# Client-Member Incident Report

To be completed and submitted to management within twenty-four (24) hours of the occurrence. All incidents involving client-members must be documented in CAISI and discussed with team members. Additionally, a copy of the Client-Member Incident Report must be placed in the client-member’s file.

## Reporter Information

To be completed by the most involved staff member present at the time of the incident.

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| --- | --- | --- | --- |
| Name: |  | Position: |  |
| Program: |  | Supervisor: |  |
| Date of Report: |  | Time of Report: |  |

## Incident Information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Client-Member Name: |  | | | | | | |
| Date of Incident: |  | | | Time of Incident: | |  | |
| Location of Incident: |  | | |  | |  | |
| Incident Severity: | | ☐ Near Miss | ☐ Minor | | ☐ Moderate | | ☐ Critical |

## Incident Type:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ☐ Medical: | ☐ Fall | ☐ Seizure | ☐ Fainting | ☐ Self-harm |
|  | ☐ Overdose | ☐ Withdrawal | ☐ Injury | ☐ Illness |
|  | ☐ Other: |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ☐ Medication: | ☐ Wrong meds. | ☐ Wrong resident | ☐ Wrong date/time | ☐ Allergy |
|  | ☐ Missed dose | ☐ Extra dose | ☐ Wrong dose | ☐ Initialing incident |
|  | ☐ Spoilage | ☐ Missing meds. |  |  |
|  | ☐ Other: |  | | |

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ☐ Behavioral: | ☐ Guest activity | ☐ Property dmg. | ☐ Aggression | ☐ Threats |
|  | ☐ Other: |  |  |  |

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| Describe the client-member’s history with CommunitiCare Health, including when they became involved with the organization, what services they are connected with, where they have been living, etc. |
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| What happened? Please provide a brief, factual account of the incident. Include how, where and when the incident occurred; the immediate responses of witnesses and staff; who (if anyone) was injured; and the nature and extent of any injuries. |
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## Witness Information

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Program: |  |
| Phone Number: |  | Email: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Program: |  |
| Phone Number: |  | Email: |  |

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## Response Information

Who was notified?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ☐ Co-Worker(s) | Time: |  | Name(s): |  |
| ☐ Supervisor | Time: |  | Name: |  |
| ☐ On-Call Manager | Time: |  | Name: |  |
| ☐ Police | Time: |  | Name: |  |
|  |  |  | Badge Number: |  |
| ☐ Fire | Time: |  | Name: |  |
| ☐ Ambulance | Time: |  | Name: |  |
| ☐ Landlord | Time: |  | Name: |  |
| ☐ Pharmacist | Time: |  | Name: |  |
| ☐ Other | Time: |  | Name: |  |

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| Please describe the immediate response of staff. |
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For injuries:

|  |  |  |
| --- | --- | --- |
| ☐ First Aid treatment administered | Time: |  |
| ☐ Person went to hospital, doctor or clinic | Time: |  |

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| Please describe any treatment which was required (i.e. include name and contact information of individual administering First Aid/CPR, whether informed consent obtained for treatment, etc.) |
|  |

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## Signatures

NOTE: ED signature required for all Moderate and Critical Incidents.

|  |  |  |  |
| --- | --- | --- | --- |
| Reporter: |  |  |  |
| Supervisor: |  |  |  |
| ED: |  |  |  |
|  | Name | Signature | Date |

## For Management Completion

|  |  |  |
| --- | --- | --- |
| Follow-up/Corrective Action Plan | Target Date | Person(s) Responsible |
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|  |  |  |
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| Additional comments: |
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