



Route According to checklist - * If exposure notify nurse immediately

Staff completing form Staff Work Phone #

(Please Print legibly)

Supervisor/Team Leader/Counselor Work Comp Rep. - Within 24 hours

INCIDENT/ ACCIDENT REPORT FORM

(Use black ink NO WHITEOUT)

Legal Name of Person Involved: Date of Report

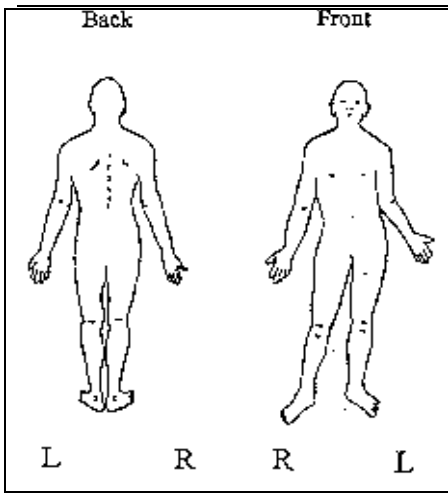
Date of Incident/ Accident: Time of Incident/ Accident: a.m./p.m.

Witnesses: Name Name Phone Phone

Dept #: Specific Location and Address of Incident/ Accident (e.g. Riverfront Productions, Mankato Thrift Shop Chaska, Carver/Scott, Rosemount, Fairmont, New Ulm, Highland, Front Street, Blue Earth County or Community Job Site)

Description of Incident/Accident/Injury: Completely describe the nature of the incident or accident, circumstances under which the incident occurred, note specific details including the scene before, during, and after the incident/ accident. Circle the location of the injury on the diagram. Specify any equipment involved. If the incident involves an injury, specify the first aid given and by whom.

Blank lines for description of incident.



Blank lines for marking injury location on the diagram.

Action taken to prevent reoccurrence:

Blank line for action taken.

INJURIES

Nature of Injury: N/A Arrived with Injury Abrasion Bite Burn Scratch(es) Bruise(s) Cut/Laceration Puncture Other (Describe)

Does injury require a tetanus shot? Yes No If yes, date of last tetanus shot

Was blood or OPIM present? Yes No Were gloves used? Yes No

Name of the First Aid provider: Is First Aid provider vaccinated for HBV? Yes No

Reviewed by Health Care Professional Date reviewed:

EXPOSURE INCIDENT *** Needs to be completed by the end of the day ***(If exposure please refer to red folder and follow flow chart)

This is is not an exposure incident. Supervisor Signature

Health Care Professional notified immediately and Exposure Incident Report form completed: N/A Yes

By Whom: Date

OUTSIDE MEDICAL TREATMENT N/A **Faxed to Work Comp. Rep. within 24 hours**

Date MRCI notified of Injury: _____
Name of Supervisor who first received knowledge of injury: _____
Date of Initial Visit: _____
Name of Treating Physician/Name of Facility: _____
Address: _____ Phone: _____
Date of First Day of Lost Time: _____ Date MRCI notified of Lost Time: _____ Date Returned to Work: _____

VULNERABLE ADULT/OMBUDSMAN REPORTING N/A

(Reports must be made within 24 hours of initial knowledge of situation to CEP, guardian and county casemanager.)

Was report made? **Yes** - Caller Initials: _____ Date Reported: _____ CEP Reported to: _____
 No - Error in Therapeutic Conduct: no harm /no VA report required Accident Client-to-Client
Aggression not requiring outside medical attention Physical Injury that has a reasonable explanation

Ombudsman within 24 hours for serious injury or death Date: _____ Completed by: _____
 DHS notified within 24 hours for serious injury or death Date: _____ Completed by: _____

SIGNATURES

Signature and Title of Person Completing form Date

Signature of Supervisor/Team Leader Date

Signature of Counselor/ Program Coordinator Date

Signature of Program Manager/Director Date

LICENSED PROGRAM INFORMATION

(List names of contacts who must be notified within 24 hours) (circle method of delivery)

Residence: _____ verbal/fax/e-mail: Date/Time _____ Date sent _____ Initials _____
Case Manager: _____ verbal/fax/e-mail: Date/Time _____ Date sent _____ Initials _____
Legal Rep: _____ verbal/fax/e-mail: Date/Time _____ Date sent _____ Initials _____

Has a pattern been identified relating to this incident? Yes No

Action Taken: _____

Designated Coordinator Signature

Does this situation require a second report? no yes (# _____)

This report requires reporting to team members within 24 hours due to: (Check one)

- Serious Injury - Medical emergency/serious illness/accidents that require physician treatment or hospitalization
- Consumer to consumer physical aggression causing pain, injury or persistent emotional distress Unauthorized absence
- Circumstances involving law enforcement Fire Sexual activity between consumers involving force or coercion
- Death

ERROR IN THERAPEUTIC CONDUCT

Incident involved an error in therapeutic conduct.

- No Harm- the incident did not result in an injury or harm to the individual requiring the care of a physician.
- No VA report required.
- Harm – Harm to consumer. Resulted in injury or harm that requires the care of a physician.
- Therapeutic Error Documentation Form completed - Date: _____ By: _____

SAFETY COMMITTEE

Copy to Safety/ Health Committee Representative Date: _____ Initials: _____
Job Hazard Analysis completed Yes No
Date Reviewed by Safety Committee: _____ Reviewed By: _____
Safety Committee Recommendations: _____

Date/Time: _____ By: _____

Case Noted: Date: _____ By: _____

Note: If a consumer is involved in an incident/accident, it must be case noted. If an incident/accident involves staff only, it does not need to be case noted.