

## INCIDENT REPORT

**Confidential Information**

*(This form must be filled electronically. Handwritten forms are not accepted.)*

**Qualified Vendors or Providers are required to use this form to report all incidents to the Division.**

**DDD USE ONLY:**

Member's Assigned District:	North	South	East	West	Central	State Operated
District Where Incident Occurred:	North	South	East	West	Central	State Operated

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_

Member's Name (Last, First, M.I.): \_\_\_\_\_

Member's Date of Birth: \_\_\_\_\_ Member's AHCCCS ID: \_\_\_\_\_

Is this Member in Foster Care?    Yes    No

Is a Behavior Plan required?    Yes    No

• If yes, is the Behavior Plan current?    Yes    No    N/A      Expiration Date: \_\_\_\_\_

Is there a current Person-Centered Service Plan (PCSP)?    Yes    No      PCSP Date: \_\_\_\_\_

• Does the PCSP identify the need for an enhanced ratio?    Yes    No

○ If yes, select appropriate supervision level:    1:1    2:1    Other: \_\_\_\_\_

**Qualified Vendor or Provider responsible for Member at the time incident occurred:**

• Vendor Name: \_\_\_\_\_

• Site Name: \_\_\_\_\_ Vendor AHCCCS ID: \_\_\_\_\_

• Site Address: \_\_\_\_\_  
  City                                    State    ZIP Code

**Location of Incident:**

- Group Home            Day Treatment Adult                    Day Treatment Child (After School/Summer)
- Family Home            Intermediate Care Facility (ICF)        Employment Program
- Individually Designed Living Arrangements        Developmental Home                    School
- Community *(please provide a brief description):*

Other:

What services were being provided at time of incident:

Reporting Qualified Vendor or Provider Name *(if different from above)*: \_\_\_\_\_

Title: \_\_\_\_\_ Phone Number/Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_



How many doses were administered in error?    None    1    2    3 or more

How many doses were missed in error?    None    1    2    3 or more

Does the Member administer their own medications?    Yes    No

Did the Member refuse to take or report not taking their medication?    Yes    No

- If yes, was the Member able to explain why they refused or did not take their medication?
- 

Was the medication incident related to a failure to administer medication by staff?    Yes    No

- If yes, why was the medication not administered? *Check all that apply:*

Medication not available            Medication order expired            Medication available does not match order  
 Medication order unclear            Medication past expiration date

Other, explain: \_\_\_\_\_

- If no, was the medication administration incident a result of any of the following? *Check all that apply:*

Incorrect medication                  Incorrect member                  Incorrect dose  
 Incorrect time                          Incorrect route                      Incorrect or no documentation

Other, explain: \_\_\_\_\_

Did the Member vomit or spit out their medication after it was given?    Yes    No    N/A

- If yes, was the prescriber contacted for further instructions?    Yes    No
- Provide name of prescriber contacted: \_\_\_\_\_
- Describe instructions received: \_\_\_\_\_

Describe any symptoms the Member had before the medication incident:

Describe any new or different symptoms the Member had after the medication incident:

Was any action taken?    Yes    No

- If no, please explain why action was not taken / not needed? \_\_\_\_\_
- 

- If yes, were any of the following individuals contacted? *Check all that apply:*

Pharmacist            Primary Care Physician            Nurse Practitioner/Physician Assistant            Poison Control  
 Nurse Line \_\_\_\_\_            Other \_\_\_\_\_

- Were instructions provided?    Yes    No

- If yes, please provide a detailed description of the instructions received:
- 

- Were the instructions followed?    Yes    No

• If no, why not? \_\_\_\_\_

- Was 911 called?    Yes    No

- Was the Member transported by ambulance to an Emergency Department?    Yes    No

If yes, Name of Hospital: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

- Was the Member then discharged from the Emergency Department?  
Yes    No    Not known at time incident report was completed by staff
- Was the Member then admitted to the hospital?  
Yes    No    Not known at time incident report was completed by staff

- Was the Member taken to Urgent Care?    Yes    No

If yes, Name of Urgent Care: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Medication administered by: Name \_\_\_\_\_ Title \_\_\_\_\_

Medication error identified by: Name \_\_\_\_\_ Title \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Contact information: \_\_\_\_\_

Prescriber Type:    MD / DO    Nurse Practitioner    Physician Assistant    Other \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_  
City State ZIP Code

**INCIDENT TYPE – DEATH:**

Is this incident report related to a Member's death?    Yes    No

- If yes, complete the additional Member death questions
- If no, continue to Incident Type - Other Section

Description of the event and how was it detected?

Date of Death: \_\_\_\_\_

- Member's Diagnoses: *(List all diagnosis)* \_\_\_\_\_

Was the Member enrolled in Hospice?    Yes    No

- If yes, Date Hospice services started: \_\_\_\_\_
- If the Member was receiving Hospice, were they contacted?    Yes    No    N/A

Member Hospice Diagnosis:

Code	Description

Did the Member have advanced directives?    Yes    No    Unknown

- Code status:    Full code    Do not resuscitate    Unknown

Where was the Member at the time of death?

Hospital    Hospice Inpatient Unit    Group Home    Own Home    Other \_\_\_\_\_

What type of day was the Member having?

- Normal Routine:    Yes    No    Unknown due to Member location at time of death
- Disruptions to Normal Routine:    Yes    No    Unknown due to Member location at time of death
  - If yes, describe the disruptions: \_\_\_\_\_

Describe any symptoms the Member was exhibiting during the past 48-hours prior to the Member's death.

Unknown due to Member location at time of death

- When were symptoms first noticed? \_\_\_\_\_ Time: \_\_\_\_\_ am    pm

What activity was the Member engaged in prior to the Member's death? \_\_\_\_\_

Describe the environment prior to the Member's death.

Unknown due to Member location at time of death

Were there similar incidents that occurred during the week before the Member's death?

Yes    No    Unknown due to Member location at time of death

- If yes, describe: \_\_\_\_\_

Describe the Member's behavior prior to the incident.

Unknown due to Member location at time of death

Were emergency personnel notified?    Yes    No

• If yes, complete the following:

○ Was 911 called?    Yes    No    Unknown due to Member location at time of death

○ Was the member transported by ambulance to an Emergency Department?

    Yes    No    Unknown due to Member location at time of death

    If yes, Name of Hospital: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

○ Did the Member pass away in the Emergency Department?

    Yes    No    Unknown due to Member location at time of death

○ Was the Member admitted to the hospital?

    Yes    No    Unknown due to Member location at time of death

    ▪ If yes, did the Member pass away while in the hospital?

        Yes    No    Unknown due to Member location at time of death

○ Was the Member taken to Urgent Care?

    Yes    No    Unknown due to Member location at time of death

    If yes, Name of Urgent Care: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

○ Was any first aid provide to the Member by staff?

    Yes    No    Unknown due to Member location at time of death

    ▪ If yes, describe the measures taken: \_\_\_\_\_

\_\_\_\_\_

    ▪ If no or not needed, describe reason why: \_\_\_\_\_

\_\_\_\_\_

    ▪ Name of individual making the determination: \_\_\_\_\_ Title: \_\_\_\_\_

Prior to the Member's death, in the last 6 months,  
when was the last time the Member was treated at a Hospital? \_\_\_\_\_

• Reason for Hospital Admission? \_\_\_\_\_

    Name of Hospital: \_\_\_\_\_

    Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Prior to the Member's death, in the last 6 months,  
when was the last time the Member was treated at an Urgent Care? \_\_\_\_\_

• Reason for Urgent Care Visit? \_\_\_\_\_

    Name of Urgent Care: \_\_\_\_\_

    Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Prior to the Member's death, within the last 6 months,  
when was the last time the Member was treated in an Emergency Department? \_\_\_\_\_

• Reason for Emergency Department visit? \_\_\_\_\_

    Name of Hospital: \_\_\_\_\_

    Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Prior to the Member's death, within the last 6 months,  
when was the last time the Member received first aid from the staff providing services to the Member? \_\_\_\_\_

• Reason for first aid was administered by staff? \_\_\_\_\_

• Describe the measures taken: \_\_\_\_\_

**INCIDENT TYPE – OTHER:**

Complete this Section for all other incidents. Write clearly, objectively and in order of occurrence, without reference to the writer’s opinion. Provide a detailed description for each question.

Provide a detailed description of the incident, including all known facts:

**What happened before the incident?**

- What type of day was the Member having? \_\_\_\_\_  
 \_\_\_\_\_
  - Normal Routine?    Yes    No
  - Disruptions to Normal Routine?    Yes    No
    - If yes, describe the disruption(s): \_\_\_\_\_  
 \_\_\_\_\_
- What activity was the Member engaged in before the incident occurred? \_\_\_\_\_  
 \_\_\_\_\_
- Describe the environment before the incident occurred.
- Were there similar incidents that occurred the week prior to the incident?    Yes    No    Unknown
- Describe the Member’s behavior prior to the incident.
- Were techniques or steps taken to de-escalate the situation?    Yes    No
  - If yes, describe the techniques utilized: \_\_\_\_\_  
 \_\_\_\_\_

**What happened during the incident?**

- Was the Behavior Plan followed?    Yes    No    N/A
  - If yes, specifically, what techniques were implemented based on the plan? \_\_\_\_\_  
 \_\_\_\_\_
  - If no, please explain why not: \_\_\_\_\_  
 \_\_\_\_\_

