WESTBROOK HEALTH SERVICES
INCIDENT REPORT FORM v6.1

Submit ONE COPY of this report

(If Staff are injured, please file a separate Employee Accident/ Incident Report Form v1 to Personnel)

This event was a:

☐ ***SIMPLE INCIDENT*** ☐ ***SIMPLE ACCIDENT*** **(COMPLETE SECTIONS I and IV, ONLY. Do not complete Sections II or III)**

☐ ***CRITICAL INCIDENT*** **(COMPLETE SECTIONS I, II and IV. Do not complete Section III)**

☐ ***MANDATORY REPORTING INCIDENT*** **(COMPLETE SECTIONS I, III and IV. Do not complete Section II)**

SECTION I: INCIDENT INFORMATION

1. Employee Filing Report_____ Employee ID: _____
2. Job Title _____ Program_____
3. Date of report: _____
4. Discovery of event:
   a. Who discovered the event, if it was not the employee filing report, above: _____
   b. When (Date and Time) was the event discovered: Date: _____ Time: _____ AM / PM
   c. Where was the event discovered: _____
   d. Who was the event reported to: _____
   e. When (Date and Time) was the event reported: Date: _____ Time: _____ AM / PM
5. Witnesses _____ Title _____
   _____ Title _____
   _____ Title_____
6. Name of ☐ Consumer ☐ Other_____ Consumer Case #: _____
7. Is this consumer a ***Waiver Recipient***? ☐ Yes ☐ No
8. Is this consumer his/her own guardian? ☐ Yes ☐ No **IF NO, INDICATE BELOW:**
   ☐ Legal Representative (Parent/Guardian) ☐ Medical Power of Attorney ☐ Health Care Surrogate
   Is Legal Representative contact requested or required? ☐ Yes ☐ No
   (NOTE: Legal Representative may set their own parameters about contact except for Mandatory Reporting Incidents or Critical Incidents, which require contact):
   Who: _____ How: _____ Date: _____ Time: _____
9. Does this consumer have an Advocate? ☐ Yes ☐ No **IF YES, INDICATE BELOW:**
   ☐ WV Advocate ☐ EMS/TSN Hartley/Waiver Advocate
   Is Advocate contact required? ☐ Yes ☐ No
   Who: _____ How: _____ Date: _____ Time: _____
10. Date the event happened (if unknown, enter "*Unknown*"):_____Time: _____AM / PM
11. Where did this event occur? (Check and fill in as necessary):
    ☐ 7th Street Office ☐ Roane Office ☐ Pleasants Office ☐ Jackson Office ☐ Ritchie Office
    ☐ Residential Office ☐ Options ☐ New Day CSU ☐ Amity ☐ Consumer Home (not WHS)
    ☐ 7th Street DP ☐ Emerson DP ☐ Roane DP ☐ PI Shelter _____
    ☐ Other Transitional Housing _____ ☐ Women's Transitional Housing _____
    ☐ Roane County Group Home _____ ☐ Wood County Group Home _____
    ☐ Unknown ☐ Community / Other (Enter site, address, street, town, name of business, etc.): _____
    _____
12. Describe this event (include: **setting**, what significant events or patterns of events occurred prior (**antecedent**), what actually took place (**behavior**), what significant events occurred after (**consequences), others involved** (includes consumer to consumer. If consumer:consumer, have there been previous encounters? Patterns?)**, staff response; if med response required, what was done . ADD EXTRA PAGE IF NEEDED**):
    _____
    _____
    _____
    _____
    _____
    _____ ☐ See Extra Page
13. How long did this incident take? _____ minutes **(Time incident from start to finish, including restraint time, if any)**
14. If there was property damage, briefly describe: _____
15. **INJURY** ***(COMPLETE ONLY IF THERE WAS AN INJURY):***
    a. Describe injury or potential injury: _____
    _____ ☐ See Diagram

b. Enter which Medical staff were contacted if the injury or condition required medical treatment:
Who was notified: _____ Date: _____ Time: _____
Enter response / intervention provided, if any: _____
_____

c. Is this an ***Injury of Unknown Origin*** *(an injury that has no known probable cause*?) ☐ Yes ☐ No

d. If incident was an ***Injury of Unknown Origin***, document report to Administrator or other officials:
Who was notified: _____ Date: _____ Time: _____

16. **RESTRAINT (COMPLETE ONLY IF THERE WAS A RESTRAINT):**

a. How long did the restraint take: **_____ minutes?** (Enter very brief restraints (<60 seconds, etc.) as one (1) minute)

b. What **Non-Restrictive Measures were attempted before restraint was provided? _____**
_____

c. Who provided the restraint? (list all) _____

17. **MEDICATION ERROR (COMPLETE ONLY IF THERE WAS A MEDICATION ERROR):**

a. Were there serious consequences because of the error (If **YES**: **Critical Incident**; if **NO**: **Simple Incident**): ☐ Yes ☐ No

b. Enter name of staff that made error: _____

c. Enter Nurse Supervisor contact: How: _____ Date: _____ Time: _____

d. Enter Home Manager contact: How: _____ Date: _____ Time: _____

e. Enter Prescribing Physician contact: How: _____ Date: _____ Time: _____

f. Enter Response from above, if any: _____
_____
_____

18. Needed Follow-up, if any: _____

SECTION II: CRITICAL INCIDENT DOCUMENTATION

19. If this event was a ***Critical Incident*** (***See definitions of Critical Incidents***):

a. Check which type. **CHECK ONLY ONE** (NOTE: Waiver and OHFLAC require Legal Representative contact for Critical Incidents):
*(**Abuse and neglect are both addressed under Mandatory Reporting Incidents, below)***

☐ **c. Death due to any cause** ☐ **d. Attempted Suicide**
☐ **e. Behavior likely to lead to:** ☐ *serious injury* ☐ *significant property damage*
☐ **f. Fire resulting in:** ☐ *injury* ☐ *relocation* ☐ *interruption in services*
☐ **g. Significant involvement with law enforcement**
☐ **h. Injury:** ☐ *requires hospitalization* ☐ *results in permanent physical damage*
☐ **i. Life-threatening reaction because of** ☐ *drug* ☐ *food*
☐ **j. Serious consequence resulting from** ☐ *apparent error in medication* ☐ *dietary administration*
☐ **k. Extended or unauthorized absence of consumer that exceeds treatment plan provision for community access**
☐ **l. Removal of consumer** (Administrative Discharge by WHS for cause – not AMA, where the consumer chooses to leave) without consent of self or legal representative from ☐ *residential services* ☐ *program services*

SECTION III: MANDATORY REPORTING INCIDENT DOCUMENTATION

20. If this event was a Mandatory Reporting Incident (***See definitions of Mandatory Reporting Incidents***):

a. Check which type (CHECK only one.):
☐ **a. Abuse** ☐ **b. Neglect** ☐ **c. Emergency Condition / Exploitation**

b. Enter information regarding report (Incident Report / APS Report copy) to Executive Director/designee within 24 hours:
Who was notified: _____ Date: _____ Time: _____

c. Enter information regarding report of allegation to APS / CPS per law:
☐ **Adults:** Adult Protective Services (DHHR APS) ☐ **Children:** Child Protective Services (DHHR CPS)
1. Name of individual notified: _____ Date: _____ Time: _____
2. Did APS / CPS advise that it would be investigating? ☐ Yes ☐ No
3. Did APS / CPS state that Westbrook should hold on its investigation, pending APS / CPS investigation? ☐ Yes ☐ No

d. Enter Date/Time of filing of written report to APS per requirement / law: Date: _____ Time: _____

e. Enter name of alleged perpetrator (if known. If not known, enter "*unknown*"):_____

f. Enter status of alleged perpetrator (staff, family member, etc): _____

g. Have there been previous encounters between alleged perpetrator and victim: ☐ Yes ☐ No ☐ Unknown

h. Is there a pattern of antecedents (triggers): ☐ Yes ☐ No ☐ Unknown
If yes, briefly describe pattern: _____

i. Enter information regarding notification of OHFLAC (Licensure) regarding incident:
Who was notified: _____ Date: _____ Time: _____

SECTION IV: SIGNATURES

Employee Filing Report: _____ Date: _____

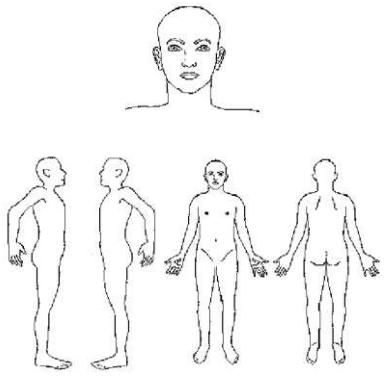
ONLY for Incidents requiring these signoff's:

Therapeutic Consultant (QMRP), if necessary: _____ Date: _____

Medical Staff:, if necessary: _____ Date: _____

Executive Director / designee, if necessary: _____ Date: _____

SECTION V: INJURY DIAGRAM



SUPERVISOR/DEPARTMENT INCIDENT INVESTIGATION AND REVIEW

1. Date of Investigation/Review: _____
2. What happened: _____
_____
_____
3. Other/Consumer condition: _____
4. Findings/outcomes with respect to this event (IMPORTANT: If allegations were made, enter whether they were **substantiated or not substantiated**? Were there issues that contributed to the incident? Was the incident avoidable/unavoidable? If an injury, was there a known or likely cause?) _____
_____
_____
_____
_____ ☐ See Extra Page

5. Administrative Actions taken **(mandatory):** ☐ Referral for medical treatment ☐ Referral to Education/Training
_____

SUPERVISOR or DEPARTMENT COMMITTEE CHAIR: _____ DATE: _____

DEPARTMENT INCIDENT COMMITTEE MEMBER INITIALS: _____ _____ _____ _____ _____

CENTRAL INCIDENT REVIEW

_____
_____
_____ ☐ **REFER TO SAFETY Committee**

CENTRAL INCIDENT COMMITTEE: _____ DATE: _____

CENTRAL INCIDENT COMMITTEE MEMBER INITIALS: _____ _____ _____