

Louisiana State University Health Sciences Center New Orleans



Incident/Accident Reporting and Investigation
December 31, 2009



Outline

- Definitions
- Reporting Responsibilities
- Reporting Forms
- Investigating the Incident/Accident
- Summary



Definitions

- **Accident:** *an unplanned event that caused personal injury or property damage. Even “minor” injuries (cuts or sprains) are considered accidents.*
- **Incident:** *an unplanned, or “near-miss”, event that could have caused personal injury or property damage*
- **Serious Illness or Injury:** *a condition requiring immediate medical assessment or treatment*
- **Minor Illness or Injury:** *a condition that does not require immediate medical assessment or treatment.*

Reporting Responsibilities



- ***Employees and Students:***
 - Shall immediately notify their supervisor of any incident/accident.
- ***Supervisors/PIs and Instructors:***
 - Ultimately responsible for reporting employee or student incidents/accidents to University Police.
 - Complete and submit the necessary reporting forms within 24 hours.
 - Note for serious illness or injury, contact 911 for medical attention.
- ***University Police:***
 - Shall respond to all reported serious incidents or accidents.
 - Shall notify Environmental Health and Safety of all incidents/accidents.

Reporting Forms



- ***DA 2000 – Employee Reporting***
 - Supervisors/PIs document ***employee*** incidents/accidents on the first page of the form. Provide copies to Environmental Health and Safety (EH&S) and Human Resource Management (HRM).
 - Supervisors/PIs document ***employee*** incidents/accidents ***sustained during medical procedures*** at hospitals and clinics, completing the entire form, including the Root Cause Analysis portion. Provide copies to EH&S and HRM.



Example of an acceptable DA 2000

To the right is an example of how to properly complete the form:

- Be sure not to leave any fields blank.
- Ask person(s) involved to describe what happened.
- Describe in as much detail as possible how the Incident /Accident occurred. Include:

- Date, Time, Employee's name, Procedure Involved, Name of Device or Equipment used, Injured Body Parts, PPE used, Personnel Present, Contributing Factors, Repeat Occurrences, etc.

- Describe the exact location where the event occurred. Include:

- Type of room/location, building name, floor, room number, Department

- Notations such as "N/A" or "not applicable" are not accepted.

**OFFICE OF RISK MANAGEMENT
UNIT OF RISK ANALYSIS AND LOSS PREVENTION
STATE EMPLOYEE INCIDENT/ACCIDENT INVESTIGATION FORM
Worker's Compensation Claims—To Be Filled Out By Injured Worker's Employer**

(PLEASE TYPE OR PRINT)

1. AGENCY LSUHSC-NO

2. ACCIDENT DATE 09/29/2009 3. REPORTING DATE 09/30/2009

4. EMPLOYEE NAME (LAST, FIRST) Researcher, Labby D.

5. JOB TITLE Laboratory Researcher

6. IMMEDIATE SUPERVISOR Boss, Nice T.

7. DESCRIBE IN DETAIL HOW INCIDENT/ACCIDENT OCCURRED (USE ADDITIONAL SHEET IF NECESSARY) On Tuesday, September 29, 2009, at 1:35p.m., Labby D. Researcher accidentally stuck the thumb on his left hand with a BRAND X suture needle. Labby, a Genetics Department employee of 3 months, was performing a suture procedure on research tissues when he accidentally stuck his left hand while holding the needle in his right hand. Jane Doe and myself, were present when the accident occurred. He was instructed to immediately remove his PPE gloves, and wash his hands with water for 15 minutes. I contracted University Police to notify them of the accident while Labby washed his hands. Since the tissues were potentially infectious, I accompanied Labby to the medical care provider of his choice, Excellent Hospital, for post-exposure medical assessment.

8. PARISH WHERE OCCURRED Orleans Parish 9. PARISH OF DOMICILE Jefferson Parish

10. WAS MEDICAL TREATMENT REQUIRED X Y N

1. EXACT LOCATION WHERE EVENT OCCURRED The needle-stick occurred in the procedure room located in the Clinical Sciences Building, 533 Bolivar St., New Orleans, LA, 70112; 3rd floor, room 399, Genetics Department

12. NAME (S) OF WITNESSES Jane Doe & Nice T. Boss

13. NAME OF PERSON COMPLETING THIS SECTION OF REPORT Nice T. Boss

14. SIGNATURE Nice T. Boss 15. DATE 09/30/2009



Example of an Insufficient DA 2000

Agency Information non-specific (Baton Rouge, Shreveport, New Orleans?)

•Reporting date should be completed immediately following an Incident/Accident

•Job Title is incorrect.

•Details surrounding the event do not provide sufficient information. Does not include:

- Date, Time, Procedure Involved, Name of Device or Equipment used, PPE used, Personnel Present, Contributing Factors, Repeat Occurrences, etc.

•Notations such as "N/A" or "not applicable" are not accepted.

•The location information is incomplete and does not appropriately describe the exact location the event occurred.

•Be sure not to leave any fields blank.

OFFICE OF RISK MANAGEMENT
UNIT OF RISK ANALYSIS AND LOSS PREVENTION
STATE EMPLOYEE INCIDENT/ACCIDENT INVESTIGATION FORM
Worker's Compensation Claims—To Be Filled Out By Injured Worker's Employer

(PLEASE TYPE OR PRINT)

1. AGENCY LSU

2. ACCIDENT DATE 09/29/2009 3. REPORTING DATE 10/5/2009

4. EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) Passafiume, LARRY D.

5. JOB TITLE Lab Worker

6. IMMEDIATE SUPERVISOR Boss, Nice T.

7. DESCRIBE IN DETAIL HOW INCIDENT/ACCIDENT OCCURRED (USE ADDITIONAL SHEET IF NECESSARY) Labby stuck her thumb with a needle Tuesday.

8. PARISH WHERE OCCURRED Orleans Parish 9. PARISH OF DOMICILE N/A

10. WAS MEDICAL TREATMENT REQUIRED X Y N

11. EXACT LOCATION WHERE EVENT OCCURRED Genetics 533

12. NAME (S) OF WITNESSES Jane

13. NAME OF PERSON COMPLETING THIS SECTION OF REPORT Nice T. Boss

14. SIGNATURE [Signature] 15. DATE 10/10/2009

Reporting Forms



- ***DA 1973-E1 Employer Report of Injury/Illness***
 - Instructors document ***student*** incidents/accidents using the entire form. Provide copies to EH&S and HRM.
 - Supervisors/PIs and instructors document ***employee*** accidents which involves an injury relating in *medical expenses* or worker's compensation on this form and submit to Human Resources Management within 5 days.

Example of an adequate DA 1973



- Be sure to fill out all applicable fields.
- Ask person(s) involved to describe what happened. Describe in as much detail what work activity was the employee doing when the incident occurred.
 - Give weight, size and shape of material or equipment involved; describe what procedures were involved, and indicate if correct procedures were followed.
- Describe in as much detail what caused the incident to happen:
 - Give full details the events that resulted in injury or disease, what happened and how, and include the name of any objects or substances involved.
- Describe in detail what part of the body was injured and the name of the injury/illness.

OFFICE OF WORKER'S COMPENSATION
 POST OFFICE BOX 94040
 BATON ROUGE, LA 70804-9040
 (225) 342-7565

EMPLOYER REPORT OF INJURY / ILLNESS LDOL-WC-1007

Employee Social Security Number 000-00-0000
Employer UI Account Number
Employer Federal ID Number 000000000
Location Code 000

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately. Forms for cases resulting in more than 7 days of disability or death are to be sent to the OWCA by the 10th day after the incident or as requested by the OWCA.

