Nurse Response Form

Name: _____

License Number: _____

Date: _____

PLEASE PRINT ALL RESPONSES: Provide information where applicable. If necessary attach additional information on separate sheet(s).

Name	Maiden Name	Other Names
Street Address	City	State Zip
Home Phone	Cell Phone	Work Phone

LIST ALL NURSING EDUCATION PROGRAMS COMPLETED:

Name of Nursing School	Location (City/State)	Year of Graduation	Type of Degree

LIST ALL PREVIOUS AND CURRENT LICENSES REGISTRATIONS:

Type of Licensure or Registration	State	License/Registration Number	Year of License/Registration	Active, Inactive, or Lapsed

LICENSE/REGISTRATION INFORMATION

Total Years of Nursing Experiences (LPN, RN APPN):	Length of Time of Employment at Facility of Occurrence:
State of Initial License/Registration:	Length of Time Worked in Unit/Dept Where the Incident Occurred:
Year of Initial License/Registration as Nurse:	Length of Time in Specific Nursing Role at Time of Incident (i.e., 12 yrs of ER; 2 yrs in long term; 4 yrs in assisted living).

Type(s) of Continued Competence or Professional Development that You Have Completed in the Last 5 Years?

- ☐ Continued education
- ☐ Formal nursing education
- ☐ Work site monitor/mentor/sponsor
- ☐ Writing articles, publishing
- ☐ Workshop/conference presentation 2 hours and above
- ☐ Workshop conference or presentation
- ☐ Other _____

The Nurse Practice Act (www.ibn.idaho.com) governs your nursing practice – when was the last time you reviewed the information?

List ALL Previous Nursing/CNA/ Employment: Start with your current or most recent employment as number 1:

Facility Name	City/State	Dates of Employment	Telephone number	Reason for Leaving: Enrolled in school, currently employed, resigned, resigned in lieu of termination, terminated
1.				
2.				
3.				
4.				

COMPLETE BELOW INORMATION FOR THE CURRENT OR MOST RECENT EMPLOYER:

Director of Nursing or Supervisor		Phone number	
Address	City	State	Zip

What triggered this event being reported to the Board of Nursing? Describe in detail on the last page (s).

_____

Medical History. List all visits with healthcare providers within the past year. Use additional sheet if needed.

Date	Practitioner Name	Clinic	Reason for Visit

Medication information. List all Current Medication. Be Very Specific to Include All Prescription Medications, Samples, and Over the Counter (OTC) Products. Use Additional Sheets if Necessary).

Date	Medication	Dosage	Quantity	Refills	Physician/ Provider	Pharmacy	Reason for Medication

Legal or Court Action. List All Prior, Current, and Pending Criminal Activities or Convictions:

Date	Violation	Court Date	Outcome	Probation/Incarceration

History and Account of Incident:

Date of incident _____ ?	Time of incident _____ ?
Type of Shift ☐ 8 hour ☐ 10 hour ☐ 12 hour ☐ on call _____ hours ☐ other	Shift start time _____ ? Shift end time _____ ?
Number of days work in a row at time of incident _____ ?	Where you working in temporary capacity? ☐ Yes ☐ No
Type of Assignment: ☐ Direct patient care ☐ Team Leader ☐ Charge ☐ Nurse Mg/supervisor ☐ Combination leadership/patient care	Number of patients assigned directly to you at the time of incident _____ ? Number of staff member you were responsible for supervising at time of incident _____ ? Number of patients you were responsible for overall which would include direct care patients and those you supervised _____ ?

Individual Factors- Check All Factors for You that Contributed to this Incident:

☐ Language barrier	☐ Cognitive impairment	☐ High work volume/stress
☐ Fatigue/lack of sleep	☐ Drug/alcohol impairment/abuse	☐ Functional ability deficient
☐ Inexperience/training	☐ No rest breaks/meal breaks	☐ Lack of orientation/training
☐ Overwhelming assignment	☐ Mental health issues	☐ Lack of team support
☐ Conflict with team members	☐ Personal Pain management	☐ Other (describe in detail or use additional paper if needed).

Patient Demographics:

Was Patient's family/friend present at the time of incident? ☐ Yes ☐ No	Patient Gender ☐ Female ☐ Male	Patient Age _____

Pertinent patient characteristics at the time of incident (mark all that apply):

☐ Agitation/combativeness	☐ Altered level of consciousness	☐ Pain/discomfort
☐ Incontinence	☐ Sensory deficits (hearing/vision/touch)	☐ Insomnia
☐ Communication/language	☐ Communication/language difficulty	☐ Depressed/anxious

☐ Inadequate coping/stress management ☐ None ☐ unknown ☐ Other_____

Healthcare Team Involvement: Please provide names and contact information for other health care team members involved or witnessing the incident.

Select other health care team areas that were involved in the incident:

☐ Supervisory nurse/personnel	☐ Floating/temporary staff	☐ Patient
☐ Physician	☐ Nurse aide of UAP	☐ Patient family/friend
☐ Other prescribing provider	☐ Medication aid	☐ Other health care professionals (PT, RT, OT)
☐ Staff nurse	☐ Pharmacist	☐ Other

Name of Witness		Phone Number (home and cell)	
Address of Witness	City	State	Zip code

If there are more witness names, list on the back of this page or attach a separate sheet.

Name of Witness		Phone Number (home and cell)	
Address of Witness	City	State	Zip code

Identify factors related to the health care team that may have contributed to the incident:

☐ Breakdown of health care team communication	☐ Lack of multidisciplinary care planning
☐ Lack of patient education	☐ Lack of patient involvement in their plan of care
☐ Lack of family/caregiver education	☐ Majority of staff had not worked together previously
☐ Illegible handwriting	☐ Intradepartmental conflict/non-supportive environment
☐ Intimidating/threatening behavior	☐ Other

System and Environment

Community population: ☐ Less than 10,000 ☐ 10,000 to 50,000 ☐ Greater than 50,000

Type of Facility: Number of beds in facility_____

☐ Ambulatory Care	☐ Behavioral Health/Mental Health	☐ Hospital
☐ Critical Access Hospital	☐ Home Care	☐ Clinic
☐ Long Term Care	☐ Assisted living	☐ Other

Type of medical record system:

☐ Electronic documentation	☐ Electronic physician orders
☐ Electronic medication administration	☐ Paper documentation
☐ Combined paper/electronic records	☐ Other

Identify any staffing issues that may have contributed to the incident:

☐ Lack of supervisory/management support	☐ Lack of other health care team support
☐ Lack of experienced nurses	☐ Lack of nursing support staff
☐ Lack of clerical support	☐ Other

Identify system elements that may have contributed to the incident – Check all that apply:

COMMUNICATION FACTORS:

☐ No adequate channels for resolving disagreements	☐ Communication systems equipment failure
☐ Medical records not accessible	☐ Computer system failure
☐ Shift change (patient hand-off)	☐ Patient identification failure
☐ Patient transfer (hand-off)	☐ Intradepartmental communication breakdown/conflict
☐ Patient name similar/same	☐ Lack of patient education
☐ Lack of ongoing education/training	☐ Unknown
☐ None	☐ Other

LEADERSHIP/MANAGEMENT FACTORS:

☐ Poor supervision/support by others	☐ Unclear scope and limits of authority/responsibility
☐ Inadequate/outdated policies/procedures	☐ Assignments or placement of inexperienced staff

☐ Nurse shortage, sustained at institution level ☐ Inadequate patient acuity system to support staff assignment
☐ None ☐ Unknown ☐ Other_____

CHECK ALL THAT APPLY IN EACH CATEGORY

ENVIRONMENTAL FACTORS:

☐ Poor lighting
☐ Frequent interruptions/distractions
☐ Lack of adequate supplies/equipment
☐ Patient transfer (hand-off)
☐ Code situation
☐ Lack of ongoing education/training
☐ None
☐ Increased noise volume
☐ Physical hazards
☐ Multiple emergency situations
☐ Intradepartmental communication breakdown/conflict
☐ Equipment Failure
☐ Unknown
☐ Other_____

BACKUP AND SUPPORT FACTORS:

☐ Ineffective system for provider coverage
☐ Inadequate/outdated policies/procedures
☐ Lack of nursing expertise system for support
☐ None
☐ Other
☐ Lack of adequate provider response
☐ Assignments or placement of inexperienced staff
☐ Lack of adequate response by other depts.
☐ Unknown

NARRATIVE OVERVIEW (PRINT RESPONSE): In your own words, provide details of incident from your viewpoint on the matter. Include your response to the action, your observations regarding contributing factors, and your recommendation for preventing reoccurrence of this incident. Attach additional information as needed.

The information I have provided to the Idaho Board of Nursing is true, complete and correct.

Your signature	**Date:**