

COMMUNITY LIVING disABILITY SERVICES

Subject: **Day Services: Incident Reporting – Appendix A – Incident Report**

ADULT DISABILITY SERVICES

**DAY SERVICES
INCIDENT REPORT**



January 2019

*** 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

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

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:

Date Issued:	January 1, 2019
Replacing:	July 15, 1999

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C	155.12A	1 of 2
Location	Section	Page

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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 NVCII?: 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

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Replacing:	July 15, 1999

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C	155.12A	2 of 2
Location	Section	Page