

# HOSPITAL FAX REPORTING OF INCIDENTS AND ABUSE

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## GENERAL INSTRUCTIONS:

1. These instructions apply to reporting all hospital incidents, and suspected abuse, neglect, mistreatment and misappropriation of patient property under the Patient Abuse Law.
2. Complete a separate blank form for each occurrence following the instructions below.
3. Use the attached tables to enter a description for those items that are marked “see table.”
4. Submit your completed report by fax to the Department immediately for (1) fires; (2) suicide; (3) serious criminal acts; (4) pending or actual strike; (5) serious physical injury or harm to a patient resulting from accident or unknown cause; and, (6) suspected abuse, neglect, mistreatment or misappropriation involving nursing home, rest home, home health, homemaker and hospice patients. **Notify the Department immediately by phone at 617-753-8150 of any deaths resulting from incidents, medication errors, abuse or neglect; and full or partial evacuation of the facility for any reason.** Submit other completed reports within seven days of the date of the occurrence of an incident seriously affecting the health and safety of patients.
5. Fax your completed report to the Department at **617-753-8165**.

## LINE BY LINE INSTRUCTIONS

**FROM:** Please provide the name and address of the facility making the report.

**DATE OF REPORT:** Enter the date that you are submitting your report to the Department.

**FOR ABUSE, NEGLECT, MISTREATMENT or MISAPPROPRIATION OCCURRING IN NURSING HOME, REST HOME, HOME HEALTH, HOMEMAKER OR HOSPICE SETTING, NOT AT THE REPORTING HOSPITAL:**

**FACILITY/AGENCY NAME:** Indicate the name of the provider at which the suspected abuse, neglect, mistreatment or misappropriation occurred.

**ADDRESS:** Indicate the address (city or town, if street address is not known) of the provider at which the suspected abuse, neglect or misappropriation occurred.

Please indicate the date and time of the occurrence. If you are not able to determine when the event occurred, state “unknown”.

**PATIENT INFORMATION:** Please provide information here regarding the patient involved. The information reported here should reflect the patient’s condition prior to the occurrence. If more than one patient was injured, or if one patient has injured another patient, provide additional patient information under the narrative portion of the report or on an additional page. Please indicate:

**NAME:** The patient's first and last name.

**AGE; SEX; ADMISSION DATE:** Enter each for the named patient.

**AMBULATORY STATUS:** Select the term from Table #1, "Ambulatory Status", that most closely describes the patient's ability to walk.

**ADL STATUS:** Activities of Daily Living (ADLs) such as eating, dressing or personal grooming. Select the term from Table #2, "Patient ADL Status", that most closely describes the patient's ability to perform these functions.

**COGNITIVE LEVEL:** Select the term from Table #3, "Patient Cognitive Status", that best describes the patient's cognitive status at the time of the occurrence.

**MENTALLY RETARDED/DEVELOPMENTALLY DISABLED:** Indicate whether or not the patient is mentally retarded or developmentally disabled. If the resident is either, indicate the name of the Service Coordinator (mentally retarded) or Case Manager (developmentally disabled) assigned to the patient, if known.

**RACE/ETHNICITY:** Indicate the Patient's Race and Ethnicity. Complete the Hispanic Indicator. The rules for coding race and ethnicity and the Hispanic Indicator are the same as used by the Division of Health Care Finance and Policy in its inpatient discharge data submission regulations. See the instructions in the Electronic Records Submission Specification:

[http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114\\_1\\_17\\_hdd\\_data\\_specs.doc](http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_1_17_hdd_data_specs.doc)

The details are on page 25 of this document.

**DPH OCCURRENCE TYPE:** For all reports, select the term from Table #4, "Occurrence Type", that best describes the occurrence you are reporting. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

**SERIOUS REPORTABLE EVENT:** Indicate whether or not this is a report of a "serious reportable event" as described in the current National Quality Forum (NQF) list of serious reportable events (SRE). If it is an SRE, check of the type of SRE on the table on page 2. For additional information regarding NQF see

<http://www.qualityforum.org/pdf/news/prSeriousReportableEvents10-15-06.pdf>

**TYPE OF HARM:** Select the term from Table #5, "Type of Harm", that best describes the harm or injury that resulted from the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report. Note that harm includes psychological injury as well as physical harm, and **SHOULD NOT BE DESCRIBED AS "NONE" SIMPLY BECAUSE THERE WAS NO PHYSICAL HARM.**

**BODY PART AFFECTED:** Use terms such as "arm", "foot", etc.; indicate left or right when it applies.

**PATIENT'S ACTIVITY AT TIME OF OCCURRENCE:** Select the term from Table #6, "Patient's Activity" that best describes the patient's activity at the time of the occurrence. You may select "Other" and describe what happened in one or two words if none of the examples listed are applicable to your report.

**PLACE OF OCCURRENCE:** Specify where the event occurred. Examples would include: "patient's room", "dining room", "shower room", or any other short phrase that specifies the type of setting in which the occurrence took place.

**WHAT EQUIPMENT, IF ANY, WAS BEING USED AT TIME OF OCCURRENCE:** Specify if any equipment was in use, such as "Hoyer lift", or "walker".

**ANY SAFETY PRECAUTIONS IN PLACE:** Check the "yes" or "no". If "yes", describe the precautions that were in place.

**NARRATIVE:** Describe fully what occurred. Indicate who, what, when, where, why and how what is being reported occurred. Include information on how any person injured was treated. If there were any unusual circumstances involved, describe these fully.

**CORRECTIVE MEASURES NARRATIVE:** Describe what actions have been taken in response to the occurrence.

**GENERAL INFORMATION:** Please indicate your name and title, as the person preparing this report, a phone number at which we can contact you if we need additional information, and the date and time of the occurrence. If you are not able to determine when the event occurred, state "unknown".

**STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE:** Indicate who was present and in charge at the facility (not on the unit) when the occurrence reported happened.

**NOTIFICATION:** Indicate whether or not the patient's family and physician, and police were notified. Provide the name of the physician notified.

**WITNESS INFORMATION:** List the name and title for individuals who saw or heard what occurred. Indicate if any of witnesses were directly involved in what occurred. Other patients, visitors and volunteers should be listed as witnesses if they have direct knowledge of what occurred.

**ACCUSED INFORMATION:** When reporting suspected abuse, neglect or misappropriation, indicate the name of the accused, a phone number at which the accused can be contacted, if the accused is a nurse, nurse aide or other licensed professional please indicate the individual's license or registration number. Check the appropriate block if you are not reporting abuse, or the identity of the person(s) suspected of abuse, neglect or misappropriation of a patient's money or belongings is unknown. If more than one individual is suspected, indicate on an additional sheet the other individual's names, a phone number at which they may be contacted, and if any person was acting as a nurse aide, home health aide or homemaker.

REPORTING TABLES:

Table #1: Ambulatory Status:

Independent  
Supervised  
Dependent/Assist  
Wheels Self  
Wheelchair  
Bedfast  
Unknown

Table #2: Patient ADL Status:

Independent  
Supervised  
Dependent  
Unknown  
Other

Table #3: Patient's Cognitive Status:

Alert/Oriented  
Dementia  
Confused  
Alzheimer's  
Comatose  
Unknown  
Other

Table #4: Occurrence Type:

Fall  
Abuse  
Neglect  
Misappropriation  
Surgical Error  
Medication Error  
Accident  
Emergency Services  
Death  
Suicide  
Infection Control  
Criminal Act  
Fire  
Pending Strike  
Equipment Malfunction  
Injury of Unknown Origin  
Other (Describe)

Table #5: Type of Harm:

Fracture  
Laceration  
Bruise/Hematoma  
Reddened Area  
Dislocation  
Burn  
Unwelcome Sexual Contact/Advance  
Emotional Harm/Upset  
Care Not Provided  
Quality of Care  
Decline in Condition  
Infection  
Confinement  
Property  
Funds  
Death  
No Harm  
Other (Describe)  
Unknown

Table #6: Patient's Activity

Ambulating  
Toileting  
Transfer/Assist  
Getting Out of Bed  
Getting Up From Chair  
Reaching  
Standing/Sitting Still  
Crowded Area  
Other(Describe)  
Unknown

**HOSPITAL FAX REPORT FORM**

TO: INTAKE STAFF  
DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH CARE QUALITY  
FAX NUMBER: 617-753-8165

FROM: Hospital Name: \_\_\_\_\_  
Address (Street): \_\_\_\_\_  
Address (City/Town) \_\_\_\_\_

DATE OF REPORT: \_\_\_\_\_ NUMBER OF PAGES: \_\_\_\_\_

*IF ABUSE, NEGLECT, or MISAPPROPRIATION IN A NURSING HOME, REST HOME, HOME HEALTH, HOMEMAKER, OR HOSPICE AGENCY AND NOT THE REPORTING HOSPITAL:*

ABOUT: Facility/Agency Name: \_\_\_\_\_  
Address: \_\_\_\_\_

DATE OF OCCURRENCE: Month \_\_\_\_\_ Date \_\_\_\_\_ Year \_\_\_\_\_  
TIME OF OCCURRENCE: \_\_\_\_\_ am \_\_\_\_\_ pm

**PATIENT INFORMATION:**

Name: First \_\_\_\_\_ Last \_\_\_\_\_

Age: \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Admission Date: Month \_\_\_\_\_ Date \_\_\_\_\_ Year \_\_\_\_\_

Ambulatory Status (See table #1): \_\_\_\_\_

ADL Status (See table #2): \_\_\_\_\_

Cognitive Level (See table #3): \_\_\_\_\_

Mentally Retarded/Developmentally Disabled: \_\_\_ Yes \_\_\_ No.

If yes, Service Coordinator or Case Manager (if known): \_\_\_\_\_

**RACE:**

- Asian  Black/African American  White
- American Indian/Alaska Native
- Native Hawaiian or Other Pacific Islander
- Unknown/Not Specified
- Other Race (specify) \_\_\_\_\_

**HISPANIC INDICATOR**

- Patient is Hispanic/Latino/Spanish
- Patient is not Hispanic/Latino/Spanish

**ETHNICITY: Please check all that apply:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cuban                            | <input type="checkbox"/> Asian Indian     | <input type="checkbox"/> Honduran              |
| <input type="checkbox"/> Dominican                        | <input type="checkbox"/> Brazilian        | <input type="checkbox"/> Japanese              |
| <input type="checkbox"/> Mexican/Mexican American/Chicano | <input type="checkbox"/> Cambodian        | <input type="checkbox"/> Korean                |
| <input type="checkbox"/> Puerto Rican                     | <input type="checkbox"/> Cape Verdean     | <input type="checkbox"/> Laotian               |
| <input type="checkbox"/> Salvadoran                       | <input type="checkbox"/> Caribbean Island | <input type="checkbox"/> Middle Eastern        |
| <input type="checkbox"/> Central American (not specific)  | <input type="checkbox"/> Chinese          | <input type="checkbox"/> Portuguese            |
| <input type="checkbox"/> South American (not specific)    | <input type="checkbox"/> Columbian        | <input type="checkbox"/> Russian               |
| <input type="checkbox"/> African                          | <input type="checkbox"/> European         | <input type="checkbox"/> Eastern European      |
| <input type="checkbox"/> African American                 | <input type="checkbox"/> Filipino         | <input type="checkbox"/> Vietnamese            |
| <input type="checkbox"/> American                         | <input type="checkbox"/> Guatemalan       | <input type="checkbox"/> Other Ethnicity       |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> Haitian          | <input type="checkbox"/> Unknown/Not Specified |

REPORTING HOSPITAL: \_\_\_\_\_ DATE OF OCCURRENCE: \_\_\_\_\_

DPH Occurrence Type (See table #4): \_\_\_\_\_

Is this a serious reportable incident as defined by NQF \_\_\_\_ Yes \_\_\_\_ No.

If yes, indicate type(s) below:

- Artificial insemination with the wrong donor sperm or donor egg
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Patient death or serious disability associated with patient elopement (disappearance)
- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products
- Patient death or serious disability associated with an electric shock or elective cardioversion while being cared for in a healthcare facility
- Patient death or serious disability associated with a fall while being cared for in a healthcare facility
- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Intraoperative or immediately post-operative death in an ASA Class I patient
- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility
- Patient death or serious disability associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility
- Infant discharged to the wrong person
- Patient suicide or attempted suicide resulting in serious disability, while being cared for in a healthcare facility
- Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a health care facility
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility
- Patient death or serious disability due to spinal manipulative therapy
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
- Abduction of a patient of any age
- Sexual assault on a patient within or on the grounds of the healthcare facility
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare facility

REPORTING HOSPITAL: \_\_\_\_\_ DATE OF OCCURRENCE: \_\_\_\_\_

Type of Harm (See table #5): \_\_\_\_\_

Body Part Affected: \_\_\_\_\_ L: \_\_\_\_\_ R: \_\_\_\_\_

Patient's activity at time of occurrence (See table #6): \_\_\_\_\_

Place of Occurrence: \_\_\_\_\_

What equipment, if any, was being used at time of occurrence? \_\_\_\_\_

Any safety precautions in place? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe what precautions were in place:

**NARRATIVE:** (Please address the following: What happened? What factors contributed to the occurrence? Any relevant information which establishes cause? Have there been similar incidents in the past? How were the injuries treated? [Attach additional pages as needed.] )

Were there any unusual circumstances involved? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe. [Attach additional pages as needed.]

REPORTING HOSPITAL: \_\_\_\_\_ DATE OF OCCURRENCE: \_\_\_\_\_

**CORRECTIVE MEASURES NARRATIVE – Please address the following:**

N/A - Incident occurred with another provider \_\_\_\_\_.  
Was there an internal investigation: Yes \_\_\_\_\_ No \_\_\_\_\_ If No - why? If yes - what are the investigation findings?  
What action was taken with regard to: Patient?; Staff?; Facility practice? What is the patient's current status?  
What corrective action taken regarding equipment involved, if applicable? [Attach additional pages as needed.]

**GENERAL INFORMATION:**

Report prepared by: \_\_\_\_\_  
Title: \_\_\_\_\_  
Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

**STAFF PERSON IN CHARGE OF FACILITY AT TIME OF OCCURRENCE:**

N/A (Incident occurred with another provider): \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Directly Involved: YES \_\_\_\_\_ NO \_\_\_\_\_

**NOTIFICATION:**

Was family notified: Yes \_\_\_\_\_ No \_\_\_\_\_  
Was MD notified: Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of MD if notified: \_\_\_\_\_  
Were police notified: Yes \_\_\_\_\_ No \_\_\_\_\_

**WITNESS INFORMATION:** (Check here if unwitnessed: \_\_\_\_\_)

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Directly Involved: YES \_\_\_\_\_ NO \_\_\_\_\_  
\_\_\_\_\_  
YES \_\_\_\_\_ NO \_\_\_\_\_

**ACCUSED INFORMATION:** (Check here if unknown or not applicable: \_\_\_\_\_)

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
\_\_\_\_\_  
(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

AIDE \_\_\_\_; RN/LPN \_\_\_\_  
If RN/LPN or other licensed individual, indicate license #: \_\_\_\_\_