**Quality Incident Form (QIF)**

For the purpose of this guidance; a quality incident is defined as: ***An incident where shortfalls or errors in care practice are apparent but do not constitute abuse or neglect***.

Every care provider should aim to provide effective, high-quality, personalised care and support for every individual. When the provider's standards fall short there will be concerns over the quality of care. A quality incident is not safeguarding and does not merit a safeguarding concern being submitted. However if concerns regarding the quality of care are allowed to continue unaddressed then there is a risk of the poor care becoming normalised, leading to abuse and neglect, and a safeguarding concern.

Examples of quality incidents (this list is not exhaustive):

* A one-off medication error that has resulted in no harm
* Inadequate staffing levels which are not on-going and has no significant impact upon care provided
* Lack of appropriate equipment or equipment failure to meet assessed needs e.g. hoist slings, slide sheets, continence pads, where no harm has occurred
* Lack of Personal Protective Equipment or failure to follow infection control procedures where no harm has occurred
* Resident on resident altercation which does not result in harm and action is taken to reduce risk
* Isolated missed care calls which does not increase the risk of harm to the adult
* Pattern of care calls not attended on time, which does not increase the risk of harm to the adult
* Money is not recorded/stored safely or properly
* Incident of records not being completed satisfactorily
* No activities/stimulation available

Examples of quality concerns (this list is not exhaustive):

* A one-off medication error that has resulted in no harm
* Inadequate staffing levels which are not on-going and has no significant impact upon care provided
* Lack of appropriate equipment or equipment failure to meet assessed needs e.g. hoist slings, slide sheets, continence pads, where no harm has occurred
* Lack of Personal Protective Equipment or failure to follow infection control procedures where no harm has occurred
* Resident on resident altercation which does not result in harm and action is taken to reduce risk
* Isolated missed care calls which does not increase the risk of harm to the adult
* Pattern of care calls not attended on time, which does not increase the risk of harm to the adult
* Money is not recorded/stored safely or properly
* Incident of records not being completed satisfactorily
* No activities/stimulation available

Identify. Establish if the incident is a quality incident using the definition and examples above.

Check. Fact find to check what has happened with the people involved. (This is not about blame but finding out the correct information in order to address the concern). In line with personalised care, speak to the adult/s involved to gain their view and desired outcome. Complete appendix 1.

Action Use appendix 2 to help decide on the most appropriate action plan (appendix 1 can be used to note the action plan). Communicate with the adult/s and staff what action is going to be taken.

Record and review. Record all quality incidents in a format that allows themes and trends to be identified and record an action plan. Always ensure the voice of the adult is included. Review the action plan at a time specified within appendix 1 to assure that the action has been undertaken and been effective to address the concern. There is no requirement to contact Lincolnshire County Council Safeguarding Customer Service Centre to advise of a quality incident. However, your records should be available to contract officers to demonstrate you have identified a quality incident and the action taken.

Examine. Review your quality records for patterns of quality incidents. A pattern could be a safeguarding concern. Remember safeguarding duties apply to an adult who:

* has care and support needs
* is experiencing, or at risk of, abuse or neglect

**AND**

* as a result of their care and support needs, are unable to protect themselves from either the risk of, or the experience of abuse or neglect.

If you consider there is a safeguarding concern please complete and submit a safeguarding concern form found [here.](https://www.lincolnshire.gov.uk/safeguarding/lsab/4?documentId=231&categoryId=20076)

**Appendix 1: Use this to help address the incident.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** | | | **Date:** |  |  |
| **What happened?** | **What needs to happen?** | **Who is going to do what?** | **When is this going to be done by?** | **Review date** | **Lessons learnt** |
| *Example: Adult does not receive medication as prescribed on one occasion, but no harm occurs.)* | *Example: speak to the adult to check their welfare, views and desired outcome. The voice of the adult ensures their views and wellbeing are prioritised.*  *Speak to the staff member administering the medication*  *Consider if this is a one- off incident for the member of staff or forms a pattern*  *Advise GP and other professionals as needed. (****Refer to appendix 2 for prompts on possible actions****)* | *Example: Manager to discuss with the adult and gain their view on what happened and what they would like to happen as an outcome of the quality incident.*  *Manager to talk to the staff concerned to determine why it occurred.*  *Manager to advise GP and other professionals as needed.*  *Consider training needs*  *Manager to arrange a colleague to observe staff member for accuracy when administering medication)* | *Example: Within 24 hours* | *Example: 1 month)* | *(Example: avoid risk of occurring again by minimising staff burnout*  *Reflect on whether the response was a personalised approach that had the adult at the centre and what steps could be put in place to ensure practice is person-led and outcome focused)* |

|  |  |
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| **Appendix 2: Aide Memoire for Quality Incidents**  This document is intended as an aide to prompt consideration of possible actions in response to the quality incident. Please note this is non-exhaustive. | |
| **Points for Consideration** | |
| 1. **Has this happened before?** 2. **Is there a pattern?**   **If yes, please consider the safeguarding criteria, detailed on page 1.**  **If no, please consider if the following actions are applicable to this case. If not, please be clear as to why this is the case.** | |
| Complete a review of the care plan for those involved |  |
| Complete a review of the relevant risk assessments |  |
| Address any staff professional conduct concerns |  |
| Address any professional boundaries |  |
| Is a care assessment required? |  |
| Analyse staff competencies |  |
| Address any identified training needs |  |
| Provide supervision with relevant individuals |  |
| Is there any internal disciplinary action to be taken? |  |
| Complete a review of relevant internal process |  |
| Complete a review of any relevant policies and procedures |  |
| Signpost to other agencies for additional support |  |
| Notification to other agencies for further action if applicable. Please ensure the CQC are notified when a quality incident includes a circumstance that requires [CQC](https://www.legislation.gov.uk/uksi/2009/3112/made) notification. |  |
| Source further guidance |  |