Yukon
Health and Social Services
Continuing Care

CRP SS	❒	109 Copper Road	❒
CRP A/B	❒	Home Care	❒
CRP C/D	❒	Macaulay Lodge	❒
CRP E/F	❒	TC #2	❒
CRP H/K	❒	TC #3	❒
McDonald Lodge	❒	TC #4	❒

Resident Label
or
Client name: _____
YHIP: _____
DOB: _____

INCIDENT REPORT *(PLEASE PRINT LEGIBLY)*

Date of Incident: _____ Time of incident: _____

Report initiated by: _____ Initials: _____ Date: _____ Time: _____

A. Involved in Incident: *(specify names)*

Staff: _____
(Complete sections A, B, D,E)

Client/Resident: _____
(Complete sections A, B, C, D, E)

Other Staff Witness: _____

Visitor: _____

Volunteer: _____

Other: _____

B. Type of Incident: *(Check all that apply.)*

❒ Event or situation that **could have** caused staff/ resident/visitor injury but **did not** (i.e., Near Miss).
❒ Client/Resident Injury — Details of injury:

_____

❒ Staff Injury — Details of Injury:

_____

❒ Aggressive Behaviour Event (ABE):
- ❒ Physical
- ❒ Verbal

❒ Burn
❒ Choking
❒ Equipment Malfunction

❒ Fall: ❒ Witnessed ❒ Un-witnessed
❒ Post Fall Assessment: ❒ yes ❒ no
❒ Loss/Damage to Property
❒ Smoking
❒ Fire/Fire Alarm
❒ Unsafe Conditions
❒ Wandering/Elopement
❒ Other: _____

C. Client/resident related incidents: *(indicate status PRIOR to incident)*

Mobility: ❒ 1P Assist ❒ 1P Transfer ❒ 2P Transfer ❒ Independent ❒ Lift

Mobility aids: ❒ None ❒ Cane ❒ Walker ❒ Wheelchair ❒ Geri-chair
❒ Other (Specify): _____

Orientation: ❒ Alert/Oriented ❒ Confused ❒ Restless ❒ Sedated ❒ Aggressive
❒ Resistant ❒ Other (Specify): _____

Safety devices in use at time of incident: ❒ Call Bell in reach ❒ Bed Alarm ❒ Brakes (Bed, w/c)
❒ Caution Signs ❒ W/c Seatbelt ❒ Bedrails in Place
❒ Proper Footwear ❒ Other (Specify): _____

INCIDENT REPORT

D. Description of Incident: *(Include location, observed details, action taken, witnesses and outcome. If staff injury, please describe what you were doing at the time and what part of your body was injured.)*

(Please print legibly attach GC PN or personal note) _____

Staff Name *(print)*: _____ Signature: _____ Date: _____

E. Follow-up Action: *(include actions taken, comments, referrals, physician's orders where applicable, etc.)*

Incident recorded in progress notes:	❒ Yes	❒ No *(incident not resident related)*	
Physician notified:	❒ Yes	❒ No	Date/Time: _____
Family notified:	❒ Yes	❒ No	Date/Time: _____
R.C.M.P./Fire Department notified:	❒ Yes	❒ No	Date/Time: _____
Coroner notified:	❒ Yes	❒ No	Date/Time: _____
Post fall/risk assessment:	❒ Yes	❒ No	Date/Time: _____
WCB Employee Form completed:	❒ Yes	❒ No	Date/Time: _____

Team Leader/Supervisor: _____

Name *(print)*: _____ Signature: _____ Date: _____

Program Manager:

Name *(print)*: _____ Signature: _____ Date: _____

Manager, Quality/Risk and Clinical Practice: _____

Name *(print)*: _____ Signature: _____ Date: _____

Print Clear