

John Dempsey Hospital, UCHC

Charge Nurse Accident Review Report: Form A (Patient Handling Injuries)

Instruction: This report is to be completed by the Charge Nurse for every Patient Handling workers' compensation incident. Forward one copy of this form by the end of the shift to your Manger **AND** one copy to Peg Swets (MC 4035/ FAX - 4660). If unable to complete, forward the incomplete form by the end of the shift, and the completed form within 48 hours.

Employee Name: _____ **Incident Date:** _____

Nature of the Injury (i.e. strain, contusion etc.): _____

Body Part Injured: _____

Job Title: _____

Department/Unit _____

Location of Injury: _____

UCHC Employee Per Diem

Working Overtime? Yes No

Floor Census: # Patients _____ # Patient 1to1's _____

RNs _____ #LPNs _____ #NCAs _____ #MAs _____

Description of Incident: (Check most appropriate)

	Transfer Start	End
Bed	<input type="checkbox"/>	<input type="checkbox"/>
Chair	<input type="checkbox"/>	<input type="checkbox"/>
Ambulate	<input type="checkbox"/>	<input type="checkbox"/>
Commode	<input type="checkbox"/>	<input type="checkbox"/>
Floor	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>
Repositioning in:	Bed <input type="checkbox"/>	Chair <input type="checkbox"/> Other <input type="checkbox"/>

Root Causes: (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Equipment not available/working | <input type="checkbox"/> Working at unsafe speeds |
| <input type="checkbox"/> Patient refused proper lift | <input type="checkbox"/> Equipment failed | <input type="checkbox"/> Chose not to use equipment |
| <input type="checkbox"/> Too crowded to use lift | <input type="checkbox"/> Patient assessment inaccurate | <input type="checkbox"/> Other (specify below) _____ |
| <input type="checkbox"/> Staff not trained on equipt. | <input type="checkbox"/> Unsafe body position | _____ |
| <input type="checkbox"/> Algorithm led to wrong action | <input type="checkbox"/> Failure to obtain assistance | _____ |

Recommended Action:

- | | |
|--|---|
| <input type="checkbox"/> Train/Retrain on patient handling protocols | <input type="checkbox"/> Call Research Safety consult |
| <input type="checkbox"/> Work order for equipment repair | <input type="checkbox"/> Clean up/clear out area |
| <input type="checkbox"/> Monitor employee patient handling practices | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Revisions to patient handling protocols | |

Describe incident: _____

Comments _____

Charge Nurse Signature: _____ **Date:** _____