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 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: _____

See page 11 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

INCIDENT TYPE – MEDICATION:

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

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

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)

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
  - 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