NHS
Cambridgeshire

Incidence & Near Miss Reporting Guidance

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1. Incident and Near Miss Reporting

Why report incidents and near misses?

Research has shown that the more incidents that are reported the more information is available about any problems, and the more action can be taken to make healthcare safer. The benefits of incident and near miss reporting include:

- Identifying trends across organisations that may not be apparent for one organisation
- Pre-empting complaints
- Making sure areas of concern are acted on
- Targeting resources more effectively
- Increasing awareness and responsiveness

NHS Cambridgeshire requires all its own staff to report incidents and near misses to the PCT risk team. They look at all incidents reported and link these with other clinical governance information (such as PALS and clinical audit) to identify any trends, disseminate learning in an appropriate way and facilitate learning between organisations.

Most incidents relate to system failure rather than individual mistakes. Incident reporting needs an open and fair culture so staff feel able to report problems without fear of reprisal and know how to resolve and learn from incidents.

What is an incident?

An unplanned occurrence or event where there is loss of life, injury, loss or damage to persons or property. It can include any event that may give rise to physical, emotional or psychological harm.

What is a near miss?

A near miss is any incident that had the potential to cause harm but was prevented, resulting in no harm.

2. Reporting using the DATIX system

The trust currently uses the DATIX web-based system for incident reporting. This system allows prompt, thorough reporting and requires line manager review and recording of action taken, so learning from the incident can be disseminated.

DATIX is a web-based incident reporting system that can be used by anyone with access to the NHS net. When a member of staff witnesses an incident or near miss, they can access the website and complete a form on-line, which is then sent to their line manager for review and completion of additional action taken.

The web-based form is fairly straightforward to use. The table in Appendix 1 gives general details of the requirements of the form. If you have any problems or queries, please call the risk team on 01223 885798. Training for the DATIX system is available if required.

The website address for incident reporting is:

http://nww.riskreporting.cambridgeshire.nhs.uk

The PCT risk team can be contacted at 01223 885798 (or 884356)

The DATIX form asks for details of the incident, and the organisations and people involved. It collects information about immediate and further action taken, so that any learning is shared. Some information is collected because it is required by the NPSA as part of their collation of all patient safety incidents.

The form should act as both a record of the incident and a prompt to support action planning and reporting. Thus the member of staff completing the form should include as much information as possible, so the reasons for the incident can be reviewed and appropriate action taken to avoid reoccurrence.

Staff are asked to give the category (and, in some cases, sub-category) of the incident. The categories are defined by the National Patient Safety Agency and cover a wide range of areas. These are given in Appendix 2.

Staff are also asked to give a risk severity grade to the incident.. The person reporting the incident is asked to make this judgment as they are usually in the best position to determine the severity of the risk.

The incident grades are Low, Moderate, High or Extreme. Low and Moderate incidents are resolved locally, while High and Extreme incidents are discussed at EMT and Board level.

The grade of incident is usually calculated by considering the likelihood and consequence of the incident If staff are unsure or concerned about the category or grade of the incident, support is available from the risk team. Further details about the grading system are given in section 7.

The risk team looks at all the incidents that are reported to spot any trends or reoccurring themes. In this way the PCT can make sure it learns from incidents and can put systems in place to stop them happening again.

3. Review and reporting of incidents

When a member of staff sends in an incident form, this is forwarded to their manager who will discuss any additional action that needs to be taken to manage the incident.

The DATIX form is also sent to the PCT Risk Manager for review and trend analysis, and, if appropriate, to the relevant PCT specialist and other agencies / experts as detailed below.

Incidents or Near Misses involving Patient Safety

All incidents involving patient safety are reported to the National Patient Safety Agency (NPSA).

Medication or Device Incidents or Near Misses

Specific information is required by the NPSA for medication incidents:

- At what stage in the process did the incident / near miss occur?
- What drugs were involved?
- If relevant, the incorrect and corrected details of form, dose, strength or route of administration.

Any suspected adverse drug reactions, defects in medicinal products or devices, or adverse events relating to blood products are reported to the Medicines and Healthcare products Regulatory Agency (MHRA). This is the government agency which is responsible for ensuring that medicines and medical devices work, and are acceptably safe. http://www.mhra.gov.uk/home/idcplg?IdcService=SS_GET_PAGE&nodeId=285

Serious Untoward Incidents (SUIs)

The definition of a SUI is wide ranging and includes any incident that causes unexpected death, a hazard to public health, a trend leading to reduced standards of care, damage to reputation, a claim for significant damages or suspected fraud. SUIs should be reported to the PCT who will pass that information to the NHS East of England, who review trends from all SUIs across the area.

Fire/unwanted fire signals

Details of any fire that takes place in your work area, or false alarm calls are reported to the PCT fire officer so that any trends can be identified.

RIDDORs

(Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995).

The organisation or practice must report any accident **connected with work** that results in any employee, or a self-employed person working on the premises, or a member of the public being killed or suffering a major injury (including as a result of physical violence) or being taken to hospital. These can be reported via www.riddor.gov.uk

Security Issues

The PCT pass details of any security issues to our Local Security Manager Specialist (LSMS). The LSMS looks at counter-fraud and security issues - broadly defined as protecting people and property in the NHS, e.g. threatening staff or deliberate damage to NHS property.

Catastrophic Incidents

Any catastrophic incident must be reported immediately and directly to the Healthcare Commission eg multiple deaths.

4. What to report

The definition of an incident is very wide ranging and staff often find it difficult to know what to report, particularly for less serious incidents. The NPSA categories in Appendix 2 give a good guide to the type of patient safety incidents that are reported. Appendix 3 gives examples of the types of incident that may occur in a commissioning environment.

PCT staff have access to a wide range of information about other healthcare organisations. If staff have concerns that an incident has occurred in another organisation they should discuss this with their line manager to determine if any action needs to be taken and if an incident from should be completed.

For further guidance on what to report, please call the risk team.

5. Deciding what action to take

Initial action

When an incident occurs immediate action should be taken to:

- Make person(s) / area safe.
- Obtain medical aid if required.
- Notify practice manager / line manager on duty.
- Complete the incident form(s) and initial risk assessment of the event.

Further action

All incidents should be reviewed to determine if further action is required to reduce the risk of the incident or near miss reoccurring. When incidents are being reviewed, think about any particular circumstances that might be relevant, such as:

- Is the incident more likely to occur on weekdays or weekends, during the day or during evenings and nights?
- Does it relate to something that is done infrequently such as maintenance of areas or equipment, adjustment of medical equipment etc?
- Did it occur because of an unplanned event such as a spillage?
- Was it due to an emergency such as sudden changes in a patient's condition?
- Did any changes in the environment affect the incident such as changes in weather?
- Is there an unavoidable risk? - all healthcare involves the acceptance of a degree of risk to service users, for example minor slips, trips and falls in the elderly.

Further details about reviewing incidents are given in the Investigation of Incidents guidance.

For Low and Moderate risk incidents, action should be carried out by the staff involved to minimise the risk of reoccurrence. The organisation should be looking for trends, which can draw attention to any underlying system problems.

All High or Extreme Risk incidents should be reviewed by senior staff to understand why they occurred, how they could have been prevented and how they will be prevented in the future. Investigation tools such as Root Cause Analysis should be used to highlight system problems. These risks are added to the PCT Risk Register.

It is important to discuss the learning from such incidents across the whole team. For some incidents it is very valuable to share the learning with other healthcare organisations so that they do not repeat the processes that led to the risk occurring. The PCT should act as a conduit for sharing learning for all incidents that are reported.

The table below summarises the action required for each grade of incident.

GRADING	REVIEW ARRANGEMENTS
1-3 Low	Complete DATIX incident form. Manager and staff to monitor and review at local level and report follow up actions on DATIX when agreed.
4-6 Moderate	Complete DATIX incident form. Manager and staff to monitor and review at local level and report intial follow up actions on DATIX within 1 working day.
8-12 High	Inform the Manager on duty **immediately**, who will take action as soon as possible. Complete DATIX incident form. Urgent review & investigation to be completed within Directorate, remedial action plans to be formalised and put in place within 5 days.
15 – 25 Extreme	Inform the Manager on duty **immediately**, who will take action as soon as possible. Complete DATIX incident form. Urgent review & investigation to be completed within Directorate, remedial action plans to be formalised and put in place within 2 days.

6. Reporting Serious Untoward Incidents

A Serious Untoward Incident (SUI) is any incident that occurs on an NHS site or elsewhere whilst in NHS funded or NHS regulated care. It includes

- an accident or incident where a person to whom the PCT owes a duty of care (staff, patients, service users, clients, contractors, visitors) suffers or could potentially have suffered a serious injury, major permanent harm or unexpected death that is not part of the disease process or current care delivery.
- an incident where there is damage or potential damage to the organisation's assets that will cause a significant disruption in services or an enforcement notice that will result in prosecution.
- an incident where there is police involvement or media interest.

There are regional requirements for the reporting and investigation of SUIs, including timescales and requirements for reporting. If a member of staff or directorate thinks an incident may meet the definition of a SUI, they should report this immediately to the manager on duty, and complete and return a SUI form, as set out in the EoE SUI policy and PCT SUI procedure. Please call the PCT risk team for more details on 01223 885798.

7. Deciding on the level of the risk

Deciding on the level of the risk will help decide what action is needed. The risk score is based on the **likelihood** that the incident will occur and what is likely to happen or did happen as a **consequence** of the incident.

Assessment is subjective so don't spend too long deciding on the risk score – just use professional and life experiences for this. Take a view from a colleague if it helps. Incident assessment can be carried out by an individual, or a group (e.g. the staff member involved and the line manager).

Likelihood

Incidents and near misses are assessed against likelihood using the descriptors and descriptions show in the table below.

Likelihood		
Level	**Descriptor**	**Description**
1	Rare	This will probably never happen/recur
2	Unlikely	Do not expect it to happen/recur but it is possible it may do so
3	Possible	Might happen or recur occasionally
4	Likely	Will probably happen/recur but it is not a persisting issue
5	Almost certain	Will undoubtedly happen/recur,possibly frequently

Consequence

The table below gives eight different definitions for consequence depending on the type of incident, as recommended by the NPSA – use the column which relates most closely to the circumstances of the incident.

To decide on the consequence identify the impact you would expect if this event were to reoccur in similar circumstances. Be realistic – for instance if a patient falls 3 times each day, and never hurts themselves, it is highly unlikely that he/she will have a fractured neck of femur tomorrow. Again don't be too concerned that your assessment is fallible; this is a factor with all qualitative assessment tools.

Consequence / Potential Consequences					
	1	2	3	4	5
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death or multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved Minor implications for patient safety if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Multiple complaints/ independent review Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service Inquest/ombudsman inquiry Gross failure to meet national standards Gross failure of patient safety if findings not acted on
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence

Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget / Schedule slippage	5–10 per cent over project budget / Schedule slippage	Non-compliance with national 10–25 per cent over project budget / Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget / Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Purchasers failing to pay on time Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Risk Score

Once you have decided on the likelihood and consequence, multiply the two scores together using the matrix below to determine the level of risk grading.

	LIKELIHOOD				
CONSEQUENCES	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost Certain - 5**
Catastrophic - 5	5	10	15	20	25
Major - 4	4	8	12	16	20
Moderate - 3	3	6	9	12	15
Minor - 2	2	4	6	8	10
Negligible - 1	1	2	3	4	5

(Adapted from AS/NZS 4360 1999 Risk Management Standard)

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

8. Further Information

If you need clarification on any issues around incident reporting, please contact Sue Nellis, Quality Performance Project Administrator, 01223 885798 or Wendy Lefort, Clinical & Practice Governance Manager, 01223 884356, wendy.lefort@cambridgeshirepct.nhs.uk

Appendix 1 - DATIX Summary Sheet for PCT incidents

Further guidance is available in **PCT Incident & Near Miss Reporting Guidance**

Web address:	**nww.riskreporting.cambridgeshire.nhs.uk**
You have to make an entry in the fields with a red asterisk. Other fields are optional – include information if it is relevant to the incident. For many of the fields, you click on the box to the right of the field to see the possible selections The system locks out after 30 mins. To avoid losing a partially completed form, click submit. You will get a message saying some fields are not complete – the lock-out feature is disabled.	
Trust name:	**Cambridgeshire PCT – (Commissioner)**
Clinical group or team:	This will probably be blank
Directorate:	**Commissioning** or one of the other options if you are reporting an incident about another organisation
Speciality:	**Your directorate** should be in the list – if not choose **Not Applicable** and contact the risk team to make sure it is added
Location (type):	Give the area where the incident took place – there are several options including GP waiting room/reception, Patient's Home, Residential Care Home/NHS Nursing Home, Office etc
Location (exact):	Name of office or surgery (eg Nightingale Court) To go to the right point in the list, click in the box at the top of the list and type the first few letters of the relevant location
Description of event	Record what actually happened (do not include names in this section)
Immediate action taken	Record what was done about the incident at the time it happened (action taken later will be recorded by the practice manager)
For some fields you can select more than one option. These have one large box and one small box – remember to add each selection by clicking on **Add to table**	
Incident type	There are 18 incident types (as specified by the National Patient Safety Agency). An Incident Type & Category sheet is available. For some types, extra information is requested eg Medication
Category	The categories depend on the incident type you have selected.
Sub-Category	For most categories this is Not Applicable.
Result	There are 8 options, including a) No Harm Incident where an incident actually happened but did not cause any harm and b) Near Miss where an incident almost happened but was stopped
Severity	You have to say how serious the risk is. This is based on the Likelihood and Consequence of the incident.

RISK MATRIX	**LIKELIHOOD**				
CONSEQUENCES	**Rare - 1**	**Unlikely - 2**	**Possible - 3**	**Likely - 4**	**Almost Certain - 5**
Catastrophic - 5	Moderate	High	Extreme	Extreme	Extreme
Major - 4	Moderate	High	High	Extreme	Extreme
Moderate - 3	Low	Moderate	High	High	Extreme
Minor - 2	Low	Moderate	Moderate	High	High
Negligible - 1	Low	Low	Low	Moderate	Moderate

Person affected by incident	Record enough information so the person can be identified / contacted in case of further investigation / action / feedback.
Detail of person reporting the event	Record all the contact details available - put **NA** if not available
Your Manager	Please select **Lefort, Wendy** if you have not agreed another manager within your team
When you press submit, you are asked if you want to add another contact. Then choose **Finish**, **Print and Finish** or **Edit**. **Print and Finish** will show you the form –select print to send this to your normal printer	

For clarification or further information, contact Wendy Lefort, 01223 884356,

Appendix 2 - NPSA Incident Types, Categories and Sub-Categories

Access

DISCHARGE - DELAY/FAILURE
DISCHARGE - INAPPROPRIATE
DISCHARGE - REFUSAL
DISCHARGE PLANNING FAILURE
DISCHARGE SUMMARY DELAY
SELF DISCHARGE
FAILURE TO FOLLOW-UP MISSED APPOINTMENT
FAILURE TO REFER
LACK OF/DELAYED AVAILABILITY OF BEDS (general)
LACK OF/DELAYED AVAILABILITY OF BEDS (high dep)
TRANSFER - DELAY/FAILURE
TRANSPORT - DELAY/FAILURE
OTHER

Accident

CONTACT WITH ELECTRICITY
EXPOSURE TO HARMFUL SUBSTANCE
- Exposure to Radiation
- Exposure to Asbestos

MOVING AND HANDLING
- Moving & Handling - Patient/Positioning
- Moving & Handling - Non-patient
- Moving & Handling – Display Screen Equipment Issues

STRUCK BY FALLING OBJECT
CONTACT WITH HOT / COLD
STRUCK BY MOVING VEHICLE
SLIP/TRIP/FALL
- Slip/Trip/Fall on same level
- Slip/Trip/Fall from Height

ROAD TRAFFIC ACCIDENT
CONTACT WITH FURNITURE/FITTINGS
OTHER

Clinical Assessment and Treatment

DELAY/DIFFICULTY IN OBTAINING CLINICAL ASSISTANCE
DELAY OBTAINING BLEEP HOLDER OR ON-CALL STAFF
DIAGNOSIS - DELAY/FAILURE TO
DIAGNOSIS - WRONG
TREATMENT - DELAY/FAILURE IN RECOGNISING COMPLICATIONS
DELAY/FAILURE TO MONITOR
TREATMENT - FAILURE TO DISCONTINUE
PATIENT INCORRECTLY IDENTIFIED
BLOOD TRANSFUSION ERROR
SCANS/X-RAYS/SPECIMENS - INADEQUATE/INCOMPLETE
SCANS/X-RAYS/SPECIMENS - MISLABELLED/UNLABELLED
SCANS/X-RAYS/SPECIMENS - WRONG
SCANS/X-RAYS/SPECIMENS - MISSING
TEST REQUEST FORM - NONE/INCOMPLETE
TEST - FAILURE/DELAY TO UNDERTAKE
TEST RESULTS/REPORT - FAILURE/DELAY TO INTERPRET OR ACT ON
TEST RESULTS/REPORT - INCORRECT
TEST RESULTS/REPORT - FAILURE/DELAY TO RECEIVE
TEST RESULTS/REPORT - MISSING
TEST RESULT/REPORT - MISLABELLED
OTHER

Community

DOG / HOUSEHOLD PETS
STAFF LOCATION UNKNOWN
CAR BREAKDOWN
UNHYGIENIC ENVIRONMENT
UNSAFE ENVIRONMENT
INADEQUATE SUPPORT
OTHER
DELAY/FAILURE TO PROVIDE SOCIAL CARE
DELAY/FAILURE OF CARE AGENCY TO PROVIDE CARE
FAILURE OF RESIDENTIAL CARE HOME TO PROVIDE CARE

Equipment Issues

BLEEP SYSTEM FAILURE
FAILURE OF DEVICE/EQUIPMENT
DELAY FAILURE TO PROVIDE EQUIPMENT TO USER
IT/TELECOMMUNICATIONS FAILURE
LACK/UNAVAILABILITY OF DEVICE/EQUIPMENT
USER ERROR OF DEVICE/EQUIPMENT
WRONG DEVICE OR EQUIPMENT USED
INADEQUATE CHECK ON EQUIPMENT/SUPPLIES
FAILURE/DELAY IN COLLECTION/DELIVERY SYSTEMS
OTHER

Fire Issues

FIRE (inc. accidental)
FIRE ALARM FALSE
FIRE ARSON (MALICIOUS)
DEFECTIVE FIRE EQUIPMENT
OTHER

Infection Control

FAILURE OF STERILISATION OR CONTAMINATION OF EQUIPMENT
FAILURE TO DECONTAMINATE EQUIPMENT
INFECTION - CROSS/HEALTHCARE ACQUIRED
INFECTION - WOUND
UNSAFE/INAPPROPRIATE CLINICAL ENVIRONMENT
UNSAFE/INAPPROPRIATE CLINICAL WASTE ISSUE
EXPOSURE TO BODILY FLUIDS
NEEDLESTICK INJURY
- Dirty Needlestick Injury
- Clean Needlestick Injury

CUT BY SHARP OBJECT – NOT NEEDLESTICK
NOTIFIABLE DISEASE
OTHER

Information

FAILURE TO OBTAIN CONSENT
HEALTHCARE RECORD - MISSING/INADEQUATE/ILLEGIBLE
NO ACCESS TO MEDICAL DOCUMENTATION
CONFIDENTIALITY BREACH
INCORRECT MENTAL HEALTH ACT RECORDS
HEALTHCARE RECORD - DELAY IN OBTAINING
HEALTHCARE RECORD - MISLABELLED
HEALTHCARE RECORD - NOT SIGNED/DATED BY STAFF
CARE PLAN/ASSESSMENT - MISSING/INADEQUATE/ILLEGIBLE
REFERRAL - MISSING/INADEQUATE/ILLEGIBLE
APPOINTMENT RECORDING ERROR
DOCUMENTATION MISFILED
OTHER

IT Security

VIRUS ATTACK
ILLEGAL SOFTWARE
PASSWORD COMPROMISED
LOSS OF DATA
LOSS/THEFT OF IT EQUIPMENT
E-MAIL CONFIDENTIALITY BREACHED
INTERNET MISUSE
OTHER

Maternity

UNEXPECTED NEONATAL ADMISSION TO SCBU
BIRTH TRAUMA (other)
DELAY IN PAEDIATRICIAN ARRIVING WITHIN 15 MINS OF CALL
UNDIAGNOSED CONGENITAL ABNORMALITY
OTHER

Medication

Prescribing

ILLEGIBLE PRESCRIPTION
INCORRECT OR INAPPROPRIATE PRESCRIPTION
NO SIGNATURE
ALLERGY NOT RECORDED

Dispensing

LABEL ERROR
WRONG MEDICINE/STRENGTH
WRONG QUANTITY
DELAY/PROBLEM OBTAINING MEDICATION

Administration

WRONG PATIENT
WRONG MEDICINE
    Wrong dose
WRONG FORMULATION
WRONG FREQUENCY/RATE/TIME
WRONG ROUTE
MEDICINE OMITTED
EXPIRED MEDICINE
ALLERGY RECORDED BUT TREATMENT GIVEN
NO RECORD OF ADMINISTRATION

Monitoring and Advice

ADVERSE DRUG REACTION
WRONG/OMITTED VERBAL OR WRITTEN ADVICE
FAILURE TO MONITOR SIDE EFFECTS/THERAPY
FAILURE PATIENT TO FOLLOW DIRECTIONS

Medicine Security

MEDICINES OBTAINED BY THEFT OR DECEPTION
CONTROLLED DRUG ISSUE
DELIVERY/TRANSPORT MEDICATION ISSUE
INCORRECT STORAGE
MEDICINES MISSING/UNACCOUNTED FOR
MEDICINES FOUND LOOSE/NOT GIVEN
MEDICINE KEY ISSUES

Other

OTHER
PATIENT TRANSFERRED OR DISCHARGED WITH NO/INCORRECT MEDICATION/PRESCRIPTION
MAR CHART OR MDS (E.G. DOSSETT) BOX ISSUE

Organisation

ENVIRONMENTAL ISSUE
Flooding
    Oil Pollution
    Effluent Pollution
    Food Issue
SERVICE FAILURE (Lighting/Power/Heating etc.)
ON CALL SYSTEMS FAILURE
OTHER

Security Issues

INTRUDER
THEFT
    Theft of Staff Property
    Theft of Trust Property
    Theft of Patient Property
    Theft from/of Staff Vehicle
    Theft from/of Trust (loan) Vehicle
ABSCONDER/MISSING PERSON
VANDALISM
UNSAFE ENVIRONMENT - (inc PERSONAL SAFETY)
LOST OR MISPLACED PROPERTY
BOGUS STAFF MEMBER
ACCIDENTAL DAMAGE
FRAUD OR DECEPTION
FORCED ENTRY
OTHER
SECURITY FALSE ALARM

Service Users Issues

ALLERGIC REACTION
DEVELOPED PRESSURE SORES
    Pressure ulcer developed within our care
    Pressure ulcer acquired elsewhere
DELAY/FAILURE TO START CARDIO PULMONARY RESUSCITATION
CONCERN OVER A DO NOT RESUSCITATE ORDER
UNEXPECTED OR SUSPICIOUS DEATH
ISSUE CONCERNING PATIENT DIGNITY
ALCOHOL AND ILLEGAL DRUGS USED
TOURNIQUET PROBLEM
CHAPERONE ISSUES
PATIENT SELF HARM
SUICIDE
SUICIDE ATTEMPTED
SUDDEN ONSET OF ILLNESS
OTHER

Staffing Issues

INADEQUATE LEVELS
INADEQUATE SKILLS MIX
CONCERN OVER COMPETENCE
INADEQUATE SUPERVISION
ACTING BEYOND SCOPE OF PRACTICE
OTHER

Surgical / Theatre Issues

THEATRE LIST DETAILS INCORRECT
LATE AMENDMENTS TO LIST
INCOMPLETE PRE-OPERATIVE PREPARATION OF PATIENT
DIATHERMY BURN
TOURNIQUET PROBLEM
OPERATION SITE WRONGLY MARKED
WRONG OPERATION PERFORMED
INCORRECT SWAB OR INSTRUMENT COUNT
DEEP VEIN THROMBOSIS NO PROPHYLAXIS
UNPLANNED RETURN TO THEATRE
UNEXPECTED ACUTE ADMISSION
OTHER

Violence Issues

FIREARMS/DANGEROUS WEAPONS
VERBAL (inc telephone)
    by other
    by patient
    to staff by staff
PHYSICAL
    by other
    by patient
    to staff by staff
    Homicide by Patient
RACIAL
    by other
    by patient
    to staff by staff
CHILD ABUSE Identified
SEXUAL
    by other
    by patient
    to staff by staff
BULLYING
    by other
    by patient
    to staff by staff
ADULT ABUSE Identified
OTHER (Specify)

Appendix 3 – Examples of Incidents or Near Misses in a commissioning environment

Information Governance	Security Issues	Health and Safety
• Lost or stolen IT equipment • Disclosure of confidential information • Evidence of shared passwords	• Theft of personal property • Unauthorised person gaining access to premises	• Spillage • Burn due to hot water / radiator • Slip or trip on PCT premises • Injury when moving equipment
Organisational	**Abuse Issues**	**Other organisations**
• Failure of power supply	• Physically abuse colleague or member of public • Verbally abuse colleague or member of public • Persistent callers	• Breech of confidentiality from another organisation • Concern about care raised between organisations