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 ExploitationList 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  |
| [ ]  **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 |      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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