BrisDoc Patient care by people who care

NHS

Learning Events Reporting Policy

Version:	Owner:	Created:
6.2	Sarah Pearce	1st March 2022
Published:	**Approving Director:**	**Next Review**
1st May 2025	Nigel Gazzard	1st August 2025

Learning Events Reporting Policy.

CONTENTS

Learning Events Reporting Policy.

1. Introduction

It is a mandatory requirement for health care organisations to have learning event reporting policies and procedures in place. This is an important part of good risk management and informs the organisational liability with respect to insurance and indemnity cover.

The reporting of both clinical and non-clinical learning events of any level of severity, and including significant events and near misses (hereafter referred to as learning events), is fundamental to BrisDoc's risk management strategy. BrisDoc has a statutory duty to ensure that all users of provided services are cared for in a safe environment; that staff can work in a safe environment; and that risks are reduced to a minimum. This is also consistent with BrisDoc's values as set out in the four-way model.

PATIENT CARE

Ensuring BrisDoc maintains a safe service to our patients by adhering to organisation policies and procedures written in accordance with national guidance and regulations

To allow any mistakes or shortcomings to be addressed and rectified quickly and learning to be shared to avoid reoccurrence.

WORKFORCE CARE

Ensure staff feel empowered and supported to report any mistakes or near misses in a non-punitive and blame free culture.

Providing effective shared learning opportunities for staff.

Offer staff a safe portal to report safety and quality concerns.

QUALITY CARE

Reviewing of learning event reports and taking learning where possible to identify improvement opportunities helps to evaluate and maintain a high quality service.

Allow and encourage reporting where quality checks identify a problem or where quality checks are inaccurate or incomplete.

RESOURCE CARE

Identify where improvements can be made to minimise inefficiencies in stock and time management.

Ensure where accidental damage is reported, repairs can be made in a timely and financially responsible fashion.

Provide a framework to follow when considering when serious incidents need reporting to insurers to provide financial protection where there is a risk to the organisation of legal proceedings.

Learning Events Reporting Policy.

It is the responsibility of all staff employed by or working on behalf of BrisDoc to report learning events, significant events, and near misses through the reporting framework identified in the learning event reporting procedure (appendix 1). It is their duty to report those learning events in which they are directly involved and those of which they are aware.

This policy will be operated within a learning environment, where lessons are learned and quickly acted upon in a positive and constructive way.

BrisDoc actively promotes a non-punitive approach to learning event reporting and will fully support any individual reporting a learning event. In many instances, the root causes of learning events lie in the management and organisational systems that support the delivery of care. In this case, blame cannot, and should not, be attributed to individuals. The essence of BrisDoc's reporting procedure is to identify and address the underlying causes of learning events. All learning events will be investigated in accordance with best practice and processes, and managed in a sensitive and non-punitive manner. Learning events that have caused harm or created the potential for harm to a patient will be notified to the insurer. BrisDoc will comply with its duty of candour to inform patients where their diagnosis, care or treatment has caused actual or potential harm in accordance with its Being Open Policy.

Disciplinary procedure will only be considered in the following cases:

- Repeated error involving the same individual, where the error has been highlighted and learning identified.
- Deliberate failure to report a learning event
- Failure to cooperate with an investigation
- Criminal actions
- Actions so far removed from reasonable practice that any competent practitioner/ member of staff would have been able to predict the outcome.

It is BrisDoc policy that all learning events are:

- Reported via the learning event portal in the staff weblinks page on the BrisDoc website (https://learning event.brisdoc.co.uk)
- Investigated, and where appropriate an action plan (appendix 2) put in place within 1 month of the date of the learning event being reported
- Risk assessed (appendix 3)
- Significant learning events are investigated using the root cause analysis approach (appendix 4)
- Reported to external bodies (including statutory agencies) in the timescales required when necessary.

When a learning event is received, a discussion needs to take place and a decision needs to be reached as to whether the matter requires notification to Insurers. The decision process and outcome should be documented on BrisDoc's Learning event Reporting Information System (LERIS) or GP TeamNet for future consideration, even where the decision reached is not to notify.

