|  |  |  |
| --- | --- | --- |
| 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. |

|  |  |  |
| --- | --- | --- |
| **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)*:  |

|  |
| --- |
| **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) | [x]  | 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: Date Reported** |
|  |  |  |  |  |
| Name (please print first and last name clearly) | Department | **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  |  |  | [ ]  | 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 🕿 | [x]  | 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)*** |

|  |
| --- |
| **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 |  |  |  |  |

|  |
| --- |
| **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 |  | Signature of Manager / Director CEO (affiliate/contract site) |  | DD |  | MM |  | YYYY |  |
| Date | Date |
|  |

|  |  |  |
| --- | --- | --- |
| **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.* |
|  |
|  |
|  |
| **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 |       |      |
|  | [ ]  **IF Abusive/Aggressive to MNU staff** alsonotify 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) |
|       |       |