Lake County Board of Developmental Disabilities/Deepwood

UI/MUI REPORTING FORM CONFIDENTIAL Reporting Individual Name: Provider: Individual Address: Complete one report for each incident or injured individual. Report should be completed immediately. PART 1 Completed by employee who discovered the incident A. Date of Incident: **B**. Time: ___:___ Wed D. Witnessed? C. Day of Week: Mon Tues Thurs Fri Sat Sun Yes/ No _____(A,V or O) ODODD#_ E. Others Involved (Aggressor, Victim or Other) ODODD#_ Specific location and address where incident occurred: Location: Address: (e.g. ARC @ AB Dinning Room) F. Describe incident in detail including preceding or contributing events/actions, identification, of parties (use staff names) involved in the incident and the resolution of the incident (Use supplemental form if more space is needed): Before the incident: During the incident: After the Incident: Were there witnesses(besides yourself)? Yes No (If alleged abuse/neglect, use ODODD# instead of name for any individual served as witnesses) 1. Witness' Name: Title: 2. Witness' Name: Title: Title: 3. Witness' Name: Date Completed: ____/___ Time: ___:___ Signature Title: Type Name: NOTIFICATION Manager: (name) Time: Med. Pers.: (name) Time: Date: PART II Completed by LPN,RN or STAFF if no nurse available I. First aid/treatment given by: H. Severity of Injury/Illness If nursing available, stop here: Nurse Completes. If no Nurse, Staff Complete. 1. No apparent injury/illness 1. None G. Nature of injury/illness 2. Minor (temporary injury/illness; no further 2. Staff 1. None/NA 9. Laceration/ complications) 3. RN/LPN 3. Moderate(injury/illness not serious; requiring medical 4. Physician 2.Bruise scratch/abrasion 5. Other: attention) Airway 10. Puncture 4. Severe (serious injury/illness requiring medical obstruction treatment and/or resulting in change in physical status) J. Required Emergency Services? 11. Skin Irritation 4. Bite Yes 5. Death 5. Burn 12. Teeth injury No K. For Medication/Treatment Errors 6. Exposure 13. Unable to 7. Transcription error 1. Incorrect time 4. Incorrect route cold/heat

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Incorrect individual

6. Omission

2. Incorrect medication

3. Incorrect dosage

Determine

14. Other

7. Eye Injury

8. Head injury

8. Stray pills

9. Other

INDIVIDUAL NAME: PART II Contd-Completed by LPN,RN or STAFF if no nurse available . Assessment/Treatment (Military) Date: ___/__/ _Time: Signature: Title: Type Name: PART III M.NOTIFICATION: LIST NAME OF PERSON SPOKEN TO (if message left- list phone number) DATE: TIME: **Notified by: Print Name** Superintendent Reporting Line (Board Operated Programs Only x5113) Physician: Director of Nursing: Family Guardian (Check all that apply): MUI Reporting Line (350-5253): Residential Provider: Day Program: Child Protective Service (350-4000): Law Enforcement: Individual's SSA: Other: Emailed MUI Incident Report to IA@lakebdd.org (Potential MUIs Only) POTENTIAL Major Unusual Incident Yes PART IV Completed by Manager (All potential MUIs require notification to the N. Type of incident: MUI Reporting Line 440-350-5253 (LAKE) O. One Sentence summary of incident: P. Immediate actions taken to ensure health/welfare: (e.g. removed staff from duty; sent consumer to ER) Q. Possible Causes and Contributing Factors for the Incident: R. Preventative Measures (Specific actions, by whom):

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Signature:_ Type Name: Date Completed: ____/___ Time: ___:___