National Patient Safety Agency

THE NHS CONFEDERATION

The Incident Decision Tree

Information and advice on use

Contents

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Welcome to the Incident Decision Tree

This printable version of the Incident Decision Tree is designed as a back-up for trusts to distribute to users who are unable to access the electronic tool. We advise use of the electronic version wherever possible as research indicates it promotes more objective decision-making.

Both versions of the downloads are available from www.npsa.nhs.uk/idt

The Incident Decision Tree helps NHS managers decide initial action to take with staff involved in a patient safety incident. It is intended to promote a consistent and fair approach, avoiding unnecessary and costly suspensions.

The tool is based on a flowchart which guides you through a series of structured questions about the individual's actions, motives and behaviour at the time of the incident. The responses to these questions lead you to suggestions for appropriate management action.

The Incident Decision Tree has been designed to be quick and easy for managers to use, it comprises:

Section A The flowchart.

Section B Background information and general advice on using the tool.

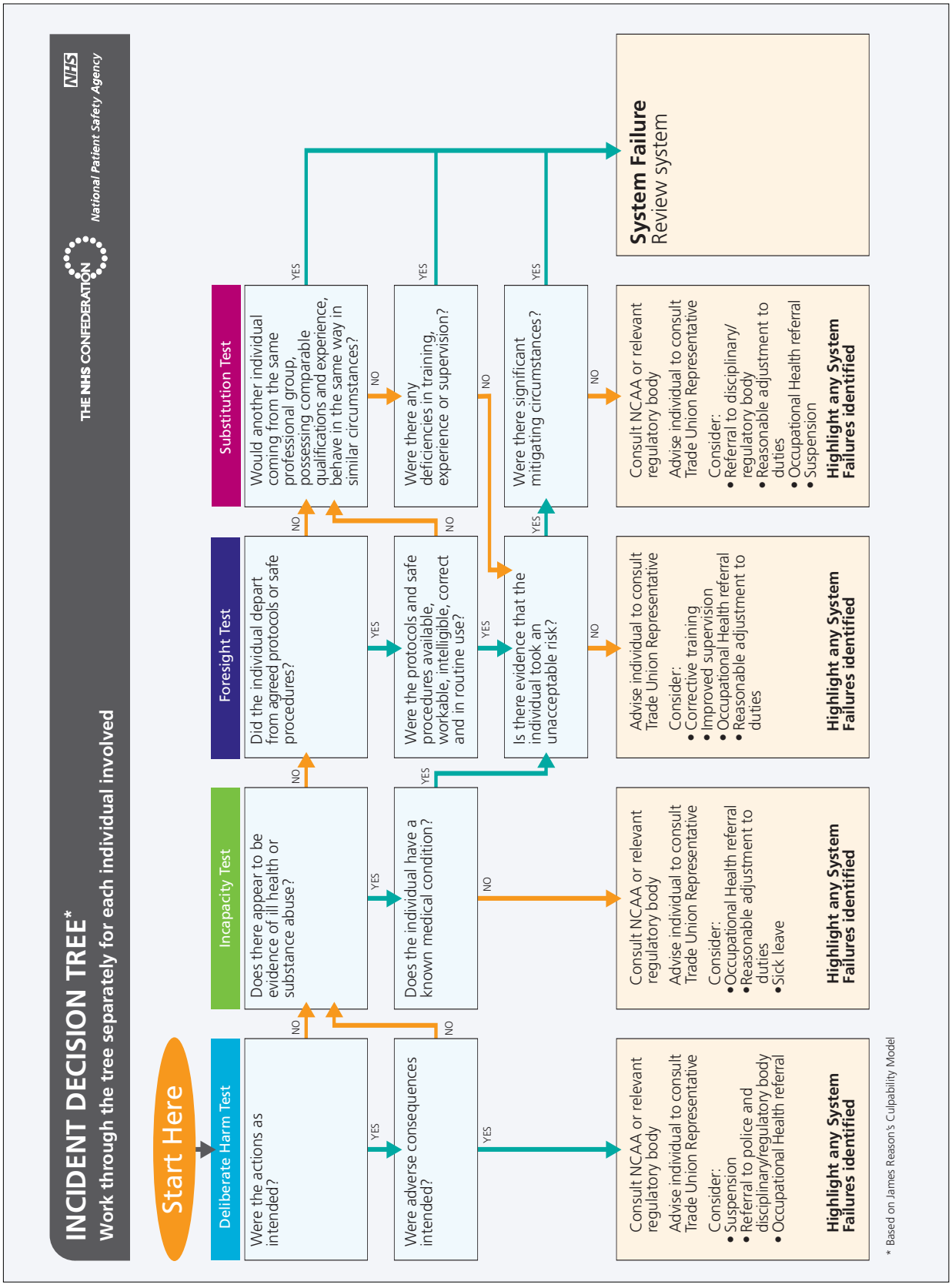
Section C Pathway through the flowchart and detailed guidance on answering individual questions.

Section D Advice on what to do should you be unable to answer a question.

Section E Information about systems failures.

Section F A glossary of terms used in the tool.

Section A
The Incident Decision Tree flow chart



Section B
Background information and advice on use

Who the Incident Decision Tree can be used for

The Incident Decision Tree can be used for any employee involved in a patient safety incident, whatever their professional group. The Incident Decision Tree is specifically for use following a patient safety incident. Although it promotes good management practice, it is not designed for use in other situations, such as poor general performance or absenteeism.

If more than one employee is involved, it is essential to work through the Incident Decision Tree separately for each person. To emphasise this point, the employee is referred to as 'the individual' throughout.

Who the Incident Decision Tree can be used by

It is designed for use by any manager dealing with staff involved in a patient safety incident. This includes chief executives, directors, service managers, clinical governance managers and human resources professionals.

When to use the Incident Decision Tree

Ideally, it should be used as soon as possible after the patient safety incident, while facts are still fresh in people's minds. However, this is not always possible and it can be used at any point during the investigation.

If new information comes to light, it can be worked through afresh and may or may not indicate a different conclusion.

How the Incident Decision Tree works

Based on a flowchart (see Section A), the Incident Decision Tree guides you through a series of structured questions about the individual's actions, motives and behaviour at the time of the incident.

These questions move through four sequential 'tests':

- The Deliberate Harm Test
- The Incapacity Test
- The Foresight Test
- The Substitution Test

Working through each test in turn, possible reasons for the individual's actions are reviewed and the most likely explanation identified. Your responses lead to a list of recommended options for consideration.

In the majority of cases system failure turns out to be the cause of the incident.

The Deliberate Harm Test

In the overwhelming majority of patient safety incidents the individual had the patient's wellbeing at heart. However in a few, exceedingly rare, cases the intent was to cause harm. The Deliberate Harm Test asks questions to help identify or eliminate this possibility at the earliest possible stage.

The Incapacity Test

If intent to harm has been discounted, the Incapacity Test helps to identify whether ill health or substance abuse caused or contributed to the patient safety incident.

The Foresight Test

If intent to harm and incapacity have been discounted, the Foresight Test examines whether protocols and safe working practices were adhered to.

The Substitution Test

Finally, if protocols were not in place or proved ineffective, the Substitution Test helps to assess how a peer would have been likely to deal with the situation.

Golden rules

- Work through the Incident Decision Tree separately for each individual involved.
- Pause to gather information where you need to, but do not procrastinate about sending the individual off-site if patient safety is at real risk.
- Never make assumptions about:
  - the incident
  - the individual's behaviour or motivation
  - the individual's ability to deal effectively with the situation
  - the protocols and safe procedures in place at the time

Check the facts thoroughly for yourself

- Always record the facts you have gathered and the reasons you have arrived at your decision.
- Work through the Incident Decision Tree afresh if new information comes to light.

Help using the Incident Decision Tree

If you need help, first explore the guidelines following the relevant section or check pages 7-8 for answers to frequently asked questions.

If you need further advice or support please contact your local human resources department or, in case of difficulty, your local NPSA Patient Safety Manager.

You can obtain your Patient Safety Manager's contact details by telephoning the NPSA on 020 7927 9500.

Communicating your decision

Sharing your decision with the individual

In many situations it is helpful to share the worked-through Incident Decision Tree with the individual, showing how you have arrived at your decision.

However, it is important to explain to the individual that management has used judgement in the situation and 'owns' the final decision regarding action. Concerns arise if it appears that the Incident Decision Tree has been applied slavishly.

Sharing your decision with the individual's representative

If the individual is being supported by a staff-side representative, you are encouraged to share the worked-through Incident Decision Tree with the representative.

Staff-side organisations have been involved in the development of the tool at national level and actively support its use.

Communicating the situation to other employees

If action is taken following a patient safety incident, it is important to decide what and how to communicate with the individual's colleagues. Things you might want to tell them include:

- the individual has been sent home from duty
- the individual's practice has been temporarily restricted
- an incident investigation is being instigated.

Failure to communicate effectively leads to speculation and sometimes to hostility about the individual. A balance needs to be struck between honouring confidentiality and ensuring that temporary arrangements are understood by colleagues.

Once a final decision on action has been taken, it is again important to determine how this should be communicated to the workforce.

