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| **Form Field** | **Instructions** |
| Provider Name: Click or tap here to enter text. | Enter agency’s name as it appears on your license. Include DBA (Doing Business As) if operating under a different name. Do not abbreviate. |
| Site Address: Click or tap here to enter text. | The address of the licensed and/or contracted program or service in which the individual participates. |
| NJIRMS#: Click or tap here to enter text. | The identifying number issued to you in the Incident Notification email from DMHAS. |
| Incident Report Contact: Click or tap here to enter text.Title: Click or tap here to enter text.Contact Number: Click or tap here to enter text.Email Address: Click or tap here to enter text. | List the person to contact when additional information is needed. |
| Investigation Completed by: Click or tap here to enter text. | List the name and title of the person who completed the internal investigation. |
| County of Program: Click or tap here to enter text. | The county in which the consumer’s program is located. If ambulatory service, identify the county in which the agency’s license or contract is issued. |
| Incident Date: Click or tap to enter a date. | List the actual date the alleged incident occurred. |
| Alleged Victim(s): Click or tap here to enter text.Alleged Perpetrator(s): Click or tap here to enter text. | Fill in full, legal name. Do not use initials, nicknames, or abbreviations. If person goes by another name, then that name should be added in brackets. i.e. Ralph (Butch) Smith.  |
| Incident Code: Click or tap here to enter text. | List the allegation or event code(s) that were assigned to the incident. Refer to the *AO 2:05* and *Incident Reporting Levels and Categories List* for closing criteria and definitions. |
| [ ]  Substantiated/Yes[ ]  Unsubstantiated/No | Substantiated/Yes = There is a preponderance of credible evidence that an allegation or a situation is true and/or occurred.Unsubstantiated/No = There is less than preponderance of credible evidence, facts, or information to support that the allegation or situation is true and/or occurred.  |
| Note: Preponderance of evidence means that there is evidence sufficient to generate a belief that the conclusion is likely and more probable than not. It is the greater weight of credible evidence, the tipping of the scales. A preponderance of evidence does not necessarily mean the largest amount of data or the largest number of witnesses. The focus is on the quality of the evidence. |
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| **Form Field** | **Instructions** |
| **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. | All allegations require a summary of the agency’s analysis, evaluation, and/or internal investigation.List the methods used to gather information during your internal review or investigation. For example, (name of agency representative) completed interviews with AV(s), AP(s), witnesses, collateral contacts and/or collected written statements; reviewed assessments, logs, MARs, protocols, policy and procedure; reviewed video surveillance, photographs, emails, text messages.Provide a summary of the interviews and reviews.Outline how you have reached your finding.Attach all interviews, written statements, and additional supporting documents to support your findings (i.e. policy and procedures, clinical record, photographs, etc.) upon submission for review.If applicable, identify new/additional information such as allegations, victims, perpetrators, etc. |
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| 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. | Select Yes or No to indicate if the agency representative(s) involved in this incident adhered to agency practices, policy & procedure, State and Federal standards, regulations and related statues regarding Treatment, Service Delivery, etc. leading up to the incident.If no, include a description/further detail and corrective actions planned/taken. |
| **List and attach the policies/procedures reviewed for this incident:**Click or tap here to enter text. | Identify the name of the agency Policy & Procedure(s) that was reviewed and attach a copy upon submission for review. |

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| **Form Field** | **Instructions** |
|  | Select the actions taken and/or planned as a result of your agency’s investigative findings/outcome of review. Options have been provided for selection. If your action is not listed, select “Other” and describe in the space provided, in the next step. |
| Detailed description of actions/additional information:Click or tap here to enter text. | Be specific in defining ALL actions in the space provided. Include a description/further detail in the space provided below (i.e. treatment received with name of provider/facility, referral information, name of training, type of disciplinary action, dates of follow up appointments or meetings, etc.).If related concerns/issues were found during your analysis of this incident, identify them here and list action(s) planned/taken to remedy the identified concern (e.g., the treatment plan was not signed, dates, and timed). |
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| **Form Field** | **Instructions** |
