Occurrence Report

Instructions:
All sections of pages 1 & 2 **MUST** be completed by reporter.
Fill out separate report for EACH person involved in the occurrence.

1.☐ Non-Person
☐ Person Involved★
Last Name:
First Name:
PHIN:
Phone #:
Sex: ❑ F ❑ M
DOB *(DD / MM / YYYY)*: ____ / ____ / ________

★ *If this section is NOT Addressographed, it MUST be completed.*

ID Number (Data Entry Staff Only) ________________

2. Date & Time of Occurrence *(DD/MM/YYYY)* ____ **/** _____ **/** ________ *(24 hour clock)* __________________________

3. Occurrence Involved *Check ONE* ❑ Agency Personnel ❑ Client ❑ Medical Staff ❑ Staff ❑ Student ❑ Visitor

4. Site/Facility
Please Print Clearly

5. Program/Department
Please Print Clearly

6. Location *Check ONE Only*

❑ Bathroom –Client's
❑ Bathroom – Public/Staff
❑ Cafeteria
❑ Client home
❑ Client/Hospital/Elder Room
❑ Corridor/Hall
❑ Dining Room
❑ Elevator
❑ Entrance
❑ Examination/Treatment Room
❑ Kitchen
❑ Laundry Area
❑ Lounge/Sitting Area
❑ Medication Room
❑ Multipurpose Room
❑ Nurse's Desk
❑ Office
❑ Outside
❑ OR
❑ Parking Lot
❑ Recovery Room
❑ Seclusion Room
❑ Smoking Room
❑ Staff Room
❑ Stairs
❑ Waiting Area
❑ Other: ________________

7. Narrative Description of Occurrence *What happened? (Facts Only)*

8. Degree of Injury at Time of Occurrence *See Definitions on Page 4* ❑ Minor ❑ Major ❑ Unknown ❑ None Apparent

9. Contributing Factors: *Check all that apply*

❑ Body Mechanics
❑ Client Behavior/Mental Status
❑ Client Education Concern
❑ Client Information Missing
❑ Client Interference
❑ Client Not Available
❑ Client Physical Condition
❑ Client Self-Medicating
❑ Clothing or Footwear
❑ Do Not Use Abbreviation
❑ Drug Name, Label, Packaging Problem
❑ Drug Storage Or Delivery Problem
❑ Environmental Conditions
❑ Error Calculating Dose (Calculating Dose Error)
❑ Failure To Check Chart/Assignment
❑ Fainted/Seizures
❑ Faulty Device/Equipment (See # 13)
❑ Gait
❑ Illegible Handwriting
❑ Incontinent
❑ Infusion Pump Training Not Up to Date
❑ Interruption to Workflow
❑ Lack of security
❑ Medication Not Checked Properly
❑ Miscommunication of Information
❑ Miscommunication of Order
❑ Misunderstanding of Communication or Information
❑ Order Information Missing
❑ Policy/Procedure Variance
❑ Restraint In Use
❑ Sedation
❑ Side Rail In Use
❑ Staffing Or Workflow
❑ Transcription Error
❑ Unexpected Movement
❑ Wet Floor
❑ Other:____________________

10. Recommendations: In your opinion, what could be different to prevent similar occurrences?

11. Reporter (Name & Title) ______________________________ _________________ **Date Reported** ____ **/** ____ **/** ______
Please Print Clearly *Department* *DD / MM / YYYY*

12. Was there a Witness other than the reporter? ❑ YES ❑ NO If YES, who?

13. TYPE OF OCCURRENCE – *Select (✓) and Complete ONLY ONE of Sections A through E.*

☐ A. STAFF/WORKPLACE INJURY

Type of Injury (Classification) *Check ONE Only*

❑ Abrasion
❑ Abuse (Physical)
❑ Abuse (Verbal)
❑ Amputation
❑ Bang / Bruise
❑ Blood or Body Fluid Exposure
❑ Burn
❑ Chemical Burn
❑ Cut
❑ Electric Shock
❑ Fall
❑ Fracture
❑ Needle Stick
❑ Repetitive Strain
❑ Strain/Sprain
❑ Other: ________________

Body Part Injured:____

Did you take time off work? ❑ YES ❑ NO

Did you see a Physician? ❑ YES ❑ NO **If YES, who & when?** _____ / _____ / ________
DD / MM / YYYY

All Workplace Injuries MUST be reported to a Manager or designate immediately. The Manager or designate will notify Human Resources within 24 hours or by the next business day, and forward the Occurrence Report.

☐ B. FALLS ☐ Witnessed ☐ Un-Witnessed

Fell From *Check ONE Only:* ❑ Bed/Crib ❑ Chair ❑ Exam Table/Stretcher ❑ Stairs ❑ Toilet/Commode ❑ Tub/Shower ❑ Wheelchair/Scooter ❑ Other: ____________________

Fell **While** *Check ONE Only:* ❑ Laying ❑ Sitting ❑ Standing ❑ Transferring ❑ Walking ❑ Unknown ❑ Other: ____________________

Status of Equipment or Restraint at time of fall:	Bed Alarms	Height of Bed	Brakes	Restraints	Siderails	Walking Aid Use
	☐ On ☐ Off ☐ n/a	☐ Up ☐ Down ☐ n/a	☐ On ☐ Off ☐ n/a	☐ On ☐ Off ☐ n/a	☐ Up ☐ Down ☐ n/a	☐ Yes ☐ No ☐ n/a

☐ C. MEDICATION or TREATMENT/TEST/PROCEDURE VARIANCES

Category *Check ONE Only:* ❑ **INTRAVENOUS/BLOOD** ❑ **MEDICATION** ❑ **TREATMENT/TEST/PROCEDURE**

High Alert Med ☐ Yes ☐ NO

Type *Check ONE Only:*

- ❑ Adverse Reaction
- ❑ Blood Type/Product
- ❑ Break In Sterile Technique
- ❑ Cancellation
- ❑ Consent Issue
- ❑ Delay in Treatment/Test/Procedure
- ❑ Delivery/Pick Up Problem
- ❑ Discontinued
- ❑ Do NOT Use Abbreviation Usage
- ❑ Duplication
- ❑ Foreign Body Left In Client
- ❑ Inappropriate Results
- ❑ Incomplete/Omitted Procedure
- ❑ Incorrect Client
- ❑ Incorrect Dose
- ❑ Incorrect Med Consumed
- ❑ Incorrect Med Dispensed
- ❑ Incorrect Narcotic Count
- ❑ Incorrect Order
- ❑ Incorrect Procedure/Service
- ❑ Incorrect Rate of Flow
- ❑ Incorrect Route/Site
- ❑ Incorrect Time
- ❑ Infiltration
- ❑ Injury To Client
- ❑ Lab Specimen
- ❑ Labeling Problem
- ❑ Other:____________________
- ❑ Med. Reconciliation not Complete
- ❑ Misplaced Medication
- ❑ No M.D. In Attendance
- ❑ Omitted Dose
- ❑ Outdated Product
- ❑ Surgical Count
- ❑ Two Client Identifiers NOT Used
- ❑ Unordered Drug

Medication Ordered	Frequency	Dose	Route
Med Given:			

☐ D. ABUSIVE/AGGRESSIVE BEHAVIOR

Was a Code White Called? ☐ YES ☐ NO

Abusive/Aggressive Behavior Occurrences should be reported to Manager or designate ASAP or by the next working day.

Form of Abuse - *Check ONE only*

- ❑ Financial
- ❑ Mental/ Emotional
- ❑ Physical
- ❑ Physical/Sexual
- ❑ Religious
- ❑ Sexual
- ❑ Verbal
- ❑ Verbal/Physical
- ❑ Verbal/Sexual

From Who - *Check ONE only*

*Name*____________________

- ❑ Agency Personnel
- ❑ Client
- ❑ Family member
- ❑ Manager
- ❑ Physician
- ❑ Staff
- ❑ Visitor
- ❑ Other: ____________________

To Who - *Check ONE only*

*Name*____________________

- ❑ Agency Personnel
- ❑ Client
- ❑ Manager
- ❑ Physician
- ❑ Staff
- ❑ Visitor
- ❑ Other: ____________________

☐ E. MISCELLANEOUS *Check ONE Only*

- ❑ Breach Of Confidentiality
- ❑ Client/ Visitor Injury: Self-Inflicted
- ❑ Client/ Visitor Injury: Unwitnessed
- ❑ Client/ Visitor Injury: Witnessed
- ❑ Communication Outage
- ❑ Code Called Color
- ❑ Fire
- ❑ Inappropriate Disposal Of Sharps or Biomedical Supplies
- ❑ Left Against Medical Advice
- ❑ Missed Assignment
- ❑ Missing Client
- ❑ Property Missing
- ❑ Pressure Ulcer Risk Assessment Not Completed
- ❑ Safe Surgical Checklist Not Complete
- ❑ Sterilizer Malfunction
- ❑ Unauthorized Access
- ❑ Unauthorized Drugs or Equipment or Weapons
- ❑ Unauthorized Smoking
- ❑ VTE Protocol Not Followed
- ❑ Other____________________

