North Carolina Incident Response Improvement System

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

PROVIDER INFORMATION

Corporation: ____________________

NAME

Name and Title of Person completing this form: ____________________

TITLE

____

Local Facility/Unit/Group Home

NPI Number: __________

Name: ____________________

License Number: __________

Director: ____________________

Physical Address: ____________________

____

Mailing Address: ____________________

____

City: ____________________ **Zip Code:** __________

Phone Number: (   )   -

Fax Number: (   )   -

E mail address: ____________________

County where services provided: __________

Host LME:

County of Residence: __________

Home LME:

INCIDENT INFORMATION

Date and Location

Date of Incident: ________ ○ **Unable to determine at this time**

Time of Incident: ________

Date Provider Learned of Incident: ________

Was the consumer under the care of the reporting provider? m Yes m No m N/A

Was a Licensed Residential Service being provided? m Yes m No m N/A

Location of the Incident:

- m Consumer's Home
- m Friend's home
- m Group home/Supported living facility
- m Home of Family Member
- m Hospital
- m School
- m Service facility
- m State Facility
- m Work
- m Unknown
- m Other
- m Community

Explain 'Other' in Comments ________

Other People Involed:

- ○ Friend
- ○ Friend of Family
- ○ Other Consumer
- ○ Family Member
- ○ Staff
- ○ Stranger
- ○ No one
- ○ Unknown
- ○ Other

Explain 'Other' in Comments ______________________________

____

____

Does this incident include an allegation against the facility?	m Yes	m No
Will this allegation require a submission of a Consumer Incident Report?	m Yes	m No

Service Types Provided At the Time of the Incident:

Was the consumer under the care of the reporting provider?	m Yes	m No	m N/A
Was a Licensed Residential Service being provided?	m Yes	m No	m N/A

Service: ______________________________

License#: ____________

Was a Non-Residential Licensed Service being provided?	m Yes	m No	m N/A

Service: ______________________________

License#: ____________

Was an Un-Licensed Service being provided?	m Yes	m No	m N/A

Service: ______________________________

CONSUMER INFORMATION

	First	MI	Last
Consumer's Name:	____________	___	____________

Address where Incident Occurred: ○ Address Unknown

Address1: ____________________

Address2: ____________________

City: ____________

State: ________ **Zip:** ____________

Location: ____________________

LME Client Record Number: ________

Consumer's Date of Birth: ________ ○ Date of Birth unknown

Gender: m Male m Female

Height: ________ ft ________ in ○ Unknown

Weight: ________ lbs ○ Unknown

Dates of Last 2 Medical Exams: ________ ○ None ________ ○ None

Diagnoses: Enter up to 5 different diagnoses starting with the primary diagnosis.

____

____

____

____

____

Current Medications:

____

____

____

Medical Diagnosis:

____

____

____

Does consumer have TBI (Traumatic Brain Injury)? m Yes m No m Unknown

Is consumer receiving ICF-MR/DD services? m Yes m No m Unknown

Does consumer receive CAP-MR/DD funding? m Yes m No m Unknown

Comprehensive Waiver? m Yes m No m Unknown

Supports Waiver? m Yes m No m Unknown

Self-Directed Waiver? m Yes m No m Unknown

Innovations Waiver? m Yes m No m Unknown

Is this person in the Money Follows the Person program? m Yes m No m Unknown

Treatments

Did this incident result in or is it likely to result in permanent physical or psychological impairment? m Yes m No

Has this incident resulted in or is it likely to result in a danger to or concern to the community or a report in a newspaper, television or other media? m Yes m No

Was the consumer treated by a licensed health care professional for the incident? m Yes m No m Unknown ____________ Date

If hospitalized ...

was it for a medical condition? m Yes m No m Unknown ____________

was it for a MH/DD/SAS issue? m Yes m No m Unknown ____________ Date

Is the consumer enrolled in an opioid treatment program, (methadone maintenance)? If 'Yes', complete the entries in the following box. m Yes m No

Methadone Maintenance

1. Date of Admission to Methadone Maintenance Treatment ____________

2. Date of Initial Methadone dosage ____________

3. Initial Methadone dose received ________ mg

4. Date of last Methadone dosage prior to incident: ____________

5. Last Total Methadone dose received prior to death

			mg	Date
Dosed at Clinic?	m Yes	m No	_____	____________
Given Take-Homes?	m Yes	m No	_____	____________

6. Total Methadone dose received on the date of death (if different from above)

Dosed at Clinic?	m Yes	m No	_____	____________
Given Take-Homes?	m Yes	m No	_____	____________

7. Name of consumer's methadone treatment center physician ____________________

Mental Health Services

Did the consumer receive mental health services? If so, make the appropriate selections from those available below.

