DEVELOPMENTAL PATHWAYS INCIDENT REPORT
(PLEASE PRINT)

REPORTING AGENCY: _____ TODAY'S DATE: _____

REPORTING FACILITY/CONTRACTOR: _____

NAME OF PERSON RECEIVING SERVICES:	**PERSON REPORTING:**
INCIDENT DATE: _____ **INCIDENT TIME: _____A.M/P.M**	**FUNDING SOURCE:** ☐ **HCB-DD- Residential/ Day & State** ☐ **SLS- HCB & State** ☐ **CES – Children's Extensive Support** ☐ **Early Childhood** ☐ **Family Support** ☐ **CWA – Children With Autism**
DURATION OF INCIDENT: (If applicable) **_____Minutes**	**LOCATION OF INCIDENT: (Be Specific)**
Did you observe this incident? ☐ **Yes** ☐ **No**	**WITNESSES:**

MEDICAL/INJURY

- ☐ **Injury/Accident (M1)**
  - ☐ **Minor** ☐ **Significant** ☐ **Major**
  - **Location on body: _____**
- ☐ **Medical/Psychiatric Emergency (M2)**
  - **Due to:** ☐ **Illness** ☐ **Seizure** ☐ **Psychiatric** ☐ **Injury**
- ☐ **Death of Consumer (M3)**
  - **Location: _____**
- ☐ **Seizure of Unusual Nature (M4)**
  - ☐ **First Ever** ☐ **Type unseen**
  - ☐ **Too long** ☐ **Led to Injury**
- ☐ **Hospital Admission (M 5)**
- ☐ **Medication/Charting Error (M8)**
  - ☐ **Med not dispensed/taken**
  - ☐ **Non-prescribed med taken**
  - ☐ **Incorrect dose taken**
  - ☐ **Incorrect time**
  - ☐ **Charting error**
  - ☐ **Incorrect route**
  - ☐ **Counting error (controlled meds)**
  - ☐ **Other**

Person Who Made Error:

_____

SOCIAL/BEHAVIORAL

- ☐ **Lost or Missing Person (S1)**
- ☐ **Stolen Property of Persons Receiving Services (S2)**
- ☐ **Emergency Control Procedure (S3) (COMPLETE SECTION 2)***
- ☐ **Safety Control Procedure (S7) (COMPLETE SECTION 2)***
- ☐ **Self-Injurious Behavior (SIB) (S4)**
- ☐ **Aggression Toward Others (S5)**
  - ☐ **Significant** ☐ **Major**
- ☐ **Alleged Mistreatment, Abuse, Neglect, Exploitation(MANE) (S6) ***
- ☐ **Unusual Behavior requiring review (S8)**

Please Specify: _____

*** HRC review Required**

If multiple types are checked specify which is the primary code: _____
(Use the originating event or HRC review priority code)

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:

Signature of Person Reporting: **Date:**	**Addendum Attached? Yes ☐ No ☐**

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

Reviewed By: **Date:**	**Reviewed By:** **Date:**

TO BE COMPLETED BY MANAGER/COORDINATOR/ADMINISTRATOR

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

Completed By: **Date**

PROGRAM PERSON RESPONSIBLE FOR FOLLOW UP:

WHERE TO FIND DOCUMENTATION OF FOLLOW-UP:

Reviewed By CCB (Resource Coordinator) **Date:**	**Data Entry: Yes ☐** **Date:** **Data Entered By:**	**DDD Notified?** **Yes ☐ No ☐**

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:

DEVELOPMENTAL PATHWAYS INCIDENT REPORT ADDENDUM

ADDENDUM PAGE 2 OF _____ (List total number of attachments to Incident Report)

AGENCY REPORTING	NAME OF PERSON RECEIVING SERVICES
INCIDENT DATE	PERSON REPORTING

CONTINUED DESCRIPTION OF INCIDENT	
Signature of Person Reporting:	**Date:**