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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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 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 | | | | | | | | |  | | | 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 | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | None | | | | | | |  | | | | Fracture | | | | | | | | |
| Site/Facility/Building: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | Minor | | | | | | |  | | | | Chemical or Biological Exposure | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  | | | | Major (CO) | | | | | | |  | | | | 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 | | | |
|  | | 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:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | Name (please print first and last name clearly) | | | | | | | | | | | | | | | | | | Department | | | | | | | | | | | | | | | |  | | DD | | |  | MM | | | | | |  | | YYYY | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | Date Reported | | | | | | | | | | | | | | | |
| **Witness** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Yes |  | |  | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
|  | | | 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 | | | | | | | | | | | | | |  | | |  | | | | | | | | | |
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|  | |  | | | |  | | | | | | **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 | | | | | | | | | | | | | | |  | | | Other | | | | | | | | | | | | | | |  | | | | Code Pink – infant abduction | | | | | | | | | | | | | | |  | | Client not available | | | | | | | | | | | | | | |
|  | | Motor vehicle crash | | | | | | | | | | | | | | |  | | | *Specify:* | | | | | | | | | | | | | | |  | | | | Code Orange – multi casualties | | | | | | | | | | | | | | |  | | 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](mailto:recallalert@southernhealth.ca) by scanning and emailing the occurrence report | |  | | [recallalert@southernhealth.ca](mailto: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 Call  by 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 Services  After 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 Centre  Emergency 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.

|  |  |
| --- | --- |
| * 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** | | | | | | **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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| **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 | | | | |  | |  | | | | | | |  | 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 | | | | | | |  | | 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. | | | | | | | | | | | | | | | | | | | | | |
|  | | Other *Specify:* | | | | **COVID-19** | | | | | | | | | | | | | | | |  |  | | Visitor | | | | | | | | |
|  | | Other | | | | | | | | |
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|  | **Staff Signature** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | DD | | | | | |  | MM | | | |  | YYYY | | |  | | | | | | | |
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|  | **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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **For all employee COs/occurrences/near misses, immediately** send to Payroll | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |  | | | |
|  | | **For all COs/occurrences/near misses**  Workplace Safety & Health program at  Email: [wsh@southernhealth.ca](mailto: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. | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Date Staff swabbed for Covid-19: ( ) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date Staff tested postitive for Covid-19: ( ) | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Follow up actions / Steps required** | | | | | | | | **Assigned to** | | | | | | | | | | | **Target Date for Completion** | | | | **Date of Completion** | | |
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| **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)* | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | Other *Specify:* | COVID-19 | | | | | | | | | | | | | | | | | | | | | |  |
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|  | **Staff Signature following review of actions taken** | | | | | | | | |  | | DD | |  | MM | |  | YYYY | | | |  | | | |
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|  | **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 | | | | | | | | | | | | | | | | |
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| **Further review required (if applicable)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | **Regional Manager Workplace Safety & Health program Signature** | | | | | | | | |  | | DD | |  | MM | |  | YYYY | | | |  | | | |
|  |  | | | | | | | | |  | | Date reviewed | | | | | | | | | |  | | | |