

**Department of Health and Human Services**

**Adult Developmental Services**

**Reportable Event Instructions**

***When Must a Report Be Made 14-197 CMR CH12 3 A***

The Reportable Events listed in Section 2 (2) (A) (1) -(16) shall be reported through the Reportable Event Database (also known as EIS) as soon as possible within one (1) business day of the Reportable Event.

1. In the event that a Required Reporter does not have access to the Reportable Event Database and can reasonably anticipate that the Reportable Event Database will not be accessible within one (1) business day from the time of the Reportable Event, a report shall be faxed to the Department

***Who Must Report: Refer to 14-197 CMR CH12 Section 2.1***

**Mandated Reporters are required to make reports of abuse, neglect, and exploitation of incapacitated and dependent adults directly to Adult Protective Services (APS) Central Intake at 1-800-624-8404.**

**If the report to APS Central Intake also is a Reportable Event, it must be entered into the Reportable Event Database (EIS) within one (1) business day.**

**Instruction for Completing the Reportable Event Form**

The Developmental Services Reportable Event consists of a three-page form to document events that have, or may have, an adverse impact upon the safety, welfare, rights or dignity of adults with an Intellectual Disability or Autism.

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| ***Page One: The event narrative and identifying information.*** | |
| **Identifier** | **Required Text** |
| Event Category | Check one or more categories which the event fits most appropriate. See instructions for page two and three of the reportable event form. |
| **Identifying Information (Consumer information)** | |
| Client First Name | Consumer’s first name |
| Client Last Name | Consumer’s last name |
| Gender | Indicate male or female |
| Date of Birth | Consumer’s date of birth |
| Social Security Number | Consumer’s social security number |
| Event **Start** Date | Date event began |
| Event **Start** Time | Time event began |
| Event **End** Date | Date event ended (date defaults to same day. Change if event ends on another date) |
| Event **End** Time | Time event ended. (Change default end time to correct time the event ended) |
| **Information Regarding Direct Reporting to DHHS** | |
| Date Reported to DHHS or Community Case Manager | This is the ***date of a person to person direct contact*** with DHHS personnel (i.e.: Office of Aging and Developmental Services, Case Manager, Crisis Services, APS Intake Line) This is not the date reported to Guardian, unless the Guardian is a State Guardian Rep. neither is it any other non-DHHS personnel. |
| DHHS Person Reported To | Give ***name of DHHS person contacted*** **or Community Case Manager** for the date reported to DHHS. See above. |
| Department Reported To | Select the DS department area the ***person reported to*** *is from*. Select APS Intake Unit, DS Caseworker (includes Community Case Workers), DS Crisis, DS Regional Supervisor/PA or Incident Data Specialist.  **Notification to DHHS Licensing is NOT a reportable event notification to the Office of Aging and Developmental Services.** |
| **NOTE:** If direct contact has not been made to a DHHS personnel enter the following:  Date reported: Please use todays date (date entering the report to EIS).  Person reported: Write EIS Entry.  Department reported to: Choose Incident Data Specialist. | |
| **Program Type and Incident Location Information** | |
| Program Type | Supporting program type during reportable event occurrence. Choose from the DS list provided or check other and specify what other Program Type. |
| Incident Location | Where the reportable event took place. Choose from list provided or check Other and provide the location. |
| **Reportable Event Information** | |
| Short Description of Event | Describe the event briefly and accurately. **This is a first person account of what happened.** Write legibly and use an additional piece of paper and attached to the form if more space is needed. Limit narrative to 4,000 characters. |
| Short Description of Action Taken | Describe what actions were taken as a result of the event. **This is a first person account of follow up to the event.** Do Not write the complete narrative in both description boxes. Limit narrative to 4,000 characters. |
| **Note**: Narrative may include name of consumer for whom the report is written about. Do not use name of other consumers who may have been involved in the event. Use housemate or peer instead of other consumer’s proper names.  Use staff names or other involved persons’ names within the narrative to make the report clear as to who played what role in the event. Include these names and their role in worker detail for who was involved. (See worker detail below) | |

