Truecare
Support Services

Incident/Injury Report

To be completed for ALL incidents and accidents where an injury has or could have resulted.

Work Location:

☐ Organisation / Facility ☐ In the Community
☐ Client Home ☐ Other

Today's Date:

_______/_______/_______

Status of the involved person:

☐ Employee ☐ Client
☐ Visitor ☐ Volunteer ☐ Contractor

Outcome:

☐ Hazard ☐ Near Miss
☐ Incident ☐ First Aid

Details of involved person:

Surname: ________________ First name: ___________ DOB: _______/_______/_______

Home Address: ________________________________ Phone: ____________________

________________________________ Sex: M / F

Employment Status:

☐ Casual ☐ Full-time ☐ Contractor
☐ Permanent P/T ☐ Other:_________

Details of witnesses (if any):

Name: ______________________________ Phone: ____________________
Address: ____

Name: ______________________________ Phone: ____________________
Address: ____

Details of incident or accident:

Date: _______/_______/_______ Time of Injury: _____________ AM / PM

Activity engaged in at time of incident: ____

Exact location of person at time of incident: ____

Describe how and what happened (please give full details & include a diagram, if appropriate. Use a separate sheet if necessary. Please include car registration number if reporting a Motor Vehicle Accident).

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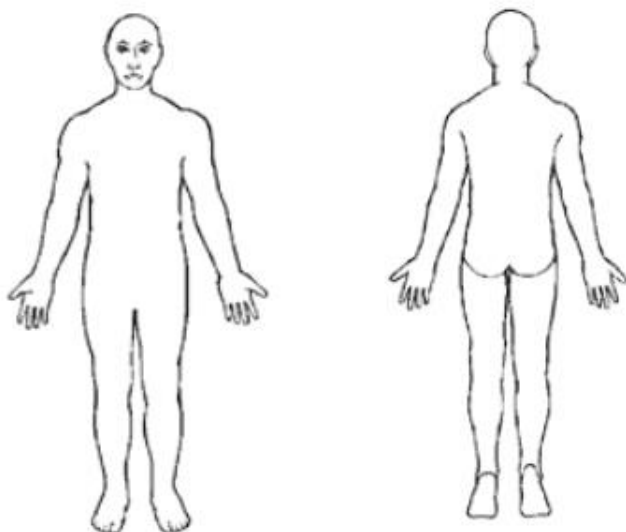
Details of injury if applicable: (supervisor may need to assist completion)

Cause of Injury:

- ☐ Lift/bend/push/pull Object
- ☐ Psychological/Stress - Bullying/Harassment
- ☐ Surface/Material or Sun Exposure
- ☐ Lift/bend/push/pull Person
- ☐ Psychological/Stress - Workload/Organisation
- ☐ Electric Shock
- ☐ Static or Repetitive Posture or Arm Usage
- ☐ Hazardous Substance/ Material
- ☐ Hand Held Tools
- ☐ Workplace Violence
- ☐ Biological Agency
- ☐ Contact with Animal/Insect
- ☐ Slip/Trip/Fall – Indoors
- ☐ Entrapment in Equipment/Machinery
- ☐ Vehicle Accident - Work Vehicle
- ☐ Slip/Trip/Fall – Outdoors
- ☐ Strike/Struck by Equipment/ Machinery
- ☐ Vehicle Accident - Own Vehicle
- ☐ Superficial if not cause by above
- ☐ Involuntary Movement of client
- ☐ Behaviour of client
- ☐ Other: ______________________________

Nature of injury/illness (e.g. burn, sprain, cut etc.) ___________________________

Location on body (please circle and specify): _________________________________



How did the injury occur? (e.g. fall, grabbed by person, muscular stress):

____

____

____

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Treatment administered if required: ☐ Yes ☐ No

Treatment: ____

Referral required: Yes ☐ No ☐ Who to: ______________________________

First aid attendant (Print Name): ________________________ Signature: ______________

Incident or accident investigation:

Question	Yes	No	N/A
Did the incident occur as part of the involved person's normal activities?	**Yes** ☐	**No** ☐	**N/A** ☐
Did equipment contribute?	**Yes** ☐	**No** ☐	**N/A** ☐
Was the equipment used designed for activity?	**Yes** ☐	**No** ☐	**N/A** ☐
Was the equipment properly maintained?	**Yes** ☐	**No** ☐	**N/A** ☐
Did the equipment fail?	**Yes** ☐	**No** ☐	**N/A** ☐
Had a risk assessment been undertaken?	**Yes** ☐	**No** ☐	**N/A** ☐
Did safety instructions accompany activity?	**Yes** ☐	**No** ☐	**N/A** ☐
Are there documented safe work procedures (SWP) for activity?	**Yes** ☐	**No** ☐	**N/A** ☐
Were these SWP followed?	**Yes** ☐	**No** ☐	**N/A** ☐
Was appropriate PPE used?	**Yes** ☐	**No** ☐	**N/A** ☐
Was the involved person trained in this activity?	**Yes** ☐	**No** ☐	**N/A** ☐
Did a known behaviour problem contribute?	**Yes** ☐	**No** ☐	**N/A** ☐
Was there a known behaviour management plan?	**Yes** ☐	**No** ☐	**N/A** ☐
Was it followed?	**Yes** ☐	**No** ☐	**N/A** ☐
Did poor housekeeping contribute?	**Yes** ☐	**No** ☐	**N/A** ☐
Did the work environment contribute?	**Yes** ☐	**No** ☐	**N/A** ☐

After reviewing the above prompts and through interview/site visits what are the identified cause(s):

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Remedial actions recommended:

☐ Conduct task analysis	☐ Re-instruct persons involved	☐ Improve Infrastructure
☐ Conduct hazard systems audit program	☐ Improve skills mix	☐ Add to inspection
☐ Develop/review task procedures	☐ Provide debriefing and/or counselling	☐ Improve communication/ reporting procedures
☐ Improve work environment	☐ Request maintenance	☐ Improve security
☐ Review WHS policy/programs	☐ Improve personal protection	☐ Temporarily relocate employees involved
☐ Provide or replace equipment/tools	☐ Improve work congestion/ Housekeeping	☐ Behaviour Support Plan Review
☐ Improve work organisation	☐ Investigate safer alternatives	☐ Request MSDS
☐ Develop and/or provide training	☐ Other:____________________	

What, in your own words, has been implemented or planned to prevent recurrence:

____

____

Remedial actions completed:

____

____

Did the injured person stop work: **Yes** **No**

If yes, state date: ______/______/______ Time: ______________ AM / PM

Outcome:

☐ Treated by Doctor ☐ Lodged workers comp claim ☐ Contacted by RTW Coordinator

☐ WorkCover notified ☐ Insurer notified ☐ Returned to normal duties

☐ Returned to modified duties ☐ Hospitalised ☐ OHS Committee/ representative advised

Signature (Staff): ______________________________ **Date:** ______/______/______