

INCIDENT INVOLVED: ☒ Resident ☐ Visitor ☒ Staff ☒ Other oth inc

DATE OF INCIDENT (D/M/Y) 23 Oct 2024	Time 02:48 PM	LOCATION OF INCIDENT room	WITNESSED BY mng
DATE OF DISCOVERY (D/M/Y) 23 Oct 2024	Time 02:48 PM	LOCATION OF DISCOVERY room	DISCOVERED BY mng
TYPE OF INCIDENT <div><div><input checked="" type="checkbox"/> Fall <input checked="" type="checkbox"/> Fire <input checked="" type="checkbox"/> Security <input checked="" type="checkbox"/> Elopement <input checked="" type="checkbox"/> Aggressive Behavior <input checked="" type="checkbox"/> Other <u>other incident</u></div><div><input checked="" type="checkbox"/> Resident Abuse <input checked="" type="checkbox"/> Treatment <input checked="" type="checkbox"/> Loss of Property <input type="checkbox"/> Choking <input type="checkbox"/> Death</div></div>		SAFETY DEVICES IN USE BEFORE OCCURRENCE Yes No N/A Fob was within reach <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Call bell within reach <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> Caution signs in place <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> Other <u>other safety</u>	
OTHER WITNESSES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Name: <u>nm 1</u> Position: <u>pos 1</u> Name: <u>nm 2</u> Position: <u>pos 2</u>			
Condition At Time Of Incident <div><input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Sedated <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other (Specify)</div>	Fall Assessment <div><input checked="" type="checkbox"/> Medication Change <input checked="" type="checkbox"/> Cardiac Medications <input type="checkbox"/> Mood Altering Medications <input type="checkbox"/> Visual Deficit <input checked="" type="checkbox"/> Relocation <input checked="" type="checkbox"/> Temporary Illness</div>	Ambulation <div><input type="checkbox"/> Unlimited <input checked="" type="checkbox"/> Limited <input checked="" type="checkbox"/> Required assistance <input type="checkbox"/> Wheelchair <input checked="" type="checkbox"/> Walker <input checked="" type="checkbox"/> Other (Specify) <u>other Ambulation</u></div>	Fire Yes No Alarm pulled <input checked="" type="checkbox"/> <input type="checkbox"/> False alarm <input type="checkbox"/> <input checked="" type="checkbox"/> Extinguisher used <input checked="" type="checkbox"/> <input type="checkbox"/> Personal injury <input type="checkbox"/> <input checked="" type="checkbox"/> Resident or facility property damage <input checked="" type="checkbox"/> <input type="checkbox"/>
FACTUAL CONCISE DESCRIPTION OF INCIDENT, INJURY, AND ACTION TAKEN:			
Fact			

Attachments:-

- <https://hamiltondinnerapp.intellidt.com/uploads/public/FormResponses/media/6729b9e89c1d51730787816.jpeg>
- <https://hamiltondinnerapp.intellidt.com/uploads/public/FormResponses/media/6729b9e89d0551730787816.jpeg>

NOTIFICATION			
INFORMED OF INCIDENT	INITIAL	PERSON NOTIFIED	NOTIFIED RESIDENT'S RESPONSIBLE PARTY
<input checked="" type="checkbox"/> Assistant General Manager <input checked="" type="checkbox"/> General Manager <input checked="" type="checkbox"/> Risk Management Committee <input checked="" type="checkbox"/> Other <u>other notification</u>	<u>agm</u> <u>gm</u> <u>rmc</u> <u>oth</u>	Family Doctor: <u>doc</u> Time: <u>02:50 PM</u> Other: <u>other notified</u> Time: <u>02:50 PM</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Name: <u>RAO</u> Date: <u>23 Oct 2024</u> Time: <u>02:50 PM</u>
COMPLETED BY Rahi		POSITION developer	DATE 23 Oct 2024 02:50 PM

FOLLOW UP (For Management Use Only)

ISSUE (Problem)
Issue text
FINDINGS (Gather Information)
Findings text
POSSIBLE SOLUTIONS (Identify Solution)
Solutions text

ACTION PLAN
Plan text
FOLLOW UP (Examine Result – Did the Plan work?)
Follow up text