District 2 Public Health
Procedure for Reporting Adverse Incidents
Non-Clinical Incidents

As stated in the Public Health Master Agreement, each "county has the responsibility to ensure that the health and safety of the patients, clients, consumers, or customers served under this contract are not placed in jeopardy, and to report to the Department any adverse incidents in this regard. An "adverse incident" is defined as an incident that caused or could have caused the injury to or death of a client. The contractor's employees, and all subcontractors performing services pursuant to this Contract, are required to report adverse incidents."

District 2 utilizes two forms for reporting an adverse event:

- **The form titled: Report for Non-Clinical Incidents, rev.05/2016 located in the General Guidelines and attached here.**
- **The form titled: District 2 Public Health Medical Incident Report Form, rev. 05/2016, also located in the General Guidelines and attached here.**

The *Report for Non-Clinical Incidents* will be completed when a patient or customer in the Health Department falls, slips, or is in any way injured (EX: falls in the hallway, hits their head, falls in the parking lot). The person witnessing the event or the person it is reported to will report to the County Nurse Manager or Nurse in the Health Department. An assessment of the person should be made by the nurse and appropriate first aid given. This documentation should be included on the form. Forward a copy of this form to the District Nursing Director within 24 hours of the incident and maintain the original in the Health Department files in the event it is needed for legal purposes.

***The Medical Incident Report Form* will be completed when a vaccine or other medication has been administered/dispensed incorrectly in any way (wrong vaccine, wrong person, incorrect dosage, incorrect time period, etc.) by the nurse(s) discovering the error and the nurse committing the error. This form should be submitted within 24 hours of the discovery of the error to the District Nursing Director. This form is collected at the District Office and yearly the Safe Patient Committee reviews these forms for Quality Assurance purposes. The original copy should be maintained in the County with a copy sent to the DND.**

NOTE: THESE FORMS SHOULD NOT BE USED TO SUBMIT WORKMAN'S COMP ISSUES.

DISTRICT 2
Report for Non-Clinical Incidents
NOT PART OF MEDICAL RECORD
SHADED AREAS MUST BE COMPLETED

HEALTH DEPARTMENT NAME_____

SECTION I: IDENTIFICATION INFORMATION

000 NAME: (LAST,FIRST,MIDDLE INITIAL)

000A IF < 18, NAME OF ACCOMPANYINGADULT

020 CITY, STATE AND ZIP		030 DOB:
040 SEX O41 [ ] M 042 [ ] F	050 MEDICAL RECORD #:	060 TELEPHONE

070 STATUS AT TIME OF OCCURANCE:
071 [ ]PATIENT 072 [ ] VISITOR 073 [ ] EMPLOYEE
074 [ ] OTHER _____

SECTION II: TIME AND LOCATION OF OCCURRENCE

200 DATE OF OCCURANCE: 210 TIME OF OCCURRENCE:

_____ _____
MONTH DAY YEAR [ ] AM [ ] PM

220 LOCATION:
221 [ ] WAITING AREA_____
222 [ ] EXAM ROOM_____
223 [ ] LAB_____
224 [ ] PUBLIC AREAS _____
225 [ ] GROUNDS_____
226 [ ] OTHER_____

SECTION III: NATURE OF OCCURRENCE

CHECK ALL APPLICABLE BOXES
300 [ ] FALL
301 [ ] WHILE WALKING/RUNNING 302 [ ] WHILE SITTING
303 [ ] OFF EXAM TABLE 304 [ ] OFF SCALE
305 [ ] UNOBSERVED
306 [ ] UNATTENDED CHILD
307 [ ] OTHER_____
308 [ ] WITNESSED (List name(s) of witness(es)

309 [ ] UNWITNESSED

CHECK ALL APPLICABLE BOXES
310 [ ] MEDICATION VARIANCE:
311 [ ] DOSAGE 312 [ ] DRUG REACTION
313 [ ] OTHER_____

CHECK ALL APPLICABLE BOXES
320 [ ] EQUIPMENT VARIANCE"
321 [ ] MALFUNCTION 322 [ ] UNAVILABILITY 323 [ ] USAGE
324 [ ] SPECIFY EQUIP INVOLVED _____
325 [ ] SERIAL # _____

