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  
SHAPED AREAS MUST BE COMPLETED

HEALTH DEPARTMENT NAME______________________________________

SECTION I: IDENTIFICATION INFORMATION

000 NAME: (LAST, FIRST, MIDDLE INITIAL)

000A IF < 18, NAME OF ACCOMPANYING ADULT

020 CITY, STATE AND ZIP

030 DOB:

040 SEX

041 [ ] M

042 [ ] F

050 MEDICAL RECORD #: 060 TELEPHONE

070 STATUS AT TIME OF OCCURRENCE:

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 [ ] UNAVAILABILITY   323 [ ] USAGE

324 [ ] SPECIFY EQUIP INVOLVED

325 [ ] SERIAL #

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

Do not use this form  
For Workman’s Comp related incident

District 2
5/2018
1. **Patient / Client**
   - Name
   - Address
   - Phone Number

2. **Reported By**
   - Date and Time of Discovery
   - Date and Time of Event

3. **County**
   - District

**Medical Incident Type (known or suspected error):**

<table>
<thead>
<tr>
<th>Medication/Vaccine</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Omission of dose</td>
<td>☐ Documentation Error</td>
</tr>
<tr>
<td>☐ Extra dose given</td>
<td>☐ Security</td>
</tr>
<tr>
<td>☐ Incorrect dose given</td>
<td>☐ Exposure to bio-hazardous waste</td>
</tr>
<tr>
<td>☐ Incorrect dosage form or route</td>
<td>☐ Other Medical Error (please describe)</td>
</tr>
<tr>
<td>☐ Incorrect administration time</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Wrong drug/vaccine given</td>
<td>☐</td>
</tr>
</tbody>
</table>

- **Date Administered** ______/______/______
- **Expiration Date** ______/______/______
- **Lot #** ______________________________

**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.**

<table>
<thead>
<tr>
<th>Action Taken (Check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Communicated the event to the patient/client and/or patient/client’s family or guardian about any necessary action needed.</td>
</tr>
<tr>
<td>☐ Communicated the event to the participant’s physician (if applicable).</td>
</tr>
<tr>
<td>☐ Counseled and/or reassigned employee.</td>
</tr>
<tr>
<td>☐ Directed employee to complete additional training or repeat specific training.</td>
</tr>
<tr>
<td>☐ Changed procedures/processes.</td>
</tr>
<tr>
<td>☐ Reviewed policies, guidelines, standards, non-protocols and other relevant expectations with staff.</td>
</tr>
</tbody>
</table>

**Narrative of immediate resolution and action taken:**

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**DPH District 2**

**Rev. 05/2018**
DISTRICT 2 PUBLIC HEALTH
MEDICAL INCIDENT REPORT FORM

Printed Name
Employee Committing Error
Signature
Date

Printed Name
Employee Discovering Error (if different)
Signature
Date

Printed Name
Employee Completing Report
Signature
Date

Printed Name
Supervisor
Signature
Date

Printed Name
District Clinical Coordinator
Signature
Date

Printed Name
District Health Director
Signature
Date

Comments:

DPH District 2
Rev. 05/2018