

Workplace Incident Form

Employers are required to send written notice of certain kinds of accidents to the Director of the Occupational Health and Safety Division of the Department of Labour: Within **24 hours** if someone at the workplace is killed from any cause or if there is an **accidental explosion** at the workplace (even if no one was hurt) and Within **7 days** if there is a **fire or accident** at the workplace that causes **bodily injury** to an employee.

“Bodily injury” means unconsciousness, substantial blood loss, fracture of an arm or leg, amputation of a leg, arm, hand or foot, burns to a major part of the body, loss of sight in an eye or any injury that places life in jeopardy.

EMPLOYEE TO COMPLETE SECTIONS 1 TO 6

1. Contact information

| | | | |
|--|-------------------|--|---|
| Name: | | Department: | |
| Contact information: | | Position: | Resident/Client involved: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of incident: | Time of incident: | Location of incident: | |
| Date of report: | Time of report: | To whom was incident reported?: | |
| Witness to incident: | | Telephone number: | |
| Witness to incident: | | Telephone number: | |
| WCB Lost time? <input type="checkbox"/> Yes* <input type="checkbox"/> No | | WCB Medical Aid? <input type="checkbox"/> Yes* <input type="checkbox"/> No | First Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No |

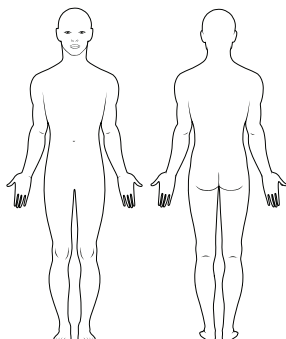
2. Incident type: (check all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Fall | <input type="checkbox"/> Exposure | <input type="checkbox"/> Violence | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Trip/Slip | <input type="checkbox"/> Body mechanics | <input type="checkbox"/> Physical injury | <input type="checkbox"/> Equipment malfunction |
| <input type="checkbox"/> Reaction | <input type="checkbox"/> Needle stick | <input type="checkbox"/> Threatening behaviour | <input type="checkbox"/> Other (describe): |
| <input type="checkbox"/> Struck against/by | <input type="checkbox"/> Missing item/theft | <input type="checkbox"/> Verbal threat | |
| <input type="checkbox"/> Caught in | | <input type="checkbox"/> Written threat | |
| | | <input type="checkbox"/> Harassment/Bullying | |
| | | <input type="checkbox"/> Domestic violence | |

3. Result of injury: (check all that apply)

- | | | | | | |
|---|--|------------------------------------|--|-------------------------------------|--|
| <input type="checkbox"/> No apparent injury | <input type="checkbox"/> Bruise | <input type="checkbox"/> Burn | <input type="checkbox"/> Pain: Dull/aching Sharp | <input type="checkbox"/> Laceration | <input type="checkbox"/> Nauseated |
| <input type="checkbox"/> Abrasion | <input type="checkbox"/> Strain/Sprain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Puncture | <input type="checkbox"/> Rash | <input type="checkbox"/> Possible fracture |
| <input type="checkbox"/> Other (describe): | | | | | |

4. Part of body: circle location on body injured

| | |
|--|---------------------------------|
|  <p>Right Left Left Right</p> | Describe injury in more detail: |
|--|---------------------------------|

Step 1: Control the Scene

Step 2: Collect the Facts

Step 3: Identify/Review Possible Contributing Factors

Step 4: Conduct Interviews/Identify the Root Causes

Step 5: Develop & Implement Corrective Actions

Step 6: Report and Evaluate Corrective Actions

5. Incident source: (check all that apply)

- | | | | | |
|--|--|--|-------------------------------------|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Bed (describe): | <input type="checkbox"/> Tub | <input type="checkbox"/> Ladder | <input type="checkbox"/> Fire |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Shower | <input type="checkbox"/> Shelving | <input type="checkbox"/> Flood |
| <input type="checkbox"/> Transfer | <input type="checkbox"/> Walker/Cane | <input type="checkbox"/> Toilet/Commode | <input type="checkbox"/> Stove | <input type="checkbox"/> Infectious organism |
| <input type="checkbox"/> Mechanical lift | <input type="checkbox"/> Chair | <input type="checkbox"/> Employee | <input type="checkbox"/> Heat/Cold | <input type="checkbox"/> Stairs |
| <input type="checkbox"/> Repetitive task | <input type="checkbox"/> Spill (describe): | <input type="checkbox"/> Resident/Client | <input type="checkbox"/> Chemical | <input type="checkbox"/> Equipment (describe): |
| <input type="checkbox"/> Over reaching | | <input type="checkbox"/> Intruder | <input type="checkbox"/> Ice/Snow | |
| <input type="checkbox"/> Other (describe): | | | <input type="checkbox"/> Electrical | <input type="checkbox"/> Wet floor |

6. Additional Incident description: To ensure that root causes are identified so that timely remedial action takes place to prevent recurrences, describe any additional details not included above.

SUPERVISOR TO COMPLETE SECTIONS 7 TO 14

7. Incident factors: (check all that apply)

| Environment | Material/Equipment | Organizational Factors | Task | Employee |
|--|--|--|---|---|
| <input type="checkbox"/> Slippery floor <input type="checkbox"/> Clutter <input type="checkbox"/> Building condition (describe): <input type="checkbox"/> Fire <input type="checkbox"/> Explosion <input type="checkbox"/> Poor lighting <input type="checkbox"/> Snow <input type="checkbox"/> Ice <input type="checkbox"/> Not using designated safe path <input type="checkbox"/> Noise <input type="checkbox"/> Poor ventilation <input type="checkbox"/> High/Low temperature <input type="checkbox"/> Building security <input type="checkbox"/> Other: | <input type="checkbox"/> Bed position <input type="checkbox"/> Bed up <input type="checkbox"/> Bed down <input type="checkbox"/> Rails up <input type="checkbox"/> Rails down <input type="checkbox"/> Brakes locked <input type="checkbox"/> Equipment <input type="checkbox"/> Failure <input type="checkbox"/> Unavailable <input type="checkbox"/> Improper labeling <input type="checkbox"/> Defective safety devices <input type="checkbox"/> Inadequate tools/materials <input type="checkbox"/> Alarm malfunction <input type="checkbox"/> Other: | <input type="checkbox"/> Inadequate safety measures <input type="checkbox"/> Staff shortage <input type="checkbox"/> Appropriate staffing <input type="checkbox"/> Policy/Procedure/Protocol not in place <input type="checkbox"/> Policy/Procedure <input type="checkbox"/> not in place <input type="checkbox"/> not enforced <input type="checkbox"/> outdated <input type="checkbox"/> Work load <input type="checkbox"/> Maintenance required on: <input type="checkbox"/> Other: | <input type="checkbox"/> Resident/Client transfer <input type="checkbox"/> Resident/Client repositioning <input type="checkbox"/> Resident/Client lifting <input type="checkbox"/> Manual material handling <input type="checkbox"/> Medication dispensing/preparation <input type="checkbox"/> Cleaning activities <input type="checkbox"/> Laundry <input type="checkbox"/> Maintenance (describe): <input type="checkbox"/> Delivery of care <input type="checkbox"/> Snow removal <input type="checkbox"/> Other: | Were any of the following a factor: <input type="checkbox"/> Body mechanics <input type="checkbox"/> Footwear <input type="checkbox"/> Training <input type="checkbox"/> Care plan information <input type="checkbox"/> Distraction <input type="checkbox"/> Fatigue <input type="checkbox"/> Miscommunication <input type="checkbox"/> PPE <input type="checkbox"/> Safety devices <input type="checkbox"/> Equipment operation <input type="checkbox"/> Policy/Procedure application |

8. Resident/Client risk factors (if the incident of violence involved a resident/client, **identify the most appropriate catalyst, cause or influencer of the violent behaviour**)

| Resident/Client behaviour | Resident/Client care | Situational events |
|---|--|---|
| <input type="checkbox"/> Person exhibiting challenging behavior as a result of a cognitive impairment (e.g. Dementia, autism, mental health disorder, Alzheimer's): | <input type="checkbox"/> Treatment or care being delivered that may cause discomfort or agitation (e.g. physical transfers, toileting, bathing, etc.) Identify the treatment or care: | <input type="checkbox"/> Transition event: Resident/client is between points of care (e.g. move to different room, location, etc.) <input type="checkbox"/> Intervening event Resident/client restricted in order to keep from harming himself/herself or others. <input type="checkbox"/> Redirecting: helping resident/client to go to a specific location (e.g. their room, cafeteria). |

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9. Resident/Client behaviour pattern (if the incident of violence involved a resident/client, complete the information below)

What behavior was observed prior to the incident of violence?

What was happening just before the incident of violence occurred?

What happened right after the incident of violence occurred?

10. If this was a violence incident, was the Employee provided with support information (e.g. Counselling contact)

Yes No Not applicable

11. Root cause analysis: Describe what acts, failures to act and/or conditions contributed most directly to this incident.

A.

B.

C.

12. Corrective actions: What action has been taken, or will be taken to prevent recurrence? What is the plan to communicate remedial steps taken to prevent recurrences which includes debriefing with employees?

| | Responsible party | Completion date |
|----|-------------------|-----------------|
| A. | | |
| B. | | |
| C. | | |

13. Agencies notified:

JOSHSC Co-Chair OH&S Division Corporate / Legal

14. Employee comments: Preventative Action satisfactory? Yes No

Reviewed by:

Signature:

Date:

Reviewed by:

Signature:

Date:

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