m Yes m No

Licensed Residential Services

- .4300 - Therapeutic Community
- H0019 (.1700) - Child and Adolescent Residential Treatment - Levels III [Behavioral Health - Long Term Residential
- H0019 (.1800) - Child and Adolescent Residential Treatment - Levels IV [Behavioral Health - Long Term Residential
- H2020 (.1300) - Child & Adolescent Residential Treatment - Level II Group - Program Type
- S5145 - Child and Adolescent Residential Treatment - Level II - Family Type (Licensed by DSS- 131D)
- Y 2347/ H0046 - Therapeutic Foster Care (licensed by DSS)
- YA230 (.1900) - Psychiatric Residential Treatment Facility [PRTF]
- YA241 (.5200) - Wilderness Camp
- YM725,811-816,YP710, - IPRS Only Licensed Supervised Living (.5600)
- YM725,811-816,YP710,YP720 - Supervised Living Alternative Family Living (.5600F)
- YM725,811-816,YP710,YP720 - Supervised Living Adult MH (.5600A)
- YM755, 740, 750 - IPRS Only Licensed Family Living (.5600)
- YP485 (.5000) - Facility Based Crisis Program - Non-Medicaid
- YP760, 770, 780 - IPRS Only Licensed Group Living (.5600)
- YP820 (.6000) - Inpatient Hospitalization

Licensed Services

- H0035 (.1100) - Partial Hospitalization - Children and Adults
- H0035 (.5000) - Professional Treatment Services In Facility-Based Crisis Program
- H2012 (.1400) - Child and Adolescent Day Treatment
- H2017 (.1200) - Psychosocial Rehabilitation [PSR]
- YA125 (.5100) - Hourly Respite [CMSED]- Licensed
- YA213 (.5100) - Community Respite [CMSED]
- YP630, YP640 - Supported Employment
- YP660 (.5400) - Day/Evening Activity
- YP690 (.5401) - Drop-In Center - Attendance
- YP692 (.5401) - Drop-In Center - Coverage Hours
- YP730 (.5100) - Community Respite

Non-Licensed Services

- - LME Care Coordination- if no other service
- - Peer Support Service: B-3 Service

- ○ .5600 Unlic - Supervised Living Unlicensed
- ○ 0.5700 - Assertive Community Treatment Team [ACTT]
- ○ 90772 - Medication Management
- ○ 90801 - Clinical Evaluation/ Intake
- ○ 90805- 90809 - Individual Therapy
- ○ 90862 - Medication Checks- Individual
- ○ 96101 - Psychological Testing
- ○ H0001 - Behavioral Health Assessment
- ○ H0031 - Mental Health Assessment
- ○ H0032 - Targeted Case Management- MH
- ○ H0036 HA - Community Support: Children/Adolescents
- ○ H0036 HB - Community Support: Adults
- ○ H0036 HQ - Community Support: Group
- ○ H2011 (.6100) - Mobile Crisis Management
- ○ H2015HT - Community Support Team [CST]
- ○ H2022 - Intensive In-Home Services
- ○ H2033 - Multisystemic Therapy
- ○ T1023 - Diagnostic Assessment
- ○ T1023:GT - Diagnostic Assessment- Telemedicine
- ○ Y2345 - Criterion V
- ○ YA125 (.5100) - Hourly Respite [CMSED]-Unlicensed
- ○ YA213 (.5100) - Community Respite [CMSED]
- ○ YM050 - Personal Care Services
- ○ YM580 - Day Supports
- ○ YM600 - Financial Support Services
- ○ YM645 (.5801) - Long-Term Vocational Support- MH/SA
- ○ YM686 - Guardianship
- ○ YM716 - Individual Supports
- ○ YM755, 740, 750 - IPRS Only-Unlicensed Group Living (.5600)
- ○ YM755, 740, 750 - IPRS Only Unlicensed Supervised Living (.5600)
- ○ YM755, 740, 750 - IPRS Only Unlicensed Family Living (.5600)
- ○ YM850 - Residential Supports
- ○ YP010 (.6301) - Hourly Respite - Individual
- ○ YP011 (.6301) - Hourly Respite - Group
- ○ YP020 - Personal Assistance - Individual

- O YP230 - Assertive Outreach
- O YP630, YP640 - Supported Employment
- O YP730 (.5100) - Community Respite
- O YP831-834, H0004, HQ, HR, HS - Behavioral Health Counseling & Therapy and Outpatient Treatment
- O YP836 - Mental Health Assessment - Non-Licensed Provider

When did the consumer last receive a mental health service? ____________ O N/A

Did the consumer express any suicidal ideation during the last mental health service? m Yes m No

Did the consumer express any homicidal ideation during the last mental health service? m Yes m No

Developmental Disablity Services

Did the consumer receive developmental disability treatment/habilitation services? If so, make the appropriate selections from those available below. m Yes m No

Licensed Residential Services

- O .2100 - Specialized Community Residential Center for Individuals with DD
- O .2101 - Intermediate Care Facility for Persons with MR
- O H0045 - CAP-MR/DD- Respite Care - Institutional
- O H2016 - Innovations Residential Supports Level 1 and Level 1 AFL
- O H2016H1 - Innovations Residential Supports Level 4 and Level 4 AFL
- O S5150US - Innovations Respite- Facility
- O T2014 - Innovations Residential Supports Level 2 and Level 2 AFL
- O T2020 - Innovations Residential Supports Level 3 and Level 3 AFL
- O Y 2347/ H0046 - Therapeutic Foster Care (licensed by DSS)
- O YM725,811-816,YP710, - IPRS Only Licensed Supervised Living (.5600)
- O YM725,811-816,YP710,YP720 - Supervised Living DD Adult (.5600C)
- O YM725,811-816,YP710,YP720 - Supervised Living Alternative Family Living (.5600F)
- O YM725,811-816,YP710,YP720 - Supervised Living Minor DD (.5600B)
- O YM755, 740, 750 - IPRS Only Licensed Family Living (.5600)
- O YP760, 770, 780 - IPRS Only Licensed Group Living (.5600)

Licensed Services

- H0045HI - CAP-MR/DD- Crisis Respite
- S5102 - CAP-MR/DD- Adult Day Health Care Services
- T2021 - CAP-MR/DD- Day Support - Individual
- T2021 - Innovations Day Supports- Individual
- T2021HQ - CAP-MR/DD- Day Support - Group - 2 or More Clients,
- T2027 - Innovations Day Supports Developmental Day
- T202HQ - Innovations Day Supports- Group
- YA213 (.5100) - Community Respite [CMSED]
- YP610 (.2400) - Developmental Day Services
- YP620 (.2300) - Adult Developmental Vocational Program [ADVP]
- YP630, YP640 - Supported Employment
- YP650 (.5500) - Community Rehabilitation Program [Sheltered Workshop]
- YP730 (.5100) - Community Respite

Non-Licensed Services

- \- LME Care Coordination- if no other service
- .5600 Unlic - Supervised Living Unlicensed
- 90772 - Medication Management
- 90801 - Clinical Evaluation/ Intake
- 90862 - Medication Checks- Individual
- 96101 - Psychological Testing
- H2011 - Innovations Crisis Services Primary Response
- H2011 - CAP-MR/DD- Crisis Services
- H2011 (.6100) - Mobile Crisis Management
- H2014 - Developmental Therapy - Professional - Individual
- H2014HM - Developmental Therapy - Paraprofessional - Individual
- H2014HQ - Developmental Therapy -Professional - Group
- H2014U1 - Developmental Therapy - Paraprofessional - Group
- H2015 - Innovations Community Networking Service
- H2015 - Home and Community Support - Individual
- H2015HQ - CAP-MR/DD- Home and Community Support - Group of 2 or More Clients
- H2015U1 - Innovations Community Networking Class and Conference
- H2015U2 - Innovations Community Networking Transportation
- H2023 - CAP-MR/DD- Long Term Vocational Supports - Individual
- H2023HQ - CAP-MR/DD- Long Term Vocational Supports - Group [2-3 clients]
- H2025 - CAP-MR/DD- Supported Employment - Individual

- ○ H2025 - Innovations Supported Employment Services- Individual
- ○ H2025HQ - Innovations Supported Employment Services-Group
- ○ H2025HQ - CAP-MR/DD- Supported Employment - Group
- ○ NL ADVP - Non-licensed ADVP
- ○ S5110 - CAP-MR/DD- Individual Caregiver Training and Education
- ○ S5110 - Innovations Natural Supports Education- Individual
- ○ S5111 - Innovations Natural Supports Education Conference
- ○ S5125 - CAP-MR/DD- Personal Care Services
- ○ S5125 - Innovations Personal Care Services
- ○ S5150 - Innovations Respite- Individual
- ○ S5150 - CAP-MR/DD- Respite - Non Institutional - Individual
- ○ S5150HQ - CAP-MR/DD- Respite - Non Institutional Nursing - Group [2-3 Clients]
- ○ S5161 - CAP-MR/DD- Personal Emergency Response System
- ○ S5165 - Innovations Home Modifications
- ○ S5165 - Home Modifications
- ○ T 1017 (.5900) - Targeted Case Management [TCM]-DD
- ○ T1005 - CAP-MR/DD- Enhanced Respite Care
- ○ T1005TD - CAP-MR/DD- Respite Care - Nursing - RN
- ○ T1005TD - Innovations Respite Nursing Respite: RN
- ○ T1005TE - CAP-MR/DD- Respite Care - Nursing - LPN
- ○ T1005TE - Innovations Respite Nursing Respite: LPN
- ○ T1015 - Innovations In-Home Intensive Supports
- ○ T1019 - CAP-MR/DD- Enhanced Personal Care
- ○ T1023:GT - Diagnostic Assessment- Telemedicine
- ○ T1999 - CAP-MR/DD- Specialized Equipment and Supplies
- ○ T1999 - Innovations Individual Goods and Services
- ○ T2001 - CAP-MR/DD- Transportation
- ○ T2013 - Innovations In-Home Skill Building- Individual
- ○ T2013HQ - Innovations In-Home Skill Building- Group
- ○ T2014HI - CAP-MR/DD- Home Support - Level 2
- ○ T2016 - CAP-MR/DD- Home Support - Level 5
- ○ T2020HI - CAP-MR/DD- Home Support - Level 3
- ○ T2025 - Innovations Specialized Consultation Services
- ○ T2025 - CAP-MR/DD- Specialized Consultative Services
- ○ T2025-U1 - Innovations Financial Support Services

