HOW TO COMPLETE THE LCBDD
Unusual Incident Report Form

To ensure legibility, please print or type.

This form is to be completed by the individual with first knowledge of the incident.

FRONT SIDE OF FORM

A. INDIVIDUAL IDENTIFICATION BOX:
Individual Name: Print full legal name of individual.
Individual's Address: This is the legal residential address of the involved individual.

B. PROVIDER INFORMATION BOX:
Provider Contact Person: Name of Provider Agency representative or Individual Provider to contact for further information.
Phone Number: This is the contact phone number associated with the listed 'Provider Contact Person'.

C. INCIDENT INFORMATION:
Date Incident Occurred: Print month/date/year that incident occurred.
Time of Incident: May use approximate time, or if time of occurrence is unknown, write “unknown”.
Date and Time Incident Discovered: This is the date and time that you became aware of the incident. (Example: Individual received a black eye on Friday and reported it to OVC staff on Monday. Discovery date would be Monday.)
Specific Location Where Incident Occurred: This is the exact location, with address if necessary, where incident occurred.

D. INCIDENT DESCRIPTION BOX:
Explain Incident (who, what, when, where): Describe incident in detail including preceding or contributing events/actions. This should be a factual account of what was seen, heard and done, without emotional content.

- When possible, use exact quotations of any relevant statements made. (If you heard an individual swear, state what was heard.)
- Use full names of all staff and individuals involved, no initials, no agency specific codes/numbers for individual, nor generic “staff” or “another individual” designation.
- Write clearly, using exact wording in descriptions. Do not use catch phrases such as “assisted to the ground”. Instead describe what you physically did to lower the individual to the floor. If an individual was “struck” or “hit” state whether a closed fist or open hand was used and where on body contact was made.
- Include as many details as possible within your description of the incident.

E. WITNESSES:
This includes all individuals, staff or other individuals present at the time of the incident.
Name: Print full name of witness.
Title: Acceptable completion for “Title” might be “individual”, a job title or “vending company employee”.
Phone #: Phone number where the witness may be contacted for information regarding the incident.

F. PRIMARY PERSON INVOLVED (PPI): Print full name of the PPI and include their relationship to the individual. This could be staff, brother, caregiver, neighbor, etc.

G. STAFF SIGNATURE:
Staff Signature/Title/Date: The staff completing the description of incident must sign their name, list their title or job position, and identify the date they completed the form.

Printed Name: The name of the staff listed above as completing the description of incident must legibly print their name as it is signed in the above line.

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H. INDIVIDUAL IDENTIFICATION BOX:
Individual Name: Print full legal name of individual, as printed on first page of form.

I. INJURY INFORMATION BOX:
Did Injury Occur: Indicate "Yes" or "No".
Assessment Completed by Whom? Print name of individual who completed the medical assessment of the individual.
Title: Print job title or designation associated with the individual completing the medical assessment.
Date: This is the date the assessment was completed.
Type and Location of Injury: Identify any observable or known injury and describe the location, such as left lower leg.
Was Emergency Transport required to hospital? By whom?: Identify if the individual needed to be transported to the hospital and if transport was by ambulance (List name of ambulance service, if known) or by an individual.
Name of Hospital/ ER Treatment only?/Hospital Admittance?: List name of hospital where individual was taken, indicate if they received emergency room treatment only or if they were admitted to the hospital for further evaluation/treatment.

J. IMMEDIATE ACTION DESCRIPTION BOX:
Describe Immediate action taken to ensure health and welfare of the individual involved: This is a description of the first steps taken to immediately address the situation. For example, if the incident involved a physical confrontation between individuals, the immediate action would begin with separating the individuals. If the report concerns the fall of a individual, the immediate action would include medically assessing first aid given to the individual.

K. MEDICAL FOLLOW-UP BOX:
Describe any further medical follow-up required: This is a description of any additional follow-up that will be necessary to address the outcome of the incident with any medical professionals.

L. SUMMARY OF REPORTING GUIDELINES:
REQUIREMENTS FOR MUI REPORTING TO INVESTIGATIVE AGENTS (IAs): This is a reminder that all Alleged Abuse, Neglect, Exploitation, Misappropriation, Suspicious/Accidental Death, or Media Inquiries about an MUI must be verbally reported to an IA within 4 hours of the discovery of the incident. (This includes all peer-to-peer incidents within these categories.) For all categories of MUIs, a written incident report must be received by an IA by 3:00 pm on the next working day following discovery of an incident. (Working day means Monday-Friday except for holidays as defined in Section 1/14 of the Ohio Revised Code.)

