


<b>NF03*</b> <b>Form</b> <b>DCSC</b>	Health Information and Quality Authority <b>Designated Centre – Special Care Unit (DCSC)</b> Serious injury <sup>†</sup> to a resident that requires immediate medical and/or hospital treatment	 <p>Health Information and Quality Authority          An tÚdarás Um Fhaisnéis agus Cálíocht Sláinte</p>
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Section 1. Designated centre details		For official use
Centre name		<input type="checkbox"/>
Centre ID (OSV)		<input type="checkbox"/>
Unit or ward name (if applicable)		<input type="checkbox"/>

Section 2. Resident's details		For official use
Resident's unique identifier <sup>†</sup>		<input type="checkbox"/>
Describe the current <b>status of the resident</b> , such as physical or mental state:		<input type="checkbox"/>
Please notify HIQA of any further adverse outcome(s) <b>within three weeks</b> , following submission of this notification.		

\* Please complete this form with HIQA's statutory notification guidance. You can download the guidance at [www.hiqa.ie](http://www.hiqa.ie)

<sup>†</sup> For more information on what is defined as a 'serious injury' please read our statutory notification guidance.

Section 2. Resident's details		For official use
Has an NF03 form been submitted for this person in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
If <b>yes</b> , how many NF03 forms have been previously submitted?		<input type="checkbox"/>

Section 3. Injury details			For official use
<b>Date of injury</b>		<b>Time of injury</b>	<input type="checkbox"/>
<b>Nature of injury</b> Please tick the relevant box or boxes	Vital organ trauma	<input type="checkbox"/>	<input type="checkbox"/>
	Fracture	<input type="checkbox"/>	
	Concussion	<input type="checkbox"/>	
	Burn	<input type="checkbox"/>	
	Sprain or strain	<input type="checkbox"/>	
	Unknown	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	
If you have ticked <b>other</b> , please provide details:			<input type="checkbox"/>
<b>Describe</b> the resident's injury, including where on the body the injury is:			<input type="checkbox"/>

Section 3. Injury details		For official use
<b>How</b> did the injury happen? Please tick the relevant box or boxes	Fall <input type="checkbox"/>	<input type="checkbox"/>
	Fire or heat <input type="checkbox"/>	
	Unknown <input type="checkbox"/>	
	Other <input type="checkbox"/>	
If you have ticked <b>Other</b> , please provide details:		<input type="checkbox"/>
<b>Where</b> did the injury happen? Please tick the relevant box or boxes	Resident's bedroom <input type="checkbox"/>	<input type="checkbox"/>
	Corridor <input type="checkbox"/>	
	Communal room <input type="checkbox"/>	
	Garden or grounds <input type="checkbox"/>	
	Bath or shower room <input type="checkbox"/>	
	Toilet <input type="checkbox"/>	
	Kitchen <input type="checkbox"/>	
	Unknown <input type="checkbox"/>	
Other <input type="checkbox"/>		
If you have ticked <b>other</b> , please provide details:		<input type="checkbox"/>

Section 4. Circumstances of the injury		For official use
<b>What</b> was the resident doing when the injury happened? Please tick the relevant box or boxes	Receiving care <input type="checkbox"/>	<input type="checkbox"/>
	Leisure activity <input type="checkbox"/>	
	Unknown <input type="checkbox"/>	
	Other <input type="checkbox"/>	
If you have ticked <b>other</b> , please provide details:		<input type="checkbox"/>
<b>Who</b> was the resident with when the injury happened? Please tick the relevant box or boxes	Alone <input type="checkbox"/>	<input type="checkbox"/>
	Care staff <input type="checkbox"/>	
	Resident's family member <input type="checkbox"/>	
	Another resident (unsupervised) <input type="checkbox"/>	
	Other <input type="checkbox"/>	
If you have ticked <b>other</b> , please provide details:		<input type="checkbox"/>
What was the <b>intent</b> of the injury?	Accidental or unintended <input type="checkbox"/>	<input type="checkbox"/>
	Self harm <input type="checkbox"/>	
	Alleged assault <input type="checkbox"/>	
	Other <input type="checkbox"/>	
If you have ticked <b>other</b> , please provide details:		<input type="checkbox"/>
<b>If requested</b> please submit a copy of the outcome of the investigation with the status of actions or recommendations to the Office of the Chief Inspector within <b>20 days</b> of the request.		

<b>Section 4. Circumstances of the injury</b>		For official use
Please describe the <b>circumstances</b> that led to the injury:		<input type="checkbox"/>

<b>Section 5. Medical or hospital treatment</b>		For official use	
What <b>immediate action</b> was taken following the injury?		<input type="checkbox"/>	
What <b>treatment</b> has the resident received? Please tick the relevant box or boxes	Medical treatment	<input type="checkbox"/>	<input type="checkbox"/>
	Hospital treatment	<input type="checkbox"/>	
If you have ticked <b>medical treatment</b> , please provide details of the medical attention that was required:		<input type="checkbox"/>	

**Section 5. Medical or hospital treatment**For  
official  
useIf you have ticked **hospital treatment**, please provide these details:

Date hospitalised:

Hospital name:

Date of discharge:

Who was the resident  
discharged to?

Section 6. Declaration			For official use
I, the undersigned, declare that the information I have provided in this notification form is true to the best of my knowledge and belief.			
Name (print)			<input type="checkbox"/>
Position	Person in charge	<input type="checkbox"/>	<input type="checkbox"/>
	Authorised signatory for and on behalf of the registered provider	<input type="checkbox"/>	
Signed			<input type="checkbox"/>
Date			<input type="checkbox"/>
Contact number (during office hours)			<input type="checkbox"/>

This form should be either:

- **emailed** to: [notify@hiqa.ie](mailto:notify@hiqa.ie) or,
- **posted** to: Notifications Team, Regulatory Support Services, Health Information and Quality Authority, Dublin Regional Office, George's Court, George's Lane, Smithfield, Dublin 7, D07 E98Y.

Telephone no: (01) 814 7400

Email: [notify@hiqa.ie](mailto:notify@hiqa.ie)