Maine Reportable Events

Adult Developmental Service Event

☐ Physical or Verbal Abuse ☐Neglect ☐ Sexual Abuse/Exploitation ☐ Exploitation (Non-Sexual) ☐ Rights Violation ☐ Serious Injury to Consumer ☐ Suicidal Acts, Attempts, Threats ☐ Death ☐ Restraint ☐ Medication Error ☐ Dangerous Situation - Other
Event Start Time: * _____ am / pm End Date: * _____ Event End Time: * _____ am / pm
Short Description of Event:* _____
_____

Worker Details

Was Worker involved in event?:* ☐ Yes ☐ No ☐ Unknown
Name: _____
Worker Type: ☐ Direct Service ☐ Management/Supervisor
Role: ☐ Participant ☐ Witness ☐ Other _____
Was another Person involved in event?:* ☐ Yes ☐ No ☐ Unknown
Name: _____
Role: ☐ Participant ☐ Witness ☐ Other _____

Reporter Details

Reporter ID:* ☐ Consumer ☐ Family Member ☐ Guardian ☐ Staff ☐ CCM ☐ Other _____
Reporter Role:* ☐ Participant in event ☐ Witness ☐ Hearsay ☐ Other_____
Method of reporting:* ☐ Call ☐ E-mail ☐ Fax ☐ In-Home Visit ☐ Letter ☐ Other _____
Location:* ☐ Adult Day Care ☐ Hospital ☐ In Community ☐ Nursing Facility ☐ Personal Residence ☐ Residential Care ☐ Day Habilitation ☐ Other _____

Agency/ Contact/ Filer Details

Filer Type:* ☐ Agency Staff ☐ DHHS Staff ☐CCM ☐Guardian ☐ Friend ☐ Anonymous☐ Other _____
Filer Name:* _____
Filer Phone:* _____ Filer Email: _____

Notifications

Client's Family Notified:* ☐ Yes ☐ No
Guardian Notified:* ☐ Yes ☐ No ☐ No Guardian If yes, Who Notified Guardian: _____
Guardian Name: _____ Guardian Address:_____
Guardian Phone: _____

Physical or Verbal Abuse

Source of Abuse: ☐ Self ☐ Family Member ☐ Direct Care Staff ☐ Other Provider Staff ☐ Client to Client ☐ Other_____
Other Source:_____
Type of Abuse: ☐ Physical Abuse (Includes Assault) ☐ Cruel Punishment ☐ Unreasonable Confinement ☐ Emotional Abuse ☐ Intimidation ☐ Verbal Abuse
Was the person injured as a result of abuse?: ☐ Yes ☐ No
Was treatment required?: ☐ Yes ☐ No
If treatment required select location: ☐ Inpatient ☐ Outpatient ☐ Emergency Room ☐ Physician's Office ☐ Crisis Intervention

Neglect

Source of Neglect: ☐ Self ☐ Family Member ☐ Direct Care Staff ☐ Other_____
Other Source: _____
Type of Neglect: ☐ Self Neglect ☐ Caregiver Neglect ☐ Safety Issues/At Risk ☐ Deprivation of essential needs ☐ Lack of adequate protection ☐ Caregiver under influence ☐ Inability to give informed consent
Was treatment required?: ☐ Yes ☐ No
If treatment required select location: ☐ Inpatient ☐ Outpatient ☐ Emergency Room ☐ Physician's Office ☐ Crisis Intervention

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**

Note:- Required fields are marked with an asterisk (*)

Sexual Abuse/Exploitation
Source of Abuse: □ Family Member □ Direct Care Staff □ Client to Client □ Other_____
Other Source: _____
Type of Alleged Abuse: □ Non-consensual sexual activity □Sexual contact by paid provider □Client to client sexual abuse
□ Sexual contact with incompetent person
Was the person injured as a result of abuse?: □ Yes □ No
Was treatment required?: □ Yes □ No
If treatment required select location: □ Inpatient □ Outpatient □ Emergency Room □ Physician's Office □ Sexual Abuse Assault
Other Crisis Helpline If Other: _____

Exploitation (Nonsexual)
Exploitation Source: □ Family Member □ Direct Care Staff □ Client to Client □ Provider Non-Direct Service Staff
□ Other _____
Other Suspect Perpetrator Type (Do not use name): _____
Exploitation Type: □ Unpaid/Inadequately Paid Work □ Financial Theft/Exploitation □ Property Theft Property Damage
□ Medication □ Theft □ Other_____ Other Exploitation Type: _____

Rights Violations
Rights Violations: □ Behavior Modifications □ Communications □ Discipline □ Humane treatment □ Medical Care □ Nutrition
□ Personal Property □ Physical Exercise □ Physical Restraints □ Religious Practice □ Records □ Social Activity □ Sterilization □ Voting □ Work

