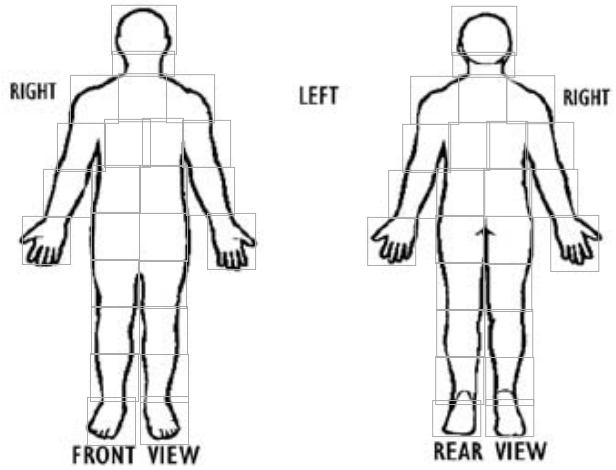
INCIDENTS, INJURIES & HAZARDS REPORT

Select type:	☐ **CLIENT INCIDENT/INJURY** ☐ **WHS INCIDENT/INJURY** ☐ **CLINICAL NOTE/CONCERN** ☐ **HAZARD** ☐ **DRILL**		
Date occurred		Time occurred	☐ am ☐ pm
Nature of incident	☐ Absent/Missing Client ☐ Injury ☐ Medical emergency ☐ Fall/trip/slip ☐ Abuse/neglect/assault ☐ Near miss ☐ Medication related ☐ Behavioural ☐ Sexual abuse/misconduct ☐ Hazard or Potential Hazard ☐ Manual Handling ☐ Confidentiality/Data/Privacy Breach ☐ Procedures ☐ Equipment ☐ Notifiable Infectious Disease ☐ Property damage/loss ☐ Environmental ☐ Restrictive practice/restraint ☐ Motor Vehicle Accident ☐ Evacuation ☐ Service delivery missed/incomplete ☐ COVID-19 ☐ Other ……		
Omnicare division	☐ Aged Care ☐ NDIS ☐ Social Support Groups ☐ Meal Services ☐ Head Office ☐ Mods & Maint ☐ Other ……		
Location of incident	☐ Branch Location …….. ☐ Client home ☐ Community ☐ Address ……		
Category of incident	☐ Category 1 ☐ Category 2 ☐ unsure **Category 1 is for the most serious incidents** that result in serious outcomes or trauma. Category 1 incidents ***must*** be reported as soon as possible and within 24 hours and must also be **reported by law to the appropriate regulatory body. Category 2 is for all other incidents including** incidents that impact the health, safety, security and/or wellbeing of clients, employees, representatives, the organisation or others, and property damage. Category 2 incidents ***must*** be reported as soon as possible and within 24 hours.		
Describe what, where and how it happened (include as much detail as possible including a diagram if appropriate. Attach separate sheet if necessary. Include what you believe caused the incident. If a behaviour, what may have triggered the response and what were the consequences? If medication related, include whether missed tablet, incorrect tablet taken or incorrect dosage, client refusal, etc). **NOTE: IF INJURY, COMPLETE DETAILS ON PAGE 2. If Property/ Asset or Environmental damage complete page 4.**			
Immediate response actions to remove hazard, make the situation safe (e.g. barricades, power isolated).			
DETAILS OF WHO WAS INVOLVED			
First and last name, role and phone number e.g. Joe Bloggs (Support Worker) and Mary Jones (Client).			
WITNESS(ES) TO INCIDENT (each witness may need to provide an account of what happened)			
Witness 1 first and last name and phone no.		Witness 2 first and last name and phone no.	
INCIDENT REPORTED TO (report all incidents to your Supervisor/Manager immediately)			
☐ Supervisor/Manager ☐ CEO ☐ Service Area Manager ☐ WH&S Coordinator ☐ Client's Coordinator	Supervisor name: …… ☐ Client-related incident? If yes, enter details into CIMs, as note type "Incident" ☐ Entered into CIMs Client's Coordinator: ……..		
Were emergency services contacted at time of incident? Yes ☐ No ☐	Which emergency services were involved at time of incident? ☐ Police ☐ Ambulance ☐ Fire ☐ SES ☐ Other ……		
INCIDENT REPORT COMPLETED BY	**Time:**	**Date:**	
First and last name Phone number Email address		Signature	
Send this incident report to your Supervisor/Manager and compliance@omnicare.org.au within 24 hours and keep a copy for your records			

