

INCIDENT INVOLVED:

☐ Resident

☒ Visitor

☐ Staff

☐ Other

DATE OF INCIDENT (D/M/Y) 23 Oct 2024	Time 02:07 PM	LOCATION OF INCIDENT inc	WITNESSED BY w1	
DATE OF DISCOVERY (D/M/Y) 23 Oct 2024	Time 02:07 PM	LOCATION OF DISCOVERY dis	DISCOVERED BY d1	
TYPE OF INCIDENT <div><div><input type="checkbox"/> Fall <input type="checkbox"/> Fire <input type="checkbox"/> Security <input type="checkbox"/> Elopement <input type="checkbox"/> Aggressive Behavior <input type="checkbox"/> Other</div><div><input type="checkbox"/> Resident Abuse <input type="checkbox"/> Treatment <input type="checkbox"/> Loss of Property <input type="checkbox"/> Choking <input type="checkbox"/> Death</div></div>		SAFETY DEVICES IN USE BEFORE OCCURRENCE <div>Yes No N/A</div> <div>Fob was within reach <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>Call bell within reach <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>Caution signs in place <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>Other</div>		OTHER WITNESSES? <div><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div> <div>Name:</div> <div>Position:</div> <div>Name:</div> <div>Position:</div>
Condition At Time Of Incident <div><input type="checkbox"/> Oriented <input type="checkbox"/> Sedated <input type="checkbox"/> Disoriented <input type="checkbox"/> Other (Specify)</div>	Fall Assessment <div><input type="checkbox"/> Medication Change <input type="checkbox"/> Cardiac Medications <input type="checkbox"/> Mood Altering Medications <input type="checkbox"/> Visual Deficit <input type="checkbox"/> Relocation <input type="checkbox"/> Temporary Illness</div>	Ambulation <div><input type="checkbox"/> Unlimited <input type="checkbox"/> Limited <input type="checkbox"/> Required assistance <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Other (Specify)</div>	Fire <div>Yes No</div> <div>Alarm pulled <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>False alarm <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Extinguisher used <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Personal injury <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Resident or facility <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>property damage</div>	
FACTUAL CONCISE DESCRIPTION OF INCIDENT, INJURY, AND ACTION TAKEN:				

Attachments:-

NOTIFICATION			
INFORMED OF INCIDENT	INITIAL	PERSON NOTIFIED	NOTIFIED RESIDENT'S RESPONSIBLE PARTY
<input type="checkbox"/> Assistant General Manager		Family Doctor:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<input type="checkbox"/> General Manager		Time:	Name:
<input type="checkbox"/> Risk Management Committee		Other:	Date:
<input type="checkbox"/> Other		Time:	Time:
COMPLETED BY R		POSITION dev	DATE 23 Oct 2024 02:07 PM

FOLLOW UP (For Management Use Only)

ISSUE (Problem)
FINDINGS (Gather Information)

POSSIBLE SOLUTIONS (Identify Solution)
ACTION PLAN
FOLLOW UP (Examine Result – Did the Plan work?)