

Examples of notifiable safety incidents

Guidance updated 30 June 2022

The changes clarify how you should apply the term “unexpected or unintended” to decide if something qualifies as a notifiable safety incident or not.

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These case studies provide examples of how to apply the notifiable safety incident criteria.

Example 1: Maternity

What happened

A woman in an NHS hospital experienced pain during an elective caesarean section. She found this experience traumatic and subsequently had an acute episode of severe anxiety and depression that lasted more than 28 days. It was discovered that she had been not receiving enough anaesthesia from an epidural line.

Does this qualify as a notifiable safety incident?

1. Did something unintended or unexpected happen during the care or treatment?

Yes. The woman had not received enough anaesthesia.

2. Did it occur during provision of a regulated activity?

Yes. The incident occurred while the woman was receiving care under the regulated activity 'maternity and midwifery services'.

3. Has it resulted in death or severe or moderate harm?

Yes. The incident has resulted in "prolonged psychological harm" (psychological harm lasting more than 28 days).

The woman was receiving care in an NHS hospital so the harm definitions in Regulation 20(8) apply. If the maternity care had been delivered in an independent hospital, Regulation 20(9) would apply instead.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

Example 2: Care home

What happened

An occupational therapist completed an assessment with a care home resident whose mobility was deteriorating. They advised that grab rails were needed in his bathroom before it was safe for him to use the bath, and that in the meantime staff should assist him with a wash each morning. The manager failed to update the man's care plan or inform the care staff of this change, so staff supported him to take a bath the following morning as usual. He slipped when getting out of the bath and broke his arm. The arm was put in a plaster cast and the man needed full assistance for all aspects of his care for six weeks until the cast was removed. He made a full recovery.

Does this qualify as a notifiable safety incident?

1. Did something unintended or unexpected happen during the care or treatment?

Yes. The man slipped getting out of the bath when the occupational therapist's advice was not followed.

2. Did it occur during provision of a regulated activity?

Yes. The incident occurred during the provision of the regulated activity 'accommodation for persons who require nursing or personal care'.

3. Has it resulted in death or severe or moderate harm?

Yes. The injury in this case is a broken arm and would fall under Regulation 20(9)(b)(ii) as if the injury was left untreated the person using the service could experience one or more of the scenarios referred to in Regulation 20(9)(a)(i) to (v). The person was receiving care in a care home so the definitions in section 9 rather than 8 apply.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

Example 3: Surgery

What happened

An elderly woman undergoes a coronary artery bypass operation. The operation is carried out according to plan, with no unexpected or unintended incidences. But the woman suffers a large stroke during the operation and dies soon after.

Does this qualify as a notifiable safety incident?

1. Did something unintended or unexpected happen during the care or treatment?

No. In this case, nothing unexpected or unintended occurred during the course of treatment.

2. Did it occur during provision of a regulated activity?

Yes. The incident occurred during provision of the regulated activity 'Surgical procedures'.

3. Has it resulted in death or severe or moderate harm?

Yes. The incident resulted in death. The woman was receiving care in an NHS hospital so the definitions in Regulation 20(8) apply.

Conclusion

In this case, one of the answers to the three questions is “no”. So, this does not qualify as a notifiable safety incident. Of course the overarching aspect of the duty of candour, to be open and transparent about what happened, always applies, whether or not something is a notifiable safety incident.

Example 4: Mental health

What happened

A prescribing error on a mental health ward resulted in a detained patient being given double her normal dose of lithium for several days. She developed lithium toxicity, which required inpatient admission. She made a full recovery.

Does this qualify as a notifiable safety incident?

1. Did something unintended or unexpected happen during the care or treatment?

Yes. A patient was given the wrong dose of her medication.

2. Did it occur during provision of a regulated activity?

Yes. It occurred during provision of the regulated activity 'assessment or medical treatment for persons detained under the Mental Health Act 1983'.

3. Has it resulted in death or severe or moderate harm?

Yes. The incident resulted in moderate harm as defined in 20(7) (significant, but not permanent, harm, and a moderate increase in treatment). The patient was receiving care in an NHS trust so the definitions in Regulation 20(8) apply.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

Example 5: Dental

What happened

A child with an unknown allergy to latex went for a dental check-up. The dentist wore latex gloves. The child had a very severe anaphylactic reaction which required hospitalisation. The child made a full recovery.

Does this qualify as a notifiable safety incident?

1. Did something unintended or unexpected happen during the care or treatment?

Yes. The child had an allergic reaction.

2. Did it occur during provision of a regulated activity?

Yes. It occurred during provision of the regulated activity 'diagnostic and screening'.

3. Has it resulted in death or severe or moderate harm?

Yes. The incident meant that the person required further treatment to prevent death from anaphylaxis (Regulation 20 (9)(b)(i)). The patient was receiving care in a dentist surgery so the definitions in Regulation 20(9) apply. Note that on the facts provided in this example, there is no suggestion of error or fault on the part of the provider. But neither is required for something to qualify as a notifiable safety incident.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out. Note, there was no fault in this case, but there is no need for someone to have been at fault for an incident to qualify as a notifiable safety incident.

Example 6: General practice

What happened

A young man fell over while playing badminton and goes to his GP the next day with a swollen and painful foot and ankle. His GP decides not to order an x-ray and sends him home with advice to rest, ice, compress and elevate the leg. He tells the man he can weight bear fully. Over the following week, the pain and swelling does not improve, and the man goes back to the GP surgery and sees a different doctor who sends him for an x-ray. He is found to have a fracture of the base of fifth metatarsal that should have been put into a plaster cast and should have been non-weight bearing. Due to this mismanagement, the patient develops a non-union over the following six weeks which causes him ongoing pain and eventually requires surgical intervention in hospital.

Does this qualify as a notifiable safety incident?

1. Did something unintended or unexpected happen during the care or treatment?

Yes. The GP made a misdiagnosis.

2. Did it occur during provision of a regulated activity?

Yes. It occurred during provision of the regulated activity 'treatment of disease, disorder or injury'.

3. Has it resulted in death or severe or moderate harm?

Yes. The incident resulted in prolonged pain, impairment of motor functions, and the need for surgical intervention. The patient was receiving care in a GP surgery so the definitions in Regulation 20(9) apply.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

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