

Patient to Patient Assault Incident Review Report

1. General Information								
EVENT NUMBER	INCIDENT DATE	INCIDENT TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	EXACT INCIDENT LOCATION (BUILDING, UNIT, WARD)					
PATIENTS MEDICAL RECORD NUMBERS (MRN)								
PATIENT 1		PATIENT 2		PATIENT 3		PATIENT 4		
	DATE ADMITTED TO FACILITY	DATE ASSIGNED TO WARD	ASSIGNED MEDS	DATE / TIME OF LAST MEDS	HISTORY OF AGGRESSION	NUMBER OF AGGRESSIVE ACTS IN LAST 30 DAYS		
Patient 1			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO			
Patient 2			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO			
Patient 3			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO			
Patient 4			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO			
DESCRIBE INCIDENT LOCATION'S MILIEU PRIOR TO INCIDENT								
DESCRIBE INCIDENT LOCATION'S STAFF DEMOGRAPHICS PRIOR TO INCIDENT								
Total number of staff at location prior to incident:								
For the following provide the number of staff that were:								
Full time: <input type="checkbox"/> Yes <input type="checkbox"/> No		Transitory (e.g., PERT Team / Security / Janitorial Performing overtime: <input type="checkbox"/> Yes <input type="checkbox"/> No						
On-call / part time: <input type="checkbox"/> Yes <input type="checkbox"/> No		With less than one year's experience at hospital Performing overtime: <input type="checkbox"/> Yes <input type="checkbox"/> No						
Performing overtime: <input type="checkbox"/> Yes <input type="checkbox"/> No								
Redeployment: <input type="checkbox"/> Yes <input type="checkbox"/> No								
2. Incident Information								
DATE OF INCIDENT	TIME OF INCIDENT <input type="checkbox"/> AM <input type="checkbox"/> PM	EXACT LOCATION OF INCIDENT (BUILDING, UNIT, WARD)						
BODY PARTS AFFECTED BY INCIDENT								
Patient 1:	<input type="checkbox"/> Head	<input type="checkbox"/> Face	<input type="checkbox"/> Eyes	<input type="checkbox"/> Ears	<input type="checkbox"/> Neck	<input type="checkbox"/> Torso	<input type="checkbox"/> Limbs	<input type="checkbox"/> Scratch / Bite
Patient 2:	<input type="checkbox"/> Head	<input type="checkbox"/> Face	<input type="checkbox"/> Eyes	<input type="checkbox"/> Ears	<input type="checkbox"/> Neck	<input type="checkbox"/> Torso	<input type="checkbox"/> Limbs	<input type="checkbox"/> Scratch / Bite
Patient 3:	<input type="checkbox"/> Head	<input type="checkbox"/> Face	<input type="checkbox"/> Eyes	<input type="checkbox"/> Ears	<input type="checkbox"/> Neck	<input type="checkbox"/> Torso	<input type="checkbox"/> Limbs	<input type="checkbox"/> Scratch / Bite
Patient 4:	<input type="checkbox"/> Head	<input type="checkbox"/> Face	<input type="checkbox"/> Eyes	<input type="checkbox"/> Ears	<input type="checkbox"/> Neck	<input type="checkbox"/> Torso	<input type="checkbox"/> Limbs	<input type="checkbox"/> Scratch / Bite
DESCRIBE THE MOST SERIOUS INJURY(S)								
Was there a physical exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No								
If yes, to what: <input type="checkbox"/> Blood <input type="checkbox"/> Other body fluids <input type="checkbox"/> Liquid chemicals <input type="checkbox"/> Fumes								
Describe method of exposure:								
Did patient require transport to an emergency medical facility following the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Did patient require any onsite medical treatment following the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No								
What onsite medical treatment was provided:								

3. Investigation Report

DATE(S) OF INVESTIGATION

INCIDENT SUMMARY

INCIDENT DESCRIPTION (ADD PAGES AS NECESSARY)

ESTABLISHED POLICIES / PROCEDURES RELEVANT TO THE INCIDENT

REVIEWER'S ROOT CAUSE DETERMINATION

REVIEWER'S RECOMMENDATIONS

REPORT SUBMITTED BY:

REPORT REVIEWED AND APPROVED BY:

DSHS SAFETY MANAGER:

DATE