INCIDENT REPORT

Use name of primary person served only; for all others use initials or first name with last initial. Additional incident reports should be created when multiple person served are involved.

|  |  |  |
| --- | --- | --- |
| **First & Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **CMH ID #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  **COFR (for admin use)** |
|  **Make separate report for each person served involved** |  |
| **DOB:**  |  |
|  |  **Check one: Medicaid \_\_\_\_\_ Non-Medicaid \_\_\_\_\_** |
| Date **Occurred/Noticed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  Date Reported: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Time **Occurred/Noticed:** **a.m.** **[ ]  p.m.** **[ ]**  |  Time Reported: \_\_\_\_\_\_\_a.m. [ ]  p.m. [ ]  |

**Site of Incident (*select one*):**

**[ ]  1. AFC** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **[ ]  2. Home of Person Served****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****[ ]  3. In Vehicle**

 Name of AFC home Address of consumer’s home

**[ ]  4. CMH-Ionia** **[ ]  5. CMH – Portland** **[ ]  6. CMH – Belding** **[ ]  7. Community**

**[ ]  8. Other (details):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Setting (*select all that apply*):**

**[ ]  1. Indoors** **[ ]  2. Outdoors** **[ ]  3. During Transport** **[ ]  4. Other (**details**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What happened? (add additional paper if you run out of space)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Injured, Type of Injury (***please describe***):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immediate Action Taken(*select all that apply*):

[ ]  0. None [ ]  1. Insured Safety [ ]  2. Checked for Injuries [ ]  3. Monitored [ ]  4. First Aid [ ]  5. Called 911[ ]  6. Other (*list*) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ] 7. Emergency Physical Management (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  8. Seclusion OR Restraint (CIRCLE correct one and explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person Served has Behavior Treatment Plan in Place (Fill out if they have a plan) (Use additional paper to explain if needed):

1. Was the behavior plan utilized in this incident? Y/N, If No, why not: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Were restrictive/intrusive measures utilized? Y/N, If Yes, note restrictive/intrusive measures taken:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If physical intervention occurred, report each intervention, and amount of time intervention used EACH TIME. (Ie. Hold for 5 mins, then released)

|  |  |
| --- | --- |
| Type of Physical Intervention used (detailed) | Length of Time (mins) |
|  |  |
|  |  |
|  |  |
|  |  |

1. Use of PRN medication for behavior modification during incident: Y/N, If yes, please note medication and when used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Action taken to prevent reoccurrence of incident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contacted/Notified (*select all that apply*):

[ ]  0. Doesn’t Apply [ ]  1. Supervisor [ ]  2. CMH Rights Office [ ]  3. Other (*list*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:      Supervisor/Designee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:

Forward reports about persons served to Primary Case Holder OR Supervisor, if primary clinician is reporting.

|  |
| --- |
| REVIEW |
|  |
| ***Review:*** (Completed by primary case worker if report originates from provider agency or paraprofessional;completed by program manager/supervisor if report originated by staff.)**1. Reviewer agrees with action taken:**[ ]  1. Yes [ ]  2. No (Explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. Could anything have been done to prevent, de-escalate, or lessen the incident? [ ]  1. No [ ]  2. Unknown [ ]  3. Yes (If yes, explain)     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3. Debriefing completed?: [ ]  1. Yes [ ]  2. No(If yes, describe details of debriefing:)     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Debriefing: \_\_\_\_\_\_\_ Debriefing on incident occurred with staff within 24 hours? Yes [ ]  No [ ]  If No, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CRITICAL EVENT CRITERIA: select all that apply. If none apply, select “none of the above.”**Person Served’s Service Program(s) at time of incident (*select all that apply*):** [ ]  1. Specialized Residential (Contracted AFC) [ ]  2. Community Living Supports in own home [ ]  3. SED/CWP/HSW [ ]  4. Targeted Case Management/Supports Coordination [ ]  5. ACT Services [ ]  6. Home-Based [ ]  7. Wraparound Services [ ]  None of the above**Type of Incident (*select all that apply):***[ ]  Unexpected Death not due to natural progression of illness or condition [ ]  Injury requiring ER/urgent care center treatment, or hospital admission [ ]  Serious physical illness requiring hospital admission [ ]  Serious challenging behavior with significant property damage, harm to self/other, unauthorized LOA[ ]  Arrest [ ]  Conviction [ ]  Medication Error Check one: [ ] Wrong med/wrong person [ ] wrong dose [ ] wrong time [ ] missed med [ ] wrong route[ ]  None of the above

|  |  |
| --- | --- |
| **Reviewer Comments/Recommendations:** | **Medical Staff Comments/Recommendations:** |
| **Reviewer Signature/Credentials:** **Date:** | **Medical Staff Signature/Credentials:** **Date:** |

**STOP! FORWARD TO RECIPIENT RIGHTS FOR FURTHER PROCESSING** |
| **Recipient Rights Officer Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_ Date:** **\_\_\_\_\_\_\_\_\_\_\_\_\_*****(Select all that apply:)*****[ ] Proper Action Taken** **[ ] Recipient Rights Investigation Initiated** **[ ] Referred for Sentinel Event Review**[ ] Critical Incident [ ] OtherComments: |