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**: _____ ☐**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: _____

Service Group: ☐**I**ntellectual **D**isability, ☐**A**utism **S**pectrum **D**isorder, ☐**OBRA**

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 client, ☐other **CLI**ent, ☐**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), ☐**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 ☐**M**ou**TH** ☐**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 check L or R ☐**ARM** L☐R☐ ☐**EAR** L☐R☐ ☐ **FIN**gers L☐R☐ ☐**HEa**D ☐**LEG** L☐R☐ ☐**NOS**e ☐**THR**oat
☐**BAC**k ☐ **EIB**owL☐R☐ ☐**FO**o**T** 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: ☐**ACC**ident no apparent injury ☐**F**ire **N**o Emg Response ☐**PS**ych ER **A**dmit ☐**V**ictim **F**orcible **R**ape
☐accident **VEH**icle no apparent injury ☐medical **ER A**dmit ☐**PS**ych ER **N**o admit ☐**V**ictim **PH**ysical other
☐**A**ggressor **PH**ysical alleged ☐medical **ER N**o admit ☐**R**e**F**used **M**edication ☐**V**ictim **T**heft /**L**arceny
☐**A**ggressor **S**e**X**ual alleged ☐**PIC**a ☐**S**elf **EN**dangering/sib ☐**V**ictim **S**e**X**ual other
☐**AWoL /** Missing Person ☐**P**olice **AR**rest ☐**V**ictim **A**ggravated **A**ssault ☐**W**rong **F**ood **C**onsistency
☐**FIR**e Emergency Response ☐**POL**ice no-arrest ☐**BEH**avior other:

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

Or, if approved multiple type (see approved list): Total **Hrs**: __**Min**: __ and Total **Occurrences**: ___

Restraint(s): ☐**B-S**afety **B**elt ☐**FL**oor control-**S**upine (Face Up) ☐**S**afety **C**u**F**fs ☐**N**on-**S**tandard **N**ot-approved
(up to 4) ☐**B**ody boa**RD** ☐**F**our-**P**oin**T** ☐**S**itting **F**loor **C**ontrol
☐**CHE**mical ☐**L**ifted **A**nd **C**arried ☐**S**tanding **R**estraint **H**olds
☐**ESC**ort ☐**PH**ysical **I**solation ☐**N**on-**S**tandard **C**ommissioner approved

Behavior(s): ☐**AG**gressor to **C**lient ☐**PIC**a ☐**RUN**ning away
(up to 4) ☐**AG**gressor to **S**taff ☐**P**roperty **D**estruction ☐**SEL**f-endangering
☐**DIS**ruptive behavior ☐**REM**ove sutures,tubes,etc ☐**S**elf **I**njurious **B**ehavior

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**: _____
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, ☐Self, ☐Staff, ☐Other:

Abuse / **Neglect** suspected?: ☐**Y**es ☐**N**o, if "yes"; **Reported**:__/__/____to: _____
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? ☐ **Y**es ☐ **N**o, if "yes" immediate phone call to DDS Regional Administration required. Completed: __/__/____

☐ Client file, ☐ DDS data entry, ☐ DDS case manager CAMRIS entered on__/__/____by:__ December 2014