GOVERNMENT OF BERMUDA

Ministry of Health

Ageing and Disability Services

Care Homes Mandatory Reporting Form

Complete and submit this form to Ageing and Disability Services for mandatory reporting requirements in accordance with criteria 20.2 in the Code of Practice. Note- mandatory reporting for Administrator/Operator changes is done on the Change of Information form prior to any changes made.

Name of Care Home:	
Type of Report:	☐ Injury resulting in hospitalization (falls, medication errors, etc) ☐ Unexplained injury ☐ Suspected, alleged or known Abuse or Neglect ☐ Missing persons ☐ Unauthorized or inappropriate use of restraint ☐ Regulatory action by another authority (e.g. Health and Safety; Tax Commissioner, Bermuda Health Council, etc) ☐ Other:

Name of Care Recipient(s) involved in an incident (if any):

	Date of Birth:	
	Date of Birth:	
	Date of Birth:	

General description of Care Recipient(s) prior to incident (level of care, communication/ mobility/sensory/cognitive challenges):

Description of Incident or Issue (continues on page 2)

Date:		**Time:**	

Continental Building, 25 Church Street, Hamilton, HM 12, Bermuda
Phone: (441) 292-7802/ Fax: (441) 292-9125/ ads@gov.bm

Witnesses or key persons involved in incident:		
Name:		
	Contact information:	
	Position in Care Home :	
Name:		
	Contact information:	
	Position in Care Home :	
Name:		
	Contact information:	
	Position in Care Home :	

Actions (check all that apply):	
☐ Hospitalization	Date:
☐ Contacted Next of Kin	Date:
☐ Contacted GP	Date:
☐ Contacted ADS (other than this form)	Date:
☐ Senior Abuse Report sent to Senior Abuse Registrar	Date:
☐ Reported to Epidemiology and Surveillance	Date:
☐ Reported to Occupational Health and Safety	Date:
☐ Reported to Bermuda Nursing Council	Date:
☐ Other (include date):	
Provide outline of additional actions taken and plan to prevent reoccurrence:	

Signature **Date**

Print Name **Position in Care Home**