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 ASSISTANCE? 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
Workers’ Compensation
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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 (patient) 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
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) Unsafe acts by people: (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: ________________________________
- 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: ________________________________
Workers’ Compensation
Incident / Accident Investigation Form
Home Health Care

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: _______________

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Additional Notes:
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