Incident Management

Policy

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1 INTRODUCTION

NHS Lothian is committed to the delivery of high quality, safe, effective patient care in a safe working environment and to preventing injury and ill health arising from its undertakings.

Appropriate management of incidents is a key component of the overall risk management process. Effective risk management is not about eradicating or avoiding risk altogether, but minimising the risk and its impact. Hence, a consistent approach is required across NHS Lothian, as described by this policy, to ensure that when things do go wrong, learning is maximised and shared so that repetition can be avoided in the future. NHS Lothian recognises that incidents, including near misses, provide a rich source of key information on risk and recovery; it therefore strives to establish and maintain an environment, both physical and cultural, to promote incident reporting.

The policy can be summarised as follows:

- It is the responsibility of all staff to report all incidents and near misses and be involved in review, investigation and learning from incidents as appropriate and relevant to their role.

- All such reports require to be actively managed at different levels of the organisation, and for reports to be routinely offered to give assurance that lessons have been learned and that this learning has been routinely shared with all relevant groups.

- Actions are reviewed by senior management in a manner that allows the NHS Lothian Healthcare Governance and Risk Management Committee to provide the Lothian NHS Board with an assurance statement.

This policy is in support of, and should be read in conjunction with, NHS Lothian Risk Management Strategy and NHS Lothian Health and Safety Policy. An operational procedure complements the policy and informs implementation by providing further detail of the standard methodology for incident management and specific processes for certain types of incident.

1.1 Definitions

The following terms are used to describe the types of incidents to be reported:

Incident
A broad term used to describe an unintended or unexpected event that led to, **or could have** led to, harm, including death, disability, injury, disease or suffering.

The incident can be described further depending on the consequence or potential consequence:

- **Adverse Event**
  An incident that led to actual harm for patients, public, staff or organisation, including: immediate or delayed emotional reactions, physical or psychological harm.

- **Significant Adverse Event – also sometimes referred to as 'Red' Incident or 'Critical incident'**
  An extraordinary event that could have, or did have **serious consequences**, including immediate or delayed emotional reactions, physical or psychological harm for patients, public, staff or organisation.

- **Near miss**
  An incident where a harmful outcome was avoided, either by chance or by intervention.

A full glossary of terms used throughout this document is provided at Appendix 1.

1.2 National Context

Effective management of incidents, which includes promotion of a safety culture where individuals and team are encouraged to report and can see the value of reporting through timely feedback, is a cornerstone to national policy in the NHS. A number of key publications support this policy, beginning with the Department of Health (2000) 'An Organisation with a Memory' and, most recently, NHS Quality Improvement Scotland (2006) 'Safe Today – Safer Tomorrow'. A full list of references and useful resources is given in appendix 2.

In terms of demonstrating effective management of incidents, NHS Quality Improvement Scotland (NHS QIS) Standards for Clinical Governance and Risk Management came into effect in November 2005. These standards include key criteria relating to management of incidents as part of overall risk management. Every Health Board in NHS Scotland must work towards full compliance with the standards as part of the local delivery plan.

Statute requires that certain types of incidents are reported to the Health and Safety Executive (HSE) under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations). Appropriateness of informing professional bodies such as the General Medical Council, Nursing and Midwifery Council and Royal Pharmaceutical Society of Great Britain should also be considered.

Specific, and in some cases, statutory reporting requirements to external bodies, including the Mental Welfare Commission, the police and Scottish Healthcare Supplies, also apply to a range of incidents. A list of the most relevant bodies is provided in Appendix 3.

1.3 Local policies and procedures

A number of NHS Lothian and local joint policies and procedures will also have an impact on how an incident is handled, and this is explored in more detail in the operational procedure. Key examples of this would be the arrangements for reporting and review of medication incidents and incidents concerning child protection. Arrangements for child protection incidents are detailed in the NHS Lothian Child Protection Policy, which recognises the particular nature, and importance, of a multi-agency approach to such occurrences.

2 STATEMENT OF INTENT

2.1 Aim

The aim of this policy is to ensure that all incidents are managed in partnership; reported, investigated and learned from in such a way as will best support the control of risks to patients, staff, and others, and in accordance with national standards.

2.2 Objectives

A number of key objectives are identified as follows:

- to promote an environment, both physical and cultural, which encourages reporting of incidents, including near misses, so that comprehensive information is available to facilitate learning and change;
- to facilitate local ownership of reporting systems by development of local implementation procedures and protocols;
- to ensure that clear procedures are in place to escalate information about relevant incidents
- without undue delay;
- to ensure active investigation and management in all services so that the greatest benefit is gained from incident reports;

- to assure every employee, and their representative, who reports an incident that it will be evaluated and reviewed within their service and that they will receive prompt feedback on any investigation;

- to provide support to staff who are involved in an incident in any way;

- to monitor and review incident trends on a regular basis to maximise learning from low grade/high volume incidents;

- to establish clear systems and processes to promote the importance of learning and sharing the learning from incidents, including near misses;

- to enable the organisation to comply with its legal duties in respect of incidents.

2.3 Scope

This policy encompasses all incidents, including near misses, arising out of NHS Lothian business, whether on NHS Lothian premises or elsewhere. All permanent and temporary staff, including contractors, bank and agency staff, who work within or for NHS Lothian must comply with this policy.

With regard to errors which may be reported as incidents, staff, including managers, should be aware that:

- NHS Lothian is interested in any incident (as defined in section 1.1);

- mistakes are not the primary focus of any incident report; however, many incidents will involve one or more significant mistakes or departures from procedure by staff;

- it is important to focus on identifying why crucial mistakes were made and to act on those findings;

- in other incidents there will be no significant mistake, but there may still be scope for seeking improvements in practice.

3 RESPONSIBILITIES AND IMPLEMENTATION

3.1 Individuals

- All staff should demonstrate an awareness of this policy and their responsibility to report incidents, including near misses.

- All staff have a duty of care to follow this policy and procedure to allow NHS Lothian to fulfil its legal obligations under the Health and Safety at Work etc. Act 1974 and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.

- NHS Lothian expects staff to participate in incident investigations

- All staff are required to undertake training as appropriate to their role on the content, implementation and management of this policy, procedures and local protocol. This will be covered at induction, through local orientation, and further training provided as appropriate with any amendments to policy or documentation.

3.2 Line Managers

All line managers are responsible for:

- implementing the policy locally and, following any incident, ensuring that the correct procedure is followed. Where managers find themselves unable, for technical reasons, to meet these obligations, they should seek advice from the Health and Safety Department or Risk Management Team, or other appropriate person e.g. Facilities, Medical Physics etc. If the difficulties are of a managerial nature, the matter should be referred through normal line management channels;

- ensuring that local procedures and protocols are in place to report all incidents and staff, (including locum and agency) and contractors are aware of them;

- ensuring appropriate level(s) of review and investigation are carried out and recorded and that partnership advice is sought on the nature and extent of partnership involvement;

- sharing lessons, providing feedback, considering recommendations for change and evaluating any changes;

- evaluating risk identified through incident reporting and, if necessary, adding to risk assessments and the risk register.

The directorate/REAS/CH(C)P Quality Improvement Teams will support the Clinical/REAS/CH(C)P management teams in these responsibilities.

3.3 Health and Safety and Risk Management Teams

Are responsible for:

- identifying incidents reportable under RIDDOR and reporting these to the Health and Safety Executive;

- assisting managers in the investigation of incidents;

- producing statistical information on incident trends and collating information relating to significant adverse events for deliberation and action planning by relevant groups and managers, including Healthcare Governance and Risk Management Committee/Groups, Health and Safety committees, Management and Quality Improvement Teams;

- providing appropriate training for managers, staff and their representatives in relation to the requirements of this policy.

3.4 The Medical Director is the executive with responsibility for the effectiveness of the incident management system. The Board of NHS Lothian will, through the executive management team:

- review incident statistics on a quarterly basis;

- ensure follow up and investigation procedures are followed as appropriate and lessons that are learned are disseminated.

