



## INCIDENT/ACCIDENT REPORT

**Client Name:** \_\_\_\_\_

**Client Age:** \_\_\_\_\_ **Client Gender:**  M  F **Client Grade:** \_\_\_\_\_

**Client Plan Type:**  IEP  504  Behavior Plan  IHP  ITP  Other

**Date of Incident:** \_\_\_\_\_ **Time** \_\_\_\_\_ **Duration** \_\_\_\_\_

**Location of incident:** \_\_\_\_\_

**First Aid given (if applicable):** \_\_\_\_\_

**Staff Name (please print)** \_\_\_\_\_

**Date report is completed:** \_\_\_\_\_

**What was happening directly before the behavior occurred (antecedent)?**

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**What was the concerning or unsafe behavior?**

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**What interventions were used prior to or instead of restraint?** *(Check all used)*

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|--|--|
| <input type="checkbox"/> Positive reinforcement    | <input type="checkbox"/> Modeling      |
| <input type="checkbox"/> Incompatible behavior     | <input type="checkbox"/> Help strategy |
| <input type="checkbox"/> High probability behavior | <input type="checkbox"/> Wait strategy |
| <input type="checkbox"/> Redirection               | <input type="checkbox"/> Other         |
| <input type="checkbox"/> Prompting                 | <input type="checkbox"/> None          |

*If none, please explain why no other interventions were used:*

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**What type of restraint was used?** *(Check all used)*

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|---|--|
| <input type="checkbox"/> None   | <input type="checkbox"/> Release from hold: grab, bite, hair pull, choke<br><i>(circle type of hold)</i> |
| <input type="checkbox"/> Elbow check  |  |
| <input type="checkbox"/> Shoulder check   | <input type="checkbox"/> Two person stability hold   |
| <input type="checkbox"/> Supportive guide   | <input type="checkbox"/> Two person escort: forward or reverse<br><i>(circle one)</i>                    |
| <input type="checkbox"/> One person stability hold: seated or standing<br><i>(circle one)</i> |  |

**All Staff involved:**

Staff Name: _____
Staff role: Participant, Leader, Monitor (observer) <i>(circle one)</i>
Training: Safety Care

Staff Name: _____
Staff role: Participant, Leader, Monitor (observer) <i>(circle one)</i>
Training: Safety Care

**Summarize the incident and resolution. Include how return to previous activity or environment occurred, if it did.**

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**Did client or staff injury occur?**  Yes  No

**If yes, please detail who was injured, type of injury, date, time, medical personal involved, and medical treatment administered**

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**Parent/Guardian notification**

**1. Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Who was contacted:** \_\_\_\_\_

**How were they contacted?** \_\_\_\_\_

**Others notified:** \_\_\_\_\_

**2. Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Who was contacted:** \_\_\_\_\_

**How were they contacted?** \_\_\_\_\_

**Others notified:** \_\_\_\_\_

**3. Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Who was contacted:** \_\_\_\_\_

**How were they contacted?** \_\_\_\_\_

**Others notified:** \_\_\_\_\_

**Staff Debriefing** *(to be completed as soon as possible, no later than 1 day if injury occurs)*  
*This occurs if an injury occurred or when Safety Care or other restraint procedure was put into place.*

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Was incident handled in compliance with Safety Care?  Yes  No

Review Client Plan-revisions needed?  Yes  No

Please detail ideas of how to prevent or reduce future use of restraint:

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**Client Debriefing:**

What triggered the escalation?

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What can client and/or staff do to reduce the future use of restraint?

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\_\_\_\_\_  
**Staff Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Please Print**

\_\_\_\_\_  
**Supervisor Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Please Print**

\_\_\_\_\_  
**Director of Clinical Services Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**