INCIDENT MANAGEMENT REPORT FORM

All reportable incidents must be called in to the Incident Management Point Person at (717) 434-3707. After calling, complete this form & email to **incidentmanagement@shadowfax.org** within 24 hours. Send the hard copy to Incident Management at Tremont

Office Use Only

ID# _____

Date & Time Call Received _____

Date Entered into EIM _____

Due Date _____

Extension Date _____

NOTE: This form is to be completed for ALL INCIDENTS, including Medication Errors involving the Six R's of Administration: Right Individual, Right Medication, Right Dosage, Right Time, Right Technique/Method, Right Route

Name of Individual: _____

Location of Incident: _____

Date the incident occurred: _____ Time the incident occurred: _____AM/PM

Date the incident was discovered: _____ Time the incident was discovered: _____AM/PM

Type of Reportable Incident: (check one)

- ☐ Death
- ☐ Suicide Attempt
- ☐ Serious Illness
- ☐ Serious Injury
- ☐ Abuse
- ☐ Sexual Abuse
- ☐ Neglect
- ☐ Passive Neglect
- ☐ Site Closure
- ☐ Self-Neglect
- ☐ Missing Individual
- ☐ Behavioral Health Crisis Event
- ☐ Fire
- ☐ Exploitation
- ☐ Rights Violation
- ☐ Law Enforcement
- ☐ Medication Error
- ☐ Physical Restraint
- ☐ Optionally Reportable Incident (not required by ODP)

Plans/orders that are in place that relate to the incident: (Check all that apply.)

- ☐ Choking Prevention
- ☐ Behavioral Support
- ☐ Other: _____
- ☐ Seizure Protocol
- ☐ Fall Prevention
- ☐ Other: _____

Were plans/orders implemented as written? Yes/No (Circle one)

If not, explain why they were not followed. _____

Detailed Description of Incident:

What happened prior to, during, & after the incident? **Be specific** with dates, times, & names of all people involved. Indicate the current status. List **objective** signs/symptoms. _____

Attach additional pages as necessary.

Was this incident a result of a Medication Error? Yes/No (Circle one)

If yes, select all that apply below and complete "Additional Questions for Medication Errors"

- ☐ Overdose **(Call 911)**
- ☐ Wrong Dose (gave too much or too little)
- ☐ Wrong Time (gave too early or too late)
- ☐ Wrong Route (gave by wrong route)
- ☐ Wrong Form (EX: tablet instead of liquid)
- ☐ Omission (missed a dose of medication)
- ☐ Wrong Person (gave person someone else's medication)
- ☐ Wrong Med (gave a discontinued medication)
- ☐ Wrong Med (supposed to be given for another reason)
- ☐ Wrong Position (person was positioned improperly)
- ☐ Wrong Technique/Method (medication was prepared improperly i.e.: not shaking a suspension

What was the response to the incident? (select all that apply)

***Nurses must be notified immediately for ALL Medication Errors upon discovery ***

- ☐ Contacted nurse
- ☐ Contacted health care professional
- ☐ Contacted program supervisor
- ☐ Called poison control
- ☐ Other: _____
- ☐ Observed for Side Effects
- ☐ ER Visit
- ☐ Hospitalization
- ☐ Had blood level of medication done

Addl. Follow-up Actions Taken: Indicate what steps have been taken to protect the health and safety of the individual. Were potential hazards identified and communicated to management?

_____

_____

Witnesses to Incident:

Name of Witness (first & last name)	Relationship of the Witness to the Individual

Notification: Indicate each person notified about the incident.

Nurses must be notified immediately for ALL Medication Errors.

The Point Person and Family Member must be notified within 24 hours of the incident.

Title of Person Notified	First & Last Name of Person Notified	Date Notified	Time Notified
Point Person			
Family **			
Nurse			
On-Call Supervisor			
Supervisor			
Doctor			
Residential Staff			
Day Program Staff			
911			
Other:			

**If the Family Member was not notified, indicate the reason.

(Only reason not to notify is due to an individual not having family, or the family/individual doesn't want notification.)

_____

_____

Printed Name of Person Completing Report: _____

Signature of Person Completing Report: _____

Date: _____ Time: _____

Additional Questions for Medication Errors Form

List all of the medication(s) involved in the error by name:

Medication:	Strength:	Dosage:	Dosage times:	Reason Prescribed:

Were any medications involved in this medication error a controlled substance? Circle one: YES NO

Did the error occur over multiple consecutive administrations?

☐ Yes ☐ No If yes, neglect incident MUST be reported

Why did the error occur? (select all that apply)

☐ Another individual obtained unattended medication
☐ Did not compare log to label
☐ Did not get prescription or refill from health care provider
☐ Did not order prescription or refill from pharmacy
☐ Did not pick up prescription or refill from pharmacy
☐ Did not receive prescription ordered from pharmacy
☐ Error in Medication Administration Record (MAR)/Medication Log
☐ Unknown
☐ Got wrong prescription from pharmacy
☐ Miscommunication between residential provider and day service provider
☐ Misidentified person
☐ Mismeasured liquid medication
☐ Misread label
☐ Mixed up size or strength of tablets
☐ Other: _____

Position of person giving medication: (check one)

☐ Direct care staff ☐ LPN ☐ Individual
☐ Supervisory staff ☐ Management or Administrative staff ☐ Other: _____

Additional Information:

Name of the person making the error (if known): _____

Indicate the shift that the person who made the error was working (list the specific hours): _____

Number of medications supposed to be given to this individual at the same time as the error was made (including the medication where the error was made): _____

Number of medications this person receives on a daily basis (do not include medications that are taken on an episodic basis): _____

Number of people (including this person) that the staff person who made the error has to give medications to around the same time as the error occurred: _____