University College London Hospitals
NHS Foundation Trust

uclh

# Risk Management - Incident Reporting

## UCLH policy & procedure

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| **Author** | Catherine Mooney, Deputy Director Quality & Safety |
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| **Responsible Director** | Professor Tony Mundy, Medical Director Corporate |
| **Monitoring Committee** | Quality & Safety Committee |
| **Target Audience** | All Trust Staff |
| **Related Trust Policies** | Being Open Policy<br>Complaints Policy<br>Duty of Candour Policy<br>Handling of Clinical Negligence and Risk Pooling Scheme Claims Policy<br>Management of Work-Related Stress Policy & Procedure<br>Raising Concerns Policy & Procedure<br>Risk Management Policy and Procedure<br>Risk Management Strategy |
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**Appendices**

## 1.0 Summary

**1.1** This policy describes how staff at University College London Hospitals NHS Foundation Trust (UCLH) should report clinical and non-clinical incidents, including near misses, potential or actual incidents and Serious Incidents (SIs). It covers all incidents, whether they involve patients, relatives, visitors, members of staff, contractors, or the general public, or are associated with research. The policy supports the UCLH Risk Management Strategy and Risk Management Policy and Procedure which describe in more detail the Trust's overall approach to the management of risks.

## 2.0 Introduction

UCLH is committed to creating an open and fair culture in which staff are confident about reporting incidents and near misses. Evidence suggests that by creating a 'reporting culture', organisations can improve their ability to learn when things go wrong and improve patient safety. There are clear procedures at UCLH for supporting staff, patients and relatives, who are involved in incidents and these are set out within the Management of Workplace Stress Policy and Procedure and the Being Open Policy. To support an open culture UCLH also has a policy on open disclosure called the Raising Concerns Policy & Procedure.

## 3.0 Objectives

**3.1** The purpose of this policy is to describe:

- The processes by which staff report near misses and incidents including serious incidents
- The processes by which incidents and all serious incidents are investigated.
- The roles and responsibilities of staff groups
- How incidents should be graded
- The requirements for reporting both internally and externally

## 4.0 Scope

**4.1** This policy applies to all staff working across UCLH in all clinical and non-clithe Rnical areas. It applies to the management of all incidents within UCLH associated with the UCLH services, operations and business including clinical and non clinical.

## 5.0 Duties

**5.1** Duties and responsibilities for staff at all levels across UCLH are described in detail in **Appendix 1** and referenced throughout this Policy. Reference should also be made to the Risk Management Strategy, which outlines key responsibilities for risk management at UCLH.

## 6.0 Policy & Procedures

This policy and related procedures detail the processes to be followed for incident reporting (including incidents, serious incidents and near misses). Staff should refer to the UCLH Complaints Policy or the UCLH Handling of Clinical Negligence and Risk Pooling Scheme Claims Policy for the investigation and management of complaints and claims. If the first notification of a serious incident is as a complaint or claim then the UCLH serious incident

(SI) process takes precedence and must be followed in tandem with the complaint/ claim investigation. In those cases where there is both an SI and a complaint, careful consideration must be given, at the outset of the investigations to ensure clarity on the approach and clear lines of communication with the patient / complainant. Depending on the nature of the two events (complaint and incident) it may be appropriate to have a single SI investigation. The definition and procedure for SIs is contained in the Procedure.

## 7.0 Implementation

**7.1** This procedures will be made available to Directors, Divisional Managers and all staff who are responsible for:

- Reporting and managing incidents
- Investigating all incidents

## Procedure for Incident Reporting

## 8.0 Reporting incidents and near misses

**8.1** A reportable incident is any unintended or unexpected event that could have or did lead to harm, loss or damage that contains one or more of the following components:

- It is an accident or other incident which results in injury or ill health.
- It is contrary to the specified or expected standard of patient care or service.
- It places patient(s) or staff member(s), or visitor(s), contractor(s) or members of the public at unnecessary risk.
- It puts UCLH in an adverse position with potential loss of reputation.
- It puts UCLH property or assets in an adverse position or at risk of loss or damage; and should be reported using the UCLH incident reporting system (Datix)

**8.2** Reporting a 'near miss' event is as important as reporting incidents that actually occurred and caused harm. Although a 'near miss' did not cause harm the potential for recurrence probably still exists and this needs to be managed effectively.

**8.3** Incidents should be graded according to the NPSA definition:

| Degree of Harm | Definition |
|---|---|
| No Harm | The incident reported ran to completion but no harm was experienced by the person involved / affected |
| Low | Person affected required extra observation or minor treatment[1] as an actual effect of this incident rather than as a result of their underlying medical condition. |
| Moderate | Person affected required a moderate increase in treatment[2]; the incident caused significant but not permanent harm to the person. |
| Severe | Incident that appears to have resulted in permanent harm to the person affected. This means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage that is related directly to the incident and not related to the natural course of the person's illness or underlying condition. |

| | |
|---|---|
| Death | Incident that directly resulted in the death of the person affected rather than as a result of their underlying medical condition |

[1] Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned. Nor does it include a return to surgery or re-admission.

[2] A moderate increase in treatment is an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

**8.4** Steps to take following a near miss or incident:

**8.4.1** Immediate action

Before the reporting system is commenced some incidents will require prompt and specific action to deal with the problem. This may involve:

- Emergency medical care.
- Summoning assistance.
- Ensuring that all at risk patients, staff, visitors and others are moved to a safe environment.
- Treating/caring for others affected.
- If the incident could recur, taking immediate action to prevent this.
- Notifying senior members of staff on duty.
- Where appropriate, notifying a patient's family, and considering the need to make an apology to the patient and family; an apology invariably improves relationships and communications and, is not an admission of liability (Being Open Policy).
- Recording the action taken in the patient's medical record, and consideration should be given to copying or retaining the patient record at this stage to aid further analysis.

Where death or serious injury has occurred or you regard the incident as very serious, reporting must be immediate, i.e. by telephone to senior managers, or to Site Managers or on call managers outside normal working hours. The Quality and Safety Department should also be informed at the earliest possible time via email or telephone, and the UCLH Datix reporting form completed.

**8.4.2** Equipment

If any piece of equipment is involved in an incident:

- Remove it from service (marking it clearly out of order).
- Retain the device/equipment involved in the incident, including packaging and instructions where appropriate.
- Isolate any faulty equipment in a safe place for later inspection without altering its settings.

- If it is a machine try to leave all switches and controls as they were at the time of the incident unless it is not safe to do so, in which case make a note of all settings.
- Send the device to the Medical Physics department.
- Medical Physics will be responsible for reporting any relevant incidents to the Medicines and Healthcare Products Regulatory Agency (MHRA).

## 9.0 The Line Manager's Role

**9.1** On receipt of an incident form, the incident handler's role is to:

- Identify if any harm has come to the patient (near miss, no harm, short term, long term* or death*) and escalate to more senior staff if *
- Ascertain immediate causes (i.e. local analysis of what happened, and why (root causes).
- Take action and record what actions were taken, or will be taken, including an indication of whether further analysis/investigation is required.
- Inform the member(s) of staff who completed the incident form on what action you intend to initiate or to take giving immediate and ongoing feedback.
- Inform other staff who are able to take action by copying the form to them or ensuring the appropriate section is ticked on the Datix form, e.g. medication errors to the Pharmacy or needlestick injuries to Occupational Health.
- Where the incident affects a patient, ensure that relevant information is added to the patient record.
- Ensure that staff preserve all relevant documents, equipment, devices, drugs or any other item that may be used to assist any subsequent analysis of what happened. Medical records should be copied so that the originals can be made available for ongoing treatment, and kept securely, in preparation for a legal claim for example.
- Let the Quality and Safety team know if they are unable to view the Incident form or need it to be reallocated

**9.2** Line managers and staff should work together to ensure that information about the incident and the outcomes are shared as widely as possible, seeking advice if needed from relevant departments, e.g.:

- the Quality & Safety team,
- the Research and Development Directorate if the incident is research related,
- the Infection Control Team,
- Occupational Health and safety services.
- Partner organisations i.e. Interserve, Logica, etc.

This information would normally be discussed locally within Divisional Quality and Safety (Governance) Groups.

*Notifying the Quality & Safety team, while necessary, is not a sufficient response to an incident.*

## 10.0 Follow-up actions and Lessons Learned

**10.1** For all incidents and near misses, After Action Review (AAR) may be conducted in order for lessons to be learned and behavioural patterns to be altered post event. AAR is **not** a substitute for formal investigation, but may be used in conjunction with the incident reporting and investigation process. Where AAR has taken place the summary report may be included with any completed report and the AAR box ticked.

- For no harm and low harm incidents actions and learning should be managed at a local level.
- Moderate harm incidents should be managed at divisional level
- Severe harm incidents or those that led to the death of a patient should be managed according to the serious incident procedure

## 11.0 Action plans

**11.1** Where formal actions are required to prevent a recurrence of a near miss or incident, an action plan should be prepared detailing:

- Root cause/s
- Actions to be taken,
- Member of staff leading on the action,
- Timescale for action to be implemented, and
- Deadlines for completion.

**11.2** Action plans should be monitored at local governance meetings in accordance with the timescales stated for each action. Once the action plan has been implemented it should be retained by the relevant department.

## 12.0 Serious Incident Monitoring Body

Camden Clinical Commissioning Group (CCG) with support from the North and East London Clinical Support Unit (CSU) monitors the management of all externally reportable Serious Incidents (SIs) that occur. This is achieved by notification of each SI onto STEIS [1] by the Quality & Safety team within 2 working days of the incident being identified. Subsequent action, progress and outcomes are monitored by the CCG via the Clinical Quality Review. STEIS is updated with key findings – root cause(s) and recommendations. Internal red incidents follow a similar process as external SIs, but they are not reported to the CCG or entered onto STEIS as they are outside national definitions, but the Trust wishes to learn from the event. Learning from SIs is monitored via the QSC.

[1] STEIS - Strategic, Executive, Information System.

## 12.1 Serious Incidents (including Never Events)

**12.2** A Serious Incident, or SI, is an event determined by the Director of Quality & Safety or Corporate Medical Director to be sufficiently serious to warrant a formal investigation reportable to the Quality & Safety Committee and Board of Directors, which meets the definitons of the NHS England Serious Incident Framework. A RCA investigation is required

into all incidents classified as an SI. If a serious incident is reported initially as a complaint or claim, this process must also be followed.

**12.3** When an incident appears to be an SI, the first step is to alert the appropriate Board Medical Director, DCD, and Divisional Manager who will organise for a 72 hour review of the incident to be held. The Trust Safety Manager should be involved. This will help determine severity of the incident and support available to staff and patients/families and the responsibilities under the duty of candour. Out of normal working hours the Hospital Site Manager must be informed immediately, who will contact the Director or Manager on call.

**12.4** The Trust Safety Manager/Deputy Director of Quality & Safety will brief the Corporate Medical Director and the Director of Quality and Safety. The Corporate Medical Director will be informed of the circumstances as outlined in the 72 hour review and will make the final decision on whether it should be classified as a 'Serious Incident'.Where the incident is serious and involves a research subject or a research study then the decision about which incidents to investigate, should be taken in conjunction with the Director or Deputy Director of Research & Development.

**12.5** As soon as the decision has been made other senior managers may be informed. Depending on the nature of the incident these could include:

- A nominated lead for the serious incident investiagation
- Director of Communications where appropriate
- Director of Research and Development (if an incident is research related)

**12.6** The SI Report templates for External SIs, and Internal red incidents will be forwarded to the investigation lead by the Quality & Safety team to ensure that the latest version only is in circulation.

**12.7** A 'Case manager' from quality and safety will be agreed for each SI who will monitor and support the investigation process.

**12.8** Completed serious incident investigation reports will be sent via email to the Trust Safety Manager for first line quality assurance. Further quality assurance will be undertaken by the Deputy Director of Quality & Safety. External SI reports are then sent to the Corporate Medical Director and Director of Quality and Safety for approval, and the updated action plan will be forwarded to the next QSC for monitoring and sign off.

**12.9 Never Events** are serious incidents that are considered to be entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers [1]. Any possibility that a Never Event has occurred must be reported and will be assessed by the Director of Quality and Safety.

**12.10** The list of Never Events is set out (on page 8) and includes changes recently introduced and effective from February 1st 2018 highlighted in bold. There is one new event – **the unintended connection of a patient requiring oxygen to an airflow meter (no. 15)**

**Surgical**

- Wrong site surgery **(*now excludes the extraction of primary [milk] teeth unless done under a general anaesthetic, excludes spinal surgery*)**.
- Wrong implant/prosthesis: now
  - ***includes the implantation of an intrauterine contraceptive device that differs from the one in the procedural***
  - ***excludes the insertion of contraceptive hormone in the wrong arm***
  - ***excludes where the implant/prosthesis differs from the one intended due to incorrect pre-procedural measurements or incorrect interpretation of the pre-procedural data, e.g. wrong intraocular lens due to wrong biometry or using the wrong dataset from correct biometr .***
- Retained foreign object post procedure

**Medication**

- Mis-selection of a strong potassium solution
- Administration of medication by the wrong route
- Overdose of insulin due to abbreviations or incorrect device (***now includes when a healthcare professional withdraws insulin from an insulin pen or a pen refill and then administers it using a syringe and needle)***
- Overdose of methotrexate for non-cancer treatment
- Mis-selection of high strength midazolam during conscious sedation

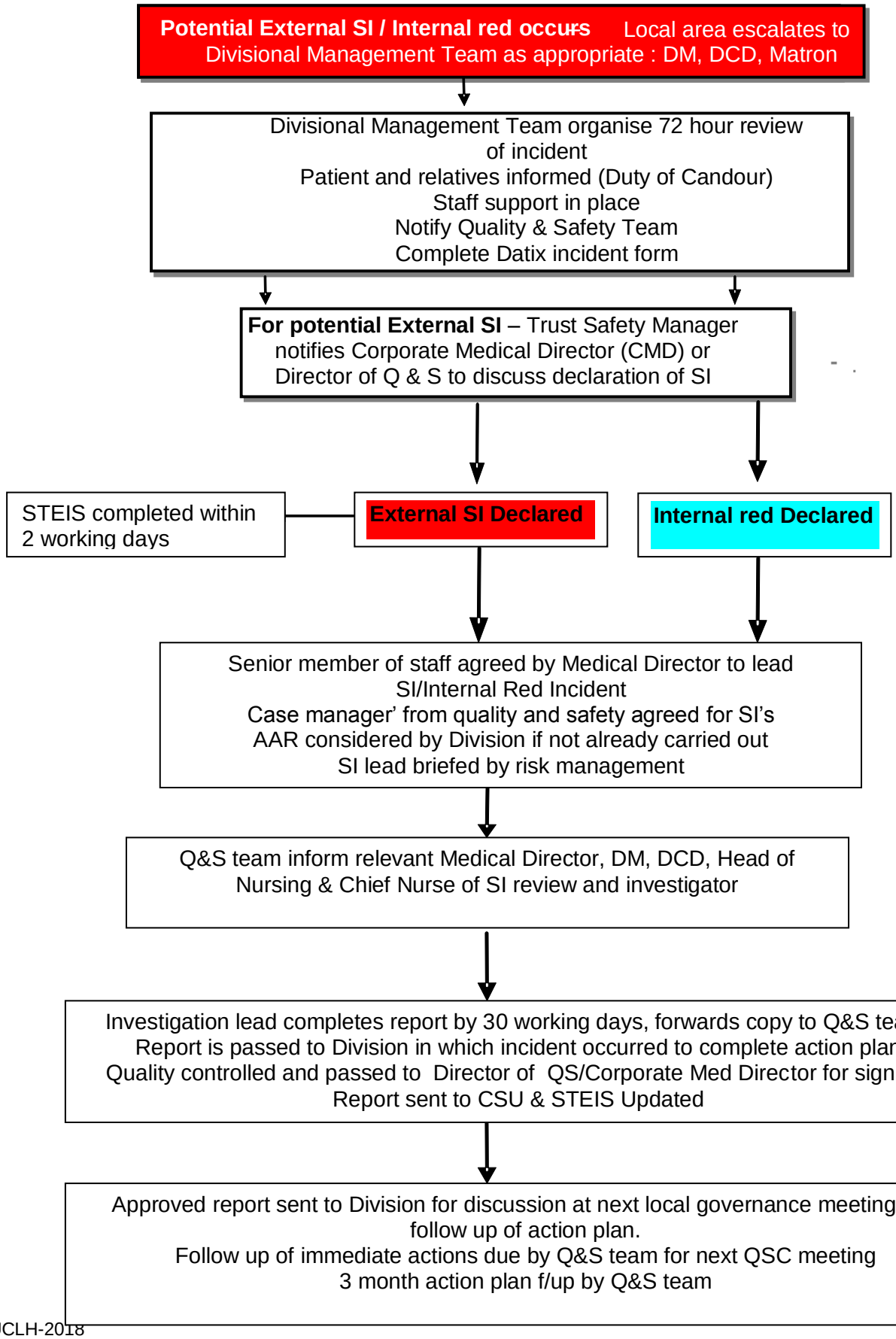
**Mental health**

- Failure to install functional collapsible shower or curtain rails

**General**

- Falls from poorly restricted windows
- Chest or neck entrapment in bed rails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Misplaced naso- or oro-gastric tubes
- Scalding of patients
- **Unintentional connection of a patient requiring oxygen to an air flow meter**

## Procedure for managing a Serious Incident (SI)



## 13.0 Support for staff involved in an incident

**13.1** UCLH recognises that it has a responsibility to all staff to support them following incidents, and guidance on the processes available are set out in the Management of Work-Related Stress Policy and the Being Open Policy. Senior and junior doctors and nurses and any other staff who are involved in an incident (particularly a serious incident) will need support from their peers, colleagues and managers. It is the Line Manager's responsibility to ensure that individuals are supported appropriately. They may also require external support from Oasis (the UCLH advice and counselling service) and/or Occupational Health. Staff involved must be kept informed of the progress of an investigation at all stages. Individuals who have been away from work may require additional support and supervision to aid confidence when returning to work. Junior doctors directly involved in a serious incident or internal red incident should have their names and details of their involvement forwarded to the Postgraduate Medical Educational Supervisor to ensure that appropriate support is made available to them. This should be undertaken by an appropriate person identified at the 72 hour review.

**13.2** UCLH has a clear policy of discouraging any tendency to blame staff when they report incidents; however this does not exclude staff from their professional accountability. There may be exceptional circumstances when the need for disciplinary action may have to be considered in accordance with the UCLH Human Resources policies and procedures.

Additionally, depending on the outcome of investigations into incidents, UCLH may be required, on rare occasions, to adhere to Department of Health policies and other national regulatory bodies, and report matters associated with professional conduct.

