



**Centre universitaire de santé McGill
McGill University Health Centre**

*Les meilleurs soins pour la vie
The Best Care for Life*

REPORT AND ANALYSIS

WORK-RELATED INCIDENT/ACCIDENT AND OCCUPATIONAL DISEASE

OCCUPATIONAL HEALTH AND SAFETY DEPARTMENT

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sstohs@muhc.mcgill.ca

Summary of Instructions

This form must be completed by MUHC employees for all work-related incidents or accidents, and occupational diseases.

► DEFINITIONS

INCIDENT: An unforeseen and sudden event that, in other circumstances, could have consequences such as injury to a hospital worker or to property damages.

ACCIDENT: An unforeseen and sudden **event that occurred in the workplace**, for which the consequences include injury to a hospital worker or to property damages.

- THE EMPLOYEE'S OBLIGATION IS TO IMMEDIATELY INFORM HIS OR HER SUPERVISOR OF THE EVENT AND TO COMPLETE THE INCIDENT / ACCIDENT REPORT (**PAGE 1 – SECTION A, B, C, D**) WITH THE ASSISTANCE OF THE SUPERVISOR.
- THE SUPERVISOR ENSURES A FOLLOW-UP OF THE EVENT AND COMPLETES PAGE 2 "ANALYSIS OF THE CAUSES OF THE INCIDENT / ACCIDENT AND PLAN OF ACTION".

► PROCEDURE

► ONCE PAGE 1 SECTIONS A, B, C, AND D ARE COMPLETED – THE REPORT MUST BE SIGNED BY THE EMPLOYEE AND THE SUPERVISOR WHO WILL THEN FORWARD THE DOCUMENT AS FOLLOWS:

- The white copy must be sent to the department of Occupational Health and Safety within 24 hours of the event.
- The yellow copy remains with the employee.
- The pink copy is for the supervisor.

► IF THE EMPLOYEE CANNOT BE PRESENT FOR MEDICAL REASONS, THE SUPERVISOR MAY COMPLETE THE REPORT TO THE BEST OF HIS ABILITIES AND FOLLOW THROUGH USING THE SAME PROCEDURE. THE EMPLOYEE'S VERSION MAY BE RECEIVED AT A LATER DATE AND ANNEXED TO THE "ANALYSIS OF THE CAUSES OF THE INCIDENT / ACCIDENT AND PLAN OF ACTION" SECTION, PAGE 2.

► WITH THE PREVENTION OF SIMILAR CASES BEING THE OBJECTIVE, THE SUPERVISOR HAS THE OBLIGATION TO FOLLOW-UP ON THE EVENT AND TO COMPLETE PAGE 2, "ANALYSIS OF THE CAUSES OF THE INCIDENT / ACCIDENT AND PLAN OF ACTION". THE INFORMATION MUST BE SIGNED AND SENT TO THE OCCUPATIONAL HEALTH AND SAFETY DEPARTMENT WITHIN 5 DAYS OF THE EVENT.

► SECTION A (PAGE 1/3)

IDENTIFICATION : COMPLETE PERSONAL INFORMATION

► SECTION B

DATE OF EVENT: INDICATE THE DATE AND PRECISE TIME THE EVENT TOOK PLACE
WORK SHIFT: INDICATE THE SHIFT AS WRITTEN ON THE WORK SCHEDULE

NATURE OF INJURY

EXAMPLES:

- Allergic reaction
- Anxiety, stress
- Burn
- Conjunctivitis
- Cut, laceration, wound
- Discal hernia
- Fracture
- Inflammation, swelling
- Injury or trauma
- Intoxication
- Pain
- Perforation, prick
- Strain, sprain, tear
- Superficial contusion
- Viral infection

INJURED BODY PART

EXAMPLES:

- Head
- Eye
- Nose
- Mouth
- Neck
- Back:
 - Cervical
 - Dorso-cervical
 - Dorsal
 - Dorso-lumbar
 - Lumbar
 - Coccyx
- Shoulder
- Chest
- Respiratory system
- Arm
- Elbow
- Hand
- Knee
- Ankle
- Foot

CAUSE OF INJURY

EXAMPLES:

- Chemical products
- Containers
- Floors, hallways, surfaces, structures
- Furniture
- Infectious or parasitic agent
- Medical or surgical instruments
- Person other than injured worker
- Tools, instruments and materials

TYPE OF CONTACT

EXAMPLES:

- Aggression by patient, visitor
- Allergic reaction
- Climbing up or down stairs
- Contact with infectious agent
- Cut, scratch, burn
- Fall
- Hit or crushed by object
- Lifting or dropping something heavy
- Prick, bite
- Repositioning patient in bed/chair
- Slip on surface, trip
- Transferring patient from chair/bed

EXECUTED TASK(S)...

- The employee indicates exactly what tasks he was doing at the moment of the incident / accident (ex. cutting vegetables, helping patient to...)

FREQUENCY OF EXECUTED TASK(S)

- Define the frequency (ex. ten times/hour, once/day, once/month...)

► SECTION C

DESCRIBE THE INCIDENT / ACCIDENT WITH THE MOST OBJECTIVITY POSSIBLE BY AVOIDING PERSONAL COMMENTS OR HASTY CONCLUSIONS (Employee's version of the event answering the following questions: Who, What, When, Where and How).

► SECTION D

STATE YOUR SUGGESTIONS TO HELP AVOID SIMILAR ACCIDENTAL EVENTS FROM RECURRING.

► ANALYSIS OF THE CAUSES OF THE INCIDENT / ACCIDENT (PAGE 2/3)

Indicate the immediate causes in the left side of the table and establish the associated fundamental causes. The key to success is to ask "why" until the fundamental causes are established for each of the immediate causes. This step will also facilitate the elaboration of the corrective measures and the plan of action.

► PLAN OF ACTION

Please indicate all corrective measures taken and applied in order to correct the immediate causes. When possible, the corrective measures should aim to eliminate the fundamental causes and establish a new course of action.

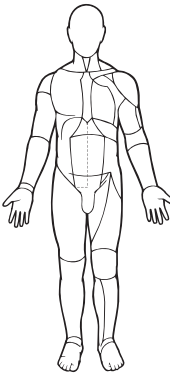
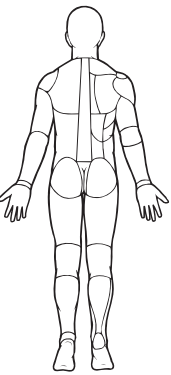


Work-Related Incident / Accident and Occupational Disease Report

A) Identification of Injured Employee

Family Name		Given Name at Birth		Employee No.
Job Title			Department Name	
Work Ext. No.	Home Tel. No.		Cell Tel. No.	
E-mail Address			Hospital Site	

B) Identification of the incident / accident

Date of Event		Time		Date Declared		Time		Declared to : Extension:
Y	Y	Y	Y	:	AM	Y	Y	
M	M	D	D	:	PM	M	M	
Work Shift (hr)	From :	To :	Overtime <input type="checkbox"/> Yes <input type="checkbox"/> No		No. of consecutive days worked :			
Nature of injury : _____								
Injured body part : _____								<input type="checkbox"/> Right <input type="checkbox"/> Left
Cause of injury : _____								
Type of contact : _____								
Task being done at the moment of the event :							<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Front  </div> <div style="text-align: center;"> Back  </div> </div> <p>If applicable, indicate site of pain or of injury</p>	
Frequency of task executed by the worker :				Exact location where the event took place :				
Witness(es)				Telephone number(s)				
Consequences of the Event								
Work shift completed ?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, specify : _____					
Loss of time ?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify : _____					
Sought medical attention ?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify where : _____					
Injury to anyone else ?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify : _____					
Property damages ?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify : _____					
Risk still present ?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify : _____					

C) Description of the incident / accident

Employee's version of the event answering the following questions: **WHO; WHAT; WHEN; WHERE; HOW ?** (Be detailed and objective).

Use additional sheets as required.

D) What are your suggestions to help avoid similar accidental events from recurring ?

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EMPLOYEE

IMMEDIATE SUPERVISOR

Name :	Name :
Signature :	Signature : CONTINUED ON THE BACK ►
Date :	Date :
Extension :	Extension :

►► IMPORTANT: THE IMMEDIATE SUPERVISOR SENDS THE REPORT ACCORDING TO THE ESTABLISHED PROCEDURES FROM THE SUMMARY OF INSTRUCTIONS ◀◀

Name of employee _____ Date of the Event _____

Y Y Y Y / M M / D D

Incident / Accident Cause Analysis

Immediate Causes (Please complete the appropriate sections)	Fundamental Causes (All immediate causes originating from one or more FUNDAMENTAL CAUSES) >> Describe each cause while asking the question why <<
1 PROCEDURES Were procedures created for a secure use, were these known and were they followed? PLEASE DESCRIBE. Not applicable <input type="checkbox"/>	What may have contributed to the deficiency? (ex. lack of preventative care, inadequate repairs, inadequate criteria of purchase, wrongful standard of use). PLEASE DESCRIBE.
2 EQUIPMENT/MATERIALS Was the equipment defective, inappropriate, unguarded? PLEASE DESCRIBE. Not applicable <input type="checkbox"/>	What led to this deficiency ? (ex. problems with preventative or reparative maintenance, purchasing criteria, handling/use policies). PLEASE DESCRIBE.
3 WORKPLACE CONDITIONS What are the conditions that may have contributed to the event ? (ex. congestion, inadequate protective equipment). PLEASE DESCRIBE. Not applicable <input type="checkbox"/>	Why were these conditions present? (ex. absence of standards, inadequate inspection of environment). PLEASE DESCRIBE.
4 PEOPLE FACTORS Was the employee aware of the procedures, was he or she attentive? PLEASE DESCRIBE. Not applicable <input type="checkbox"/>	What may have contributed to this unsafe behaviour? (ex. lack of training/orientation, inadequate sensitivity to health and safety matters). PLEASE DESCRIBE.
5 TIME Was the employee rushing to complete the task in the allotted time? Was he affected by variations to his work shifts? PLEASE DESCRIBE. Not applicable <input type="checkbox"/>	What contributed to these factors? (ex. inadequate organization of chores, lack of personnel). PLEASE DESCRIBE.

Plan of Action

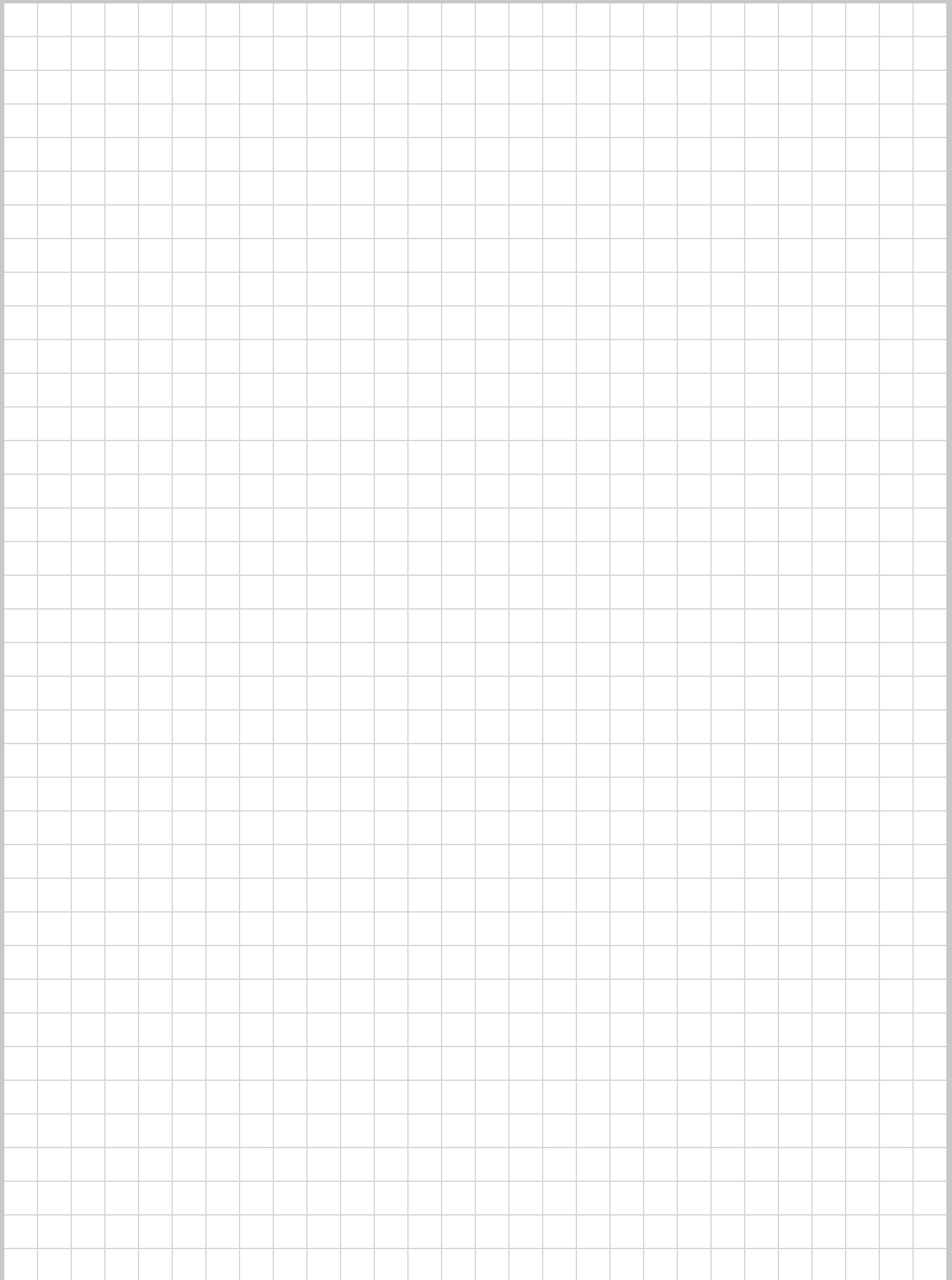
The goals of the corrective measures are to eliminate the fundamental causes that provoked the incident / accident.

Corrective measure(s) taken/ to be taken	By whom	Date completed Y Y Y Y / M M / D D	Comments (if not completed, please indicate why)
1			
2			
3			
4			
5			

SUPERVISOR

Name :	RESERVED FOR OCCUPATIONAL HEALTH AND SAFETY DEPARTMENT
Date : Extension :	
	<input type="checkbox"/> Prevention Sector <input type="checkbox"/> SISST <input type="checkbox"/> Attendance Management Sector <input type="checkbox"/>

You may use this page for a rough draft or to draw a diagram of the incident / accident site.



0.25 inches