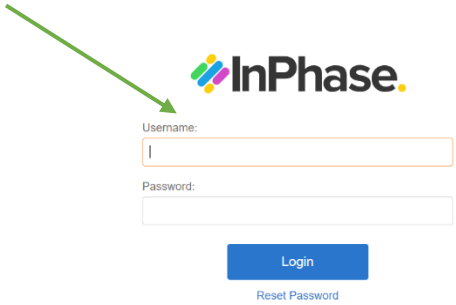
How to Report an Incident on InPhase

The InPhase system can be accessed via the following web link

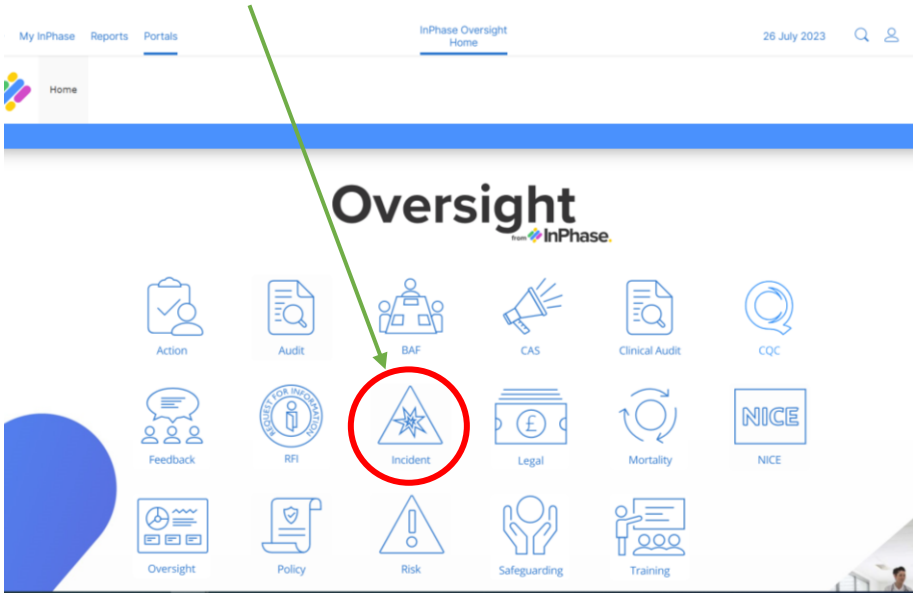
https://elft.inphase.com/login

Step 1: Once you have successfully opened InPhase:

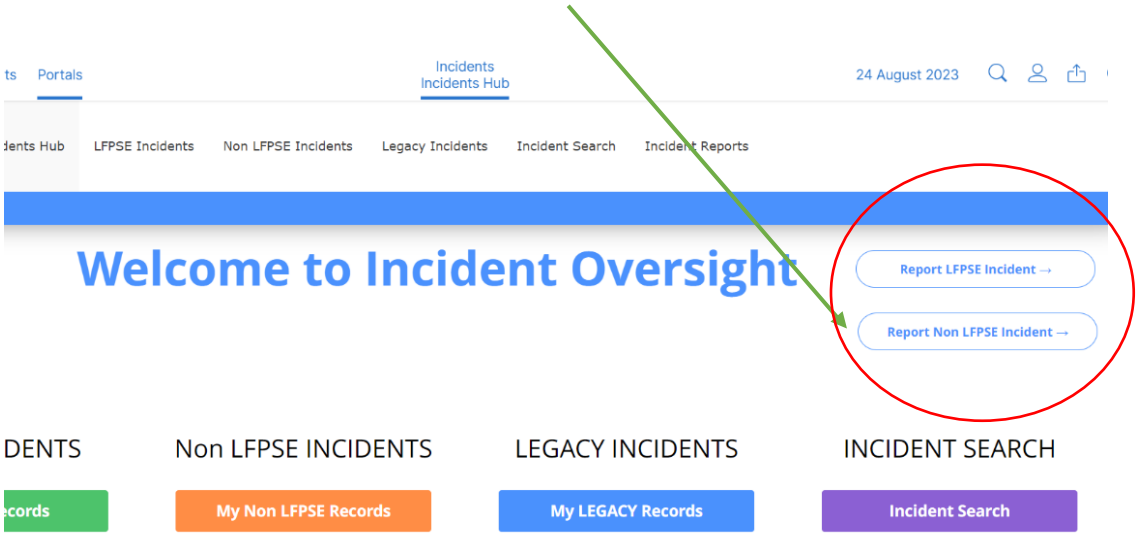
Go to login and type in your NHS mail address and password.



Step 2: You should now see the InPhase home page. Here you will select the Incident module.



Step 3: On the right hand corner you will see the option to Report an **LFPSE Incident** or a **Non LFPSE Incident**.



Why are we introducing two incident reporting forms?

All NHS provider organisations are required to export anonymised patient safety incident data to NHSE, this is currently undertaken manually by the central Risk and Governance Team via a system called the National Reporting Learning System (NRLS)

NHSE are making significant changes to this process, replacing the NRLS with a new system called Learn From Patient Safety Events (LFPSE)

This will mean a number of key changes for staff reporting incidents;

- NHSE are introducing a set of new questions for all NHS Providers to create a national dataset.
- The system will provide functionality to report good practice.
- Changes to the levels of harm, including the introduction of psychological harm (see section 5 for further details)
- Incident information will be exported automatically to LFPSE when a reporter submit an incident report, this before review by managers or speciality leads. Managers will have functionality to correct any information, this will automatically resubmit when the form is saved during the manager review / approval process

In order to meet LFPSE reporting requirements our supplier has recommended that we create two separate incident reporting forms, separating patient safety and non-patient safety incidents. Only the LFPSE incident reporting form will be enabled to submit incidents to NHSE, this will potentially reduce the numbers of queries raised by NHSE for non-patient incidents submitted incorrectly.

LFPSE - Patient Safety Incident Reporting Form

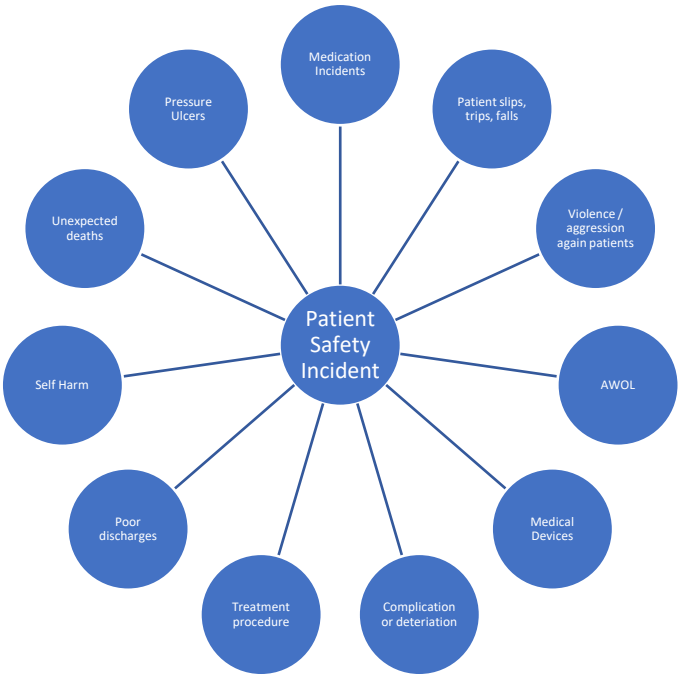
Please use the LFPSE incident reporting form for reporting patient safety incidents.

NHSE define this as “Something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm.”

What does this mean?

This encompasses all patient safety incidents, including “near misses”, if you know that something did not go as intended or expected – whether an act or an omission – and as a direct result the incident could have or did harm one or more patients.

Some examples of patient safety incidents fig 1



Please note that this is not exhaustive and will potentially include incidents we normally report under the care and treatment dropdowns and violence and aggression when a patient is harmed.

Non LFPSE - Non patient safety incident form

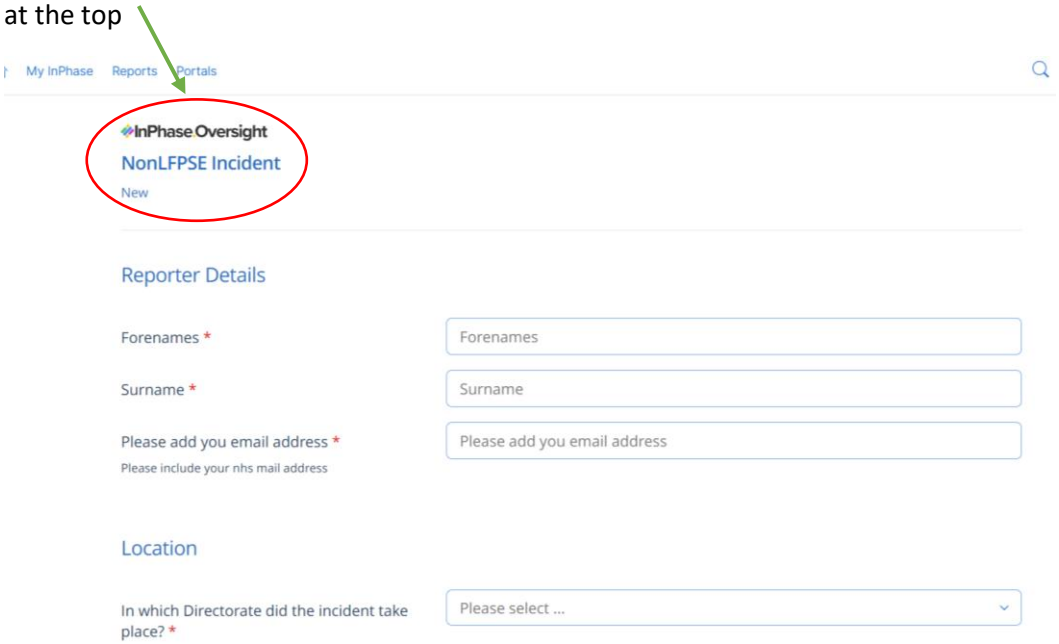
For non-patient safety incidents please use the non LFPSE incident form

Some examples in fig 2

LFPSE Incident – Reporting a Patient Safety Incident

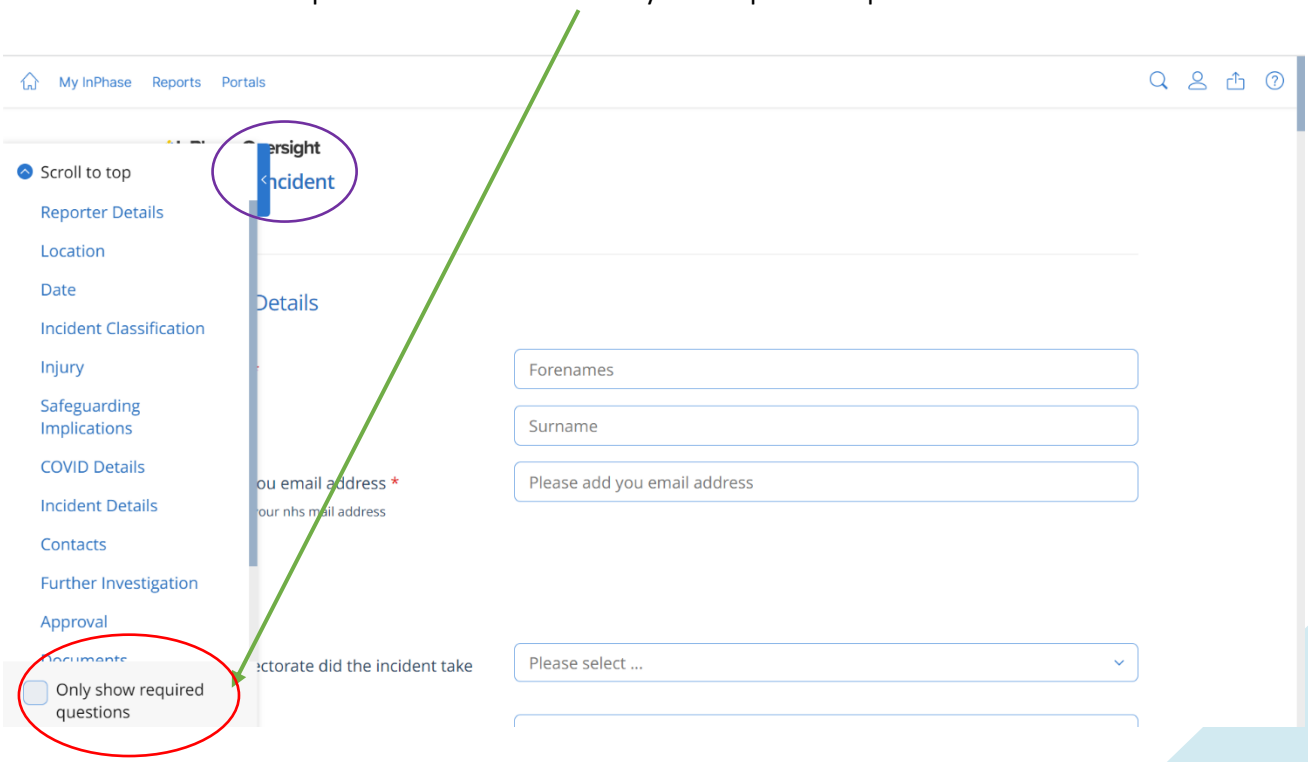
Non LFPSE Incident – Non Patient Incident

