



Incident & Injury Report Form

ONLY USE THIS FORM IF YOU HAVEN'T FILLED OUT AN INCIDENT/INJURY REPORT ON VISUAL CARE

Family Name:

First Name:

Subee uses reports of incidents and injuries to continuously improve how we do things. Use this form to complete a record which outlines the detail of an injury which has occurred within the workplace. Please note that you need to notify the office as soon as an injury occurs to ensure you receive appropriate treatment and procedures are followed. Employee, client or contractor or third party stakeholder to complete Section 1-3.

SECTION 2: INCIDENT DETAILS

Date of Incident:

Time of Incident:

Location of Incident:

Witness Details:

Activity in which the person was engaged at the time of injury/incident and how the events occurred:

SECTION 1: INJURED CLIENT/WORKER DETAILS

Family Name:

First Name:

Position:

Date:

Response to stabilise the situation: *Eg: 000 called, first aid provided, isolation of power*

Was appropriate PPE being worn:
If yes, please outline

Yes No

Did incident occur during client service?

Yes No

Was the clients care plan being followed?

Yes No

Injury sustained: *Please complete below Section 3 if you have ticked 'Yes'*



IN HOME CARE • NDIS • AGED CARE • NURSING
GARDENING • DOMESTIC ASSISTANCE

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Family Name:

First Name:

SECTION 3: INJURY DETAILS

Nature of injury:
Eg: fracture burn,
sprain etc.

Referral for further treatment: Yes No

Name of Doctor/Hospital:

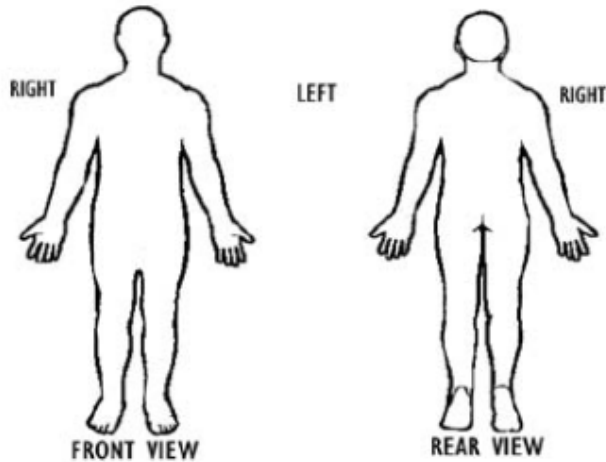
Has WorkCover medical cert been provided: Yes No

Time unfit for work:

If no please advise why:

Any additional information:

Body location of
injury (indicate
location of injury
on the diagram):



Treatment given
on site and by
whom:

To be completed by individual who has
provided the above information:

Name:

Signature:

To be completed by individual who
has received the report:

Name:

Signature:

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SECTION 4: INVESTIGATION (HR/TEAM LEADER TO COMPLETE)

REPORTING DETAILS:

Reportable Incident:

Yes No

Notified:

TRACK Report:

Report ID:

Assigned to:

Reported to Workers Compensation insurer:

Yes No

iCare Claim Number:

RTW Coordinator Name:

Have relevant third parties been notified? (client, family/NOK/Guardian, COS, residential aged care & disability accommodation)

Yes No

Who:

Date:

Family Name:

First Name:

RISK MANAGEMENT:

Has a Risk Assessment been conducted in the last 12 months: Yes No

Has a similar incident/near miss occurred previously: Yes No

Were there procedures in place to minimise the risk: Yes No

Key contributing factors: Yes No

Corrective Action which will be implemented: Yes No

Assigned to:

Due by:

Attached Documents

Interviews

Photos Risk Assessments

Witness Statements

Related Incidents

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SECTION 5: RISK MANAGEMENT

RISK MANAGEMENT

Evaluate the likelihood, consequences and level of risk following implementation of the above corrective actions.

LIKELIHOOD		
Descriptor	Level	Definition
Rare	1	May occur, sometime (“once in a life time / once in a hundred years”)
Unlikely	2	May occur somewhere within the organisation over an extended period of time
Possible	3	May occur several times across the organisation or a region over a period of time
Likely	4	May be anticipated multiple times over a period of time. May occur once every few repetitions of the activity or event
Almost Certain	5	Prone to occur regularly Is anticipated for each repetition of the activity

CONSEQUENCE		
Descriptor	Level	Definition
Insignificant	1	No injury
Minor	2	Injury/ ill health requiring first aid
Moderate	3	Injury/ill health requiring medical attention
Major	4	Injury/ill health requiring hospital admission
Severe	5	Fatality

Risk level

Likelihood	Consequence				
	Insignifi- cant	Minor	Moderate	Major	Severe
Almost Certain	Medium	High	Extreme	Extreme	Extreme
Likely	Medium	Medium	High	Extreme	Extreme
Possible	Low	Medium	Medium	High	Extreme
Unlikely	Low	Low	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Key

Extreme:	Notify Executive Management and HR immediately. Corrective actions should be taken immediately. Cease associated activity.
High:	Notify Executive Management and HR immediately. Corrective actions should be taken within 2 working days of notification
Medium:	Notify Team Leader . Team Leader is to follow up that corrective action is taken within 7 days.
Low:	Notify Team Leader . Team Leader is to follow up that corrective action is taken within a reasonable time.

Forward A COPY to the Quality Manager *Quality Manager to Complete*

Entered on Visual Care

Tabled at Management/Quality Meeting

Corrective Action Undertaken / Completed

Corrective Actions Reviewed for Effectiveness