

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
- Panel staff / Agency / Locum – Go to section D
- Member of the public-Proceed to section F
- Volunteer – Go to section D
- External Contractor – Go to section E
- Work Placement / Trainee – 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 *E.g. Antenatal, Audiology, Radiotherapy, Intellectual Disability, Psychology*  
(Service / Specialty) \_\_\_\_\_

**SECTION D: STAFF MEMBER / AGENCY / PANEL STAFF / WORK PLACEMENT / VOLUNTEER DETAILS ONLY**

Category of person \_\_\_\_\_

Employee no. \_\_\_\_\_

Date absence commenced (if known)

Date returned to work (if known)

Lost days

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	  <i>E.g. Arm, Spine, Lung, Other Physiological</i>
<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)	
<input type="checkbox"/> Permanent Incapacity (incl. Psychosocial)	<b>Category 3</b>
<input type="checkbox"/> Death	<b>Category 2</b>
	<b>Category 1</b>

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

<b>Birth Specific Injury (Baby)</b>	<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 _____
<b>Birth Specific Injury (Mother)</b>	<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 _____
<b>Blood Specific Injury</b>	<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 _____
<b>Diagnosed Disease Disorder or Cond.</b>	<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 _____
<b>Diagnosed Infection</b>	<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 _____
<b>General Injuries</b>	<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 _____
<b>Hearing / Sight Injury</b>	<input type="checkbox"/> Hearing Impairment / loss <input type="checkbox"/> Sight Impairment / loss	<input type="checkbox"/> Tinnitus <input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
<b>Misdiagnosis</b>	<input type="checkbox"/> Cancer <input type="checkbox"/> Fracture	<input type="checkbox"/> Infection <input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
<b>Musculoskeletal / Soft Tissue</b>	<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 _____
<b>Personal Loss</b>	<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 _____
<b>Surgery Specific Injury</b>	<input type="checkbox"/> Damage to organ / body part <input type="checkbox"/> Dental Damage / Loss <input type="checkbox"/> Retained foreign object <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 _____
<b>Traumatic/Emotional</b>	<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"/> <b>Diagnosis</b>	<b>Diagnosis Type</b> <input type="checkbox"/> Delayed Diagnosis <input type="checkbox"/> Misdiagnosis/Incorrect Diagnosis <input type="checkbox"/> Missed Diagnosis	<b>Care process</b> <input type="checkbox"/> Assessment/Monitoring <input type="checkbox"/> Tests/Investigations <input type="checkbox"/> Test Interpretation	<input type="checkbox"/> Incomplete/inadequate: <input type="checkbox"/> <i>Communication</i> <input type="checkbox"/> <i>Consent</i> <input type="checkbox"/> <i>Documentation</i> <input type="checkbox"/> <i>Equipment</i> <input type="checkbox"/> <i>Unknown/other</i> <input type="checkbox"/> Lack of availability <input type="checkbox"/> Not performed when indicated/Delayed <input type="checkbox"/> Other adverse event/Patient safety incident
	<input type="checkbox"/> <b>Care Management</b>	<b>Stage of Care</b> <input type="checkbox"/> Community <input type="checkbox"/> Outpatient/ED <input type="checkbox"/> Inpatient	<b>Care process</b> <input type="checkbox"/> Assessment/Monitoring <input type="checkbox"/> Tests/Investigations <input type="checkbox"/> Treatment/Intervention	<input type="checkbox"/> Incomplete/inadequate: <input type="checkbox"/> <i>Communication</i> <input type="checkbox"/> <i>Consent</i> <input type="checkbox"/> <i>Documentation</i> <input type="checkbox"/> <i>Equipment</i> <input type="checkbox"/> <i>Unknown/other</i> <input type="checkbox"/> Lack of availability <input type="checkbox"/> Not performed when indicated/Delayed <input type="checkbox"/> Pre-existing medical condition <input type="checkbox"/> Retained foreign object <input type="checkbox"/> Wrong body part/site/side <input type="checkbox"/> Wrong patient <input type="checkbox"/> Wrong process/treatment/procedure <input type="checkbox"/> Other adverse event/Patient safety incident
	<input type="checkbox"/> <b>Surgical/Medical Procedures</b>	<b>Stage of Care</b> <input type="checkbox"/> Pre Procedure <input type="checkbox"/> Intra Procedure <input type="checkbox"/> Post Procedure	<b>Care process</b> <input type="checkbox"/> Assessment/Monitoring <input type="checkbox"/> Tests/Investigations <input type="checkbox"/> Treatment/Intervention	<input type="checkbox"/> Incomplete/inadequate: <input type="checkbox"/> <i>Communication</i> <input type="checkbox"/> <i>Consent</i> <input type="checkbox"/> <i>Documentation</i> <input type="checkbox"/> <i>Equipment</i> <input type="checkbox"/> <i>Unknown/other</i> <input type="checkbox"/> Lack of availability <input type="checkbox"/> Not performed when indicated/Delayed <input type="checkbox"/> Retained foreign object <input type="checkbox"/> Wrong body part/site/side <input type="checkbox"/> Wrong patient <input type="checkbox"/> Wrong process/treatment/procedure <input type="checkbox"/> Other adverse event/Patient safety incident
	<b>Name of Initial Procedure</b> <i>e.g. cannulation, colonoscopy</i> <hr/> <b>Name of Subsequent Procedure (e.g if required return to theatre)</b> <i>e.g. EUA, hysterectomy</i> <hr/>			
<input type="checkbox"/> <b>Labour/Delivery</b>	<b>Delivery type</b> <input type="checkbox"/> Caesarean Section (Elective) <input type="checkbox"/> Caesarean Section (Emergency) <input type="checkbox"/> Instrumental Delivery (Forceps) <input type="checkbox"/> Instrumental Delivery (Vacuum/Ventuse/Kiwi) <input type="checkbox"/> Instrumental Delivery (Multiple Instruments) <input type="checkbox"/> Non Instrumental Delivery	<b>Care process</b> <input type="checkbox"/> Assessment/Monitoring <input type="checkbox"/> Tests/Investigations <input type="checkbox"/> Treatment/Intervention	<input type="checkbox"/> Adverse event: <input type="checkbox"/> <i>Cord Prolapse</i> <input type="checkbox"/> <i>Eclampsia</i> <input type="checkbox"/> <i>Low Apgars/Cord PH</i> <input type="checkbox"/> <i>Placental Abruption</i> <input type="checkbox"/> <i>PPH</i> <input type="checkbox"/> <i>Shoulder Dystocia</i> <input type="checkbox"/> <i>Uterine Rupture</i> <input type="checkbox"/> <i>Other</i> <input type="checkbox"/> Adverse event requiring transfer/return to theatre: <input type="checkbox"/> <i>Cord Prolapse</i> <input type="checkbox"/> <i>Eclampsia</i> <input type="checkbox"/> <i>Low Apgars/Cord PH</i> <input type="checkbox"/> <i>Placental Abruption</i> <input type="checkbox"/> <i>PPH</i> <input type="checkbox"/> <i>Shoulder Dystocia</i> <input type="checkbox"/> <i>Uterine Rupture</i> <input type="checkbox"/> <i>Other</i> <input type="checkbox"/> Incomplete/inadequate: <input type="checkbox"/> <i>Communication</i> <input type="checkbox"/> <i>Consent</i> <input type="checkbox"/> <i>Documentation</i> <input type="checkbox"/> <i>Equipment</i> <input type="checkbox"/> <i>Unknown/other</i> <input type="checkbox"/> Lack of availability <input type="checkbox"/> Not performed when indicated/Delayed <input type="checkbox"/> Retained foreign object <input type="checkbox"/> Wrong process/treatment/procedure	

**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.	
<b>Clinical Care</b>	<input type="checkbox"/> <b>Medication</b>	<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	
	<input type="checkbox"/> <b>Nutrition</b>	<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"/> <b>Blood / Blood Product</b>	<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"/> <b>Diagnostic Radiology (DR) &amp; Nuclear Medicine (NM)</b>	<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"/> <b>Radiotherapy</b>				
<b>Bio Hazards</b>	<input type="checkbox"/> <b>Biological Hazards / Acquired Infections</b>	<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, 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.
<b>Behavioural Hazards</b>	<input type="checkbox"/> <b>Self-Injurious Behaviour</b>	<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"/> <b>Violence, Harassment and Aggression</b>	<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  Please specify name of instigator _____	<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"/> Direct Physical Assault <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"/> <b>Child Abuse</b>		
	<input type="checkbox"/> <b>Adult Abuse</b>		
<b>Physical Hazards</b>	<input type="checkbox"/> <b>Slip / Trip / Fall</b>	<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"/> <b>Non Mechanical (Incl. Person / Animal)</b>	<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"/> <b>Ergonomics (Incl. manual / people handling)</b>	<input type="checkbox"/> Manual Handling <input type="checkbox"/> Other <input type="checkbox"/> Patient Handling <input type="checkbox"/> Physical Intervention	
	<input type="checkbox"/> <b>Mechanical Components</b>	<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"/> <b>Temperature (Excluding Fire)</b>	<input type="checkbox"/> Hot <input type="checkbox"/> Cold	
	<input type="checkbox"/> <b>Fire</b> <input type="checkbox"/> <b>Vibration</b> <input type="checkbox"/> <b>Electrical</b> <input type="checkbox"/> <b>Noise</b> <input type="checkbox"/> <b>Radiation</b>	<input type="checkbox"/> Please Specify  _____	
		<input type="checkbox"/> Liquid / Food / Steam <input type="checkbox"/> Equipment / Utensils <input type="checkbox"/> Atmosphere / Environment  <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** (For entry on Incident Review screen on NIMS)

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: DDMMYYYY

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 \_\_\_\_\_ DDMMYYYY

2 \_\_\_\_\_ DDMMYYYY

3 \_\_\_\_\_ DDMMYYYY

Line/Department Manager name [Block Capitals]: \_\_\_\_\_ Title: \_\_\_\_\_

Signature of Line/Department Manager: \_\_\_\_\_ Date: DDMMYYYY

**SECTION M: TO BE COMPLETED BY QUALITY AND PATIENT SAFETY OFFICE** (For entry on Incident Review screen on NIMS)

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

QPS Advisor Name [Block Capitals]: \_\_\_\_\_

Signature of QPS Advisor: \_\_\_\_\_ Date: DDMMYYYY