**Basic Responsibility**

Licensed Nurses and Interdisciplinary Team (IDT)

**Purpose**

1. To provide consistent clinical documentation in the electronic medical record.
2. To standardize the Event documentation among all the skilled nursing facilities within Ohio Living.

**Policy**

1. An Event is opened when a resident has an acute or chronic condition that warrants on-going assessment and/or monitoring or is at risk for developing an acute or chronic condition
2. The Event type is the general description/category for the Event.
3. The short description gives you the type of Event, EX: “Fall without injury,” Swelling of left lower extremity (would be for a soft tissue Event), etc.
4. The initial Progress Note is the specific reason, behavior, symptom and/or cause for initiating the Event. By reading the initial Progress Note, one could determine what the cause was for opening the event.
5. A licensed nurse opens an Event:
	1. At the time of the occurrence
	2. Upon admission, EX: Status Post Hip Fracture, Status Post Myocardial Infarction
	3. When an acute Event occurs
	4. When there is exacerbation of an existing chronic condition that requires monitoring.

**Procedure**

1. All Events must be completed before the end of the shift.
2. Completing Events: When documenting on an Event, you will not be able to change anything that was saved. If “Assessment Complete” hasn’t been checked on the Event, any sections that were left blank can still be updated. If you do not have enough documentation, you can start an Event, but only enter the information that you are sure of. Do not select Assessment Complete at the bottom of the page – this locks all sections.
3. An Event can only be closed by a nursing supervisor, Unit Manager or DON.
4. Open Events must be documented on every shift:
	1. Every open Event must have a progress note attached to it each shift.
	2. The on-coming nurse will run the “Facility Activity Report” and will choose “Events-Open” and the unit. The report may be sorted by resident name or by unit/room/bed. Click the “Report” button in the bottom right corner. These are the Events, which must be documented on during the shift.
5. A section that is left blank is considered “not applicable” only when that section or question does not have N/A as a choice.
6. Episodic Occurrence: This Event is used when there may be an acute Event, but it is not clear what Event is appropriate and the resident needs to be monitored in order to determine whether there is a problem. EX.: C/O vertigo 3 pm 1-1-07, Had a nosebleed at 7A that lasted 10 minutes, C/O “I’m just not felling right” 2P 1-1-07, etc.
7. Transfer Events:
	1. Documents to send when transferring a resident to the hospital:
		1. A printed copy of the Transfer Event (or appropriate hospital-required form)
		2. Copy of the Advance Directives (print from Resident Documents)
		3. From the Resident tab go to Reports send the following:
			1. The physician’s order report (don’t include d/c orders when running the report)
			2. CCD
8. Assessments that are to be done with Events:
	1. Behavior Management Follow-up: Completed by Social Services and/or licensed nursing prior to closing an **AGGRESSIVE/COMBATIVE BEHAVIOR EVENT**.
	2. Neuro Checks Progress Notes Templates to be completed with Neurological or Fall Event every 2hrs for 24hrs whenever a head injury is suspected or can’t be ruled out.