

Care Compliance System

Incident & Accident Report Form

1. Incident Details

Date and Time of Incident: _____

Location of Incident: _____

Person(s) Involved (Name/DOB): _____

Staff Member Reporting: _____

2. Description of Incident

- Describe exactly what happened (factual account only):

3. Immediate Action Taken

First Aid Administered? [] Yes [] No

GP/Ambulance Called? [] Yes [] No

Family Notified? [] Yes [] No

Details of action: _____

4. Witness Statements

Name of Witness 1: _____ Signature: _____

Name of Witness 2: _____ Signature: _____

5. Manager's Review & Root Cause Analysis

Was the care plan followed? [] Yes [] No

Was staffing adequate? [] Yes [] No

Environmental factors (e.g., wet floor, lighting)? _____

Root Cause (Why did this happen?): _____

Action Plan to Prevent Recurrence: _____