

Privileged and confidential report for use by legal counsel and in
accordance with risk management/quality assurance and peer review activities
NURSING HOME/EXTENDED HEALTH CARE FACILITIES

RISK MANAGEMENT/QUALITY ASSURANCE CONFIDENTIAL REPORT OF EVENT. THIS REPORT SHOULD NOT BE INCLUDED IN THE MEDICAL RECORD.

PRIVILEGED AND CONFIDENTIAL REPORT FOR USE BY LEGAL COUNSEL AND IN ACCORDANCE WITH RM/QA PEER REVIEW ACTIVITIES NURSING HOME/EXTENDED HEALTH CARE FACILITIES			PATIENT'S NAME ADDRESS MEDICAL RECORD NO.		
NAME OF HEALTH CARE FACILITY ADDRESS CITY STATE ZIP			ROOM NO. USE ADDRESSOGRAPH WHEN AVAILABLE		
DESCRIPTION OF EVENT (INCLUDE PERTINENT PATIENT/VISITOR/ EMPLOYEE COMMENTS IF ANY)			I.D. STATUS <input type="checkbox"/> In-patient 3001 <input type="checkbox"/> Visitor 3002 <input type="checkbox"/> Other (Specify) 3099		
			SEX <input type="checkbox"/> Male 3101 <input type="checkbox"/> Female 3102 DATE OF BIRTH (digits only) MONTH DAY YEAR		
EVENT DATE (digits only) MONTH DAY YEAR TIME : <input type="checkbox"/> AM <input type="checkbox"/> PM			PRIMARY DIAGNOSIS		
LOCATION OF EVENT TYPE OF FACILITY <input type="checkbox"/> SNF 3301 <input type="checkbox"/> ICF 3302 <input type="checkbox"/> RESIDENTIAL 3303 <input type="checkbox"/> REHABILITATION 3304 <input type="checkbox"/> OTHER (Specify) 3399			PRE-EVENT STATUS <input type="checkbox"/> 3201 ORIENTED <input type="checkbox"/> 3202 DISORIENTED		
SPECIFIC AREA <input type="checkbox"/> Resident 3401 Room <input type="checkbox"/> Bathroom/ Shower 3402 <input type="checkbox"/> Stairs 3403 <input type="checkbox"/> Corrido 3405 <input type="checkbox"/> Doctor's Office 3406 <input type="checkbox"/> Elevator 3407 <input type="checkbox"/> Nurses' Station 3408 <input type="checkbox"/> Sidewalk/ Parking Lot 3409 <input type="checkbox"/> Dining Room 3410 <input type="checkbox"/> Recreational Room 3411 <input type="checkbox"/> Therapy Room 3499 <input type="checkbox"/> Other (Specify)					
TYPE OF EVENT (CHECK ONE)		DIAGNOSIS RELATED		EQUIPMENT/INSTRUMENT	
MEDICATION ADMINISTRATION 3501 <input type="checkbox"/> Documentation/Transcription 3502 <input type="checkbox"/> Dosage 3503 <input type="checkbox"/> IV Flow Rate 3504 <input type="checkbox"/> Labeling 3505 <input type="checkbox"/> Omission 3506 <input type="checkbox"/> Patient Identification 3507 <input type="checkbox"/> Reaction 3508 <input type="checkbox"/> Route/Site 3509 <input type="checkbox"/> Wrong Medication 3510 <input type="checkbox"/> Wrong IV Solution 3599 <input type="checkbox"/> Other		3701 <input type="checkbox"/> Delay in Diagnosis 3702 <input type="checkbox"/> Improper Test Performed 3703 <input type="checkbox"/> Inaccurate Test Results 3704 <input type="checkbox"/> Physician Not Available/Delayed 3705 <input type="checkbox"/> Specimen Lost 3706 <input type="checkbox"/> Test Ordered and Not Performed 3799 <input type="checkbox"/> Other		3901 <input type="checkbox"/> Availability 3902 <input type="checkbox"/> Defective 3903 <input type="checkbox"/> Improper Usage 3999 <input type="checkbox"/> Other	
