MRCI CLIENT DIRECTED SERVICES

1. Complete Report _____ Initials
2. Notify MRCI Case Mgr. ____ Initials
3. Copy for working file _____ Initials
4. Route a copy to Supervisor ____ Initials
5. Route original to H.R. _____ Initials

INCIDENT/ ACCIDENT REPORT FORM

(Use black ink NO WHITEOUT)

Section 1 – Completed by Employee: _____ Phone: _____

(Please print legibly)

Legal Name of Person Involved:_____ Date of Report _____

Date of Incident/ Accident:_____ Time of Incident/ Accident: _____ am/pm

Witnesses: Name _____ Phone: (___)_____

Name _____ Phone: (___) _____

Dept #: _____ Specific Site: _____ Location/Room _____

Address of Incident: _____

INCIDENT/ACCIDENT

Describe the incident/accident. Use facts and specific detail to describe the incident. (Include what was happening prior to the incident):

_____

_____

_____

_____

_____

_____

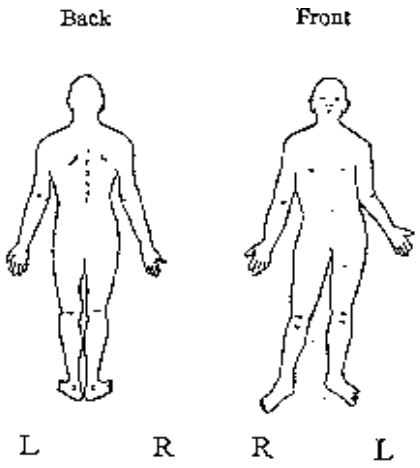
_____

Action taken to prevent reoccurrence: _____

_____

INJURIES ☐ **Yes** ☐ **No** ****** If there are *NO* injuries, please go to Section 3, 4 and 5 if applicable**

Circle site of injury:



Nature of Injury: ☐ Arrived with Injury ☐ Abrasion ☐ Bite ☐ Burn ☐ Bruise(s) ☐ Cut/Laceration Puncture ☐ Other _____

Describe what the injury looks like: _____

Identify First Aid Provided: _____

Does injury require medical attention (tetanus shot, stitches, etc.)? ☐ Yes ☐ No

Was blood or OPIM present? ☐ Yes ☐ No

Did the First Aid Provider wear gloves? ☐ Yes ☐ No

First Aid Provider: ☐ self _____ ☐ Other _____

MRCI's Health Services Coordinator Signature: _____

Date Reviewed: _____

Did the employee/client leave work due to injury? ☐ Yes ☐ No

If yes, what time?_____ How and who transported? _____

Where were they transported? _____

EXPOSURE INCIDENT **** Needs to be completed by the end of the day* ******(If exposure please read Exposure Incident Procedure and fill out Form #80-123. Notify Health Services Coordinator or Human Resources immediately)***

This ☐ is ☐ is not an exposure incident. Supervisor Signature_____

MRCI Health Services Coordinator Notified? ☐ N/A ☐ Yes

If injury requires *outside* medical attention please call Human Resources immediately and fill out Section 2.

Section 2 - Completed by Employee or Supervisor ONLY if incident/accident involved outside medical treatment

OUTSIDE MEDICAL TREATMENT * Please send any doctor's notes or medical treatment regarding this injury to H.R.*

Date of Initial Visit to Medical Provider:_____ Name of Treating Physician/Name of Facility: _____

Address of Facility: _____

Time Employee began work on day of injury: _____ Date of First Day of Lost Time: _____

Supervisor who first received knowledge of injury _____

Date Returned to Work:_____ Please describe injured employee's normal work schedule: _____

_____

Section 3 - Completed by Supervisor or Program Manager: _____ **Phone:** _____

OMBUDSMAN / DHS REPORTING ☐ N/A

☐ **Ombudsman notified within 24 hours for serious injury or death.** Date:_____ Completed by: _____

☐ **DHS (for clients in a licensed program) notified within 24 hours for serious injury or death.** Date: _____

Completed by: _____

If this report involves maltreatment of a vulnerable adult, report to CEP within 24 hours. See vulnerable adult reporting checklist

LICENSED PROGRAM INFORMATION ☐ N/A

Incidents requiring team notification within 24 hours are:

☐ Serious injury*
☐ Death*
☐ Any mental health crisis that requires a 911 call or mental health crisis intervention team
☐ Unauthorized or unexplained absence from program
☐ Physical conduct by a person served against another person served
☐ Maltreatment of a minor
☐ Medical emergency, unexpected illness, or significant unexpected change in an illness or medical condition that requires to call 911, physician treatment or hospitalization
☐ An act or situation involving a person that requires a 911 call, law enforcement, or the fire department
☐ Sexual activity between persons served involving force or coercion
☐ Emergency use of manual restraint
☐ Maltreatment of a vulnerable adult – Note: Route original to Program Manager to provide confidentiality.

* Reporting of these incidents must also be made to MN Department of Human Services and MN Office of the Ombudsman.

(List names of contacts who must be notified within 24 hours)

Residence:_____ ☐ verbal ☐ fax ☐ e-mail Date/Time _____ Initials _____ MAILED: ☐

Case Manager:_____ ☐ verbal ☐ fax ☐ e-mail Date/Time _____ Initials _____ MAILED: ☐

Legal Rep: _____ ☐ verbal ☐ fax ☐ e-mail Date/Time _____ Initials _____ MAILED: ☐

Has a pattern been identified relating to this incident? ☐ Yes ☐ No

Action Taken: _____

Designated Coordinator Signature _____

Does this situation require a second report? ☐ yes (#_____) ☐ no

Section 4 – Please Sign

SIGNATURES

_____ _____

Signature and Title of Person Completing form Date | Signature of Supervisor/Team Leader/Counselor Date

_____ _____

Signature of Program Manager Date | Signature of Vice President Date

Section 5 – Safety Committee

Copy to Safety Committee Representative Date: _____ Initials: _____

Safety & Health Investigation/Job Hazard Report completed : ☐ Yes ☐ No

Date Reviewed by Safety Committee:_____ Reviewed By: _____

Safety Committee Recommendations: _____

Case Noted: Date: _____By:_____

Note: If a client is involved in an incident/accident, it must be case noted. If an incident/accident involves staff only, it does not need to be case noted. ** **Please fill out a Follow-Up Report (Form # 80-23a) if anything further happens.**