WORKFIRST CASUALTY COMPANY

Workers' Compensation
Incident / Accident Investigation Narrative
Home Health Care

WHAT IS THE DEFINITION OF AN INCIDENT AND/OR ACCIDENT?

Incident - is defined as an event that may lead to an insurance claim for bodily injury and/or property damage.

Accident - is defined as an event that caused bodily injury or property damage.

WHY INVESTIGATE ACCIDENTS?

An investigation is completed to identify ways to prevent the same or similar occurrence from happening in the future. A written investigation will allow management the opportunity to evaluate their safety management system through a fact finding process, NOT FAULT FINDING.

All individuals involved in an incident should complete one of the investigation forms. Work First Casualty has developed investigation forms that should be completed by the injured employee, witnesses, and the supervisor.

IMPORTANT: Benefits of conducting an accident investigation as soon as possible.

- The events/facts that led up to the accident will change over time as people communicate with each other about the incident.
- Obtaining signed statements from all parties involved following an accident insures that you, the employer, have an accurate account of how the injury occurred.
- The statements provided by all parties involved in the accident will help identify issues that can be corrected in your safety management system.
- The statements may also provide information to Work First Casualty to help identify third-party liability, possible fraudulent claims, and assist in the defense of a claim.
- It is a critical component of your Incident Rate Reduction program and will help to keep your workers' compensation costs low.

WHY IS IT IMPORTANT THAT A HOME HEALTH CARE COMPANY REPRESENTATIVE TAKE PART IN COMPLETING THE INCIDENT INVESTIGATION?

- It shows the injured employee that you care about their safety while working at a patient's location.
- It provides the Home Health Care Company an opportunity to evaluate the safety environment of the patient's home while evaluating their own safety and health programs.
- It may identify the causes of the injury so corrective actions can be implemented.
- The Home Health Care Company has the duty to inquire and *verify* that the worksite is safe for their staff members.

REMEMBER you are providing your workers' compensation coverage to your employees while on assignment. If you are questioning the claim you and Work First Casualty will be required to defend against the claim, not the patient.

WHAT IF MY CLIENT WILL NOT ALLOW ME TO CONDUCT AN INVESTIGATION?

You will need to evaluate your relationship with the client. This is a red flag that the client or their family may try to hide facts of the accident to reduce their potential liabilities.

WHAT DO I DO WITH THE FORMS AFTER THEY ARE COMPLETED?

Provide a copy of the completed forms to your *claims adjuster* and maintain a copy for your files. Review the facts of the investigation, then work with your internal staff to develop an action plan to correct the causes identified as part of your investigation. Include a time line for implementation and who is accountable for each item.

NEED ASSISSTANCE? *If you would like assistance in setting up supervisor training on how to use these forms, please contact the Work First Casualty Loss Prevention Department at 877-772-4667 or email a request to APS@workfirstcasualty.com*

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Section I: Client (Patient) Information

Client name: _____

Client address: _____

City:_____ State:_____ Zip:_____

Where did the incident / accident occur (Check one)? □ Onsite □ Offsite

Type of work activities performed at client (patient0 site: _____

_____

Section II: Injured Employee Information

Name (First, Middle, Last):_____

Home address:_____ Phone #:_____

City:_____ State:_____ Zip:_____

Gender: □ Male □ Female Date of Birth:_____ SSN/Emp.Id:_____

Date hired :_____ Total length of employment: _____ (years\months)

Date placed with client:_____ Length of time at client site: _____ (years\months)

Tasks being performed at time of injury:_____

_____

Consecutive days worked:_____ Employee's shift at time of incident: _____

Section III: Incident / Accident Information

Did incident result in injury? □ Yes □ No Date of injury: _____ Time of injury: _____

Date reported to supervisor: _____ Date reported to Home Health Care Company:_____

What part of employee's workday? □ Entering or leaving work □ Doing normal work activities

□ During meal period □ During break □ Working overtime □ Other _____

What part of the body was injured? Describe in detail. _____

_____

_____

What was the nature of the injury? Describe in detail. _____

_____

_____

Describe, step-by-step the events that led up to the injury. Include names of devices used, objects, tools, materials and other important details. _____

_____

_____

_____

_____ □ Check if, description is continued on attached sheets

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Section III cont.: Incident Information

What personal protective equipment was being used (Check all that apply)?

□ None at time of Injury □ Googles □ Face shield □ Mask

□ Respirator □ Gown □ Apron □ Safety shoes/boots

□ Gloves (Circle one) □ Nitrile □ Latex □ Vinyl □ Chemical resistant

□ Other PPE (Describe)_____

If possible, have all witnesses complete an incident / accident witness statement form.

Name(s) of witnesses or other individuals involved in incident: (First, Middle, Last)

_____ Phone #:_____ Injured? □ Yes □ No

_____ Phone #:_____ Injured? □ Yes □ No

_____ Phone #:_____ Injured? □ Yes □ No

Section IV: Treatment Facility

Where was the employee seen for treatment? □ Emergency Room □ Hospital □ Urgent care clinic

Name and address of treating facility:_____

_____

Name and address of treating physician: _____

_____

Drug screen administered? □ Yes □ No Date administered: _____

Section V: Why did the incident/accident happen?

Unsafe workplace conditions: (Check all that apply)

□ Work area is unsanitary
□ No training or insufficient training
□ Lack of needed personal protective equipment
□ Lack of appropriate equipment / tools
□ Safety device is defective
□ Unsafe Lighting
□ Unsafe Ventilation
□ Tool or equipment defective
□ Unsafe Clothing
□ Other: _____

Unsafe acts by people: (Check all that apply)

□ Aggressive or violent patient
□ Distractions, verbal abuse from patient
□ Unsafe lifting
□ Taking an unsafe position or posture
□ Failure to wear personal protective equipment
□ Using equipment in an unapproved way
□ Using defective equipment
□ Failure to use the available equipment/tools
□ Operating equipment without permission
□ Other: _____

Section V cont.: Why did the incident/accident happen?

Was the injured employee correctly matched to the needs of the client? □ Yes □ No, if no please explain._____

_____

_____

Was injured employee trained and oriented to the work site through the use of a comprehensive care plan? □ Yes □ No, if no please explain. _____

_____

_____

Was the employee performing tasks that were outside of the care plan? □ Yes, if yes please explain

□ No _____

_____

_____

Section VI: How can future incidents be prevented?

What changes do you suggest to prevent an incident/injury from happening again?

(Check all that apply)

□ Stop this activity □ Enforce existing policy □ Train the employee(s) □ Train the supervisor

□ Redesign task steps □ Redesign work area □ Provide assistive devices

□ Obtain a detailed care plan □ Review the care plan with employee prior to placement

□ Routinely conduct client site inspections □ Personal Protective Equipment

□ Other (Describe suggestion) _____

What should be (or has been) done to carry out the suggestion(s) checked above? _____

_____

_____

_____

_____

□ Attachments: (Photos, sketches, interview notes, etc.)
Please attach all corresponding notes and documents.

Section VII: Who completed and reviewed this form? (Please Print)

Company Name: _____

Completed by:_____ Date: _____

Title:_____ Phone #: _____

Reviewed by: _____ Date: _____

Additional Notes: