# INSTRUCTIONS FOR COMPLETING ESRD FACILITY REPORT TO THE DIRECTOR

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES**
**REGULATORY LICENSING UNIT – FACILITY LICENSING GROUP**

This form is designed to be used to notify DSHS of reportable occurrences and of the action taken by the facility to identify and address any opportunity to improve care related to the occurrence. A separate letter to notify DSHS of such occurrences is **NOT** required. A completed form with all requested information may allow the surveyor to review the occurrence without requiring additional information or copies of medical records.

## Directions for Completing the Reporting Form

Please consider printing or typing the information if your handwriting is sometimes difficult for others to read. Be as complete as you can: complete information may allow the surveyor to review the incident without contacting you for more information. Use a separate report for each occurrence: a patient who has died in one occurrence; three patients who convert to Hepatitis B + are three occurrences.

**What should be reported:**
*Death related to treatment:* deaths occurring in the facility before or after treatment; deaths occurring elsewhere (home, hospital, etc.) immediately after treatment; deaths from a procedure variance such as an air embolism, exsanguination, incorrect dialysate, etc…

**DSHS Tracking Number:** Completed by the Department.

**Identifying the facility:** Include the name, address and phone numbers for the facility. Facility License # is on your facility license. Facility Provider # is the Medicare six digit number that begins with "45". The contact person(s) listed will be the person(s) the surveyor will ask for should a follow-up phone call be needed.

**Reporting information:** Record date you are making this report, the date and time of the event reported, circling am or pm. Check which event you are reporting on this form.

**Patient's current condition:** refers to the condition at the time the report is completed. If the patient is re-hospitalized unrelated to the occurrence, mark "in hospital", and include an explanation in the narrative.

*Total Heparin Dose:* record total dose given during the involved treatment
*Access:* check the boxes that apply.

On the chart provided, record the pre/post measures of pulse, blood pressure, and weight as example:

| | ***Pulse*** | | ***Blood Pressure*** | | ***Weight*** | |
|---|---|---|---|---|---|---|
| **Date** | **Pre** | **Post** | **Pre** | **Post** | **Pre** | **Post** |
| 2/14 | 80 | 74 | 130/74 | 120/65 | 84kg | 80kg |

On the second chart, record the labs as requested, as example:

| **Hct. or Hgb.** | | **Kt/V or URR** | | **Potassium** | |
|---|---|---|---|---|---|
| **Date** | **Result** | **Date** | **Result** | **Date** | **Result** |
| 2/9 | 33.1 | 2/1 | 67% | 2/1 | 4.5 |

Check all of the listed events that apply to the incident.

**Directions for Page 2:**
**Brief summary of the reportable incident:** describe what happened; who was involved (ie, RN, LVN, PCT, MD) and what action was taken at the time of the event. For example: "The RN charge nurse was notified by the PCT before treatment that this patient complained of shortness of breath. The RN assessed the patient and called the MD. She was directed to begin tx to attempt to remove excess fluid. Tx was started at 8:20. At 9:10 the patient became more SOB and the physician was called again. Patient was noted to stop breathing; CPR initiated and 911 called. (Code sheet and treatment record attached)."

**Narrative report of your investigation:**
What is your evaluation of the actions taken in regard to this incident? For example: "Discussed incident with RN on duty and MD. Both agree that assessment was accurate and dialysis was treatment indicated. Arrest was handled effectively and competently, 911 called immediately with response in 4 minutes by ambulance. Patient had been adequately ventilated by staff."

**Action to be taken as a result of this review:** Check all that apply. For the example given, "no action required" would be applicable.

**Sign and date the form**, and print your name and title. Return the form via fax or mail to the number or address provided. Do not put any information in the box marked "For Department Use".

Thank you for your cooperation. Revised 8/07

**DSHS Use Only**
**Tracking Number:**

# TEXAS DEPARTMENT OF STATE HEALTH SERVICES
# REGULATORY LICENSING UNIT – FACILITY LICENSING GROUP
# ESRD FACILITY REPORT TO THE DIRECTOR

Name of Facility: _____ Facility License #: _____
Address: _____ Facility Provider #: 45-_____
City: _____ Zip: _____
Telephone: _____ Fax: _____
Contact person(s): _____

## Reporting Information

Date of this report: ___/___/___ Date of the event: ___/___/___ Time of the event: _____am/pm

**Reportable Event Patient/Staff Occurrence:** ***(check all that apply to this event)***

- ☐ Hepatitis B Conversion, patient
- ☐ Hepatitis B Conversion, staff
- ☐ Death related to treatment (tx)

**If the incident involves a patient, please complete the following, if applicable:**

Patient's Last Name: _____ First: _____ Middle: _____
DoB: ___/___/___ SS#: _____ Started dialysis: ___/___/___ Admitted here: ___/___/___
Diagnoses *(all)*: _____
_____
Patient's Current Condition: *(check one)* ☐ Dialyzing incenter ☐ In Hospital ☐ Deceased

**Treatment Information:** ☐ HD incenter ☐ PD ☐ Home HD
Current Dry Weight: _____*Kg* Total Heparin Dose: _____*Units* Reuse #: _____
Access Type: *(check applicable)* ☐ Graft ☐ Fistula ☐ Central Catheter ☐ PD

**Complete for the treatment involved and last two treatments:**

| | *Pulse* | | *Blood Pressure* | | *Weight* | |
|---|---|---|---|---|---|---|
| **Date** | **Pre** | **Post** | **Pre** | **Post** | **Pre** | **Post** |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Provide the three most recent:**

| *Hct. or Hgb.* | | *Kt/V or URR* | | *Potassium* | |
|---|---|---|---|---|---|
| **Date** | **Result** | **Date** | **Result** | **Date** | **Result** |
| | | | | | |
| | | | | | |
| | | | | | |

**Hospitalization/Death involved the following during a dialysis treatment:** *(check all that apply)*

☐ Suspected dialyzer reaction ☐ Cardiac arrhythmia ☐ Seizure ☐ Hypotension
☐ Suspected medication reaction ☐ Suspected air embolism ☐ Blood loss ☐ Hypertension
☐ Suspected blood transfusion reaction ☐ Suspected pyrogen reaction ☐ Fluid Overload
☐ Do Not Resusitate (DNR) ☐ Chemical Exposure ☐ Other _____

**Brief summary of reportable incident; what happened and how it was handled:**

_____
_____
_____
_____
_____
_____
_____

**Narrative report of your investigation:** (How was the incident handled: are there actions you will consider to reduce the potential of similar events in the future?)

**Action you will take as a result of this review:** *(check all that apply)*

☐ Inservice and monitoring ☐ Corrective action and monitoring ☐ No action required
☐ Revision of policy/procedure ☐ Development of policy/procedure ☐ MedWatch report
☐ Other: _____
☐ Information is incomplete at this time; follow up narrative will be sent within 30 days

Signature: _____ Date: _____

Print Name: _____ Title: _____

Copy for your files and forward within ten working days of occurrence to:

**Texas Department of State Health Services**
**Regulatory Licensing Unit**
**Facility Licensing Group**
**Delivery Code 2835**
**PO Box 149347**
**Austin, TX 78714-9347**
**FAX: 512-834-4514**

**For Department Use**
Received in CO by: _____On: _____
Sent to Zone by: _____ On: _____
Received in Zone by: _____On: _____
Reviewed by: _____ On: _____
☐ No Action required ☐ Action required:
_____
_____
_____
CO notified of disposition by: _____
On: _____