TRINITY ASSISTANCE CORPORATION

UNUSUAL EVENT FORM

REPORT #:_____ **(ex: 10216 JJ)** month, day year and client initials

Date Received by QA: _____ (QA TO COMPLETE)

Client Name:	**Date:**	**Time:**
Name & Title of staff REPORTING:	**Initials of other clients involved:**	
List Name of other staff involved:	**Other's involved and relation to client if any:**	

Where? Where event took place, i.e. in client home (bedroom, kitchen) and address

Description of place (client home/bedroom):_____

Complete Address:_____

Staff location at time of event:_____**(Approx. how far from individual)**

Ensure originals remain in the client's chart and only send COPIES with UE to QA.

(Put an X next to all documents that apply.)

Document Name		**Document Name**	
Hospital/ED Visit or Urgent Care Discharge Summary		Medication Error Report Form	
Body Diagram		Sleep Chart	
Seizure Log		Toileting/Positioning Log	
Head-To-Toe Checklist		Other: _____	

What? Put (X) on applicable event (letter).

Category	Number	QA ONLY	Category	Number	QA ONLY
A. Medical			**E. Staff Behavior**		
B. Property Damage			**F. Safety Issues**		
C. Criminal			**G. Emergencies**		
D. Client Behavior			**H. Complaints**		

NOTIFICATIONS: To be completed within 24 hours of discovery.

NOTIFICATIONS	Name of Person Notified	Date Notified MM/DD/YYYY	Time Notified AM/PM	How was person Notified-email, phone, in person
FAMILY MEMBER/ ADVOCATE				
Program Supervisor				
ON-CALL After Hours				
Care Coordinator (Done by Program Supervisor)				
QUALITY ASSURANCE- Send DETAILED email				
Police-Fire-9-1-1 When applicable				
RN/LPN Full Name and title				
QA TO NOTIFY President/CEO				

Brief Narrative of Events: **To be completed by staff observing or discovering event. Include the following: who, what, where, when, how & corrective actions taken. State facts only and avoid giving your opinion. Continue narrative on a blank progress note if necessary and attach.**

IMMEDIATE ACTIONS (what was done to ensure the individual's safety):

CURRENT STATUS OF CLIENT (resting, at ED, at baseline):

PLAN TO PREVENT (to be completed by Program Supervisor):

ITEMS NEEDED TO CLOSE EVENT (To be completed by QA-not closure on separate sheet):

1. _____

2. _____

3. _____

4. _____

Completed By: _____ Title: _____ Date: _____

Reviewed By: _____ Title: _____ Date: _____

Quality Assurance Notification Email completed: ldambrosia@trinityassistance.org; Fax: (585)270-0058

Date: _____ Time:_____ By whom: _____