Guardian Light
quality care services

Guardian Light Quality Care Services

INCIDENT REPORT

CONFIDENTIAL – Quality & Risk Management Use

1. INCIDENT INFORMATION

Individual involved	
Date of birth	
Facility / program	Guardian Light Quality Care Services
Address	7060 Temple Drive NE, Calgary
Location of incident / room #	
Date of incident (day, month, year)	
Time of incident (24 hr)	
Shift	☐ Day ☐ Evening ☐ Overnight (awake)
Type of incident	☐ Behavioural / agitation ☐ Physical aggression ☐ Self-injurious behaviour ☐ Property damage / disruption ☐ Seizure ☐ Fall ☐ Injury ☐ Medication error ☐ PRN medication given ☐ Incontinence / hygiene care ☐ Staffing issue (below required ratio) ☐ Physical intervention / restraint ☐ Other: _____
Recurring incident?	☐ Yes – previous date(s): _____ ☐ No
Report prepared by (name, role)	
Staff present / involved (name, role, time arrived if called in)	
Other witnesses	
Date / time report completed	

2. SUMMARY OF INCIDENT

3–5 sentences: what happened, when, where, who was involved, what staff did, and the outcome. Facts only.

3. RELEVANT BACKGROUND

Optional: recent similar incidents, medication changes, health concerns, or anything else that gives context.

4. DESCRIPTION OF EVENTS (CHRONOLOGICAL)

One row per event, in time order. Include what happened just before the incident, each staff action, medication times, and when the individual returned to baseline. Describe exactly what you saw and heard.

Time	Event / Observation

5. BEHAVIOUR ANALYSIS (ABC)

Complete for behavioural incidents.

Setting event (e.g., staffing change, illness, poor sleep)	
Antecedent (what happened right before)	
Behaviour (what was observed; start–end time)	
Consequence (staff response and outcome)	

6. SEIZURE OBSERVATIONS

Complete for seizures only.

Seizure type (as observed)	☐ Tonic-clonic ☐ Focal ☐ Absence ☐ Unsure / other: _____
Start / end time	Start: _____ End: _____ Onset witnessed? ☐ Yes ☐ No
Duration	
Description (stiffening, jerking, body parts, sides, eyes, colour)	
Breathing during / after	
Incontinence	☐ None ☐ Bladder ☐ Bowel
Post-ictal presentation and duration	

Rescue medication per seizure plan	☐ Not prescribed ☐ Not required ☐ Given – see Section 8
Emergency services (911) called?	☐ Yes – time: _____ ☐ No – reason: _____

7. INTERVENTIONS USED

☐ Verbal reassurance / calm communication ☐ Verbal redirection ☐ Gave space / reduced demands
☐ Removed hazards / items within reach ☐ Protective support (describe below) ☐ Seizure protocol followed
☐ Backup staff called ☐ PRN medication (Section 8) ☐ Personal / hygiene care provided

Physical intervention / restraint used: ☐ No ☐ Yes – type, duration, staff involved (must be approved in the individual's plan):

Details of interventions:

8. MEDICATION ADMINISTERED (PRN / RESCUE)

☐ None ☐ Yes – complete table

Time	Medication	Dose	Route	Given by	Reason	Effect / response (time)

Given per PRN protocol (incl. interval / combination): ☐ Yes ☐ No **Recorded on MAR:** ☐ Yes ☐ No
On-call / nurse consulted: ☐ Yes ☐ No

Post-medication observations (sedation, stiffness, unusual movements, other side effects):

9. VITAL SIGNS / POST-INCIDENT ASSESSMENT

Complete when required by protocol (e.g., after a seizure, fall, or head injury).

Time	BP	HR	RR	O_2 sat	Temp	LOC / orientation

10. INJURIES, PROPERTY DAMAGE AND CARE

Injury to individual	☐ None noted ☐ Yes – describe: _____ Body check by: _____ at ____
Injury / exposure to staff	☐ None ☐ Yes – describe: _____
Property damage	☐ None ☐ Yes – describe: _____
First aid / medical attention	☐ Not required ☐ Provided – describe: _____

Infection control (if bodily fluids involved)	PPE used: _____ Area cleaned / disinfected with: _____
Skin check (if incontinence)	☐ Intact ☐ Concerns – describe: _____

11. STAFFING

Required staffing ratio	☐ 1:1 ☐ 2:1 ☐ Other: _____
Staff on site at time of incident	Number: _____ ☐ Met required ratio ☐ Below required ratio
Backup / additional staff called	☐ No ☐ Yes – who: _____ called at: _____ arrived at: _____
Shift extended / other staffing impact	

12. NOTIFICATIONS

Notified	Name	Date / time	Method
Supervisor / Program Manager			
On-call / Nurse			
Behaviour / Clinical Consultant			
Physician / Prescriber			
Family / Guardian / POA			
Other:			

13. RECOMMENDATIONS / FOLLOW-UP

Actions to prevent a repeat, clinical referrals, care plan changes, staffing needs, and monitoring.

Recommendation / action	Responsible	Due date

14. SIGN-OFF

	Name	Signature	Date
Report completed by			
Supervisor / Reviewer			

Supervisor comments / actions taken	