*Date AA Rec’d IR:* Month/ Day/ Year

**Incident Report**

 If describing a different individual in report, use initials only. Full names for others involved are acceptable. Type or handwrite legibly in blue or black ink. No white out. For the notification section, either the staff or Program Manager can complete this information. It is required that the Vendor Agency notify at minimum the guardian and Service Coordinator.

***REMINDER: All incidents must be reported within 24 hours, and incident report submitted within 48 hours***

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| Individual Name: Client First name last name  |

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| DOB: Month/ Day/ Year  |

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| Region: Number 1-10  |

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| Date of Incident: Month/ Day/ Year | Time of incident: Hour: Minute [ ] am [ ] pm Mark one |
| Location of incident: Examples- home, community location, business name, etc. |
| Name of agency providing services at the time of incident: Vendor/Provider Agency or N/A |
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| **MEDICAL** | **LEGAL** |
| [ ]  Hospitalization – medical – admittance not ER visit-(Must be admitted to hospital, not Emergency Room)[ ]  Hospitalization – psychiatric – admittance not ER visit-(example- NH Hospital, 5 West, Hampstead, Cypress)[ ]  Injury of individual not requiring medical intervention\*-(did not seek professional treatment- example- minor injury)[ ]  Injury of individual requiring medical intervention\*-(went to medical facility, such as ER, Urgent Care, PCP)[ ]  Illness of individual not requiring medical intervention\*-(example- vomiting, diarrhea)[ ]  Illness of individual requiring medical intervention\*-(went to medical facility, such as ER, Urgent Care, PCP- example- medical or psychiatric evaluation)[ ]  Seizure-(use this form if no seizure documentation process in place; include duration of seizure; and notify nurse)[ ]  Medication refusal-(use this form if no refusal documentation process in place)[ ]  Fall-(any fall regardless of severity)[ ]  Other:      *(incident that doesn’t fall in any of the above categories)* *\*by nursing or medical intervention we mean treatment at a medical facility (e.g. ER, Urgent Care, PCP, etc.)* | [ ]  Possible/suspected violation of client rights- *(i.e. potential abuse, neglect, exploitation, or service rights violation)*[ ]  Individual missing/eloped *(even temporarily)-*(absent without supervision as per Service Agreement)[ ]  Police involvement*(any circumstance involving the police, including wellness checks)* |
| **INDIVIDUAL VICTIM OF** |
| [ ]  Theft-(someone stole something from individual)[ ]  Assault-(acts of physical violence made against individual)[ ]  Sexual Assault-(acts of unwanted sexual contact made towards individual)[ ]  Car Accident-(individual in vehicle that is involved in an accident)[ ]  Fire hazard/arson-*(individual victim of fire event)**(this section is only for incidents that the individual is a victim of, not staff)* |
| **SOCIAL** |
| [ ]  Behavior incident – no behavior plan-(Any reportable behavioral incidents involving an individual that does not have a behavior plan)[ ]  Behavior incident w/behavior plan-(Any behavioral incidents by an individual with a behavior plan, if no other documentation process in place per plan)[ ]  Mental Health episode *(suicidal ideation, unusual emotional moods, etc.)-*(Suicidal ideation, unusual emotional moods, etc.)[ ]  Physical Restraint utilized-(make sure to complete Emergency Physical Restraint Report if emergency physical restraint is outside of behavior plan requirements)[ ]  Other:      (incident that doesn’t fall in any of the above categories) |

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| **What happened prior to the incident:** |
| Describe what was happening immediately before incident. Who, what, where, and when. Recount facts only, no opinions. Keep it clear and concise. Do not give unnecessary details of the day. Do not make assumptions. Include where you and individual were prior to incident. Include exactly what you and the individual were doing prior to incident. Describe any environmental factors at that time. |
| **Describe what occurred during this incident (include specific information, i.e. behavior, injury etc.):** |
| Who, what, where, and when. Recount facts only, no opinions. Keep it clear and concise. Do not give unnecessary details of the day. Do not make assumptions. Include where you and individual were at time of incident. Include exactly what you and the individual were doing at the time of incident. Describe any environmental factors at that time. |
| **What action did the reporter or others employ in response to this incident:** |
| Describe what your (staff) response was to the incident/ individual. Describe how the individual reacted to your (staff’s) response. Describe how the incident was resolved. |

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| Signature of ReporterSignature of person completing report, as per agency policy | DateMonth/ Day/ Year | TimeHour: Minute |
| Printed Name of ReporterFirst name last name of person completing report | Title Job title |

*Individual Name:* Client First name last name  *Date of Incident:* Month/ Day/ Year

**NOTIFICATIONS**

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| **Who was notified (Include name, date/time and method of contact):**  |
| **Name** | **Relationship  to individual** | **Date** | **Time** | **Method of contact** | **By Whom** |
| First name last name | Service Coordinator | Month/ Day/ Year | Hour: Minute [ ] am [ ] pm | (example- phone, email) |  Name |
| First name last name | Program Manager | Month/ Day/ Year | Hour: Minute [ ] am [ ] pm | (example- phone, email) |  Name |
| First name last name | Guardian | Month/ Day/ Year | Hour: Minute [ ] am [ ] pm | (example- phone, email) |  Name |
| First name last name | Additional Service Provider (ex: home) | Month/ Day/ Year | Hour: Minute [ ] am [ ] pm | (example- phone, email) |  Name |
| First name last name | Nursing (if applicable) | Month/ Day/ Year | Hour: Minute [ ] am [ ] pm | (example- phone, email) |  Name |
| Other: First name last name | Relationship | Month/ Day/ Year | Hour: Minute [ ] am [ ] pm | (example- phone, email) |  Name |

**REVIEWS**

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| **Program Manager Review/Follow-up**  |
| Vendor Agency Manager review of incident, which could include follow-up/ next steps, preventative measures, and processing with staff, individual or team. Ensure all additional attachments (example- Nursing/ Medical Intervention Report and Emergency Physical Restraint Report) are included with this report. |
| Type of Program individual was in during this incident (e.g. CPS, Res, CSS, SEP, 521, etc.): CPS, Res, CSS, SEP, 521, etc.)Has the individual had a service transition within the past 6 months (new home, new home care provider, significant change in service delivery)? [ ]  Yes [ ]  No Mark one If yes, describe the transition and its relationship (if any) to the incident that occurred above: Describe transition and potential relationship to incident |
| If it is a behavioral incident with plan, was the behavior plan followed?  [ ]  Yes [ ]  No [ ]  N/A Mark one |
| Signature of Program ManagerSignature of Manager completing report, as per agency policy | DateMonth/ Day/ Year | TimeHour: Minute |
| Printed Name of Program ManagerFirst name last name of Manager reviewing report | Title Job title |

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| **Service Coordinator/Case Manager Review/Follow-up** |
| Service Coordinator review of incident, which could include any additional follow-up/ next steps, preventative measures, and processing with team. Ensure all additional attachments (example- Emergency Physical Restraint Report, Hospital Discharge paperwork) are included with this report. |
| Is a team meeting required at this time? [ ] Yes [ ] No Mark one |
| Signature of Service Coordinator/Case ManagerSignature of Service Coordinator completing report, as per agency policy | DateMonth/ Day/ Year | TimeHour: Minute |
| Printed Name of Service Coordinator/Case ManagerFirst name last name of Service Coordinator reviewing report | Title Job title |