

UTAH STATE DEVELOPMENTAL CENTER		
<b>REPORTABLE INCIDENTS</b>		PAGE 1 OF 4
<b>DIRECTIVE:</b> 11.09	EFFECTIVE DATE: 08-27-98	<b>REVISION DATE: 12-27-2010</b>
REVIEWING ENTITY: Program Administrator		
AUTHORITY REFERENCE:	CFR: 442.430 DHS #05-03, 2-03 DSPD #5-3, 6-01 1-5, 205; 1-8; 1-12	Utah Health Facility Licensure Rules March 00; R432-152-6

I. **DIRECTIVE**

This **directive** will be in support of all Federal, State, and Department laws and policies which relate to reporting abuse and neglect. The policy will not preclude direct reporting to **Adult Protective Services and** local law enforcement. Willful mistreatment of any individual will not be tolerated. Any event, which subjects individuals with disabilities to abuse (sexual and otherwise), neglect, or exploitation (sexual and otherwise), must be reported. All injuries received by persons with disabilities or staff, whether accidental or suspected by another person must be reported. Missing persons and damaged and/or missing property must be reported. Other reportable incidents that include medication errors, physical or chemical emergency behavioral interventions, AWOL, etc. must be reported. Any incidents, which are in violation of the Department of Human Services, Division of Services for People with Disabilities, and/or Utah State Developmental Center Code of Conduct Policies, **and/or Code of Ethics**, must be reported. These violations, as well as violations of Federal and State Regulations and Laws, may become subject to appropriate administrative and/or criminal action. Failure to report incidents may be interpreted as condoning the mistreatment of individuals and may be subject to administrative or criminal action.

II. **PROCEDURE**

**REPORTABLE INCIDENTS:**

- A. "Policy Violation" includes all actions or events which result in direct violation of the Code of Conduct Policy (Developmental Center Employee Code of Conduct #11.17.06, **DSPD's Code of Conduct # 1.20 January 2000, DHS's Code of Ethics 02-03 May 12, 2010**).
- B. All injuries (explained or otherwise) level two and above (where nursing intervention is required).
- C. All significant inappropriate behavioral incidents.**
- D. All attempts and/or successes of an individual going absent without leave (AWOL).**

**REPORTING PROCESS:**

- A. Any witnessed or suspected incidents of abuse, neglect, and/or exploitation will be reported to Adult Protective Services and/or law enforcement. The APS hotline number is 1-800-371-7897. Immediately after contacting APS, staff witnessing or suspecting an incident of individual mistreatment will contact a supervisor, complete a Policy Violation form, and get the form to a Unit Director, or designee, for delivery to the administrator as soon as possible.**

**Medication policy violations will be documented on the Policy Violation Form and follow the procedures in Medication Administration Directive # 20.01.**

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**Other incidents involving employee actions that violate any DHS, DSPD, and/or USDC policy will be reported on a Policy Violation Form.**

- B. All injuries will be reported to the LPN/RN on duty for treatment as necessary and documented on a Medical (pink) Incident Report Form. The employee who is supporting the individual at the time of witnessing or finding the injury will complete the Medical Incident Report Form. The completed form will be turned into the LPN/RN on duty.
- C. All significant inappropriate behavioral incidents (individual behavior causing physical injury to self or others, sexual aggression, property destruction, theft, etc.) will be reported to the QMRP, or designee, and documented on a Behavioral (blue) Incident Report Form. The form will be completed by the employee who is supporting the individual at the time of the incident and given to a supervisor.

**Other behavioral incidents will be tracked on an individual's Antecedent – Behavior – Consequence (ABC) form, or as otherwise indicated in the Individual Behavior Support Plan.**

- D. All individual Absent Without Leave (AWOL) incidents will be reported to the switchboard once the supervisor or designee has been notified and a general search of USDC buildings and grounds has been completed. The switchboard will contact law enforcement. An AWOL (white) Incident Report Form will be completed by the employee who is supporting the individual at the time the AWOL was discovered. The completed form will be given to a supervisor.
- E. If any parties, to include Unit Directors, QMRP and administrative managers, feel that a report is not accurate, they should note their concerns of inaccuracy on the report form. The original form should not be changed.

## **INVESTIGATIONS**

- A. Policy Violation, and Medical, Behavioral, and AWOL Incident Report Forms (see attached form # A, B, C, D) will have a box for Health Care Administrator Review. All Policy Violations related to client mistreatment, neglect or abuse, and any injuries of unknown origin will be given to the administrator for review. The date and initials of the administrator, or designee, will be documented on the form.
- B. The administrator will assign trained administrative staff to investigate incidents of mistreatment, neglect or abuse, as well as injuries of unknown origin.

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REVIEWING ENTITY: Program Administrator		
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- C. All investigations of mistreatment, neglect or abuse, as well as injuries of unknown origin will be initiated and reported to the administrator or designated representative within 5 working days of the incident by assigned USDC staff.**
- D. The written report of all investigations will be submitted to the USDC administrator and the Utah Bureau of Health Facility Licensing, Certification and Resident Assessment Department.**
- E. On the original copy of Medical, Behavioral, and AWOL Incident Report Forms, the QMRP/team and Unit Director will complete the "Team Follow Up/Recurrence Prevention" section of the incident report form and ensure it is entered into E Chart.**
- F. Building secretaries will enter documentation from completed Medical, Behavioral, and AWOL Incident Report Forms on E Chart. Documentation from Policy Violations forms will be entered into E Chart by the administrative assistant when an individual is involved, and by the Human Resource Department for other policy violations. Medication Policy Violations will be entered into E Chart by building RNs.**
- G. Other types of policy violation incidents (workplace harassment, unprofessional conduct, inattentiveness to duty, time abuse, etc) will have a preliminary review coordinated by the Unit Director. Any necessary follow up will be completed by the Human Resource Department.**
- H. All criminal investigations will be done by the American Fork Police Department and/or the Office of Aging and Adult Services.**

**Reporting of Incidents to Parents/Guardians:**

- A. All level three or above injuries are reported to the parents/guardians by the building nurse, unless parent/guardian has requested different notification.**
- B. Parent/guardian will be notified by Social Worker or QMRP of substantiated abuse, neglect or exploitation of an individual.**

**Utah Bureau of Health Facility Licensing**

**A written report of all investigations will be submitted to the USDC administrator and the Utah Bureau of Health Facility Licensing, Certification and Resident Assessment Department.**

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POLICY NUMBER: 11.09	EFFECTIVE DATE: 08-27-98	<b>REVISION DATE: 12-27-2010</b>
REVIEWING ENTITY: Program Administrator	Approved by: Karen Clarke, Superintendent	
AUTHORITY REFERENCE:	CFR: 442.430 DHS #05-03, 2-03 DSPD #5-3, 6-01 1-5, 205; 1-8; 1-12	Utah Health Facility Licensure Rules March 00; R432-152-6

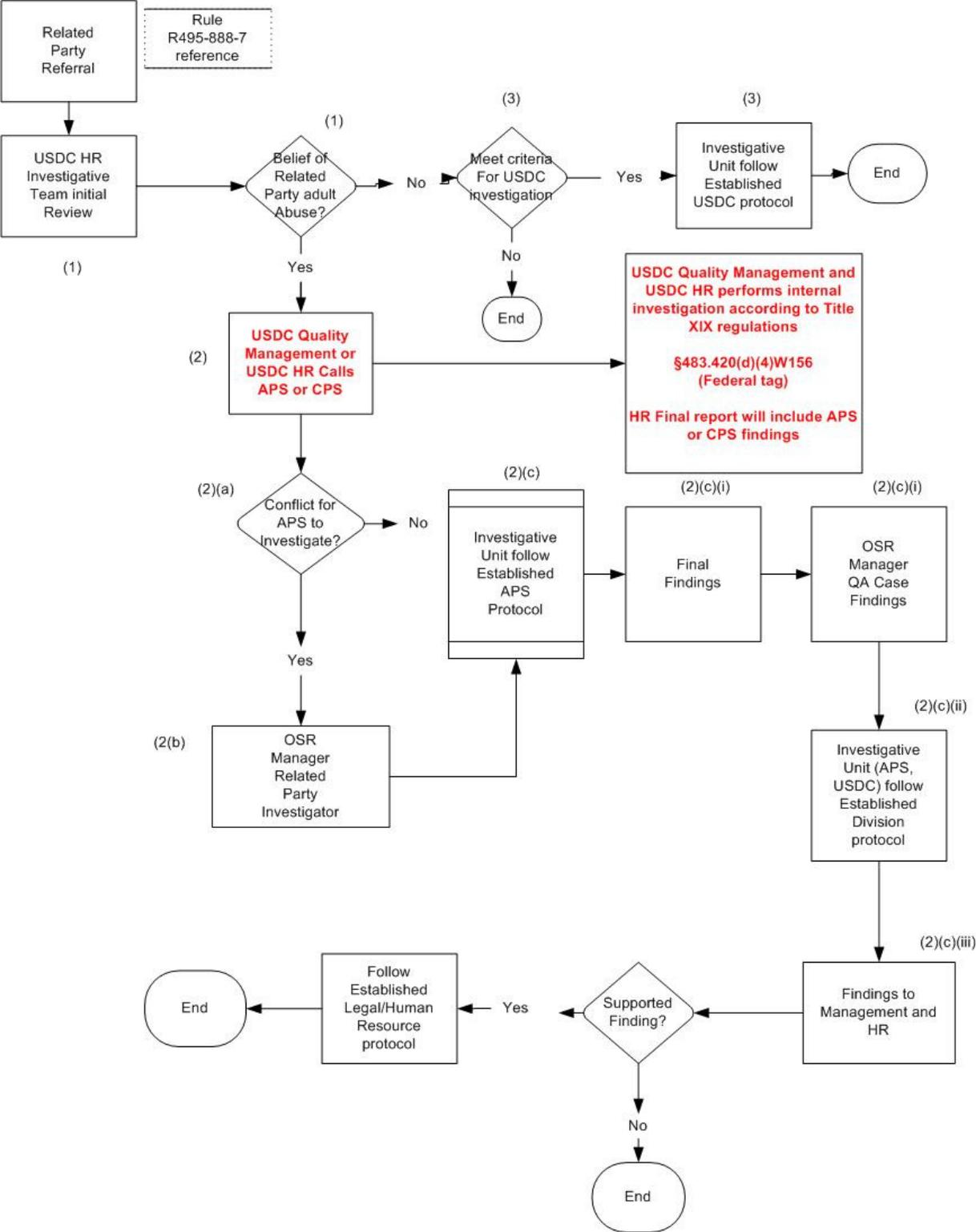
**Compliance Reviews:**

The Health Department, Office of Aging and Adult Services, and the Developmental Center's Information Office will conduct appropriate compliance reviews.

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Karen Clarke, Superintendent

RELATED PARTIES USDC-APS  
INVESTIGATIONS FLOWCHART  
(6/13/08)



UTAH STATE DEVELOPMENTAL CENTER  
MEDICAL INCIDENT REPORT & REVIEW FORM

Health Care Administrator Review  
Initials: \_\_\_\_\_ Date: \_\_\_\_\_

INSTRUCTIONS: Direct Care staff complete sections 1 through 3 as they apply to the incident. Give directly to nurse after form is completed.

**FACTS:** Incident Date: \_\_\_\_\_ Time: \_\_\_\_\_ am \_\_\_ pm \_\_\_ Attachments Required: Yes \_\_\_ No \_\_\_

Person Filing Report - Name/Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

(If cause of injury, or other reason for needing medical attention, was not witnessed, check shift logs, check with nursing staff, QMRP and other apartment staff for possible cause of injury/need for medical attention)

Is the cause of the injury known? \_\_\_\_\_ Yes \_\_\_\_\_ No.

Specific Location of Incident: \_\_\_\_\_

Cause of Incident: (Circle all that apply) Accidental, Aggression, Chemical, Equip/Product Failure, Fall, Policy Violation, Possible Abuse, Seizure Disorder, SIB, Staff Intervention, Unknown/Other: \_\_\_\_\_

Was accident caused by failure of a machine, a product, or another environmental factor: Yes \_\_\_ No \_\_\_ (If yes explain) \_\_\_\_\_

**APS Hotline Called: Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM Intake Workers Name: \_\_\_\_\_ Left a voicemail message \_\_\_\_\_**

**PERSONS INVOLVED AND/OR NOTIFIED:** (Be sure to include all names/roles that apply from list below)

(Role: Individual, Witness, Staff, Citizen, Supervisor, Administrator On Site, Administrator On Call, Authorized by, Nurse, Unit Director, Law Enforcement.)

**Individual's Name:** \_\_\_\_\_ **Bldg/Apt.** \_\_\_\_\_ **Role:** Individual injured/needed medical attention

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

**PROVIDE A DETAILED DESCRIPTION OF THE INCIDENT(S) BELOW** (Attachment Required? Yes No)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SEIZURE:** Multiple Seizures: Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am \_\_\_ pm \_\_\_ Duration of Seizure (single seizure): \_\_\_\_\_

Duration of Seizure Period (multiple seizures): \_\_\_\_\_ Number of Seizures: \_\_\_ Cyanotic: Yes \_\_\_ No \_\_\_ Injury From Seizure: Yes \_\_\_ No \_\_\_

PRN Medication Required: Yes \_\_\_ No \_\_\_

Describe Seizure Event: (What was individual doing before, during, and after seizure.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INJURY/MEDICAL EMERGENCY:** \* FILL OUT NOTIFICATION PORTION OF FORM IN DETAIL

SEVERITY OF TREATMENT: (#) DETERMINES SEVERITY LEVEL

(1) \_\_\_ Observation and/or Minor Treatment - Name: \_\_\_\_\_

(2) \_\_\_ Nursing Intervention - Name: \_\_\_\_\_

(3) \_\_\_ Practitioner Intervention - Name: \_\_\_\_\_

(4) \_\_\_ Medical Step-Down Services Authorized by: \_\_\_\_\_

(5) \_\_\_ Community Hospitalization/Treatment Authorized by: \_\_\_\_\_

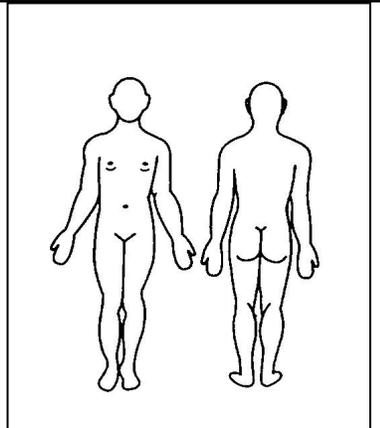
Body Part Determined: \_\_\_\_\_

Cause of Injury: \_\_\_\_\_

Treatment Date: \_\_\_\_\_ Treatment Time: \_\_\_\_\_ am \_\_\_ pm \_\_\_ Medication Given: Yes \_\_\_ No \_\_\_

Were Pictures Taken: Yes \_\_\_ No \_\_\_ Date Pictures Taken: \_\_\_\_\_ Time: \_\_\_\_\_ am \_\_\_ pm \_\_\_

Description of Treatment: Refer to Nurse's Notes for Details of Incident or See Medication Error Program.



UTAH STATE DEVELOPMENTAL CENTER  
MEDICAL INCIDENT REPORT & REVIEW FORM

**PARENT/GUARDIAN NOTIFICATION (As Per Policy)**

Name Parent/Guardian Notified: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am \_\_\_\_\_ pm \_\_\_\_\_

Notified By: \_\_\_\_\_ Conversation Comments (Detail To Be Noted In EChart): \_\_\_\_\_

**TEAM FOLLOW UP/RECURRENCE PREVENTION (to be filled out by QMRP):** Could this have been prevented? Yes \_\_\_ No \_\_\_

If yes, how, If no, why: \_\_\_\_\_

**Description of Inservice** (include incident number on inservice role): \_\_\_\_\_

**INCIDENT CLOSURE: QMRP (or designee)**

**SIGNATURE:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**POLICY VIOLATION** Yes \_\_\_ No \_\_\_ (Refer to Policy Violation Document)

**WAS THE UNIT DIRECTOR NOTIFIED:** Yes \_\_\_ No \_\_\_ N/A \_\_\_\_\_

**REQUIRED UNIT DIRECTOR CLOSURE:** Yes \_\_\_ No \_\_\_ N/A \_\_\_\_\_

**UNIT DIRECTOR/Department Head SIGNATURE:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Comments: \_\_\_\_\_

UTAH STATE DEVELOPMENTAL CENTER  
BEHAVIORAL INCIDENT REPORT & REVIEW FORM

Health Care Administrator Review  
Initials: \_\_\_\_\_ Date: \_\_\_\_\_

INSTRUCTIONS: Direct Care staff complete sections 1 through 4 as they apply to the incident. Give directly to nurse after form is completed.

**FACTS:** Incident Date: \_\_\_\_\_ Time: \_\_\_\_\_ am \_\_\_ pm \_\_\_ Multiple Attachments Required: Yes \_\_\_ No \_\_\_  
Person Filing Report - Name/Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

Specific Location of Incident: \_\_\_\_\_

**PERSONS INVOLVED AND/OR NOTIFIED:** (Be sure to include all names/roles that apply from list below)

(Role: Individual, Witness, Staff, Citizen, Supervisor, Administrator On Call, Administrator On Site, Authorized by, Nurse, Unit Director, Law Enforcement.)

**PRIMARY INDIVIDUAL INVOLVED:** \_\_\_\_\_ Birth Date: \_\_\_\_\_ Bldg/Apt: \_\_\_\_\_

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

Name: \_\_\_\_\_ Building/Apt. \_\_\_\_\_ Phone #: \_\_\_\_\_ Role: \_\_\_\_\_ Injured: Yes \_\_\_ No \_\_\_

**BEHAVIOR:** Behavior Source: Observed \_\_\_ Suspected \_\_\_ Unknown \_\_\_

**Antecedent:** Describe what was going on before the incident: \_\_\_\_\_

**Behavior:** CATEGORY/TYPE: (Mark All That Apply)

Aggression Type: Verbal, Hit, Kick, Slap, Pull Hair, Bite, Pinch, Scratch, Head Butt, Choke, Other \_\_\_\_\_

Sexual: Sexual Talk, Fondling/Groping, Removing Own Clothing, Removing Other's Clothing, Exhibitionism, Masturbation, Sexual Penetration

(If the Aggressor and/or Victim(s) are injured, a Medical Incident Report & Review Form needs to be completed)

**Primary Aggressor:** \_\_\_\_\_ Victim: \_\_\_\_\_ Type: \_\_\_\_\_

**Aggressor:** \_\_\_\_\_ Victim: \_\_\_\_\_ Type: \_\_\_\_\_

**Unknown Aggressor:** \_\_\_\_\_ Unknown Victim: \_\_\_\_\_ Type: \_\_\_\_\_

**Other:** \_\_\_\_\_

**SELF-INJURIOUS BEHAVIOR (SIB)**

Kick \_\_\_ Hit \_\_\_ Head Bang \_\_\_ Scratch \_\_\_ Biting \_\_\_

Tissue Damage \_\_\_ Insertion \_\_\_ PICA \_\_\_ Hair Pull \_\_\_

Choking \_\_\_ Sexual \_\_\_ (Refer to Medical Incident Form)

Other: \_\_\_\_\_

**PROPERTY DESTRUCTION**

Public \_\_\_ USDC \_\_\_

Staff \_\_\_ Self \_\_\_

Other Individual \_\_\_ Inventory # \_\_\_\_\_

Other: \_\_\_\_\_

**THEFT**

Public \_\_\_ USDC \_\_\_

Staff \_\_\_ Other Individual \_\_\_

Inventory # \_\_\_\_\_

Other: \_\_\_\_\_

**Consequence:** De-escalation Techniques used prior to use of restraint: Behavior Program **Interventions:** Yes \_\_\_ No \_\_\_ N/A \_\_\_

MANDT Graded System of Alternatives: Yes \_\_\_ No \_\_\_ N/A \_\_\_ **Other, list:** \_\_\_\_\_

Describe the De-escalation Techniques used to manage behavior: (And, if N/A marked above, please explain) \_\_\_\_\_

**RESTRAINT: PURPOSE:** Emergency \_\_\_ Program (includes protect from harm) \_\_\_ **TYPE:** Physical \_\_\_ Mechanical \_\_\_

\*\*(Medical Ordered Mechanical Restraints are not documented on this form. (Refer to medical order and use a Restraint Frequency Form).

Person Authorizing Restraint: \_\_\_\_\_ Restraint Frequency Form Attached Yes \_\_\_ No \_\_\_ N/A \_\_\_

Time In: \_\_\_\_\_ am \_\_\_ pm \_\_\_ Time Out: \_\_\_\_\_ am \_\_\_ pm \_\_\_ Frequency of Checks: \_\_\_\_\_ (See Attached In/Out Form)

Interventions Used: BSP Interventions \_\_\_ Change of Environment \_\_\_ Change of Staff \_\_\_

Mandt Interventions: One Person One Arm \_\_\_ One Person Two Arm \_\_\_ One Person Side Body Hug \_\_\_ Two Person One Arm \_\_\_

Two Person Side Body Hug \_\_\_ Other Method Used: Describe \_\_\_\_\_

UTAH STATE DEVELOPMENTAL CENTER  
**BEHAVIORAL INCIDENT REPORT & REVIEW FORM**

**CRISIS TEAM:** Was Crisis Team assistance necessary, if yes check box \_\_\_\_\_

**MEDICAL EMERGENCY:** \* FILL OUT NOTIFICATION PORTION OF FORM IN DETAIL

SEVERITY OF TREATMENT: (#) DETERMINES SEVERITY LEVEL

(1) \_\_\_ Observation and/or Minor Treatment - Name: \_\_\_\_\_

(2) \_\_\_ Nursing Intervention - Name: \_\_\_\_\_

(3) \_\_\_ **Clinical Director/Practitioner** Intervention - Name: \_\_\_\_\_

\_\_\_ **Psychotropic One Time Order (POTO)** Medication Delivered – Medication Name/Dose: \_\_\_\_\_

Treatment Date: \_\_\_\_\_ Treatment Time: \_\_\_\_\_ am \_\_\_ pm

Description of Observation/Evaluation and Treatment: Refer to Nurse's Notes for Additional Details.

4

**Observed of Effects of POTO:** \_\_\_\_\_

**ADDITIONAL DIRECT CARE STAFF INFORMATION:**

Other Information: \_\_\_\_\_

5

Was Behavior Data Completed: Yes  No

**PARENT/GUARDIAN NOTIFICATION (As Per Policy and HIPAA Regulations)**

Name Parent/Guardian Notified: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am \_\_\_ pm

Notified By: \_\_\_\_\_ Conversation Comments (Detail To Be Noted In EChart): \_\_\_\_\_

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**TEAM FOLLOW UP/RECURRENCE PREVENTION (to be filled out by QMRP):** Could this have been prevented? Yes \_\_\_ No \_\_\_

If yes, how. If no, why: \_\_\_\_\_

7

**Description of Inservice** (include incident number on inservice role): \_\_\_\_\_

**Initials of Core Team Members in Attendance:** Beh. Spc. \_\_\_\_\_ Soc. Work. \_\_\_\_\_ Nurse \_\_\_\_\_

**INCIDENT CLOSURE: QMRP (or designee)**

**SIGNATURE:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**POLICY VIOLATION** Yes \_\_\_ No \_\_\_ (Refer to Policy Violation Document)

**WAS THE UNIT DIRECTOR NOTIFIED:** Yes \_\_\_ No \_\_\_ N/A \_\_\_

**REQUIRED UNIT DIRECTOR CLOSURE:** Yes \_\_\_ No \_\_\_ N/A \_\_\_

**UNIT DIRECTOR/Department Head SIGNATURE:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Comments: \_\_\_\_\_

UTAH STATE DEVELOPMENTAL CENTER  
AWOL INCIDENT REPORT & REVIEW FORM

Health Care Administrator Review  
Initials: \_\_\_\_\_ Date: \_\_\_\_\_

INSTRUCTIONS: Direct Care staff complete sections 1 and 2 as they apply to the incident. Give directly to nurse after form is completed.

**FACTS:** Incident Date: \_\_\_\_\_ Time: \_\_\_\_\_ am \_\_\_ pm \_\_\_ Multiple Attachments Required: Yes \_\_\_ No \_\_\_  
Person Filing Report - Name/Title: \_\_\_\_\_ Phone #: \_\_\_\_\_

Specific Location of Incident: \_\_\_\_\_

**PERSONS INVOLVED AND/OR NOTIFIED:** (Be sure to include all names/roles that apply from list below)

(Role: Individual, Witness, Staff, Citizen, Supervisor, Administrator On Site, Administrator On Call, Authorized by, Nurse, Unit Director, Law Enforcement.)

Individual's Name:	Bldg/Apt.	Phone #:	Role:
_____	_____	_____	Individual that went AWOL
Name: _____	Building/Apt. _____	Phone #: _____	Role: _____
Name: _____	Building/Apt. _____	Phone #: _____	Role: _____
Name: _____	Building/Apt. _____	Phone #: _____	Role: _____
Name: _____	Building/Apt. _____	Phone #: _____	Role: _____
Name: _____	Building/Apt. _____	Phone #: _____	Role: _____
Name: _____	Building/Apt. _____	Phone #: _____	Role: _____

**AWOL/MISSING:** Time Last Seen: \_\_\_\_\_ am \_\_\_ pm \_\_\_ Specific Last Known Location: \_\_\_\_\_

Name of Staff/Person that found individual missing: \_\_\_\_\_

Last Seen Wearing: \_\_\_\_\_

Supervisor contacted: Name \_\_\_\_\_ Switchboard contacted: Name \_\_\_\_\_

Found Date: \_\_\_\_\_ Time: \_\_\_\_\_ Location: \_\_\_\_\_ Found By Whom: \_\_\_\_\_

Describe the Individual's Mood/Behavior Prior to the Individual Leaving: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the Activity the Individual Was Involved in Before He/She Left: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the Individual's Mood/Behavior After He/She Was Found: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was the Individual Found to Be Injured: Yes \_\_\_ No \_\_\_ (If Yes an Medical Incident Report Form needs to be completed)

When the Individual Was Found, Was or Will He/She Examined By a Medical Professional: Yes \_\_\_ No \_\_\_ (Refer to Medical Incident Report )

Was the Individual Involved in Any Property Damage/Theft: Yes \_\_\_ No \_\_\_ If Yes, USDC Property \_\_\_ Staff Property \_\_\_ Private Property

\_\_\_\_\_

Was the Individual Involved in Any Aggression Towards Others: Yes \_\_\_ No \_\_\_ If Yes, USDC Staff \_\_\_ Other Person(s) \_\_\_

Other Pertinent Information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PARENT/GUARDIAN NOTIFICATION (As Per Policy and HIPAA Regulations)**

Name Parent/Guardian Notified: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ am \_\_\_ pm \_\_\_

Notified By: \_\_\_\_\_ Conversation Comments (Detail To Be Noted In EChart)

**TEAM FOLLOW UP/RECURRENCE PREVENTION (to be filled out by QMRP):**

How will this incident be prevented in the future: \_\_\_\_\_

**Description of Inservice** (include incident number on inservice role): \_\_\_\_\_

**INCIDENT CLOSURE: QMRP (or designee)**

**SIGNATURE:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**POLICY VIOLATION: Yes \_\_\_ No \_\_\_** (Refer to Policy Violation Document)

**WAS THE UNIT DIRECTOR NOTIFIED:** Yes \_\_\_ No \_\_\_ N/A \_\_\_

**REQUIRED UNIT DIRECTOR CLOSURE:** Yes \_\_\_ No \_\_\_ N/A \_\_\_

**UNIT DIRECTOR/Department Head SIGNATURE:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Comments:** \_\_\_\_\_