INCIDENT REPORT

YAKUTAT COMMUNITY HEALTH CENTER

This report is CONFIDENTIAL and intended to be used only for improvement of quality care and/or staff education. It will not at any time become part of a patient or personnel record.

TYPE OF INCIDENT (CHECK ALL THAT APPLY)

EVENT	SAFETY	RISK
1. ☐ Muscular skeletal injury	10. ☐ Personal article loss/damage	16. ☐ Release of medical record and/or information without proper authorizations
2. ☐ Body Fluid Exposure	11. ☐ Patient care equipment malfunction	17. ☐ Physical or sexual abuse of patient
3. ☐ Laceration w/out body fluid exposure	12. ☐ Patient care equipment unavailability	18. ☐ Other Specify _____
4. ☐ Fall	13. ☐ Property damage/loss	19. ☐ Other Specify _____
5. ☐ Patient Assault	14. ☐ Informed consent not obtained when required	WHO WAS AFFECTED OR INVOLVED?
6. ☐ Chemical Exposure	15. ☐ Patient or patient rep threatens legal action	☐ Patient ☐ Visitor ☐ Employee
7. ☐ Burn		☐ Other _____
8. ☐ Other Employee Injury		
9. ☐ Patient Treatment/error		

Name of Reporter _____ (Optional, may be necessary for follow-up)

Event Date 5/5/22 Time 1:30 am Exact location of event m

Name of Person Affected _____

Brief Factual Description of Occurrence:

m

Were established policies followed? ○ Yes ○ No ○ No Policy in Place

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What policy/process change(s) do you recommend?

What can be done to prevent future occurrences?

IMMEDIATE ACTION TAKEN:

_____ _____

Signature/Title of individual reporting the event (Optional, may be necessary for follow-up) **Date Submitted**

Click here to send an email. You will NOT be anonymous.

Click here to print a report and submit anonomously

ATTENDING MEDICAL PROVIDER COMMENTS (if appropriate)

Significant Findings:

If employee event: do you anticipate that the employee's injury/event will result in time off? ○ Yes ○ No

If patient event: do you anticipate that the patient's injury/event will require further evaluation or treatment. ○ Yes ○ No

If yes, please explain.

_____ _____

Medical Provider Signature **Date**

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SUPERVISOR REVIEW

Has employee filled out workman's comp forms? ☐ Yes ☐ No ☐ NA

Job title of employee: _____

Recommendations to improve policy/process:

_____ _____

Supervisor's Signature: **Date**

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SUBMIT THIS REPORT TO
THE CHIEF COMPLIANCE OFFICER

Date Received: _____

NOTIFICATIONS:	**Yes**	**NA**		**Yes**	**NA**
Medical Director	○	○	Department of Health	○	○
Executive Health Director	○	○	OSHA Report documented	○	○
Yakutat Tribal Health Board	○	○	OSHA Report submitted	○	○
Police department	○	○	External Agency(s) _____	○	○
Guardian/parent/family member	○	○	Other_____	☐	

QUALITY IMPROVEMENT/RISK MANAGEMENT COMMITTEE REVIEW (if appropriate)
Comments:

_____ _____
Medical Director Signature **Date**

OTHER ACTION TAKEN:

_____ _____
Compliance Officer Signature **Date**

Event Category:

☐ A- Unsafe Conditions	☐ E- Harm, treatment required	☐ I- Death
☐ B- Near Miss	☐ F- Hospitalization required	☐ U- Undetermined
☐ C- No Harm	☐ G- Permanent Injury	
☐ D- Monitoring Required	☐ H- Near Death	