Elizabeth Richardson Center

ERC

Enhancing lives
Removing barriers
Creating opportunities

ERC ACCIDENT/CRITICAL INCIDENT and INVESTIGATION REPORT

Report of ☐ **Accident** ☐ **Near Miss** ☐ **Critical Incident** (see check list below)

Check "Critical Incident" as applicable: ☐ Medication errors, ☐ Use of seclusion or restraint, ☐ Communicable disease, ☐ Infection control, ☐ Violence, ☐ Use or possession of weapon(s), ☐ Elopement or wandering, ☐ Vehicular accidents, ☐ Biohazard accidents, ☐ abuse or neglect, ☐ Unauthorized or possession of licit or illicit substances, ☐ Suicide or attempted suicide.

Date of this Report ______________ Date & Time of Injury ________________________
Date Time

Name of Individual Involved: ____________________________ ☐ Employee ☐ Client

If a client was injured, please use figures on back of this form to indicate location of injury/injuries.

Gather and record the facts/take pictures – Where did the incident/accident take place?

How did it happen? (Describe sequence of events that led to incident/accident?)

Exactly what happened? (Describe incident/accident.)

To whom was the incident/accident reported? (Include 911, physicians, case managers, etc.)

Who witnessed the accident?

What immediate steps were taken to prevent this from happening again?

Was a report to supervisor delayed? ☐ No ☐ Yes If yes, why?

MEDICAL TREATMENT

Was first aid provided? ☐ No ☐ Yes If yes, describe ____________________________

Was off-site medical treatment required? ☐ No ☐ Yes If so, who and where was the medical treatment administered? (Name and address of physician/clinic, etc.)

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INVESTIGATION FINDINGS:

What action(s) are being taken, and by whom, to prevent recurrence of this type of accident/incident/injury in the future?

Recommendations/Conclusions:

Printed name of person filling out the accident report: ____________________________

Signature of person filling out accident report: ____________________________________

NOTE: If this is a report of Abuse/Neglect, additional forms may be required for DDS/OLTC

ROUTE THIS REPORT TO:

IF STAFF INJURY – Route to Immediate Supervisor of Injured Staff
IF CLIENT INJURY – Route to Case Manager of Injured Client (Certified Teacher at PS)

Supervisor/Case Manager/Certified Teacher Signature __________________________ Date__________

Investigated By Program Management Team

Signature of Program Director ____ Date__________

Sent to Chief of Operations (COO)

Signature of COO ____ Date__________

IF INJURY IS TO A CLIENT – PLEASE PLACE AN "X" AT THE LOCATION OF THE INJURY/INJURIES.

Right Hand - Inside

Right Hand - Outside

Left Hand - Inside

Left Hand - Outside