ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities



# INCIDENT REPORT

***Confidential Information***

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

**Qualified Vendors 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 1:2 Other: ____________________

Vendor or Independent Provider Name Responsible for Member at the time incident occurred:

- Vendor Name: ____________________
- Site Name: ____________________ Vendor AHCCCS ID: ____________________
- Site Address: ____________________ ____________________ ______ __________
  *City* *State* *ZIP Code*

Location Type:

Group Home  Day Treatment Adult (DTA)  Day Treatment Teen (DTT)  Family Home

Individually Designed Living Arrangements (IDLA)  Developmental Home  School (public, private, charter)

Community *(please provide a brief description)*: ____________________

Other: ____________________

Describe Service provided at time of incident:

Reporting Vendor or Independent Provider Name *(If different from above)*: ____________________

Title: ____________________ Contact Information: ____________________

Address: ____________________ City: ____________________ State: ______ ZIP Code: __________

See page 10 for EOE/ADA disclosures

## INDIVIDUAL / STAFF INVOLVED #1

Individual / Staff involved in incident *(Last, First, M.I.)*: ____________________

Immediate Supervisor: ____________________ Phone Number: ____________ N/A

## INDIVIDUAL / STAFF INVOLVED #2

Individual / Staff involved in incident *(Last, First, M.I.)*: ____________________

Immediate Supervisor: ____________________ Phone Number: ____________ N/A

## INDIVIDUAL / STAFF INVOLVED #3

Individual / Staff involved in incident *(Last, First, M.I.)*: ____________________

Immediate Supervisor: ____________________ Phone Number: ____________ N/A

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Is this incident report related to medication or medication administration? Yes No

- If yes, complete the additional medication questions
- If no, continue to Incident Type - Death and/or Incident Type - Other Section

**INCIDENT TYPE – MEDICATION:**

Provide a description of the event and how was it detected?

Does this incident involve more than one medication? Yes No

Provide a list of the Medication(s) involved in incident:

| Medication Name | Dosage Prescribed | Dosage Administered (Given) | Frequency Prescribed | Frequency Administered (Given) | Route Prescribed | Route Administered (Given) | Time Due | Time Administered (Given) |
|---|---|---|---|---|---|---|---|---|
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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

- If yes, was the prescriber contacted for further instructions? Yes No
- Provide name of prescriber contacted: ______________
- Describe instructions received: ______________

Describe the Member's condition before the medication incident:

______________________________

Describe the Member's condition 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

**Possible Cause of Contributing Factors:** *(Select all that apply)*

Lack of knowledge
Use of unapproved abbreviations
Illegible prescription
Miscommunication
Look alike/sound alike medication
Failure to adhere to work procedure
Wrong labeling/instruction
Missing documentation
Order not checked against medication administration record (MAR) prior to medication administration
Other ______

**Interventions Taken:** *(Select all that apply)*

Medical services provided
Communication process improved
Member Education/training provided
Policy / procedure reviewed, revised
Informed staff who made error
Staff education / re-education provided
Corrected dose/frequency
Behavioral Health Services Provided
Other ______
No action taken, provide a detailed explanation:

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*

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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

**INCIDENT TYPE – DEATH:**

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 |
|---|---|
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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
- Interruptions to Normal Routine: Yes No Unknown due to Member location at time of death
  - If yes, describe the interruptions: ______________________________

Did the Member complain about any unusual symptoms or were any unusual symptoms observed prior to death?

Yes No Unknown due to Member location at time of death

- If yes, describe the symptoms: ______________________________
- When were symptoms first noticed? ___________________ Time: ____________ am pm

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

Was anything unusual happening in the environment prior to the Member's death?

Yes No Unknown due to Member location at time of death

- If yes, describe: ______________________________

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: ______________________________

Was the Member showing signs of agitation prior to the incident?

Yes No Unknown due to Member location at time of death

- If yes, describe: ______________________________________________

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 an Urgent Care? ________________

- 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
  - Interruptions to Normal Routine? Yes No
    - If yes, describe the interruptions: ______
- What activity was the Member engaged in before the incident occurred? ______
- Was anything unusual happening in the environment before the incident occurred? Yes No
  - If yes, describe what was unusual in the environment: ______
- Were there similar incidents that occurred during the week before this one? Yes No Unknown
- Was the Member displaying signs of agitated prior to the incident? Yes No
- 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 ruing the event: ______
      Name of staff involved in the technique: ______
    - Did the technique result in and injury to the Member? Yes No
      - If yes, please describe the injury: ______
    - Did the technique result in and injury to staff? Yes No
      - If yes, please describe the injury: ______
  - Does this incident require a change to the Member's BTP? Yes No

- Were there any recent changes to the BTP 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, to request: *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 Member taken 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 any 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

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 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

  - If made via telephone, name of person receiving the report: ______________________________

  Report #: ______________________________

  - If no or NA, explain why: ______________________________

**LAW ENFORCEMENT NOTIFIED:** Yes No N/A

- If no or NA, 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 (ACDL) Probation DES Case Worker Other __________

  Date of Notification: ______________ Time of Notification: __________ am pm

## CORRECTIVE ACTION/COMMENTS

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: ______________________________

Electronic Signature: ______________________ Date: __________ Time: ________ am pm

Supervisor's name: ______________________________

Electronic Signature: ______________________ Date: __________ Time: ________ am pm

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1