

A direct observation checklist and discussion guide designed to identify the level of risk due to fatigue to be completed by the Supervisor when a worker has been identified as exhibiting signs of fatigue.

This form is referenced in SOP "PRC-10.082"

Date: _____

Time: _____

Worker being assessed:

Person conducting assessment:

Name: _____

Name: _____

Signed: _____

Signed: _____

Position Title: _____

Position Title: _____

DIRECT OBSERVATION

This will help Supervisors record observations about the person's appearance, behaviour and performance.

How did the person come to your attention?

- ☐ Direct observation of person's behaviour or performance
- ☐ Self report of fatigue
- ☐ Concerns raised by other employees or individuals regarding person's fatigue or performance
- ☐ Other

Please indicate whether the person displayed any of the following signs of fatigue:

Appearance

- ☐ Bloodshot eyes
- ☐ Poor coordination
- ☐ Frequent blinking
- ☐ Long eye blinks
- ☐ Heavy eyelids
- ☐ Slow or disjointed speech
- ☐ Repeated yawning

Performance

- ☐ Loss of attention
- ☐ Difficulty following instructions
- ☐ Request repeat of instructions
- ☐ Making mistakes
- ☐ Slow reaction times
- ☐ Automatic or repetitive behaviour
- ☐ Difficulty concentrating
- ☐ Lack energy
- ☐ Poor memory

Mood

- ☐ Emotional outbursts
- ☐ Mood changes
- ☐ Argumentative
- ☐ Restlessness
- ☐ Poorly considered decisions
- ☐ Over focus on minor issues

DISCUSSION WITH THE WORKER

This provides Supervisors with a structured format to discuss their concerns with the person.

Question

Risk Assessment

1. In the last 3 months, have you had any other incidents where you were fatigued at work?

☐ No ☐ Yes

If yes, specify:

2. How many consecutive shifts have you worked since your last 48-hour break?

1 2 3 4 5 6 7 8+

3. How much sleep have you had in the last 24 hours?

☐ 8 hours or more

☐ 7 hours

☐ 6 hours

☐ 5 hours or less

4. How much sleep have you had in the last 48 hours?

☐ 13+ hours

☐ 13 hours

☐ 12 hours

☐ 11 hours or less

5. Have you had any problems with your sleeping in the last 7 days?

☐ No ☐ Yes

If yes, specify:

6. How many hours have you been awake?

☐ <14 hrs

☐ 14 hrs

☐ 15 hrs

☐ 16 – 17 hrs

☐ 18 hrs or more

7. Did you ☐ No ☐ Yes

respond to
any call outs
overnight?

If yes, specify including length and time/s:

8. Are there any ☐ No ☐ Yes

personal or
health factors
that affect
your ability to
work safely?

If yes, specify:

9. Do you have ☐ No ☐ Yes

concerns
about your
ability to stay
alert and
work safely?

If yes, specify:

Overall assessment

Please indicate
your overall
fatigue risk
assessment



☐ Low ☐ Moderate ☐ High ☐ Extreme

SIGNS OF FATIGUE	SUGGESTED ACTION
The worker has no obvious signs of fatigue	<ul style="list-style-type: none"> Continue to monitor Remind worker about fatigue and alertness management strategies such as interaction with others, coffee, exercise, cold air on face, working in well-lit areas etc.
The worker has some early warning signs of fatigue	As above plus... <ul style="list-style-type: none"> Rotate tasks Provide short breaks Encourage the use of alertness strategies Increase supervision
The worker has some serious signs of fatigue or The worker reports he/she is fatigued	As above plus... <ul style="list-style-type: none"> Have workers work together, if possible Remove from safety sensitive work Arrange for suitable alternate duties, if required Schedule regular supervision for remainder of shift
The worker has many serious signs of fatigue or The worker reports he/she is severely fatigued	<ul style="list-style-type: none"> Prevent worker from working Replace worker, if necessary Send home (provide transport if there is concerns about the person's capacity to drive) Complete incident report (if required) Review situation to determine possible causes and action required

Outcome/Action Taken

Please detail action/s taken: <div style="border-bottom: 1px solid black; height: 20px; margin-top: 10px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 10px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 10px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 10px;"></div>	
Has the assessment resulted in a change of hours?	<div style="display: flex; justify-content: space-around; align-items: center;"> <input type="checkbox"/> No <input type="checkbox"/> Yes </div> <div style="margin-top: 5px;"> If yes, please specify: <div style="border-bottom: 1px solid black; height: 20px; margin-top: 5px;"></div> <div style="border-bottom: 1px solid black; height: 20px; margin-top: 5px;"></div> </div> <div style="margin-top: 10px;"> <input type="checkbox"/> Program Manager notified <input type="checkbox"/> Human Resources notified </div>
Date:	
Supervisor Name:	
Supervisor Signature:	