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# Safeguarding Quality Performance

## Tier 1 Incident Referral Form

**Please complete all sections on the form providing as much detail as possible:**

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| **Details of Service User:** |
| Name and Address of Service Provider: |  |
| Service User Name: |  |
| Service User Date of Birth: (if known) |  |
| Tel No of Service: |  |
| Mosaic ID (If known): |  |
| Date and time of incident: |  |
| Name of Social Worker (if known): |  |

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| **Details of Staff Member completing the Incident form (this should be the person who has been involved in the incident or witnessed concerns):** |
| Name of staff member completing form: |  |
| Job Role |  |
| Managers Email address: |  |
| Address/Place of work: |  |

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| **Details of incident *(please include as much information as possible):**** Brief details of incident
* Please advise of any known clinical diagnosis of the Service User
* Was medical attention required? If so, explain further
* Was there any other Service User/member of staff involved in the incident
* Does the Service User have capacity?
* Source of Risk details (if known)
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| **Please provide brief details of any internal investigation undertaken and what changes has the Service/Organisation made or implemented to reduce the risk of similar incidents reoccurring?** |
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| **Agreed Action(s) *(for example):**** Any staff re-training;
* Required changes to policies/procedures;
* Re-assessment of Service User; updating of risk assessments;
* Referral to other Professions as appropriate e.g. Speech & Language Team, Moving and Handling Team, GP/District Nurse/Social Worker, Tissue Viability Nurse (TVN); Later Life & Memory Service (LLAMS); Reporting Injuries Diseases Dangerous Occurrences **(**RIDDOR)
* Have Family members been informed of the incident (if appropriate)
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**Please make sure you retain a copy of this completed form for inspection purposes by:**

**PMMD Quality Performance Officer oversight when they complete any monitoring visits.**

**Care Quality Commission (CQC) (if necessary)**