UNIVERSITY OF NEBRASKA MEDICAL CENTER

PLEASE COMPLETE ALL APPLICABLE SECTIONS

CONFIDENTIAL REPORT OF OCCURRENCE

A

Name ______________________________

Address ______________________________

DOB ______________________________

Location where incident occurred ____________

Employee personnel # ____________

MEDICAL CENTER DIVISION	INCIDENT DATE	INCIDENT TIME	REPORT #
☐ BF BUSINESS AND FINANCE ☐ CO CHANCELLORS OFFICE ☐ COD COLLEGE OF DENTISTRY ☐ COM COLLEGE OF MEDICINE ☐ CON COLLEGE OF NURSING ☐ COP COLLEGE OF PHARMACY ☐ COPH COLLEGE OF PUBLIC HEALTH ☐ EI EPPLEY INSTITUTE ☐ ITS INFORMATION TECHNOLOGY ☐ MMI MUNROE-MEYER INSTITUTE ☐ SAHP SCHOOL OF ALLIED HEALTH PROFESSIONS	(Digits Only)	____:____ A.M. ____:____ P.M.	
	REPORT DATE (Digits Only)	IDENTIFICATION ☐ 1-Patient ☐ 4-Student ☐ 2-Employee ☐ 5-Volunteer ☐ 3-Visitor ☐ 6-NA	Sex Age

B

CONDITION BEFORE

(Patients Only)

- ☐ 1–Normal
- ☐ 2–Senile
- ☐ 3–Disoriented
- ☐ 4–Sedated
- ☐ 5–Unconscious
- ☐ 5.1– General anesthetic
- ☐ 6–Other (List) ____________ ____________

LOCATION OF OCCURRENCE

- ☐ 41 OFFICES
- ☐ 42 ELEVATORS
- ☐ 43 CORRIDORS
- ☐ 44 STAIRS
- ☐ 45 GENERAL PREMISES, INTERIOR
- ☐ 50 PATIENT'S ROOM
- ☐ 51 PATIENT'S BATHROOM
- ☐ 52 NURSES STATION
- ☐ 53 SURGERY & RECOVERY
- ☐ 56 LABORATORY
- ☐ 61.1 PARKING LOTS
- ☐ 61.2 SIDEWALKS
- ☐ 61.3 STEPS
- ☐ 61.4 STREETS ON CAMPUS
- ☐ 62 GENERAL PREMISES, EXTERIOR
- ☐ 62.1 OFF CAMPUS
- ☐ 63 CLINIC

LIST EXACT LOCATION ______________________________

DEPARTMENT WHERE INCIDENT OCCURRED:

LIST: ______________________________ ☐ NOT APPLICABLE

NATURE OF OCCURRENCE

- ☐ 10.3 INHALATION
- ☐ 11 BURN/SCALD
- ☐ 12 CHEMICAL BURN
- ☐ 13 CONCUSSION
- ☐ 14 CONT/INFECT DISEASE
- ☐ 14.2 EXPOSURE TO HIV
- ☐ 14.3 EXPOSURE TO T.B.
- ☐ 14.4 EXPOSURE TO HEPATITIS
- ☐ 15.1 CONTUSION/BRUISE
- ☐ 15.2 CUT/LACERATION
- ☐ 15.4 SCRATCH/ABRASION
- ☐ 15.5 DAMAGE TO PROPERTY
- ☐ 16.1 FRACTURE
- ☐ 16.2 DISLOCATION
- ☐ 18 SPRAIN/STRAIN
- ☐ 19 PUNCTURE WOUND
- ☐ 21 BODY FLUID EXPOSURE
- ☐ 21.1 FOREIGN BODY, EYE
- ☐ 21.2 FOREIGN BODY, OTHER
- ☐ 21.3 BITES, HUMAN
- ☐ 21.4 BITES, INSECT/ANIMAL
- ☐ 21.6 HERNIA
- ☐ 21.7 DERMATITIS
- ☐ 21.8 AMPUTATION
- ☐ 21.9 LOSS OF PERSONAL PROPERTY
- ☐ 23 REPETITIVE MOTION
- ☐ 24 PATIENT COMPLAINT
- ☐ 25 AMA
- ☐ 20 NO APPARENT INJURY

INCIDENT FACTOR

If more than one factor, check predominating one and describe other in lower part of report.

A – Falls

- ☐ 01 FALL FROM BED, RAIL UP X ________
- ☐ 02 FALL FROM BED, RAIL DOWN
- ☐ 03 FROM CHAIR OR EQUIP.
- ☐ 04 UNEVEN DIFFERENT SURF.
- ☐ 05 ON SAME LEVEL
- ☐ 06 FAINTING/SEIZURE
- ☐ 06.1 SLIPS/FALLS
- ☐ 06.2 TRIPPED

B – Medication

- ☐ 07 WRONG PATIENT
- ☐ 08 DOSAGE
- ☐ 09 ROUTE
- ☐ 10 UNORDERED
- ☐ 11 DUPLICATION
- ☐ 12 OMISSION
- ☐ 13 TRANSCRIPTION
- ☐ 13.1 COMPUTER ENTRY ERROR
- ☐ 14 WRONG MEDICATION
- ☐ 15 LABELING
- ☐ 16 WRONG TIME
- ☐ 17 OTHER
- ☐ 18 IV OR INJECTION TECHNIQUE
- ☐ 18.1 INFILTRATION/ EXTRAVASATION
- ☐ 19 NARCOTIC COUNT

C – Other

- ☐ 20 STRUCK BY PATIENT
- ☐ 21 STRUCK BY EQUIPMENT
- ☐ 22 STRUCK EQUIPMENT
- ☐ 22.1 STRUCK AGAINST
- ☐ 23 STRUCK BY TOOL/OBJECT
- ☐ 24 LIFTING/MOVING PATIENT
- ☐ 25 LIFTING/MOVING OTHER
- ☐ 26 BIT BY PATIENT
- ☐ 27 CHEMICALS/SOLVENTS
- ☐ 28 HOT LIQUIDS/STEAM
- ☐ 29 SCRATCHED BY PATIENT
- ☐ 30 SPONGE COUNT
- ☐ 30.2 NEEDLE COUNT
- ☐ 30.3 INSTRUMENT COUNT
- ☐ 31 WRONG PATIENT
- ☐ 32 CAUGHT/IN/ON/BETWEEN
- ☐ 34 NEEDLE PUNCTURE
- ☐ 34.1 PUNCTURE WOUND – OTHER
- ☐ RESEARCH SPECIMINE
- ☐ 33 MISCELLANEOUS (LIST) ____________

C

IF STUDENT

- ☐ Graduate
- ☐ Undergraduate
- ☐ Campus/Remote

IF EMPLOYEE/RESIDENT

Dept: ______________________________

ZIP: ____________ Phone #: (Work) ______________________

Primary Investigator Contact Info.: ______________

ON DATE OF OCCURRENCE

Shift Start Time ____________ End ____________

IF VISITOR

Address: ______________________________

____

Home Phone: ______________________________

Work Phone: ______________________________

D

BRIEF DESCRIPTION OF OCCURRENCE, INCLUDING CAUSES (For Additional Space, Use Reverse Side.)

____

____

IF EQUIPMENT IS SUSPECTED OF BEING THE CAUSE OF THE INCIDENT, PLEASE REFER TO HOSPITAL POLICY #9.095.

EQUIPMENT INVOLVED: **BMI/INV TAG #** **SERIAL #**

Was person seen by a physician? ☐ Yes ☐ No

If "yes," time seen: ____________ A.M. / ____________ P.M.

MEDICAL PROVIDER'S NAME (PRINT)

EMPLOYEE WAS SEEN IN: ☐ EMPLOYEE HEALTH ☐ E.D. ☐ OTHER (List) ____________

E

PHYSICIAN'S FINDINGS AND RECOMMENDATIONS ______________________________

____

____

PHYSICIAN'S SIGNATURE

F

Name and title of person preparing report	Supervisor's Signature	Risk Management Reviewed by:

NOT PART OF MEDICAL RECORD

	CONTINUATION FROM SECTION "D"
G	

	NAMES AND ADDRESSES OF WITNESSES:
H	

	STATE CORRECTIVE ACTION, DATE AND SIGN (IF APPLICABLE)
I	

REPORT ROUTING

Send reports for patients and visitors to: Hospital Risk Management (7470)

Send reports for employees and students to: UNMC Risk Management (5060)

FOR INFORMATION CONTACT UNMC RISK MANAGEMENT AT EXT. 9-5221