

Incident Reports

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INCIDENT REPORTS

Function/Purpose

A report has two functions:

1. It informs the administration of the incident so management can prevent similar incidents in the future.
2. It alerts administration and the facility's insurance company to a potential claim and the need for investigation.

Regulations issued require all employers with more than ten employees at any time during the previous calendar year must maintain records of recordable occupational injuries and illnesses.

When to Report

Incidents that must be reported and documented include:

1. Exposure Incidents: skin, eye, mucous membrane or parental contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.
2. Accident, Injury: patient, visitor, employee slips or falls, or other incident, which results or may result in injury.
3. Event, Behaviors, or Actions: incidents that are unusual, contrary to agency policy or procedure or which may result in injury.
4. Property damage or missing articles.
5. Administration of wrong medication or vaccine.

OSHA Recordkeeping Requirements

OSHA 300 Log-recordable and non recordable injuries are distinguished by the treatment provided; i.e., if the injury required medical treatment, it is recordable; if only first aid was required, it is not required, it is not recordable. However, medical treatment is only one of several criteria for determining record ability. Regardless of treatment, if the injury involved loss of consciousness, restriction of work or motion, transfer to another job or termination of employment, the injury is recordable. An explanation, with examples, is included on the backside of the OSHA 300 Form.

Who Should Report

Only people who witness the incident should fill out and sign the incident report. Each witness should file a separate report. Once the report is filed, the supervisor, department heads may review it.

Because incident reports will be read by many people must follow strict guidelines when completing form. If an incident report form does not leave enough space to fully describe an incident, attach an additional page of comments.

Document the incident as it occurred.

Employee Responsibility

All employees are responsible for preparing an incident report as soon as possible and reporting immediately to their supervisor or in the supervisors absence report to the administration any incident or injury.

Supervisor Responsibility

Upon receiving a report of an incident, written or oral, the supervisor shall conduct an investigation. Following the investigation, supervisors are to review and complete the Incident Report. The supervisor shall take action to implement corrective measures immediately when the investigation reveals such actions are necessary.

Tips for Reporting Incidents:

1. Include essential information, such as identity of the person involved in the incident, the exact time and place of the incident and the name of the individual you notified.
2. Document any unusual occurrences that you witnessed.
3. Record the events and the consequences for the client in enough detail that administrators can decide whether or not to investigate further.
4. Write objectively, avoiding opinions, judgments, conclusions, or assumptions about who or what caused the incident. Tell your opinions to your supervisor later.
5. Describe only what you saw and heard and the actions you took to provide care at the scene. Unless you saw a client fall, write "found patient lying on the floor".
6. Do not admit that you are at fault or blame someone else. Steer clear of statements like "better staffing would have prevented this incident".
7. Do not offer suggestions about how to prevent the incident from happening again.
8. Do not include detailed statements from witnesses and descriptions of remedial action; these are normally part of an investigative follow-up.
9. Do not put the report in the medical record. Send it to the person designated to review it according to your facility's policy.

The following are SAMPLE copy of "Incident/Complaint Report"

INSTRUCTIONS FOR COMPLETION OF FORM

The Complaint/Incident Report Form is to be used to document the following:

1. Any type of accident, vehicle or otherwise, which may or may not involve injuries.
2. Client – provider conflicts.
3. Employee conflicts.
4. Complaints.

When reporting a complaint/incident follow these steps:

1. Complete the form and obtain appropriate signatures.
2. Submit the original form to the Quality Management Department.
3. If a copy is kept at the local office, it must be filed in a locked cabinet.

If any further assistance is needed, please contact your supervisor.

By signing this "Signature Page," I acknowledge that I received the following procedure, and I will abide by the procedure outlined in the packet. If I have any questions regarding the procedure or anything within the forms, I will address my concerns to the Rainbow Treatment Center Policy Committee or the QM dept.

I have read, understand, and acknowledge all of the above STATEMENTS OF PRIVACY LAWS and the ACKNOWLEDGEMENT OF RESPONSIBILITY:

Signature

Date

Print Name

RTC Department

INCIDENT/COMPLAINT REPORT

EMPLOYEE: Return this COMPLETED FORM to your SUPERVISOR as soon as possible.

Name of Person Involved: _____

Address: _____ City: _____

Phone Number: _____ Age: _____ DOB: _____ Sex: M ___ F ___

SS#: _____ Date of Incident: _____ Time: _____ am/pm

Exact Location of Incident: _____

Check Type of Accident: _____ Check:

- | | |
|--|-----------------|
| <input type="checkbox"/> Clerical/Data Entry | _____ Client |
| <input type="checkbox"/> Communications | _____ Employee |
| <input type="checkbox"/> Testing Process | _____ Visitor |
| <input type="checkbox"/> Result reporting | _____ Volunteer |
| <input type="checkbox"/> Safety | _____ Other |
| <input type="checkbox"/> Medical Device Failure | |
| <input type="checkbox"/> Policy/Procedural Violations | |
| <input type="checkbox"/> Adverse Drug Reaction | |
| <input type="checkbox"/> Vehicle Accident | |
| <input type="checkbox"/> Exposure to Hazardous Substance | |
| <input type="checkbox"/> Medication Error (Wrong: Route, Dosage, Medication, Schedule) | |

EMPLOYEE: Involved _____ yes _____ no

Were they doing their regular job duties: _____ yes _____ no Observed by employee yes

Employee Classification: _____

Protective Equipment being used: _____ yes _____ no

Description of Incident/Complaint (Who, What, Where, How, Why, Include sequence of events, personnel involved, body part injured, reason incident occurred) (Use additional form if necessary)

Actions Taken by Staff Members: _____

Witness Name: _____ Phone Number: _____

Address: _____

Witness Name: _____ Phone Number: _____

Address: _____

MEDICAL FOLLOW-UP: Was Medical Attention Sought: _____ yes _____ no

Treatment Refused: _____ yes _____ no First Treatment Date: _____

Treating Physician: _____ Phone Number: _____

Address: _____

First Day Off Work: _____ Return to Work Date: _____

Duties Restricted: _____ yes _____ no Explain: _____