TML\MSH Microbiology Department Policy & Procedure Manual	**Policy # MI\LS\31\v02**	Page 1 of 3
Section: **Laboratory Safety Manual**	Subject Title: **Reporting Work Related Incidents**	
Issued by: **LABORATORY MANAGER**	Original Date: April 20, 2001	
Approved by: Laboratory Director	Revision Date: October 22, 2003	

Policy:

Mount Sinai Hospital supports that all workplace employee accidents/incidents resulting in personal injury, in potential for injury and / or loss of process (damage to equipment) are reported to their Manager/supervisor and to Occupational Health and Safety using the Hospital's **'Employee Incident Report'.** Following the completion of the Employee Incident Report, the responsible Manager/supervisor must assist with the investigation/debriefing into the causes of the accident/incident. This policy includes everything from needle stick injuries to cuts and falls.

Purpose:
Timely reporting of a work related accidents/incidents is necessary to comply with the provincial Workplace Safety & Insurance Act, which requires employers' to submit a written signed report within three work days of learning of a work-related accident/incident.

Responsibility:
Employee, Manager/supervisor, Occupational Health Nurse, WSIB Case Coordinator

Key Elements:
- Procedure for the Employee
- Procedure for the Manager/supervisor
- Where to Report Monday to Friday, 0730-1530 hours
- Where to Report After Hours
- Employee Incident Report Form

Related Documents:

Emergency Procedure Manuals Home	**Code Blue**
FIRST AID	MI\LS\29\v01
MEDICAL EMERGENCY	MI\LS\30\v01
WORKPLACE ACCIDENT INVESTIGATION	MI\LS\32\v01
INCIDENT REPORTING, EMPLOYEE	V-d-11
EMPLOYEE INCIDENT REPORT FORM: MSH GENERAL MANUAL	APPENDIX 9
MANAGEMENT OF NEEDLE STICK INJURIES AND SIGNIFICANT BODY FLUID EXPOSURE	VI-e-10
FOLLOWING ACCIDENTAL PUNCTURE WITH A USED NEEDLE OR INSTRUMENT OR MUCOSAL EXPOSURE	4.50.001

Procedure:

EMPLOYEE

- Completes the employee portion of the Employee Incident Report ensuring that all sections of the form are completed and details are accurate.
- If unable to work or first aid treatment required, reports to Occupational Health & Safety for assessment and treatment. If Occupational Health and Safety is closed the employee may report to the Emergency Department.
- Advises Occupational Health and Safety when a workplace incident has resulted in lost time or the need to see a medical practitioner for treatment.

MANAGER/SUPERVISOR

- Ensures that an Employee Incident Report is completed when a workplace incident occurs that has or could have caused an employee injury or illness.
- Reviews the completed Employee Incident Report Form to ensure that all sections of the report are complete.
- Reviews incident details with employee and identifies any corrective actions needed or taken. As required, utilizes other resources such as witnesses to the incident, union representatives, health and safety representatives and Risk Management. Occupational Health & Safety is available to assist with the investigation as required.
- Signs and dates the report in the Manager Signature Area.
- Sends the original of the Employee Incident Report to the Occupational Health & Safety Department.
- Sends a copy to the Safety Committee for review.
- Notifies Risk Management as required.

Where to Report Monday to Friday,

0730-1530 hours: Report to: **MSH Occupational Health and Safety**

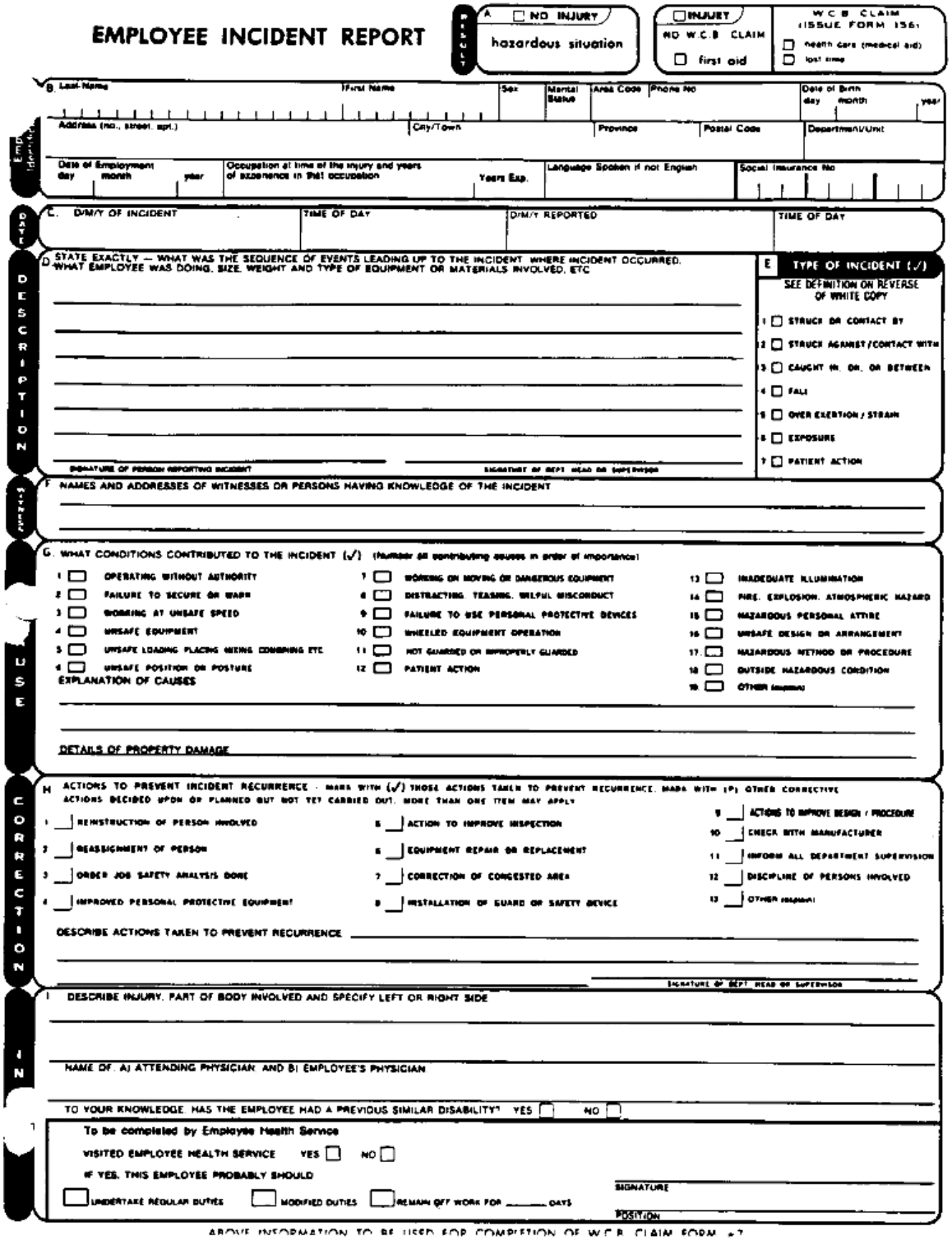
Hours:	Monday to Friday, 0730-1530 hours, **Closed** 1200-1300
Location:	60 Murray St, South Side Entrance
Telephone:	416-586-1572

Occupational Health and Safety provides assessment(s), treatment(s) and referral(s), as is/are necessary, for employees who have sustained an injury/incident/accident.

Where to Report After hours

Report to the **MSH Emergency Department** at ext. #5054, who will follow-up and notify Occupational Health and Safety.

The Emergency Department responds only when the incident is obviously serious or Occupational Health and Safety is closed.



EMPLOYEE INCIDENT REPORT

A ☐ NO INJURY — hazardous situation

☐ INJUET — NO W.C.B CLAIM — ☐ first aid

W.C.B CLAIM (ISSUE FORM 156) — ☐ health care (medical aid) ☐ lost time

EMPLOYEE IDENTIFICATION

B. Last Name | First Name | Sex | Marital Status | Area Code | Phone No | Date of Birth (day, month, year)

Address (no., street, apt.) | City/Town | Province | Postal Code | Department/Unit

Date of Employment (day, month, year) | Occupation at time of the injury and years of experience in that occupation | Years Exp. | Language Spoken if not English | Social Insurance No

DATE

C. D/M/Y OF INCIDENT | TIME OF DAY | D/M/Y REPORTED | TIME OF DAY

DESCRIPTION

D. STATE EXACTLY — WHAT WAS THE SEQUENCE OF EVENTS LEADING UP TO THE INCIDENT, WHERE INCIDENT OCCURRED, WHAT EMPLOYEE WAS DOING, SIZE, WEIGHT AND TYPE OF EQUIPMENT OR MATERIALS INVOLVED, ETC

SIGNATURE OF PERSON REPORTING INCIDENT | SIGNATURE OF DEPT HEAD OR SUPERVISOR

E TYPE OF INCIDENT (✓)

SEE DEFINITION ON REVERSE OF WHITE COPY

1 ☐ STRUCK OR CONTACT BY
2 ☐ STRUCK AGAINST / CONTACT WITH
3 ☐ CAUGHT IN, ON, OR BETWEEN
4 ☐ FALL
5 ☐ OVER EXERTION / STRAIN
6 ☐ EXPOSURE
7 ☐ PATIENT ACTION

WITNESSES

F. NAMES AND ADDRESSES OF WITNESSES OR PERSONS HAVING KNOWLEDGE OF THE INCIDENT

USE

G. WHAT CONDITIONS CONTRIBUTED TO THE INCIDENT (✓) (Number all contributing causes in order of importance)

1 ☐ OPERATING WITHOUT AUTHORITY
2 ☐ FAILURE TO SECURE OR WARN
3 ☐ WORKING AT UNSAFE SPEED
4 ☐ UNSAFE EQUIPMENT
5 ☐ UNSAFE LOADING, PLACING, MIXING, COMBINING ETC
6 ☐ UNSAFE POSITION OR POSTURE
7 ☐ WORKING ON MOVING OR DANGEROUS EQUIPMENT
8 ☐ DISTRACTING, TEASING, WILFUL MISCONDUCT
9 ☐ FAILURE TO USE PERSONAL PROTECTIVE DEVICES
10 ☐ WHEELED EQUIPMENT OPERATION
11 ☐ NOT GUARDED OR IMPROPERLY GUARDED
12 ☐ PATIENT ACTION
13 ☐ INADEQUATE ILLUMINATION
14 ☐ FIRE, EXPLOSION, ATMOSPHERIC HAZARD
15 ☐ HAZARDOUS PERSONAL ATTIRE
16 ☐ UNSAFE DESIGN OR ARRANGEMENT
17 ☐ HAZARDOUS METHOD OR PROCEDURE
18 ☐ OUTSIDE HAZARDOUS CONDITION
19 ☐ OTHER (explain)

EXPLANATION OF CAUSES

DETAILS OF PROPERTY DAMAGE

CORRECTION

H. ACTIONS TO PREVENT INCIDENT RECURRENCE - MARK WITH (✓) THOSE ACTIONS TAKEN TO PREVENT RECURRENCE. MARK WITH (P) OTHER CORRECTIVE ACTIONS DECIDED UPON OR PLANNED BUT NOT YET CARRIED OUT. MORE THAN ONE ITEM MAY APPLY

1 ☐ REINSTRUCTION OF PERSON INVOLVED
2 ☐ REASSIGNMENT OF PERSON
3 ☐ ORDER JOB SAFETY ANALYSIS DONE
4 ☐ IMPROVED PERSONAL PROTECTIVE EQUIPMENT
5 ☐ ACTION TO IMPROVE INSPECTION
6 ☐ EQUIPMENT REPAIR OR REPLACEMENT
7 ☐ CORRECTION OF CONGESTED AREA
8 ☐ INSTALLATION OF GUARD OR SAFETY DEVICE
9 ☐ ACTIONS TO IMPROVE DESIGN / PROCEDURE
10 ☐ CHECK WITH MANUFACTURER
11 ☐ INFORM ALL DEPARTMENT SUPERVISION
12 ☐ DISCIPLINE OF PERSONS INVOLVED
13 ☐ OTHER (explain)

DESCRIBE ACTIONS TAKEN TO PREVENT RECURRENCE

SIGNATURE OF DEPT HEAD OR SUPERVISOR

INJ

I. DESCRIBE INJURY, PART OF BODY INVOLVED AND SPECIFY LEFT OR RIGHT SIDE

NAME OF: A) ATTENDING PHYSICIAN AND B) EMPLOYEE'S PHYSICIAN

TO YOUR KNOWLEDGE, HAS THE EMPLOYEE HAD A PREVIOUS SIMILAR DISABILITY? YES ☐ NO ☐

To be completed by Employee Health Service

VISITED EMPLOYEE HEALTH SERVICE YES ☐ NO ☐

IF YES, THIS EMPLOYEE PROBABLY SHOULD

☐ UNDERTAKE REGULAR DUTIES ☐ MODIFIED DUTIES ☐ REMAIN OFF WORK FOR _____ DAYS

SIGNATURE

POSITION

ABOVE INFORMATION TO BE USED FOR COMPLETION OF W.C.B. CLAIM FORM #7