

# OCDD / Acadiana Region Supports & Services Center Accident/Incident Report

## Section A: Individual Report

Report Number Computer Generated: \_\_\_\_\_

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Home/Program: \_\_\_\_\_  
Date: \_\_\_\_\_ Witnessed: \_\_\_\_\_ **OR** Discovered: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM  
Nurse notified: \_\_\_ No \_\_\_ Yes Time: \_\_\_\_\_ AM/PM Name of nurse contacted: \_\_\_\_\_

**Description of Incident** Ask yourself these questions when completing the description: How did the incident happen? **OR** What did you discover? What was the person doing prior to the incident? Where were you and the witness(es) when the incident/injury occurred/was discovered? What were you and the witness(es) doing when the incident/injury occurred or was discovered? What did you and the witness(es) do?

Name/Address of Witness: \_\_\_\_\_ Name/Address of Witness: \_\_\_\_\_

Reported by: \_\_\_\_\_ Personnel # \_\_\_\_\_ Date Reported: \_\_\_\_\_

### Location: (Mark only one)

- |                                      |   |                                       |   |   |
|--------------------------------------|---|---------------------------------------|---|---|
| <input type="checkbox"/> Bedroom     | <input type="checkbox"/> Canteen          | <input type="checkbox"/> Office Area  | <input type="checkbox"/> Infirmary            | <input type="checkbox"/> Inside Vehicle         |
| <input type="checkbox"/> Bathroom    | <input type="checkbox"/> Indoor Rec Area  | <input type="checkbox"/> Therapy Area | <input type="checkbox"/> Outdoor              | <input type="checkbox"/> Visit Away With Family |
| <input type="checkbox"/> Living room | <input type="checkbox"/> Outdoor Rec Area | <input type="checkbox"/> Break Area   | <input type="checkbox"/> Porch/Patio/Sidewalk | <input type="checkbox"/> Off Premises           |
| <input type="checkbox"/> Dining room | <input type="checkbox"/> Medical Area     | <input type="checkbox"/> Program Area | <input type="checkbox"/> Work/Job Placement   | <input type="checkbox"/> Unknown                |
| <input type="checkbox"/> Kitchen     | <input type="checkbox"/> Laundry          | <input type="checkbox"/> Hallway      | <input type="checkbox"/> Church/Chapel        | <input type="checkbox"/> Other: _____           |

## Section B: Program Review

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> <b>Verbal/Emotional Abuse</b>               | <input type="checkbox"/> <b>Major Injury Known to be Caused by Another Client</b>     | <input type="checkbox"/> All other Major Injuries                                |
| <input type="checkbox"/> <b>Physical Abuse</b>                       | <input type="checkbox"/> <b>Death of Client</b>                                       | <input type="checkbox"/> Client-Client Altercation with Minor or No Injury       |
| <input type="checkbox"/> <b>Sexual Abuse</b>                         | <input type="checkbox"/> <b>Sensitive Situation</b>                                   | <input type="checkbox"/> Emergency Restraints (personal, chemical or mechanical) |
| <input type="checkbox"/> <b>Neglect</b>                              | <input type="checkbox"/> <b>Involuntary Sexual Contact Among Clients</b>              | <input type="checkbox"/> Life Threatening Emergency                              |
| <input type="checkbox"/> <b>Exploitation</b>                         | <input type="checkbox"/> <b>Unauthorized Departure placing Clients/Others at Risk</b> | <input type="checkbox"/> Medication Error  |
| <input type="checkbox"/> <b>Extortion</b>                            | <input type="checkbox"/> Unauthorized Departure placing No One at Risk                | <input type="checkbox"/> No Injury   |
| <input type="checkbox"/> <b>Major Injury Resulting in a Fracture</b> | <input type="checkbox"/> Choking as Related to Nutritional Management                 | <input type="checkbox"/> Minor Injury  |
| <input type="checkbox"/> <b>Major Injury Resulting in Sutures</b>    | <input type="checkbox"/> Illness  |  |
| <input type="checkbox"/> <b>Major Injury of Unknown Cause</b>        |   |  |

**TO BE COMPLETED FOR PRIORITY INCIDENTS OR INCIDENTS OF UNKNOWN ORIGIN ONLY.**

Name of Administrative Officer/Duty Officer contacted: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM.

