

SOUTH FRASER HOME SUPPORT SERVICE SOCIETY

INCIDENT/INJURY REPORT FORM

Incident No: _____

EMPLOYEE INFORMATION

Last Name: _____ Given Name(s): _____ Gender: M F
 Date of Birth: _____ dd/mm/yy Phone (home): _____
 Years in current position: _____ Job Title: _____ Status: Full-Time Part-Time Casual
 Area: _____ Mgr./Supervisor: _____ Phone/Local: _____
 Date of Incident: _____ Time of Incident: _____ Shift Start Time: _____ Shift End Time: _____
dd/mm/yy
 Date Reported: _____ Time Reported: _____ Reported To: _____
dd/mm/yy
 Hours worked in 24 hours preceding incident: _____ (# of hrs) Day _____ of a _____ day rotation

INCIDENT INFORMATION

Incident category: Injury/Illness Chemical Hazard Equipment malfunction Property
 Biohazard Near miss Motor vehicle accident Other _____
 Actions Following Incident: (check all that apply)
 First Aid Remained at Work Medical Aid (saw/will see doctor) Lost time injury (missed/will miss time beyond injury date)
 Client Name: _____ Address: _____

Location of Incident (Room): _____ **Witness(es):** _____

Description of injury/illness, the nature of the injury (e.g. strain, cut, bruise, blood exposure, burn, etc.) **and the body part affected** (e.g. back, shoulder, finger).

Have you had a previous incident causing similar pain or discomfort? Y N

Describe how the incident happened:

How do you feel this incident could have been prevented? (e.g. procedure, layout, equipment) (Recommendations)

Did the injury result from a violent incident? Y N **If yes, please answer the questions below.**

Assailant Name (if known): _____ Gender: M F Age: _____
 Assailant Description: _____
 Was the assailant known from previous violent incidents? Y N Have there been similar incidents in the past? Y N
 Reported to Police/Security? Y N Investigation initiated? Y N Police Report No: _____

Signature of Employee: _____

Date Report Completed: _____

Copies Sent to Supervisor? Y N

Copies Available to OH&S Representative? Y N

INCIDENT/INJURY REPORT FORM

Incident No: _____

INJURY/ILLNESS INFORMATION

NATURE OF INJURY (check all that apply)

- Cut / laceration / puncture / scratch / abrasion (no BBF)
- Bruise / contusion / crush
- Sprain / strain (soft tissue injury)
- Fracture / dislocation
- Heat effects - burn / scald / heat exhaustion
- Cold effects
- Blood or body fluid exposure (BBF)
- Bite:
 - Human
 - Insect or animal
- Occupational illness / allergic reaction / diseases
 - Headache / dizziness
 - Respiratory symptoms
 - Dermatitis / cutaneous irritation
 - Eye irritation / burning eyes
 - Multiple system involvement
- Hearing Effects (e.g. explosion, loud noise)
- Documentation of exposure (e.g. antineoplastics)
- Psychological trauma / PTSD

BODY PART AFFECTED (check all that apply, indicate side)

No reaction to any systems or body part

<input type="checkbox"/> Eyes	R	L
<input type="checkbox"/> Mouth (teeth, tongue)	R	L
<input type="checkbox"/> Head / face	R	L
<input type="checkbox"/> Ears	R	L
<input type="checkbox"/> Neck	R	L
<input type="checkbox"/> Arms	R	L
<input type="checkbox"/> Shoulder	R	L
<input type="checkbox"/> Hand / wrist / finger(s)	R	L
<input type="checkbox"/> Upper back	R	L
<input type="checkbox"/> Middle back (thoracic)	R	L
<input type="checkbox"/> Lower back	R	L
<input type="checkbox"/> Buttock	R	L
<input type="checkbox"/> Trunk (chest, rib, abdomen, hip)	R	L
<input type="checkbox"/> Groin	R	L
<input type="checkbox"/> Upper / lower leg	R	L
<input type="checkbox"/> Knee	R	L
<input type="checkbox"/> Ankle	R	L
<input type="checkbox"/> Foot / toe(s)	R	L

MECHANISM OF INJURY (check all that apply)

- Exertion (assisted or unassisted):**
 - Equipment / material handling:*
 - Pulling / Pushing
 - Lifting/lowering
 - Other _____
 - Natural Activity*
 - Walking/running
 - Reaching
 - Bending
 - Cumulative trauma
 - Twisting
 - Patient Handling: (please complete box A, pg 3)*
 - Repositioning a client
 - Assisting client to walk/stand
 - Transferring a client
 - Repetitive, cumulative activity
 - Assist from floor
 - Unexpected client movement
 - Preventing a client fall
 - Other
 - Other:* _____
- Fall** (includes falling against, into objects, trips, slips)
- Struck / bumped / banged / hit by / rubbed / abraded**
- Caught in / under / between wall, equipment, door**
- Exposure to hazardous substance / agents:**
 - Chemical Name:* _____
 - Inhalation
 - Ingestion
 - Skin/eye contact
 - Latex or powder in gloves
 - Medicines (e.g. antineoplastics)
 - Solvents/gases/fumes/corrosives/poisons/smoke
 - Soaps
 - Cold, heat, noise
 - Radiation, electricity
 - Dusts
 - Communicable Diseases:
 - Parasite (e.g. scabies, lice, ringworm)
 - Bacteria (e.g. TB, chicken pox, rubella)
 - Fungus (e.g. mould)
 - Other _____
 - Airborne transmission
 - Direct contact transmission
 - BBF spill / splash
 - Sharps Handling*
 - Recapping needle
 - Subcutaneous or IM injection
 - Disposing needle / sharp in container
 - Clean needle
 - Other
- Violence / Aggression** (please complete box B, pg 3)
- Drug / Immunization reaction**
- Other allergic reaction (e.g. bee sting)**
- Unknown event**

INCIDENT/INJURY REPORT FORM

Incident No: _____

INJURY/ILLNESS INFORMATION

BOX A: PATIENT HANDLING

BOX B: VIOLENCE/AGGRESSION

Was client confused? Y N
 Under the influence of drugs / alcohol? Y N
 Was adequate assistance available? Y N
 How many employees were involved in activity at the time of the incident? one two three or more
 Activity: washing/bathing dressing toileting
 other _____

Was equipment used? Y N

If yes, check one:

- Floor lift Transfer board/slider board
- Ceiling lift Mechanical transfer aid
- Low friction sheets Transfer / Walking belts
- Other _____

INCIDENT TYPE: (check one)

- Verbal – threats of violence, verbal assault
- Physical:
 - Biting
 - Hitting / kicking / beating
 - Squeezing / pinching / scratching / twisting
 - Sexual assault
 - Other _____
- Psychological – critical incident stress
- Other _____

INCIDENT INVOLVED:

- Client Another worker
- Family member of client
- Other member of public
- Other _____

CONTRIBUTING FACTORS (check all that apply)

Equipment / Device

- Not functioning properly
- Not available: in use elsewhere
- Protective equipment unavailable
- Labeling / signage inadequate
- Poor design
- Other – specify below

Patient-Related Factors

- Physically aggressive
- Verbally aggressive
- Resistive
- Suddenly fatigued
- Unable to follow directions
- Misunderstood directions
- Inconsistent weight bearing
- Client heavy
- Client fell
- Moved unexpectedly
- Other – specify below:

Environment

- Temperature
- Workplace design / layout
- Obstacles on path
- Floor slippery
- Floor uneven
- Lighting inadequate
- Excessive noise
- Limited work space
- Ventilation inadequate
- Improper storage
- Other – specify below

Organizational / Administrative

- Working alone
- Inadequate information
- Inadequate staffing at time of incident
- Inappropriate work/organization scheduling
- Insufficient/lack of education/training
- Inadequate/lack of equipment
- Lack of safe work procedures
- Lack of PPE
- Normal staffing but excessive workload
- Poor ergonomic design of environment
- Other – specify below:

Practice

- Patient not assessed
- Patient improperly assessed
- Poor communication
- Improper use of equipment
- Inattentive
- Insecure grip
- Improper technique
- Load not secured
- Repetitive work
- Static postures for extended periods
- Did not follow designated procedure
- Did not use designated equipment
- Rushing
- Misconduct
- Awkward posture
- Emergency response
- Other – specify below

Worker

- Fatigued
- Distracted
- Unwell
- Language difficulties
- Untrained in the techniques
- Inexperienced
- Pre-existing condition / injury
- Emotional stress involved
- Other – specify below:

Specify other contributing factors:

