Maine Department of Health and Human Services

OFFICE OF AGING AND DISABILITY SERVICES

REPORTABLE EVENT

☐ Dangerous Situation ☐ Death ☐ Emergency Department Visit ☐ Emergency Restraint ☐ Hospital Admission – Planned/Unplanned
☐ Law Enforcement Intervention ☐ Lost or Missing Person ☐ Medical Treatment Other Than Hospital ☐ Medication Error
☐ Physical Plant Disaster ☐ Physical Assault/Altercation ☐ Rights Violation ☐ Serious Injury ☐ Suicide Attempt ☐ Suicide Threat
☐ Transportation Accident

IDENTIFYING INFORMATION

Client First Name	Client Last Name	Gender M/F	Date of Birth:	Social Security Number

Event Start Date	Event Start Time	Event End Date	Event End Time

INFORMATION REGARDING DIRECT REPORTING TO DHHS

Date Reported to DHHS: | DHHS Person Reported To:

Department Reported to ☐ DS Caseworker ☐ DS Crisis ☐ DS Regional Supervisor/PA ☐ Incident Data Specialist (EIS entry only)

PROGRAM TYPE AND INCIDENT LOCATION INFORMATION

Program Type: ☐ DS Home Supports ☐ DS Community Supports ☐ DS Employment Support ☐ DS Crisis ☐ Other (Specify):

Incident Location: ☐ DS Community Support ☐ DS Crisis ☐ DS Employment Support ☐ DS Home Support ☐ In Community ☐ Hospital
☐ Nursing Facility ☐ Personal Residence ☐ Other (Specify):

REPORTABLE EVENT INFORMATION

Short Description of Event: (Limit to 4000 Character)

Short Description of Actions Taken: (Limit to 4000 Character)

REPORTER DETAILS (Person Who Had A Role In This Event)

Reporter Name: | Address:

Work Telephone: | E-mail Address: | Title:

Reporter Type: (Reporter's relationship to the individual who is the subject of the report) ☐ Consumer ☐ Caseworker ☐ Family Member ☐Guardian
☐ DS Provider Direct Care ☐ DS Provider/Manager/Supervisor ☐ DS Crisis Team ☐ DS APS Intake Unit ☐ Other (Specify):

Reporter Role: ☐ Participant in event ☐ Witness ☐ Hearsay ☐ Other (Specify):

Method of Reporting: ☐ Call ☐ E-mail ☐ Fax ☐ Hand-delivered to DHHS ☐ In-Home Visit ☐ Letter ☐ Other (Specify):

AGENCY CONTACT / FILER DETAILS (Person/Agency Responsible For Content And Reporting To DHHS)

Filer Type: ☐ Agency Staff ☐ State Staff ☐ Family Member ☐ Guardian ☐ APS Intake (OES) ☐ Other (Specify):

Name:	Phone Number:	E-mail :	Information Received: ☐ AM Date: Time: ☐PM

Provider or Agency/Address Location:

WORKER DETAILS

Was Worker(s) involved in event? ☐ **Yes** ☐ **No** ☐ **Unknown** **Name(s):**

Worker Type: ☐ **Direct Service** ☐ **Management/Supervisor** ☐ **Other (Specify):** **Role:** ☐ **Participant** ☐ **Witness** ☐ **Other (Specify):**

Was another Person(s) involved in event? ☐ **Yes** ☐ **No** ☐ **Unknown** **Names(s):** **Role:** ☐ **Participant** ☐ **Witness** ☐ **Other (Specify):**

FAMILY/GUARDIAN NOTIFICATIONS

Guardian Notified? ☐ **Yes** ☐ **No** ☐ **No Guardian** **If *Yes,* Who Notified Guardian?**

Guardian Name:	**Address:**	**Phone:**

Client Name:

ADULT DEVELOPMENTAL SERVICES EVENT TYPES & CATEGORIES

Reportable Events must be received by DHHS within 1 business day of the event.

DANGEROUS SITUATION 14-197 CMR CH12 2A xvi

Type of Dangerous Situation: ☐ Arson ☐ Hostage taking ☐ Other Event that poses jeopardy to client and/or public safety that is not listed in other categories (Specify):

Was emergency services called: ☐ Yes ☐ No

If yes, indicate type? ☐ Ambulance/rescue/paramedics ☐ Law Enforcement ☐ Fire Department ☐ Warden Service ☐ Crisis Team ☐ Other (Specify):

DEATH 14-197 CMR CH12 2A i

Death was: ☐ Expected ☐ Unexpected

Preliminary Cause of Death? ☐ Natural causes – age related ☐ Complications due to illness or other diagnosis ☐ Suicide - completed ☐ Homicide ☐ Accidental Death:

Location at time of death? ☐ Private Home ☐ Agency Home ☐ Nursing Facility ☐ Hospital ☐ Hospice ☐ Assisted Living Facility ☐ Other (specify):

EMERGENCY DEPARTMENT VISIT 14-197 CMR CH12 2A iv

Please indicate method of transportation to Emergency Department:

☐ Call to 911 – member transported to Emergency Department ☐ Agency transported member to Emergency Department ☐ Member took self to Emergency Department ☐ Family/others took member to Emergency Department

EMERGENCY RESTRAINT 14-197 CMR CH12 2Axiv

Type of Restraint ☐ Personal Holding ☐ Chemical ☐ Blocking	***If restraint was a personal holding, please indicate type?*** ☐ 1 Person ☐ 2 Person
Is there an approved behavior plan in place? ☐ Yes ☐ No	***Single or Multiple Restraint*** ☐ Single ☐ Multiple

SINGLE RESTRAINT INFORMATION

Single restraint start time:	***Single restraint end time:***
Total restraint time:	

MULTIPLE RESTRAINT INFORMATION

Multiple restraint – Start time of first restraint:	***Multiple restraint – End time of last restraint:***
Total Multiple restraint time:	***Duration of each restraint:***

HOSPITAL ADMISSION PLANNED/UNPLANNED 14-197 CMR CH12 2A v

Why was the member admitted: ☐ Admission ☐ Observation

LAW ENFORCMENT INTERVENTION 14-197 CMR CH12 2A xi

Type of Intervention: ☐ Individual receiving services involved with criminal activity ☐ Individual receiving services involved is part of a police investigation ☐ Individual receiving services is a victim of a crime ☐ Crisis intervention involves police or law enforcement personnel

LOST OR MISSING PERSON 14-197 CMR CH12 2A ix

Indicate time member was missing: ☐ Less than 5 hours ☐ 5-10 hours ☐ More than 10 hours

Did member runaway? ☐ Yes ☐ No

MEDICAL TREATMENT OTHER THAN HOSPITAL 14-197 CMR CH12 2A vii

Reason for seeking treatment: ☐ Medical Condition ☐ Flu ☐ Other (Specify):

Where did person receive treatment? ☐ Physician's Office ☐ Urgent Care ☐ Other (Specify):

MEDICATION ERROR 14-197 CMR CH12 2A vi

Please list name(s) of medication(s) involved:

Type of Error? ☐ Refusal to take prescribed medication ☐ Incorrect route ☐ Incorrect method of administration ☐ Incorrect dosage ☐ Incorrect schedule ☐ Took medication that was not prescribed to the individual receiving services ☐ Individual receiving services had an allergic reaction ☐ Did not follow procedures when assisting member with self-medication

Reason medication error occurred? ☐ Administration error ☐ Supply exhausted ☐ Forgot ☐ Refusal ☐ Prescription unfilled ☐ Incorrect chart entry ☐ Non-compliance ☐ Forgot to take on activity ☐ Forgot to send to program ☐ Other (Specify):

PHYSICAL ASSAULT/ALTERCATION 14-197 CMR CH12 2A xiii

Individual receiving services initiates a physical altercation with: ☐ Staff ☐ Another individual receiving services ☐ Member of the Community ☐ Other (Specify):

Was the individual physically assaulted by another individual receiving services? ☐ Yes ☐ No

Was Emergency Services involved? ☐ Yes ☐ No

If yes, indicate type: ☐ Ambulance ☐ Rescue/Paramedics ☐ Law Enforcement ☐ Crisis Outreach Team ☐ Other Emergency Service (specify):

PHYSICAL PLANT DISASTER 14-197 CMR CH12 2A x

Type of disaster: ☐ Fire ☐ Flood ☐ Natural Disaster ☐ Other incident that caused displacement (Specify):

RIGHTS VIOLATION 14-197 CMR CH12 2A xv

Type of Rights Violation: ☐ Behavior Modification ☐ Communications ☐ Discipline ☐ Humane Treatment ☐ Medical Care ☐ Nutrition ☐ Personal Property ☐ Physical Exercise ☐ Religious Practice ☐ Records ☐ Social Activity ☐ Voting ☐ Work

SERIOUS INJURY 14-197 CMR CH12 2A viii

Type of Injury: ☐ Laceration requiring sutures or staples ☐ Bone fracture ☐ Joint dislocation ☐ Loss of limb ☐ Serious burn ☐ Skin wound due to poor care

Cause of Injury? ☐ Accident ☐ Medical condition (seizures, etc) ☐ Treatment error (medication reaction, etc.) ☐ Origin unknown ☐ Other (Specify):

Where did person receive treatment? ☐ Emergency Room ☐ Outpatient services other than emergency room ☐ Inpatient ☐ Physician's office ☐ Emergency intervention on site ☐ Other (specify):

SUICIDE THREAT 14-197 CMR CH12 2A iii

Type of threat: ☐ Made a verbal threat to kill themselves ☐ Describes a way to carry out a suicide plan ☐ Talks or writes about death or suicide

TRANSPORTATION ACCIDENT 14-197 CMR CH12 2A xii

Type of Transportation Accident: ☐ Individual receiving services is a pedestrian ☐ Individual receiving services is a cyclist ☐ Individual receiving services is a passenger in motorized vehicle-includes ATVs ☐ Individual receiving services is involved in a watercraft accident