- T2025U2 - Innovations Employer Supplies
- T2025-U3 - Innovations Crisis Services Behavioral Consultation
- T2028 - CAP-MR/DD- Augmentative Communication - Purchases
- T2029 - Innovations Assistive Technology Equipment and Supplies
- T2033 - CAP-MR/DD- Home Support - Level 1
- T2033HI - CAP-MR/DD- Home Support - Level 4
- T2034 - Innovations Crisis Services Out of Home
- T2038 - Innovations Community Transition
- T2039 - CAP-MR/DD- Vehicle Adaptations
- T2039 - Innovations Vehicle Modifications
- T2041 - Innovations Community Guide- Monthly
- T2041 U1 - Innovations Community Guide- Periodic
- V5336 - CAP-MR/DD- Augmentative Communication - Repairs
- YA213 (.5100) - Community Respite [CMSED]
- YM050 - Personal Care Services
- YM580 - Day Supports
- YM600 - Financial Support Services
- YM686 - Guardianship
- YM700 - Independent Living - MR/MI
- YM716 - Individual Supports
- YM755, 740, 750 - IPRS Only-Unlicensed Group Living (.5600)
- YM755, 740, 750 - IPRS Only Unlicensed Family Living (.5600)
- YM755, 740, 750 - IPRS Only Unlicensed Supervised Living (.5600)
- YM850 - Residential Supports
- YP010 (.6301) - Hourly Respite - Individual
- YP011 (.6301) - Hourly Respite - Group
- YP020 - Personal Assistance - Individual
- YP230 - Assertive Outreach
- YP630, YP640 - Supported Employment
- YP730 (.5100) - Community Respite

When did the consumer last receive a development disability service? ○ N/A

Did the consumer express any suicidal ideation during the last development disability service? ☐ Yes ☐ No

Did the consumer express any homicidal ideation during the last development disability service? ☐ Yes ☐ No

Substance Abuse Services

Did the consumer receive substance abuse services? If so, make the appropriate selections from those available below. m Yes m No

Licensed Residential Services

- .4300 - Therapeutic Community
- H0012HB (.3400) - Substance Abuse Non-Medical Community Residential Treatment - Adult
- H2034 (.3400) - Substance Abuse Medically Monitored Community Residential Treatment
- H2034 (.5600) - Substance Abuse Halfway House- Licensed
- H2036 - Medically Supervised or ADATC Detoxification/Crisis Stabilization
- Y 2347/ H0046 - Therapeutic Foster Care (licensed by DSS)
- YM725,811-816,YP710, - IPRS Only Licensed Supervised Living (.5600)
- YM725,811-816,YP710,YP720 - Supervised Living SA Adult (.5600E)
- YM725,811-816,YP710,YP720 - Supervised Living SA Minor (.5600D)
- YM755, 740, 750 - IPRS Only Licensed Family Living (.5600)
- YP760, 770, 780 - IPRS Only Licensed Group Living (.5600)
- YP790 (.3200) - Social Setting Detoxification
- YP820 (.6000) - Inpatient Hospitalization

Licensed Services

- H0010 (.3100) - Non-Hospital Medical Detoxification
- H0014 (.3300) - Ambulatory Detoxification
- H0015 (.4400) - Substance Abuse Intensive Outpatient Program [SAIOP]
- H0020 (.3600) - Opioid Treatment
- H2012 (.1400) - Child and Adolescent Day Treatment
- H2035 (.4500) - Substance Abuse Comprehensive Outpatient Treatment [SACOT]
- YA213 (.5100) - Community Respite [CMSED]
- YP630, YP640 - Supported Employment
- YP730 (.5100) - Community Respite

Non-Licensed Services

- - LME Care Coordination- if no other service
- - Peer Support Service: B-3 Service
- .5600 Unlic - Supervised Living Unlicensed
- 0.3800 - Substance Abuse Services for DWI Offenders
- 0.3900 - Drug Education Schools
- 0.4000 - Treatment Alternatives for Safer Communities (TASC)
- 90772 - Medication Management
- 90801 - Clinical Evaluation/ Intake
- 90805- 90809 - Individual Therapy
- 90862 - Medication Checks- Individual
- 96101 - Psychological Testing
- H0005 (.3500) - Alcohol and/or Drug Services; Group Counseling by Clinician
- H2011 (.6100) - Mobile Crisis Management
- T1023:GT - Diagnostic Assessment- Telemedicine
- YA213 (.5100) - Community Respite [CMSED]
- YM050 - Personal Care Services
- YM580 - Day Supports
- YM600 - Financial Support Services
- YM645 (.5801) - Long-Term Vocational Support- MH/SA
- YM686 - Guardianship
- YM716 - Individual Supports
- YM755, 740, 750 - IPRS Only-Unlicensed Group Living (.5600)
- YM755, 740, 750 - IPRS Only Unlicensed Supervised Living (.5600)
- YM755, 740, 750 - IPRS Only Unlicensed Family Living (.5600)
- YM850 - Residential Supports
- YP010 (.6301) - Hourly Respite - Individual
- YP011 (.6301) - Hourly Respite - Group
- YP020 - Personal Assistance - Individual
- YP230 - Assertive Outreach
- YP630, YP640 - Supported Employment
- YP730 (.5100) - Community Respite
- YP830 - Alcohol and/or Drug Assessment - Non-Licensed Provider
- YP831-834, H0004, HQ, HR, HS - Behavioral Health Counseling & Therapy and Outpatient Treatment
- YP835 - Alcohol and/or Drug Services; Group Counseling by Non-Licensed Provider

When did the consumer last receive a substance abuse service? ____________ O N/A

Did the consumer express any suicidal ideation during the last substance abuse service? m Yes m No

Did the consumer express any homicidal ideation during the last substance abuse service? m Yes m No

Hospital Discharge

Date of last discharge from a State facility/hospital ____________ m Never m Unknown

Name of State Facility/Hospital

- R. J. Blackley ADATC
- O'Berry Neuro-Medical Center
- J. Iverson Riddle Developmental Center
- Black Mountain Neuro-Medical Center
- Murdoch Developmental Center
- Julian F. Keith ADATC
- Cherry Hospital
- Caswell Developmental Center
- Central Regional Hospital - Raleigh Campus
- Longleaf Neuro-Medical Center
- Walter B. Jones ADATC
- Central Regional Hospital
- Broughton Hospital
- Whitaker School
- Wright School

Date of last discharge from a Non-State facility/hospital ____________ m Never m Unknown

Name of Non-State Facility/Hospital ________________________________

Associated Incident Reports

Have other Incident Reports been submitted for this incident because more than one consumer was involved / affected by this incident? m Yes m No

How many other consumers required, or will require, incident reports for this same incident? __________

Enter the LME Client Record Number or the Consumer's Initials in the spaces below.

____

____

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____

DEATH INFORMATION

Manner of Death:

Choose One

m Terminal Illness / Natural Cause

m Accident

m Homicide / Violence

m Suicide

m Unknown Cause

If 'Suicide' selected above, choose the suicide method from this list.

- m Gunshot
- m Hanging
- m Drowning
- m Stabbing
- m Other

Did death occur within 14 days of discharge from a State Operated Facility? m Yes m No

Did death occur within 7 days of Restrictive Intervention? * m Yes m No

Associated Injuries: (Check All That Apply)

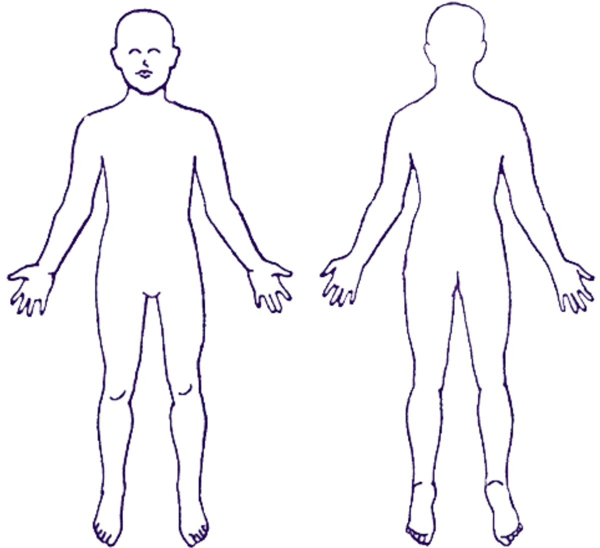
- o Airway Obstructed
- o Amputation
- o Bite: Animal
- o Bite: Human
- o Bleeding
- o Broken Bones
- o Bruise
- o Burn
- o Choking
- o Crush
- o Cut/Laceration
- o Dislocation
- o Electrocution
- o Head Injury
- o Ingestion of a Foreign Body
- o Heat/Cold
- o Infection
- o Inhalation
- o Poison
- o Puncture Wound
- o Rash/Hives
- o Scratch
- o Sting
- o Stress/Anxiety
- o Swelling
- o Unknown
- o Other

Explain 'Other' in Comments ______________________________

____

____

Associated Body Parts:



Explain 'Other' in Comments ______________________________

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____

Death Due To: (Check All That Apply)

- ○ Abuse/Neglect/Exploitation
- ○ Adaptive Equipment
- ○ Assault
- ○ Behavioral Outburst
- ○ Choking
- ○ Clothing
- ○ Drowning
- ○ Drug Overdose
- ○ Drug Overdose - Methadone Toxicity
- ○ Eating Behavior/Chewing/Physical Disability
- ○ Environment
- ○ Exposure
- ○ Fall
- ○ Fire
- ○ Food Consistency
- ○ Gunshot
- ○ Ingestion of Foreign Matter (PICA)
- ○ Inhalation
- ○ Insect Bite
- ○ Medical Procedure
- ○ Medication Error
- ○ Motor Vehicle Accident
- ○ Natural Disaster
- ○ Poison
- ○ Restraint Manual/Mechanical
- ○ Seizure
- ○ Self-Injurious Behavior
- ○ Sexual Assault
- ○ Stabbing
- ○ Unknown
- ○ Other

Explain 'Other' in Comments ______________________________

RESTRICTIVE INTERVENTION

Is the use of Restrictive Intervention part of the Consumer's Person-Centered Plan? m Yes m No

Was the Restrictive Intervention administered properly? m Yes m No

(Planned use, administered by a person trained to implement the plan, administered as written and adhering to the timelines in the plan)

Did the use of Restrictive Intervention result in the consumer's discomfort, injury, complaint, or require treatment by a licensed health-care professional? m Yes m No

General 1

Date of Intervention ____________ Time ______ m AM m PM

Intervention Type (Number in order of use)

Sequence		Duration Hours	Duration Minutes
	Isolation Time-Out		
	Seclusion		
	Restraint - Sitting		
	Restraint - Standing		
	Restraint - Face-down		
	Restraint - 3-Person Face Up		
	Protective Device		

(Describe device in Comments)

Intervention Curriculum Used: (Check All that apply)

- NCI - North Carolina Interventions - Part A
- NCI - North Carolina Interventions - Part B
- CPI - Crisis Prevention Institute
- TCI - Therapeutic Crisis Intervention
- None / Do not know
- Other

(Explain 'Other' in Comments) ______________________________

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____

Describe what happend to cause a restrictive intervention, including specifics of the individual's behavior, (e.g. frequency, intensity, duration), and actions learding to the behavior.

____

____

____

General 2

Purpose of the Intervention (Check All that apply)

- Prevent Harm to Self
- Prevent Harm to Others
- Prevent Serious Property Damage
- Planned Intervention According to Person-Centered Plan *
- Other

*** Enter the Person-Centered Plan Date:** __________

(Explain 'Other' in Comments) ______________________________

____

____

Positive and/or Less Restrictive Interventions Attempted: (Check All that apply)

- Verbal Redirection
- Distractions (e.g. take a walk)
- Removing Consumer from situation (verbal and physical prompt)
- Separation from group (verbal and physical prompt)
- Treatment Session
- Other

(Explain 'Other' in Comments) ____________________

Status Check

Consumer Status Checks:
(Check All that apply and explain abnormalities in the Comments Section)

Item	INITIAL CHECK	ENDING CHECK	FOLLOW-UP
Consciousness	m Alert m Dazed m Unconscious	m Alert m Dazed m Unconscious	m Alert m Dazed m Unconscious
Speech	m Normal m Abnormal	m Normal m Abnormal	m Normal m Abnormal
Breathing	m Normal m Abnormal	m Normal m Abnormal	m Normal m Abnormal
Movement	m Normal m Abnormal	m Normal m Abnormal	m Normal m Abnormal
Skin Color	m Normal m Pale m Flushed	m Normal m Pale m Flushed	m Normal m Pale m Flushed
Orientation	O Person O Place O Time	O Person O Place O Time	O Person O Place O Time
Affect / Mood	m Appropriate m Inappropriate	m Appropriate m Inappropriate	m Appropriate m Inappropriate
Behavior	m Person calmed down, regained self-control m Consumer was no longer combative m Consumer was no longer displaying inappropriate behavior		

m Yes m No

Was the person monitored continuously during the intervention and for 30 minutes afterward?

Name and Title of person providing the monitoring: ____________________ ____________________

Explain below:

____

____

____

Staff

Staff Invoved in Intervention

Staff		Current Certifications In: CPR	First Aid	Intervention Used
Name:	____________	m Yes m No	m Yes m No	m Yes m No
Title:	____________			
Name:	____________	m Yes m No	m Yes m No	m Yes m No
Title:	____________			
Name:	____________	m Yes m No	m Yes m No	m Yes m No
Title:	____________			
Name:	____________	m Yes m No	m Yes m No	m Yes m No
Title:	____________			
Name:	____________	m Yes m No	m Yes m No	m Yes m No
Title:	____________			

Debriefing

Date of Debriefing ____________

Describe the debriefing with the individual and /or guardian

____

____

____

Also describe the debriefing with staff

___

___

___

(What could have been done differently to avoid the need for restrictive intervention in this situation? What can be done to reduce the need for future restrictive interventions?)

Person-Centered Plan (Part 1)

1. Has the need for a crisis or behavior plan, (or plan revision), been communicated to the Person-Centered Planning team? m Yes m No

2. Has the Person-Centered Planning team previously addressed this issue? m Yes m No

3. Does the consumer have an approved Crisis Plan? m Yes m No

Was the current plan effective in addressing the issue? m Yes m No

Was the plan used prior to the intervention? m Yes m No

Who approved the plan?

	Agency	Date
O Client Rights Committee		
O Intervention Advisory Committee		
O LME Client Rights Committee		
O Physician		

Person-Centered Plan (Part 2)

4. Does the consumer have an approved Behavior Plan? m Yes m No

Was the current plan effective in addressing the issue? m Yes m No

Was the plan used prior to the intervention? m Yes m No

Who approved the plan?

	Agency	Date
O Client Rights Committee		
O Intervention Advisory Committee		
O LME Client Rights Committee		
O Physician		

5. Was the restrictive intervention completed as specified in the Person-Centered Plan? m Yes m No

a. Was restrictive intervention administered by a person trained to implement the plan? m Yes m No

b. Was restrictive intervention administered adhering to the timelines of the plan? m Yes m No

If No, explain what happened that was different than specified in the plan.

____

____

____

6. Was intervention over 15 minutes? m Yes m No m Yes, but not authorized

Who authorized the additional time? **Name** ____________________

Title ____________________

Person-Centered Plan (Part 3)

7. Number of Restrictive Interventions in the last 30 days ________

8. Total length of time of restrictive interventions used in the past 30 days (including the time in this incident):

m 0-15 Minutes

m 16-30 Minutes

m 31-45 Minutes

m 46-59 Minutes

m 1-10 hours

m 11-20 hours

m 21-30 hours

m 31-40 hours

m More than 40 hours

9. Significant Medical Conditions known prior to this intervention: (Check All that apply)

o Heart Condition

o High Blood Pressure

o Physical Disabilities

o Asthma

o Seizure Condition

o None

o Other

Explain 'Other' in Comments: ______________________________

Plans for Follow-up: (Check All that apply)

- ○ Convene Treatment Plan
- ○ Take Plan for Restrictive Intervention to Client Rights Committee for Review
- ○ Develop Planned Restrictive Intervention Plan
- ○ Take Plan for Restrictive Intervention to Intervention Advisory Committee
- ○ Discuss with Physician
- ○ None
- ○ Other

Explain 'Other' in Comments

INJURY INFORMATION

Description: Check All That Apply

- ○ Abrasion/Scrape
- ○ Ache/Pain
- ○ Airway Obstructed
- ○ Amputation
- ○ Bite: Animal
- ○ Bite: Human
- ○ Bleeding
- ○ Broken Bone
- ○ Bruise
- ○ Burn
- ○ Choking
- ○ Crush
- ○ Cut/Laceration
- ○ Discoloration
- ○ Dislocation
- ○ Electrocution
- ○ Foreign Body
- ○ Heat/Cold
- ○ Indication of Pain
- ○ Infection
- ○ Poison
- ○ Puncture
- ○ Rash/Hives
- ○ Scratch
- ○ Sting
- ○ Sprain/Strain/Twist
- ○ Swelling
- ○ Other

Explain 'Other' in Comments: ______________________________

____

____

Injured Body Parts

Explain 'Other' in Comments: ______________________________

____

____

____

Due To: Check All That Apply

- ○ Abuse/Neglect/Exploitation
- ○ Adaptive Equipment
- ○ Assault
- ○ Behavioral Outburst
- ○ Choking
- ○ Clothing
- ○ Drug Overdose
- ○ Eating Behavior/Chewing/Physical Disability
- ○ Environment
- ○ Exposure
- ○ Fall
- ○ Fire
- ○ Food Consistency
- ○ Gunshot
- ○ Ingestion of Foreign Matter (PICA)
- ○ Inhalation
- ○ Insect Bite
- ○ Medical Procedure
- ○ Medication Error
- ○ Motor Vehicle Accident
- ○ Natural Disaster
- ○ Poison
- ○ Restraint Manual/Mechanical
- ○ Seizure
- ○ Self-Injurious Behavior
- ○ Sexual Assault
- ○ Stabbing
- ○ Suicide Attempt
- ○ Water Accident
- ○ Unknown
- ○ Other

Explain 'Other' in Comments: ______________________________

____

____

MEDICATION ERROR

Did a medication error threaten the consumer's Health or Safety, (as determined by a physician or pharmacist)? m Yes m No m N/A

Check All That Apply

- - - - - - - - - - Complete this section if the consumer in Opioid Treatment program, - - - - - - - - - -

- Missed Dose
- Wrong Dose
- Dose Preparation Error
- Wrong Time
- Wrong Administrative Technique
- Wrong Patient
- Wrong Medication
- Loss or Spillage of Medication
- Refusal
- Other

If Loss or Spillage of Medication checked, enter the amount of loss or spillage: ________ mgs

Explain 'Other' in Comments: ____________________

____

____

- - - - - - - - Complete this section if the consumer NOT in Opioid Treatment program, - - - - - - - - -

- Missed Dose
- Wrong Dose
- Wrong Time
- Wrong Medication
- Refusal
- Other

Explain 'Other' in Comments: ____________________

____

____

ALLEGATION OF ABUSE, NEGLECT OR EXPLOITATION

As required by law, report any allegation of, or suspected abuse, neglect, or exploitation of a child or disabled adult to the county Department of Social Services. In addition, report any allegation of, or suspected abuse, neglect, or exploitation of any consumer by a staff to the Health Care Personnel Registry.

Check All that apply:

- o Verbal Abuse
- o Physical Abuse
- o Emotional Abuse
- o Sexual Abuse/Assault/Rape
- o Neglect
- o Exploitation
- o Fraud Committed Against Consumer
- o Diversion of Consumer Drugs
- o Misappropriation of Consumer Property
- o Mental Anguish

Explain Abuse in Comments: ____

____

____

Estimated Value of Diverted Drugs: __________

Estimated Value of Misappropriated Property: __________

Allegation Made Against (Select only one)

- m Friend
- m Friend of Family
- m Other Consumer
- m Staff *
- m Family Member
- m Stranger
- m Other

Explain Abuse in Comments: ____

____

____

* If the allegation is made against a Staff member, the Supervisor must complete the HCPR section of this Incident Report prior to submitting to the LME.

CONSUMER BEHAVIOR

Was this act potentially a serious threat to the health or safety of the consumer or others? m Yes m No

Was the consumer arrested as a result of this incident? m Yes m No

Was an Amber or Silver Alert issued due to the Consumer's Absence? m Yes m No

Check All That Apply:

- o Aggressive Behavior
- o Destructive Behavior
- o Illegal Act
- o Inappropriate Sexual Behavior
- o Suicide Attempt (unsuccessful)
- o Unplanned consumer absence of more than 3 hours over time specified in the PCP or that requires police contact
- o Diversion of Drugs
- o Other

(Explain 'Other' in Comments) ______________________

____

____

If 'Illegal Act' chosen above, select the Illegal Act from the list below:

- m Assault
- m Attempted Homicide
- m Homicide
- m Sexual Assault
- m Theft, Robbery, Burglary
- m Other

(Explain 'Other Illegal Act' in Comments) ______________________

____

____

SUSPENSION, EXPULSION

Check Only One - Note details in the Comments below:

From what service was the consumer expelled or suspended: what rule or policy was not adhered to and, if suspended or expelled from an Opioid Treatment Center, describe details of withdrawal regimen: medically supervised withdrawal, dates withdrawal began and ended, dose when withdrawal began, and withdrawal dosage changes by dates.

Number of Days

m Suspension from MH, DD, or SA Services One day or More ____

m Expulsion from MH, DD, or SA Services

Comments:

____

____

____

FIRE INFORMATION

Check All That Apply:

Number of Consumers

o Fire that threatens the Health or Safety of Consumers or Others ____

o Fire That Results in Injury

o Fire That has an Impact on Public Confidence

AUTHORITIES AND OTHERS CONTACTED

Authorities or persons you have notified of this incident:

	Contact Name	Phone	Date Notified
O County DSS	______	______	______
County: ______			
O Law Enforcement Agency	______	______	______
Agency Name: ______			
O Parent/Guardian	______	______	______
O Clinical Home/Treatment Plan Team	______	______	______
O ______	______	______	______
O ______	______	______	______

SUPERVISOR ACTIONS

Level of Incident:

IRIS will determine the level based on the information contained in the incident report.

Describe the cause of this incident:

Describe the cause of this incident, (the details of what led to this incident).

______

______

______

Incident Prevention:

Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident.

______

______

______

Incident Submission:

Name of Supervisor Authorizing Report: ____________________

Title of Supervisor Authorizing Report: ____________________

Phone #: ____________ **Email Address:** ____________________

The following checked agencies were notified by providers:

- ○ Local Management Entity Where Services Provided
- ○ State Methadone Authority
- ○ Local Management Entity Where Consumer Resides
- ○ DMH/DD/SAS Quality Management
- ○ DMH/DD/SAS Advocacy
- ○ State Operated Services
- ○ DHSR Complaint Intake Unit
- ○ DHSR Healthcare Personnel Registry

When re-submitting the Incident Report, please enter your explanation here.

____

____

____

○ By checking this box, I attest that the information contained in this Incident Report is true and an accurate representation of the incident.

HCPR - FACILITY ALLEGATION

Allegations

Report to Health Care Personnel Registry Investigations Branch

Name and Title of person completing this form: ____________________

Title

____

Actual Incident Location:

Address1: ____________________

Address2: ____________________

City: ____________ **Zip:** ________

Type of Facility: ____________________

Type of Care and Setting: ____________________

Choose the Type(s) of Allegation Being Made:

- ○ Resident Abuse
- ○ Resident Neglect
- ○ Diversion of Resident Drugs
- ○ Diversion of Facility Drugs
- ○ Fraud Against Resident
- ○ Fraud Against Facility
- ○ Misappropriation of Facility Property
- ○ Misappropriation of Resident Property
- ○ Injury of Unknown Source

Diversion of Resident Drugs Est. Value: ________

Diversion of Facility Drugs Est. Value: ________

Misappropriation of Facility Property Est. Value: ________

Misappropriation of Resident Property Est. Value: ________

Injury of Unknown Source:

Allegation Description:

Additional Resident Information

Did this incident result in physical injury/harm? m Yes m No

Physical Injury/Harm:

Did this incident result in mental anguish lasting 5 days or more? m Yes m No

Diagnoses:

Is the resident interviewable? m Yes m No

Mental Anguish:

Memory & Orientation:

When submitting this Facility Allegation to HCPR, you must enter an explanation here:

Accused Staff

This allegation is being made against how many Staff Members? ______

Staff 1

First MI Last

Staff Full Name: ____________ ___ ____________

Staff Social Security #: ____________

Staff Title: ____________

Staff Date of Birth: ____________ ____________

Staff Home Phone: ____________ ____________

Staff Last Known Address: ____________

City: ____________

State: ____________ **Zip:** ____________

Other Information:

Staff 2

	First	MI	Last
Staff Full Name:			

Staff Social Security #:

Staff Title:

Staff Date of Birth:

Staff Home Phone:

Staff Last Known Address:

City:

State: **Zip:**

Other Information:

Staff 3

	First	MI	Last
Staff Full Name:			

Staff Social Security #:

Staff Title:

Staff Date of Birth:

Staff Home Phone:

Staff Last Known Address:

City:

State: **Zip:**

Other Information:

Witnesses

How many Witnesses are there to this incident? ______

Witnesses 1

First MI Last

Staff Full Name: ______ ______ ______

Title/Relationship: ______

Last Known Address: ______

City: ______

State: ______ **ZIP:** ______

Witness Home Phone: ______ **Witness Other Phone:** ______

Witnesses 2

First MI Last

Staff Full Name: ______ ______ ______

Title/Relationship: ______

Last Known Address: ______

City: ______

State: ______ **ZIP:** ______

Witness Home Phone: ______ **Witness Other Phone:** ______

Witnesses 3

First MI Last

Staff Full Name: ______ ______ ______

Title/Relationship: ______

Last Known Address: ______

City: ______

State: ______ **ZIP:** ______

Witness Home Phone: ______ **Witness Other Phone:** ______