Medscape
www.medscape.com

How Should Incident Reports Be Handled?

Melanie L. Goodman, JD, CPNP, MN

|January 03, 2002

How soon after an incident should an incident report be filed? If an incident report is not filed immediately and one's supervisor later asks for a report to be completed from memory, weeks after the incident, is this legally acceptable? What guidelines could you suggest?

An incident form involving patients should be recorded as soon after the incident as possible, no later than the end of the workday on which it occurred or was discovered to have occurred. The person completing the form should be the individual who witnessed, first discovered, or is most familiar with the incident. It should then be presented to the immediate supervisor or the head of the risk management department.

Guidelines for filling out the form should include:

1. Give a brief narrative description of the incident, consisting of an objective description of the facts (never include the writer's judgment).
2. Use quotes where applicable with unwitnessed incident, eg, "patient states."
3. Write the name of any witnesses including the nurse practitioner if she/he is not the reporter.
4. Examine the patient and document all findings. The longer one waits to write the incident report, the more difficult it may become to remember specifics, and the report may be considered less reliable.

Most policies will state that an incident report should be completed as soon after the incident as possible, specifying the acceptable time range for filing. Therefore, always review your employer's risk management manual when you start a job for a specific answer about an acceptable timeframe in that organization.

An incident form is an administrative document, *not* part of the medical record. Do not indicate in the patient's chart that an incident form was completed. In addition, do not make copies of the incident report. However, it is important to record in the chart an objective description of the incident with any follow-up observations, diagnostic studies and results, and/or related treatment. In some states, under certain conditions, the incident report is considered confidential and cannot be used against the nurse practitioner in a lawsuit. However, if copies are made or the chart reflects that an incident report was completed, the incident report can then be subpoenaed by the patient and used against the defendants in court.

Filing of an incident report is usually included under risk management policies and procedures of the employing agency rather than any specific law. However, many regulatory agencies require that risk management programs be in place in order to approve licensing of a facility.

The objective of an incident report is not to punish a health professional but to determine the cause of the problem. This is usually done through a quality-assurance review and analysis of the incident report which attempts to:

1. Identify and document trends within service(s) and those that cross over services.

2. Recognize and identify programs to correct identified problems.
3. Assess conformance to require standards of practice and care. Remember that incident reports are not only for patients, but can also include staff and visitors.

Every nurse practitioner needs to learn the risk management policies and procedures in her/his work environment. This is the best way to protect yourself and your patients.

Medscape Nurses. 2002;4(1)

Cite this article: Melanie L Goodman. How Should Incident Reports Be Handled? *Medscape*. Jan 03, 2002.