


# Title page



**NC Department of  
Health and Human Services  
NC Nurse Aide I Curriculum**

**Module N  
Incident Report**

July 2024

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**Objectives**

1. Define and describe the significance of an incident report
2. Discuss the importance of accurate, detailed reporting and documentation
3. Determine which incidents require a report and who is involved in reporting
4. Provide guidelines for reporting and recording

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**Incident Reporting**

- Method of documenting facts surrounding an unexpected event in the healthcare setting
- Based on factual, objective account of what occurred



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# Module N Handout 2

### Incident Report

- Confidential and intended for use among the facility staff, management and legal team
- Not part of the resident's record



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### When is an Incident Report Required?

- A resident falls, verbalizes or shows fear or signs of harm, develops unusual signs of pain, has a visible misalignment of an extremity or develops a noticeable change in gait
- A resident is reported missing from the healthcare facility



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### When is an Incident Report Required?

- A mistake is made while providing resident care
- An item or personal belonging is damaged, broken, or missing



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# Module N Handout 3

**When is an Incident Report Required?**

- The nurse aide performs a task outside the nurse aide's range of function
- The nurse aide is threatened and feels unsafe



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**When is an Incident Report Required?**

- Inappropriate actions, sexual advances or remarks
- An angry outburst occurs by family members or staff



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**Incident Report - Importance**

- Required by the facility based upon State and Federal guidelines
- Completed by individuals involved at the scene, those on duty at the time, and those who observed the incident
- Detailed accurate account of who was involved, what, when and where the incident occurred, what immediate actions and additional steps were taken to prevent recurrence

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# Module N Handout 4

### Incident Report – Guidelines

- Describe in detail what was seen or heard; do not make assumptions
- Document the time the incident occurred
- Details should be recorded in sequence
- Describe the person's reaction to the incident
- If subjective information is documented, it should include *exactly* what the resident or involved party said



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### Incident Report – Guidelines

- State the facts; do not include opinions or place blame
- Describe the action taken to give care and whether the injury was a direct result of the incident
- Describe the outcomes noted from actions taken



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### Incident Report – Points to Remember

- Complete the report as soon as possible to ensure details are not forgotten
- Reporting and recording events of the incident is a protective rather than punitive measure
- Never try to hide an injury or mistake
- Documentation is reviewed by management and members of the healthcare team to look for trends
- New policies and procedures may be established to prevent future incidents



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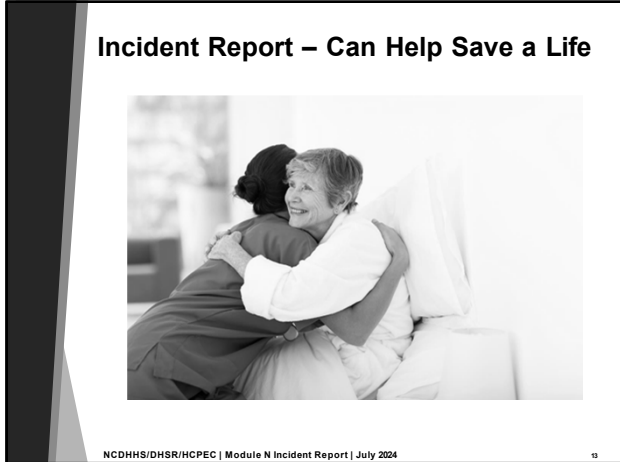
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# Module N Handout 5



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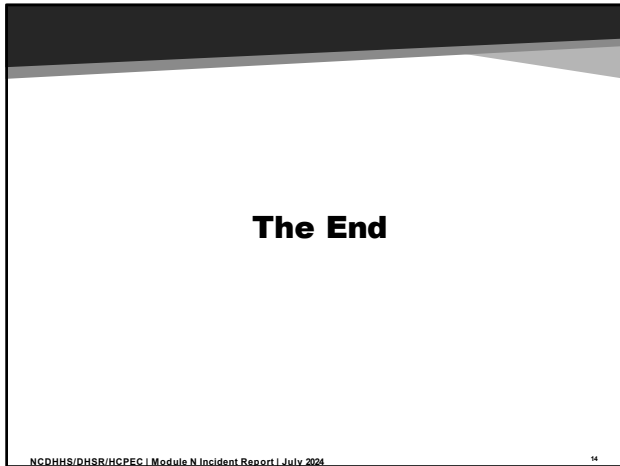
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