Medical negligence occurs where a medical professional has provided care that was below a reasonable standard, resulting in bodily injury (which could also include mental anguish) or a mis-diagnosis. Since April 2019 NHS Resolution has provided clinical indemnity for

primary care under the Clinical Negligence Scheme for General Practice (CNSGP) which requires notification when a letter of notification or claim is received by the provider. CNSGP does not cover any private primary care, services provided by primary care that are not covered by the GMS/PMS/APMS contract, or legal support/cover required for inquests/claims. If a complaint reveals a claim for medical negligence, or if it is considered that there is even a low risk of legal action, the case must be notified as a circumstance to AJG Insurance as soon as possible and a notification form must be completed. No correspondence should be issued to a complainant or their representative in connection with a claim or potential claim without prior authorisation of the insurers.

If there is ever any doubt regarding whether a learning event is reportable to insurers, then it should refer the matter to AJG Insurance as soon as possible.

The decision to notify should be reviewed and the decision documented at each stage of the investigation process and AJG Insurance notified as and when required.

All serious untoward learning events should be reported as soon as possible to our insurance company, via the Governance Team.

Some learning events may be appropriate for notifying to BrisDoc's employee and public liability insurers.

2. Definitions

2.1 Learning event

The generic term learning event is defined as '*any clinical or non-clinical adverse event, including near misses, that resulted in harm or had the potential for harm, or a risk'* to:

- Staff
- Patients
- Members of the public/ visitors
- External contractors
- Property
- Information integrity or security
- System functionality

This may include personal injury, ill health, harm, patient dissatisfaction, property and vehicle loss or damage, system(s) failure, failure to adhere to a policy or procedure.

2.2 Learning event Categories

Learning events are categorised on LERIS according to the level of harm as follows:

Category	Descriptor
No harm	No injuries or obvious harm. No loss of property. No significant likelihood of service issues arising from this learning event.
Near miss (potential harm)	Any unexpected or unintended occurrence that did not lead to harm, loss or damage, but had serious potential to do so and was prevented either by intervention or luck.

Low harm	Any learning event that required extra observation or minor treatment, repair, inconvenience to another service. Minimal harm to one or more persons, equipment, reputation. Resolution is at local service delivery level.
Moderate harm	Any learning event that resulted in a moderate increase in treatment and which caused significant but not permanent harm to one or more persons, reputation, significant inconvenience, loss of equipment, service downtime. Resolution is above/outside service delivery level.
Severe harm	Any learning event where permanent damage/change/harm was caused. Patient harm that related directly to the learning event and not to the natural course of illness or underlying condition. Patient harm was a contributory factor in a death Extended service downtime. Adverse/reputational media involvement.
Catastrophic	A learning event that directly resulted in the death of one or more persons. Death must be related to the learning event rather than the underlying condition or illness.

2.3 Significant Incident

BrisDoc follows NHS England guidelines when assessing the criteria to decide if an event meets the threshold to be declared as a Significant Incident (SI); A learning event categorised as catastrophic or severe harm is likely to be an SI.
SI's are reported to the Commissioner and investigated using the root cause analysis approach in accordance with NHS England patient safety methodology.

A local community learning event that affects multiple service providers or a single service provider so as to compromise its ability to function e.g. act of terrorism; significant fire, contamination; accident – multi-vehicle, building collapse. A major learning event will be co-ordinated by the Commissioner in conjunction with the police, fire and ambulance services within an established gold/silver/bronze command structure. BrisDoc services will receive instruction about how they can help/participate.

2.4 Grading

All learning events are graded or scored as to their severity of consequence and likelihood of reoccurrence within the reporting portal in accordance with BrisDoc's risk assessment matrix. The matrix is included in appendix 3.

2.5 Hazard

A hazard is anything with the potential to cause harm.

2.6 Risk

Risk is the likelihood that harm from one or more particular hazards is realised.

2.7 Accident

An accident is an unplanned event that resulted in harm or loss.

3. Responsibilities

3.1 Executive Directors

It is the Directors' responsibility to ensure risk management processes including learning event reporting procedures are in place in each service provided by BrisDoc.

3.2 Line Managers / Heads of Service

The Line Manager/ Head of Service is the first point of contact for staff that have witnessed a learning event. Line Managers/ Heads of Service must:

- promote a culture where it is acceptable and safe for staff to report learning events,
- provide support for staff following a learning event, which may include referral to the occupational health department / and or complete the five-point plan.
- Complete the five-point plan with staff members to support them if applicable (particularly when an event involves violence and / or aggression.

Staff must be aware of deputising arrangements for when line managers or heads of service are on leave or unavailable.

Specifically Heads of Service will:

- Ensure staff report the learning event using the learning event portal,
- Investigate learning events in the agreed timeframe, reporting exceptions to the relevant governance meeting/board,
- Ensure the management action plan is completed if appropriate and returned to the Governance Team,
- Ensure feedback is provided to staff members,
- Lead the review of learning event outcomes and learning within their service at team and significant event meetings,
- Liaise with the Governance Manager / Senior Manager e.g. Workforce, Facilities, Digital and Analytics, with respect to onward reporting and learning

3.3 Individual staff

Individual staff are responsible for reporting learning events (including near misses) appropriately and assisting in any learning event investigations, which may require their assistance. This includes:

- **All** employees of BrisDoc
- Self employed staff working on behalf of BrisDoc
- Bank and agency staff
- Volunteers.

Every member of staff must be aware of this learning event reporting policy and procedure. Staff must be familiar with BrisDoc policies and should complete induction, local and external training in order to ensure continued competence when carrying out their duties.

3.4 Governance Manager

The Governance Manager is the central point of contact for learning event and risk reporting and is responsible for:

- Monitoring learning events and reporting to BrisDoc groups and the Leadership Board,
- Liaising with external bodies as appropriate,
- Notifying external agencies as appropriate,
- Identifying and acting on themes and ensuring learning,
- Preparing data of all learning events and complaints for inclusion in the Corporate dashboard, and
- Liaising with other BrisDoc managers including the Health and Safety leads as necessary.

3.5 Programme and Service Director

Learning events involving systems failure that impact on BrisDoc's continuity of business will be investigated and reviewed in accordance with the Business Continuity Plan (appendix 5).

3.6 Caldicott Guardian and Information Governance Lead

Learning events involving information security or information governance will be reviewed in accordance with the relevant information governance policy, by the Caldicott Guardian and/or IG Lead.

4. Support to patients / being open

BrisDoc supports an open and honest approach to any learning event and subsequent investigations and a commitment to sharing the lessons learned with patients, relatives, carers and staff.

Information and learning regarding serious patient related learning events must be provided as soon as practical after the event and where appropriate, to relatives/ carers.

If a patient feels that they need further information or support they should be provided with a patient advice and liaison service (PALS) leaflet and the contact details of the PALS manager.

5. Feedback to staff

Staff have the option to ask to be provided with feedback about the outcome of the investigation into the learning event they reported. Providing feedback is the responsibility of the investigatory manager working with the line manager as appropriate.

6. BrisDoc Services

Each Service will dedicate time each quarter at a team or SEA meeting to review learning events, accidents and complaints; analyse learning and trends; and agree and monitor action plans that will reduce occurrence and manage risks.

7. Quality Meetings

Learning events will be reviewed and discussed at monthly learning event meetings and at the Quality Group meeting which is attended by Practice Plus colleagues. The meetings will focus on collated learning events, complaints, and receive any feedback of learning and actions put in place by a BrisDoc service relevant for sharing corporately for all urgent care related learning events and complaints.
The Practice Services Governance Board will do the same for all practice related learning events and complaints. Action points will be discussed and learning outcomes developed to ensure that BrisDoc learns from all learning events and puts processes in place to ensure risk of recurrence is reduced as far as is practicably possible.

8. Insurer Notifications

BrisDoc is responsible for promptly notifying its medical professional liability insurer of claims and circumstances which may give rise to a claim under CNSGP and/or for which BrisDoc may need legal support from CNA under the policy e.g. an inquest. Failure to do so may result in legal support for an inquest/negligence claim being managed by CNSGP not being covered by the policy. Such notice should include:

a. details of what happened and the services and activities that were being performing at the relevant time; and
b. the nature of any, or any possible, bodily injury; and
c. details of how BrisDoc first became aware of the claim or circumstance; and
d. all such further particulars as the insurer may require.

A "c**ircumstance**" is defined in the policy as:
"any circumstances of which you become aware, or should reasonably have become aware, that may reasonably be expected to give rise to a Claim."

Examples of a circumstance are:

- Any complaint, written or verbal, in which the patient or patient's representative expresses dissatisfaction regarding the treatment received and alleges that, as a result, the patient suffered bodily injury.
- A request for access to medical records received from a solicitor or third party on the basis that a Claim against you/your service (to include any of your employees) is being contemplated.
- Any learning event in which a Serious Learning event Report is generated.
- Any unexpected or unusual death of which you become aware.
- Any adverse outcome or clinical "near miss" in which you believe there may have been a negligent act, error or omission, irrespective of whether or not the patient is aware of this or whether the patient or patient's representative has made a complaint.

9. Related Policies

- Complaints Policy
- Risk Management Policy
- Disciplinary Policy and Procedure
- Health and Safety Policy
- Business Continuity Plans
- Being Open Policy

- Information Security

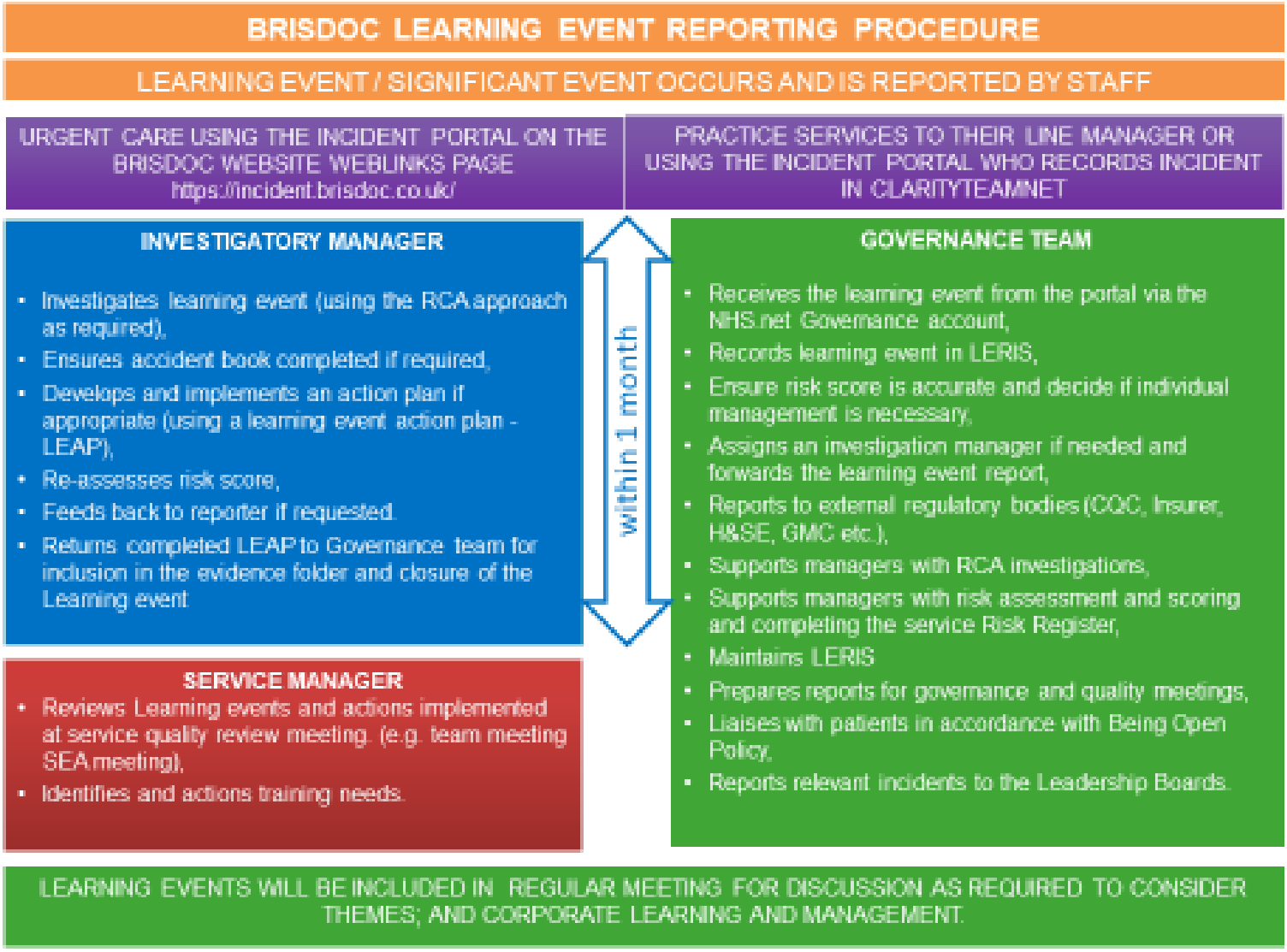
10. Change Register

Date	Version	Change	Reason for Change	Name
June 2009	1		New Policy	Dixine Douis
June 2010	2		Routine review	Dixine Douis
Jan 2012	3		Format	R Channing - Brown
April 2013	3.1	Minor personnel changes	Role changes	Dixine Douis
Nov 2013	4		New Owner	Clare – Louise Nicholls
April 2015	4.1		General review and edit	Clare – Louise Nicholls
July 2015	4.2	Addition of Caldicott Gaurdian Role		
Sept 2015	4.3	Inclusion of New Timescales		Clare – Louise Nicholls
28.6.18	4.4	Inclusion of the learning event portal, new learning event categories. Update learning event descriptors. Remove learning event form in appendices. Update reporting procedure to reflect use of the portal.	Routine review	Clare-Louise Nicholls
01.05.20	5	Updated Core values. Removed reference of DAC and replaced with LERIS Replaced updated IMP to include quality impact Job title/boards/groups updates Refresh insurance requirements post CNSGP Removal of change register pre-2018. Updated appendix 1 to new version. Update risk appendices in accordance with update risk management policy	Routine review.	Sarah Pearce, Clare-Louise Nicholls
28.03.22	6	Changed reference from Incident to Learning events to reflect change in process. Added 5 point plan as appendix.	Re named policy as Learning events	

10/0/2023	6.1	Changed SI definition to align with NHS England guidance		
01/05/2025	6.2	replaced by PSIRF Policy – this may take some time to get signed off but hope to achieve by the end of June- agreed extension for 3 months to complete.		Sarah Pearce

11. Appendices

APPENDIX 1 – LEARNING EVENT REPORTING PROCEDURE



APPENDIX 2 – LEARNING EVENT ACTION PLAN

LEARNING EVENT/SIGNIFICANT EVENT MANAGEMENT ACTION PLAN

LEARNING EVENT REFERENCE NUMBER :	
Target Closure date:	

1.Describe your findings *please use a timeline of events*
2.Learning event Review Method *e.g. review of case notes, discussions with key individuals, email correspondence*
3.Existing Controls and Assurances *e.g. policies, procedures, clinical guidelines, on-going work/projects*
4.Key reasons why this learning event occurred, i.e. root causes and/or contributory factors *which of the identified findings in section 1 had the biggest impact and led to this event happening? (this might* be *one or all of those identified.)*

APPENDIX 2 – LEARNING EVENT ACTION PLAN

5.Recommendations for actions to be taken *In addition to the controls and assurances already in place what actions are required to address the key reasons why the learning event occurred identified in section above?*

How has the learning event impacted the following areas and how will the identified actions lead improvements?

Patient Care	Impact:	Impact after Action plan complete:
Workforce Care	Impact:	Impact after Action plan complete:
Quality Care	Impact:	Impact after Action plan complete:
Resource Care	Impact:	Impact after Action plan complete:

LEARNING EVENT / SIGNIFICANT EVENT MANAGEMENT ACTION PLAN

ACTION PLAN	Learning event Ref.

Recommendations (from section 5)	Actions	Person responsible	Action due date	Resource requirements	Report / monitoring arrangements	Status
Recommendation 1:						
Recommendation 2:						
Feedback issued to reporter:						
Date:_____ By: _____ Method:_____ Brief summary of feedback given:						

APPENDIX 3 – RISK ASSESSMENT TOOL

Risk score *(Initial risk score)*	**What was the consequence of the learning event, and what is the likelihood of it happening again?**					**Target risk score on implemented**	
	Consequence		**Likelihood**			**Consequence**	
Risk Matrix	**1**		**2**		**3**		
Consequence	Insignificant		Minor		Moderate		
Likelihood	Rare		Unlikely		Possible		

		Severity of Consequence				
Likelihood	Almost certain	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	15
	Unlikely	2	4	6	8	10
	Rare	1	2	3	4	5
		Negligible	Minor	Moderate	Major	Catastrophic

See risk assessment pack for criteria for consequence and likelihood descriptions.

Line Manager Name	
Signature	
Date	

RISK ASSESSMENT MATRIX TOOL

In accordance with the BrisDoc Risk Management Policy assess the likelihood and severity (or consequence) of the risk and calculate the risk score.

Severity/Consequence of event occurring again

Description	**Category**	**Risk to patient, staff, business**
Catastrophic	5	Learning event leading to death, non-delivery of business objectives, event which impacts on large number of patients/staff, multiple breeches to statutory duty, prosecution,

APPENDIX 3 – RISK ASSESSMENT TOOL

		national media coverage/total loss of public confidence, >25% over project budget/loss of >1% of budget, loss of contract, 1day loss of service.
Major	4	Major injury leading to long term incapacity, significant harm to patient, >14days off work, uncertain delivery of business objectives, enforcement action/multiple breeches of statutory duty, uncertain delivery of service due to lack of staff, national media coverage, 10-15% over project budget/loss of 0.5-1% of budget, >12hrs interruption to service.
Moderate	3	Moderate injury requiring professional intervention, some harm to patient, 4-14days off work, unsafe staffing level, single breech of statutory duty, local media coverage/long term reduction in public confidence, >8hrs interruption to service, 5-10% over project budget/0.25-0.5% loss of budget, late delivery of business objectives.
Minor	2	Minor injury, minimal harm to patient, low staffing reduces service quality, breech of statutory legislation, local media coverage/short-term reduction in public confidence, >1hr interruption to service, <5% over project budget/loss of 0.1-0.25% of budget, minor impact on business objectives, >3days off work.
Negligible	1	Minimal injury, no harm to patient, no time off work, no/slight impact on business objectives, insignificant cost increase/financial loss, rumours, <30mins interruption to service, <1 day shortage of staff, no/minimal breech of statutory duty.

Likelihood of event occurring again

Almost certain	81% -100% likelihood of occurrence	5	Will undoubtedly happen/recur, possibly frequently
Likely	51% - 80% likelihood of occurrence	4	Will probably happen/recur but is not a persisting issue
Possible	21% - 50% likelihood of occurrence	3	Might happen or recur occasionally
Unlikely	6% - 20% likelihood of occurrence	2	Do not expect it to happen/recur but possible it may do so
Rare	0% - 5% likelihood of occurrence	1	This will probably never happen

APPENDIX 3 – RISK ASSESSMENT TOOL

Score the risk

		Severity of Consequence				
Likelihood	Almost certain	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	15
	Unlikely	2	4	6	8	10
	Rare	1	2	3	4	5
		Negligible	Minor	Moderate	Major	Catastrophic

The risk score = likelihood multiplied by severity/consequence

Risk Score 1 - 4 Low Risk, (Green)
For low risks quick and easy controls (measures) can be implemented immediately and further action planned for when resources permit or no further action may be required.

Risk Score 5 - 9 Moderate Risk, (Yellow)
Actions to control moderate risks will be implemented as soon as possible, and no later than the next financial year.

Risk Score 10 – 12 High Risk, (Orange)
Actions to control high risks will be implemented as soon as possible and no later than within 3 months of the risk being identified. The Corporate Leadership Board is made aware.

Risk Score 15 - 25 Extreme Risk, (Red)
Extreme risks require emergency action and a contingency plan. They are beyond BrisDoc's risk appetite. The Corporate Leadership Board is made aware and immediate action is implemented. Any process, procedure or operational service must be stopped immediately.

BrisDoc Risk Assessment Form

Date	Location	Assessor	Persons affected by harm		Further assessments required	
			Employees		Fire	
Task Assessed:		**Overall Risk Score**			Driving	
			Patients		DSE	
					Manual Handling	
			Contractors		Pregnancy	
					Other	

Hazard	Who/What is at risk?	Existing Controls	Severity	Likeli-hood	Risk Score	Additional Controls/Measures	Residual Risk Score

Action Plan

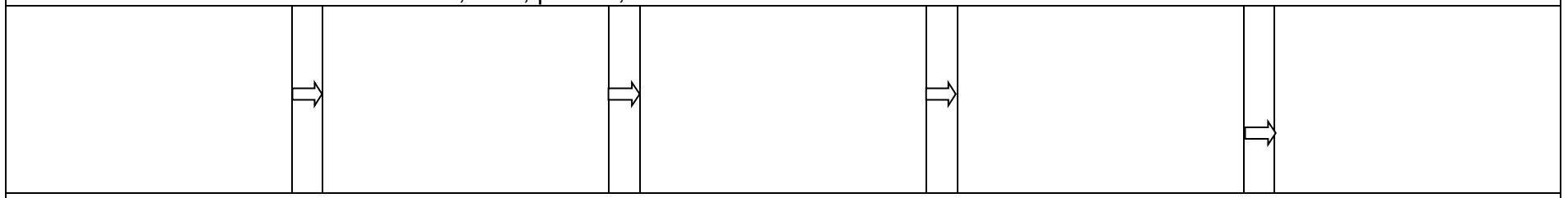
When and with whom was this learning event/risk discussed?		
Describe the immediate action taken.	By Whom	When
What actions need to be taken next?	By Whom	By when
Describe which relevant policies and procedures have been consulted		

Indicate if advice has been taken or is needed from other agencies and which e.g. HSE, Professional Body, CCG.				
Which Organisational Objective does this risk affect?	Patient Care	Workforce Care	Quality Care	Resource Care
Which other risk (if any) does this hazard inter-relate with?				

Risk Assessment Review Date:	
Assessment completed by:	Signature
Line Manager	Signature

APPENDIX 4 – ROOT CAUSE ANALYSIS FORM

ROOT CAUSE ANALYSIS FORM

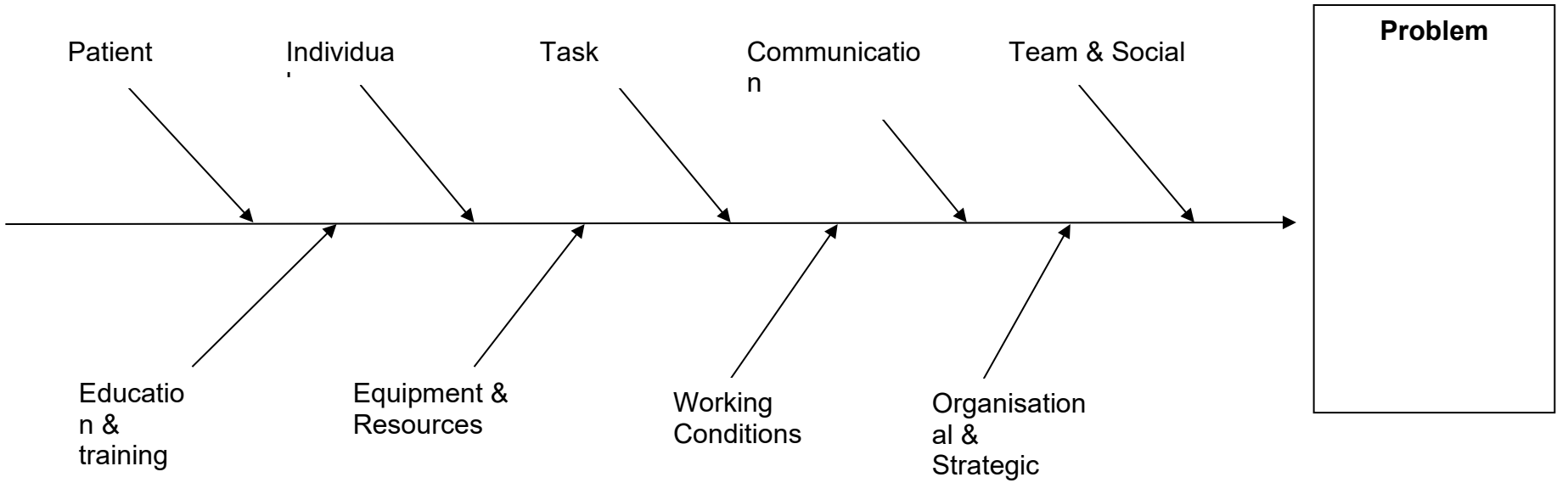
LEARNING EVENT REFERENCE
CHRONOLOGICAL TIMELINE - date, time, person, action

KEY ISSUES
HAZARDS / RISKS IDENTIFIED

APPENDIX 4 – ROOT CAUSE ANALYSIS FORM

APPENDIX 4 – ROOT CAUSE ANALYSIS FORM

INVESTIGATORY ACTIONS

CONTRIBUTORY FACTORS



APPENDIX 4 – ROOT CAUSE ANALYSIS FORM

IMPROVEMENT ANALYSIS - what is already in place, is it good enough, can it be improved?
RECOMMENDATIONS
TIME PLAN FOR IMPROVEMENT STRATEGY

Appendix 5

Business Continuity Learning event Reporting & Post Learning event Review

Location of the learning event	
Date & Time of the learning event	
Specific Service Areas disrupted	
Duration of Learning event	
Reported By (inc contact details)	
Learning event Details. Summary: Severity: Known Causes: Injuries/Personnel Evacuated/Infrastructure Damage/Environmental Impact/Records Damaged	
Action Plans Immediate Actions Taken: Actions Plans Utilised: Resumption/Continuity Actions: 3rd Party Contacts/Involvement	
LERIS record opened	
Learning event Review Summary/Lesson Learnt	
Follow Up Actions/Contacts	
LERIS Completed	

Appendix 6

Five Point Plan for supporting Staff following events of Violence and Aggression.

Patient Care

Patient focused - understanding our patients needs and ensuring we prioritise the "patients view" in all our everyday activities and actions.

Workforce Care

Teamwork and individual responsibility - every person counts, supporting each other, sharing information, valuing and encouraging.

Quality Care

Commitment to do what we say and improve what we do. A commitment to excellence and quality when serving patients and colleagues.

Resource Care

Optimising the use of all resources across the local health economy. Taking care of our working environment and equipment.

Introduction

BrisDoc is committed to "work-force care", and recognising that every person counts. We recognise that working with the general public does carry some risk and that occasionally members of our teams are involved in incidents of violence and aggression with patients and/or carers or other members of the public. When these incidents occur we wish to take all possible steps to ensure that the member of staff feels supported and reassured that we have reduced the risk of re-occurrence as far as possible.

This five-point plan outlines a framework of actions to be taken –and documented – for members of staff who have reported an event of violence and/or aggression. Whilst it may not be appropriate OÁR possible to complete all steps, line managers should use and complete the plan to ensure they have considered all points to ensure assurance is provided.

Guidance is provided for managers completing the plan.

Key Principles:

- **There are no set criteria for events that may be classed as "violence or aggression". All incidents where staff members have raised concerns or have felt vulnerable will be taken seriously.**
- **Although there are inherent risks with working with the general public, dealing with incidents of violence and aggression are not considered to be an acceptable part of the job.**
- **This five-point plan should be used in conjunction with the BrisDoc Policy on Violence and Aggression. The framework is not prescriptive and should be responsive to the member of staff's needs and the individual event.**

		Completed/date /other comments
Step 1	**Immediate debrief with member of staff involved – either by telephone or face to face. This should occur within 24 hours.**	
Step2	**Communicate details of event appropriately with patient's GP surgery (if the event involves a patient, and we know the details). Ensure any additional notes are added to record as appropriate.**	
Step 3	**If appropriate or possible, send a letter to patient outlining BrisDoc's stance in response to violent and aggressive patients.**	
Step 4	**Carry out a review of risk assessment. Are processes and procedures up to date? Are any changes or improvements required to premises or equipment (eg panic buttons/door locks?)**	

Step 5	**Carry out a further review and debrief with the member of staff six weeks after the event.**	

Guidance notes for managers

Step 1. An immediate de-brief should take place with members of staff involved as soon as possible after the event has occurred or been reported, and ideally within 24 hours. The debrief should be carried out ideally by the member of staff's line manager but can also be another senior staff member from the same service. Items for discussion and documentation should include:

- How is the member of staff feeling? There may be an inclination to dismiss the event, particularly if other members of staff were involved, but it is important to stress that people react differently and that experiencing feelings of shock or vulnerability after such events is expected.
- Has the member of staff completed any conflict resolution training – do they feel any or improved training could have produced a different outcome? It is important not to imply any blame for the event, but to allow the member of staff to discuss and reflect on the event.
- Stress that you or other managers are available if they wish to discuss the event further, or if they feel they need any additional support.

Step 2. If the event involved a patient, ensure that the patient's GP is informed if possible and that patient notes (including Adastra/Emis) are updated appropriately with any details if it is felt that the patient represents a risk to other Healthcare professionals in future.

Step 3. If it is possible and/or appropriate a letter should be sent to the patient outlining BrisDoc's stance on unacceptable behaviour towards staff. Ensure that the member of staff involved is aware of this, and understands if this is not possible (ie if the unacceptable behaviour was demonstrated by a relative).

Step 4 A review of the environment should be carried out and the risk assessment updated to ensure all possible safety measures are in place to protect staff – eg are panic buttons working, could lone working have been avoided, are door and entry systems secure? Communicate the outcome of any findings to the member of staff involved.

Step 5. A further de-brief with the member of staff should take place six weeks (or earlier if the staff member requires it) after the event. Ensure that the staff member is feeling safe, secure and supported and offer any ongoing support that may be necessary, including counselling.