

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

Time of incident 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

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)

Date returned to work (if known)

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
<input type="checkbox"/> Near Miss e.g. Nearly given wrong drug	
<input type="checkbox"/> No Injury e.g. Wrong drug given but no harm occurred	
<input type="checkbox"/> Injury not requiring first aid	
<input type="checkbox"/> Injury or illness, requiring first aid	
<input type="checkbox"/> Injury requiring medical treatment	
<input type="checkbox"/> Long-term disability / Incapacity (incl. psychosocial)	<i>E.g. Arm, Spine, Lung, Other Physiological</i>
<input type="checkbox"/> Permanent Incapacity (incl. Psychosocial)	
<input type="checkbox"/> Death	

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

Birth Specific Injury (Baby)	<input type="checkbox"/> Apgar score <5@ 1 min &/or; 7@5mins &/or pH ≤ 7.0 <input type="checkbox"/> Aspiration <input type="checkbox"/> Cerebral irritability / neonatal seizure <input type="checkbox"/> HIE - Hypoxic Ischaemic Encephalopathy with Hypoglycaemia <input type="checkbox"/> HIE Grade 1 - Hypoxic Ischaemic Encephalopathy	<input type="checkbox"/> HIE Grade 2 - Hypoxic Ischaemic Encephalopathy <input type="checkbox"/> HIE Grade 3 - Hypoxic Ischaemic Encephalopathy <input type="checkbox"/> Hypoglycaemia - severe <input type="checkbox"/> Kernicterus <input type="checkbox"/> Neonatal death <input type="checkbox"/> Nerve Injury - brachial plexus (incl. Erbs Palsy)	<input type="checkbox"/> Nerve Injury - face <input type="checkbox"/> Other unexpected deterioration <input type="checkbox"/> Stillbirth <input type="checkbox"/> Sub-galeal / sub-aponeurotic haemorrhage <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
Birth Specific Injury (Mother)	<input type="checkbox"/> Death <input type="checkbox"/> Hysterectomy (Perinatal) <input type="checkbox"/> Incontinence (faecal) <input type="checkbox"/> Incontinence (urinary)	<input type="checkbox"/> Perineal tear <input type="checkbox"/> Post-Partum Haemorrhage <input type="checkbox"/> Rhesus iso-immunisation <input type="checkbox"/> Incontinence (faecal & urinary)	<input type="checkbox"/> Unknown <input type="checkbox"/> Uterine rupture <input type="checkbox"/> Other _____
Blood Specific Injury	<input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Fainting <input type="checkbox"/> Immunological haemolysis	<input type="checkbox"/> Febrile non-haemolytic transfusion reaction	<input type="checkbox"/> Non-immunological haemolysis <input type="checkbox"/> Other _____
Diagnosed Disease Disorder or Cond.	<input type="checkbox"/> Asbestosis <input type="checkbox"/> Cancer <input type="checkbox"/> Acute Radiation Syndrome <input type="checkbox"/> Narcolepsy/Cateplexy	<input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Brucellosis <input type="checkbox"/> Legionnaires	<input type="checkbox"/> Unknown <input type="checkbox"/> Dermatitis <input type="checkbox"/> TB <input type="checkbox"/> Pleural Plaques <input type="checkbox"/> Other _____
Diagnosed Infection	<input type="checkbox"/> Clostridium Difficile <input type="checkbox"/> COVID-19 <input type="checkbox"/> CPE <input type="checkbox"/> ESBL	<input type="checkbox"/> Hepatitis <input type="checkbox"/> MRSA <input type="checkbox"/> Norovirus <input type="checkbox"/> Unknown	<input type="checkbox"/> VRE <input type="checkbox"/> VRSA <input type="checkbox"/> Other _____
General Injuries	<input type="checkbox"/> Allergic Reaction (incl. anaphylaxis) <input type="checkbox"/> Brain Injury / Concussion <input type="checkbox"/> Burn / scald / corrosion <input type="checkbox"/> Choking / asphyxia <input type="checkbox"/> Circulatory / volume depletion <input type="checkbox"/> Circulatory / volume overload <input type="checkbox"/> Pain/Discomfort	<input type="checkbox"/> Cut / Laceration / Graze / scratch <input type="checkbox"/> Death <input type="checkbox"/> Dental injury &/or loss <input type="checkbox"/> Deterioration <input type="checkbox"/> Haemorrhage <input type="checkbox"/> Blister	<input type="checkbox"/> Malaise / Nausea <input type="checkbox"/> Nerve injury / Loss of Function <input type="checkbox"/> Puncture / bite <input type="checkbox"/> Rash / irritation <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
Hearing / Sight Injury	<input type="checkbox"/> Hearing Impairment / loss <input type="checkbox"/> Sight Impairment / loss	<input type="checkbox"/> Tinnitus <input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
Misdiagnosis	<input type="checkbox"/> Cancer <input type="checkbox"/> Fracture	<input type="checkbox"/> Infection <input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
Musculoskeletal / Soft Tissue	<input type="checkbox"/> Amputation <input type="checkbox"/> Bruising <input type="checkbox"/> Crushing <input type="checkbox"/> Dental Fracture / Tooth loss <input type="checkbox"/> Dislocation <input type="checkbox"/> P. Ulcer Stage 1: Intact skin with non-blanchable redness over bony prominence <input type="checkbox"/> P. Ulcer Stage 2: Part thickness dermis loss: blister/open ulcer/no slough <input type="checkbox"/> P. Ulcer Stage 3: Full thickness tissue loss: +/- visible subcutaneous fat <input type="checkbox"/> P. Ulcer Stage 4: Full thickness tissue loss/necrosis: exposed bone/tendon/muscle	<input type="checkbox"/> Fracture <input type="checkbox"/> Repetitive Strain Injury (RSI) <input type="checkbox"/> Slipped / Prolapsed Disc <input type="checkbox"/> Sprain / Strain <input type="checkbox"/> Soft tissue injury	<input type="checkbox"/> Swelling / Inflammation <input type="checkbox"/> Unknown <input type="checkbox"/> Whiplash <input type="checkbox"/> Other _____
Personal Loss	<input type="checkbox"/> Additional / Further Surgery <input type="checkbox"/> Limb Deformity <input type="checkbox"/> Defamation of Character	<input type="checkbox"/> Loss of Wages / Income / Business <input type="checkbox"/> Loss of Consortium	<input type="checkbox"/> Unknown <input type="checkbox"/> Organ Retention <input type="checkbox"/> Other _____
Surgery Specific Injury	<input type="checkbox"/> Damage to organ / body part <input type="checkbox"/> Dental Damage / Loss <input type="checkbox"/> Foreign body left in situ <input type="checkbox"/> Unknown	<input type="checkbox"/> Loss of organ / body part <input type="checkbox"/> Nerve injury / Loss of Function <input type="checkbox"/> Inadequate anaesthesia	<input type="checkbox"/> Unexpected complication / deterioration <input type="checkbox"/> Other _____
Traumatic/Emotional	<input type="checkbox"/> Anxiety / Trauma <input type="checkbox"/> PTSD	<input type="checkbox"/> Stress <input type="checkbox"/> Unknown	<input type="checkbox"/> Worried Well <input type="checkbox"/> 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	<input type="checkbox"/> Birth Specific Procedures	<input type="checkbox"/> Caesarean Section (Elective) <input type="checkbox"/> Caesarean Section (Emergency) <input type="checkbox"/> Instrumental Delivery (Forceps) <input type="checkbox"/> Instrumental Delivery (Vacuum) <input type="checkbox"/> Instrumental Delivery (Multiple Instruments) <input type="checkbox"/> Non Instrumental Delivery	<input type="checkbox"/> Communication / Consent <input type="checkbox"/> Diagnosis / Assessment <input type="checkbox"/> Documentation / Records <input type="checkbox"/> Equipment <input type="checkbox"/> General Care / Management <input type="checkbox"/> Procedure / Treatment / Intervention <input type="checkbox"/> Screening / Prevention <input