

IMS ID No: **WORKPLACE INCIDENT REPORT**Queensland Government
Queensland Health1 Staff Visitor Contractor Volunteer Student Patient *NOTE: Patient incidents are reported in PRIME***Incident Category** * Incident requires immediate notification to WH&S Unit2 Notification - Nil injury Work Caused Illness* Fatality * Near Miss
 Work Caused Injury* Dangerous Event* Serious Bodily Injury* Electrical Incident *
 Security**3 Personal Data**Employee Payroll /
Patient UR Number Surname Given Names

Date of Birth

 Day Month Year

Gender

 M or F**4 Employment Data**Division Work Area Name

Position

Eg: RN, EN, AO Employment Type

Eg. Casual, volunteer, full-time

Shift Type Eg. Fixed,

standard, flexible.

Work

Telephone Manager's Name

Manager's

Telephone

Starting Date and Time

On Day of Incident

 Day Month Year Time

Intended Finishing Date and Time

On Day of Incident

 Day Month Year Time**5 Incident Details** (If insufficient room attach details/diagram/drawing)Location of Incident
Exactly where did the incident occur
eg: Ward 1A, Room 12, Bed 11Cost Centre Number
(Employee's work unit)

Date and Time of the Incident

 Day Month Year Time

Date and Time Reported

 Day Month Year TimeReported to Name Position Witness Name Witness Name

What happened unexpectedly?

How exactly did/could the illness, injury or damage happen?

Experience in task

 YearsWas a patient involved in the incident? No Yes - Include UR number →

Injury/Illness (classification)	Body Part Affected (location)	Action at the Time (task involved)	What Happened (mechanism)	Prime Cause (agency)
<input type="checkbox"/> Brain injury/concussion <input type="checkbox"/> Fracture <input type="checkbox"/> Wound/laceration/ contusion/bruising <input type="checkbox"/> Amputation <input type="checkbox"/> Sharp/needle puncture <input type="checkbox"/> Internal injury <input type="checkbox"/> Burn <input type="checkbox"/> Nerve/spinal injury <input type="checkbox"/> Joint/ligament/muscle/ tendon injury <input type="checkbox"/> Ear/eye/nose injury <input type="checkbox"/> Poisoning <input type="checkbox"/> Electrocution <input type="checkbox"/> Musculoskeletal disease <input type="checkbox"/> Mental illness/stress <input type="checkbox"/> Digestive system <input type="checkbox"/> Skin disease/dermatitis <input type="checkbox"/> Nervous system/sense organ diseases <input type="checkbox"/> Respiratory disease <input type="checkbox"/> Heart/circulatory <input type="checkbox"/> Infection/virus <input type="checkbox"/> Cancer/melanoma <input type="checkbox"/> Nil injury	<input type="checkbox"/> Head <input type="checkbox"/> Eye (L) (R) <input type="checkbox"/> Ear (L) (R) <input type="checkbox"/> Mouth <input type="checkbox"/> Nose <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Back: upper / lower <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen / pelvic <input type="checkbox"/> Shoulder (L) (R) <input type="checkbox"/> Upper arm / elbow / forearm (L) (R) <input type="checkbox"/> Wrist (L) (R) <input type="checkbox"/> Hand / fingers / thumb: (L) (R) <input type="checkbox"/> Hip <input type="checkbox"/> Upper/low leg (L)(R) <input type="checkbox"/> Knee (L) (R) <input type="checkbox"/> Ankle/foot/toe (L/R) <input type="checkbox"/> Circulatory / respiratory / diges- tive/ nervous system <input type="checkbox"/> Psychological <input type="checkbox"/> Nil	General <input type="checkbox"/> Computer/keyboard use <input type="checkbox"/> Administration <input type="checkbox"/> Direct patient care <input type="checkbox"/> Drug administration <input type="checkbox"/> Driving/riding <input type="checkbox"/> Walking/running <input type="checkbox"/> Patient/person restraint <input type="checkbox"/> General duties Patient Handling <input type="checkbox"/> On bed <input type="checkbox"/> Rolling/turning/pt holds <input type="checkbox"/> Patient transfer <input type="checkbox"/> Emergency (patient fall /collapse) <input type="checkbox"/> Mechanical aid/hoist Manual Handling <input type="checkbox"/> Lifting/carrying <input type="checkbox"/> Push/pulling <input type="checkbox"/> Twisting/bending <input type="checkbox"/> Reaching <input type="checkbox"/> Repeated movements <input type="checkbox"/> Machinery/equipment	<input type="checkbox"/> Slip or trip <input type="checkbox"/> Fall from height/same level <input type="checkbox"/> Hitting moving/ stationary object <input type="checkbox"/> Hit by moving object <input type="checkbox"/> Assault by patient <input type="checkbox"/> Assault by person(s) <input type="checkbox"/> Tendon/muscular stress <input type="checkbox"/> Repetitive movement <input type="checkbox"/> Vehicle accident <input type="checkbox"/> Harassment/bullying <input type="checkbox"/> Work pressure Exposure/contact with: <input type="checkbox"/> Mental stress factors <input type="checkbox"/> Heat/cold <input type="checkbox"/> Sound/pressure <input type="checkbox"/> Chemical/substance <input type="checkbox"/> Radiation <input type="checkbox"/> Electricity <input type="checkbox"/> Animal/insect <input type="checkbox"/> Biological factors <input type="checkbox"/> Other: _____	<input type="checkbox"/> Machinery <input type="checkbox"/> Fixed plant <input type="checkbox"/> Electrical installation <input type="checkbox"/> Mobile equip/plant <input type="checkbox"/> Road/air transport <input type="checkbox"/> Powered equipment <input type="checkbox"/> Non powered equipment <input type="checkbox"/> Furniture and fixtures <input type="checkbox"/> Chemical exposure <input type="checkbox"/> Asbestos <input type="checkbox"/> Fire <input type="checkbox"/> Indoor environment <input type="checkbox"/> Outdoor environment <input type="checkbox"/> Animal/insect <input type="checkbox"/> Biological agencies <input type="checkbox"/> Blood/body fluid exposure <input type="checkbox"/> Needle/clinical sharp <input type="checkbox"/> Non clinical sharp <input type="checkbox"/> Manual handling patient <input type="checkbox"/> Manual handling other <input type="checkbox"/> Physical violence <input type="checkbox"/> Verbal violence <input type="checkbox"/> Violence perpetrator: Staff / Patient / Visitor

6 **Workers' Compensation** Will a WorkCover claim be submitted for this incident? Yes No Unsure7 **Completed by** Signature Name Date Day Month Year**PLEASE GO TO SECTION 8 ON PAGE 2**

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Risk Rating

Please refer to the Workplace Incident Report Form Procedures for instructions on how to complete the risk matrix below.

Likelihood	Consequence				
	<i>Negligible</i> No injury / illness—no time lost	<i>Minor</i> Injury or illness requiring first aid only— lost time of < 4 days	<i>Moderate</i> Serious Injury/ Illness - > 4 days lost or event that is notifiable	<i>Major</i> Fatality	<i>Extreme</i> Multiple Fatality
<i>Rare</i> May only occur in exceptional circumstances	Low	Low	Low	Medium	High
<i>Unlikely</i> Might occur at least once (not to be expected)	Low	Medium	Medium	High	Very High
<i>Possible</i> Could occur at least once (capable of happening/foreseeable)	Low	Medium	High	Very High	Very High
<i>Likely</i> Is expected to occur occasionally (to be expected)	Medium	High	Very High	Very High	Extreme
<i>Almost Certain</i> Is expected to occur frequently (in most circumstances)	Medium	Very High	Very High	Extreme	Extreme

Risk Rating

Eg. If you had a likelihood of *possible* and a consequence of *minor*, the risk rating would be *medium*.

IF THE RISK RATING IS "VERY HIGH" OR "EXTREME", OR THE CONSEQUENCES ARE "MAJOR" OR "EXTREME" NOTIFY WH&S UNIT IMMEDIATELY

NOW HAND THIS FORM TO YOUR LINE MANAGER

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Management Review

INCIDENT INVESTIGATION

What task was being performed at the time of incident? (If insufficient room attach details)

Has a similar event occurred within this work area in the past 6 months? Yes No

If **YES** what was done to prevent recurrence?

From your review, indicate the prime cause of the incident:

- | | | |
|--|--|---|
| <input type="checkbox"/> Unsafe equipment or plant | <input type="checkbox"/> Work area unsuitable/unsafe | <input type="checkbox"/> Hazard not risk assessed |
| <input type="checkbox"/> Correct procedure not applied to task | <input type="checkbox"/> Patient or visitor action | <input type="checkbox"/> Worker inexperience |
| <input type="checkbox"/> Appropriate procedure non existent | <input type="checkbox"/> Workload factors | <input type="checkbox"/> Supervision lacking |
| <input type="checkbox"/> Unsafe work practices in use | <input type="checkbox"/> Staff training inappropriate | <input type="checkbox"/> Inappropriate equipment in use |
| <input type="checkbox"/> Hazard(s) not identified | <input type="checkbox"/> Work practices not defined | <input type="checkbox"/> Incidents not reviewed |
| <input type="checkbox"/> PPE not used | <input type="checkbox"/> Work practice review not done | <input type="checkbox"/> Work area security deficient |
| <input type="checkbox"/> Safe work practices not enforced | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other _____ |

Was time off required? Yes No If yes indicate: <1day 1day >than 1day _____ (how many)

Was treatment required? Nil First Aid DEM/OH/GP Treatment Hospitalisation Blood/Body Fluid Protocol

What action do you as the Line Manager intend to take to prevent recurrence:

Corrective Action	Action Required and Task(s) Allocated to	Action by Date	Date Completed
<input type="checkbox"/> Change to work practices <input type="checkbox"/> Change to work area layout/design <input type="checkbox"/> Debriefing or counselling <input type="checkbox"/> Undertake task analysis or risk assessment <input type="checkbox"/> Submit equipment maintenance requisition <input type="checkbox"/> Review staff training <input type="checkbox"/> Seek WH&S input to identify preventive controls <input type="checkbox"/> Refer to Executive for decision/guidance <input type="checkbox"/> Nil Action required <input type="checkbox"/> Other _____			

Has the person reporting the incident been advised of actions taken to prevent recurrence? Yes No

Date Notified / /

By Whom

Signature

Name & Position

Date

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Department Head Comments

Do you concur with the Manager/Supervisor's review and recommended corrective action? Yes No

Signature

Name & Position

Date

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WH&S Comments

Is further investigation required? Yes No

WHSQ Notified? Yes No

Event Id:

 No

Signature

Name

Date