### Initial Action to Prevent Similar Occurrence:

\_\_\_\_\_  
\_\_\_\_\_

### Follow-up Action to Prevent Future Occurrence:

\_\_\_\_\_  
\_\_\_\_\_

Supervisory Review by: \_\_\_\_\_ Date of Review: \_\_\_\_\_

### Possible Cause: (Mark only one)

- |  |  |
|--|--|
| <input type="checkbox"/> Accidental                    | <input type="checkbox"/> Staff Action  |
| <input type="checkbox"/> Injury Resulting from Seizure | <input type="checkbox"/> Unsafe Condition  |
| <input type="checkbox"/> Other Medical Condition       | <input type="checkbox"/> Suspected abuse, neglect, exploitation                              |
| <input type="checkbox"/> Undetermined                  | <input type="checkbox"/> Action of client (if applicable, complete Behavioral Event section) |

### Behavioral Event

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Provoked  | <input type="checkbox"/> SIB                  |
| <input type="checkbox"/> Assaulted | <input type="checkbox"/> PICA                 |
| <input type="checkbox"/> Combative | <input type="checkbox"/> Property Destruction |

**IMC Disposition:** Date Completed: \_\_\_\_\_ By: \_\_\_\_\_  
 Minor Occurrence     Incident     Priority Incident     Referred for Investigation     APS Notified     BPS Notified  
 Referred for Medical Treatment     Referred for Administrative Review     Referred to IDT/QMRP for Review     Report Complete

Revised: July 20, 2009

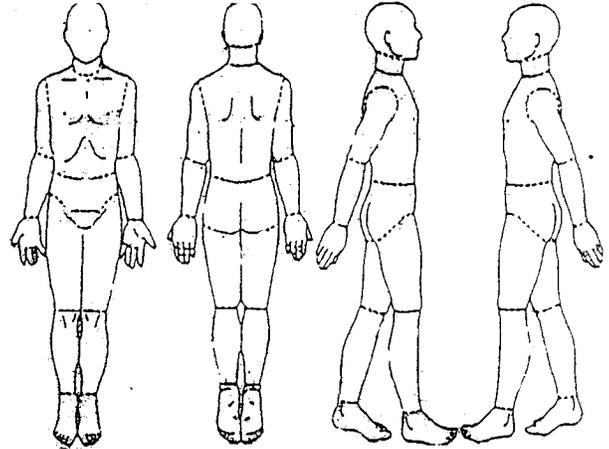
## Section C: Initial Medical Assessment/Treatment

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time of Assessment: \_\_\_\_\_ AM/PM

- Treatment Required:**
- First Aid or less required
  - Emergency or Physician's Care Required
  - More than First aid Required

- Medication Errors Only:**
- Wrong Person
  - Wrong Time
  - No MD Order
  - Wrong Treatment
  - Documentation Error
  - Wrong Dosage
  - Wrong Medication
  - Wrong Adrain Route
  - Transcription Error
  - Omission

**Assessment/Treatment:** (Include physician, ER care/treatment)



Estimated age of injury: \_\_\_\_\_

Review Completed by/Title: \_\_\_\_\_ Date: \_\_\_\_\_

## Section D: Injury Description

**Primary area of the Body** (Mark all that apply)

- Right
- Left
- Middle
- Internal
- Front
- Back
- Upper
- Lower

**Specific Area of Body** (Mark all that apply)

- |                                     |                                     |                                    |                                  |                                    |                                |                                      |
|-------------------------------------|-------------------------------------|------------------------------------|----------------------------------|------------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Head/Scalp | <input type="checkbox"/> Tongue     | <input type="checkbox"/> Upper Arm | <input type="checkbox"/> Thumb   | <input type="checkbox"/> Buttocks  | <input type="checkbox"/> Knee  | <input type="checkbox"/> Instep      |
| <input type="checkbox"/> Face       | <input type="checkbox"/> Teeth      | <input type="checkbox"/> Elbow     | <input type="checkbox"/> Chest   | <input type="checkbox"/> Anus      | <input type="checkbox"/> Leg   | <input type="checkbox"/> Toe         |
| <input type="checkbox"/> Ear        | <input type="checkbox"/> Nose       | <input type="checkbox"/> Forearm   | <input type="checkbox"/> Breast  | <input type="checkbox"/> Groin     | <input type="checkbox"/> Shin  | <input type="checkbox"/> N/A         |
| <input type="checkbox"/> Eyes       | <input type="checkbox"/> Neck       | <input type="checkbox"/> Wrist     | <input type="checkbox"/> Ribs    | <input type="checkbox"/> Genitalia | <input type="checkbox"/> Ankle | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chin       | <input type="checkbox"/> Collarbone | <input type="checkbox"/> Hand      | <input type="checkbox"/> Back    | <input type="checkbox"/> Hip       | <input type="checkbox"/> Foot  |                                      |
| <input type="checkbox"/> Mouth/Lips | <input type="checkbox"/> Shoulder   | <input type="checkbox"/> Finger    | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Thigh     | <input type="checkbox"/> Heel  |                                      |

**Primary Type of Injury** (Mark one)

- |                                  |                                   |                                      |                                     |                                    |   |   |
|----------------------------------|-----------------------------------|--------------------------------------|-------------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> Bite    | <input type="checkbox"/> Hematoma | <input type="checkbox"/> Fracture    | <input type="checkbox"/> Concussion | <input type="checkbox"/> Infection | <input type="checkbox"/> Ingest (swallow) | <input type="checkbox"/> Cracked/Missing Nail |
| <input type="checkbox"/> Cut     | <input type="checkbox"/> Puncture | <input type="checkbox"/> Strain      | <input type="checkbox"/> Knot/bump  | <input type="checkbox"/> Sunburn   | <input type="checkbox"/> Chafed/Chapped   | <input type="checkbox"/> Sting                |
| <input type="checkbox"/> Scratch | <input type="checkbox"/> Burn     | <input type="checkbox"/> Sprain      | <input type="checkbox"/> Blister    | <input type="checkbox"/> Redness   | <input type="checkbox"/> Irritation/Rash  | <input type="checkbox"/> STD                  |
| <input type="checkbox"/> Bruise  | <input type="checkbox"/> Abrasion | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Lesion     | <input type="checkbox"/> Rash      | <input type="checkbox"/> Pregnancy        | <input type="checkbox"/> No Injury            |
|                                  |                                   |                                      |                                     |                                    |   | <input type="checkbox"/> Other _____          |

**Primary Source of Injury** (Mark one)

- |   |  |                                     |   |  |
|---|--|-------------------------------------|---|--|
| <input type="checkbox"/> Heat               | <input type="checkbox"/> During Follow Down      | <input type="checkbox"/> Kick       | <input type="checkbox"/> Picked at        | <input type="checkbox"/> During Escort/Transport |
| <input type="checkbox"/> Chemical           | <input type="checkbox"/> Object/Foreign Body     | <input type="checkbox"/> Hair pull  | <input type="checkbox"/> Sexual Assault   | <input type="checkbox"/> Splinter                |
| <input type="checkbox"/> Human Bite/Scratch | <input type="checkbox"/> Pressure (Grab/Hold)    | <input type="checkbox"/> Push/Shove | <input type="checkbox"/> Sexual Contact   | <input type="checkbox"/> Razor                   |
| <input type="checkbox"/> During Restraint   | <input type="checkbox"/> Bumped into             | <input type="checkbox"/> Insect     | <input type="checkbox"/> Hit/Slap         | <input type="checkbox"/> Head Bang               |
| <input type="checkbox"/> Rub/Friction       | <input type="checkbox"/> Twisted (arm, etc.)     | <input type="checkbox"/> Animal     | <input type="checkbox"/> Scratch          | <input type="checkbox"/> Undetermined            |
| <input type="checkbox"/> Slip/Trip/Fall     | <input type="checkbox"/> Sports/Exercise Related | <input type="checkbox"/> Choke      | <input type="checkbox"/> Friction         | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> PMAB               | <input type="checkbox"/> Stubbed (Toe)           | <input type="checkbox"/> Pinch      | <input type="checkbox"/> Medication Error |  |

- Seriousness of Injury**
- None Apparent
  - Minor
  - Major
  - Fatal

Persons Notified	NAME / SIGNATURE	Date	Time	Follow-Up
QMRP/IPC				
Name of Legally Responsible person contacted (as applicable)				
Social Worker				
Client Rights Officer				
Safety Officer				
OCDD Waiver Section				
Support Coordinator				
Other				