Step 4: Select the appropriate Incident form. You will see the name of the form you are completing at the top

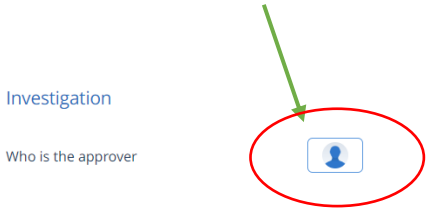


Step 5: On the left hand corner of your Incident reporting form, you will see an arrow sidebar icon; this sub section will allow you to jump to different and specific sections on your form.

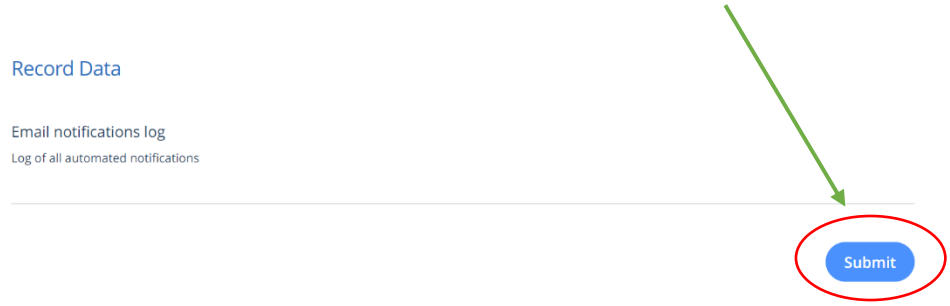
In this subsection, you also have the option to 'only show the required questions', this option will filter and show all the questions that are mandatory and require a response.



Step 6: You will now see the option to select the approver – this will be your manager.



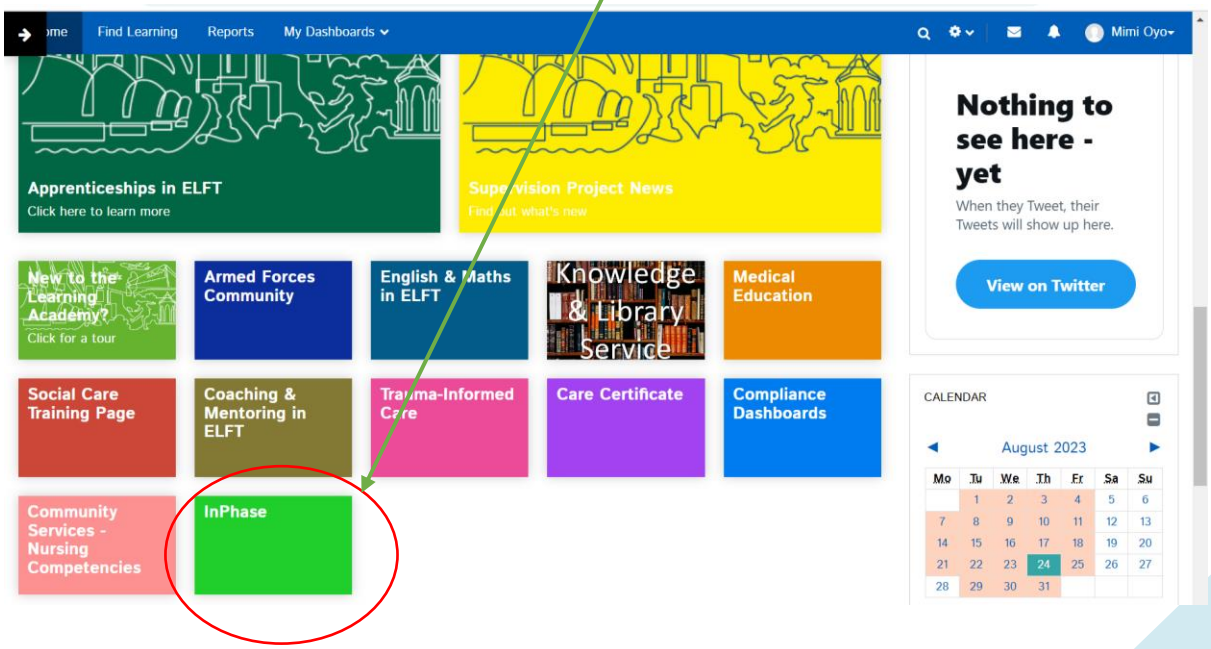
Step 7: Once your Incident form has been completed, click submit.



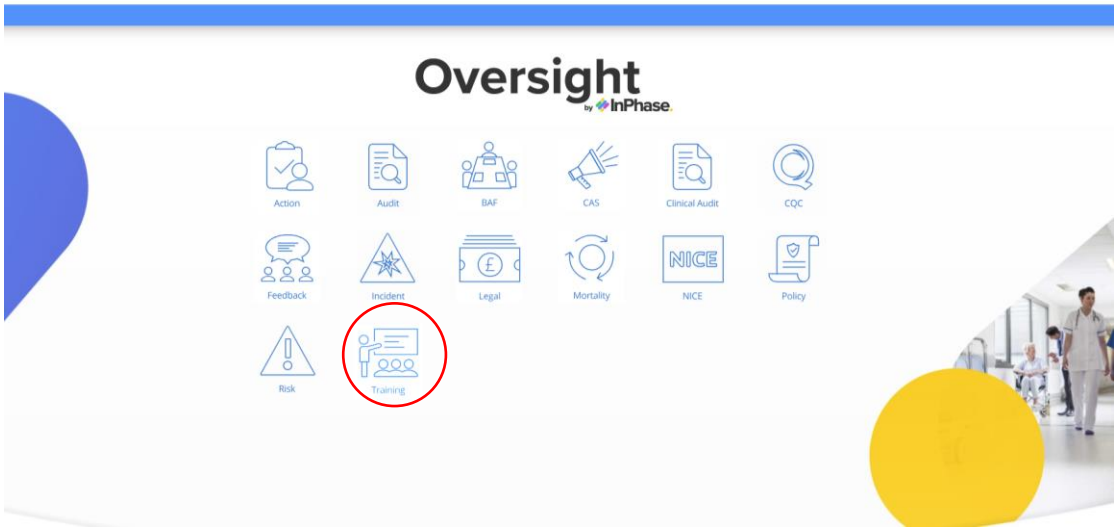
Training Videos on InPhase

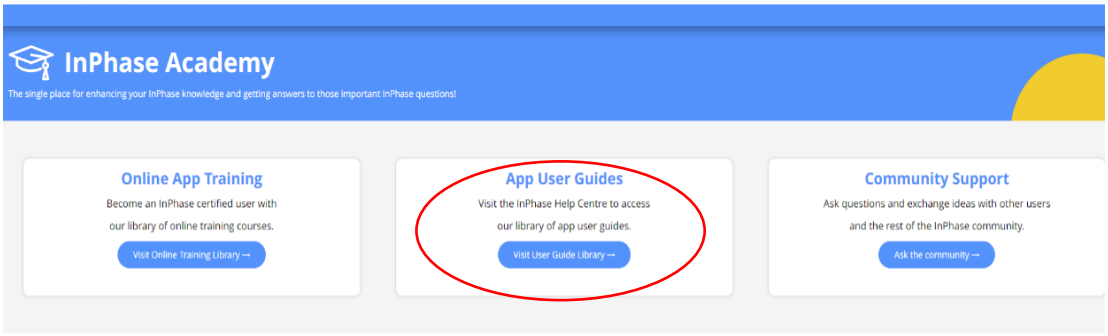
To watch training videos on InPhase you can access them via two option, the ELFT Learning Academy or by selecting the training module on InPhase

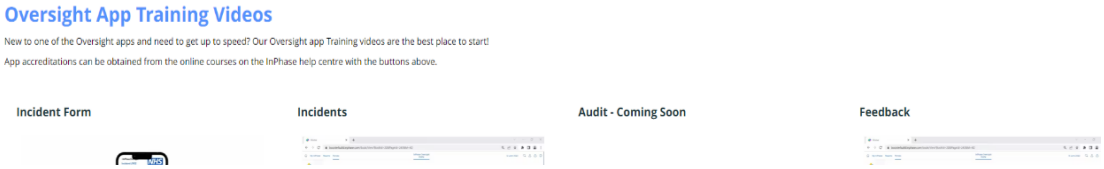
1. You can access the InPhase training videos and supporting guidance on the ELFT Learning Academy (ELA), by clicking on the Icon on your computer desktop or by going to https://learningacademy.elft.nhs.uk/ on any device. You can Sign in using your NHS Mail address.



2. InPhase training module
   Once logged on to InPhase, you will see the training module on the homepage. You will then be directed to the in-house training site. You may be asked to register, please complete the registration form to enable access.







If you have any questions or need further support, please email elft.inphasesupport@nhs.net

1. Levels of Harm; changes introduced by NHS England

In the NHS, degree of harm recording relates to the actual impact on a patient from the particular incident being reported. Patient safety incident harm definitions should always be applied based on the best information about the actual impact of the incident at the time of recording. The harm grading can be reviewed and updated as more information becomes available, but should not be used to speculate about, for example more severe "potential harm" if that does not appear to have been caused.

The full definitions of the harm gradings are as follows:

Physical harm

No physical harm

No physical harm

Low physical harm

Low physical harm is when **all of the** following apply:

- minimal harm occurred - patient(s) required extra observation or minor treatment
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
- did not or is unlikely to affect that patient's independence
- did not or is unlikely to affect the success of treatment for existing health conditions

Moderate physical harm

Moderate harm is when **at least one** of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm

Severe physical harm

Severe harm is when **at least one** of the following apply:

- permanent harm / permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more

Fatal (previously documented as 'Death')

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Psychological harm

Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

No psychological harm

Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

Low psychological harm

Low psychological harm is when **at least one** of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm

Moderate psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm

Severe psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months

- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

An introduction to Learn From Patient Safety Events

The Learn From Patient Safety Events (LFPSE) service is an improved central NHS England service for the recording and analysis of patient safety events. Receiving records of patient safety events from staff across all parts of the NHS, the LFPSE service will provide a national collection of patient safety data to support the NHS to learn and improve, particularly around the identification of new and under-recognised risks, so action can be taken to keep patients safe.

The LFPSE service builds on previous national reporting systems, and introduces a range of key features to improve the quality of data collected. It also utilises technological advances in data analysis to support the review of recorded events. This provides better opportunities for learning and will enable the NHS to access real-time patient safety data to support improvement and timely responses to identified risk.

The LFPSE service will replace the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS), creating a single national system for recording and learning from patient safety events.

Once work has been completed to implement our new incident reporting system using INPHASE, all new patient safety events will be automatically uploaded to the LFPSE service.

What changes will you notice when recording a patient safety event?

Staff will continue to record patient safety events in the same way using our incident reporting systems, however you will see a difference in the questions being asked about the event.

Questions have been introduced by NHSE to better support the NHS to accelerate the pace of safety improvement. Better data means better learning.

NHSE state "In some cases this may mean it takes longer to record a patient safety event. The LFPSE service is looking to find the right balance between information collected and speed staff can complete a report. While shorter forms might be quicker to complete, if they don't collect information that can be used to make real changes to safety, they are not fit for purpose.

The new set of questions shifts focus to the processes and systems that fail, to better understand the mechanism by which patient safety incidents occur. This will support the NHS to target improvement work at systems and processes, rather than at the downstream impacts, and ensure resources are deployed where they have the most impact."

LFPSE will also introduce another key feature giving staff the ability to submit examples of good practice and where something has gone right to make care safer. Sharing these examples is important to improving safety across the NHS as it supports the spread of innovation and good practice