



Maine Department of Health and Human Services

**REPORTABLE EVENTS**

*Adult Developmental Service Event:*

- Physical or Verbal Abuse  Neglect  Sexual Abuse/Exploitation  Exploitation (Non-Sexual)
- Rights Violation  Serious Injury to Consumer  Suicidal Acts, Attempts, Threats  Death
- Restraint  Medication Error  Dangerous Situations – Other (As listed on the following page)

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	

REPORTABLE EVENT INFORMATION

*Short Description of Event:*

*Short Description of Actions Taken:*

WORKER DETAILS

Was Worker(s) involved in event? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Name(s): _____	Was another Person(s) involved in event: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Names(s) _____
Worker Type: <input type="checkbox"/> Direct Service <input type="checkbox"/> Management/Supervisor Role: <input type="checkbox"/> Participant <input type="checkbox"/> Witness <input type="checkbox"/> Other (Specify) _____	Role: <input type="checkbox"/> Participant <input type="checkbox"/> Witness <input type="checkbox"/> Other (Specify) _____

REPORTER DETAILS

Reporter (Name, Telephone (work) #, Address, & E-mail: \_\_\_\_\_)

Reporter Title: \_\_\_\_\_

Reporter ID: (Reporter's relationship to the individual who is the subject of the report)  
 Consumer  Family Member  Guardian  Staff  CCM  Other (Specify) \_\_\_\_\_

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

Method of Reporting:  Call  E-mail  Fax  In-Home Visit  Letter  Other (Specify) \_\_\_\_\_

Location:  Adult Day Care  Hospital  In Community  Nursing Facility  Personal Residence  Residential Care  Day Habilitation  
 Other: \_\_\_\_\_

SERVICE LOCATION DETAILS

Agency Name, Telephone #, & Address: \_\_\_\_\_

Program/Facility Name, Telephone #, Address: \_\_\_\_\_

AGENCY CONTACT / FILER DETAILS

Filer Type:  Agency Staff  DHHS Staff  CCM  Guardian  Friend  Anonymous  
 Other (Specify) \_\_\_\_\_

Filer (Name, Telephone (work) #, & E-mail: \_\_\_\_\_)

NOTIFICATIONS

Client's Family Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Guardian Notified	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No Guardian
If yes, Who Notified Guardian:	Guardian Name, Address & Phone #:			

Client Name: \_\_\_\_\_

**ADULT DEVELOPMENTAL SERVICES EVENT TYPES & CATEGORIES**

**The following event types must be reported IMMEDIATELY to your local DHHS Office with follow-up with written report to Regional Incident Data Specialist:**

PHYSICAL OR VERBAL ABUSE	NEGLECT	SEXUAL ABUSE/ EXPLOITATION	EXPLOITATION (NONSEXUAL)	RIGHTS VIOLATIONS	SERIOUS INJURY TO CONSUMER
<p><b>Source of Abuse</b></p> <input type="checkbox"/> Self <input type="checkbox"/> Family Member <input type="checkbox"/> Direct Care Staff <input type="checkbox"/> Other Provider Staff <input type="checkbox"/> Client to Client <input type="checkbox"/> Other (Specify) _____ Other Source: _____  <p><b>Type of Abuse</b></p> <input type="checkbox"/> Physical Abuse (Includes Assault) <input type="checkbox"/> Cruel Punishment <input type="checkbox"/> Unreasonable Confinement <input type="checkbox"/> Emotional Abuse <input type="checkbox"/> Intimidation <input type="checkbox"/> Verbal Abuse <p><b>Was the person injured as a result of the abuse?</b></p> <input type="checkbox"/> YES <input type="checkbox"/> NO <p><b>Was treatment required?</b></p> <input type="checkbox"/> YES <input type="checkbox"/> NO <p><b>If treatment required, select location:</b></p> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency <input type="checkbox"/> Physician's Office <input type="checkbox"/> Crisis Intervention	<p><b>Source of Neglect</b></p> <input type="checkbox"/> Self <input type="checkbox"/> Family Member <input type="checkbox"/> Direct Care Staff <input type="checkbox"/> Other (Specify) _____ Other Source: _____  <p><b>Type of Neglect</b></p> <input type="checkbox"/> Self Neglect <input type="checkbox"/> Caregiver Neglect <input type="checkbox"/> Safety Issues/At Risk <input type="checkbox"/> Deprivation of essential needs <input type="checkbox"/> Lack of adequate protection <input type="checkbox"/> Caregiver under influence <input type="checkbox"/> Inability to give informed consent <p><b>Was treatment required?</b></p> <input type="checkbox"/> YES <input type="checkbox"/> NO <p><b>If treatment required, select location:</b></p> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Physician's Office <input type="checkbox"/> Crisis Intervention	<p><b>Source of Abuse</b></p> <input type="checkbox"/> Family Member <input type="checkbox"/> Direct Care Staff <input type="checkbox"/> Client to Client <input type="checkbox"/> Other (Specify) _____ Other: _____  <p><b>Type of Alleged Abuse</b></p> <input type="checkbox"/> Non-consensual sexual activity <input type="checkbox"/> Sexual contact by paid provider <input type="checkbox"/> Client to client sexual abuse <input type="checkbox"/> Sexual contact with Incompetent person <p><b>Was the person injured as a result of abuse?</b></p> <input type="checkbox"/> YES <input type="checkbox"/> NO <p><b>Was treatment required?</b></p> <input type="checkbox"/> YES <input type="checkbox"/> NO <p><b>Treatment Location:</b></p> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Physician's Office <input type="checkbox"/> Sexual Abuse Assault Line <input type="checkbox"/> Other Crisis Helpline: _____	<p><b>Exploitation Source</b></p> <input type="checkbox"/> Family Member <input type="checkbox"/> Provider Direct Care Staff <input type="checkbox"/> Provider Non-Direct Service Staff <input type="checkbox"/> Client to Client <input type="checkbox"/> Other (Specify) _____ Other: _____  <p><b>Other Suspect Perpetrator Type (Do Not Use Name)</b></p> _____  <p><b>Exploitation Type</b></p> <input type="checkbox"/> Unpaid/Inadequately Paid Work <input type="checkbox"/> Financial Theft/Exploitation <input type="checkbox"/> Property Theft <input type="checkbox"/> Property Damage <input type="checkbox"/> Medication Theft <input type="checkbox"/> Other (Specify) _____ Other: _____  <p><b>Other Exploitation Type</b></p> _____ _____ _____	<input type="checkbox"/> Behavior Modifications <input type="checkbox"/> Communications <input type="checkbox"/> Discipline <input type="checkbox"/> Humane treatment <input type="checkbox"/> Medical Care <input type="checkbox"/> Nutrition <input type="checkbox"/> Personal property <input type="checkbox"/> Physical Exercise <input type="checkbox"/> Physical Restraints <input type="checkbox"/> Religions Practice <input type="checkbox"/> Records <input type="checkbox"/> Social Activity <input type="checkbox"/> Sterilization <input type="checkbox"/> Voting <input type="checkbox"/> Work	<p><b>Serious Injury Type</b></p> <input type="checkbox"/> Laceration requiring sutures or staples <input type="checkbox"/> Bone Fracture <input type="checkbox"/> Joint Dislocation <input type="checkbox"/> Loss of Limb <input type="checkbox"/> Serious Burn <input type="checkbox"/> Skin wound due to poor care <input type="checkbox"/> Other (Specify) _____ Other Injury Type: _____  <p><b>Cause of Injury</b></p> <input type="checkbox"/> Fall <input type="checkbox"/> Accident <input type="checkbox"/> Seizure <input type="checkbox"/> Medical Condition <input type="checkbox"/> Treatment Error <input type="checkbox"/> Poor Care <input type="checkbox"/> Origin Unknown <input type="checkbox"/> Other (Specify) _____  <p><b>Where did person receive treatment:</b></p> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Physician's Office <input type="checkbox"/> Emergency Intervention On-Site <input type="checkbox"/> Other (Specify): _____ Other Injury Treatment Location: _____
<i>DANGEROUS SITUATIONS - OTHER</i>			<i>SUICIDAL ACTS, ATTEMPTS, THREATS</i>		<i>DEATH</i>
<p><b>Other Event Types</b></p> <input type="checkbox"/> Criminal justice Involvement <input type="checkbox"/> Consumer Violence (Non-Assault) <input type="checkbox"/> Runaway <input type="checkbox"/> Lost/Missing Person <input type="checkbox"/> Loss of Home (Disaster) <input type="checkbox"/> Arson <input type="checkbox"/> Hostage Taking <input type="checkbox"/> Other Event Jeopardy to Client and/or Public Safety	<p><b>Specify Other Significant Jeopardy Event Type:</b></p> _____  <p><b>Why is this event of particular risk to this person?</b></p> _____ _____	<p><b>Was Emergency Services involved?</b></p> <input type="checkbox"/> Ambulance Rescue/Paramedics <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Fire Department <input type="checkbox"/> Warden Services <input type="checkbox"/> Crisis Outreach Team <input type="checkbox"/> Other Emergency Service	<p><b>Suicidal Act/Attempt/Threat</b></p> <input type="checkbox"/> Serious attempts <input type="checkbox"/> Threats <p><b>Was treatment provided as a result of attempt?</b></p> <input type="checkbox"/> YES <input type="checkbox"/> NO	<p><b>Treatment Location:</b></p> <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Physician's Office <input type="checkbox"/> Crisis Intervention <input type="checkbox"/> Other (Specify): _____ Other Treatment Location: _____	<input type="checkbox"/> Completed suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Natural Causes Age Related <input type="checkbox"/> Accidental Death <input type="checkbox"/> Complication to Illness <input type="checkbox"/> Unexplained death <input type="checkbox"/> Other Death (Specify) _____ _____

*The only approved behavioral methods for use in emergencies are **Personal holding/Restraint or Chemical Restraint**. The permitted use of emergency personal holding is to protect the person from physically injuring himself/herself or some other nearby person. Chemical restraint must be performed under medical order and supervision. Emergency chemical restraint orders must be renewed every 12 hours. Each drug administration must be reported. **All other forms of severely intrusive behavior management are strictly forbidden for use on an emergency basis including the use of locked time out or any other aversive procedure.***

Client Name: \_\_\_\_\_

<b>RESTRAINT(S)</b>
<b>Is this an Incidental Restraint to the Reportable Event?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Behavioral Method (Mark Type of Restraint)</b>
<input type="checkbox"/> Personal Holding Restraint <input type="checkbox"/> Blocking <input type="checkbox"/> Chemical restraint Drug Used: _____
<b>Single Restraint</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Time Start: _____ Time End: _____      Time Total: _____
<b>Multiple Restraint</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Start 1 <sup>st</sup> Restr.: _____      End Last Restr.: _____ Total Time of Restraints Only (not the incident time): _____ Number of Restraints _____
<b>Precipitating Conditions and Behavior Changes</b>
<input type="checkbox"/> Unknown – no observed circumstances. <input type="checkbox"/> Gradual increase in agitation due to Behavior. <input type="checkbox"/> Explosive aggression with environment stress. <input type="checkbox"/> Explosive aggression without provocation. <input type="checkbox"/> Other Precipitation _____
<b>Behavior Exhibited</b>
<input type="checkbox"/> Assault on staff. _____ <input type="checkbox"/> Assault on others. _____ <input type="checkbox"/> Self-injury _____ <input type="checkbox"/> Other Behavior: _____
<b>Intervention Steps</b>
<input type="checkbox"/> Asked individual to stop the behavior. <input type="checkbox"/> Encouraged the individual to express concern or difficulty. <input type="checkbox"/> Attempted alternate activity – distraction <input type="checkbox"/> Offered other choices. <input type="checkbox"/> Changed the environment to reduce stress. <input type="checkbox"/> Mediated the conflict between the person and other(s). <input type="checkbox"/> Other Intervention: _____
<b>General Information</b>
<input type="checkbox"/> Medical attention required – Report to DHHS. <input type="checkbox"/> Medical attention to other person. <input type="checkbox"/> Medical attention to staff. <input type="checkbox"/> Damage to personal property. <input type="checkbox"/> Damage to staff property. <input type="checkbox"/> Damage to others property. <input type="checkbox"/> Minor staff injury – no outside treatment. <input type="checkbox"/> Minor injury to self – no outside medical treatment required. <input type="checkbox"/> No injury. <input type="checkbox"/> No property damage.
<b>Procedure Effectiveness</b>
<input type="checkbox"/> High – Person calmed down – No further incident. <input type="checkbox"/> Moderate – Continued minor disruption – No intervention needed. <input type="checkbox"/> Low – Individual required continued attention. <input type="checkbox"/> None – Second use of intervention.

<b>MEDICATION ERROR</b>
<b>Medication Event Type</b>
<input type="checkbox"/> Omission <input type="checkbox"/> Wrong Dose <input type="checkbox"/> Wrong Medication <input type="checkbox"/> Wrong Method of Administration <input type="checkbox"/> Wrong Route <input type="checkbox"/> Wrong Time (> 1 Hr. Variance) <input type="checkbox"/> Medication Refused <input type="checkbox"/> Non-Compliance <input type="checkbox"/> Other (Specify) _____
<b>Medication Event Other:</b> _____
<b>Event Reason</b>
<input type="checkbox"/> Administration Error <input type="checkbox"/> Supply Exhausted <input type="checkbox"/> Forgot <input type="checkbox"/> Refusal <input type="checkbox"/> Prescription Unfilled <input type="checkbox"/> Incorrect Chart Entry <input type="checkbox"/> Non-Compliance <input type="checkbox"/> Other Reason (Specify) _____ <input type="checkbox"/> Forgot to take on Activity <input type="checkbox"/> Forgot to send to program
<b>Other Reason for Event:</b> _____
<b>Administered/Set-Up By</b>
<input type="checkbox"/> Consumer <input type="checkbox"/> Provider <input type="checkbox"/> Provider Set-up Only <input type="checkbox"/> Provider Admin. Only <input type="checkbox"/> Family Member <input type="checkbox"/> Direct Service Worker <input type="checkbox"/> Other (Specify) _____
Administered by Other: _____
<b>Name of Drug:</b> _____
<b>Was Treatment Required as a Result of Problem?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Treatment Type</b>
<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Emergency Room <input type="checkbox"/> Physician's Office <input type="checkbox"/> Emergency Intervention On-Site
<b>Was the Nurse/Physician/ER Contacted?</b>
<input type="checkbox"/> Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Emergency Room
Date of Contact: _____      Time of Contact: _____
What instructions were given? _____