Adriel - Significant Incident Report

(Must be submitted to office within 24 hours of incident)

Client Name:		Date of Report:
Date of Incident:	Time of Incident:	FC Region:
Name of Foster Parent Filing Report:		
Additional People Involved in Incident:		

Type of Incident		
□ AWOL/unauthorized absence*	□ Hospitalization or Professional Med. Treatment*	
□ Alleged Abuse	□ Property Damage (see part I.)	
□ Assault	□ Restraint (see part III.)	
□ Injury to Youth (see part II.)	□ School Suspension/Expulsion	
□ Injury to Foster Parent (see part II.)	□ Self harm/Suicide Attempt	
□ Medication Error (youth refusal)	□ Medication Error (Parent Error)	
*Must speak with an Adriel worker or on-call worker within 1 hour of gaining knowledge of incident.		

Description of Incident

(if needed provide addition information on a separate page)

Antecedent (circumstances leading up to the behavior/incident):

Behavior:

Outcome:

Follow-Up (If necessary):

Notification				
Consultant Notification (immediate notification mandatory)				
Date:	Time:	Name of Consultant:		
Guardian Notification (Guardian Notification (consultant to complete)			
Date:	Time:	Person Contacted:		
Other parties notified				
Date:	Time:	Person Contacted:		
Law Enforcement Involvement				
Date:	Time:	Name of Officer:		
Was youth incarcerated	$? \square YES \square N($)		
, as your mourocratou		~		

Page 3 of 6

Signatures in the following order:

Foster Parent:	Date:
Consultant/Case Manager:	Date:
Regional FCA Manager:	Date:

Significant Incident Report Addendum

I. PROPERTY DAMAGE		□ N/A		
Property:		Owner:		
Property:		Owner:		
Property:		Owner:		
II. INJURIES		□ N/A		
Name:	Injury:		Treatment:	
Was this injury restraint-related?	\Box YES			
Name:	Injury:		Treatment:	
Was this injury restraint-related?	\Box YES	\Box NO		
Name:	Injury:		Treatment:	
Was this injury restraint-related?	\Box YES	\Box NO		
Was professional medical attention required	? \Box YES	\Box NO		
If so, describe:				
III. RESTRAINT A. Basic Information		□ N/A		
A. Basic information				
PRIMARY RESTRAINER:				
DURATION OF RESTRAINT:				

If duration of restraint lasted longer than 15 minutes for children aged nine and younger or 30 minutes for children aged ten and older please indicate: Approval from: Rationale for Approval:

B. Describe how less restrictive interventions (specified in the youth individual service plan) were used for this youth				
Intervention:			Outco	ome:
Intervention:			Outco	ome:
Intervention:			Outco	ome:
	a client may only be used t was necessary in this in			ion where there is imminent danger to a client or others.
			••	
Data				
D. If injuries were susta	lined during the restraint	(which should	d be noted	above), describe how the injuries occurred
F: Describe what Staff	could have done to help	prevent the inj	juries from	happening (for next time)
I. Clients should be close	sely monitored at all time	es for signs of	distress. Ir	dicate if any of the following signs were observed:
□Labored breathing □Rapid breathing □Grunting sounds				
			sounds	
□Flushed skin	□Vomiting □Discomfort in extremities			
	C C			
□Other:				
Comments:				
		_		
Is youth under 100 lbs?□Yes□NoHave there been multiple restraints in a 24 hour period?□Yes□No				

G. During restraint, the client's need for ambulating, fluid intake, toileting, or other needs should be monitored every 15 minutes.

Describe results of assessments of these needs: