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.

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| **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)

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

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| 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  Other  Comments: |