Best Practice Nursing Agency

# Incident Report Form

**Must be completed by staff within 24 hours of incident**

In determining what to include in an incident report and which details can be omitted, just concentrate on the facts. Describe what you saw when you arrived on the scene or what you heard that led you to believe an incident had taken place. Put second hand information in quotation marks, whether it comes from a client, colleague, visitor or patient, and clearly identify the source. Include the full names of those involved and any witnesses, as well as any information you have about how, or if, they were affected. Add other relevant details such as your immediate response—calling for help for example, and notifying the client's family or physician.

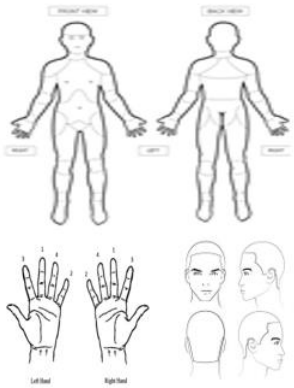
| **PARTICULARS OF INCIDENT:** | | |
|---|---|---|
| Date: | Time: am/pm | Location: |
| **TYPE OF INCIDENT:** (please tick box below) | | |
| ☐ Injury ☐ illness ☐ First Aid ☐ Environmental ☐ Other: | | |
| Reported by: | | Phone: |
| Role in the event: | | Email: |
| **DETAILS OF INJURED PERSON:** (please tick box below) | | |
| ☐ Employee ☐ Client ☐ Visitor ☐ Office Staff ☐ Other: | | |
| Name: | Gender: ☐ Male ☐ Female | Date of Birth: |
| Address: | Suburb: | Email: |
| **WITNESS(S):** | | |
| Name: | Phone: | Email: |
| Name: | Phone: | Email: |

**NATURE OF INJURY:** (please tick box, indicate all relevant below)

□ Slip/Trip/Fall □ Manual Handling □ Bruising □ Fracture □ Sprain/Strain □ Skin tear □ Cuts/Scratch □ Abrasion □ Burn

□ Bite/Sting □ Concussion □ Psychological □ Violence □ Verbal Behaviour □ Physical Assault □ Other:

**BODILY LOCATION/S**



**Brief description of incident:** (describe the task, equipment, tools and people involved. Include any action taken)

**DESCRIBE ANY ILLNESS OR INJURY:** What part of the body is affected and how?

**DESCRIBE ANY PROPERTY DAMAGE:** What damage was caused and how?

**ANALYSIS:** What do you think caused or contributed to the incident?

**PREVENTION:** What action has been taken to prevent a reoccurrence?

| **TREATMENT:** (please tick box below) | | |
|---|---|---|
| Was first aid or treatment required? □ YES □ NO | Person providing treatment: | |
| Referred to Hospital? □ YES □ NO | Name of Hospital: | |
| Type of treatment provided: | | |
| **PERSON COMPLETING INCIDENT FORM:** | | |
| Name: | Signature: | Date: |

Submit a completed copy to info@bpna.com.au or fax 02 9588 2827 within 24 hours

**OFFICE USE ONLY: ACTION TAKEN** (please tick box below)

| | |
|---|---|
| Has the incident been acknowledged by management? | □ YES □ NO |
| Does the incident require further investigation? | □ YES □ NO |
| Investigation Methods: | □ Phone □ SMS □ Interviews □ Written statements □ Other: |
| Brief Summary of findings: (refer to attachments if necessary) | |
| Causal factors identified: | □ People: □ Equipment/plant: □ Environment:<br>□ Processes/procedures: □ Organisational factors: |
| Recommendations: | □ Elimination: □ Substitution: □ Isolation:<br>□ Administrative: □ PPE: |
| Will recommendations eliminate all hazards? | □ YES □ NO |

| **Manager investigating Incident:** | | |
|---|---|---|
| Name: | Signature: | Date: |