Incident Management and Recording Policy

February 2020

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Lead Manager	Head of Health and Safety
Responsible Director	Director of Human Resources and Organisational Development
Approved By	Corporate Management Team
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I. Scope of Policy Implementation

This policy is written in support of the general statements and principles as set out in the NHS Greater Glasgow & Clyde Health & Safety Policy.

II. Roles and Responsibilities

The framework of accountability and responsibility for managers and staff on the implementation of this policy follow that laid out within the Health and Safety Policy.

It is the responsibility of Local Managers and Heads of Departments to ensure that actions are in place to ensure the implementation of the policy. In particular the timely and efficient use of the Datix Incident Reporting System.

1. Introduction

The reporting of incidents forms part of the Risk Management Strategy and should be recognised as a means of improving the quality of patient care and minimising risk to staff, patients, visitors and contractors. The open reporting of even minor incidents allows weaknesses to be identified in the systems, customs and practices. Investigation must be balanced with the need to counsel and support staff through any potential or actual incident, and to provide appropriate support whilst ensuring that incidents are thoroughly investigated.

This policy sets out for staff how to report, record and investigate clinical and non-clinical incidents, including near misses and potential incidents. It covers *all* incidents, whether they involve patients, relatives, visitors, staff, contractors, volunteers or the general public.

- An **'incident'** is any event or circumstance that led to unintended or unexpected harm, loss or damage.
- A **'Near Miss'** is an event or occurrence which, but for skilful management or a fortunate turn of events, **would** have led to harm, loss or damage.
- A **Significant Incident** is an event deemed at Director level to be sufficiently serious to warrant a formal investigation reportable to relevant Directorate / HSCP Senior Management with investigation monitored by the appropriate Health & Safety or Clinical and Care Governance Forum. Usually it would involve the risk of death or serious injury / ill-health, major damage to property, loss of a service, create a major health risk, or are a threat to the strategic objectives of the NHSGGC. **There is a policy on the Management of Significant Clinical Incidents for further information.**

  This would also include **Reportable** incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Such incidents are reported to the Health and Safety Executive (HSE) by the Health and Safety Service. The Health and Safety Service will also undertake investigation of RIDDOR incidents as

appropriate. Further information and guidance on RIDDOR can be sought from the Health and Safety Service or found on HSE Web Page http://www.hse.gov.uk/riddor/

NHSGGC recognises the importance of reporting incidents:

- The management of risk is the responsibility of all managers and staff throughout NHSGGC. We aim to achieve this within a progressive, honest and open environment, where risks, incidents, accidents, mistakes and near misses are identified quickly and acted upon in a positive and constructive way
- No disciplinary action will result except where, after a full investigation, there has been criminal or malicious activity, professional malpractice, or acts of gross misconduct. Disciplinary action may be considered where incidents or violations have not been reported.
- Staff will be provided with education, training and support to enable them to meet this responsibility.

NHSGGC promotes and seeks to encourage a culture of reporting so as to identify and learn from sources of error and risk which may lead to damage, loss or harm, complaint or legal claim for negligence.

Staff should report incidents, in the first instance, to their line manager who will advise on action.

Understanding and learning from incidents is an important part of risk management. The occurrence of an incident or near miss might trigger a review of a risk assessment of a work area or of a particular practice, to work out how to minimise the chance of similar incidents occuring in the future. The type and frequency of incidents should also be taken into account when compiling Risk Registers.

The Health and Safety Service together with the Clinical Risk, Occupational Health Service and other specialist departments can provide advice and support on the investigation and handling of Significant incidents. This investigation will be separate from any local investigations undertaken by local management.

From 1st January 2020 all NHS boards will inform HIS of any Significant Reviews commissioned for category 1 events. HIS has produced a supplementary guidance document for the notification process. This is available on the HIS website and is titled Adverse Events – guidance on national notification data. This supplementary guidance will be updated periodically.

2. Reporting Incidents

2.1 The reporting system

When an incident or a near miss occurs, the NHSGGC Incident Reporting System must be used. An overview of the process is provided in appendix 1

NHSGGC has committed to the use of a web based incident reporting system. The proprietrory system currently used is called Datix. This may change during the term of this policy.

