COMMUNITY LIVING disABILITY SERVICES
Subject: **Day Services: Incident Reporting – Appendix A – Incident Report**

ADULT DISABILITY SERVICES

Manitoba Families

DAY SERVICES
INCIDENT REPORT

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

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

_____

3. **DATE OF INCIDENT:** **TIME OF INCIDENT:**
4. **TYPE OF INCIDENT:**

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

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

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**

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

5. **NAME(S) OF PARTICIPANT(S) INVOLVED:**

1) _____ Date of Birth: _____
2) _____ Date of Birth: _____
3) _____ Date of Birth: _____

STAFF: 1) _____ 2) _____

6. **LIST ANY FACTORS (SITATIONS OR BEHAVIOUR) THAT MAY HAVE INFLUENCED OR PRECIPITATED THIS INCIDENT:**

7. DESCRIBE INCIDENT (attach additional pages as required):

8. 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 If **YES**, certificate date: _____

9. **PRESENT STATUS (stability of situation/safety issues):**

10. REPORTING OF INCIDENTS: All incidents to be reviewed/assessed by the Supervisor or Designate to determine if and to whom the incident is reportable. Indicate date reports filed.

Name of Community Service Worker: _____

DATE NOIFIED: _____ **VERBAL REPORT:** _____ **WRITTEN REPORT:** _____

1) Agency Director/Supervisor: _____
2) Community Service Worker: _____
4) Pharmacy/Doctor Notified: ☐ YES ☐ NO If **YES**, date notified: _____

11. 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**