



Gathering the Facts and Documents

Occupational Health and Safety Act (OHSA)

Incident Checklist

Purpose of this checklist:

Having all of the facts is essential to enable the union to enforce health and safety rights. This checklist provides ONA with all of the relevant information required to enforce these rights.

It is very important to provide the union with information in a timely manner in order to assess whether a health and safety appeal is required before the Ontario Labour Relations Board. The *Occupational Health and Safety Act (OHSA)* requires appeals to be filed under a strict 30 calendar-day time limit from the issuance of an order or the refusal to make an order or the decision by a Ministry of Labour, Training, and Skills Development (MLTSD) health and safety inspector.

This checklist is divided into four parts to gather all relevant facts:

1. [Contact Information;](#)
2. [The Incident Description;](#)
3. [The Documents to Collect; and](#)
4. [Witness Information.](#)



Part 1 Contact Information

Date Completed/Updated:	
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Bargaining Unit:		Local #	
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Number of members at the ONA Bargaining Unit:	
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Bargaining Unit President name:	
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Email:		Phone:	
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ONA Joint Health and Safety Committee Rep:	

Email:		Phone:	
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Which Union Representative above is the main contact for this issue?	

Contact info for any other union Involved:	

Employer's HR Contact information (who will receive the appeal, if filed):			
Name:			
Address:			
Email:		Phone:	
Fax:			



Part 2 The Incident Description

Facts about the Incident

1. Date of MLTSD inspector's field report or order:

2. What is the incident? Describe what happened. Please provide as much detail as possible; attach an additional sheet if required.

3. What was the health and safety hazard (e.g. patient, equipment, materials, lack of staff)?

4. Where did the incident occur (unit, area, patient room #)?

5. When did the incident occur (date, time, etc.)?

6. Was an ONA member injured/ill or at risk of injury/illness (injury includes both physical and/or psychological)?

Yes No

If yes, please provide contact information in [Section 4: The Witnesses](#).

7. Were other workers, patients or visitors/family members injured/ill or at risk of injury/illness?

Yes No

If yes, provide contact information in [Section 4: The Witnesses](#).

8. What was the nature of the injury(ies)/illness?

9. a. Was it treated as a critical injury by your employer?

Yes No

b. If no, should this have been treated as a critical injury?

Yes No

If you answered yes to either question a or b, in [Appendix A: Notice Requirements](#), please complete the section called Notice of Critical Injury.



c. If this was treated as a critical injury, has or is a worker(s) member(s) of the Joint Health and Safety Committee investigating the critical injury?

Yes No

If not, why not?

If yes, is there any documentation from the investigation that you can provide?

10. If the incident did not result in a critical injury, was a worker disabled from performing usual duties (or even briefly unable to) and/or require medical attention?

Yes No

If you answered yes, in [Appendix A: Notice Requirements](#), please complete the section called Notice of Accident.

11. List anything that you think would have prevented the incident (e.g. equipment, infection control practices, increased security, personal safety devices or panic alarms, appropriate flagging policy)?

12. Was this related to workplace violence from a patient, visitor/family member or other factors?

Yes No

If yes, please complete [Appendix B: Incidents of Workplace Violence](#).



Facts about the MLTSD Action or Inaction

1. Was the MLTSD contacted? If yes, who contacted (called or emailed) the MLTSD?

Yes No

Name of complainant:

Date of first call to MLTSD?

Subsequent follow-up calls?

2. Did the person who called the MLTSD state the call was anonymous?

Yes No

3. When did the MLTSD inspector conduct a field visit to the workplace?

4.

a. What workplace issues or concerns were identified directly to the inspector?

b. What evidence was sent to the inspector before or after the field visit?

5. Who did the MLTSD inspector speak to during their field visit?

6.

a. Which members (i.e. worker and/or employer) of the Joint Health and Safety Committee accompanied the inspector?

b. Was the complainant in attendance? If not, please provide reason.

Yes No

7. Did the inspector record the interview?

Yes No
Unsure



8. What did the ONA members say to the inspector when interviewed?

9. Did the inspector issue an order in the field visit report?

Yes No

10. What, if anything, is missing from the inspector's order and/ or field visit report that you think should have been written?



Other Key Facts

1. Was this incident or like incident discussed or the risks leading up to the incident or like incident discussed at the Joint Health and Safety Committee?

If so, when?

Please describe and attach minutes.

2. What health and safety training related to the incident was offered by the hospital prior to the incident? Please list all training provided and the method used (i.e. online, in person, etc.)

3. Were these health and safety concerns raised with the supervisor? If so, when and how?

4. What could have been done by the employer/supervisor or others to prevent the incident?

5. Any other key facts or issues you think are important for ONA to know (e.g. any Professional Responsibility Workload Forms filed)?

6. Was a grievance filed related to this issue? If so, please include the grievance number(s).



Part 3 The Key Documents

The following documents are required to fully assess an appeal.
 Please circle yes or no if the following documents are attached.
 If not attached, please indicate when the documents will be sent to ONA.

The MLTSD inspector's:	Field visit report	Prior MLTSD orders related to unit/incident/or other similar incidents:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Notice of critical incident, if relevant:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Orders	Notice of accident or illness and any information provided with the notice:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Health and Safety Committee minutes where issues/incident discussed:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Copy of ONA's complaint to the MLTSD:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any prior health and safety relevant Minutes of Settlement?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Notes from meeting with MLTSD inspector:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Workload (PRWRF) complaints related to unit and/or incident:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Incident report:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint Health and Safety Committee recommendations made pertaining to the issues/incident.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Policy related to incident (e.g. workplace violence prevention):	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any employer response to relevant recommendations?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Procedure(s) facility-wide or on unit related to incident (e.g. the flagging procedure):	Yes <input type="checkbox"/> No <input type="checkbox"/>	Any other relevant documents?	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Please attach and list.



Part 4 The Witnesses

1. What is the name of the worker directly involved in the incident?
Please list all that apply and include the name of their union if unionized.

Name:			
Phone:			
Email:			
FT or RPT or casual			
Unit:		Position:	
ONA member?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If no, please indicate their union or if they are non-union			

2. Who from the Bargaining Unit spoke with the ONA member directly affected by the incident?

Name:			
Phone:			
Email:			

3. Who were the witnesses to the incident? Please list with email, phone number and relevance to the incident:

(i) Name:			
Phone:		Email:	
(ii) Name:			
Phone:		Email:	
(iii) Name:			
Phone:		Email:	

4. Other key relevant workers involved with the incident:

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5. Please add any other comments, which may assist in understanding the incident.

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Appendix A Notice Requirements

Notice of Critical Injury

Notification Required for Critical Injuries. Please complete the questions below if this incident involved a critical injury and/or you believe that this incident should have been treated as a critical injury by your employer.

1. Check mark any and all of the criterion for a critical injury relevant to this incident. Injury of a serious nature that:	<input type="checkbox"/>	Places life in jeopardy;
	<input type="checkbox"/>	Produces unconsciousness;
	<input type="checkbox"/>	Substantial loss of blood; Fracture of a leg or arm but not a finger or toe;
	<input type="checkbox"/>	Amputation of leg, arm, hand or foot, but not finger or toe;
	<input type="checkbox"/>	Consists of burns to a major portion of the body; Causes the loss of sight.

2. Please check any and all parties who were notified.

For each party notified, indicate who was notified, time/day and by what method.			
Union:	<input type="checkbox"/>	Who?	
		Time/Day?	
		Method?	
MLTSD:	<input type="checkbox"/>	Who?	
		Time/Day?	
		Method?	
Joint Health and Safety Committee:	<input type="checkbox"/>	Who?	
		Time/Day?	
		Method?	

a. Was the Joint Health and Safety Committee and ONA notified within 48 hours?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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b. If yes, please check any and all information provided by the employer with this notification.	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	The name, address, and type of business of the employer;
	<input type="checkbox"/>	<input type="checkbox"/>	The name of the worker;
	<input type="checkbox"/>	<input type="checkbox"/>	The nature of the bodily injury or occupational illness;
	<input type="checkbox"/>	<input type="checkbox"/>	The address of the worker,
	<input type="checkbox"/>	<input type="checkbox"/>	The nature and circumstances of the occurrence, including a description of any machinery, equipment or procedure involved;
	<input type="checkbox"/>	<input type="checkbox"/>	The time, date and place of the occurrence; and
	<input type="checkbox"/>	<input type="checkbox"/>	The names and address of the legally qualified medical practitioner, registered nurse who holds an extended certificate of registration under the <i>Nursing Act, 1991</i> or medical facility that is attending to or attended to the worker.
<input type="checkbox"/>	<input type="checkbox"/>	The steps taken to prevent a recurrence or further illness.	

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Notice of Accident

Notification required for injuries that cause a worker to be disabled from performing their usual duties (even if unable to briefly) and/or requiring medical attention.

1.

a. Was the Joint Health and Safety Committee and ONA notified within four days?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
b. If yes, please check any and all information provided by the employer with this notification.	Yes	No
	<input type="checkbox"/>	The name, address, and type of business of the employer;
	<input type="checkbox"/>	The name of the worker;
	<input type="checkbox"/>	The nature of the bodily injury or occupational illness;
	<input type="checkbox"/>	The nature and circumstances of the occurrence, including a description of any machinery, equipment or procedure involved; and
	<input type="checkbox"/>	The time, date and place of the occurrence;
	<input type="checkbox"/>	The names and addresses or other contact information of any witnesses to the occurrence; and
<input type="checkbox"/>	The steps taken to prevent a recurrence or further illness.	

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Appendix B Incidents of Workplace Violence

1. Does your employer have appropriate security to have responded in this situation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Can security put their hands on a patient?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Does your employer have personal panic alarms linked to security with GPS/locating type ability?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Does your employer have a flagging system that identifies alerts and tracks patients with a history of violent behaviour?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Did this patient or person have a history of violent behaviour?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
a. If yes, was the patient previously flagged?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. If previously flagged, was this information provided to all staff at risk before the incident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Did your manager perform a risk assessment prior to the incident (e.g. increase in acuity)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Does your employer have a police transfer of information protocol or memorandum of understanding that was applied in this situation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Was this patient assessed and provided appropriate treatment in a timely manner by the appropriate health-care provider (i.e. psychiatrist, physician, etc)? If no, please explain.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Were workers in this unit appropriately trained in de-escalation, self-protection, and self- defense?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Did a shortage of staffing in any way contribute to the incident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Did the layout or other aspects of the unit in any way contribute to the incident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Did any clinical practices or other processes established by your employer/supervisor contribute to this incident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Was there anything that your supervisor could have done differently to protect the workers?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
a. If yes, please list what your supervisor could have done to better protect the workers.		



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