UNUSUAL OCCURRENCE REPORT

CONFIDENTIAL INTERNAL DOCUMENT - NOT PART OF MEDICAL RECORD

REPORTED REVIEWED BY:

PATIENT IDENTIFICATION

DATE OF OCCURRENCE:
TIME OF OCCURRENCE: (Military Time)
OCCURRENCE: [ ] PATIENT [ ] VISITOR
EXACT SITE OF OCCURRENCE:

CONDITION OF PATIENT:
[ ] AGITATED [ ] ORIENTED
[ ] ALERT [ ] CONFUSED
[ ] UNRESPONSIVE [ ] SEDATED

(OCCURRENCE)

REASON FOR

HOSPITALIZATIONS:

OBSERVED AMBULATION PRIVILEGE

[ ] RESTRICTED [ ] UNRESTRICTED

ROOM

[ ] BED RAILS

[ ] 1 UP [ ] 4 UP
[ ] 2 UP [ ] N / A
[ ] 3 UP

HALLWAY

[ ] CONDITIONS ON FLOOR

(WET / OBSTRUCTED)

[ ] YES [ ] NO

BATHROOM

[ ] CONDITIONS ON FLOOR

WET / OBSTRUCTED

[ ] YES [ ] NO

WHILE WALKING

[ ] RESTRAINTS ORDERED

[ ] YES [ ] NO

FOUND ON FLOOR

OUT OF BED

[ ] FROM STRETCHER

[ ] TYPE

[ ] IN USE

[ ] YES [ ] NO

[ ] FROM GERI-CHAIR

[ ] FROM CHAIR

[ ] FROM WHEELCHAIR

[ ] URINE / BM ON FLOOR

[ ] WATER SPILL

[ ] TRIPPED ON CORD

[ ] OTHER

FALL PROTOCOL AT TIME OF FALL

[ ] YES [ ] NO

NATURE OF OCCURRENCE

(check all that apply)

Type I. SLIP / FALL

Type II. AMA

Type III. PROPERTY LOSS / DAMAGE

Type IV. EQUIPMENT FAILURE

SUMMARY OF FACTS

AREAS / PERSONS NOTIFIED

1. NURSE MANAGER

SUPERVISOR

[ ] YES [ ] NO [ ] N/A

NAME

DATE

TIME

WITNESSES / PERSONS FAMILIAR W/ INCIDENT

NAME (TITLE):

PHONE #:

Print Name

Signature

Title

DATE

REPORTED PREPARED BY:

REPORTED REVIEWED BY:

DEPARTMENT DIRECTOR / NURSE MANAGER:

REMEMBER: ANY INCIDENT WHICH REQUIRES PROMPT ACTION IS REPORTED IMMEDIATELY TO THE APPROPRIATE PERSON

RUSH: UNUSUAL OCCURRENCE REPORT TO QA / RISK MANAGER WITHIN 24 HOURS

WHITE COPY - Risk Manager

RUSH: YELLOW COPY - Nursing Department

Unusual Occurrence Report_MEDICAL AFFAIRS

PAGE 1 of 2
FOLLOW UP / INVESTIGATION
UNUSUAL OCCURRENCE

PATIENT IDENTIFICATION

PATIENT / VISITOR NAME: ____________________________

DATE IF INCIDENT: ____________________________

INCIDENT FOLLOW-UP INVESTIGATION. COMPLETE ALL SECTIONS BELOW AND FORWARD TO RISK MANAGEMENT ASAP

PATIENT INCIDENT REQUIRING PHYSICIAN EXAMINATION

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. WAS PATIENT SEEN BY PHYSICIAN?</td>
<td></td>
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<td>4. X-RAY ORDERED</td>
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<td>2. WAS TREATMENT OFFERED?</td>
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<td>5. RESTRAINTS ORDERED?</td>
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<tr>
<td>3. WAS PROPER NOTIFICATION OF INCIDENT DOCUMENTED IN MEDICAL RECORD</td>
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<td>6. OTHER:___________________________</td>
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</tbody>
</table>

SITE OF INJURY

- NO INJURY
- BUTTOCKS
- HAND
- ARM
- CHEST
- LEGS / FEET
- ABDOMEN
- FACE / HEAD
- NECK
- BACK
- GROIN
- SHOULDER

TYPE OF INJURY

- ABRASION
- HEMATOMA
- BURN
- LACERATION
- FRACTURE
- SPRAIN / STRAIN
- OTHER:___________________________

SEVERITY OF INJURY

- MINOR
- MODERATE
- SEVERE

CONTRIBUTING FACTORS:

ACTION TAKEN:

RECOMMENDATION FOR PREVENTION:

Report Prepared By: ____________________________
(NAME) ____________________________
(SIGNATURE) ____________________________
(TITLE) ____________________________
(DATE) ____________________________

Report Reviewed By: ____________________________
(NAME) ____________________________
(SIGNATURE) ____________________________
(TITLE) ____________________________
(DATE) ____________________________