The use of a web based incident reporting system allows incidents to be reported in real-time reducing delays experienced with paper systems. Access to the reporting system is open to all staff via Staffnet.Where staff do not have regular access to a PC this can be arranged via local line management

The reporting form is styled in a manner to make it easy to use with many of the options based on drop down tables. Help and support on the use of the forms can be found on Datix home page or via contact with Datix Administration.

Information relating to training on the use of Datix is available via the Datix Homepage (Link).

It is recognised that on occasion access to IT systems may be compromised. It is recommended that local managers print a few copies of the paper version to be used in such circumstances, that will then require to be input to Datix using the paper copy as reference as soon as possible.

2.2 What is an 'Incident'?

An incident:

- is an event which results in or has the potential to result in injury or ill health
- is contrary to the specified or expected standard of patient care or service
- places patient(s) or staff member(s), or visitor(s), contractor(s) or member(s) of the public at unnecessary risk of harm
- places NHSGGC in an adverse position with potential loss of reputation
- places NHSGGC property or assets in an adverse position or at risk of loss or damage
- Act of ommission or commission by a member of staff which results in an injury

2.3 Near miss reporting

A near miss is an occurrence that might have led to harm, damage or loss but did not happen due to discovery, chance or skilful management. Reporting a 'near miss' event is as important as reporting incidents that actually occurred and caused harm. Although a 'near miss' did not cause harm the potential for recurrence probably still exists and this needs to be managed effectively.

Recording of Near Miss Events can be confusing. A Near Miss is recorded on Datix as an Outcome not a category. Therefore, the incident Category should be selected, as if the incident actually took place, and 'Near miss' should be chosen as the Outcome.

Example 1: A needle was found within a waste bag but fortunately no-one was injured. The incident Category would be 'Needlesticks / Sharps' and the incident Outcome would be a 'Near miss'.

Example 2: A wrong medication is prescribed but a nurse recognises the error before it is given. This is still categorised as a 'Medication – Prescribing' incident with an outcome of 'Near miss'.

2.4 Your duties as a NHSGGC employee

NHSGGC aims to promote a culture in which all staff are individually conscious of their responsibility to reduce and prevent unsafe practices and routinely to raise concerns.

As a member of staff you are required to inform your line manager of incidents and near misses as soon as possible following the incident. Your duty to report applies even if you are not directly or potentially affected.

The NHSGGC Risk Management Strategy states:

> *"In order to ensure full reporting of incidents, a 'just culture' will be operated within which staff are free to report on incidents and concerns in the knowledge that they will be supported."*

2.5 Steps to take following an incident

It should not be the responsibility of an individual member of staff to solely undertake any of the following actions. Support should be expected from colleagues and line management:

1. Individual care of the person(s) affected by the incident
   - Provide first aid / emergency medical / psychiatric treatment
   - Treat and care for others affected
   - Ensure that all patients, staff, visitors and others at risk, are moved to a safe area if there is an environmental threat
2. Create a safe environment
   - Summon assistance. This may be local to the area of the incident, from elsewhere within the Board or may be the Emergency Services
   - Take immediate action if the incident could recur
   - If equipment / machinery is involved, remove it from service (marking it clearly out of order). Isolate any faulty equipment in a safe place for later inspection without altering its settings. You should record any settings that may be lost when the machine is turned off. Make a record of the equipment's serial number. Contact Clinical Physics or the Estates Department as appropriate

- Appropriate records, materials and equipment, including disposable equipment used in conjunction with any device, must be retained. Where appropriate photographs should be taken in compliance with the appropriate policy

3. Communication
    - Notify line manager as appropriate
    - Notify senior members of staff if incident is significant
    - Where appropriate, notify next of kin for both patient and staff injury incidents
    - Consider the need to provide an explanation or an apology to the patient and family; an apology invariably improves relationships and communications and, note, is not an admission of liability
    - Record all actions taken
    - For significant incidents, statements of events should be obtained from witnesses, injured person and person in charge

Where death or significant injury has occurred or you regard the incident as very serious, **reporting must be immediate**, i.e. by telephone to senior managers, or on call managers outside normal working hours.

Health and Safety Services should also be informed in person or by telephone as soon as possible. The relevant H&S Team should be added as an investigator to the incident report on Datix.

The patient's consultant must be informed of significant clinical incidents especially if this resulted in an adverse outcome, at the earliest opportunity.

2.6 Duty of Candour

Informing and Involving Patients / Families (Duty of Candour)

The Duty of Candour procedure, and regulations to be made using the power in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016) will require organisations to make sure that they are open and honest with people when an unintended or unexpected incident resulting in death or harm has happened to patients in our care. In principle all patients / families should be informed if they are involved in a significant incident such as a RIDDOR incident or Significant Clinical Incident (SCI).

As soon as such an incident has been identified it is essential that an appropriate person is identified to inform patients and families. Who this person is will depend on the individual circumstances but is likely to be the consultant in charge of the overall patient care, where this person is not available a suitable senior clinician should be identified.

Patients should also be advised of the intention to undertake a RIDDOR or SCI investigation and where appropriate offered the opportunity to input to this process. This may be in the form of a face to face discussion, letter or may on occasion involve a further meeting with patients / families. It is good practice to document this interaction in the patient record including any queries patient or family may have.

It is important that the process and remit of an investigation is carefully explained to the patients / families. It may be that there are issues / concerns they have out with the scope of the investigation and if this is the case then support should be given to ensure these are addressed via the appropriate channels. At this stage agreement should also be made on the level of contact the patient / family wish during the process and on the type of feedback. It is acknowledged that not all patients / families will wish to be involved in the process and this should also be respected.

In all instances those decisions relating to the involvement of patients and families must be recorded by the investigation team and made visible in the report. Datix has also been updated to allow the service to log whether the patient was informed. This will allow the board to monitor patient involvement in line with Duty of Candour legislation. It is both natural and desirable for those involved in treatment which produces an adverse outcome, for whatever reason, to sympathise with the patient or the patient's family and to express sorrow or regret at that outcome. Such expressions of regret would not normally constitute an admission of liability, either in part or full, and where staff wish to do so NHS GG&C encourage such expressions to patients and / or families.

The duty of candour procedure must be carried out by the responsible person as soon as practicable after becoming aware that an individual who has been the subject of an unintended or unexpected incident, and in the reasonable opinion of a registered health professional has resulted in or could result in:

- A person died
- A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions
- A person's treatment increased
- The structure of a person's body changed
- A person's life expectancy shortened
- A person's sensory, motor or intellectual functions was impaired for 28 days or more
- A person experienced pain or psychological harm for 28 days or more
- A person needed health treatment in order to prevent them dying
- A person needed health treatment in order to prevent other injuries as listed above

For further information please refer to the Duty of Candour policy or the LearnPro module both of which can be accessed from this link.

In some circumstances deaths of patients may require to be reported to the Procurator Fiscal. Further guidance on this is covered by the Significant Clinical Incident Policy (Link).

2.7 Reporting

Access to the Datix reporting system is via Staffnet.

If you have not completed the incident form before, read through it before you fill it in. Guidance on completion is available at the Datix staffnet page, Guide to Reporting an Incident also via a link at the top of the online reporting form DIF1. At the initial time of completion not all the necessary information may be available. This should not delay the reporting process as missing information can be added later.

The key information you will be asked is:

- The location of where the incident occurred (Where)
- The date and time of the incident (When)
- Personal details relating to the person involved in the incident (victim / injured party)
- Description of the incident (What, why and how)
- The outcome for? the person involved (injury / result)
- The immediate treatment given to the person involved
- Any immediate action taken
- Any remedial action taken to minimise risk of recurrence
- Others who were involved in observing or reporting the incident (witnesses)
- The severity of the incident (see section 2.10)

It is imperative that the person(s) reporting the incident confine themselves to **issues of fact**. There is no place for any opinion or assumptions, however well intended. Merely state the facts as they are. Incident forms may have to be **disclosed** in the event of subsequent litigation. Therefore it is important that details are **accurate and factual**.

