PIKES PEAK RESPITE SERVICES INCIDENT REPORT

PERSON RECEIVING SERVICES (PRS) NAME: _____ **INCIDENT DATE:**_____ **DATE OF REPORT:** _____

REPORTING PARTY: _____ **REPORTING SERVICE:**

TIME OF INCIDENT: _____ **DURATION:** ___ _ _ _____

INCIDENT LOCATION: _____ **Did you observe the incident?** ☐ **Yes** ☐ **No**

WITNESS (ES): _____

TYPE OF INCIDENT (Check most appropriate to situation)

All incidents must be reported to Pikes Peak Respite Services and the Service Coordinator within 24 hours. Incident types with an * below, must be reported to Beverly Seemann 719-659-6344 if they occur outside of Pikes Peak Respite Services standard business hours.

☐ ***Mistreatment (Abuse/Neglect/Exploitation)** *as defined in Colorado Revised Statute 25.5-10-202*
☐ ***Death**
☐ **Unusual incidents or actions by PRS (may include, but not limited to examples below):**
*Offense committed by PRS Problematic sexual behavior Seizure Incontinence Fall Other: _____
☐ ***Lost/Missing Person**
☐ **Injury**
☐ **Medical Emergency** (ER/911/Urgent Care)
☐ **Hospital admission**
☐ Psychiatric ☐ Medical
☐ **Medication Error**
☐If side effects noted, describe: _____
☐ **Emergency Control Procedure (ECP)** *as defined by DIDD 8.608.4* (The unanticipated use of a restrictive procedure or restraint in order to keep the PRS and others safe)

a. Description of the emergency control procedure employed_____
Time: _____ End Time: _____
b. Explanation of why the procedure was judged necessary_____
c. Assessment of the likelihood that the behavior that prompted the use of the emergency control procedure will recur:

_____

_____

Was use of ECP compliant with DIDD regulations regarding restrictive interventions/restraint? Explain: _____

☐ **Safety Control Procedure (SCP)** *per DIDD 8.608.4* (Safety control procedures must be developed when it can be anticipated that there will be a need to use restrictive procedures or restraints to control a previously exhibited behavior which is likely to occur again).
*If the safety control procedure is used more than three times within the previous thirty (30) days, the person's interdisciplinary team shall meet to review the situation and to endorse the current plans or to prepare other strategies.

☐ **Lost/Stolen property belonging to PRS** Approximate or known value of property: _____

DESCRIPTION OF ANTECEDENTS (What happened prior to the incident?):

DESCRIPTION OF INCIDENT (factual information only including who, what, where, when, and why). * IF LAW ENFORCEMENT OR DHS NOTIFIED, INCLUDE REFERENCE NUMBER, AGENCY NAME, AND CONTACT INFORMATION: _

☐

*Attach additional pages if/as needed.

INTERVENTION(S) USED (Check boxes as applicable)**:**

☐Verbal redirection ☐Protocol/Support Plan Implemented (indicate type/s):_____

DESCRIPTION OF IMMEDIATE ACTIONS TAKEN/INTERVENTIONS USED:

☐ Attach additional pages if/as needed.

IR WRITTEN BY - NAME (PRINT):_____ **TITLE:** _____

SIGNATURE:_____ **DATE:** _____

Person(s) Notified	Date	Name	How notified	IR Sent √
☐ **TRE: SC** ☐ **QET** ☐ **TRE On-Call**				
☐ **Guardian** ☐ **Advocate** ☐ **Authorized Rep** ☐ **GAL**				
☐ **Residential supervisor** ☐ **HHP** ☐ **Nurse** ☐ **On-Call**				
☐ **Day Services** ☐ **PASA Staff** ☐ **Nurse**				
☐ **CDPHE (GRSS only)**				
☐ **Other** ☐ **Therapist** ☐ **DHS** ☐ **Police** ☐ **DIDD** ☐ **PCP**				

SECONDARY REVIEW: TO BE COMPLETED BY WRITER'S SUPERVISOR/AGENCY ADMINISTRATOR (AS APPLICABLE)

FOLLOW-UP ACTION COMPLETED/NEEDED/MEASURES TAKEN TO PREVENT RECURRENCE:

*If Follow-up is not documented on this form, indicate where it can be located:

PERSON RESPONSIBLE FOR FOLLOW-UP:

***ALL FOLLOW UP NOT INCLUDED IN THIS REPORT SHOULD BE SUBMITTED TO TRE QET WITHIN 30 DAYS.**

NAME (PRINT):_____ **TITLE:** _____

SIGNATURE:_____ **DATE:** _____