3.5 Caldicott Guardian

The appointed Caldicott Guardian has responsibility for confidentiality guidelines with regard to patient identifiable information. Any incident that may involve issues surrounding confidentiality, information security or access to further clinical information must be referred initially to the Guardian for advice. All employees of NHS Lothian are contractually responsible for confidentiality of information. Failure to comply with confidentiality guidelines may result in

disciplinary action, which could include dismissal. All members of staff will be provided with the appropriate training and information on an ongoing basis.

4 SUPPORT FOR STAFF

4.1 Support

It is recognised that the effect on staff resulting from an incident may have far-reaching consequences – partners, children and others may also be affected. Staff must therefore be treated as individuals so that support is provided in a meaningful way. The organisation must demonstrate, through the actions of staff and managers, that it cares about the harm that may have been caused, and about the well-being of the individual(s) affected.

Staff who are involved in an incident in any way may be psychologically and/or emotionally affected by the event, as well as possibly physically injured. This may arise from witnessing an event or being responsible for its cause through accident, error or negligence.

Assistance needs to be pro-active, and may include a combination of practical and emotional support, for example:

- help with preparing statements; help with investigation, time out and ongoing day to day support;

- collaborative debrief with in-house specialists, counselling, compassionate leave.

The manager must ensure such needs are considered and met where necessary. Staff representatives are able to assist in supporting staff with such issues.

4.2 Training

All staff are required to undertake training sessions on the content, implementation and management of this policy, procedures and local protocol. This will be covered at induction, through local orientation. Further training will be provided with any amendments to policy or documentation as necessary and at appropriate times.

Risk Management and Health and Safety Teams provide training in incident investigation and Root Cause Analysis. This is available to all managers, partnership representatives and any member of staff who may be required to undertake investigations. It is recommended that all staff with management responsibility should attend as part of their training in health and safety and risk management.

5 INCIDENTS INVOLVING PATIENTS

5.1 Incidents involving Patients

Where an incident has a direct impact on a patient, it should be discussed with them by the most appropriate member of the clinical team as soon as is practical. When a patient is able to give explicit consent, incidents must not be disclosed to the patient's next of kin, carer, GP, the media or other parties.

When consent is **not** possible (e.g. children, ventilated patients or vulnerable adults), discussion with a parent / carer or guardian may be appropriate. The manager or senior member of the clinical team should carry out this duty. Information on any incident that may have a bearing on a patient's treatment should also be recorded in their health records.

5.2 Being Open

When patients and relatives are affected by an incident, NHS Lothian will demonstrate transparency and openness and give an apology. **Saying sorry is not an admission of liability**, but an understanding of the distress or worry experienced. Further guidance may be found in the publication: National Patient Safety Agency (2005) 'Being Open: Communicating Patient Safety Incidents with Patients and their Carers'

When harm has occurred, the Clinical Director and/or the Chief Nurse of the relevant service should ensure that:

- the most appropriate staff to meet with the patient and/or relatives/carer are identified;
- a prior meeting between staff is held to establish facts and understand aims of meeting;
- a meeting with the patient and/or relatives/carer is held as soon after the incident as possible;
- follow up in writing is made within 14 days and further opportunities to meet are offered.

6 SIGNIFICANT ADVERSE EVENTS - 'RED' or CRITICAL INCIDENTS

When a serious incident occurs, it must be managed appropriately. This includes:

- appropriate immediate action to ensure the safety of people, equipment and premises;
- ensuring that details of the incident are communicated quickly and appropriately through line management (see algorithm - Appendix 4);
- learning from significant adverse events so that generic learning outcomes can be shared;
- ensuring appropriate support for staff (see section 4).

Examples of Significant Adverse Events are:

Life threatening events
Unexpected death (including suicide)
Homicide on health service premises
Unplanned ward/department/service closure
Major outbreaks of infection
Serious physical or verbal assault (including racial abuse)
Serious injury or harm
Near fatal acts of deliberate self-harm
Events attracting undue/critical media attention

Judgement is required in categorising an event as 'significant' and will be informed by use of the Grading matrix (see appendix 5).

