NIMS
National Incident Management System

HC NIRF 01 – V11
Date issued: 20/03/2020

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

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

SECTION E: EXTERNAL CONTRACTOR DETAILS ONLY

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

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 ☐ COVID-19 ☐ CPE ☐ 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	Please Specify, if known _____ e.g COVID-19, MRSA, etc	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 K: 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. _____

Date D D M M Y Y Y Y

Contact Details _____

SECTION L: 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: _____ **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: _____ **Title:** _____

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: _____ **Date:** D D M M Y Y Y Y

*Mandatory Fields