Requirement 4 - Incident grading and stakeholder reporting

Statement of requirement

- All reported incidents are graded according to the actual impact on the patient(s) and the potential future risk to patients and to the organisation, and reviewed to establish stakeholder reporting requirements.

Note 1: It is assumed for the purposes of this requirement that all 'fast-track' reporting needs under requirement 2 have already been met. In practice, in some organisations the designated person for requirements 2 and 3 may be the same person and/or requirements 2 and 3 may be dealt with at the same time in a 'seamless' manner.

Note 2: In line with the requirements of the Department of Health *Risk Management System* standard (6), the grading system adopted for adverse patient incidents should not be significantly different from those adopted for other types of incidents, or for proactive risk assessment purposes.

Incident grading

Grading incidents according to the actual impact on the patient(s), and the potential future risk to patients and to the organisation, will establish:

1. the level of local investigation and causal analysis that should be carried out (see requirement 5); and
2. the reporting requirements in relation to the National Patient Safety Agency and the relevant Regional Office of the Department of Health.

The designated person should grade the incident using the matrix contained in Figure 3, and the information contained in Tables 1 and 2, in accordance with the following three steps:

Step 1 : First, the actual impact, or apparent outcome of the incident on the patient, or patients, is identified from Table 1 and the appropriate box is marked.

Step 2 : Then, the likelihood (or 'chances') of recurrence of a similar incident ***within your local organisation*** is selected from Table 2. In practice, this is subjective and will depend on the knowledge and expertise of the designated person. People should take expert advice if they are unsure – incidents may well fall outside the immediate experience of those immediately involved. Wherever practicable, a consensus view should by arrived at by two or more persons with some knowledge of the potential likelihood of a similar incident recurring.

Step 3 : Finally, the *most likely* consequences of the incident if it does happen again is selected from Table 1, and the appropriate box is marked to establish the risk category - high, moderate, low or very low. Again, this is subjective and will depend upon the knowledge and expertise of the designated person and any others involved in the grading process.

A. ACTUAL IMPACT ON PATIENT(S)

1. Apparent outcome of the incident in terms of harm etc.

None	Minor	Moderate	Major	Catastrophic

B. POTENTIAL FUTURE RISK TO PATIENTS AND TO THE ORGANISATION

3. Most likely consequences (if in doubt grade up, not down)

2. Likelihood of recurrence	None	Minor	Moderate	Major	Catastrophic
Almost certain					
Likely					
Possible					
Unlikely					
Rare					

RISK Very Low Low Moderate High

Figure 3 – Incident Grading Matrix

The immediate assessment of incident grade should be undertaken quickly, and it is not necessary for the assessor to be in possession of all the facts at the time of grading the incident. There is always scope for re-grading the incident as the facts and issues emerge. Incidents could also be graded post the development of the improvement strategy to determine the potential reduction in risk when this has been fully implemented. This process may also assist in prioritising the actions planned in the improvement strategy.

Because of the subjective nature of the grading process, it is essential that the person, or persons, designated with authority to grade adverse patient incidents have been trained to do so, and that their performance is periodically audited.

The level of investigation and analysis required for individual events should be dependent upon the incident grading and not whether the incident is an adverse event or a near miss.

Table 1 – Definitions for impact/consequence

Descriptor	Actual or potential unintended or unexpected Impact on patient(s)	Numbers of persons affected or potentially affected at one time	Actual or potential impact on organisation
Catastrophic	∞ Death **Including-** ▪ unexpected death of a patient whilst under the direct care of a health care professional ▪ death of a patient on GP or Health Centre premises ▪ suicide or homicide committed by an NHS patient being treated for a mental disorder ▪ known or suspected case of health care associated infection which may result in death, e.g. hospital acquired legionellosis	∞ Many (>50), e.g. cervical screening concerns, vaccination error	∞ International adverse publicity/severe loss of confidence in the organisation ∞ Extended service closure ∞ Litigation >£1 million
Major	∞ Major permanent harm **The following specific incidents not resulting in death should be categorised as major:** ▪ procedures involving the wrong patient or body part ▪ haemolytic transfusion reaction ▪ retained instruments or other material after surgery requiring re-operation ▪ known or suspected case of health care associated infection which may result in major permanent harm, e.g. Hepatitis C ▪ patient receiving a radiation dose much greater or less than intended whilst undergoing a medical exposure ▪ rape (but only on determination that a rape has actually occurred, or the organisation believes there is sufficient evidence to make the allegation a serious one) ▪ infant abduction, or discharge to the wrong family	∞ 16-50	∞ National adverse publicity/major loss of confidence in the organisation ∞ Temporary service closure ∞ Litigation £500k - £1 million ∞ Increased length of stay >15 days ∞ Increased level of care > 15 days
Moderate	∞ Semi-permanent harm (up to 1 year) **Including-** ▪ known or suspected health care associated infection which may result in semi-permanent harm	∞ 3-15	∞ Local adverse publicity/moderate loss of confidence in the organisation ∞ Litigation £50k - £500k ∞ Increased length of stay 8-15 days ∞ Increased level of care 8-15 days
Minor	∞ Non-permanent harm (up to 1 month) **Including-** ▪ known or suspected health care associated infection which may result in non-permanent harm	∞ 1-2	∞ Litigation < £50k ∞ Increased length of stay 1-7 days ∞ Increased level of care 1-7 days
None	∞ No obvious harm	N/A	∞ Minimal impact, no service disruption