# INCIDENT FORM

ROYAL FREE HAMPSTEAD NHS TRUST & THE ROYAL FREE & UNIVERSITY COLLEGE LONDON MEDICAL SCHOOL (RF CAMPUS)

***Please complete this form to record all incidents/accidents (including NEAR MISSES) to PATIENTS, STAFF and other persons.***
***Please complete a SEPARATE form for each person directly affected.***
***Please use BLACK INK and complete in BLOCK CAPITALS***

RECORD FACT ONLY, NOT OPINION,

PLEASE REPORT WITHIN 48 HOURS & WHERE DEATH OR SERIOUS INJURY HAS OCCURRED REPORT IMMEDIATELY

***Completing this form does not constitute an admission of liability of any kind by any person***
***Any Equipment involved in the incident should be quarantined where possible for examination.***

## 1 Please indicate type of incident being reported **(Tick as many as apply)**

☐ **Clinical Incident** ☐ **Drug** ☐ **Violence** ☐ **Security**
☐ **Work Related Ill Health** ☐ **Accident** ☐ **Equipment** ☐ **Fire** ☐ **Other** (_____)

## 2 Individual Affected ***(Complete a separate form per person affected)***

☐ **None** ☐ **Staff (Trust)** ☐ **Agency** ☐ **Med Stud.** ☐ **Visitor** ☐ **Other (_____)**
☐ **Patient** ☐ **Staff (Med. School)** ☐ **Bank** ☐ **Volunteer** ☐ **Contractor**

**Surname** _____ **Firstname**_____

**Address** ***(non staff)***

**Sex** ☐ **Female** ☐ **Male**

**Date of Birth** **/ /**

**Contact Number** ***(or bleep/extension)*** _____ **Division & Dept.** _____/_____

*If Patient* **Hospital Number**

**Type** **IP** | **Day** **Out** | **A&E**

**Consultant**

*If Staff* ***(specify if trainee)*** **Job Title** **Department**

## 3 Details of the incident

**Incident Type** ☐ **'Near Miss'** ☐ **Actual Harm**

**Date of Incident** **/ /** **Time** ☐☐:☐☐ **(24 hr)** ☐ **Weekend or Bank hol.**

**Area/Ward/Site**_____ **Exact Location** *(i.e. cubicle 1, room 3, etc)*_____

**Overview of Incident/Risk** ***(record FACT ONLY,NOT OPINION. Please describe the incident and context in which it occurred)***

**Continue overleaf if necessary**

## 4 Drug/Blood/Blood Product Incident – **please complete details below**

**Drug/Blood Product involved**_____

**Route** ☐ **IV** ☐ **IM** ☐ **Oral** ☐ **PR** ☐ **SC** ☐ **Topical** ☐ **Other (**_____**)** **Self medication** ☐ **Yes** ☐ **No**

**Single/Dual Checking required** ☐ **Single** ☐ **Dual** **Single/Dual Checking performed** ☐ **Single** ☐ **Dual**

**Who if anyone, has been notified of the drug/blood incident?** *(please tick as many as apply)*

☐ **None** ☐ **Patient/Carer** ☐ **Manager** ☐ **Consultant** ☐ **Pharmacist** ☐ **Other** (_____)

## 5 Incidents Involving Equipment **(Quarantine equipment where possible, or make a record of state of equipment)**

**Does Incident involve equipment** ☐ **Yes** ☐ **No** **If** yes**, Type/Dept** ☐ **IT** ☐ **Estates** ☐ **Medical Device**

**Make of equipment** _____

**Identification No** ***(Batch/Serial/RFH)*** _____

**Problem** _____

**Have you notified anyone of the equipment failure/shortfall** ☐ **Yes** ☐ **No**

**If *yes*, specify** ☐ **Manager** ☐ **Cons.** ☐ **Equip Tech.** ☐ **Health & Safety** ☐ **Med. Physics** ☐ **Works/Shift Engineer**

## 6 Details of Any Injury Sustained

**Was the individual affected injured in the incident** ☐ **Yes** ☐ **No**

**If yes, Part of the body injured**_____ **Extent of injury**_____

*If staff member:* **Sent off sick** ☐ **Yes** ☐ **No** ☐ **Not known** **If** yes**, no of days**_____ **or** ☐ **N/K**

## 7 Treatment Received

**Treatment** ☐ **NONE** ☐ **First Aid** ☐ **GP** ☐ **OH** ☐ **A&E** ☐ **Other (**_____**)**

**Attention received**

**X-ray performed** θ **Yes** θ **No**
**Attended by:** **Job Title** **Date: / / Time :**

## 8 Person Involved/Witness to the Incident

| | | | |
|---|---|---|---|
| **1. Name** | _____ | **1. Name** | _____ |
| **2. Home Address** (Non Staff) | _____ | **2. Home Address** (Non Staff) | _____ |
| | _____ | | _____ |
| **3. Ward/Dept** | _____ | **3. Ward/Dept** | _____ |
| **4 . Designation** | _____ | **4. Designation** | _____ |

## 9 Person Reporting Incident

**Name (please print)**_____ **Job Title**_____

**Date Reported / /** **Dept/Specialty**_____

**Incident Notified to** ☐ **Patient/Next of Kin** ☐ **Consultant** ☐ **Manager** ☐ **Other (**_____**)**

## 10 CONTINUATION SHEET (Continued from first page where necessary)

Please forward completed form to the local area co-ordinator

TO BE COMPLETED BY LOCAL AREA CO-ORDINATOR

**Severity of Incident** ____ ***(see severity scoring table)***

**Incident Report Review** **No action taken/Incident Unavoidable**

____ **Action Required**

**Action Taken**

**Specify (proposed)action/recommendations/Implementations**

**Name** **Bleep/Ext.** **Date / /** **RIDDOR form Completed** θ**Yes** θ**No**

**Documents appended** θ**Yes** θ **No**

FOR CGSC USE ONLY

**Date received** / /

**Notify/Copy to**

- θ **Health and Safety**
- θ **Occupational Health**
- θ **Manual Handling**
- θ **Claims**
- θ **Medical Physics**
- θ **Pharmacy**
- θ **Nursing Directorate**
- θ **Fire Officer**
- θ **Security**
- θ **Works Department**
- θ **Supplies**
- θ **North Camden Locality Mental Health**
- θ **Other**

**Action Taken** θ **Yes** θ **No**

**Further Investigation** θ **Yes** θ **No**