REPORTING AGENCY: **Caring Hands Community Services**

INCIDENT REPORT

NAME OF PERSON:

OCCURRENCE DATE:	**TIME:**
DURATION OF INCIDENT:	**LOCATION:**

IF CONTROL PROCEDURE, DURATION OF PHYSICAL INTERVENTION:

WAS INCIDENT OBSERVED DIRECTLY? ☐ **Yes** ☐ **No**

TYPE OF INCIDENT

MEDICAL/INJURY

- ☐ Injury to Consumer
- ☐ Medical Emergency
- ☐ Hospitalization
- ☐ Death of Consumer
- ☐ Seizure of Unusual Nature
- ☐ Medication/Charting Error (Attach Med Error Form)
- ☐ Alleged M.A.N.E. (*Mistreatment, Abuse, Neglect, Exploitation*)

SOCIAL/BEHAVIORAL

- ☐ Lost or Missing Person
- ☐ Aggression toward Others
- ☐ Self-Injurious Behavior
- ☐ Property Damage
- ☐ Theft or Vandalism
- ☐ Unusual Behavior
- ☐ Emergency Control Procedure (see pg. 2)
- ☐ Safety Control Procedure (see pg. 2)
- ☐ Stolen Property of Persons Receiving Services

OTHER:

WITNESSED BY: **OR REPORTED BY:**

NOTE POINT OF INJURY OR PAIN:

PERSONS NOTIFIED:	**DATE:**	**ROUTED:**
☐ **Nurse:**		☐
☐ **Case Manager:**		☐
☐ **Guardian/Parent/Provider:**		☐
☐ **Dept. of Health (Group Homes only):**		☐
☐ **DDID/CCB Critical Incident**		☐
☐ **Other:**		☐
☐		☐

Description of Incident: (FACTUAL INFORMATION ONLY)

Describe the events and environment leading up to the incident:

How was the situation handled?

over

Name of Person: _____ Date: _____

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CONTROL PROCEDURE SECTION (complete this section only if control procedure was used)	
Was an Emergency/Safety Control Procedure used? ☐ **Yes** ☐ **No**	
Starting time of procedure:	**Ending time:**
Describe the procedure used:	
Why was the procedure used?	
Has this type of behavior occurred with this person before? ☐ **Yes** ☐ **No**	
Is it likely that this behavior will recur? ☐ **Yes** ☐ **No**	
Is there a behavioral ISSP? ☐ **Yes** ☐ **No**	**Was it implemented?** ☐ **Yes** ☐ **No**
Comment:	
Measures to be taken or suggestions for preventing a reoccurrence of this incident:	

Report Written By (print/type name): _____

SIGNATURE OF PERSON COMPLETING REPORT: _____

DATE REPORT WRITTEN:

TO BE COMPLETED BY SUPERVISOR:

Follow-up action requested:

☐ **No follow-up necessary**

☐ **IDT meeting/review necessary** ☐ **Additional training needed** ☐ **Other:**

Comments: _____

_____

_____

_____

Person responsible for follow-up:

Follow-up action completed:

If follow-up is not completed in this section, indicate where documentation of follow-up can be located:

Date Completed: **Completed By:**

Signatures: **Date:**

Nurse: _____ _____

Case Manager: _____ _____

Supervisor: _____ _____