



NICS Primary Care Significant or Serious Incident - Notification Form

The purpose of this form is to comply with national guidance and enable timely information sharing and facilitate learning from Serious Incidents (SI's) requiring Investigation, and Significant Event Audits (SEAs) in Primary Care. Please complete this form with as much detail as possible.

Please email your form to: nics.admin@nhs.net

DO NOT INCLUDE PATIENT IDENTIFIABLE INFORMATION OR THAT OF INDIVIDUALS OTHER THAN THOSE OF THE REPORTER FOR COMMUNICATION PURPOSES.

In your opinion is this incident a Significant Incident (SI) SIRI
or a Significant Event Audit (SEA)? *(See below for definition of incidents)* SEA

When, Where and Your Details

Type of Incident (a) <i>(Please see appendix for list of Incident types)</i>	Reporting Organisation:
Further descriptor for incident (b)	
Date of Incident:	Reporter Name:
Time of Incident:	Reporter Job title/Role:
Location of Incident:	Reporter Tel No:
Date Incident Identified:	Reporter Email:
Name of other Organisations Involved (where relevant): <i>eg: GP Practise, Hospital, Ambulance Service, OoH, Care Homes, Mental Health Services, Police, etc.</i>	
Care Sector: <i>eg: General Practise, Nursing, Therapies, Other. If Other please specify.</i>	



Patient Details *This information should only be supplied if this form is transmitted via a secure transmission i.e. NHS.Net email account – please do not include patient name or other patient identifier.*

Patient Date of Birth:	Patient Gender:
Patient Registered GP Practice:	Patient Ethnic Group:
Patient NHS Number:	

What Happened?

Description of What Happened including how the SI/SEA was identified:
Immediate Action Taken:
Any Further Information:
Details of any Police, Media Involvement/Interest:
Please indicate which other organisations have been notified? <input type="checkbox"/> CQC <input type="checkbox"/> IG Toolkit <input type="checkbox"/> HSE <input type="checkbox"/> MHRA <input type="checkbox"/> NRLS <input type="checkbox"/> CCG
Details of contact with or planned contact with patient/family or carers:

Learning Outcomes:

What lessons might be learned and shared with others?		
Have you identified any factors you are not in a position to change?		
<u>ACTION POINT</u>	<u>WHO</u>	<u>BY WHEN</u>



What impact or potential impact did the event have on the patient?

Apparent Outcome of Incident:

Please describe:

*Please categorise significance/potential significance (tick A for actual harm and P for potential harm)
Definitions of harm can be found in the National Framework.*

None	Low Harm	Moderate Harm	Severe Harm	Death
P A	P A	P A	P A	P A

Likelihood of Reoccurrence:

Before reviewing this event – Please attempt to assess the likelihood of a similar event happening again.

Almost certain	Likely	Don't know	Unlikely	Rare
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Definition of Serious, Significant and Never events	
<p>SI - Definition of a Serious Incident - The definition of a 'Serious Incident' is set out in the 'Serious Incident Framework March 2013 – (NHS England Patient Safety Domain). Broadly, 'Acts and/or omissions occurring as a part of NHS funded healthcare' , including the community) that resulted in;</p> <ul style="list-style-type: none"> • Unexpected or avoidable death, serious harm, injury, abuse, psychological or psychological; or where healthcare did not take appropriate action • or a Never Event – see never events policy. • Or an event that seriously prevents or threatens to prevent an organisations ability to continue to deliver an acceptable quality of healthcare. 	<p>SEA - Definition of a Significant Event - The Royal College of General Practitioners (RCGP) states that significant events suitable for analysis are events where the practitioner can identify an opportunity for making improvements, either because the outcome was substandard or because there was a potential for an adverse outcome ('near miss'), but these incidents involve a lower level of safety concern than a 'serious incident'</p>

This form should be completed and sent to NICS as soon as possible to when the incident was identified.

Email your form to: nics.admin@nhs.net

APPENDIX - Incident Types a) and further information b)



Type of incident a) general	Type of incident b) descriptor
Access, admission, transfer, discharge (including missing patient)	Cold chain
Clinical assessment (including diagnosis, scans, tests, assessments)	Communication - 111, Out of Hours
Consent, communication, confidentiality	Communication failure
Disruptive, aggressive behaviour (includes patient-to-patient)	Confidentiality & Communication - Breach of confidentiality
Documentation (including electronic & paper records, identification and drug charts)	Consent - failure to gain consent
Implementation of care and ongoing monitoring / review	Diagnosis - delay, failure to
Infection Control Incident	Diagnosis - wrong
Infrastructure (including staffing, facilities, environment)	Discharge - delay, failure
Medical device / equipment	Do not resuscitate (DNR)
Medication	Documentation - missing, delayed, inadequate
Other	Documentation - patient incorrectly identified
Patient abuse (by staff / third party)	End of Life issue
Patient accident	Healthcare professional issue
Self-harming behaviour	Immunisation, vaccination
Treatment, procedure	Infection control - Cdiff
	Infection control - MRSA
	Infection control - Other
	IT system failure
	Prescribing/Dispensing - lost prescription
	Prescribing/Dispensing - Other
	Prescribing/Dispensing - preparation incorrect
	Prescribing/Dispensing - wrong dose, quantity
	Prescribing/Dispensing - wrong drug
	Prescribing/Dispensing - wrong label
	Prescribing/Dispensing - wrong patient
	Prescribing/Dispensing - EPS
	Pressure ulcer
	Professional Registration issues
	Referral - delayed 2WW
	Referral issue
	Safeguarding concern
	Scans, X-rays, specimens
	Screening incident
	Sepsis
	Sharp incident
	Slip, Trip, Fall
	Suicide suspected
	Test results or reports - failure to report, act, receive, incorrect, missing