**SOARR** **Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INCIDENT REPORT FORM**

 **Staff Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please document all incidents (client problems, visitor problems, staff errors, vehicle accidents, injuries, confrontations, equipment failures, emergency events, etc.) Give the original to the Program Director and if client-related, insert a copy in the client’s chart.

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| DATE: TIME: |
|  ❑ Outpatient Client ❑ Visitor ❑ Equipment /Property ❑ Staff ❑ Other |
| Name of witness / first person to attend: ❑ Staff ❑ Client ❑ Visitor |
| Location: |
| Description of what happened (brief description of incident including the immediate actions and outcome) Objective information only. |
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| Immediate actions and outcome: |
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| Contributing factors (consider system, staff, client and visitor issues – did any of these contribute to the incident?) |
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| Prevention (Ideas of how this could have been prevented): |
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| Family notified? : ❑ Yes ❑ No ❑ N/A |
| Medical/Clinical Staff notified? : ❑ Yes ❑ No ❑ N/A |
| Reported By: Position: Tel#: |
| Other persons: Position: Tel#: |
| Staff member responsible for area at time of incident: |
| Has the incident been documented in the client’s chart: ❑ Yes ❑ No ❑ N/A |
| Unit Manager or Department Head: |
| Outcome: ❑ 1. Potential for harm, dangerous state but no event ❑ 2. Potential for harm, dangerous state and event intercepted ❑ 3. No adverse outcome ❑ 4. Minor outcome, clinical review, extra observations or monitoring ❑ 5. Moderate outcome, clinical review with administration intervention ❑ 6. Mod/significant outcome, Transfer to another facility for treatment ❑ 7. Significant outcome, emergency hospital admission  ❑ 8. Severe outcome, Permanent disability or contributed to the client’s death |
| Preventive measures taken to prevent reoccurrence:  |
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| Administration: |
| Review by: Position:  |
| Date: |
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