**13.3** The National Patient Safety Agency has published an 'Incident Decision Tree' designed to help managers to consider a range of possible actions when an incident has occurred. This is an electronic, interactive tool which enables managers to:

- decide if it is appropriate to suspend staff from duty,
- explore alternatives to suspension such as temporarily relocating staff or changing their duties,
- consider other possible actions as an investigation progresses.

This tool can be downloaded from: npsa.nhs.uk

**13.4** Managers and staff are advised to refer to the related 'principle of professional support' in the UCLH Being Open Policy.

## 14.0 Learning Lessons from Incidents

### 14.1 Local Learning

It is the responsibility of the division to ensure that there are systems in place to learn from incidents and in particular serious incidents including monitoring and following up on action plans.

See 'Guidance for Divisional Management and Quality & Safety (Governance) Groups

## 15.0 Organisational Learning from Incidents

Organisational learning from individual incidents is communicated, both internally and externally, through a variety of ways including the following:

- Quality and Safety and local clinical governance meetings
- Quality and Safety committee structure
- Quality & Safety Bulletin
- CEO briefings and local briefings
- Staff training and audit days
- Service Improvement groups
- Clinical training events arising from incidents
- Reviewing and feeding back lessons from NRLS reports
- Using After Action Review (AAR) to support immediate reflection and learning

## 16.0 Mechanisms for ensuring that lessons learned result in changes in culture and practice will include:

- *Policy development through a range of clinical and non clinical leads and groups*
- *Clinical guidelines development and implementation through the Clinical Guideline Development Group*
- *Education and training on an internal and external basis*
- *Dissemination and discussion at local clinical governance groups*
- *Review by and actions of the Quality and Safety Committee and Chairs of other relevant committees.*

## 17.0 Sharing Lessons across the Local Health Community/Reference

**17.1** Lessons may be shared across the local health community in a number of ways. Examples include:

- via the Clinical Quality Review Group
- reviews and analysis revealing potential national issues will be passed on to the National Patient Safety Agency via the NRLS.
- Medicine & Healthcare Products Regulatory Agency [MHRA]

## 18.0 Training in incident reporting and incident investigation

- Training requirements for incident reporting are defined in the Mandatory Training Policy.
- For additional training on incident reporting and incident investigations the Quality and Safety team can provide training on an ad hoc basis as required. Some Clinical Divisions and Corporate Directorates have clinical governance leads who can also act as a source of advice and expertise.

