Incident & Adverse Event Report Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

An incident and adverse event report is the internal risk-management record of an unexpected event affecting a client, visitor, or staff member: the facts observed, the response, the outcome, and the notifications made. It is kept apart from the clinical record; the chart gets the clinical impact only.

Event basics the clock starts here
Do: record the date, exact clock time, precise location, and event type; near misses count.
Pitfall: "during the afternoon shift" instead of a time; regulator deadlines run from when you knew.

Persons involved and witnesses who was there
Do: name who was affected (client, visitor, staff) and every witness, with role and contact.
Pitfall: the unlisted witness; unreachable by the time anyone investigates.

Factual narrative the discipline of the form
Do: write first person, in sequence, only what you saw and heard; keep the words people used.
Pitfall: conclusions, blame, or cause-guessing; they turn a QA record into an admission.

Immediate actions and care the response on paper
Do: record the assessment offered, first aid, the EMS decision, and what the person chose.
Pitfall: an event with no documented response reads as neglect even when care was given.

Injury and outcome leave the file ajar
Do: state apparent injury or "none observed," plus a follow-up window and an owner.
Pitfall: "no injury" closing the file at the scene; some injuries surface days later.

Notifications made duties, dated and timed
Do: log each person and agency notified with date, time, and by whom; know your deadline.
Pitfall: the missed clock; CMS next business day, NDIS and aged care 24 hours, Saskatchewan 3 days.

Reporter identity and review the observer signs
Do: have the person who observed the event write and sign; a supervisor reviews and dates.
Pitfall: secondhand authorship; a report by someone who was not there loses its value.

Routing and the chart the split that protects it
Do: file with risk management or QA, apart from the chart; chart the clinical impact only.
Pitfall: "incident report filed" in a progress note invites discovery of the whole file.

Before you file

- [ ] Written by the person who saw it
- [ ] Exact times: event, response, notifications
- [ ] Facts in sequence; no blame, no cause-guessing
- [ ] Care offered, given, or declined recorded
- [ ] Outcome carries a follow-up window and owner
- [ ] Every required notification, dated and timed
- [ ] Chart holds the impact, not this report

Drafting with AI

Capture the facts while they are fresh: what you saw, clock times, who was there, what you did, who you told.

"Draft an objective incident report from these facts, first person, no conclusions: client fall, 2:47 PM, waiting room, ice pack accepted, EMS declined, owner notified 3:35 PM."

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

300 to 600 words	15 to 30 min by hand	Same day	Risk mgmt · QA · carriers
typical length	clinical team estimate	faster clocks may apply	who reads it

Full guide and sample report:
bastiongpt.com/template/incident-report

Incident & Adverse Event Report Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Practice/program: | Report #: | Date of event: | Time:

Exact location: | Person affected (initials): | Role (client / visitor / staff):

Event type
Fall · medication error · elopement · aggression or assault · restraint or seclusion · self-harm or suicide attempt · death · privacy event · near miss · other

Witnesses
Name, role, and contact for each person who saw any part of the event

Factual narrative
First person, in sequence, only what was seen and heard; no conclusions, blame, or speculation

Immediate actions and care provided
Assessment offered; first aid; EMS called or declined; who examined; what the person chose

Injury and outcome
Apparent injury or none observed; follow-up window and who reassesses

Notifications made
Person or agency, date, time, by whom; note any mandatory deadline for your setting

Routing
File with risk management or practice QA files, apart from the clinical record. Chart the clinical impact (condition, assessment, care) in the clinical record; do not reference this report there.

Reporter name and role (observer): | Signature: | Date/time completed:

Supervisor review (name, signature): | Date: