neighborcare health

(rev 11/2009)

Instructions for Incident Reports

Whenever an incident occurs:

An Incident Report form must be completed immediately after an incident occurs and couriered to appropriate Medical/Dental Director's assistant (see below).

An incident can be classified as one or any of the following:

- Difficult interaction
- Adverse outcome
- Patient complaint
- Patient injury
- Staff injury
- Occupational exposure
- Documentation/ Communication
- Lab issue
- Medication issue

If a staff member sustained injury on the job, please forward a copy of the incident to HR and fill out an L&I form.

The form also contains sections to capture information regarding injury to persons, damage to property, and accidents.

Although you may not have sufficient information to initially answer all questions, it is important that the form be completed as fully as possible at the time of the accident. Do not delay sending in the report form; an incomplete form is better than none at all. Be certain to include your name and daytime telephone number where indicated on the form.

If you have any questions or need assistance regarding the completion of the Incident Report form, please contact your site/clinic manager.

DO NOT send or save electronically. Please print and mail off original copy and DO NOT make or maintain any copies of the incidents reported.

Only exception is if a staff injury occurs – Please forward a copy to HR.

Mail/fax the completed Incident Report to:

Medical /Administrative

Ming Vorachak – Jesse Epstein

Fax: (206) 461-8382

HR Dept – Jesse Epstein

Fax: (206) 262-0859

Dental

Kris Thorngren – Georgetown

Fax: (206) 762-6355

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Employee Report of Incident

Reported by (please print): _____ Date of Incident: _____
Employee Name & Title

Affected individual is (check one): ☐ Employee ☐ Patient ☐ Other (explain):

Name of affected individual (s):

Time of Incident: _____:_____ ☐ AM ☐ PM Location:

Witness(es): Phone:

Phone:

Description: What Happened – Where – When – Why - What did I do:
(Attach additional pages if needed)

What happened? _____

Where? _____

Why? _____

What did I do? _____

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Were any injuries sustained? ☐ Yes If yes, please fill out the occupational exposure portion below.

☐ No If no, please sign, date and forward to Site/Clinic Manager.

TYPE OF INJURY/EXPOSURES

- ☐ Puncture Wound
- ☐ Laceration
- ☐ Foreign Body
- ☐ Sprain/Strain
- ☐ Hernia
- ☐ Fracture/Dislocation
- ☐ Infectious Disease
- ☐ Burn/Scald
- ☐ Irritations/Dermatitis
- ☐ Respiratory
- ☐ Tendonitis
- ☐ Contusion
- ☐ Other _____

PART OF BODY

- ☐ Head
- ☐ Eyes
- ☐ Nose
- ☐ Mouth
- ☐ Ear
- ☐ Neck
- ☐ Shoulder
- ☐ Back, upper
- ☐ Back, lower
- ☐ Chest
- ☐ Arms
- ☐ Wrist
- ☐ Hand
- ☐ Finger
- ☐ Hip
- ☐ Thigh
- ☐ Knee
- ☐ Leg
- ☐ Ankle
- ☐ Foot
- ☐ Toes
- ☐ Internal

Please Indicate:
☐ Left or ☐ Right

CAUSE

- ☐ Fall From Chair or Equipment
- ☐ Fall on Same Level
- ☐ Fall From Different Level
- ☐ Fall From Fainting
- ☐ Slip on Something
- ☐ Spill/Spray
- ☐ Slip, no fall
- ☐ Struck by Person
- ☐ Struck by Equipment
- ☐ Struck by Tool or Object
- ☐ Pulling
- ☐ Pushing
- ☐ Lifting
- ☐ Reaching or Bending
- ☐ Exposure
- ☐ Overexertion
- ☐ Inhalation
- ☐ Heart Attack
- ☐ Recurrence of old injury
- ☐ Other _____

LOCATION

- ☐ Parking Lot
- ☐ Patient Room
- ☐ Procedure Room
- ☐ Storage Area
- ☐ Supply Room
- ☐ Lunch Room
- ☐ Other_____
- ☐ Office
- ☐ Lab
- ☐ Stairway
- ☐ Restroom
- ☐ Restroom

How could this have been prevented?

TREATMENT

Did you receive First Aid Treatment? ☐ Yes ☐ No By Whom? _____ When? _____

Were you seen by a Registered Nurse? ☐ Yes ☐ No Where? _____ When? _____

Were you seen by a Physician? ☐ Yes ☐ No By Whom? _____ When? _____

Employee Signature: _____ Date: _____

Forwarded to Site/Clinic Manager on (date): _____

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Supervisor and/or Safety Investigation Report

(To be completed by supervisor and/or safety representative if applicable. If not applicable, skip and fill out Follow-up plan)

SEVERITY POTENTIAL	PROBABLE RECURRENCE	SEVERITY OF INJURY	INCIDENT RESULTED IN
☐ Major	☐ Frequent	☐ First Aid	☐ Injury
☐ Serious	☐ Occasional	☐ Medical	☐ Fatality
☐ Minor	☐ Rare	☐ Lost Work Days	☐ Property Damage

CAUSE: (check contributing factor, if applicable)

Unsafe Conditions

- ☐ Inadequately guarded
- ☐ Unguarded
- ☐ Defective tools/equipment/substance
- ☐ Unsafe design or construction
- ☐ Hazardous arrangement
- ☐ Unsafe illumination
- ☐ Unsafe ventilation
- ☐ Unsafe clothing
- ☐ Insufficient instruction

Why did the unsafe condition exist?

_____

Unsafe Acts

- ☐ Operating without authority
- ☐ Operation at unsafe speed
- ☐ Making safety devices inoperative
- ☐ Using unsafe equipment or equipment unsafely
- ☐ Unsafe loading, placing, mixing
- ☐ Taking unsafe position
- ☐ Working on moving or dangerous equipment
- ☐ Distraction, teasing, horseplay
- ☐ Failure to use personal protective devices

Why was the unsafe act committed?

_____

Was the incident avoidable? ☐ Yes ☐ No

Is this the same description as the employee's? ☐ Yes ☐ No, Explain

_____

_____

GUIDES TO CORRECTIVE ACTION (To be completed by Supervisor)

Based on the cause checked above, I am taking the following corrective action(s):

Unsafe Condition

- ☐ Remove
- ☐ Guard
- ☐ Warn
- ☐ Supervisor Training

Unsafe Act

- ☐ Stop the worker
- ☐ Study the job
- ☐ Instruct (tell-show-try)
- ☐ Follow up
- ☐ Enforce

If supervisor unable to handle, then recommend to:

- ☐ Site Manager
- ☐ QI Committee
- ☐ Safety committee
- ☐ Asset/Facility Manager
- ☐ Other

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Follow-up Plan

(To be completed by Site/Clinic Manager and/or Assistant Medical/Dental Director)

Follow–up: _____

What I am actually doing to prevent similar incidents: _____

Further Recommendations: _____

X _____ Date: _____
Site/Clinic Manager Signature

X _____ Date: _____
Asst Medical/Dental Director Signature

X _____ Date: _____
Medical/Dental Director Signature

X _____ Date: _____
Director of Operations Signature