type="checkbox"/> Specimens / Results <input type="checkbox"/> Tests / Investigations <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Adverse Effect <input type="checkbox"/> Failure / Malfunction <input type="checkbox"/> Foreign Body left in Situ <input type="checkbox"/> Inappropriate for Task / Wrong device <input type="checkbox"/> Incomplete / Inadequate <input type="checkbox"/> Lack of Availability <input type="checkbox"/> Not performed when indicated / Delay <input type="checkbox"/> Pre Existing Medical Condition <input type="checkbox"/> Shoulder Dystocia <input type="checkbox"/> Unavailable / Mislabeled / Lost <input type="checkbox"/> Wrong Body Part / Site / Side <input type="checkbox"/> Wrong Patient <input type="checkbox"/> Wrong Process / Treatment / Procedure <input type="checkbox"/> Other _____
	<input type="checkbox"/> Clinical Procedures	<input type="checkbox"/> Invasive <input type="checkbox"/> Non Invasive	_____	_____
	<input type="checkbox"/> Medication	<i>Route of administration</i> <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="checkbox"/> Sub Cutaneous <input type="checkbox"/> Intra Muscular <input type="checkbox"/> Topical <input type="checkbox"/> Rectal <input type="checkbox"/> Inhalation <input type="checkbox"/> Other / Unknown	<input type="checkbox"/> Administration <input type="checkbox"/> Monitoring <input type="checkbox"/> Ordering / Supply / Transport <input type="checkbox"/> Preparation / Dispensing (Pharmacy) <input type="checkbox"/> Prescribing <input type="checkbox"/> Reconciliation <input type="checkbox"/> Storage	<input type="checkbox"/> Adverse Drug Reaction <input type="checkbox"/> Contra-indicated <input type="checkbox"/> Drug Interaction <input type="checkbox"/> Failure / Malfunction of equipment <input type="checkbox"/> Incomplete / Inadequate <input type="checkbox"/> Not performed when indicated / delayed <input type="checkbox"/> Omitted/Delayed Dose <input type="checkbox"/> Wrong Dose / Strength <input type="checkbox"/> Wrong Drug <input type="checkbox"/> Wrong Formulation / Route <input type="checkbox"/> Wrong Frequency <input type="checkbox"/> Wrong Label / Instructions <input type="checkbox"/> Wrong Patient <input type="checkbox"/> Wrong Quantity / Duration
		<i>What medication was involved?</i> Medication One _____ Medication Two _____		
	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Parenteral <input type="checkbox"/> Enteral <input type="checkbox"/> Special Diet <input type="checkbox"/> General Diet <input type="checkbox"/> Other _____	<input type="checkbox"/> Communication / Consent <input type="checkbox"/> Prescribing / Requesting <input type="checkbox"/> Preparation / Dispensing <input type="checkbox"/> Administration <input type="checkbox"/> Storage <input type="checkbox"/> Documentation / Records <input type="checkbox"/> Equipment <input type="checkbox"/> Supply / Ordering / Transport <input type="checkbox"/> Presentation / Packaging <input type="checkbox"/> Transfusing blood <input type="checkbox"/> Other _____	<input type="checkbox"/> Adverse Effect <input type="checkbox"/> Incomplete / Inadequate <input type="checkbox"/> Not performed when indicated / Delay <input type="checkbox"/> Wrong Consistency <input type="checkbox"/> Wrong Diet / Wrong Blood Product <input type="checkbox"/> Wrong Process / Treatment / Procedure <input type="checkbox"/> Wrong Patient <input type="checkbox"/> Lack of Availability <input type="checkbox"/> Wrong dispensing label / instructions <input type="checkbox"/> Inappropriate for task / Wrong device <input type="checkbox"/> Other _____
	<input type="checkbox"/> Blood / Blood Product	<input type="checkbox"/> Whole Blood <input type="checkbox"/> Red Cells <input type="checkbox"/> Platelet (Apheresis) <input type="checkbox"/> Platelets (Pooled) <input type="checkbox"/> Other _____	<input type="checkbox"/> Diagnostic Exposure > intended <input type="checkbox"/> X-ray Over Exposure <input type="checkbox"/> Wrong body part / side <input type="checkbox"/> Dose to comforters / carers <input type="checkbox"/> Wrong Patient <input type="checkbox"/> Inadvertent dose to foetus <input type="checkbox"/> Total dose or Volume Variation <input type="checkbox"/> Dose (NM) or Volume Variation (1 fraction)	<input type="checkbox"/> Above Notifiable levels <input type="checkbox"/> Below Notifiable levels <input type="checkbox"/> <1mSv <input type="checkbox"/> >1mSv <input type="checkbox"/> <10% <input type="checkbox"/> 10-20% <input type="checkbox"/> >20%
<input type="checkbox"/> Diagnostic Radiology (DR) & Nuclear Medicine (NM)	<input type="checkbox"/> Checking Patient ID procedure <input type="checkbox"/> Clinical Details on Referral <input type="checkbox"/> Communication / Consent <input type="checkbox"/> Documentation / Records <input type="checkbox"/> Equipment <input type="checkbox"/> Performing procedure <input type="checkbox"/> Pregnancy Status <input type="checkbox"/> Unknown	<input type="checkbox"/> Wrong Drug <input type="checkbox"/> Wrong Dose <input type="checkbox"/> Wrong Process / Treatment / Intervention <input type="checkbox"/> Failure / Malfunction <input type="checkbox"/> Inadvertent deterministic effects		
<input type="checkbox"/> Radiotherapy				
Bio Hazards	<input type="checkbox"/> Biological Hazards / Acquired Infections	<input type="checkbox"/> Bacteria <input type="checkbox"/> Fungus / Mould <input type="checkbox"/> Prion <input type="checkbox"/> Virus <input type="checkbox"/> Organism Unknown	<input type="checkbox"/> Please specify, if known: _____ <i>E.g. COVID-19; MRSA etc.</i>	<input type="checkbox"/> Exposure to Bite (Human) <input type="checkbox"/> Exposure to Bite (Insect / Animal) <input type="checkbox"/> Exposure to Bodily Fluids <input type="checkbox"/> Exposure to Ingestion/Food/Water <input type="checkbox"/> Exposure to Needle Stick <input type="checkbox"/> Exposure to Skin Contact <input type="checkbox"/> Inhalation/Airborne <input type="checkbox"/> Equipment, Implements, Facilities, <input type="checkbox"/> Sharps (Non Needle) <input type="checkbox"/> Unknown <input type="checkbox"/> 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	<input type="checkbox"/> Self-Injurious Behaviour	<input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional	<input type="checkbox"/> Absconsion / Missing <input type="checkbox"/> Attempted Suicide <input type="checkbox"/> Banging Self Against Walls/Furniture/Surfaces <input type="checkbox"/> Hitting Body/Slap/Punch Self incl. Scratching & Picking <input type="checkbox"/> Inappropriate Eating <input type="checkbox"/> Inappropriate Touching <input type="checkbox"/> Self-Harm <input type="checkbox"/> Stripping Clothes in Public Area <input type="checkbox"/> Suicide <input type="checkbox"/> Throwing objects <input type="checkbox"/> Other _____
	<input type="checkbox"/> Violence, Harassment and Aggression	<input type="checkbox"/> By a Family Member / Relative <input type="checkbox"/> By a Member of the Public <input type="checkbox"/> By a Peer / Student <input type="checkbox"/> By a Prisoner <input type="checkbox"/> By a Service User <input type="checkbox"/> By a Staff Member	<input type="checkbox"/> Aggressive towards inanimate object <input type="checkbox"/> Discrimination/Prejudice/Racial <input type="checkbox"/> Intimidation / Threat <input type="checkbox"/> Neglect <input type="checkbox"/> Non-Compliant / Obstructive / Rude <input type="checkbox"/> Physical Assault / Abuse <input type="checkbox"/> Physical Harassment <input type="checkbox"/> Sexual Assault / Abuse <input type="checkbox"/> Sexual Harassment <input type="checkbox"/> Unintentional Aggressive Behaviour <input type="checkbox"/> Bullying <input type="checkbox"/> Verbal Assault / Abuse <input type="checkbox"/> Verbal Harassment <input type="checkbox"/> Other _____
	<input type="checkbox"/> Child Abuse		
	<input type="checkbox"/> Adult Abuse		
Physical Hazards	<input type="checkbox"/> Slip / Trip / Fall	<input type="checkbox"/> From Height <input type="checkbox"/> From Equipment / Furniture <input type="checkbox"/> Same Level / Ground <input type="checkbox"/> On Stairs <input type="checkbox"/> On Steps <input type="checkbox"/> Other _____	<input type="checkbox"/> Unknown <input type="checkbox"/> Pre Existing Medical Condition <input type="checkbox"/> Inadequate supervision gen health / post op <input type="checkbox"/> Obstruction / protruding object <input type="checkbox"/> Surface contaminants <input type="checkbox"/> Rough terrain / irregular surface <input type="checkbox"/> Inappropriate equipment use <input type="checkbox"/> Failure / malfunction of equipment <input type="checkbox"/> Horseplay <input type="checkbox"/> Physical training / sport <input type="checkbox"/> Weather Condition <input type="checkbox"/> Inadequate Lighting / design <input type="checkbox"/> Other _____
	<input type="checkbox"/> Non Mechanical (Incl. Person / Animal)	<input type="checkbox"/> Object / Tools (Non Sharps) <input type="checkbox"/> Sharps (Non Needle) <input type="checkbox"/> Other <input type="checkbox"/> Person	<input type="checkbox"/> Human Use / Error <input type="checkbox"/> Obstruction / Protruding Object <input type="checkbox"/> Physical Training / Sport <input type="checkbox"/> Defective Equipment <input type="checkbox"/> Unsafe / Inappropriate system <input type="checkbox"/> Unknown <input type="checkbox"/> Task <input type="checkbox"/> Load <input type="checkbox"/> Working Environment <input type="checkbox"/> Individual Capability <input type="checkbox"/> Other _____
	<input type="checkbox"/> Ergonomics (Incl. manual / people handling)	<input type="checkbox"/> Manual Handling <input type="checkbox"/> Other <input type="checkbox"/> Patient Handling <input type="checkbox"/> Restraint / Intervention	
	<input type="checkbox"/> Mechanical Components	<input type="checkbox"/> Catering equipment <input type="checkbox"/> Door / Gate / Barrier <input type="checkbox"/> Healthcare Equipment <input type="checkbox"/> Lifting Equipment / Accessories <input type="checkbox"/> Office / Business equipment	
	<input type="checkbox"/> Temperature (Excluding Fire)	<input type="checkbox"/> Hot <input type="checkbox"/> Cold	<input type="checkbox"/> Liquid / Food / Steam <input type="checkbox"/> Equipment / Utensils <input type="checkbox"/> Atmosphere / Environment
	<input type="checkbox"/> Fire <input type="checkbox"/> Vibration <input type="checkbox"/> Electrical <input type="checkbox"/> Noise <input type="checkbox"/> Radiation	<input type="checkbox"/> Please Specify _____	<input type="checkbox"/> Defective Equipment <input type="checkbox"/> Human Use / Error <input type="checkbox"/> Unknown <input type="checkbox"/> Unsafe System <input type="checkbox"/> Explosion <input type="checkbox"/> Exposure <input type="checkbox"/> Electrical Wiring / installation

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
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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
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2 _____

D	D	M	M	Y	Y	Y	Y
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3 _____

D	D	M	M	Y	Y	Y	Y
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Line/Department Manager name [Block Capitals]: _____

Title: _____

Signature of Line/Department Manager: _____

Date:

D	D	M	M	Y	Y	Y	Y
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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
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