NHS
Gloucestershire Hospitals
NHS Foundation Trust

Simple guides

Serious Incidents, Never Events and Duty of Candour

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond those that affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. Report it as an incident via DATIX and tell your manager or one of the patient safety team.

In this guide:

Creating the right environment for reporting of incidents is as important as the reporting of incidents; it will potentially save lives

Always take time to discuss incidents as a team in a supportive environment that leads to shared understanding and creating a safe space for staff to discuss issues and find solutions at a team level is essential.

Always use incident reporting positively - never use it against a person or to apportion blame. Always think about the system, process and environment that led to the mistake or error and also look for things that worked so they can be replicated.

Always feedback to your staff or ask for feedback from your team leader.

Duty of Candour is a legal requirement to inform the family or next of kin about certain 'harm related' incidents. It includes incidents that, in the reasonable opinion of a healthcare professional, could result in, or appear to have resulted in, the death of the person using the service or severe harm, moderate harm, or prolonged psychological harm. The Trust must ensure that they have an open and honest approach to patients who have been harmed. The legislation requires the Trust to:

- Tell patients in a timely manner when particular incidents have occurred.
- Provide in writing a truthful account of the incident and an explanation about the enquiries and investigations that organisation will carry out.
- Offer an apology in writing.
- Provide reasonable support to the person after the incident.

How do we learn from incidents?

As well as being open and honest with our patients, one of the main reasons to carry out an investigation is to learn what went wrong with the system or process and use these insights to make improvements to prevent the incident from arising again.

At a local level and for most incidents feedback and changes will be made by the manager or the lead clinician, this can be done very quickly and easily as part of team meetings and safety briefings. An example might be, following a patient fall, putting extra safety measures in place for the patient and for future patients at risk of falling on the ward or including something extra in a handover relevant to the area such as always handing over the NEWS2 score.

Within the Division, for more serious incidents there will be an action plan which will have been developed from the learning in the investigation report. The plan and report can be shared with staff (as they are anonymous) but do be aware that the incident can be upsetting for staff involved, please ask your Divisional Risk Manager or check the Datix system if you want to see any report involving your area.

We also complete local and hospital wide trend analysis and feed the information into specialist groups such as the Falls Prevention Group or Infection Control Committee who then will take the learning, consider any national best practice or evidence and make changes to the process through policy and training. The incidents you report are changing what we teach.

Where there is a specific issue identified in an investigation, the learning can be used as part of an improvement project, which can be supported by the Gloucestershire Safety & Quality Improvement Academy through the silver programme or undertaken utilising the improvement tools and techniques as part of a Specialty or Department Improvement Plan.

Never Events

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Strong systemic protective barriers are defined as barriers that must be successful, reliable and comprehensive safeguards or remedies – for example, a uniquely designed connector that stops a medicine being given through the wrong route.

The current Never Events List comprises of the following type of incidents:

Surgical

1. Wrong site surgery
2. Wrong implant or prosthesis
3. Retained foreign object post procedure

Medication

4. Mis-selection of a strong potassium solution
5. Administration of medication by the wrong route
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation

General

9. Falls from poorly restricted windows
10. Chest or neck entrapment in bed rails
11. Transfusion or transplantation of ABO-incompatible blood components or organs
12. Misplaced naso- or oro-gastric tubes
13. Scalding of patients
14. Unintentional connection of a patient requiring oxygen to an air flowmeter

The classification of an of an incident as a Never Event is undertaken by the Medical Director, in close liaison with the Clinical Commissioning Group Safety Lead.

Why is incident reporting important?

Serious incidents, like all incidents, are reported because we need to know when things go wrong or don't go as planned.

They are an essential source of information to help us learn about what happened and make changes to stop it happening again. The Care Quality Commission has access to national incident reporting systems and can view our reported incidents, but they don't see the names of patients or staff.

Anyone can report an incident and we encourage you to do so if you see or hear about something that might be an incident or even a near miss. You do this by clicking on the link from the front page of the intranet (see quick link to Datix), if you don't have access to this, ask your manager or a colleague to report the incident for you or call 5757.

You can report an incident anonymously simply by putting "Anon" in the name fields on the online incident form, however, given the importance of feedback we always encourage you to include your details.

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How are serious incidents investigated?

Serious incidents have an in-depth investigation to examine the process or system using a Root Cause Analysis approach which, as the name suggests, aims to get to the cause of what happened.

This takes time because it is important not to make superficial judgements from limited information and tackle the wrong issues in a rush to put things right.

The investigation will be carried out by the Clinical Investigation Team and may involve a team of people to provide expert advice, some of whom may have been involved in the incident and who use a range of tools, such as case note reviews, structured judgement reviews, staff statements, team review meetings and timeline of events to gather information in order to piece together the sequence of events and the potential weaknesses in our systems or processes.

The report makes recommendations for improvement are made and this learning is converted into an action plan developed by the local specialty team or department and monitored by the relevant Division.

As part of the Root Cause Analysis investigation we sometimes learn something new that may not have caused or contributed to the incident. So looking at incidents can also help us to make things safer even if they haven't caused any harm.

A 'near miss' is something that was prevented from happening but which, if action had not been taken, could have resulted in harm, e.g. a scrub nurse stepping in to prevent wrong site surgery. Near misses provide equally valuable opportunities for learning as incidents themselves.

How do I get feedback about an incident I reported?

If you report an incident using the link on the incident reporting system Datix, you should receive an email when a manager has looked into the incident telling you what they have done in response to the issue that you have raised.

Lots of clinical areas give the whole team feedback about incidents which have happened at their daily safety brief and you can learn from incidents that have happened elsewhere on the Safety pages of intranet, newsletters or through our Safety Briefs.

With around 16,000 incidents reported each year this doesn't always happen so please ask your line manager or clinical lead for feedback and go to the feedback meetings and read the newsletters.

As a result of reported incidents:

- **We have introduced new approaches to manage violent and aggressive patients**
- **We have improved the management of sepsis in the Trust**
- **We have revised the checking procedure for insertion of hips and knee implants**
- **We have undertaken several improvement projects including:**
  - Managing the V&A patient in critical care
  - Increasing the number of insulin doses given on time
  - Paediatric sepsis management
  - Improving handovers

Where can I get support?

Sometimes incidents can be very distressing, and people involved can become what is called "a second victim".

This means they may have been affected in a negative way, for example they may blame themselves for what happened or lose their confidence as a result.

If you have been involved in or report an incident and need support you can talk to your manager or a trusted colleague. You could talk to your clinical or educational supervisor or make a confidential appointment with a member of our staff support service or with Occupational Health.

For more information visit

- Staff intranet: access the incident reporting pages