INCIDENT REPORT

This form is to be completed by the person discovering the incident. The pertinent information should be recorded in the resident's clinical record. This report should be turned into the Director or Administrator immediately.

Facility _____ # _____ Telephone # _____

Visitor/Volunteer Name _____ Address _____ Phone _____

Resident _____ Resident Record # _____ Age ___ Sex __ Hm # ___

Date of Incident _____ Day _____ Time _____ am/pm Shift ____ Bed rails: up _____ down ____

Were postural supports/restraints in place? _____ If yes, describe: _____ Mobility (self, max / mod / min, etc,) ____

Status at time of incident: Alert __ Confused __ Forgetful __ Combative __ Sight _____ Hearing _____

Mental Diagnosis: _____ List all medications given within 8 hrs. of incident (drug, dose, time)

_____

_____

Description of Incident: (Be factual, clear, concise, NO opinions, conclusions, or assumptions)

_____

_____

_____

Injuries as described in medical record: _____

_____

Treatment rendered and recorded in medical record: _____

_____

Witness: _____ Telephone _____ Witness: _____ Telephone _____

Name of Physician notified _____ Date _____ Time _____

Name of Responsible party notified _____ Date _____ Time _____

List Tests ordered _____ Results _____

Sent to Emergency Room: Name _____ Date _____ Time _____ Admitted to acute Yes__ No__

Returned to facility ____ Date _____

Incident Reported by: _____

FORM COMPLETED BY: _____ Charted by: _____ Date _____ Time _____

Reviewed by: Administrator _____ Date _____ DON _____ Date _____

Summary of 48 hour observation / follow-up: _____

_____

THIS FORM IS NOT PART OF THE MEDICAL RECORD

INCIDENT STATISTICS

Review information in Incident Report and complete the following statistical information. This information will be transferred to the Monthly Incident Log (RSOf – 13A).

Circle the appropriate numbers to describe the incident:

CAUSE OF INCIDENT:

1. Fall while ambulating
2. Fall during transfer
3. Fall from bed
4. Fall from chair
5. Fall from commode / toilet
6. Fall: unknown source
7. Choking
8. Burn
9. Assault
10. Self-inflicted
11. Missing resident
12. Equipment / assistive device malfunction
13. During transfer / repositioning
14. Unknown cause of incident
15. Other _____

STATUS

1. Attended during incident
2. Unattended during incident
3. Unknown

SEVERITY OF INJURY:

1. No treatment required
2. Inhouse treatment
3. Emergency room treatment
4. Hospitalization
5. Death

INJURY:

1. None Apparent
2. Laceration
3. Hematoma / bruise
4. Fracture
5. Skin tear / abrasion / small cut
6. Sprain
7. Burn
8. Allergic reaction
9. Aspiration
10. Other _____

LOCATION OF INCIDENT:

1. Resident room
2. Corridor
3. Bathroom
4. Dining area
5. Rehab Dept.
6. Activity area
7. Grounds
8. Stairs
9. Lobby
10. Shower
11. Unknown
12. Other _____

If #3, 4 or 5 is circled for severity of injury, then the adminstrator should complete the Legal Confidential Investigative Data Sheet (RLf – 03) and send to corporate legal department. Include a copy of this form (RSOf – 13).

Information transferred to Monthly Incident Log (RSOf – 13A)

by _____ Date _____

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