

State Hospital

Incident Report

SI-815

Patient #:		Name:			Unit/Ward:		Seq#:		
Start Date:		Start Time (H:MM):			Shift: 1 2 3		DOW (Sun=1):		
Location Code:		Category Code (s):		Effect Code(s):		Body Part Code(s):		Closure Code(s):	
Fall A:		Fall was B:		Ambulation C:		Surface D:		Footwear E:	
Med Error Type A:		No. of Doses:		Med Error Reason B:		Med Type C: / /		Severity D:	
SIB Method A:				SIB Instrument B:					
Assault Patient A:				Assault Result B:			Assault Provocation/Reason C:		
Aggression Patient A:				Aggression Result B:			Aggression Provocation/Reason C:		
Death Type A:		Coroner Notified B:		Coroner Status C:			Autopsy Status D:		
Alleged Abuse Type A:		Referred for Investigation B:		Alleged Noneconsensual Sexual Activity Patient A:			Referred for Investigation B:		
AWOL A:		Circumstances B:		Search C:		Consequences D: / /		AWOL Return Date & Time:	
ADR Drug & Dose:			ADR Action A: /		ADR Type B:		ADR Severity C:	Pharmacy Review D:	
Physical Restraint: Yes <input type="checkbox"/> No <input type="checkbox"/>		Total Min/Sec. in PR:	Mech Restraint: Yes <input type="checkbox"/> No <input type="checkbox"/>		Total Minutes in MR:	Exclusion: Yes <input type="checkbox"/> No <input type="checkbox"/>	Total Minutes in Exclusion:	Seclusion: Yes <input type="checkbox"/> No <input type="checkbox"/>	Total Minutes in Seclusion:
Restraint/Seclusion/Exclusion Authorized by:			Patient approved family notification of S/R? Yes <input type="checkbox"/> No <input type="checkbox"/>			Was Patient on increased level of supervision at time of incident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Containment related injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	
NRI 1:	Loc:	St. Dt:	St. time:	End Dt:		End time:	1:	2:	3:
NRI 2:	Loc:	St. Dt:	St. time:	End Dt:		End time:	1:	2:	3:
Description of Event (Who, What, Where, When,-Reference Others Involved by Patient Number Only):									
Signature & Title Date									
Names of Witnesses			Relationship/Title			Location		Work Phone No.	
Medical/Nursing Intervention (Completed by RN -- Include specific, measurable description of injury and interventions):									
<input type="checkbox"/> Pain Assessment Completed? <input type="checkbox"/> STAT Med Administered for Medical Reasons <input type="checkbox"/> STAT Med Administered for Psych Reasons <input type="checkbox"/> PRN Med Administered for Medical Reasons									
Name & Dose of Medication Administered:									
RN Signature & Title Date									
Physician Notified?: Yes <input type="checkbox"/> No <input type="checkbox"/>		Date:		Time (Military):		By Whom:			
Physician Name:		Examined? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date:	Time (Military):		Hospital Adm? Yes <input type="checkbox"/> No <input type="checkbox"/>	ER? Yes <input type="checkbox"/> No <input type="checkbox"/>	Where:	
Notify Family/Other: Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>									
Physician Signature & Title Date									

Patient's Report about the incident:

Not Applicable

Signature

Date

Others Notified (Including Family)	Date	Time	Notified by:

Treatment Team Directors review and additional action to prevent reoccurrence:

Treatment Team Director's Signature

Date

PI/RM Review:

- Discussed at morning report
- Follow up corrective action needed
- Follow up corrective action requested
- No further action needed at this time

PI/RM Director/Designee Signature

Date

Administrative Review (CEO, RM Committee, Safety Committee, Pharmacy as applicable):

Signature

Date

Signature

Date

Signature

Date