CENTRAL STATE HOSPITAL
PROCEDURE

SUBJECT: **CLIENT ACCIDENT AND INJURY REPORT**

ANNUAL REVIEW MONTH: November

RESPONSIBLE FOR REVIEW: Nurse Executive (CSH)

LAST REVISION DATE: January 2004

This procedure provides instructions for completing form CSH-464 (Rev. 5/03), Client Accident and Injury Report.

Participants:

Staff Person in Charge of Client at time of Accident/Injury
Attending/Examining Physician
Person Notifying Client's Representative
Unit Director/Team Leader/ Nurse Supervisor/etc.
Division Chief/Medical Director/ Associate Nurse Executive
Division Chief
Chief Medical Officer
Director, Information Systems and Program Evaluation
Director, Health Information Management Supervisor
Central State Hospital (CSH) Safety Officer
Chairperson of Human Rights Committee
Chairperson of the Human Rights Panel

DATE — Enter either a date of occurrence (when the date is known or witnessed) or a date of discovery.

TIME — Enter either a time of occurrence (when the time is known or witnessed) or a time of discovery.

DEMOGRAPHICS

- Stamp the report with the client’s stamp plate in the right lower corner.

ACCIDENT/INJURY INFORMATION

- For Location of Occurrence, enter where the incident occurred, e.g., in the restroom, in the recreation area, on the bus, in the hallway, in the restroom at EWAC, etc. If you do not know the location of the client when the injury occurred (like in an "unknown" or unwitnessed injury) put "unknown" here.
- For Mental Condition, put only the Mental Condition of the Client at the time the A&I occurred. If unknown, leave this blank.
- In your own words, describe what happened, e.g., the client was pushed by another client and fell and hit his head on the chair. If the injury is unknown then put how it was discovered. You do not need to go into great detail about what the injury was or how it was treated. Example: Mr. B was found with a scratch to his back at "injury check."

ACCIDENT/INJURY CATEGORY

There are six major accident/injury categories. Check only one of the following:

- ACCIDENT: FALL (client accidentally or unintentionally falls/slips), DO NOT check this category if the client is pushed by another client and falls (see ASSAULT: PHYSICAL category below),
- ACCIDENT: OTHER (the accident/injury is accidentally or unintentionally caused by the client, another client or staff and does not involve a slip/fall);
- ASSAULT: SEXUAL (accident/injury involving sexual contact intentionally caused by another client/staff/visitor);
- ASSAULT: PHYSICAL (accident/injury involving physical contact, other than sexual, intentionally caused by another client/staff/visitor), e.g., client was intentionally pushed by another client and fell. If you are filling out an A&I on the client who did the assault, whether or not he/she was injured, you still need to code this as assault. Do not interpret an injury that was obtained as a result of assaulting someone else as "self-inflicted", even though the client "brought it on himself."

Indicated the responsible person in the "Assaulted by" space ONLY if you check assault. Then check the appropriate box to indicate if the "aggressor" was or was not injured.
Note: If the aggressor was injured, a separate A&I should be completed. If the aggressor was NOT injured a separate A&I is NOT needed.

- SELF-INFLICTED: SUICIDE ATTEMPT (self-inflicted injury by the client with the intent to commit suicide).
- SELF-INFLICTED: OTHER (accident/injury intentionally caused by the client such as self-injurious behavior, but not categorized as a suicide attempt). Only use this when the client INTENDED to injure him/her self, eg SIB. If the injury is accidental, not intentional, use the Accident category.
- UNKNOWN (origin of the accident/injury is not known).

TYPE OF INJURY

If no injury from the accident, check "No Injury." If there is an injury, indicate the specific type(s) of injury that occurred as a result of the accident. Check all that apply. If someone were to fall or get hit or some similar "injury" but doesn't have a visible injury, then check "Other" in the blank provided. If you do not check other, DO NOT PUT ANYTHING ON THIS LINE. Do not repeat what you entered previously about how the A&I happened.

