State of Hawaii
Department of Health
Developmental Disabilities Division
ADVERSE EVENT REPORT FORM

PLEASE PRINT LEGIBLY OR TYPE:

SECTION A: GENERAL INFORMATION

1. PARTICIPANT NAME: (Last, First, MI)	2. EVENT DATE: (MM/DD/YY)	3. EVENT TIME:

4. DATE OF VERBAL REPORT:	5. REPORTER'S NAME:	6. VERBAL REPORT RECIPIENT:

7. RELATIONSHIP TO PARTICIPANT:	8. ISLAND:	9. NAME OF REPORTER'S AGENCY: (If applicable)

10. PRIMARY ADVERSE EVENT TYPE: (CHECK ONLY ONE)

☐ SUSPECTED ABUSE/NEGLECT/FINANCIAL EXPLOITATION
☐ INJURY FROM A KNOWN/UNKNOWN CAUSE REQUIRING MEDICAL TREATMENT
☐ MEDICATION ERRORS AND/OR UNEXPECTED REACTION TO MEDICATION OR TREATMENT
☐ CHANGE IN PARTICIPANT'S BEHAVIOR THAT MAY REQUIRE A NEW OR UPDATED BEHAVIOR SUPPORT PLAN
☐ CHANGE IN PARTICIPANT'S HEALTH CONDITION REQUIRING MEDICAL TREATMENT
☐ DEATH
☐ PARTICIPANT'S WHEREABOUTS UNKNOWN
☐ ANY USE OF RESTRAINT
☐ ANY USE OF SECLUSION
☐ ANY USE OF PROHIBITED RESTRICTIVE INTERVENTION OR PROCEDURE

11. COMMENTS:

12. ☐ POSSIBLE MEDIA COVERAGE?
If yes, check the box.

13. EVENT LOCATION:
☐ Own/Family Home ☐ Community ☐ Program Site ☐ Foster Home* ☐ DOM Home* ☐ ARCH*
☐ Other:
*Include Name of Licensed/Certified Home:

14. Event occurred during billable service:
☐ No ☐ Yes

15. PERSON(S) PRESENT: ☐ No Persons Present ☐ Agency Staff ☐ CD Worker ☐ Caregiver
☐ Unknown ☐ Family ☐ Other Participants
☐ Other Person 1:
☐ Other Person 2:
☐ Other Person 3:

16. WHO WAS NOTIFIED? (Check all that apply)

	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)

☐ No treatment required Date/Time Treatment Location (Name of Facility)

☐ 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:

Person 1: Person 2:

Person 3: Person 4:

☐ **INJURY FROM A KNOWN/UNKNOWN CAUSE REQUIRING MEDICAL TREATMENT**

Type: ☐ Broken bone ☐ Sprain ☐ Laceration ☐ Burn ☐ Other:

Cause: ☐ Known ☐ Unknown **Fall**: ☐ Attended Fall ☐ Unattended Fall

☐ Accident (explain):

Location: ☐ Head ☐ Neck ☐ Face ☐ Chest ☐ Stomach ☐ Back ☐ Arm ☐ Hand

☐ Foot ☐ Leg ☐ Other Injury Location (describe):

☐ **MEDICATION ERRORS AND/OR UNEXPECTED REACTION TO MEDICATION OR TREATMENT (Check all that apply)**

☐ Missed Dose ☐ Wrong Time ☐ Wrong Dose ☐ Documentation Error

☐ Wrong Medication ☐ Wrong Route/Method

Medication: ☐ Over the counter ☐ Prescription

☐ **Unexpected Reaction to Medication** ☐ **Unexpected Reaction to Treatment**

Who Discovered the Medication Error:

Was the MD that Prescribed the Medicaiton Notified? ☐ No ☐ Yes

Medication Name: Dose: Route:	Medication Name: Dose: Route:
Medication Name: Dose: Route:	Medication Name: Dose: Route:

Medication Name: Dose: Route:	Medication Name: Dose: Route:
Medication Name: Dose: Route:	Medication Name: Dose: Route:

☐ **CHANGE IN PARTICIPANT'S BEHAVIOR THAT MAY REQUIRE A NEW OR UPDATED BEHAVIOR SUPPORT PLAN**

☐ **Change in behavior** ☐ **New behavior**

☐ Assaultive ☐ Aggressive ☐ Threat to Others ☐ Threat to Self ☐ Sexualized Behavior ☐ Property Destruction

☐ Other Behaviors:

Is there a current behavior support plan? ☐ Yes ☐ No

☐ **CHANGE IN PARTICIPANT'S HEALTH CONDITION REQUIRING MEDICAL TREATMENT**

☐ Chest Pain ☐ Seizure ☐ Sepsis ☐ 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 (Duration Time in Hours)**:

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

The following questions must be completed for the following adverse event types:

- **ANY USE OF RESTRAINT**
- **ANY USE OF SECLUSION**
- **ANY USE OF PROHIBITED RESTRICTIVE INTERVENTION OR PROCEDURE**

Describe the intervention procedure.

Describe what happened before the behavior that caused the use of the restrictive intervention or procedure.

Other interventions that were attempted and the results of those interventions.

Description of any injuries the participant sustained.
Consequences of the use of the restrictive intervention or procedure.
How the rights of the participant were restored.
What did not work that may require a new or updated PBS plan?
20. **SECTION D: REMEDIATION PLAN OF ACTION TO PREVENT RECURRENCE OF THE EVENT** (Attach additional pages as necessary).
REPORTER'S SIGNATURE: PRINT NAME: DATE: