



Disability Development Resources, LLC

Providing... Direction. a Difference. Results.

INCIDENT REPORT

Date _____

Time: _____ am./p.m.

INVOLVED: (Check all that apply)

Consumer: _____

DSP: _____

Property/Location: _____ **Site Name:** _____

Vehicle VIN/Plate #: _____ / _____

TYPE OF REPORT: (Check all that apply)

Death/Attempt

- Death
- Suicide
- Suicide Attempt
- Homicide

Accident/Injury (Consumer)

- Home
- Community
- Location Unknown

Accident/Injury (DSP/Other)

- Home
- Community
- Location unknown

Medical (Consumer/DSP/Other)

- First Aid required
- Medical attention required
- Emergency medical attention required
- Suspected/contagious/infectious disease
- Failure to report/respond
- Consumer emergency measure/ Intervention (CIT)
- Emergency services/hospitalization

Medication Related

- Error in dispensing
- Adverse reaction
- Self-administration error
- Medication count error
- Waste of medication
- Medication to wrong Consumer
- Wrong method of administration
- Wrong dosage
- Missed dose
- Error resulting in ER/hospital visit
- Person responsible for error (Name/Title): _____

Human/Civil Rights

Violation/Allegation

- Neglect
- Exploitation
- Mistreatment
- Corporal punishment
- Unreasonable use of force/threat
- Mental/verbal abuse
- Threat of abandonment as punishment
- Retaliatory acts
- Medication as a punishment
- Restraint/seclusion
- Commercial exploitation
- Physical abuse
- Sexual abuse/exploitation
- Programmatic abuse
- Breach of confidentiality (HIPAA/ Article 9)

Consumer Misconduct/Violation/ Allegation

- AWOL/missing
- Property destruction
- Injury to self/others
- Community/public disturbance
- Theft
- Inappropriate sexual behavior
- Law enforcement required
- Use/possession of weapon
- Verbal assault

Vehicle Related

- Theft
- Damage
- Collision
- Injury (DSP/Consumer/Other)
- Death (DSP/Consumer/Other)
- Misuse of vehicle

Site

- Site disaster
- Community complaint
- Health/safety (communication/ water/heating/cooling/electricity)
- Adverse weather condition
- Incident involving news media
- Biohazard

Employee/Other Misconduct Violation/Allegation

- Theft
- Fraud
- Property damage
- Injury to self/others
- Inappropriate sexual behavior
- Community/public disturbance
- Drug use
- Law enforcement required
- Use/possession of weapon
- Violation of no-smoking policy

Complaint/Grievance/Appeal

- Complaint/Grievance/Appeal filed with DSP/Consumer or their family/Responsible Person
- Complaint/Grievance/Appeal filed with employer by DSP

Other

- _____
- _____
- _____
- _____

**Contact
made by
(Initials)**

NOTIFICATION (as applicable):

Director: _____ Date: _____ Time: ____:____ a.m./p.m.
Guardian: _____ Date: _____ Time: ____:____ a.m./p.m.
Other: _____ Date: _____ Time: ____:____ a.m./p.m.

DDD REPRESENTATIVE CONTACTED (as applicable):

Support Coordinator: _____ Date: _____ Time: ____:____ a.m./p.m.
Other: _____ Date: _____ Time: ____:____ a.m./p.m.

SPECIFIC AUTHORITIES NOTIFIED (as applicable):

Adult Protective Services:

Name: _____ Title: _____ Date: _____ Time: ____:____ a.m./p.m.

Child Protective Services:

Name: _____ Title: _____ Date: _____ Time: ____:____ a.m./p.m.

Police:

Name: _____ Title: _____ Date: _____ Time: ____:____ a.m./p.m.

Fire/Paramedic:

Name: _____ Title: _____ Date: _____ Time: ____:____ a.m./p.m.

Dept. of Health Services:

Name: _____ Title: _____ Date: _____ Time: ____:____ a.m./p.m.

County Health Dept.:

Name: _____ Title: _____ Date: _____ Time: ____:____ a.m./p.m.

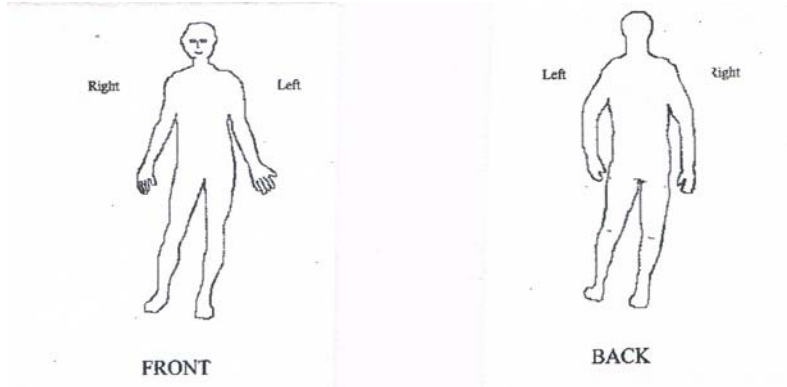
Doctor/Pharmacy/Medical Facility:

Name: _____ Title: _____ Date: _____ Time: ____:____ a.m./p.m.

DESCRIPTION OF INCIDENT: Give a statement of the FACTS leading up to and including the event.

Include the initials of all others involved. If a mark/injury is present, use the body chart (see next page) to indicate type and location of mark.

IN CASES WHERE THERE IS A PHYSICAL MARK OR INJURY, PLEASE USE AN ARROW TO NOTE THE LOCATION ON THE FIGURES BELOW.



LOCATION/TYPE OF MARK/INJURY
(if applicable)

- CUT
- BITE
- SCRATCH/SCRAPE
- BRUISE
- BURN
- REDDENED AREA
- OTHER: _____

Was an Emergency Measure needed (CIT)? Yes No N/A
 If yes, describe action taken: _____

Reporter's Name/Title (Print): _____

Reporter's Signature: _____

Date: _____

STOP HERE – THE REST OF THE DOCUMENT IS FOR THE LIASON'S COMPLETION

DDR INCIDENT MANAGEMENT LIASION'S REVIEW

CONSUMER BEHAVIOR/FINDINGS: Yes No (If yes, complete this section)

Was there an identified antecedent? Yes No N/A
 List: _____

Is this a typical behavior for the Consumer? Yes No N/A
 Were appropriate interventions used? Yes No N/A
 List: _____

Did inappropriate DSP/family/other behavior contribute to this incident?

Yes No N/A

How: _____

Were the Consumer's rights upheld?

Yes No N/A

If not, what was violated: _____

Was the Consumer treated with dignity and respect?

Yes No N/A

If not, how: _____

Was the incident a result of a possible medication side effect/adverse reaction/medical condition?

Yes No N/A

If so, list: _____

Did the DSP receive appropriate training/supervision?

Yes No N/A

If so, list: _____

Did an environmental condition contribute to this incident?

Yes No N/A

If so, how: _____

Other/comments: _____

Is a corrective action plan required?

Yes No N/A

If so, explain: _____

INCIDENTS/ACCIDENTS/INJURIES to DSP/FAMILY/OTHERS (all other findings):

Was the incident a result of DSP/family/others' behavior?

Yes No N/A

If so, how: _____

Was the incident a result of a medical condition?

Yes No N/A

If so, how: _____

Was the incident a result of an environmental condition?

Yes No N/A

If so, how: _____

Was the incident a result of a Consumer behavior?

Yes No N/A

If so, how: _____

Was a vehicle accident report for insurance completed? Yes No N/A

Is a corrective action plan required? Yes No N/A

If so, explain: _____

INCIDENT MANAGEMENT LIASION'S REVIEW/COMMENTS:

SIGNATURE: _____ DATE: _____

DIRECTOR'S REVIEW/COMMENTS:

SIGNATURE: _____ DATE: _____

COPY TO (as applicable):

Site: _____ DATE: _____

Consumer/Responsible Person: _____ DATE: _____

Support Coordinator: _____ DATE: _____

Other: _____ DATE: _____

Other: _____ DATE: _____

Other: _____ DATE: _____

Other: _____ DATE: _____

Other: _____ DATE: _____

Other: _____ DATE: _____

Other: _____ DATE: _____

Other: _____ DATE: _____

Other: _____ DATE: _____