

REPORTS POLICY:

INCIDENT REPORT & INTERNAL REVIEW, SERIOUS INJURY REPORT, BIRF REPORT, AND DEATH REPORT

Purpose

This report's policy is purely to give a brief introduction and overview to the above-mentioned report forms. Employees will be trained in the use of these forms via the *Incident Response, Reports, and Review* policy, the *Internal Review Policy*, and the *Incident Reporting Instructional Course*.

Policy

Service providers are required to notify the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD) within 24 hours of the death or serious injury of a person served. Other incidents require the completion of an Incident Report form, but do not need to be reported to the OMHDD. The OMHDD reviews reports of death and serious injuries of persons receiving services or treatment for mental illness, developmental disabilities, chemical dependency, or emotional disturbance. Reports can be completed online or by fax 24 hours a day.

The forms may be located on their website: <https://mn.gov/omhdd/reporting-death-or-seriousinjury/download-forms.jsp>

Completed forms may be faxed to 651-797-1950.

After the appropriate Regional Ombudsman receives and reviews the reports they may reach out for additional information, request a review by the Medical Review Subcommittee, refer the report to DHS licensing, or suggest strategies to prevent similar injuries from occurring in the future.

As of January 1st, 2014, all service providers licensed under MN Statutes, Chapter 245D must complete and submit the Behavioral Intervention Report Form (BIRF) to report all occurrences of any of the following:

- Planned, temporary transitional use of all imposed forms of restraint, time-out procedures, seclusion, and punitive penalty consequences;
- Emergency, temporary transitional use of all imposed forms of restraint, time-out procedures, seclusion, and punitive penalty consequences;
- Emergency use of manual restraint
- PRN psychotropic medication(s) administration in order to avert displayed behaviors or in response to displaced behaviors as identified on the BIRF reporting form;
- Law enforcement and/or other first responder calls and involvement in response to displayed behaviors as identified on the BIRF reporting form; and
- Emergency psychiatric hospitalization in response to displayed behaviors as identified on the BIRF reporting form.

All BIRF reporting forms are received and reviewed by DHS and the Office of Ombudsman for Mental Health and Developmental Disabilities.



Below are examples of an Incident Report Form, a Serious Injury Report Form, a BIRF Report Form, and a Death Report Form. When there is an incident, the staff on duty and the supervisor of the home must fill out official versions of the necessary form. The most up to date and official versions of these forms can be found in the office in the “Reports” book.

--- Example ---

Incident Report and Internal Review

All incidents must be reported within 24 hours of the incident or within 24 hours of when the program became aware of the incident. A separate form must be completed for each staff present – do not use identifying information, such as names or initials, if the incident involved another person receiving services. In such cases refer to the other persons as “Person 1”, “Person 2”, and so on. Additionally, do not use identifying information for the staff persons, instead use “Staff 1”, “Staff 2”, and so on.

Date of incident: _____ Time of incident: _____ am/pm

Location of incident: _____

Person name: _____

Program name: _____ License Number: _____

I. Incident Type (check all that apply):

Death or serious injury (must also be reported using the forms from the Office of Ombudsman for Mental Health and Developmental Disabilities)

Any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition that requires the program to call 911, physical treatment, or hospitalization

Any mental health crisis that requires the program to call 911 or a mental health crisis intervention team

Any act or situation involving a person that requires the program to call 911, law enforcement, or the fire department

Unauthorized or unexplained absence from a program

Conduct by a person against another person that: is so severe, pervasive, or objectively offensive that it substantially interferes with a person’s opportunities to participate in or receive service or support; places the person in actual and reasonable fear of harm; places the person in actual and reasonable fear of damage to property of the person; or substantially disrupts the orderly operation of the program

Any sexual activity between persons that involves force or coercion

Any emergency use of manual restraint (also refer to Emergency Use of Manual Restraint Policy)

A report of alleged or suspected child or vulnerable adult maltreatment (also refer to Maltreatment of Minors of Vulnerable Adults Reporting Policy)

II. Description of Incident:



III. Description of staff response to the incident:

Applicable coordinated service and support plan addendum(s) were implemented for the person(s) involved.

Applicable program policies and procedures were implemented as written.

Staff person(s) who responded to the incident:

Name/Signature of reporting staff:

Date:

IV. Persons Notified (within 24 hours of the incident)

Name – Date – Time for all

Case manager: _____

Legal representative or designated emergency contact _____

Other: _____

Other: _____

Other: _____

Ombudsman**:

DHS Licensing or OHFC for ICF/DD**:

**Notified of death and serious injuries only

V. Internal Review of Incident

Items A to C are required for serious injuries, including deaths, emergency use of manual restraint, and alleged or suspected maltreatment. Items D and E are required for ALL Incidents.

- A. Were the related policies and procedures followed?
 - a. If no, explain
- B. Were the policies and procedures adequate?
 - a. If no, explain
- C. Is there a need for additional staff training?
 - a. If yes, what training is needed, when will it be provided, and who will attend?
- D. Is the incident similar to past events with the persons or the services involved?
 - a. If yes, identify the incident patterns.
- E. Is there a need for corrective action by the program to protect the health and safety of the persons receiving services and to reduce future occurrences?
 - a. If yes, identify the corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the program. (Include applicable implementation dates, staff assigned to take corrective action and attach relevant documentation.)



For emergency use of manual restraints only: Is there a need to revise the person’s service and support strategies?

Name/Signature of staff completing internal review:

Date:

-- Example --

Serious Injury Report

(If all information is not available within 24 hours, please submit the report with the information you have.)

Date of report:

I. PERSON SERVED INFORMATION

First Name:

MI:

Last Name:

Person’s Facility Name (if applicable):

Gender: Female Male Other

Date of Birth:

Ethnicity:

	African		Choose not to respond
	African American		Hispanic or Latino
	American Indian or Native Alaskan		Other
	Asian		Pacific Islander or Native Hawaiian
	Caucasian or White		

County of residence: County of financial responsibility:

Address Type: Address at time of report (temporary) Permanent address (home)

Person’s address: Apt/Suite #:

City:

County: State: Zip Code:

Person’s home number:

Person’s mobile number:

May we leave a message: Yes No



II. REPORTER INFORMATION

Do you wish to have your identity private? ___ Yes ___ No

Do you have concerns about retaliation ___ Yes ___ No

First name:

Last name:

Title:

Agency/Program name (if applicable):

Reporter email address:

Address:

Apt/Suite #:

City: County: State: Zip Code: Contact number: Ext.:

May we leave a message: ___ Yes ___ No

Mobile number:

Fax number:

Who else did you report this to? (check all that apply):

<input type="checkbox"/>	Administration	<input type="checkbox"/>	Licensing Agency
<input type="checkbox"/>	Adult or Child Protection or CEP	<input type="checkbox"/>	Medical Resources Health Care Provider
<input type="checkbox"/>	Attorney Legal	<input type="checkbox"/>	Office of Health Facility Complaints
<input type="checkbox"/>	County Agency	<input type="checkbox"/>	Other – Describe:
<input type="checkbox"/>	Facility or Program or Agency Staff	<input type="checkbox"/>	Other Advocacy or Ombudsman Agency
<input type="checkbox"/>	Guardian or Legal Representative	<input type="checkbox"/>	Private Agency
<input type="checkbox"/>	Hospital Review Board	<input type="checkbox"/>	State Agency
<input type="checkbox"/>	Law Enforcement	<input type="checkbox"/>	Treatment Team

III. ADDITIONAL PERSON SERVED INFORMATION

Person served Category (Check all that apply):

<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	Mental Illness
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	Chemical Dependency/Substance Use Disorder		Mentally Ill and Dangerous
	Developmental/Intellectual Disabilities		Other
	Emotional Disturbance		Sex Offender

Legal Representatives (check all that apply):

	Health Care Agent		Private Conservator
	Health Care Directive		Private Guardian
	None		Public Guardian
	Nonparent/Relative		Representative Payee
	Parent		Substitute Decision Maker (Commitment Statute 253B.092)
	Power of Attorney		Tribal Custody
	Power of Attorney for Health Care Agent		

Legal Status (Check all that apply):

	Committed – Chemical Dependency (CD)		Juvenile Court Placement
	Committed – Developmental Disability (DD)		None
	Committed – Mentally Ill (MI)		Probation
	Committed – Mentally Ill and Dangerous (MI & D)		Provisional Discharge
	Committed – Sexual Psychopathic Personality (SPP)		Rule 20



	Committed – Sexually Dangerous Person (SDP)		Stay of Commitment
	Emergency Hold Court Hold		Unknown
	Incarcerated (Jail or Prison)		Voluntary Admission
	Informal Juvenile Placement by Parents		

IV. SERIOUS INJURY INFORMATION

Date of injury (if known): Time of injury: AM/PM

Did the injury occur where the person lives? ___ Yes ___ No

If not, name of Agency, Facility, or Program where the injury occurred (if applicable): Address:

City: State: Zip Code:

Telephone number:

Fax:

County:

Location Where Serious Injury Occurred (check one):

	Adult Day Care Services		Crisis Home
	Assisted Living Program – Class E		Crisis Respite Services
	Board and Lodge		Day Training and Habilitation Services
	Board and Lodge Housing with Services		Detox Services
	Boarding Care Home		Family Adult Day Services
	Chemical Dependency Treatment Residential		Family Child Care
	Children’s Residential Facilities		Forensic Facility
	Community		Foster Care



	Foster Care, Adult		Psychopathic Personality – residential
	Foster Care, Child – DHS		Relatives/Friends Home
	Foster Care, Child – DOC		Residential Facilities for Adults with Mental Illness
	Group Home for DD		Residential Services for Persons with Physical Handicaps
	Group Home for MI		Residential Services, ICF/DD certified
	Halfway House		Residential Services, non-ICF/DD certified
	Homeless		School
	Hospice – Class D		Semi-Independent Living Services
	Hospitals and Critical Access Hospital		Shared Housing
	Incarcerated		Sheltered Employment/Rehab
	Job or Work (other than in program)		Sober House
	MN Sex Offender Program – Moose Lake		State Operated Residential Treatment Facility for DD
	MN Sex Offender Program – Saint Peter		State Operated Residential Treatment Facility for MI
	Nursing Home		Supervised Living Facility

	Other – Describe:		Temporary Placement
	Outpatient Surgical Center		Unknown



	Own home or Apartment		Waiver Services, Residential Habilitation
	Psychiatric Hospital		

Living Arrangement or Programs/Services received (check all that apply):

	245D Community Residential Setting – Adult		Early Intensive Developmental & Behavioral Intervention
	245D Community Residential Setting – Child		Family Adult Day Services
	245D Home and Community Based Services – Adult		Forensic Nursing Home
	245D Home and Community Based Services – Child		Foster Care Child – Department of Corrections
	245D Residential Facility (ICF/DD)		Home Care Provider: Class A, Class B, Class C, Class F
	Acute Care Hospital		Homeless
	Adult Day Center/Facility		Hospice – in facility
	Adult Foster Care		Hospice – in home
	Adult Rehabilitative Mental Health Treatment Center (ARMHS)		Housing with Services/Assisted Living
	Assertive Community Treatment (ACT)		Intensive Residential Treatment (IRTS)
	Behavioral Health Home		Lives at home with parents/family - child
	Board and Lodge		Lives with Relatives
	Board and Lodge with Services		Mental Health Center
	Boarding Care Home		MN Sex Offender Program



	Certified Community Behavioral Health Clinic		Nursing Home
	Child Foster Care		Other
	Children’s Residential Facility		Other Certified Treatment Provider
	Children’s Therapeutic Services and Supports		Own Apartment/Home
	Community Addiction Recovery		Residential treatment for adults with Mental Illness
	DBT provider (certified)		Shared Housing
	Direct Care & Treatment - CBHH		Substance use disorder treatment - nonresidential
	Direct Care & Treatment - AMRTC		Substance use disorder treatment - residential
	Direct Care & Treatment - CABHS		Supervised Living Facility
	Direct Care & Treatment - MSH		Wet House
	Direct Care & Treatment - MSOCS		

Type of Injury (check one):

	Attempted Suicide		Heat Exhaustion or Sun Stroke
	Complication of Medical Treatment		Ingestion of Poison or harmful objects/ Substances
	Complication of previous injury		Internal Injuries
	Concussion, no loss of consciousness		Lacerations involving tendons or organs



	Requiring medical assessment		
	Dental injuries (avulsion of teeth)		Multiple Fractures
	Dislocation		Near Drowning
	Extensive Burns (second or third Degree)		Other injury considered serious by Physician or health care professional
	Extensive Frostbite (second or third Degree)		Potential Closed Head Injury
	Eye Injuries		
	Fracture		
	Head Injury with loss of consciousness		

Circumstances Surrounding the Serious Injury (check all that apply):

	Attempted Suicide		Self-Injurious Behavior
	Person served to person served		Sports/activity related
	Fall		Staff to person served
	Other – Describe:		Restraint
	Unknown		

Injury Type Specifics:

Describe how serious injury occurred:

Describe the medical attention received and when:

Describe any medication changes since the time of the serious injury:

Describe any follow-up appointments, assessments, or medical services needed since the serious injury:

Describe any changes to the abuse prevention plan or individual programming as a result of the serious injury:

Describe any policies, protocols, or staff straining being implemented to address this issue:

V. DIAGNOSTIC INFORMATION



DD/ID and Personality Disorders:

Medical Conditions:

Psychiatric Dx:

Medications (use a separate sheet if necessary)

Medication Name	Dosage	Frequency

Please attach supporting documentation

Complete this form and fax to 651-797-1950



--- Example ---

BIRF Report

Provider NPI/UMPI Code:

Provider Name/Address:

Provider Phone Number:

Provider Email:

Services Provided at the time of the intervention:

Person Completed this form:

Complete Affirmation Statements:

Person Receiving Services:

Name –

Date of Birth –

Gender –

Diagnosis:

Prescribed Psychotropic Medications:

Type of service plans:

Positive Support Transition Plan?

Functional Behavior Assessment Plan?

Diagnostic Assessment Plan?

Does the person have any conditions for which physical intervention is contraindicated? Date of Intervention:

Time intervention began –

Intervention Location Type –

Intervention Location Address –

Provider staff involved in the behavior intervention:

Name –

Title –

Displayed behaviors resulting in intervention:



Self-injury/physically injures or harms self?

Self-endangerment/risks personal safety?

Property destruction/property damage that could harm the person or other people? Other behavior?

De-escalation Efforts:

Time when de-escalation occurred –

Length of time involved in de-escalation efforts –

Describe the less restrictive alternative methods that were attempted, if any, to de-escalate the situation and maintain safety before the intervention occurred.

Interventions Used:

Total Time:

Number of Uses:

Manual/physical hold?

Mechanical restraint?

Wearing of self-harm/Self-injury protection equipment?

Wearing seat belt restraints?

Time out from activities?

Room time-out/seclusion?

Penalty consequences?

Single incidents vs. multiple episode clarification:

Other Interventions used for displayed behaviors:

PRN?

Called 911?

Emergency Psychiatric hospitalization?

None?

Need for specialized and intensive behavioral consultation and support services from outside professionals?

Is there a plan for a crisis respite placement?

