

## School of Nursing Clinical Incident Form

For any adverse event please complete the following incident form including the student reflection and learning questions and submit to the Clinical Placement Coordinator via email at [michellb@nipissingu.ca](mailto:michellb@nipissingu.ca) in person to the School of Nursing office A201.

This form is to record adverse events that impact the student (e.g., fall/needle stick injury) or those where a student's actions may impact or cause harm to a patient (e.g., medication error, fall).

**For any adverse event (injury to self or others)**

- 1) See medical attention if required
- 2) Ensure you have met the Nipissing University School of Nursing Policy and Placement Agency Policies for reporting an adverse event
- 3) Complete all that apply, including the Student Learning and Reflection Section on page 4.

STUDENT NAME(S): \_\_\_\_\_

CLINICAL ROTATION: \_\_\_\_\_ SHIFT:  Day  Evening  Night

INSTITUTION: \_\_\_\_\_ INSTRUCTOR: \_\_\_\_\_

PATIENT NUMBER (IF APPLICABLE): \_\_\_\_\_ #OF PEOPLE INVOLVED: \_\_\_\_\_

AGENCY INCIDENT FORM COMPLETED  Yes Date: \_\_\_\_\_  No Reason: \_\_\_\_\_

<b>Primary details of adverse event</b>	Date(dd/mm/yy):	Date or reporting (dd/mm/yy):	Type of event:
	Time:		<input type="checkbox"/> Harmful incident <input type="checkbox"/> No harm incident <input type="checkbox"/> Near miss
	Who/what did the incident impact? <input type="checkbox"/> Student <input type="checkbox"/> Patient <input type="checkbox"/> Staff <input type="checkbox"/> Visitor <input type="checkbox"/> Volunteer <input type="checkbox"/> Property  <input type="checkbox"/> Other: __		
Discovered/Reported by (name/ role ie RN/Staff person etc):			
<b>Type of Incident</b>	<input type="checkbox"/> MEDICATION ADMINISTRATION <input type="checkbox"/> PATIENT INCIDENT <input type="checkbox"/> STUDENT INCIDENT <input type="checkbox"/> SPECIAL INCIDENT (Please complete the special incident form) <input type="checkbox"/> OTHER  <i>Only complete the sections outlined for the type of incident being reported.</i>		
<b>Follow-up action taken:</b>	Immediate:	Long term:	
	<input type="checkbox"/> Occupational Health at Clinical Agency utilized		

<b>MEDICATION ADMINISTRATION</b>	
Type of Incident: (Check all that apply)	<input type="checkbox"/> Omission <input type="checkbox"/> Incorrect Dose <input type="checkbox"/> Incorrect Medication <input type="checkbox"/> Incorrect Patient <input type="checkbox"/> Incorrect Frequency <input type="checkbox"/> Incorrect Time <input type="checkbox"/> Incorrect Route <input type="checkbox"/> Documentation <input type="checkbox"/> Near Miss <input type="checkbox"/> Other (please provide details)
Please provide a description of the adverse event that occurred:	

<b>PATIENT INCIDENT</b>	
Type of Incident: (Check all that apply)	<input type="checkbox"/> Fall <input type="checkbox"/> Near Fall <input type="checkbox"/> Unwitnessed Fall <input type="checkbox"/> Wrong Treatment <input type="checkbox"/> Documentation Error <input type="checkbox"/> Other Injury <input type="checkbox"/> Equipment related <input type="checkbox"/> Hospital/ patient property <input type="checkbox"/> Treatment <input type="checkbox"/> Procedural <input type="checkbox"/> Missing Patient <input type="checkbox"/> Incident identified by student <input type="checkbox"/> Other (please provide details)
If patient fall please complete this section:	Was orientation a factor in the fall? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Alert/ Normal <input type="checkbox"/> Sedated <input type="checkbox"/> Disoriented / Confused  Was Ambulatory status a factor in the fall? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unlimited <input type="checkbox"/> Needs assistance <input type="checkbox"/> Bathroom Privileges <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Non-Ambulatory <input type="checkbox"/> Restraints <input type="checkbox"/> Other:  Was patient environment a factor in the fall? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes (i.e., bed height, side rails, call bells) describe in reflection section
Please provide a description of the adverse event that occurred:	

<b>STUDENT INCIDENT</b>	
<p>Type of Injury, accident or exposure: (Check all that apply)</p>	<p><input type="checkbox"/> Needle Puncture    <input type="checkbox"/> Laceration opening Medication</p> <p><input type="checkbox"/> Infectious Disease Exposure    <input type="checkbox"/> Musculoskeletal Injury</p> <p><input type="checkbox"/> Fall    <input type="checkbox"/> Fainting    <input type="checkbox"/> Assault by Patient</p> <p><input type="checkbox"/> Other (please provide details)</p>
<p>Please provide a description of the adverse event that occurred:</p>	

<b>OTHER</b>	
<p>If the adverse event does not fall into any of the other categories please provide a description of the event here.</p>	

**Student(s) Reflection and Learning**

Provide a detailed description of the adverse event. What were the contributing factors to the event? Reflect on individual, procedural, environmental, and system level factors:

What were the potential outcomes to your patient that did or could have resulted from the incident?

What have you learned about yourself, your nursing practice, and the environment in which you are practicing?

How could an event like this be prevented in the future?

**OFFICE USE  
ONLY if  
student  
injury**

- Claim form completed (Student & Placement Employer)
- Authorization to Represent Employer completed
- Completed forms & copy of Incident report forwarded to the HR Generalist, Health, Safety & Wellness