- Were emergency measures utilized during this incident?    Yes    No
  - If yes, what type of Prevention & Support was utilized during the event: \_\_\_\_\_  
Name of staff involved in the technique: \_\_\_\_\_
  - Did the technique result in an injury to the Member?    Yes    No
    - If yes, please describe the injury: \_\_\_\_\_
  - Did the technique result in an injury to staff?    Yes    No
    - If yes, please describe the injury: \_\_\_\_\_
- Does this incident require a change to the Member's BP?    Yes    No
- Were there any recent changes to the BP due to prior incidents?    Yes    No
  - If yes, related to incidents that occurred in the past:    30 days    60 days    90+ days
- Was the Member injured?    Yes    No    N/A
  - If yes, describe injuries: \_\_\_\_\_
  - How was the Member injured: \_\_\_\_\_
- Was the Behavioral Health Crisis Line called?    Yes    No    N/A
  - If yes, please describe the outcome: \_\_\_\_\_
- Was 911 called?    Yes    No    N/A
  - If yes, *check all that apply*:
    - Support from Law Enforcement
    - Name Responding Law Enforcement Entity: \_\_\_\_\_
    - City: \_\_\_\_\_    State: \_\_\_\_\_    ZIP Code: \_\_\_\_\_
    - Name of the Responding Officer: \_\_\_\_\_    Badge # \_\_\_\_\_
    - Enforcement Report # \_\_\_\_\_
    - Support from Paramedic Evaluation / Transport
      - Was the Member transported by ambulance to an Emergency Department?    Yes    No
        - If yes, Name of Hospital: \_\_\_\_\_    City: \_\_\_\_\_    State: \_\_\_\_\_
      - Was Member then discharged from Emergency Department?
        - Yes    No    Not known at time incident report was completed by staff
      - Was Member then admitted to the hospital?
        - Yes    No    Not known at time incident report was completed by staff
- Was Member taken to Urgent Care by staff?    Yes    No    N/A
  - If yes, Name of Urgent Care: \_\_\_\_\_    City: \_\_\_\_\_    State: \_\_\_\_\_
- Was first aid provided by staff?    Yes    No    Not needed
  - If yes, describe the measures taken: \_\_\_\_\_
  - If no or not needed, describe reason why: \_\_\_\_\_
  - Name of individual making the determination: \_\_\_\_\_    Title: \_\_\_\_\_



**NOTIFICATIONS**

**This Section applies to all Incident Types - Medication, Death and Other**

Incidents must be reported to the Division no later than 24 hours after the occurrence of the incident. Sentinel incidents must be reported to the Division immediately using the after-hours phone line at (602) 375-1403 or 1-(855) 375-1403 and a hard copy of the incident report submitted no later than 24 hours after the occurrence of the incident.

**PARENT / GUARDIAN NOTIFIED:**    Yes        No        N/A – No appointed Guardian

- If yes, name of person notified: \_\_\_\_\_  
 Relationship to Member:    Parent        Guardian        Public Fiduciary        TSS Case Worker  
 Date of Notification: \_\_\_\_\_    Time of Notification: \_\_\_\_\_    am        pm
- If no, explain why: \_\_\_\_\_

**SUPPORT COORDINATOR NOTIFIED:**    Yes        No

- If yes, name of person notified: \_\_\_\_\_  
 Date of Notification: \_\_\_\_\_    Time of Notification: \_\_\_\_\_    am        pm
- If no, explain why: \_\_\_\_\_

**PROTECTIVE SERVICES NOTIFIED:**    Yes        No        N/A

- If No or NA, explain why: \_\_\_\_\_
- If yes, please indicate all agencies notified:  
 Adult Protective Services (APS)        Department of Child Safety (DCS)        Tribal Protective Services  
 Other \_\_\_\_\_  
 Date of Notification: \_\_\_\_\_    Time of Notification: \_\_\_\_\_    am        pm  
 Report made via:    On-Line        Telephone        Fax  
     o If made via telephone, name of person receiving the report: \_\_\_\_\_  
 Report #: \_\_\_\_\_

**LAW ENFORCEMENT NOTIFIED:**    Yes        No        N/A

- If No, explain why: \_\_\_\_\_
- If yes, how was Law Enforcement notified?    911 call        Non-Emergent call  
 Date of Notification: \_\_\_\_\_    Time of Notification: \_\_\_\_\_    am        pm  
 Name Responding Law Enforcement Entity: \_\_\_\_\_  
 City: \_\_\_\_\_    State: \_\_\_\_\_    ZIP Code: \_\_\_\_\_  
 Name of the Responding Officer: \_\_\_\_\_    Badge # \_\_\_\_\_  
 Enforcement Report # \_\_\_\_\_

**OTHER AGENCY NOTIFIED:**    Yes        No        N/A

- If yes, please indicate all agencies notified:  
 Arizona Center for Disability Law        Probation        DES Case Worker        Primary Care Provider  
 Behavioral Health Provider        Dept. of Health Services  
 Other \_\_\_\_\_  
 Date of Notification: \_\_\_\_\_    Time of Notification: \_\_\_\_\_    am        pm

**CORRECTIVE ACTION/COMMENTS****This Section applies to all Incident Types - Medication, Death and Other**

As a result of this incident, what steps were taken to prevent an incident of this type from happening again?

Provide detailed information including the following:

- In retrospect, what could have been done to better support the Member?
  
  
  
  
  
  
  
  
  
  
- If the incident was a result of the Member's escalating behavior(s), what de-escalation techniques could have been implemented in this situation to provide support to this Member?
  
  
  
  
  
  
  
  
  
  
- Were safety risks in the environment identified that have been removed?      Yes      No
  - If yes, describe the environmental safety risks that contributed to this incident?

- Was additional staff training provided as a result of this incident?      Yes      No
  - If yes, describe the training provided:

Name of person completing this form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am pm

Supervisor's name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am pm