Will there be a temporary suspension from services?

Will there be discharge or termination from further services?

Injuries:



To staff?

To others?

Injury Care:

Type of Injury:

Post intervention debriefing sessions with:

The person receiving the intervention.

The staff involved?

Others involved?

Notification of incident and intervention usage:

County/Tribal Lead Agency funding the provided services:

County or Tribe where the services are actually provided:

--- Example ---

Death Report

(If all information is not available within 24 hours, please submit the report with the information you have.)

Date of report:

I. PERSON SERVED INFORMATION

First Name:

MI:

Last Name:

Person's Facility Name (if applicable):

Address:

Apt/Suite #:

City: County: State: Zip Code: Gender: ___ Female ___ Male ___ Other

Date of Birth:

Date of Death:

Time of Death: AM/PM

Ethnicity:

	African		Choose not to respond
	African American		Hispanic or Latino
	American Indian or Native Alaskan		Other



	Asian		Pacific Islander or Native Hawaiian
	Caucasian or White		

Legal Representatives (check all that apply):

	Health Care Agent		Private Conservator
	Health Care Directive		Private Guardian
	None		Public Guardian
	Nonparent/Relative		Representative Payee
	Parent		Substitute Decision Maker (Commitment Statute 253B.092)
	Power of Attorney		Tribal Custody
	Power of Attorney for Health Care Agent		

Legal Status at Time of Death (Check all that apply):

	Committed – Chemical Dependency (CD)		Juvenile Court Placement
	Committed – Developmental Disability (DD)		None
	Committed – Mentally Ill (MI)		Probation
	Committed – Mentally Ill and Dangerous (MI & D)		Provisional Discharge
	Committed – Sexual Psychopathic Personality (SPP)		Rule 20
	Committed – Sexually Dangerous Person (SDP)		Stay of Commitment
	Emergency Hold Court Hold		Unknown



	Incarcerated (Jail or Prison)		Voluntary Admission
	Informal Juvenile Placement by Parents		

Person served Category (check all that apply):

	Brain Injury		Mental Illness
	Chemical Dependency/Substance Use Disorder		Mentally Ill and Dangerous
	Developmental/Intellectual Disabilities		Other
	Emotional Disturbance		Sex Offender

II. REPORTER INFORMATION

First name:

Last name:

Title:

Agency/Program name (if applicable):

Address:

Apt/Suite #:

City: State: Zip Code:

Contact number: Ext.:

Fax number:

Other Agencies Involved/Referred to/Notified (check all that apply):

	Administration		Licensing Agency
	Adult or Child Protection or CEP		Medical Resources Health Care Provider
	Attorney Legal		Office of Health Facility Complaints
	County Agency		Other – Describe:
	Facility or Program or Agency Staff		Other Advocacy or Ombudsman Agency



	Guardian or Legal Representative		Private Agency
	Hospital Review Board		State Agency
	Law Enforcement		Treatment Team



III. DEATH INFORMATION

Did the person die where they lived? ___ Yes ___ No

If not, Name of Agency, Facility, or Program where death occurred (if applicable):

Address:

City: _____ State: _____ Zip Code: _____

Telephone #:

Fax #:

County:

Date admitted to place of death:

Death Type (check one):

	Accident		Natural
	Could not be determined		Pending Investigation
	Homicide		Suicide

Was death expected: ___ Yes ___ No

Hospice Care: ___ Yes ___ No

Limited Treatment: ___ Yes ___ No

DNR/DNI Order: ___ Yes ___ No

Autopsy Ordered: ___ Yes ___ No

Cause of Death:

Circumstances Surrounding Death:

IV. DIAGNOSTIC INFORMATION

DD/ID and Personality Disorders:

Medical Conditions:

Psychiatric Dx:

Medications (use a separate sheet if necessary)

Medication Name	Dosage	Frequency

Please attach supporting documentation
 Complete this form and fax to 651-797-1950

