Incident Reporting

Overview

Why is incident reporting important?

Before attempting to resolve any problem you first need to become aware of it!

Incident reporting helps teams and organisations to:

- **Identify** the type, frequency and severity of adverse incidents (what went wrong where with who?)
- **Consider** the causes of the incidents (Why did it go wrong?)
- **Learn** from the incidents
- **Share** this learning with colleagues
- **Implement** changes to minimize future recurrences

What to report

You should report all patient safety incidents. More information is available on the [What is Patient Safety?](#) page.

There are a number of national reporting systems in addition to local NHS Board reporting systems that collect specific data systematically. Their findings and recommendations are published periodically.

National reporting systems:

- [Serious Hazards of Transfusion](#)
- [Scottish Surveillance of Healthcare Associated Infection Programme](#)
- [Scottish Audit of Surgical Mortality](#)

How to report an incident

Your NHS Board will have one or more paper or computer-based reporting systems with dedicated support staff. This information is normally included in induction programmes.

For incidents involving staff, patients and the public you will need to complete an **Incident Record 1 (IR1)** form to report what happened. The IR1 will prompt you to also report the incident to the **Health and Safety Executive (HSE)** if necessary.

In primary care settings the term ‘**significant event’** has historically been used to include all patient safety incidents as well as examples of **good practice**.

A significant event is any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice, team or organisation.

Analysing the incident

There are a number of tools that may help you analyse and learn from an incident, including:
- Root cause analysis (RCA)
- Significant event analysis (SEA)
- The Incident Decision Tree (IDT)

**Root Cause Analysis (RCA)** is a method that is used to try and find the cause(s) of a serious incident.

It usually involves a trained multidisciplinary group and may include people that were not involved in the incident. It is time and resource intensive and may not be feasible for individual health care workers.

**A Significant Event Analysis (SEA)** seeks to answer four core questions:

- What happened?
- Why did it happen?
- What has been learned?
- What has been changed?

Teams and individuals are encouraged to share their findings, reflections and learning during dedicated meetings. SEA is embedded in primary care as part of contractual, educational and appraisal obligations.

Access Significant Event Analysis resources [here](#).

**Incident decision tree (IDT)**

The Incident Decision Tree helps managers and senior clinicians decide initial action to take with staff involved in a patient safety incident. [Access the National Patient Safety Agency’s incident decision tree](#).

**References**

The following references were used to generate content for this section:


Amoore, J., Ingram, P. Learning from adverse incidents involving medical devices BMJ 2002;325:272-275


Root causes of sentinel events, all categories. Oakbrook, IL: Joint Commission, 2006.


Serious Hazards of Transfusion (SHOT) http://www.shotuk.org/

Significant event analysis: guidance for primary care teams: http://www.nes.scot.nhs.uk/initiatives/significant-event-analysis