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| **Reporter Details (Person who had a role in this event)** | |
| Reporter Name | The person who was involved in the event is the reporter. The reporter should be the responsible person to complete the narrative portion of this form in their own words. |
| Reporter Address | The address of the home or community program supporting consumer that reporter may be employed by. This is NOT the personal address of a reporting staff person. It MAY be the address of a reporting person if a family or community member whose address may be important and not available elsewhere on this report. |
| Work Phone | Reporter’s phone number where they can be reached if necessary. |
| E-mail Address | Include reporter’s e-mail address if known. Use staff’s business e-mail address. Do Not use staff’s personal e-mail address. |
| Title | Title of person reporting the event. |
| Reporter Type | Check the box that corresponds to the reporter’s relationship to the consumer. |
| Reporter Role | Check the role reporter had to the event. If other, please specify the role. |
| Method of Reporting | Check how you forwarded this report to support staff for documentation to DHHS. |
| **Agency Contact / Filer Details**  **(Person/Agency responsible for content and reporting to DHHS)** | |
| Filer Type | The filer type is the relationship of the person entering the reportable event to the EIS electronic reporting system. |
| Name | Agency staff’s name that is entering the information to DHHS using the EIS notification system. |
| Phone Number | Above agency staff’s contact phone number. |
| E-mail Address | Above Agency staff’s contact business e-mail. |
| Date and Time Information Received | Enter the date and time the report was forwarded to the filer. This date may differ from the actual date the report is entered to EIS. |
| Provider or Agency/Address Location | Provider or Agency supporting consumer and the address of the home or community location of the supporting provider or agency. |
| NOTE: In certain circumstances the Filer may not have access to direct reporting to DHHS through the EIS system. In this event the filer and filer information would be the person responsible for reporting and the paper copy would be forwarded to the appropriate District DHHS Office. | |
| **Worker Details** | |
| Was worker(s) involved in event | Worker is defined as any support person that participated in, witnessed or heard about the incident. If yes, please include all workers’ names. |
| Worker Type | The worker type is the relationship of the worker to the consumer. |
| Role | Workers’ role to the event. |
| Was another person involved in the event | Other person is any non-support staff that may have been involved in the event. Include all names. DO NOT list other consumer’s names who may have been involved in the event. |
| Role | Other person’s role in the event. |
| **Family/Guardian Notifications** | |
| Guardian Notified | Indicate if Guardian was notified. Check *No Guardian* if consumer is their own Guardian. |
| Who Notified Guardian | List name of person who notified guardian of this event |
| Guardian’s Name | Name of Guardian. |
| Address | Guardian’s address. Include Town, State and zip code. |
| Phone | Guardian’s phone number. |

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| **Reportable Events Page Two and Three: Event Types and Categories** |
| DANGEROUS SITUATION **14-197 CMR CH12 2 A xvi** |
| DEATH **14-197 CMR CH12 2A i** |
| EMERGECY DEPARTMENT VISIT **14-197 CMR CH12 2A iv** |
| EMERGENCY RESTRAINT **14-197 CMR CH12 2A xiv** |
| HOSPITAL ADMISSION PLANNED/UNPLANNED **14-197 CRM CH12 2A v** |
| LAW ENFORCMENT INTERVENTION ***14-197 CRM CH12 2A xi*** |
| LOST OR MISSING PERSON ***14-197 CRM CH12 2A ix*** |
| MEDICAL TREATMENT OTHER THAN HOSPITAL ***14-197 CMR CH12 2A vii*** |
| MEDICATION ERROR ***14-197 CMR CH12 2A vi*** |
| PHYSICAL ASSAULT/ALTERCATION ***14-197 CMR CH12 2A xiii*** |
| PHYSICAL PLANT DISASTER ***14-197 CMR CH12 2A x*** |
| RIGHTS VIOLATION ***14-197 CMR CH12 2A xv*** |
| SERIOUS INJURY ***14-197 CMR CH12 2A viii*** |
| SUICIDAL ACTS THREATS ***14-197 CMR CH 12 2A iii*** |
| TRANSPORTATION ACCIDENT ***14-197 CMR CH 12 2A xii*** |

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| ***DANGEROUS SITUATION 14-197 CMR CH12 2 A xvi***  ***Type of Dangerous Situation:***  \*Arson \*Hostage Taking \*Other Event that poses jeopardy to client and/or public safety that is not listed in other categories: (Specify)  **Was Emergency Services involved?**  \* Yes \* No  ***If yes, Indicate type?***  \*Ambulance/Rescue/Paramedics \*Law Enforcement \*Fire Department \*Warden Services \*Crisis Team \*Other Emergency Service: (Specify) |

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| ***DEATH 14-197 CMR CH12 2A i***  **D*eath was:***  \*Expected \* Unexpected  ***Preliminary Cause of Death?***  \*Natural Causes – Age Related \*Complication to Illness or other diagnosis  \* Suicide – completed \*Homicide \*Accidental Death  ***Location at time of death?***  \*Private Home \* Agency Home \*Nursing Facility \*Hospital \*Hospice \*Assisted Living Facility \*Other (Specify): |

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| ***EMERGECY DEPARTMENT VISIT 14-197 CMR CH12 2A iv***  ***Please indicate method of transportation to Emergency Department:***  \*Call to 911 – member transported to Emergency Department \* Agency transported member to Emergency Department \* Member took self to Emergency Department \* Family/others took member to Emergency Department |

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| ***EMERGENCY RESTRAINT 14-197 CMR CH12 2A xiv***  **Type of Restraint**  \*Personal Holding \*Chemical restraint \*Blocking Restraint  **If restraint was a person holding, please indicate type?**  \*1 Person \*2 Person  **Is there an approved behavior plan in place?**  \* Yes \* No  **Single or Multiple Restraint**  \* Yes \* No  ***SINGLE RESTRAINT INFORMATION***  \*Single Restraint Start Time \*Single Restraint End Time \* Total Restraint Time  ***MULTIPLE RESTRAINT INFORMATION***  \*Multiple Restraint – Start Time of ***First*** Restraint: \*Multiple Restraint End Time of ***Last*** Restraint \*Total Multiple Restraint time \*Duration of each restraint: |

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| ***HOSPITAL ADMISSION PLANNED/UNPLANNED 14-197 CRM CH12 2A v***  ***Why was the member admitted?***  \*Admission \*Observation |

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| ***LAW ENFORCMENT INTERVENTION 14-197 CRM CH12 2A xi***  ***Type of Intervention:***  \*Individual receiving services involved with criminal activity \*Individual receiving services involved is part of a police investigation \*Individual receiving services is a victim of a crime \* Crisis intervention involves police or law enforcement personnel |

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| ***LOST OR MISSING PERSON 14-197 CRM CH12 2A ix***  ***Indicate time member was missing:***  \*Less than 5 hours \* 5-10 Hours \* More than 10 Hours  ***Did member runaway?***  \*Yes \*No |

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| ***MEDICAL TREATMENT OTHER THAN HOSPITAL 14-197 CMR CH12 2A vii***  ***Reason for seeking treatment:***  \*Medical Condition \*Flu \*Other (Specify):  ***Where did person receive treatment?***  \*Physician’s Office \*Urgent Care \*Other (Specify): |

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| ***MEDICATION ERROR 14-197 CMR CH12 2A vi***  ***Please list name (s) of medication (s) involved:***  ***Type of Error?***  \*Refusal to take prescribed medication \*Incorrect Route \*Incorrect method of administration \*Incorrect dosage \* Incorrect schedule \*Took medication that was not prescribed to the individual receiving services \* Individual receiving services had an allergic reaction \*Did not follow procedures when assisting member with self-medication  ***Reason medication error occurred?***  \*Administration Error \*Supply Exhausted \*Forgot \*Refusal \*Prescription Unfilled \*Incorrect Chart Entry \*Non-Compliance \*Forgot to take on activity \*Forgot to send to program\*Other (Specify) |

