COUNTY HOSPITAL
OCCURRENCE REPORT

Complete this section for all occurrences

Date Of Occurrence:_____ Time Of Occurrence:_____

Addressograph

( ) Home Health Patient ( ) Inpatient: ( ) Acute ( ) Swingbed
( ) ER Patient
( ) Outpatient ( ) Other:_____ (see back)

Rm #/Department/Location of Occurrence:_____

( ) Medication / IV Related Occurrence

( ) Wrong Drug ( ) PO Med ( ) IV Med Med/IV Nurse:
( ) Wrong Route ( ) IM Med ( ) IV Infiltrate ( ) FT
( ) Wrong Dose ( ) SC Med ( ) Plain Fluids infusing ( ) PT
( ) Wrong Patient ( ) Rectal Med ( ) Medicated Fluids infusing ( ) PRN
( ) Wrong Time ( ) Topical Med ( ) Wrong IV Rate
( ) Omission: # doses omitted _____ ( ) Wrong IV Fluid
( ) Duplication: # doses duplicated _____ ( ) IV Site Problem (see narrative)
( ) Near Miss Physician Notified: ( ) Yes ( ) No

Did this occurrence result in the need for increased monitoring of the patient? ( ) Yes ( ) No
Did this occurrence result in changes in this patient's vital signs? ( ) Yes ( ) No
Did this occurrence result in the need to treat this patient with another medication as a result of the occurrence?
( ) Yes ( ) No
Did this occurrence result in the need for additional laboratory testing ( ) Yes ( ) No
Narrative (to include **NAME** of Medication) _____

Prompt: Documentation should include Patient Assessment/Reassessment; Patient Monitoring/VS; Physician Notification, etc.

( ) Fall Occurrences

Mental Status/Condition of the Patient/Person prior to the fall (Check all that apply):
( ) Alert/Oriented ( ) Confused/Disoriented ( ) Sedated
( ) Unconscious ( ) Agitated ( ) Combative
( ) Dizzy ( ) Unknown ( ) Other:_____
Medications (sedatives, narcotics or diuretics, etc) given in the past 12 hours: ( ) Yes* ( ) No
*Drug Name/Time of last dose:_____

Fall from: ( ) Bed: Siderails: ( ) Down ( ) Up - ( ) x2 ( ) x4
( ) Chair ( ) Equipment/Stretcher ( ) Exam Table
( ) BSC ( ) Shower/Bathroom ( ) Other:_____
( ) While Ambulating ( ) While Transferring _____

Injury: ( ) None Apparent
( ) Minor (bruise, abrasion, hematoma, laceration)
( ) Major (fracture, spinal cord injury, head injury, LOC)

Was the patient's physician notified: ( ) Yes ( ) No
Was patient identified as fall risk on assessment: ( ) Yes ( ) No ( ) N/A
Fall Protocol/Bed Alarms in use: ( ) Yes* ( ) No ( ) N/A
*Did Alarm Sound: ( ) Yes ( ) No
Were protective devices (restraints, etc) in use at time of fall: ( ) Yes ( ) No

Narrative: _____

Prompt: Documentation should include Brief Description of Events/Findings; Nsg Action/Tx; Patient Monitoring/Follow-Up; Current/Repeat VS; Physician Notification, etc.

Over

( ) Other Occurrence: (Be as specific and descriptive as possible)

Name of person completing report:_____

Date/Time Occurrence Report completed:_____

Forward competed report to your Immediate Supervisor then to Quality Manager