The Sun Home Health

We Believe In Excellence! - Since 1997

- ☐ The Sun Home Health Care Delaware
- ☐ The Sun Home Health
- ☐ The Sun Home Health Care Columbus
- ☐ The Sun Adult Day Care

Incident Report

Directions

I, do hereby make the following statement to,
of my own free will and accord, concerning an incident that occurred at on at hours.

Section 1

Date of Incident Time of Incident

Date Reported Reported to Time of Reported

Street and Town where incident Occurred

If Employee Incident, number of hours worked that day Was employee sent to ER or MD ☐ Yes ☐ No

If yes, give details

Section 2

Patient/Employee Name

Telephone Diagnosis

Section 3

Check off and describe in "facts" only as they relate to the incident.

- ☐ Patient or staff injury
- ☐ Unplanned absence of caregiver
- ☐ Damage to personal property
- ☐ Power failure
- ☐ Patient or staff infection
- ☐ Damage/fault equipment or misuse of equipment
- ☐ Adverse Reaction
- ☐ Exposure Incident
- ☐ Medication Error
- ☐ Failure of Staff to report accident
- ☐ Harrassment
- ☐ Environmental safety issues
- ☐ Other (Specify)

Describe the injury (if applicable)

Describe incident

List other individuals/objects/equipment present/involved at the time of incident

Section 4

Describe exactly what happened; why it happened; what the causes were. If an injure, state part of body injured. If property or equipment damaged, describe damage.

Vital signs (if applicable) when the incident is supine and at one and three minutes after standing till unable to stand use supine to sitting position

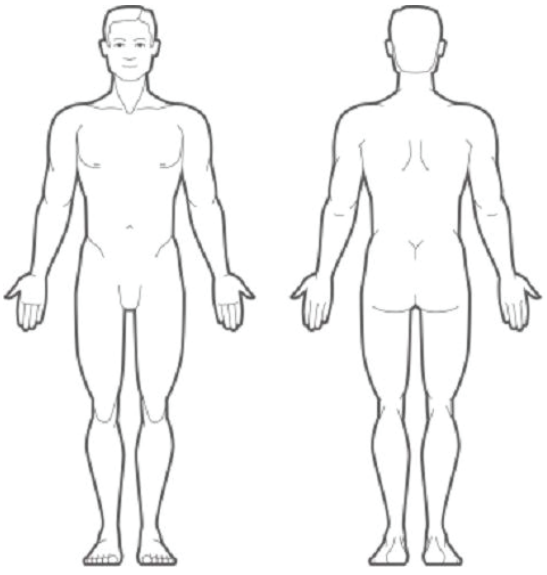
Vital Signs	Initial Incident Supine	One Minute After Standing	Three Minute After Standing
Temperatures			
Pulse			
Respirations			
Blood Pressure			

Type of Injury

- None apparent ○
- Abrasion ☐
- Skin Tear ☐
- Laceration ☐
- Hematoma ☐
- Swelling ☐
- Burn ☐
- Sprain ☐
- Fracture ☐
- Bruise ☐
- Other (Specify below)

Level of Consciousness _____

Indicate on diagram location of injury



Injured person name

Address

Phone No

Body Substance	☐ Faces	☐ Blood	☐ Urine	☐ Sputum	Other
Type of accident	☐ Needle stick	☐ Bite	☐ Splash	☐ Spill	Other

Source Individual

Known to be HBV/HCV infected?	☐ Yes	☐ No
Legally obtained consent of HBV/HCV and or HIV infection test?	☐ Yes	☐ No
Known to be HIV infected?	☐ Yes	☐ No
Results of testing made know to employee?	☐ Yes	☐ No

Employee

Informed of applicable laws and regulations concerning disclosure of identity and infectious status of source individuals?	☐ Yes	☐ No
Legally obtained consent for HBV/HCV and/or HIV infectiviy testing?	☐ Yes	☐ No
Post exposure prophylactics due?	☐ Yes	☐ No
Referred for medical evaluation and blood testing?	☐ Yes	☐ No

Section 5

Manage investigating the incident must complete this section. Explain in detail what follow-up was initiated related to the incident, interventions taken to prevent recurrence and who is responsible for implementation, as well as when the corrective action will be implemented. Submit to the Director/Administrator when the investigation of the incident is complete.

Incident Assessment

Was this incident the result of ☐ Unsafe work procedure/practice ☐ Unsafe work condition
☐ Impropar equipment/tools ☐ Other (describe) _____

Staff Injury only

How might this injury have been avoided? (e.g. training, maintenance, use of proper equipment) _____

Follow-Up Related to the incident

Physician informed immediately?	☐ Yes ☐ No		If yes, by whom	_____
Physician instructions given?	☐ Yes ☐ No		If yes, comment	_____
Family informed or incident?	☐ Yes ☐ No	N/A	If yes, who was informed	_____
other involved agencies informed?	☐ Yes ☐ No	N/A	If yes, by whom	_____

☐ Human Resources Manager Notified
☐ Worker's Compensation Report filed
☐ Exposure Protocol follow-up initiated
☐ Review of agency policy and procedure with staff
☐ Review of agency and procedure with patient/family member
☐ Other _____

Interventions taken to prevent recurrence

Person responsible to Implementation
Date corrective action will be implementd

Signature of person completing form/name of person reporting incident	Date	Time
Signature of Manager responsible for Investigating incident	Date	Time
Signature of Director/Administrator	Date	Time