**INCIDENT/ACCIDENT REPORT FORM**

[Organisation Name]

⚠️ Complete this form as soon as possible after any incident. Be factual and objective.

**SECTION 1: INCIDENT DETAILS**

|  |  |
| --- | --- |
| **Date of Incident:** | [DD/MM/YYYY] |
| **Time of Incident:** | [HH:MM] |
| **Location:** | [Exact location where incident occurred] |
| **Incident Reference:** | [Auto-generated or assigned reference number] |

**SECTION 2: PERSON(S) INVOLVED**

|  |  |
| --- | --- |
| **Name of Person:** | [Full name of person involved] |
| **Date of Birth:** | [DD/MM/YYYY] |
| **Room/Unit:** | [Room number or unit] |
| **Others Involved:** | [Names of any other people involved or present] |

**SECTION 3: TYPE OF INCIDENT (tick all that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
| ☐ Fall | ☐ Medication Error | ☐ Physical Injury | ☐ Safeguarding |
| ☐ Behaviour | ☐ Missing Person | ☐ Property Damage | ☐ Near Miss |
| ☐ Equipment Failure | ☐ Fire/Evacuation | ☐ Death | ☐ Other: \_\_\_\_\_\_\_ |

**SECTION 4: DESCRIPTION OF INCIDENT**

**Describe exactly what happened (who, what, when, where, how):**

|  |
| --- |
| [Provide detailed, factual account of the incident. Include what led up to it, what happened, and immediate aftermath.] |

**SECTION 5: INJURIES SUSTAINED**

|  |  |
| --- | --- |
| **Were injuries sustained?** | ☐ Yes ☐ No |
| **Description of Injuries:** | [Type, location, severity of any injuries] |
| **First Aid Given:** | [Details of any first aid administered] |
| **Medical Attention:** | ☐ Not Required ☐ GP Called ☐ 999 Called ☐ Hospital Attended |

**SECTION 6: IMMEDIATE ACTIONS TAKEN**

|  |
| --- |
| [List all immediate actions taken to ensure safety and wellbeing] |

**SECTION 7: NOTIFICATIONS MADE**

|  |  |
| --- | --- |
| **Family/Next of Kin:** | ☐ Yes (Date/Time: \_\_\_\_) ☐ No (Reason: \_\_\_\_) |
| **Manager on Call:** | ☐ Yes (Date/Time: \_\_\_\_) ☐ Not Required |
| **GP/Healthcare:** | ☐ Yes (Date/Time: \_\_\_\_) ☐ Not Required |
| **Safeguarding/CQC:** | ☐ Yes (Date/Time: \_\_\_\_) ☐ Not Required |

**SECTION 8: REPORT COMPLETED BY**

|  |  |
| --- | --- |
| **Staff Name:** | [Full name] |
| **Job Title:** | [Role] |
| **Signature:** |  |
| **Date & Time:** | [DD/MM/YYYY HH:MM] |

**SECTION 9: MANAGER REVIEW (Office Use Only)**

|  |  |
| --- | --- |
| **Reviewed By:** | [Manager name] |
| **Date Reviewed:** | [DD/MM/YYYY] |
| **Root Cause:** | [Analysis of contributing factors] |
| **Preventive Actions:** | [Actions to prevent recurrence] |
| **Follow-up Required:** | ☐ Yes (Details: \_\_\_\_) ☐ No |

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