**Nursing Incident Report
Template**

**–––––––––––––––––––– Confidential*– For Internal Health Services Use Only* ––––––––––––––––––––**

This form is intended for documenting any unusual or adverse events involving patients, staff, or visitors within a healthcare or nursing environment. This includes falls, injuries, medical errors, equipment issues, behavioral incidents, or any other unexpected outcomes. Please complete this form as soon as is safely possible, ideally within 24 hours of the event. Submit to the designated supervisor or safety officer upon completion.

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| --- |
| **Individual Involved in the Incident** |
| **Full name:** |  | **Date of birth:** |
|  |  |  |
| **Role / Relationship to facility:** |
| [ ]  Patient | [ ]  Staff | [ ]  Visitor | [ ]  Other |  |  |
|  |  |  |  |  |  |
| **Unit / Department / Room:** |  | **Primary nurse or attending staff:** |
|  |  |  |

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| **Event Summary & Circumstances** |
| **Date of incident:** |  | **Time of incident:** |  | **Location (unit/room/area):** |
|  |  |  | (AM / PM) |  |  |
| **Type of incident (check all that apply):** |
| [ ]  Fall |  | [ ]  Medication error |  | [ ]  Treatment error |
| [ ]  Equipment malfunction |  | [ ]  Behavioral event |  | [ ]  Needle stick / Exposure |
| [ ]  Breathing/Cardiac distress |  | [ ]  Other |  |  |
|  |  |  |  |  |  |
| **Brief description of incident:** |
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| **Description of Events** |
| **Were any injuries sustained?** |  |  |
| [ ]  Yes | [ ]  No |  |  |
| **If yes, describe the nature and severity of the injuries:** |
|  |
| **Was first aid provided on-site?** |  | **If yes, by whom?** |
| [ ]  Yes | [ ]  No |  |  |
| **Was the individual transferred to emergency care?** |  | **Facility or provider:** |
| [ ]  Yes | [ ]  No |  |  |
| **Method of transport:** |
| [ ]  Ambulance | [ ]  Wheelchair | [ ]  Other |  |  |
|  |  |  |  |  |  |

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| **Observed or Informed Witnesses** |
| **Did anyone witness the incident?** |  |  |
| [ ]  Yes | [ ]  No |  |  |
| **If yes, list witness names and roles:** |
| Name |  |  |  | Contact info or unit |  |  |
|  |  |  |  |  |  |  |
|  |
| [ ]  Staff | [ ]  Patient | [ ]  Visitor |  |  |
|  |
| Name |  |  |  | Contact info or unit |  |  |
|  |  |  |  |  |  |  |
|  |
| [ ]  Staff | [ ]  Patient | [ ]  Visitor |  |  |
|  |
| **Were statements collected?** |
| [ ]  Yes | [ ]  No | [ ]  Verbal | [ ]  Written |  |

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| **Emergency & External Involvement** |
| **Police — Agency** |  | **Fire / EMT — Unit** |  | **Hospital transfer — Facility** |
|  |  |  |  |  |
| **Incident reported to family or guardian?** |  | **Name of contact:** |
| [ ]  Yes | [ ]  No |  |  |
| **Date/time of notification:** |  | **Notifier:** |
|  |  |  |

**Report filed by:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Full name** |  | **Position / Role** |  | **Shift / Unit** |
|  |
| **Contact information** |
|  |  |  |  |  |
|  | **Signature** |  | **Date of submission** |  |

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| **–––––––––––––––––––– Internal Review & Administrative Use Only ––––––––––––––––––––** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Reviewed by (Name / Title):** |  | **Date of review:** |  | **Classification of incident:** |
|  |  |  |  |  |
| **Corrective / Preventive actions recommended:** |
|  |
| **Follow-up required?** |  | **Date report closed:** |
| [ ]  Yes | [ ]  No |  |  |
| **Additional notes:** |
|  |

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
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