## 19.0 Monitoring requirements

| 1. Key process/part of this policy for which compliance or effectiveness is being monitored | 2.Monitoring method (i.e. audit, report, on-going committee review, survey etc.) | 3. Job title and department of person responsible for leading the monitoring | 4. Frequency of the monitoring activity | 5. Monitoring Committee responsible for receiving the monitoring report/audit results etc. | 6. Committee responsible for ensuring that action plans are completed |
|---|---|---|---|---|---|
| Timeliness of SI report completion | Datix | Trust Safety Manager | Monthly | QSC(via performance pack&monthly SI report) | QSC |
| Key performance indicators | Datix | Quality & Safety Analyst | Monthly | Relevany Divisions | QSC through performance pack |

* For Duty of Candour Compliance please Duty of Candour Policy

**References**

1. NHS Improvement “Revised Never Events policy and framework

**Appendix 1**

## Roles & responsibilities

### The Chief Executive

- The Chief Executive has overall responsibility for Quality & Safety at UCLH. He has delegated delivery responsibility within the management structure to:

    - The Medical Directors of the Clinical Boards for all across the full range of functions and services in their areasdati
    - Corporate Directors for their respective areas

### The Corporate Medical Director

The Chief Executive has nominated the Corporate Medical Director as the Executive responsible for Quality & Safety. He is responsible for overseeing the work of the Quality & Safety team which is led by the Director of Quality and Safety. The Corporate Medical Director is also responsible for assessing potential Serious Incidents and deciding which incidents will be analysed / investigated as SI's. Where the incident is serious and involves a research subject or a research study then the decision about which incidents to investigate, how the investigation should be organised and the terms of reference for any investigation should be taken in conjunction with the Director or Deputy Director of R&D.

The Corporate Medical Director's responsibilities are to provide a leadership focus for management of clinical incidents throughout UCLH and to ensure that training and resources are available to support this. The Corporate Medical Director is also responsible for overseeing the implementation of this policy & procedure and ensuring that it is evaluated and its effectiveness reviewed.

### The Director of Quality and Safety

The Director of Quality and Safety provides day-to-day leadership on activities through the management of the Quality & Safety Department, ensuring that the Trust's key Quality & Safety objectives are met. He/she is responsible for ensuring that processes are reviewed, updated and driven forward at UCLH. The Director of Quality and Safety reports to the Corporate Medical Director and both are accountable to the Chief Executive and the Board of Directors for ensuring that this Policy & Procedure is implemented effectively. The Director of Quality & Safety is also responsible for assessing potential Serious Incidents and deciding which incidents will be analysed/investigated as SIs.

### The Deputy Director of Quality & Safety

The Deputy Director of Quality & Safety has the following responsibilities:

- Advising on external reporting requirements.
- Maintaining and monitoring the reporting system of incidents within UCLH.
- Analysing trends to inform clinical division decisions and corporate management decisions.

- Supporting reviews of serious incidents.
- Reviewing samples of incidents for consistency and lessons to be learned.
- Advising on the need for independent investigations by external agencies or individuals.
- To be overall responsible for incident management including the trust-wide incident reporting system and incident investigations
- To promote an open and fair culture throughout the Trust, where the focus of incident management is on learning lessons and improving services.

**Medical Directors Clinical Boards**

The Medical Directors of the Medicine Board, the Specialist Hospitals Board and Surgery & Cancer Board, and the Directors of Corporate areas are responsible for quality and safety activities in their respective Boards/areas.

This includes operational delivery and implementation of this Policy & Procedures and providing leadership in the management of incidents within their area.

- Reviewing trends of incidents ensuring that actions are in place to minimise the risk of recurrence locally.
- Reviewing Divisional systems.
- Agreeing the review process for the more serious incidents, whether the analysis/investigation should be led by the division, elsewhere within the Trust or externally.
- Agreeing how to handle reporting of individual serious incidents outside the Trust.

**Divisional Managers and Divisional Clinical Directors**

Divisional Managers and Divisional Clinical Directors have the following responsibilities:

- Monitoring trends of incidents and their outcomes and ensuring comprehensive investigation and action for incidents of a serious nature.
- Promoting an open culture within the division
- Overseeing implementation of action plans associated with SI's and internal red incidents
- Overseeing compliance with duty of candour – see being open and the duty of candour policies

**All managers**

Managers working throughout the Trust are responsible for the local implementation of this policy and procedures in their departments, wards and/or other clinical and non-clinical areas. They have responsibility for promoting an open and fair culture amongst their staff and for engendering the importance of safety awareness at a local level amongst their staff. Furthermore they are responsible for ensuring that local safety activities are carried out to support Trust-wide learning by:

- Reviewing incidents, accidents, mistakes and 'near misses' reported to their department, ensuring that appropriate immediate action is taken.
- Undertaking initial categorisation of the type of event and seriousness on the incident form

- Fostering an environment in which staff are encouraged to report incidents and discuss the implications constructively and openly.
- Maintaining departmental policies and procedures and ensuring staff are aware of them and are trained to follow them.
- Ensuring that there is a regular multidisciplinary governance meeting which reviews the serious incidents and actions arising and all relevant policies and procedures
- Deciding who should assist with the review of incidents and investigations and when this should be escalated beyond the departmental level.
- Ensuring that the required actions have been taken and are followed through.

**Divisional Governance (Quality and Safety) Leads are responsible for:**

- Implementing this Policy & Procedure at a local level by ensuring incidents are reported in a timely manner by staff.
- with the Quality & Safety team to ensure that local intelligence on safety issues is communicated appropriately throughout the organisation and incidents are reported and analysed

**Quality and Safety Team**

The Quality & Safety team is responsible for monitoring all incidents on the Trust's (Datix) database. Analysis and trends of incidents are fed back quarterly to Divisions and Departments, and, in anonymised form daily to the National Patient Safety Agency. The data is used, both in the Trust and by the National Patient Safety Agency, to target risk reduction programmes. Data is also used to assist in compliance with Health and Safety legislation.

- To advise the Patient Safety and Risk Steering Group on trends and statistical analyses of incidents and near misses

**All staff**

Key responsibilities of staff are to:

- Report incidents in accordance with the Trust's Incident Reporting Procedure
- Maintain confidentiality of patient and Trust information.

**Appendix 2**

**Definitions of terms used within the context of this document**

| | |
|---|---|
| **Incident** | Any unintended or unexpected event that did lead to harm, loss or damage. |
| **Near Miss** | An event that had the potential to cause harm loss or damage but was prevented, resulting in no harm, loss or damage. |
| **Serious Incident (SI)** | An event deemed at Director level to be sufficiently serious to warrant a formal analysis reportable to the Quality & Safety Committee (or the Research and Development Governance Committee) and Board of Directors. Usually it would involve the risk of death or serious injury, major damage to property, create a major health risk or involve multiple clinical problems such as a serial drug error, or be a threat to the strategic objectives of the Trust. An 'SI' reportable to the NCL Cluster may relate to the national definitions of an SI, however there may be some incidents that fall outside the national definitions and would not be reportable to the NCL Cluster, these may be dealt with as a 'Red or Amber report'. |
| **Never Event** | An event that is considered to be entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. All never events are classified as serious incident (SI). |
| **Research Incident** | Harm to a patient who is a subject in a research study or trial or incident in a research study or trial. |
| **Harm** | Injury (physical or psychological), disease, disability or death; applies to patients when not related to the natural course of the patient's illness or underlying condition or treatment. |
| **Likelihood** | How often an event might happen (per procedure/episode or within a specified timeframe). |
| **Severity** | The degree of harm, financial or reputational loss, or achievement suffered by an individual, group, or the Trust. |
| **Grade** | A measurement of the risk useful for assessing the priority for control measures for the treatment of different risks. |
| **Investigation** | A formal process of analysing an event and recording the outcomes. |
| **Root cause analysis (RCA)** | A structured approach to retrospectively review an incident and identify the true cause(s) of a problem, via its contributory factors. |
| **After action review (AAR)** | A learning tool which promotes multi-professional reflection after "actions", which may have been negative or positive, so that learning starts with those directly involved and behaviours are changed as a result of the lessons learned. |