

Degree of harm FAQ

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Introduction

Grading the degree of harm to a patient resulting from a patient safety incident can be a challenge for reporters, but by grading patient safety incidents or prevented incidents according to the impact or harm they cause patients, local organisations can ensure consistency and comparability of data. This consistent approach locally will enable the NRLS to compare, analyse and learn from data nationally.

This guide aims to provide answers to some frequently asked questions on the reporting of degree of harm to the NRLS.

Definitions

The definitions of harm published in 'Seven steps to patient safety' (NHS National Patient Safety Agency) have been used since the beginning of the NRLS.

The degree of harm is the ACTUAL impact on a patient from a particular, individual incident.

The NRLS Team strongly advise reporting organisations to **not** use a risk matrix (described separately in Seven Steps to patient safety) for their degree of harm categorisation and listing. Although actual harm is one aspect of a risk matrix, it does not reflect the whole matrix outcome and does not align with the NRLS definitions of actual harm. Local organisations can record risk matrix gradings in a separate field from that which feeds NRLS PD09 Degree of harm.

Also, never use "negligible" as a description for No Harm as reporters use this for both harm and no harm incidents.

The following **short definitions** should be used in your local risk management system and be mapped to the correct NRLS PD09 code. If you are not sure which field feeds PD09 Degree of harm please ask your vendor.

PD09 Mapping	Degree of harm (Severity/Actual Impact on patient)
No code	No harm
B	Low (Minimal harm - patient(s) required extra observation or minor treatment)
C	Moderate (Short term harm - patient(s) required further treatment, or procedure)
D	Severe (Permanent or long term harm)
E	Death (Caused by the Patient Safety Incident)

The narrative of what happened (incident description) should demonstrate why a degree of harm has been chosen, i.e. state what the outcomes of the incident are.

Longer definitions follow on page 3.

No harm

This has two sub-categories:

No harm (Impact prevented) – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. This may be locally termed a 'near miss'.

No harm (impact not prevented) - Any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care.

This has no mapping. Ensure that the corresponding PD16 (Was the patient harmed?) = B (No) prior to upload otherwise the incident will be rejected.

Low

Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

Moderate

Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe

Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

Death

Any unexpected or unintended incident that directly resulted in the death of one or more persons.

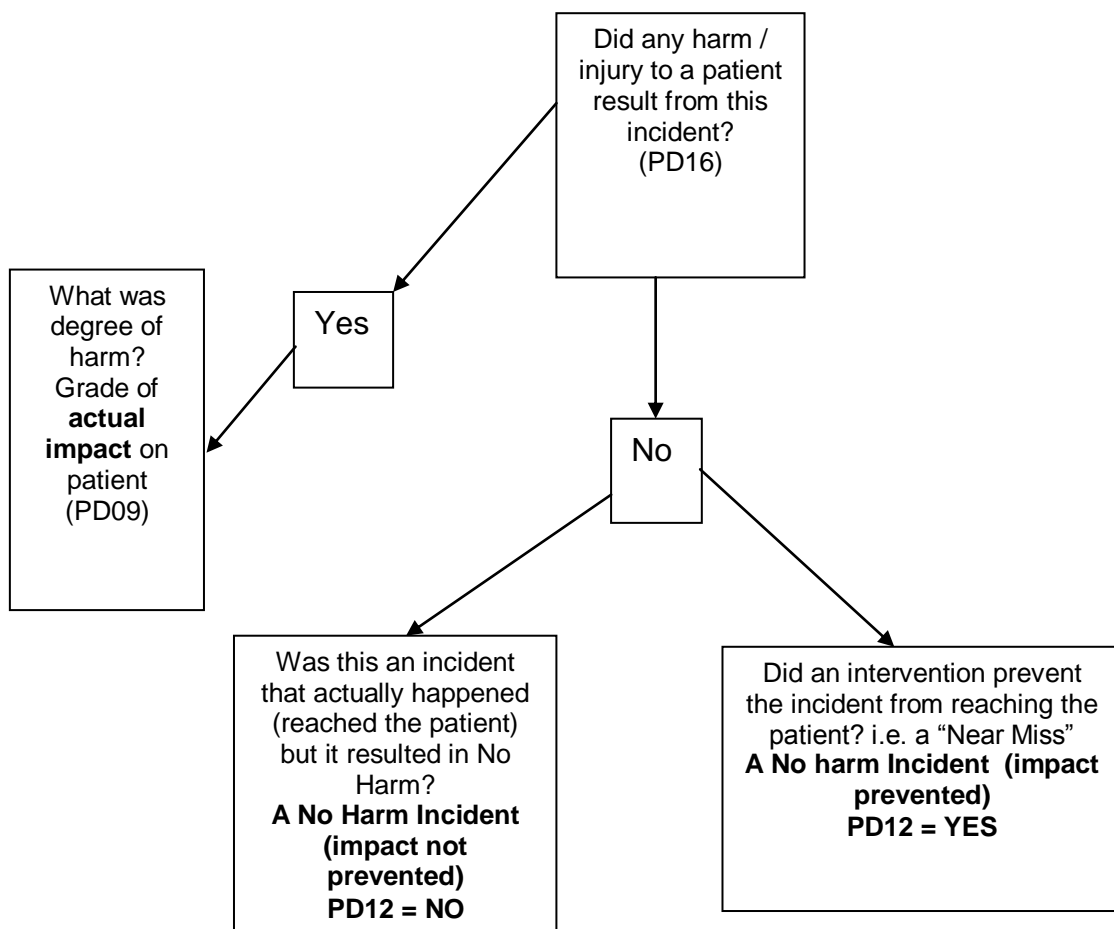
Frequently Asked Questions

1. What is the difference between an incident resulting in no harm (impact not prevented) and no harm (impact prevented) (May locally be termed a 'near miss')?

An incident resulting in No harm (impact prevented) has a degree of harm of 'no harm' but was an incident that was prevented from occurring or where the impact was prevented from occurring. For example, a patient is nearly given someone else's medication; however, the nurse double checking the patient's identification realises the mistake and does not give the patient the medication. This may be locally termed a 'near miss'

Alternatively, an incident can occur but still result in no harm. For example, a patient is prescribed one 'painkiller' (e.g. paracetamol) and given two instead. This has not been prevented in any way but has not caused any harm in this particular case. This would be a No harm (impact not prevented) incident.

NRLS business rules governing the reporting of no harm incidents are used in local risk management systems, as illustrated below.



2. What about psychological harm?

The Seven Steps definition of ‘harm’ does not exclude psychological harm – harm can be physical or psychological. For example, psychological distress that required a period of counselling would be moderate harm, and psychological distress that left the patient unable to return to work or resume their normal life would meet the definition of severe harm. If this is the basis on which the incident grading is being applied, this should be made clear in the free text description of the incident

3. Can Grade of pressure ulcer be matched to an NRLS degree of harm?

The degree of harm depends on the actual degree of harm for this patient as a result of this PSI and does not correlate exactly with grade of pressure ulcer. For example typically full recovery with a scar would be expected from a grade 3 pressure ulcer and therefore would be Moderate. However if the same ulcer was on the heel and expected to affect mobility even after healing, then that would be Severe. Each pressure ulcer must be assessed for degree of harm, using grade of pressure ulcer only as a guide and the reason for choice be demonstrated in the free text description of the incident.

4. What about maternity, fetal and neonatal incidents?

Maternity, fetal and neonatal incidents such as intrauterine deaths should be reported to the NRLS, however a degree of harm of death should only be chosen if it is considered that a patient safety incident, such as an omission in care during the antenatal period, has led to or contributed to the death. The degree of harm can be amended and re-uploaded to the NRLS after further investigation.

5. What if a death is mainly attributable to natural disease process but a patient safety incident is thought to have contributed to or hastened the death?

This should be reported as degree of harm death. The degree of harm can be amended and re-uploaded to the NRLS after further investigation.

6. How do we select the degree of harm when the ultimate outcome of a patient safety incident is not known?

A best assessment at time of the incident should be carried out and if at a later date more information is received about the outcome of the patient, the incident’s degree of harm can be updated and the incident re-uploaded to the NRLS. For example, whilst the NRLS definition of severe harm is permanent harm, given the requirement for early reporting, a need for CPR, ITU or HDU admission can be taken as a proxy for severe harm in some cases. If the patient makes a full recovery the report can be amended to moderate harm and re-uploaded.

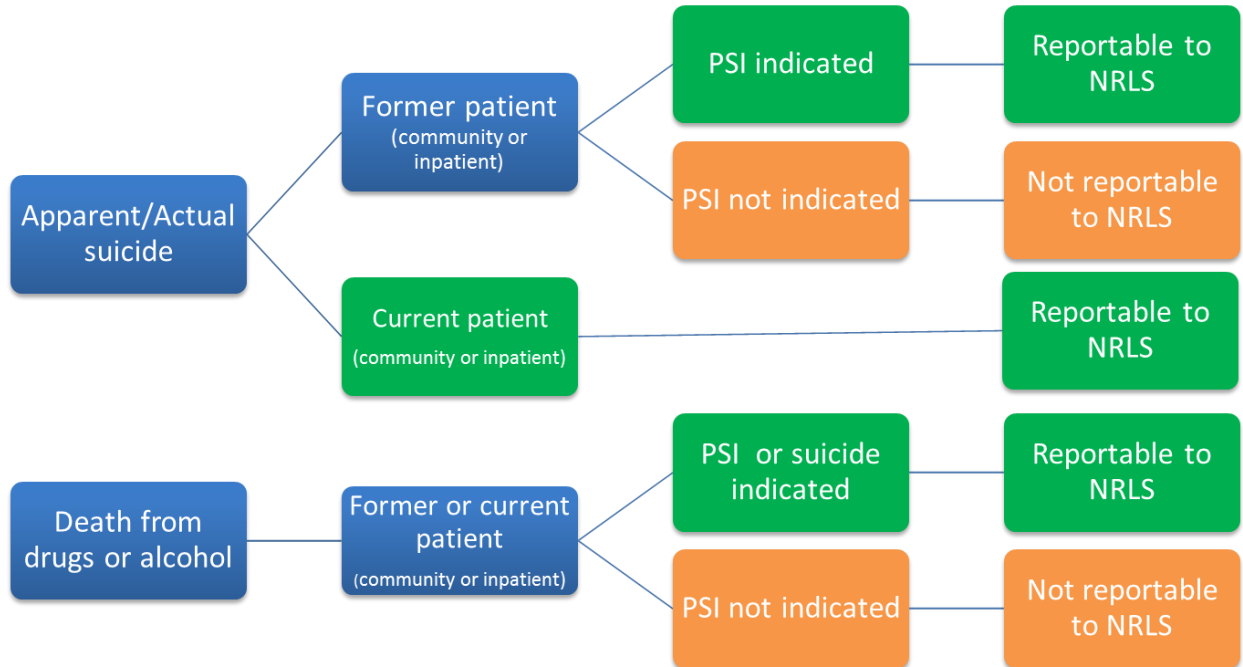
7. What about homicide by a mental health patient?

An incident report should be made for the patient committing the homicide where there is concern there may have been a failure in care or service provision, as it can be argued that permanent psychological harm is the outcome for the patient. An incident type mapped to NRLS IN05 ZD would be chosen.

If another patient receiving NHS funded care is the victim then a second incident report would be completed with a degree of harm of death for that patient.

8. What about suicides, self-harm and deaths from drugs and alcohol?

The following summarises the guidance for organisations providing specialist mental health services;



NOTE: ‘Former patient’ is defined as any patient who has been discharged from the Trust’s services or who does not have a current open episode for inpatient or community care. If a patient dies from apparent suicide after discharge, whether 1 day or 6 months later or during referral to MH services, judgement as to whether a patient safety incident may have occurred, such as inappropriate discharge or failure in communication needs to be made before reporting to the NRLS.

The free text incident description should demonstrate how the incident meets the reporting criteria i.e. whether patient is former or current, details of the act or omission that indicates it is or might be a PSI, clearly indicating the actual injuries if severe or stating that death occurred.

Whilst MH services are rightly mindful that determining if a death is suicide is the role of the coroner, all contextual information that would suggest the likelihood of fatal self-harm needs to be included in the initial incident report.

It is accepted that sometimes toxicology or wider investigation is needed to determine if a death is from self-harm, accident or natural causes, and MH services may have to initially report on the basis that they suspect rather than can confirm self-harm, but they should not routinely report all unexpected deaths solely because the possibility of self-harm cannot yet be excluded. CQC accepts late reporting in circumstances where self-harm did not initially appear a likely cause of death.

9. When is an incident not reportable as a death to the NRLS?

- Natural or expected death, unless a patient safety incident contributed to the death.
- Unconfirmed hearsay reports of death – Not reportable to the NRLS
- Unexpected death (**excluding** suicide) –reportable if there is a suspicion that it is related to provision of care and treatment e.g. potentially preventable deaths from physical causes would be reportable (e.g. pneumonia in an inpatient not promptly diagnosed and treated)
- It should be noted that routinely reporting all deaths known to a service to the NRLS, even when the vast majority are expected to be natural causes unrelated to PSIs is not acceptable practice. It makes it much more difficult to review and identify incidents where national learning is possible, and is also likely to make local monitoring of trends very difficult since any deaths attributable to PSIs will be obscured within these wider numbers. If for local management purposes providers wish staff to notify them of all deaths occurring in their caseloads/units via their local incident reporting system, they should set up a separate field in their LRMS that is not routinely uploaded to the NRLS.

10. Can we delete incidents reported as deaths if they are later found to be due to natural causes?

Routine deletions are not permitted but the incident can be re-uploaded as no harm with a rationale for why this has been done.

11. Physiological and sometimes neurological observations are taken after an inpatient fall, so does this make all falls low harm?

No, this would not make it necessary to report all falls as low harm, as the observations are precautionary rather than treatment of harm. Should any initial observations be abnormal and necessitate an extended observation period, this would indicate that a degree of harm other than no harm may be appropriate.

12. How can you tell the difference between low harm and moderate harm?

This is usually self-explanatory but a useful rule of thumb would be ‘if the patient had not been in hospital when this incident occurred, could the harm have been treated at home or in a minor injuries unit?’ If the answer is ‘no’ the incident is more likely to be moderate than low harm.

13. Are patient safety incidents resulting in fractured hips classed as severe harm?

A patient who has fractured a hip from an inpatient fall is unlikely to regain the levels of mobility and independence they had prior to the fall, in which case the degree of harm is severe. However in a few cases the patient could recover (moderate) or die (death). Each incident should be judged individually.

14. Are patient safety incident falls resulting in sub-dural haematoma classed as severe harm?

A patient who has a sub-dural haematoma from an inpatient fall is unlikely to regain the levels of mobility and independence they had prior to the fall; but in a few cases the patient could recover (moderate) or die (death). Each incident should be judged individually.

15. Does discharge from hospital indicate full recovery?

No, discharge from hospital does not in itself indicate full recovery.

16. Is the degree of harm changed in the NRLS if clinical reviewers think it is wrong?

No, no changes are made to any incident once it has arrived in the NRLS, apart from removal of person identifiable information. However, feedback is given via the Monthly Provisional Organisation Data if clinical reviewers note death or severe harm incidents where the free text does not appear to justify the degree of harm selected

17. If my monthly provisional data summary shows a number of incidents where the degree of harm of severe or death appears incorrect, does that mean these should not have been reported as death or severe harm incidents?

Not necessarily. It may be that there was just insufficient information in the incident description to evidence that this incident was reportable as death or severe. In this case re-upload these incidents with more information, such as injuries sustained, whether patient was a former or current patient in the case of suicide and details of the suspected patient safety incident.

18. No harm has no NRLS mapping in Degree of harm. Are incidents resulting in no harm still reportable to the NRLS?

Yes they are. The reason why there is no mapping for No harm in the degree of harm field is due to the NRLS business rules (see FAQ no. 1).

19. If reporting incidents which have occurred in another organisation, what should the degree of harm be?

If reporting incidents which occurred in other organisations use the actual degree of harm, just as you would for an incident that occurred in your organisation. The harm should not be downgraded because it occurred elsewhere in NHS funded care. The nature of typical patient pathways that cross primary, secondary and tertiary care means that effective reporting and learning frequently relies on one organisation identifying and reporting incidents that occurred earlier in the care pathway.

20. If a patient safety incident is considered unavoidable/unpreventable should it still be reported to the NRLS?

Patient safety incidents should be reported whether currently considered preventable or not. In addition to improving safety around preventable incidents, we aim to also identify incidents currently considered unpreventable. With improvements in knowledge, practice, and/or technology, together we can work to ensure that more of these become preventable too'.

Reference

National Patient Safety Agency. (2004) *Seven Steps to patient safety*. Available in full and in summary form at www.nrls.nhs.uk/sevensteps.