BACK-UP STAFFING INCIDENT REPORTING FORM

Participant Name: _____ Participant 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 EOR: _____ Contact Number: _____

EOR 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 hour's participant was without staff: _____

Indicate specific reason back-up staffing was not available: _____

What options were provided to the participant /legally responsible person? _____

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

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

How was time covered? _____

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

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

_____

_____

_____

_____

_____*Back-up staffing available but declined by participant/legally responsible person (as applicable)*

Indicate name of service	Number of hours participant was without staff

If the week has the end/beginning of a month, the hours should be separated by the month, so two reports should be completed (for reporting purposes)

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

_____

_____

Who was notified of the incident? _____

_____ _____

Signature/Credentials of person completing form: Date:

EOR Action: _____**Action Pending** _____**Action Complete**

_____

EOR Signature: _____ **Date:** _____

Quality Management Action: _____ **Action Pending** _____ **Action Complete**

_____

_____

Signature/Credentials _____ Date: _____

Email or Fax to Quality Management Coordinator
Fax: 252-215-6880
Email Address: IncidentReporting@TrilliumnNC.org