Work Related Injury / Near Miss

TIME SENSITIVE ACTIONS FOR YOU

- **REPORT THE WORK RELATED INCIDENT TO YOUR SUPERVISOR**
- **CALL INM INTAKE AT 204-940-8482 OR COMPLETE ATTACHED INJURY/NEAR MISS FORM**

IF YOU …

MISS TIME FROM WORK OR attend a **HEALTHCARE PROVIDER** due to the Work Related Injury of Illness **THEN….**

- **The attached MODIFIED DUTY FORM (MDF) may be completed by your healthcare provider** and returned as soon as reasonably possible as per the instructions on the form.
- **You must REPORT THE INJURY TO WORKERS COMPENSATION BOARD (WCB)** by phone at 204-954-4100 or 1-800-362-3340 from 8 a.m. to 7 p.m. weekdays or report online at www.wcb.mb.ca
- If you are unable to attend work as scheduled follow absence reporting protocol and advise that absence is due to work related injury or illness.

Complete employee responsibility sheet can be found at
http://www.wrha.mb.ca/professionals/safety/files/INM/EmployeeResponsibilities.pdf

WORK RELATED INJURY / NEAR MISS FORM

Both sides of this form are to be completed by the Employee immediately following Injury/Near Miss (including incidents of violent, aggressive or reactive behaviours both physical and verbal). ***PLEASE PRINT CLEARLY***

EMPLOYEE PERSONAL INFORMATION:

First Name:	Last Name:	Gender: ❑ Female ❑ Male
Work Phone:	Home Phone:	Cell Phone:
Email:		
Site:	Department:	Job Title:

Job Status: ❑Full Time ❑ Part Time ❑ Casual

Actions Following Incident: *(please check all that apply)*

❑ Report Only ❑ First Aid ❑ Lost Time Injury ❑ Saw/will see healthcare provider

Name of healthcare provider/location _____

If your injury affects your ability to perform your full job duties/hours, have your healthcare provider complete a WRHA Modified Duty Form (MDF) and return as instructed on the form.

DESCRIPTION OF INCIDENT:

Incident Date:	Day	Month	Year	Incident Time:	❑am ❑pm

Location of Incident: I was in/at (complete all that apply)

❑ Site Interior: *please be specific*	Building Name:	
	Floor/Wing:	Room/Area:
❑ Site Exterior:	i.e. parking lot	
❑ Client's Address	Street number, street name	

Others involved in the incident: ❑Patient ❑Other Worker ❑ Family Member ❑Public

Identifier: *(name, HRN, etc.)*

Activity: What was your task/duty at the time the incident occurred? *E.g. walking, carrying, patient transfer*

Detailed Description of Incident: (attach another page if necessary)

Witness(es): ❑ no ❑yes Name(s):

If related to patient/resident/client violent, aggressive or reactive behaviour complete the following

C.A.R.E. Screening Complete ❑ no ❑yes	C.A.R.E. Alert Active ❑no ❑yes
Code White Called: ❑ no ❑yes	

Signature of Employee

Signature:	Date:	Day	Month	Year

PLEASE COMPLETE BOTH PAGES

WORK RELATED INJURY / NEAR MISS FORM

Employee Name:				Incident Date:	Day	Month	Year

PART OF BODY INJURED: ***(check all that apply)***

❑ Near Miss Report			❑ No Body Part Injured			❑ Psychological			❑ Verbal Abuse		
Head	❑R	❑L	Neck	❑R	❑L	Shoulder	❑R	❑L	Hip(s)	❑R	❑L
Face	❑R	❑L	Back-Upper	❑R	❑L	Arm-Upper	❑R	❑L	Leg-Upper	❑R	❑L
Eye(s)	❑R	❑L	Back-Lower	❑R	❑L	Arm-Lower	❑R	❑L	Leg-Lower	❑R	❑L
Nose	❑R	❑L	Back-Mid	❑R	❑L	Elbow	❑R	❑L	Knee	❑R	❑L
Mouth/Teeth	❑R	❑L	Abdomen	❑R	❑L	Wrist	❑R	❑L	Ankle	❑R	❑L
Ear(s)	❑R	❑L	Pelvis	❑R	❑L	Hand	❑R	❑L	Foot	❑R	❑L
Hearing	❑R	❑L	Chest	❑R	❑L	Finger(s)/Nails	❑R	❑L	Toe(s)/Nails	❑R	❑L

❑ Other: *please specify*

Comments:

NATURE/TYPE OF INJURY: ***(check all that apply)***

❑ Near Miss Report	❑ No Body Part Injured	❑ Psychological	❑ Verbal Abuse
Sprain/Strain ❑	Foreign Object ❑	*Loss of Consciousness** ❑	**Follow Post Exposure Protocol for the following**
Pain Only ❑	Chemical Exposure ❑	*Electrical Contact** ❑	
Bruise/Crush/Abrasion ❑	Dermatitis/Rash ❑	*Fracture/Dislocation** ❑	Needlestick/Biological
Cut/Laceration Minor ❑	Exposure to cold/heat ❑	*Amputation** ❑	Puncture ❑
*Cut/Laceration requiring treatment at hospital** ❑	Hearing Loss/Deafness ❑	Illness–Work Related ❑	Blood/Body Fluid
	Bite – Animal/Insect ❑	Specify:	Splash or Spill ❑
Burn/Scald ❑	Concussion ❑	Infection ❑	Bite – Human ❑
*Burn – Third Degree** ❑	❑ Other: *please specify*		

Comments:

**Serious Injury* – SEE BELOW*

REPORT IMMEDIATELY TO MANAGER/SUPERVISOR AND ***COMPLETE THIS SECTION***

INM Reported to	Full Name:			Position:
Report Date	Day	Month	Year	Report Time: ❑am ❑pm

END OF EMPLOYEE REPORTING SECTION

On duty Manager/Supervisor/Delegate

must forward both pages immediately to OESH by email to INMintake@wrha.mb.ca or *Fax* 204-944-8417
DO NOT SEND via INTERDEPARTMENTAL MAIL.
An investigation/corrective action form may be forwarded to the Immediate Manager by email for completion.

Manager/Supervisor to determine if additional reporting is required as follows

Serious Incidents: If the incident checked above is ***Italicized/BLUE /****, this means that it is considered a serious injury under the Workplace Safety and Health Act and must be reported immediately to the Provincial Workplace Safety and Health Branch @ 204-945-3446 (regular working hours) or 204-945-0581 (after working hours).

❑yes – Name of Officer Contacted: _____

Must be investigated by the Workplace Safety & Health Committee co-chairs or designates.

❑Notification to co-chairs Date:

Patient Safety Event Reporting: through RL6 is also required if the incident meets the criteria. ❑yes Incident #	**IRIMS:** An IRIMS (security) report through RL6 is also required if the incident meets the criteria. ❑yes Incident #

Critical Incident Stress Management (CISM) must be offered where a traumatic event falls beyond the usual range of human experience. The event does not have to meet the criteria of a Critical Incident or Critical Occurrence. These events can cause unusually strong emotional and stress reactions, which can overwhelm how a person copes. Please consult the Operational Procedure on CISM.

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

MODIFIED DUTY FORM

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY if there has been a change in patient's abilities. WRHA will pay up to **$25.00** for the **COMPLETED** form. Completed forms can be faxed to **WRHA OESH CONFIDENTIAL FAX LINE 204-940-2570**

Employee Name:	**Position:**	**Site:**
Authorization of Employee: *I authorize the release of this information to the Winnipeg Regional Health Authority Occupational and Environmental Safety & Health Department.* _____ _____ *Employee Signature* *Date*	**General Nature of illness/injury:** *(specific diagnosis should not be included)*	

RETURN TO WORK:

Start Date: _____/_____/_____
dd mm yyyy

☐ **Full Functional Abilities** ☐ **Reduced Functional Abilities**

Estimated Duration: _____

Recommended Gradual Hours ***(if applicable)***

Graduated	Hours / Day	Days / Week
week 1		
week 2		
week 3		
week 4		
week 5		

FUNCTIONAL ABILITIES

(Please be specific and check all that apply)

KEY

***FREQUENCY**
N – Never
O – Occasional (up to 33% of the day)
F – Frequent (between 34-66% of the day)
C – Constant (between 67-100% of the day)

Mobility/Posture	N	O	F	C	Mobility/Posture	N	O	F	C
Sitting	☐	☐	☐	☐	Neck ROM *(specify)*	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Shoulder/Reaching ☐ R ☐ L At Shoulder Level	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Below Shoulder Level	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	Above Shoulder Level	☐	☐	☐	☐
Deep Squat/Crouch	☐	☐	☐	☐	Low Back Bending/Twisting	☐	☐	☐	☐
Stairs/Climbing	☐	☐	☐	☐	Hand Dexterity/Fine Motor	☐	☐	☐	☐
Other:	☐	☐	☐	☐	Gripping ☐ R ☐ L ☐ Power ☐ Pinch	☐	☐	☐	☐

Strength / Exertion *(check all that apply)*	**0 - 10lbs**				**10 – 20lbs**				**20 – 50lbs**			
	N	**O**	**F**	**C**	**N**	**O**	**F**	**C**	**N**	**O**	**F**	**C**
LIFTING: Floor to Waist	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LIFTING: Waist to Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LIFTING: Above Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CARRYING	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PUSH/PULL FORCE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional recommendations regarding functional abilities:

Healthcare Provider Information:

Name:	**Clinic Information:**
Signature:	**Date:**

Employee Responsibilities and Procedures
Work Related Injury or Illness - Absence from Work

Reporting and Initial Medical Attention (where applicable)

You must immediately notify your Supervisor/Manager as soon as a work related injury or illness has occurred. Follow the OESH Work Related Injury/Near Miss Process by either completing the INM form or calling (204) 940-8482 to report. *Note: WRHA Community/Corporate must report by phone.*

If you feel that the work related injury or illness requires medical attention or prevents you from continued work and/or carrying out any of your job duties, include this information in the report you make to both your Supervisor/Manager and OESH and seek care from a healthcare provider (for example; physician, chiropractor, physiotherapist, athletic therapist) as soon as reasonably possible.

If the work related injury/illness prevents you from attending work and/or carrying out your job duties **or** you seek care from a healthcare provider,

- contact your Supervisor/Manager. You must advise of your expected return to work date if known and may be required to provide your manager with a medical note supporting your absence.
- **report the injury to Workers Compensation Board** (WCB) by calling (204) 954-4100 or 1-800-362-3340 from 8 a.m. – 7 p.m. weekdays or apply at www.wcb.mb.ca. Ensure you make note of your claim number.

If you apply for WCB benefits, it may take several weeks until you receive your first payment. You may be entitled to a payroll advance if available and/or in accordance with your collective agreement where applicable to assist you while waiting for the WCB decision. Contact HR Shared Services for more information – (204) 940-8500 (select option 5).

You may wish to contact your union office as they may be of assistance to you. Your manager may be in contact with you throughout your absence.

Keep all receipts for treatment, medications and travel and submit to the Workers' Compensation Board of Manitoba as you may be eligible for reimbursement.

Returning to work immediately with no restrictions to regular duties and hours

If the work related injury or illness did not require modifications to your regular duties and you did not miss time from work (other than the day of injury) you will report to work for your next scheduled shift.

Returning to work immediately with restrictions to regular duties and hours

You must speak directly to your Manager and Occupational Health Nurse or Disability Management Coordinator **before returning to work in any capacity**.

If further medical information (in the form of a **Modified Duty Form** or otherwise) is reasonably required and is requested, you must provide that information to OESH or your manager to coordinate your return to work.

A team meeting may be held, in a manner consistent with your Collective Agreement (where applicable), which may include your Disability Management Coordinator, Occupational Health Nurse, you, your manager, Union, Human Resources and WCB to assist you in your recovery and to develop a safe return to work plan.

Where medical restrictions are identified that are temporary/unknown/unspecified duration, you may be required to schedule a follow up appointment with your Healthcare Provider until cleared to return to regular work duties, or the restrictions are deemed permanent. If reasonably required and requested, OESH shall be provided with updated medical certificates or Modified Duty Forms if there is a change in your medical condition (improvement or worsening) that affects your ability to perform your job duties, or attend work regularly.

Extended absences due to work related injury or illness *(If it is not anticipated that you will return to work immediately)*

If you file a WCB or MPI claim, your benefits must be pre-paid in order to ensure their continuation. Certain benefits must be pre-paid. Contact HR Shared Services - (204) 940-8500 (select option 5) for information and to **make arrangements to pre-pay your benefits** where applicable.

Depending on your collective agreement, you may be entitled to a wage supplement or top up. **You must request this supplement in order to receive it.** Contact HR Shared Services for more information – (204) 940-8500 (select option 5). You must provide a copy of your WCB cheque stub.

If it is not anticipated that you will return to work immediately, or you are off for more than 60 days, it is **recommended that you apply for HEB Disability and Rehabilitation Benefits** or Great West Life (for WRHA Community employees) where applicable, **even if you are in receipt of WCB or MPI benefits.** If accepted, they become a secondary insurer and may cover benefits that may not be covered by WCB or MPI. Contact HR Shared Services for more information – (204) 940-8500 (select option 5).

In the event that a decision related to acceptance has not been made by the secondary insurer and the employee is on a WRHA paid return to work the employee cannot be paid wages for hours worked by the employer beyond day 119. This may impact the Return to Work.

You must speak directly to your Manager and Occupational Health Nurse or Disability Management Coordinator **before returning to work** in any capacity.

If a ***Modified Duty Form*** is reasonably required and is requested, you must provide the ***Modified Duty Form*** to OESH to coordinate your return to work.

A team meeting may be held, in a manner consistent with your Collective Agreement (where applicable), which may include your Disability Management Coordinator, Occupational Health Nurse, you, your manager, Union, Human Resources and WCB to assist you in your recovery and to develop a safe return to work plan.

Where medical restrictions have been identified that are temporary, or of unknown/unspecified duration, you may be required to schedule a follow up appointment with your Healthcare Provider until cleared to return to regular work duties, or the restrictions are deemed permanent.

If reasonably required and requested, OESH shall be provided with updated medical certificates or Modified Duty Forms if there is a change in your medical condition (improvement or worsening) that affects your ability to perform your job duties, or attend work regularly.

Declared fit to return to regular duties and hours

If declared fit to return to regular duties, you must immediately contact OESH or your Manager and may be required to submit a completed ***Modified Duty Form*** where reasonably required by OESH to coordinate your return to regular duties.

A team meeting may be held, in a manner consistent with your Collective Agreement (where applicable), which may include your Disability Management Coordinator, you, your manager, Union, Human Resources and WCB to assist you in your recovery and to develop a safe return to work plan.