

group policies and procedures

# Incident Policy

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| --- | --- |
| Category | Risk Management Governance |
| Author | Castleman Healthcare Ltd |
| Responsible Director | Dr Sam Ghazawy/Dominic Hennessy |
| Date of issue | September 2016 |
| Next review date | July 2017 |
| Document ref & version | Incident Policy Sept 2016 |

**Related policies and guidance**



**Document revision and approval history**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Version | Date | Author | Approved by | Comments |
| V1 | July 16 |  |  | Reviewed comments and changes made |
| Final | Sept 16 |  |  |  |
|  |  |  |  |  |

# 1. AIM OF POLICY

Castleman Healthcare Ltd has a responsibility to ensure the safety and wellbeing of patients and staff and to investigate when things go wrong. This policy informs staff on the process of reporting clinical and non-clinical incidents, including hazards, near misses and potential incidents.

The reporting and management of incidents is a critical tool in assisting the organisation to effectively manage risk. The reporting of incidents and near misses provides valuable data, which can help improve safety, prevent the recurrence of incidents and facilitate wider organisational and cross-organisational learning.

The aim of this policy is to ensure that the organisation is compliant with all relevant regulations and guidelines and to support staff in reporting, investigating and managing incidents.

This Policy applies to all members of Castleman Healthcare Ltd staff, including independent contractors.

This document details the standard requirements for incident reporting and should be used in conjunction with the Incident Reporting Procedure.

This document also details the process for Serious Untoward Incident reporting and aligns with the CCG’s regional policies.

# 2. Objectives

The objectives of the policy are to ensure that the NPSA guidance on the Seven Steps to Patient Safety (2009) are followed by:

1. Promoting a culture of learning through review and reflection of incidents and near misses,
2. Ensuring a consistent approach across the organisation in the reporting and management of incidents,
3. Enabling the effective reporting and provision of information on incident trends to ensure that lessons can be learnt and improvements made reducing re-occurrence of similar incidents,
4. Improving the safety of service users, staff and visitors,
5. Minimising the human, organisational and financial impacts of incidents through effective management,
6. Enabling the identification and correction/ improvement of weaknesses in practices, systems or equipment,
7. Ensuring the onward reporting of serious hazards and incidents to relevant stakeholders

# Roles & Responsibilities

All staff are responsible for being aware of the requirements of this policy, reporting an incident when it occurs and participating in incident investigation processes,

**Castleman Healthcare Ltd Board**

The Board has overall responsibility and decision-making powers with regard to incident handling within Castleman Healthcare Ltd.

**Directors**

The designated Director for overall responsibility for risk management is Dr Sam Ghazawy and the Clinical Governance Director is Dr Dominic Hennessy. The Director is responsible for ensuring that the appropriate support and advice is provided by the Castleman Healthcare Ltd Managers to fulfil the Policy.

Castleman Healthcare Ltd Director will provide the strategic lead on incidents issues and will be responsible for ensuring that incidents information is reported through to the appropriate committees and that the Managers are monitored for compliance with the objectives of the Incidents Process.

**Directors are responsible for:**

1. Ensuring all staff are informed of the need to report incidents which arise.
2. Ensuring all directly employed staff understand the incident reporting system and receive feedback from incidents reported.
3. Ensuring sessional staff are aware of the Incident Reporting Policy.
4. Initiating any investigations required following an incident.
5. Allocating sufficient resources (both financial and human) for incident investigation and follow up.
6. Ensuring any recommendations made as a result of investigations are put into place.

**Castleman Healthcare Ltd Line Managers**

Line Managers are responsible for ensuring that their staff receive appropriate training to ensure they are fully aware of the procedures for reporting and formally recording all incidents relating to their work or workplace. Following any incident or injury, Line Managers must ensure that there is an appropriate investigation or root cause analysis of the circumstances as soon after the event as possible.

# Definition of Terms

**Incident**: An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors, members of the public or Castleman Healthcare Ltd itself.

**Near Miss:** An incident that did not lead to harm, loss or damage but had serious potential to do so and where lessons can be learnt from changes in procedures, processes and systems.

**Hazard**: Is any situation or physical factor, which has the potential to cause an incident.

**Serious Incident Requiring Investigation (SIRI):** A serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following:

1. The unexpected or avoidable death of one or more patients, staff, visitors or members of the public
2. Permanent harm to one or more patients, staff, visitors or members of the public, or where the outcome requires lifesaving intervention or major surgical/medical intervention, or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm (Seven Steps, 2009)
3. A scenario that prevents, or threatens to prevent, a provider organisation’s ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment
4. Allegations of abuse
5. Security incidents
6. Adverse media coverage or public concern for the organisation or the wider NHS; or
7. One of the core set of Never Events
8. All apparent or actual suicides of people with an open episode of care (either community or inpatient) at time of death
9. Major outbreaks, serious incidents of communicable disease or exposure to environmental hazards caused by healthcare failures or other NHS system failures that have put patients/staff at harm/risk of harm or restrict service delivery
10. Information Technology incidents including systems failure leading to serious outcomes and data loss resulting in severe breach of confidentiality.

**Never Events:** Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Incidents are considered to be never events if:

1. The incident either resulted in severe harm or death or had the potential to cause severe harm or death.
2. There is evidence that the never event has occurred in the past and is a known source of risk (for example through reports to the National Reporting and Learning System or other serious incident reporting system).
3. There is existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.
4. Occurrence of the never event can be easily identified, defined and measured on an on-going basis.

**Root Cause Analysis (RCA):** A systematic process whereby the factors that contributed to an incident are identified. As an investigation technique for patient safety incidents, it looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which an incident happened.

**Significant Event Audit:** An audit process where data is collected on specific types of incidents that are considered important to learn about how to improve patient safety.

**Clinical Incident:** Is any untoward event or near miss that involves a patient, e.g. drug errors, patients falling, patient complaint; this will include:

1. Operation on the wrong patient/body part
2. Surgical foreign body left in situ
3. Intra operative problems
4. Diathermy burns/reaction to prep agent/pressure sores
5. Performance of operation that is not indicated
6. Failure to warn (informed consent)
7. Failure to act on abnormal test results
8. Medication errors
9. Infusion problems
10. Problems with medical records
11. Clinical Equipment malfunction
12. Self-harm
13. Unexpected death

**Non-Clinical Incident:** Is an untoward event that involves any person (e.g. member of staff, visitors, voluntary workers, contractors etc.). It may also involve a patient where the event relates to health & safety issues rather than clinical issues. A non-clinical incident may be an accident or a near miss. The following is a non-exhaustive list of non-clinical incidents:

1. Physical or verbal aggression
2. Slip, trip or fall
3. Needlestick or sharps injury
4. Any work related ill health including stress
5. Burns or scalds
6. Accidental exposure to electricity
7. Accidental exposure to chemical agents
8. Accidental exposure to biological agents
9. Accidental exposure to radiation
10. Manual handling injuries to staff
11. Upper Limb Disorders/Repetitive Strain
12. Struck or Trapped by any Object
13. Failure of non-clinical equipment
14. Theft, loss or damage of any property

# Reporting

Castleman Healthcare Ltd recognises that incidents may occur because of problems with systems, processes or by individuals. Castleman Healthcare Ltd promotes a positive approach to incident reporting throughout the organisation. Staff are encouraged and will be supported to be open and honest about events and issues that have or could cause damage to people, property or the organisation. Castleman Healthcare Ltd operates an open and fair blame culture and will accept vicarious liability for the actions of staff as long as they were carrying out their duties in accordance with Castleman Healthcare Ltd policy, their professional standards, information, instruction, training and supervision they had received.

Castleman Healthcare Ltd Staff has a statutory duty to report any incident they are involved in immediately. This includes hazard concerns and near misses that have the potential to cause harm or loss.

All incidents need to be reported to the Line Manger. The Incident Form (see Appendix I) should be filled in and emailed to the Line Manager and details of incident logged in Castleman Healthcare Ltd Quality Log.

IG incidents should be logged using the online toolkit: <https://nww.igt.hscic.gov.uk/home.aspx>

Grading of incidents should occur as soon as possible after the incident and a review of grading should take place after the investigation has concluded – see Appendix 2

|  |  |  |
| --- | --- | --- |
| **Grading** | **Action** | **Timescales** |
| Minor Incidents | Investigated by managers and reviewed by Management.  The principles of root cause (RCA) or significant event audit (SEA) and relevant NPSA guidance should be applied | Logged in Castleman Healthcare log within 24 hours  Resolved within 21 days |
| Moderate Incidents | Investigated by managers and Castleman Healthcare Clinical Governance lead  The principles of root cause (RCA) or significant event audit (SEA) and relevant NPSA guidance should be applied | Logged in Castleman Healthcare log within 24 hours  Resolved within 28 days |
| Major/Catastrophic Incident | National SIRI guidelines to be followed  Serious Incident Reporting form to be emailed to NHS | Logged in Castleman Healthcare log within 24 hours  Resolved within 45 days |

# Process for reporting an incident

Initiate any **immediate actions** required to prevent a recurrence (e.g. isolate defective equipment);

Complete an **Incident Report Form** as soon as possible (within 24 hours of the event), ensuring that where appropriate **Severity Grading** is allocated;

Complete any **supporting documentation** (further details, witness statements etc);

**‘Extreme’** Incidents (i.e. those involving death, serious injury etc) **must be reported immediately**, as Dorset Diagnostics is required to notify these to the Commissioners as SUI’s

Incident / Near Miss occurs

Send Incident Form to Manager

Use trend data to inform Quality Improvement and Patient safety activity

Manager to assess incident, and ensure immediate **preventative actions have been taken**

Manager to liaise with Director or Operations to decide **appropriate investigation methodology** (depending on severity);

Incident form sent to Director of Operations

Retain Incident Report Form in **secure** location and **circulate copies** to relevant staff if relevant;

**Initiate investigation** as advised;

Ensure that Director of Operations is kept appraised of internal investigation;

Notify Clinical Governance board of any identified organisational learning

Director of Operations to update CCG

**Review incident data** at appropriate meetings;

**Minutes** of meetings to summarise issues;

**Feedback to staff** by line managers;

**Assess trends** on a quarterly basis and develop action plans to address key issues

Incident data review

Feedback to Service and Clinical Governance Board

# Serious Incidents

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

Castleman Healthcare Ltd must report SIs and potential SIs to the Patient Safety and Risk Team at Dorset CCG. This must be done by completing the Serious Incident Reporting form, Appendix III which must be sent by email. The words ‘Serious Incident Notification’ must be used in the subject of the email.[[1]](#footnote-1)

|  |  |
| --- | --- |
| Patient Safety and Risk team | HSE Info line (08:00 – 18:00) |
| T: 01305 368052/36/56 | T: 0845 3009923 |
| Email:  matt.wain@dorsetccg.nhs.uk | Website:  http://www.hse.gov.uk/riddor/report.htm |

SIs must be reported as soon as possible after the incident is detected and no later than two working days after the incident being identified. The report must not contain any patient or staff identifiable data (including initials of names) and the description should be concise.

Castleman Healthcare Ltd must ensure that all serious incidents are disclosed to those affected in a timely manner, appropriately reported and investigated, with the findings being shared with those involved in accordance with the Being Open guidance and the contractual Duty of Candour requirements. Staff leading serious incident investigations should have up to date training and be competent in investigative methodology, techniques and analysis, report writing, and including human factors.

Castleman Healthcare Ltd is accountable for effective governance and learning following a serious incident. Castleman Healthcare Ltd should ensure that:

* Relevant policies and procedures are in place
* Incidents are reported
* All incident investigations and action plans are reviewed
* Data trends are monitored
* Serious incidents are investigated and closed in a timely manner

**Notifying the CQC of incidents reported to, or investigated by the Police**

Castleman Healthcare Ltd is required to notify the CQC without delay of incidents reported to, or investigated by the Police.

**Steps to be taken when a serious incident occurs:**

|  |  |
| --- | --- |
| Steps | Details |
| 1 | Incident Occurs |
| 2 | Log incident on Quality Log |
| 3 | Report incident email Patient Safety and Risk Team |
| 4 | Grade incident |
| 5 | Establish appropriate investigation |
| 6 | Undertake investigation |
| 7 | Develop action plan |
| 8 | Submit incident investigation report and action plan to commissioner |
| 9 | Implement action plan |
| 10 | Commissioner signs off incident as closed |
| 11 | Share lessons |
| 12 | Review implementation of actions |

# Investigating Incidents

Adverse incidents and near misses are subject to an appropriate level of investigation and root cause analysis and where relevant an action plan for improvements prepared. Not all events need to be investigated to the same extent or depth and the investigation and analysis should be relative to the seriousness, complexity of the event and/ or whether it resulted in actual harm and the potential for learning, such as those which are high frequency but may be of low severity

Any investigation should have the following aims:

1. To ensure timely and appropriate follow-up
2. To establish the facts
3. To identify factors contributing to the events
4. To determine what actions are to be taken to remedy any identified deficiency
5. To prevent, as far as possible, similar occurrences in the future
6. To meet national, regional and legal reporting requirements

To ensure the achievement of these aims is possible, an investigation should feature the following components:

1. Collection of evidence about what happened – to include clinical records (where relevant), correspondence, witness statements, etc.
2. Consideration of the evidence, including a comparison with relevant standards, protocols or guidelines, whether national or local
3. Establishment of the facts and, based upon these, the drawing of conclusions and making of recommendations for action to minimise risk
4. The drawing up of an action plan with prioritised actions, responsibilities, timescales and strategies for measuring effectiveness of actions
5. The implementation of the improvement strategy and track progress; including the effectiveness of actions

# Learning

The sharing of the lessons learnt post investigation is a critical part of incident management. Learning from incidents is a collaborative, decentralized and reflective process that draws on experience, knowledge and evidence from a variety of sources. The learning process is a process of change evidenced by demonstrable, measurable and sustainable change in knowledge, skills, behaviour and attitude. Learning can be demonstrated at organisational level by changes and improvements in process, policy, systems and procedures relating to patient safety within healthcare organisations. Individual learning can be demonstrated by changes and improvements in behaviour, beliefs, attitudes and knowledge of staff at the front line of healthcare delivery.

The Practice maintains a register of all incidents occurring within the organisation. This register of incidents and the resulting actions taken are likely to impact upon other policies and procedures within the Practice.

All registered incidents are re-evaluated after a 6-month period to assess the effectiveness of the implemented actions, in ensuring that either the type of incident is no longer being reported or the volume of those types of incidents has reduced.

If there is no change in the volume of each type of incident, the Board is alerted and appropriate action taken.

To provide staff with an example of what could occur, how to respond to such events and how to avoid them, previous incidents are used in security and confidentiality training sessions.

Examples of learning:

* Solutions to address incident root causes which may be relevant to other teams, services and provider organisations;
* Identification of the components of good practice which reduced the potential impact of the incident, and how they were developed and supported;
* Systems and processes that allowed early detection or intervention which reduced the potential impact of the incident;
* Lessons from conducting the investigation which may improve the management of investigations in future; and
* Documentation of identification of the risks, the extent to which the risks have been reduced, identified and how this is measured and monitored.

Learning points should be grouped or themed to help the reader(s) identify those points applicable to their team, service, specialty, division or wider.

# Appendix 1 Incident Reporting Form

|  |  |
| --- | --- |
| Incident Register Number | |
| **Reported by:** | **Date/time discovered:** |
| Incident details | |
| **Type of incident** *[tick a category]*:   |  |  | | --- | --- | |  | **Confidentiality**  e.g. breach due to unauthorised access, potential breach due to lost record, etc. | |  | **Integrity**  e.g. records altered without authorisation, etc. | |  | **Availability**  E.g. records missing, misfiled, theft etc. | | |
| **Incident details**,state the facts only, where it occurred; what information was involved etc. | |
| **Date reported**: | |
| **Initial action(s) taken**, (what did you do, who will / have you reported the incident to)**:** | |

|  |  |
| --- | --- |
| **Investigation and management** | |
| **\*\*\*Insert name and Position of person investigating the incident\*\*\*** | **Date investigation commenced:** |
| **Investigations, findings, actions and recommendations:** | |
| **Post-incident reporting** | |
| **Incident and investigation outcome reported to** [add any other relevant notes here, e.g. issue and outcome discussed at staff meeting]: | **Primary Care Trust**  **YES/NO** |
| **Information Commissioner**  **YES/NO** |
| **Practice Insurer**  **YES/NO** |
| **Other**  ***[Insert details]*** |

# Appendix 2 – Grading of Incidents

Assessing and grading an incident’s risk severity in a consistent way provides the Castleman Healthcare Ltd with a way of identifying levels of risk and the actions to deal with them. A risk severity grade is achieved by using the 2-dimensional risk-grading matrix (as below) (***consequence*** and ***likelihood***) to identify a severity score/colour

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Likelihood score** | | | | | | | |
| **Risk Grading Matrix** | | | **1** | **2** | **3** | **4** | **5** |
|  |  |  | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost** |
| ***Score*** | **Certain** |
| **5 Catastrophic** | | **5** | **10** | **15** | **20** | **25** |
| ***Consequence*** | **4** | **Major** | **4** | **8** | **12** | **16** | **20** |
| **3** | **Moderate** | **3** | **6** | **9** | **12** | **15** |
| **2** | **Minor** | **2** | **4** | **6** | **8** | **10** |
| **1** | **Negligible** | **1** | **2** | **3** | **4** | **5** |

For grading risk, the scores obtained from the risk matrix are assigned colour grades

|  |  |  |  |
| --- | --- | --- | --- |
| **Green** | **1** | **- 3** | **Low risk** |
| **Yellow** | **4** | **- 6** | **Moderate risk** |
| **Amber** | **8** | **- 12** | **High risk** |
| **Red** | **15 - 25** | | **Extreme risk** |

**Assessing and grading Consequence and Likelihood to grade incident severity and risk**

To establish the overall risk grading of an incident, we need to first assess and grade the incident in terms of the consequence/impact, followed by an assessment of the likelihood or reoccurrence.

**Consequence Grading for Incidents**

Consequence is defined as the severity of the actual or potential harm or outcome of an incident. Where there is more than one consequence of a single incident, use the most severe to grade the severity. Consequence scores and grades are:

1. Negligible
2. Minor
3. Moderate
4. Major
5. Catastrophic

These are shown below in a table with some descriptors of incidents. Work along the columns to assess the consequence of the harm or outcome of an incident (actual or potential), on the scale of 1 to 5. The score is the number given at the top of the column, the grade is the colour.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table 1** | **Consequence grading/scoring (severity levels)** | | | | |
|  | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
|  | No injury or minimal injury | Minor injury or illness, | Moderate injury requiring | Major injury leading to long- | Serious injury or harm egg. |
|  | but no first aid required | requiring minor intervention | professional intervention | term incapacity/disability | very serious suicide attempt |
| **Impact on the safety of** | No time off work | Requiring time off work for | Requiring time off work for 4- | Requiring time off work for | Incident leading to death |
|  | 14 days (RIDDOR reportable |  |
|  | >3 days | >14 days |
| **patients, staff or public** | incident) |
| **(physical or psychological** |  |  |  |  |  |
| **harm)** |  |  | An event which impacts on a | Mismanagement of care with | An event which impacts on a |
| small number of service |  |  |
|  |  |  | long-term effects | large number of patients |
|  | users |
|  |  |  |  |  | Meets the definition of an SI |
|  |  | A Never Event |
| **Quality/complaints/audit** |  |  |  | Non-compliance with |  |
| Peripheral element of | Overall treatment or service | Treatment or service has | national standards with | Totally unacceptable level or |
| treatment or service | suboptimal | significantly reduced | significant risk to patients if | quality of treatment/service |
| suboptimal | effectiveness |
|  | unresolved |  |
| Informal complaint/inquiry | Formal complaint (stage 1) | Formal complaint (stage 2) | Multiple complaints/ | Inquest/ombudsman inquiry |
| complaint | independent review |
|  | Single failure to meet | Repeated failure to meet | Critical report | Gross failure to meet |
| internal standards | internal standards | national standards |
|  | Minor implications for | Major patient safety |  | Gross failure of patient |
| implications if findings are | Low performance rating | safety if findings not acted |
| patient safety if unresolved |
| not acted on | on |
|  |  | Local resolution (with |  |  |
| Local resolution | potential to go to | Critical report |
| independent review) |
|  | Reduced performance rating |  |  |  |
| if unresolved |
|  | Short-term low staffing level | Low staffing level that | Unsafe staffing level or | Unsafe staffing level or | Ongoing unsafe staffing |
|  | that temporarily reduces | reduces the service quality | competence (>1 day) | competence (>5 days) | levels or competence |
|  | service quality (< 1 day) |
| **Human resources/** |  |  | Late delivery of key | Uncertain delivery of key | Non-delivery of key |
| objective/ service due to lack | objective/service due to lack | objective/service due to lack |
| **organisational** |
| of staff | of staff | of staff |
| **development/staffing/** |
|  |  | Poor staff attendance for | No staff attending |  |
| **competence** | No staff attending mandatory |
|  | training /key training on an |
|  | mandatory/key training | mandatory/ key training |
|  | ongoing basis |
|  |  |  | Low staff morale | Very low staff morale | Loss of several key staff |
|  |  |  |  | Loss of key staff |  |
|  | No or minimal impact or | Breech of statutory | Single breech in statutory | Multiple breeches in | Multiple breeches in |
|  | breech of guidance/ |
|  | legislation | duty | statutory duty | statutory duty |
|  | statutory duty |
|  |  |  | Challenging external | Low performance rating | Zero performance rating |
| **Statutory duty/** | Reduced performance rating | recommendations/ |
| **inspections** |  | if unresolved | improvement notice |  |  |
|  |  |  |  | Improvement notices | Complete systems change |
|  | required |
|  |  |  |  | Enforcement action | Prosecution |
|  |  |  |  | Critical report | Severely critical report |
|  | Rumours |  |  | National media coverage | National media coverage |
|  | Local media coverage – short- | Local media coverage – long- | with <3 days’ service well | with >3 days’ service well |
| **Adverse publicity/** | term reduction in public | term reduction in public | below reasonable public | below reasonable public |
| confidence | confidence | expectation. MP concerned |
| **reputation** |  |  |  | expectation | (questions in the House) |
|  |  |  |  |  |
|  | Potential for public concern | Elements of public |  |  | Total loss of public |
|  | expectation not being met | confidence |
|  |  |  |  | Non-compliance with |  |
|  | Insignificant cost increase/ | <5 per cent over project | 5–10 per cent over project | national 10–25 per cent over | Incident leading >25 per cent |
| **Business objectives/** | schedule slippage | budget | budget | project budget | over project budget |
| **projects** |  |  |  |  |
|  | Schedule slippage | Schedule slippage | Schedule slippage | Schedule slippage |
|  |  |  |  | Key objectives not met | Key objectives not met |
| **Finance including claims** | Small loss Risk of claim | Loss of 0.1–0.25 per cent of | Loss of 0.25–0.5 per cent of | Uncertain delivery of key | Non-delivery of key |
| objective/Loss of 0.5–1.0 per | objective/ Loss of >1 per cent |
| remote | budget | budget |
| cent of budget | of budget |
|  | Claim less than £10,000 | Claim(s) between £10,000 | Claim(s) between £100,000 | Claim(s) >£1 million |
| and £100,000 | and £1 million |
|  |  |  | Purchasers failing to pay on | Loss of contract / payment by |
| time | results |
|  |  |  |  | Failure to meet |
| specification/ slippage |
| **Service/business** | Loss/interruption of >1 hour | Loss/interruption of >8 hours | Loss/interruption of >1 day | Loss/interruption of >1 week | Permanent loss of service or |
| **interruption** | facility |

**Likelihood of re-occurrence scoring**

The likelihood score should only be assessed once the consequence or impact of an incident has been graded.

The likelihood score is an assessment of how likely it is that an adverse incident will re-occur:

* 1. That the same incident or event will happen again ***and***
  2. With the same level of consequence (the same impact)

For example, if the incident was a fall in which someone sustained a fracture, how likely is it that the fall will happen again (consider place and person), and how likely is it that if a fall does recur that the injury will again be a fracture.

It is important to take into consideration the control measures already in place to stop the event occurring again at the same level, including any actions taken after the incident.

As with the assessment of ‘consequence’, the likelihood of the incident re-occurring is assigned a number from ‘1’ to ‘5’ - the higher the number the more likely it is to re-occur and is based on frequency:

* + 1. Rarely
    2. Unlikely
    3. Possibly
    4. Likely
    5. Almost certainly

Table 2 provides definitions of descriptors to help score the likelihood of an incident risk being realised by assessing frequency.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table 2** | **Likelihood score** | | | | |
|  | **1** | **2** | **3** | **4** | **5** |
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Very Likely** |
| **Frequency** | Extremely unlikely |  |  |  | Continuous |
|  |  |  |  |
|  |  |  |  | exposure to risk. |
|  | to happen/recur – | Unlikely to | May | Will probably |
|  | Has happened |
|  | may occur only in | occur/reoccur but | occur/reoccur. But | occur/reoccur. Has |
|  | before regularly |
| **How often might** | exceptional | possible. Rarely | not definitely. | happened before |  |
| **it or does it** | circumstances – | occurred before, | Happened before | but not frequently | and frequently – is |
|  | has never | less than once per | but only | – several times a | expected to happen |
| **happen (at the** | happened before | year. Could happen | occasionally once | month. Will occur | in most |
| **same level)** | circumstances. |
| and don’t think it | at some time | or twice a year | at some time. |
|  | Occurs on a daily |
|  | will happen (again) |  |  |  |
|  | basis |
|  |  |  |  |  |
|  |  |  |  |  |  |

**Example incident:**

A member of staff slips and falls down some steps, injuring their hand, requiring first aid. The incident graded by the person who fell, it is their assessment of the severity:

**Consequence:** Minor (injury, impact) – scores 2 **Likelihood:** Unlikely (to re-occur)– scores 2 Overall incident grading would be 2x2 = 4 = Yellow

1. <http://www.dorsetccg.nhs.uk/Downloads/aboutus/Policies/Corporate/Procedure%20for%20the%20management%20of%20Serious%20Incidents%20Aug%202015.pdf> [↑](#footnote-ref-1)