State of Hawaii

DDD USE ONLY

DATE/TIME RECEIVED

Date Time Met?

Verbal

Written

Department of Health

Developmental Disabilities Division

# ADVERSE EVENT REPORT FORM

**THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE DDD CASE MANAGER**

**WITHIN 72 HOURS OF THE ADVERSE EVENT**

**Please Print or Type:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Waiver Participant  Non-Waiver Participant | Event occurred during billable service:  Yes  No | | 1. EVENT DATE (MM/DD/YY) | | 1. EVENT TIME |
| 3. PARTICIPANT NAME (Last, First, MI) | | 4. BIRTHDATE (MM/DD/YY) | 5. SEX | 6. MEDICAID ID | 7. CM UNIT |
| 8. REPORTER’S NAME | | 9. RELATIONSHIP | 10. ISLAND | 11. TELEPHONE NO. | 12. FAX NO. |
| 13. NAME OF REPORTER’S AGENCY (If applicable) | | | | | |
| ADVERSE EVENT INFORMATION | | | | | |
| **SECTION A: GENERAL INFORMATION**  14. EVENT LOCATION:  Own/Family Home  Community  Program Site  Other      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Foster Home\*  DOM Home\*  ARCH\* \*Include Name of Licensed/Certified Home      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| 15. PERSON(S) PRESENT: Agency Staff  Caregiver  Family  Other Participants  CD Worker  Unknown   Other      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| 16. WHO WAS NOTIFIED? (Check all that apply)   | Notified | Name | Date/Time | Report No. | | --- | --- | --- | --- | | Police | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Adult Protective Services (APS) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Child Welfare Services (CWS) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | DDD Certification Unit | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | Office of Health Care Assurance | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | Case Manager | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | Guardian | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | Caregiver | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | | | | | |
| 17. WHAT WAS DONE? (Check all that apply)   | Treatment | Date/Time | Treatment Location (Name of Facility) | | --- | --- | --- | | No treatment required |  |  | | Treated by ambulance/emergency medical personnel | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Treated at Urgent Care | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Treated at Emergency Room | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Admitted to Hospital | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| 18. **SECTION B: DISCOVERY** Fully describe the event and potential causes and/or contributory factors (e.g., WHO, WHAT, WHEN and HOW the event occurred and WHY it occurred). Attach additional pages as necessary. | | | | | |
| 19. **SECTION C: NATURE/TYPE OF ADVERSE EVENT BEING REPORTED** Check the appropriate box related to the type/nature of adverse event being reported and answer all items under that subsection. Select ONLY ONE as the primary event. | | | | | |
| **SUSPECTED ABUSE/NEGLECT/FINANCIAL EXPLOITATION**  Type: Physical Psychological/Verbal  Sexual  Neglect Financial Exploitation  List of person(s) and relationship to participant who were present when suspected abuse/neglect occurred       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **INJURY FROM A KNOWN/UNKNOWN CAUSE REQUIRING MEDICAL TREATMENT**  Type:  Broken bone Sprain Laceration Burn Other      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Location:  Head Neck  Face Chest Stomach Back Arm Hand Foot Leg  Cause:  Known  Unknown Fall:  Attended Fall  Unattended fall  Accident (explain):  Other (describe):  **On the body diagram below, circle the body part(s) affected or injured.**  [Illustration: Diagram of the human body](https://www.google.com/imgres?imgurl=http://www.lindastorm.net/wp-content/uploads/2016/11/human-body-diagram-picture-human-body-diagram-picture-aof-700x525.png&imgrefurl=http://www.lindastorm.net/human-body-diagram-picture/human-body-diagram-picture-human-body-diagram/&docid=zl61OfHmCTGCsM&tbnid=7t6rpfI6BwaxRM:&vet=10ahUKEwi0jZmHp-vTAhVL22MKHeupBxA4rAIQMwhBKD8wPw..i&w=700&h=525&bih=943&biw=1920&q=diagram%20of%20the%20human%20body&ved=0ahUKEwi0jZmHp-vTAhVL22MKHeupBxA4rAIQMwhBKD8wPw&iact=mrc&uact=8) | | | | | |
| **MEDICATION ERRORS AND/OR UNEXPECTED REACTION TO MEDICATION OR TREATMENT**  **Medication Error**: Missed Dose Wrong Dose Wrong Time Wrong Medication Documentation Error  Wrong Route/Method Medication:  Over the counter Prescription Drug Name:      \_\_\_\_\_\_\_\_\_  **Unexpected Reaction to Medication** **Unexpected Reaction to Treatment** | | | | | |
| **CHANGE IN** **PARTICIPANT’S BEHAVIOR** **THAT MAY REQUIRE A NEW OR UPDATED BEHAVIOR SUPPORT PLAN**  **New behavior**  **Change in behavior**  Aggressive Assaultive Threat to Self  Threat to Others Property Destruction Sexualized Behavior  Other:  Is there a current behavior support plan?  Yes No | | | | | |
| **CHANGE IN PARTICIPANT’S HEALTH CONDITION REQUIRING MEDICAL TREATMENT**  Chest Pain  Sepsis  Seizure Aspiration/Pneumonia Abdominal problem  Respiratory problem  Skin problem  Decubitus  GT dysfunction Other:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **DEATH**  The following documentation is required in Section B: Discovery (on page 1):   * Description of the circumstances surrounding the death * Any medical resources involved at the time of death (i.e. emergency response, hospice care). | | | | | |
| **PARTICIPANT’S WHEREABOUTS UNKNOWN**  Status: Unknown Found Length of time missing:  If found, participant’s status: Injury noted No injury | | | | | |
| **ANY** **USE OF RESTRAINT**  Check type of restraint used:  Chemical Restraint  Mechanical Restraint  Physical Restraint  Did the participant sustain any injuries as a result of being restrained?  Yes No | | | | | |
| **ANY USE OF SECLUSION**  Did the participant sustain any injuries during the use of seclusion?  Yes  No | | | | | |
| **ANY USE OF PROHIBITED RESTRICTIVE INTERVENTION OR PROCEDURE**  Did the participant sustain any injuries during the use of a prohibited restrictive intervention or procedure?  Yes  No | | | | | |
| **When an adverse event for use of restraint, seclusion, or prohibited restrictive intervention or procedure is checked, the following documentation is required in Section B: Discovery (on page 1) :**   * Description of the restrictive intervention or procedure * Description of what happened before the behavior that caused the use of the restrictive intervention or procedure, including environmental and other contributing factors * Other interventions that were attempted and the results of those interventions * Consequences of the use of the restrictive intervention or procedure * Description of any injuries the participant sustained * How the rights of the participant were restored   Note: For chemical restraints, documentation must also include description of behaviors after medication was given, including any side effects.  **For additional information on restraint, seclusion, or prohibited restrictive intervention,**  **refer to DDD P&P 2.02 on Restrictive Interventions and 2.03 on Behavior Support Review.** | | | | | |
| 20. **SECTION D: REMEDIATION PLAN OF ACTION TO PREVENT RECURRENCE OF THE EVENT** (Attach additional pages as necessary). | | | | | |
| AGENCY/REPRESENTATIVE SIGNATURE PRINT NAME       DATE | | | | | |
| **FOR DDD USE ONLY** | | | | | |
| 21. **SUMMARY OF ACTION TAKEN BY CASE MANAGER** | | | | | |
| 22.  **CASE MANAGER ASSESSMENT**  Appropriate immediate action taken by agency/CDPA/caregiver of licensed or certified home to safeguard the participant as indicated in Section A – #17 What Was Done (p.1)  Inappropriate immediate action taken by agency/CDPA/caregiver of licensed or certified home to safeguard the participant as indicated in Section A – #17 What Was Done (p.1)  Appropriate plan of action to prevent recurrence of the adverse event by agency/CDPA /caregiver of licensed or certified home as indicated in Section D – #20 Remediation  Inappropriate plan of action to prevent recurrence of the adverse event by agency/CDPA /caregiver of licensed or certified home as indicated in Section D – #20 Remediation | | | | | |
| 23. **CASE MANAGER PLAN OF ACTION** (Complete ONLY if assessment indicates provider agency/CDPA/caregiver action plan is inappropriate or additional actions by the case manager are warranted. (Include timelines.)  ISP updated | | | | | |
| 24. CASE MANAGER SIGNATURE PRINT NAME       DATE | | | | | |
| 25. **SUPERVISOR REVIEW & COMMENTS:**  CM met timeline for review/assessment? Yes No  Explain if not met.    CM assessment appropriate # 22 ? Yes No  Explain if not appropriate.    CM plan of action appropriate # 23 ? Yes No Not Applicable  Explain if not appropriate. | | | | | |
| 26. UNIT SUPERVISOR SIGNATURE PRINT NAME       DATE | | | | | |
| 27. **DISTRIBUTION:**   | REPORT SENT TO: | DATE: | OHCA/Other | DATE: | | --- | --- | --- | --- | | Provider/CD Employer/Caregiver | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | OHCA | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | DDD-OCB-Outcomes Section | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | DDD-OCB Certification Unit | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |