NIMS
National Incident Management System

HC NIRF 01 – V10
Date issued: 03/05/2018

NATIONAL INCIDENT REPORT FORM (NIRF)
NIRF - 01 PERSON

NIMS record Number:

Incident: An event or circumstance which could have, or did lead to unintended and / or unnecessary harm. Please complete this form to the best of your knowledge at the time of reporting the incident.

SECTION A: GENERAL INCIDENT DETAILS

Date of incident D D M M Y Y Y Y

Time of incident H H M M *Use 24 hour clock*

Location *E.g. Hospital, Health Centre, Residential Centre etc.*

Specific Location *E.g. Ward, Clients home etc.* **Offsite?** ☐

SECTION B: PERSON AFFECTED DETAILS

First name _____

Surname _____

Date of birth D D M M Y Y Y Y

☐ **Female** ☐ **Male**

Description of incident:

Division (tick one only ✓)

- ☐ **Acute Hospital**
- ☐ **Social Care**
- ☐ **Health and Wellbeing**
- ☐ **Primary Care**
- ☐ **Mental Health**
- ☐ **Ambulance Service**
- ☐ **National Corporate Services (staff only)**

Who was involved…? (tick one only ✓)

- ☐ **Service user** – (Resident/Patient/Client) Go to section **C**
- ☐ **Staff member** – Go to section **D**
- ☐ **Agency / Panel staff** – Go to section **D**
- ☐ **Member of public**-Proceed to section **F**
- ☐ **Volunteer** – Go to section **D**
- ☐ **External Contractor** – Go to section **E**
- ☐ **Student** – Go to section **D**

SECTION C: SERVICE USER DETAILS ONLY

Healthcare Record No _____

Lead Clinician _____

This incident involved… (tick one only ✓)

- ☐ **Neonatal Specialties**
- ☐ **Paediatric Specialties**
- ☐ **Adolescent Specialties**
- ☐ **Adult Specialties**
- ☐ **Older Person Specialties**

Incident Occurred under (Service / Specialty) *E.g. Antenatal, Audiology, Radiotherapy, Intellectual Disability, Psychology* _____

SECTION D: STAFF MEMBER / AGENCY / PANEL STAFF / STUDENT / VOLUNTEER DETAILS ONLY

Category of person _____

Employee no. _____

Date absence commenced (if known) D D M M Y Y Y Y

Date returned to work (if known) D D M M Y Y Y Y

Work days lost ☐

Note: For employee incidents reportable to HSA that result in an absence from duty for more than three consecutive days, excluding the day of the accident, the date absence commenced and the date employee returned to work should be recorded on the NIMS

SECTION E: EXTERNAL CONTRACTOR DETAILS ONLY

Company Name _____

Company no. _____

SECTION F: WHAT WAS THE OUTCOME AT THE TIME OF THE INCIDENT?

✓ Outcome		Body Part Affected
☐ **Near Miss e.g. Nearly given wrong drug**	**Category 3**	
☐ **No Injury** e.g. Wrong drug given but no harm occurred		
☐ **Injury not requiring first aid**		
☐ **Injury or illness, requiring first aid**		
☐ **Injury requiring medical treatment**	**Category 2**	
☐ **Long-term disability / Incapacity (incl. psychosocial)**	**Category 1**	
☐ **Permanent Incapacity (incl. Psychosocial)**		
☐ **Death**		

E.g. Arm, Spine, Lung, Other Physiological

SECTION G: TYPE OF INJURY (tick one only ✓)

Birth Specific Injury (Baby)	☐ Apgar score <5@ 1 min &/or; 7@5mins &/or pH ≤ 7.0 ☐ Aspiration ☐ Cerebral irritability / neonatal seizure ☐ HIE - Hypoxic Ischaemic Encephalopathy with Hypoglycaemia ☐ HIE Grade 1 - Hypoxic Ischaemic Encephalopathy	☐ HIE Grade 2 - Hypoxic Ischaemic Encephalopathy ☐ HIE Grade 3 - Hypoxic Ischaemic Encephalopathy ☐ Hypoglycaemia - severe ☐ Kernicterus ☐ Neonatal death ☐ Nerve Injury - brachial plexus (incl. Erbs Palsy)	☐ Nerve Injury - face ☐ Other unexpected deterioration ☐ Stillbirth ☐ Sub-galeal / sub-aponeurotic haemorrhage ☐ Unknown ☐ Other _____
Birth Specific Injury (Mother)	☐ Death ☐ Hysterectomy (Perinatal) ☐ Incontinence (faecal) ☐ Incontinence (urinary)	☐ Perineal tear ☐ Post-Partum Haemorrhage ☐ Rhesus iso-immunisation ☐ Incontinence (faecal & urinary)	☐ Unknown ☐ Uterine rupture ☐ Other _____
Blood Specific Injury	☐ Excessive Bleeding ☐ Fainting ☐ Immunological haemolysis	☐ Febrile non-haemolytic transfusion reaction	☐ Non-immunological haemolysis ☐ Other _____
Diagnosed Disease Disorder or Cond.	☐ Asbestosis ☐ Cancer ☐ Acute Radiation Syndrome ☐ Narcolepsy/Cateplexy	☐ Hepatitis ☐ HIV ☐ Brucellosis ☐ Legionnaires	☐ Unknown ☐ Dermatitis ☐ TB ☐ Pleural Plaques ☐ Other _____
Diagnosed Infection	☐ Clostridium Difficile ☐ ESBL ☐ Hepatitis	☐ MRSA ☐ Norovirus ☐ Unknown	☐ VRE ☐ VRSA ☐ Other _____
General Injuries	☐ Allergic Reaction (incl. anaphylaxis) ☐ Brain Injury / Concussion ☐ Burn / scald / corrosion ☐ Choking / asphyxia ☐ Circulatory / volume depletion ☐ Circulatory / volume overload ☐ Pain/Discomfort	☐ Cut / Laceration / Graze / scratch ☐ Death ☐ Dental injury &/or loss ☐ Deterioration ☐ Haemorrhage ☐ Blister	☐ Malaise / Nausea ☐ Nerve injury / Loss of Function ☐ Puncture / bite ☐ Rash / irritation ☐ Unknown ☐ Other _____
Hearing / Sight Injury	☐ Hearing Impairment / loss ☐ Sight Impairment / loss	☐ Tinnitus ☐ Unknown	☐ Other _____
Misdiagnosis	☐ Cancer ☐ Fracture	☐ Infection ☐ Unknown	☐ Other _____
Musculoskeletal / Soft Tissue	☐ Amputation ☐ Bruising ☐ Crushing ☐ Dental Fracture / Tooth loss ☐ Dislocation	☐ Fracture ☐ Repetitive Strain Injury (RSI) ☐ Slipped / Prolapsed Disc ☐ Sprain / Strain ☐ Soft tissue injury	☐ Swelling / Inflammation ☐ Unknown ☐ Whiplash ☐ Other _____
	☐ P. Ulcer Stage **1**: Intact skin with non-blanchable redness over bony prominence ☐ P. Ulcer Stage **2**: Part thickness dermis loss: blister/open ulcer/no slough ☐ P. Ulcer Stage **3**: Full thickness tissue loss: +/- visible subcutaneous fat ☐ P. Ulcer Stage **4**: Full thickness tissue loss/necrosis: exposed bone/tendon/muscle		
Personal Loss	☐ Additional / Further Surgery ☐ Limb Deformity ☐ Defamation of Character	☐ Loss of Wages / Income / Business ☐ Loss of Consortium	☐ Unknown ☐ Organ Retention ☐ Other _____
Surgery Specific Injury	☐ Damage to organ / body part ☐ Dental Damage / Loss ☐ Foreign body left in situ ☐ Unknown	☐ Loss of organ / body part ☐ Nerve injury / Loss of Function ☐ Inadequate anaesthesia	☐ Unexpected complication / deterioration ☐ Other _____
Traumatic/Emotional	☐ Anxiety / Trauma ☐ PTSD	☐ Stress ☐ Unknown	☐ Worried Well ☐ Other _____

SECTION H WHAT TYPE OF HAZARD DID THIS INCIDENT RELATE TO? (Tick one option from Steps 1, 2, 3 & 4)

	Step 1.	Step 2.	Step 3.	Step 4.
Clinical Care	☐ **Birth Specific Procedures**	☐ Caesarean Section (Elective) ☐ Caesarean Section (Emergency) ☐ Instrumental Delivery (Forceps) ☐ Instrumental Delivery (Vacuum) ☐ Instrumental Delivery (Multiple Instruments) ☐ Non Instrumental Delivery	☐ Communication / Consent ☐ Diagnosis / Assessment ☐ Documentation / Records ☐ Equipment ☐ General Care / Management ☐ Procedure / Treatment / Intervention ☐ Screening / Prevention ☐ Specimens / Results ☐ Tests / Investigations ☐ Unknown ☐ Other _____	☐ Adverse Effect ☐ Failure / Malfunction ☐ Foreign Body left in Situ ☐ Inappropriate for Task / Wrong device ☐ Incomplete / Inadequate ☐ Lack of Availability ☐ Not performed when indicated / Delay ☐ Pre Existing Medical Condition ☐ Shoulder Dystocia ☐ Unavailable / Mislabelled / Lost ☐ Wrong Body Part / Site / Side ☐ Wrong Patient ☐ Wrong Process / Treatment / Procedure ☐ Other _____
	☐ **Clinical Procedures**	☐ Invasive ☐ Non Invasive		
	☐ **Medication**	*Route of administration* ☐ Oral ☐ Intravenous ☐ Sub Cutaneous ☐ Intra Muscular ☐ Topical ☐ Rectal ☐ Inhalation ☐ Other / Unknown	☐ Administration ☐ Monitoring ☐ Ordering / Supply / Transport ☐ Preparation / Dispensing (Pharmacy) ☐ Prescribing ☐ Reconciliation ☐ Storage	☐ Adverse Drug Reaction ☐ Contra-indicated ☐ Drug Interaction ☐ Failure / Malfunction of equipment ☐ Incomplete / Inadequate ☐ Not preformed when indicated / delayed ☐ Omitted/Delayed Dose ☐ Wrong Dose / Strength ☐ Wrong Drug ☐ Wrong Formulation / Route ☐ Wrong Frequency ☐ Wrong Label / Instructions ☐ Wrong Patient ☐ Wrong Quantity / Duration
		What medication was involved? *Medication One* _____ *Medication Two* _____		
	☐ **Nutrition**	☐ Parenteral ☐ Enteral ☐ Special Diet ☐ General Diet ☐ Other _____	☐ Communication / Consent ☐ Prescribing / Requesting ☐ Preparation / Dispensing ☐ Administration ☐ Storage ☐ Documentation / Records ☐ Equipment ☐ Supply / Ordering / Transport ☐ Presentation / Packaging ☐ Transfusing blood ☐ Other_____	☐ Adverse Effect ☐ Incomplete / Inadequate ☐ Not performed when indicated / Delay ☐ Wrong Consistency ☐ Wrong Diet / Wrong Blood Product ☐ Wrong Process / Treatment / Procedure ☐ Wrong Patient ☐ Lack of Availability ☐ Wrong dispensing label / instructions ☐ Inappropriate for task / Wrong device ☐ Other_____
	☐ **Blood / Blood Product**	☐ Whole Blood ☐ Red Cells ☐ Platelet (Apheresis) ☐ Platelets (Pooled) ☐ Other _____		
	☐ **Diagnostic Radiology (DR) & Nuclear Medicine (NM)**	☐ Checking Patient ID procedure ☐ Clinical Details on Referral ☐ Communication / Consent ☐ Documentation / Records ☐ Equipment ☐ Performing procedure ☐ Pregnancy Status ☐ Unknown	☐ Diagnostic Exposure > intended ☐ X-ray Over Exposure ☐ Wrong body part / side ☐ Dose to comforters / carers	☐ Above Notifiable levels ☐ Below Notifiable levels
			☐ Wrong Patient ☐ Inadvertent dose to foetus	☐ <1mSv ☐ >1mSv
			☐ Total dose or Volume Variation ☐ Dose (NM) or Volume Variation (1 fraction)	☐ <10% ☐ 10-20% ☐ >20%
	☐ **Radiotherapy**		☐ Wrong Drug ☐ Wrong Dose ☐ Wrong Process / Treatment / Intervention ☐ Failure / Malfunction ☐ Inadvertent deterministic effects	
Bio Hazards	☐ **Biological Hazards / Acquired Infections**	☐ Bacteria ☐ Fungus / Mould ☐ Prion ☐ Virus ☐ Organism Unknown		☐ Exposure to Bite (Human) ☐ Exposure to Bite (Insect / Animal) ☐ Exposure to Bodily Fluids ☐ Exposure to Ingestion/Food/Water ☐ Exposure to Needle Stick ☐ Exposure to Skin Contact ☐ Inhalation/Airborne ☐ Equipment, Implements, Facilities, Sharps (Non Needle) ☐ Unknown ☐ Other _____

SECTION H CNTD: WHAT TYPE OF HAZARD DID THIS INCIDENT RELATE TO? (Tick one option from Steps 1, 2 & 3)

	Step 1.	Step 2.	Step 3.
Behavioural Hazards	☐ **Self-Injurious Behaviour**	☐ Intentional ☐ Unintentional	☐ Absconsion / Missing ☐ Attempted Suicide ☐ Banging Self Against Walls/Furniture/Surfaces ☐ Hitting Body/Slap/Punch Self incl. Scratching & Picking ☐ Inappropriate Eating ☐ Inappropriate Touching ☐ Self-Harm ☐ Stripping Clothes in Public Area ☐ Suicide ☐ Throwing objects ☐ Other _____
	☐ **Violence, Harassment and Aggression** ☐ **Child Abuse** ☐ **Adult Abuse**	☐ By a Family Member / Relative ☐ By a Member of the Public ☐ By a Peer / Student ☐ By a Prisoner ☐ By a Service User ☐ By a Staff Member	☐ Aggressive towards inanimate object ☐ Discrimination/Prejudice/Racial ☐ Intimidation / Threat ☐ Neglect ☐ Non-Compliant / Obstructive / Rude ☐ Physical Assault / Abuse ☐ Physical Harassment ☐ Sexual Assault / Abuse ☐ Sexual Harassment ☐ Unintentional Aggressive Behaviour ☐ Bullying ☐ Verbal Assault / Abuse ☐ Verbal Harassment ☐ Other _____
Physical Hazards	☐ **Slip / Trip / Fall**	☐ From Height ☐ From Equipment / Furniture ☐ Same Level / Ground ☐ On Stairs ☐ On Steps ☐ Other _____	☐ Unknown ☐ Pre Existing Medical Condition ☐ Inadequate supervision gen health / post op ☐ Obstruction / protruding object ☐ Surface contaminants ☐ Rough terrain / irregular surface ☐ Inappropriate equipment use ☐ Failure / malfunction of equipment ☐ Horseplay ☐ Physical training / sport ☐ Weather Condition ☐ Inadequate Lighting / design ☐ Other _____
	☐ **Non Mechanical (Incl. Person / Animal)**	☐ Object / Tools (Non Sharps) ☐ Sharps (Non Needle) ☐ Other ☐ Person	☐ Human Use / Error ☐ Obstruction / Protruding Object ☐ Physical Training / Sport ☐ Defective Equipment ☐ Unsafe / Inappropriate system ☐ Unknown ☐ Task ☐ Load ☐ Working Environment ☐ Individual Capability ☐ Other _____
	☐ **Ergonomics (Incl. manual / people handling)**	☐ Manual Handling ☐ Other ☐ Patient Handling ☐ Restraint / Intervention	
	☐ **Mechanical Components**	☐ Catering equipment ☐ Door / Gate / Barrier ☐ Healthcare Equipment ☐ Lifting Equipment / Accessories ☐ Office / Business equipment	
	☐ **Temperature (Excluding Fire)**	☐ Hot ☐ Cold	☐ Liquid / Food / Steam ☐ Equipment / Utensils ☐ Atmosphere / Environment
	☐ **Fire** ☐ **Vibration** ☐ **Electrical** ☐ **Noise** ☐ **Radiation**	☐ Please Specify _____	☐ Defective Equipment ☐ Human Use / Error ☐ Unknown ☐ Unsafe System ☐ Explosion ☐ Exposure ☐ Electrical Wiring / installation

