HARBOR REGIONAL CENTER
Special Incident Report
For Harbor Vendors and Long-Term Care Facilities

Instructions for provider Special Incident Reporting (Cal. Code of Regulations Title 17, § 54327)

1. Verbally notify Harbor within 24 hours of incident by calling the assigned Service Coordinator or Service Coordinator of the Day. If it is after-hours, call the On-Call Manager at (310) 540-1711
2. Submit written SIR within 48 hours of the incident by email: sirs@harborrc.org
3. Notify the appropriate licensing agency according to Title 22 regulations, if applicable
4. Notify authorities (APS, CPS, LTC Ombudsman, Law Enforcement) per mandated reporting requirements for SIRs involving a victim of crime and/or an allegation of abuse or neglect

Individual's Name: _____ **UCI #:** _____ **DOB:** _____

Service Coordinator: _____ **Vendor #:** _____

Incident Date: _____ **Incident Time:** _____ ☐ **AM** ☐ **PM** ☐ **Unknown**

Date Vendor LEARNED of Incident: _____ **Date Vendor CALLED Harbor:** _____

Date Vendor submitted WRITTEN Report: _____

Incident Location: _____ **Red boxes require a response - indicate N/A if not applicable*

1. INCIDENT TYPE(S) – CHECK ALL THAT APPLY

☐ **Death**
☐ **Medication Error**
(Fill out section 7)

Victim of a Crime
- ☐ Aggravated Assault
- ☐ Burglary
- ☐ Larceny
- ☐ Personal Robbery
- ☐ Rape or Attempted Rape

Suspected Abuse/Exploitation
(Fill out Section 8)
- ☐ Alleged Violation of Rights
- ☐ Emotional/Mental Abuse
- ☐ Financial Abuse
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Physical/Chemical Restraint

Suspected Neglect / Failure To
(Fill out Section 8)
- ☐ Assist w/ Personal Hygiene
- ☐ Prevent Malnutrition/Dehydration
- ☐ Protect From Health/Safety Hazard
- ☐ Provide Care - Elder/Adult
- ☐ Provide Food/Clothing/Shelter
- ☐ Provide Medical Care

Missing Person
- ☐ Missing Person – Law Enforcement Notified
- ☐ Missing Person - Law Enforcement Not Notified

Medical Treatment – Beyond First Aid
(Fill out Section 6)
- ☐ Bites That Break The Skin
- ☐ Burns
- ☐ Choking
- ☐ Dislocation
- ☐ Fracture
- ☐ Internal Bleeding
- ☐ Laceration Requiring
- ☐ Sutures/Staples/Dermabond
- ☐ Puncture Wounds Requiring Treatment

Unplanned/Unscheduled Hospitalization Due To
(Fill out Section 6)
- ☐ Cardiac-related
- ☐ Diabetes-related
- ☐ Seizure-related
- ☐ Internal Infection
- ☐ Nutritional Deficiency
- ☐ Respiratory Illness
- ☐ Wound/Skin Care
- ☐ Involuntary Psychiatric Hospitalization
- ☐ Voluntary Psychiatric Hospitalization
- ☐ Other:

Behavioral Acts
- ☐ Aggressive Act Involving A Weapon
- ☐ Aggressive Act To Another Individual
- ☐ Aggressive Act To Family/Visitors
- ☐ Aggressive Act To Self
- ☐ Aggressive Act To Staff
- ☐ Arrest/Detainment
- ☐ Drug/Alcohol Abuse
- ☐ Fire Setting
- ☐ Psych Emergency Team/No Hospitalization
- ☐ Property Damage
- ☐ Severe Verbal Threats
- ☐ Suicide Threat
- ☐ Suicide Attempt

Injury From
- ☐ Accident
- ☐ Another Individual
- ☐ Behavior Episode
- ☐ Seizure
- ☐ Unknown Origin

Other
- ☐ Disease Outbreak
- ☐ Sexual Misconduct
- ☐ Other:

2. AGENCIES NOTIFIED AND/OR INVOLVED

	Contact Name	Date Notified	Phone #	Report #
Community Care Licensing (DSS)				
Health Care Licensing (DHS)				
Parent/Guardian/Conservator				
Law Enforcement				
Adult Protective Services				
Child Protective Services				
Long-Term Care Ombudsman				
Other				

3. DESCRIPTION OF INCIDENT

(who/what/where/when/why, description of perpetrator, treatment administered, transported to hospital, etc.)

4. SPECIFIC PREVENTATIVE ACTION TAKEN/PLAN TO PREVENT REOCCURRENCE

(new or modified services/supports/equipment, follow-up care, next planning team meeting, trainings etc.)

5. ACTION(S) TAKEN BY VENDOR IN RESPONSE TO SPECIAL INCIDENT

☐ Staff Training ☐ Staff Terminated ☐ Planning Team Meeting ☐ Referral to Clinical Services

☐ Staff Suspended ☐ Policies Revised ☐ Review/Revise Behavioral Plan ☐ Other:

6. FOR HOSPITALIZATIONS & ER VISITS ☐ NOT APPLICABLE

Hospital Name: _____ **Admission Date:** _____

Diagnosis (if available): _____

Discharge Date (if available): _____ **Discharged To (if available):** _____

Follow-up needed after discharge (i.e. PT, specialist appointment) (if available): _____

Did individual require additional support/equipment? _____

Medication Changes (if applicable): _____

7. FOR MEDICATION ERRORS ☐ NOT APPLICABLE

Type of Medication Error (check all that apply)

☐ **Missed Dose** ☐ **Wrong Medication** ☐ **Wrong Time** ☐ **Medication Refusal**
☐ **Wrong Dose** ☐ **Wrong Person** ☐ **Wrong Route** ☐ **Documentation Error**

Name and dosage of medication(s):

Any adverse reactions? _____

Day(s) affected by medication error: _____

Primary Care Physician (MD, NP, PA, or Psychiatrist) notification (name & date): _____

8. FOR ALLEGED PERPETRATOR ☐ NOT APPLICABLE

Name of Alleged Perpetrator: _____

Relationship to Individual: ☐ **Another Individual Served** ☐ **Relative/Family Member** ☐ **Vendor/Employee of Vendor**
☐ **Other Person Known to Individual** ☐ **Unknown** ☐ **Other:**

*If individual required medical attention due to abuse/neglect, fill out Section 6 “Hospitalization & ER visit” above

Was there a witness to the alleged abuse/neglect? ☐ **Yes** ☐ **No** **If yes, fill out contact information below**

Witness Name: _____ **Address:** _____ **Phone #:** _____

*If there are multiple witnesses, include their names and contact information in Section 3 above

9. REPORT SUBMITTED BY

Name: _____ **Title:** _____

Vendor Name: _____ **Contact E-mail:** _____

Date Completed: _____ **Telephone #:** _____