Adverse Incident Management
Mid Highland Community Health Partnership
Report for Governance Committee

Introduction

There are two ways risk in its broadest sense can be managed. Firstly, the proactive approach. This is ensuring that risks are eliminated or minimised to as low a level as possible. This is undertaken through the medium of Risk Assessment. The second way to manage risk is the re-active approach. That is noting what has gone wrong and putting measures into place to ensure there is no repetition of the loss or harm that has happened.

This report will confine itself to the latter approach and should be treated as a briefing paper to assure the Governance Committee of the Mid Highland CHP that all measures are being implemented to reduce as far as possible or to eliminate, recurrence of said loss or harm. An adverse incident can be clinically or non clinically related.

All parts of NHS Highland are involved. Independent practitioners such as General Practices are not involved in the process and should have their own management arrangements in place. All salaried practices are involved.

Reactive Risk Management/Adverse Incident Management

1/ The Context

1.1 Any organisation needs to apply itself to ensuring that all who interact with, or are involved in its operation are free, as far as possible from risk. This risk may come from any number of sources so what is referred to as a “foreseeable risk” has to be managed and reduced. What is foreseeable should be looked on in the sense of possibility, probability or certainty. There are two measures of this. Firstly, if something has gone wrong before then it could go wrong again. That would be the experiential context. Secondly, if it is foreseeable that something might go wrong but has not as yet gone wrong then is foreseeable. This is the prospective context.

1.2 Once something has gone wrong then, as mentioned, it is paramount to try to ensure that there is no repetition. The context of this should be seen in the harm that has been done or the loss that has been experienced. An “accidents will happen” approach is not good enough when attempting to reduce said loss or harm. It is estimated that anything between 0.5% and 3.5% of the gross national product is lost.

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1 Risk has many definitions, The Business Dictionary defines risk as “A probability or threat of a damage, injury, liability, loss, or other negative occurrence that is caused by external or internal vulnerabilities, and that may be neutralized through pre-emptive action”.

2 A foreseeable risk is one which can be anticipated by having occurred before or can be seen to have the potential to go wrong.
in adverse incidents\textsuperscript{3}. Neither is an aversion to risk culture, as all of life carries inherent risks.

1.3 There are various estimates of the average cost of an adverse incident. In 2002 Haefeli\textsuperscript{4} estimated that the average cost of an adverse incident that was RIDDOR\textsuperscript{5} reportable was £1986 with the non RIDDOR reportable accident being estimated at £228. The Health and Safety Executive (hereinafter referred to as the HSE) estimated that the uninsured cost per adverse incident was £2097 with an estimate of £141 for each incident of plant damage\textsuperscript{6}. It appears that there is a fairly consistent cost of a more serious adverse incident of around £2,000 at 2002 prices. In the Mid Highland CHP, a conservative estimate of the cost of reported adverse incidents, without any associated cost is therefore circa. £600,000 per annum. All of the foregoing does not include the human and social costs of such incidents.

1.4 The HSE will from now be reducing proactive inspection visits to concentrate on investigation of adverse incidents reported to them. This will also have an associated cost as the HSE have proposed that they will recover costs of such investigations and consultations\textsuperscript{7}.

1.5 There are very compelling reasons for ensuring that adverse incidents are reduced to as low a level as they can be.

2/ Incident Management in NHS Highland

2.1 NHS Highland requires by law\textsuperscript{8} to report and keep a record of all adverse incidents. The organisation is also duty bound to investigate, make conclusions and develop actions to reduce or minimise recurrence of such incidents.

2.2 NHS Highland, along with all other businesses is also obliged to report “near miss” incidents\textsuperscript{9}. Such incidents may indicate that there is an issue that requires to be addressed. It may be a warning of something that may be about to go wrong, or it may be a signal to help prevent a serious adverse incident.

2.3 It is important to note at an early stage that this paper will continually refer to “reported” adverse incident. It is estimated, for example that only one in five incidents of violence and aggression are actually reported\textsuperscript{10}. A general rule for all adverse incidents is that they should

\textsuperscript{3} The Gross Domestic Product is an integral part of the UK national accounts and provides a measure of the total economic activity in a region. See http://www.statistics.gov.uk/CCI/nugget.asp?ID=56

\textsuperscript{4} See Haefeli et al “Perceptions of the Cost Implications of Health and Safety Failures” 2002 Health and Safety Economics Unit

\textsuperscript{5} Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 1995. This requires employers to report incidents and near misses of a more serious nature to the Health and Safety Executive. This would be incidents such as injuries causing more than 3 days absence from work, amputations, serious fractures, etc. For further information see “A Guide to the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995” HSE Books – ISBN 9780717662906.


\textsuperscript{8} Under RIDDOR regulations all businesses in the United Kingdom are required to keep an “accident book” and report certain adverse incidents to the HSE

\textsuperscript{9} A near miss is an incident that had the potential to cause loss or harm rather than actual loss or harm.

\textsuperscript{10} Mayhew C., “Preventing Client Initiated Violence: A Practical Handbook”, Research and Public Policy Series No. 30 Canberra; Australian Institute of Criminology, 2000.
be reported if they are significant enough in nature to cause alarm, distress, loss or harm, or as described, have the potential to do so.

3/ How Incidents are Reported in NHS Highland

3.1 NHS Highland, in common with many other NHS Boards uses an electronic software system called DATIX. This system is web based and has the capacity to handle a number of programmes, including safety alerts and complaints. The main use of the system in NHS Highland is at present for handling adverse incidents and safety alerts. A complaints module has recently been added.

3.2 As an incident occurs the person who witnessed it, who was involved in it, or who was told about it, would report the incident via a local personal computer connected to the NHS Highland intranet.

3.3 Once completed an alert will be automatically issued to “key” individuals for information. The person who completes the incident is known as the reporter. A handler is assigned by the reporter. The handler is usually the reporters’ immediate line manager or supervisor. It is the task of the handler to assign a risk rating\(^{11}\) to the incident. It is also the handlers’ duty to commence an investigation if this is deemed necessary. If the risk rating is calculated as being high or very high then it is usually necessary to escalate the investigative duty to a more senior member of staff. This will usually be the local manager, whether clinical or non clinical. Complex and serious incidents will usually merit and specific investigation and review.

3.4 Reports of adverse incidents are produced on a regular basis either as an individual incident or a series of incidents of the same nature such as Slips, Trips and Falls, or Tissue Viability. This gives senior management the opportunity to review and examine such reports for trends and patterns and order effort and resource to be directed to areas of concern.

3.5 The Clinical Governance Support Team\(^{12}\) has a section dedicated to administering and supporting the DATIX incident management process. This team is based at John Dewar Building in Inverness.

4/ How Incidents are Graded and Dealt with

4.1 The grading of adverse incidents in NHS Highland is based on the product of the Likelihood and the Severity. The result of this is a grading of Low, Medium, High or Very High\(^{13}\). This is perhaps the most challenging part of incident reporting and the part that is most easily misinterpreted or misrepresented. An assessment of likelihood of something recurring could be almost certain, but the severity, if it does happen again could be minor. This will lead to the risk rating being high. This, in itself, may not mean that this is something to cause immediate alarm and action, but the very fact that there is a strong likelihood of recurrence should lead to action being taken to reduce recurrence.

\(^{11}\) For an explanation of risk rating see 4.1

\(^{12}\) The Clinical Governance Support Team are part of the Clinical Governance Department and are based at John Dewar Building in Inverness.

\(^{13}\) See AS/NZS 4360, Standards for Risk Management 2004
4.2 NHS Highland has guidance for staff and managers on how to grade incidents, but caution should be exercised when interpreting these results as an accurate judgement has to be made of what actually happened not the potential for what might have happened.

4.3 Depending on the level of risk the adverse incident or near miss has been identified as a commensurate level of action is undertaken within a specified timeframe. For low level incidents a close monitor is kept to ensure that, though low level, numerous incidents will show a pattern, either on an overall geographical basis or on a site by site basis. Medium level incidents are investigated and actions taken at a local level to reduce recurrence. High and, especially very high level incidents will merit further and closer investigation, often by a higher level manager.

4.4 Within NHS Highland there is a team who support the management of Moving and Handling and a team who do the same for the Management of Violence and Aggression. As part of their remit they monitor, investigate and help managers deal with adverse incidents.

5/ How Serious Incidents are Dealt With

5.1 Serious incidents, in certain instances will lead to a review of the incident. This is referred to as a Critical Incident Review (hereinafter referred to as a CIR). A panel will be convened which is independently chaired and attended by all the parties involved. This CIR is not convened to apportion blame but to address the issues and develop actions to prevent recurrence. The results of this are always reviewed by the CHP Clinical Governance Group. Depending on the incident the results may be shared throughout NHS Highland.

5.2 At the time of the incident, if it is severe enough, an incident de-brief may be held. This will involve the staff involved and will be facilitated locally. The purpose of this is to allow the staff involved to review the issues and express how they felt and how they intend to take issues forward. This is usually held immediately or as soon as possible following the incident.

6/ RIDDOR Reporting

6.1 As previously described, all employers are obliged, by law to keep an “accident Book” This book can take many forms. NHS Highland, in common with most other board areas in Scotland uses the DATIX system. However, certain incidents and near misses require to be reported to the HSE. The HSE will review the nature and severity of the incident or near miss and act accordingly. This may be anything from a monitoring brief, in the case of an over three day absence from work, to a telephone call requiring an explanation of the incident and actions being taken, to a full blown investigation which may be run in

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14 The remit of both teams is to provide expert advice to all levels of staff and management in NHS Highland in the specific areas of Moving and Handling and the Prevention and Management of Violence and Aggression. They provide tailored training and support, which is the most significant part of their remit.


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conjunction with the police and other investigative and prosecution agencies.

6.2 The HSE have now moved to an online approach to incident reporting and, as previously described, intend to commence charging organisations as part of their cost recovery programme.

7/ Incident Management and Audit

7.1 Incidents of all grades are dealt with by the most appropriate and pragmatic approach at the most appropriate managerial level, and within the set down timescales. Due to the nature and volume of incidents\(^{17}\) there are challenges in dealing with all incidents. Throughout Northern Highland there is no dedicated incident management and administration time so incidents are managed as part of the ongoing job. This is supported by the Clinical Governance Support Team.

7.2 Reports are produced and analysed by the Clinical Governance Support team. These reports are issued on a regular basis and are monitored at local and CHP level.

7.3 The Health and Safety Management Audit System has a section dedicated to the audit of incident management at a local level. This includes how incidents are reported, managed, analysed, audited and monitored. It includes an audit of the involvement of staff at a very local level. This allows managers to see how they are progressing with their implementation of incident management and identifies areas of weakness and focuses actions.

7.4 Training for staff in the Mid Highland CHP is offered on a regular basis throughout the CHP. To date, well over 300 staff and managers have taken advantage of the recent training programme. A further round of training is scheduled for later this year.

8/ The Future

8.1 The online reporting method will continue with the DATIX system applications being reviewed to assess the likelihood of further additional modules.

8.2 The eventual aim is to ensure that all incidents are reported in as timely a manner as possible. And are dealt with in the same manner. That is not to say this is not the case at this time. However, the lack of reporting of incidents is well researched throughout industry and the NHS in general and NHS Highland in particular are no different in this respect.

8.3 Consideration needs to be given at this stage or in the very near future relating to the future management of adverse incidents with the advent of integration with Highland Regional Council. This will work both for those who transfer to NHS Highland and those who transfer to the Council.

Conclusion

\(^{17}\) NHS Highland had 9,946 adverse incidents reported in 2010 - 2011 of which 1,065 were reported in the Mid Highland CHP
Incident management is a complex and multi-factorial process that includes all staff of NHS Highland. Adverse incidents occur on a regular basis and can be clinically or non clinically related. The process is straightforward, but can be a challenge to follow due to the issues of time and opportunity cost constraints.

The reporting of adverse incidents does not in itself gauge how well or otherwise NHS Highland in general and the Mid Highland CHP in particular is managing but it gives a picture of what is wrong and had the potential to go wrong and gives the opportunity to rectify matters. In doing so the direct and indirect cost can be reduced.

The reasons for cutting the cost of adverse incidents are self evident so the robust management of adverse incidents is paramount. This, along with the pro-active approach of Risk Assessment.

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