# INCIDENT REPORT FORM

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| **Instructions and how to submit this form**   1. If you are reporting an incident, complete only pages 1,2 and 3 only 2. If completing this form electronically, email it to info@meditechstaffing.com.au 3. If completing a hard-copy version, fax to (02) 9763 1133 alternatively you can scan or take a picture of this form and email to info@meditechstaffing.com.au 4. **You must call (02) 9764 4488 to confirm that this form has been received** | |
| Part 1: Reporter Details | |
| Person making the report |  |
| Position title |  |
| Client |  |

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| Part 2: Incident Details | | | | |
| Date of incident |  | | Time of incident |  |
| If you did not see the incident, date you were first told about the incident |  | | Time first told of incident |  |
| Address/location of incident: |  | | | |
| For incidents involving **ASSAULT**: (Please mark one only) *‘Other’ refers to those who are not client or workers but who were involved in the incident.* | | | | |
| Client to client  Client to worker | | Worker to client (must be marked as Category 1 below)  Client to other  Other to client | | |
| **Incident Category** | | | | |
| **Category 1** | | | **Category 2** | |
| Death  Risk of death  Abuse, neglect or exploitation  Serious harm or injury  Serious medication error that creates a risk for a service user  Attendance by an ambulance  Major damage to building or other property  Sexual harassment of a service user  Sexual harassment of a staff member while at work  A service user who is missing and where there is potential for high risk behaviour  Alleged criminal activity, inappropriate sexual behaviour of a service user, property damages resulting in closure of a service for emergency situations.  Negative media attention for LifeScope | | | Medication error  Exposure to bodily fluids or spills of hazardous substances  Assault without injury  Injury requiring minor Treatment only (first aid treatment)  Verbal or attempted physical abuse  Breach of policy and procedure  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| Part 3: Who was involved? | | | |
| Person 1 - | | | |
| Name: |  | | |
| Position/Relationship: |  | | |
| Is this person a?  Paid staff  Carer | What was their part?  Participant  Witness  Victim | Injured?  Yes  No | Medical professional required?  Yes  No |
| Person 2 - | | | |
| Name: |  | | |
| Position/Relationship: |  | | |
| Is this person a?  Paid staff  Carer | What was their part?  Participant  Witness  Victim | Injured?  Yes  No | Medical professional required?  Yes  No |
| Person 3 - | | | |
| Name: |  | | |
| Position/Relationship: |  | | |
| Is this person a?  Paid staff  Carer | What was their part?  Participant  Witness  Victim | Injured?  Yes  No | Medical professional required?  Yes  No |
| Person 4 - | | | |
| Name: |  | | |
| Position/Relationship: |  | | |
| Is this person a?  Paid staff  Carer | What was their part?  Participant  Witness  Victim | Injured?  Yes  No | Medical professional required?  Yes  No |

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| **Part 4: Details of Injury** | |
| **What happened? Describe the incident and the immediate response of staff.**  *This section should be a brief, factual account of the incident. Include impact to client who was involved; how, where and when the incident occurred; who did what; who (if anyone) was injured and the nature and extent of injuries (if applicable).* | |
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| Nature of injury/illness  e.g. burn, sprain, cut, etc. |  |
| Mechanism  e.g. fall, grabbed by person, etc. |  |
| Location on body  e.g. back, right thumb, left arm, etc. |  |
| Was any property or equipment damaged? | Yes  No |
| Details of damage |  |

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| **Part 5: First Aid Treatment (Only if provided)**  *To be completed by the person providing First Aid* | | | |
| **Details of Injury Attended**  *Description of injury and condition: (please place an ‘X’ & indicate location), for Items marked* ***\**** *raise a Wound Care Management Form* | | | |
| Abrasion \* | Unconfirmed Fracture \* | Rash | Vomiting |
| Bruising | Haematoma | Reddened Area | None Sustained |
| Burn \* | Infection | Skin Tear with Tissue Loss \* | Other : |
| Cut \* | Laceration \* | Skin Tear without Tissue Loss\* |
| Dislocation | Leg Ulcer \* | Soreness |
| Excoriation | Pressure Area \* | Sprain |
| **Location on body** *(e.g. Back, right thumb, left arm)* | |  | |
| **Wound Care Management Form Raised** | | Yes  Not applicable | |

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| **Observations** | | | |
| **Time Taken:** |  | **Conscious?** | Yes  No |
| **Pulse** |  | **Respiration** |  |
| **BP** | / | **Skin** |  |

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| **Treatment Given**  *Describe first aid treatment given* |
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| **Outcome** | | |
| Returned to Work | Home | Referred to doctor |
| Transferred to hospital | Reported to supervisor |  |

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| Person Provided First Aid: | |  | | |  |  |
|  | |  | | |  |  |
| Signature: | |  | | | Date: |  |
| Part 6: Manager’s Report *Part 6 to be completed by house supervisor/coordinator, line manager, CEO or agency manager* | | | | | | | |
| Name |  | | | | | | |
| Telephone number |  | | | | | | |
| Position title |  | | | | | | |
| Any additional information about the incident (after investigation)? | | | | | | | |
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| What actions have been taken and what follow-up actions will be taken in response to the incident? *Please describe what actions have been taken to address safety risks and what will be done to prevent reoccurrence* | | | | | | | |
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| Staff to client assault and/or abuse in care *These refer to alleged or actual physical or sexual assault where a client in care is the victim, and the perpetrator is a staff member, a carer or a member of the carer’s household.* | | | | | | | |
| Is this an incident of worker to client assault? | | | Yes  No *If yes, complete remaining items in this section.* | | | | |
| Have immediate client safety needs been met? | | | Yes  No | | | | |
| Has an investigation been initiated? | | | Yes  No | | | | |
| Is this an incident of abuse in care? | | | Yes  No | | | | |
| Please provide details: *e.g. Worker stood down or client removed from placement, quality of support review or other review recommended.* | | | | | | | |
| **Compulsory Treatment** *(for Disability Services clients only):* | | | | | | | |
| Are any of the clients subject to compulsory treatment under the Disability Act (2006) or Aged Care Act (1997) | | | | Yes  No | | | |

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| **Other areas informed** | | | | | |
| Support Advocacy offered? | Yes  No  N/A |  |  | Contact Name: |  |
| Line manager/CEO informed | Yes  No  N/A | Date and Time: |  | Contact Name: |  |
| Police contacted | Yes  No  N/A | Date and Time: |  | Contact Name: |  |
| Police Case Number |  | | | Telephone: |  |
| Coroner Contacted | Yes  No  N/A | Date and Time |  | Contact Name: |  |
| Coroner Case Number |  | | | Telephone: |  |
| Report quality | Yes  No | | | | |

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| Manager’s Name: |  |  |  |
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| Signature: |  | Date: |  |

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| **Part 7: Senior Management Review & Endorsement** | | |
| **Name** |  | |
| **Position** |  | |
| **Incident report quality checked** | | **Yes  No** |
| **Immediate needs of the client are being suitably addressed** | | **Yes  No** |
| **All appropriate immediate actions have been taken in response to the incident** | | **Yes  No** |
| **Corrective Action Request required** | | **Yes  No** |
| **Continuous Improvement Report required** | | **Yes  No** |
| **Please describe what actions have been taken** | | |
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| Manager’s Name: |  |  |  |
|  |  |  |  |
| Signature: |  | Date: |  |