ISO 9001:2015 Certified Hospital

Approved 25/11/2019

MOI TEACHING AND REFERRAL HOSPITAL

INCIDENT REPORT FORM

UNIT/AREA .... DATE: ....

Section 1 Details of one affected	Staff ☐ Patient ☐ Visitor/Relative/Caretaker ☐ Volunteer ☐ Student ☐ Other Specify ....
Section 2 Details of Incident	Date:
	Time:
Section 3 Please describe clearly what happened *Root Cause*	....
Section 4 Type of Incident	☐ Communications(discharge, transfer, inappropriate referral, staff, verbal abuse) ☐ Privacy violation ☐ Testing Process ☐ Result reporting ☐ Documentation ☐ Safety ☐ Medical Device Failure ☐ Adverse Drug Reaction ☐ Other specify ....
Section 5 Person reporting incident	Name :
	Designation:

*(**NB**: Please return your completed forms to Quality Assurance Department MTRH)*

<table>
<tr><td rowspan="1">Section 6
Summary of Action Taken</td><td colspan="2">IMMEDIATE SUPERVISOR/NURSE MANAGER/ADMINISTRATOR/HEAD OF DEPARTMENT
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<tr><td rowspan="5">What changes will be implemented as a result of this incident</td><td colspan="2">……………………………………………………………………………………
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<tr><td>Type of Incident</td><td>Accident ☐ Near miss ☐ Potential risk ☐ Significant event ☐ Adverse event ☐ Mass incident ☐ Mass accident ☐</td></tr>
<tr><td>Result</td><td>Was person harmed? Yes ☐ No ☐
Degree of Harm = None ☐ Moderate ☐ Major ☐ Death /Catastrophic ☐</td></tr>
<tr><td>Supervisors Name</td><td></td></tr>
<tr><td>Date</td><td></td></tr>
</table>

To be filled by QA Officers

Section 5	
Category	Security ☐ Health & Safety ☐ Medication ☐ Clinical ☐ Communication ☐

Follow up Report

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BY:……………………………………………………………………… Date: ……………………

*(**NB**: Please return your completed forms to Quality Assurance Department MTRH)*