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. 12/2021 located in the General Guidelines andattached here.

- The form titled: ***Medical Incident Report Form***, rev. 12/2021, 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 WORKERS' 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 041 [ ] M 042 [ ] F	050 MEDICAL RECORD #:	060 TELEPHONE

70 STATUS AT TIME OF OCCURANCE:
71 [ ]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

Patient / Client Name ______________________________

Address ______________________________

Phone Number ______________________________

Reported By ______________________________

Date / Time of Discovery ______________________________

Date / 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

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:

Printed Name	Signature	Date

Comments:____