

HARBOR REGIONAL CENTER

Special Incident Report For Harbor Vendors and Long-Term Care Facilities

Instructions for provider Special Incident Reporting (Cal. Code of Regulations Title 17, § 54327)

1. Verbally notify Harbor within 24 hours of incident by calling the assigned Service Coordinator or SCOD
2. Submit written SIR within 48 hours of the incident by email: sirs@harborrc.org
3. Notify the appropriate licensing agency according to Title 22 regulations, if applicable
4. Notify authorities (APS, CPS/CFWB, LTC Ombudsman, Law Enforcement) per mandated reporting requirements for SIRs involving a victim of crime and/or an allegation of abuse or neglect

Individual's Name: _____ **UCI #:** _____ **DOB:** _____ **Age:** _____
Service Coordinator: _____ **Vendor #:** _____ **Vendor Name:** _____
Incident Date: _____ **Incident Time:** _____ **AM** **PM** **Unknown**
Date Vendor LEARNED of Incident: _____ **Date Vendor CALLED Harbor:** _____
Date Vendor submitted WRITTEN Report: _____
Incident Location: _____ **Red boxes require a response – indicate N/A if not applicable*

1. INCIDENT TYPES (S) – CHECK ALL THAT APPLY

<p>Death Medication Error (Please fill our Section 7)</p> <p>Missing Person Missing Person –Police Notified</p> <p>Victim of a Crime Aggravated Assault Burglary Larceny Personal Robbery Rape or Attempted Rape Simple Assault Battery Fraud Identity or Credit Theft Attempted or Actual Homicide or Manslaughter Stalking Hate Crime Human Trafficking</p> <p>Injury From Accident Another Individual Served Behavior Episode Unknown Origin</p> <p>Suspected Abuse/Exploitation (Please fill out Section 8) Alleged Violation of Rights Emotional/Mental Abuse Financial Abuse Physical Abuse Sexual Abuse Physical/Chemical/Mechanical Restraint Exploitation Verbal Isolation</p>	<p>Suspected Neglect Including Failure To: (Please fill out Section 8) Assist w/ Personal Hygiene Prevent Malnutrition/Dehydration Protect From Health/Safety Hazard Provide Care - Elder/Adult Provide Food/Clothing/Shelter Provide Medical Care Prevent TWO or more falls within 30 days Abandonment Provide for Mental Health Needs</p> <p>Medical Treatment – Beyond First Aid (Please fill out Section 6) Bites That Break The Skin Burns Choking Condition Requiring Medical Intervention Emergency Room Dislocation Fracture Internal Bleeding Laceration Requiring Sutures/Staples/Dermabond Puncture Wounds Requiring Treatment Injury Resulting from Seizure Bruising/Contusion/Hematoma (Include size and location) Pressure Injury Stage 2 or Unstageable Any Head Injury/Concussion Requiring medical attention</p>	<p>Unplanned/Unscheduled Hospitalization Due To: (Please fill out Section 6) Cardiac-related Diabetes-related Seizure-related Internal Infection Dental-related Nutritional Deficiency Respiratory Illness Wound/Skin Care Bowel Obstruction Involuntary Psychiatric Hospitalization Voluntary Psychiatric Hospitalization</p> <p>Behavior Aggressive Act Involving A Weapon Aggressive Act To Another Individual Aggressive Act To Family/Visitors Aggressive Act To Self Aggressive Act To Staff Arrests Drug/Alcohol Abuse Community Safety Fire Setting Psych Emergency Team/No Hospitalization Property Damage Severe Verbal Threats Suicide Threat Suicide Attempt</p> <p>Other Disease Outbreak Other Sexual Incident Pregnancy Extended ER visit lasting 5 days or more Other</p>
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2. AGENCIES NOTIFIED AND/OR INVOLVED
 (Check off all that apply. If selected, please complete all fields.)

	Contact Name	Date Notified	Phone #	Report #
Community Care Licensing (DSS)	_____	_____	_____	_____
Health Care Licensing (DHS)	_____	_____	_____	_____
Parent/Guardian/Conservator	_____	_____	_____	_____
Law Enforcement	_____	_____	_____	_____
Adult Protective Services	_____	_____	_____	_____
Child Protective Services / CFWB	_____	_____	_____	_____
Long-Term Care Ombudsman	_____	_____	_____	_____
Other	_____	_____	_____	_____

3. DESCRIPTION OF INCIDENT
 (who/what/where/when/why, description of perpetrator, treatment administered, transported to hospital etc.)

4. SPECIFIC PREVENTATIVE ACTION TAKEN/PLAN TO PREVENT REOCCURRENCE
 (new or modified services/supports/equipment, follow-up care, next planning team meeting etc.)

5. ACTION(S) TAKEN BY VENDOR IN RESPONSE TO SPECIAL INCIDENT

- | | | | |
|-----------------|------------------|-------------------------------|-------------------------------|
| Staff Training | Staff Terminated | Planning Team Meeting | Referral to Clinical Services |
| Staff Suspended | Policies Revised | Review/Revise Behavioral Plan | Other: |

6. FOR HOSPITALIZATIONS & ER VISITS**NOT APPLICABLE**

Hospital Name: _____ Admission Date: _____
 Diagnosis (if available): _____
 Discharge Date (if available): _____ Discharged To (if available): _____
 Follow-up needed after discharge (i.e. PT, specialist appointment) (if available): _____
 Does client require any support/equipment daily? _____
 Medication Changes (if applicable): _____

7. FOR MEDICATION ERRORS**NOT APPLICABLE**

Type of Medication Error (check all that apply)

Missed Dose	Wrong Medication	Wrong Time	Documentation Error
Wrong Dose	Wrong Person	Wrong Route	Medication Refusal

Name and dosage of medication(s):
 (Only list medications related to this SIR incident)

Any adverse reactions? _____

Day(s) affected by medication error: _____ Time medication was to be given: _____ AM PM

Primary Care Physician (MD, NP, PA, or Psychiatrist) notification (name & date): _____

8. FOR SUSPECTED ABUSE OR NEGLECT**NOT APPLICABLE**

Name of Alleged Perpetrator: _____ Age: _____

Has this person previously abused/neglected the client? Y/N: _____ If yes, when was last incident? _____

Relationship to Individual: Another Individual Served Relative/Family Member Vendor/Employee of Vendor
 Other Person Known to Individual Unknown Other:

If individual required medical attention due to abuse/neglect, please fill out Section 6 "Hospitalization & ER visit" above

Witness Name: _____ Address: _____ Phone #: _____

9. REPORT SUBMITTED BY

Name: _____ Title: _____

Vendor Name: _____ Vendor Email: _____

Date Completed: _____ Telephone #: _____