

IRISK Incident Reporting Form

ANTELOPE MEMORIAL HOSPITAL AMH FAMILY PRACTICE CLINIC _____

DEMOGRAPHICS

Department: _____
 Location: _____
 Date/Time of Incident: _____
 Status: _____
 Incident Witnessed? Yes No
 Witness Name: _____
 Address: _____
 Diagnosis/Treatment: _____
 Brief Description of Incident: _____

ADDRESSOGRAPH OR PATIENT /VISITOR INFORMATION

Name, Date of Birth, Male/Female

Severity of Injury	Injury	Mental Status	Patient Status
<input type="checkbox"/> Minor <input type="checkbox"/> Moderate <input type="checkbox"/> Serious <input type="checkbox"/> Death <input type="checkbox"/> None <input type="checkbox"/> Not Applicable <input type="checkbox"/> Unknown	<input type="checkbox"/> Abrasion/Bruise <input type="checkbox"/> Amputation <input type="checkbox"/> Anoxia/Resp. Distress <input type="checkbox"/> Blister <input type="checkbox"/> Burn <input type="checkbox"/> Circ. Impairment <input type="checkbox"/> Contusion <input type="checkbox"/> Contracture <input type="checkbox"/> Damaged Teeth <input type="checkbox"/> Decubitus <input type="checkbox"/> Death <input type="checkbox"/> Fracture <input type="checkbox"/> None	<input type="checkbox"/> Alert <input type="checkbox"/> Confused <input type="checkbox"/> Comatose <input type="checkbox"/> Unconscious <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other _____ 	At Time of Incident : <input type="checkbox"/> Inpatient <input type="checkbox"/> Apart. Res. <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Home Care <input type="checkbox"/> Hospice <input type="checkbox"/> Outpatient <input type="checkbox"/> Student/Vol. <input type="checkbox"/> Resident Patient

INCIDENT TYPE

Equipment	Treatment/ Procedure	Occurrence Screens	Falls		
<input type="checkbox"/> Disconnected/ Dislodged <input type="checkbox"/> Electrical Issue <input type="checkbox"/> Implant <input type="checkbox"/> Improper Use <input type="checkbox"/> Malfunction/Defect <input type="checkbox"/> Not Available <input type="checkbox"/> Tampered With <input type="checkbox"/> Testing Equipment <input type="checkbox"/> Wrong Equipment <input type="checkbox"/> Other DISPOSITION: <input type="checkbox"/> Biomed <input type="checkbox"/> Continued Use <input type="checkbox"/> Hold for Investigation <input type="checkbox"/> Hold for Repairs <input type="checkbox"/> Outside Investigator <input type="checkbox"/> Sequestered <input type="checkbox"/> To Manufacturer <input type="checkbox"/> To Risk Manager <input type="checkbox"/> Other	Equipment Type: _____ Serial #: _____ Model #: _____ Lot #: _____ Implanted Date: _____ Explanted Date: _____ Operator: _____ Does this incident need to be reported to the FDA? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Application/Removal of cast/splint <input type="checkbox"/> Consent Issue <input type="checkbox"/> Delay <input type="checkbox"/> Deviation from P&P <input type="checkbox"/> Dietary Issue <input type="checkbox"/> Dressing Change <input type="checkbox"/> Injection Site <input type="checkbox"/> Monitoring <input type="checkbox"/> Not Documented <input type="checkbox"/> Omitted <input type="checkbox"/> Patient ID <input type="checkbox"/> Patient Refused <input type="checkbox"/> Placement/Invasive Procedure <input type="checkbox"/> Positioning <input type="checkbox"/> Prep Issue <input type="checkbox"/> Procedure Canceled <input type="checkbox"/> Repeat Procedure <input type="checkbox"/> Reporting of Test Results <input type="checkbox"/> Suture Removal <input type="checkbox"/> Technique <input type="checkbox"/> Transcription Issue <input type="checkbox"/> Transfer/Moving Patient <input type="checkbox"/> Unlabeled/Missing Specimen <input type="checkbox"/> Wrong Site <input type="checkbox"/> Other	<input type="checkbox"/> Anesthesia Complication <input type="checkbox"/> Aspiration <input type="checkbox"/> Incorrect Sponge/ Needle or Instrument Count <input type="checkbox"/> Meconium Aspiration Staining <input type="checkbox"/> Return to Surgery <input type="checkbox"/> Unattended Delivery <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Ambulating – Other <input type="checkbox"/> Assault/Violence <input type="checkbox"/> Change in Dx <input type="checkbox"/> Combative Behavior <input type="checkbox"/> Contraband <input type="checkbox"/> Documentation Issue <input type="checkbox"/> Left W/O Being Seen by Doctor <input type="checkbox"/> Elopement <input type="checkbox"/> Fire <input type="checkbox"/> In Bed – Other Accident <input type="checkbox"/> Patient Dx/Tx Follow-up <input type="checkbox"/> Patient Rights Violation <input type="checkbox"/> Property Missing or Damaged <input type="checkbox"/> Self-Inflicted Injury <input type="checkbox"/> Sexual Acting Out <input type="checkbox"/> Sexual Encounter <input type="checkbox"/> Struck by Object <input type="checkbox"/> Other	<input type="checkbox"/> Ambulating with Assistance <input type="checkbox"/> Ambulating without Assistance <input type="checkbox"/> Bedside Commode <input type="checkbox"/> During Transfer <input type="checkbox"/> During Transfer <input type="checkbox"/> Eased to Floor <input type="checkbox"/> Faint <input type="checkbox"/> Found on Floor <input type="checkbox"/> Scales <input type="checkbox"/> Other ACTIVITY <input type="checkbox"/> Ambulating with Assistance <input type="checkbox"/> Ambulating with Gait Aid <input type="checkbox"/> Ambulating without Assistance <input type="checkbox"/> Bathroom Privileges <input type="checkbox"/> Bedrest <input type="checkbox"/> Bedside Commode Only <input type="checkbox"/> Wheelchair SIDE RAILS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Two-Up <input type="checkbox"/> Four-Up <input type="checkbox"/> Down <input type="checkbox"/> Non-Applicable <input type="checkbox"/> Ordered <input type="checkbox"/> Not Used <input type="checkbox"/> Unavailable	BED POSITION <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Non-Applicable CONDITION OF THE FLOOR <input type="checkbox"/> Dry <input type="checkbox"/> Icy <input type="checkbox"/> Snow <input type="checkbox"/> Wet <input type="checkbox"/> Other RESTRAINTS <input type="checkbox"/> Ankle Restraints <input type="checkbox"/> Chemical <input type="checkbox"/> Not Applicable <input type="checkbox"/> Posey Belt <input type="checkbox"/> Seat Belt <input type="checkbox"/> Side Rails <input type="checkbox"/> Wrist Restraints <input type="checkbox"/> Other Fall Prevention: <input type="checkbox"/> Yes <input type="checkbox"/> No Meds taken in last 4 hours: <input type="checkbox"/> Yes <input type="checkbox"/> No Medication Name: _____

