Department of Mental Health & Substance Abuse Services

DOCUMENTATION REQUIRED FOR THE MOST COMMON INCIDENTS REPORTED BY RESIDENTIAL AND NON-RESIDENTIAL FACILITIES/AGENCIES

The following is a list of the most common types of incidents/allegations that are reported by residential and non-residential facilities/agencies. When reporting the following incidents/allegations, provide the following information along with your incident report. Please note that the information/documentation requested for each type of incident is not all-inclusive and you may be asked to provide additional information during the investigation.

Accidents with or without injury: Please note whether accident was a result of participation in recreational activity, deficient facility condition (i.e. broken step, raveling rug, etc.), etc. If accident was a result of deficient facility condition, provide pictures of the location of the accident. Provide documentation of any injuries and the medical attention that was received. Provide the location of staff at the time of the accident. Provide a description of how the staff responded to the accident. Provide a copy of any related policy.

Service Recipient Self-injury: Provide documentation of the injury and any medical attention that was provided. Document the staff/client ratio and include the full names of staff present at the time of the incident. Provide a detailed description of what the on-duty staff was doing prior to the service recipient self-injury. If checks were required (i.e. 15 minutes checks, one-on-one supervision), provide documentation of such checks. Provide a copy of all witness statements collected. If there were any disciplinary actions as a result of this incident, provide a copy. If there is video evidence, it must be saved for review by Licensure staff.

Deaths: Provide a copy of the service recipient's chart/record that also includes a list of all current medications, medical illnesses, physicals and follow-ups. Provide the name(s) of the staff on duty at the time of the death or at the time the death was discovered. Provide a copy of the autopsy report (if accessible) and official documentation of the cause of death. Provide a copy of the DNR, if applicable. Provide a copy of the medical emergency policy.

Elopements: Document the staff/client ratio and include the full names of the staff. Document the actual location and duties of the staff at the time of the elopement, Include a detailed description of what the staff was actually doing. Provide a copy of any witness statements collected, documentation of any injuries and treatment, and save a copy of any video evidence. If checks were required (i.e. 15 minutes checks, one-on-one supervision), provide documentation of such checks. If there were any disciplinary actions as a result of the elopement, provide a copy. Provide documentation of any notification to other authorities such as APS, CPS and law enforcement.

Physical /Verbal Abuse of Clients by Staff: Provide names of all staff involved AND name, social security number and date of birth of all alleged perpetrators. Provide a copy of all witness statements collected. Provide confirmation on whether there is video evidence. If there is video evidence it must be saved for review by Licensure staff. Provide documentation that the appropriate authorities have been notified (i.e. APS, CPS, law enforcement). Provide the current status of the alleged perpetrator (staff), copy of the criminal background checks that also include the abuse and sex registries conducted at the time of hire. Provide the most current address, telephone number, and email address of the alleged perpetrator. Provide documentation of any injuries and treatment the service recipient may have received. If there were any disciplinary actions as a result of this incident, provide a copy.