WORK RELATED INJURY / NEAR MISS FORM

All pages of this form are to be completed by the Employee immediately following an Injury/Near Miss incident (including incidents of violent, aggressive, or reactive behaviours, both physical and verbal).
*****PLEASE PRINT CLEARLY AND COMPLETE ALL FIELDS*****

EMPLOYEE PERSONAL INFORMATION:

First Name:	Last Name:	Gender: ☐ F ☐ M ☐ Other
DOB:	Home Ph:	Cell Ph:
Work Ph:	Employee ID:	Job Title:
Site:	Program:	Department:
Job Status: ☐ Full Time ☐ Part Time ☐ Casual	EFT:	Union:

If you are a member of the Manitoba Nurses Union, do you agree to the release of the information you are providing to the MNU, as per the collective agreement? ☐ Yes ☐ No

"ORG CHIEF" REFERS TO THE MANAGER/SUPERVISOR YOU DIRECTLY REPORT TO:

Org Chief Name:	Phone:	E-mail:
Community Team Manager Name (if applicable):		

INCIDENT INFORMATION:

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 (if applicable)	Street number, street name	

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

<u>Employee Description of Incident:</u> Do not include information protected by privacy regulations such as names of patients, co-workers, family members, etc. Don't enter diagnosis.

Use blank page if needed for additional info

Did this event create emotional distress in an employee or team? ☐ Yes ☐ No ☐ N/A

If "Yes" mark the "Psychological Injury" checkbox within the "Type of Injury/ Exposure" section below

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

Abdomen: ☐ R ☐L	Ankle: ☐ R ☐L	Lower Arm: ☐ R ☐L	Upper Arm: ☐ R ☐L
Lower Back: ☐ R ☐L	Mid Back: ☐ R ☐L	Upper Back: ☐ R ☐L	Chest: ☐ R ☐L
Ear: ☐ R ☐L	Elbow: ☐ R ☐L	Eye: ☐ R ☐L	Face: ☐ R ☐L
Fingers/Nails: ☐ R ☐L	Foot: ☐ R ☐L	Hand: ☐ R ☐L	Head/Hearing: ☐ R ☐L
Hip: ☐ R ☐L	Knee: ☐ R ☐L	Lower Leg: ☐ R ☐L	Upper Leg: ☐ R ☐L
Mouth/Teeth: ☐ R ☐L	Neck: ☐ R ☐L	Nose: ☐ R ☐L	Pelvis: ☐ R ☐L
Shoulder: ☐ R ☐L	Toes/Nails: ☐ R ☐L	Wrist: ☐ R ☐L	Other (Specify):

PLEASE COMPLETE ALL PAGES

WORK RELATED INJURY / NEAR MISS FORM

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

Allergic Reaction: ☐	*Amputation***: ☐	*Asphyxiation***: ☐	Bite Animal: ☐
Bite Human: ☐	Bite Insect: ☐	Blood & Body Fluid Spill/Splash: ☐	Bruise/Crush/Abrasion: ☐
Burn/Scald: ☐	*Burn Third Degree***: ☐	Chemical Exposure: ☐	*Concussion***: ☐
Cut/Laceration/Puncture (Minor): ☐	*Cut/Laceration/Puncture** (Requiring Hospital Treatment):* ☐	Dermatitis/Rash: ☐	*Electrical Contract***: ☐
Exposure to Cold/Heat: ☐	*Eyesight Loss***: ☐	Foreign Object: ☐	*Fracture/Dislocation***: ☐
Hearing Loss: ☐	Illness – Not Work Related: ☐	Illness – Work Related: ☐	Infection: ☐
*Internal Haemorrhage**:* ☐	Internal Injury: ☐	*Loss of Consciousness** ☐	Needlestick: ☐
No Injury: ☐	Pain: ☐	Pain – No Incident: ☐	*Paralysis**:* ☐
Physical Reaction: ☐	*Poisoning**:* ☐	Psychological Injury: ☐	Sprain/Strain: ☐
Other (Specify):			

Signature of Employee:	**Date:**	Month	Day	Year

END OF EMPLOYEE REPORTING SECTION
EMPLOYEE TO REPORT AND SUBMIT THIS FORM IMMEDIATELY TO MANAGER/SUPERVISOR/DELEGATE
*****ON DUTY MANAGER/SUPERVISOR/DELEGATE TO COMPLETE THE FOLLOWING SECTION*****

On duty Manager/Supervisor/Delegate

Name of Supervisor reported to:				Job Title:
Report Date	Month	Day	Year	Reporting Type: Report Only ☐ Medical Aid ☐ Time Loss ☐ First Aid ☐

Was there a witness to the injury / near miss? ☐ Yes ☐ No ☐ Unknown

Name/s of witness/es:

Witness Statement:

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

Serious Incidents: If the incident checked in the TYPE OF INJURY/ EXPOSURE section above is *Italicized and marked with *, this means that it is considered a serious injury under the Workplace Safety and Health Act and must be reported immediately to Manitoba Workplace Safety and Health (WSH)@ 204-957-7233 or toll free at 1-855-957-7233**

Is this a Serious Injury as per the WSH Act? ☐ Yes ☐ No ☐ Unknown

If "Yes" – List the name of the Officer contacted:

Date and time incident reported to WSH:

Directions given by MB WPSH Officer:

Security Incident: An (IRIMS) security report is required if the incident meets the criteria for a security event
https://home.wrha.mb.ca/old/ces/security/files/Procedure_SIM.pdf

Does this incident meet criteria for reporting as a Security Incident? ☐ Yes ☐ No ☐ Unknown

If "Yes" – Provide IRIMS incident #

Patient Safety Event: If this is an event that concurrently resulted, or could have resulted, in unintended harm to a patient, and/or damage to, or loss of, equipment or property a separate patient safety report must be completed in RL6.

Did this event meet the definition of a Patient Safety Event? ☐ Yes ☐ No ☐ Unknown

Enter the Patient Safety Event RL6 # (if incident qualifies as a patient safety event):

Critical Incident Stress Management (CISM) should be considered when an event falls outside typical experience for one's role or program. The event does not have to meet the criteria of a Critical Incident or Critical Occurrence. These events can cause unusual responses, emotional distress, and stress reactions, which can be overwhelming. Each person will experience an event differently and be affected in a unique way. Please consult the Operational Procedure on CISM

Are you engaging a CISM (as defined above) intervention in response to this event? ☐ Yes ☐ No ☐ N/A

Has the worker identified an impact resulting from this incident for which psychological / emotional support resources are being / will be provided? ☐ Yes ☐ No ☐ N/A

Manager/ Supervisor/ Delegate must forward all pages immediately either directly, by email, or fax, to Site OESH Office
DO NOT SEND via INTER-DEPARTMENTAL MAIL.
After submission of this report, a Corrective Action / Investigation Form (CAI Form 2) will need to be completed by the reporting Manager and returned to the appropriate OESH Specialist