Medication/IV/Blood	Communication / Miscellaneous	Follow-Up
<p>MEDICATION NAME</p> <input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Crossmatch Issue <input type="checkbox"/> Infiltration <input type="checkbox"/> Not Available <input type="checkbox"/> Patient ID <input type="checkbox"/> Transcription Issue <input type="checkbox"/> Wrong Additive <input type="checkbox"/> Wrong Dose <input type="checkbox"/> Wrong Drug <input type="checkbox"/> Wrong Route <input type="checkbox"/> Wrong Solution <input type="checkbox"/> Wrong Time <input type="checkbox"/> Omission <input type="checkbox"/> Other	<p>COMMUNICATION</p> <input type="checkbox"/> Confidentiality Issue <input type="checkbox"/> Consent Issue <input type="checkbox"/> No Interpreter <input type="checkbox"/> Patient Education <input type="checkbox"/> Staff Attitude <input type="checkbox"/> Systems <input type="checkbox"/> Other	<p>COMPLETE AND SIGN IF APPLICABLE</p> <p>Physician Notified? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Date: Time: Treatment Action _____</p> <hr/> <p>Physician Signature</p>
<p>SIDE EFFECT</p> <hr/> <p>MEDICATION TYPE</p> <input type="checkbox"/> Anesthetic <input type="checkbox"/> Anti-Anxiety <input type="checkbox"/> Anti-emetic <input type="checkbox"/> Anti-hypertensive <input type="checkbox"/> Anti-inflammatory <input type="checkbox"/> Antibiotic <input type="checkbox"/> Beta Blocker <input type="checkbox"/> Blood/Blood Product <input type="checkbox"/> Calcium Channel Blocker <input type="checkbox"/> Decongestant <input type="checkbox"/> Diuretic <input type="checkbox"/> Electrolytes <input type="checkbox"/> Hypnotic <input type="checkbox"/> Laxative <input type="checkbox"/> Lipids <input type="checkbox"/> Pain Reliever <input type="checkbox"/> Sedatives <input type="checkbox"/> TPN <input type="checkbox"/> Other	<p>MISCELLANEOUS</p> <input type="checkbox"/> Aspiration <input type="checkbox"/> Assault/Violence <input type="checkbox"/> Cardiac/Respiratory Arrest <input type="checkbox"/> Needle/Sharp Stick-Non-Employee <input type="checkbox"/> Other Accident while Ambulating <input type="checkbox"/> Procedure Not Followed <input type="checkbox"/> Other	<p>Supervisor Notified? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Date: Time:</p> <hr/> <p>Supervisor Signature</p> <p>Pharmacist Notified? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Date: Time:</p> <hr/> <p>Pharmacist Signature</p> <p>Pt./Representative and/or Family Notified? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Date: Time:</p>

Please describe what happened: _____

Completed by: _____ **Date** _____

