For Office Use Only

Incident Class: ______________________

Incident Number: ______________________

INCIDENT REPORT
QUALITY ASSURANCE DOCUMENT

INSTRUCTIONS: An incident report should be completed as soon as possible after an incident occurs. Sections A through D of the incident report should be completed by the staff member(s) that was directly involved and/or on-shift when the incident occurred or was discovered. The Residential Manager should complete section E of the report, review with supervisor and email immediately to the Quality Assurance Director and Quality Assurance Coordinator as soon as possible. Also, please mail hard copies of the final version to the QA Director and Coordinator.

Resident Name: ______________________ Age: ________ DOB: ______________

Type of Health Insurance: ______________________ Program/Residence: ______________

Legal Status: ☐ Probation ☐ Parole ☐ Mental Health Court ☐ Drug Court ☐ N/A

Date of Incident: ______________________ Time of Incident: ______________________

Specific Location Of Incident: ______________________

Primary Staff Member(s) Involved: ______________________
(First Name, Last Name, Title)

Others Involved: (specify resident/visitor/other staff) ______________________
Must include every staff member who witnessed or has first hand knowledge of incident.

TYPE OF INCIDENT: (Check appropriate box under #1, #2, or #3)

1 DEATH:

☐ **Complete Incident Report and Report of Death form.**

2 ALLEGATIONS OF ABUSE OR NEGLECT:

Abuse and neglect involve an act (or failure to act) by an employee.

- ☐ Physical Abuse
- ☐ Psychological Abuse
- ☐ Sexual Abuse
- ☐ Neglect
- ☐ Deliberate Inappropriate Use of Restraint
- ☐ Obstruction of Reports of Reportable Incidents
- ☐ Unlawful Use or Administration of Controlled Substance
- ☐ Aversive Conditioning

3 SIGNIFICANT INCIDENTS:

Significant Incidents occur on program premises or when the resident was under the actual or intended supervision of a custodian when the event occurred.

- ☐ Crime
- ☐ Financial Exploitation
- ☐ Fire / Fire Setting
- ☐ Injury of Unknown Origin*
- ☐ Missing Resident
- ☐ Mistreatment:
  - Unauthorized Restraint or Seclusion
  - Inappropriate Use of Time Out
  - Intentional Improper Administration of Medication
- ☐ Sexual Assault
- ☐ Sexual Contact Between Children
- ☐ Suicide Attempt
- ☐ Wrongful Conduct
- ☐ Adverse Drug Reaction**
- ☐ Assault**
- ☐ Falls by Residents**
- ☐ Fights**
- ☐ Medication Error**
- ☐ Other Incident**
- ☐ Self-Abuse**
- ☐ Verbal Aggression by Residents**

*In some cases definitions are abbreviated. The revised 14 NYCRR Part 524 contains full incident definitions.
**Meets definition of Significant Incident reportable to JC and OMH only when resulting in serious injury or harm.

A. DESCRIPTION OF INCIDENT

Date/Time/Specific Location/Narrative of Incident/Staff Intervention(s):

B. CURRENT MEDICATIONS (Either type medications below or email an attachment of the current medications.)

C. DESCRIBE CONDITIONS AT CONCLUSION OF INCIDENT AND FOLLOW UP

Including final outcome of incident, current status of resident, date and time family was notified, date and time treatment providers were notified.

PRINT NAME OF STAFF COMPLETING REPORT ____________________ TITLE ____________________

STAFF SIGNATURE ____________________ DATE ____________________

D. NOTIFICATIONS (Check all that apply)

- ☐ 1 Use of Manager on call.
- ☐ 2 Use of Assistant Executive Director/Quality Assurance Director
- ☐ 3 Use of other resources: a) ☐ Police b) ☐ Ambulance c) ☐ Fire Department
- ☐ 4 Therapist Consulted/Informed: Time ________ Date ________
- ☐ 5 Psychiatrist/Physician Consulted/Informed: Time ________ Date ________
- ☐ 6 Family Contacted: Time ________ Date ________
- ☐ 7 E.R. Visit a) Medical ________ b) Psychiatric ________
- ☐ 8 Admission a) Medical ________ b) Psychiatric ________

E. RESIDENTIAL MANAGER; FOLLOW UP ACTION/RECOMMENDATIONS

(Was staff intervention appropriate? Programmatic/procedural changes needed?)

