INSTRUCTIONS FOR INTERNAL GENERAL EVENTS REPORTS (GER)

Purpose:

The purpose of the General Events Report (GER) procedure is to document any injuries or incidents that occur involving a participant that do not include suspected abuse, neglect or exploitation, environmental hazards or suspicious injury.

Report Procedure:

1. Ensure the safety of the individual
2. Fill out the General Events form
3. Report the event to your Alta Mira Service Coordinator
   - Office: (505) 262-0801
   - On-call: (505) 991-2309
4. Submit the completed GER to your Service Coordinator **within 1 BUSINESS DAY**
   - Special Exceptions for certain situations of restraint
5. The participant's Service Coordinator will review and ask any additional questions, as necessary

Report Contents:

GER Reportable Incidents		Complete all information, including date, participant name, Service Coordinator, Alta Mira Nurse, and answer all Yes/No options on this section. Upon selection of GER, proceed to the page numbered on the right hand column and complete the information for the corresponding section.
Section 1	Injury (pages 1-2)	Complete as much information as possible. Make sure to note the severity of injury and the specific location of the injury on the body. On the following page, indicate the injury type and cause by checking off all boxes that apply.
Section 2	Medication Error/Event (pages 2-3)	Indicate the Medication Error/Event Type and Reason by checking off all boxes that apply. Complete the following section, giving more detailed information about the error/event.
Section 3	Use of PRN Psychotropic Medication (page 3)	Complete this section indicating when the PRN psychotropic medication was administered. If applicable, also complete a PRN MAR indicating administration.
Section 4	Restraint Related to Behavior (page 3)	Complete this section indicating when physical restraint was utilized for purposes of de-escalating challenging behaviors. **Note: If this results in "extended restraint" – you are required to contact OBS within one business day.**
Section 5	Restraint- other (page 3)	Complete this section indicating when physical restraint was utilized for purposes other than challenging behaviors.
Section 6	Other	Complete this section by checking all boxes that apply to any situation that is not noted in Sections 1-5.
Required Signatures Section		Complete the form by signing and dating this section as the staff/contractor reporting the incident.

ALL ALLEGATIONS OF ABUSE, NEGLECT, EXPOLITATION, DEATH, SUSPICIOUS INJURY, AND/OR ENVIRONMENTAL HAZARDS MUST BE REPORTED ON A **WHITE** ANE REPORT FORM.

DO NOT USE THE BLUE GER FORM FOR THESE TYPES OF INCIDENTS.

Alta Mira Specialized Family Services, Inc.
1605 Carlisle N.E., Albuquerque, NM 87110
(505) 262-0801Main * (505) 262-1588 fax

DDSD General Events Report (GER) – INTERNAL INCIDENT REPORT

(Report due within 1 business day to Alta Mira Specialized Family Services)

Staff/Contractor Reporting Incident: _____

Event Date: _____ **Event Time:** _____ **FSS Service Coordinator:** _____

Participant: _____ **AM Nurse:** _____

GER Reportable Incidents

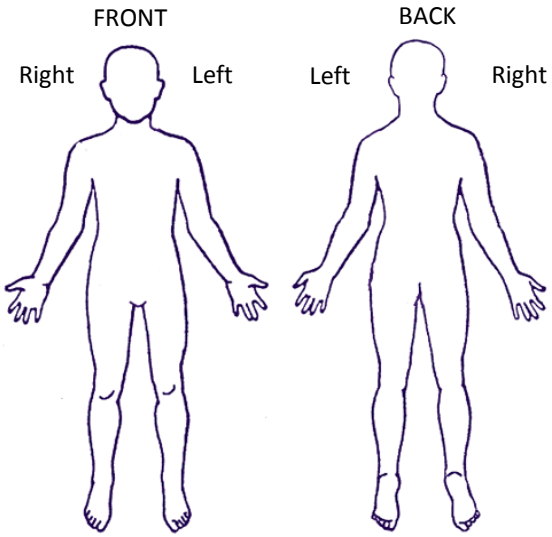
☐ **Emergency Services – unplanned use (ER, Urgent Care, 911)**	**See Section # 6**
☐ **Out of Home Placement – Medical**	**See Section # 6**
☐ **Missing Person/Elopement**	**See Section # 6**
☐ **Law Enforcement Intervention that results in arrest or detention**	**See Section # 6**
☐ **Fall without Injury**	**See Section # 1**
☐ **Injury - falls, choking, skin breakdown, infection, etc.**	**See Section # 1**
☐ **Physical Restraint**	**See Section # 4**
☐ **Emergency Services –planned use (ER, Urgent Care, 911)**	**See Section # 6**
☐ **Suicide – Attempt or Threat**	**See Section # 6**
☐ **Medication Errors**	**See Section # 2**
☐ **Medication Error - Documentation**	**See Section # 2**
☐ **Injury/Illness requiring First Aid or No Intervention**	**See Section # 1**
☐ **Use of PRN Psychotropic Medication**	**See Section # 3**
☐ **Other**	**See Section # 6**

1. Injury - Complete Full Section on Both Page 1 and 2

This event was: ☐ Observed ☐ Discovered

Time of Injury: _____

Injury Severity: ☐ Very Minor (No Treatment) ☐ Minor (First Aid)
☐ Moderate (Nurse/Physician) ☐ Severe (Hospitalization)
☐ Fatal (Death)



