

INCIDENT REPORT FORM

Reference No

Use this form for all incidents, accidents, and hazards (including near misses) that occur on Trust property or involve Trust staff, visitors, patients or independent contractors working within Liverpool PCT.

Please use black ink and BLOCK CAPS. Sections highlighted in **Red MUST be completed**.

This form should be filled in within 24 hours of the incident then sent to the line manager for completion.

The completed form should be sent to the Corporate Governance and Compliance Department, No 1 Arthouse Square, 61-69 Seel Street, Liverpool, L1 4AZ, Telephone: 0151 285 4858 within three days or an electronic version of the form emailed to **risk@liverpoolpct.nhs.uk** or faxed to 0151 285 4602. A copy of the incident form should be retained locally for future reference.

Incidents with a severity of Major or Death should be reported immediately to: Risk Manager/PCT Director/Head of Governance & Compliance. Out of Hours incidents contact 0151 706 2000 and ask for the Director on Call.

Completing and signing this form does not constitute an admission of liability of any kind, either by the person making the report or any other person. In addition, it is acknowledged that the details on this form may change following further investigation.

1 Where did the incident take place?

| | |
|--|--|
| Service: | |
| Site of occurrence: (i.e. Art House, Bevan) | |
| Location: (i.e. Department) | |
| Location Type: (Kitchen, reception) | |

2 When did the incident take place?

| | | | |
|-------|--|-----------------|--|
| Date: | | Time (24hr): | |
|-------|--|-----------------|--|

3 Person affected

| | | | | |
|--------------------------|---|-------------------------------------|---------------------------------------|--------------------------|
| Surname: | | | | |
| First name: | | | | |
| Gender: | Male | <input type="checkbox"/> | Female | <input type="checkbox"/> |
| Address: | | | | |
| Postcode: | | Phone No: | | |
| <input type="checkbox"/> | Staff | | | |
| | Occupation: | | | |
| | Department: | | | |
| <input type="checkbox"/> | Other | | | |
| | <input type="checkbox"/> Visitor | <input type="checkbox"/> Contractor | <input type="checkbox"/> Agency/Locum | |
| | <input type="checkbox"/> Other (specify): | | | |
| | Job title (if applicable): | | | |
| <input type="checkbox"/> | Patient | | | |
| | NHS #: | Date of birth: | | |
| | Ethnic origin (code, see guidance) | | | |

4 Details of the person reporting the incident

| |
|-------------------|
| Name: |
| Job Title: |
| Contact No: |
| Place of work: |
| Date reported: |
| Role in incident: |
| Email: |

5 Details of staff involved / witnesses

| | | |
|-------------------|---|---------------------------------------|
| Name: | | |
| Job Title: | | |
| Status: | <input type="checkbox"/> LPCT employee | <input type="checkbox"/> Contractor |
| | <input type="checkbox"/> Visitor | <input type="checkbox"/> Agency/Locum |
| | <input type="checkbox"/> Other (specify): | |
| Role in incident: | | |
| Contact No: | | |
| Name: | | |
| Job Title: | | |
| Status: | <input type="checkbox"/> LPCT employee | <input type="checkbox"/> Contractor |
| | <input type="checkbox"/> Visitor | <input type="checkbox"/> Agency/Locum |
| | <input type="checkbox"/> Other (specify): | |
| Role in incident: | | |
| Contact No: | | |

6 Description of Incident **[Required]**

Please state facts only, not opinions or speculation. Continue on a separate sheet if necessary

| 7 Type of Incident | |
|--------------------------|---|
| <input type="checkbox"/> | Health and Safety Incident Please indicate which type of incident you are reporting; |
| <input type="checkbox"/> | Slips, Trips and Falls |
| <input type="checkbox"/> | Records, Identification |
| <input type="checkbox"/> | Communication, consent, confidentiality |
| <input type="checkbox"/> | Infrastructure |
| <input type="checkbox"/> | Abuse, aggressive behaviour by visitor or other |
| <input type="checkbox"/> | Abuse, aggressive behaviour by staff |
| <input type="checkbox"/> | Other, Please specify: |
| <input type="checkbox"/> | Patient Safety Incident (Please contact Risk Management Department) |

| 8 Degree of Harm / Severity [Required] | |
|--|---|
| <input type="checkbox"/> | No Harm (Impact prevented) Had potential to cause harm, but the impact was prevented. |
| <input type="checkbox"/> | No Harm (Impact not prevented) Incident occurred but with no harm to person. |
| <input type="checkbox"/> | Minor Person/Patient required extra observation or minor treatment. Staff did not need debriefing or <=3 days absence. |
| <input type="checkbox"/> | Moderate Person/Patient required moderate increase in treatment; did not lead to permanent harm. Staff needed debriefing or >3 days absence. |
| <input type="checkbox"/> | Major Person/Patient: Permanent harm. Staff: Major injury (HSE). |
| <input type="checkbox"/> | Death Person/Patient died as a direct result of the incident. |

| 9 Immediate actions taken | |
|---------------------------|--|
| | |

| 10 Is the Incident RIDDOR reportable? | |
|---|--|
| Is hospitalisation for more than 24 hrs likely? (extended stay for inpatient) | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A |
| Has there been a dangerous occurrence? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A |
| Has death or major injury occurred? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A |
| Staff only: | |
| Incapacity to work for more than 3 days? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A |
| Work related illness/condition? | <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A |

| 11 Medication Incident Details | | |
|---|--|--|
| Drug Details | Correct/Intended | Incorrect |
| Drug name: | _____ | _____ |
| Form: | _____ | _____ |
| Dose/strength: | _____ | _____ |
| Route: | _____ | _____ |
| Is this a controlled drug error? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the drug part of a clinical trial? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| At what stage of the medication process did the incident occur? | | |
| <input type="checkbox"/> Prescribing | <input type="checkbox"/> Preparation | <input type="checkbox"/> Administration |
| <input type="checkbox"/> Monitoring | <input type="checkbox"/> Advice | <input type="checkbox"/> Other |
| Incident type: | | |
| <input type="checkbox"/> Adverse drug reaction when used as intended. | <input type="checkbox"/> Contra-indication to the use of the medicine. | |
| <input type="checkbox"/> Mismatching between patient and medicine. | <input type="checkbox"/> Omitted medicine/ingredient. | |
| <input type="checkbox"/> Wrong method of preparation/supply. | <input type="checkbox"/> Wrong/omitted/passed expiry date. | |
| <input type="checkbox"/> Patient allergic to medicine. | <input type="checkbox"/> Inappropriate use of drug. | |
| <input type="checkbox"/> Wrong/omitted patient information leaflet. | <input type="checkbox"/> Wrong/omitted verbal patient directions. | |
| <input type="checkbox"/> Wrong/transposed/omitted medicine label. | <input type="checkbox"/> Wrong/unclear dose or strength. | |
| <input type="checkbox"/> Wrong drug/medicine. | <input type="checkbox"/> Wrong formulation. | |
| <input type="checkbox"/> Wrong frequency. | <input type="checkbox"/> Wrong storage. | |
| <input type="checkbox"/> Wrong quantity. | <input type="checkbox"/> Wrong route. | |
| <input type="checkbox"/> Other (specify): | | |

| 12 Risk Grading | | (Refer to guidance for details) | | | | |
|--|-----------------------------------|-----------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|--|
| Check the appropriate box for risk rating below. | | | | | | |
| | Likelihood | | | | | |
| Severity | 1 Rare | 2 Unlikely | 3 Possible | 4 Likely | 5 Almost Certain | |
| Negligible | Low <input type="checkbox"/> | Low <input type="checkbox"/> | Low <input type="checkbox"/> | Moderate <input type="checkbox"/> | Moderate <input type="checkbox"/> | |
| Minor | Low <input type="checkbox"/> | Moderate <input type="checkbox"/> | Moderate <input type="checkbox"/> | High <input type="checkbox"/> | High <input type="checkbox"/> | |
| Moderate | Low <input type="checkbox"/> | Moderate <input type="checkbox"/> | High <input type="checkbox"/> | High <input type="checkbox"/> | Catastrophic <input type="checkbox"/> | |
| Major | Moderate <input type="checkbox"/> | High <input type="checkbox"/> | High <input type="checkbox"/> | Catastrophic <input type="checkbox"/> | Catastrophic <input type="checkbox"/> | |
| Catastrophic | Moderate <input type="checkbox"/> | High <input type="checkbox"/> | Catastrophic <input type="checkbox"/> | Catastrophic <input type="checkbox"/> | Catastrophic <input type="checkbox"/> | |

| 13 Manager's/Team Actions [Required] | |
|---|--|
| Summarise immediate actions taken, including actions taken to prevent recurrence. Ensure that the incident is reported to your line manager. | |
| | |

| | | |
|------------------------------|--|------------|
| Manager: | Job Title: | Signature: |
| People Informed: | <input type="checkbox"/> Director <input type="checkbox"/> Risk Manager Department <input type="checkbox"/> Other: | |
| Who else should be notified? | Number of pages attached: | Date: |

| | | | |
|-----------------|---|---------------|--------------------|
| Office use only | Date received: | Date entered: | Datix Incident No: |
| | Copy to: <input type="checkbox"/> Occ Health <input type="checkbox"/> Complaints <input type="checkbox"/> Estates <input type="checkbox"/> Medicines Mgt <input type="checkbox"/> Infection Control <input type="checkbox"/> Clinical Governance <input type="checkbox"/> LSMS <input type="checkbox"/> Lead Commissioner <input type="checkbox"/> Other | | |
| V2 | Reported to HSE by: <input type="checkbox"/> Phone <input type="checkbox"/> Post <input type="checkbox"/> Online | Ref #: | |

Reference No _____

Incident Investigation Report

| | |
|---------------|-------------------|
| Investigator: | Contact Number: |
| Designation: | Date of Incident: |
| Base: | Date of Report: |

Background to the incident, including chronology

| |
|--|
| |
|--|

Main issues identified by investigation

| |
|--|
| |
|--|

Contributory factors

| Factor | Details |
|---|---------|
| <input type="checkbox"/> Patient Factors (e.g. clinical condition, social/ physical/ psychological factors, relationships) | |
| <input type="checkbox"/> Individual factors (e.g. physical/ psychological/ social/ domestic/ personality) | |
| <input type="checkbox"/> Task factors (includes work guidelines/ procedures/ policies, availability of decision making aids) | |
| <input type="checkbox"/> Communication factors (includes verbal, written and non-verbal between individuals, teams, and/or organisations) | |
| <input type="checkbox"/> Team and social factors (includes role definitions, leadership, support, and cultural factors) | |
| <input type="checkbox"/> Education and training factors (e.g. availability of training) | |
| <input type="checkbox"/> Equipment and resource factors (e.g. clear machine displays, poor working order, size, placement, ease of use) | |
| <input type="checkbox"/> Work and environment factors (e.g. poor/excess administration, physical environment, work load and hours of work, time pressures) | |
| <input type="checkbox"/> Organisation and strategic factors (e.g. organisational structure, contractor/ agency use, culture) | |
| <input type="checkbox"/> Other (specify) | |

Action taken and planned

Please detail any immediate action taken as a result of this incident, and actions planned to reduce the risk of a similar incident occurring.

| |
|--|
| |
|--|

Key messages/lessons learnt from this incident

| |
|--|
| |
|--|

Hints and Tips for completing an Incident Report Form

General

Remember that items in **Red** are mandatory.

If you are unsure about how to complete a section please discuss the options with someone else – a colleague, a manager, or Risk Department on 0151 285 4858.

1 Where did the incident take place?

Service – the service managerially responsible for the area/activity where the incident happened i.e. the service who will review and investigate the incident. If you're not sure use the service you work for.

Site and Location work together to identify the physical location.

Site – the physical site address e.g. Art House Square, Royal Liverpool Hospital, GP premises. For a non-NHS locations (i.e. complainants home) use 'Other'.

Location – Specific location i.e. 'IM&T department 2nd floor'. PCT buildings i.e. Art House Square, Bevan House. For a non-Trust locations state the exact location.

Location Exact– The exact location i.e. Reception Area, Kitchen, Stairwell, Car Park.

2 When did the incident take place?

Please remember to use the 24 hour clock for times. If you are not sure of the exact time please give an approximate time that indicates the time period e.g. for late evening you could enter '˜ 2100'.

3 Person affected

This is the person either actually affected or potentially affected if it is a single individual. For instance:

- If you are reporting a problem with a patients records, then the person affected is the patient.
- If a piece of equipment is discovered to be faulty during the daily checking process then there will not be a person affected.

Ethnic Origin:

| | |
|---------------------------------|---------------------|
| A White – British | K Bangladeshi |
| B White – Irish | L Asian – Other |
| C White – Other | M Black – Caribbean |
| D Mixed white & black Caribbean | N Black – African |
| E Mixed white & black African | P Black – Other |
| F Mixed white & Asian | Q Chinese |
| G Mixed – Other | R Other |
| H Indian | S Not stated |
| J Pakistani | |

4 Details of the person reporting the incident

This is the person who is actually filling out the incident reporting form.

5 Details of staff involved/witnesses

Boxes are provided to record information about 2 people. If more people were involved please use a separate sheet to record the same information for each additional person and attach the sheet to the form.

6 Description of Incident

Start with a one sentence statement of what you think the incident is e.g. "Visitor slipped in reception area", "Fire Alarm activated accidentally", "Encrypted pen drive mislaid".

Record what happened, in the order that it happened. Stick to the facts; avoid opinions and speculation. Bullet points are OK for this.

List any contributory factors that you have already identified.

Record any other relevant information or detail that is not recorded elsewhere on the form.

7 Type of Incident

Choose a tick box to describe the Category of the incident you are reporting.

9 Medication Incident Details

Record the relevant details about the drug(s). Select one option only from each box: Medication Process Stage and Incident Type.

12 Risk Grading

The risk grading is used to identify the probable significance of a substantially similar incident occurring in the future.

For each relevant dimension use the risk matrix to select the Severity, Likelihood and Rating. (A more detailed version with descriptions is available as a separate document.)

Severity – The probable severity if a substantially similar incident were to occur (average).

Likelihood – How likely is it that a substantially similar incident will occur in the future, based on your knowledge of the area, activity, patients, equipment etc.

Rating – Use the risk matrix to choose the rating at the intersection of the row (severity) and column (likelihood) that you have chosen.

Then identify the dimension with the highest Rating and record this on the risk matrix by placing a cross in the relevant box.

e.g.

| | |
|----------|-------------------------------------|
| Moderate | <input checked="" type="checkbox"/> |
|----------|-------------------------------------|

13 Manager's/Team Actions

List all of the actions that have been taken in response to the incident, and to prevent a similar incident occurring in the future.

Include any changes/updates made to information on the form (date, change, reason, person).