Incident Report

(Behaviour, Client Injury and Medication Error)

Date of Incident: _____**Time of Incident:**_____

Location of Incident: _____

Client's Name: _____

Reporter's Name:_____

Witness' Name:_____

Type of Incident (Behaviour):

Behavioural Concerns: *(Please tick all that apply)*

☐Property Damage ☐Inappropriate Language ☐Running Away

☐Harm to Self ☐Noncompliance (Unsafe in Nature) ☐Threatening others

☐Harm to Others ☐Verbal Altercation ☐Other:_____

Type of Medication Error/Incident: *(Please Tick)*

☐Prescription ☐ Pharmacy ☐ Incorrect Dose ☐Omission

☐ Client Refusal ☐ Incorrect Client ☐Drug Allergy ☐Documentation

☐ Other:_____

Other:

☐Possible Infectious agent (blood or body substances)

Medication Prescribed:

Drug: _____

Dose: _____

Route: _____

Time to be Administered:_____

Prescribed By: _____

Medication Administered:

Drug: _____

Dose: _____

Route: _____

Time: _____

Prepared By: _____

Checked By: _____

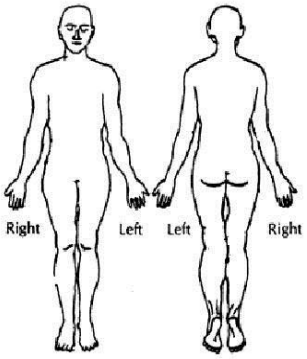
Administered By: _____

Any other persons involved:

Name: _____

Injury/Impact to the person _____

Bodily Location of Injury/Illness: (*Please list below and indicate on diagram)*



Antecedent: *(Prompt: What happened before? Who discovered the incident/error? Why did incident/error occur?)*

Description of Incident:

Consequences of Incident/Error/Intervention/Injury: *(What did you do?)*

Client's response to Intervention:

Hypothesis: *(In your opinion what factors contributed to the incident?)*_____

_____

_____

_____

_____

_____

_____

Were Restrictive Practices Used: Yes / No

Medication/Injury Reporting

Reported to Doctor: Yes / No

Seen by Doctor: Yes / No

Doctors Comments:

_____

_____

Verbal Report Made: ☐ **Date Reported:** _____
Name of Person Reported to: _____
Date Written Report Completed: _____

Checklist:

☐ I have filled out all of the form?

☐I have contacted the Office/On-Call?

☐ I have followed all of the Line Manager's recommendations?

☐ I have submitted the Report?

Staff Name: _____ **Signature:** _____ **Date:** _____

Witness to Incident Name: _____ **Signature:** _____ **Date:** _____

If additional sheets are required, please attach.

MANAGER TO COMPLETE

Brief description of incident: _____

_____

_____

Actions taken to address the incident:

_____

_____

_____

_____

_____

Further actions to be followed up:

_____

_____

_____

_____

Family/Appointed Decision Maker informed: Yes / No

Investigation required: Yes / No

Rationale for decision: _____

_____

_____

Has the Chief Executive Officer been informed? N/A / Yes / No

Has the NDIS Commission been informed? Yes / No

Has the incident been entered onto the Incident Register? Yes / No

Manager's Name: _____ **Signature:** _____ **Date:** _____

Version 1

Author:	CEO Breakaway
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Approved:	10/19
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