Lake County Board of Developmental Disabilities/Deepwood

UI/MUI REPORTING FORM

CONFIDENTIAL

Individual Name: _____ Reporting 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: ___:____ **C**. Day of Week: ◯ Mon ◯ Tues ◯ Wed ◯ Thurs ◯ Fri ◯ Sat ◯ Sun **D**. Witnessed? ☐ Yes/ No ☐

E. Others Involved (Aggressor, Victim or Other) ODODD#_____(A,V or O) 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: _____

3. Witness' Name: _____ Title: _____

Signature _____ Date Completed: _____/_____/_____ Time: ____:_____

Type Name: _____ Title: _____

NOTIFICATION

Manager: (name)_____ Date: _____/_____/_____ Time: ____:_____

Med. Pers.: (name)_____ Date: _____/_____/_____ Time: ____:_____

PART II Completed by LPN,RN or STAFF if no nurse available

If nursing available, stop here: Nurse Completes. If no Nurse, Staff Complete.

G. Nature of injury/illness

- ◯ 1. None/NA
- ◯ 2.Bruise
- ◯ 3. Airway obstruction
- ◯ 4. Bite
- ◯ 5. Burn
- ◯ 6. Exposure cold/heat
- ◯ 7. Eye Injury
- ◯ 8. Head injury
- ◯ 9. Laceration/ scratch/abrasion
- ◯ 10. Puncture
- ◯ 11. Skin Irritation
- ◯ 12. Teeth injury
- ◯ 13. Unable to Determine
- ◯ 14. Other

H. Severity of Injury/Illness

- ◯ 1. No apparent injury/illness
- ◯ 2. Minor (temporary injury/illness; no further complications)
- ◯ 3. Moderate(injury/illness not serious; requiring medical attention)
- ◯ 4. Severe (serious injury/illness requiring medical treatment and/or resulting in change in physical status)
- ◯ 5. Death

I. First aid/treatment given by:

- ◯ 1. None
- ◯ 2. Staff
- ◯ 3. RN/LPN
- ◯ 4. Physician
- ◯ 5. Other:

J. Required Emergency Services?

- ☐ Yes
- ☐ No

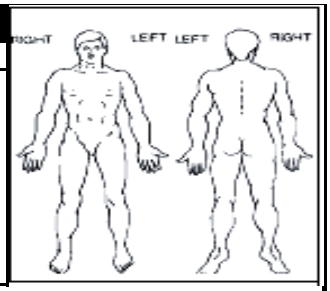
K. For Medication/Treatment Errors

- ◯ 1. Incorrect time
- ◯ 2. Incorrect medication
- ◯ 3. Incorrect dosage
- ◯ 4. Incorrect route
- ◯ 5. Incorrect individual
- ◯ 6. Omission
- ◯ 7. Transcription error
- ◯ 8. Stray pills
- ◯ 9. Other

INDIVIDUAL NAME:_____

PART II Contd-Completed by LPN,RN or STAFF if no nurse available

L. Assessment/Treatment Time: : (Military)



Signature: _____ **Date:** ____/____/_____**Time:**____:_____

Type Name: **Title:**

PART III M.NOTIFICATION:

LIST NAME OF PERSON SPOKEN TO (if message left- list phone number)	DATE: TIME:	Notified by: Print Name
Superintendent MUI 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)		

PART IV Completed by Manager

POTENTIAL Major Unusual Incident ☐ **Yes** ☐ **No**
(All potential MUIs require notification to the MUI Reporting Line 440-350-5253 (LAKE)

N. Type of incident:

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):

Signature: _____ **Date Completed:** _____/_____/_____ **Time:** ____:_____

Type Name: _____ **Title:** _____