Resident Incident Report Form

Resident Name	Room #	MR#

Date of Incident	Time of Incident	Place of Incident ☐ Resident Room ☐ Bathroom ☐ Dining Room ☐ Hallway (Rm#) ☐ Unknown ☐ Other (Specify)_____

Type of Incident
- ☐ Fall witnessed
- ☐ Found floor
- ☐ Injury __ skin tear __ bruise
- ☐ Equipment failure
- ☐ Burn
- ☐ Environmental hazard
- ☐ Choking
- ☐ Allergic reaction
- ☐ Resident to resident altercation
- ☐ Resident to staff altercation
- ☐ Physical device
- ☐ Aggressive act
- ☐ Resident was victim
- ☐ Resident was perpetrator
- ☐ Elopement
- ☐ Other:_____

Environment at time of fall:
☐ Shift change ☐ Noisy ☐ Quiet
Other:_____

How Did Incident Occur
- ☐ From Bed
- ☐ From Toilet
- ☐ From chair, w/c
- ☐ While walking
- ☐ Lowered to floor
- ☐ During transfer

Transfer belt used: Yes / No
- ☐ Other_____

Alarm Sounded ☐ Yes ☐ No

Witnesses/Persons Involved:
Staff Name: _____
Volunteer/Visitor:_____
Roommate's Statement:
_____
_____
_____

Describe the incident in detail in the nurse's notes and attach a copy to this form.

Resident's
Comments/Interview:_____
_____
_____

Observations following the incident: *Check VS for all falls and implement neurological flow sheet if head injury suspected*

T_____ P_____ R_____ O2 Sats:_____ BS:_____

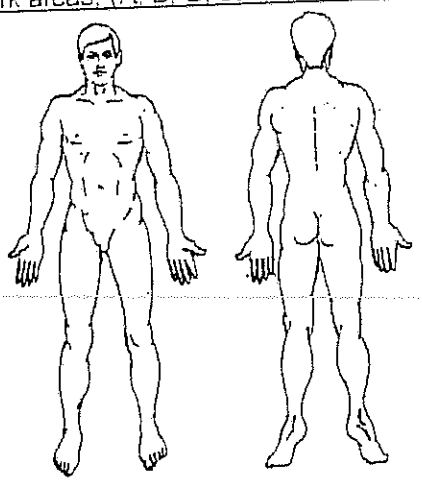
B/P: Lying_____ Sitting_____ Standing _____

Neuro: ☐ N/A ☐ Normal ☐ Not normal for resident
Skin: ☐ N/A ☐ Intact ☐ Injury:_____
Range of Motion: ☐ N/A ☐ Normal ☐ Not normal for resident
☐ Suspected fracture ☐ Pain

Other:_____

Protocol: Falls without suspected head injury VS qshift X 24hrs
Falls with suspected head injury VS and Neuros Q4hrs x 24hrs

Mark areas, (A, B, C, etc.) for multiple areas



CODES:
☐ No Injury ☐ Pain (indicate where)_____
1.Skin Tear 2. Abrasion 3. Bruise 4. Hematoma
5. Swelling 6. Redness 7. Other_____
Size:
Area A L _____ cm; W _____cm; D_____cm
Color:_____

Area B L _____ cm; W _____cm; D_____cm
Color:_____

Area C L _____ cm; W _____cm; D_____cm
Color:_____

Medical Treatment: ☐ None needed ☐ Cleanse/dress ☐ Steri-strips ☐ Cold pack ☐ Xray:_____
☐ Emergency Room ☐ Hospitalized at:_____

Documentation:
- ☐ Interdisciplinary progress notes
- ☐ Chart flagged for 24 hr follow-up
- ☐ Care plan updated ☐ N/A
- ☐ Temp. care plan initiated ☐ N/A
- ☐ NAR assignment sheet updated ☐ N/A

Immediate action taken to prevent further injury to resident:
- ☐ Removed to a place of safety
- ☐ Low bed
- ☐ Tab alarm Bed / W/C
- ☐ Sensor alarm
- ☐ Mat on floor
- ☐ Remove clutter
- ☐ Lap buddy
- ☐ Increased monitoring
- ☐ Change in environment
- ☐ Change in toileting
- ☐ Other_____

Safety Measures in Place at incident:
- ☐ Low Bed
- ☐ Matt on floor
- ☐ Motion Sensor
- ☐ Tabs Alarm circle: wheelchair / bed
- ☐ Pressure Alarm circle: wheelchair / bed
- ☐ Lap buddy
- ☐ Front Clip Belt
- ☐ Velcro belt
- ☐ Back Clip Belt
- ☐ ½ Side rails L/R ☐ Perimeter mattress
- ☐ Grab bars circle L / R

Other_____

Prior Mental Status (Check all that apply)

Oriented to:
- ☐ person
- ☐ place
- ☐ time

- ☐ Forgetful
- ☐ Confused
- ☐ Totally disoriented

Sensory
- ☐ Wears glasses On / Off
- ☐ Hearing device On / Off

Prior Mobility Status
- ☐ Indep. ambulation
- ☐ Independent transfer
- ☐ Independent bed

Mobility
- ☐ Independent toileting
- ☐ Independent with w/c
- ☐ Assist w/ ambulation
- ☐ Assist w/ Transfer
- ☐ Assist w/ bed

Mobility
- ☐ Assist w/ toileting
- ☐ Assist with w/c
- ☐ Does not ambulate

Toileting:
Last time:_____
- ☐ Incontinent
- ☐ Toilets self Ind.
- ☐ Toileting plan

Medications
- ☐ Psychotropics
- ☐ HTN meds
- ☐ Diuretics
- ☐ Narcotics
- ☐ Cardiac meds
- ☐ Other _____

Behaviors:
- ☐ Impulsive
- ☐ Poor judgment
- ☐ Agitated
- ☐ Physically Abusive
- ☐ _____

Possible Contributing Factors
- ☐ Acute Illness (URI, UTI, etc)
- ☐ Medical Condition(s) / DX:
- ☐ Unsteady gait
- ☐ Improper footwear/clothing issues
- ☐ No footwear
- ☐ Balance problems
  - __sitting
  - __standing
- ☐ Environment (lighting, wet floor, etc)

Environment at the Time of the Fall:

	Yes	No		Yes	No		Yes	No
Lighting OK	☐	☐	Furniture in usual place	☐	☐	Floor mat	☐	☐
If NOC night light used?	☐	☐	Room change in the past month	☐	☐	Siderail / Grab bar Up/Down	☐	☐
Floor dry	☐	☐	Noisy	☐	☐	Personal alarm	☐	☐
Equipment OK	☐	☐	Crowded	☐	☐	- Alarm sounding?	☐	☐
Area clutter free	☐	☐	Quiet	☐	☐	Motion detector	☐	☐
Call light in reach	☐	☐	Employee shift change	☐	☐	Bed in lowest position	☐	☐
Other:	☐	☐	Change in resident's environment	☐	☐	Sensor alarm - Bed sensor	☐	☐
				☐	☐	- Chair sensor	☐	☐

Alarm/Sensor functioning at time of incident ☐ Yes ☐ No **Call light within reach** ☐ Yes ☐ No
Call light used ☐ Yes ☐ No **Equipment in use functioned properly** ☐ Yes ☐ No
Type of equipment_____

Unexplained Injury No _____ Yes _____

Further investigation must be completed and report made to CEP and MDH.

Plan/Recommendations to prevent further injury/incidents:

☐OT Referral ☐ PT Referral ☐ Medication Change ☐ Review by MD / NP

☐ Physical Device Review/Reduction

☐Environmental Changes *(Describe)*

☐ Other

☐ No Change

Nurse Manager / Supervisor Signature Date

Potential Vulnerable Adult Issue: ____ No ____ Yes

If yes, report to CEP (WCSS/Sheriff's Department) _____ AND Online via MDH Secure Website _____

If yes, reported by: _____ Date_____ Time_____

Fax to Adult Protection Intake Worker at WCSS Fax# : 218-631-7616 Phone: 218-631-7605

Comments

Administrator Notified: Date: _____ Time: _____ Notification by: Admin Hotline_____ Email_____

DON/Designee Notified: Date: _____ Time: _____Notification by: Telephone _____ Email

Social Services Notified: Date: _____ Time: _____Notification by: Telephone _____ Email: _____

Family Notified: Date: _____ Time: _____Notification by: Telephone _____ In Person_____

MD Notified: Date: _____ Time: _____Notification by: Fax _____ Telephone _____

Signature of person completing report:	Date: