|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Incident Type:** Choose an item. | | | **Date: of Incident:** | | **Time:** | |
|  | | |  | |  | |
| **Name of person involved:** | |  | | | | |
| **Phone:** | | | | | | |
| **Address of Incident:** | | | | | | |
| **Client/Resident :** | Yes No | | | | | |
| Yes No | Yes No | | | | | |
| **Other:** | Yes No | | | | | |
| **Staff member:** | Yes No | | | **Position:** Choose an item. | |  |
| ***Describe exactly what happened:*** | | | | | | |

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| --- | --- |
| **Injury to person if applicable:**  Please describe injury/damage to property /equipment etc.: | Mark the location of the injury |
|  |

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| --- | --- | --- | --- |
| **Please describe actions taken:**  (including any medical care attended if applicable) : | | | |
| **Incident reported to:** | | | |
| **Date: Tuesday, 14 December 2021** | | **Time: 12:17:57 PM** | |
| **Name of reporter:** | | **Position:** Choose an item. | |
| **Name of person completing form:** | **Position:** Choose an item. | | |
| **Supervisor /Coordinator only** | | | |
| **Incident:**  **Near Miss:** | | | Yes No  Yes No |
| **Is this a Reportable Incident to WorkSafe/Dept. of Health etc.?**  **List authority:** | | | Yes No **If yes, Call CEO immediately** |

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| **Actions taken by Supervisor/Coordinator:** |
| **Date Incident entered into Carelink (if applicable):** |

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| --- |
| Have any controls been initiated to prevent this incident occurring again? Please List: |

|  |  |  |
| --- | --- | --- |
| **Does this incident highlight a deficit?** | | |
| Policy: | Yes No | Please list: |
| Education: | Yes No |
| Equipment: | Yes No |
| Resources: | Yes No |
| Other: | Yes No |  |

|  |  |  |
| --- | --- | --- |
| **Staff Injury:** | Yes No N/A | |
| **Date of Follow up call to client/ staff member:** | | Time: |
| **Outline their condition:**  **Date Notification of Injury Form completed and forwarded to Incident Mailbox ( incidents@mercyservices.org.au:** | | |

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| --- | --- | --- | --- |
| **Name of coordinator/supervisor:** | **Position:** Choose an item. | | |
| **Date form completed:** | | | |
| **Head of Department** | | | | |
| **Date Review by Head of Dept**: | | | | |
| **Name:** | | **Position:** Choose an item. | | |
| **Further actions required:** | | | | |
| **Quality, Health & Safety Coordinator** | | | |
| **Allocated Incident Number:** | | | |
| **Is this an ongoing risk to be entered into Risk Register:** | | | Yes No |
| **Date Entered in Risk Register:** | | | |
| **Further actions required:** | | | |