 Privilege changed       | 14 Sutures, specify number _____      |
| 03 Examined by physician             | 07 Placed in seclusion    | 11 Referred to clinic(s)   | 15 Transferred to another unit ward   |
| 04 Placed on precautions             | 08 Placed on sick call    | 12 Referred to X-ray       | 16 Treated by physician               |
|                                      |                           |                            | 17 Other, specify _____               |
|                                      |                           |                            | 18 Unknown when this report completed |

### 5. FOLLOW-UP ACTION. Circle all that apply and complete items as applicable.

- |                                          |                                     |                             |                                       |
|------------------------------------------|-------------------------------------|-----------------------------|---------------------------------------|
| <i>Corrected environmental condition</i> | 04 Establish new/revised procedures | 09 Notified family, specify | 11 Treatment plan modified            |
| 01 Physical plant defect, specify _____  | 05 Medication(s) modified           | To: _____                   | 12 Treatment plan reviewed            |
|                                          | 06 Medication(s) reviewed           | By: _____                   | 13 Other, specify _____               |
| 02 Medical device, specify _____         | 07 No further action                | Date & Time: _____          |                                       |
| Inventory # _____                        | 08 Notified county BSU, specify     | 10 Notified police, specify | 14 Unknown when this report completed |
| 03 Equipment, specify _____              | To: _____                           | To: _____                   |                                       |
| Inventory # _____                        | By: _____                           | By: _____                   |                                       |
|                                          | Date & Time: _____                  | Date & Time: _____          |                                       |

6. **FALL.** Circle one number in each category

<b>A. FALL FROM/BY</b>	<b>B. PATIENT WAS</b>	<b>C. AMBULATION STATUS:</b>	<b>F. FOOTWEAR</b>
01 Bed	01 Attended	01 Ambulatory, walks independently	01 Shoes/boots
02 Chair	02 Gerichair, no tray	02 Assisted ambulation, braces, cane, walker, crutches, etc.	02 Slippers
03 Commode	03 Gerichair, with tray	03 Partial ambulation, wheelchair tray chair, wheeled platform	03 Stockings/socks
04 Found on door	04 In restraint	04 Non ambulatory, cannot move independently	04 Bare feet
05 Gerichair	05 In seclusion	05 Non-mobile, completely bedfast	05 Not applicable
06 Lost balance			
07 Running	<b>C. SIDE RAILS</b>	<b>E. WALKING SURFACE</b>	<b>G. MEDICATION STATUS</b>
08 Sink	01 Not applicable	01 Dry	01 Within 4 hours of fall (# 7 C)
09 Shower/tub	02 ½ rails	02 Not applicable	02 Not within 4 hours of fall
10 Slipping	03 Full rails	03 Unknown	03 Changed within last 3 days (#7 C)
11 Stretcher		04 Wet	04 Not changed within last 3 days
12 Tripped Over _____		05 Other, specify _____	
13 Wheelchair			
14 Other, specify _____			

7. **MEDICATION ERROR.** Circle all that apply in each Subcategory.

<b>A. ERROR TYPE</b>	<b>B. REASON FOR ERROR</b>	<b>C. TYPE MEDICATION(S):</b> specify by generic name _____
01 Omission	01 Charting mistake	01 Antihistamine drug
02 Wrong dose(s)	02 Communication	02 Anti-infective agent
03 Wrong drug	03 Failure to check ID	03 Autonomic drug
04 Wrong patient	04 Incomplete/confused order	04 Blood formulation & coagulation
05 Wrong route	05 Forget to give	05 Cardiovascular
06 Wrong time	06 Medication missing	06 Analgesic/antipyretic
07 Unable to determine	07 Mislabeled	07 Anticonvulsant
08 Other, specify _____	08 Measured dose	08 Antidepressant
	09 Misread Kardex	09 Tranquilizer, antipsychotic
	10 Misread label	10 Respiratory or cerebral stimulant
	11 Patient off unit	11 Anxiolytic/sedative/hypnotic
	12 Pharmacy dispensing problems	12 Lithium
	13 Prescribing error	13 Diagnostic agent
	14 Transcription	
<b>D. DISCIPLINE INVOLVED</b>	15 Other, specify _____	
01 Licensed practical nurse		
02 Physician		
03 Pharmacist		
04 Registered nurse		

8. **SELF-INJURIOUS BEHAVIOR.** Circle all that apply in each subcategory.

<b>A. METHOD</b>	<b>C. INSTRUMENT</b>	<b>D. PRECIPITATING EVENTS</b>
01 Biting	01 Belt	01 Imminent discharge
02 Burning	02 Cigarette	02 Contact/visit with family/friend
03 Cutting	03 Clothing	03 Commitment decision/order
04 Drowning	04 Comb	04 Death of family/friend
05 Electrocution	05 Chemical(s)	05 Discharge planning
06 Hanging	06 Electrical outlet	06 Response to mental illness symptoms
07 Head banging	07 Fingernail(s)	07 Rejection by community placement
08 Ingestion	08 Glass	08 Refused increased privilege(s)
09 Inhaling	09 Gun	09 Removed form privilege(s)
10 Jabbing	10 Hand(s)	10 Return to prison/jail
	11 Illegal contraband drugs	11 Transfer within hospital
	12 Key(s)	12 Other, specify _____
<b>B. PATIENT WAS</b>		
01 On precautions, specify _____		
02 Not on precautions		

9. **ASSAULT.** Circle all that apply in each subcategory.