Counselling, support and time off

Involvement in a serious patient safety incident can be highly traumatic. The situation can also be distressing for colleagues and bystanders.

One of your first actions should be to ensure that those affected by the incident have speedy access to appropriate counselling and support. This may be through your occupational health department, employee assistance scheme or the individual's staff-side organisation.

Irrespective of considerations regarding patient safety, the individual may need some time away from work in the immediate aftermath to recover from the incident. The duration will depend on the circumstances. Granting special paid leave for this purpose is different to formal suspension. See page 19 for important information about suspension, exclusion and restrictions to practice.

Make sure the individual sees this as a supportive gesture by management rather than a punitive act. Also ensure lines of communication are kept open whilst the individual is away from work.

Frequently asked questions

What is the difference between 'suspension', 'exclusion' and 'sending someone home'?

The individual(s) involved in a serious patient safety incident may be left traumatised and distressed and it is sometimes wise to send them home from duty. This is not formal suspension and does not prevent the individual from coming back on site if they so choose.

Formally suspend the individual if their return to work could:

- present a real danger to patients or colleagues and there is no other practical way of removing this risk; or
- hamper the incident investigation.

Formal suspension must be set out in writing and must comply with your trust's local policy.

If the incident occurred out-of-hours you may need to wait until the next working day to discuss the need for formal suspension with a senior human resources adviser and/or the relevant trust director.

Although legally a neutral act, suspension is seen as highly punitive by most individuals and should be avoided if at all possible. It is also costly to the NHS.

'Exclusion' or 'exclusion from work' has been adopted by the Department of Health to describe the suspension of a doctor or dentist. This is to avoid confusion with action taken by the GMC or GDC to suspend a practitioner from the register. See page 19 for important information about suspension, exclusion and restrictions to practice.

What is the difference between 'unacceptable risk', 'recklessness' and 'negligence'?

'Recklessness' and 'negligence' are legal terms used to describe situations where the individual may have acted criminally. The Incident Decision Tree has one purpose: to guide initial management action following a patient safety incident. It therefore does not explore the standards of proof legally required to support claims of 'recklessness', 'reckless behaviour' or 'negligence.'

'Unacceptable risk' is a lay expression used in the Incident Decision Tree to explain the concept of an individual taking a risk that would normally be considered unreasonable in the service concerned.

Is it compulsory to use the Incident Decision Tree?

The Incident Decision Tree is a tool to assist decision-making, not a mandatory process. However, some trusts are asking their managers to use it following every patient safety incident. Check with your local human resources department.

Does the Incident Decision Tree compromise my managerial judgement?

The Incident Decision Tree does not take away your managerial judgement by providing firm 'answers' or 'solutions', but instead suggests a range of possible options. The outcome of a particular incident still needs to be based on the investigation of individual circumstances.

Can the Incident Decision Tree be used for situations other than patient safety incidents?

The Incident Decision Tree has been designed specifically for use following a patient safety incident. Although it promotes general good management practice, it may not prove effective in other circumstances.

Do I need to carry out a separate incident investigation?

Yes. The Incident Decision Tree only focuses on staff issues. It does not replace the need for a thorough incident investigation.

Can I start part-way through the Incident Decision Tree?

No, the tool is designed to pose each question in turn in a structured way.

The incident happened some time ago. Can I still use the Incident Decision Tree?

Yes. The Incident Decision Tree can be used immediately following an incident or some time later.

New information has come to light since I completed the Incident Decision Tree. What do I do?

Simply work through the Incident Decision Tree afresh using the new information. You may need to reconsider your original conclusion.

Several people were involved in the incident and I don't have time to run through it for each individual. What should I do?

It is essential to work through the Incident Decision Tree separately for each individual. Although the basic facts might be the same, there could be significant variables in each person's motivation, state of mind and understanding of the risks. Treating them as a group or focusing only on certain individuals is poor management practice and intrinsically unfair.

Example

A patient began to bleed heavily during a routine operation. Theatre called the transfusion laboratory for urgent blood. Unfortunately the laboratory technician issued blood intended for another patient in error. Three other individuals subsequently failed to check the name on the blood against the request form and the patient was given the wrong blood. In essence four people made the same basic mistake:

- the laboratory technician
- the porter
- the theatre nurse
- the consultant anaesthetist

However, each one of these had different levels of responsibility, understanding of the risks involved and mitigating circumstances. To have taken blanket action against them would have been unfair. To have singled some out for investigation but not

I can't answer one of the questions. What should I do?

If you can't answer the question after reading the guidelines following it, see page 49.

Where can I find out more information about systems failures?

See page 50.

What formats and versions is the Incident Decision Tree available in?

There will be separate versions of the Incident Decision Tree for:

- primary care
- secondary/tertiary care, ambulance and mental health services.

You are currently using the secondary/tertiary care, ambulance and mental health services version.

For more information please visit the NPSA website at www.npsa.nhs.uk or email idt@npsa.nhs.uk

Contact numbers

Up-to-date contact numbers for relevant organisations can be found on the NPSA website at www.npsa.nhs.uk

Background to the Incident Decision Tree

The NPSA has created the Incident Decision Tree to help NHS managers determine a fair and consistent course of action to take with staff following a patient safety incident.

An open and fair culture

The Incident Decision Tree forms part of a suite of tools the NPSA is developing to promote an open and fair culture in the NHS: a culture in which staff feel able to report patient safety incidents without undue fear of reprimand.

Why the Incident Decision Tree has been developed

We know from research carried out in the NHS and in other industries that systems failures are often the root cause of safety incidents. Despite this, where a serious patient safety incident occurs in the NHS the most common response is to formally suspend the staff involved from duty and then deal with them according to disciplinary procedures. This route can be unfair to employees and divert managers from identifying contributory systems failures. Suspension of key employees can also diminish trusts' ability to provide high-quality patient care.

The Incident Decision Tree has been developed to help managers:

- decide whether it is necessary to suspend staff from duty following a patient safety incident;
- explore alternatives to suspension, such as temporary relocation or modification to duties; and
- consider other measures that might need to be taken as the investigation into the incident progresses.

Although individual accountability is in no way diminished by this approach, it helps trusts focus on the 'what' and 'why' rather than the 'who'.

In 2001 a joint declaration by the government and the medical profession called for the NHS to be more open in the way it deals with professional mistakes and to 'recognise that honest failure should not be responded to primarily by blame and retribution but by learning and a drive to reduce future risk to patients.'

How the Incident Decision Tree has been developed

We have drawn on the experience of the aviation industry in developing the Incident Decision Tree, particularly the pioneering 'Culpability Decision Tree' model created by Professor James Reason.

The Incident Decision Tree is co-sponsored by the NHS Confederation. Other organisations actively involved in its development include the National Clinical Assessment Authority (NCAA), the Royal Colleges and the National Audit Office (NAO). Staff-side has contributed to the development of the Incident Decision Tree at a national level and actively supports its use.

The National Patient Safety Agency

The National Patient Safety Agency (NPSA) is a special health authority formed in 2001 to improve patient safety in the NHS by ensuring that patient safety incidents are widely reported and, more importantly, learnt from. The NPSA is not a complaints-handling, investigative or regulatory body.

Research shows that about ten per cent of patients admitted to UK hospitals suffer some kind of patient safety incident. Mostly these are minor and transient, but a very small number prove severe and fatal. It is estimated that up to half these incidents may be preventable.

Traditionally patient safety incidents have been infrequently reported, particularly where patients have suffered no lasting harm. Where submitted, reports have been filed away locally rather than used to prevent such incidents from happening elsewhere in the NHS.

The NPSA is working with NHS staff, patients, carers and organisations with an interest in patient safety to change this situation by identifying issues and appropriate solutions.

The NPSA's aims

- encourage widespread reporting and national learning from patient safety incidents; and
- help the NHS move away from a culture where individual front-line staff are routinely blamed when errors occur, towards an understanding that underlying system problems are most often responsible for incidents.

How we do this

- by collecting and analysing information on patient safety incidents from local NHS organisations, NHS staff, patients and carers;
- by taking into account other safety-related information from a variety of existing reporting systems;
- by learning lessons and ensuring that they are fed back into health care and treatment is organised and delivered; and
- by ensuring that where risks are identified, work is undertaken on producing solutions to prevent harm, and to specify national goals and establish mechanisms to track progress.

Measuring our success

Paradoxically, an increase in reporting of patient safety incidents will be evidence of the NPSA's success in encouraging an open and fair culture, where staff learn from things that go wrong and are able to avoid events recurring.

Experience from other sectors, such as aviation, shows that as reporting rises the number of serious incidents begins to decline and the NPSA anticipates a similar pattern in the NHS.

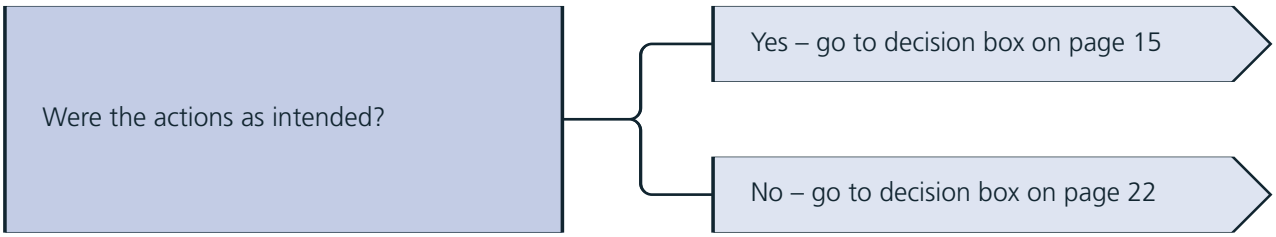
How you can learn more about our work

Visit our website at www.npsa.nhs.uk

Our contact details are:
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD
tel: 020 7927 9500
email: enquiries@npsa.nhs.uk

Section C
The tool

The Deliberate Harm Test pathway



Guidance

In the overwhelming majority of patient safety incidents the individual had the patient's wellbeing at heart. However, in a few exceedingly rare cases the intent was to cause harm. The Deliberate Harm Test asks questions to help identify or eliminate this possibility at the earliest possible stage.

Actions not outcome

This question asks whether the actions were as intended, not whether the outcome was as intended. This is an important distinction.

Examples

A nurse injects a patient with drug X instead of drug Y, as a result of which the patient dies. The question is whether the nurse intended to administer drug X, not whether she intended the patient to die.

A doctor carries out an operation on child A instead of child B, as a result of which child A is disfigured.

The question is whether the doctor intended to operate on child A, not whether he intended child A to be disfigured.

Acts of omission

Acts of omission are as important as acts of commission, so apply the question in the same way to cases that involve slips, lapses, general forgetfulness or a decision not to take action.

Examples

- failing to administer medication
- failing to call the cardiac arrest team
- failing to write-up case-notes
- deciding not to seek a second opinion in a difficult case
- failing to check a patient's health record

Consider whether the individual:

- forgot to take the action
- was prevented from taking the action
- decided not to take the action
- refused to carry out an instruction

Example

A nurse failed to give a patient their sleeping tablet. This might be because the nurse:

- forgot to give the medication
- was called to deal with an emergency
- felt the patient would be better off without a sleeping tablet
- decided to leave the shift on time without arranging for someone else to give the medication

In the first two scenarios, the actions were not as intended; in the second two scenarios the actions were as intended.

Consulting the individual

The only person who can answer the question accurately is the individual. It is therefore important to try and discuss the matter with them. However, there may be circumstances where:

- this is not possible (for example, the individual has been arrested); or
- you simply do not believe their answer.

In these cases, you will have to form a view based on the balance of probability using the information before you.

If new facts come to light you can work through the Incident Decision Tree afresh.

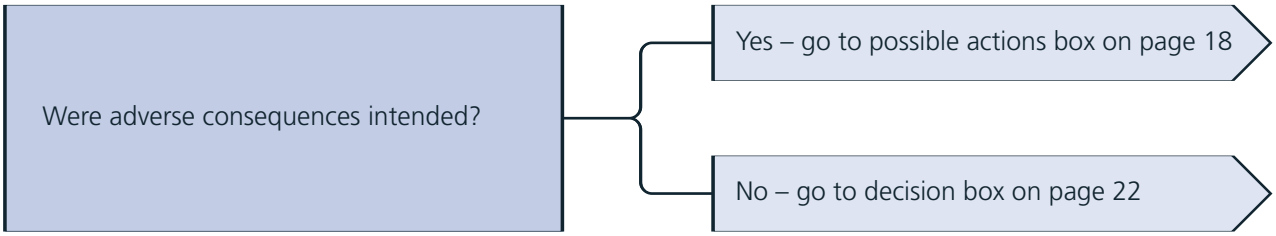
Individual denies involvement

If the individual says they were not involved in the incident, this question can be difficult to answer. It is possible that the individual:

- really was not involved;
- is traumatised and confused about what happened; or
- is lying to cover up malicious intent.

Bear in mind that in a 'blame culture' individuals sometimes feel pushed into denying mistakes through fear of punishment by management and/or their regulatory body.

You will probably need to pause and try to collect more information. You may eventually have to make a decision based on your best judgement.



Guidance

This question tries to identify the individual's motives for taking the action they did.

In most cases where the actions were as intended, the individual did not mean the patient harm.

However, if the evidence suggests deliberate harm was intended, immediate suspension is likely to be inescapable.

Harm not intended

Consider whether the individual actually meant the patient harm. The likelihood is that they did not.

Examples

A pharmacist decided to dispense a generic inhaler in place of the branded drug shown on a prescription, in order to keep costs down. However, the GP knew the patient had previously complained that the generic drug did not work and had deliberately not prescribed it. The pharmacist definitely intended to dispense the generic drug, but did not intend to cause harm.

A nurse gave a distraught relative a mild tranquilliser without prescription. The tranquilliser reacted badly with another medicine the person was taking and they spent several hours in the medical assessment unit. The nurse definitely intended to give the drug, but did not intend to cause harm.

Examples of deliberate harm

There are several ways deliberate intent to harm may emerge:

The individual did something to the patient to cause harm.

Examples
- deliberately giving a patient the wrong drug, with the aim of causing pain, disability or death
- deliberately disconnecting an infusion pump
- attacking a patient

The individual withheld treatment or care from the patient to cause harm.

Examples
- deliberately withholding vital medication from a patient
- deliberately failing to ventilate an elderly patient

The individual withheld prescribed medication from the patient so that someone else could benefit from it.

Examples
- using painkiller or mood-altering drugs prescribed for a patient on themselves
- supplying painkilling or mood-altering drugs prescribed for a patient to a third party

The individual caused the patient fear or humiliation.

Examples
- restraining a patient unnecessarily or for too long
- deliberately leaving a patient in their own excreta

The individual took advantage of the patient's vulnerability for their own gratification.

Example
- sexually assaulting a sedated patient

Assisting with self-harm

Co-operating with a patient's intent to self-harm must be viewed as 'intent to harm', however ill the patient and whatever the individual's ethical beliefs and motives, unless the actions are agreed as part of a harm reduction programme.

Examples

- providing emetics to a bulimic/anorexic patient
- colluding with a suicidal patient sectioned under the Mental Health Act to enable them to escape from the premises

Possible actions

Consult NCAA or relevant regulatory body

Advise individual to consult trade union representative

Consider:

- suspension
- referral to police and disciplinary/regulatory body
- occupational health referral

Highlight any systems failures identified

Guidance

- Act quickly and decisively to protect patient safety.
- Urgently consider whether the action might constitute a criminal act.
- Other than in situations of assisted suicide, it is unlikely that the individual will admit guilt.

Recommended action

Take the following action urgently to protect patient safety:

- If the individual is a doctor or dentist contact the NCAA for advice.
- If the individual belongs to another profession, contact the relevant regulatory body for advice.
- Obtain senior human resources advice and support.
- Decide whether to suspend the individual. See page 19 for important information about suspension, exclusion and restrictions to practice.
- Advise the individual to notify their trade union and/or professional body.
- Set up a disciplinary investigation.
- Decide how to communicate the situation to other staff.
- Check whether any other staff involved in the incident need urgent counselling, support or time off.

Ensure the relevant trust executive director is aware of:

- the situation
- your concerns
- the action you have taken
- the further action you intend to take

For contact numbers visit the NPSA website at www.npsa.nhs.uk

Incident out-of-hours

If the incident occurs out-of-hours you face two potential complications:

- your access to professional advice is likely to be limited; and
- the individual may not be your direct report (for example, where you are the duty manager on call).

If the individual is a doctor or dentist obtain immediate advice from the NCAA on their 24-hour helpline.

If the individual is still at work, consider sending them home until a decision can be taken about formal suspension.

Ensure that the trust director on call is fully-briefed about the situation. If you are the trust duty director, try to contact your chief executive or chair. If the case involves a doctor or dentist, also try to contact the medical director.

For contact numbers visit the NPSA website at www.npsa.nhs.uk

Formal suspension

Formal suspension is appropriate only where:

- the individual's continued presence at work could present a real danger to patients or colleagues and there is no other practical way of removing this risk; or
- the individual's continued presence at work might hamper the incident investigation.

Suspension should not be used lightly and the long-term potential impact on the individual must be considered.

Before suspending (excluding) any doctor or dentist always:

- consult the NCAA
- check Health Service Circular HSC 2003/012 – 'Doctors and Dentists Discipline and Suspension' or later guidance.

It may be helpful to obtain professional advice from internal sources, such as a senior clinician, chief nurse, or clinical governance lead, or from external bodies, such as the appropriate royal college.

If the individual has gone off sick but their return might jeopardise patient safety, formal suspension may still be necessary.

If the individual has already been 'sent off duty' and a decision is taken to suspend formally, make sure they are notified in writing of this change in status.

Ensure that your trust's suspension review mechanism is followed.

Poor reasons for suspension

Suspension should not generally be used:

- to pacify an angry patient or relative;
- because of media interest in the incident;
- because management needs to 'be seen to be doing something'; or
- because it is the easiest option.