RESIDENTIAL MANAGER SIGNATURE ____________________ DATE ____________________

STEL 21A

Southern Tier Environments for Living, Inc.

ADDENDUM TO INCIDENT REPORT FORM

Resident Name: ____________________

Date: __________ Time: __________ Program/Residence: __________

ADDITIONAL INFORMATION/FOLLOW-UP

Include all staff involved and/or providing information into incident

Print Name	Signature	Date

QUALITY ASSURANCE PURPOSES ONLY:

NEW YORK STATE JUSTICE CENTER NOTIFIED BY: ____________________

DATE NOTIFIED: __________ CONFIRMATION #: __________

NYS JUSTICE CENTER - VPCR: 1-855-373-2122
DEATH REPORTING LINE: 1-855-373-2124

Risk-Rescue Rating

To be completed <u>only</u> in the event of a self-harm incident.

Resident ______________________________ **Age** _______ **Sex** ____________________

Circumstances:

Risk Score _____________
Rescue Score _____________
Risk-Rescue Rating _____________

RISK FACTORS

1. **Agent used:**
   1. Ingestion, cutting, stabbing
   2. Drowning, asphyxiation, strangulation
   3. Jumping, shooting
2. **Impaired consciousness:**
   1. None in evidence
   2. Confusion, semicoma
   3. Coma, deep coma
3. **Lesions/Toxicity**
   1. Mild
   2. Moderate
   3. Severe
4. **Reversibility:**
   1. Good, complete recovery expected
   2. Fair, recovery expected with time
   3. Poor, residuals expected, if recovery
5. **Treatment required:**
   1. First aid, emergency ward care
   2. House admission, routine treatment
   3. Intensive care, special treatment

Total Risk Points: ___________________

RESCUE FACTORS

1. **Location:**
   3. Familiar
   2. Nonfamiliar, nonremote
   1. Remote
2. **Person initiating rescue:***
   3. Key person
   2. Professional
   1. Passerby
3. **Probability of discovery by a rescuer:**
   3. High, almost certain
   2. Uncertain discovery
   1. Accidental discovery
4. **Accessibility to rescue:**
   3. Asks for help
   2. Drops clues
   1. Does not ask for help
5. **Delay until discovery:**
   3. Immediate 1 hour
   2. Less than 4 hours
   1. Greater than 4 hours

Total Rescue Points: ____________________

RISK SCORE

5. High risk	(13-15 risk points)
4. High moderate	(11-12 risk points)
3. Moderate	(9-10 risk points)
2. Low moderate	(7-8 risk points)
1. Low risk	(5-6 risk points)

RESCUE SCORE

1. Least rescuable	(5-7 rescue points)
2. Low moderate	(8-9 rescue points)
3. Moderate	(10-11 rescue points)
4. High moderate	(12-13 rescue points)
5. Most rescuable	(14-15 rescue points)

*Self-rescue automatically yields a rescue score of 5.
**If there is undue delay in obtaining treatment after discovery, reduce final rescue score by one point.

Note: From "Risk-Rescue Rating in Suicide Assessment" by A. Weisman and J.W. Worden, 1972, *Archives of General Psychiatry* , 26. pp. 553-560. Copyright 1972, American Medical Association. Reprinted by permission.

Southern Tier Environments for Living, Inc.

SELF-HARM EVENT DOCUMENTATION

To be completed only in the event of a self-harm incident.

NAME OF INDIVIDUAL: ______________________________

DATE OF EVENT: ______________________________

METHOD OF HARM: Be very specific - for example, if drug overdose, how many and what kind; if cutting wrist, how deeply, what they cut with.

TREATMENT/RESULT: Describe medical intervention required (for example, stitches, gastric lavage, CPR, hospitalization). Explain how treatment was obtained (did the person tell someone or was it discovered by someone else?) How did others respond to the event (for example, were they angry, did they increase support…).

DEGREE OF LETHALITY: How likely was it that the behavior would result in death: Did the client believe he/she would die, regardless of whether they actually could have?

SELF-HARM EVENT DOCUMENTATION

LIKELIHOOD OF RESCUE: List any factors that increased or decreased the likelihood of rescue for example, the presence of other people, calls for help, both actual and perceived by the person.