PATIENT BEHAVIOR 3601 <input type="checkbox"/> Attempted Suicide/Suicide 3602 <input type="checkbox"/> Elopement 3603 <input type="checkbox"/> Self-Inflicted Injury 3604 <input type="checkbox"/> Wandering 3699 <input type="checkbox"/> Other		PATIENT'S RIGHTS 3801 <input type="checkbox"/> Alleged Molestation/Rape 3802 <input type="checkbox"/> Assault by Staff Member 3803 <input type="checkbox"/> Assault by Resident 3804 <input type="checkbox"/> Assault by Other 3805 <input type="checkbox"/> Dentures Damaged/Lost 3806 <input type="checkbox"/> Property Damaged/Lost 3807 <input type="checkbox"/> Improper Use of Restraints 3808 <input type="checkbox"/> Improper Consent 3809 <input type="checkbox"/> No Consent 3810 <input type="checkbox"/> Verbal/Written Complaint 3899 <input type="checkbox"/> Other		Removed From Service: 4001 <input type="checkbox"/> Yes 4002 <input type="checkbox"/> No Date _____ (digits only) Warning: If the event involves an equipment malfunction, DO NOT RELEASE THIS EQUIPMENT from your supervision without approval from the Risk Manager/Administrator.	
PHYSICIAN NOTIFIED DATE TIME (AM OR PM)		FAMILY/CONSERVATOR NOTIFIED DATE TIME (AM OR PM)		FALL/FOUND ON FLOOR 4301 <input type="checkbox"/> Alleged Fall 4302 <input type="checkbox"/> Found on Floor/Sidewalk 4399 <input type="checkbox"/> Other	
WITNESS NAME ADDRESS		DIETARY 4101 <input type="checkbox"/> Beverage Spill 4102 <input type="checkbox"/> Incorrect Diet 4103 <input type="checkbox"/> No Diet Ordered 4199 <input type="checkbox"/> Other		OTHER EVENTS 4201 <input type="checkbox"/> Fire 4202 <input type="checkbox"/> Patient Instructions 4203 <input type="checkbox"/> Transfer 4299 <input type="checkbox"/> Other	
ASSESSMENT (CHECK ONE)		FOLLOW-UP			
4501 <input type="checkbox"/> No Apparent Injury		4509 <input type="checkbox"/> Change in Mental Status 4510 <input type="checkbox"/> Concussion 4511 <input type="checkbox"/> Death 4512 <input type="checkbox"/> Decubitus Ulcer 4513 <input type="checkbox"/> Dental Impairment 4514 <input type="checkbox"/> Foreign Body 4515 <input type="checkbox"/> Fracture/Dislocation 4516 <input type="checkbox"/> Hearing/Visual Impairment 4517 <input type="checkbox"/> Hematoma		4518 <input type="checkbox"/> Hemorrhage 4519 <input type="checkbox"/> Infection 4520 <input type="checkbox"/> Infiltration/Extravasation 4521 <input type="checkbox"/> Loss of Consciousness 4522 <input type="checkbox"/> Pneumothorax 4523 <input type="checkbox"/> Puncture/Laceration 4524 <input type="checkbox"/> Rash/Hives 4525 <input type="checkbox"/> Respiratory Distress 4526 <input type="checkbox"/> Skin Tear	
4502 <input type="checkbox"/> Abrasion/Contusion 4503 <input type="checkbox"/> Anaphylaxis 4504 <input type="checkbox"/> Bite 4505 <input type="checkbox"/> Brain Damage 4506 <input type="checkbox"/> Burn/Scald 4507 <input type="checkbox"/> Cardiac Arrhythmia 4508 <input type="checkbox"/> Cardiopulmonary Arrest 4599 <input type="checkbox"/> Other (Specify)		VITAL SIGNS TIME BLOOD PRESSURE PULSE RESPIRATIONS		MENTAL STATUS RANGE OF MOTION	
TREATMENT 4601 <input type="checkbox"/> Yes 4602 <input type="checkbox"/> No 4603 <input type="checkbox"/> Refused		IF YES, DESCRIBE TREATMENT			
X-RAY 4701 <input type="checkbox"/> Yes 4702 <input type="checkbox"/> No Refused		IF YES, SPECIFY X-RAY TYPE AND PERTINENT FINDINGS			
TRANSFER 4801 <input type="checkbox"/> Yes 4802 <input type="checkbox"/> No Refused		IF YES, INDICATE DESTINATION AND METHOD OF TRANSFER			
PERSON COMPLETING REPORT (PRINT NAME AND TITLE)		REVIEW DATE (digits only)		PHYSICIAN'S NAME TIME DATE (digits only)	
MEDICAL DIRECTOR'S SIGNATURE		ADMINISTRATOR'S SIGNATURE		REPORT DATE (digits only)	
REVIEW DATE (digits only)		REVIEW DATE (digits only)		REVIEW DATE (digits only)	

PLEASE COMPLETE THIS REPORT AND FORWARD TO RISK MANAGER WITHIN 24 HOURS

Complete a Report of Event Form within 24 hours whenever there is an unusual or unexpected occurrence that is not consistent with the routine operation of the health care facility or the routine care of the resident. Examples of when a form should be completed are listed below.

- Burn/Scald from Food or Hot Beverage
- Delay or Complication in Diagnosis or Treatment
- Elopement from the Health Care Facility
- Equipment or Instrument Malfunction
- Fall or Person Found on the Floor
- Lack of Consent or Inadequate Informed Consent
- Lost Belonging(s)
- Occurrence Involving Medication
- Self-Inflicted Injury
- Suicide/Attempted Suicide
- Problem with Transfer
- Violation of Patient's Rights

This list is not meant to be all-inclusive. Consult a supervisor/administrator if you have any questions about when to complete this form.

Any staff member who discovers or is involved in an event should complete the form and forward it to the administrative department responsible for risk management within 24 hours.

When completing the form

- 1) Use an addressograph when available
- 2) Print clearly using a black ball-point pen
- 3) Be brief and objective
- 4) Be sure to clearly indicate the following:

a) Facility Name	d) Date of Event
b) Patient Name	e) Type of Event
c) Time of Event	f) Assessment
- 5) Provide specific information when the other category is checked.

Notify a supervisor/administrator/physician immediately of any injury and/or life-threatening event.

DETAILED PROCEDURE FOR COMPLETING THE RM/QA REPORT OF EVENT FORM

Name of Health Care Facility – Print the name and address of the health care facility.

Patient's Name – Use an addressograph or print the name and address of the person involved in the event.

Identification Status – Check the box indicating the status of the person involved in the event.

Sex – Check the box indicating the sex of the person involved in the event.

Date of Birth – Provide data as indicated using digits only.

Event Date – Provide the date the event occurred. **This field cannot be left blank.**

Time – Indicate the time when the event occurred.

Primary Diagnosis – Indicate the principle diagnosis.

Pre-Event Status – Indicate the person's mental status before the occurrence.

Description of Event – Write a brief and objective description of the event. Include pertinent comments made by the person involved. **Do not write "see attached."**

Location of Event – Check one box that describes the type of facility, such as SNF (skilled nursing facility), ICF (intermediate care facility), residential or rehabilitation facility. If other, specify the type of facility.

Specific Area – Check one box that describes the location where the event occurred.

Type of Event – Check **one** box that best describes the event. **For conditions of fall, check all that apply.**

Physician Notified – Indicate physician's name, date and time of notification.

Family/Conservator Notified – Indicate the name of the family member or conservator who was notified, if applicable.

Witness – Complete name and address of the witness.

Assessment – Check one box that describes the injury sustained. **These findings should be reflected in the person's medical record.**

Follow-up

- **Vital Signs** – Document the time and the person's blood pressure, pulse and respirations after the event.
- **Mental Status** – If applicable, note any change in the person's level of consciousness after the event.
- **Range of Motion** – Note any change in the person's ability to move his or her limbs after the event.
- **Treatment** – Check the appropriate box. If yes, describe the treatment.
- **X-ray** – Check the appropriate box. If yes, specify the x-ray study performed and include the pertinent findings.
- **Transfer** – Check the appropriate box. If yes, specify the receiving location of the patient and method of transportation, e.g., wheelchair, stretcher, ambulance, helicopter.
- **Physician's Name** – Indicate the name of the physician who examined the person after the event, the time and date.

Person Completing Report – Print name and title, sign the report and include the date the report was prepared in the space provided.

Report Review – The Medical Director and Administrator must sign the report and indicate the date it was reviewed.

The completed report must be forwarded to the administrative department **within 24 hours** of the event.