

SERIOUS INCIDENT REPORT

Use of form: Any incident meeting the requirements of BRL CW Memo 2004-03 and / or HFS 57 shall be reported to the department. Use of this form is voluntary; however, completion of this form, or an equivalent that contains all the information requested on this form, will assist in meeting the requirements of s. 48.66(3), Wis. Stats., and HFS 52.11(12) and (14), HFS 54.06(3), HFS 57.13(1) and (5), 57.135(1), 57.27(3)(c), and 57.38(1)(L), and HFS 59.01(1) and 59.07(4). Personally identifiable information gathered on this form will be used only to determine compliance with the above-mentioned rules and to assist in investigations concerning serious incidents.

Instructions: This form or its equivalent shall be completed in ink and mailed or faxed to the regional licensing office serving your facility. A copy of the completed form shall be placed in the resident's record. Note: If restraints were utilized, Section I must be completed. If more space is needed, attach separate sheet(s).

A. Facility Information

Name – Facility	Facility ID Number
Address – Facility	Telephone Number – Facility

B. Incident Type

<input type="checkbox"/> Any reported incident of child abuse or neglect <input type="checkbox"/> Any serious injury or trauma requiring the services of a licensed medical practitioner <input type="checkbox"/> The death of a resident <input type="checkbox"/> Any use of a restraint on a resident of a group home <input type="checkbox"/> Any injury of a resident sustained by being restrained <input type="checkbox"/> Any condition requiring the removal of residents from the facility <input type="checkbox"/> Any damage to the premises that would affect compliance with licensing rules	<input type="checkbox"/> A medication administration error <input type="checkbox"/> Any serious incident requiring the services of a law enforcement agency <input type="checkbox"/> A suicide attempt <input type="checkbox"/> Closure of the facility or a unit within the facility <input type="checkbox"/> Outbreak of a serious communicable disease as defined in HFS 145 <input type="checkbox"/> A fire on the premises that requires the services of the fire department
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C. Incident Description

Date Incident Occurred (mm/dd/yyyy)	Time Incident Began <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Time Incident Ended <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Location incident occurred (Include address: street, city, state)		

Yes No Were physical restraints used? If "Yes", Section I must be completed.

Describe the incident and the circumstances leading up to it. Include specific time, place, staff involved, resident(s) involved and what de-escalation techniques were used.

D. Resident(s) Involved in the Incident

Name – Resident	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
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Name – Placing Agency

Name – Resident	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
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Name – Placing Agency

Name – Resident	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
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Name – Placing Agency

Name – Resident	Birthdate (mm/dd/yyyy)	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
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Name – Placing Agency

E. Staff / Foster Parent(s) Involved in the Incident

Name	Job Title	Telephone Number
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Name	Job Title	Telephone Number
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Name	Job Title	Telephone Number
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Name	Job Title	Telephone Number
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F. Other Agencies Involved in the Incident (Medical, Law Enforcement, Placing Agency, School, etc.)

Name	Telephone Number
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Address – (Street, City, Zip Code)

Name	Telephone Number
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Address – (Street, City, Zip Code)

Name	Telephone Number
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Address – (Street, City, Zip Code)

G. Staff / Volunteers Who Witnessed the Incident

Name	Job Title	Telephone Number
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Name	Job Title	Telephone Number
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Name	Job Title	Telephone Number
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H. Facility Follow-Up Action

Describe the facility's immediate follow-up with resident(s) involved in the incident. Include debriefing and medical care and / or any resultant changes in the resident's treatment plan.

Describe the facility's follow-up with staff / foster parent(s) involved in the incident.

Describe the specific measure(s) the facility will take to prevent further similar incidents from occurring.

I. Physical Restraint Information (Note: Complete this section only if physical restraints were used.)

Describe the circumstances leading up to the use of restraint, the behavior that prompted the restraint, efforts made to de-escalate the situation, the alternatives to restraint that were attempted and the reasons they were not successful.

Describe the administration of the restraint; the type of restraint including the holds used and the reasons such holds were necessary; the verbal / physical behavior of the resident during and after the use of the restraint; and the beginning and ending time of the restraint.

Describe how the restraint was ended, any injuries sustained by a resident or staff member that occurred and any medical care received including the name and title of the person providing care.

Provide a description of any crisis intervention training each staff involved in the restraint has received, including dates of completion.

Describe any follow-up debriefing provided to residents and staff.

J. Reporting Information

Date – Submitted to Department (mm/dd/yyyy)	Date – Notification of Parent / Guardian / Legal Custodian (mm/dd/yyyy)	Date – Notification of Placing Person / Agency (mm/dd/yyyy)	
Name – Person Completing Report		Title – Person Completing Report	Date – Report Completed
SIGNATURE – Person Completing Report			Date Signed
Name – Supervisor		Title – Supervisor	
SIGNATURE – Supervisor			Date Signed

For Department Use Only

<input type="checkbox"/> Yes <input type="checkbox"/> No Further action needed?	
If "Yes", what action was taken?	
If "No", explain.	
SIGNATURE – Licensing Specialist	Date Signed