IRISk Patient Incident Reporting Form
Mobridge Regional Hospital

Professional People with a Personal Touch!

Patient Name:
SSN number:
Date of Birth:

DEMOGRAPHICS

Department: ____________________
Location: ____________________
Date/Time of Incident: ____________________
Status: ____________________
Incident Witnessed? ____________________
Witness Name: ____________________
Address: ____________________
Diagnosis/Treatment: ____________________
Description of Incident: ____________________

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Severity of Injury	Injury		Mental Status	Patient Status	
☐ Minor	☐ Abrasion/Bruise	☐ Contracture	☐ Alert	Time of Incident:	______
☐ Moderate	☐ Amputation	☐ Damaged Teeth	☐ Confused	☐ Inpatient	
☐ Serious	☐ Anoxia/Resp. Distress	☐ Decubitus	☐ Comatose	☐ Apart. Res.	
☐ Death	☐ Blister	☐ Death	☐ Unconscious	☐ Employee	
☐ None	☐ Burn	☐ Fracture	☐ Not Applicable	☐ Visitor	☐ Outpatient
☐ Not Applicable	☐ Circ. Impairment	☐ None		☐ Home Care	☐ Student/Vol.
☐ Unknown	☐ Confusion			☐ Hospice	☐ Resident Patient

INCIDENT TYPE

Equipment

☐ Disconnected/ Disloged
☐ Electrical Issue
☐ Implant
☐ Improper Use
☐ Malfunction/Defect
☐ Not Available
☐ Tampered With
☐ Testing Equipment
☐ Wrong Equipment
☐ Other

DISPOSITION:
☐ Biomed
☐ Continued Use
☐ Hold for Investivation
☐ Hold for Repairs
☐ Outside Investigator
☐ Sequestered
☐ To Manufacturer
☐ To Risk Manager
☐ Other

Equipment Type:
Serial #:
Model #:
Lot #:
Implanted Date:
Explanted Date:
Operator: ____________________

Does this incident need to be reported to the FDA?
☐ Yes ☐ No

Treatment/Procedure

☐ Application/Removal of cast/splint
☐ Adverse Reaction
☐ Consent Issue
☐ Delay
☐ Deviation from P&P
☐ Dietary Issue
☐ Dressing Change
☐ Injection Site
☐ Monitoring
☐ Not documented
☐ Omitted
☐ Patient ID
☐ Patient Refused
☐ Placement/Invasive Procedure
☐ Positioning
☐ Prep Issue
☐ Procedure Cancelled
☐ Repeat Procedure
☐ Reporting of Test Results
☐ Suture Removal
☐ Technique
☐ Transcription Issue
☐ Transfer/Moving Patient
☐ Unlabeled/Missing Specimen
☐ Wrong Site
☐ Other

Occurrence Screens

☐ Anesthesia Complication
☐ Aspiration
☐ Incorrect Sponge/Needle or Instrument Count
☐ Meconium Aspiration Staining
☐ Return to surgery
☐ Unattended Delivery
☐ Against Medical Advice
☐ Ambulating-Other
☐ Assault/Violence
☐ Change in Dx
☐ Combative Behavior
☐ Contraband
☐ Documentation Issue
☐ Left W/O Being Seen by Doctor
☐ Elopement
☐ Fire
☐ In Bed-Other Accident
☐ Patient Dx/Tx Follow up
☐ Patient Rights Violation
☐ Property Missing or Damaged
☐ Self-Inflicted Injury
☐ Sexual Acting Out
☐ Sexual Encounter
☐ Struct by Object
☐ Other

Falls

☐ Ambulating with assistance
☐ Ambulating without assistance
☐ Bedside Commode
☐ During Transfer
☐ During Transfer
☐ Eased to Floor
☐ Faint
☐ Found on Floor
☐ Scales
☐ Other

ACTIVITY
☐ Ambulating with Assistance
☐ Ambulating with Gait Aid
☐ Ambulating without Assistance
☐ Bathroom Privileges
☐ Bedrest
☐ Bedside Commode Only
☐ Wheelchair

SIDE RAILS
☐ Yes ☐ No
☐ Two-Up
☐ Four-Up
☐ Down
☐ Non-Applicable
☐ Ordered
☐ Not Used
☐ Unavailable

BED POSITION
☐ High
☐ Low
☐ Non-Applicable

CONDITION OF THE FLOOR
☐ Dry
☐ Icy
☐ Snow
☐ Wet
☐ Other

RESTRAINTS
☐ Ankle Restraints
☐ Chemical
☐ Not Applicable
☐ Posey Belt
☐ Seat Belt
☐ Side Rails
☐ Wrist Restraints

Fall Prevention
☐ Yes ☐ No
hours:

☐ Yes ☐ No
Medication Name: ____________________

Medication/ IV/ Blood

MEDICATION NAME

- ☐ Adverse Reaction
- ☐ Allergic Reaction
- ☐ Crossmatch Issue
- ☐ Infiltration
- ☐ Not Available
- ☐ Patient ID
- ☐ Transcription Issue
- ☐ Wrong Additive
- ☐ Wrong Dose
- ☐ Wrong Route
- ☐ Wrong Solution
- ☐ Wrong Time
- ☐ Other

SIDE EFFECT

MEDICATION TYPE

- ☐ Anesthetic
- ☐ Anti-Anxiety
- ☐ Anti-emetic
- ☐ Anti-hypertensive
- ☐ Anti-inflammatory
- ☐ Antibiotic
- ☐ Beta Blocker
- ☐ Blood-Blood Product
- ☐ Calcium Channel Blocker
- ☐ Decongestant
- ☐ Diuretic
- ☐ Electrolytes
- ☐ Hypnotic
- ☐ Laxative
- ☐ Lipids
- ☐ Pain Reliever
- ☐ Sedatives
- ☐ TPN
- ☐ Other

Communication / Miscellaneous

COMMUNICATION

- ☐ Confidentiality Issue
- ☐ Consent Issue
- ☐ No Interpreter
- ☐ Patient Education
- ☐ Staff Attitude
- ☐ Systems
- ☐ Other

MISCELLANEOUS

- ☐ Aspiration
- ☐ Assault/Violence
- ☐ Cardiac/Respiratory Arrest
- ☐ Needle/Sharp Stick-Non-Employee
- ☐ Other Accident while Ambulating
- ☐ Procedure Not Followed
- ☐ Other Accident while Ambulating

Follow-Up

Is follow-up required?
☐ Yes ☐ No

Physician Notified?
☐ Yes ☐ No

Date:

Time:

Treatment:

Action:

____
____
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____

Supervisor Notified?
☐ Yes ☐ No

Date:
Time:

Pt. / Family Notified?
☐ Yes ☐ No

Date:
Time:

Sentinel Event?
☐ Yes ☐ No

Date:
Time:

Is this reportable as a potential Claim?
☐ Yes ☐ No

Please describe what happened: ______________________________

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____
____
____

Completed by: ______________________________ Date: ______________

Quality Director Reviewed: ______________________________ Date: ______________

Dept. Head Reviewed/Action: ______________________________ Date: ______________

Mobridge Regional Hospital & Clinics

"Near Miss Good Catch" Award Submission Form

Today's Date: ____________

Name(s): ______________________________ Phone Ext.:________

______________________________ ________

Department/Unit: ______________________________ Location: ________

Supervisor's Name: ____________________________ Shift: __________

Tell Us Your Story

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Continue on reverse or separate sheet if necessary

☐ Yes. OK to print my name in Patient Safety Updates Newsletter with a general description of how my good catch will help keep patients safe. (The details of the story will not be included.)

☐ Please do not print my name in the newsletter.

Return Form to Safety/QA/QI