Kansas
Department of Health and Environment

Confidential Cover Page

Risk Management SOC 3 AND 4
REPORTABLE INDIVIDUAL INCIDENT REPORT FORM (IIR)

(Please attach additional sheets as needed)

28-52-2. Incident reporting. (a) Each medical care facility shall identify a written form on which employees and health care providers shall report clinical care concerns to the risk manager, chief of staff, or administrator. The original or complete copy of the incident report shall be sent directly to the risk manager, chief of staff, or administrator, as authorized in the facility's risk management plan. (b) The risk manager, chief of staff, or administrator shall acknowledge the receipt of each incident report in writing. This acknowledgment may be made in the following manner: (1) file stamping each report; (2) maintaining a chronological risk management reporting log; (3) signing or initialing each report in a consistent fashion; Or (4) entering pertinent information into a computer database. (c) Incident reports, investigational tools, minutes of risk management committees, and other documentation of clinical analysis for each reported incident shall be maintained by the facility for not less than one year following completion of the investigation. (Authorized by and implementing K.S.A. 65-4922; effective Feb. 27, 1998.)

Name of Facility _____ ***CCN# 17-**_____
(or State ID#)

CCN is CMS Certification Number: If your facility is not CMS Certified, please list State ID#

☐ **Check this box if this event/occurrence is an amendment to a previous QR report submitted. What Quarter?** _____

Facility Type: Hospital ☐ Psychiatric Hospital ☐ Ambulatory Surgical Center ☐ Other ☐]_____

Address _____ City _____

Name and Title of Risk Manager_____

Email address _____

Phone Number _____ Date: _____

With this submission, as the above listed Risk Manager I hereby attest that the report submitted to Kansas Department of Health and Environment is true, complete and accurate to the best of my knowledge without known errors or omissions.

Signature _____
(Electronic Signatures Accepted)

Kansas
Department of Health and Environment

SOC 3 / 4 RISK MANAGEMENT

REPORTABLE INDIVIDUAL INCIDENT REPORT FORM **(IIR)**

Date of the Incident: _____ **Date Incident Reported to RM:** _____

1. Facts of the Incident (Detailed description to include who, what, where, when, why, and how): **(Please attach additional sheets as needed)**

2. Standard of Care (SOC) Determination and Assignment:

3. Indicate the category type of incident/occurrence such as:
   ☐ Fall ☐ Abuse, Neglect or Exploitation ☐ Assessment/treatment ☐ Professional licensure event ☐ Delay ☐ Facility process or system-related ☐ Scope of Practice ☐ Impairment due to drug, alcohol or cognition ☐ Falsification ☐ Documentation of Narcotics ☐ Medication Error ☐ Improper Procedure ☐ EMTALA-Related ☐ IV line mix-up ☐ Drug Diversion ☐ Unprofessional conduct ☐ IV infiltration
   ☐ Other:

4. Root Cause Analysis (RCA) for failure/ Specify recommendations for Minimizing Future Occurrences:

5. Specify corrective actions taken to remediate the incident or prevent occurrence/ re-occurrence: such as
   ☐ Policy / Procedure Change ☐ Suspension of Privileges ☐ Termination ☐ Counseling/Education
   ☐ Restriction of Privileges ☐ Revocation of Privileges ☐ Pending
   ☐ Other: (Be Specific)

6. All **IIR** reports are submitted to KDHE as the licensing agency. In addition, please indicate any referral reports sent to following additional licensing agencies and attach evidence of referral. *The number of events/occurrences and number of reporting boards need to match your submitted Quarterly Reports (QR).*
   _____Board of Healing Arts _____Board of Nursing _____Board of Pharmacy
   _____Other

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Fax: 785-559-4250
KDHE.riskmanagement@ks.gov

Return this report to:

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KDHE/BCHS/Health Facilities Program
1000 SW Jackson St., Suite 330
Topeka, KS. 66612-1365
785-296-1249
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