



**Critical Incident / Unusual Occurrence  
Homecare**

DATE:

CLIENT:

REPORTING STAFF (Name):

POSITION:

- Medication Incident (Error / Other)
- Client Fall (Witnessed / Unwitnessed)
- Difficult Client Behaviour(s)
- Safety Concerns (Employee)
- Missed Visit (CFS Error)
- Continuing Care Reportable Incident\*
- Other

\*Follow AH&W Guidelines

**REPORT OF INCIDENT:** (concisely describe / carefully document details)

**PRE-INCIDENT CIRCUMSTANCES:** (describe location, time, who was present, and circumstances leading up to the incident)

Cont'd. over page

**ACTION TAKEN:** (follow-up: reporting to supervisor, contact with emergency or support services, ensuring client safety – include times and dates)

**LEARNING OUTCOME:**

**REPORTED TO:**

**DATE:**

**TIME:**

**SUPERVISOR COMMENTS:**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**REVIEWED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

- |  |  |  |                                      |
|--|--|--|--------------------------------------|
| <b>Recommendations:</b>                      | <input type="checkbox"/> Communication Required          | <input type="checkbox"/> Policy/Procedure Review | <input type="checkbox"/> Mgmt Review |
| <input type="checkbox"/> Disciplinary Action | <input type="checkbox"/> Client/Case Conference Required | <input type="checkbox"/> OH&S Review             |                                      |