If staff are involved in an incident on other NHS employers' premises, they must report and complete an incident form for that organisation. The member of staff should upon return to base inform their line manager of the incident. Staff involved in an incident elsewhere e.g. a patient's home, should complete a NHSGGC Datix form as soon as they return to their place of work.

All staff with honorary contracts must complete a form if they are involved in an incident on NHSGGC property. Volunteers and students on work experience should similarly complete a form if they are involved in an incident whilst on NHSGGC property and also make a report to the organisation which has placed them in NHSGGC.

It is acceptable for staff to complete forms on behalf of other people if the need arises, after full establishment of the facts.

For each incident, only one form is normally necessary (unless more than one person has been affected / harmed) as multiple forms providing different versions of the same incident lead to double or multiple counting of the incident. The most senior person present at the incident should ensure that at least one form is completed.

Where it is necessary to record more than one person involved by the incident this can be done by using the repeating section of 'persons affected' on the Datix DIF1 reporting form.

Example 1: A patient became violent in the ward area and four members of staff were involved but not harmed. Therefore 1 incident form on Datix will be required relating to the incident.

Example 2: Medication incident where patient A gets patient B's medications and as a result patient B does not receive any medications. Although both incidents relate to the same initial error, 2 incidents forms will be required as harm (or potential harm) has occurred to two patients).

To help improve safety at NHSGGC, the incident reporting process has to be pursued to a conclusion at the level of the local management team. This requires local ownership and commitment to action. Line managers and staff should work together to ensure that the specific concerns raised are acted upon and information about the event and the outcomes shared as widely as possible, seeking corporate advice if needed from relevant departments, for example:

- Clinical Risk
- Health and Safety Services
- Clinical Physics Department
- Estates
- Radiation Protection
- Infection Control Team,
- Occupational Health.
- Pharmacy
- Falls prevention
- Fire Safety Team

Notifying any of the above, while necessary, is not a sufficient response to an incident. A Datix must also be completed.

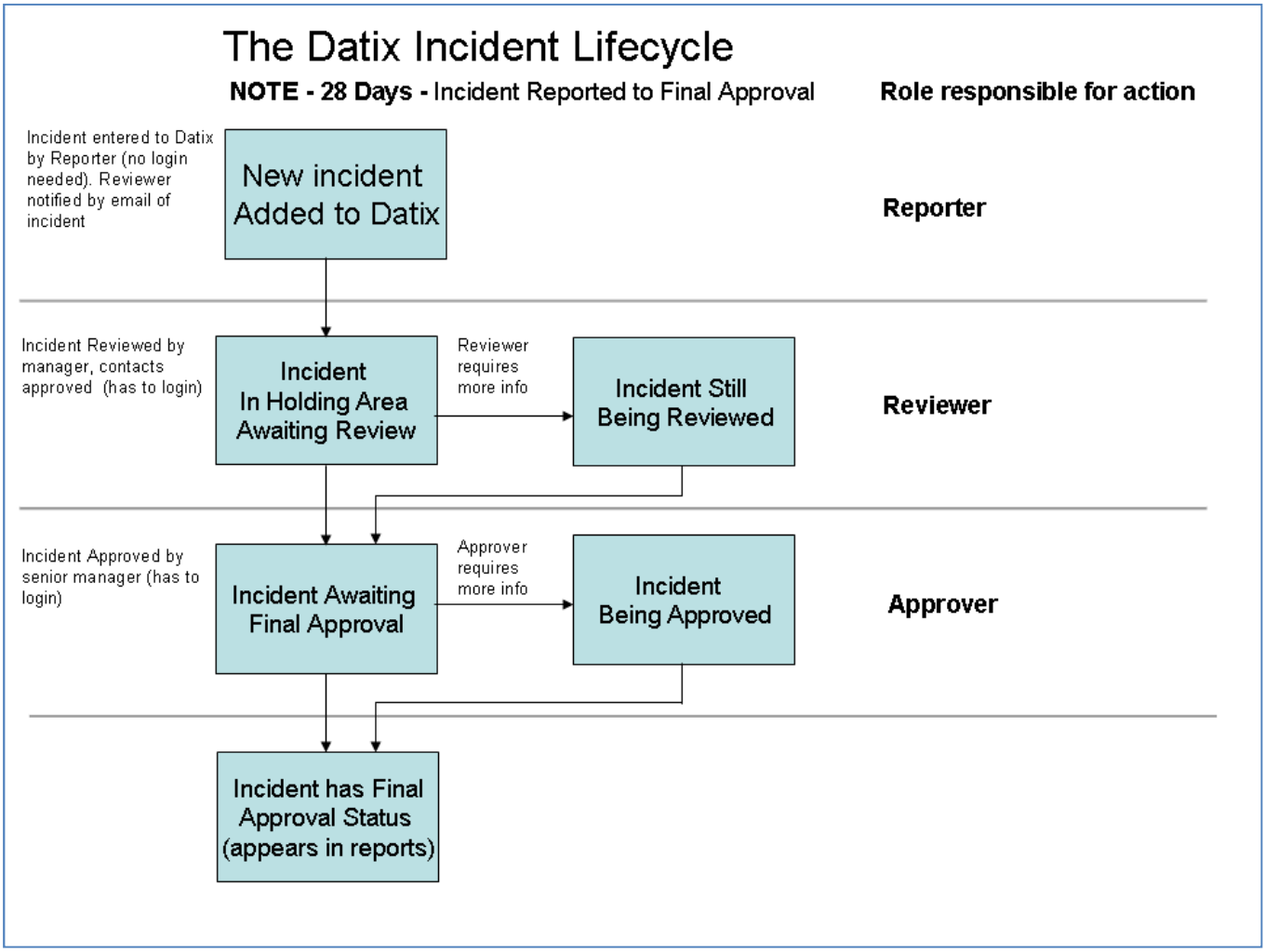
Those noted above may carry out investigations into the incident (where appropriate). It should be noted that such action does not remove the need for local management to investigate the incident.

2.8 Timescales

As a Reporter you should complete the online form (DF1) as soon as possible after the event, **within one working day**, unless, exceptionally, there are reasons for delay. Do not delay reporting because some information is unavailable; this can be added later.

It is the line manager's role to review the form (DF2), to complete further mandatory sections such as severity and whether RIDDOR applies. This initial review should be undertaken **within 7 days**.

The Incident management system (Datix) will report incidents as overdue, that is, those which are not marked as being Finally Approved, when 28 calendar days have elapsed since the incident was first input to the system.



2.9 Reporting of Fire Alarm Activations

All Fire Alarm Activations and Fire Events are to be recorded on the Datix incident reporting system on NHSGGC Staffnet with sufficient detail included about the event including contributing factors and timeline of events. The Duty Holder(s) should ensure that a Datix form is completed. All Fire related Datix alerts are sent automatically to the site based Fire Safety Officer for review.

2.10 Management of Incident Review and Approval

Completion of the initial report DIF1 should be as soon as possible after the event, **within one working day**, unless there are exceptional reasons for delay. Do not delay reporting because some information is unavailable; this can be added later.

There are 2 roles within the Datix chain, the Reviewer and the Approver. Guidance on these roles and the timescales for actions to be taken can be found within Manager's Guide to Incident Review.

Key actions required through the process include applying the severity of the incident which (depending on the severity allocated) will trigger further actions and reporting. Similarly selecting whether an incident meets the criteria of being reportable to the HSE under the RIDDOR regulations. When it is believed that the incident is RIDDOR reportable the Health and Safety Service must be notified immediately. It will then be the role of the Health and Safety Service to conclude if the incident does meet the necessary criteria.

On receipt of notification from Datix, the **line manager's role (Reviewer)** is to:

- Ensure the correct Category has been selected, where at all possible avoiding using 'Other'
- Ensure names of persons involved are not included in the free text sections.
- Record on the form what action was taken, or will be taken, including an indication of whether further investigation is required by them.
- Ascertain if any sickness absence has occurred due to the incident.
- Ensure contact has been made with any identified Investigators
- Attach any relevant related papers, which include witness statements for non-clinical incidents only.
- Submit the form for final approval
- The Datix system provides automatic feedback to reporters who have provided an email address. This feedback is taken from the 'Lessons Learned and Actions Taken' field on the form. Where the reporter has not provided an email address, inform the member(s) of staff on what action you intend to initiate or to take. Providing feedback to staff is essential and must be recorded on Datix.
- For incidents that affect patients; ensure that relevant information is added to the patient's notes.
- Ensure that staff preserve all relevant documents, equipment, devices, drugs or any other item that may be used to assist any subsequent investigation.

It should be noted that Manager's do have the access rights to be able to generate incident statistics data for their areas of responsibility. Information related to training is available on the Datix Homepage.

2.11 RIDDOR Reportable Incidents

The **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations** place a statutory duty on NHSGGC to report certain incidents within prescribed timescales. Specified **Injuries** and **Dangerous Occurrences** require immediate reporting to the Health and Safety Executive. An Incident which resulted in an employee being unable to attend work or unable to carry out their normal duties for 7 days, must be reported within 15 days to the HSE.

All RIDDOR reporting is the responsibility of the Health and Safety Service.

If in doubt whether an incident falls within RIDDOR or not, guidance should be sought from the Health and Safety Service. Where a RIDDOR report is made the Datix record (RIDDOR section) will be updated by the Health and Safety Service including adding a copy of the Riddor report to the Datix record.

2.12 Severity Rating of incidents

5 or 4	**Extreme or Major**	Management level investigation required, record and analyse investigation results retrospectively.
3	**Moderate**	Local investigation required, record and analyse investigation results retrospectively.
2 or 1	**Minor or Negligible**	Consider local investigation, record and analyse investigation results retrospectively.

If the incident has a severity rating of **4** or **5** (Extreme or Major) consideration must be given to reporting it to senior staff within the Clinical Risk or Health and Safety Services. (See Significant Clinical Incidents Policy for more information).

Moderate rated incidents of **3** should be reviewed by the Local Management Teams and an action plan drawn up to eliminate or reduce the risk of recurrence.

Minor and negligible incidents of **1** and **2** may require to be investigated, in addition to the review and approval process, at the discretion of the line manager who receives the report.

Further information can be found in appendix 2

2.13 Follow-up actions

If the rating is a **4** or **5** there must be an investigation, which investigates causation. One approach to this is Root Cause Analysis (further information on root cause analysis is available here).

In consultation with the Clinical Risk Team or Health and Safety Service consideration should be made whether the severity of the incident is such that it merits formal classification as a

'Significant Incident'. This will not necessarily be the case for all these incidents. These incidents should also be discussed with the Clinical Director or General Manager.

If the severity is moderate, there should at least be a local investigation, led by the line manager, using if appropriate, a root cause analysis type approach.

If the severity is minor or low this does not mean that the incident can be ignored. These incidents represent small failures and vulnerabilities that may signal action to avoid repeat or escalation of a situation**.**

For incidents severity graded 3,4 or 5 there should be a discussion at the appropriate Directorate / Partnership Management Forum and / or Health and Safety Committee. This could be done in a number of ways, depending on the issues arising from the incident and the subsequent investigation. One approach would be to make case presentations quarterly, but clearly, where there are serious and pressing issues, these should be brought to the next possible meeting.

It is important that all the facts of an incident are reviewed. Human error may seem to be the immediate cause, but an incident is rarely due to a single act or omission. Usually an incident occurs because of a combination of actions, events and the surrounding circumstances.

The line manager will communicate with colleagues, formally or informally and agree the level of requirements needed to resolve the issue and introduce preventive measures against recurrence of this or similar problems.

Reference should always be made to existing policies or procedures that relate to the incident and apply to local circumstances, as they may contain specific instructions on immediate action to be taken, e.g. Infection Control policies, Health and Safety policies, resuscitation, medical devices, manual handling, radiation safety and others listed in public folders and on the intranet.

2.14 Communicating with patients and families

When an incident has occurred, NHSGGC's policy is to communicate the facts as openly and rapidly as possible with patients and their families or individuals close to the family. This should be done whenever possible by a senior member of staff in conjunction with a member of staff known to the person affected. It is particularly important in circumstances where external agencies may become involved, to inform those affected, including staff, before this happens.

If there is likely to be a need for continuing communication with a patient or family about an incident, it is essential that one person is nominated to act as the main point of liaison and that the family knows to whom to direct their concerns. This can be the patient's Consultant who will decide, considering the patient condition, the level of explanation given to the patient and how this explanation is recorded in the patient's notes.

Experience shows that identifying this lead person as early as possible is essential in supporting the patient and family.

In some instances senior managers may consider informing the NHSGGC Communications Team in preparation for media enquiries.

3. Roles and Responsibilities

3.1 Every member of staff

Everyone in the organisation has a responsibility to:

- Maintain general risk awareness and accept personal responsibility for maintaining a safe environment, notifying line managers of any identified risks
- Report incidents, accidents, mistakes and 'near misses' and action taken using the incident reporting system - Datix
- Comply with NHSGGC rules, regulations and guidance to protect the health, safety and welfare of anyone working in, using, staying within, or visiting NHSGGC premises
- Maintain confidentiality of patient and NHSGGC information
- Be aware of emergency procedures, e.g. resuscitation, first aid, evacuation and fire precautions, as relevant to the employee's particular work area
- Co-operate in the investigation and review of incidents to improve services and reduce risks

3.2 Local Managers and Departmental Heads

Every Local Manager and Departmental Head has a responsibility to:

- Review and / or approve incidents and near misses reported to their department
- Undertake initial categorisation of the type of event and seriousness on the incident form
- Initiate local investigation(s) as required
- Foster an environment in which staff are encouraged to report incidents and discuss the implications constructively and openly
- Maintain departmental policies and procedures and ensure staff are aware of them and are trained to follow them
- Contribute to directorate and corporate discussions and reviews (both on own initiative and when asked to do so)
- Provide feedback to staff regarding the actions taken following an incident
- Provide information requested by investigating parties timeously
- interrogate Datix and produce and analyse their own reports

3.3 Directors / Chief Officers / Management Team and other Senior Staff

Each directorate / partnership has a clear risk management responsibility and is responsible for:

- Reviewing all serious incidents and a sample of the less serious ones
- Ensuring that the required actions have been taken and are followed through
- Ensuring that there is a regular multidisciplinary governance meeting which reviews the significant incidents and actions arising and all relevant policies and procedures
- Deciding who should lead the review of incidents and investigations and when this should be escalated beyond the departmental level

3.4 Clinical Risk

This department has a number of support responsibilities in relation to NHSGGC wide risk management arrangements. These include:

- Advising on external reporting requirements
- Maintaining and monitoring the reporting system of clinical incidents within the NHSGGC
- Analysing trends to inform directorate / partnerships decisions and corporate management decisions
- Supporting reviews of significant incidents

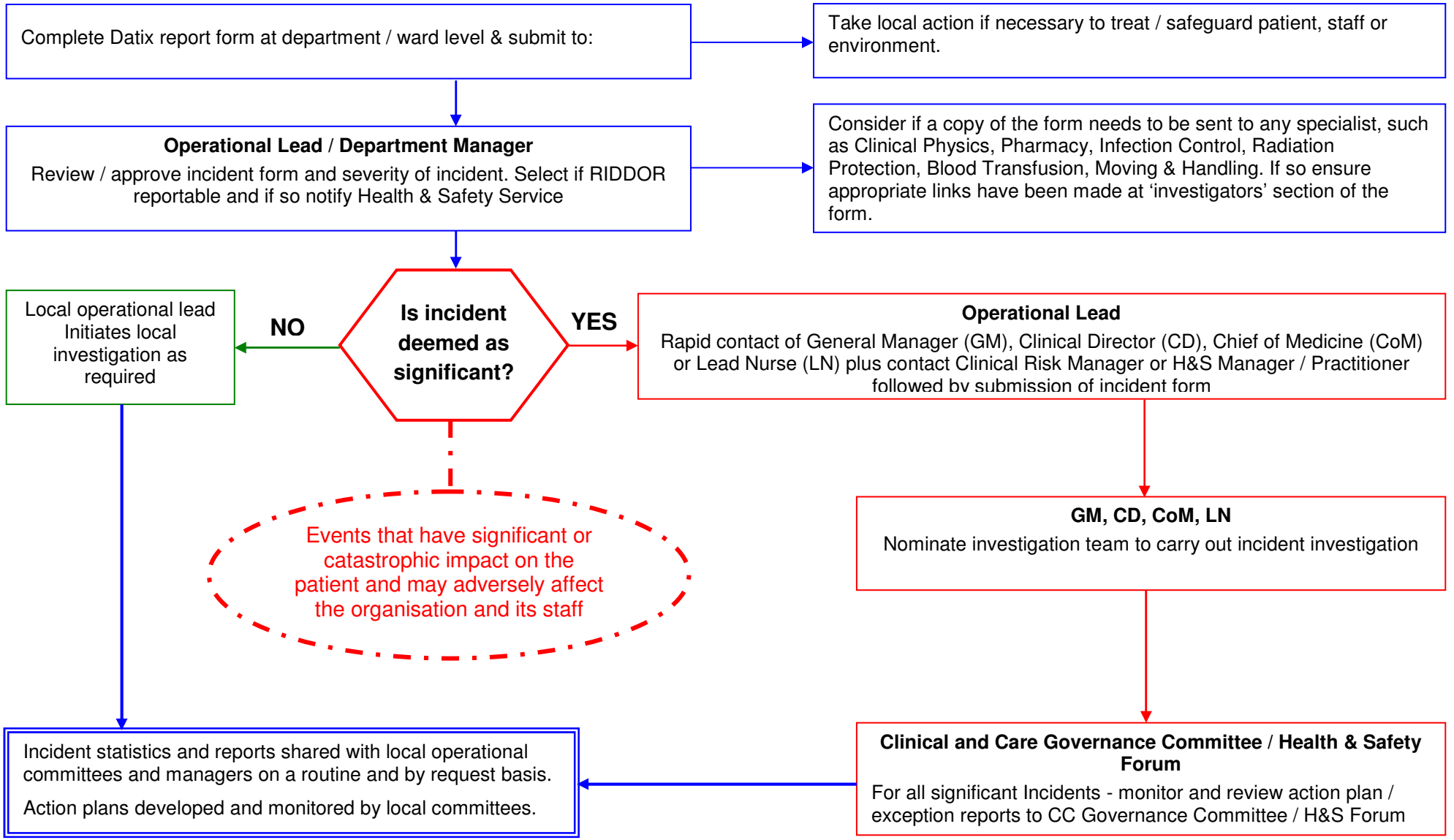
3.5 Health and Safety Service

This department has a number of support responsibilities in relation to NHSGGC wide risk management arrangements. These include:

- Liaising with the Health & Safety Executive in the establishment and maintenance of procedures for reporting, investigating, recording and analysing Reportable accidents and incidents where appropriate
- Ensuring reporting of accidents and ill health is undertaken in accordance with statutory requirements, for example RIDDOR
- Investigating RIDDOR incidents as required
- Conducting / Assisting other investigations where appropriate

Appendix 1

Inicident Flow Diagram



Appendix 2

Risk Matrix and Severity / Impact Definitions

Likelihood	Impact / Consequences				
	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

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 outcome 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
Objectives / 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.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury	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.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints / Claims	Locally resolved verbal complaint.	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim. Complex justified complaint

Service / Business Interruption	Interruption 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 impact 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
Staffing 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 ineffective training/implementation of training.Ongoing problems with staffing levels.	Uncertain delivery of key objective/ service due to lack of staff. Major error due to ineffective training/ implementation 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.
Financial (including damage / loss / 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).
Inspection / Audit	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 Publicity / Reputation	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 Inquiry/ FAI.