**RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER**
**FINANCE DEPARTMENT POLICY & PROCEDURE**

| SUBJECT: | **EVENT NOTIFICATION REPORTING** | Policy No: | **101.11** |
|---|---|---|---|
| | | Revision No.: | **3** |
| | | Revision Date: | **May 2001** |
| | | Page 1 of 2 | |

I. **PURPOSE:**

To establish uniform guidelines for reporting all events and unusual occurrences which may result in unsafe conditions or injury to patients, employees or visitors, and to ensure appropriate follow-up.

II. **PROCEDURE:**

A. An Event Notification form (See Attachment I) will be initiated whenever:

1. A patient or a visitor sustains an injury.
2. Any other event which may result in injury or pose risks to a patient/visitor/staff.

B. Event Reporting Process

1. Non-Critical Events
Employee will:

a. report event to immediate supervisor.
b. complete the Event Notification Report for delivery to Risk Management after appropriate review by supervisor.

C. Event Notification Form (HS-10) (Attachment I)

a. Who completes form:

1) Rancho employee who witnesses or has information related to the event or occurrence is responsible for completing an Event Notification Form.
2) Supervisory personnel, including physicians, will be accountable for ensuring expeditious reporting of events within their areas of responsibility.



EFFECTIVE DATE: January 1, 1982

Reviewed: April 2003
Reviewed: July 2004
Reviewed: November 2005

APPROVED BY:

b. How to complete: (see reverse side of Event Notification form)

D. Filing Form

The completed Event Notification form (white and yellow copies) is delivered as follows:

Non-Nursing Staff Member – Event Notification Deposit Box located on east wall of Nursing Administration (between Room 150 and 152 in the Harriman Building within 24 hours of the event.

GUIDELINES

1. Legible, factual, concise documentation on the Event Notification form.
2. Do not copy the Event Notification Report.

Cross Reference: Administrative Policy No. B704 & DHS Policy #934

COUNTY OF LOS ANGELES

Attachment I

DEPARTMENT OF HEALTH SERVICES

# EVENT NOTIFICATION

| FACILITY | DEPT/SERVICE | PATIENT IDENTIFICATION STAMP |
|---|---|---|
| EVENT DATE / EVENT TIME / EVENT LOCATION / ROOM NO. | | |
| ■ REPORTING / TELEPHONE / TODAY'S DATE | | |
| MEDICAL RECORD NO. / NAME (Patient/Non-Patient) LAST, FIRST / AGE / BIRTHDATE | | |
| PRIMARY DIAGNOSIS / ADMIT DATE | | |
| SURGERY/PROCEDURE | | |
| EVENT RELATED TO MEDICATION ☐ YES ☐ NO | MEDICATION / TIME | ☐ INPATIENT ☐ OUTPATIENT ☐ NON-PATIENT |
| EQUIPMENT/DEVICE INVOLVED ☐ YES ☐ NO | EQUIPMENT/DEVICE | SERIAL NUMBER |

DESCRIBE EQUIPMENT/DEVICE PROBLEM

CONDITION OF PATIENT BEFORE EVENT

| | |
|---|---|
| **EVENT**<br>☐ TREATMENT PROBLEM<br>☐ FALL<br>☐ MEDICATION ERROR<br>☐ BIRTH RELATED<br>☐ COMPLAINT<br>■ OTHER | DESCRIBE EVENT. INCLUDE ALL IMPORTANT FACTS |
| **INJURY** | WAS THERE AN INJURY? ☐ YES ☐ NO ☐ UNKNOWN / IF YES, EXPLAIN |
| **SEVERITY** | ☐ MINOR ☐ MODERATE ☐ SEVERE ☐ NONE ☐ UNKNOWN |
| **TREATMENT AFTER EVENT** | X-RAYS ☐ YES ☐ NO / LABORATORY TEST(S) ☐ YES ☐ NO / DESCRIBE TREATMENT |
| **ACTION(S) AFTER EVENT** | PATIENT/FAMILY NOTIFIED ☐ YES ☐ NO / PATIENT/FAMILY ATTITUDE ☐ COOPERATIVE ☐ HOSTILE / COMMENTS<br>PHYSICIAN NOTIFIED ☐ YES ☐ NO / NAME / PHONE / DATE / TIME<br>SUPERVISOR/MANAGER NOTIFIED ☐ YES ☐ NO / NAME / PHONE / DATE / TIME |
| **CONDITION AFTER EVENT** | |

DO NOT WRITE BELOW THIS LINE

CONFIDENTIAL
DO NOT COPY

**This form should be completed when:**

- A patient or visitor sustains an injury.
- A patient or his/her relative seems unhappy about the treatment or results of a treatment.
- A bad result occurs or is anticipated, regardless of whether the treatment has been proper or improper.
- A therapeutic mishap occurs.
- A critical care or very high risk patient is transferred from a community hospital to a County facility, or any transfer that you feel was detrimental to the patient's recovery.

COUNTY OF LOS ANGELES — **EVENT NOTIFICATION** — DEPARTMENT OF HEALTH SERVICES

PATIENT IDENTIFICATION STAMP (1)

☐ INPATIENT ☐ OUTPATIENT ☐ NON PATIENT

SERIAL NUMBER (23)

(26) EVENT: ☐ TREATMENT PROBLEM ☐ FALL ☐ MEDICATION ERROR ☐ BIRTH RELATED ☐ COMPLAINT ☐ OTHER

(27) INJURY ☐ YES ☐ NO

SEVERITY (29)

(30) TREATMENT AFTER EVENT

(31) ACTION(S) AFTER EVENT ☐ YES ☐ NO ☐ COOPERATIVE ☐ HOSTILE — COMMENTS

(32) CONDITION AFTER EVENT

DO NOT WRITE BELOW THIS LINE

CONFIDENTIAL DO NOT COPY

DO NOT PLACE IN PATIENT'S MEDICAL RECORD

1. Imprint with patient ID plate and indicate appropriate status.
2. May be abbreviated, i.e., LAC+USC/Women's; LBCHC; OVMC; MLK; HARBOR/UCLA; RLAMC
3. Treating Department/Service, e.g., Medicine, Surgery, etc.
4. Include month, day, and year.
5. Indicate a.m., p.m. or military time.
6. Where the event occurred; be specific, i.e., Ward, radiology building, hallway outside of Room 113, etc.
7. If event occured in a specific room, identify room number here.
8. Your full name, legibly printed.
9. Your work location phone number where you can be reached (may be beeper number, if so, include a code).
10. Include month, date, and year.
11. Please write this number in even if the identification stamp is present.
12. Full name of patient or nonpatient.
13. State age in years or months.
14. Include month, day, and year.
15. Primary Diagnosis.
16. Use if inpatient only.
17. Type of surgery/procedure if applicable.
18. Complete if medication could have contributed to the event, e.g., sleeping pill and fall; also include unt reactions to medication, e.g., rash.
19. If number 18 is completed, give name of medication, dosage, route and site of medication.
20. If number 19 is completed, time medication is given.
21. Specify whether any equipment/device was directly involved in the reported event.
22. Include mechanical equipment, IV pumps, instruments, IV lines, catheters, etc.
23. Include serial number of equipment, when applicable.
24. Describe the problem related to the equipment/device.
25. General condition of patient prior to event, e.g., comatose, stable, alert.
26. Check appropriate box - then describe in detail the event; be as precise and factual as possible.
27. Check appropriate box.
28. If number 27 is yes, describe the injury.
29. If number 27 is yes, rate severity of injury to the best of your ability using the following definitions:

    __Minor:__ a non-life threatening injury that should not result in hospitalization or increased hospital stay.
    __Moderate:__ a non-life threatening injury that may result in hospitalization, a surgical procedu increased/prolonged stay.
    __Severe:__ a life threatening injury that results in permanent disability or death.
    __None__
    __Unknown__

30. Indicate whether X-rays or lab testing were done as a result of the event and describe results if known a other treatment provided.
31. Indicate whether patient's family was notified and their attitudes or comments regarding the event. Indic name of physician/manager notified, a phone number, beeper number, date, and time of notification.
32. Describe the current condition of the patient.