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 outlinmes 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 1: INJURED WORKER DETAILS

Family Name:

First Name:

Position:

Date:

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:

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

Was appropriate PPE being worn: ☐ Yes ☐ No

If yes, please outline

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'*

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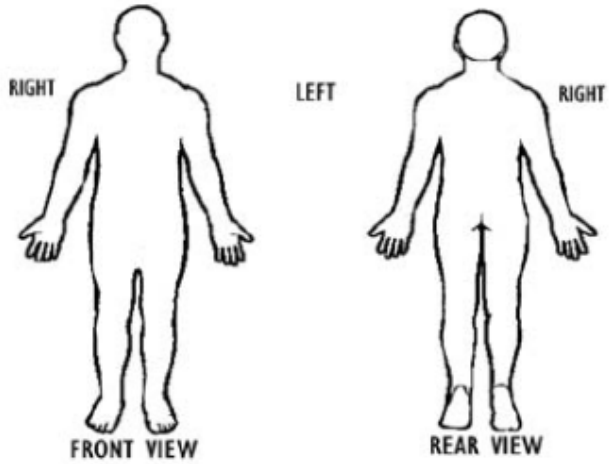
First Name:

SECTION 3: INJURY DETAILS

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

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



Treatment given on site and by whom:

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:

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

Name:

Signature:

To be completed by induvial who has received the report:

Name:

Signature:

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Family Name:

First Name:

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:

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		
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 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	