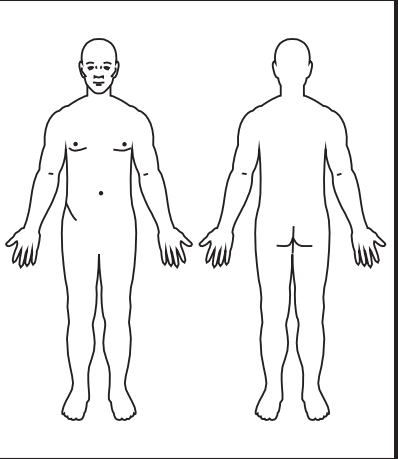


# HHNA ACCIDENT / INCIDENT NOTIFICATION REPORT

For **Employees** of Heather Hill Nursing Agency

PERSONAL DETAILS			
Where Employed:			
Surname:			
Given Names:			
Shift Date:	Shift Time:	<input type="checkbox"/> am	<input type="checkbox"/> pm
Incident Date:	Incident Time:	<input type="checkbox"/> am	<input type="checkbox"/> pm

OCCUPATION / EMPLOYMENT TYPE (please select one)	
<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Endorsed Enrolled Nurse
<input type="checkbox"/> Assistant Nurse	<input type="checkbox"/> Personal Carer

INCIDENT DETAILS	
Describe <b>ALL</b> of the following	<input type="checkbox"/> <b>HOW</b> the injury occurred (eg fall, lifting, aggression, travelling etc) <input type="checkbox"/> <b>WHAT</b> caused the injury (eg wet floor, resident, motor vehicle etc) <input type="checkbox"/> <b>WHY</b> did it happen <input type="checkbox"/> <b>WHO</b> - If a resident is involved, the name of the resident is required
	
Name of resident involved (if any):	

**PLEASE CONTACT HHNA PRIOR TO THE PROVISION OF ANY TREATMENT  
PHONE 3720 9122 (24/7 PHONE SERVICE)**  Yes

**INCIDENT DETAILS CONTINUED**

- |   |   |
|---|---|
| <input type="checkbox"/> First Aid treatment provided       | <input type="checkbox"/> Attending after-hours Doctor         |
| <input type="checkbox"/> Consulted a Doctor for treatment   | <input type="checkbox"/> Attend a hospital for treatment only |
| <input type="checkbox"/> Admitted to a hospital (overnight) | <input type="checkbox"/> Consulted a Physiotherapist          |
| <input type="checkbox"/> No medical treatment required      | <input type="checkbox"/> Reported to RN ASAP                  |

Name of hospital if admitted overnight:

**INCIDENT LOCATION**

Describe where the injury occurred *eg A Wing or Ipswich Road, Oxley (if motor vehicle accident)*

Where:

Name of Witness:

**WITNESS REPORT**

Surname:

Designation (eg RN, EEN etc):

Given Names:

Details (**only write what you actually witnessed**):

**FORM COMPLETED BY**

Surname:

First Name:

Signature:

Date:

**When completed please ensure form is given to the HHNA Managing Director**

**OFFICE USE ONLY**

**WHSO to investigate:**

- |  |                              |                             |   |                              |                             |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Does a hazard exist?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is a Risk Assessment required?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are controls in place to prevent further incident?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Workplace Health and Safety Kit Posted? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Did injury occur as a result of not following procedures or training?                            |                              |                             |   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| This Accident / Incident is to be included in the next Injury Risk Management Committee meeting? |                              |                             |   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Managers Name:

Managers Signature:

Date: