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| --- | --- | --- |
| **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:       |

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| **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:** |