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| ***PHYSICAL ASSAULT/ALTERCATION 14-197 CMR CH12 2A xiii***  ***Individual receiving services initiates a physical altercation with:***  \*Staff \*Another individual receiving services \*Member of the Community \*Other (Specify):  ***Was the individual physically assaulted by another individual receiving services?*** \* Yes \* No  ***Was Emergency Services Involved?***  \* Yes \* No  ***If Yes, indicate type:***  \* Ambulance \*Rescue/Paramedics \*Law Enforcement \*Crisis Outreach Team \* Other Emergency Service (specify): |

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| ***PHYSICAL PLANT DISASTER 14-197 CMR CH12 2A x***  ***Type of disaster:***  \*Fire \*Flood \*Natural Disaster \*Other incident that caused displacement (Specify): |

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| ***RIGHTS VIOLATION 14-197 CMR CH12 2A xv***  **Type of Rights Violation:**  \*Behavior Modification \*Communication \*Discipline \*Humane Treatment  \*Medical Care Nutrition \*Personal property \*Physical Exercise  \*Religions Practice \*Records \*Social Activity \*Voting \*Work |

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| ***SERIOUS INJURY 14-197 CMR CH12 2A viii***  ***Type of Injury?***  \*Laceration requiring sutures or staples \*Bone Fracture \*Joint dislocation \*Loss of limb \*Serious Burn \*Skin wound due to poor care  ***Cause of Injury?***  \*Accident \*Medical Condition (seizures, etc.) \*Treatment error (medication reaction, etc.) \* Origin Unknown \* Other (Specify):  ***Where did person receive treatment?***  \*Emergency Room \*Outpatient services other than emergency room \*Inpatient \*Physician’s office \*Emergency Intervention on site \*Other (Specify): |

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| **SUICIDAL ACTS THREATS 14-197 CMR CH 12 2A iii**  ***Type of threat:***  \*Make a verbal threat to kill themselves \*Describes a way to carry out a suicide plan \*Talks or writes about death or suicide |

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| **TRANSPORTATION ACCIDENT 14-197 CMR CH 12 2A xii**  ***Type of Transportation Accident:***  \*Individual receiving services is a pedestrian \*Individual receiving services is a cyclist \*Individual receiving services is a passenger in motorized vehicle-includes ATV’s \*Individual receiving services is involved in a watercraft accident |

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| Department of Health and Human Services  Office of Aging and Disability Services  **Incident Data Specialists for Reportable Events** |
| Lisa Merrill, Assistant Developmental Services Information Manager  30 Skyway Drive, Unit 100, Caribou, ME  Phone: **493-4121** Fax: 493-4173 Toll Free: 1-800-432-7366 |
| District 1 & 2 Portland  Crystal Tidwell Phone: **822-2227** Fax: 822-0295  151 Jetport Boulevard, Portland, ME 04101  York & Cumberland County |
| District 3 Lewiston  Bruce Russo Phone: **753-9152** Fax: 7539158  200 Main St., Lewiston, ME 04240  Androscoggin, Oxford & Franklin County |
| District 5 Augusta  Sandie Johnson Phone: **287-7180**  Fax: 287-7186  41 Anthony Ave., Augusta, ME 04333  Kennebec & Somerset County |
| District 4 Rockland  Suzanne Freitas Phone: **596-4256**  Fax: 596-2304  91 Camden St., Suite 103, Rockland, ME 04841  Knox, Waldo, Lincoln & Sagadahoc County |
| District 6 & 7 Bangor  Tonya Horton Phone: **561-4218**  Fax: 561-4301  396 Griffin Rd., Bangor, ME 04401  Piscataquis, Washington, Hancock & Penobscot County |
| District 8 Caribou  Lorraine Curtis Phone: **493-4107** Fax: 493-4173  30 Skyline Dr., Unit 100, Caribou, ME 04736  Aroostook County |
| State Wide  Adult Protective Services Referral Line  11 High St., Houlton, ME  Phone: **1-800-624-8404** Fax: 532-5004 |
| DS Crisis Services 7/24 Phone: **1-800-568-1112** |

*(7/10/2018)*