INCIDENT REPORT

Manitoba Families

****APPROVED HOMES ONLY**** Revised August 17, 2007

***PLEASE USE BLACK INK AND PRINT LEGIBLY. COMPLETE ALL SECTIONS.**

1. **AGENCY OR FACILITY NAME:** _____
2. **ADDRESS:** _____

_____

3. **DATE OF INCIDENT:** _____ **TIME:** _____

TYPE OF INCIDENT:

ABUSE
- ☐ DEPRIVATION/NEGLECT
- ☐ PHYSICAL
- ☐ EMOTIONAL
- ☐ SEXUAL
- ☐ FINANCIAL
- ☐ VERBAL

MEDICATION
- ☐ ERROR
- ☐ OMISSION
- ☐ P.R.N.
- ☐ REFUSAL
- ☐ OTHER

OTHER:
- ☐ OFF-SITE INJURY OR BRUISING
- ☐ SEIZURE
- ☐ MISCELLANEOUS (EXPLAIN) ____

BEHAVIOURAL
- ☐ RESIDENT TO SELF
- ☐ RESIDENT TO RESIDENT
- ☐ RESIDENT TO STAFF
- ☐ RESIDENT TO OTHER
- ☐ STAFF TO RESIDENT
- ☐ PROPERTY DAMAGE
- ☐ RESTRAINT USED

PUBLIC HEALTH:
- ☐ COMMUNICABLE DISEASE
- ☐ INFESTATION OF BUGS
- ☐ OTHER

LEGAL
- ☐ RESIDENT
- ☐ STAFF
- ☐ POLICE INVOLVEMENT

ACCIDENT:
- ☐ FALL
- ☐ INJURY
- ☐ MOBILITY LIMITATIONS
- ☐ DEFECTIVE STRUCTURE
- ☐ MEDICAL FOLLOW-UP

☐ **AWOL**

☐ **FIRE**

3. NAME(S) OF RESIDENT(S) INVOLVED

1.) _____ DATE OF BIRTH: _____

2.) _____ DATE OF BIRTH: _____

3.) _____ DATE OF BIRTH: _____

STAFF: 1.) _____ 2.) _____

4. LIST ANY FACTORS (SITUATIONS OR BEHAVIOR) WHICH MAY HAVE INFLUENCED OR PRECIPITATED THIS INCIDENT:

_____

_____

5. **DESCRIBE INCIDENT** (Attach additional pages as required)

_____

_____

6. **ACTION TAKEN:** (Attach additional pages as required)

_____

_____

RESTRAINT USED: YES ☐ NO ☐ If **"YES"** please explain _____

a) Is the use of the restraint approved in the care plan? YES ☐ NO ☐

b) Staff trained in **NVCI**? YES ☐ NO ☐ c) **Certificate date:** _____

7. PRESENT STATUS: (Stability of Situation/Safety Issues, etc.)

_____

_____

8. REPORTING OF INCIDENTS: All incidents to be reviewed/assessed by the Supervisor or Designate to determine if and to whom the incident is reportable. Refer to Regulations and Guidelines in Licensing Manual. Indicate date reports filed.

Name of Community Service Worker: _____

DATE NOTIFIED:	**VERBAL REPORT**	**WRITTEN REPORT**
1) Agency Director/Supervisor:		
2) Supervising Agency (CSW):		
3) Licensing Authority (Resource Coord.):		
4) Pharmacy/Doctor notified : _____	☐ yes ☐ no	If yes, date notified : _____

9. FOLLOW UP: INCLUDE MEASURES TAKEN OR PLANNED TO PREVENT SIMILAR INCIDENTS IN THE FUTURE

_____

_____

SIGNATURE OF STAFF INVOLVED **DATE REPORT COMPLETED**

SIGNATURE OF SUPERVISOR **DATE:**