

State of Connecticut DDS – Incident Report – Form 255

Critical Incident? Yes No

1 - Client Name: _____ DDS#: _____ Incident Date: __/__/____
 Responsible Provider: _____ Date of this Report: __/__/____ DDS Case Mgr Name: _____
 Responsible Program: _____ Res, Day, Other, Rdid#: _____
 If not directly at responsible program: COMmunity, Fam Home Visit, RECreation/leisure, VEHicle, OTHer: _____
 Service Group: Intellectual Disability, Autism Spectrum Disorder, OBRA

2a – INJURY		<input type="checkbox"/> Observed <input type="checkbox"/> Discovered at: __:__ <input type="checkbox"/> Am <input type="checkbox"/> Pm , Time of treatment: __:__ <input type="checkbox"/> Am <input type="checkbox"/> Pm	
If different than incident date; Treatment date: __/__/____			
Cause: <input type="checkbox"/> ADaptive Eq <input type="checkbox"/> EAting Behavior <input type="checkbox"/> FOod Consistency <input type="checkbox"/> MOtor Vehicle <input type="checkbox"/> SeLF caused			
<input type="checkbox"/> ASsaUlt <input type="checkbox"/> ENVIronment <input type="checkbox"/> INGestion of foreign material <input type="checkbox"/> REStraint <input type="checkbox"/> SHAving			
<input type="checkbox"/> BUMped Into <input type="checkbox"/> EXPosure <input type="checkbox"/> InSect Bite <input type="checkbox"/> SCRatching/picking <input type="checkbox"/> UNDEtermined			
<input type="checkbox"/> CLOthing <input type="checkbox"/> FALL <input type="checkbox"/> MEDical Procedure <input type="checkbox"/> SEIzure <input type="checkbox"/> OTHer: _____			
Injured by whom: <input type="checkbox"/> ACCident by client, <input type="checkbox"/> other CLient, <input type="checkbox"/> FAMily member, <input type="checkbox"/> SIB, <input type="checkbox"/> STAff, <input type="checkbox"/> UNKNown, <input type="checkbox"/> OTHer: _____			
Type: <input type="checkbox"/> ABRasion/scrape <input type="checkbox"/> BLEeding <input type="checkbox"/> CHOKing <input type="checkbox"/> FRActure <input type="checkbox"/> PUNcture <input type="checkbox"/> SPRain/strain			
<input type="checkbox"/> AIRway obstructed <input type="checkbox"/> BRUise <input type="checkbox"/> CUT <input type="checkbox"/> indication of PAIn <input type="checkbox"/> RASH/hives <input type="checkbox"/> swelling/ EDEma			
<input type="checkbox"/> BITe <input type="checkbox"/> BuRN <input type="checkbox"/> DISlocation <input type="checkbox"/> POIson <input type="checkbox"/> OTHer: _____			
Severity of injury: <input type="checkbox"/> MODerate (nurse/MD treatment), <input type="checkbox"/> SEVere (hospital, ER/admission), <input type="checkbox"/> DEATH			
Treatment provided, highest level: <input type="checkbox"/> NONE, <input type="checkbox"/> SeLF, <input type="checkbox"/> FAMily, <input type="checkbox"/> STAff/LPN, <input type="checkbox"/> RN NURse, <input type="checkbox"/> PHYsician/other medical, <input type="checkbox"/> ER/HOSPital			
Body part(s): <input type="checkbox"/> ABDomen <input type="checkbox"/> BUTtocks <input type="checkbox"/> EYE <input type="checkbox"/> GENitals <input type="checkbox"/> INTernal <input type="checkbox"/> MOuTH <input type="checkbox"/> SHOulder <input type="checkbox"/> TONGue			
(up to 3) <input type="checkbox"/> ANKle <input type="checkbox"/> CHEst <input type="checkbox"/> FACe <input type="checkbox"/> HANd <input type="checkbox"/> KNEe <input type="checkbox"/> NECK <input type="checkbox"/> TEETH <input type="checkbox"/> WRISt <input type="checkbox"/> R			
and check L or R <input type="checkbox"/> ARM <input type="checkbox"/> EAR <input type="checkbox"/> FINgers <input type="checkbox"/> HEaD <input type="checkbox"/> LEG <input type="checkbox"/> NOSe <input type="checkbox"/> THRoat			
<input type="checkbox"/> BACK <input type="checkbox"/> EIBowl <input type="checkbox"/> FOoT <input type="checkbox"/> HIP <input type="checkbox"/> LIPs <input type="checkbox"/> RECTum <input type="checkbox"/> TOE <input type="checkbox"/> R			