Practical alternatives

In all cases explore alternatives to suspension. These might include placing restrictions on the individual's practice, such as:

- stopping them from administering drugs
- stopping them from performing certain surgical procedures
- stopping them from working with certain groups of patients
- moving them to another work area

- placing them under more intense supervision
- requiring them to obtain a second opinion on certain cases.

Before suspending (excluding) any doctor or dentist always:
- consult the NCAA
- check Health Service Circular HSC 2003/012 – 'Doctors and Dentists Discipline and Suspension' or later guidance.

The individual's attitude and previous behaviour

In deciding whether to suspend you may wish to consider the individual's:
- previous behaviour; and
- attitude towards the incident.

You might be more inclined to suspend if the individual:
- has already received relevant re-training or counselling;
- is not prepared to explore alternatives to suspension;
- has lied about the incident or tried to cover it up;
- shows no remorse for the incident; or
- does not appear willing to learn from the incident.

You might be less inclined to suspend if:
- other individuals have made similar errors;
- no previous incidents involving the individual have come to light;
- the individual is prepared to consider alternatives to suspension;
- the individual has been open and honest about the incident; or
- the individual is clearly willing to learn from the incident.

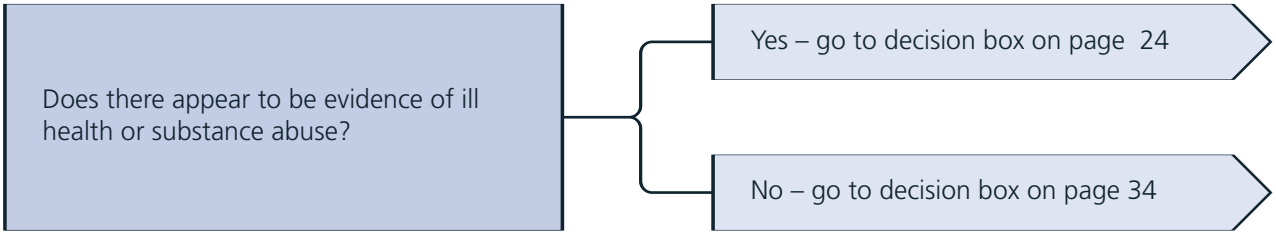
Example

A staff nurse working on a care of the elderly ward reported to the sister that she had telephoned the senior house officer for diamorphine for a terminally-ill patient in severe pain. She reported that the senior house officer had asked the nursing staff to administer the drug, saying that he would call in as soon as possible to write up a prescription retrospectively. The sister handed the drugs cabinet keys to the staff nurse without question and the patient was given the medication.

The following day it transpired that the staff nurse had not telephoned the doctor. Initially she lied about this, but subsequently admitted she had not even tried to call because: "You can never get hold of them." The staff nurse said she did not regret her actions and had administered drugs without prescription before. She was fully aware that she was breaching protocols.

By contrast, the sister was shocked by the incident and mortified that she had accepted the staff nurse's explanation. She, too, realised she had breached protocols and volunteered to move to another ward whilst the investigation took place. The trust decided that both individuals had taken an unacceptable risk and that there were no significant mitigating circumstances. The staff nurse was suspended, as it was believed that her attitude toward the incident and her previous behaviour indicated an ongoing risk to patients. She was subsequently dismissed and reported to the NMC. The sister was not suspended, but was temporarily redeployed. She was subsequently disciplined, but not dismissed.

The Incapacity Test pathway



Guidance

If intent to harm has been discounted, the Incapacity Test helps to identify whether ill health or substance abuse caused or contributed to the patient safety incident.

The Incident Decision Tree can be used whether or not the individual is absent on sick leave.

Assessing situation at time

When considering this question, focus on the situation at the time of the incident.

Example

A doctor claimed he made a surgical error because he was having an asthma attack. Although the doctor was known to be asthmatic, there was no evidence of him experiencing symptoms at the time of the incident and the trust answered 'no' to the question.

The individual is likely to be stressed and traumatised after a serious patient safety incident, but this does not necessarily mean they were in that frame of mind at the time of the incident.

Impact of illness

If there is evidence that the individual was unwell at the time of the incident you need to consider how great an impact this was likely to have had on their actions. This is a matter of judgement, with no hard and fast rules.

Example

If the individual says they had a sore throat or mild headache, you would probably answer 'no' to the question.

If they had been complaining all day of migraine, had a high fever or had been regularly breaking down weeping with severe depression, you would probably answer 'yes' to the question.

Cases of doubt

If the incident has just occurred and there is doubt whether the individual is genuinely ill, seek immediate advice from occupational health.

If this is not possible, other factors to consider when answering the question might include whether the individual:

- mentioned feeling ill to colleagues before the incident;
- was waiting for an appointment with a medical adviser;
- had just returned from sick leave and was not fully recovered;
- had discussed going home sick but stayed on, perhaps because of low staffing levels;
- had taken any medication which might have affected their judgement or performance; or
- had recently suffered one or more serious life events.

Stress

Stress can be a difficult area to assess and may relate to work or to outside circumstances. Again, the degree and pattern of the stress are important to consider.

Research indicates that an individual who has recently suffered a serious life event is at a greater risk of making safety errors.

If the available evidence suggests the individual was suffering from severe stress at the time of the incident answer 'yes' to this question. If in doubt, seek an occupational health opinion.

Out-of-character behaviour might be a symptom of physical or psychological illness.

However, inappropriate behaviour does not necessarily indicate that the individual was unwell.

Examples

A reliable physiotherapist started to forget patient appointments and case histories. She was eventually found to be in the early stages of Alzheimer's Disease.

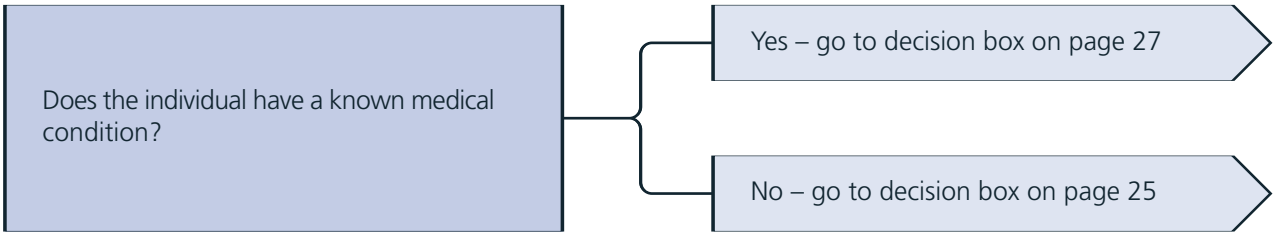
An experienced nurse with an unblemished record hit a colleague when a disagreement broke out in theatre. The trust decided the nurse must have been ill at the time, although there was no evidence to support this. It later transpired that the assault related to a long-standing personal vendetta.

Substance abuse

If there is evidence that the individual was intoxicated or affected by substance abuse at the time of the incident, answer 'yes' to the question.

Substance abuse includes intoxication through alcohol or recreational drugs, solvent abuse, inhaling anaesthetic gases and inappropriate self-medication (such as self-injecting with opiates).

If you are unable to determine whether the individual was affected by substance abuse, it is important to obtain an urgent medical opinion from occupational health.



Guidance

This question considers whether the individual was suffering from a known medical condition when the incident occurred.

The individual may or may not have been aware of their illness at the time.

Awareness of condition at time

The individual may or may not have been aware of their illness at the time. The full picture might only have emerged after the event.

You will probably need to establish the facts with:

- the individual
- the individual's line manager
- Occupational Health

> **Example**
>
> A consultant orthopaedic surgeon made a serious surgical error, unaware at the time that he was diabetic and on the point of collapse. In this example, the answer to the question would be 'yes'.

Definition of 'known medical condition

A 'known medical condition' is any chronic health problem with the potential to affect the individual's ability to carry out their work. Common examples include diabetes, hypertension, epilepsy, migraine, asthma, dermatitis, arthritis, multiple sclerosis, hepatitis B, severe visual impairment, clinical depression and alcoholism. Cognitive problems resulting from dementia or head injury can also be a cause of long-term ill health.

In many cases the health problem is well-controlled and does not interfere with the individual's work.

Patient safety incidents may be linked to situations where the individual is:

- unaware they are ill;
- newly-diagnosed and adjusting to the condition or medication;
- unaware the condition has deteriorated; or
- failing to take their medication.

If the individual was clearly unwell at the time of the incident, but did not have a pre-existing chronic condition (for example they had influenza or a stomach upset), answer 'no' to this question.

Possible actions

Consult NCAA or relevant regulatory body

Advise individual to consult trade union representative

Consider:

- occupational health referral
- reasonable adjustment to duties
- sick leave

Highlight any systems failures identified

Guidance

If the individual has a substance abuse problem it could present a continuing danger to patients. This risk should be assessed urgently with the help of occupational health, who may need to consult specialist services.

Recommended action

Take the following action urgently to protect patient safety.

- If the individual is a doctor or dentist contact the NCAA for advice.
- If the individual belongs to another profession, contact the relevant regulatory body for advice.
- Obtain senior human resources advice and support.
- Decide whether to suspend the individual. Go to page 19 for important information about suspension, exclusion and restrictions to practice.
- Advise the individual to notify their trade union and/or professional body.
- Set up a disciplinary investigation.
- Decide how to communicate the situation to other staff.
- Check whether any other staff involved in the incident need urgent counselling, support or time off.

Ensure the relevant trust executive director is aware of:

- the situation
- your concerns
- the action you have taken
- the further action you intend to take

For contact numbers visit the NPSA website at www.npsa.nhs.uk

Criminal acts

In cases of alcohol or substance abuse the patient safety incident may have involved a criminal act.

Examples
- An ambulance driver over the alcohol limit.
- A doctor self-administering controlled drugs with no prescription.

In such circumstances you should urgently consider:
- suspending the individual;
- referring the case to the police; and
- instigating a disciplinary investigation.

See page 19 for important information about suspension, exclusion and restrictions to practice.

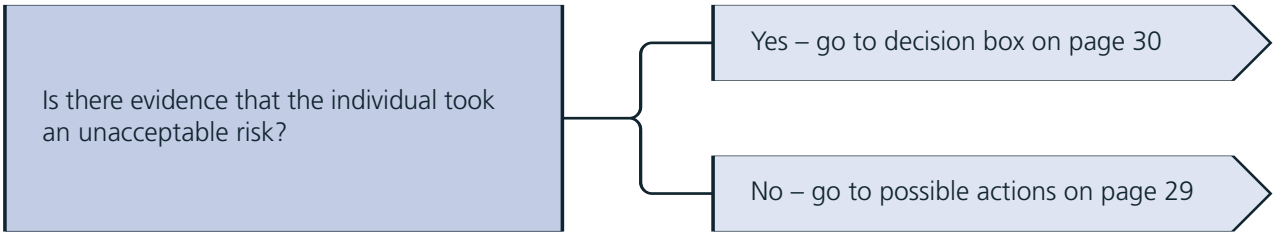
Continuing ill health

If the individual remains unwell, formal suspension is not generally helpful and the stress it causes may hinder recovery.

Recommended action
- If the individual is a doctor or dentist contact the NCAA for advice.
- If the individual belongs to another profession, contact the relevant regulatory body for advice.
- Refer the individual to occupational health.
- Consider whether adjustments could be made to the individual's duties to enable them to remain at work.
- Consider whether the individual could carry on practising during the investigation if certain restrictions were placed on their work.

Before placing any restrictions on a doctor or dentist's practice always:
- consult the NCAA
- check Health Service Circular HSC 2003/012 – 'Doctors and Dentists Discipline and Suspension' or later guidance.

For contact numbers visit the NPSA website www.npsa.nhs.uk



Guidance

'Unacceptable risk' is a lay definition to guide initial management action following a patient safety incident.

The Incident Decision Tree does not explore the standards of proof legally required to support any subsequent allegation of 'reckless behaviour' or 'criminal negligence'.

This box is probably the most difficult to answer and careful judgement must be exercised.

You need to decide whether the individual with a known medical condition took an unacceptable risk in exposing patients to it. The answer will be 'no' in most cases.

Regulatory bodies' interpretations

It is important to note that different professional and regulatory bodies have different interpretations of 'unacceptable risk' and 'professional accountability'. If in doubt, check the situation with the body concerned.

For contact numbers visit the NPSA website www.npsa.nhs.uk

Factors to consider

Awareness of condition

First determine whether the individual was aware of their medical condition or had good reason to believe at the time that they were suffering from the condition.

If they were unaware of their condition they cannot be considered to have taken an unacceptable risk.

Examples

- the surgeon who continued to operate despite being aware she was HIV positive.
- the nurse who failed to inform her employer she was a TB carrier.
- the paramedic who carried out invasive procedures despite being aware he was hepatitis B positive.
- the alcoholic doctor who anaesthetised patients knowing he was intoxicated.

Awareness of implications

If the individual was aware of their condition, establish whether they realised the danger this might present to patients.

If the individual was unaware of the implications, they cannot be considered to have taken an unacceptable risk.

Example

A theatre nurse who knew she was in the early stages of Parkinson's disease dropped an instrument, injuring a patient. The nurse had been advised by her doctor to 'carry on as normal' and told that adjustments to her working practice and environment would not be necessary for some time.

The trust decided the nurse had not taken an unacceptable risk because she was unaware of the implications of her illness.

Use of proper safeguards

Finally, explore whether the individual took proper safeguards to protect patients from exposure to the risk.

Example

A patient contracted influenza after being treated by a nurse who was in the early stages of the infection. The nurse was unaware of her condition. She could not therefore be considered to have taken an unacceptable risk.

Guidance

If you decide the individual did not take an unacceptable risk, consider action to ensure that their medical condition or substance abuse is being properly managed and does not present a future risk to patient safety.

Possible actions

Advise individual to consult trade union representative

Consider:

- Corrective training
- Improved supervision
- Occupational health referral
- Reasonable adjustment to duties

Highlight any systems failures identified.

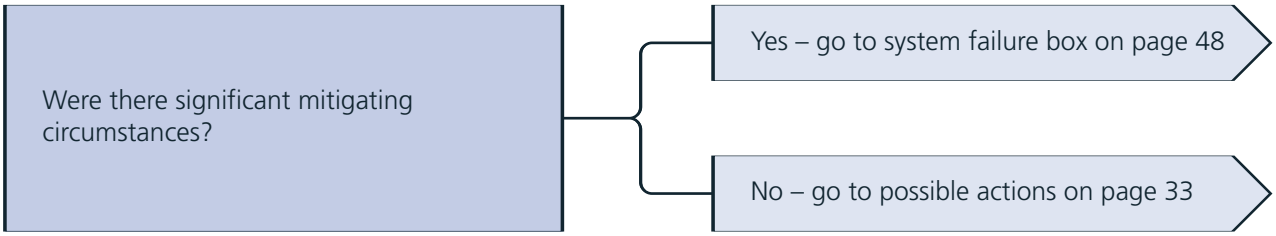
Guidance

If you decide the individual did not take an unacceptable risk, consider action to ensure that their medical condition or substance abuse habit is being properly managed and does not present a future risk to patient safety.

Support and education

- Check with occupational health that the individual is receiving proper medical support and guidance.
- Check that any risks their condition presents are understood by:
  - the individual
  - the individual's manager
  - the individual's colleagues (if appropriate)

  and that effective and sensitive plans are in place to deal with these.
- Consider any beneficial adjustments that could be make to the individual's duties or working environment.



Guidance

If you decide the individual took an unacceptable risk, you next need to consider any mitigating circumstances.

Mitigating circumstances may or may not be significant enough to affect the way you decide to proceed. They must be set in the context of all the other factors involved in the case.

Mitigating circumstances fall into three broad categories:

- work pressures
- external pressures
- environmental factors

Sometimes a combination of these is present.

Work pressures

Examples include:

- tiredness
- short-staffing
- bullying
- anxiety about job security
- lack of management support

Example

A midwife failed to notice discrepancies in an electronic heartbeat trace, as a result of which a baby was born in poor condition and needed resuscitation.

The individual maintained that tiredness had impaired her judgement and observation. It transpired she had been on duty for 15 hours without a break and had worked a total of 65 hours over the previous five days to cover colleagues' absence.

The trust decided the individual took an unacceptable risk, but accepted the mitigation and identified the case as a system failure.

External pressures

External pressures usually relate to anxiety or preoccupation about events or problems outside work. They might involve needing to leave work promptly or early to care for dependants or to deal with a personal issue.

Examples

A theatre nurse cut corners sterilising instruments. She needed to leave work early to check on a sick, elderly relative and her manager had previously been unsympathetic to the situation.

A doctor put up the wrong intravenous drip just after receiving news that her son had been involved in a road traffic accident.

A radiographer filed reports in the wrong case-notes whilst waiting to hear whether his wife was being made redundant.

Environmental factors

A wide range of environmental factors could be involved in the patient safety incident.

Examples include:

- distraction
- difficult working conditions
- shortage of supplies

Examples

A nurse administered a drug to the wrong patient for no accountable reason. However, the trust accepted as mitigation the fact that the nurse had felt faint and disorientated because of the heat on the ward. The air conditioning had broken, the temperature was more than 40 degrees centigrade, and two other nurses had gone home sick because of the conditions.

An accident and emergency doctor used an adult cannula on a young child, as no paediatric cannulae were available. This caused severe bruising and pain.

A cardiac arrest team had difficulties defibrillating a patient because the patient's bed was jammed against the wall and they could not reach her easily.

Combination of factors

Sometimes the individual cites a range of mitigating circumstances, some of which you may decide to accept, others to reject.

Example

A consultant paediatrician slapped a three year-old child across the face during an out patient consultation.There was no dispute that this action constituted an unacceptable behaviour. The consultant pleaded mitigating circumstances, citing fear that the child was going to bite him; tiredness and stress covering a colleague's out patient list as well as his own; and anxiety about his son's imminent examination results.

The trust accepted all these were true, but did not consider the excuses justified the individual's action. They therefore answered 'no' to the question.

Possible actions

Consult NCAA or relevant regulatory body

Advise individual to consult trade union representative

Consider:

- Referral to disciplinary/regulatory body
- Reasonable adjustment to duties
- Occupational health referral
- Suspension

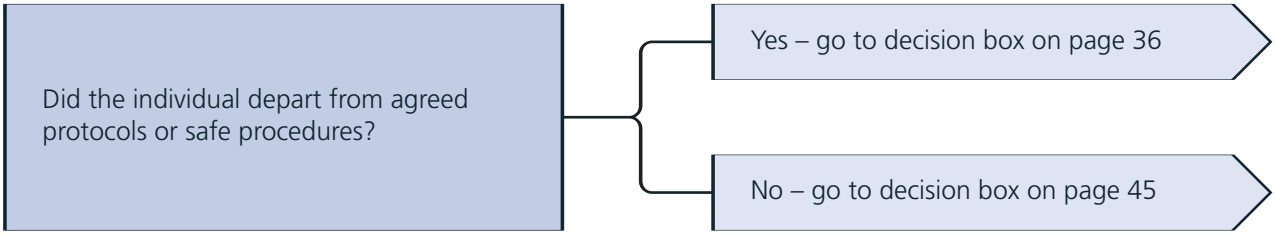
Highlight any systems failures identified.

Guidance

If the individual took an unacceptable risk and there were no mitigating circumstances, suspension may be necessary until investigations are completed.

For further guidance see page 19.

The Foresight Test pathway



Guidance

If intent to harm and incapacity have been discounted, apply the Foresight Test to determine whether protocols and safe working practices were properly adhered to.

This test examines whether the incident arose because:

- no protocol or safe procedure existed;
- the protocol was poor;
- there were conflicting protocols;
- good protocols were misapplied;
- the individual decided to ignore protocols; or
- the individual took an unreasonable risk.

The Foresight Test does not try to remove an individual's personal responsibility for their actions, but sets it in the context of potential problems with protocols.

Check protocol exists

First clarify whether the action was governed by an agreed protocol or procedure. Do not simply assume this to be the case – check the documentation yourself.

It is impossible to proceduralise every eventuality.

Likewise, it is dangerous to apply protocols slavishly, without using judgement or taking into account particular circumstances. Failure to react to unusual circumstances can be as dangerous as routine contravention of protocols.

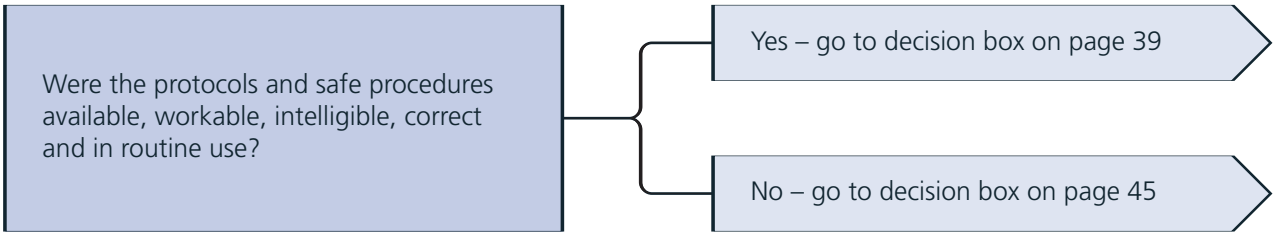
The Substitution Test acts as a safety-net when assessing situations where protocols were inadequate or not in place.

Professional codes of conduct

Do not assume the individual received instruction on safe procedures during their professional training.

Example

A surgeon operated on the wrong side of a patient's body, the site having been incorrectly marked. The surgeon had not examined the patient before operating and the trust assumed an agreed safe procedure had been violated. While it is good surgical practice for the doctor to examine the patient before operating, this is not yet enshrined in any protocol or professional code of conduct. The trust should therefore have checked the situation, answered 'no' to the question and moved across the flowchart to apply the Substitution Test.



Guidance

Pause at this point to check the facts carefully. Do not automatically assume that protocols were workable and in routine use.

Remember to establish the situation at the time of the incident; working practices may have been revised subsequently.

Was the protocol available?

A protocol was only 'available' if the individual had ready access to it. For example, if a protocol could only be accessed via the trust intranet but there was no computer in the work vicinity, the protocol could not be considered 'available'.

Was the protocol workable, intelligible and correct?

What at first sight appears to be a workable protocol may be problematic in practice.

Ask the following questions:

- Was the protocol clear?

  The individual might have mis-interpreted an ambiguous or badly-written protocol.
- Was the individual unwittingly applying an outdated protocol?
- Were conflicting protocols in circulation?
- Was the protocol technically accurate but too laborious to apply routinely?

  If the protocol was technically accurate, but too time-consuming or complex to apply the individual may have had to disregard it in order to get the job done.
- Did the protocol promote correct and sensible action?

  If the protocol was badly written or unworkable the individual may have made a professional judgement to disregard it.

Example

Following a theft, a cardiac unit introduced a locked-drugs policy. However, night-duty staff thought it unsafe to leave patients in outlying beds long enough to obtain adrenaline from the new drug cabinet. After raising the issue to no avail, nurses started to store adrenaline ampoules in the desk drawer to gain speedier access. Some ampoules fell onto the floor and a visiting child was found playing with them.

In this case a protocol introduced for a sound reason proved unworkable, leading to a dangerous situation. The trust answered 'no' to the question and applied the Substitution Test to the individuals concerned.

A protocol that is workable in routine situations might have failed in unusual circumstances, such as atypical presenting symptoms or equipment malfunction.

Was the protocol in routine use?

It is unrealistic to assume that because a protocol existed staff were using it routinely.

Consider the following factors:

Did the individual know of the protocol's existence?

Check whether the individual had been briefed about the protocol:

- during their induction; or
- when the protocol was introduced, if this was later.

Example

A maternity patient, who had undergone a Caesarean section, became distressed when a midwife took her baby into the night nursery. This contravened a recently introduced trust protocol. It transpired that the midwife had just returned from long-term sick leave and had not been informed of the change in practice. The trust answered 'no' to the question and applied the Substitution Test.

Did the individual forget to use the protocol?

Sometimes the individual was so used to applying a familiar protocol that they acted instinctively and forgot there had been a change in practice. This may happen when:

- an old protocol is replaced;
- an individual changes departments or locations; or
- an individual changes organisations.

Example

A new junior doctor rang the cardiac arrest team bleep number used at her former hospital, leading to a dangerous delay in resuscitating a patient.

Did the individual decide not to apply the protocol?

If the individual was aware of the protocol but decided not to apply it you need to establish their reason for doing this.

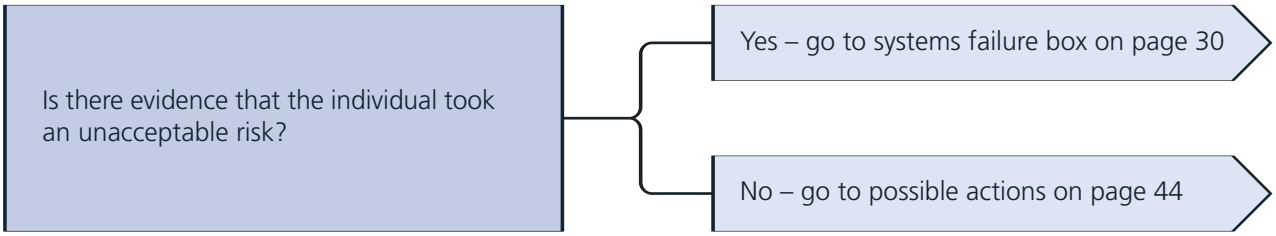
If their action stemmed from difficulties applying the protocol, you would normally answer 'no' to the question and apply the Substitution Test.

If there was another reason, you would normally answer 'yes' to the question and move down the flowchart to the next box in the Foresight Test.

Did the individual cut corners because they knew the protocol so well?

Sometimes the individual was so familiar with the protocol they felt over-confident about cutting corners. Corner-cutting usually causes problems where the case concerned turns out to be atypical.

The individual may be alone in cutting corners, or may work in an environment where this is routine.



Guidance

'Unacceptable risk' is a lay definition to guide initial management action following a patient safety incident.

The Incident Decision Tree does not explore the standards of proof legally required to support any subsequent allegation of 'reckless behaviour' or 'criminal negligence.'

This box asks you to consider whether the individual took a risk that would normally be considered unreasonable in the service concerned. It is probably the most difficult question to answer and careful judgement needs to be exercised.

There are many reasons why an individual might violate a sound protocol.

Sometimes the individual violates a protocol for no apparent or explicable reason.

Generally, the more control the individual had over the situation, the more likely you are to decide they took an unacceptable risk.

Regulatory bodies' interpretations

It is important to note that different professional and regulatory bodies have different interpretations of 'unacceptable risk' and 'professional accountability.' If in doubt, check the situation with the body concerned.

For contact numbers visit the NPSA website at www.npsa.nhs.uk

Factors to consider

There are many reasons why an individual might violate a sound protocol, including:

- habit
- someone else's benefit (for example a patient, colleague or patient's relative)
- their own benefit
- arrogance
- failure to exercise self-discipline
- nothing apparent or explicable

Other factors to take into account when answering the question include:

- information available to the individual at the time
- choices in front of them
- speed with which they had to make a decision
- degree of awareness they had of the risk being created

Compare and contrast

- A staff nurse working on a busy ward was called to deal with a violent relative and forgot to give a diabetic patient their insulin.
- Another staff nurse forgot to give a patient their sleeping tablet because she popped into the day room to catch an episode of her favourite soap opera and became absorbed in the plot.

Violation for known reason

Habit

One important possibility to consider is the 'reckless individual in the reckless environment'. If the individual was working in an environment where cutting corners or ignoring protocols was endemic, it could be argued that they knew no different or that they should not be penalised for common practice.

Someone else's benefit

Sometimes the intent was altruistic, aimed at helping a patient, colleague or other person. Motivation will vary from case to case.

Compare and Contrast

- An accident and emergency doctor violated protocols by giving priority to an adult friend with a minor cut over a child with a high fever.
- A healthcare assistant tried to perform the Heimlich manoeuvre when a colleague choked on a sandwich in the staff restaurant. The individual had received no first-aid training. No-one else was in the restaurant at the time, but the individual could have tried to summon help by telephone.

Even where well-intentioned, it is still important to determine whether the risk was acceptable or unacceptable.

Hard and fast rules cannot be set and you must use your own judgement.

Examples

A surgical patient was receiving opiate analgesia via a syringe pump. The charge nurse, who had just come on duty, realised that the pump had been set up to run much too fast and the patient's breathing was slow and shallow. The charge nurse urgently summoned medical staff assistance but there was no response. The patient stopped breathing. The charge nurse decided there was no option but to deliver a naloxone injection himself to try and save the patient's life. In doing so he knowingly breached trust protocols (which were generally clear, workable and in routine use) and his own profession's standards of accountability. However, the nurse was faced with a life or death situation and the risk to the patient of waiting for medical help was much greater than the nurse giving the injection. The trust decided to answer 'no' to the question.

A porter passing through an elderly care unit noticed a nurse struggling with a confused and argumentative patient, who was trying to leave the ward. The porter tried to restrain the patient, but he seized the patient roughly and fractured several of the patient's ribs. The porter realised he was breaching trust protocols: the nurse had not asked for assistance; nobody appeared to be in immediate physical danger; and the porter had no training in handling elderly patients. In essence, the porter had simply decided to 'pitch in'. The trust decided to answer 'yes' to the question and moved across to the flowchart to explore any mitigating circumstances.

Own benefit

Sometimes a patient is put at risk when an individual violates protocols for their own benefit. They may or may not be conscious of the danger created.

Examples

- cutting corners to leave work early
- paying more attention to chatting with colleagues than to the task in hand
- excitement of 'sailing close to the wind'

Some individuals gain an adrenaline buzz from taking risks and do so for no other purpose. James Reason refers to this behaviour as 'optimising violations'.

Usually it is clear that the individual took an unacceptable risk. If so, move across the flowchart and explore any mitigating circumstances.

Arrogance

Sometimes the individual violated a protocol because they resented the constraints it imposed on them. For example, they may have decided to undertake procedures for which they were not qualified or trained.

Example

A midwife took it upon herself to deliver a baby by ventouse suction, despite the fact that her trust's policy was for this procedure to be carried out by an obstetrician. Subsequently, the midwife explained she had witnessed ventouse deliveries countless times and felt she could perform them as well as any doctor. She was fully aware of trust policy and had made no attempt to contact medical staff.

The trust answered 'yes' to the question and moved across the flowchart to consider whether there were any mitigating circumstances.

Failure to exercise self-discipline

This category involves issues such as:

- physical or verbal retaliation
- refusing to liaise with a disliked colleague

Example

A consultant obstetrician blocked a consultant neonatologist from attending the delivery of a very premature baby. This directly contravened trust policy. The obstetrician's reason was that he had had a major disagreement with the neonatologist and did not want to see her.

The trust answered 'yes' to the question and looked into mitigating circumstances.

Violation for no explicable reason

Sometimes, there is simply no explanation or apparent motivation for the individual's action. You must therefore rely entirely on your own judgement when considering 'unacceptable risk'.

Often these cases involve a 'perceptual slip', such as picking up the wrong medication, or ticking the wrong box on a form.

Example

An occupational health nurse picked up an ampoule of hepatitis B vaccine instead of an ampoule of tetanus vaccine and gave the wrong injection. She only realised the error when discarding the packaging. The nurse could not offer any explanation for her action. Her track record was unblemished and there were no obvious mitigating circumstances.

The trust answered 'yes' to the question, but felt that suspension for an honest mistake was not appropriate. A drug-storage system failure was identified and addressed.

Possible actions

Advise individual to consult trade union representative

Consider:

- Corrective training
- Improved supervision
- Occupational health referral
- Reasonable adjustment to duties

Highlight any systems failures identified.

Guidance

There are some circumstances where no action is required regarding the individual. For example, if they acted heroically in extreme circumstances or there was nothing they could have done to prevent the mishap.

In other situations, the incident highlights the need for the individual to receive:

- corrective training
- improved supervision
- occupational health advice
- reasonable adjustment to duties

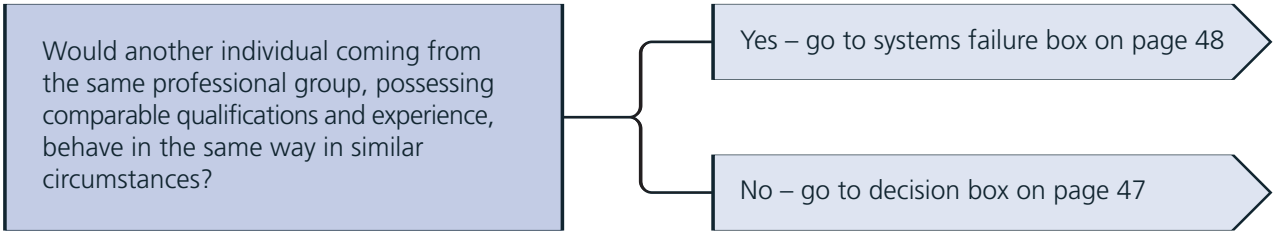
Needs of other staff

The patient safety incident may highlight the need for a wider group of staff to receive corrective training or improved supervision. If one individual made the error, so might another.

Consider the following:

- some individuals will be the least likely person in the team to repeat the error; and
- some individuals will be so nervous about repeating the error their anxiety makes them more prone to mistakes.

The Substitution Test pathway



Guidance

If protocols were not in place or proved ineffective, apply the Substitution Test to assess how a peer would have been likely to deal with the situation.

This test also highlights any deficiencies in the following that may have been involved in the patient safety incident:

- training
- experience
- supervision

Factors to consider

Take into account how events unfolded and were perceived by those involved in real time.

You may need to obtain advice about acceptable practice from internal sources, such as a senior clinician, chief nurse or clinical governance lead, or from external sources such as the individual's professional body or the relevant royal college.

Example

A patient told a radiographer that she was feeling heat from the X-Ray equipment. The radiographer dismissed the concerns and continued with the procedure, as the protocol advised switching off the machine only if the malfunction warning light appeared. It transpired that the warning system had failed and the patient suffered burns as a consequence.

The trust decided that a peer would have been likely to heed the patient's concerns and answered 'no' to the question.

Where behavioural issues are involved, it is important not to deduce the norm from blanket judgements and prejudices.

Examples

"All surgeons have temper tantrums."

"Most nurses find it difficult to think on their feet."

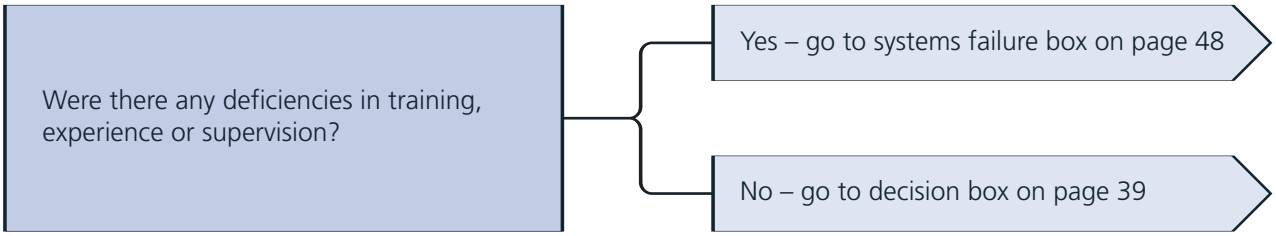
"Radiographers find talking to patients difficult."

"All accident and emergency staff should be used to coping under pressure."

"Porters can't be expected to use common sense."

Consider what a 'reasonable' peer acting sensibly, maturely and sensitively would have done.

For contact numbers visit the NPSA website at www.npsa.nhs.uk



Guidance

Consider whether the individual was properly equipped to deal with the situation. If not, a system failure is indicated.

Problems may be immediately apparent, or may emerge only on discussion with the individual or their manager.

Factors to consider

Carefully check the following possibilities:

- Gaps or deficiencies in the individual's training.
- Being 'thrown in at the deep end', with insufficient experience to handle the situation.
- Inadequate supervision.

Training

Look into any training the individual had received and make sure it was:

- comprehensive;
- well-designed; and
- effectively delivered.

Supervision

Check that supervision was both active and supportive.

Do not make automatic assumptions about the standards of training or supervision received.

Sometimes a lack of training or supervision can affect an individual's ability to apply common sense and 'think on their feet'. If this is the case, additional coaching or support may be necessary.

Example

A newly-qualified nurse was asked by the ward sister to 'draw up a syringe of erythromycin' and give it to a sick child. The new recruit assumed this meant an intravenous syringe and duly injected the child with the drug. The child died as a consequence. The drug was in syrup form and the sister had meant a paediatric oral medicine syringe, but had not thought to check that the junior understood the instruction. This case involved both inadequate supervision and deficiencies in training.

The trust answered 'yes' to the question 'Were there any deficiencies in training, experience or supervision?' and addressed the system failures.

Systems failure – review the system

For more information on systems failures see page 50

Section D
What to do if you're unable to answer a question

Guidance

The Incident Decision Tree can be worked through stage by stage. The questions do not have to be answered in one go.

If you cannot answer a question it is important to pause and try to establish the facts. Do not make assumptions.

Gather as much evidence as you can, but recognise that there could be situations where information proves patchy or inadequate. In these circumstances you may have to answer the question based on your best judgement.

Management needs to have reasonable belief about a situation before taking action, but does not need to establish proof beyond reasonable doubt.

You will probably find it helpful to sift through the available information with a senior human resources colleague, your line manager, or someone else who can help you assess the situation.

Assess immediate danger to patient safety

If the incident has just come to light and you are pausing to gather more information, check whether the individual is likely to present an immediate danger to patient safety. If this is a genuine risk, consider sending them off duty whilst the need for formal suspension is evaluated.

See page 19 for important information about suspension, exclusion and restrictions to practice.

New information emerges

If you have already worked through the Incident Decision Tree and new information arises, simply run through it afresh.

Section E
Systems failures

System failure caused incident

If the Incident Decision Tree indicates that a system failure led to the patient safety incident, focus needs to shift onto tackling the underlying problems highlighted. The aim should be to improve practice and minimise the likelihood of recurrences.

Research into patient safety shows that the majority of staff try to create a safe environment and prevent things from going wrong. Despite some high-profile cases, the overwhelming majority of incidents are not caused by malicious intent or even by lack of competence on the part of the individual delivering the care. The best people can make the worst mistakes.

System failure contributed to incident

Even in situations where the individual was clearly responsible, or where no one could have prevented the incident, systems failures might still be identified. These should be investigated in parallel to any other action.

Support for individual

Whatever the underlying cause of the incident, the individual and their colleagues might still need support, coaching and assistance in coming to terms with the events.

Causal factors

Patient safety incidents usually have four basic components, or causal factors:

- active failures
- latent system conditions
- violations
- contributory factors

Each of these components should be considered in the systems approach to safety. There may be more than one causal factor in any incident.

Active failures

These are actions or omissions by frontline staff that are sometimes called 'unsafe acts'. They include slips, lapses, mistakes or violations of a procedure, guideline or policy. Usually short-lived and often unpredictable, active failures are influenced by latent system conditions and contributory factors (see page 52) such as stress, inadequate training and assessment, poor supervision or high workload.

Examples

An infusion bag with added potassium is incorrectly stored on the first shelf (for saline only) rather than the normal place on the second shelf. In an emergency a staff member picked up the bag from the first shelf assuming it was saline and gave the patient the wrong bag.

A heart monitor used in an ambulance constantly alarmed. When checked there appeared to be no problem with either the patient or the monitor. As this continued and the crew were distracted, they ignored the alarm when in fact the patient had had a cardiac arrest.

Latent system conditions

These are the underlying, rather than immediate, factors that can lead to patient safety incidents. They relate to aspects of the system in which people work. They are usually actions or decisions taken at the higher levels of an organisation, which seem well thought out and appropriate at the time but can create potential problems within the system. These factors can lie dormant and unrecognised for some time. Alternatively, they may be recognised but changing them is not a priority. The latent conditions combined with local conditions (active failures and contributory factors) create the potential for incidents to happen.

Examples of latent system factors include decisions on:

Planning
Fixed staffing levels may be adequate until extreme conditions occur, such as higher than average sickness absence or more than the usual number of critically ill patients.

Designing
Designing a new clinic, practice, ward or diagnostic centre without considering vulnerable groups, such as children or mental health patients, and leaving dangerous equipment within their reach.

Policy-making
Having a strict take-home policy for drugs, which doesn't take into account difficult times to get to a pharmacy (such as Christmas) or rare drugs that may not be local stock items.

Communicating
Having only a limited reporting structure for patient safety incidents, meaning that vital lessons are not learned across the organisation.

Violations
These occur when an individual or group deliberately ignores a known protocol or chooses not to follow a procedure. This may be because:

- they are not aware of the procedure;
- the situation dictates a deviation;
- it has become habit;
- the procedure has been found not to work; or
- the procedure has been surpassed by a new one but has yet to be rewritten.

Contributory factors

These are factors that can contribute to an incident in relation to:

Patients
These are unique to the patient(s) involved in the incident, such as their age, language or the complexity of their condition.

Individuals
These are unique to the individual(s) involved in the incident. They include psychological factors, home factors, and work relationships.

Tasks
These include aids that support the delivery of patient care, such as policies, guidelines and procedural documents. They need to be up to date, available, understandable, useable, relevant and correct.

Communication
These include communication in all forms: written, verbal and non-verbal. Communication can contribute to an incident if it is inadequate, ineffective, confusing, or too late. These factors are relevant between individuals, within and between teams, and within and between organisations.

Team and social factors

These can adversely affect the cohesiveness of a team. They involve communication within a team, management style, traditional hierarchical structures, lack of respect for less senior members of the team and perception of roles.

Education and training

The availability and quality of training programmes for staff can directly affect their ability to perform their job or to respond to difficult or emergency circumstances. The effectiveness of training as a method of safety improvement is influenced by content, delivery style, understanding and assessment of skill acquisition, monitoring and updates.

Equipment and resources

Equipment factors include whether the equipment is fit for purpose, whether staff know how to use the equipment, where it is stored and how often it is maintained. Resource factors include the capacity to deliver the care required, budget allocation, staffing allocation and skill mix.

Working conditions and environmental factors

These affect ability to function at optimum levels in the workplace, and include distractions, interruptions, uncomfortable heat, poor lighting, noise and lack of or inappropriate use of space.

Examples of system failures

- Inadequate procedures for obtaining and checking references.
- Failure to react to employees' concern regarding a colleague's alleged substance abuse.
- Protocol that works only in very restricted situations.
- Lax arrangements for accessing controlled drugs.
- Failure to offer hepatitis B vaccinations to 'at risk' staff.
- Lack of flexibility and support for staff experiencing personal problems.
- Failure to monitor individual with known alcohol addiction.
- Poor labelling of drug supplies.
- Unacceptable delay in obtaining occupational health appointments.
- Failure to address sudden deterioration in an individual's performance.
- Malfunctioning fire-alarms causing distraction.
- Inadequate lighting in a theatre suite.

Root Cause Analysis

If a system failure is identified, the NPSA has developed a toolkit and guidance on root cause analysis techniques to examine the system in which the patient safety incident occurred.

Root cause analysis helps identify what happened, how and why. The analysis can then be used to identify areas for change and develop recommendations and sustainable solutions that minimise the chances of a particular incident reoccurring in the future.

Further information can be found on www.npsa.nhs.uk

Section F
Glossary

Circular HSC 2003/012	DH Circular 'Doctors and Dentists Discipline and Suspension'
Culpability Tree	Tool developed for the aviation industry by Professor James Reason for determining action regarding staff involved in a safety incident
Deliberate harm	Intention to cause pain, suffering or death
DH	Department of Health
Exclusion	Term adopted by DH to describe the suspension from duty of a doctor or dentist
GDC	General Dental Council
GMC	General Medical Council
IDT	Incident Decision Tree
NCAA	National Clinical Assessment Authority
Negligence	Legal term describing a breach of duty of care which results in damage
NMC	Nursing and Midwifery Council
NAO	National Audit Office
NPSA	National Patient Safety Agency
Optimising violations	Deliberate risk-taking to gain excitement
Patient Safety Manager	NPSA employee with designated responsibility for helping healthcare providers improve patient safety
Perceptual slip	Term used to describe mistakes such as picking up the wrong item or ticking the wrong box on a form
Recklessness	Legal term used to describe acting without care or thought for the consequences
Restrictions to practice	Constraints placed on a practitioner, such as not being allowed to perform certain types of surgery
Root cause analysis	A system for determining what happened, how and why
System failure	Flaw in processes or environmental problem that may lead to a patient safety incident