Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg
Caring for Health *À l'écoute de notre santé*

WINNIPEG REGIONAL HEALTH AUTHORITY
WORK RELATED INJURY/NEAR MISS

Section I - To be completed by **EMPLOYEE**
Section II & III - To be completed by **EMPLOYEE** and **DESIGNATED "IN CHARGE"** person
Section IV - To be completed by **Department Manager/Director**

***** PLEASE PRINT CLEARLY *****

SECTION I: INJURY/NEAR MISS DETAILS: To be completed by Employee

1. Last Name: ____________ **2.** Given Name(s): ____________ **3.** Gender: ❒ Male ❒ Female
4. Employee No.: ________ **5.** Phone (Work): ________ **6.** Phone (Home): ________ **7.** Job Title: ________
8. Department: ________ **9.** Hospital/Site: ________ **10.** Manager or Supervisor: ________
11. Manager/Supervisor Tel. No.: ________ **12.** Status: ❒ F/T ❒ P/T **13.** Years in current position/job: ________
14. Date of Incident: ________ **15.** Time of Incident: ________ a.m./p.m. **16.** Shift Start Time: ________ a.m./p.m.
17. Shift End Time: ________ a.m./p.m. **18.** Date Reported: ________ **19.** Time Reported: ________ a.m./p.m.
20. Reported To: ____________ **21.** Job Title: ____________
22. Hours Worked in 24 Hours before Incident on this or any other job: ________
23. Day and Length of Rotation at Time of Injury on this or any other job: Day ________ of a ________ Day Rotation

Incident Category: (please fill in box of all that apply)
24. ❒ Injury/Illness **25.** ❒ Motor Vehicle Accident **26.** ❒ Near Miss **27.** ❒ Significant Property Damage **28.** ❒ Other _____
(NEAR MISS: An opportunity to improve safety and health based on a condition or incident with potential for more serious consequences).

Actions Following Injury/Near Miss (please fill in box of all that apply)
29. ❒ Remained at Work **30.** ❒ First Aid **31.** ❒ Medical Aid (saw/will see doctor) **32.** ❒ Lost Time Injury
33. Location of Incident (Building/floor/room number/client home) ____________

Region of Body Injured:
Please fill in circle of all that apply: ❍ **No Injury (Go to {*} Description of Injury/Near Miss)**

Head	❍ (R)	❍ (L)	Lower Back	❍ (R)	❍ (L)	Lower Arm	❍ (R)	❍ (L)	Cardio/Respiratory	❍
Eyes(s)	❍ (R)	❍ (L)	Neck	❍ (R)	❍ (L)	Hand/Wrist	❍ (R)	❍ (L)	Occupational Exposure	❍
Ear (s)	❍ (R)	❍ (L)	Abdomen	❍ (R)	❍ (L)	Nails/Fingers	❍ (R)	❍ (L)	Multiple Injuries	❍
Hearing	❍ (R)	❍ (L)	Hip	❍ (R)	❍ (L)	Upper Leg	❍ (R)	❍ (L)	Others	❍
Chest	❍ (R)	❍ (L)	Shoulder	❍ (R)	❍ (L)	Lower Leg	❍ (R)	❍ (L)		
Upper Back	❍ (R)	❍ (L)	Upper Arm	❍ (R)	❍ (L)	Foot	❍ (R)	❍ (L)		

Work Related Illness/Injury: Please fill in circle of all that apply

❍ Cut/Laceration/Puncture	❍ Chemical Exposure	❍ Electrical Shock	❍ Concussion
❍ Bruise/Crush/Abrasion	❍ Burn & Scald	❍ Hearing Loss/Deafness	❍ Exposure to cold
❍ Foreign Body	❍ Blood/Body Fluid Spill/Splash	❍ Animal/Insect Bite	❍ Exposure to heat
❍ Sprain & Strain	❍ Human Bite	❍ Dermatitis	
❍ Fracture/Dislocation	❍ Needle Stick	❍ Critical Incident	
❍ Internal Injury	❍ Infection/Infestation	❍ Amputation	

{ * } Description of Injury/Near Miss. Describe in detail how the injury/near miss occurred:
(Please give reason(s) for any delay in reporting. Please note if this is a repeat injury/near miss)

____
____
____
____
____

Was there a witness to the injury/near miss? ❒ Yes ❒ No Name of Witness: ____________

If you miss work or access treatment for this injury at any time you must notify your Department Director, Manager or Supervisor and/or the Human Resources Dept. and/or the Occupational Health Nurse

Section II - A: DIRECT CAUSES
TO BE COMPLETED BY EMPLOYEE AND DESIGNATED "IN CHARGE" PERSON

DIRECT CAUSES (Please fill in circle/box of all that apply)