14. PROPERTY DAMAGE ☐ YES ☐ NO

If Yes, Check ONE - See Definitions on Page 4 ☐ None ☐ Minor ☐ Major ☐ Unknown

15. EQUIPMENT ☐ YES ☐ NO

Was Preventative Maintenance Schedule up to Date? ☐ Yes ☐ No

Type *Check ONE Only* ❑ damaged/broken ❑ defective ❑ missing

❑ Taken out of service By: ____________________ ❑ Locked away in secure location (specify) ____________________

Item Name/Description: ____________________

Manufacturer: ____________________ Model #: ____________________ Serial #: ____________________

16. NOTIFICATIONS *All occurrences must be promptly reported to Manager/ or designate*

- ❑ Chart Documentation
- ❑ PPCO (Phone:1-866-440-6366) Protection for Person in Care Office
- ❑ Maintenance
- ❑ Pharmacy
- ❑ R.C.M.P.
- ❑ Security
- ❑ Workplace Health & Safety
- ❑ Other:

All Occurrences:	Reported By	Reported To	Date *(DD/MM/YYYY)*
Manager or designate			
Physician			
Client or Decision Maker			
Human Resources			

When you have completed Pages 1 & 2, this form is to be signed and handed in to your manager or designate ASAP. Workplace Injuries, Critical Occurrences & Critical Incidents (See definitions pg. 3& 4) must be reported to your Manager or designate immediately.

Signature of Reporter:

17. TYPE OF EVENT *Check ONE Only*	
❑ **Occurrence**	An unintended, undesired outcome. (Refer to Policy AD-01-135)
❑ **Near Miss**	Has the potential to cause injury, unexpected death or property damage BUT DID NOT. (Refer to AD-01-135)
❑ **Critical Occurrence**	Results in serious harm to staff or visitors; disruptions to the delivery of service and programs; an emergency or disaster; the potential to negatively affect public confidence, credibility and trust. (Refer to Policy AD-06-55)
❑ **Critical Incident**	While receiving care harm has come to a client such as death, disability, injury or harm, unplanned admission to hospital or unusual extension to hospital stay and does not result from the individual's underlying health condition or from a risk inherent in providing the health services (Refer to Policy AD-06-60)

Important Note: Critical Incident or Critical Occurrence must be reported to Senior Management and Patient Safety Coordinator .

18. INITIAL MANAGER / DESIGNATE FOLLOW-UP ON OCCURRENCE

What immediate action was taken?

Indicate what was discussed with staff involved in the occurrence and if feedback was given.

Documents Attached? ☐ *YES* ☐ *NO* *If YES, what is attached?* ____

Recommendations & Plans for Follow-up:

Investigation lead by: Signature____ **Date Reviewed:** _____/_____/_______

DD / MM / YYYY

- ☐ **Critical Incident / Occurrence reported to Patient Safety Coordinator**
- ☐ **Incident Resolved – No further follow-up required. Submit to Patient Safety.**
- ☐ **Learning opportunity for other programs regionally**
- ☐ **Further assessment or follow required by:**____

19. Secondary Department Follow-up on Occurrence

What immediate action was taken?

Indicate what was discussed with other department involved in the occurrence.

Documents Attached? ☐ *YES* ☐ *NO* *If YES, what is attached?* ____

Recommendations & Plans for Follow-up:

Investigation lead by: Signature________________________________ **Date Reviewed:** _____/_____/_______

DD / MM / YYYY

☐ **Incident Resolved – No further follow-up required. Submit to Patient Safety.**

Occurrences Where Two (2) Occurrence Reports Must Be Completed

Example: An elder of a Long Term Care Facility becomes physically aggressive to a nurse/HCA causing an injury to her/him. Two occurrence reports must be filled out.
1. For the **Aggressive Behavior** (**physical)** on the part of the client, and
2. For the **Injury** received to the nurse/HCA.

Definitions for PROPERTY DAMAGE

None: A property related event that occurred that did not result in any financial loss.
Minor: A property related event that resulted in a financial loss of less than $5,000.00.
Major: A property related event that resulted in a financial loss of $5,000.00 or more.
Unknown: Select this option when you do not know the extent of the property damage.

Definitions for Degree of Injury

Major: An occurrence that results in but is not limited to: i) Death, ii) Fracture of a bone, iii) Amputation, iv) Loss of sight, v) Major bleed.
A Major Accident involving staff must be reported to the Workplace Safety & Health Division of Manitoba (1-800-282-8069 or 204-687-0872) in accordance with Workplace Safety and Health Act and a full investigation conducted immediately.

Minor: An occurrence that is considered to be an injury/occurrence that requires first aid treatment, but is not a major accident as defined above.