



Incident Reporting

Cedar Ward Harrogate



INCIDENT REPORTING

- There is a high level of incident reporting on cedar ward
- Staff feedback in module 1 stated that 100% of violent incidents are reported
- Improves Practice
- Feeds into other areas of development

Incident details

*Specialty

This is your Specialty ie Community Hospitals Community Services inc Nursing/Health Visitors/Podiatry Learning Disabilities Mental Health Unscheduled Care/Out of Hours Service

Mental Health

*Team

This is your team and is linked both to your Directorate and Specialty. If you cannot find your team in this list then you may have entered the incorrect Directorate or Specialty

Adult Mental Health

*Unit

This is where the incident happened Please refer to your coding sheet to ensure you put the correct one

Harrogate District Hospital

*Location (type)

Cedar Ward

Location (exact)

This will be for example patient bedside, car park bathroom etc

Female Dormitory

*Incident Type

What sort of incident has happened. What ever you choose here will limit your choices for incident code further on. If you are reporting a patient fall please use Accidental Injury to patient. If a member of staff has

Violence and Aggression to Patient

Definitions for Consequence			
Moderate	<ul style="list-style-type: none"> • Semi-permanent harm (up to 1 year) <p>Including –</p> <ul style="list-style-type: none"> • RIDDOR reportable incident • Fracture • known or suspected health care associated infection which may result in semi-permanent harm 	<ul style="list-style-type: none"> • 3 – 15 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Non-permanent harm (up to 1 month) <p>Including –</p> <ul style="list-style-type: none"> • Known or suspected health care associated infection which may result in non-permanent harm 	<ul style="list-style-type: none"> • 1 – 2 	<ul style="list-style-type: none"> • Litigation < £50k • Increased length of stay 1 – 7 days • Increased level of care 1 – 7 days
None	<ul style="list-style-type: none"> • No obvious harm 	N/A	Minimal impact, no service disruption

Definitions for likelihood of recurrence

Descriptor	Description
Almost Certain	Will undoubtedly recur, possibly frequently daily
Likely	Will probably recur, but is not a persistent issue weekly
Possible	May recur occasionally monthly
Unlikely	Do not expect it to happen again but it is possible annually
Rare	Can't believe that this will ever happen again in the foreseeable future 5-10 years

Incident Grading

Risk Management Grading Matrix

The impact of the Incident

None	Minor	Moderate	Serious	Major
Example No Injury	Example Graze	Example Fracture		

Risk Grading

Likelihood					
Consequences	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
None 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Serious 4	4	8	12	16	20
Major 5	5	10	15	20	25

Email alert.

- Service manager
- Ward manager
- General Manager
- Risk Manager



Investigation by service manager

- Yellow or above investigated
- One off incidents with a Serious Consequence
- Reoccurring incidents with no obvious impact
- Don't bother with those that are unlikely to happen again and if they did there would be no harm.



Investigation includes

- Discussion with person filling in report.
- Discussion with unit manager
- Discussion with others on duty
- Discussion with patient
- Check Risk Assessment and Notes
- Check Violence and aggression care plan
- Ward manager trained in Route Cause Analysis



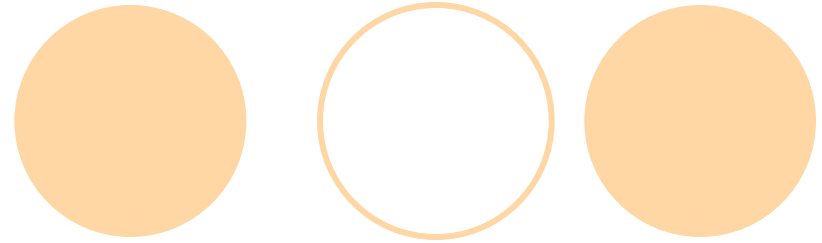
Feedback

- Action plans agreed with ward manager and implemented with the team
- Feedback to staff very important.
- Training needs relating to violence and aggression passed on to in house C&R instructor
- Governance board. Particularly serious incidents.

TRENDS



- Time of Day
- Staff
- Patients
- Place
- Type e.g.
- Yearly review





BENEFITS

- Highlights need for immediate action
- Evidence to argue for action within PCT
- Highlights good practice
- Highlights training, supervision and staffing needs



Any Questions?