SECTION H CNTD: WHAT TYPE OF HAZARD DID THIS INCIDENT RELATE TO? (Tick one option from Steps 1, 2, & 3)

	Step 1.	Step 2.		Step 3.
Chemical Hazards	☐ **Acid / Alkaline** ☐ **Agri Chemicals** ☐ **Gas** ☐ **Other Chemical Products** ☐ **Particulates** ☐ **Petroleum / Synthetic Oil Based Products** ☐ **Sanitation / Cleaning Chemicals** ☐ **Toxic Metals**	☐ Animal Remedy ☐ Arsenic ☐ Asbestos ☐ Bleach ☐ Cadmium ☐ Carbon Dioxide ☐ Carbon Monoxide ☐ Chemical Fertilizer ☐ Crystalline Silica ☐ Detergent ☐ Diesel / Kerosene ☐ Disinfectant ☐ Drain / Oven Cleaner ☐ Drugs ☐ Fungicide ☐ Glue / Adhesive ☐ Grease ☐ Herbicide ☐ Hydrochloric Acid	☐ Insecticide ☐ Lead ☐ Metallic Dust ☐ Motor / Gear / Hydraulic Oil ☐ Natural Gas ☐ Organic Dust ☐ Paint / Paint Product ☐ Petrol ☐ Polish ☐ Radon ☐ Rodenticide ☐ Soap ☐ Sodium Hydroxide ☐ Solvents ☐ Spent / Used Oil Product ☐ Sulphuric Acid ☐ Wrong Patient ☐ Other _____	☐ Lack of Supervision ☐ Unknown ☐ Human / User Error ☐ Unsafe System

SECTION I: IMMEDIATE ACTIONS TAKEN

SECTION J: REPORTED BY: *person who discovers the incident and unless otherwise stated within the organization, this person is responsible for completing the NIRF.*

First name _____

Surname _____

Date notified D D M M Y Y Y Y

Category of person *E.g. Nurse, Catering Staff, Cleaner*

Local system reference no. _____

Reporter Signature _____

Date D D M M Y Y Y Y

Contact Details _____

SECTION K: WITNESS DETAILS (Name, Contact No. etc.)

SECTION L: TO BE COMPLETED BY LINE/DEPARTMENT MANAGER

Has open disclosure happened? (tick one only ✓) ☐ Yes ☐ No

If No, please specify: _____

CATEGORY 1 INCIDENTS ONLY

SAO Name [Block Capitals]: _____ **Date notified to SAO:** D D M M Y Y Y Y

SAO Email and Contact Details: _____

Is there a requirement to report this incident to any external regulators/agencies/insurers (other than the State Claims Agency)? ☐ Yes ☐ No

If Yes: Name regulator(s)/agency(ies) reported/notified to: **Date Notified:**

1 _____ D D M M Y Y Y Y

2 _____ D D M M Y Y Y Y

3 _____ D D M M Y Y Y Y

Line/Department Manager name [Block Capitals]: _____ **Title:** _____

Signature of Line/Department Manager: _____ **Date:** D D M M Y Y Y Y

SECTION M: TO BE COMPLETED BY QUALITY AND PATIENT SAFETY OFFICE

Is this incident a Serious Reportable Event (SRE)? (tick one only ✓) ☐ Yes ☐ No

QPS Advisor Name [Block Capitals]: _____

Signature of QPS Advisor: _____ **Date:** D D M M Y Y Y Y