Portsmouth Hospitals NHS
NHS Trust

Governance Directorate: Risk Management
Serious Clinical Event & Near Miss
Analysis & Action Plan

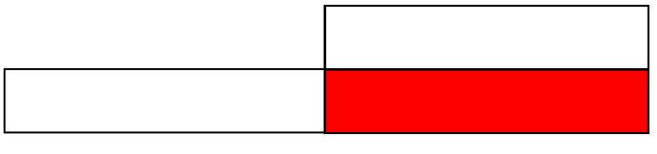
Incident: **NUMBER:** **DATE:**

GENDER: **AGE:**

Incident grading:

Actual Impact on patient:

Potential future Risk to patients and to the organisation:



Synopsis:

ROOT CAUSE ANALYSIS:

Explanation of Incident Coding:

Actual impact on patients:

Apparent outcome of the incident in terms of harm etc.

None	Minor	Moderate	Major	Catastrophic

Potential future risk to patients and to the organisation

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

Most likely consequences:

Incident Grading Matrix

RISK:

- High
- Moderate
- Low
- Very Low

Definitions of impact / consequences:

None/Near Miss:	**No obvious harm**
Minor:	**Non-permanent harm**
Moderate:	**Semi-permanent harm (up to 1 year)**
Major:	**Major permanent harm**
Catastrophic:	**Death**

For detailed explanation of definitions refer to:
'Doing Less Harm' DoH NPSA 2001 www.doh.gov.uk or www.npsa.org.uk

Positive Aspects Of Incident:

AIR No:

Causations: Factors relating to incident:

AIR No:

Patient:
Staff:
Team:
Task:
Work Environment:
Management and Organisation:
Trust / NHS Context:

ACTION PLAN:

AIR No:

Action	Implementation Date	Lead Person
1)		
2)		
3)		
4)		
5)		
6)		

ACTION PLAN REVIEW DATE: