Southern Health Santé Sud

EXAMPLE HOW TO CAPTURE
Do Not Use Abbreviation
Safety Event Report

Safety Event #: _____

Date of Safety Event _____ / _____ / _____
DD MM YYYY

Time of Safety Event: _____ (24 hour clock)

(Addressograph or label who the Safety Event happened to)
☐ Not applicable (i.e. did not happen to anyone)

SECTION A

TYPE OF EVENT (check only 1 box)

☐	Near Miss (NM)	An event that happened but did not reach the client or employee.
☐	Occurrence (O)	An event or circumstance where there may be minor or major injury to an individual and/or damage to, or loss of, equipment or property.
☐	Critical Incident (CI) ☎	An unintended event that occurs when health services are provided to an individual and result in a consequence to him or her that is serious and undesired such as death, disability, injury or harm, unplanned admission to hospital or unusual extension of a hospital stay and does not result from the individual's underlying health condition or from a risk inherent in providing the health services.
☐	Critical Occurrence (CO) ☎	An event involving substantial risk or harm to employees, physicians, volunteers, students, visitors and others associated with the organization or to reputation through negative media/social media, security, or property damage of a potential financial loss greater than $25,000.

WHO DID THE SAFETY EVENT HAPPEN TO? (check only 1 box)

☐	Agency Personnel	☐	Outpatient	**For employee related events complete Sections, A & C*
☐	Client in the Community	☐	Physician	
☐	Employee*	☐	Student	
☐	Inpatient/Resident	☐	Visitor	
☐	Other	☐	Volunteer	
	Specify:			

DEGREE OF INJURY AT TIME OF SAFETY EVENT

☐	None apparent
☐	Unknown
☐	Minor
☐	Major
☐	Death

TYPE OF INJURY *(select **ALL** that apply)*

☐	No injury
☐	Bruise/Crush/Abrasion
☐	Burn
☐	Chemical or Biological Exposure
☐	Cut/Laceration
☐	Fracture (confirmed)
☐	Fracture (suspected)
☐	Puncture
☐	Sprain/Strain
☐	Other *(specify)*:

ACTUAL LOCATION OF SAFETY EVENT AND OFFICE BASE:

Site/Facility/Building:

Community Address

PROPERTY DAMAGE

☐	None
☐	Minor
☐	Major (CO)

LOCATION (check only 1 box)

☐	Bathroom	☐	Client's Home	☐	Corridor/Hall	☐	Entrance	☐	Grounds	☐	Lounge	☐	Mobile Clinic	☐	Parking Lot	☐	Street/Highway		
☐	Client's Bathroom	☐	Client's Room	☐	Dining Room	☐	Exam Room	☐	Kitchen	☐	Meeting Room	☐	Office	☐	Stairs				
☐	Other *(specify)*:																		

PROGRAM/DEPARTMENT OF WHERE THE EVENT TOOK PLACE (check only 1 box)

Acute Care	Community Programs/Services	Long Term Care	Support Services
☐ Ambulatory Care Clinic (Outpatient Services)	☐ Emergency Response Services	☐ Personal Care Home	☐ Environmental Services (Housekeeping/Laundry)
☐ Cancer Care Services	☐ Home Care	☐ Transitional Care Centre	☐ Health Information Services
☐ Dialysis	☐ Medical Clinics		☐ Privacy & Access
☐ Emergency Room	☐ Mental Health	**Regional Administration**	☐ Logistics and Supply Chain
☐ Medical Device Reprocessing	☐ Palliative Care	☐ Office	☐ Nutrition & Food Services
☐ Medical Unit	☐ Primary Care	**Rehabilitation Services**	☐ Physical Plant (Maintenance)
☐ Obstetrics	☐ Public Health-Healthy Living	☐ Audiology	☐ Information Communication/Technology
☐ Operating Room		☐ Occupational Therapy	**Pharmacy**
☐ PACU/Same Day Surgery (Peri-Operative Unit)	**Diagnostic Services**	☐ Physiotherapy	☐ Pharmacy ☐ LTC Pharmacy
☐ Surgical Unit	☐ Imaging (CT, X-Ray etc…)	☐ Rehab Unit	**Other Program / Department**
☐ Special Care Unit/ ICU	☐ Laboratory	☐ Speech Language Pathology	☐ Other (specify location)

REPORT INITIATED BY:

Name (please print first and last name clearly)	Department	**DATE REPORTED** DD	MM	YYYY

COMPLETE ONE OF SECTIONS 1-4. ALSO COMPLETE SECTION C IF THIS IS A STAFF SAFETY EVENT

1. FALLS

Fell From:				***Fell While:***		***Contributing Factors:*** *(select **ALL** that apply)*			
☐	Bed (fall mat)	☐	Standing/Walking	☐	Unwitnessed	☐	Body mechanics	☐	Education
☐	Bed (no fall mat)	☐	Toilet/commode	☐	Witnessed	☐	Care Plan / Risk Factors	☐	Environment
☐	Car/Vehicle	☐	Transferring			N/A	Client/Patient/Resident not available	☐	Equipment (see #5)
☐	Chair	☐	Tub/shower			☐	Clothing	☐	Medication / Treatment
☐	Exam table/Stretcher	☐	Wheelchair/scooter			☐	Cognition	☐	Physical / Medical Condition
☐	Other Specify:					☐	Communication (verbal/written)	☐	Staffing / Workflow
								☐	Violence / Behavior

2. VIOLENT / AGGRESSIVE BEHAVIOR — NOTE: PHYSICAL VIOLENCE OR THREAT OF PHYSICAL VIOLENCE IS A CODE WHITE

Form of Violence/Response (select **ALL** that apply)	From Whom (select **ALL** that apply)	To Whom (select **ALL** that apply)	Contributing Factors: (Select **ALL** that apply)	
☐ Threat of Physical Violence	☐ Agency personnel	☐ Agency personnel	☐ Body mechanics	☐ Education
☐ Physical	☐ Client	☐ Client	☐ Care Plan / Risk Factors	☐ Environment
☐ Verbal	☐ Physician	☐ Physician	N/A Client/Patient/Resident not available	☐ Equipment (see #5)
☐ Emotional	☐ Staff	☐ Staff	☐ Clothing	☐ Medication / Treatment
☐ Sexual	☐ Supervisor	☐ Supervisor	☐ Cognition	☐ Physical / Medical Condition
☐ Financial	☐ Visitor	☐ Visitor	☐ Communication (verbal/written)	☐ Staffing / Workflow
☐ Additional Staff required	☐ Other Specify:	☐ Other Specify:		☐ Violence / Behavior
☐ Security required	**Name From:**	**Name To:**		
☐ Police / RCMP called ☎				

3. MEDICATION / THERAPEUTIC & DIAGNOSTIC

Category: *(check one)* ☐ Medication including IV Medications ☐ IV/TPN Fluids only ☐ Blood/Blood Product ☐ Treatment/Test/Procedure *(Describe)*

Type: *(Check **ONE** only)* ***REMINDER: For all medication related adverse reactions & Serious Adverse Drug Reaction (SADR) refer to Mandatory Reporting Policy (ORG.1810.PL.010)***

☐ Blood type / product variance	☐ Exposure to body fluids	☐ Inappropriate disposal (biomedical supplies)	☐ Medication found on floor / bedside
☐ Break in sterile technique	☐ Foreign body left in client	☐ Incomplete / omitted procedure	☐ Misplaced medication
☐ Consent not obtained	☐ Illicit substance (suspected)	☐ Information missing on chart/order	☐ Omitted dose
☐ Duplication of treatment	☐ Inaccurate results	☐ IV infiltration	☐ Outdated product
☐ Other *Specify:*			

Incorrect:

☐ Client	☐ Rate of Flow	***Contributing Factors:*** *(Select **all** that apply)*	
☐ Delivery	☐ Reason	☐ Body mechanics	☐ Education
☐ Dose	☐ Site / Route	☐ Care Plan / Risk Factors	☐ Environment
☐ Labelling / Packaging	☐ Storage (e.g. Break in cold chain)	☐ Client/Patient/Resident not available	☐ Equipment (see #5)
☐ Medication	☐ Surgical Count Discrepancy	☐ Clothing	☐ Medication / Treatment
☐ Medication Order	☐ Time	☐ Cognition	☐ Physical / Medical Condition
☐ Narcotic Count	☐ Transcription	☐ Communication (verbal/written)	☐ Staffing / Workflow
☐ Procedure / Service		Do Not Use Abbreviations	☐ Violence / Behavior

Medication Name	**DIN# /Homeopathic Medicine # /Naturopathic Product #**	**D**

write Do Not Use Abbreviations in the blank line under Contributing Factors

data entry staff can type in Do Not Use Abbreviations in the database under Contributing Factors Other Specifications.

4. MISCELLANEOUS (CHECK ONE ONLY)

☐ Breach:		☐ Pressure Injury *(circle below)*		**C**	
	☐ information technology security	2 3 4 unstageable		☐	
	☐ personal health info. (PHIA) ☎	☐ Property damage (see #5)		☐	
	☐ personal information (FIPPA) ☎	☐ Self-inflicted injury		☐	
☐ Hazardous Workplace Condition		☐ Skin Tear		☐	t
☐ Left against medical advice		☐ Staff Injury		☐	dition
☐ Missing property (see section #5)		☐ Statement of Claim e.g. Lawsuit ☎		☐ Communication (verbal/written)	☐ Staffing / Workflow
☐ Motor vehicle crash		☐ Unauthorized Access (physical location)			☐ Violence / Behavior
☐ Negative media / social media ☎		☐ Other *Specify:*			

Disaster Management Response

☐ Code Black – bomb threat ☎	☐ Code Brown – chemical spill ☎	☐ Code Green – evacuation ☎	☐ Code Grey – external air ☎
☐ Code Orange – multi casualties ☎	☐ Code Pink – infant abduction ☎	☐ Code Red – fire ☎	☐ Code Yellow – missing client ☎
Code White (complete Section 2 above)	***REMINDER: Fill out After Action Report for all Disaster Management Responses (ORG.1210.PL.001.FORM.01)***		

5. EQUIPMENT / PROPERTY

ITEM NAME/DESCRIPTION: **MANUFACTURER:** **SERIAL #** **MODEL#** **LOT#**

EVENT TYPE: ☐ Damaged/defective ☐ Missing **OWNED BY**: ☐ Site/Program ☐ Client ☐ Employee ☐ Other *Specify:*

ACTION TAKEN: ☐ Taken out of service ☐ Locked away in secure location **BY (name)**: **WHERE (location)**:

REMINDER: If an event involves a Medical Device Incident (MDI) refer to Mandatory Reporting Policy (ORG.1810.PL.010)

6. NOTIFICATION

Record Name of Person Notified if Applicable	Report By	Reported To	Date	Time (24 hour clock)
NEAR MISSES / OCCURRENCES:				
☐ Direct Supervisor / Person in Charge				
☐ Physician				
☐ Next of Kin				
☐ Client				
☐ Pharmacy (as applicable)				
☐ Other (Specify)				
CRITICAL INCIDENTS / CRITICAL OCCURRENCES ☎ (Critical Occurrences involving staff are also required to complete notifications in Section C)				
☐ Manager				
☐ *Check if copy of Safety Event Report was sent*				
☐ Director				
☐ *Check if copy of Safety Event Report was sent*				
☐ Regional Lead				
☐ *Check if copy of Safety Event Report was sent*				

Record Name of Person Notified if Applicable	Report By	Reported To	Date	Time (24 hour clock)
■Patient Safety Coordinator(s) are to receive a scanned copy of the Safety Event Report for **all** Critical Occurrences and Critical Incidents.				
☐ After Hours: for contact please see On-Call Policy				
CLIENT ABUSE:				
☐ Protection for Persons in Care Office (PPCO) Reporting is **ONLY** online. https://www.gov.mb.ca/health/protection/				
☐ Child & Family Services after hours: 1-866-345-9241				
OTHER CONTACTS AS APPLICABLE:				
☐ Emergency Preparedness Specialist				
☐ Regional Infection Control Coordinator				
☐ Privacy & Access Specialist **(Report ALL Breach of PHIA/FIPPA)**				
☐ Police/RCMP				
☐ Other *Specify:*				

IF THIS IS A STAFF SAFETY EVENT, LEAVE THIS PAGE BLANK AND COMPLETE SECTION C ONLY

SECTION B: Report and Event Analysis ☐ **CHECK IF COMPLETING SECTION C**

PART 1: REPORT BY STAFF MEMBER

Details related to Safety Event (NM, O, CI, CO) the facts of what happened:

Action taken, how did you respond, what did you do? *If this is a staff safety event, complete Section C only.*

PART 2: ANALYSIS OF EVENT: *If this is a staff safety event, complete Section C only.*

Findings, factors that are thought to have contributed to the event. For client falls, state date of last fall if known.

FOLLOW UP ACTIONS / STEPS REQUIRED	ASSIGNED TO	TARGET DATE FOR COMPLETION	DATE OF COMPLETION

FOR NEAR MISSES / OCCURRENCES:		FOR ALL CRITICAL INCIDENTS / CRITICAL OCCURRENCES:	
	/ /		/ /
Signature of Direct Supervisor / Person in Charge	DD MM YYYY Date	Signature of Manager / Director CEO (affiliate/contract site)	DD MM YYYY Date

SECTION C: STAFF SAFETY EVENT REPORT

For office use only **Event #:**

Southern Health Santé Sud

PART 1: REPORT BY STAFF MEMBER

Name: **Employee #:** **Manager Name:**

Facility / Building / Location: (where it happened)

Department /Job Title: **Union Affiliation:** ☐ NONE ☐ MNU ☐ MGEU (PT) ☐ CUPE (CS) ☐ CUPE (FS)

Date of Event: / / DD / MM / YYYY **Time:** 24 hr clock **Witness** ☐ Yes ☐ No Name (please print)

Actions following event: Check all that apply unless it is Report only. Note that missing time from work or seeking medical attention (doctor, chiropractor, etc.) requires a WCB claim.

☐ Report only ☐ First Aid ☐ Remained at work ☐ Disabled longer than day of event ☐ Medical Aid (saw/will see doctor) ☐ Lost Time Injury

☐ Light Duties Offered Date: Details of duties offered:

Detailed description of event (include task/duty offered at time of event): *DO NOT reference client/resident names in Section C.*

Part of body injured: Check all that apply. Must be completed by employee.

☐ Head	☐ Ear(s)	☐ Abdomen	☐ Shoulder	☐ Hand	☐ Knee	☐ Mouth/Teeth	
☐ Face	☐ Hearing	☐ Pelvis	☐ Arm	☐ Finger(s)/Nails	☐ Ankle	☐ **None**	
☐ Eye(s)	☐ Neck	☐ Chest	☐ Elbow	☐ Hip(s)	☐ Foot	☐ Other *Specify:*	
☐ Nose	☐ Back	☐ Cardio/Respiratory	☐ Wrist	☐ Leg	☐ Toe(s)/Nails		

Type of injury: Please check all that apply.

☐ Bite – Animal/Insect	☐ Foreign Object	☐ **Violence**			
☐ Bruise/Crush/Abrasion	☐ Hearing Loss	(select options for type and by)			
☐ Burn/Scald	☐ Internal Injury	Form of abuse			
☐ Chemical Exposure	☐ Sprain/Strain	☐ Physical			
☐ Concussion	Follow Post Exposure Protocol:	☐ Verbal			
☐ Cut/Laceration (minor)	☐ Bite – Human	☐ Other			
☐ Dermatitis/Rash	☐ Needlestick	From who			
☐ Exposure to Cold/Heat	☐ Blood/Body Fluid Splash	☐ Patient			
☐ Infection *Specify:*		☐ Staff			
☐ Other *(Specify):*		☐ Visitor			
		☐ Other			

Serious injuries marked by asterisk (*) must be reported immediately to manager/supervisor.

☐	Amputation*
☐	Asphyxiation or Poisoning*
☐	Burn – Third Degree*
☐	Electrical contact*
☐	Fracture/Dislocation*
☐	Loss of consciousness*
☐	Permanent or temporary loss of sight*
☐	Cut/Laceration requiring medical treatment at hospital*

For all serious injuries an investigation report form will be provided by the Regional Workplace Safety & Health committee co-chair(s) and submitted to the Workplace Safety & Health program.

Staff Signature / / DD / MM / YYYY

Manager / Director (Person in Charge Signature) / / DD / MM / YYYY

NOTIFICATION

Record Name of Person Notified	Report By	Reported To	Date	Time (24 hour clock)
Manager / Director / Person in Charge (send Section C: Staff Safety Event Report)				
☐ **For all employee Occurrences / COs immediately** send to Payroll for WCB reporting				
☐ **For all Near Misses / Occurrences / COs notify** Workplace Safety & Health program		wsh@southernhealth.ca		
☐ **IF Abusive/Aggressive to MNU staff** also notify Labour Relations (within 96 hrs)		LabourRelations@southernhealth.ca		
☐ **For Critical Occurrences:** Manager / Director				
Serious Injuries (Critical Occurrences) under the Workplace Safety and Health Act must be **IMMEDIATELY reported by phone ☎ / fax or email** as noted below:				
☐ Complete investigation report form provided by Regional Workplace Safety & Health Committee co-chair(s) and submit to the Workplace Safety & Health program		wsh@southernhealth.ca		
☐ Province of Manitoba Department of Labour and Family Services – Workplace Safety and Health **204-957-7233** or **1-855-957-7233**				
☐ Manager Occupational Safety and Health - **Cell: 204-870-1342**				

ANALYSIS OF STAFF NEAR MISS / OCCURRENCE: Findings, factors that are thought to have contributed to the near miss/occurrence.

FOLLOW UP ACTIONS / STEPS REQUIRED	ASSIGNED TO	TARGET DATE FOR COMPLETION	DATE OF COMPLETION

ACTIONS TAKEN:

☐ Care planning *(i.e. discuss client care plan with team members)* ☐ Team conference *(i.e. discuss follow up actions/steps required with team members)*

☐ Defusing *(i.e. discuss staff injury/near miss and follow up actions/steps required with staff member)* ☐ Other Specify:

Staff Signature (post review of actions taken) DD / MM / YYYY **Manager Signature** (post review of actions taken) DD / MM / YYYY

NOTIFICATION: Manager Occupational Safety & Health / Musculoskeletal Injury Prevention (MSIP) Program

REVIEW OF FOLLOW UP ACTIONS (IF APPLICABLE) ☐ Effective ☐ Not Effective

FURTHER REVIEW REQUIRED (IF APPLICABLE) Comments:

Manager Occupational Safety & Health/MSIP Program Signature DD / MM / YYYY (Date Reviewed)