DETAILS OF INJURED PERSON (injured person/first aid officer/representative may complete)			
First and last name of injured person (use separate forms for multiple injured			
Address			
Date of birth		Gender	
Home phone		Mobile phone	
Next of kin name		Next of kin contact no.	
Occupation		Employer	
Person type	☐ Employee ☐ Contractor ☐ Volunteer ☐ Visitor	☐ Casual ☐ Full-time ☐ Permanent P/T Years in job: ……	☐ Client ☐ Client's Carer ☐ Public ☐ Other ……
Location of injury on body (clearly indicate location of injury(ies) on the diagram)			
Nature and location of injury, e.g. fracture, burn, sprain, cut, foreign body in left eye			
What first aid treatment was provided on site?		Name of person who provided first aid	
Ambulance called Yes ☐ No ☐	Sent to hospital Yes ☐ No ☐	Name of doctor or hospital:	
Supervisor/Service Area Manager to complete FOR STAFF INJURIES:			
Medical Certificate or Certificate of Capacity received? Yes ☐ No ☐	Certificate of Capacity attached to this report Yes ☐ No ☐	Referral for further treatment? Yes ☐ No ☐	Further treatment required
Did the injured person take time off work? Yes ☐ No ☐	Length of time taken off work	Has the injured person returned to work? Yes ☐ No ☐	Date injured person returned to work
☐ Completed Certificate of Capacity sent to WH&S and RTW Coordinator at compliance@omnicare.org.au			
WH&S Coordinator/RTW Coordinator to complete:			
Employer/third party representative lodgement form, Certificate of Capacity and Incident Report sent to: ☐ EML/icare at newpiclaims@icare.nsw.gov.au ☐ WSIB at michaell@wsib.com.au		Date sent to EML/iCare: ……	Entered into Injury Register Yes ☐ No ☐
RTW Coordinator to complete:			
Injury management required? Yes ☐ No ☐	Name of RTW Coordinator	Recover at Work Plan completed Yes ☐ No ☐ Date	Date of next RAW Plan review
Injury Register updated Yes ☐ No ☐	Workers Comp Claim? Yes ☐ No ☐	Workers Comp Claim No. (if applicable)	Omnicare Workers Comp Policy No. 111228401

SUPERVISOR/MANAGER CHECK

☐ Completed correctly & legibly ☐ Category check ☐ Notification to ☐ Service Area Manager ☐ WH&S Coordinator ☐ Return to Work Coordinator	☐ If Injury, ensure page 2 completed. If injured worker requires more than first aid and/or requires time off, request injured worker to obtain Certificate of Capacity identifying work restrictions from their Nominated Treating Doctor (or hospital). ☐ Send this Incident Report to WH&S Coordinator and RTW Coordinator at compliance@omnicare.org.au

SERVICE AREA MANAGER

Mandatory Reporting requirement to Regulatory Authority? Yes ☐ No ☐ ☐ CEO Notified	Reported to Regulatory Authority: ☐ SafeWork Aust phone: **13 10 50** ☐ EPA ☐ OAIC ☐ Police ☐ NDIS Quality & Safeguards Commission ☐ Aged Care Quality & Safety Commission By who ……..…….…. Date submitted: ……..……..
☐ Entered into Incident Register	**Incident Report No.:**

INCIDENT INVESTIGATION (to be completed by Supervisor/Manager and/or Service Area Manager)

Details:

Investigation conducted on ……(date) by ……..

REMEDIAL ACTIONS ☐ Conduct task analysis ☐ Re-instruct persons involved ☐ Improve design/construction/ guarding ☐ Add to Continuous Improvement register	☐ Improve client/staff skills mix ☐ Add to Internal Audit plan ☐ Develop/review tasks procedures ☐ Provide debriefing and/or counselling ☐ Improve communication /reporting procedures	☐ Improve work environment ☐ Performance Management ☐ Disciplinary Action ☐ Add to Risk Register ☐ Other ……..

RISK ASSESSMENT ☐ Major ☐ Moderate ☐ Minor Review of Care Plan or processes required? Yes ☐ No ☐ Notify Behaviour Support Specialist? Yes ☐ No ☐	**Details of Risk Assessment/Review of Care Plan/Processes conducted:**

ACTIONS REQUIRED **What actions?**	**By who**	**By when**	**Date completed**

CONTINUOUS IMPROVEMENTS Continuous Improvement logged Yes ☐ No ☐ Reporting staff informed of outcome Yes ☐ No ☐	**Continuous improvement actions/ communications**
Incident Register updated Yes ☐ No ☐	

ASSET/PROPERTY INVOLVED	
☐ Vehicle ☐ Building ☐ Equipment ☐ other ……	**Asset Details** (vehicle registration, make/model, equipment type/serial number, building name location)

DETAILS OF DAMAGE TO ASSET (include images where possible)			
Anticipated repair cost:			
Details of second party (if relevant) Copy of Driver Licence; Registration number of vehicle; photos of damage; Insurer:			
Close out date		**Closed out by**	