

IMPORTANT REPORTING INSTRUCTIONS

Support Staff **Contact your supervisor immediately when an incident occurs.** If you cannot reach your supervisor, call the JNCS Emergency Number: **1 877 466 0022**. You must report Special Incidents if they occurred during the time the person was receiving support from JNCS, or if you become aware of incidents that occurred to the person during non-support hours. Submit the completed form to your supervisor as soon as possible, but no later than 24 hours.

Complete Sections 2 thru 10.

Supervisor **Notify Regional Center** of all reportable incidents **within 24 hours** and **submit this written Special Incident Report within 48 hours**. Submit the written Special Incident Report to the Regional Center with whom the program is vendored, and if a "reportable incident," the Regional Center having case management responsibility for the person receiving Services. • Notify person legally responsible for the Consumer. (i.e. guardian, conservator) per requirements. • If the consumer participates in the Alternative Family Program, notify Community Care Licensing, per regulations. For all incidents, submit a copy of the report with fax confirmation to JNCS Quality Team **within 48 hours**, and file the original report in the official consumer record.

Complete Section 1 and Sections 11 thru 14.

1. Regional Center _____ JNCS Program _____ Program Vendor # _____ Dept _____

SUPPORT STAFF TO COMPLETE IN FULL: Sections 2 thru 10

2. Consumer's Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	UCI Number:	Date of Report:
Consumer's Diagnosis:	Mode of Communication: Check <input type="checkbox"/> Gesture <input type="checkbox"/> Pictures <input type="checkbox"/> Body Applicable Boxes: <input type="checkbox"/> Sign <input type="checkbox"/> FC <input type="checkbox"/> Aug <input type="checkbox"/> Written			
Check Applicable Boxes: <input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal		<input type="checkbox"/> Ambulatory <input type="checkbox"/> Non-Ambulatory		<input type="checkbox"/> Hearing <input type="checkbox"/> Non-Hearing

3. SPECIAL INCIDENTS (per Title 17, Code 54327) Check the boxes below and fill in the blanks that apply to this incident:

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|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Death of consumer (however caused) <input type="checkbox"/> Consumer is missing <input type="checkbox"/> Consumer is victim of a crime <p>Belief or Knowledge of Suspected Abuse or Exploitation:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Financial <input type="checkbox"/> Psychological <input type="checkbox"/> Physical and / or Chemical Restraint <input type="checkbox"/> Emotional / Mental abuse <p>Belief or Knowledge of Suspected Neglect Including:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Failure to provide medical care <input type="checkbox"/> Failure to prevent malnutrition or dehydration <input type="checkbox"/> Failure to protect from health / safety hazard <input type="checkbox"/> Failure to assist in personal hygiene <input type="checkbox"/> Failure to assist in providing food, clothing, or shelter <p>Serious Injury or Accident Beyond Basic First Aid:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lacerations requiring sutures or staples <input type="checkbox"/> Puncture wounds / bites requiring medical treatment <input type="checkbox"/> Fractures or dislocations <input type="checkbox"/> Burns that require medical treatment <input type="checkbox"/> Medication errors or reactions <input type="checkbox"/> Internal bleeding <input type="checkbox"/> Injury of unknown origin <input type="checkbox"/> Other: _____ | <p>Unplanned or Unscheduled Hospitalization Due To:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Respiratory illness <input type="checkbox"/> Seizure activity <input type="checkbox"/> Cardiac activity <input type="checkbox"/> Internal infection <input type="checkbox"/> Diabetes-related illness <input type="checkbox"/> Wound / skin care <input type="checkbox"/> Nutritional deficiencies <input type="checkbox"/> Involuntary psychiatric admission <input type="checkbox"/> Other _____ <p>Other Observations and Events:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alleged violation of consumer's rights <input type="checkbox"/> Sexual harassment / inappropriate sexual contact <input type="checkbox"/> Pregnancy <input type="checkbox"/> Diagnosis of communicable disease <input type="checkbox"/> Aggressive act to: <input type="checkbox"/> Self, <input type="checkbox"/> Attempted suicide, <input type="checkbox"/> Threat of suicide <input type="checkbox"/> Aggressive act to: <input type="checkbox"/> Staff, <input type="checkbox"/> Consumer, <input type="checkbox"/> Family / community member <input type="checkbox"/> Aggressive act to: <input type="checkbox"/> Property, <input type="checkbox"/> Property Damage <input type="checkbox"/> Other aggressive act: _____ <input type="checkbox"/> Fire, Flooding or other disaster _____ <input type="checkbox"/> Any Minor Accident (even if no injuries) (vehicle, falls, other) _____ <input type="checkbox"/> Minor Injury _____ <input type="checkbox"/> Illness Not Requiring Hospitalization _____ <input type="checkbox"/> Seizure (non-hospitalization) <input type="checkbox"/> Planned Hospitalization (such as surgery) _____ <input type="checkbox"/> Other: _____ |
|---|---|

