Appendix 6

DHMH, Developmental Disabilities Administration
Internally Investigated Incident Report

I) Individual #1 Name :			Sex: ☐M ☐F
Address:			DOB: / /
City:	State:	Zip:	
Individual's social security number: / /			
Date and time incident occurred: / /	at / ☐AM ☐PM (Check One)		
If different, when was incident discovered: / /	at / ☐AM ☐PM (Check One)		
# of individuals present at the time of incident:	# of staff present at time of incident:		
Address where incident occurred, if different from individual's address:			
Is the address where incident occurred a DDA licensed site/service? ☐Y ☐N			
What program? ☐Community Residential ☐Day – Rehab ☐OCYF ☐Other			
☐Transportation ☐SRC ☐FISS ☐Medical day ☐Vocational ☐CSLA ☐IFC			

Individual #2 Name:	***Social Security Number:*** / /
Individual #3 Name:	***Social Security Number:*** / /

II) Agency Name:	Contact:	Title:
Phone #: ( ) -	Email Address: @	
Incident reported to contact person:	at : ☐ am ☐ pm	

***III) Incident Type** (**Check <u>only</u> the primary incident category that indicates the <u>suspected or known cause</u> of the incident**):*

☐Physical Aggression	☐ Theft (<$50)	☐ER visit **not** resulting from a level III injury
☐Injury (Level II)	☐Hospital treatment for chronic condition; Hospital Name:	
☐Medication error requiring R.N. consult	☐ Leave w/o notification (< 4 hours)	

IV) Describe the circumstances and chronology of the incident (Include the individual(s) name(s) and the titles of staff involved, the staff's efforts to respond to the situation, and the individual(s) status at the time)*:*

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V) Indicate the agency's response, findings, and conclusions from this incident investigation (If indicated, was the individual's team convened in response to this incident? If so, what was the plan of response? Explain)***:***

VI) Summarize any corrections made, preventative actions initiated, and/or disciplinary actions taken in response to this incident:

Name of staff person completing this report:

Date report completed: / / ***Signature:***

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Individual Name: **Date of Incident:**

VII) Standing Committee Review:

1) Did the response to and investigation of this incident comply with agency policies and procedures?
☐ Yes ☐ No **If No, Explain:**

2) Did your agency's response to this incident comply with COMAR Regulations? ☐ Yes ☐ No **If No, Explain:**

3) Does your incident data rule out the possibility of a pattern of this kind of incident at your agency?
☐ Yes ☐ No **If No, Explain:**

4) Are there quality assurance measures already in place to address this kind of incident? ☐ Yes ☐ No
If No, Explain:

5) After a review of this incident the Standing Committee requests that the following action(s) be taken:

Name of Standing Committee Chairperson/Representative:

Date Standing Committee Reviewed Report: / /

Signature of Standing Committee Chairperson/Representative:

[ATTACH A COPY OF THE STANDING COMMITTEE'S SIGN IN SHEET]