

# Operational Incident Report Form



This form must be completed immediately after a reportable event occurs.

- To be completed by individual with the most knowledge of the event and/or their immediate supervisor.
- Completed Form must be submitted to Supervisor immediately for review/signature.
- Completed Form with required attachments must be submitted within the next business day for timely processing: > *Completed Operational Incident Forms must be submitted to the SHP Risk Manager and Compliance Department.*

## General Information

Company/Facility Name: Location:

Report prepared by: Title:

Email: Phone:

## Incident Information

**IMPORTANT: If a Member or Employee was harmed during the event, please use the Member or Employee Incident Report Forms as required, not this Operational Incident Report Form.**

Incident Type:

- Facility Emergency** (Including, but not limited to: Fire; Flood, Natural Disasters, etc.)
- Breach of SHP Confidentiality or Privacy Standards**
- Reporting of Near Misses/Close Call(s)**
- Lost or Stolen of PHI/SHP Data/Equipment**
- Threats to Personal Safety/Hazards or Unsafe Work Conditions**
- Unapproved Deviation of Policies/Protocols**

Date(s) of Incident: Time of Incident: Date Reported:

Did the incident occur at the SHP office? Yes No Did the incident impact any Members? (if yes, Member Information Form required) Yes No Location of Incident:

Location Details:

Provide a narrative of the incident including a timeline of events. The incident should be described in sufficient detail to allow for an understanding of the nature and consequences of the incident. Include a description of the following information as applicable:

- The incident/violation location (e.g. SHP office, member event, via internet communication, employee home).
- Who was involved in the incident/violation, including others present at the incident location?
- Actions taken immediately following the incident/violation, and by whom, to limit any consequences of the event.
- Whether there was any deviation from approved Protocols (P&Ps/SOPs) at the time of the incident/violation. ■

The steps taken to mitigate this event at the time of the incident/violation.

- Any surveillance and/or communications conducted after the incident.
- Any perceived Member or employee impact associated with the incident.
- Loss or stolen equipment (document date/time of last known location of equipment and time/date one realized equipment was loss or stolen).
- Stolen equipment (document if a police report was generated for this theft and how quickly they were called).

**Employee(s)** (Names of individuals involved in incident):

(1) Name: Role: Address: Phone:

Activities of the above individuals at the time of incident:

Did Employee(s) deviate from approved protocols? Yes No

(2) Name: Role: Address: Phone:

Activities of the above individuals at the time of incident:

Did Employee(s) deviate from approved protocols? Yes No

**Visitor(s)/Witness(s)** (Names of individuals involved in incident):

(1) Name: Role: Address: Phone:

Activities of the above individuals at the time of incident:

Name: Role:

Address: Phone: Activities of the above individuals at the time of incident:

Any Police complaint/report filed: Yes No

Police Report Number and Details:

Employee Signature: Date/Time: **Supervisor Signature**

Supervisor Signature: Date/Time:

**Risk Manager and Compliance Department Complete the Rest of This Form**

*Please submit completed Form and required Attachments to company's Risk Manager at [cbaker@sonderhealthplans.com](mailto:cbaker@sonderhealthplans.com) and Compliance Department at [compliancedepartment@sonderhealthplans.com](mailto:compliancedepartment@sonderhealthplans.com).*

Risk Manager Received Date/Time:

Risk Manager or Designee:

Risk Manager Signature:

### Investigator Comments/Notes

*For Risk Mgmt & Compliance Only*

### Investigative Review & Summary

*Below Sections are for Compliance & Risk Mgmt Completion Only*

Date Form Received: Incident Reporting Age/Lag:

#### Identified Root Cause of Incident or Near-Miss Event: (Check all that apply)

Deviation of Approved P&Ps/SOPs Without Permission  
Using Authorized System/Access in an Unapproved Way

Inadequate Security Protocols

Inadequate Privacy Protocols

Inadequate Security Training

Inadequate Privacy Training

Other:

#### What changes are suggested to prevent this incident/near miss from happening again?

Establish New Security Controls

Establish New Privacy Controls

Train the Employee(s)

Train the Supervisor(s)

Redesign Work Station/Work Areas

Write a New P&P and/or SOP

Enforce Existing Policy(ies)

Establish a New Routine Monitoring for Risk

Other:

Describe measures taken to mitigate any problems identified. For measures identified but not yet taken, please include a timeline for their implementation: (use additional space as necessary)

Will or was this event reported to external entities and/or regulatory agencies?: Yes No *If yes, please identify what agencies and the date(s) reported or to be reported:*

DHHS Date Rpted:

Other ( ) Date Rpted:

CMS Date Rpted: GA State Date Rpted:

Report Submitted to/Name: Title: Signature: Date/Time:

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## Member Information Form

*If more than*

***1 Member has been impacted by the event, submitter may submit a spreadsheet with the below information to submit in lieu of completing individual Member Information Forms for this submittal. If no Member(s) were impacted, such as a near-miss, please do not leave this page blank and write N/A for Not Applicable on this page.***

Member's Name: D/O/B: Member's Address:

Member ID: Phone:

Identify how this individual Member was impacted by the event below, please be specific, must include all elements disclosed per Member for required breach notifications:

(e.g.: Unauthorized disclosure of their D/O/B, Treatment Dates of Service, email, etc.)

