Print Form

INNOVATIONS INCIDENT REPORTING
FOR FAILURE TO PROVIDE BACK-UP STAFFING

Consumer's Name: _____ Consumer DOB: _____

County of Service Provision: _____

Date of Incident: _____ Time of Incident: _____ ☐AM ☐PM

Location where services were scheduled to occur: _____

Name of person(s) who discovered issue: _____

Name of Provider Agency: _____ Contact Number: _____

Provider Agency Address: _____

Name of Provider to provide staffing: _____ Contact Number: _____

☐ ***Back-up staffing not available (as applicable)***

Indicate name of service(s): _____

Indicate the number of hours consumer was without staff: _____

Indicate specific reason back-up staffing was not available:

_____

_____

What options were provided to the consumer/legally responsible person?

_____

_____

Who was notified of the incident (list names)?_____

How was the consumer's health and safety ensured? _____

How was time covered? _____

What follow-up was provided to consumer/legally responsible person? _____

What corrective measures will your agency implement to prevent this from occurring in the future?

_____

_____

☐ ***Back-up staffing offered but declined by consumer/legally responsible person (as applicable)***

Indicate name of service(s): _____

Indicate the number of hours consumer was without staff: _____

Indicate reason consumer/legally responsible person declined back-up staffing:

_____

_____

Who was notified of the incident? _____

Signature/Credentials of person completing form: _____ Date: _____

Supervisor Action: ☐ **Action Pending** ☐ **Action Complete**

_____

_____

Signature/Credentials _____ Date: _____

Quality Management Action: ☐ **Action Pending** ☐ **Action Complete**

_____

_____

Signature/Credentials _____ Date: _____