**Friends and Places Together– Incident/Accident Report**

Part A – to be completed and sent to Chief Officer within 48 hours of incident/accident by (or on behalf of) each person affected by an accident, occupational disease, violence (actual or threat) Please tick all appropriate boxes, leave blank boxes that don’t apply, use a continuation sheet if necessary: Tick here if continuation sheet has been used

**Report No:**

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| **1. Person injured/affected:**    Name: Gender: Male Female  Home address:    Status: Carer Client/Service User  / |

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| **2. Incident/Accident details:**    Date of incident/accident Time:  Premises/site Exact location:      (eg. room no., kitchen) |

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| **3. About the Incident/Accident:** What happened? (who was doing what at the time of the accident). |

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| **4. Witnesses name and contact details:**    /  **Statement(s) attached: Yes No** |

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| **5. Accident Type (please tick one box only)**  moving/handling of object slip/trip/fall on same level violence moving/handling of person  fall from height road traffic collision struck against machinery/equipment  animal contact struck by electrical injury near miss  sharp object awkward movement hot/cold contact hazardous substance  other (please specify) |

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| **6. Complete for violent incidents only - Incident details (please tick one box)** please tick if person  was not necessarily  **Nature of Incident -** Physical assault threat/verbal abuse property damaged responsible for  (inc. telephone and written) their actions  **Nature of Activity -** support/ personal care transporting client other  assisting (please specify)  **Other Factors -** was carer/ were police was a weapon some form of prejudice  client alone? involved? used?    physical intervention/restraint challenging behaviour  **Details of third party/aggressor involved:** Name & Address: |

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| **7. If injured:**  What part(s) of the body were affected e.g. head, arm (please indicate left or right)  **If injured detail injury**: cut/abrasion  bruise burn/scald  twist/strain  fracture foreign objectother(please specify)  **consequences**: none first aid received sent to hospital  **any other details:** (details of first aid should be included here and records kept locally)  **people informed: e.g. next of kin, parents** |

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| **8.**      Signature Date    If signing on behalf of the affected person please state your: Name Position  Address |

**PART B - *To be completed by the Chief Officer***

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| **9. What action has been/could be taken to prevent a re-occurrence?** |

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| **10. Recommended action to be taken?** |

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| **11. Staff completing this form**    Name signed Job title    (please print)      Office address Tel no. Date |