SPECIAL CIRCUMSTANCES: Note any stressors or other factors that contributed to the event, for example, recent loss, anniversary of loss, substance use.

MOTIVATION: Did the person want to die? Following the event, how did the person feel about not having died? Were they trying to accomplish something other than dying, (for example, to elicit nurturing from others, to avoid making a life change, etc.)

Completed by: ______________________________

Date: ______________________________

With Input From: ______________________________

____

____

____

REPORT OF DEATH TO THE JUSTICE CENTER

The following information is needed when a death occurs within a STEL program. Please complete this form in its entirety and send with attached STEL incident report to the Quality Assurance Department.

Client Information:

Name: ______________________

Date of Birth: ______________________

Gender: ______________________

Race: ______________________

SSN: ______________________

eight (feet/inches): ______________________

Weight (lbs.): ______________________

Mental Health Diagnosis/Information (including Substance Abuse Diagnosis):
Axis I (enter as many that apply):

____

____

____

Axis II (enter as many that apply):

____

____

____

Date of last Emergency Room visit for psychiatric and/or substance abuse reasons:

From: ______________________

To: ______________________

Date of last hospitalization for psychiatric or substance abuse reasons:

From: ______________________

To: ______________________

Physical Illnesses/Conditions Diagnosed Prior to Death:
Axis III (enter as many that apply):

____

____

____

Date of last Emergency Room visit for physical health reasons:

From: ______________________

To: ______________________

Date of last hospitalization for physical health reasons:

From: ______________________

To: ______________________

Death Information:

Date of Death: ____________________

Location of Death (address; specific location/room within the STEL program; or the specific name of the facility/hospital/ address outside of STEL where client died):

County of Death: ____________________

Pronounced Time of Death: ____________________ ☐ A.M. ☐ P.M.

Actual Time of Death: ____________________ ☐ A.M. ☐ P.M.

Immediate Cause of Death: ____________________

Due to or as a consequence of:

Manner of Death (details about how the client died):

Source of Death Notification:

☐ Death Certificate ☐ Hospital ☐ Coroner ☐ Medical Examiner

Name of Source: ____________________ Phone #: ____________________

Was an autopsy completed: ☐ Yes ☐ No ☐ Unknown

Name of Medical Examiner: ____________________

Coroner Case Number: ____________________

Within 24 hours of death, was client on DNR/DNI status?

☐ Yes ☐ No ☐ Unknown

Within 24 hours of death, was client given stat/PRN medication for behavioral and/or psychiatric reasons?

☐ Yes ☐ No ☐ Unknown

Is there any indication that this death may have resulted from:

- ☐ an accident
- ☐ a homicide
- ☐ a suicide
- ☐ a medication error
- ☐ a medication/drug overdose
- ☐ the use of a controlled substance and/or alcohol
- ☐ the attempted use of a restraint
- ☐ the attempted use of seclusion/timeout
- ☐ an unexplained death
- ☐ an unexpected death

Client Narrative Summary:

Describe the recipient's psychiatric, behavioral, and medical status within 90 days prior to death:

Most recent visit with Primary Care Physician: ______

Had the client received care from a specialist? ☐ Yes ☐ No

If yes, what type of specialist: ______

Acute medical issues 90 days prior to death?

- ☐ Choking
- ☐ Fall
- ☐ Seizure
- ☐ Weight loss - ______ lbs.
- ☐ Weight gain - ______ lbs.
- ☐ Change in bowel habits
- ☐ Change in bladder habits
- ☐ Change in ambulation
- ☐ Change in food intake
- ☐ Change in medication
- ☐ Change in fluid intake
- ☐ Other: ______

Acute psychiatric issue 90 days prior to death:

- ☐ Change in psychiatric status
- ☐ Change in behavior planning/supervision
- ☐ Other (specify): ______

Special diet 90 days prior to death:

- ☐ Food (specify): ______
- ☐ Fluid (specify): ______

Changes in service providers/treatment providers 90 days prior to death (check all that apply):

- ☐ Residence
- ☐ Supervision
- ☐ Care Coordination
- ☐ Medical Provider
- ☐ Medication
- ☐ Program
- ☐ Treatment Plan
- ☐ Behavior Plan
- ☐ Transportation
- ☐ Diet