



TOOLKIT 8 · INCIDENT REPORTING · TOOL 1 OF 5

Patient Safety Incident Report

Anything that harmed a patient, or could have. Any type. Anonymous if you wish. Ten minutes

Why report. Every incident is information the facility cannot get any other way. Near misses count. Nobody is disciplined for a report made in good faith; the report is separate from any HR process. You need not give your name.

Date · time · location	
Reporter (optional) · role	
Patient (name, no.) — or "no patient involved"	

1 · TYPE

☐ Medication
☐ Fall
☐ Identification
☐ Surgery / procedure
☐ Infection
☐ Pressure injury
☐ Equipment
☐ Blood / transfusion
☐ Documentation
☐ Communication
☐ Behaviour / violence
☐ Environment
☐ Other

2 · WHAT HAPPENED (FACTS, IN ORDER, NO NAMES OF STAFF)

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3 · OUTCOME FOR THE PATIENT

Near miss — did not reach	Reached — no harm	Reached — monitoring or minor treatment	Moderate harm	Severe harm	Death
☐	☐	☐	☐	☐ → Sentinel Event Policy	☐ → Sentinel Event Policy

4 · CONTRIBUTING FACTORS (TICK ALL)

☐ Staffing / workload
☐ Communication / handover
☐ Training / supervision
☐ Equipment / supplies
☐ Environment
☐ Policy absent or unclear
☐ Patient factors
☐ Task / procedure design
☐ Team / culture

5 · IMMEDIATE ACTION TAKEN

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6 · WHAT WOULD STOP IT HAPPENING AGAIN

Manager review: received (date) · severity confirmed · analysis needed? (Tool 2/3) · feedback to reporter and ward (date) · learning shared (Tool 5)

Based on the WHO Minimal Information Model for Patient Safety Incident Reporting (2016).

ASF standards: Governance — incident reporting; Sentinel Event Policy