Types Of Incident List & Form

Clinical Incidents
Near Miss Incidents
Non-Clinical Incidents
Workplace Incidents

1. Incidents related to administrative issues or planning include:

- Incorrect agreements and/or conventions
- Mix-up of patient data in medical records
- Lack of a resuscitation statement or referral in place

2. Incidents related to patient examination include:

- Delayed/incorrect examination results
- Incorrect examination application
- Digression from protocols and working agreements

3. Incidents related to the treatment of the patient include:

- Contracting an infection (think for example, of COVID-19)
- Fall incident, eg because the patient falls out of bed or is not mobile enough for a toilet visit
- Wrong diagnosis and/or incorrect treatment plan

4. Incidents related to the dispense of medication include:

- The wrong dose of prescription indicated
- Wrong medication supplied
- Incomplete or incorrect medication handoffs

5. Incidents related to internal communication include:

- Communication issues regarding the intake, transfer, and discharge of a patient
- Miscommunication or misunderstanding of orders

6. Incidents related to healthcare workers include:

- Needle, cutting, and splashing incidents
- Aggression by patients or their families

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Incident Type List

A. Medication error

1. Dose Omission
2. Extra dose
3. Wrong
    - Dose/over dosage
    - Dose/under dosage
    - Drug
    - Duration
    - Rate (IV)
    - Route
    - Strength/concentration
    - Technique
    - Time
    - Patient
4. Prescription/refill delayed
5. Medication list incorrect
6. Monitoring error (includes contraindicated drugs)
    - Drug-drug interaction
    - Drug-food/nutrient interaction
    - Documented allergy
    - Drug-disease interaction
    - Clinical (lab value, vital sign)
    - Other monitoring error
7. Unauthorised drug
8. Inadequate pain management
9. Other medication error

B. Adverse Drug Reaction (not a medication error)

C. Equipment /Supplies/Devices

- Disconnected
- Electrical problem
- Equipment not available
- Equipment malfunction
- Equipment wrong or inadequate

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- Inadequate supplies
- Operator training or knowledge Problem
- Medical device problem
- Broken item (s)
- Outdated Item (s)
- Sterilization problem

D. Fall

E. Error related to

1. Surgery/invasive procedure
    - Sterile technique Procedure/treatment/test problem
    - Consent missing
    - Count incomplete/ incorrect
    - Count incorrect-sponges
    - Count incorrect-equipment/instruments
    - Foreign body in patient
    - Preparation inadequate/wrong
    - Procedure not ordered
    - Procedure cancelled or not performed
    - Procedure delayed
    - Procedure not completed
    - Wrong procedure
    - Wrong patient
    - I.D missing/incorrect Wrong site
    - Wrong side (L vs. R)
    - Other

2. Laboratory test problem Not ordered
    - Ordered, not performed
    - Sample Delayed
    - Not completed
    - Reporting error
    - Incorrect reading
    - Redo
    - Wrong Pt Sample
    - Wrong Sample Collection (Tube)
    - Transportation Problem
    - Quantity Problem

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3. Radiology/imaging test problem
    - Not ordered
    - Ordered, not performed
    - Delayed
    - Not completed
    - Report unavailable
    - Incorrect reading
    - Film unavailable or inadequate
    - Unanticipated radiation exposure
    - Wrong procedure
    - Wrong patient
    - Wrong site
    - Wrong side (L vs. R)
    - Other

4. Respiratory Care
    - Self/unplanned extubation
    - Unplanned/emergent intubation following a procedure/test
    - Vent alarms not set properly
    - Vent settings wrong/changed without authorization
    - Vent alarms not audible
    - Medical gas problem
    - Other

F. Complication of Procedure/Treatment/Test

1. Complication following surgery or invasive procedure
    - Death
    - Cardiopulmonary arrest
    - Unplanned transfer in ICU
    - Unplanned return to OT
    - Removal of tube or other medical device by patient
    - Acute renal failure
    - Stroke or other neurological deficit
    - Deep venous thrombosis
    - Pulmonary embolism
    - Pneumothorax
    - Other

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2. Anesthesia/Sedation Even
    - Death
    - Apnea
    - Respiratory depression
    - Upper airway obstruction
    - Laryngospasm
    - Seizure or seizure like movements
    - Myoclonus/Muscle rigidity
    - Allergic reaction
    - Anaphylaxis
    - Cardiopulmonary arrest
    - Intubation trauma
    - Others

3. Emergency Department
    - Unplanned return to ER within 72 hrs. Requiring admission
    - Left without being seen
    - Left before visit completed
    - Other

4. Maternal complication
    - Death
    - Unplanned transfer to ICU
    - Intrapartum foetal death
    - Uterine rupture
    - Unanticipated blood transfusion
    - DVT
    - Others

