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  Treated by ambulance/emergency medical personnel  Treated at Urgent Care  Treated at Emergency Room  Admitted to Hospital | | | | Date/Time | | | Treatment Location (Name of Facility) | | |
| 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 Medication Notified?  No Yes | | | | | | | | | |
| Medication Name:  Dose:  Route: | | | | | | | Medication Name:  Dose:  Route: | | |
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| 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: | | | | | | | | | |