DOCUMENTING AFTER AN INCIDENT

1. Document a brief factual description of the incident in the medical record.

2. Documentation should be pertinent, clear and concise.

3. Documentation should reflect how the resident was assessed for injury (e.g. vital signs, range of motion testing of limbs for fractures, eye exams to detect concussions, x-rays, etc.), the results of the assessments (both positive and negative), treatment provided, affects of the treatment, and any special precautions taken thereafter to minimize recurrences (e.g. medication reduction, bed alarm, etc.).

4. Document resident complaints of pain or lack of pain. Details should identify the exact site, type and intensity of pain and if medication was administered.

5. Documentation in the medical record should be completed immediately.

6. Documentation should identify the time the physician was notified, as well as any orders received, if applicable.

7. Documentation should identify the time and name of the responsible party that was notified. Document if message is left on answering machine, however, continue calling until personal contact is made with the responsible party regarding the incident and document the personal contact in the medical record.

8. Resident should be placed on the incident monitoring log and a note regarding the resident's status should be documented in the medical record once a shift for a minimum of 48 hours or until the condition and/or injury resolves. (*Charting frequency depends upon the facility policy and procedure*). Any changes in resident's condition should be communicated to the responsible party and the physician, if applicable.

9. New interventions/approaches should be added to the care plan based upon root cause to reduce the risk of a recurrence of the incident.