

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

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|--|---|---|---|---|
| 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 <div>Fob was within reach <input checked="" type="checkbox"/> <input 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 type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Other <u>other safety</u></div> | | 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 <div>Alarm pulled <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>False alarm <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Extinguisher used <input checked="" type="checkbox"/> <input type="checkbox"/></div> <div>Personal injury <input type="checkbox"/> <input checked="" type="checkbox"/></div> <div>Resident or facility property damage <input checked="" type="checkbox"/> <input type="checkbox"/></div> | |
| FACTUAL CONCISE DESCRIPTION OF INCIDENT, INJURY, AND ACTION TAKEN: | | | | |
| Fact | | | | |

Attachments:-

- <https://hamiltondinnerapp.intellidt.com/uploads/public/FormResponses/media/6729d1e84759c1730793960.jpeg>
- <https://hamiltondinnerapp.intellidt.com/uploads/public/FormResponses/media/6729d1e8484c81730793960.jpeg>

| NOTIFICATION | | | |
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| 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)

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

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