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| SHSSLogoColour.png | | | | | | | **VECTR CONCERNS**  **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. | | | | | | | | | | | |

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| **Who did the Safety event happen to?** (check only 1 box) | | | | | | | | | | | | **Degree of Injury at**  **Time of Safety Event** | | | | **Type of Injury** *(select* ***ALL*** *that apply)* | | | | | |
|  | Agency Personnel | |  | Outpatient | | | *\*For employee related events complete Sections, A & C* | | | | |  | No injury | | | | |
|  | Client in the Community | |  | Physician | | |  | None apparent | | |  | Bruise/Crush/Abrasion | | | | |
|  | Employee\* | |  | Student | | |  | Unknown | | |  | Burn | | | | |
|  | Inpatient/Resident | |  | Visitor | | |  | Minor | | |  | Chemical or Biological Exposure | | | | |
|  | Other | |  | Volunteer | | |  | Major | | |  | Cut/Laceration | | | | |
|  | *Specify:* | | | | | |  | Death | | |  | Fracture (confirmed) | | | | |
| **Actual Location of Safety Event and Office Base:** | | | | | | | | | | | | **Property Damage** | | | |  | Fracture (suspected) | | | | |
| Site/Facility/Building: | |  | | | | | | | | | |  | None | | |  | Puncture | | | | |
|  | |  | | | | | | | | | |  | Minor | | |  | Sprain/Strain | | | | |
| Community Address | |  | | | | | | | | | |  | Major (CO) | | |  | Other *(specify)*: | | | | |
| **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)*: | | | | | | | | | | | | | | | | | | | | |

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| **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) | | |

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| **Report Initiated By: Date Reported** | | | | |
|  |  |  |  |  |
| Name (please print first and last name clearly) | Department | **DD** | **MM** | **YYYY** |

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| **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 | | | | | | | | |  | | | | | | | | |  | | | | |  | Violence / Behavior | |
|  | | | | | |  | | | | | | | | | | | | |  | | | |  | | |  |
| **Medication Name** | | | | | | **DIN# /Homeopathic Medicine # /Naturopathic Product #** | | | | | | | | | | | | | **Dose** | | | | **Route** | | | **Frequency** |
| **4. miscellaneous (**check **one** only**)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Breach: | | | | | | | |  | | Pressure Injury *(circle below)* | | | | | | | | ***Contributing Factors:***  *(Select* ***all*** *that apply)* | | | | | | | |
|  |  | information technology security | | | | | | |  | | 2 3 4 unstageable | | | | | | | |  | Body mechanics | | | |  | Education | |
|  |  | personal health info. (PHIA) 🕿 | | | | | | |  | | Property damage (see #5) | | | | | | | |  | Care Plan / Risk Factors | | | |  | Environment | |
|  |  | personal information (FIPPA) 🕿 | | | | | | |  | | Self-inflicted injury | | | | | | | |  | Client/Patient/Resident not available | | | |  | Equipment (see #5) | |
|  | Hazardous Workplace Condition | | | | | | | |  | | Skin Tear | | | | | | | |  | Clothing | | | |  | Medication / Treatment | |
|  | Left against medical advice | | | | | | | |  | | Staff Injury | | | | | | | |  | Cognition | | | |  | Physical / Medical Condition | |
|  | 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:* **VECTRS Concerns** | | | | | | | |  | | | | | | | |
| 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)*** | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **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: contact Manager On-Call 204-239-2211 |  |  |  |  |
| **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 |  |  |  |  |

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| **other contacts as applicable:** | | | | |
| Emergency Preparedness Specialist |  |  |  |  |
| Regional Infection Control Coordinator |  |  |  |  |
| Privacy & Access Specialist  **(Report ALL Breach of PHIA/FIPPA)** |  |  |  |  |
| Police/RCMP |  |  |  |  |
| Other *Specify:* |  |  |  |  |

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| **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:** | | | | | | | | | | | | | | | | | | | | |
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| **Action taken, how did you respond, what did you do?** *If this is a staff safety event, complete Section C only.* | | | | | | | | | | | | | | | | | | | | |
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| **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.** | | | | | | | | | | | | | | | | | | | | |
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| **Follow up actions / Steps required** | | | | | | | | **Assigned to** | | | **Target Date for Completion** | | | | **Date of Completion** | | | | |
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| **For near misses / Occurrences:** | | | | | | | | | | **For all critical Incidents / critical Occurrences:** | | | | | | | | | | | |
|  |  |  | | / |  | / |  | |  |  | |  |  | / | |  | / |  |  |
| Signature of Direct Supervisor / Person in Charge |  | DD | |  | MM |  | YYYY | |  | Signature of Manager / Director  CEO (affiliate/contract site) | |  | DD |  | | MM |  | YYYY |  |
| Date | | | | | | | | | Date | | | | | | | |
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| **SECTION C: STAFF SAFETY EVENT REPORT** | | | | | | | | | | | | | | | | | | | | | | | ***For office use only* Event #:** | | | | | | | | | | | | | | LogoB+W.jpg | | | | | | | | | |
| **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:** | | |  |  | | | | / | |  | | / | |  | | | | **Time:** | | |  | | | | | |  | **Witness** | | | | |  | | Yes |  | | | | | | | | | |  |
|  | | |  | DD | | | |  | | MM | |  | | YYYY | | | |  | | | 24 hr clock | | | | | |  |  | | | | |  | | 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.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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. | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | **Serious injuries** marked by asterisk (\*) must be reported immediately to manager/supervisor. | | | | | | | | | | | | | | | | |
|  | Bite – Animal/Insect | | | | | |  | | | | Foreign Object | | | | | | | | |  | | **Violence** | | | | | | | |  | | | Amputation\* | | | | | | | | | | | | | |
|  | Bruise/Crush/Abrasion | | | | | |  | | | | Hearing Loss | | | | | | | | | (select options for type and by) | | | | | | | | | |  | | | Asphyxiation or Poisoning\* | | | | | | | | | | | | | |
|  | Burn/Scald | | | | | |  | | | | Internal Injury | | | | | | | | |  | | Form of abuse | | | | | | | |  | | | Burn – Third Degree\* | | | | | | | | | | | | | |
|  | Chemical Exposure | | | | | |  | | | | Sprain/Strain | | | | | | | | |  | |  | | Physical | | | | | |  | | | Electrical contact\* | | | | | | | | | | | | | |
|  | Concussion | | | | | | Follow Post Exposure Protocol: | | | | | | | | | | | | |  | |  | | Verbal | | | | | |  | | | Fracture/Dislocation\* | | | | | | | | | | | | | |
|  | Cut/Laceration (minor) | | | | | |  | | | | Bite – Human | | | | | | | | |  | |  | | Other | | | | | |  | | | Loss of consciousness\* | | | | | | | | | | | | | |
|  | Dermatitis/Rash | | | | | |  | | | | Needlestick | | | | | | | | |  | | From who | | | | | | | |  | | | Permanent or temporary loss of sight\* | | | | | | | | | | | | | |
|  | Exposure to Cold/Heat | | | | | |  | | | | Blood/Body Fluid Splash | | | | | | | | |  | |  | | Patient | | | | | |  | | | Cut/Laceration requiring medical treatment at hospital\* | | | | | | | | | | | | | |
|  | Infection *Specify:* | | | | | | | | | | | | | | | | | | |  | |  | | Staff | | | | | | 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. | | | | | | | | | | | | | | | | |
|  | Other *(Specify):* | | | |  | | | | | | | | | | | | | | |  | |  | | Visitor | | | | | |
|  | | Other | | | | | |
| **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](mailto:wsh@southernhealth.ca) | | | | | | | |  | | |  | | |
|  | **IF Abusive/Aggressive to MNU staff** alsonotify Labour Relations (within 96 hrs) | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | [LabourRelations@southernhealth.ca](mailto: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](mailto: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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Follow up actions / Steps required** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Assigned to** | | | | **Target Date for Completion** | | | | | | | | | **Date of Completion** | | | | |
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| **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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Manager Occupational Safety & Health/MSIP Program Signature** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | DD / MM / YYYY (Date Reviewed) | | | | | | | | | | | | | | |
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