<p>4. MEDICAL TREATMENT REQUIRED:</p> <ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Basic First Aid <input type="checkbox"/> Personal Doctor Visit <input type="checkbox"/> Emergency Medical Treatment <input type="checkbox"/> Hospitalization 	<p>DESCRIBE NATURE OF TREATMENT PROVIDED:</p> <p>Administered at: _____ Administered by: _____</p>	<p>FOLLOW-UP REQUIRED?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date: _____</p> <p>Purpose: _____</p> <p>_____</p>
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5. Date Incident Occurred: _____ Time Incident Occurred: _____ AM PM	Location of Incident:	Staff Person Involved:	Witnesses to Incident:
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6. DESCRIPTION OF INCIDENT (Who was there? Where did it occur? When? What exactly happened?)

7. IMMEDIATE ACTION TAKEN BY STAFF (What did you do during the incident & immediately after? What else happened as a result?)

8. LAW ENFORCEMENT Yes No **5150 Hold:** Yes No

Officer's Name: _____	Agency: _____ (Check box)	<input type="checkbox"/> LAPD <input type="checkbox"/> Sheriff <input type="checkbox"/> Campus Police <input type="checkbox"/> Other: _____	Division: _____ Report No: _____ Booking No: _____ Phone No: _____
Badge Number: _____			

9. CONSUMERS RESIDENCE

Check applicable box below: Provider Responsible

<input type="checkbox"/> Residential <input type="checkbox"/> Parent	Name: _____ Ph: _____
<input type="checkbox"/> Self/Spouse <input type="checkbox"/> Other	Address: _____
	City: _____ Zip: _____

10. REPORT SUBMITTED BY

Print Name: _____

Signature: _____

Agency/Title: _____

Date: ____/____/____ Ph: _____

SUPERVISOR TO COMPLETE IN FULL: Sections 11 thru 14

11. Prevention Plan (Specifically, what will be done, so that this incident won't happen again, or the likelihood will be minimized?)

12. OTHER AGENCIES / INDIVIDUALS NOTIFIED

<u>Agency/Person</u>	<u>Contact Name</u>	<u>Contact Phone/Fax</u>	<u>Contact Date and Initials</u>	<u>Mailed Date and Initials</u>
Regional Center _____	_____	_____	_____/_____/_____	_____/_____/_____
Regional Center _____	_____	_____	_____/_____/_____	_____/_____/_____
___ APS or ___ CPS _____	_____	_____	_____/_____/_____	_____/_____/_____
Guardian / Conservator _____	_____	_____	_____/_____/_____	_____/_____/_____
Other _____	_____	_____	_____/_____/_____	_____/_____/_____

13. REPORT APPROVED BY

Print Name: _____ Signature: _____
Agency/Title: _____ Date: ___/___/_____ Ph: _____

14. ADDITIONAL INFORMATION OR FOLLOW-UP: Date / / Initials _____ Supervisor Follow-up Yes No

JNCS QUALITY TEAM REVIEW

Signature: _____ Title: _____
Date: _____ Log: _____ Follow-up: _____
