

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

DATE OF INCIDENT (D/M/Y) <b>23 Oct 2024</b>	Time <b>02:48 PM</b>	LOCATION OF INCIDENT <b>room</b>	WITNESSED BY <b>mng</b>
DATE OF DISCOVERY (D/M/Y) <b>23 Oct 2024</b>	Time <b>02:48 PM</b>	LOCATION OF DISCOVERY <b>room</b>	DISCOVERED BY <b>mng</b>
<b>TYPE OF INCIDENT</b>  <input checked="" type="checkbox"/> Fall <input checked="" type="checkbox"/> Resident Abuse <input checked="" type="checkbox"/> Fire <input checked="" type="checkbox"/> Treatment <input checked="" type="checkbox"/> Security <input checked="" type="checkbox"/> Loss of Property <input checked="" type="checkbox"/> Elopement <input type="checkbox"/> Choking <input checked="" type="checkbox"/> Aggressive Behavior <input type="checkbox"/> Death <input checked="" type="checkbox"/> Other <u>other incident</u>		<b>SAFETY DEVICES IN USE BEFORE OCCURRENCE</b>  <b>Yes No N/A</b> 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>	<b>OTHER WITNESSES?</b>  <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>
<b>Condition At Time Of Incident</b>  <input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Sedated <input type="checkbox"/> Disoriented <input checked="" type="checkbox"/> Other (Specify)	<b>Fall Assessment</b>  <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	<b>Ambulation</b>  <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>	<b>Fire</b>  <b>Yes No</b> 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"/>
<b>FACTUAL CONCISE DESCRIPTION OF INCIDENT, INJURY, AND ACTION TAKEN:</b>			
<b>Fact</b>			

Attachments:-

- <https://hamiltondinnerapp.intellidt.com/uploads/public/FormResponses/media/6729d531cabb21730794801.jpeg>
- <https://hamiltondinnerapp.intellidt.com/uploads/public/FormResponses/media/6729d531cce8e1730794801.jpeg>

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