Appendix C3:

Nursing Home/Hospital Administrators- Employee Incident Information

Form Approved
OMB No. 0920-0914
Exp. Date 01/31/2015

Hospital Code: _____ **Incident ID: _____**

Workplace Violence Prevention Study

EMPLOYEE INCIDENT INFORMATION

Data Source: _____ Electronic Source: □01 Yes □02 No

1. Date of Incident: ___ / ___ / ___ □99 Unknown / Not specified

2. Time of Incident: _____ am / pm □99 Unknown / Not specified

3. Department Where Incident Occurred: _____ □99 Unknown / Not specified

4. Location of Incident: (check all that apply)

□01 Admitting / Triage
□02 Corridor Hallway/Stairwell
□03 Day Room
□04 Bathroom
□05 Entrance / Exit / Restricted Entry
□06 Lobby / Waiting Room
□07 Nurses Station
□08 Patient Room
□09 Seclusion / Time Out Room
□10 Dining Area
□11 Outdoor Areas
□99 Unknown / Not Specified
□88 Other (Specify:_____)

5. Victim occupation: _____ □99 Unknown / Not specified
(See NHSN Occupation Codes)

6. Activity at Time of Incident: (check all that apply)

□01 Escorting
□02 Restraining
□03 Approaching / Redirecting
□04 Assisting co-worker
□05 Medical care / Nursing duties
□06 Responding to code / Intervening / Physically confronting / Taking down
□07 Combative / Defiant / Unruly (further unspecified)
□08 Elopement
□09 Unprovoked / Came up from behind
□10 Monitoring / Observing
□99 Unknown / Not Specified
□88 Other (Specify:_____)

7. Perpetrator Relationship to Victim:

□01 Criminal □03 Employee (Circle one: present / past) □05 Patient Visitor
□02 Patient □04 Domestic □99 Unknown / Not Specified

8. Number of Perpetrators: _____ □99 Unknown / Cannot be determined

9. Type of Violent Event: (check all that apply)

□01 Physical Assault
□02 Verbal Assault / Threat
□03 Sexual Assault / Harassment
□04 Unknown / Not Specified
□88 Other (Specify: _____)

10. Weapon(s) Used: (check all that apply)

□01 Fists / Hands / Nails □05 Floor / Door / Wall □09 Food / Utensils / Meal tray
□02 Feet □06 Body (nonspecific) □11 Words / Verbal Threat □03 Gun / Knife □07 Furniture □99 Unknown / Not Specified
□04 Teeth □08 Medical supply / Instrument
□88 Other (Specify: _____)

11. Type of Physical Injury: (check all that apply)

□01 Abrasion / Cut / Laceration / Scratch □05 Dislocation / Fracture
□02 Bite □06 Exposure to bodily fluids
□03 Bruise / Contusion / Blunt Trauma □07 No Physical Injury
□04 Sprain / Strain □99 Unknown / Not Specified
□88 Other: (Specify: _____)

12. Part of Body Injured: (check all that apply)

□01 Head/Face/Neck □04 Back □07 Multiple body parts (not further specified)
□02 Arm/Hand/Shoulder □05 Groin / Buttocks □08 No body part was physically hurt
□03 Chest/Abdomen □06 Leg / Hip / Feet □99 Unknown / Not Specified
□88 Other (Specify: _____)

13. Was the employee unable to work for at least one full day after the incident?

□01 Yes - Number of days: _____ □02 No □99 Unknown

14. Did the employee have restricted work duty?

□01 Yes - Number of days: _____ □02 No □99 Unknown

15. Was medical attention provided? □01 Yes □02 No □99 Unknown

16. Number of employees in the vicinity when the incident occurred? _____ (For each employee, describe their actions in response to the incident, if any.)

a. _____
b. _____
c. _____
d. _____
e. _____
f. _____

17. Recommendations, if applicable, of police advisors, employees, or consultants.

Recommendation	**Title of Person Making Recommendation**
a.	

b.	
c.	
d.	
e.	
f.	

18. Actions taken by the facility in response to the incident.

a. _____

b. _____

c. _____

d. _____

e. _____

f. _____

19. Was law enforcement called? ☐01 Yes ☐02 No ☐99 Unknown

ADDITIONAL COMMENTS:

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Workplace Violence Prevention Study

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(See NHSN Occupation Codes)

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d. _____
e. _____
f. _____

17. Recommendations, if applicable, of police advisors, employees, or consultants.

Recommendation	**Title of Person Making Recommendation**
a.	

b.	
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18. Actions taken by the facility in response to the incident.

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c. _____

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19. Was law enforcement called? ☐01 Yes ☐02 No ☐99 Unknown

ADDITIONAL COMMENTS: