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 ExploitationList 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:       |
| 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:        |