Family Service Foundation
INCIDENT REPORT

Staff filling out report___________ **Date of Report** __________________________

Client's name _________________ **Date/Time of Incident** ___________________

Program _____________________ **Incident Location** ________________________

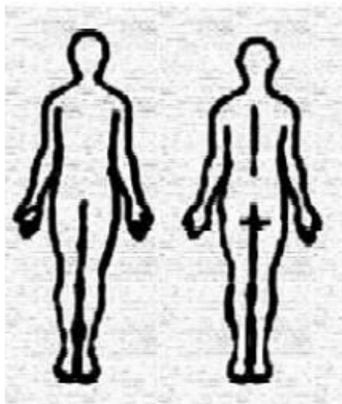
Staff/Consumers present (initial only) ____________________

Description of Incident (include any injuries incurred and location of injury)

____

____

____



Type of Incident (check all that apply)
________accident/injury to consumer
________elopement
________illness of consumer
________medication error
________consumer injures other consumer or staff
________community/family interaction will have serious consequence
________seizure
________restraint

Antecedents (what is happening just before the incident occurred ? See BMP for help if needed)

____

____

Consequence (what happened immediately following the incident? See BMP for help if needed)

____

____

Measure to prevent occurrence of similar incident (See BMP for help if needed)

____

____

Use of Restraint ? YES_____ NO_____ (If yes, fill in the table below)

For Planned Use of Restraint

Type of restraint (check all that apply)
_____Basket Hold/Wrap Around: One Person
_____Basket Hold/Wrap Around: Two Person
_____Take-Down Restraint: One Person
_____Take-Down Basket Hold: Two Person

For how long?__________
_____Two-Person Floor Restraint
_____Bent-Elbow Hold and Walk
_____Two-Person Clasped hands
_____Mechanical Restraint (complete attached form)

FORM 826 (Revised 5/03)

Does Consumer have a BMP goal related to the incident? Yes or No
Was the BMP implemented correctly? Yes or No

Comments:
____

____

Was the Nurse notified? Yes or No.

Indicate the Date and Time of notification: Date:____________ Time:______________

What was the Nurses' instruction?____

Was parent or guardian notified? Yes or No Name:____

Was Consumer taken to ER? Yes or No

First Aid given? Yes or No Description:____

Results of Internal Review:
____

____

____

____

____

<u>Notification To: Name and Date</u>

OHCQ:___________________ **DDA:___________________________**

MDLC:___________________ **Resource Coord:__________________**

POLICE:__________________ **Report#_________________________**

<u>Please initial and date following review</u>:

Res. Manager/Supv. of Day Program______________

Director of Res./Day Program____________________

Director of DD Program________________________

Family Service Foundation
INCIDENT REPORT

MECHANICAL RESTRAINT

Did staff check on the consumer every fifteen minutes ? ________

Did staff escort the consumer to the bathroom and offer fluids at least every two hours ? _______

Did staff provide the consumer the opportunity for motion and excercise for a period of not less than 10 minutes during each 2 hours in which the restraint is used ? _________

Did staff provide the consumer meals at regularly scheduled hours ? _________

Comments:____

____

____

____