5. Neonatal complication
    - Neonatal death
    - Birth injury or trauma
    - Other

6. Nosocomial Infection
    - Intravascular catheter infection
    - Wound or surgical site infection
    - Nosocomial pneumonia
    - Antibiotic associated diarrhea
    - Others

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7. Cardiopulmonary arrest outside of ICU setting
8. IV site complication (phlebitis etc)
9. Extravasation of drug or radiologic contrast
10. Catheter or tube problem

G. Transfusion

1. Apparent transfusion reaction
2. Event related to blood product administration
3. Event related to blood product sample collection
4. Mismatched unit
5. Wrong component requested
6. Wrong component issued
7. Wrong patient requested
8. Wrong patient transfused

H. Behavioral

1. Assault by patient
2. Assault by staff
3. Assault by visitor
4. Sexual assault/rape
5. Refusal of therapy
6. Suicide attempt
7. Self-harm or injury

I. Skin Integrity

1. Pressure ulcer
    - Admitted from other facility with ulcer
    - New ulcer<24h after admission

J. Care co-ordination/records

1. Communication inadequate with other providers in organization
2. Communications inadequate with outside providers/agencies
3. Communication inadequate with patient or family
4. Records/chart unavailable
5. Records/chart incomplete

K. Other Miscellaneous

1. Disappearance of child from paediatrics
2. Disappearance of infant from nursery

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3. Discharge against medical advice (DAMA)
5. Privacy inadequate
6. Confidentiality disclosure
7. Missing or incorrect patient I.D.
9. Incomplete/incorrect order entry information
10. Unexpected death
11. Lost belongings
12. Food/Nutrition services
    - Tube feeding problem
    - Drug/food interaction issue
13. Other

STAFF

- Assault by patient
- Assault by staff
- Assault by visitor
- Exposure to blood or body fluids
- Exposure to chemicals or drugs
- Fall

VISITOR

- Assault by patient
- Assault by staff
- Assault by visitor
- Exposure to blood or body fluids
- Exposure to chemicals or drugs
- Fall

OTHER

- Damage to property
- Environmental hazard
- Fire
- Lost/stolen property
- Power failure
- Unauthorized presence
- Inappropriate behavior by staff
- Medication safety – Automated dispensing machine Problem situation
- Medication safety – Narcotics discrepancy
- Medication safety – Drug diversion/theft
- Medication safety – Other (specify)

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Incident Reporting Form

Incident Report Form

Please make certain any persons involved are safe and ensure every effort is made to treat persons involved and prevent injury to others. This report is to be only completed if it involves patient / visitor or equipment / property. If you would like to provide an anonymous report please don't write any identifying details.
Please mention incident reference and document follow-up care in the patient's medical record.

Affix Patient ID Sticker / Patient Details (name, reg. no., bed no., doctor's name, age)

Date: Time:

□ Inpatient □ Outpatient □ Visitor □ Equipment/property

Name of Harmed (or Nearly Harmed):……..

Ward/Dept: …… Exact Location:…….

Patient's Admission Diagnosis:……

Description of what happened:

(Brief description of the incident including the immediate actions and outcome. Also document in medical record. Objective information only)

Harm Score (check one)*:

Select the highest level of harm present at the time of the incident report. If harm cannot be determined at the time of the report, select D as the level of harm.

No Actual Incident

A. Unsafe Conditions

Incident, No Harm

B1. The incident did not reach the individual by chance ("Near-miss")

B2. The incident did not reach the individual because of active recovery efforts by caregivers ("Near-miss")

C. The incident reached the individual but did not cause harm (an error of omission such as a missed medication does not reach the patient)

D. The incident reached the individual and required additional monitoring or treatment to prevent harm.

Incident, Harm

E. The individual experienced temporary harm and required treatment or intervention.

F. The individual experienced temporary harm and required initial or prolonged hospitalization.

G. The individual experienced permanent harm.

H. The individual experienced harm and required intervention necessary to sustain life (e.g. transfer to ICU).

Incident, death

I.The individual died.

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Immediate actions and outcome:

……

……

Prevention: (Ideas of how this could have been prevented)

……

……

Reported to :

1. Name:	**Position:**	**3. Name:**	**Position**
2. Name:	**Position:**	**4. Name:**	**Position**

Reported by: Name:	**Position:**
Phone no.	

Action Taken Report Form (ATR)

ACTION TAKEN REPORT ON REPORTED INCIDENT
(To be filled by respective Head of Department)

……

……

Incident Reference No.:
Root Cause Analysis of the Incident:
Corrective Action:

……

……

Preventive Action Plan:

Timeline for Corrective Action: Incident Harm Score	**Timeline for submission of ATR**
I	Within 24 hours
E – H	Within 48 hours
B1 – D	Within 72 hours
A	Within 1 week