Your Hospital's Logo Here

UNUSUAL OCCURRENCE REPORT

CONFIDENTIAL INTERNAL DOCUMENT - NOT PART OF MEDICAL RECORD

PATIENT IDENTIFICATION

DATE OF OCCURRENCE:

TIME OF OCCURRENCE (Military Time)

OCCURRENCE: ☐ PATIENT ☐ VISITOR

EXACT SITE OF OCCURRENCE:

CONDITION OF PATIENT: *(CHECK ALL THAT APPLY)* ☐ AGITATED ☐ ALERT ☐ UNRESPONSIVE ☐ ORIENTED x ☐ CONFUSED ☐ SEDATED

REASON FOR HOSPITALIZATIONS:

NATURE OF OCCURRENCE (check all that apply)

Type I. SLIP / FALL

☐ OBSERVED
☐ REPORTED
☐ ROOM
☐ HALLWAY
☐ BATHROOM
☐ WHILE WALKING
☐ FOUND ON FLOOR
☐ OUT OF BED
☐ FROM STRETCHER
☐ FROM GERI-CHAIR
☐ FROM CHAIR
☐ FROM WHEELCHAIR
☐ URINE / BM ON FLOOR
☐ WATER SPILL
☐ TRIPPED ON CORD
☐ OTHER _____

AMBULATION PRIVILEGE
☐ RESTRICTED
☐ UNRESTRICTED

BED RAILS
☐ 1 UP ☐ 2 UP ☐ 3 UP ☐ 4 UP ☐ N / A

CONDITIONS ON FLOOR (WET / OBSTRUCTED)
☐ YES ☐ NO

RESTRAINTS ORDERED
☐ YES ☐ NO

TYPE _____
IN USE:
☐ YES ☐ NO

PATIENT INJURY:
☐ YES ☐ NO

VISIBILITY
☐ DAYLIGHT ☐ LIGHTS On ☐ LIGHTS Off

FALL PROTOCOL AT TIME OF FALL
☐ Yes ☐ No

Type II. AMA

☐ COMPLAINT - HOSPITAL
☐ COMPLAINT - PHYSICIAN
☐ PSYCHIATRIC
☐ SUBSTANCE ABUSE _____
☐ OTHER _____
☐ OTHER _____

Type III. PROPERTY LOSS / DAMAGE

☐ PATIENT ARTICLE _____
☐ HOSPITAL ARTICLE _____

☐ EMPLOYEE PROPERTY _____
☐ FIRE

Type IV. EQUIPMENT FAILURE

☐ PATIENT INJURY ☐ NO ☐ YES
☐ TYPE OF INJURY (SPECIFY) _____

☐ FAILURE/MALFUNCTION (SPECIFY) _____

☐ SERIAL # / MANUFACTURER _____

SUMMARY OF FACTS

AREAS / PERSONS NOTIFIED

	YES	NO	N/A	NAME	DATE	TIME
1. NURSE MANAGER SUPERVISOR	☐	☐	☐			
2. PHYSICIAN	☐	☐	☐			
3. FAMILY	☐	☐	☐			
4. SECURITY	☐	☐	☐			
5. NURSING UNIT	☐	☐	☐			
6. HOUSEKEEPING	☐	☐	☐			
7. MAINTENANCE	☐	☐	☐			
8. OTHER	☐	☐	☐			
9. RISK MANAGER	☐	☐	☐			

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

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

	YES	NO	N/A
1. WAS PATIENT SEEN BY PHYSICIAN?	☐	☐	☐
2. WAS TREATMENT OFFERED?	☐	☐	☐
3. WAS PROPER NOTIFICATION OF INCIDENT DOCUMENTED IN MEDICAL RECORD	☐	☐	☐
4. X-RAY ORDERED	☐	☐	☐
5. RESTRAINTS ORDERED?	☐	☐	☐
6. OTHER:_____	☐	☐	☐

SITE OF INJURY			TYPE OF INJURY		SEVERITY OF INJURY
☐ NO INJURY	☐ BUTTOCKS	☐ HAND	☐ ABRASION	☐ HEMATOMA	☐ MINOR
☐ ARM	☐ CHEST	☐ LEGS / FEET	☐ BURN	☐ LACERATION	☐ MODERATE
☐ ABDOMEN	☐ FACE / HEAD	☐ NECK	☐ FRACTURE	☐ SPRAIN / STRAIN	☐ SEVERE
☐ BACK	☐ GROIN	☐ SHOULDER	☐ OTHER: _____		

CONTRIBUTING FACTORS:

ACTION TAKEN:

RECOMMENDATION FOR PREVENTION:

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

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