


NF03* Form DCOP	Health Information and Quality Authority Serious incident or injury[†] to a resident that requires hospital admission or resulted in death	 Health Information and Quality Authority <small>An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte</small>
--	---	--

Section 1. Designated centre details	
Centre name	
Centre ID (OSV)	
Unit or ward name (if applicable)	

Section 2. Resident's details	
Resident's unique identifier [†]	
Is this resident under the age of 18?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Describe the current status of the resident , such as physical or mental state:	
Please notify the Authority of any further adverse outcome(s) within three weeks , following submission of this notification.	
Has an NF03 form been submitted for this person in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>

* Please complete this form with the Authority's statutory notification guidance. You can download the guidance at www.hiqa.ie

[†] For more information on what is defined as a 'serious incident' and 'serious injury' please read our statutory notification guidance.

Section 2. Resident's details

If **yes**, how many NF03 forms have been previously submitted?

Section 3. Serious incident or serious injury

This is a serious incident report

Proceed to Section 6

This is a serious injury report

Proceed to Section 4

Section 4. Injury details

Date of injury

Time of injury

Type of injury

Please tick the relevant box or boxes

Burn

Concussion

Fracture

Other

Sprain or strain

Unknown

Vital organ trauma

If you have selected **other**, please provide details:

Section 4. Injury details

Describe the resident's injury, including where on the body the injury is:

How did the injury happen?
Please tick the relevant box or boxes

- | | |
|--------------|--------------------------|
| Fall | <input type="checkbox"/> |
| Fire or heat | <input type="checkbox"/> |
| Unknown | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |

If you have ticked **other**, please provide details:

Where did the injury happen?
Please tick the relevant box or boxes

- | | |
|-------------------------------|--------------------------|
| Resident's bedroom | <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"/> |
| Outside the centre (visiting) | <input type="checkbox"/> |
| Unknown | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |

Section 4. Injury details

If you have ticked **other**, please provide details:

Section 5. Circumstances of the injury

What was the resident doing when the injury happened?
Please tick the relevant box or boxes

- | | |
|------------------|--------------------------|
| Receiving care | <input type="checkbox"/> |
| Leisure activity | <input type="checkbox"/> |
| Unknown | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |

If you have ticked **other**, please provide details:

Who was the resident with when the injury happened?
Please tick the relevant box or boxes

- | | |
|---------------------------------|--------------------------|
| Alone | <input type="checkbox"/> |
| Nursing staff | <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 **other**, please provide details:

Section 5. Circumstances of the injury

What was the intent of the injury?	Accidental or unintended	<input type="checkbox"/>
	Self-harm	<input type="checkbox"/>
	Alleged assault	<input type="checkbox"/>
	Other	<input type="checkbox"/>

If you have ticked **other**, please provide details:

Please describe the **circumstances** that led to the injury:

Section 6. Circumstances of the incident

Describe the circumstances of the incident:

Who was the resident with when the incident happened?

Please tick the relevant box or boxes

- | | |
|---------------------------------|--------------------------|
| Alone | <input type="checkbox"/> |
| Nursing staff | <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"/> |

Describe the actions taken in the centre in response to the incident:

Section 7. Hospital admission

What **immediate action** was taken following the incident/injury?

--

Please provide details of hospital admission:

Date of admission:	
Hospital name:	
Date of discharge:	
Who was the resident discharged to?	

Section 8. Declaration

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)	
Position	Person in charge <input type="checkbox"/>
	Other <input type="checkbox"/>
If you ticked other , please specify your role in the designated centre	
Date	
Contact number (during office hours)	

The most secure and convenient way to submit the notification form is through the [HIQA Portal](#).

Should you wish to continue in hardcopy, please return the completed, signed form by email to notify@hiqa.ie **or** by post to:

Notifications Team
Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7

Tel: 01 814 7400