When an executive director or other senior manager initiates a case review or significant adverse event review, a review team will be appointed. In agreeing membership of the team, consideration needs to be given to inclusion of members with appropriate objectivity to the event. The employee director (or appointed deputy) will be contacted and the nature and extent of partnership involvement throughout the process will be agreed and actioned. This will be proportionate to the investigation.

7 LEARNING FROM INCIDENTS

The use of quantitative and qualitative information on incidents, and effective communication of trends and outcomes of incidents, including near misses, is crucial to improving current processes, practices, and identifying dysfunctional and poor systems. This principle applies not only to information about incidents generated from incident management processes within Lothian, but also to valuable information which comes from external sources. In the same way as incidents are reported to external bodies as described in section 1.2 (see also appendix 3), information is shared both for action and learning in formats such as alerts, Safety Action Notices, NPSA alerts (via NHS QIS).

Through all staff taking responsibility for reporting incidents, assisting in identifying contributory factors and reviewing and acting upon relevant information from external sources, experience and lessons from incidents and near misses can be used to drive change.

The review of such information is a formal part of the process to be undertaken by every team and at all levels of management, working in partnership with staff and partnership representatives throughout the organisation. Operational managers are responsible, through management structures, for ensuring that the outcome of both internal and external incident reviews are shared widely, but appropriately.

This will enhance opportunities:

- to provide information, including trends, to inform action planning;
- to identify the need for further attention by multi-disciplinary teams;
- for the formation of local learning groups, when appropriate;
- for sharing information which could be useful to others.

Unless it is essential, when reports are being produced for wide dissemination, every attempt must be made to remove any information which could lead to identification of either individual patients or staff.

8 MONITORING AND REVIEW

8.1 NHS Lothian Healthcare Governance and Risk Management Committee

The Healthcare Governance and Risk Management Committee will review all incident statistics, monitor trends and play an integral part in the process of accident / incident minimisation. It will also ensure full liaison with staff side representation, professional groups and staff associations prior to and during the implementation of safety initiatives.

8.2 Divisional/CHP/REAS Groups and Committees

Divisional/Primary & Community Services Healthcare Governance and Risk Management groups and Health and Safety Committees will periodically discuss the incident statistics and use these to inform organisational objective-setting and action plans. Healthcare Governance, Risk Management and Health and Safety Staff will support this work.

8.3 Quality Improvement Teams

Quality Improvement teams will be responsible for overseeing and reviewing the incident statistics for their area, and will support operational management in identifying safe systems,

monitoring locally the effectiveness of any corrective actions implemented, and sharing learning from incidents.

For non-clinical services, where alternative arrangements for Quality Improvement exist, this responsibility will be delivered through the appropriate existing management structures.

8.4 Internal audit

Managers are responsible for ensuring compliance with the procedures. This will be supported by periodic independent audits by the internal auditors, as part of the NHS Lothian internal audit programme.

9 GOVERNANCE

NHS Lothian Healthcare Governance and Risk Management Committee has responsibility for providing assurance to the NHS Lothian Board that effective incident management is in place throughout the organisation as part of the broader risk management processes.

CH(C)P/REAS/Divisional Management Teams (and Executive Directors in the case of single system services) are responsible, through their management structures, for assuring effectiveness of operational procedures within all relevant services, whether hosted or directly managed.

10 REVIEW OF POLICY

The Health and Safety Department and Risk Management Team will review this policy annually and recommend changes as required to the NHS Lothian Health & Safety and Healthcare Governance & Risk Management Committees.

September 2007

Appendix 1

GLOSSARY OF TERMS

Adverse event	An unintended or unexpected event that led to harm, including death, disability, injury, disease or suffering.
Consequence	Most predictable consequence to the individual or organisation if the circumstances in question were to occur.
CH(C)P	Community Health (and Care) Partnership
DATIX	An IT risk management information system. Comprises of a complex, modular, inter-relational database. Modules used in some parts of NHS Lothian are incident reporting, complaints, claims and risk register.
Escalation	The process of delegating upward, ultimately to the Board, responsibility for the management of a risk deemed to be impossible or impractical to manage locally.
Healthcare Governance	The system by which a healthcare organisation is directed and internally controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all three areas of clinical, corporate and staff governance.
Incident	An unintended or unexpected event that led to, or could have led to, harm including death, disability, injury, disease or suffering.
Likelihood	Probability of an event occurring, wherever possible based upon the frequency of previous occurrences.
Near Miss	An incident in which a harmful outcome was avoided, either by chance or by intervention.
REAS	Royal Edinburgh Hospital and Associated Services
Risk	The chance of something happening that will impact on the organisation's ability to achieve its objectives.
Risk Grade	The classification of risk expressed as a combination of its likelihood and severity of consequence.
Risk Management	Incorporates all the activities required to identify and control the exposure to risk which may have an impact on the achievement of an organisation's objectives.
Risk Register	A database of risks, always changing to reflect the dynamic nature of risks and their management. Its purpose is to help managers prioritise available resources to minimise risk to best effect and provide assurances that progress is being made.
Root Cause Analysis	Structured technique to establish the true systematic causes of an event as opposed to its apparent causes.
Significant Adverse event Or 'Red' incident	A significant adverse event is defined as an extraordinary event that could have, or did have serious consequences, including immediate or delayed emotional reactions, physical or psychological harm for patients, public, staff or organisation.
System Failure	The most likely cause of an adverse event. Typically due to a flaw in the design or operation of a system of work rather than an individual's actions or inaction.

Appendix 2

REFERENCES AND RESOURCES

Department of Health (2000) *An organisation with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer.* London, The Stationary Office

Department of Health (DoH) and National Patient Safety Agency (NPSA) (2001) *Doing Less Harm*: *Improving the safety and quality of care through reporting, analysing and learning from adverse incidents involving NHS patients-Key requirements for healthcare providers.* London. The Stationary Office

Successful Health and Safety Management, Health and Safety Executive (1997)

SEHD guidance (2003) 'Managing incidents presenting actual or potential risks to the public health' – Guidance on Roles and Responsibilities of the Incident Control Team

NHS Quality Improvement Scotland (2004) *Healthcare Governance: Working towards safe and effective, patient-focused care*, Scotland: NHS QIS

NHS Quality Improvement Scotland & Abbott Risk Consulting (2004) *Risk Management Report,* Edinburgh

NHS Quality Improvement Scotland (2006) *Safe Today - Safer Tomorrow Patient Safety – Review of Incident and Near-Miss Reporting*. Edinburgh

NHS Quality Improvement Scotland (NHS QIS) Standards for Clinical Governance and Risk Management (November 2005)

National Patient Safety Agency *Incident Decision Tree*
http://www.npsa.nhs.uk/web/display?contentId=3020
National Patient Safety Agency Root *Cause Analysis toolkit*
http://www.npsa.nhs.uk/web/display?contentId=2665
National Patient Safety Agency (2005) 'being open: communicating patient safety incidents with patients and their carers'
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy1_11.pdf

Reason J (1990) *Human Error*. New York: Cambridge University Press

Dineen, M D ((2002) *Six steps to root cause analysis*, Oxford: Consequence

Mayatt, V.L. (ed) (2002) *Managing Risk in healthcare law and practic*e, Butterworths Tolley

Appendix 3

REPORTING BODIES

External bodies and organisations who may need to be informed of specific incidents

National Services Scotland (NSS) Central Legal Office

NSS Counter Fraud Services

Environmental Health

Food Standards Agency

Health and Safety Executive (HSE) – RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences

Mental Welfare Commission

NHS Quality Improvement Scotland

Police

Procurator Fiscal

Scottish Centre for Infection and Environmental Health (SCIEH)

Scottish Healthcare Supplies (SHS)

Serious Hazards of Transfusion (SHOT)

Scottish Environmental Protection Agency (SEPA)

This list is not exhaustive, but are those most commonly considered

Appendix 4

SIGNIFICANT ADVERSE EVENT REVIEW

Algorithm for Routine and Urgent Communication Cascade for SIGNIFICANT EVENTS and CRITICAL INCIDENTS

The following algorithm sets out in a simplified ACTION format (left hand side of algorithm):

- The responsibility of staff to report all incidents and near misses;
- The requirement for all such reports to be actively managed at different levels of the organisation and for reports to be routinely offered to give assurance that lessons have been learned and that this learning has been shared with all relevant groups AS A MATTER OF ROUTINE, and
- That these actions have been reviewed by senior management in a manner that allows the NHS Lothian Healthcare Governance and Risk Management Committee to provide the Lothian NHS Board with an assurance statement.

A secondary function is to highlight when managers within the service should trigger a cascade of urgent information to key Senior Executive staff and Non Executive board members relating to an incident / significant event. The trigger of a cascade is IN ADDITION to continued active management of an incident as set out in the routine algorithm.

It is expected that the current lines of managerial and professional reporting will be followed e.g.:

- CH(C)P General Manager and Chief Operating Officer to Chief Executive
- CH(C)P Clinical Director and Associate Medical Director (LUHD) to Medical Director
- CH(C)P Chief Nurse and Associate Director of Nursing (LUHD) to Director of Nursing
- Pharmacy, Infection Control, Emergency Planning to Director of Public Health

Communication must be effective, and when a decision to cascade information about an incident is made, there should be agreement between the senior managers involved as to who is taking responsibility for which aspects of communication. The name of a lead manager responsible for coordinating the initial work into the incident should also be made clear. This may be changed as the investigation process develops. Staff at all levels can expect to be supported by senior colleagues during this process.

Cascade of information does not assume transfer of responsibility for the management of an incident. In many cases the investigation and conclusion of an incident will remain with a local management team. Where it is decided to escalate the management of an incident to a senior level or to be managed as an NHS Lothian issue, this will be agreed in partnership with relevant staff.

Decision to cascade information about an incident / event / near miss is not dependent upon this being managed by NHS Lothian.

Algorithm for Routine and Urgent Communication Cascade for SIGNIFICANT EVENTS and CRITICAL INCIDENTS

ROUTINE REPORTING OF SIGNIFICANT ADVERSE EVENTS

ALL STAFF to REPORT SIGNIFICANT EVENT / INCIDENT OR NEAR MISS using NHS LOTHIAN TEMPLATE

LOCAL SERVICE/ CLINICAL/ ON-CALL *(if OOH)* **MANAGER** to ASSESS INITIAL INCIDENT REPORT and ENSURE IMMEDIATE ACTION to manage incident and decide whether IMMEDIATE / URGENT cascade needed

CLINICAL DIRECTORATE / CH(C)P/REAS MANAGEMENT to review all INCIDENT / NEAR MISS REPORTS and LOCAL ACTION TAKEN

- Confirm local action is appropriate
- Consider further action within service
- Consider Learning Points to be shared
- Decide whether IMMEDIATE / URGENT cascade needed

SENIOR MANAGEMENT group for CH(C)P / REAS/LUHD reviews COMPLETED INCIDENT REPORT and confirms management action taken including record within RISK REGISTER and learning shared from all INCIDENT / NEAR MISS REPORTS

Primary&Community Services/ LUHD Healthcare Governance Management group to receive ROUTINE REPORTS of INCIDENT OR NEAR MISS OUTCOMES and will sample routine reports to assure incident report system is functioning

Senior Manager of Operating Division / CH(C)P/REAS or On-call Public Health consultant to receive INCIDENT/ NEAR MISS report identified as URGENT/ HIGH RISK for example

- Unexpected death or injury to patient or staff
- Evidence of major service failure
- Potential press interest

and trigger Cascade action

CASCADE FOR URGENT ALERT

1 Medical/Nurse Director / Director of PH
1 Chief Executive
1 Exec Director(s) on Call
1 Communications Team

2 Chair of HCG&RM Committee
2 Chair of NHS Board
2 Employee Director
2 Professional Lead

3 Non Executive Directors esp Chairs of Operating division/CH(C)Ps/

NHS Lothian Healthcare Governance and Risk Management Committee undertakes formal review of Corporate Risk register and receives exception reports on specific high risk incident to be assured management action has been taken

ANY manager in group 1 (or their depute) May decide immediate alert to SEHD / cascade of an EXCEPTIONAL CIRCUMSTANCE

GRADING MATRIX

Table 1 – Impact/Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience /clinical outcome not directly related to delivery of clinical care	Unsatisfactory patient experience/clinical out come directly related to care provision readily resolvable	Unsatisfactory patient experience/ clinical outcome; short term effects expect recovery <1wk	Unsatisfactory patient experience/ clinical outcome; long term effects expect recovery >1wk	Unsatisfactory patient experience/ clinical outcome; continued ongoing long term effects
Object ves / **Project**	Barely noticeable reduction in scope quality or schedule	Minor reduction in scope quality or schedule	Reduction in scope or quality of project; project objectives or schedule	Significant project over run	nability to meet project objectives; reputation of the organisation seriously damaged
Injury (phys ca and psycho og ca) to pat ent/v s tor/staff	Adverse event leading to minor injury not requiring first aid	Minor injury or illness first aid treatment required	Agency reportable e g Police (violent and aggressive acts) Significant injury requiring medical treatment and/or counselling	Claim above excess evel Multiple justified complaints	ncident leading to death or major permanent incapacity
Comp a nts / c a ms	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care	Below excess claim Justified complaint nvolving lack of appropriate care	Claim above excess evel Multiple justified complaints	Multiple claims or single major claim Complex justified complaint
Serv ce / Bus ness nterrupt on	nterruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service with minor impact on patient care	Some disruption in service with unacceptable impact on patient care Temporary loss of ability to provide service	Sustained loss of service which has serious mpact on delivery of patient care resulting in major contingency plans being invoked	Permanent loss of core service or facility Disruption to facility leading to significant "knock on" effect
Staff ng and Competence	Short term low staffing level temporarily reduces service quality (< 1 day) Short term low staffing level (>1 day) where there is no disruption to patient care	Ongoing low staffing level reduces service quality **Minor error** due to ineffective training/implementation of training	Late delivery of key objective / service due to lack of staff **Moderate error** due to neffective training/implementation of training Ongoing problems with staffing levels	Uncertain delivery of key objective/ service due to ack of staff **Major error** due to neffective training/ mplementation of training	Non delivery of key objective/service due to lack of staff Loss of key staff **Critical** error due to ineffective training/ implementation of training
F nanc a (nc ud ng damage/ oss/fraud	Negligible organisational/ personal financial loss (£<1k) (**NB.** Please adjust for context	Minor organisational/personal financial loss (£1 10k)	Significant organisational/personal financial loss (£10 100k)	Major organisational/personal financial loss (£100k 1m)	Severe organisational/personal financial loss (£>1m)
Inspect on / Aud	Small number of recommendations which focus on minor quality improvement issues	Recommendations made which can be addressed by low level of management action	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action Low rating Critical report	Prosecution Zero rating Severely critical report
Adverse Pub c ty / Reputat on	Rumours no media coverage Little effect on staff morale	Local media coverage short term Some public embarrassment Minor effect on staff morale/public attitudes.	Local media long term adverse publicity Significant effect on staff morale and public perception of the organisation	National media/adverse publicity less than 3 days Public confidence in the organisation undermined Use of services affected	National/international media/adverse publicity more than 3 days MSP/MP concern (Questions in Parliament) Court Enforcement Public nquiry/ FA

Table 2 – Likelihood Definitions

Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	Can t believe this event would happen will only happen in exceptional circumstances	Not expected to happen but definite potential exists unlikely to occur	May occur occasionally has happened before on occasions reasonable chance of occurring	Strong possibility that this could occur likely to occur	This is expected to occur frequently / in most circumstances more ikely to occur than not

Table 3 Risk Matrix

Likelihood	**Consequences / Impact**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	**Medium**	**High**	**High**	**V High**	**V High**
Likely	**Medium**	**Medium**	**High**	**High**	**V High**
Possible	**Low**	**Medium**	**Medium**	**High**	**High**
Unlikely	**Low**	**Medium**	**Medium**	**Medium**	**High**
Rare	**Low**	**Low**	**Low**	**Medium**	**Medium**