Specific Body Part(s): (mark on picture to right; note injury size and color)

For example: Right index finger laceration, ½-inch wide, red

Comments/Corrective Actions Taken/ Explanation:

Complete Injury Section on Page 2

Injury Type:

- ☐ Abrasion
- ☐ Airway Obstruction
- ☐ Allergic Reaction
- ☐ Bite/Sting
- ☐ Bleeding
- ☐ Bruise
- ☐ Burn
- ☐ Choking
- ☐ Other: _____
- ☐ Concussion
- ☐ Cut/Lesion/Laceration/Skin Breakdown
- ☐ Dislocation
- ☐ Fracture
- ☐ Frostbite
- ☐ Hematoma
- ☐ Infection
- ☐ Loss of Consciousness
- ☐ Pain
- ☐ Poisoning
- ☐ Punctures
- ☐ Rash/Hives
- ☐ Scrape/Scratch
- ☐ Sprain/Strain
- ☐ Sunburn
- ☐ Swelling/Edema

Injury Cause:

- ☐ Abuse
- ☐ Accident-Motor Vehicle
- ☐ Accident-Other
- ☐ Adaptive Equipment
- ☐ Assault
- ☐ Bumped into
- ☐ Other: _____
- ☐ Eating Behavior
- ☐ Environmental Hazard
- ☐ Exposure
- ☐ Fall with injury
- ☐ Fall with NO injury
- ☐ Ingestion of Foreign Material
- ☐ Insect
- ☐ Medical Condition
- ☐ Medical Procedure
- ☐ Restraint
- ☐ Seizure
- ☐ Self-Injurious Behaviors

2. Medication Error/Event: Complete Full Section on Both Pages 2 and 3

Medication Error/Event Type:

- ☐ Charting error
- ☐ Omission/Missed Dose
- ☐ Order Expired
- ☐ Transcription–wrong dose
- ☐ Transcription–wrong individual
- ☐ Transcription–wrong medication
- ☐ Inability to take medication (due to illness or other reason)
- ☐ Transcription -omission
- ☐ Transcription –wrong route
- ☐ Transcription–wrong time
- ☐ Wrong dose
- ☐ Wrong individual
- ☐ Wrong medication
- ☐ Wrong route
- ☐ Wrong time
- ☐ Extra Dose Given
- ☐ Missed Medication
- ☐ Lost Medication
- ☐ Contamination
- ☐ Other: _____

Reason for Error:

- ☐ Forgot to take on activity
- ☐ Forgot to send to program
- ☐ Pharmacy Error
- ☐ Omission unavoidable
- ☐ Medication not available
- ☐ Staff action/inaction
- ☐ Medication Refused
- ☐ Other: _____

Error discovered date: _____ Error discovered time: _____

Error date: _____ Total transcription errors: _____

Name(s) of Medication(s)** _____ Dosage: _____

_____ Dosage: _____

_____ Dosage: _____

(If error/event involves more medication than three, attach a list of the medication and dosages to this form)**

Medication Dosage Time: _____ Staff Involved: _____

Description of Occurrence Explanation:

Complete Medication Section on Page 3

Healthcare Coordinator Instructions (list title):

Medical Attention Required? ☐ YES ☐ NO

Medical Attention Type:

☐ Consult with Nurse ☐ Consult with Physician

☐ Consult with Emergency Room ☐ Consult Poison Control Center ☐ Immediate Physician's Visit

☐ Immediate Emergency Room Visit ☐ Observe and Report Only ☐ None

3. Use of a PRN Psychotropic Medication:

Date: _____ Time: _____ Medication: _____

Prescribing Physician: _____ Approved by HRC Program:

Reason for Administration: _____

Purpose of Medication: _____

Response to Medication Administration:

4. Restraint Related to Behavior:

Begin Time: _____ End Time: _____

Begin Date: _____ End Date: _____

Status: ☐ Emergency ☐ Approved by HRC Program (HWC/MANDT)

Injury caused by restraint? ☐ Yes ☐ No

Extended Restraint (more than 10 minutes)? ☐ Yes* ☐ No

*If yes, OBS must be notified within 1 business day. During evening or holidays, call the OBS Crisis Line at (505) 250-4292

5. Restraint - Other:

Restraint Type: ☐ Chemical ☐ Mechanical ☐ Physical ☐ Other

Begin Time: _____ End Time: _____

Begin Date: _____ End Date: _____

Comments/Summary:

6. Other:

- ☐ Accident no apparent injury
- ☐ Alcohol/Drug Abuse Altercation
- ☐ Altercation - harm to participant
- ☐ Altercation - harm to provider/others
- ☐ Elopement
- ☐ Emergency Services - unplanned
- ☐ Emergency Services - planned
- ☐ Exploitation
- ☐ Fire
- ☐ Hospital
- ☐ Law Enforcement Involvement
- ☐ Missing Person/AWOL
- ☐ Out of Home Placement
- ☐ Possible Criminal Activity/Misconduct
- ☐ Property Damage
- ☐ Sensitive Situation
- ☐ Suicide Attempt
- ☐ Theft/Larceny
- ☐ Other:

Please explain:

Required Signatures:

Staff/Contractor Reporting Incident: _____ **Date:** _____

FSS Service Coordinator: _____ **Date:** _____

FSS Program Manager: _____ **Date:** _____

QA/QI Committee Review Date: _____