Mission Safe: Injury/Incident Reviews

Injury/Incident Reviews – What are they, why are they needed, who should do them, how should they look, and when should they be done?|

WHAT – An injury or incident review is a two-part look at the injuries or incidents that occurred in a given period of time. One part is an examination of the individual event, documents, and conclusions that are associated with each of the injuries or incidents during the time being considered. The other part is a search for commonality, repetition, or trends among the incidents and their causes or victims. The injury-by-injury portion of the review is in essence an audit – examining the various documents, conclusions, and outcomes to ascertain level and consistency of quality. Under scrutiny should be:

- the **original report of injury** by the employee (e.g., Section I of the Workplace Incident Reporting Form)
  - Was it complete – i.e., not just were all spaces filled, but did the responses actually answer the questions posed? Do we know what the injured was doing just before the injury? Do we know what happened to cause the injury? Are we clear with regard to what caused the injury and what the injury really is? If any answer is *no*, why, and how do we find the appropriate answer?
  - Was it timely – not just was it reported within 24 hours, but was it reported as soon as reasonably possible? If not, why not?

- the **supervisor's report** that, together with the above, notified management of the injury (e.g., Section II of the Workplace Incident Reporting Form)
  - Was it filled according to your protocol, which may actually have Human Resources (HR) complete many of the identity and employment specifics?
  - Was it timely – not just was it reported within 24 hours, but was it reported as soon as reasonably possible? If not, why not?

- the **supervisor's investigation** that determined the cause(s) of the injury (e.g., Section III of the Workplace Incident Reporting Form)
  - Were causes of injury identified? Does it appear that all causes were identified? If not, a) determine the additional causes; b) does it appear that an effort to discover all causes was attempted? If so, will additional training help the supervisor identify what was missed; if not, has disciplinary or corrective action been taken? If so, describe; if not, it should be taken against both this supervisor and his/her supervisor.
  - Were there any suggested preventative action recommendations? Were recommendations made for all causal factors? If not, determine why.
  - Did the supervisor have the authority to implement any of the identified recommendations? If so, have they been implemented? If not, determine why.
  - Have the recommendations that were beyond the authority of the supervisor (if any) been implemented? If not, determine why.
  - Was it timely – not just was it reported within 24 hours, but was it reported as soon as reasonably possible? If not, why not?
  - Was it reviewed by upper management (at least at the branch level)? If not, why not?

- the **First Report of Injury** (FROI) that notified the state and the insurance company of the injury
  - Was it complete? If not, try to determine why.
  - Was there any indication that the person who filled the form had to go back to the employee or supervisor for additional information? If so, is the reason evident or discoverable? Was satisfactory information obtained in a timely manner?

  - How long did it take from time of injury for the insurance company to be notified? If more than 24 hours, who (employee, supervisor, or filing individual) and what caused the delay? Can something be done to help prevent such a delay in the future? If so, identify and implement or make recommendation; if the latter, schedule follow-up to ascertain completion.

- **resulting changes, suggestions for change, training, or disciplinary measures** arising from the injury – this is basically a summary field – each of these should have been discussed, status determined, reason(s) for non-completion (if any) documented, and corrective action (if any) taken in the evaluation of the supervisor's investigation

WHY –Injury/Incident reviews help prevent reoccurrences. There are both humanitarian and fiscal reasons to prevent unnecessary injuries, none of which really need extensive explanation. On the humanitarian side, it's the right thing to do: in our society inflicting unnecessary pain and suffering on a prisoner is considered barbaric and unconscionable – why should it acceptable when done to an employee? On the fiscal side, wasting money cuts profits, or in the case of non-profit entities, compromises the ability to meet the mission.

WHO – Normally injury/incident reviews should be done by members from both management and workers, with the majority falling to the latter. Members should come from all, or at least most, departments, and should serve a rotating term that is long enough for members to become proficient at the process yet not so long that they become cliquish (rotating terms of two to three years are common). It is best if members are volunteers, or at least not conscripts – someone who doesn't want to participate will add little to the process and may actually cause it to fail.

HOW – Exact protocols can vary significantly depending on the organization, its make-up, the services it delivers, etc. How the *What* (above) is accomplished is not overly important – it has to work for the individuals and entity in which they exist, but it doesn't have to be transportable to another entity. Whatever the process, it must encourage all to participate, must be capable of reaching definite conclusions in a reasonable amount of time, must not be biased towards entity or worker, and must be fair and consistent (i.e., given the same circumstances must reach the same conclusions regardless of individuals or personalities involved).

WHEN – It is best to review injuries/incidents relatively soon after they have occurred and the facts have been determined– that way, if additional information is needed to make any determination, there is a better possibility of finding what is needed. Quarterly-scheduled reviews (i.e., every three months) are most common, but more frequent is fine. Less frequent may introduce too much time between the event and the review, and, for larger associations, may make the review excessively long.