M. REQUIRED NOTIFICATIONS FOR A UI BOX:
RESIDENTIAL STAFF/FAMILY NOTIFICATION: All reported incidents are initially considered an Unusual Incident (UI) and if the incident occurs at a site operated by the county board or at a site operated by an entity with which the county board contracts, the county board or contract entity shall notify the licensed provider or staff, guardian, or other person whom the individual has identified, as applicable, at the individual's resident. This notification must be completed the same day that the Unusual Incident is discovered and documented in this section for the identified individual.

INDEPENDENT PROVIDER NOTIFICATION TO THE SSA: All Independent Providers shall complete an Unusual Incident Report Form, notify the individuals guardian or other person whom the individual has identified, as applicable, and send the completed Unusual Incident Report form to the SSA on the same day the Unusual Incident is discovered.

N. REQURIED NOTIFICATIONS FOR A POTENTIAL OR IDENTIFIED MUI:
Any potential MUI must be reported to an IA as only an Investigative Agent is authorized to designate an unusual Incident (UI) as a Major Unusual Incident (MUI). All verbal or written contact with an IA to establish MUI status of an incident must be documented as **County Board verbal notification** and/or **County Board written notification** and the **Name of the IA contacted** should be identified.
Guardian/SSA/Residential Provider/Residential Staff-Family/Law Enforcement/Children Services/Support Broker/Other: Once an incident has been identified by an IA as an MUI, appropriate notification and documentation must be completed on the day of occurrence or discovery and include a statement of the immediate action taken.

O. STAFF COMPLETION SIGNATURE:
Staff Signature/Title/Date: The staff completing the notifications must sign their name, list their title or job position, and identify the date they completed the form.
Printed Name: The name of the staff listed above as completing the notificatrions must legibly print their name as it is signed in the above line.
This form should be completed as soon as possible following the incident. If the incident is believed to be a potential MUI, or involves alleged abuse, neglect, exploitation, misappropriation, suspicious/accidental death, or media inquiries, staff must ***immediately*** make verbal contact with a supervisor or IA and follow their direction for completion of the incident report form.

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P. INDIVIDUAL IDENTIFICATION BOX:
Individual Name: Print full legal name of individual, as printed on first page of form.

UNUSUAL INCIDENT INVESTIGATION SUMMARY

REQUIREMENTS FOR UI INVESTIGATION:
Revised OAC 5123:2-17-02 states Unusual Incidents shall be reported and investigated by the Provider. This includes identification of the cause and contributing factors when applicable, and the development of preventive measure to protect the health and welfare of any at-risk individuals.

Independent providers shall complete an Incident Report, notify the individual's guardian or other person whom the individual has identified and then forward the incident report to the Service and Support Administrator on the same day the Unusual Incident is discovered.

NOTE: All potential Major Unusual Incidents must be addressed by the Investigative Agents of the Lorain County Board of Developmental Disabilities - MUI/Investigation Unit.

Q. IDENTIFY THE LEVEL OF SUPERVISION AT TIME OF INCIDENT OCCURRENCE AS LISTED IN THE ISP/IHP: List the specific levels of supervision identified within the individual's ISP or IHP for all environments with all associated timeframes.

R. LIST ALL PROBABLE CAUSES AND/OR CONTRIBUTING FACTORS TO THE INCIDENT: This would include all physical environmental factors and/or any medical/psychological issues of the individual that may have been present at the time of the incident and provided some impact to the situation. Additionally, personal interactions of the individual or events prior to the incident should also be identified.

S. PREVENTATIVE MEASURES TAKEN TO PROTECT THE HEALTH AND WELFARE OF ALL AT-RISK INDIVIDUALS INVOLVED IN THIS INCIDENT: This section should address preventative measures that have been implemented for all individuals involved in the incident and should include input from any appropriate team member. ***Causes and contributing factors should be addressed by the preventative measures.***

T. DOCUMENTATION CHECK-OFF BOX: This box should be checked when all documentation necessary to verify that the implementation of the proposed preventative measures has been completed and attached to this UI/MUI Incident Report form.

U. SUPERVISORY SIGNATURE:
Supervisor Signature/Title/Date: The supervisor completing the Investigation Summary section must sign their name, list their job title or job position, and identify the date they completed this section.
Print Name: The name of the supervisor listed above as completing the form must legibly print their name as it is signed in the above line.

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V. INDIVIDUAL IDENTIFICATION BOX:
INDIVIDUAL NAME: Print full legal name of individual, as printed on the first page of form.

W. WITNESS STATEMENT:
Printed Name: Print the witness' name.
Date: Print the date of the witness' statement.
Contact Phone Number: Print the witness' contact number.
Relationship: Print the witness' relationship to the individual.
Print the witness' statement in the box below this identifying information.
Signature: The witness completing the statement must sign their name on the signature line.

Revised 09/2017