

Clinical Indemnity Scheme Notification Report Form:

STARS ID No. _____

Location _____

Clinical Area/Unit/Department _____

Date of occurrence (dd/mm/yyyy) ____/____/____

Time of occurrence (24hrs) ____:____ hrs

Date event reported (dd/mm/yyyy) ____/____/____

Service User/Patient Personal Details:

ID No. _____

Name _____

D.O.B.(dd/mm/yyyy) ____/____/____

Gender M F

Patient Safety Incident / Adverse Event **Near Miss**

Was the Service User Actually Harmed? Yes No Not yet known

Describe the harm sustained including **patient outcome**:

Did any actions prevent the incident from reaching the service user? Yes No Not yet established

Describe the preventative actions taken?

Incident Type _____ (see STARS Pick list)

Brief Description of Incident:

Specialty involved? _____ **Sub-specialty?** _____ (see STARS Pick list)

Risk Analysis Matrix – based on current available information; may be amended upon receipt of additional information.

Likelihood	Impact score				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/remote (1)	1	2	3	4	5

Contributory Factor(s): (See list)

Primary: _____

Secondary: _____

Low Risk 1 – 5 ■ Moderate Risk 6 - 12 ■ High Risk 15 - 25 ■

Reported by: Name : _____ (print) Title: _____ Signature: _____

Reported to: Name: _____ (print) Title: _____ Signature: _____

Reviewed by: Name: _____ (print) Title: _____ Signature: _____

Date Received in RM Office: ____ / ____ / ____

Date Logged onto STARS: ____ / ____ / ____