# DESTINY MANAGEMENT

Accident/Incident Investigation Report

- **Immediately investigate if any of the following occur: Fatalities, Critical Injuries, Lost Time, Occupational Illness, Property Damage, Fire or Environmental Release.**
- **Complete report within 24 hours of occurrence.**
- **Photos are highly recommended immediately following an incident if possible**
- **Note: Incident reports are confidential quality assurance documents.**

**This report is concerning:** ☐ **Employee** ☐ **Visitor** ☐ **Volunteer**
☐ **Other** _____

1. Use this form: for reporting work related injuries, illnesses, "near misses", and for incidences involving property losses or liability – no matter how minor.
2. Any injury resulting in death, or hospitalization shall be reported to the DMI President immediately.
3. If a Client was being transported, complete Vehicle Accident Report and forward with the incident report.
4. Complete Worker's Compensation Forms as applicable i.e. work missed because of incident/injury/illness or medical care by a physician/hospital required:
   a. # 18 (to be completed by **employee** as soon as practical / within 30 days of incident) See WC section on page 6. (Obtain from supervisor or DMI website)
   b. # 19 (to be completed by **DMI President.)** See WC section on page 6.
5. Forward a copy of report to, Risk Management / Safety Committee, upon completion.
6. File in employee **medical** record as applicable. The QM Coordinator must document the incident on the agency's Accident/Incident/Near Miss Log.
7. Post accident drug testing is required for any staff person injured on the job.

## Individual's Report:

I am reporting a work related: ☐ Injury ☐ Illness ☐ Near Miss ☐ Other Incident

Post accident drug test conducted (Date): _____ ☐ NA

**INDIVIDUAL TO COMPLETE**

**PART 1: PERSONAL IDENTIFICATION**

Name (Last, First) _____ Facility/Office: _____

☐ Male ☐ Female Age: _____ Months with DMI: ____ Months doing this job: ___

Job Title: _____ Work Phone: _____ Home Phone: _____

☐ Regular Full Time ☐ Regular Part Time ☐ Temporary

Supervisor Name (Last, First) _____ Title: _____ Work Phone: _____

**PART 2: ACCIDENT/INCIDENT DESCRIPTION**

Date Reported: _____ Reported to: _____

Incident Type (check all that apply):

☐ Personal Injury/Illness ☐ Death ☐ Workplace Violence

☐ Communicable Disease/Infection Control ☐ Use and unauthorized Possession of Weapon

☐ Property Damage ☐ Vehicle Accident ☐ Near Miss/No Injury

☐ Illegal use/possession of illegal substance ☐ Biohazard ☐ Sexual Assault

☐ Illegal use/possession of legal substance ☐ Hazardous Materials

☐ Other: _____

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**INDIVIDUAL TO COMPLETE**

Date of Incident: _____ Time of Incident:_____

Exact Location of Incident: _____

County Incident Occurred In: _____

Specific task being performed at time of incident: _____

_____

_____

Step by step events leading up to the incident: _____

Equipment involved: _____

Materials being handled: _____

Unusual conditions: _____

Other relevant conditions: _____

Cause of Incident: _____

**If** you had a near miss, how could you have been hurt? : _____

_____

_____

Witness Name(s): _____ Telephone: _____

Witness Name(s): _____ Telephone: _____

**Please include a statement from each witness on the Accident/Incident Investigation Report-Witness Statement**

Were there injuries(s)? ☐ Yes ☐ No

If Yes, note nature and indicate injuries on diagram.

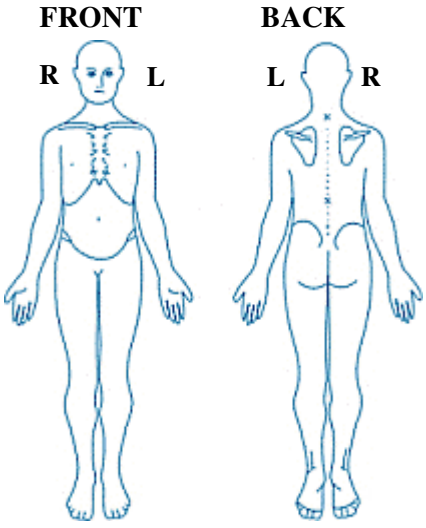
☐ Abrasion ☐ Chipped Tooth ☐ Broken Bone

☐ Bruise ☐ Burn (heat)

☐ Insect Bite ☐ Cut, lac. punct.

☐ Damage to body system ☐ Sprain, strain ☐ Hernia

☐ Other: _____




Was First Aid Given: ☐ Yes ☐ No If Yes, describe:

_____

_____

Was medical evaluation deemed unnecessary? ☐ Yes ☐ No

Was medical evaluation required? ☐ Yes ☐ No

**If Yes**, Please Provide the Following Information:

Date of initial evaluation: _____

Medical Facility Name: _____

Type of Transportation: _____

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**INDIVIDUAL TO COMPLETE**

Treated for: _____

Treated By (name & phone #): _____

Has this part of your body been injured before? ☐ Yes ☐ No

If yes, when? _____

Any Additional Information: _____

_____

_____

What could have been done to prevent this incident? : _____

_____

_____

What action has or will be taken to prevent reoccurrences? :

_____

_____

By signing below, I herby certify that the above information is true and correct to my understanding of the incident.

Signature*: _____ Date: _____

*Signing of this form does not constitute acceptance of individual fault.

## Supervisor Report:

**SUPERVISOR TO COMPLETE**

**PART 3: ADDITIONAL INCIDENT INFORMATION:**

Supervisor Comments: (additional information on nature of incident details,

etc.):_____

| **Process/ environment-related: (Check all that possibly apply)** | **Personnel-related: (Check all that possibly apply)** |
|---|---|
| Housekeeping<br>Work procedure, or lack of<br>Repetitive motion<br>Equipment condition<br>Personal protective equipment availability<br>Flooring/ ground<br>Lighting<br>Ventilation<br>Unsafe clothing/shoes<br>**Other:** _____ | Equipment use or selection<br>Level of support/ assistance<br>Awkward posture(s)<br>Personal protective equipment use<br>Following of procedure/policy<br>Level of attention to task<br>Work pacing<br>Operating at unsafe speed<br>Poor weather conditions<br>Inexperience of person in the task<br>Unsafe Lifting<br>Distraction, teasing, horseplay<br>Other: _____ |

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**SUPERVISOR TO COMPLETE**

Were unsafe acts reported prior to the incident? ☐ Yes ☐ No
Have there been similar near misses prior to this incident? ☐ Yes ☐ No

## PART 5: ACTION PLAN/RECOMMENDATIONS

Check all that possibly apply:

Evaluate equipment/ facility condition (02)*
Provide appropriate tool/ equipment (03)
Provide/improve personal protective equipment (04)
Provide initial/ refresher training (05)
Post safety signage in area (06)
Review safety inspection and/ or maintenance program (07)
Review formal work procedure (08)
Assess newly identified hazard(s) (09)
Review as job performance issue (10)
Stop this act (11):
Revise Policy /Procedure(12)
Other (13)_____
_____
_____
_____
_____
_____

* For facility-related concerns in indoor common areas (e.g., hallways), coordinate with the facility supervisor. For public areas (e.g. , sidewalks, parking lots), work with the Destiny Management President.

FOLLOW-UP ACTION:
For each follow-up effort checked above, indicate its action code (# in parentheses) and describe the planned action. As actions are completed, record completion date, and initial the original copy for recordkeeping purposes.

| Action Code | Description of Planned Action | Date Completed (Can submit form before completing) | Supervisor Initial (Can submit form before completing) |
|---|---|---|---|
| | | | |

**Debriefing** ☐ Yes ☐ No

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SUPERVISOR TO COMPLETE

## Property Damage

**(Complete this portion for Risk Management review only if applicable)**

Agency Property Damaged: _____

What caused the property damage? _____

Estimated/Actual Costs to repair: _____

What action(s) has been taken or will be taken to prevent reoccurrences?

_____

_____

❑**This IS a work related injury, illness, incident requiring medical care by a medical professional beyond first aid, communicable disease, or the employee will miss more than one day of work. Therefore, a copy of this report must be forwarded to the DMI President.**

❑**This IS NOT a work related injury, illness, incident requiring medical care by a medical professional beyond first aid, communicable disease, or the employee will not miss more than one day of work. Therefore, a copy of this report must be forwarded to the Safety & Health Committee and the Risk Management Committee.**

By signing below, I hereby certify that the above information is true and correct to my understanding of the incident.

Supervisor Signature**: _____Date:_____

** Signing of this form does not constitute acceptance or assignment of individual fault

PRESIDENT TO COMPLETE

PART 6: DESTINY MANAGEMENT PRESIDENT – REVIEW/WORKER'S COMPENSATION REPORTING

## Worker's Compensation

**N. C. Industrial Commission Workers Compensation (WC)**

| | | |
|---|---|---|
| Yes □ | No □ | Was a Worker's Compensation Claim Filed? (Must file if employee misses more than one day from work **or** if cumulative medical costs exceed $ 2,000.00) |
| **If Yes:** | | |
| 1. Yes □ | No □ | Date: _____ Employee was provided a blank copy of Form 18. **Employee** must complete **and** forward a copy of form 18 to the N.C. Industrial Commission and to Destiny Management, within 2 years of the injury. |
| 2. Yes □ | No □ | Date: _____ Employee was provided a completed copy of Form 19. |
| 3. Yes □ | No □ | Date: _____ DMI's insurance carrier sent a copy of completed Form 19 to the N.C. Industrial Commission within 5 calendar days. |

Destiny Management President Signature: _____ Date:_____

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**DO NOT WRITE BELOW THIS LINE**
**Internal Use Only**

| SECTION 7: RISK MANAGEMENT / SAFETY COMMITTEE – INVESTIGATION/REVIEW |
|---|
| Investigation Comments:<br><br>☐ Continued on back |
| Required Action (Will review/follow-up at the next scheduled meeting.):<br><br>☐ Continued on back |
| Follow up review conducted: _____<br>Date |
| Risk Management / Safety & Health Committee:<br><br>_____ _____<br>Signature Date |