

INCIDENT REPORT

Confidential Information

(This form must be filled electronically. Handwritten forms are not accepted.)

Qualified Vendors or Providers are required to use this form to report all incidents to the Division.

DDD USE ONLY:

Member's Assigned District: North South East West Central State Operated
District Where Incident Occurred: North South East West Central State Operated

Date of Incident: _____ Time of Incident: _____

Member's Name (Last, First, M.I.): _____

Member's Date of Birth: _____ Member's AHCCCS ID: _____

Is this Member in Foster Care? Yes No

Is a Behavior Plan required? Yes No

• If yes, is the Behavior Plan current? Yes No N/A Expiration Date: _____

Is there a current Person-Centered Service Plan (PCSP)? Yes No PCSP Date: _____

• Does the PCSP identify the need for an enhanced ratio? Yes No
◦ If yes, select appropriate supervision level: 1:1 2:1 Other: _____

Qualified Vendor or Provider responsible for Member at the time incident occurred:

- Vendor Name: _____
- Site Name: _____ Vendor AHCCCS ID: _____
- Site Address: _____
City State ZIP Code

Location of Incident:

- Group Home Day Treatment Adult Day Treatment Child (After School/Summer)
- Family Home Intermediate Care Facility (ICF) Employment Program
- Individually Designed Living Arrangements Developmental Home School
- Community (please provide a brief description):

Other:

What services were being provided at time of incident:

Reporting Qualified Vendor or Provider Name (if different from above): _____

Title: _____ Phone Number/Email: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

How many doses were administered in error? None 1 2 3 or more

How many doses were missed in error? None 1 2 3 or more

Does the Member administer their own medications? Yes No

Did the Member refuse to take or report not taking their medication? Yes No

- If yes, was the Member able to explain why they refused or did not take their medication?

Was the medication incident related to a failure to administer medication by staff? Yes No

- If yes, why was the medication not administered? *Check all that apply:*

Medication not available Medication order expired Medication available does not match order

Medication order unclear Medication past expiration date

Other, explain: _____

- If no, was the medication administration incident a result of any of the following? *Check all that apply:*

Incorrect medication Incorrect member Incorrect dose

Incorrect time Incorrect route Incorrect or no documentation

Other, explain: _____

Did the Member vomit or spit out their medication after it was given? Yes No N/A

- If yes, was the prescriber contacted for further instructions? Yes No

• Provide name of prescriber contacted: _____

• Describe instructions received: _____

Describe any symptoms the Member had before the medication incident:

Describe any new or different symptoms the Member had after the medication incident:

Was any action taken? Yes No

- If no, please explain why action was not taken / not needed? _____

- If yes, were any of the following individuals contacted? *Check all that apply:*

Pharmacist Primary Care Physician Nurse Practitioner/Physician Assistant Poison Control

Nurse Line _____ Other _____

- Were instructions provided? Yes No

- If yes, please provide a detailed description of the instructions received:

- Were the instructions followed? Yes No

• If no, why not? _____

- Was 911 called? Yes No

- Was the Member transported by ambulance to an Emergency Department? Yes No

If yes, Name of Hospital: _____ City: _____ State: _____

- Was the Member then discharged from the Emergency Department?
 Yes No Not known at time incident report was completed by staff
- Was the Member then admitted to the hospital?
 Yes No Not known at time incident report was completed by staff

- Was the Member taken to Urgent Care? Yes No

If yes, Name of Urgent Care: _____ City: _____ State: _____

Medication administered by: Name _____ Title _____

Medication error identified by: Name _____ Title _____

Prescriber Name: _____ Contact information: _____

Prescriber Type: MD / DO Nurse Practitioner Physician Assistant Other _____

Pharmacy Name: _____

Pharmacy Address: _____
City State ZIP Code

INCIDENT TYPE – DEATH:

Is this incident report related to a Member's death? Yes No

- If yes, complete the additional Member death questions
- If no, continue to Incident Type - Other Section

Description of the event and how was it detected?

Date of Death: _____

- Member's Diagnoses: *(List all diagnosis)* _____

Was the Member enrolled in Hospice? Yes No

- If yes, Date Hospice services started: _____
- If the Member was receiving Hospice, were they contacted? Yes No N/A

Member Hospice Diagnosis:

Code	Description

Did the Member have advanced directives? Yes No Unknown

- Code status: Full code Do not resuscitate Unknown

Where was the Member at the time of death?

Hospital Hospice Inpatient Unit Group Home Own Home Other _____

What type of day was the Member having?

- Normal Routine: Yes No Unknown due to Member location at time of death
- Disruptions to Normal Routine: Yes No Unknown due to Member location at time of death
 - If yes, describe the disruptions: _____

Describe any symptoms the Member was exhibiting during the past 48-hours prior to the Member's death.

Unknown due to Member location at time of death

- When were symptoms first noticed? _____ Time: _____ am pm

What activity was the Member engaged in prior to the Member's death? _____

Describe the environment prior to the Member's death.

Unknown due to Member location at time of death

Were there similar incidents that occurred during the week before the Member's death?

Yes No Unknown due to Member location at time of death

- If yes, describe: _____

Describe the Member's behavior prior to the incident.

Unknown due to Member location at time of death

Were emergency personnel notified? Yes No

• If yes, complete the following:

○ Was 911 called? Yes No Unknown due to Member location at time of death

○ Was the member transported by ambulance to an Emergency Department?

Yes No Unknown due to Member location at time of death

If yes, Name of Hospital: _____ City: _____ State: _____

○ Did the Member pass away in the Emergency Department?

Yes No Unknown due to Member location at time of death

○ Was the Member admitted to the hospital?

Yes No Unknown due to Member location at time of death

▪ If yes, did the Member pass away while in the hospital?

Yes No Unknown due to Member location at time of death

○ Was the Member taken to Urgent Care?

Yes No Unknown due to Member location at time of death

If yes, Name of Urgent Care: _____ City: _____ State: _____

○ Was any first aid provide to the Member by staff?

Yes No Unknown due to Member location at time of death

▪ If yes, describe the measures taken: _____

▪ If no or not needed, describe reason why: _____

▪ Name of individual making the determination: _____ Title: _____

Prior to the Member's death, in the last 6 months,
when was the last time the Member was treated at a Hospital? _____

• Reason for Hospital Admission? _____

Name of Hospital: _____

Address: _____ City: _____ State: _____

Prior to the Member's death, in the last 6 months,
when was the last time the Member was treated at an Urgent Care? _____

• Reason for Urgent Care Visit? _____

Name of Urgent Care: _____

Address: _____ City: _____ State: _____

Prior to the Member's death, within the last 6 months,
when was the last time the Member was treated in an Emergency Department? _____

• Reason for Emergency Department visit? _____

Name of Hospital: _____

Address: _____ City: _____ State: _____

Prior to the Member's death, within the last 6 months,
when was the last time the Member received first aid from the staff providing services to the Member? _____

• Reason for first aid was administered by staff? _____

• Describe the measures taken: _____

INCIDENT TYPE – OTHER:

Complete this Section for all other incidents. Write clearly, objectively and in order of occurrence, without reference to the writer's opinion. Provide a detailed description for each question.

Provide a detailed description of the incident, including all known facts:

What happened before the incident?

- What type of day was the Member having? _____

 - Normal Routine? Yes No
 - Disruptions to Normal Routine? Yes No
 - If yes, describe the disruption(s): _____

- What activity was the Member engaged in before the incident occurred? _____

- Describe the environment before the incident occurred.
- Were there similar incidents that occurred the week prior to the incident? Yes No Unknown
- Describe the Member's behavior prior to the incident.
- Were techniques or steps taken to de-escalate the situation? Yes No
 - If yes, describe the techniques utilized: _____

What happened during the incident?

- Was the Behavior Plan followed? Yes No N/A
 - If yes, specifically, what techniques were implemented based on the plan? _____

 - If no, please explain why not: _____

- Were emergency measures utilized during this incident? Yes No
 - If yes, what type of Prevention & Support was utilized during the event: _____
Name of staff involved in the technique: _____
 - Did the technique result in an injury to the Member? Yes No
 - If yes, please describe the injury: _____
 - Did the technique result in an injury to staff? Yes No
 - If yes, please describe the injury: _____
- Does this incident require a change to the Member's BP? Yes No
- Were there any recent changes to the BP due to prior incidents? Yes No
 - If yes, related to incidents that occurred in the past: 30 days 60 days 90+ days
- Was the Member injured? Yes No N/A
 - If yes, describe injuries: _____
 - How was the Member injured: _____
- Was the Behavioral Health Crisis Line called? Yes No N/A
 - If yes, please describe the outcome: _____
- Was 911 called? Yes No N/A
 - If yes, *check all that apply*:
 - Support from Law Enforcement
 - Name Responding Law Enforcement Entity: _____
 - City: _____ State: _____ ZIP Code: _____
 - Name of the Responding Officer: _____ Badge # _____
 - Enforcement Report # _____
 - Support from Paramedic Evaluation / Transport
 - Was the Member transported by ambulance to an Emergency Department? Yes No
 - If yes, Name of Hospital: _____ City: _____ State: _____
 - Was Member then discharged from Emergency Department?
 - Yes No Not known at time incident report was completed by staff
 - Was Member then admitted to the hospital?
 - Yes No Not known at time incident report was completed by staff
- Was Member taken to Urgent Care by staff? Yes No N/A
 - If yes, Name of Urgent Care: _____ City: _____ State: _____
- Was first aid provided by staff? Yes No Not needed
 - If yes, describe the measures taken: _____
 - If no or not needed, describe reason why: _____
 - Name of individual making the determination: _____ Title: _____

NOTIFICATIONS

This Section applies to all Incident Types - Medication, Death and Other

Incidents must be reported to the Division no later than 24 hours after the occurrence of the incident. Sentinel incidents must be reported to the Division immediately using the after-hours phone line at (602) 375-1403 or 1-(855) 375-1403 and a hard copy of the incident report submitted no later than 24 hours after the occurrence of the incident.

PARENT / GUARDIAN NOTIFIED: Yes No N/A – No appointed Guardian

- If yes, name of person notified: _____
 Relationship to Member: Parent Guardian Public Fiduciary TSS Case Worker
 Date of Notification: _____ Time of Notification: _____ am pm
- If no, explain why: _____

SUPPORT COORDINATOR NOTIFIED: Yes No

- If yes, name of person notified: _____
 Date of Notification: _____ Time of Notification: _____ am pm
- If no, explain why: _____

PROTECTIVE SERVICES NOTIFIED: Yes No N/A

- If No or NA, explain why: _____
- If yes, please indicate all agencies notified:
 Adult Protective Services (APS) Department of Child Safety (DCS) Tribal Protective Services
 Other _____
 Date of Notification: _____ Time of Notification: _____ am pm
 Report made via: On-Line Telephone Fax
 o If made via telephone, name of person receiving the report: _____
 Report #: _____

LAW ENFORCEMENT NOTIFIED: Yes No N/A

- If No, explain why: _____
- If yes, how was Law Enforcement notified? 911 call Non-Emergent call
 Date of Notification: _____ Time of Notification: _____ am pm
 Name Responding Law Enforcement Entity: _____
 City: _____ State: _____ ZIP Code: _____
 Name of the Responding Officer: _____ Badge # _____
 Enforcement Report # _____

OTHER AGENCY NOTIFIED: Yes No N/A

- If yes, please indicate all agencies notified:
 Arizona Center for Disability Law Probation DES Case Worker Primary Care Provider
 Behavioral Health Provider Dept. of Health Services
 Other _____
 Date of Notification: _____ Time of Notification: _____ am pm

CORRECTIVE ACTION/COMMENTS**This Section applies to all Incident Types - Medication, Death and Other**

As a result of this incident, what steps were taken to prevent an incident of this type from happening again?

Provide detailed information including the following:

- In retrospect, what could have been done to better support the Member?

- If the incident was a result of the Member's escalating behavior(s), what de-escalation techniques could have been implemented in this situation to provide support to this Member?

- Were safety risks in the environment identified that have been removed? Yes No
 - If yes, describe the environmental safety risks that contributed to this incident?

- Was additional staff training provided as a result of this incident? Yes No
 - If yes, describe the training provided:

Name of person completing this form: _____

Signature: _____ Date: _____ Time: _____ am pm

Supervisor's name: _____

Signature: _____ Date: _____ Time: _____ am pm