Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

WORK RELATED
INJURY/NEAR MISS FORM

Section I - To be completed by **EMPLOYEE** and submitted within 24 hours of incident
Note: Corporate and Community staff must follow the OESH Intake process by calling 940-8482
Section II & III & IV - To be completed by **EMPLOYEE** and **DESIGNATED "IN CHARGE"** person
Section V – 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 or Supervisor Tel. No.: _____

12. Status: ❒ F/T ❒ P/T ❒ Casual **13.** Years in current position/job: _____

14. Date of Incident: _____ **15.** Time of Incident: _____ am/pm

16. Shift Start Time: _____ am/pm **17.** Shift End Time: _____ am/pm

18. Date Reported _____ am/pm **19.** Time Reported: _____ am/pm

20. Reported To: _____

21. Job Title: _____

22. Hours Worked in 24 Hours before Incident on this or any other job: _____

23. Day /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/No Injury

27. ❒ Structural/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. ❒ Report Only **30.** ❒ First Aid

31. ❒ Medical Aid (saw/will see healthcare provider) **32.** ❒ Lost Time Injury

If you miss work or access medical 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. Ensure that you receive your facility/site Return to Work Package.

Part of Body Injured: **Please check off all that apply:** ☐ No Injury (Go to Description of Injury/Near Miss below)

Head	☐(R) ☐(L)	Lower Back	☐(R) ☐(L)	Lower Arm	☐(R) ☐(L)
Face	☐(R) ☐(L)	Neck	☐(R) ☐(L)	Hand/Wrist	☐(R) ☐(L)
Eyes(s)	☐(R) ☐(L)	Abdomen	☐(R) ☐(L)	Nails/Fingers	☐(R) ☐(L)
Ear (s)	☐(R) ☐(L)	Hip	☐(R) ☐(L)	Upper Leg	☐(R) ☐(L)
Hearing	☐(R) ☐(L)	Shoulder	☐(R) ☐(L)	Lower Leg	☐(R) ☐(L)
Chest	☐(R) ☐(L)	Upper Arm	☐(R) ☐(L)	Knee	☐(R) ☐(L)
Upper Back	☐(R) ☐(L)	Elbow	☐(R) ☐(L)	Foot/Ankle	☐(R) ☐(L)
Cardio / Respiratory	☐	Occupational Exposure	☐		

Others ☐ _____

Nature of Injury: **Please check off all that apply**

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

☐ Others _____

Description of How Injury/Near Miss Occurred.

Activity: *What was your task or duty at the time the injury/near miss occurred (eg, walking, carrying, patient transfer)?*

_____

_____

Usual/unusual: *Was the task or duty being performed at the time the injury/near miss occurred a task or duty that you regularly perform?* ☐ No ☐ Yes

Location: *Where did the injury/near miss occur (specify site, building, floor, room, client's address)?* _____

_____

Repeat Injury: ☐ No ☐ Yes 1st Injury Date: _____

Please give a detailed description of how the incident occurred. Please give reason(s) for any delay in reporting.

_____

_____

_____

_____

_____

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

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
- ❒ Equipment Failure

❍ 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)

Biological
- ❒ Blood/Body Fluid Spill/Splash
  - ❒ Foley/Urine Bag
  - ❒ Irrigation
  - ❒ IV or other line tubing
  - ❒ Contaminated Equipment
  - ❒ Patient Action
- ❒ Airborne
- ❒ Parasite (e.g. scabies, lice, ringworm)
- ❒ Bacteria (e.g. chicken pox, rubella, staph)
- ❒ Fungus (e.g. mould)

❍ **5. Exposure to Hazardous Substance/Agent** cont'd
Puncture/Wound (through needle &/or other)
- ❒ Needle Clean
- ❒ Needle Recapping
- ❒ Needle/Sharp Disposing in Container
- ❒ Needle/Sharp Improper Disposal
- ❒ Needle Stray (garbage/bedding)
- ❒ Drawing Blood
- ❒ Starting IV
- ❒ Suturing
- ❒ Subcutaneous or IM Injection
- ❒ Removing Cartridge from Tubex Holder
- ❒ Scalpel
- ❒ Knife
- ❒ Manipulating Equipment
- ❒ Lancet
- ❒ Patient Action
- ❒ 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 5

Verbal:
- ❒ Threats of violence
- ❒ Verbal assault

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

Incident Involved
- ❒ Patient/Resident/Client
- ❒ Family member of patient/resident/client
- ❒ 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
- ❒ Machine Guarding Removed
- ❒ Failure of atmosphere supplying respirator
- ❒ Other _____

2. Environment

- ❒ Workplace Design /Layout
- ❒ Obstacle On Path - ❒ Inside ❒ Outside
- ❒ Floor/ Surface Slippery (Inside)
- ❒ Walkway Slippery (Outside)
- ❒ Floor Uneven
- ❒ Lighting Inappropriate
- ❒ Excessive Noise
- ❒ Limited Space / Overcrowding
- ❒ Ventilation Inadequate
- ❒ Other _____

3. Patient/Resident/Client/Staff Related Factors

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

4. Organizational/Administrative

- ❒ Working Alone or in Isolation (where assistance is not readily available by contacting fellow employees in cases of emergency or injury)
- ❒ Information not available
- ❒ Information not shared
- ❒ Job requiring multiple # of people done independently by one employee
- ❒ 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 _____

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 _____

Section III: PREVENTIVE/CORRECTIVE MEASURE PLAN OF ACTION–Employee and "In Charge" Person

Corrective Action	✓	**Details –** if more space is needed please attach an additional sheet	**Notification** Department	Email	Phone	Memo	Date
Job Hazard Analysis Request /Revise							
Repair/Replace Equipment							
Employee Training/Education							
Revise Procedure (includes PPE)							
Action for safety in Housekeeping							
Improve Design							
Install Guards, Safety Devices, Signage							
Revise Patient Care Plan							
Implement Working Alone Protocol							
Consult with OESH							
Other: _____ _____							

Please fill in: EMPLOYEE NAME _____ EMPLOYEE NUMBER _____

Section IV: OTHER REPORTING REQUIRMENTS AND INFORMATION - MUST BE COMPLETED BY DESIGNATED "IN CHARGE" PERSON

Workers Compensation Board of Manitoba (WCB)

Employers must report any work related injury/illness that involves time loss from work and/or a need for medical attention to the WCB. Employers must report the incident within five (5) working days of the incident or within five (5) working days of when they first learn of the incident. WCB charges late fees for reports that are delayed longer than 5 days post-injury. Employers must ensure that the injured/ill worker is given the facility/site/program Return to Work package if the worker requires medical attention or misses time from work as a result of the work related injury/illness.

There is centralized WCB reporting within your facility/site/program. It is not up to the designated "in charge person" to report to WCB. Follow your facility/site/program specific Injury/Near Miss Form Operational Procedure which outlines the reporting process within your facility/site/program. **Note: WRHA Corporate Staff working in a facility/site must follow the WRHA Corporate Injury/Near Miss Form Operational Procedure by calling OESH INM intake at 940-8482.**

Manitoba Labour and Immigration - Workplace Safety and Health Division

Serious injuries must be reported to **Province of Manitoba – Department of Labour and Immigration - 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:

Death; serious injury (fracture, loss of sight, third degree burns, paralysis, internal haemorrhage, amputation, poisoning, electrical contact, asphyxiation, unconsciousness, cuts requiring medical treatment at a hospital, any other injury likely to endanger life or cause permanent disability); collapse or structural failure of a building, tower, crane, hoist, temporary construction support system or excavation; uncontrolled or spill of escape of a toxic, corrosive or explosive substance; 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: _____

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)

Designated "In Charge" Person's Comments/Discussion Notes: (any pertinent information)

_____

_____

_____

_____

_____

_____

Please fill in:

EMPLOYEE NAME _____ **EMPLOYEE NUMBER** _____

Section V: 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 Related to Direct and Indirect Causes / Preventive/Corrective Measures

_____

_____

_____

_____

_____

_____

Department Manager: _____ Signature: _____
Please print

Date: _____

_____

Distribution – Facility/Site/Program specific instructions can be found in your Facility/Site/Program Operational Procedure for Injury/Near Miss Reporting

1. Before shift end fax copy of report to Occupational Health Unit (OESH) @ 204-787-1172.
2. Send copy to Department Manager
3. Keep original for continued follow-up to resolution and for final filing in staff file.

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 in facility – copy to WRHA PCH Program Safety Coordinator

Please fill in:

EMPLOYEE NAME _____ **EMPLOYEE NUMBER** _____