5122-2-25 Attachment B

MAJOR INCIDENT REPORTING FORM

Hospital:	Incident No.	Category	Incident Adm Cat:	Incident Type:
		Major		

Incident Date:	Incident Time:	Reported Date:	Reported Time:	Discharge Date of Patient: (if applicable)	Discharge Time:

Location where Incident Occurred:

Participants Involved: (Identify participants such as "Alleged Victim(s)," "Alleged Perpetrator(s),", "Witness(es)," or "Others." If an employee, state full name and position. If a patient/client, use non-patient identifier and legal status.)

No.	IDENTIFIER	NAME: PATIENT/EMPLOYEE/OTHER	PATIENTS/EMPLOYEES ID	INVOLVEMENT	POSITION: Employee Only
1.					
2.					
3.					
4.					
5.					

OSHP Notified? (Identify Trooper name, mode and time of notification.)

Facts of Incident: (Brief summary overview of the facts as determined at the time of report to Central Office).

Action Plan (Immediate plan to mitigate problem):

Document Date:

After reviewing the requirements does this required an M&M?

Initial Review Due Date:

Copy the following individuals:

Tracy J. Plouck, Director
Dr. Mark Hurst, Medical Director
Karl Donenwirth, Deputy Director, Hospital Services
Dr. Justin Trevino, Asst., Medical Director
Lalita Jambhale, QA/PI Director, Hospital Services
Michaela Peterson, Chief Legal Counsel
Latonya White, Medical Director Office
Marc Baumgarten, Chief of Legal Office
Nacrina Alvarez de Blanco, Security Consultant
RPH Police Chief

Submit Major Incident To Central Office

OhioMHAS Morbidity, Mortality and Reviewable Sentinel Event Report Form

I. INITIAL REVIEW (Due by 5pm of the second business day following the event or its discovery)

Date discovered	
Date of Incident	Incident No.

Hospital/CSN Name	Patient Name	Date of Initial Review

PATIENT'S ID No.	Sex	Date of Birth	Age	Date Submitted

Admission Date	Discharge Date	Race/Ethnicity	
		☐ Amer. Indian ☐ AA/Black ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Other	Patient Informed ☐ Yes ☐ No; explain _____ Guardian Informed ☐ Yes ☐ No ☐ N/A Family Informed ☐ Yes ☐ Pt. refused IC ☐ Other

Legal Status

☐ Emerg ☐ Prob C ☐ Vol ☐ Forensic: _____ ☐ Other, provide# _____

Type of event: _____

Description of the Event (include date, time, place, sequence of events, and relevant background information):

Diagnoses (Psychiatric, Substance Use, Other Medical Diagnosis):

Medications:

List of problems identified in initial review:

Initial Review Actions

Actions to reduce risk of recurrence to involved patient

Action	Person Responsible
1.	
2.	
3.	
4.	
5.	

Description of other patients at risk for similar event:

Immediated actions to reduce risk of recurrence to other patients

Action	Person Responsible
1.	
2.	
3.	
4.	
5.	

Actions to Prepare for Root Cause Analysis (RCA)	
Action	Person Responsible
1.	
2.	
3.	
4.	
5.	

Initial Review Participants(CCO/designee and at least two M&M member inclusive of treatment team members)	
Name/Title	Name/Title (continued)
1.	2.
2.	4.
3.	6.
Statewide safety alert recommendation: ☐ Yes ☐ No	
If yes, RPH suggestion for content of safety alert:	

Date to Remember

RCA Review Due Date: _____

Please send the RCA report to the following:

Central Office Morbidity & Mortality Group:

RCA Review Submission