2b – UNUSUAL		- All dangerous / life threatening, illegal, police/fire, significant first/rare. Also 'significant behavior <u>not</u> covered by program/guideline'	
Time: __:__ <input type="checkbox"/> Am <input type="checkbox"/> Pm			
Type: <input type="checkbox"/> ACCident no apparent injury <input type="checkbox"/> Fire No Emg Response <input type="checkbox"/> PSYch ER Admit <input type="checkbox"/> Victim Forcible Rape			
<input type="checkbox"/> accident VEHicle no apparent injury <input type="checkbox"/> medical ER Admit <input type="checkbox"/> PSYch ER No admit <input type="checkbox"/> Victim PHYsical other			
<input type="checkbox"/> Aggressor PHYSical alleged <input type="checkbox"/> medical ER No admit <input type="checkbox"/> ReFused Medication <input type="checkbox"/> Victim Theft /Larceny			
<input type="checkbox"/> Aggressor SeXual alleged <input type="checkbox"/> PICa <input type="checkbox"/> Self ENdangering/sib <input type="checkbox"/> Victim SeXual other			
<input type="checkbox"/> AWoL / Missing Person <input type="checkbox"/> Police ARrest <input type="checkbox"/> Victim Aggravated Assault <input type="checkbox"/> Wrong Food Consistency			
<input type="checkbox"/> FIRE Emergency Response <input type="checkbox"/> POLice no-arrest <input type="checkbox"/> BEHAVior other:			

2c – RESTRAINT		Final Date OUT: __/__/____, Either: Time IN : __:__ <input type="checkbox"/> Am <input type="checkbox"/> Pm, Time OUT: __:__ <input type="checkbox"/> Am <input type="checkbox"/> Pm	
Or, if approved multiple type (see approved list): Total Hrs: __ Min: __ and Total Occurrences: __			
Restraint(s): <input type="checkbox"/> B-Safety Belt <input type="checkbox"/> FLoor control-Supine (Face Up) <input type="checkbox"/> Safety CuFfs <input type="checkbox"/> Non-Standard Not-approved			
(up to 4) <input type="checkbox"/> Body boaRD <input type="checkbox"/> Four-Point <input type="checkbox"/> Sitting Floor Control			
<input type="checkbox"/> CHEmical <input type="checkbox"/> Lifted And Carried <input type="checkbox"/> Standing Restraint Holds			
<input type="checkbox"/> ESCort <input type="checkbox"/> PHYSical Isolation <input type="checkbox"/> Non-Standard Commissioner approved			
Behavior(s): <input type="checkbox"/> AGgressor to Client <input type="checkbox"/> PICa <input type="checkbox"/> RUNning away			
(up to 4) <input type="checkbox"/> AGgressor to Staff <input type="checkbox"/> Property Destruction <input type="checkbox"/> SELf-endangering			
<input type="checkbox"/> DISruptive behavior <input type="checkbox"/> REMove sutures,tubes,etc <input type="checkbox"/> Self Injurious Behavior			
Status: <input type="checkbox"/> Emergency <input type="checkbox"/> Prc/hrc approved		Person(s) Applying: _____	
Injury caused by restraint: <input type="checkbox"/> Yes <input type="checkbox"/> No		In-Charge during: _____ Authorizing signature: _____	
Monitoring, at least every 30 min: <input type="checkbox"/> Yes <input type="checkbox"/> No		Person(s) Removing: _____	
Exercise, at least 10 min every hr: <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency restraint trauma check within 24 hrs by: _____	

3 – Summary / Comments include events surrounding / interventions:

also see attached

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

Reporter's Relationship to client: Family, Abuse / Neglect suspected?: Yes No, if "yes"; Reported: __/__/____ to: _____

Self, Staff, Other: _____ Person Completing form Signature: _____

4 - Supervisor review: _____ on: __/__/____ Follow-Up: _____

team to review guardian/PRRP notified also see attached

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

Critical Incident? Yes No, if "yes" immediate phone call to DDS Regional Administration required. Completed: __/__/____