INDIVIDUAL INCIDENT REPORT INSTRUCTIONS
MASSACHUSETTS DEPARTMENT OF DEVELOPMENTAL SERVICES
AUTISM WAIVER

Initial Report: Individual Information

Individual's Name – Name of individual for whom the incident report is being completed. When the individual is identified in HCSIS, the other needed personal information will be completed by the system.

Individual's Service Coordinator – This is only needed if the paper incident report is being sent directly to the DDS Clinical Manager. When entering into the HCSIS computer system, this information will be imported from Meditech.

Is the individual subject to a Level II or Level III Behavior Plan? – Answer "no".

Home Address: - This is only needed if the paper incident report is being sent directly to the DDS Clinical Manager. When entering into the HCSIS computer system, this information will be imported from Meditech.

Initial Report: Filing Agency Information

Filing Agency: - Name of agency completing the incident report.

Was your agency providing services to the individual at the time of the incident? – This needs to be answered "yes" if your agency or another agency was providing services to the individual at the time of the incident. If the individual being at home with their family at a time when services were not being provided, the answer would be "no." If the agency was providing or should have been providing services are the time of the incident, the answer would be "yes."

Staff Filling Out Paper Form – This should be answered if an initial report was completed on paper before entering into HCSIS. The person filling out the paper form should be identified here.

Staff Responsible for Incident Follow-up – The staff person who will be following up on any action that needs to be taken as a result of this incident should be identified here.

Initial Report: Incident Classification

Date Incident Discovered – Enter the date (MM/DD/YYYY) the reporter learned of the incident. This date would be when the reporter observed the incident or, if not observed, when they first learned of the incident after it occurred.

Approximate Time Incident Discovered – Enter the approximate time (HH:MM AM/PM) the reporter observed the incident or when they first learned of the incident after it occurred.

Complete Only if Known

Date Incident Occurred – MM/DD/YYYY

Approximate Time Incident Occurred – HH:MM AM/PM

Did Staff Directly Observe the Incident? – Answer yes/no/unknown. Answer "yes" only if staff directly observed the incident as it occurred.

Was Supervision, At the Time of the Incident Being Provided as Assigned? – It is important to know whether the individual at the time of the incident was being supervised in a manner consistent with supervision requirements identified in the child's behavioral plan. An example would be if the staff person takes the child into the community and leaves the child unattended for a period of time resulting in an incident. The answer to the question would be 'no.'

Responsible Site – Enter "not applicable".

Incident Categories – Choose the most appropriate incident category and secondary category, if available under the chosen primary category, to identify the incident. The categories are organized by degree of severity. The most severe primary and secondary category that fits the incident should be chosen. For example, if an individual is involved in a physical altercation and is transported to the hospital and examined and released from the emergency room as a result of that altercation, the choice should be "unexpected hospital visit" as a primary category with the secondary category of "ER Visit."

Did the incident involve the ingestion of non-food substances? – Answer yes, no, or unknown.

Did the incident involve the unauthorized use of drugs or alcohol? – Answer yes or no.

Did the incident involve suicidal threat or ideation? – Answer yes or no.

Did the incident involve non-compliance with a medical directive? – Answer yes or no.

Did the incident involve a medication refusal? – Answer yes or no.

Description of Any Injury Associated with the Incident

Is there an Injury? – Answer yes/no. This should be answered "yes" only if the injury is to the individual for whom the incident report is being completed. If answered "yes", the following questions relating to the injury should also be completed.

Cause of Injury – choose all available causes that apply. If "other" is chosen, describe the injury in the next question.

If Other, Specify – Describe the injury if "other" is chosen under "cause of injury."

Briefly Describe the Injury Including Cause and Factors – this is a narrative question where a fuller description should be given of what contributed to this injury occurring.

Type of Injury – choose all appropriate answers for the type(s) of injuries that occurred from the available choices. If "other" is chosen, specify the type of injury in the following question.

If Other, Specify – Specify the type of injury if "other" is chosen under "type of injury."

Body Part Affected by Injury – choose all appropriate answers for body part(s) affected by the injury. If "other" is chosen, specify the body parts affected in the following question.

If Other, Specify – Specify the body part(s) affected by the injury if "other" is chosen under "body part affected by injury."

Initial Report: Incident Description I

Incident Description - Include all pertinent information necessary for the reader to have a full understanding of the incident. This could include any antecedents or causes, others involved in the incident, etc. Whenever an individual other than the person for whom the report is written is entered, their confidentiality should be protected by substituting the name with a descriptor such as "Individual A". Descriptors should also be substituted for staff names whenever there is any accusation of staff wrongdoing.

When an incident report is being sent to others beyond authorized reviewers in HCSIS, a careful review should be made to ensure confidentiality of personal identifying information has been maintained as outlined in the HCSIS Incident Management System Guidelines.

Initial Report: Incident Description II

What Is the Most Recent Status of the Individual? – This requires a narrative response. The most recent status of the individual refers to the individual's state or

condition at the time the incident report is being completed. For example, is the individual presently upset/calm/resting comfortably?

Is the Incident Location Known? – Answer yes/no as to whether it is known where the incident occurred. If known, answer the next two questions.

Where Did the Incident Occur? – If known, choose one from the available choices of where the incident occurred. Choose "family residence" if the incident happened in the child's home.

Site Location of Incident (Address) – Enter "not applicable."

If Not at Provider Site, Information About Incident Location

Location Name/Description: - If the incident did not occur at the family home, describe where it did occur; e.g. restaurant, drug store, etc.

Location Name and Address – If the incident did not occur at the family home, give the actual name and address of the site, if known.

Initial Report: Actions Taken To Protect Health, Safety and Rights

Actions Taken to Protect Health, Safety and Rights – Outline in narrative all immediate actions taken to protect the individual. Describe administrative, health/safety, treatment and other actions taken to address the incident to date.

Treatment Provided By – Choose all that apply from the available list to identify everyone who provided any treatment for this incident.

Initial Report: Involved Parties

People Involved with the Incident – Enter the names of those who completed the incident report, was an eyewitness to the incident, initially reported the incident and/or was the reporting provider staff or DDS Autism Waiver staff person to initially discover or be made aware of the incident. Do not enter others who were made aware of the incident beyond those described above. Whenever an individual is entered, their confidentiality should be protected by substituting the name with a descriptor such as "Individual A". Staff names and phone numbers would typically be entered since the information requested in this section is not suggestive of any potential wrongdoing. Information about potential wrongdoing would be described in the incident description, where descriptors should be substituted for staff names.

When an incident report is being sent to others beyond authorized reviewers in HCSIS, a careful review should be made to ensure confidentiality of personal identifying

information has been maintained, as outlined in the HCSIS Incident Management System Guidelines.

Initial Report: Notification

Was the On-Call Person Notified? – Choose "yes – have notified," or "no," as to whether you or other staff have notified the On-Call person.

Name of On-Call Person Notified – The name of the On-Call person notified, if applicable.

Has Executive Office of Elder Affairs Been Notified? (Only applies to individuals greater than 59 years old. Choose 'N/A' for all other individuals) – Choose "no," as this is not applicable.

Has D.P.P.C. Been Notified? – Choose "no," as this is not applicable.

Has DCF Been Notified? (Only applies to individuals less than 18 years old. Choose 'N/A' for all other individuals)

Has Family/Guardian Been Notified? - Choose "yes – have notified," "no – will notify" or "no," as to whether you or other staff have notified the family/guardian of this incident.

Was Law Enforcement Involved? - Choose "yes "no" or "unkown," as to whether law enforcement was involved in this incident. Law Enforcement is considered involved when their presence is needed to respond to a crime or to assist in keeping an individual safe.

Signature of the Staff Filling Out Paper Incident Report – Person completing the paper incident report should sign the paper report to be submitted.

Position – The position of the person filling out the paper incident report should be entered.

Telephone – The work telephone number of the person filling out the paper incident report should be entered.

Date/Time of Report – The date/time the report is completed should be entered. (MM/DD/YYYY) (HH:MM AM/PM)

Name of Supervisor – The name of the supervisor completing the supervisory review should be entered.

Position – The position of the supervisor should be entered.

Signature of Supervisor – The signature of the supervisor should be entered on the paper incident report if this review is completed on paper.

Telephone – The telephone number of the supervisor should be entered.

Date/Time of Review – The date/time the supervisory review is completed should be entered. (MM/DD/YYYY) (HH:MM AM/PM)

Initial Report: HOSPITAL VISIT (Complete Only for a Hospital Visit)

Length of time in ER/Urgent Care/Crisis Unit - Choose between available selections for the amount of time an individual spent in the ER/Urgent Care/Crisis Unit until they were discharged from the ER/Urgent Care/Crisis Unit or were admitted to the hospital.

Admission Information – complete only if the individual was admitted to a medical or psychiatric/detoxification unit.

Date of Admission – enter (MM/DD/YYYY)

Hospital Name – Identify which hospital the individual went to for all secondary categories (Medical Hospitalization, Psychiatric Hospitalization, E.R. Visit, or Emergency Psychiatric Services Evaluation). Select from the available list of hospitals or select "other" if the hospital name is not available on the list or "unknown" if the name of the hospital is not known.

Reason for ER/Hospital Visit – Choose from drop down list.

Was the admission from the ER? – Answer yes/no/unknown.

If yes, did you contact the individual's doctor's office prior to going to the ER? – Answer yes/no/unknown.

If yes, did you get an appointment at the doctor's office? – Answer yes/no/unknown.

If no, reason for no appointment at doctor's office. – Choose reason for no appointment.

What occurred during the hospital visit? – Check all that apply.

If "other", please specify – identify what occurred during the hospital visit if it is not a choice available in the previous question.

Discharge Information - unless the individual was admitted from a day service and is followed outside of the day service, the incident report should not be completed until the individual is discharged so that discharge information can be completed.

Date of Discharge – (MM/DD/YYYY)

Discharge Diagnosis 1 – Dropdown list on screen. Choose the appropriate diagnosis from the appendix at the end of these instructions.

Discharge Diagnosis 2 – Dropdown list on screen. Choose the appropriate diagnosis from the appendix at the end of these instructions.

Discharge Diagnosis 3 – Dropdown list on screen. Choose the appropriate diagnosis from the appendix at the end of these instructions.

If Other was chosen as discharge diagnosis, please specify – Describe the discharge information if "Other" is selected in any of the above 3 diagnoses.

Did You Get Instructions Upon Discharge? - Outline any instructions obtained upon discharge.

What Changed for this Person Upon Discharge? – Choose all dictionary choices that apply.

Current Status – What is the person's capabilities upon discharge? Choose all that apply.

Specify any Follow-up Appointments Scheduled with a Health Care Professional – Identify all appointments that have been scheduled for the person upon discharge.

Any Additional Clarifying Information – Outline any information deemed important that was not covered in other questions on the hospital screen.

Final Report: Additional Information – This section is to be used to update and/or correct any information provided in the initial report. Most questions, therefore, are repeat questions from the initial report. If there are no additions or corrections, the question does not need to be answered again.

Incident Description – Make any additions or corrections to the incident narrative here. If there are no additions or corrections, this question does not need to be answered.

Are There Additional Action Steps for This Incident? – This question should be answered yes/no as to whether there are any additional action steps beyond those identified in the initial report under the question "Actions Taken to Protect Health, Safety and Rights") that have been or will be taken as a result of this incident. Once the initial report is submitted, the information provided in the "Actions Taken to Protect Health, Safety and Rights" question cannot be changed. The "Additional Action Steps" question is the place to note any further action that has now been taken, or will be taken as a result of this incident.

Action Step/Targeted Completion Date/Responsible Party – Identify each action step that that has been or will be taken, the date each action did or will occur, and the person responsible for each action.

Final Report: Involved Parties

People Involved with the Incident – answer only if there are corrections or additions.

Final Report: Verification of Time and Categorization

Initial Report Information is Correct to the Best of my Knowledge – If the information in the initial report does not need to be changed, answer "yes." The rest of the information in this section can be skipped until the report finalization section. If there is information to be added or corrected, the answer is "no," and then the information that needs to be changed should be corrected for the appropriate section. The remaining questions are as follows:

Date Incident Discovered

Approximate Time Incident Discovered

Do You Know the Date and/or Approximate Time the Incident Occurred.

