

ADMINISTRATIVE REVIEW FORM FOR UNANTICIPATED HOSPITALIZATION

Individual's Name: _____

Date of Unanticipated Hospitalization: _____

Major Unusual Incident Number: _____

Date Form Initiated: _____

Name of Person Initiating Form: _____

Title of Person Initiating the Form: _____

Contact Information for Person Initiating Form: _____

Provider Name: _____

PART 1 – TO BE COMPLETED BY THE INDIVIDUAL'S PROVIDER

DESCRIPTION – Indicate which situation applies.

- ☐ Hospitals admission lasting 48 hours or longer due to one or more of the specified diagnoses (i.e. aspiration pneumonia, bowel obstruction, dehydration, medication error, seizures, or Sepsis.)
- ☐ Hospital re-admission lasting 48 hours or longer due to any diagnosis that is the same diagnosis as a prior hospital admission lasting 48 hours or longer within the past 30 calendar days.

HISTORY/ANTECEDENTS: Explain what led to the unanticipated hospitalization.

Describe the medical history of the individual.

Have there been recent similar illnesses?

If so, please describe the illness and date or the occurrence,

What was the health of the individual in the 72 hours leading up to the hospitalization?

Did the individual complain of feeling unwell or deviate from routine (e.g., change in behavior, eating, sleeping, or bathroom habits)?

SYMPTOMS AND RESPONSE - What were the individual's symptoms (e.g., fever, rash, bloody stool, or trouble breathing) and over what length of time?

What actions did the provider take to address the symptoms?

PART 2 – TO BE COMPLETED BY THE INVESTIGATIVE AGENT IN COLLABORATION WITH THE INDIVIDUAL’S TEAM

DETAILS OF HOSPITALIZATION

Date of Admission: _____

Date of Discharge: _____

WHEN UNANTICIPATED HOSPITALIZATION IS BASED ON A HOSPITAL ADMISSION LASTING 48 HOURS OR LONGER DUE TO ONE OR MORE OF THE FOLLOWING DIAGNOSES

Indicate which apply:

- | | |
|---|--|
| ☐ Aspiration Pneumonia | ☐ Medical Error |
| ☐ Bowel Obstruction | ☐ Seizure |
| ☐ Dehydration | ☐ Sepsis |

WHEN UNANTICIPATED HOSPITALIZATION IS BASED ON A HOSPITAL RE-ADMISSION LASTING 48 HOURS OR LONGER DUE TO ANY DIAGNOSIS THAT IS THE SAME DIAGNOSIS AS A PRIOR HOSPITAL ADMISSION LASTING 48 HOURS OR LONGER WITHIN THE PAST 30 CALENDAR DAYS

Indicate the diagnosis of the hospitalizations:

Provide the dates of the prior hospital admission and discharge:

DISCHARGE SUMMARY – Attach discharged summary.

FOLLOW-UP APPOINTMENT/CHANGES TO MEDICATION/CONTINUING CARE – List the changes and the continuing needs of the individual.

The person responsible for these changes. _____

Confirm follow-up appointments have been made. _____

CAUSES AND CONTRIBUTING FACTORS

- | | |
|--|---|
| ☐ Medication change | ☐ Failure to monitor input/output of fluids |
| ☐ Medication error | ☐ Failure to follow bowel protocol |
| ☐ Aspiration due to improper diet texture | ☐ Failure to provide timely medical care |
| ☐ Refusal to follow diet | ☐ Failure to monitor urination and/or bowel movements |
| ☐ Insufficient fluid intake | |
| ☐ Chronic medical diagnosis that places individual at higher risk | |
| ☐ Refusal of staff assistance | ☐ Other: <div data-bbox="883 1560 1511 1694" style="border: 1px solid black; width: 387px; height: 64px; display: inline-block; vertical-align: top;"></div> |
| ☐ Lack of health care coordination | |

ADMINISTRATIVE REVIEW SUMMARY AND CONCLUSION

PREVENTION PLAN – Describe the prevention plan being implemented to address causes and contributing factors (e.g., environmental change, staff training, medication changes, or diet change).

Name of Investigative Agent Completing Form: _____

Date Form Completed: _____