Incident/Injury Report

To be completed for ALL incidents and accidents where an injury has or could have resulted.

|  |  |
| --- | --- |
| **Work Location:**Organisation / Facility In the Community Client Home Other | **Today’s Date:** / /  |
| **Status of the involved person:**Employee ClientVisitor Volunteer Contractor | **Outcome:** Hazard Near Miss Incident First Aid |
| **Details of involved person:**Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name: \_\_\_\_\_\_\_ DOB: \_ / / Home Address: \_ Phone:  \_ Sex: M / FEmployment Status: Casual Full-time Contractor Permanent P/T Other: \_\_\_\_\_\_ |
| **Details of witnesses (if any):**Name: Phone: Address: Name: Phone: Address:  |
| **Details of incident or accident:**Date: / / Time of Injury: AM / PMActivity engaged in at time of incident: Exact location of person at time of incident: Describe how and what happened (please give full details & include a diagram, if appropriate. Use a separate sheet if necessary. Please include car registration number if reporting a Motor Vehicle Accident).         |

|  |
| --- |
| **Details of injury if applicable: (supervisor may need to assist completion)**Cause of Injury: Lift/bend/push/pull Psychological/Stress - Surface/Material or Object Bullying/Harassment Sun Exposure Lift/bend/push/pull Psychological/Stress - Electric Shock  Person Workload/Organisation Static or Repetitive Hazardous Substance/ Hand Held Tools Posture or Arm Usage Material Workplace Violence Biological Agency Contact with  Animal/Insect Slip/Trip/Fall – Entrapment in Vehicle Accident - Indoors Equipment/Machinery Work Vehicle Slip/Trip/Fall – Strike/Struck by Vehicle Accident -  Outdoors Equipment/ Machinery Own Vehicle Superficial if not Involuntary Movement Behaviour of cause by above of client client Other: Nature of injury/illness (e.g. burn, sprain, cut etc.) Location on body (please circle and specify): How did the injury occur? (e.g. fall, grabbed by person, muscular stress):         |

|  |
| --- |
| **Treatment administered if required:** Yes NoTreatment: Referral required: Yes No Who to: First aid attendant (Print Name): Signature:  |
| **THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY A SENIOR STAFF MEMBER ON DUTY** |
|  |
| **Incident or accident investigation:**Did the incident occur as part of the involved person’s normal activities? **Yes** □ **No** □ **N/A** □Did equipment contribute? **Yes** □ **No** □ **N/A** □Was the equipment used designed for activity? **Yes** □ **No** □ **N/A** □Was the equipment properly maintained? **Yes** □ **No** □ **N/A** □Did the equipment fail? **Yes** □ **No** □ **N/A** □Had a risk assessment been undertaken? **Yes** □ **No** □ **N/A** □Did safety instructions accompany activity? **Yes** □ **No** □ **N/A** □Are there documented safe work procedures (SWP) for activity? **Yes** □ **No** □ **N/A** □Were these SWP followed? **Yes** □ **No** □ **N/A** □Was appropriate PPE used? **Yes** □ **No** □ **N/A** □Was the involved person trained in this activity? **Yes** □ **No** □ **N/A** □Did a known behaviour problem contribute? **Yes** □ **No** □ **N/A** □Was there a known behaviour management plan? **Yes** □ **No** □ **N/A** □Was it followed? **Yes** □ **No** □ **N/A** □Did poor housekeeping contribute? **Yes** □ **No** □ **N/A** □Did the work environment contribute? **Yes** □ **No** □ **N/A** □ |
| After reviewing the above prompts and through interview/site visits what are the identified cause(s):                **Remedial actions recommended:**□Conduct task analysis □ Re-instruct persons involved □ Improve Infrastructure □ Conduct hazard systems audit □ Improve skills mix □ Add to inspection program□ Develop/review task procedures □ Provide debriefing and/or counselling □ Improve communication/ reporting procedures□ Improve work environment □ Request maintenance □ Improve security□ Review WHS policy/programs □ Improve personal protection □ Temporarily relocate employees involved□ Provide or replace □ Improve work congestion/ □ Behaviour Support Plan equipment/tools Housekeeping Review □ Improve work organisation □ Investigate safer alternatives □ Request MSDS□ Develop and/or provide training □ Other:  |
| **What, in your own words, has been implemented or planned to prevent recurrence:**   |
| **Remedial actions completed:**   |
| **Did the injured person stop work: Yes No**If yes, state date: / / Time: AM / PMOutcome: □ Treated by Doctor □ Lodged workers comp claim □ Contacted by RTW Coordinator □ WorkCover notified □ Insurer notified □ Returned to normal duties □ Returned to modified duties □ Hospitalised □ OHS Committee/ representative advised |
| **Signature (Staff):**   **Date:**  / /  |