

 **RADIOLOGIC & IMAGING SCIENCES PROGRAMS**

INCIDENT REPORT FORM

This form is in accordance with the RISP Clinical Incident Reporting Policy found in the Program’s Clinical Handbook.

**Any major or minor incident must be reported by submitting this form to the Clinical Preceptor within 24 hours of the incident’s occurrence.**

Name(s) of involved student(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of the incident \_\_\_\_\_\_\_\_\_\_ Clinical site where the incident occurred\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select the box that corresponds with the clinical course in which you were enrolled in at the time of the incident

* R151
* R171
* R271
* R272
* R274
* Other (Please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did the incident occur during direct or indirect technologist supervision?**

(*Please check the box next to the corresponding answer below)*

* Direct Supervision
* Indirect Supervision

**Where did the Incident occur?** *Be specific. Include both the name of the Clinical Site as well as the department or area.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe the event and details of the Incident*.*** *Be specific and document the time of the incident as well as the name(s) of any witnesses*. *Remember to follow all HIPAA guidelines to avoid using patient identifiers such as patient name, MRN#, ASN#, etc.in order to protect the patient’s privacy when describing the event.* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Could this incident have been avoided?** *(Circle or highlight your answer)* **YES NO**

**If yes, what could have been done to prevent the incident from occurring? If no, explain why this incident was unavoidable.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Once this document is completed and signed, please submit via email to both the Clinical Preceptor and the Clinical Coordinator as soon as possible. Once finalized, this document will become part of the student’s permanent record.*

Student Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Student ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Faculty Use Only:**

Major Incident

*\*****Major incidents*** *result in harm or potential harm to a person(s) involved. Examples of a major incident include but are not limited to mismarking an image, imaging the incorrect side, imaging the incorrect part, imaging the wrong patient, making a repeat exposure without a supervising technologist present, or injuring oneself or another person in an avoidable situation.*

*If a major incident is reported and is determined to be caused by negligence, unsafe practices in a clinical setting, inappropriate behavior, or a RISP policy violation, the student could face disciplinary action, which is at the discretion of the clinical coordinator and/or program director.*

*Associated penalty or disciplinary action given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 Minor Incident

***\*Minor incidents*** *do not result in harm or potential harm to a person(s) involved and/or were not caused by negligence, unsafe practices in a clinical setting, inappropriate behavior, or a RISP policy violation. These types of incidents are considered a near miss or an unavoidable accident. Examples of a minor incident include but are not limited to an attempt to image an incorrect body part or patient, an attempt to repeat an exposure without a supervising technologist present, or an unavoidable injury.*

 *If a minor incident is reported, the student will receive a written warning and no further action will be taken.*

Clinical Preceptor Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_

Clinical Coordinator Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_epor

RISP INCIDENT REPORTING POLICY

RISP students must follow all OSHA guidelines, safe patient care practices, and ethical behavior throughout their clinical rotations. In addition, ionizing radiation can cause biological changes in living cells. Anyone administering ionizing radiation, including radiography students, understands the important safety guidelines of ALARA and is responsible for minimizing the potential effects of radiation exposure. Failure to follow any of the safety guidelines mentioned above could harm patients, technologists, staff members, and/or members of the public.

As a learning institution, we understand that mistakes are a part of the learning process, and unavoidable accidents can occur. To ensure the safety of our students, staff, and patients, prompt, and honest reporting of any major or minor incidents during a student's clinical rotation must be reported to the Clinical Preceptor and/or Clinical Coordinator using the program's Incident Reporting Form. By reporting clinical incidents, the program can identify any deficiencies in the student's learning environment and help implement corrective actions as needed.

The student's responsibility is to report any incidents, accidents, injuries, or near-accidents that result in risk or potential risk to patients, visitors, employees, or students during clinical hours. If an incident occurs, students should immediately inform their Clinical Preceptor. Once reported, the student must complete and submit the program's Incident Reporting Form to the Clinical Preceptor and the A.S. Radiography Clinical Coordinator. This form must be submitted within 24 hours of the occurring incident.

Some incidents are considered more significant than others. Each reported incident will undergo review and will be determined as either major or minor. Disciplinary action will be based on the severity of the incident and is at the discretion of the Clinical Preceptor, Clinical Coordinator, and Program Director. Both major and minor incidents require the completion of an Incident Reporting Form. The completed form will be filed and saved as part of the student's permanent record. If the same student continues to accumulate incident reports throughout the program for avoidable behavior, it may be identified as a poor pattern of behavior and result in steeper disciplinary action.

A brief description of major and minor incidents is given below.

**Major incidents** result in harm or potential harm to a person(s) involved. Examples of a major incident include but are not limited to mismarking an image, imaging the wrong body part or wrong patient, making a repeat exposure without a supervising technologist present, or injuring oneself or another person in an avoidable situation.

When a major incident is caused by negligence, unsafe practices in a clinical setting, inappropriate behavior, or a RISP policy violation, the student may face disciplinary action, which is at the discretion of the clinical coordinator and/or program director.

**Minor incidents**do not result in harm or potential harm to a person(s) involved and/or were not caused by negligence, unsafe practices in a clinical setting, inappropriate behavior, or a RISP policy violation. These types of incidents are considered near misses or unavoidable accidents. Examples of minor incidents include but are not limited to any attempt to image an incorrect body part or patient, any attempt to repeat an exposure without a supervising technologist present, or any unavoidable injury. If a minor incident occurs, the student will receive a written warning and no further action will be taken.