

Please check: ASI McBride Moore Living Other _____

SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH INCIDENT REPORT

IR No. _____

Consumer Involved Name: _____ Case Number: _____

Date Incident Occurred/Noticed: ____/____/____ Time Incident Occurred/Noticed: _____ AM / PM (Circle AM or PM)

Date Incident Reported: ____/____/____ Time Incident Reported: _____ AM / PM (Circle AM or PM)

Site Where Incident/Injury Occurred (Facility Name):

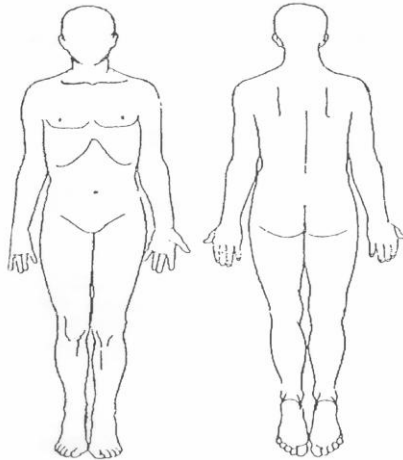
- | | | |
|--|---|--|
| <input type="checkbox"/> 1. Industrial Drive Upper level | <input type="checkbox"/> 5. SIP No. _____ | <input type="checkbox"/> 8. Work Site |
| <input type="checkbox"/> 2. Group Home (name) _____ | <input type="checkbox"/> 6. Unknown | <input type="checkbox"/> 9. New Directions |
| <input type="checkbox"/> 3. Industrial Drive Lower level | <input type="checkbox"/> 7. ACT Office | <input type="checkbox"/> 10. Other _____ |
| <input type="checkbox"/> 4. Van/Mini Van/Car | | |

Area Where Incident/Injury Occurred:

- | | | |
|--|--|--|
| <input type="checkbox"/> 1. Staff Office | <input type="checkbox"/> 5. Hallway/Ramp | <input type="checkbox"/> 9. Bedroom |
| <input type="checkbox"/> 2. Waiting Area | <input type="checkbox"/> 6. Kitchen | <input type="checkbox"/> 10. Parking Lot |
| <input type="checkbox"/> 3. Classroom | <input type="checkbox"/> 7. Living Area | <input type="checkbox"/> 11. Unknown |
| <input type="checkbox"/> 4. Bathroom | <input type="checkbox"/> 8. Dining Room | <input type="checkbox"/> 12. Other _____ |

Brief Description of Incident/Injury and Action Taken (Attach second sheet if needed):

Please indicate location of injury on figures below with an X



Front View

Back View

Type of Injury to Consumer (If applicable, check all that apply. May require a doctor's diagnosis):

- | | | | |
|---------------------------------------|---|---|-------------------------------------|
| <input type="checkbox"/> 1. No Injury | <input type="checkbox"/> 6. Sprain | <input type="checkbox"/> 11. Concussion | <input type="checkbox"/> 16. Bruise |
| <input type="checkbox"/> 2. Scratch | <input type="checkbox"/> 7. Strain | <input type="checkbox"/> 12. Swelling | <input type="checkbox"/> 17. Rash |
| <input type="checkbox"/> 3. Cut | <input type="checkbox"/> 8. Dislocation | <input type="checkbox"/> 13. Puncture | |
| <input type="checkbox"/> 4. Abrasion | <input type="checkbox"/> 9. Fracture | <input type="checkbox"/> 14. Bodily Fluids | |
| <input type="checkbox"/> 5. Bite | <input type="checkbox"/> 10. Burn | <input type="checkbox"/> 15. Other (describe) _____ | |

Seriousness of Injury :

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> 1. No Visible Injury | <input type="checkbox"/> 2. Non-Serious Injury | <input type="checkbox"/> 3. Serious Injury | <input type="checkbox"/> 4. Fatal Injury |
|---|--|--|--|

Treatment Provided (If Applicable):

- | | | |
|--|---|--|
| <input type="checkbox"/> 1. None | <input type="checkbox"/> 3. CMH Nurse | <input type="checkbox"/> 5. ER/Hospital/Medics |
| <input type="checkbox"/> 2. First Aid by On-site Staff | <input type="checkbox"/> 4. Private Physician | <input type="checkbox"/> 6. Other _____ |

Witnesses: _____

Print Name of Reporting Staff _____

Signature of Reporting Staff _____

Date _____

Recommendations reviewed by Home Manager _____
initial

**SHIAWASSEE COUNTY COMMUNITY MENTAL HEALTH
INCIDENT REPORT**

OTHER PERSONS NOTIFIED (check all that apply)

- | | | | |
|--|---------------------|--|---------------------|
| <input type="checkbox"/> 1. Provider name: _____ | Date ____/____/____ | <input type="checkbox"/> 5. Psychiatrist | Date ____/____/____ |
| <input type="checkbox"/> 2. Supports Coordinator | Date ____/____/____ | <input type="checkbox"/> 6. Recipient Rights | Date ____/____/____ |
| <input type="checkbox"/> 3. Nurse | Date ____/____/____ | <input type="checkbox"/> 7. Licensing | Date ____/____/____ |
| <input type="checkbox"/> 4. Guardian | Date ____/____/____ | <input type="checkbox"/> 8. Other _____ | Date ____/____/____ |

Home Manger's review/comments (process at weekly morning meeting)

Home Manager's Signature _____ Date _____

Nurse's Review/Comments: (process at weekly morning meeting)

Nurse's Signature _____ Date _____

Program Director's Comments/Recommendations: (process at weekly morning meeting)

Program Director's Signature _____ Date _____

PROGRAM DIRECTOR REVIEW

No Incident Report Required

Incident Category: (check only one)

- | | |
|---|--|
| <input type="checkbox"/> 1. Aggression-Self Inflicted Behavior | <input type="checkbox"/> 12. Medical Intervention |
| <input type="checkbox"/> 2. Aggression - Consumer to Consumer (Aggressor) | <input type="checkbox"/> 13. Unauthorized Leave of Absence |
| <input type="checkbox"/> 3. Aggression - Consumer to Consumer (Victim) | <input type="checkbox"/> 14. Medication Related |
| <input type="checkbox"/> 4. Aggression - Consumer to Employee | <input type="checkbox"/> 15. Accident - Consumer |
| <input type="checkbox"/> 5. Aggression- Consumer to Other | <input type="checkbox"/> 16. Neglect |
| <input type="checkbox"/> 6. Aggression- Consumer to Property | <input type="checkbox"/> 17. Seizure |
| <input type="checkbox"/> 7. Aggression- Employee to Consumer | <input type="checkbox"/> 18. Sexual Assault |
| <input type="checkbox"/> 8. Verbal Abuse-Consumer to Consumer | <input type="checkbox"/> 19. Suicide Attempt |
| <input type="checkbox"/> 9. Verbal Abuse-Consumer to Employee | <input type="checkbox"/> 20. Death |
| <input type="checkbox"/> 10. Verbal Abuse-Consumer to Other | <input type="checkbox"/> 21. Unknown Injury |
| <input type="checkbox"/> 11. Verbal Abuse-Employee to Consumer | <input type="checkbox"/> 22. Other _____ |

Did Incident Result in Physical Intervention? Yes No

Is this a 'Trigger Event'? yes No

Safety Officer's review/Comments: (process by next business day)

Safety Officer's Signature _____ Date _____

Behavioral Specialist's review/Comments: (process by next business day)

Behavioral Specialist's Signature _____ Date _____ Date Archived _____

Recipient Rights Officer's review/Comments: (process by next business day)

Recipient Rights Officer's Signature _____ Date _____ Date Archived _____