Serial No.

United Lincolnshire Hospitals NHS
NHS Trust

Confidential

Incident Report Form (IR 1)

- Use this form to record **ALL** incidents, accidents and dangerous occurrences or near misses
- **Unexpected death or serious injury involving patients, staff and others must be reported immediately by telephone to the Senior Nurse with site responsibility.**

DETAILS OF INCIDENT

Date: | | | **Time:** : **(24 hr clock)** **HOSPITAL:**

CMT/CORPORATE DEPT: **Ward/Dept/Location:**

A) Actual Outcome Severity (Tick the most appropriate box)

☐ **NEAR MISS**
☐ **CATASTROPHIC** – Death or multiple deaths
☐ **MAJOR** – Major harm/injury including permanent disability
☐ **MODERATE** – Significant harm/injury i.e. RIDDOR
☐ **MINOR** – Minor harm/injury
☐ **NONE** – No injury or harm
☐ **LOSS/DAMAGE** of property worth £ ……….

B) Potential Outcome Severity (Tick the most appropriate box)

☐ **CATASTROPHIC** – Death or multiple deaths
☐ **MAJOR** – Major harm/injury including permanent disability
☐ **MODERATE** – Significant harm/injury i.e. RIDDOR
☐ **MINOR** – Minor harm/injury
☐ **NONE** – No injury or harm
☐ **LOSS/DAMAGE** of property worth £ ……….

C) Likelihood of recurrence

☐ **RARE** ☐ **UNLIKELY** ☐ **POSSIBLE** ☐ **LIKELY** ☐ **CERTAIN**

D) Incident Type (Tick one box)

☐ (1) Access, admission, transfer, discharge (including missing patient)
(2) Accident to a person:
☐ (2.1) *Collision/contact with an object*
☐ (2.2) *Contact with sharps (includes needlestick)*
☐ (2.3) *Exposure to hazardous substances*
☐ (2.4) *Exposure to cold/heat*
☐ (2.5) *Inappropriate patient handling/positioning*
☐ (2.6) *Inappropriate non-patient handling/positioning*
☐ (2.7) *Slips, trips or falls (complete Falls Risk Assessment Pathway score)*
Patient FRAP score Pre Fall______ Post Fall______
☐ (2.8) *Other e.g. electric shock*
☐ (3) Clinical assessment (including diagnosis, scans, tests, assessments)
☐ (4) Consent, communication, confidentiality
☐ (5) Disruptive, aggressive behaviour
☐ (6) Documentation (including records, identification)
☐ (7) Fire
☐ (8) Implementation of care and ongoing monitoring/review
☐ (9) Infection control incident
☐ (10) Infrastructure (including staffing, facilities, work place)
(11) Medication:
☐ (11.1) *Prescribing*
☐ (11.2) *Preparation/dispensing*
☐ (11.3) *Administration*
☐ (11.4) *Monitoring/follow-up of medicine use*
☐ (11.5) *Advice*
☐ (11.6) *Supply or use of over the counter medicines*
☐ (12) Medical device/equipment
☐ (13) Security, criminal, malicious activity, loss of property
☐ (14) Self-harming behaviour
☐ (15) Treatment, procedure

E) Incident Description (Give brief details – information must be factual and free from personal opinion)

F) Remedial Action Undertaken or Required (Describe what has or will be done to prevent recurrence) - IR 2 TO FOLLOW YES / NO

Any equipment involved in an incident must be retained in safe keeping pending further investigation

ANONYMOUS REPORTS MAY BE SENT DIRECTLY TO THE RISK MANAGEMENT DEPARTMENT

(**Please continue overleaf)**

DETAILS OF PERSON AFFECTED (if applicable)

G) Person is: ☐ (1) Patient ☐ (2) Employed Staff ☐ (3) Volunteer Staff ☐ (4) Visitor/Member of the Public ☐ (5) Contractor ☐ (6) Agency Staff ☐ (7) Students

First Name:
Last Name:
Post/Designation:
Ethnicity:

Date of Birth if not a patient

ADDRESS:

Postcode ……………………. Tel No.

Patient Addressograph Label

DETAILS OF ANY INJURY AND/OR TREATMENT (if applicable)

H) Site of Injury: (e.g. lower back, right eye, abdomen, left ankle etc.)

I) Nature of injury: ☐ (1) Abrasion ☐ (2) Bruise/swelling ☐ (3) Burn/scald ☐ (4) Laceration

☐ (5) Sharps ☐ (6) Sprain/strain ☐ (7) Dislocation ☐ (8) Concussion ☐ (9) Fracture

☐ (10) Amputation ☐ (11) Infection ☐ (12) Other (specify) …………………………………………………..

J) Treatment: ☐ (1) None ☐ (2) First aid ☐ (3) Resident Doctor ☐ (4) GP ☐ (5) A&E

☐ (6) Occ. Health ☐ (7) Hospital treatment ☐ (8) Physiotherapy ☐ (9) Counselling ☐ (10) Medication

Is staff absence expected? **YES / NO / DON'T KNOW** **If YES**, give estimate in days ……………….. Days

NAME AND CONTACT DETAILS OF ANY WITNESSES

Person completing form: (Capitals):

Signature: ……………………………………………… Date: ……………………………

Post/Designation:………………………………………..

THIS FORM MUST BE SENT TO THE RISK MANAGEMENT DEPARTMENT IMMEDIATELY

RISK MANAGEMENT DEPARTMENT

Date Received	Initial Risk Assessment	Final Risk Assessment

Is this a R.I.D.D.O.R INCIDENT	YES / NO	**H&S Advisor Informed**	Date informed:
Is this a MEDICAL DEVICE/ EQUIPMENT/PLANT INCIDENT	YES / NO	**MHRA /NHS Estates Informed**	Date informed:
Is this a FIRE INCIDENT	YES / NO	**Fire Safety Officer Informed**	Date informed:

Further Action Required: **YES / NO** **DETAILS:** ……………………………………………………………………………………

IR 2 to follow: **YES / NO** **Review Date:** ………………………..