State of Connecticut Department of Developmental Services (DDS) – Incident Report - 255 OH/Fam (1.D.PR.009a Att A)

1 - Individual Name:_____ **DDS#** _____ **Incident** date:_____/_____/_____

Responsible **Provider**:_____ Date of this **Report**:_____/_____/_____

Responsible **Program**:_____ ☐**R**es, ☐**D**ay, ☐**O**ther, Rdid#_____

If **not** directly at responsible program: ☐**COM**munity, ☐**F**am **H**ome **V**isit, ☐**REC**reation/leisure**,** ☐**VEH**icle, ☐**OTH**er:_____

2a – INJURY ☐**O**bserved, ☐**D**iscovered at: _____:_____ ☐**A**m ☐**P**m , Time of **treatment**: _____:_____ ☐**A**m ☐**P**m

If different than incident date; **Treatment** date:_____/_____/_____

Cause: ☐**AD**aptive **E**q ☐**EA**ting **B**ehavior ☐**FO**od **C**onsistency ☐**M**otor **V**ehicle ☐**SeLF** caused
☐**AS**sa**U**lt ☐**ENV**ironment ☐**ING**estion of foreign material ☐**RES**traint ☐**SHA**ving
☐**BUM**ped Into ☐**EXP**osure ☐**I**n**S**ect **B**ite ☐**SCR**atching/picking ☐**UND**etermined
☐**CLO**thing ☐**FAL**L ☐**ME**dical **P**rocedure ☐**SEI**zure ☐**OTH**er:_____

Injured **by whom**: ☐**ACC**ident by Individual, ☐other **IND**ividual, ☐**FAM**ily member, ☐**SIB**, ☐**STA**ff, ☐**UNK**nown, ☐ **OTH**er:_____

Type: ☐**ABR**asion/scrape ☐**BLE**eding ☐**CHO**king ☐**FRA**cture ☐**PUN**cture ☐**SPR**ain/strain
☐**AIR**way obstructed ☐**BRU**ise ☐**CUT** ☐indication of **PAI**n ☐**RAS**h/hives ☐swelling/ **EDE**ma
☐**BIT**e ☐**B**u**RN** ☐**DIS**location ☐**POI**son ☐**OTH**er:_____

Severity of injury: ☐**MOD**erate (nurse/MD treatment – only for **M**otor **V**ehicle Accident), ☐**SEV**ere (hospital, ER/admission), ☐**DEA**th

Treatment provided, highest level: ☐**NON**e, ☐**SeLF**, ☐**FAM**ily, ☐**STA**ff/LPN, ☐RN **NUR**se, ☐**PHY**sician/other medical, ☐ER/**HOS**pital

Body part(s): ☐**ABD**omen ☐**BUT**tocks ☐**EYE** L R ☐**GEN**itals ☐**INT**ernal ☐**MouTH** ☐**SHO**ulder L R ☐**TON**gue
(up to 3) ☐**ANK**le L R ☐**CHE**st ☐**FAC**e ☐**HAN**d L R ☐**KNE**e L R ☐**NEC**k ☐**TEE**th ☐**WRI**st L R
and circle L or R ☐**ARM** L R ☐**EAR** L R ☐**FIN**gers L R ☐**HEaD** ☐**LEG** L R ☐**NOS**e ☐**THR**oat
☐**BAC**k ☐**ElB**ow L R ☐**FOoT** L R ☐**HIP** L R ☐**LIP**s ☐**REC**tum ☐**TOE** L R

2b – UNUSUAL **-** All dangerous / life threatening, illegal, police/fire, significant first/rare. Also 'significant behavior **not** covered by program/guideline'

Time:_____:_____ ☐ **A**m ☐ **P**m

Type: ☐**AWoL / M**issing Person ☐**P**olice **AR**rest ☐**V**ictim **A**ggravated **A**ssault ☐**V**ictim **T**heft /**L**arceny
☐**FIR**e Emergency Response ☐medical **ER A**dmit ☐**V**ictim **F**orcible **R**ape

2c – RESTRAINT Final **Date OUT**:_____/_____/_____, Either: Time **IN** : ____:____ ☐**A**m ☐**P**m, Time **OUT**:____:____ ☐**A**m ☐**P**m

Restraint(s): ☐**CHE**mical ☐**H**eld **B**y **A**rms ☐**N**on-**S**tandard **C**ommissioner ok
(up to 4) ☐**FL**oor control-**P**rone (Face Down) ☐**L**ifted **A**nd **C**arried ☐**N**on-**S**tandard **N**ot-approved
☐**FL**oor control-**S**upine (Face Up) ☐**PH**ysical **I**solation
☐**F**our-**P**oin**T** ☐**S**afety **C**u**F**fs

Behavior(s): ☐**ADL** completion ☐**DIS**ruptive behavior ☐**SEL**f-endangering
(up to 4) ☐**AG**gressor to **Individual** ☐**P**roperty **D**estruction ☐**SIB**
☐**AG**gressor to **S**taff ☐**RUN**ning away

Status: ☐**E**mergency ☐**P**rc/hrc approved
Injury **caused** by restraint: ☐**Y**es ☐**N**o
Monitoring, at least every 30 min: ☐**Y**es ☐**N**o
Exercise, at least 10 min every hr: ☐**Y**es ☐**N**o

Person(s) **Applying**: _____
In-Charge during: _____**Authorizing** signature:_____
Person(s) **Removing**: _____

3 – Summary / Comments include events surrounding / interventions:

☐also see attached

Reporter's **Name/title**:_____ ☐entered in log book/notes

Reporter's **Relationship** to Individual: ☐ Family,
☐Self, ☐Staff, ☐Other:_____

Abuse / **Neglect** suspected?: ☐**Y**es ☐**N**o, if "yes"; **Reported**:___/___/___to:_____

Person Completing form **Signature**: _____

4 - Supervisor review (Private Providers Only) on: _____/_____/_____ Follow-Up:

☐team to review ☐guardian/PRRP notified ☐also see attached

Other review: on: _____/_____/_____ Follow-Up:

☐White-Individual file, ☐yellow-DDS data entry, ☐pink-DDS case manager CAMRIS entered on:_____/ _____/ _____ by:_____