Date Incident Occurred

Approximate Time Incident Occurred

Incident Categories

Was your agency providing services to the individual at the time of the incident?

Staff Filling Out Paper Final Report

Did Staff Directly Observe the Incident?

Was Supervision at the Time of the Incident Being Provided as Assigned?

Was the On-Call Person Notified? – Choose "yes – have notified," or "no," as to whether you or other staff have notified the On-Call person.

Name of On-Call Person Notified – The name of the On-Call person notified, if applicable.

Has Executive Office of Elder Affairs Been Notified? (Only applies to individuals greater than 59 years old. Choose 'N/A' for all other individuals) – (Choose N/A as this does not apply.)

Has DPPC Been Notified? (Choose N/A as this does not apply.)

Has DCF Been Notified? (Only applies to individuals less than 18 years old. Choose 'N/A' for all other individuals)

Has Family/Guardian Been Notified?

Was Law Enforcement Involved?

Description of Any Injury Associated with the Incident.

Is There an Injury?

Cause of Injury

If Other, Specify

Briefly Describe the Injury Including Cause and Factors

Type of Injury

If Other, Specify

Body Part Affected by Injury

If Other Specify

Final Report - Finalization

Name of Person Finalizing Report – Enter the name of the person who is completing and finalizing the incident report.

Position – Position of the person finalizing the incident report.

Signature – If completed on paper, the signature of the person finalizing the incident report.

Telephone – Work phone number of the person completing the final report.

Date/Time of Review - Date (MM/DD/YYYY) and Time (HH:MM AM/PM) the report is finalized.

Appendix:

List of Diagnoses for Unexpected Hospital Visits

Allergy, Allergic Reaction
Alzheimer's disease
Anemia
Anxiety/Anxiety Disorder
Appendicitis
Arthritis
Asthma
Bipolar Disorder
Bowel obstruction
Bronchitis
Burn
Bursitis
Cancer, blood
Cancer, brain
Cancer, breast
Cancer, colon, rectum or anus
Cancer, esophagus
Cancer, kidney
Cancer, liver
Cancer, lung
Cancer, other
Cancer, pancreas
Cancer, prostate
Cancer, stomach
Cancer, testicular
Cardiac Arrest
Catheter related
Cellulitis
Cerebral Palsy
Chest pain, non-cardiac
Chest pain, possible cardiac
Choking or Aspiration
Congestive Heart Failure
Constipation
Chronic Obstructive Pulmonary Disease (COPD)
Dehydration
Dementia

Dental condition
Diabetes/Blood sugar problem
Dysphagia
Ear condition, Inner Ear
Ear condition, Outer Ear
Epilepsy / Seizure
Eye condition
Fever of Unknown Origin
Fracture
G/J-tube problems
Gallbladder problem
Gastrointestinal bleed
Gastrointestinal obstruction
Gastroesophogeal reflux disease (GERD)
Glaucoma
Hernia
Hypertension/Hypotension
Infection
Infection, MRSA
Infection, Urinary Tract
Infection, Wound or Ostomy
Injury or possible injury
Liver toxicity/cirrhosis
Medication reaction or side effect
Neurological evaluation
Other
Other, Cardiac
Other, Gastrointestinal
Other, Genitourinary
Other, Psychiatric
Pancreatitis
Parkinson’s Disease
Personality Disorder
PICA, ingested foreign object
Pneumonia, Aspiration
Pneumonia, Influenza
Pneumonia, type unknown
Poisoning or possible poisoning
Post-op complications
Psychiatric, general/unknown
Renal/Kidney condition
Respiratory distress or arrest
Schizophrenia and thought disorders
Sepsis, dental
Sepsis, Respiratory
Sepsis, unknown or other

Sepsis, Urinary tract/kidney
Sepsis, wound or ostomy
Skin condition
Sprain
Stroke (CVA)
Substance abuse
Suicidal
Thyroid condition
Ulcer, gastrointestinal
Urinary retention
Unknown