|  |
| --- |
| **INCIDENT FINDINGS** |
| Provider Name: Click or tap here to enter text. |  | NJIRMS#: Click or tap here to enter text. |
| Site Address: Click or tap here to enter text. |  | Incident Report Contact: Click or tap here to enter text. |
| County of Program: Click or tap here to enter text. |  | Title: Click or tap here to enter text. |
| Incident Date: Click or tap to enter a date. |  | Contact Number: Click or tap here to enter text. |
| Alleged Victim(s): Click or tap here to enter text. |  | Email Address: Click or tap here to enter text. |
| Alleged Perpetrator(s): Click or tap here to enter text. |  | Investigation Completed by: Click or tap here to enter text. |
| Incident Code: Click or tap here to enter text. |  | [ ]  Substantiated/Yes [ ]  Unsubstantiated/No |
| Incident Code: Click or tap here to enter text. |  | [ ]  Substantiated/Yes [ ]  Unsubstantiated/No |
| Incident Code: Click or tap here to enter text. |  | [ ]  Substantiated/Yes [ ]  Unsubstantiated/No |
| Incident Code: Click or tap here to enter text. |  | [ ]  Substantiated/Yes [ ]  Unsubstantiated/No |

|  |
| --- |
| **SUMMARY OF INCIDENT REVIEW/INVESTIGATIVE FINDINGS** |
| **Note: All allegations require a summary of the agency’s analysis/evaluation/internal investigation.****Describe the methods used to gather information during your internal review or investigation and provide a summary of the agency’s analysis, evaluation, and/or internal investigation:** |

Click or tap here to enter text.

|  |
| --- |
| **POLICIES AND PROCEDURES/AGENCY CONCERNS** |
| Practitioner performance adhered to agency policies and practices, as well as DMHAS standards, regulations, and related statutes. [ ]  Yes [ ]  No ***If no, please specify and list corrective actions:*** |

Click or tap here to enter text.

|  |
| --- |
| **List and attach the policies/procedures reviewed for this incident:** |

Click or tap here to enter text.

|  |
| --- |
| **ACTIONS TAKEN/PLANNED**Indicate the actions taken and/or planned as a result of your agency’s investigative findings/outcome of review. Include a description/further detail in the space provided below (i.e. name of hospital, treatment received, referral information, name of training, type of disciplinary action, etc.) |
| [ ] Further Investigation | [ ] Treatment Received/Planned |
| [ ] Root Cause Analysis | [ ] Coordination of Care |
| [ ] Review [ ] Revision of Agency Policy & Procedure | [ ] Treatment/Interdisciplinary Team Meeting |
| [ ] Disciplinary action(s) | [ ] Treatment Plan Change |
| [ ] Referred to Professional Licensing Board | [ ] Consumer Discharged/Withdrawal from Program |
| [ ] Staff Training/Consumer Education | [ ] Referred to Higher Level of Care |
| [ ] Increased Monitoring | [ ] Referral/Linkage to Resources |
| [ ] Increased Supervision | [ ] Counseling |
| [ ] Administrative Oversight | [ ] Assessment(s) Completed |
| [ ] Other (Specify Below)  | [ ] Funds Reimbursed |

Detailed description of actions/additional information:

Click or tap here to enter text.

|  |
| --- |
| **CONSUMER SPECIFIC INFORMATION** |

|  |
| --- |
| 1. Date consumer was last seen: Click or tap to enter a date.
 |

|  |
| --- |
| 1. Description of the consumer on the date last seen (i.e. presentation, affect, appearance, etc.):
 |
| Click or tap here to enter text. |

|  |
| --- |
| 1. List all assessments completed in the three months prior to the incident and explain the results (i.e. CSSRS, PHQ9, Risk of Hospitalization, Suicide Risk Assessment, etc.)
 |
| Click or tap here to enter text. |

|  |
| --- |
| 1. In the 30 days prior to the incident, was the consumer evaluated at a Psychiatric Screening Center or treated at an inpatient MH or SUD facility? [ ]  Yes [ ]  No
 |
| If yes, Screening Center or Facility Name: Click or tap here to enter text.Admission/Discharge Date: Click or tap to enter a date.Reason for Evaluation or admission: Click or tap here to enter text. |

