Stanford HEALTH CARE
STANFORD MEDICINE

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

# Supervisor's Report of Employee Occurrence (SREO)

- **Submit this form for every work-related injury, illness, and exposure (e.g. Blood and Bodily Fluid (BBF), chemical) within 48 hours of incident occurrence**
  - If you are unsure if the incident is work-related, still submit this form. Occupational Health will make the determination if the incident is work-related.
  - Applicable to all employees, temporary workers, contractors, residents, medical students, volunteers and physicians.
- **BBF Exposures**: Call the 1-STIX pager (17849) at time of incident *in addition* to completing this form

***Required fields**

| ***Incident Location Information** | |
|---|---|
| ***Hospital** | ☐ Stanford Health Care<br>☐ Stanford Children's Health<br>☐ Other: ______________________________ |
| ***Department Name** | |
| ***Street Address** | |
| ***Suite/Floor/Room/Building** | |
| ***City** | |
| ***State** | ☐ CA<br>☐ NV<br>☐ Other:______________________________ |
| ***Zip Code** | |
| ***Room Number (describe space if no room number is available):** | |
| ***Door Number (found on door frame, enter NA if not available)**: | |

| ***Injured/Ill/Exposed Worker Information** | | |
|---|---|---|
| ☐ **One Worker Affected** | | ☐**Two or More Workers Affected**<br>Select this option if mass exposure or illness involving two or more workers. Enter information for one worker per one form submitted. |
| ***Last Name:** | ***First Name:** | |
| ***Worker ID #:** | | |

| ***Job Title** (select most appropriate option)**:**<br>☐ Employee ☐ Temporary Worker ☐ Contractor<br>☐ Medical Student<br>☐ Other:<br>_______________________________________________________ | |
|---|---|
| **Employee Position:**<br>☐ Resident ☐ Physician ☐<br>Other:_________________________________ | |
| **Physician Employer:**<br>☐ SHC ☐ LPCH ☐ Faculty | |
| ***Worker's Home Cost Center Information:**<br>• Cost Center Name: ___________________________________________<br>• Cost Center Number: ___________________________________________ | |

| ***Incident Details**<br>• Do not include any Protected Health Information (PHI) (e.g. PHI for injured/ill worker, patient, etc.)<br>• Do not include any information regarding medical treatment injured/ill worker received | |
|---|---|
| ***Incident Date:** | ***Incident Time:**<br>☐ AM ☐ PM |
| ***Where did the incident occur** *(e.g. Patient room #__, Hallway near __, Operating Room #__)*: | |
| ***Incident Description -** What happened?<br><br>***Example****: Mr. John Doe, a full-time employee on R2, was flushing an IV line prior to disconnecting the tubing when the tubing unexpectedly disconnected. Some of the fluid sprayed into Mr. Doe's eyes.* | |
| ***What Personal Protective Equipment (PPE) was the worker wearing?** | |
| ***Was there anything unusual about the incident/area the incident occurred?** *For all Yes answers, describe:*<br>• Broken/malfunctioning equipment: ☐ No ☐ Yes:__________________________________________________<br>• Environmental issues: | |

- Lighting: ☐ No ☐
  Yes:_______________________________________________________________
- Temperature: ☐ No ☐
  Yes:___________________________________________________________
- Noise: ☐ No ☐
  Yes:____________________________________________________________________
- Visibility: ☐ No ☐
  Yes:_________________________________________________________________
- Signage: ☐ No ☐
  Yes:__________________________________________________________________
- Vibration: ☐ No ☐
  Yes:_________________________________________________________________

- Construction zone/work area: ☐ No ☐
  Yes:___________________________________________________
- Aggressive/combative patient: ☐ No ☐
  Yes:___________________________________________________
- Other: ☐ No ☐
  Yes:_______________________________________________________________________

***Did this incident involve patient handling?** ☐ No ☐Yes *For all Yes answers, complete the following questions in this section.*

- **Equipment unavailable for use:** *For all Yes answers, describe*
  - Missing: ☐ No ☐
    Yes:_______________________________________________________________
  - Out of Service: ☐ No ☐
    Yes:__________________________________________________________
  - Broken: ☐ No ☐
    Yes:_______________________________________________________________
  - Malfunctioning: ☐ No ☐
    Yes:_________________________________________________________
  - Patient refused equipment use: ☐ No ☐
    Yes:____________________________________________
- **Equipment could not be used for clinical reason**: ☐ No ☐
  Yes:_____________________________________________________________________________

***Did this incident occur in an Operating Room**: ☐ No ☐Yes *For all Yes answers, complete the following questions in this section.*

- Service Line:______________________________________________________________________
- Name of Attending Physician:_________________________________________________________

***Preventative Actions**
For questions or help, please contact EH&S at DL-EH&S@stanfordhealthcare.org

***What do you and the injured/ill worker think could've prevented the incident from occurring** (provide specific recommendations/needs)**:**

- Personal Protective Equipment: ☐ No ☐ Yes:____________________________________________
- Training: ☐ No ☐ Yes:_____________________________________________________________
- Standard Work: ☐ No ☐ Yes:________________________________________________________
- Staff: ☐ No ☐ Yes:________________________________________________________________
- Equipment: ☐ No ☐ Yes:____________________________________________________________
- Other: ☐ No ☐Yes: ______________________________________________________________

***Example:*** *Mr. Doe was not wearing eye protection when the incident happened. Eye protection could've prevented the incident from occurring.*

***What preventative actions have you already taken or will take to prevent the incident from reoccurring?**

***Example:*** *I have addressed this incident at all unit huddles and reminded staff that if they put on gloves, they should put on eye protection as well, because if something can get on their hands, it can also get in their eyes. I'm working on increasing the supply of safety glasses on the unit so that they are readily available to staff when needed.*

| **Incident Witnesses (if any)** |
| --- |
| **Name:** |

| |
|---|
| **Department:** |
| **Phone:** |

| ***Supervisor /Manager Information** | |
|---|---|
| ***Name:** | |
| ***Title:** | |
| ***Telephone Number:** | |
| ***Email:** | ***Date Form Completed:** |

| ***Sign and Date**<br>*By signing this form, I acknowledge I am the stated worker's supervisor and all of the information I have provided above is accurate to the best of my knowledge.* | |
|---|---|
| ***Supervisor's Signature:** | ***Date:** |
| **Submit this completed form to the HR Business Operations Analyst Team at HR-Analytics@stanfordhealthcare.org. This form must be submitted within 48 hours of incident or Occupational Health Services sending you a notification email, whichever occurs first.** | |