



## MONTANA STATE HOSPITAL POLICY AND PROCEDURE

### EVENT REVIEW

**Effective Date:** March 10, 2014

**Policy #:** TX-25

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- I. PURPOSE:** To provide for a process to review every event leading to the use of seclusion or restraints and to review other significant events. To identify opportunities to develop alternative strategies to support people during times of distress that may prevent the use of seclusion and restraint in the future and provide for the safety of everyone.
- II. POLICY:** To provide emotional and physical support to all people affected by the event and to promote and develop strategies to ensure a safe environment.
- III. DEFINITIONS:**
  - A. **Physical Holds** – Body holds that temporarily restrict a patient’s freedom of movement. All documentation and care procedures will be completed in the same manner used for other restraints with one exception. Physical holds do not require an event review.
- IV. RESPONSIBILITIES:**
  - A. Unit/ Shift Nurse Manager or Identified Supervisor: Meet with staff immediately following an event and complete the Initial Review Part I on the Event Review Form and submit the form to the unit Program Manager. Participate, as appropriate, in meeting with the individual and treatment team members to complete the Parts II and III of the Event Review.
  - B. Program Manager or Identified Supervisor: Arrange for and participate in Parts II and III of the Event Review process. Document and complete the Event Review. Ensure follow-up on suggestions, treatment plan recommendations, and filing of form in the medical record.
  - C. Physician/Licensed Independent Practitioner (LIP)(Attending): Participate, as appropriate, in Parts II and III of the Event Review process.
  - D. All staff members: Participate in all aspects of the Event Review process upon request.
- V. PROCEDURE:**
  - A. An Event Review will be completed for every event leading to the use of seclusion or restraints and other significant events. Physical holds do not require an Event Review.

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- B. The Unit/Shift Nurse Manager, Program Manager and/or Unit RN, in conjunction with the unit staff members, will discuss the incident and complete the Event Review Part I immediately following the event. The goal of this review is to be supportive, ensure the appropriate emotional and physical care of all people that may have been injured or emotionally upset by the event, and to review event precursors and de-escalation strategies utilized. The Event Review will be given to an identified supervisor.
  
- C. The Identified Supervisor and any other appropriate team members will meet with the patient as soon as feasible and complete Part II of the Event Review. The goal is to gain understanding of the individual’s perspective and to develop treatment strategies that will result in providing for the safety of everyone in future situations.
  
- D. The Treatment Team will meet to complete Part III of the Event Review.
  
- E. Identified Supervisor will ensure follow-up on all suggestions and treatment plan recommendations.
  
- F. Patient Safety Committee will evaluate Event Reviews at the weekly meeting for accuracy, quality and safety.

**VI. REFERENCES:** None

**VII. COLLABORATED WITH:** Program Managers, Nurse Managers, Medical Director, Director of Nursing, Associate Hospital Administrator, and Hospital Administrator.

**VIII. RESCISSIONS:** #TX-25, *Event Review*, dated May 10, 2012; #TX-25, *Event Review*, dated July 1, 2009; #TX-25, *Event Review* dated June 17, 2005

**IX. DISTRIBUTION:** All hospital policy manuals

**X. REVIEW AND REISSUE DATE:** February 2017

**XI. FOLLOW-UP RESPONSIBILITY:** Program Managers, Director of Nursing Services

**XII. ATTACHMENTS:** Attachment A. [Event Review Form](#)

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
 John W. Glueckert                      Date  
 Hospital Administrator

\_\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Thomas Gray, MD                      Date  
 Medical Director

**Montana State Hospital**  
**EVENT REVIEW Conducted with Staff**

**Patient Name:** \_\_\_\_\_ **Patient #** \_\_\_\_\_ **Unit:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Location of Event:** \_\_\_\_\_

**Psychiatrist (on duty)** \_\_\_\_\_ **Nurse Manager (on duty)** \_\_\_\_\_ **Unit RN** \_\_\_\_\_

**EVENT:** \_\_\_\_\_ Restraint \_\_\_\_\_ Seclusion \_\_\_\_\_ Transport Blanket \_\_\_\_\_ Stretcher \_\_\_\_\_ Assault \_\_\_\_\_ Suicide Attempt \_\_\_\_\_ Other \_\_\_\_\_

**INITIAL REVIEW with Staff Part I:** *The initial review, Part I, is to be completed by one of the following: Unit/Shift RN, Nurse Manager, House Supervisor, Program Manager in conjunction with the unit staff members immediately following an event.*

**The goal is to be supportive and ensure appropriate emotional and physical care.**

1. Were any staff members injured? Yes No If yes complete an incident report "Please describe injuries" \_\_\_\_\_

\_\_\_\_\_

2. Were any patients injured? \_\_\_Yes \_\_\_ No If yes complete an incident report "Please describe injuries" \_\_\_\_\_

\_\_\_\_\_

3. Describe any/all property damage and complete incident report if needed. \_\_\_\_\_

\_\_\_\_\_ Photo documentation \_\_\_Yes \_\_\_ No

4. Staff members present during the event review \_\_\_\_\_

\_\_\_\_\_

5. Who communicated with patient? \_\_\_\_\_

6. Was the Nurse Manager, House Supervisor, Program Manager notified? \_\_\_\_\_ On Scene \_\_\_\_\_ By Phone \_\_\_\_\_ Time \_\_\_\_\_

7. Was a Code Green called? \_\_\_\_\_ Yes \_\_\_\_\_ No

Was assistance arranged prior to event/procedure? \_\_\_\_\_ Yes \_\_\_\_\_ No

8. What were the signs/behaviors noted that the person was becoming upset before incident? \_\_\_\_\_

\_\_\_\_\_

9. What de-escalation strategies were implemented? \_\_\_\_\_

\_\_\_\_\_

10. Comments \_\_\_\_\_

\_\_\_\_\_

11. Is there anything that staff could have done differently to prevent this event? \_\_\_\_\_

\_\_\_\_\_

12. Does the treatment plan address the behavior that occurred during this event? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

13. How did this procedure help keep people safe? \_\_\_\_\_

\_\_\_\_\_

14. Is follow-up recommended? If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

Person Completing Part I: \_\_\_\_\_ Date/time: \_\_\_\_\_

**Submit Part I to the QI Dept.**

**Montana State Hospital**  
**EVENT REVIEW Part II Completed with Person Served**

**Patient Name:** \_\_\_\_\_ **Hosp. #** \_\_\_\_\_ **Unit:** \_\_\_\_\_ **Date of Event:** \_\_\_\_\_

**EVENT:** \_\_\_\_\_ Restraint \_\_\_\_\_ Seclusion \_\_\_\_\_ Transport Blanket \_\_\_\_\_ Stretcher \_\_\_\_\_ Assault \_\_\_\_\_ Suicide Attempt \_\_\_\_\_ Other \_\_\_\_\_

**Part II:** *The Program Manager, Nurse Manager, or designee will conduct an interview with the patient in a timely manner. The goal is to partner with the person to develop strategies that will assist in their recovery process and promote safety for all people.*

1. What lead up to the event? What is the person's perception of why the event occurred?
2. Is there anything you think we could have done differently to help you?
3. What suggestions do you have to handle and/or prevent this type of situation in the future?
4. What is your understanding of why you take medications? (purpose, benefits, concerns)
5. Do you feel your current medications are helpful? If not, what medications help you the most?
6. If you received a PRN, do you think it was helpful?
7. How did this procedure help keep you and/or others safe?

Person completing Part II: \_\_\_\_\_ Date/time: \_\_\_\_\_

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**EVENT REVIEW Part III Completed with Treatment Team**

**Part III:** *The Program Manager, Nurse Manager, or designee will discuss the event with the Treatment Team.*

1. Describe any significant changes in the person's mood or behaviors within days/weeks prior to this event. What significant events may have contributed to this?
2. How was the person able to use coping/crisis planning strategies and treatment plan goals? Is a review or update of these plans indicated?
3. Describe medication management issues and recommendations.
4. What changes will be made to the treatment plan, crisis and/or coping plan, medication, and/or unit placement?
5. List treatment Team members present:

Person completing Part III: \_\_\_\_\_ Date/time: \_\_\_\_\_

**File Part II and III in Medical Record under Treatment Plan.**