Millenium Home Health Care

INCIDENT REPORT

Name of Client/Employee	DOB	ID#

Date of Actual Incident	Time of Actual Incident	AM/PM	Location of Incident

Name, Address and Telephone Number of Individual(s) involved with incident

Date of Discovery of Incident	Time of Discovery of Incident	AM/PM	Name of Individual Who Discovered Incident

Brief Description Of Incident

_____

_____

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Type Of Incident

Property Damage
- ☐ Intentional Fire
- ☐ Accidental Fire
- ☐ Property damage plus injury
- ☐ Property damage

Abuse/Intimidation
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Assault

Substance Abuse
- ☐ Alleged drug/alcohol use
- ☐ Drinking on the job
- ☐ Smoking on the job

Medication
- ☐ Wrong dose
- ☐ Wrong site
- ☐ Administrate without order
- ☐ Wrong route
- ☐ Adverse medication reaction
- ☐ Medication missing
- ☐ Wrong medication
- ☐ Wrong time
- ☐ IV Infiltration
- ☐ Duplication
- ☐ Drug overdose

Health Episode
- ☐ Physical health episode (fainting, seizure, etc.)

Dishonesty
- ☐ Forgery
- ☐ Theft

Other
- ☐ Broken/malfunctioning equipment
- ☐ Wrong treatment
- ☐ Omitted treatment
- ☐ Consent not obtained
- ☐ Patient wanders
- ☐ Wrong diet
- ☐ Other (specify on log) _____

Injury Reported
(Check all that apply)

Injury/Accident
- ☐ Animal bite or sting
- ☐ Injury found by employee (of unknown origin)
- ☐ Self-inflicted injury
- ☐ Accidental injury
- ☐ Suicide attempt
- ☐ Patient injury
- ☐ Burn(s)
- ☐ Aggravation of pre-existing condition
- ☐ Laceration
- ☐ Back injury
- ☐ Broken tooth/teeth
- ☐ Suspected sprain/strain
- ☐ Employee injury
- ☐ Employee back injury
- ☐ Abrasion
- ☐ Employee fall
- ☐ MVA – Motor Vehicle Accident
- ☐ Needlestick
- ☐ Patient fall
- ☐ Head injury
- ☐ Allergic reaction
- ☐ No apparent injury
- ☐ Puncture
- ☐ Suspected fracture/dislocation

Death
- ☐ Homicide
- ☐ Accidental death
- ☐ Sudden death
- ☐ Suicide death

Contributing Factors To Incident
(Check all that apply)

- ☐ Ambulating without device
- ☐ Chair or equipment
- ☐ Incontinence
- ☐ Violated activity order
- ☐ Improper footwear
- ☐ Found on floor
- ☐ Ambulating with device
- ☐ Fainted
- ☐ Lost balance/dizzy
- ☐ Visitor assisted
- ☐ Unable to follow instructions
- ☐ Refused side rails
- ☐ Bedrails up
- ☐ Bedrails down
- ☐ Lowered side rails
- ☐ Patient ambulating without staff assistance
- ☐ Environmental safety factor (Specify on log)
- ☐ Other (Specify on log)

Continued on Reverse Side

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INCIDENT REPORT

Action Taken	Physician notified: ☐ Yes ☐ No NOTE: *The patient's physician must be notified of all patient incidents involving a potential or injury.* Family notified: ☐ Yes ☐ No Referred for treatment: ☐ Yes ☐ No ☐ Refused Treatment given by: ☐ Physician ☐ Hospital/Clinic ☐ Other_____ Name of Physician: _____ Treatment rendered: _____ Recommended follow-up: _____

Individuals Notified	Name of Individual Notified	Date Individual Notified	Time Individual Notified	Name of Individual Who Notified Others
1. Physician			AM/PM	
2. Family			AM/PM	
3. Clinical Coordinator			AM/PM	
4. Administrator			AM/PM	

Was Client/Employee Seen By A Physician?

☐ Yes ☐ No (Please explain) _____

SUSPECTED ABUSE/NEGLECT CASES

Name of Alleged Perpetrator:	Relationship to Patient:
Signature of Individual(s) Who Discovered Incident	Date of Signature
Signature of Individual Who Completed This Incident Report	Date of Signature

Director of Nursing, Supervisor or Designee Review of Incident	Evaluation of incident for opportunity to prevent similar occurrence: _____ Signature: _____ Date: _____