Do not use this form
For *Workman's Comp* related incident

CHECK ALL APPLICABLE BOXES:
330 [ ] PROCEDURAL/POLICY VARIANCES:
331 [ ] CONFIDENTIALITY
332 [ ]INFECTION CONTROL
333 [ ] SPECIMEN RELATED
334 [ ] NEEDLE/SHARP
335 [ ] OTHER_____

CHECK ALL APPLICABLE BOXES:
340 SECURITY VARIANCE:
341 [ ] DAMAGE/THEFT OF PROPERTY/ITEMS
342 [ ] OUT OF CONTROL BEHAVIOR
343 [ ] OTHER_____

CHECK ALL APPLICABLE BOXES:
350 MISCELLANEOUS VARIANCE;
351 [ ] COMPLAINTS/DISSATISFACTION
352 [ ] OTHER_____

SECTION IV: POST OCCURRENCE

CHECK ALL APPLICABLE BOXES:
400 [ ] PHYSICIAN/NURSE NOTIFIED 401 [ ] NONE
402 EXAMINED BY:
411[ ] EMS
403 [ ] PHYSICIAN_____
404 [ ] NURSE_____
405 [ ] REFUSED
406 [ ] OTHER_____
407 [ ] REFERRED TO:
408 [ ] DOCTOR 409 [ ] ER
410 [ ] OTHER_____

ADDITIONAL COMMENTS: (Please use back of form if additional space is needed)

NAME OF INDIVIDUAL COMPLETING REPORT:
_____*DATE*_____

SUPERVISOR'S SIGNATURE:

_____*DATE*_____

NOTIFY SUPERVISOR IMMEDIATELY
FORWARD ALL RISK MANAGEMENT/VARIANCE REPORTS TO NURSE MANAGER WITHIN 24 HOURS OF OCCURRENCE

DISTRICT 2 PUBLIC HEALTH
MEDICAL INCIDENT REPORT FORM

1. Patient / Client Name _____
Address _____
Phone Number _____
Reported By _____
Date and Time of Discovery _____
Date and Time of Event _____
County _____
District _____

Medical Incident Type (known or suspected error):

Medication/Vaccine

- ☐ Omission of dose
- ☐ Extra dose given
- ☐ Incorrect dose given
- ☐ Incorrect dosage form or route
- ☐ Incorrect administration time
- ☐ Wrong drug/vaccine given

Date Administered _____/_____/_____
Expiration Date _____/_____/_____
Lot # _____

Other

- ☐ Documentation Error
- ☐ Security
- ☐ Exposure to bio-hazardous waste
- ☐ Other Medical Error (please describe)

_____
_____
_____
_____
_____

Complete description of incident (include medication, effect on patient, dates, times, sequence of events, causes, people involved, and witnesses with contact information). *Use additional paper if necessary.*

_____
_____
_____
_____
_____
_____
_____

Action Taken (Check all that apply)

- ☐ Communicated the event to the patient/client and/or patient/client's family or guardian about any necessary action needed.
- ☐ Communicated the event to the participant's physician (if applicable).
- ☐ Counseled and/or reassigned employee.
- ☐ Directed employee to complete additional training or repeat specific training.
- ☐ Changed procedures/processes.
- ☐ Reviewed policies, guidelines, standards, non-protocols and other relevant expectations with staff.

Narrative of immediate resolution and action taken: _____

_____

DISTRICT 2 PUBLIC HEALTH
MEDICAL INCIDENT REPORT FORM

Printed Name	Signature	Date

Employee Committing Error

Printed Name	Signature	Date

Employee Discovering Error (if different)

Printed Name	Signature	Date

Employee Completing Report

Printed Name	Signature	Date

Supervisor

Printed Name	Signature	Date

District Clinical Coordinator

Printed Name	Signature	Date

District Health Director

Comments: