The Leamington United Mennonite Home and Apartments

POLICY AND PROCEDURE

CATEGORY:	SUBJECT:	SECTION:
Administration	Employee Workplace Injury	E POLICY: 3

DATE: **Signature:** _____
September, 2004 **ADMINISTRATOR**
REVISION DATE: March, 2014, February, 2015

EMPLOYEE WORKPLACE INJURY PROCEDURE

- In the event of any workplace injury, the Employee makes immediate personal contact with appropriate Department leader/Supervisor or Charge RN on weekend or after hours.

- Department Leader will direct injured staff member to the Director of Care, or in the DOC's absence, to the Charge RN for assessment of personal status, provision of first aid or medical treatment.

  In the event of a severe injury, the injured staff member will be assessed at site of injury and transferred by ambulance to hospital under the direction of the Director of Care or the Charge RN.

- In the event of death or a critical injury at the Workplace, the Administrator and/or Designate will be immediately notified. The Administrator and/or Designate will appoint a Certified LMH Health and Safety Representative (Management Representative and Union Representative) to investigate the death/critical injury and complete the Critical Injury Investigation Form.

- Department Leader/Supervisor or Charge RN will complete the HCHSA: Employee Incident Report ensuring that both employee and Department Leader signs the completed form. The completed HCHSA: Employee Incident Form is forwarded to the Administrator for approval and then filed with the Chief Financial Officer. For any incidents resulting in employee lost time/treatment (i.e. Physiotherapy, Hospital Stay or Doctor Visit) Director of Administrative Services forwards a Form 7 to WSIB. Department Leaders will complete the Employee injury: Departmental Investigation Form which will be reviewed by the LMH Leadership Team monthly and the Occupational Health and Safety Committee quarterly. An annual audit of all Departmental Investigation Forms will be completed by the Occupational Health and Safety Committee.

- The LMH injured staff member shall return a restorative plan of action to the appropriate Department Leader.

Leamington Mennonite Home

OCCUPATIONAL HEALTH & SAFETY

EMPLOYEE INJURY: DEPARTMENTAL INVESTIGATION FORM

Department:	
Department Leader:	
Date and Time of Injury:	
Employee Name and Position:	
Date of Investigation:	
Underlying/Root Cause	

Immediate Action Plan:
Signature:
Completion Date:

Further Recommendations:
Signature:
Completion Date:

JHSC Review:
Signature:
Completion Date:

Department Leader Signature:	
Date:	

*Attach to Incident Form
(as of February 17, 2017)

☐ **Copy to Management OH&S Representative**
☐ **Copy to Worker OH&S Representative**

HCHSA

Employee Incident Report

Employee Information

Last Name | Home Telephone No. ( ) -
First Name | Date of Birth (DD/MM/YY) | Work Telephone No. ( ) -
Employee ID# | SIN
Address | City/Town | Province | Postal Code

Gender (check) ☐ MALE ☐ FEMALE
Division/Dept./Unit
Occupation at time of Injury

Check: ☐ Full-time ☐ Part-time ☐ Casual ☐ Student
Years of Experience

Was the employee on the job when the injury occurred? (check)
☐ YES ☐ NO

Description of Incident

Date of Incident (DD/MM/YY)
Time of day AM/PM

Date Reported (DD/MM/YY)
Time reported AM/PM

To whom was the incident reported?
If report is delayed, please explain why.

State exactly the sequence of events leading up to the incident. Include an explanation of what the employee was doing.

Location of incident

What happened to cause the injury?
What was the root cause?

Identify the sizes, weights & types of equipment involved.

Type of Incident (check one - definitions on reverse)
1 ☐ Struck by or contact by
2 ☐ Struck against/contact with
3 ☐ Caught in, on or between
4 ☐ Fall/slip
5 ☐ Overexertion
6 ☐ Exposure
7 ☐ Patient action
8 ☐ Repetitive action
9 ☐ Other

Witnesses

Names & addresses of witnesses or persons having knowledge of the incident.

Causes

Check **all** conditions that contribute to the incident.

- ☐ Operating without authority
- ☐ Failure to secure or warn
- ☐ Working at unsafe speed
- ☐ Unsafe equipment
- 5 ☐ Unsafe loading, placing mixing, combining, etc.
- 6 ☐ Unsafe posture or position
- 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 - please explain:
- 20 ☐ Repetitive action
- 21 ☐ Sharps-related
- 22 ☐ Excessive load handling

Direct causes (check one - see reverse) 1 ☐ Physical/Environmental 2 ☐ Personal
Basic causes (check one - see reverse) 1 ☐ Job factors 2 ☐ Personal factors

Correction

Action(s) Taken	CORRECTED (check box)	PLANNED (check box)	Date (dd/mm/yy)
1	☐	☐	
2	☐	☐	
3	☐	☐	
4	☐	☐	
5	☐	☐	
6	☐	☐	
7	☐	☐	

Examples of Actions:
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:

Injury Description

Describe injury, part of body involved and specify left or right side.

No Injury (check one)
1 ☐ Hazardous situation
2 ☐ Work refusal
3 ☐ Work stoppage
4 ☐ Property damage

Injury - No WSIB Claim (check one)
1 ☐ First aid
2 ☐ No aid

WSIB Claim Treatment Memorandum (check one)
1 ☐ Health care (medical aid)
2 ☐ Lost time

Occupational Health

Did employee seek medical attention? (check one) 1 ☐ No 2 ☐ Yes
Did employee visit health service? (check one) 1 ☐ No 2 ☐ Yes
Did employee visit emergency? (check one) 1 ☐ No 2 ☐ Yes
If Yes, ER Physician Name
Tel. No. ( ) -

Did employee visit family physician? (check one) 1 ☐ No 2 ☐ Yes
If Yes, Family Physician Name
Tel. No. ( ) -

What will the employee undertake: (check one)
1 ☐ Regular duties
2 ☐ Modified duties
3 ☐ Remain off work

Has the employee had a similar disability? (check one)
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

Check attachments to this report.
1 ☐ Statements
2 ☐ Photographs
3 ☐ Treatment memo
4 ☐ Other - specify:

EMPLOYEE SIGNATURE Date | MANAGER SIGNATURE Date | OCC. HEALTH DEPT. SIGNATURE Date

Rev. 10/99
LAP-002

This information is to be used for completion of WSIB Claim Form 7