<b>A. PATIENT</b>	<b>B. ASSAULT RESULTED IN</b>	<b>C. PROVOCATION WAS</b>
01 Assaulted another patient(s)	01 Injury to this patient	01 Known, specify _____
02 Assaulted a staff member(s)	02 Injury to another patient(s)	02 Unknown
03 Assaulted a visitor/family	03 Injury to staff	
04 Assaulted by another patient(s)	04 Injury to visitor/family	<b>D. PRECIPITATING FACTOR(S)</b>
05 Assaulted by visitor/family	05 No injury	01 Known, specify _____
06 Other, specify _____	06 Other, specify _____	02 Unknown

**10. DEATH.** Circle and complete all that apply in each subcategory

**A. TYPE OF DEATH**

- 01 Accidental
- 02 Homicide (suspected)
- 03 Sudden, unexplained
- 04 Suicide

**C. CORONER STATUS**

- 01 Accepted
- 02 Declined

**B. CORONER NOTIFICATION**

- 01 Yes, specify  
To: \_\_\_\_\_  
By: \_\_\_\_\_  
Date & Time: \_\_\_\_\_

**D. AUTOPSY STATUS**

- 01 Coroner
- 02 Request to family accepted, specify name/relationship \_\_\_\_\_
- 03 Request to family refused, specify name/relationship \_\_\_\_\_
- 04 No request made

**11 ALLEGED PATIENT ABUSE:** Circle all that apply

**A. TYPE OF ABUSE**

- 01 Neglect
- 02 Non-physical
- 03 Patient exploitation
- 04 Physical
- 05 Psychological
- 06 Verbal
- 07 Violation of regulation, policy, and/or procedure
- 08 Other, specify \_\_\_\_\_

**B. REFERRED FOR INVESTIGATION**

- 01 Yes
- 02 No
- 03 Unknown at this time

**12. UNAUTHORIZED ABSENCE (UA):** Circle and complete all that apply in each subcategory

**A. TYPE OF UA**

- 01 At risk patient
- 02 Non-dangerous patient
- 03 Dangerous patient
- 04 Civil patient subject to criminal charges
- 05 Forensic unit patient

**D. GROUND SEARCH.**

- 01 No
- 02 Yes, specify by whom \_\_\_\_\_

**F. DESCRIPTION OF PATIENT**

- 01 Height, specify \_\_\_\_\_ft \_\_\_\_\_in
- 02 Weight, specify \_\_\_\_\_pounds
- 03 Hair color, specify \_\_\_\_\_
- 04 Eye color, specify \_\_\_\_\_
- 05 Scar/distinguishing marks specify \_\_\_\_\_
- 06 Clothing, specify \_\_\_\_\_
- 07 Race, specify \_\_\_\_\_
- 08 Medical problems, specify \_\_\_\_\_
- 09 Precautions, specify \_\_\_\_\_
- 10 Potential for dangerousness/violence, specify \_\_\_\_\_
- 11 Criminal charges, specify \_\_\_\_\_

**G. PATIENT RETURNED ?**

- 01 No
- 02 Yes, specify  
Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
By Whom: \_\_\_\_\_

**B UA INITIATED FROM**

- 01 Activity program area
- 02 Community hospital/clinic
- 03 Dining room
- 04 Grounds privileges
- 05 Leave of absence
- 06 Off grounds activity
- 07 Ward
- 08 Other, specify \_\_\_\_\_

**E. NOTIFICATION(S)**

- 01 Responsible relative
- 02 Base service unit/county administrator
- 03 Local police
- 04 State police
- 05 Court
- 06 Office of Mental Health & SAS
- 07 All of above
- 08 At risk individual victim
- 09 None

**C. LAST SIGHTING.**

- 01 Date, specify \_\_\_\_\_
- 02 Time, specify \_\_\_\_\_
- 03 Location, specify \_\_\_\_\_

**Definitions for coding TYPE OF UA above.**

- 01 AT RISK PATIENT- A voluntary or involuntary patient who is confused, disabled or medically dependent and potentially unable to protect self and seek safety from environmental hazards due to a mental or physical condition
- 02 NON-DANGEROUS PATIENT-A voluntary patient who consciously and voluntarily decides to leave the hospital without approval and is not considered a danger to self or others
- 03 DANGEROUS PATIENT-An involuntary patient or voluntary patient who presents a clear and present danger to self or others who consciously and voluntarily leaves the hospital without approval.
- 04 CIVIL PATIENT SUBJECT OT CRMIMINAL CHARGES- A voluntary or involuntary patient , including any patient adjudicated Not Guilty By Reason Of Insanity who is charged with a crime, serving sentence, or waiting to be sentenced and is absent without approval.
- 05 FORENSIC UNIT PATIENT- A voluntary or involuntary patient who is charged with a crime, serving sentence, or waiting to be sentenced including any patient adjudicated Not Guilty By Reason Of Insanity and who is assigned to a forensic unit and is absent without approval.

13. **REVIEWED BY:** Circle all that apply.

01 Supervisor –  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Comments, if any:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

02 Attending Physician –  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Comments, if any:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

03 Chief Clinical/Medical Officer –  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Comments, if any:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

04 Risk Manager –  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Comments, if any:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

05 Risk Management/Incident Review Committee -  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Comments, if any:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

06 Safety Manager –  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Comments, if any:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

07 Other, Specify –  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Comment if any:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*1. This report is for use in recording facts immediately available concerning a patient incident.  
This report is not for use in drawing conclusions, nor should the report format or document be  
for additional investigation.*