Report writing for incidents.

Residential means any Licensed Adult Foster Home, Residential Treatment Home, Residential Treatment Facility / Secure.

All incidents that occur within the licensed residential and/or occur outside the licensed residential to a resident that placed the resident in harms way must be documented. This includes but is not limed to;

Resident to resident incidents, resident to staff incidents, staff to resident incidents, resident to property incidents, resident to PCP, RTP issues that result in a behavior incident, staff MAR incidents, stranger to resident, resident to stranger, resident in community incident, staff behavior or noncompliance with rule or policy, or an accident that was caused by a safety hazard and the hospitalization of a resident.

The reporting form must be used and the resident progress note and/or daily shift log must make mention of the report.

The review of the incident documentation by the County and Provider will determine the category of the report and from there the appropriate actions can be taken.. (for example; The abuse rule is specific in type of incident description as is the OIT/OCR criteria for handling an investigation)

It is most important that the writer's personal opinions and biases do not enter into the reports content.

Without exception each report must be reviewed by the Administrator, Provider, and the county for factual, accurate and descriptive information that would provide to the reader a mental picture of the incident. What action steps were taken at the time of the incident if applicable and what preventative measures or recommendations were given.

Closure and completeness is very important.

The information must be written in a factual context.
It is important not to insert what you think might have happened or your opinions. All information recorded must be able to stand on its own and be verifiable where ever possible.

The County will have specific requirements on the reporting time lines for all incident reports. It is the Providers responsibility to know the specific county incident reporting requirements and documentation time lines.

Each provider must have an incident file separate from the resident chart. The purpose of this is to assure that the rights of confidentiality are observed when an incident involves another resident or names a witness that requests to remain anonymous. It is important that when the final disposition and or actions are recommended that a history of same/like incidents also be reviewed. This history does not have to be specific to a resident it may be specific to the environment, a staff person, the time of day, the policy and procedure of the facility, an outside influence etc. It is important for the reviewer to look at the whole picture, especially if there are previous incidents of this nature and not look at each report as just an isolated incident

The County representative (reviewer) must provide the provider with the completed initial report for the provider file. The Provider must follow-up with the county for the completed report copy. (note: in the case of an investigation by either the county or the division the initial report must state that an investigation has been initiated and the name of the contact person)

Report writing reminders.

- *Print or write clearly in structured sentences.*
- *Be concise and clear in each description.*
- *If you are being told something then clearly state who told you and what was said.*
- *If you experienced or observed the incident then state exactly what and how much you witnessed.*

- *If you called someone then state that in the report, who, where at, time, for what reason.*

- *If you initiated a sequence of events then state what was done, why and how.*

- *If you were told to initiate the event sequence then state that in the report: who told you, the events you did and follow up by others.*

The intent of the report is to have on file and for review an accurate written sequence of events. If the reader has a question then the report may not be complete. When you write the report you are writing it for an individual that was neither present nor aware that the event took place at the time the incident occurred or when the report was written.

The reviewer must look at the content of the written report to assure that there are no obvious unanswered questions. If there is a question the reviewer must speak with the writer to clarify and either add to the report via an addendum or determine the question has no relevancy to the report. It may be that the question raised requires some other kind of intervention and follow-up process, which is more the case than not.

Check sheet for reviewing the report. This check sheet can be used internally by the facility staff or by the county reviewer until the final file copy is in place in the provider incident file.

- ☐ Does the report state clearly what the incident was?
- ☐ Does the report state from whom the information came from and the relationship this person has with the provider, resident and staff?
- ☐ Does the report state what action took place at the time of the incident or after the fact? And who performed the action
- ☐ Does the report have personal opinions or biases in the description of the incident events?
- ☐ Does the report make sense or does it create more questions that need to be answered?
- ☐ Does the report identify follow-up actions if needed?
- ☐ Does the report have all of the required signatures?
- ☐ Was the report phoned or handed into the County and is that on the report?
- ☐ Did the County add a reply statement and do you have that updated file copy?
- ☐ Were there additional requests for information from the reviewers?
- ☐ What further action has to be taken?
- ☐ Can the report be closed, with no further action required?
- ☐ Do you have the final updated report for the file?

The following numbered steps describe each of the topics included in a detailed report.

Incident Detail's

- ☐ 1. Name of resident (s)
- ☐ 2. Date of incident
- ☐ 3. Time of incident

- ☐ 4. Name of reporting person
- ☐ 5. Date report was written

- ☐ 6. Type of incident
- ☐ 7. Description of the incident
- ☐ 8. Clear explanation of what occurred

- ☐ 9. Identify all persons involved and all witnesses

Action Taken

- ☐ 10. Immediate response by reporter
- ☐ 11. Response by provider
- ☐ 12. Response by County

Resolution

- ☐ 13. Does resolution close the report
- ☐ 14. Or explain long-term follow-up
- ☐ 15. Abuse investigation
- ☐ 16. Review in ----- months/weeks

Follow-up

- ☐ 17. Required follow-up steps listed
- ☐ 18. Responsible person identified
- ☐ 19. Deadline for completion

- ☐ 20. **Name/position/date of person reviewing this final report :**

CC's report copies

- ☐ Resident Record (original) date filed:
- ☐ CMHP date sent:
- ☐ OMHAS date sent: OIT if abuse. date sent: