

Incident Reporting: Doing it Right

Who? – The employee/staff or volunteer person who discovers, witnesses, or to whom the event is reported should be responsible for documenting the incident.

What? – Be objective. Report only FACTS. Do not report conclusions, opinions, accusations or admissions of wrong-doing. Never place blame or point your finger.

The following details are important items that should be included in the report:

1. **Time, date, and location of the incident**
2. **What happened and what effect it had on the individual(s) involved.**
Example: "Individual fell on floor, right knee injured."
3. **Medically relevant facts as well as environmental details relevant to the event**
 - a. *Example: "Carpet is folded over"*
4. **Statement of the patient or witnesses regarding degree of injury and what happened**
 - a. *Example: "I saw him trip over the carpet"*
5. **Injuries as observed by medical personnel**
 - a. *Example: "Right foot is rotated"*
6. **Information that indicates final outcome**
Example: Results of lab work, x-rays, etc.

How? – The Incident report form allows information to be recorded and preserved for quality and risk management purposes. The form should be sent through pre-determined channels to the appropriate administrative personnel. Never make copies of an incident report form. Remember the report is a confidential document. **It should not be made part of the patient record (if applicable).**

Documentation – The fact that an incident report has been completed should not be documented in the patient record; however, those events which have a direct medical effect on an individual should be recorded in their record. The chart should be complete and accurate, reflecting the individual's response to the event for at least the next 24- 48 hours.

Where? – The appropriate channels for communication should be specified by an organization's policies. Most often those persons who need to be informed of an incident include:

- **The Individual's Attending Physician** – needs to know what happened to determine the effect of the event on the patient
- **The Immediate Patient Care Supervisor** – needs to know what has happened in order to take action to prevent a recurrence.
- **The Risk Manager or Quality Improvement Coordinator**—of an organization will use the information from incident reports to institute corrective action and to develop staff education as a long-range benefit.
- **Family/Guardian of Individual** —needs to be notified of the incident and the follow-up plan of action.
- **Other Specified Personnel** —such as Human Resources, the Medical Director, Pharmacist, or Safety Officers