PURPOSE OF REPORT: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> More than 7 days of disability | <input type="checkbox"/> Possible dispute | <input checked="" type="checkbox"/> Medical Only
(no copy needed by OWCA) |
| <input type="checkbox"/> Injury resulted in death | <input type="checkbox"/> Lump Sum Compromise/Settlement | |
| <input type="checkbox"/> Amputation or disfigurement | <input type="checkbox"/> Other | |

1. Date of Report MM/DD/YY 09/29/09	2. Date / time of injury Time MM/DD/YY 9/29/09 <input checked="" type="checkbox"/> AM <input checked="" type="checkbox"/> PM	3. Normal Starting Time Day of Accident: MM/DD/YY 01:35 <input type="checkbox"/> AM <input checked="" type="checkbox"/> PM	4. If Back to Work: Give Date MM/DD/YY 9/30/09	5. At same Wage? <input type="checkbox"/> Yes <input type="checkbox"/> No	DO NOT WRITE IN THIS COLUMN
6. If Fatal injury, Give Date of Death: MM/DD/YY	7. Date Employer Knew of injury: MM/DD/YY	8. Date Disability began: MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received	
10. Employee Name: First Middle Last Labby Dee Researcher			11. <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	12. Employee Phone # (504) 568 - 0000	S.I.C.
13. Address and Zip Code XXX Residential St., Jefferson, LA, 7XXXX			14. Parish of Injury Orleans		State/Parish
15. Date of Hire 06/29/09	16. Age at illness/injury XX	17. Occupation Laboratory Researcher		18. Dept./Division Employed: Genetics	Occupation
19. Place of Injury: Employer's Premises? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		20. If No, indicate Location-Street, City, Parish and State			Nature
21. What work activity was the employee doing when the incident occurred? (Give weight, size and shape of material or equipment involved. Tell what he was doing with them. Indicate if correct procedures were followed.) Labby was performing a suture procedure on 16.4oz of research tissue. This procedure requires the use of BRAND Y needle. The researcher did not follow correct procedure and used a smaller BRAND X needle. He did not see the smaller BRAND X needle and stuck himself.					Part of Body
22. What caused the incident to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led to or contributed to this injury or illness.) This procedure calls for the use of BRAND Y needle. While passing the suture needle through the research tissue, he did not see the smaller BRAND X needle and stuck his thumb. The lighting was also dim in the room which could have increased the risk of injury.					Source
23. Part of body injured and Nature of injury or illness (ex. left leg, multiple fractures) Middle of thumb on his left hand was stuck with the suture needle.					Event
24. If Occ. Disease - Give Date Diagnosed Potentially infectious blood					NCC
25. Physician and Address street city state zip Dr. Good Practice XXX Doc St. New Orleans LA 7XXXX			26. If hospitalized, give name & address of facility Excellent Hospital		
27. Employer's Name Genetics - LSU Health Sciences Center New Orleans				28. Person Completing This Report - Please print Nice T. Boss (supervisor)	
29. Employer's Address street city state zip Clinical Sciences Bulding 533 Bolivar St., New Orleans, LA, 70112				30. Employer's Telephone Number (504) 568 - XXXX	
31. Employer's Mailing Address - If Different From Above city state zip Same as above.				32. Nature of Business - Type of Mfg., Trade, Construction, Service, etc. Laboratory Research	
33. Wage Information Employee was paid <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other The average weekly wage was \$ _____ per week.					
34. Verification of Employer Knowledge of this Report. Name: Favorite Dean Title: Department Head Date: 09/30/09					OFFICE OF RISK MANAGEMENT

Investigating the Incident/Accident



- ***Supervisors/PIs and Instructors***
 - Document the incident/accident using the necessary reporting form.
- ***University Police***
 - Conducts initial investigation.
 - Notifies EH&S of all reported incidents/accidents.
- ***EH&S***
 - Conduct Root Cause Analyses and trend analysis. Recommend changes in procedures as required.
 - Provide recommendations to the General Safety Committee based on the result of overall incident/accident trend.

Incident/Accident Reporting Summary

