

**DEVELOPMENTAL PATHWAYS INCIDENT REPORT**

**(PLEASE PRINT)**

REPORTING AGENCY: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

REPORTING FACILITY/CONTRACTOR: \_\_\_\_\_

<b>NAME OF PERSON RECEIVING SERVICES:</b>		<b>PERSON REPORTING:</b>	
<b>INCIDENT DATE:</b> _____ <b>INCIDENT TIME:</b> _____ A.M/P.M		<b>FUNDING SOURCE:</b> <input type="checkbox"/> HCB-DD- Residential/ Day & State <input type="checkbox"/> SLS- HCB & State <input type="checkbox"/> CES – Children’s Extensive Support <input type="checkbox"/> Early Childhood <input type="checkbox"/> Family Support <input type="checkbox"/> CWA – Children With Autism	
<b>DURATION OF INCIDENT: (If applicable)</b> _____ Minutes		<b>LOCATION OF INCIDENT: (Be Specific)</b>	
<b>Did you observe this incident?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>WITNESSES:</b>	

MEDICAL/INJURY	SOCIAL/BEHAVIORAL
<input type="checkbox"/> <b>Injury/Accident (M1)</b> <input type="checkbox"/> Minor <input type="checkbox"/> Significant <input type="checkbox"/> Major <b>Location on body:</b> _____	<input type="checkbox"/> <b>Lost or Missing Person (S1)</b>
<input type="checkbox"/> <b>Medical/Psychiatric Emergency (M2)</b> <b>Due to:</b> <input type="checkbox"/> Illness <input type="checkbox"/> Seizure <input type="checkbox"/> Psychiatric <input type="checkbox"/> Injury	<input type="checkbox"/> <b>Stolen Property of Persons Receiving Services (S2)</b>
<input type="checkbox"/> <b>Death of Consumer (M3)</b> <b>Location:</b> _____	<input type="checkbox"/> <b>Emergency Control Procedure (S3) (COMPLETE SECTION 2)*</b>
<input type="checkbox"/> <b>Seizure of Unusual Nature (M4)</b> <input type="checkbox"/> First Ever <input type="checkbox"/> Type unseen <input type="checkbox"/> Too long <input type="checkbox"/> Led to Injury	<input type="checkbox"/> <b>Safety Control Procedure (S7) (COMPLETE SECTION 2)*</b>
<input type="checkbox"/> <b>Hospital Admission (M 5)</b>	<input type="checkbox"/> <b>Self-Injurious Behavior (SIB) (S4)</b>
<input type="checkbox"/> <b>Medication/Charting Error (M8)</b> <input type="checkbox"/> Med not dispensed/taken <input type="checkbox"/> Non-prescribed med taken <input type="checkbox"/> Incorrect dose taken <input type="checkbox"/> Incorrect time <input type="checkbox"/> Charting error <input type="checkbox"/> Incorrect route <input type="checkbox"/> Counting error (controlled meds) <input type="checkbox"/> Other	<input type="checkbox"/> <b>Aggression Toward Others (S5)</b> <input type="checkbox"/> Significant <input type="checkbox"/> Major
<b>Person Who Made Error:</b> _____	<input type="checkbox"/> <b>Alleged Mistreatment, Abuse, Neglect, Exploitation(MANE) (S6) *</b>
	<input type="checkbox"/> <b>Unusual Behavior requiring review (S8)</b>
	<b>Please Specify:</b> _____
	<b>* HRC review Required</b>
	<b>If multiple types are checked specify which is the primary code: _____</b> <b>(Use the originating event or HRC review priority code)</b>

**DESCRIPTION OF INCIDENT, INCLUDING THE EVENTS AND ENVIRONMENT LEADING UP TO THE INCIDENT (FACTUAL INFORMATION ONLY: Who, What, when, where and why)**

**CONFIDENTIALITY NOTE: Do NOT identify any other consumers involved. However, DO identify all staff and non consumers.**


**If Medication Error, List Specific Medications:**

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<b>Signature of Person Reporting:</b>	<b>Addendum Attached? Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
<b>Date:</b>	

PERSONS NOTIFIED/COPIED	COPIES TO
<input type="checkbox"/> <b>Nurse</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Coordinator/Manager/Supervisor</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Guardian/Parent</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Director of Department/Agency</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Other Program/Provider</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Advocate /Authorized Rep.</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>HRC Liaison</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Other</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>DDD</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Law Enforcement</b> Name/Badge #: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Protective Services (adult/child)</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Dept. of Health (Group Homes)</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Investigations Manager/Director</b> Name: _____ DATE: _____	<input type="checkbox"/>
<input type="checkbox"/> <b>Other</b> Name: _____ DATE: _____	<input type="checkbox"/>

<b>Reviewed By:</b>	<b>Reviewed By:</b>
<b>Date:</b>	<b>Date:</b>

**TO BE COMPLETED BY MANAGER/COORDINATOR/ADMINISTRATOR**

**FOLLOW-UP ACTIONS TAKEN: (Include prevention measures for re-occurrence)**


<b>Completed By:</b>	<b>Date</b>
<b>PROGRAM PERSON RESPONSIBLE FOR FOLLOW UP:</b>	

**WHERE TO FIND DOCUMENTATION OF FOLLOW-UP:**

<b>Reviewed By CCB (Resource Coordinator)</b>	<b>Data Entry: Yes</b> <input type="checkbox"/>	<b>Date:</b>	<b>DDD Notified?</b>
<b>Date:</b>	<b>Data Entered By:</b>		<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>

AGENCY REPORTING	NAME OF PERSON RECEIVING SERVICES	ADDENDUM PAGE _____ OF _____
INCIDENT DATE	PERSON REPORTING	

**SECTION 1 – DDD CRITICAL INCIDENT REPORTING**

**IS THIS A CRITICAL INCIDENT REPORTABLE TO DDD?** No  Yes  (check one below)

**PLEASE NOTE THAT THE FOLLOWING TYPES OF INCIDENTS MUST BE REPORTED TO DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) WITHIN 24 HOURS:**

1. Allegations of mistreatment, abuse, neglect and exploitation (M.A.N.E.), committed by an agency staff, contractor or volunteer, meeting the definition specified in Rule 16.120, and involve one of the following factors:
  - Serious physical injuries resulting in emergency room treatment and/or hospitalization or death.
  - Adverse medical/health outcome.
  - A crime has been committed against a client by an employee or contractor of an agency providing services and support, and when there is any police involvement.
  - A crime has been committed against a person in service.
  - Exploitation of a person in service that results in potential loss in excess of \$300.00.
  - There is any police involvement in an allegation of M.A.N.E.
  - Identified through a trend analysis as an allegation of M.A.N.E. due to recurring pattern.
2.  Serious injuries or other medical crises or occurrences requiring immediate emergency medical treatment to preserve life or limb or resulting in an emergency admission to the hospital.
3.  Death
4.  Person in service was a victim of a serious crime.
5.  Serious criminal offense by person in services.
6.  Likely media interest or involvement.
7.  Missing persons where safety of person or general public is at risk, special circumstances increase serious risk or whereabouts are unknown for 8 hours or more, regardless of level of risk.

DDD Notified      By Whom: \_\_\_\_\_      Date: \_\_\_\_\_      Time: \_\_\_\_\_

**SECTION 2**

**FILL OUT IF EMERGENCY OR SAFETY CONTROL PROCEDURE (S3 or S7)**

**STARTING TIME OF RESTRAINT:** \_\_\_\_\_ **A.M./P.M. ENDING TIME OF RESTRAINT:** \_\_\_\_\_

**DESCRIBE THE HOLD USED:**

**WHAT SPECIFIC BEHAVIORS WERE CONSIDERED SERIOUS ENOUGH TO REQUIRE RESTRAINT?**

**HAS THIS TYPE OF BEHAVIOR OCCURRED WITH THIS PERSON BEFORE?**  Yes  No

**IS IT LIKELY THAT THIS BEHAVIOR WILL RE-OCCUR?**  Yes  No

**IS THERE A BEHAVIORAL ISSP ADDRESSING THIS TYPE OF BEHAVIOR?**  Yes  No

**ADDITIONAL COMMENTS:**