| Date consumer was last seen: Click or tap to enter a date. | Select the date consumer was last seen by the agency. |
| Description of the consumer on the date last seen (i.e. presentation, affect, appearance, etc.): Click or tap to enter a date. | Describe the consumer’s presentation, affect, appearance, etc. on the date last seen, in the space provided. Include any signs of decompensation, or anything unusual said/observed that could be related to this incident. |
| 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 to enter a date. | Identify all assessments completed within the last 3 months prior to the date the incident occurred. Explain the results of the assessments in the space provided. |
| 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. | Select Yes or No to indicate if the consumer was seen by a Designated Screening Center or discharged from a treatment facility within the last 30 days prior to the incident.Provide name of center or facility, dates of admission/discharge and reason for presenting in the spaces provided. |
| 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 [ ]  NoIf 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. | Select Yes or No to indicate if there were recent stressors in consumer’s life.If yes, include a description/further detail of the stressor(s), signs of decompensation and the interventions implemented in the space provided. |
| Was the consumer adherent with his/her treatment regimen (i.e. engaged in treatment, medication adherent) [ ] Yes [ ] NoIf 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. | Select Yes or No to indicate if the consumer was adherent with his/her treatment regimen.If no, include a description/further details regarding the individual’s adherence to treatment in the space provided.If individual was lost to contact, submit a copy of the agency’s *Lost to Contact* policy with the Follow Up Report.Select Yes or No to indicate if agency staff were compliant with agency policy.If no, identify the actions taken/planned by the agency in the space provided. |
| Date of last Substance Use Screening Test (i.e. UDS, swab, breathalyzer, bloodwork, etc.) Click or tap here to enter text.Results: [ ] Negative [ ]  Positive for: Click or tap here to enter text. | Select the date of the last test and select if the results were negative or positive, if applicable.If positive, list the substances identified in the space provided. |
| 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. | Select interventions identified on the consumer’s treatment plan. Options have been provided for selection.If your intervention is not listed, select “Other” and identify in the space provided. |
| Did the consumer receive education on the risk of overdose?[ ]  Yes [ ]  No [ ]  Not ApplicableProvide a detailed summary: Click or tap here to enter text. | Select Yes or No to indicate if the consumer received education on risk of overdose, if applicable.Provide a detailed summary in the space provided. |
| 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. | Select Yes or No to indicate if the consumer participated in MH and/or SUD treatment outside of your agency.If yes, describe steps taken to coordinate care and treatment in the space provided. |
| Has the consumer attempted suicide in their lifetime? [ ]  Yes [ ]  NoIf yes, explain: Click or tap here to enter text. | Select Yes or No to indicate if the consumer has a history of suicide attempts.If yes, explain in the space provided. |
| In the year prior to the incident, had the consumer experienced any suicidal and/or homicidal ideation, plan, or intent? [ ]  Yes [ ]  NoIf yes, provide details, agency intervention and outcome (i.e. crisis referral, safety plan, risk assessment(s), etc.) Click or tap here to enter text. | Select Yes or No to indicate if the consumer experienced suicidal and/or homicidal ideation, plan, or intent in the year prior to the incident.If yes, describe and provide agency interventions and outcomes in the space provided. |
| Agency policy regarding suicide risk assessment completion: Click or tap here to enter text. | Describe your agency policy regarding completion of a suicide risk assessment. |
| Have there been any recent psychiatric or medical medication changes for this consumer? [ ]  Yes [ ]  NoIf yes, describe the medication adjustment(s): Click or tap here to enter text. | Select Yes or No to indicate if the consumer had any recent medication changes.If yes, describe the changes/adjustments in the space provided. |
| Prior to the incident, had the consumer demonstrated any change in medical status? [ ]  Yes [ ]  NoIf 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. | Select Yes or No to indicate if the consumer demonstrated any signs of increased medical symptoms or illness in recent weeks.If yes, describe steps taken by agency to engage consumer and ensure follow up on medical conditions in the space provided. |
| 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. | Complete for Death incidents. Select Yes or No to indicate if you have verified or attempted to verify the Cause of Death with Medical Examiner’s office.If yes, list COD in the space provided.If no, list all attempts made to verify the COD in the space provided.  |