Carolina Family Health Centers, Inc.

Carolina Family Dental Center • Freedom Hill Community Health Center• Harvest Family Health Center •Wilson Community Health Center

Incident Report

INCIDENT #_____

PATIENT/INDIVIDUAL INFORMATION

Patient/individual name: **MR#:**
DOB: **Phone number:**
Address:

Patient/individual name: **MR#:**
DOB: **Phone number:**
Address:

Relationship to CFHC, Inc.: ☐Employee ☐Patient ☐Visitor ☐Other: _____

EVENT INFORMATION

Date of event/discovery: **Location:** **Department:**

Description of the event and the resolution or treatment provided:

Equipment involved (name, brand, serial number, etc.)- Required for potential exposure to bloodborne pathogens:

Personnel involved in the event):

List recommendations for prevention (notation required by the reviewing supervisor):

Name of the person completing the report:

_____ _____

Print the name of the employee reporting incident *Date*

_____ _____

Print the name of the Supervisor who received the incident *Date*

STOP HERE

Please forward the completed form with supporting documentation to the Administrative Assistant Compliance & the Chief Compliance Officer via email. This form must be completed electronically.

Processing and Assigning the Incident

INCIDENT # _____

SEVERITY CATEGORY (check the appropriate box)

Near Miss

☐ **Category A:** Potentially hazardous conditions, circumstances, or events that have the capacity to cause injury, accident, or healthcare error but did not reach the patient, visitor, staff person or volunteer.

Event, No Harm

☐ **Category B:** An event occurred and reached the patient, visitor, staff person or volunteer, but there is no evidence of injury or harm.

Event, Harm

☐ **Category C:** An event occurred that may have contributed to or resulted in harm required treatment and/or intervention or required increased observation or monitoring including emergency room evaluation.

☐ **Category D:** An event occurred that resulted in near death circumstances or required intervention necessary to sustain life.

Event, Death

☐ **Category E:** An event occurred that contributed to or resulted in death.

Other

☐ **Category F:** Cannot assess harm at this time.

CATEGORY ASSIGNMENT

☐ **Treatment/Procedures**	☐ **Equipment/Product**	☐ **Falls/Injuries** ☐ Potential Bloodborne Pathogen	☐ **Medications**
Communication Error Consent Problem Documentation Error Injection site problem	Electrical problem Improper use Malfunction Vehicle accident Vehicle maintenance Expired supplies	Chair/stool Exam Table Fainting While ambulating Scales	Adverse reaction Expired Medication Given without order Improper order Incorrect prescription Mislabeled Vaccine errors
☐ **Environment**	☐ **Business/Patient Relations**	☐ **Confidentiality Issues** ☐ Breach ☐ Near Miss	☐ **Patient Relations** ☐ Warning ☐ Dismissal ☐ Grievance
Defective alarms Excessive ice/snow Fire Heating/cooling problem Medical waste problem Power or communication failure Unsafe parking	Answering service problems Assault/violence Property missing or damaged Incorrect bill Incomplete records	Phone Fax Staff Telephone Waiting areas Social media Failure to use three patient identifier	Dissatisfied patient/family Excessive wait times Patient termination

TEAM or CHIEF/DIRECTOR ASSIGNMENT

☐ **Medical CIT**

☐ **Dental CIT**

☐ **Pharmacy & Therapeutics CIT**

☐ **Finance & IT CIT**

☐ **Employee Investment CIT**

☐ **Central Committee**

☐ **File** *(not assigned)*

☐ **Chief Executive Officer** **Reason:** ☐ Patient Grievance ☐ Disruptive Behavior

☐ **Director of Human Resources** **Reason:** ☐ Potential worker's compensation claim

☐ **Chief Compliance Officer** **Reason:** ☐ HIPAA

HIPAA Breach - ☐ Patient notified & reported made to Health and Human Services,
Date: _____

☐ **Chief of Staff**: _____ **Reason:** ☐ Corrective Action for HIPAA Breach

Recommendations:

1. _____
_____
_____ _____ Initial
_____

2. _____
_____
_____ _____ Initial
_____

3. _____
_____
_____ _____ Initial
_____

☐Incident ☐Not an Incident

_____ _____
Chief Compliance Officer Signature ***Date***

_____ _____
Chief Executive Officer Signature ***Date***

Action Plan Development and Implementation

INCIDENT # _____

Initally Reviewed by:_____ (Name of CIT) on _____ (Date)

List root cause(s) – Why did this happen? What staff were interviewed?What police/procedures reviewed?

Committee/Invidual's Recommendations and Goals(s)*(if any)*:

ACTION PLAN

#1 ACTION ITEM (Objective):

#2 ACTION ITEM (Objective):

ACTION PLAN RESOLUTION

Action Item # 1 Completion Date:
Summary:

Action Item #2 Completion Date:
Summary:

I attest that the Incident Report was reviewed and all action items have been completed to mitigate risk to CFHC, Inc., its patients, and employees. A summary of the incident report, action plan, and resolution will be summarized and present to the Central Compliance Committee.

_____ _____

Name of the assigend CIT chairperson or other assigned person Date

Email the completed Incident Report to the Administrative Assistant Compliance and the CCO.