5. Prior to the incident, were there recent stressors in the consumer’s life or any observed signs of decompensation/relapse that could be related to this incident (i.e. loss of significant other/relationship, financial or legal issues)? [ ]  Yes [ ]  No

|  |
| --- |
| If yes, provide a detailed summary of the stressor(s)/decompensation, and interventions implemented (i.e. referred to higher level of care, relapse intervention plan, helpline, community resources/supports, etc.): Click or tap here to enter text. |

|  |
| --- |
| 1. Was the consumer adherent with his/her treatment regimen (i.e. engaged in treatment, medication adherent)? [ ] Yes [ ] No
 |
| If no, provide further details and attach the agency’s “Lost to Contact” policy. Click or tap here to enter text. |
| Was agency staff compliant with agency policy? [ ]  Yes [ ] NoIf no, what actions have been taken/planned? Click or tap here to enter text. |

|  |
| --- |
| 1. Date of last Substance Use Screening Test (i.e. UDS, swab, breathalyzer, bloodwork, etc.) Click or tap to enter a date.

Results: [ ] Negative [ ]  Positive for: Click or tap here to enter text. [ ]  Not Applicable |
| 1. What substance use interventions were listed on the consumer’s treatment plan? [ ]  Random Testing
 |
|  [ ]  Coping Skills [ ]  Relapse Triggers Education [ ]  AA/NA with sponsor [ ]  Medication Assisted Treatment[ ]  Counseling [ ]  Not Applicable [ ]  Other Click or tap here to enter text. |

|  |
| --- |
| 1. Did the consumer receive education on the risk of overdose? [ ]  Yes [ ]  No [ ]  Not Applicable
 |
| Provide a detailed summary: Click or tap here to enter text. |

|  |
| --- |
| 1. Did the consumer participate in mental health and/or substance use treatment outside of your facility? [ ]  Yes [ ] No
 |
| If yes, describe the steps taken to coordinate care and treatment (i.e. use of Prescription Monitoring Program, communication with outside provider(s), etc.): Click or tap here to enter text. |

|  |
| --- |
| 1. Has the consumer attempted suicide in their lifetime? [ ]  Yes [ ]  No
 |
| If yes, explain: Click or tap here to enter text.  |

|  |
| --- |
| 1. In the year prior to the incident, had the consumer experienced any suicidal and/or homicidal ideation, plan, or intent? [ ]  Yes [ ]  No

If yes, provide details, agency intervention and outcome (i.e. crisis referral, safety plan, risk assessment(s), etc.) |
| Click or tap here to enter text. |

13. Agency policy regarding suicide risk assessment completion: Click or tap here to enter text.

14. Have there been any recent psychiatric or medical medication changes for this consumer? [ ]  Yes [ ]  No

 If yes, describe the medication adjustment(s): Click or tap here to enter text.

15. Prior to the incident, had the consumer demonstrated any change in medical status? [ ]  Yes [ ]  No

 If yes, provide information on how the agency ensured follow-up on medical conditions, including efforts to engage the consumer: Click or tap here to enter text.

16. For death incidents: Was the cause of death verified with the local Medical Examiner’s Office?

 [ ]  Yes If yes, what was the official cause of death: Click or tap here to enter text.

 [ ]  No If no, what attempts were made to verify: Click or tap here to enter text.

|  |
| --- |
| The information contained in this report is confidential. This document is for internal use only and is not a public document. Only those with a need to know and authority to review this report may review the report. This report may contain confidential client information, as well as protected health information, which are protected by state and federal confidentiality laws. Unauthorized disclosure of any of the contents of this report may result in civil and/or criminal penalties.***If you have received this in error, please call 1-800-382-6717 immediately.*** |