CHARACTERISTICS OF INJURY

If no injury from the accident, check "Not Applicable." If there is an injury, describe the specific characteristics of the injury by checking all that apply. This is about the injury, not about the client. So, unless the client got a head injury and is acting weird, do not check "Altered Mental Status" for a scratch on his elbow.

Licensed nurse to complete the following:

SEVERITY/ TREATMENT

SEVERITY LEVEL: Check only one. But always check one. If the client is sent to the ER, YOU MUST WAIT FOR THE CLIENT TO RETURN TO FIND OUT WHAT THEY DID TO COMPLETE THIS PART OF THE FORM.

- Check "No Treatment" when there is no injury or the injury does not require first aid, medical intervention, or hospitalization; the injury may be examined by a clinician but no treatment is applied to the injury.
- Check (0) "First Aid Only" when the injury received is of minor severity and requires the administration of minor first aid to include the application of Band-Aids, cleaning of abrasions, application of ice packs for minor bruises, and the use of over-the-counter medications such as antibiotic creams, aspirin, acetaminophen, etc. An order for diagnostic tests such as lab work or x-ray with no form of treatment other than minor first aid would also apply here.
- Check (1) "Beyond First Aid" when the injury is severe enough to require the treatment (more than minor first aid, e.g., sutures) of the client by a licensed medical doctor, osteopath, podiatrist, dentist, physician's assistant, or nurse practitioner, but the treatment required is not serious enough to require hospitalization. The treatment received may be provided on the unit, at ER or outside the facility. The most common examples are sutures and broken bones. For these types of injuries, an Incident Report must be completed. It does not matter if they go to the ER to get this done/diagnosed or if the unit doctor does it.
- Check (2) "Hospitalization" if the injury received requires medical intervention and treatment as well as admission as an inpatient to a general acute care unit within the facility (e.g., MSH) or outside facility. Check this only if they get admitted to any acute care hospital, including MSH.
- Check (3) "Death" if the injury received was so severe that it resulted in – or complications from the injury lead to – the termination of the life of the injured client.

TREATMENT: Check all treatments that apply. If medication was ordered, indicate the type of medication on the line next to the Medication box. If specific treatment is not listed, check "Other" and specify treatment the TX line. Again, you do not have to get too detailed. This is not a medical order form. Just put something like "Topical antibiotics and bandage." Remember to check "Treatment on the Unit" if treated on the unit (note the specific treatment in the space provided), check "Referred to Emergency Department" if referred to the ED, and to check "Sutures" if the client was sutured. Medication ordered would be something like "Tylenol"; you do not need to write the dose.

PAIN ASSESSMENT COMPLETED: Indicate "yes" or "no" and the pain assessment rating. If something happened to the client that warranted you doing this form, then you need to do a pain assessment of some sort. Verbal clients who are able to indicate if they have pain may simply be asked if they hurt or if they want some medicine. This is a pain assessment. If you make an assessment of the presence or absence of pain, you have done a pain assessment, and should enter it as such on this form. If the client indicates that he/she has pain, then you need to obtain treatment for the pain. This question is not asking have you filled out one of those "pain assessment" forms.

INJURY SITE DIAGRAM

Using the figures provided, indicate the site of the injury. Don't forget to do this.

POTENTIAL RISK FACTORS

CAUSE OF ACCIDENT/INJURY: Indicate those factors present at the time of the accident/injury that MAY have contributed to or put the client at risk for the accident/injury. For example, if a client who is on a medication that has dizziness as a side effect falls, then the Medication box should be checked, and the medication indicated in the space provided. If a client fell on a slippery floor, then the Environmental/Safety Issue box should be checked. If you do not know how the injury happened, do not speculate, just leave this blank. If none of these issues apply, DO NOT PUT N/A, just leave it blank. If you check "Staff Knowledge" you are indicating that the staff had no idea how to take care of the client or prevent the client from becoming injured. Be very careful in your use of this box. The "other" box is there for you to use if you think that there was some other external item or situation that contributed to the injury.

ENVIRONMENTAL/SAFETY ISSUES: If the Environmental/Safety Issues box was checked above, check all the environmental/safety issues indicated that were present at the time of the incident and MAY have contributed to the incident, e.g., did the client fall from a bed that was left in the high position? Was the lighting poor? Were the side rails up or down?, etc. Again, only put what you know to be true, not what you think happened. If none of these issues apply, DO NOT PUT N/A, just leave it blank. The "other" box is there if there were other things in the environment that contributed to the injury, such as a pile of boxes that the client fell over. In this case, you would check other and write in "a pile of boxes." Usually, something like this would have been noted in the section where you put how the injury occurred.

PHYSICAL CONDITIONS: Check all of the client's physical conditions that are applicable. These physical conditions may or may not have contributed to this incident, but could be significant when analyzing trends and patterns of incidents over time. If a physical condition is not listed, check the "Other" box and specify the condition on the line provided. Do not list all of the client's diagnoses here. That is a waste of time. If the client has cerebral palsy that affects the gait, then check unsteady gait. Almost everything that our clients have will be contained in these choices. Only use the "other" box when you think that the client has something that cannot fit into one of the categories, AND that you think could contribute to accidents or injuries. An example might be that the client is on Coumadin, which would make minor trauma look like major trauma because the blood does not clot well. If this is the case, check "other" and write in "coumadin therapy."
NOTE: Please check "alteration in mental status" ONLY when the client's mental status is altered from the client's baseline due to the A/I.

FALL RISK: Check "yes" or "no" to indicate if the client has been identified by the treatment team as at risk for falls. There is no need to write in the fall risk rating number. Either they are at risk or not.

OBSERVATION CATEGORY: Check the observation level the client was on at the time of the accident/injury. Remember, if the client received the injury while in restraints or time out, then the observation category must be 1:1.
OBSERVATION CATEGORY FOLLOWED: indicate if the observation level the client was on at the time of the accident/injury was being followed.
RESTRICTIVE PROCEDURES: If the accident/injury occurred during an episode of restraint or seclusion or time-out, specific which type: behavioral restraint, non-behavioral restraint (such as medical protective device or adaptive supportive device), or time-out.

WITNESSES

Check "yes" or "no" to indicate if there were witnesses. If yes was checked list names of all witnesses. Don't need to put any explanations here, just names.
Staff Assigned to Client: Enter the staff's name in the space provided. Don't need to put any explanations here, either. Just put the name.
Assigned Staff SS#: Enter the last four digits of the staff's SS#. This is merely for tracking purposes.
Staffing Level Met: Indicate whether or not the required staffing was met at the time of the accident/injury.

SIGNATURE

Staff Completing Form: Person completing form to sign in the space provided, including the title and date.

Attending/Examining Physician to complete the following:

PHYSICIAN EVALUATION

To be completed by the physician. Physician should indicate "yes" or "no" for representative to be notified. In the DDD, the physician should always check yes. If the client is sent to the ER for evaluation, DO NOT COMPLETE OR SIGN THIS SECTION UNTIL THE CLIENT HAS RETURNED FROM THE ED, SO THE FINDINGS AND TREATMENT SECTION CAN BE COMPLETED. Note if medication was a contributing factor to the accident/injury. If you check "yes," explain. Sign and date the form.

Person notifying client's representative to complete the following:

NOTIFICATION OF REPRESENTATIVE — To be completed by the staff member responsible for notification of accidents/injuries. If the representative or client has requested that notification not be done, indicate this by checking the appropriate box. If the representative is notified, complete the requested information, and sign this section.

Service Director or Designee to complete the following:

MANAGEMENT REVIEW — To be completed by the service director or designee, including remarks and any actions taken. If an employee was responsible for the accident/injury, specify the action taken and provide the last four digits of the employee's SS#.

Nurse Executive, Clinical Director, and Division Chief or Designees to complete the following:

SIGNATURES — NURSE EXECUTIVE, CLINICAL DIRECTOR, AND DIVISION CHIEF: Each person is to sign in the space provided indicating a review has been completed, including the date signed.

Division Chief

1. Forward the original form CSH-464 to the chief medical officer within four (4) working days from date accident/injury is discovered, and forward a copy to the chairperson of the human rights panel.

2. Maintain a copy of form CSH-464 until discharge/death of client. Forward copy(ies) to division's medical records supervisor upon notification of client's discharge or death.

Chief Medical Officer

1. Review form CSH-464 and initiate further investigation as necessary.

2. Forward form CSH-464 to Client Rights Chairperson.

Chairperson, Client Rights Committee

1. Review form CSH-464 and make follow-up as required.

2. Forward form CSH-464 to Information Systems and Program Evaluation Office.

Director, Information Systems and Performance Evaluation

1. Have form CSH-464 reviewed and filed.

2. Upon discharge/death of the client, notify the office of the division chief to forward appropriate copies of form CSH-464 to division's medical records.

3. Destroy any form CSH-464 of discharged/deceased clients upon receipt from the division chief's office.

MONITORING

CSH Safety Director

Summarize client accident data on a monthly basis and present to the CSH Environment of Care Team. Identify trends/patterns and make recommendations for actions t be taken to the CSH Management Team.

Director, Information Systems and Performance Evaluation

Prepare aggregate client accident/injury data for presentation in quarterly review reports, monthly PI report, and transmission of relevant data to the NASMHPD Research Institute.

Chairperson of Client Rights Panel

1. Initiate monitoring of forms CSH-464 for possible violation of clients' rights.
2. Make report to division chief of any violation of client's rights.

Approved:

This procedure has been approved by the CMO and CEO on 1/22/04.

Attachment:
Attachment I: Client Accident and Injury Report

Central State Hospital
Client Accident and Injury Report

Date: ☐ of occurrence ____________ **Time:** ☐ of occurrence ____________ AM/PM
☐ of discovery ____________ ☐ of discovery ____________ AM/PM

Accident/Injury Information:
Location of Occurrence: ____________________________ ***Mental Condition:*** ☐ Quiet ☐ Excited ☐ Other
State how accident/injury occurred or what happened: ____

Accident/Injury Category: Check only one
☐ Accident:Fall ☐ Assault: Sexual ☐ Self-inflicted: Suicide Attempt ☐ Unknown
☐ Accident: Other ☐ Assault: Physical ☐ Self-inflicted: Other:_____________________________
Assaulted by: __ ☐ Aggressor NOT Injured ☐ Aggressor Injured

NOTE: If aggressor is injured, a Client Accident and Injury Report must be completed on the aggressor.

Type of Injury: Check all that apply
☐ No Injury ☐ Choking ☐ Head Trauma ☐ Scratch
☐ Bite ☐ Contusion/Hematoma ☐ Laceration/Cut ☐ Swelling/Edema
☐ Bruise ☐ Fracture ☐ Scrape/Abrasion ☐ Other ________________

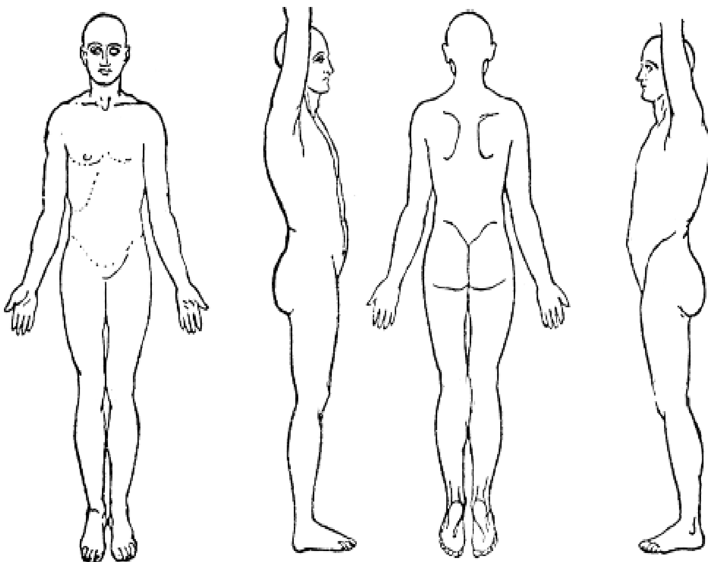
Characteristics of Injury: Check all that apply
☐ Not Applicable ☐ Discoloration ☐ Pain ☐ Skin Broken
☐ Bleeding ☐ Lethargic ☐ Redness/Erythema ☐ Swelling/Edema
☐ Death ☐ Nausea/Vomiting ☐ Respiratory Distress ☐ Unresponsive

Severity/Treatment:

Severity Level: Check only one
☐ No Treatment
☐ 0 (First Aid Only)
☐ 1 (Beyond First Aid)
☐ 2 (Hospitalization)
☐ 3 (Death)

Treatment: Check all that apply
☐ Treatment on the Unit ______________________________
☐ Lab/X-Ray ☐ Cast/Splint/etc.
☐ Medication: ______________________ ☐ Head Trauma Protocol
☐ Referred to Emergency Department ☐ Other ______________________
☐ Sutures

Pain Assessment Completed: ☐ Yes ☐ No ***Pain Rating:*** ☐ Unk ☐ 0 ☐ 2 ☐ 4 ☐ 6 ☐ 8 ☐ 10



Indicate site of injury on diagram to the left.

STAMP PLATE

CSH-464 (Rev. 5/03)

Front

Potential Risk Factors:

Cause of Accident/Injury: Check all that apply

☐ Environmental/Safety Issues ☐ Abuse ☐ Physical Condition ☐ Staff Knowledge
☐ Medication (Specify)__________________ ☐ Restraint/Seclusion/Time Out ☐ Other: _______________

Environmental/Safety Issues: Check all that apply

☐ Bed Height ☐ Equipment Failure ☐ Side Rails Up ☐ Wet/Slippery Floor
☐ During Transfer ☐ Side Rails Down ☐ Tripping Hazard ☐ Other (Specify) __________________

Physical Conditions: Check all that apply

☐ Alteration in Mental Status ☐ Hypoglycemia ☐ Hyperthermia
☐ Difficulty Swallowing ☐ Hyperglycemia ☐ Seizures
☐ Fragile Skin ☐ Hypothermia ☐ Unsteady Gait
☐ Other (Specify): ____

Fall Risk: ☐ Yes ☐ No
Indicate Observation Category: ☐ Routine ☐ 1:1 ☐ Line of Sight ☐ Q 15 Min. ☐ Q 30 Min.
Observation Category Followed: ☐ Yes ☐ No
If incident occurred during restraint/seclusion/time out, specify type ________________________________

Witnesses: ☐ Yes ☐ No ***Witness Name(s):*** __________________________ ______________________________
_______________________ __________________________ _________________________ _______________________
Unit Staffing Level Met? ☐ Yes ☐ No
Staff Assigned to Client: ____________________________________ ***Assigned Staff SS# (last 4 digits):*** ______________

Staff Completing Form:________________________________ **Title:** _________________ **Date:**___________

Physician's Evaluation: ***Should representative be notified?*** ☐ Yes ☐ No
Findings: ____
Treatment: ____
Was medication contributing factor to the accident/injury? ☐ **Yes** ☐ **No If yes, explain:** ______________________

____
Physician's Signature: ____ **Date:** ____________________

Notification of Representative:
Representative Notified: ☐ Yes ☐ No ☐ Not to be notified at request of: ☐ representative; ☐ Client
Representative Name: ____
Method of Notification: ☐ In Person ☐ Letter ☐ Phone ***Notification: Date:*** _____________ ***Time:*** __________
Representative Notified by: _________________________________ ***Comments:*** ______________________________

____

Management Review:
Remarks: ____
Action taken: ____
Employee SS#(last 4 digits): _________ ***Signature:*** ________________________________ ***Date:*** ______________

_____________________________	_____________________________	_____________________________
Nurse Executive/Designee	**Clinical Director/Designee**	**Division Chief/Designee**
_____________________________	_____________________________	_____________________________
Date	**Date**	**Date**

Back