How to Classify Adverse Incidents and Risk

Guidance for Senior Managers Responsible for Adverse Incident Reporting and Management

April 2006

This document will be subject to review and up-to-date versions will be available on the governance website.

http://www.dhsspsni.gov.uk/index/hss/governance.htm

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Introduction

1.1 This document has been produced to assist Health and Personal Social Services organisations (HPSS) in their clinical and social care governance arrangements. In particular to help develop or review processes to assess adverse incidents and their risk implications. It has been written for senior managers responsible for the reporting and overall management of adverse incidents and it is not intended as guidance for all staff. It does not provide detailed guidance for HPSS incident investigation, as this will be the subject of further work.

1.2 The following pages outline a tool to help managers classify incidents and risk, using the Australian / New Zealand Standard: Risk Management (AS/NZS 4360: 2004) and "Step 4 – Promote Reporting" from the National Patient Safety Agency (NPSA) publication "Seven Steps to Patient Safety" as primary sources.

1.3 The guidance should be used for all incidents not just those that involve patients / service users. This is in line with the systems and processes that HPSS organisations currently use to manage incidents. This document has been designed for use across the HPSS including the primary care sector and covers all incidents including clinical and social care incidents.

1.4 Organisations should follow the principles of this guidance when developing, revising and implementing their own local policies and procedures. It is of key importance however that these principles are tailored to suit the objectives, nature and size of the particular organisation. The aim of this document is to facilitate better systems for sharing learning from incidents across the HPSS and beyond. It provides a framework for appropriate and sufficient analysis of, and learning from incidents where there has been significant harm or potential harm to, and/or death of a patient, service user, staff member, visitor and/or significant damage to property or the environment.

1.5 One important principle is that all incidents should be considered and recorded centrally within organisations so that any organisation-wide implications can be captured as early as possible. However, this must not negate the importance of local management responsibility for handling incidents in their area. All types of incidents should be included: for example, social care, clinical, health and safety, fire, infection control etc.

1.6 To help with capturing all incidents within similar processes an HPSS regional definition of an incident has been devised; an adverse incident within the HPSS context is therefore defined as:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

1.7 Further associated work in this area will include the development of a regional minimum dataset for recording incidents and a set of regional codes for the most prevalent types of incidents.

2.0 Stages of Adverse Incident Management (To be read in conjunction with Flowchart One)

This section provides further guidance to support Flowchart One overleaf and gives further detail relating to each stage in the process.

Stage 1 – Incident occurs and is reported via the organisation's internal reporting mechanism to the organisation's central recording system. Incident details are also communicated internally as necessary.

Stage 2 – Determine actual incident severity (using Table 1 and Table 2). An incident will often have multiple aspects – considering all these aspects (see Table 2) decide the level of severity.

Stage 3 – Assess incident to determine immediate action required. Following this initial assessment consider whether it is appropriate to report to external organisations (See examples of organisations requiring reports in Flowchart One). If the severity of the incident means that action must precede investigation – go straight to Stage 6.

Stage 4 – Initiate incident investigation as appropriate. Following investigation re-consider in the light of further information whether it is appropriate to report to external organisations. (See sample list of organisations that may require reports in Flowchart One).

Stage 5 - This is a secondary classification mechanism for assessing ***potential future risks***. Use the following prompts:

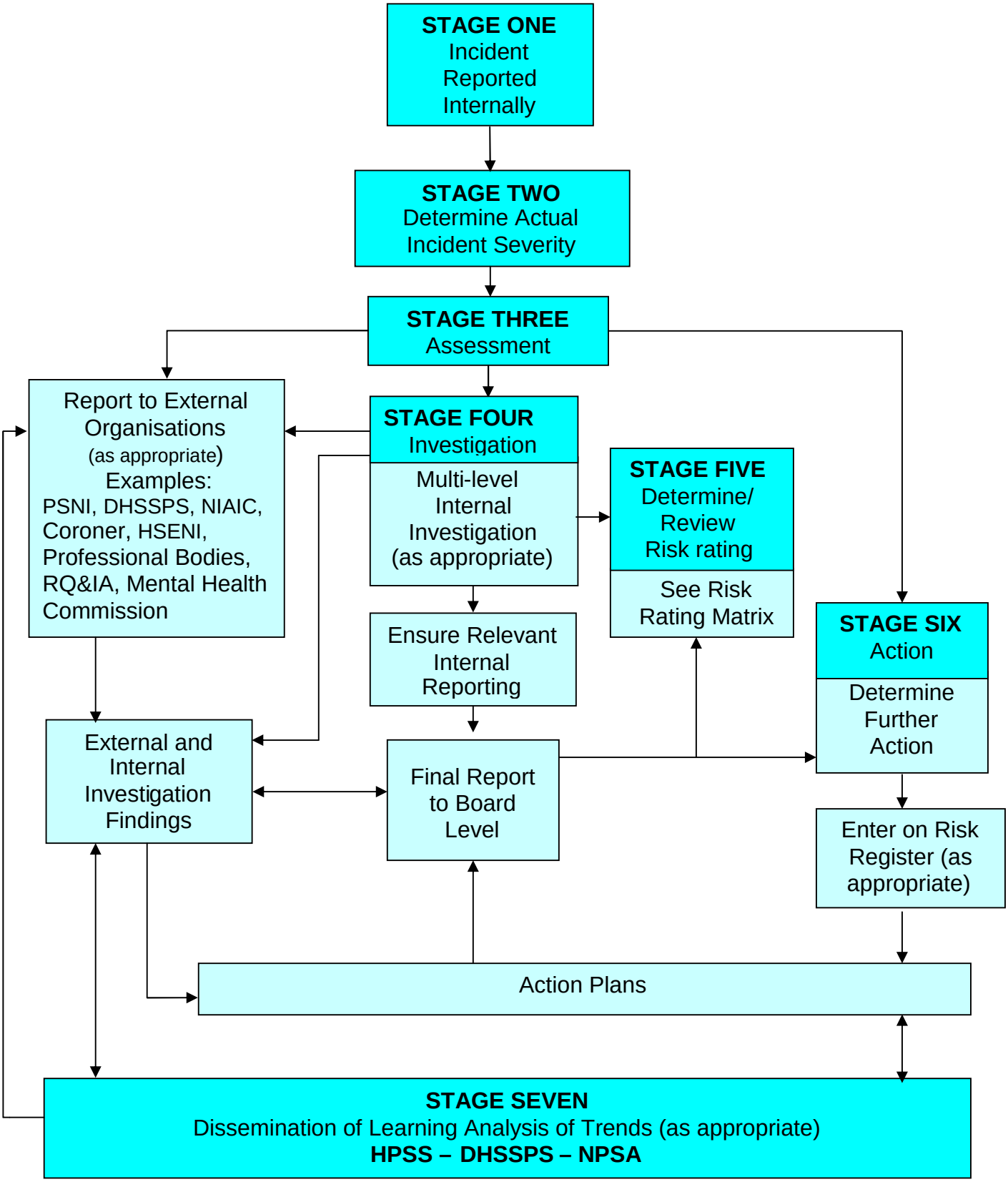
(a) Think about the likely impact if the incident were to occur again without any intervening circumstances that made the incident less severe. (Use the Impact Table – Table 2)
(b) Assess the likelihood of the incident occurring again.
(c) Use the Risk Rating Matrix (Page 6) to determine the overall risk rating.

Stage 6 – Use the Action Guidance (Table 3) to determine what further action should be taken. For example, consider whether this issue needs to be entered on the risk register and/or any organisation-wide action is required.

Stage 7 – Determine any learning from the adverse incident and communicate this within the organisation and with the appropriate regional / national bodies. Following the outcome and learning from investigations review the risk rating in Stage 5 and keep this under regular review.

STAGES OF ADVERSE INCIDENT MANAGEMENT FLOWCHART ONE

(please read in conjunction with commentary on Page 2)



3.0 Initial Grading of Incident Severity

The initial assessment of an incident should be performed quickly, even when all facts may not be available. There is always scope to re-grade as facts and issues emerge over time and following investigation. This guidance is primarily for internal reporting mechanisms but please note one particular external reporting route - Serious Adverse Incidents (most probably incidents from the Catastrophic and Major severity levels) should be reported to the DHSSPS (see Circular HSS (PPM) 02/06) - i.e. those incidents that meet the following criteria:

- Be serious enough to warrant regional action to improve safety or care;
- Be of public concern; or
- Require an independent review.

Table 1 - Actual Incident Severity (according to the facts available)

In determining the actual severity consider the outcome of the incident in terms of harm to people / resources / environment / reputation / quality.

Severity of incident	**High Level Descriptors** **(see Impact Table 2 overleaf for a more detailed list)**
Catastrophic	**Incident with widespread implications to services**
Major	**Significant disruption to services**
Moderate	**Short term disruption to services**
Minor	**No interruption to services**
Insignificant	**No adverse outcome but risk potential evident**

Impact Table 2 (based on facts available about the incident)

This table may also be used to assess the impact of risks in order to analyse future risks

	PEOPLE (Any person affected by an Incident: Staff, User, Visitor, Contractor)	**RESOURCES** (Premises, money, equipment, Business interruption, problems with service provision)	**ENVIRONMENT** (Air, Land, Water, Waste management)	**REPUTATION** (Adverse publicity, Complaints, Legal/Statutory Requirements, Litigation)	**QUALITY AND PROFESSIONAL STANDARDS** (including government priorities, targets and organisational objectives)
CATASTROPHIC	Incident that lead to one or more deaths	Severe organisation wide damage/ loss of services /unmet need	Toxic release affecting off-site with detrimental effect requiring outside assistance.	National adverse publicity. DHSSPS executive investigation following an incident or complaint. Criminal prosecution.	Gross failure to meet external standards, priorities
MAJOR	Permanent physical/emotional injuries/trauma/harm.	Major damage, loss of property / service /unmet need	Release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc)	Local adverse publicity. External investigation or Independent Review into an incident/complaint. Criminal prosecution /prohibition notice	Repeated failure to meet external standards.
MODERATE	Semi permanent physical/emotional injuries/trauma/harm (recovery expected within 1 year).	Moderate damage, loss of property / service /unmet need	On site release contained by organisation	Damage to public relations. Internal investigation (high level), into an incident/complaint. Civil action	Repeated failure to meet internal standards or follow protocols.
MINOR	Short-term injury/harm. Emotional distress. (Recovery expected within days /weeks.)	Minor damage, loss of property / service /Unmet need	On site release contained by organisation	Minimal risk to organisation. Local level internal investigation into an incident/complaint Legal challenge	Single failure to meet internal standards or follow protocol.
INSIGNIFICANT	No injury/harm or no intervention required / near miss	No damage or loss, no impact on service Insignificant unmet need	Nuisance release	Minimal risk to organisation, Informal complaint	Minor non compliance,

RISK RATING MATRIX (adapted from AS/NZ 4360, 2004 MODEL)

LIKELIHOOD	CONSEQUENCE (Potential Impact)				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost certain (will undoubtedly recur, a persistent issue)					
Likely (will probably recur, not a persistent issue)					
Possible (may recur occasionally)					
Unlikely (do not expect it to happen again)					
Rare (can't believe it will ever happen again)					

Risk Rating

Low	Medium	High	Extreme

Table 3 - Action Guidance

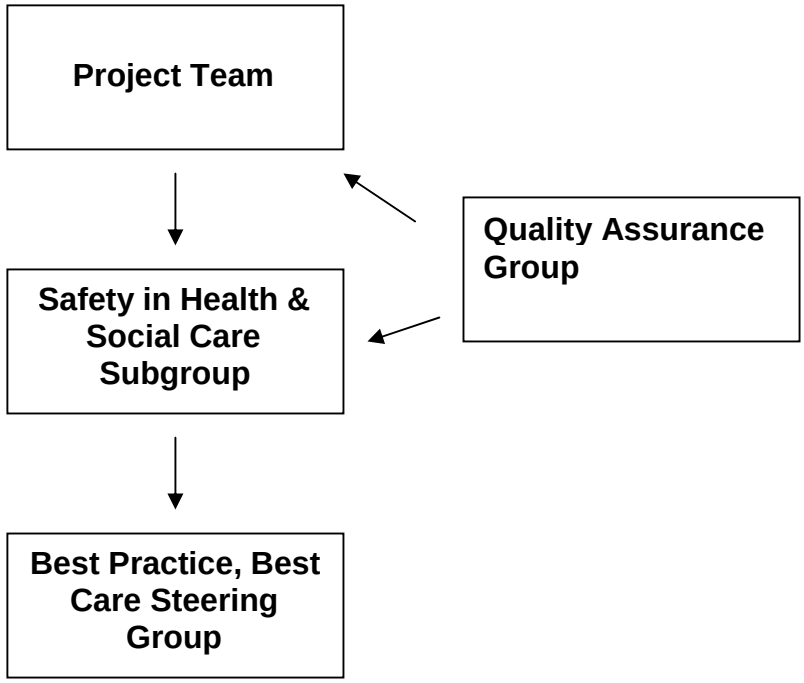
Risk Rating Level	Descriptors
Extreme	Identified risks which fall in the red area are deemed extreme risk to the organisation and must be reported to the appropriate Governance Group. These risks require immediate action to reduce the level of risk and the relevant Director / Officer will ensure they are forwarded to the Executive Management Board/Governance Committee. The appropriate Director / Officer will ensure the implementation of a time monitored action plan and provide regular reports to the Executive Management Board/Governance Committee.
High	Identified risks which fall in the orange area are deemed high risk to the organisation and require prompt action to reduce the risk to an acceptable level. These risks and agreed action plans should be considered by the local Governance Group. Risks that cannot be reduced locally should be forwarded for consideration by the Executive Management Board/Governance Committee.
Medium	Identified risks which fall in the yellow area are deemed medium risk to the organisation and require action to reduce risk to an acceptable level. Responsibility for taking action would normally remain at a local level within the appropriate Directorates/Programmes/Service Areas and monitored by the relevant Local Governance Group and entered on the Directorate Register.
Low	Identified risks which fall in the green area are deemed as acceptable risks and require no immediate action, but must be monitored regularly.

Appendices

APPENDIX A - TERMS OF REFERENCE AND MEMBERSHIP OF GROUPS

This project aims to create a standard method of adverse incident reporting across the Health and Personal Social Services including Trusts, Boards and across the Primary Care sector. This will include creating HPSS agreed standard incident definitions, a minimum dataset and recommended reporting form and regional coding of incidents.

Project Reporting Arrangements



The Project Team

The project team is multi-disciplinary and drawn from across the HPSS. The project has been able to access HPSS best practice in adverse incident management. A list of project team members is set out below:

Dr Kathryn Booth, Medical Adviser, EHSSB GP Unit / DHSSPS
Ms Tracey Boyce, HPSS Medicines Governance Project Manager, Royal Hospitals Trust
Mrs Therese Brown, Risk Management Director, Altnagelvin HSS Trust
Mrs Jacqui Burns, Risk Manager, NHSSB
Ms June Champion, Risk Manager, Royal Hospitals Trust
Dr Martina Hogan, Consultant Paediatrician, Craigavon Area Hospital Group Trust
Mrs Yvonne Kirkpatrick, Governance Manager, Belfast City Hospital Trust
Ms Irene Low, Risk Manager, Ulster Community and Hospitals Trust
Mr Alex Lynch, Governance Manager, Homefirst Community HSS Trust
Ms Marita Magennis, Social Services, Newry and Mourne HSS Trust
Mrs Mairead Mitchell, Assistant Director, Improvement and Governance, North and West Belfast Community Trust
Mr Brian Mullin, Acting APSW, Causeway HSS Trust
Ms Heather Shepherd, HPSS Regional Governance and RM Adviser
Mrs Roberta Wilson, Clinical and Social Care Governance Co-ordinator

Quality Assurance Group

Quality Assurance for the project was arranged via a virtual QA Group comprising governance leads from all HSS Trusts and HSS Boards.

APPENDIX B

REFERENCES, CIRCULARS AND GUIDANCE

The following is a list of useful documents providing further guidance in this area.

Being Open. Communicating patient safety incidents with patients and their carers. National patient safety Agency (2005) www.npsa.nhs.uk

Department of Health, Social Services and Public Safety Memorandum of Understanding

Department of Health, Social Services and Public Safety - Safety in Health and Social Care Project – Clinical and Social Care Governance - Deloitte, 31st March 2004

Circular HSS (PPM) 02/2006 – Reporting and Follow-Up on Serious Adverse Incidents within the HPSS
www.dhsspsni.gov.uk/hss/governance

Circular HSS (PPM) 5/2003 – Governance in the HPSS: Risk Management and Controls Assurance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2002 – AS/NZS 4360:1999-Risk Management (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 6/2004 – Reporting and follow-up on serious adverse incidents: Interim Guidance (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2002 – Risk Management in the Health and Personal Social Services (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 8/2004 – Governance in the HPSS: Controls assurance standards – update http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 10/2002 – Governance in the HPSS: Clinical and Social Care Governance – Guidance on Implementation (DHSSPS)
http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Circular HSS (PPM) 13/2002 – Governance in the HPSS – Risk Management (DHSSPS) http://www.dhsspsni.gov.uk/hss/governance/guidance.asp

Creating the virtuous circle: patient safety, accountability and an open and fair culture, NHS Confederation 2003.

Doing Less Harm; Improving the Safety and Quality of Care Through Reporting, Analysing and Learning from adverse incidents, Department of Health and NPSA Draft August 2001.

Making it happen – A guide for risk managers on how to populate a risk register (CASU, Keele University) www.dhsspsni.gov.uk/hss/governance

National Patient Safety Agency. 2004 Seven Steps to Patient Safety www.npsa.nhs.uk/health/resources/7steps

NIAIC Safety Notice MDEA (NI) 2006/01 Reporting Adverse Incidents and Disseminating Medical Device/Equipment Alerts. Health Estates, Northern Ireland Adverse Incident Centre.
www.dhsspsni.gov.uk/index/hea/niaic

Patient Safety: Towards Sustainable Improvement, Fourth Report to Australian Health Ministers' Conference, Australian Council for Safety and Quality in Healthcare, July 2003

Shipman Inquiry Reports www.the-shipman-inquiry.org.uk/reports

The Bristol Royal Infirmary Inquiry
www.bristol-inquiry.org.uk/final_report/report/sec2chap21_3.htm

The Confidential Enquiry into Maternal and Child Health; the Confidential Enquiry into Patient Outcome and Death; and the Confidential Enquiry into Homicide and Suicide in Hospital www.national-confidential-inquiry.ac.uk/nci/index.cfm