What Is It Called?

- Report of Incident/Injury is the same as “Unusual” and is used for both patient and staff incidents.

- Form Number is **SF 46009 (R4/2-15)**

- Where it’s located? **on the unit...or in Health Clinic**

- On Intranet, **Policy # 1220.35**
Report of Incident / Injury

- Brief, complete accounting of an event that jeopardized the safety or injured staff or patients.

- The form is initiated by the witness to the event, the staff member the patient reported the incident/injury to, or the staff member who experienced the injury.
• This form is **NOT** to be placed in the patient’s chart.

• Form is **NOT** to be mentioned in the patient’s chart.
The Report of Incident/Injury is done when:

- An event occurs which place staff or patients at risk.
- An incident occurs which falls within one of the 27 categories listed on the form. See definitions...policy #1220.35
Why complete the report?

- Quality Management tracks the data involving patient incidents to see trends and show improvement or identify areas that need attention.
- Many of The Joint Commission standards require a measurement of performance.
- RSH’s Governing Body / Division of Mental Health and Addiction use such data as quality indicators.
Ex: As a psychiatric hospital, we have patients who might injure themselves...how are we doing?

Mar 2014 - Mar 2015 Patient Self Injurious Behaviors with trendline on rate per 1000 pt days

<table>
<thead>
<tr>
<th>Month</th>
<th>SI Behaviors</th>
<th>Rate per 1000 pt days</th>
</tr>
</thead>
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<tr>
<td>Mar 14</td>
<td>11</td>
<td>1.8</td>
</tr>
<tr>
<td>Apr 14</td>
<td>7</td>
<td>1.2</td>
</tr>
<tr>
<td>May 14</td>
<td>8</td>
<td>1.3</td>
</tr>
<tr>
<td>Jun 14</td>
<td>17</td>
<td>2.0</td>
</tr>
<tr>
<td>Jul 14</td>
<td>13</td>
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<td>Jan 15</td>
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<td>Feb 15</td>
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<td>2.8</td>
</tr>
<tr>
<td>Mar 15</td>
<td>12</td>
<td>1.9</td>
</tr>
</tbody>
</table>
Human Resources uses staff incident/injury reports to identify safety problems in the workplace and track injuries. The Report of Incident/Injury is required. It also is the beginning of a Workman’s Compensation claim.

If staff are involved in an accident or are injured, the packet in the Health Clinic is required in addition to the Incident Report. This is done by the Health Nurse on duty.
• It is essential that Reports of Incident/Injury be filled out completely.
• The Report of Incident/Injury should be able to speak for you in a court of law.
• The RN signing the Nursing Comment section becomes responsible for all information preceding their signature, including the front of the form.
• The Description of the Incident section needs to answer the questions **Who, What, Where, and How.**
• The entry in the patient/client’s record must agree with the account of the incident on the report. *But don’t mention the form or filling it out...*
Details of the Form

- Patient name label in top right corner, if applicable
- INCIDENT INFORMATION:
  - Date of Incident
  - Time of Incident (Military Time Please)
  If the date or time is not known, the approximate date/time is entered with (Approx) in parenthesis. The description of the incident should indicate the circumstances of the approximation.
- Unit/Department/Location
  This is where the patient resides, or the staff member’s department
  - Date of Report
  - Time of Report (Military Time)
Incident Location

- There are 29 choices to describe the exact location of the incident.
- If none of these seem to fit, choose ‘Other’ and fill in the location on the lines provided.
- If you or the patient is unable to tell where the incident occurred, choose ‘Unknown’.
- **Choices not used at RSH**: Playground/Yard, Timeout/Observation
Incident Location

No Playground/Yard at RSH.
Incident Type (alleged)

- There are 27 choices in this section of the Report.
- The definitions for each choice are detailed in Hospital Policy 1220.35.
- Events that place staff / patients at risk for injury or injury
A person is absent or missing from the facility without permission of physician if not found after a grounds search is completed.
Contact Intentional

Used only when a patient assaults another patient or staff with their hands or an object.
Contraband

Anything that can be used as a weapon to harm anyone. *often confused with unauthorized items—see definition...*
Equipment Failure

Injury resulting from improper use of or failure of equipment.
Patient and/or employee is unable to maintain presence in previous position, striking the floor/ground. To leave an erect position suddenly and involuntarily.
Self Injurious Behavior

A purposeful act which results in an injury to the person.

- Deliberately swallowing any inedible or harmful object i.e. batteries, spoons, money, pens, plants, etc.
- Cutting or scratching self, self mutilation
- Hitting or striking objects, walls, doors etc
- Inserting or embedding foreign objects into the body or body cavities
- Throwing objects which results in injury to self
Unauthorized Items *sometimes referred to as contraband*

Any item which is not permitted by hospital or program. Examples include cigarettes, tobacco products, food stored in bedrooms, cell phones, body washes with alcohol, nail clippers, nail polish, video games, clothing with offensive sayings, etc...
State of Indiana does not allow smoking or tobacco products on state property. **Period. End of story.**

No cell phones in patient areas. **Including staff.**
Most can take pictures which violates privacy laws. And limiting communication cuts down on AWOL’s, drug traffic, etc...

RSH specializes in treatment of persons with alcohol/drug problems AND major mental illness...it’s obvious why these are banned from campus.

Everyone has a right to their privacy; Federal law...not allowed without expressed consent
Information Regarding Individuals Involved In Incident

- This section identifies the people involved in the reported incident, their categories and their roles in the incident (on right side of form).
- ID numbers are the patient’s medical record number.
- It is important that everyone’s names—both patient and staff -- are filled in completely.
- If 2 patients have contact intentional—form lists both patients and separate form for each patient (RN has to assess injuries on both).

Please list witnesses or staff witnesses.
Information Regarding Individuals Involved In Incident

- *It is important to indicate the role of the patient whose name is at the top of the report.*

- Quality Management tracks victims and perpetrators of Contact Intentional (assault or battery).

- If no one is injured, check “no injury” skip the Injury section and complete the Description of Incident. This would include incidents resulting in Property Destruction, Contraband, Theft, or Unauthorized Objects.

- Fill out the form if no injury occurred—you never know
INJURY (Check applicable boxes)

- If there is no injury, check “No Injury”.
- Check the box which best describes the injury.
- If the injury does not fall into any of the listed categories, check Other, i.e. swallowing a foreign object.
Body Part Affected

- Check the box which corresponds to the body part affected by the injury.
- Elbows, wrists and shoulders are included in the section labeled LA or RA.
- Leg, Knee Foot, left or right are included as LL or RL.
- Fingers (FI) and Toes (TO) do not need right or left designation in this section.
Apparent Cause

Check the box which best describes the cause of the injury.

The **Apparent Cause** of the incident/injury should agree with the Incident Type.

- **Ex:** Incident Type *Lifting* should have Apparent Cause as *Lifting*.
- **Ex:** *Equipment Related* can have Apparent Cause as Equipment, Furnishings or Medical Devices.
- **Ex:** *Contact Intentional* will have Other Patient or Staff marked.
- **Ex:** *Self Injurious Behavior* requires Self Intentional as the apparent cause.
Treatment Given

- First Aid is anything that the nurse does without a Doctor’s order.
- An **ASSESSMENT IS NOT FIRST AID**.
- More than First Aid is anything requiring a Doctor’s order including transporting to hospital.
Diagnostic/Examinations/Test

• To be used if the patient is sent to the Emergency Room; or
• X-Ray; or
• Other (i.e. Surgery)
Treatment Location

Indicates where Treatment occurred.

- The patient may be sent to the Emergency Room and only receive an evaluation but no treatment.
- If First Aid was given while here, then On Grounds Facility is marked.
Treatment Given By

who treated the patient.

- FP is our facility Physician.
- FS is our facility Nurse.
- NF is anyone not from our facility, as in the ER physician or nurse.
Description of the Incident: any witness can fill this section out

A brief, complete, description

- What happened
- Who it happened to,
- Where it happened and
- How it happened.

**Hint: give objective data...what you saw or heard.**

Ex: Patient was struck on right cheek by fist of other patient. *Not “patients got into a fight”...*

Ex: Patient was screaming “let me out!” and began to kick the door with Rt foot. *Not “patient upset and tried to leave”*
“See nurses’ notes” or “see below” is not acceptable.

Just describe the incident—needs to stand independent of all other documentation.

• No opinions or guesses about why the incident happened.
• If you do not know what or when it happened--Say exactly that...
Nursing Comments

- This section is for the RN to document assessment of the possible or actual injury and actions taken to treat that injury.
- “See above” is not acceptable.
- If there was no injury, the nurse must say that in this section.
- RN MUST sign this section. An RN has to do the assessment. Summarize the care given and sign.
- The RN is responsible for the information on this form up to this point--If the information is incorrect, the RN makes the correction(s).
NURSING COMMENTS/RN Assessment

- Assessment of injuries and treatment are briefly described.
- When injuries are not present, the nurses’ actions are described
  - (ex: weapon confiscated and sent to security)
- When the nurse notifies the doctor and receives orders for treating the injury, are recorded in this section.
The assessment and care given to the patient is documented in the chart as well....

- Remember no mention of this form in the chart!
Physician’s Comments

- Physicians must sign, date and time all Incident Reports. *Usually placed in the physicians’ book...*

- Actions taken by the physician i.e. assessment, treatment, orders to local hospital, are documented in this section.
Routing: Patient Injuries

- Staff start the Report of Incident or Injury
- Nurses are notified of incidents.
- RN’s notify the nursing supervisor.
- Form 46009 (R-4/2-15) is placed in doctor’s book.
- Reports are taken to the Timekeepers’ office.
- Quality Management pick the reports up for review and data entry.
Routing: Staff Injuries

- Staff are to be seen in the Health Clinic by the assigned Health Nurse on duty. Anything requiring more than First Aid is addressed by Occupational Health at Reid Hospital.
- First Report of Injury and OSHA Report are filled out in addition to the Report of Incident /Injury by the Health Nurse on duty.
- Workman’s Compensation cannot be started without the completion of these forms.
- Staff returning from Reid are to report to Human Resources during business hours.
- After hours staff must report to the supervisor on duty for evaluation of ability to return to work.
Important....

- Events that endanger or put staff or patients at risk for injury are important to document even if there is no immediate apparent injury....you never know...
- The information is used to improve safety for both staff and patients.

- The Joint Commission standards require RSH to use data to make decisions...what’s more important than safety???
You have now completed the 2015 inservice on the Unusual Incident Reporting System

Please date & print/sign your name below. Then send this page to Diane Mustard in Staff Development for recording in your training record.

Print Name:________________________________________

Signature:________________________________________

Date:________________