1. **Exertion**

Equipment/Material Handling
- ❒ Pushing
- ❒ Pulling
- ❒ Lifting/Lowering

❍ Reaching

❍ Twisting

❍ Repetitive Strain

Patient Handling
- ❒ Repositioning a Patient
- ❒ Transferring a Patient
- ❒ Lifting a Patient
- ❒ Assisting a Patient to Walk/Stand
- ❒ Preventing a Patient Fall
- ❒ Repetitive, Cumulative Activity
- ❒ Unexpected Patient Movement
- ❒ Other ______________________________

❍ 2. **Fall (includes falling against/into objects, trips, slips)**

❍ 3. **Struck/Bumped/Banged/Hit By/Rubbed/ Abraded**

❍ 4. **Caught In/Under/Between Wall, Equipment, Door**

5. **Exposure to Hazardous Substance/Agent**

Chemical
- ❒ Latex or Powder in Gloves
- ❒ Medicines (e.g. morphine, antineoplastics)
- ❒ Solvents/Gases/Fumes/Corrosives/Poisons/ Smoke
- ❒ Soaps
- ❒ Other ______________________________

Physical
- ❒ Cold, Heat, Noise
- ❒ Radiation/Electricity
- ❒ Dusts (i.e. asbestos)

❍ Chemical and Physical Combined:

Biological
- ❒ Airborne
- ❒ Blood/Body Fluid Spill/Splash
- ❒ Parasite (e.g. scabies, lice, ringworm)
- ❒ Bacteria (e.g. chicken pox, rubella, staph)
- ❒ Fungus (e.g. mould)

Puncture/Wound (through needle &/or other)
- ❒ Needle Clean
- ❒ Needle Recapping
- ❒ Needle/Sharp Disposing in Container
- ❒ Needle Stray (garbage/bedding)
- ❒ Drawing Blood
- ❒ Starting IV
- ❒ Suturing
- ❒ Subcutaneous or IM Injection
- ❒ Removing Cartridge from Tubex Holder
- ❒ Scalpel
- ❒ Knife
- ❒ Instruments
- ❒ Lancet
- ❒ Other ______________________________

- **All Blood/Body Fluid Exposures require immediate follow-up utilizing Post Exposure Prophylaxis (PEP) care map processes.**

6. **Violence/Aggressive Behaviour**
(*) See WRHA Occurrence Report Form guideline page 3

Verbal:
- ❒ Threats of violence
- ❒ Verbal assault

Physical:
- ❒ Biting
- ❒ Hitting/kicking/beating
- ❒ Squeezing/pinching/scratching/twisting
- ❒ Sexual assault
- ❒ Other ______________________________

Incident Involved:
- ❒ Patient/Resident
- ❒ Family member of patient/resident
- ❒ Other member of public
- ❒ Worker
- ❒ Other ______________________________

❍ 7. **Drug/Immunization Reaction**

❍ 8. **Other Allergic Reactions (e.g. bee sting)**

❍ 9. **Critical Incident (defined as a crisis event "sudden, powerful, overwhelming")**

❍ 10. **Natural Disaster/Forces of Nature**

Please fill in:

EMPLOYEE NAME ______________________________ **EMPLOYEE NUMBER** ____________________

Section II - B: INDIRECT CAUSES
TO BE COMPLETED BY EMPLOYEE AND DESIGNATED "IN CHARGE" PERSON

INDIRECT CAUSES (Fill in box of all that apply in each section)

1. Equipment/Device/Materials

- ❒ Not Functioning Properly
- ❒ Not Available
- ❒ Protective Equipment Not Available
- ❒ Labeling/Signage Inadequate
- ❒ Misunderstood Direction
- ❒ Equipment not regularly maintained
- ❒ Other ______________________
- ❒ Does Not Apply

2. Environment

- ❒ Workplace Design/Layout
- ❒ Obstacle On Path (Inside)
- ❒ Obstacle On Path (Outside)
- ❒ Floor/Surface Slippery (Inside)
- ❒ Walkway Slippery (Outside)
- ❒ Floor Uneven
- ❒ Lighting Inappropriate
- ❒ Excessive Noise
- ❒ Limited Space/Overcrowding
- ❒ Ventilation Inadequate
- ❒ Other ______________________
- ❒ Does Not Apply

3. Patient/Resident/Client Related Factors

- ❒ Physically Aggressive
- ❒ Verbally Aggressive
- ❒ Physically Resistive
- ❒ Suddenly Fatigued
- ❒ Unable to/Does not follow direction
- ❒ Inconsistently Weight Bearing
- ❒ Patient Heavy
- ❒ Patient Fell
- ❒ Moved Unexpectedly
- ❒ Other ______________________
- ❒ Does Not Apply

4. Organizational/Administrative

- ❒ Working Alone
  (Working in a situation where assistance is not readily available by contacting fellow employees in cases of emergency or injury)
- ❒ Information not available
- ❒ Information not shared
- ❒ Reduced staffing at time of incident
- ❒ Other staff out of unit/department (e.g. coffee/lunch, etc.)
- ❒ Staffing levels reduced by one health care worker
- ❒ Staffing levels reduced by more than one health care worker
- ❒ Normal Staffing but Unusual Workload
- ❒ Insufficient/Lack of Education/Training
- ❒ Poor Ergonomic Design of Work Environment
- ❒ Other ______________________
- ❒ Does not apply

5. Task

- ❒ Emergency Response
- ❒ Awkward posture
- ❒ Repetitive Work
- ❒ Load not secured
- ❒ Did not follow designated procedure
- ❒ Patient not assessed or assessed improperly
- ❒ Improper use of equipment
- ❒ Static postures for extended periods
- ❒ Did not use designated equipment
- ❒ Insecure grip
- ❒ Poor communication
- ❒ Improper Technique
- ❒ Other ______________________
- ❒ Does not apply

(*) WRHA Occurrence Report Form:

An Occurrence report is also required if the Health Care Worker Injury/Near Miss meets the criteria for occurrence reporting.

Occurrence Report completed ❒ Yes Form # __________
❒ No
❒ Not Applicable (N/A)

Please fill in:

EMPLOYEE NAME ______________________________ **EMPLOYEE NUMBER** ________________

Section III: PREVENTIVE/CORRECTIVE MEASURE PLAN OF ACTION
MUST BE COMPLETED BY EMPLOYEE AND/OR DESIGNATED "IN CHARGE" PERSON

Fill in box of all applicable categories of Corrective Action

- ❒ Action to Improve Housekeeping
- ❒ Review Personal Protective Equipment
- ❒ Repair/Replace Equipment
- ❒ Improve Design
- ❒ Install Guards/Safety Devices/Signage
- ❒ Further discussion required/Consult with Occupational Health and Safety
- ❒ Job Hazard Analysis Requested/Revised
- ❒ Revise Procedure
- ❒ Employee Training/Education
- ❒ Implement Working Alone Protocol
- ❒ Revise Patient Care Plan
- ❒ Other ______________________

Details of Corrective Action	Urgent		Department Notified for Action	Method of Notification			Date of Notification
	YES	NO		Email	Phone	Memo	

Signature of Employee: ______________________________ **Date:** ________________

Signature of Designated "In charge" person: ________________ **Date:** ________________

Serious injuries must be reported to **Provincial Office of Manitoba Labour Workplace Safety and Health Division @ 945-3446 (regular working hours) or 945-0581 (after working hours)**. The Division considers an accident to be serious if it results in:

a) death;
b) serious injuries defined as:
- fracture;
- loss of sight;
- third degree burns;
- any injury resulting in paralysis;
- internal haemorrhage;
- amputation;
- poisoning;
- electrical contact, asphyxiation;
- unconsciousness resulting from concussion;
- cuts requiring hospitalization or time off work;
- any other injury likely to endanger life or cause permanent disability

c) collapse or structural failure of a building, tower, crane, hoist, temporary construction support system or excavation;
d) an uncontrolled spill or escape of a toxic, corrosive or explosive substance
e) explosion, fire or flooding.

1. Reported: ❒ Yes ❒ No (does not meet requirement).

2. If Yes:
- Name of Workplace Safety & Health Officer contacted: ______________________________
- Are photos/video evidence attached? ❒ Yes ❒ No
- Is a sketch of the scene provided? ❒ Yes ❒ No
- Is there physical evidence that has been collected? ❒ Yes ❒ No If Yes, list item(s):

____

____

3. Witness Name: ____

4. Witness Statement : ____

____

(If more space needed use attached sheet or use the back of page)

Name of Designated "In Charge" person: ______________________ Date: ________________

Co-chairs Workplace Safety & Health Committee notified: ❒ Yes Date: ________________

1. Before shift end fax/send copy of report to Occupational Health Unit and/or Department Reporting to WCB
2. Send original to Nurse Manager/Department Manager
(WCB - Workers Compensation Board charges late fees for reports that are delayed longer than 5 days Post-Injury)

Please fill in:

EMPLOYEE NAME ______________________ **EMPLOYEE NUMBER** ________________

Section IV: COMPLETED PLAN OF ACTION
TO BE COMPLETED BY DEPARTMENT MANAGER/DIRECTOR WHEN PREVENTIVE/ CORRECTIVE MEASURES HAVE BEEN IMPLEMENTED AND COMPLETED

Corrective Action	Target Date	Date Completed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Comments/Discussion Notes:

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WHEN PREVENTIVE/CORRECTIVE ACTIONS HAVE BEEN COMPLETED AND SIGNED OFF SEND REPORT TO:

- **Urban Health Care Facilities - Occupational Health Unit**
- **Personal Care Homes - Designated Department**
- **Community Health Groups - WRHA Workplace Health and Wellness Unit**

Department Manager: ____________________
PRINTED NAME

Signature: ____________________ **Date:** ____________________

Please fill in:

EMPLOYEE NAME ____________________ **EMPLOYEE NUMBER** ____________________