Serious Injury to Consumer
Causes of Injury: □ Fall □ Accident □ Seizure □ Medical Condition □ Treatment Error □ Poor Care □ Origin □ Unknown
□ Other: _____
Injury Type: □ Laceration requiring sutures or staples □ Bone Fracture □ Joint Dislocation □ Loss of Limb □ Serious Burn
□ Skin wound due to poor care □ Other_____
Where did person receive treatment?: □ Inpatient □ Outpatient □ Emergency Room □ Physician's Office □ Emergency Intervention On-Site □ Other Crisis Helpline
Other Injury Treatment Location: _____

Dangerous Situations – Other
Other Event Types: □ Criminal justice Involvement □ Consumer Violence (Non Assault) □ Runaway Lost/Missing Person
□ Loss of Home (Disaster) □ Arson □ Hostage Taking Other Event
Specify Significant Jeopardy Event Type: _____
Why is this event of particular risk to this person?: _____
Was emergency services involved?: □ Ambulance Rescue/Paramedics □ Law Enforcement □ Fire Department □ Warden Services □ Crisis Outreach Team □ Other Emergency Service

Suicidal Acts, Attempts, Threats
Was treatment required?: □ Yes □ No
If treatment required select location: □ Inpatient □ Outpatient □ Emergency Room □ Physician's Office □ Crisis Intervention
Other Crisis Helpline If Other: _____

Death
Death: □ Completed Suicide □ Homicide □ Natural Causes Age Related □ Accidental Death Complication to Illness
□Unexplained Death □ Other Death If Other: _____

Restraint(s)
Is this an Incidental Restraint to the Reportable Event?: □ Yes □ No
Behavioral Method (Mark Type of Restraint): □ Personal Holding Restraint □ Blocking □ Chemical Restraint
Name of Drug: _____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
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Single Restraint
Single Restraint: □ Yes □ No
Time Start: _____ am / pm Time End: _____ am / pm Time Total: _____

Multiple Restraint
Start 1st Restr: _____ am / pm End Last Restr: _____ am / pm Time Total: _____
Number of Restraints: _____

Precipitating Conditions and Behavior Changes
Precipitating Conditions and Behavior Changes: □ Unknown – no observed circumstances □ Gradual increase in agitation due to Behavior □ Explosive aggression with environment stress □ Explosive aggression without provocation
Other Precipitation If Other: _____

Behavior Exhibited
Behavior Exhibited: □ Assault on staff □ Assault on others □ Self-injury □ Other Behavior
If Assault on staff: _____If Assault on others: _____
If Self Injury: _____If Other: _____

Intervention Steps
□ Asked individual to stop the behavior □ Encouraged the individual to express concern or difficulty □ Attempted alternate activity – distraction □ Offered other choices □ Changed the environment to reduce stress □ Mediated the conflict between the person and other(s) □ Other Intervention _____

General Information
□ Medical attention required-Report to DHHS □ Medical attention to other person □ Medical attention to staff □ Damage to personal property □ Damage to staff property □ Damage to others property □ Minor staff injury-no outside treatment □ Minor injury to self – no outside medical treatment required □ No injury □ No property damage

Procedure Effectiveness
□ High - Person calmed down - No further incident □ Moderate - Continued minor disruption - No intervention needed □Low - Individual required continued attention □ None - Second use of intervention

Medication Error
Medication Event Type: □ Omission □ Wrong Dose □ Wrong Medication □ Wrong Method of Administration □Wrong Route □ Wrong Time (> 1 Hr. Variance) □ Medication Refused □ Non-Compliance □ Other_____
Medication Event Other: _____

Event Reason
Event Reason: □ Administration Error □ Supply Exhausted □ Forgot □ Refusal □ Prescription Unfilled □ Incorrect Chart Entry □ Non-Compliance □ Forgot to take on Activity □ Forgot to send to program □ Other Reason If Other_____
_____ Other reason for Event: _____

Administered/Set-Up By
□ Consumer □ Provider □ Provider Set-up Only □ Provider Admin. Only □ Family Member □ Direct Service Worker □ Other If Other: _____ Administered by Other:_____
Name of Drug: _____
Was treatment required?: □ Yes □ No
Treatment Type: □ Inpatient □ Outpatient □ Emergency Room □ Physician's Office □ Emergency Intervention On Site
Was the Nurse/Physician/ER Contacted?: □ Nurse □ Physician □ Emergency Room
Date of Contact: _____ Time of Contact: _____ am / pm
What instructions were given?: _____

SIGNATURE.....**NAME**.....**DATE**.....**TIME**.....**am/pm**
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