Department of Health
Developmental Disabilities Division

Adverse Event Report
Instructions for Completing Form 28-3 (Rev. 01/18)

This form must be completed within 72 hours of the adverse event. Please type or write legibly.

Top of Form: DDD USE ONLY

Verbal Date: DOH-DDD Case Manager (CM) or designee to write the date the verbal report was received from the reporter. Write "NA" if the person completing the form is the case manager.

Verbal Time: The CM or designee to write the time the verbal report was received from the reporter. Write "NA" if the person reporting the event is the case manager.

Verbal Met: The CM or designee to write "Yes" if the waiver provider, LASR provider, CD provider, or caregiver of a licensed or certified home notified the CM within 24 hours or the next business day of the event occurrence or of being informed of the event. If not, enter "No". Write "NA" if the person reporting the event is the case manager.

Written Date: The CM or designee to write the date the written report was received from the reporter. Write "NA" if the person reporting the event is the case manager.

Written Time: The CM or designee to write the time the written report was received from the reporter. Write "NA" if the person reporting the event is the case manager.

Written Met: The CM or designee to write "Yes" if the waiver provider, LASR provider, CD provider, or caregiver of a licensed or certified home submitted the written report to the CM within 72 hours or the next business day of the event occurrence or of being informed of the event. If not, enter "No". Write "NA" if the person reporting the event is the case manager.

Waiver Participant: Select "waiver participant" if the participant is currently in the I/DD Waiver Program.

Non-Waiver Participant: Select "non-waiver participant" if the participant is not currently in the I/DD Waiver Program (i.e. receiving only state funded services such as LASR).

Event Occurred During Billable Services: Select "Yes" if the event occurred during a billable service (i.e. waiver provider service delivery hours, LASR program hours, CD service time). Select "No" if the event occurred when services were not being provided.

1. **Event Date**: Write or enter the date the adverse event occurred in MM/DD/YYYY. For example, September 1, 2017 shall be entered as 09/01/2017.

2. **Event Time**: Write or enter the time the adverse event occurred. The time shall be entered as the time followed by a.m. or p.m. Do not use military time or 24-hour clock format. For example, four o'clock in the afternoon shall be written as 4:00 p.m.

3. **Participant Name**: Write or enter the participant's name – Last name, First name, M.I. Be sure to use given name and not nicknames.

4. **Birthdate**: Write or enter the birthdate of the participant in MM/DD/YYYY. For example, August 30, 2006 shall be entered as 08/30/2006.

5. **Sex**: Write or enter the sex of the participant – male or female.

6. **Medicaid ID #**: Write or enter the participant's 10-digit Medicaid ID #. If participant is not in the I/DD Waiver Program, write or enter "NA".

7. **CM Unit No**.: Write or enter the case management unit to which the participant is assigned.

8. **Reporter's Name**: Write or enter the name of the person completing the form.

9. **Relationship**: Write or enter the reporter's relationship to the participant (e.g. direct support worker, foster parent, mother).

10. **Island:** Write or enter the name of the island where the participant receives services.

11. **Telephone No.:** Write or enter the phone number of the reporter.

12. **Fax No.:** Write or enter the fax number of the reporter.

13. **Name of the Reporter's Agency (if applicable)**: Write or enter the name of the agency. If the reporter is a consumer-directed provider, write or enter "CD Services".

SECTION A: GENERAL INFORMATION

14. **Event location**: Check the location where the adverse event occurred. Community includes places such as grocery store, park, or workplace. Program site includes such places as an Adult Day Health, or other center-based settings where the participant attends or meets for activities. If the adverse event occurred in the participant's residence, indicate the type of residence. If the residence is a licensed or certified home, include the name of the home as documented on the home's license or certificate. If "Other" is checked, specify the location.

15. **Person(s) Present**: Check to indicate who was present when the event occurred. If the event was not observed and the participant cannot identify who was present, check "unknown". If "other" is checked, specify the person(s). Examples include, but are not limited to, friend, bus driver, restaurant employee, sister, or father.

16. **Who Was Notified?** (Check all that apply): Check to indicate the persons or agencies notified in response to the type of event that occurred. Write or enter the name of the person notified, date, and time of the notification. If "other" is selected, specify the person contacted. For any notification to the Police Department, Adult Protective Services, and/or Child Welfare Services, enter the report number assigned by the corresponding agency.

17. **What Was Done?** Check to indicate what was done (immediate action taken) to safeguard the participant following the adverse event. Include date and time of treatment and where the treatment occurred, including name of facility, if applicable (e.g. Queen's Emergency Room, Straub Hospital).

SECTION B: DISCOVERY

18. Provide a full description of the adverse event, including potential causes and/or contributory factors. The description shall address WHO was involved, HOW, WHERE, AND WHEN the event occurred, and WHAT actions were taken in response to the event.

    For events that occurred outside of billable services:
    - Indicate date/time that the reporter was informed of the event
    - Describe the circumstances under which the information was received

    For events involving medication error(s) related to wrong medication:

- Indicate the medication that **was** given and the medication that **was not** given.

For events involving a death, this section must also include:
- Description of the circumstances surrounding the death
- Any medical resources involved at the time of death (i.e. hospice care)

For events involving any use of restraint, seclusion, or prohibited restrictive intervention or procedure, this section must also include:
- 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.

The reporter may attach diagrams, charts, and/or additional pages of description. If additional pages are attached, number pages B-1, B-2, etc.

SECTION C: NATURE/TYPE OF ADVERSE EVENT BEING REPORTED

19. Check the box **(select only one)** that best describes the adverse event and complete the information in that section.

When multiple events are involved, the reporter should use their best judgment to select the most appropriate category based on significance of the event (i.e. which event caused the most harm or most negatively impacted the participant).

Suspected Abuse/Neglect/Financial Exploitation

Chapter 346, Part X, Hawaii Revised Statutes, Adult Protective Services, mandates reporting when there is reason to believe abuse has occurred or the vulnerable adult is in danger of abuse if immediate action is not taken.

Chapter 350, Hawaii Revised Statutes mandates reporting to Child Welfare Services or the Police Department when there is reason to believe that child abuse or neglect will occur in the reasonably foreseeable future.

Mandated reporters include professionals and personnel in health care, social services, law enforcement, employees or officers of any public or private agency providing social, medical, hospital, or mental health services, including financial assistance, employees or officers of adult residential care homes, adult day care centers, foster care, or similar institutions, employees or officers of any public or private school.

Persons who are not mandated reporters are also encouraged to report suspected abuse or neglect to Adult Protective Services, Child Welfare Services, and the Police Department.

Check all that apply for type of suspected abuse, neglect, or financial exploitation. List person(s) and their relationship to the participant who were present when suspected abuse/neglect occurred.

- **Physical**: Non-accidental injury, pain, or impairment such as from hitting, slapping, improper physical restraint or poisoning.
- **Psychological/Verbal**: Threats, insults, harassment, humiliation, intimidation, or other means that profoundly confuse or frighten the participant.

- **Sexual**: Sexual contact or conduct including pornographic photographing without consent.
- **Neglect**: 1) Caregiver: failure to provide adequate food, shelter, clothing, timely health care, personal hygiene, supervision, protection from abandonment or failure to care out responsibilities that a reasonable person would exercise as an assumed legal, or contractual caregiver; and 2) Self: failure to care for one's self thereby exposing one's self to a condition that poses an immediate risk or death or serious physical harm.
- **Financial Exploitation**: Wrongful taking, withholding, appropriation or use of the participant's money, real property, or personal property.

Injury from a Known or Unknown Cause Requiring Medical or Dental Treatment

All bodily injuries sustained by the participant for which medical treatment (i.e. treatment rendered by ambulance or emergency medical personnel, urgent care or emergency room medical or dental staff, or results in hospitalization).

Check all that apply for type of injury, location of injury, and cause of injury. Using the diagram in this section, circle the body parts that describe the location of the injury.

Medication Errors and/or Unexpected Reaction to Medication or Treatment

Medication Errors means medication administration involving one or more of the following: wrong medication, wrong dose, wrong time, missed dose, wrong route/method, or failure to document or incorrect documentation.

Check all that apply for medication error. For medication errors involving wrong medication, Section B: Discovery must include the medication that **was** given and the medication that **was not** given.

Check the type of medication involved: Over the Counter or Prescription and Drug Name

Unexpected Reaction to Medication or Treatment means any unexpected reaction to medication or treatment that may or may not require medical treatment.

Check the box that describes if the event was an unexpected reaction to medication or treatment.

Change in the Participant's Behavior that may Require a New or Updated Behavior Support Plan

Check the box to indicate if the event involves a new behavior or a change in behavior.

- **New Behavior**: No history of the behavior(s) exhibited in this event and a positive behavior support plan may be necessary to address the challenging behavior(s).
- **Change in Behavior**: There is a current positive behavior support plan, but the behavior(s) exhibited in this adverse event is/are not addressed in the plan OR behavior(s) is/are addressed in the plan, but have increased in severity, intensity, and/or duration.

Check all behaviors exhibited in this event.

Check the appropriate box to indicate whether the participant has a current behavior support plan.

Change in the Participant's Health Condition Requiring Medical or Dental Treatment

Check all that apply for change in health condition. These are significant changes or deterioration in the participant's health status for which medical or dental treatment was necessary.

Death

All deaths, regardless of the cause must be reported. Section B: Discovery must include a description of the circumstances surrounding the death and documentation of any medical resources involved at the time of death (i.e. hospice care).

Participant's Whereabouts Unknown

Check to indicate if the participant's whereabouts are still unknown or if the participant was found. If the participant was found, indicate the length of time the participant was missing and if any injuries were noted.

Any Use of Restraints

Check type of restraint used. Indicate if the participant sustained any injuries as a result of being restrained.

Use the definitions below to determine if the intervention applied meets the definition of a restraint. If the intervention is **not** considered a restraint, an AER is **not** required.

*The following are **not** considered restraints:*

- Interventions used for the purpose of conducting routine physical or dental examination or diagnostic tests or completing a medical or dental treatment procedure;
- A device used to protect the participant's safety as indicated in the Individualized Service Plan (ISP) per a physician's recommendation and reviewed by the Behavior Support Review Committee; or
- Vehicular passenger restraint systems required by state law (HRS §291-11.6)

*The following are **not** considered chemical restraints:*

- Medications prescribed for the treatment of a diagnosed disorder found in the current version of the DSM;
- Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control for the diagnostic disorder per the current DSM;
- Medications prescribed to control seizures; and
- Medications for medical or dental procedures.

The following are considered restraints:

- **Chemical restraint** means a psychotropic medication prescribed by a licensed health care professional with prescriptive authority:
    - On a routine basis **without** an appropriate diagnosis found in the current version of the Diagnostic and Statistical Manual (DSM) for the purpose of behavioral control; or
    - Incidental use of medications, sometimes called PRN or as needed medication, to restrict the freedom of movement or temporarily sedate the participant.
- **Mechanical restraint** means an intervention involving a device, material, or equipment involuntarily applied to the participant's body or immediate environment (i.e. wheelchair, chair, bed, toilet, vehicle) that immobilizes, restricts or reduces any bodily movement in emergency situations to protect the participant from harming themselves or others.
- **Physical restraint** means an intervention in which physical force is applied to the participant and involuntarily restricts the participant's freedom of movement or normal access to a portion or portions of the participant's body.

Any Use of Seclusion

Seclusion is prohibited and shall not be utilized with participants.

This box shall be checked for any incident involving the involuntarily confinement of a participant in a room or area from which the participant was prevented from having contact with others or leaving

by closing the door or using another barrier. Indicate if the participant sustained any injuries as a result of the use of seclusion. Refer to Policy #3.07.

Any Use of Prohibited Restrictive Intervention or Procedure (Other than Restraints and Seclusion)

This box shall be checked for any use of prohibited restrictive intervention or procedure that restricts the participant's freedom of movement, access to other locations, property, individuals, or rights. Refer to Policy #3.07.

Section D: Remediation Plan of Action to Prevent Recurrence of the Event

20. Provide a description of what was done or what will be done to prevent the recurrence of the adverse event. This section should identify actions that will be implemented to prevent the event from recurring. Include timelines for completion and implementation. If additional pages are attached, number the additional pages as D-1, D-2, etc.

Agency/Representative Signature: The person attesting to the information on the form shall sign and print full name and date.

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21. Summary of Action Taken by Case Manager: The CM must document follow-up actions taken in response to the adverse event. Follow-up actions must include dates of face-to-face contacts, home and site visits, and telephone calls

22. Case Manager Assessment:

- **Re: immediate action taken**: The CM must check whether appropriate or inappropriate immediate action was taken by the waiver provider/CD employer/caregiver of licensed or certified home to safeguard the participant as indicated in Section A – "What Was Done". If immediate action was inappropriate, the case manager must complete the next section (Case Manager Plan of Action). Leave this section blank if the person reporting the event is the case manager.
- **Re: plan of action**: The CM must check whether the plan of action to prevent the recurrence of the adverse event is appropriate or inappropriate. If the plan of action is inappropriate, the case manager must complete the next section (Case Manager Plan of Action). Leave this section blank if the person reporting the event is the case manager.

23. **Case Manager's Plan of Action**: The CM must describe additional actions taken or to be taken to minimize the risk and prevent the recurrence of this event. Examples include, but are not limited to, revising the service plan to authorize additional services, reassessment of needs, or obtaining alternative residential placement.

If the ISP requires updates as a result of the adverse event, the CM must check the box to confirm whether the ISP has been updated.

24. **Case Manager Signature**: The CM signs and prints his/her name and date.

25. **Supervisor's Review and Comments**: The supervisor must determine whether the CM's action(s) and assessment were completed within the required timeframe. If so, the supervisor checks the box for timeline met. If not, write comment on reason and corrective action for the future.

The supervisor will check the appropriate box for CM assessment in Section 1. The supervisor will check the appropriate box for CM Plan of Action in Section 2, if applicable. If the CM updates the ISP with health and safety concerns and interventions, the supervisor must verify that this has been completed.

If the supervisor does not concur with the assessment and/or plan of action, the supervisor writes his/her comments, returns the form to the case manager and discusses the required changes. The CM changes the assessment or plan of action as appropriate. If the changes meet the supervisor's satisfaction, the supervisor signs and dates the form.

If the supervisor determines that additional follow-up date is required, the supervisor will indicate a follow-up date.

26. Supervisor Signature: Supervisor shall sign and print his/her name and date.

27. **Distribution**: Check the appropriate box and the date it was sent. CM Unit to retain original.

- **Provider/CD Employer/Caregiver**: The CM Follow-Up Report must be sent to the reporting Waiver Provider/CD Employer/Caregiver within five (5) working days of receiving the written report with the final report, if applicable submitted within 2 weeks.
- **DDD-OCB Outcomes Section**: All adverse event reports must be sent to DDD-OCB Outcomes Section.
- **DDD-OCB Certification Unit**: Send for appropriate follow-up by the DDD-OCB Certification Unit if the adverse event involves an adult foster parent.
- **Office of Health Care Assurance (OHCA)**: Send for appropriate follow-up by OHCA if adverse event involves an adult residential care home operator or DD Domiciliary home caregiver.
- **Other**: Specify persons or agencies adverse event report was sent to.