Appendix B

INCIDENT IMMEDIATE RESPONSE REPORT FORM 1 TO BE COMPLETED AS SOON AS POSSIBLE AFTER INCIDENT AND SUBMITTED TO NURSE MANAGER

Time of Incident [HH:MM]

OCISM CONTACTED

◯ YES

◯ NO

Date of Incident yyyy-mm-dd

Community

Name of Health Care Providers Involved

Name of Contact [person completing form]

Describe Incident [do not include names or identifiers of patients]

Patient Safety or Non Patient Safety

◯ ***Patient Involved YES [completed rest of Form before submitting to Regional Nurse Manager]***

◯ ***Patient not Involved NO Submit form to Regional Nurse Manager immediately***

PATIENT INVOLVED PLEASE COMPLETE APPLICABLE PARTS OF FORM

R.E.S.P.O.N.D

- ☐ Respond to immediate situation with patient needs
- ☐ Environmental safety and security for patient and other staff
- ☐ Secure and remove any product or equipment involved, note location below
- ☐ Protect other patients and staff, and ensure measures are in place to prevent recurrence of incident
- ☐ Offer support to those involved, if necessary provide quiet space and counselling
- ☐ Notify Nurse Manager/Patient Safety Officer
- ☐ Disclosure: Did it happen, if so fill out section below. Documentation.

DISCLOSURE: to whom/by whom Date yyyy-mm-dd Time HH:MM

Date Form completed yyyy-mm-dd Time Form Completed MM:HH

Regional Office to Complete

Date form received.[yyyy-mm-dd] Time form received[HH:MM] Name of person receiving form

FORM SENT TO OCISM by NM

- ◯ YES
- ◯ NO

Nurse Manager Report