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| --- | --- | --- |
| SHSSLogoColour.png | **Occurrence Report** |  |
|  |  |  |
| Occurrence #: |  |   |
| *For office use only* |  |  |  |
| Date of occurrence: |  | / |  | / |  |  |
|  |  |  |  | DD |  | MM |  | YYYY |  |
|  |
| Time of occurrence: |  | (24 hour clock) |  |  |  |  | (Addressograph or label who the occurrence happened to) [ ]  Not applicable (i.e. did not happen to anyone) |

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| **SECTION A** |
| **Type of Outcome** (check only 1 box) |
| [ ]  | Near Miss (NM) | An event that happened but did not reach the client or employee. |
| [x]  | Occurrence (O) | An event or circumstance where there may be minor injury to an individual and/or damage to, or loss of, equipment or property. |
| [ ]  | Critical Occurrence (CO) | An occurrence involving substantial risk or harm to employees, medical staff, volunteers, students, visitors and others associated with the organization or to reputation, security, or property damage of a potential financial loss greater than $25,000. |
| [ ]  | 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.  |
| **Who did the occurrence happen to?** (check only 1 box) | **Degree of Injury at** **Time of Occurrence** | **Type of Injury** (mark all applicable) |
| [ ]  | Inpatient/Resident | [x]  | Employee\* | *\*For employee related critical occurrences, occurrences, or near misses, complete all pages including Section C: Staff Occurrence / Near Miss.* | [ ]  | No injury |
| [ ]  | Outpatient | [ ]  | Physician | [ ]  | None apparent | [ ]  | Bruise/Crush/Abrasion |
| [ ]  | Client in the Community | [ ]  | Agency Personnel | [ ]  | Unknown | [ ]  | Puncture |
| [ ]  | Visitor | [ ]  | Student | [ ]  | Minor | [ ]  | Cut/Laceration |
| [ ]  | Other  | [ ]  | Volunteer  | [ ]  | Major | [ ]  | Burn |
|  | *Specify:*  | [ ]  | Death | [ ]  | Sprain/Strain |
| **Actual Location of Occurrence and Office Base:** | **Property Damage** | [ ]  | Possible Fracture |
|  |  | [x]  | None | [ ]  | Fracture |
| Site/Facility/Building: |  | [ ]  | Minor | [ ]  | Chemical or Biological Exposure |
|  |  | [ ]  | Major (CO) | [x]  | Other *(specify)*: |
| Community Address: |  |  |  | **COVID-19** |
| **Location** (check only 1 box) |
| [ ]  | Client’s room | [ ]  | Bathroom | [ ]  | Dining room | [ ]  | Corridor/hall | [ ]  | Meeting room | [ ]  | Stairs | [ ]  | Parking lot |
| [ ]  | Client’s bathroom | [ ]  | Client’s home | [ ]  | Lounge | [ ]  | Exam room | [ ]  | Office | [ ]  | Entrance | [ ]  | Street/highway |
| [x]  | Other *(specify)*: **COVID-19** |   |  [ ]  | Mobile clinic |  [ ]  | Grounds |  [ ]  | Kitchen |
| **Program/Department of where occurrence took place** (check only 1 box) |
| **Critical Care** |  |  |  |  | **Surgery** | **Seniors** | **Pharmacy** | **Public Health-Healthy Living** |
| [ ]  | EMS | [ ]  | Obstetrics | [ ]  | ETU/Rehab | [ ]  | Pharmacy | [ ]  | Families First  |
| [ ]  | Emergency Room | [ ]  | Operating Room | [ ]  | Home Care |  |  | [ ]  | Healthy Baby |
| [ ]  | Special Care Unit (ICU) | [ ]  | Post Anaesthetic Care Unit | [ ]  | Personal Care Home | **Rehabilitation Services** | [ ]  | Healthy Living |
| [ ]  | Outpatient Services /  | [ ]  | Same Day Surgery | [ ]  | Transitional Care | [ ]  | Audiology | [ ]  | Public Health Nursing |
|  | Ambulatory Care Clinic | [ ]  | Surgical Unit |  | [ ]  | Occupational Therapy | [ ]  | Unified Referral Intake System |
| **Medicine** | **Support Services** | **Health Information Services** | [ ]  | Physiotherapy |  |
| [ ]  | Chemotherapy | [ ]  | Administration/Office | [ ]  HIS | [ ] Speech Language Pathology | **Primary Healthcare Integration** |
| [ ]  | Dialysis | [ ]  | Nutrition & Food Services |  |  | [ ]  | Chronic Disease Education Team |
| [ ]  | Medical Unit | [ ]  | Housekeeping | **Mental Health** | **Lab and Diagnostics** | [ ]  | Mobile Clinic |
|  [ ]  Pediatrics | [ ]  | Laundry | [ ]  | Community Mental Health | [ ]  | Diagnostics (CT, X-Ray etc.) | [ ]  | My Health Team |
|  [ ]  Maintenance | [ ]  Crisis Stabilization Unit | [ ]  Lab | [ ]  | QuickCare Clinic |
| **Other program/department:** [ ]  Recreation  | [ ]  Karen Devine Safe House |  | [ ]  | Teen Clinic |
|  [ ]  Medical Device Reprocessing |  |  |  |  |
| [ ]  Other *(specify)*:  |  |  |  |  |
| **Report Initiated By:** |
|  |
|  |  |  |  |  |  | / |  | / |  |  |
|  | Name (please print first and last name clearly) | Department |  | DD |  | MM |  | YYYY |  |
|  |  |  Date Reported |
| **Witness** |
| [ ]  | Yes |  |  |  |  |  |
| [x]  | No |  | Name (please print first and last name clearly) |  | Witness Phone # |  |

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| **Complete one of sections 1-4. Also complete section 5 if equipment or property was involved** **also complete Section C if this is a staff occurrence/near miss** |
| **1. Falls** |
| *Select one from each section:* | *Select* ***all*** *that apply:* |
| **Fell From:** |  |  | **Fell While:** | **Contributing Factors:** |
| [ ]  | Bed | [ ]  | Wheelchair/scooter | [ ]  | Standing | [ ]  | Client behaviour/mental status | [ ]  | Fainted/seizures | [ ]  | Obstacles present |
| [ ]  | Chair | [ ]  | Exam table/stretcher | [ ]  | Transferring | [ ]  | Client physical or medical condition | [ ]  | Medication | [ ]  | Restraint in use |
| [ ]  | Toilet/commode | [ ]  | Slip/trip | [ ]  | Walking | [ ]  | Environmental conditions | [ ]  | Incontinent | [ ]  | Side rail in use |
| [ ]  | Tub/shower | [ ]  | Unknown | [ ]  | Unknown | [ ]  | Inappropriate clothing/footwear | [ ]  | Gait | [ ]  | Call bell out of reach |
| [ ]  | Car/vehicle | [ ]  | Client roll over from bed onto fall mat | [ ]  | Other | [ ]  | High risk | [ ]  | Sedation | [ ]  | Bed not in lowest position |
| [ ]  | Standing/walking |  | *Specify:* | [ ]  | Unexpected movement | [ ]  | Wet floor | [ ]  | Faulty equipment (see #5) |
| [ ]  | Other *Specify:* |  |  | [ ]  | Other *Specify:* |
| **2. Medication/Therapeutic & Diagnostic** |
| **Category** *(check one)* |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [ ]  | Medication including IV medications | [ ]  | Blood/blood product  |  |  |  |  |  |  |  |  |  |  |
| [ ]  | IV/TPN Fluids only | [ ]  | Treatment/Test/Procedure | *Describe:*  |
| **Type** *(check* ***one*** *only)* | **Contributing Factors:** *(select* ***all*** *that apply)* |
| [ ]  | Adverse reaction (ORG.1810.PL.001.SD.08) | [ ]  | Incorrect client | [ ]  | IV infiltration | [ ]  | Client behaviour | [ ]  | Communication of information |
| [ ]  | Blood type/product variance | [ ]  | Incorrect dose | [ ]  | Misplaced/found medication | [ ]  | Client education | [ ]  | Order discrepancy |
| [ ]  | Break in sterile technique | [ ]  | Incorrect labeling | [ ]  | Omitted dose | [ ]  | Client not available | [ ]  | Faulty equipment (complete #5) |
| [ ]  | Consent not obtained | [ ]  | Incorrect order | [ ]  | Outdated product | [ ]  | Environmental conditions | [ ]  | Info missing on chart/order |
| [ ]  | Duplication of treatment | [ ]  | Incorrect time | [ ]  | Rate of flow | [ ]  | Dose miscalculation | [ ]  | Product storage or delivery  |
| [ ]  | Foreign body left in client | [ ]  | Incorrect route/site | [ ]  | Surgical count discrepancy | [ ]  | Staffing or workflow |  | problem |
| [ ]  | Inaccurate results | [ ]  | Incorrect narcotic count | [ ]  | Incorrect medication | [ ]  | Staff education | [ ]  | Product name, label, packaging |
| [ ]  | Incomplete/omitted procedure | [ ]  | Incorrect procedure/service |  | administered/dispensed | [ ]  | Other |  | problem |
| [ ]  | Other | [ ]  | Transcription problem |  |  |  | *Specify:*  |
|  | *Specify:*  |  |  |
|  |  |  |  |  |  |  |  |  |
| **Medication Name** |  | **DIN / Homeopathic Medicine # / Naturopathic Product #** |  | **Dose** |  | **Route** |  | **Frequency** |
| **3. Abusive/Aggressive Behaviour** |
| *Select applicable from each column* |
| **Form of Abuse** | **From Who** | **To Whom** | **Aggressor Condition at Time** | **Contributing Factors**  |
| [ ]  | Verbal | [ ]  | Client | [ ]  | Client | [ ]  | Alert | [ ]  | Care plan discrepancy |
| [ ]  | Sexual | [ ]  | Staff | [ ]  | Staff | [ ]  | Oriented (time/place/person) | [ ]  | Client interference |
| [ ]  | Financial | [ ]  | Visitor | [ ]  | Visitor | [ ]  | Language barrier | [ ]  | Communication of information |
| [ ]  | Emotional | [ ]  | Supervisor | [ ]  | Supervisor | [ ]  | Poor hearing | [ ]  | Environmental conditions |
| [ ]  | Physical | [ ]  | Physician | [ ]  | Physician | [ ]  | Poor vision | [ ]  | Faulty equipment (#5) |
| [ ]  | Physical-Code White\* | [ ]  | Agency personnel | [ ]  | Agency personnel | [ ]  | Agitated | [ ]  | Impaired physical/mental condition |
|  | *\*Disaster management response initiated*  | [ ]  | Other | [ ]  | Other | [ ]  | Sedated | [ ]  | Other |
|  |  | *Specify:* |  | *Specify:* | [ ]  | Confused |  | *Specify:* |
|  |  |  |  |  |  | [ ]  | Other |  |  |
|  |  |  |  |  |  |  |  |  | *Specify:*  |  |  |
|  |  |  | **Name From** |  | **Name To** |  |  |  |  |
| **4. Miscellaneous *check (1) only*** |
| [ ]  | Breach of personal health info. (PHIA) | [ ]  | Needle stick  | **Disaster Management Response:** | **Contributing Factors:** *(select* ***all*** *that apply)* |
| [ ]  | Breach of personal information (FIPPA) | [ ]  | Property damage (complete #5) | [ ]  | Code Red – fire | [ ]  | Body mechanics |
| [ ]  | Breach of information technology security | [ ]  | Missing property (complete #5) | [ ]  | Code Black – bomb threat | [ ]  | Care plan discrepancy |
| [ ]  | Exposure to body fluids | [ ]  | Self-inflicted injury | [ ]  | Code Yellow – missing client | [ ]  | Client interference |
| [ ]  | Hazardous workplace condition | [ ]  | Statement of claim | [ ]  | Code Green – evacuation | [ ]  | Communication of information |
| [ ]  | Internal disclosure of staff concerns | [ ]  | Unauthorized access | [ ]  | Code Grey – external air | [ ]  | Environmental conditions |
| [ ]  | Left against medical advice | [ ]  | Pressure Injury *(circle below)* | [ ]  | Code Brown – chemical spill | [ ]  | Faulty equipment (#5) |
| [ ]  | Inappropriate disposal of sharps/  |  | 2 3 4 unstageable | [ ]  | Code Purple – hostage | [ ]  | Impaired physical/mental condition |
|  | biomedical supplies | [x]  | Other | [ ]  | Code Pink – infant abduction | [ ]  | Client not available |
| [ ]  | Motor vehicle crash |  | *Specify:* | [ ]  | Code Orange – multi casualties | [x]  | Other |
| [ ]  | Elopement/absconding |  | **Significant Public Health Event** |  | *Code White – physical (complete section 3)* |  | *Specify:* **COVID-19** |
| **5. Equipment/**P**roperty** (must be completed **in addition to** sections1-4 if equipment or property is involved) |
| **Item Name/Description:** |  |  |
| **Type:** | [ ]  | Taken out of service |  |  |  |
| [ ]  | Damaged/defective | [ ]  | Locked away in secure location | Manufacturer: |  |  |
| [ ]  | Missing |  |  |  |  |  |  |
| **Owned by:** |  |  |  | Serial #: |  |  |
| [ ]  | Site/program |  | By (name) |  |  |  |  |
| [ ]  | Client |  |  |  | Model #: |  |  |
| [ ]  | Employee |  |  |  |  |  |  |
| [ ]  | Other *Specify:*  |  | Where/location |  | Lot #: |  |  |

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| **6. Notification** |
| **Record Name of Person Notified if Applicable** | **Report By** | **Reported To** | **Date** | **Time** **(24 hour clock)** |
| **occurrences / near misses:** |
| [ ]  | Direct Supervisor / Person in Charge |  |  |       |      |
| [ ]  | Physician |  |  |       |      |
| [ ]  | Next of Kin |  |  |       |      |
| [ ]  | Client |  |  |       |      |
| [ ]  | Pharmacy (as applicable) |  |  |       |      |
| [ ]  | Report significant equipment occurrences or near misses to recallalert@southernhealth.ca by scanning and emailing the occurrence report |  | recallalert@southernhealth.ca  |       |      |
| **critical incidents / critical occurrences** |
|  | Critical occurrences involving an employee also complete notifications in Section C |  |  |  |  |
| [ ]  | Director of Health Services |  |  |       |      |
| [ ]  | *Check if a copy of the occurrence report was sent* |  |  |       |      |
| [ ]  | Regional Director / Manager  |  |  |       |      |
| [ ]  | *Check if a copy of the occurrence report was sent* |  |  |       |      |
| [ ]  | Executive Director / Vice President |  |  |       |      |
| [ ]  | *Check if a copy of the occurrence report was sent* |  |  |       |      |
| [ ]  | Regional Coordinator-Patient Safety**North/West**: 204-428-2743**East/Mid**: 204-326-6411 ext. 2097 |  | **jathompson@southernhealth.ca or casham@southernhealth.ca**  |       |      |
| [ ]  | Send copy of occurrence form to Regional Coordinator-Patient Safety (required for all critical incidents and critical occurrences) |  |  |       |      |
| [ ]  | After hours: contact Senior Leader On Callby calling 204‑239-2211 |  |  |       |      |
| **client abuse:** |
| [ ]  | Protection for Persons in Care Office(clients admitted to a facility and all outpatient departments)Fax: 204-775-8055 |  |  |       |      |
| [ ]  | Child & Family ServicesAfter hours: 888-345-9241 |  |  |       |      |
| **other contacts as applicable:** |
| [ ]  | Regional Disaster Management Officer |  |  |       |      |
| [ ]  | Infection Control Nurse |  |  |       |      |
| [ ]  | Regional Privacy & Access Officer **(Report ALL Breach of PHIA/FIPPA)** |  |  |       |      |
| [ ]  | Police/RCMP |  |  |       |      |
| [ ]  | Poison Control CentreEmergency Inquiries: 204-787-2591 |  |  |       |      |
| [ ]  | Insurance Adjuster |  |  |       |      |
| [ ]  | Payroll |  |  |       |      |
| [ ]  | Other*Specify:*  |  |  |       |      |

Occurrence Reports should not be photocopied for the purpose of maintaining accurate records. However, a copy of the original report may be sent to the Office of Chief Medical Examiner and the Protection for Persons in Care Office. A copy of Occurrence Reports may also be sent to the following individuals **who are employed by Southern Health-Santé Sud**. Any copies sent must be documented in the above notification section on this form.

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| * Director of Health Services
 | * Regional Coordinator-Patient Safety (or designate)
 |
| * Regional Directors/Managers
 | * Regional Manager Health Information Services / Regional Privacy & Access Officer
 |
| * Senior Leaders
 | * Regional Disaster Management Officer
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| **If this is a staff CO/occurrence/near miss, leave this page blank and complete Section C only.** |
| **SECTION B: REPORT and INCIDENT ANALYSIS** | **[x]  CHECK if completing section c** |
| **Part 1: Report by Staff Member** |
| **Details related to occurrence (CI, CO, O, NM), the facts of what happened:** *If this is a staff CO/occurrence/near miss, complete Section C only.* |
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| See Section C |
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| Signature of staff member: |  | Date (DD/MM/YYYY): |  | / |  | / |  |  |
| **Action taken, how did you respond, what did you do:** *If this is a staff CO/occurrence/near miss, complete Section C only.* |
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| Signature of staff member: |  | Date (DD/MM/YYYY): |  | / |  | / |  |  |
| **Part 2: Analysis of CO / Occurrence / Near Miss by Primary Department** *If this is a staff CO/occurrence/near miss, complete Section C only.* |
| **Findings, factors that are thought to have contributed to the CO/occurrence/near miss.** Consider the Incident and Outcome diagram.**For client falls, state date of last fall if known.**       |
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| Signature of person in charge: |  | Date (DD/MM/YYYY): |  | / |  | / |  |  |
| **Follow up actions / Steps required** | **Assigned to** | **Target Date for Completion** | **Date of Completion** |
|       |       |       |       |
|       |       |       |       |
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| Signature of person in charge: |  | Date (DD/MM/YYYY): |  | / |  | / |  |  |

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| **Part 3: Analysis of Occurrence / Near Miss by SECOND department** (i.e. if two departments are involved) |
| **Findings, factors that are thought to have contributed to the occurrence:** |
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| Signature of person in charge: |  | Date (DD/MM/YYYY): |  | / |  | / |  |  |
| **Follow up actions / Steps required** | **Assigned to** | **Target Date for Completion** | **Date of Completion** |
|       |       |       |       |
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| Signature of person in charge: |  | Date (DD/MM/YYYY): |  | / |  | / |  |  |

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| **For occurrences / near misses:** **(unless staff occurrence/near miss, then sign section c only)** | **For all critical incidents / critical occurrences:****(including critical occurrences involving staff recorded in section c)** |
|  |  |  | / |  | / |  |  |  |  |  | / |  | / |  |  |
| Signature of Direct Supervisor / Person in Charge |  | DD |  | MM |  | YYYY |  | Signature of Director of Health Services/ Regional Director/CEO (affiliate/contract site) |  | DD |  | MM |  | YYYY |  |
| Date | Date |

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| Additional notes: |
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| **SECTION C: STAFF OCCURRENCE / NEAR MISS**  | ***For office use only* Occurrence #:** | LogoB+W.jpg |
| **Part 1: Report by Staff Member** |
| **Name:**(please print) |  | **Manager Name:**(please print) |  |
| **Facility/Building/Location:** (where it happened) |  |
| **Department/Job Title:**  |  | **Union Affiliation:**[ ]  None | [ ]  | MNU | [ ]  | MGEU PT |
| [ ]  | CUPE | [ ]  | MGEU CS |
| **Date of Event:** |  |  | / |  | / |  | **Time:** |      |  | **Witness:** | [ ]  | Yes |  |  |
|  |  | DD |  | MM |  | YYYY |  | 24 hr clock |  |  | [x]  | No | Name (please print) |
| **Actions following incident:**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 occurrence |  |
|  |  | [ ]  | Medical Aid (saw/will see doctor) | [ ]  | Lost Time Injury |  |  |  |
| **Detailed description of incident (include task/duty at time of incident):** *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 |
| [ ]  | Face | [ ]  | Hearing | [ ]  | Pelvis | [ ]  | Arm | [ ]  | Finger(s)/Nails | [ ]  | Ankle |
| [ ]  | Eye(s) | [ ]  | Neck | [ ]  | Chest | [ ]  | Elbow | [ ]  | Hip(s) | [ ]  | Foot |
| [ ]  | Nose | [ ]  | Back | [ ]  | Cardio/Respiratory | [ ]  | Wrist | [ ]  | Leg | [ ]  | Toe(s)/Nails |
| [ ]  | Mouth/Teeth | [x]  | Other *Specify:* **COVID-19** |  |  | [ ]  | **None** |
| **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. |
| [x]  | Other *Specify:* | **COVID-19** |  | [ ]  | Visitor |
| [ ]  | Other |
|  |
|  |  |  |  | / |  | / |  |  |
|  | **Staff Signature** |  | DD |  | MM |  | YYYY |  |
|  |  |  |  | / |  | / |  |  |
|  | **Direct Supervisor / Person in Charge Signature** |  | DD |  | MM |  | YYYY |  |
| **Notification** |
| **Record Name of Person Notified**  | **Report By** | **Reported To** | **Date** | **Time** (24 hour clock) |
| **Direct Supervisor / Person in Charge** send both pages of Section C: Staff Occurrence/Near Miss: |
| [x]  | **For all employee COs/occurrences/near misses, immediately** send to Payroll |  |  |       |      |
| [x]  |  **For all COs/occurrences/near misses**Workplace Safety & Health program atEmail: wsh@southernhealth.ca *or*Fax: 204-424-9401 |  |  |       |      |
| [ ]  | **For critical occurrences:**Director of Health Services / Regional Director  |  |  |       |      |
| [ ]  | **For all** **serious injuries**, complete an investigation report form provided by Regional Workplace Safety & Health Committee co-chair(s) and submit to the Workplace Safety & Health program via email |  |  |       |      |

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| **Notification** |
| **Record Name of Person Notified if Applicable** | **Report By** | **Reported To** | **Date** | **Time** (24 hour clock) |
| **Director of Health Services / Regional Director / Manager / Supervisor:** Serious Injuries (Critical Occurrences) under the Workplace Safety and Health Act must be immediately reported **by phone** to all below: |
| [ ]  | Province of Manitoba Department of Labour and Family Services – Workplace Safety and Health **204-957-7233** or **1-855-957-7233** |  |  |       |      |
| [ ]  | Regional Manager Workplace Safety and Health **204-346-2467** |  |  |       |      |
| **Analysis of staff occurrence / near miss:**Findings, factors that are thought to have contributed to the occurrence/near miss.  |
|       |
|       |
| Date Staff swabbed for Covid-19: ( ) |
| Date Staff tested postitive for Covid-19: ( ) |
|       |
|       |
| **Follow up actions / Steps required** | **Assigned to** | **Target Date for Completion** | **Date of Completion** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Actions taken:** |  |  |  |  |  |  |  |  |
| [ ]  | Debriefing *(i.e. discuss staff injury/near miss and follow up actions/steps required with staff member)* |  |
| [ ]  | Care planning *(i.e. discuss client care plan with team members)* |  |
| [ ]  | Team conference *(i.e. discuss follow up actions/steps required with team members)* |  |
| [x]  | Other *Specify:* | COVID-19 |  |
|  |
|  |  |  |  | / |  | / |  |  |
|  | **Staff Signature following review of actions taken** |  | DD |  | MM |  | YYYY |  |
|  |  |  |  | / |  | / |  |  |
|  | **Manager Signature following review of actions taken** |  | DD |  | MM |  | YYYY |  |
| **For Southern Health-Santé Sud Workplace Safety & Health program only:** |
| **Notification** |
| **Regional Manager Workplace Safety & Health program:**  |
| **Record Name of Person Notified if Applicable** | **Report By** | **Reported To** | **Date** | **Time** (24 hour clock) |
| [ ]  | Notify Labour Relations of abuse to MNU staff |  |  |       |      |
| **Review of follow up actions (if applicable)** | [ ]  Effective[ ]  Not Effective |
|       |       |
|       |       |
|       |       |
| **Further review required (if applicable)** |
| Comments: |
|       |
|       |
|  |
|  |  |  |  | / |  | / |  |  |
|  | **Regional Manager Workplace Safety & Health program Signature** |  | DD |  | MM |  | YYYY |  |
|  |  |  | Date reviewed |  |