INCIDENT REPORTING POLICY

<table>
<thead>
<tr>
<th>DOCUMENT CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version:</td>
</tr>
<tr>
<td>Ratified by:</td>
</tr>
<tr>
<td>Date ratified:</td>
</tr>
<tr>
<td>Name of originator/author:</td>
</tr>
<tr>
<td>Name of responsible committee/individual:</td>
</tr>
<tr>
<td>Date issued:</td>
</tr>
<tr>
<td>Review date:</td>
</tr>
<tr>
<td>Target Audience</td>
</tr>
<tr>
<td>CONTENTS</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>4.1</td>
</tr>
<tr>
<td>4.2</td>
</tr>
<tr>
<td>4.3</td>
</tr>
<tr>
<td>4.4</td>
</tr>
<tr>
<td>4.5</td>
</tr>
<tr>
<td>4.6</td>
</tr>
<tr>
<td>4.7</td>
</tr>
<tr>
<td>4.8</td>
</tr>
<tr>
<td>4.9</td>
</tr>
<tr>
<td>4.10</td>
</tr>
<tr>
<td>4.11</td>
</tr>
<tr>
<td>4.12</td>
</tr>
<tr>
<td>4.13</td>
</tr>
<tr>
<td>4.14</td>
</tr>
<tr>
<td>4.15</td>
</tr>
<tr>
<td>4.16</td>
</tr>
<tr>
<td>4.17</td>
</tr>
<tr>
<td>5.</td>
</tr>
<tr>
<td>5.1</td>
</tr>
<tr>
<td>5.2</td>
</tr>
<tr>
<td>5.3</td>
</tr>
<tr>
<td>5.4</td>
</tr>
<tr>
<td>5.5</td>
</tr>
<tr>
<td>5.6</td>
</tr>
<tr>
<td>5.7</td>
</tr>
<tr>
<td>5.8</td>
</tr>
<tr>
<td>5.9</td>
</tr>
<tr>
<td>5.10</td>
</tr>
<tr>
<td>5.11</td>
</tr>
<tr>
<td>5.12</td>
</tr>
<tr>
<td>Section</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>5.13</td>
</tr>
<tr>
<td>5.14</td>
</tr>
<tr>
<td>6.</td>
</tr>
<tr>
<td>7.</td>
</tr>
<tr>
<td>8.</td>
</tr>
<tr>
<td>8.1</td>
</tr>
<tr>
<td>8.2</td>
</tr>
<tr>
<td>9.</td>
</tr>
<tr>
<td>10.</td>
</tr>
<tr>
<td>11.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
1. **INTRODUCTION**

Trusts are responsible for the safety of their patients, staff, visitors and others using their services, and must ensure robust systems are in place for recognising, reporting, investigating and responding to Serious Incidents and for arranging and resourcing investigations.

The effective management of incidents is essential to the provision of a safe and secure environment for the users of our services as well as our staff and visitors.

When an incident occurs, the immediate effects, and the aftermath, should be managed promptly and efficiently to protect life, prevent suffering and reduce damage. Then an appropriate investigation carried out to identify the causative factors, and plans put in place to prevent or reduce the likelihood of a reoccurrence.

The Trust has a legal obligation to provide a record of all accidents, and work-related illnesses, which affect staff and visitors to Trust premises, including patients. Also all NHS organisations are required to have a centralised system for collecting data on safety incidents. The Trust uses the Safeguard Risk Management Software in order to report and collate incidents and to use this information to improve systems and clinical care.

A fundamental part of any organisation with a culture of safety is to ensure that it is open and fair. For NHS organisations this means that the Trust and its staff are open, transparent and accountable when incidents occur, and things have gone wrong.

A list of definitions of terms used in this policy is at Appendix A, page 25.

2. **PURPOSE**

This policy sets out the Trust systems, processes and expectations in relation to incident reporting and learning to include the:

- Process for reporting all incidents involving staff, patients and others
- Process for reporting to external agencies
- Process for investigating incidents according to level of risk
- Process for involving and communicating with internal and external stakeholders to share safety lessons
- Process for the aggregated analysis of incidents, complaints and claims
- Process by which the organisation ensures local and organisational learning and changes in practice resulting from individual incidents and aggregated analysis
- Process for ensuring communication is open, honest, occurs as soon as possible and is well documented
- Training requirements for staff

An overview of the pathway of managing an incident is provided in the
flowchart in Appendix B.

3. **SCOPE**

The policy applies to all staff employed within the Trust (permanent or temporary or honorary), students and volunteers, contractors and employees of other organisations working on the Trust’s estate.

4. **RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES**

4.1 **THE CHIEF EXECUTIVE OFFICER AND BOARD OF DIRECTORS**

The Chief Executive Officer, through the Board of Directors, has overall responsibility for the provision of adequate systems for the management of Health & Safety, including the reporting and managing of incidents, accidents and near miss events.

4.2 **EXECUTIVE DIRECTOR OF NURSING AND QUALITY**

The Executive Director of Nursing & Quality is the designated Board of Directors’ lead for incident reporting via the Safeguard Risk management System and the implementation of Being Open and the Duty of Candour where appropriate.

4.3 **HEAD OF ALLIED PROFESSIONS AND PATIENT SAFETY**

Head of Allied Professions and Patient Safety is responsible for the operational management of the SI process including:

- Ensuring all SIs are managed and investigated appropriately ensuring robust and timely action plans are produced
- Chairing the Organisational Learning Forum (OLF) to ensure learning from incidents is shared across the Trust

4.4 **ASSISTANT DIRECTORS**

The Assistant Directors are responsible for ensuring that all staff within their sphere of responsibility are aware of the need to complete the Electronic Incident Form (IR1), and as appropriate F2508 RIDDOR report forms, and undertake an appropriate investigation.

Depending on the seriousness of the incident, the advice and/or involvement of the Patient Safety Lead, Health and Safety Lead or Head of Health, Safety & Security will be sought.

- Ensuring that the incident is reported via the Safeguard Incident Reporting System (IR1).
- Appointing a Designated Incident Manager (or more than one, if required).
- Ensuring that the Being Open and Duty of Candour Policy is implemented.
- Escalating significant incidents to the Service Director.
- Ensuring that relevant staff receive a debrief on investigation findings and lessons learned and communicating lessons learned to the Organisational
• Ensuring the completion and implementation of any action plans arising from the investigation.

4.5 HEAD OF HEALTH SAFETY AND SECURITY

The Head of Health, Safety and Security will:

• Be responsible for the day-to-day operation of the incident reporting system.

• Submit the relevant patient safety incident information through the e-form to the National Reporting and Learning System (was the NPSA).

• Report ‘Never Events’ – assisting the National Reporting and Learning System (NRLS) to identify these incidents by adding the text ‘Never Event’ within the incident description free text field on Safeguard/e-Form prior to submission.

• Make readily available to individuals who have rightful access, copies of completed incident report forms.

• Collate and analyse incident data regularly, producing summarised reports identifying trends and demonstrating a Trust-wide overview of all reported incidents for the Health and Safety Forum.

• Provide Business Division specific reports to facilitate detailed consideration of any required policy and practice changes to support organisational learning.

• Provide the Patient Safety Lead with relevant patient safety incident data in respect to the care and treatment of service users.

4.6 HEALTH AND SAFETY LEAD

The Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 1995 requires a named ‘Responsible Person’ on behalf of the Trust to report to the local office of the Health and Safety Executive (HSE).

The Health and Safety Lead has been designated as the ‘Responsible Person’ on behalf of the Trust.

The Health and Safety Lead will:

• Be responsible for ensuring the statutory notification of those specified incidents to the Health and Safety Executive (HSE)

• Receive a copy of all RIDDOR Reports, oversee the process of RIDDOR reportable incidents, checking that the forms are completed correctly and sent to the relevant office of the HSE in the prescribed timescale, normally 15 working days.

4.7 ACCOUNTABLE OFFICER FOR CONTROLLED DRUGS

The Accountable Officer for Controlled Drugs is responsible for:

• Recording, assessing and investigating concerns expressed about incidents that may have involved improper management or use of such drugs.

• Ensuring that appropriate action is taken for the purpose of protecting
service users or members of the public in cases where such concerns appear to be well-founded.

In this Trust the role of the Accountable Officer is undertaken by the Chief Pharmacist.

4.8 MENTAL HEALTH ACT MANAGER

The Mental Health Act Manager is responsible for:

- Reporting to the Care Quality Commission (CQC) the death of a detained patient.
- Reporting to the CQC the outcome of any application made to a supervisory body in relation to depriving a service user of their liberty. See Mental Capacity Act 2005 – Deprivation of Liberty Safeguards Policy.
- Reporting to the CQC the admission of a child or young person (under the age of 18) to an adult psychiatric ward or unit.
- Reporting to the CQC any absence without leave (AWOL) of a person who is detained, or liable to be detained\(^1\), under the Mental Health Act 1983 in a hospital designated as low, medium or high security.

4.9 HUMAN RESOURCES

The Human Resources function is responsible, with the Director of Nursing & Quality, Medical Director and Head of Allied Health Professionals, for external reporting to regulatory bodies for professionals including the General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC) in conjunction with the relevant senior manager.

Referrals to the National Clinical Assessment Service (NCAS), whose role is to help resolve performance concerns about dentists, doctors and pharmacists, will also be dealt with under the employment policies route by the Human Resources function in conjunction with the relevant senior manager.

4.10 DESIGNATED INCIDENT MANAGER (FOR ALL INCIDENTS)

The Designator Incident Manager is to;

- Comply with the Being Open and Duty of Candour Policy and Supporting Staff Involved in a Traumatic/Stressful Incident, Complaint or Claim Policy throughout the process.
- Support and assist the Lead Investigator (if it is not the Incident Manager)
- For non-SIs, complete an investigation to ascertain the root cause of the incident. The methodology of this investigation is dependent on the severity and complexity of the incident.
- Make appropriate entries onto the IR1 incident reporting system which outline the results of the investigation and any actions required to remedy and/or prevent reoccurrence of the incident.
- Provide a report for the patient or relevant person to comply with the Duty

---

\(^1\) Including patients failing to return from s.17 leave of absence from hospital, or absenting from escorted leave or detention under short-term powers of s.5, 135 or 136.
of Candour if required. (see Being Open and Duty of Candour Policy)

- Provide a report on the incident investigation for the Assistant Director if required.

4.11 LINE MANAGERS

It is each manager’s responsibility to:

- Ensure that all incidents regardless of type, damage or injury are accurately reported, using the Electronic Incident Form (IR1) via the Trust’s Safeguard electronic incident reporting system, as soon as is reasonably practicable, but within 12 hours of the incident (or becoming aware of the incident) by the most appropriate person in their service.

- Log on to the system on receipt of a web incident notification being automatically emailed to them and complete and submit the 'Manager’s Form.'

- Act as Designated Incident Manager for all incidents which occur in their area of control unless another person has been designated to carry out the duties of the Designated Incident Manager.

- Comply with the Duty of Candour for all incidents which are classified as a Notifiable Safety Incident and have a level of harm of moderate or higher.

- Complete an investigation into the cause of the incident, and put in place mitigating actions to manage the incident and prevent its reoccurrence.

- Complete the RIDDOR form and send it to the Health & Safety Executive, with a copy sent to the Trust Safety Team, for all incidents which require a RIDDOR Report.

4.12 LOCAL COUNTER FRAUD SPECIALIST

The Local Counter Fraud Specialist will report to NHS Protect incidents of fraud and corruption.

4.13 LOCAL SECURITY MANAGEMENT SPECIALIST (LSMS)

The LSMS will report to NHS Protect serious security related incidents including physical assaults against staff, thefts and criminal behaviour using the Security Incident Reporting System.

They will also assist in, or lead on, investigations into crime, violence and aggression and other security related issues as required.

4.14 ASSISTANT DIRECTOR LEARNING DISABILITIES (IN RELATION TO LEARNING DISABILITY COMMUNITY HOMES)

In accordance with the relevant Regulations of the Care Quality Commission (Registration) Regulations 2009, the Assistant Director for Learning Disabilities is responsible for sending relevant notifications directly to the CQC within the required timescales.

4.15 LEARNING DISABILITY REGISTERED HOME MANAGERS/DOMICILIARY CARE MANAGER

In accordance with the relevant Regulations of the Care Quality Commission (Registration) Regulations 2009, the Registered Manager for the relevant
home or Domiciliary care service is responsible for sending relevant notifications directly to the CQC within the required timescales.

4.16 ALL STAFF
All Staff are responsible for reporting all incidents on the Trust Electronic IR1 form via the Safeguard electronic incident reporting system e.g. accidents, incidents, health and safety issues, security issues, alleged clinical negligence or malpractice and alleged abuse of patients, staff and property.

4.17 COMMITTEES AND GROUPS WITH RESPONSIBILITIES

4.17.1 BOARD OF DIRECTORS
The Board of Directors has responsibility for ensuring the adequate provision of systems for the management of Health & Safety, including the reporting and managing of incidents, accidents and near miss events.

4.17.2 EXECUTIVE MANAGEMENT TEAM
Is responsible for the day to day oversight of the systems for the management of Health & Safety for the Trust.

4.17.3 QUALITY COMMITTEE
The Quality Committee is responsible for providing assurance to the Board of Directors that the framework for the reporting of incidents is being managed effectively and that organisational learning is taking place.

The Quality Committee is responsible for approving certain policies - including the Incident Reporting Policy - and to provide assurance around its key responsibilities.

4.17.4 QUALITY AND SAFETY SUB-COMMITTEE
The Quality and Safety Sub-Committee, which reports to the Quality Committee, is responsible for;

- Reviewing incidents, complaints and claims on a quarterly basis, this includes examining themes, trends, causal factors, outcomes of investigations including gaps in services and performance against action plans.
- Receiving and acting upon as appropriate on Patient Safety Benchmarking and incident analysis reports.
- It gives delegated responsibility to the Health, Safety and Security Forum for the implementation of their work streams and action plans.

4.17.5 ESTATES AND FACILITIES SUB-COMMITTEE
The Estates & Facilities Sub-Committee is a sub-committee of the Finance and Performance Committee and is responsible for monitoring and promoting effective health and safety measures at work (HASAWA, 1974, s 2 (7)), through communication and collaboration between the Trust as employer and its employees on health and safety matters.

4.17.6 ORGANISATIONAL LEARNING FORUM (OLF)
The Organisational Learning Forum (OLF) is responsible for developing and managing a structured approach to learning and sharing lessons for
improvement in practice, where lessons learned are embedded in the Trust’s
culture and practice from Serious Incidents, Complaints and Claims as a result
of investigations. The Organisational Learning Forum (OLF) reports to the
Quality & Safety Sub-Committee.

5. PROCEDURE/IMPLEMENTATION

IT IS ESSENTIAL THAT ALL INCIDENTS OF ALL TYPES ARE REPORTED
VIA THE TRUST SAFEGUARD INCIDENT REPORTING SYSTEM (IR1),
INCLUDING ALL THOSE WHICH ARE REQUIRED TO BE REPORTED
EXTERNALLY.

Staff should seek advice without delay to confirm reporting requirements from
their Manager/ Health and Safety Lead/ Directors.

The completion of an Electronic Incident Form (IR1) for Serious
Incidents is still an essential requirement.

5.1 WHAT IS AN INCIDENT?

An incident is described as:

“any event which has given rise to potential or actual harm or injury, to
patient dissatisfaction or to damage/ loss of property”

(Ref: NHS Executive).

This definition includes patient/service user injury, fire, theft, vandalism,
assault and employee accident and near misses.

It includes incidents resulting from negligent acts, deliberate or unforeseen.

Also an unplanned or unexpected event in which a member of staff/contractor
or the public has been, or could have been injured, killed, or suffer mental
trauma, or led to loss or damage to equipment or property, or other financial
loss.

For example:

- Unexpected / unexplained death
- Absconson by a detained patient
- A member of staff hurts his/her back
- A member of staff subject to verbal or physical abuse
- A member of the public falls in the car park
- Fire on work premises
- Theft, loss or damage to organisation or personal property

5.2 WHAT TO DO WHEN AN INCIDENT OCCURS (APPENDIX B)

Some incidents will require prompt and specific action to deal with the
problem. This may include the following:

- Summon emergency medical care if required
- Summoning assistance from others if required
- Ensure that patients, staff, visitors and others, are protected from the risk if
required

- Comply with the ‘Being Open Initiative’ and, if appropriate, the Duty of Candour requirements
- Notifying senior members of staff on duty
- If equipment / machinery is involved, removing it from service (marking it clearly ‘out of order’) and arrange its repair or removal.
- Recording the action taken in the patient’s care records. Records might not be at hand, but they should be found and either tracked or made secure.
- Member of staff to report the incident via the incident reporting system
- If necessary, request that all those who observed what happened prepare a witness statement as soon after the event as possible.

5.3 WHO IS RESPONSIBLE FOR REPORTING INCIDENTS?

The manager in charge of the area or service in which the incident occurred is responsible for ensuring that an incident report (IR1) has been completed, and for more significant incidents a senior manager has been informed.

However, to ensure that the report is accurate, the member of staff involved in the incident should be closely involved in the report writing.

5.4 THE INCIDENT REPORTING SYSTEM (IR1)

An electronic incident form (IR1) must be accurately completed and submitted for all incidents via the Safeguard electronic incident reporting system.

Safeguard is accessed via the Trust’s Intranet Home page using a computer user name and password.

The IR1 system hold the function of the Trust Accident Book for staff and visitors as required by legislation.

5.5 INCIDENT MANAGEMENT IN PARTNERSHIPS

Situations where the Trust has entered into a partnership with another organisation can present organisational difficulties due to the legal standing of that partnership.

The responsibility for the management of staff remains with the employing authority, even if they work in a partnership arrangement. Although the day to day management of this duty can be delegated, the responsibility continues to lie with the employer.

It is essential that a formal agreement is created between the partners to identify where the incident management role will lie, including how incidents are reported internally and externally. However, some responsibilities cannot be transferred to another organisation.

The advice of the Head of Health, Safety & Security and the Health & Safety Lead should be sought.

5.6 WHO RECEIVES NOTIFICATION OF AN INCIDENT?

On successful submission of an electronic form, a unique incident number will be generated, which when the ‘OK’ button is clicked, is automatically emailed
to:
- Any pre-designated Manager for the service/location
- Any designated subject matter expert if applicable
- The Statistics Co-ordinator
- The Safeguard holding file

5.7 WHAT TO DO WHEN YOU RECEIVE EMAIL NOTIFICATION OF AN INCIDENT OCCURRENCE

5.7.1 Designated Incident Manager

The designated manager will log on to the system using their desk computer user name and password, which will enable them to access their services' Manage Incidents list.

When an incident on the list is clicked onto, brief details of the incident are opened and the Managers Form icon is available for the manager to click on to open the full incident form. The manager can then check all the details of the incident and complete the Severity and the Incident Outcome and submit.

The designated manager is responsible for the management and closure of the incident report.

The designated manager is to consider the incident and appraise whether it has reached the criteria for a Serious Incident. If they are unsure, they are to seek advice from the Corporate Patient Safety Team.

If the incident is a Patient Safety Incident, and the actual harm is of a moderate level or higher, then the Duty of Candour applies.

For incidents which do not reach the threshold for Serious incidents, the manager should carry out an investigation of a scale and scope which is proportionate to the incident to ensure that resources are effectively used and conducted to identify;

- The cause of the incident
- Whether the incident can be prevented from occurring again
- The action taken to manage the incident
- Whether the actions taken were suitable and sufficient to manage the incident effectively
- Any post incident actions, including further management, learning and changes to systems and practices which may prevent or mitigate a future occurrence.

Any investigation should be of a suitable thoroughness to achieve the aims above.

The investigation should be based upon the Root Cause Analysis process, and may range from simple fact finding to a full investigation.

The manager is to summarise the findings of the investigation in the Outcomes and Recommendation sections of the incident reporting system.
5.7.2 **The Subject Matter Expert**

Each incident report is forwarded to a relevant subject matter expert, for example:

- Security – Trust Security Advisor
- Violence – Reducing Restrictive Interventions Team
- Falls – Trust Falls Prevention Lead
- Sudden Collapse – Trust Resuscitation Officer

The Subject Matter Expert is to read the incident report and provide assistance, guidance or other support as required to the Designated Manager and/or people involved in the incident. This may include providing support or seeking further information / clarification or carrying out an investigation.

The Subject Matter Expert should ensure that any learning from the incident has been taken and managed effectively.

The Subject Matter Expert is not to close any incident other than those for which they are also the nominated manager.

They should assist in any investigation which may take place into the causes and management of the incident.

5.7.3 **Statistics Co-ordinator**

The Statistics Co-ordinator receives the incident reports into the incident reporting system and ensures that:

- All the required information is recorded
- The entry parameters are suitable for the incident
- The correct people are informed that the incident has occurred
- Reports are produced on themes and trends as required by the Trust.

5.8 **WHAT IS THE TIME PERIOD FOR INCIDENT MANAGEMENT?**

Incidents should be reported as soon as practicable, but within 12 hours of the incident occurring or staff becoming aware of it.

Upon receipt of the email notification of an incident occurrence, the subject matter expert should review the incident and contact the manager to discuss the incident, or to provide advice on how to proceed, within 10 working days.

The completion of the investigation and closure of the incident on the reporting system by the manager should take no longer than 10 working days.

The 10 day closure target can be extended if:

- The incident investigation is complex,
- The incident is subject to the Serious Incident process
- An external investigation is underway
- The incident is under the control of the Police or Coroner
- Some other statutory body has control of the incident investigation

A monthly exception report will be prepared for the Quality & Safety Sub-
Committee detailing the areas which have outstanding incident reports. This report will also be made available to the Assistant Directors for action.

5.9 THE DUTY OF CANDOUR AND BEING OPEN

Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems.

For all patient safety incidents, regardless of harm, the Being Open guidance will be followed. As soon as possible after the incident, a suitable member of staff will;

AS SOON AS POSSIBLE AFTER THE INCIDENT
- Notify the patient, or relevant person, verbally, face to face where possible, unless the person cannot be contacted in person or declines notification, that the incident has occurred.
- This initial notification will include an apology and must be provided as soon as is practicable.
- Provide all information directly relevant to the incident which will be step by step factual explanation of what has happened.
- Advise and, if possible, agree with the patient what further enquiries are appropriate.
- Provide reasonable support to the patient or service user, their families or carers.

If, however, the incident has resulted in moderate, major or catastrophic harm, or death, then the Duty of Candour applies, then further actions are required. The Duty of Candour actions follow on from the Being Open Actions and are;

AS SOON AS POSSIBLE AFTER THE INCIDENT
- Provide support to the patient, their families or carers after the incident, throughout the investigation and ongoing as required.
- The manager is to meet the relevant person, in person, and inform them that he incident has occurred, apologise, inform them what happened as far as we are aware and what actions are to be taken next.

WITHIN 10 WORKING DAYS OF THE INCIDENT
- Share with the patient and/or Relevant Person, in writing, the original notification and the results of any further enquiries.
- This should include;
  - all the information given verbally during the face to face meeting,
  - the apology that was given
  - any further information that has come to light since the meeting and
  - an outline of the investigation that is in progress.

WITHIN 28 WORKING DAYS OF THE INCIDENT
- Investigate the incident and provide a report outlining an explanation of the events and circumstances which resulted in the incident.
• Provide and maintain written records of the interactions with the patient or relevant person

• All final incident reports must be ratified by the Assistant Director for the Business Division, or the Delegated manager, as suitable and sufficient to outline the root cause of the incident.

• If the incident is being investigated as a Serious Incident (SI), or an external investigation is underway, then the 28 day limit may be exceeded to comply with the limits of the external investigation.

**WITHIN 10 DAYS OF THE REPORT BEING ACCEPTED AND CLOSED**

• All final incident reports must be shared with, and a copy provided for, the patient or relevant person.

• The actions taken, notifications given, letters sent and outcomes are to be recorded with the initial incident on the IR1 form

The final Duty of Candour report should be concise, easy to understand by the relevant person and restricted to the incident.

See the Being Open and Duty of Candour Policy for further information.

5.10 **SERIOUS INCIDENTS**

What is a Serious Incident? The 2015 SI Framework states that there is no definitive list of events/incidents that constitutes a serious incident as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated.

The SI framework encourages providers to review each possible SI on a case by case basis and engage in discussion with commissioners. An SI that requires investigation could be defined as acts and/or omissions that have resulted in:

• unexpected or avoidable death,

• unexpected or avoidable injury that has resulted in serious harm or requires further treatment to prevent death or serious harm,

• actual or alleged abuse,

• an incident that prevents or threatens to prevent the Trust’s ability to continue to deliver an acceptable quality of healthcare

• major loss of confidence in the service

• never event (please refer to the Never Events Framework on the intranet),

• screening incident (please refer to the Screening Framework on the intranet)

This is by no means an exhaustive list and if there is any doubt as to whether an incident is a serious incident then the Corporate Patient Safety Team should be contacted for a discussion and if necessary this can be clarified with the commissioners by the Corporate Patient Safety Team.

5.11 **SIGNIFICANT INCIDENTS**

What is a significant incident? If an incident occurs which is not a Serious
incident (see 5.10 above) but the reporter, or manager believes that it is of a nature which requires the attention of a senior manager then the reporter or manager should notify the appropriate senior manager as soon as practicable.

Whether an incident falls into this category may be subjective, but as a guide, an incident will be significant if:

- Involves an unexpected major or catastrophic harm to a patient on an inpatient unit
- Involves a serious or malicious breach of practice or policy
- Involves purposeful abuse, neglect or maltreatment of a patient by Trust staff
- Presents a serious ongoing risk to the public or others,
- Adversely affects a number of patients at the same time
- It has attracted the attention of the media, local dignitaries, Member of Parliament or similar
- It may adversely affect the reputation of the Trust
- It involves someone who has some level of celebrity status or is a dignitary of some sort.

This is by no means an exhaustive list and if there is any doubt as to whether an incident is a serious incident then discuss the incident with the senior manager, or the Corporate Patient Safety Team.

5.12 MEDIA RELATIONS

The Head of Communications will be briefed by the Head of Allied Health Professions & Patient Safety or the relevant director/assistant director concerning incidents which may attract media interest. The Head of Communications or a team member will be responsible for the preparation of a “press statement” which will be approved by the relevant director/s. The Communication Team will work closely with organisational staff to determine the precise nature, frequency and content of such communication.’

5.13 STAFF WHO WISH TO RAISE A CONCERN

Staff Who Wish to Raise a Concern Within the Trust, for example open disclosure, whistle blowing etc.

There may be occasions when a member of staff witnesses or becomes aware of something within the Trust that gives them cause for concern. In these circumstances the member of staff should:

- Make an immediate note of their concern, recording relevant details such as what was said/ witnessed, date, time and details of other people involved.
- Raise their concern with their Manager and/or refer to the Trust’s Disclosure of Concerns on Healthcare Matters (Whistle blowing) Policy and Procedure which provides further guidance.

5.14 THE TRUST’S EXTERNAL REPORTING ARRANGEMENTS

The Trust is required to report certain types of incident to a range of external
agencies. All incident reports are scrutinised by the Health and Safety Lead in order that the relevant external reporting requirements are met.

The main external agencies to which the Trust reports incident are listed below (please note this is not an exhaustive list, and advice will be taken by the Health and Safety Lead in conjunction with other relevant managers, on particular issues).

5.14.1 Health and Safety Executive (HSE)

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR)1995

RIDDOR requires the reporting of incidents of a specified nature to the Health and Safety Executive (HSE), using standard forms F2508 and F2508A.

The most common report is for injuries to staff which result in an absence from duty of more than 7 consecutive days. This requires completion of form F2508.

Dangerous occurrences such as failure of lifting equipment, explosion, and failure of supporting structures also require completion of form F2508.

The reporting of diseases requires completion of form F2508A. The disease has to be diagnosed by a Medical Practitioner.

The guidance to the regulations has appendices, which list the types of injury, diseases and dangerous occurrence that need to be reported.

The manager of the area where the incident took place is responsible for completing the RIDDOR report and forwarding it to the HSE.

A copy of all RIDDOR forms are to be sent to the Trust Safety Team and the Health & Safety Lead will check, assist and advise if required.

If there is any doubt, reference should be made to the guidance, or the Health and Safety Lead contacted for advice.

5.14.2 National Reporting and Learning System (NRLS)

The Head of Health ,Safety & Security submits the relevant patient safety incident information through the e-form to the National Reporting and Learning System (NRLS). See Appendix A for incident types.

This includes the following notifications which are required by law to be reported to the NRLS who will then notify the Care Quality Commission:

- **Death of a service user** - that occurred whilst services were being provided; that was a consequence of the service being provided, and was not caused by an illness or condition that was being appropriately treated.

- **Any abuse or allegation of abuse** - abuse in relation to the service user means sexual abuse; physical or psychological ill treatment; theft, misuse or misappropriation of money or property; or neglect and acts of omission which cause harm or place at risk of harm.

- **Events that stop or may stop the service from running safely and properly** – a level of staff absence or vacancy, or damage to the service’s premises that mean that people’s assessed needs cannot be met; the failure of a utility for more than 24 hours; the failure of fire alarms,
systems or other safety-related equipment for more than 24 hours; and other circumstances or events that mean the service cannot – or may not be able to meet service user assessed needs safely.

- **Serious injuries to people who use the service** - which include: injuries that lead to or are likely to lead to permanent damage or damage that lasts or is likely to last more than 28 days; injuries or events leading to psychological harm.

The CQC require ‘these notifications to not identify the person they are about, or enable them to be identified. Individuals should be referred to using a code that is unique to them. Services must keep a record of these codes and who they refer to in case the CQC needs to make further enquiries.’

The Safeguard incident reporting system fulfils these requirements, and patient safety incident reports are checked by the Health and Safety Lead.

5.14.3 **NHS Estates**

The Trust is required to reports incidents relating to Fire, buildings, plant and non-medical equipment to NHS Estates.

Reporting can be done on line [http://nww.efm.ic.nhs.uk](http://nww.efm.ic.nhs.uk) and the paper reporting form can also be obtained from this site.

Managers dealing with such incidents must contact the Health and Safety Lead with all the relevant information to enable the Health and Safety Lead to complete the required report form.

5.14.4 **Medicines and Healthcare Products Regulatory Agency (MHRA)**

Any incident relating to medical equipment should be notified formally to the MHRA using the relevant form supplied by that office.

Managers in those areas affected can report directly to the MHRA.

Incidents relating to adverse drug reactions are reportable on the yellow forms. Reporting can be done electronically via [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk)

5.14.5 **NHS Litigation Authority (NHSLA)**

Incidents where there are likely to be civil claims require, where practicable, to be notified to the NHSLA as early as possible.

Managers should inform the Health and Safety Lead of such incidents supported by the submission of an Electronic Incident Form (IR1) to enable as much information to be gathered prior to reporting.

The Health and Safety Lead will liaise with the Claims Manager who will contact the NHSLA as appropriate.

5.14.6 **Environmental Health Office and Food Standards Agency**

Incidents relating to food will, in addition to being notified internally using the Electronic Incident Form (IR1) be notified to the Local Environmental Health Office of the Local Authority and the Food Standards Agency by the Catering Manager.

5.14.7 **Police**
Criminal incidents will, by their nature, be reported to the police. These may include assaults, actual or threatened, theft, vandalism, suspicious activity or deaths.

It is the responsibility of the person affected, or the manager on behalf of the Trust, to report the incident to the police via 101, or 999 if an emergency. If necessary the Safety Team can advise and assist a member of staff or manager to report.

An Electronic Incident Form (IR1) must be completed for all incidents reported to the police.

5.14.8 **NHS Improvement (was known as Monitor)**

NHS Improvement (Monitor) has a statutory duty to assess, authorise and regulate NHS Foundation Trusts.

NHS Improvement expect foundation trusts to notify them in writing of any incidents, events or reports that may reasonably be regarded as raising potential concerns over compliance with our licence.

Incidents of concern are highlighted to NHS Improvement by the Chief Executive Officer or Deputy Chief Executive on an ad-hoc basis.

5.14.9 **Care Quality Commission (CQC) – Mental Health Notifications**

The following must be reported directly to the CQC without delay:

- The death of a patient detained or liable to be detained under the Mental Health Act 1983. See Policy for the Management of Serious Incidents (SIs) and Policy for Service Users who are Absent Without Leave (AWOL).

- (Regulation 17 of the Care Quality Commission (Registration) Regulations 2009)

- The unauthorised absence of a patient detained or liable to be detained under the Mental Health Act 1983. See Policy for the Management of Serious Incidents (SIs) and Policy for Service Users who are Absent Without Leave (AWOL).

- (Regulation 17 of the Care Quality Commission (Registration) Regulations 2009)

- Any application and outcome made to a supervisory body in relation to depriving a service user of their liberty. See Deprivation of Liberty Safeguards Policy.

- (Regulation 18 of the Care Quality Commission (Registration) Regulations 2009)

- The admission of a child or young person to an adult psychiatric ward or unit. See Care and Treatment of Children under the age of 18 on Adult Acute Mental Health Inpatient Areas Policy.

For deaths and the admission of a child or young person to an adult psychiatric ward or unit, the Mental Health Act Manager is responsible for notifying the CQC.

For service users who are absent without leave, the Nurse in Charge is responsible for notifying the CQC. See Absent Without Leave Policy.
5.14.10 **Regulatory bodies for professionals**

Reporting to regulatory bodies for professionals including the:

- General Medical Council (GMC)
- Nursing and Midwifery Council (NMC)
- Health and Care Professions Council (HCPC)

are dealt with under the employment policies route by the Human Resources Department in conjunction with the relevant senior manager.

5.14.11 **National Clinical Assessment Service (NCAS)**

Referrals to the National Clinical Assessment Service (NCAS), whose role is to help resolve performance concerns about dentists, doctors and pharmacists, are dealt with under the employment policies route by the Human Resources Department in conjunction with the relevant senior manager.

5.14.12 **NHS England (via STEIS)**

Serious Incidents (SIs) are reported via the Strategic Executive Information System (STEIS). Reporting arrangements and responsibilities are set out within this policy.

5.14.13 **NHS Protect**

In accordance with Local Fraud Policy and Response Plan, incidents of fraud, corruption, security and violence and aggression against staff should be reported via the Local Counter Fraud Specialist. For further guidance see the Trust Fraud Policy and Response Plan.

The Local Security Management Specialist (LSMS) will report to NHS Protect any serious incidents involving physical assaults against staff using the SIRS.

5.14.14 **Information Commissioner**

Category 3 Information Governance Serious Incidents (SIs) are required to be reported to the Information Commissioner. For further guidance see the Checklist for Reporting, Managing and Investigating Information Governance Serious Incidents (DoH, 2010).

5.14.15 **Coroner’s Office**

There is a statutory duty on all healthcare personnel to report a death.

Deaths should be referred to the local coroner if there is reason to suspect that the deceased has:

- Died a violent or unnatural death (including accident or suicide)
- Died and the cause of death is unknown
- Died while in custody or otherwise in state detention e.g. Detained under the MHA or was subject to a Standard Authorisation under DoLS
- Died as a result of a medical mishap, etc. (this list is not exhaustive)
6. **TRAINING IMPLICATIONS**

Whilst there are no specific training needs identified in relation to this Incident Reporting policy, staff will be made aware of their individual responsibilities in the following ways:

- At Trust and local induction
- During Health and Safety and related training sessions
- Details of the policy review will be published in the Trust’s Weekly News Bulletin.
- Dissemination through Team/Ward meetings

The Training Needs Analysis for the Investigation of Incidents, Complaints and Claims can be found in the Training Needs Analysis document which is part of the Trust’s Mandatory Risk Management Training Policy located under policy section of the Trust website.

7. **MONITORING ARRANGEMENTS**

<table>
<thead>
<tr>
<th>Area for Monitoring/ Type of report</th>
<th>How</th>
<th>Who By</th>
<th>Reported to</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Reported Incidents</td>
<td>Report</td>
<td>Health and Safety Lead</td>
<td>Health, Safety and Security Forum</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Organisational Learning Forum</td>
<td></td>
</tr>
<tr>
<td>Unclosed Incident Reports</td>
<td>Report</td>
<td>Head of Health, Safety &amp; Security</td>
<td>Quality &amp; Safety Sub-Committee Assistant</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Directors</td>
<td></td>
</tr>
<tr>
<td>Themes and Trends of reported incidents</td>
<td>Report</td>
<td>Health and Safety Lead</td>
<td>Health, Safety and Security Forum</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Organisational Learning Forum</td>
<td></td>
</tr>
<tr>
<td>Specific incidents which provide learning for other areas of the Trust</td>
<td>Report and discussion</td>
<td>Relevant Division Representatives</td>
<td>Organisational Learning Forum</td>
<td>As required.</td>
</tr>
</tbody>
</table>

8. **EQUALITY IMPACT ASSESSMENT SCREENING**

The completed Equality Impact Assessment for the Policy for the Management of Serious Incidents will be published on the Equality and Diversity webpage of the RDaSH Website as follows: [Equality and Diversity Impact Assessment](#)
### 8.1 PRIVACY, DIGNITY AND RESPECT

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi's review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

| Indicate how this will be met | No issues have been identified in relation to this policy. |

### 8.2 MENTAL CAPACITY ACT

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court.

Therefore, the Trust is required to make sure that all staff working with individuals who use our service is familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

| Indicate How This Will Be Achieved. | All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1) |

### 9. LINKS TO ANY ASSOCIATED DOCUMENTS

- Absent Without Leave Policy – Clinical Policies
- Policy for the Investigation of Incidents, Complaints and Claims, including Analysis and Improvement – Corporate Policies
- Standard Operating Procedure for the Management of Information Governance Serious Incidents Requiring Investigation (IG SIRI) – Information Governance Policies
- Policy and Procedure for the Handling of Formal Complaints - Corporate Policies
- Claims Handling Policy - Financial Policies
- Being Open and Duty of Candour Policy: Communicating service user safety incidents with service users and their carers – Corporate policies
- Policy and Procedure for compliance with the management of Health and
Safety at Work Regulations 1999 and Health and Safety at Work action 1974 - Health and Safety policies

- Clinical Risk Assessment and Management Policy - Clinical policies, Clinical policies Section, Version 7.
- Policy for the Safe and Secure Handling of Medicines – Clinical Policies, Medicines Section, Policy number 3
- Risk Management Strategy – Trust Strategies
- Policy in Relation to the Trust Disciplinary Procedure – Employment Policies, Section B
- Policy on Supporting staff involved in a Traumatic/Stressful Incident, Complaint, or Claim – Employment Policies, Section B
- Disclosure of Concerns – Employment policies, Section B
- Safeguarding Children Policy, Clinical Policies, General Section, Policy number 29
- Safeguarding Adults Policy, Clinical Policies, General Section, Policy number 28

10. REFERENCES

- Care Quality Commission (2015) Guidance for providers on meeting the regulations
- Serious Incident Framework March 2015
- NPSA (2009) Being open – Communicating patient safety incidents with patients and their carers
- Dangerous Drugs, England and Scotland - Instrument No. 3148 The Controlled Drugs (Supervision of Management and Use) Regulations 2006

11. APPENDICES

Appendix A: Definitions and Guidance on Incident Types
Appendix B: Incident Reporting Flowchart
DEFINITIONS AND GUIDANCE ON INCIDENT TYPES

ADVERSE HEALTH CARE EVENT
The NRLS defines an Adverse Event as any event or circumstance leading to unintentional harm or suffering.

DESIGNATED INCIDENT MANAGERS
Designated Incident Managers are those staff that have been designated by the Division/Directorate Assistant Director to manage and complete the Managers Section of the IR1 incident form within their area of responsibility. These Incident Managers will have the responsibility for completing the necessary tasks to ensure appropriate investigation and learning from incidents.

HEALTH CARE NEAR MISS
A situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient.

HSE
Health and Safety Executive

ILL HEALTH
Any case of known or suspected work or environment related ill health (e.g. infection, headaches, dermatitis, etc.)

INCIDENT
An incident is described as:
“any event which has given rise to potential or actual harm or injury, to patient dissatisfaction or to damage/ loss of property” (Ref: NHS Executive).
This definition includes patient/ service user injury, fire, theft, vandalism, assault and employee accident and near misses.
It includes incidents resulting from negligent acts, deliberate or unforeseen.
Also an unplanned or unexpected event in which a member of staff/contractor or the public has been, or could have been injured, killed, or suffer mental trauma, or led to loss or damage to equipment or property, or other financial loss.

IR1 FORM
This is the electronic form on which incidents are reported and where the outcomes of the Managers actions are recorded, and to which relevant documents can be attached.

NEAR MISS
Any incident where under slightly different circumstances significant injury or loss could have occurred.
OTHER INCIDENT

This type of incident should be marginal in number and might include accidental property damage or loss, environmental incidents (e.g. accidental discharge to drains or the atmosphere), food safety/hygiene incidents, etc.

PATIENT SAFETY INCIDENT

The NRLS defines a patient safety incident as ‘any unintended or unexpected incident that could have harmed or did lead to harm for one or more patients receiving healthcare.’ It is a specific type of adverse event. This definition includes errors in treatment or care which did not harm patients (e.g. treatment error, medical equipment failure, drug error, needle stick or sharps etc.)

PERSONAL ACCIDENT

Any accident, no matter how small, which did or could have adversely, affected any person. This does not include any incident caused deliberately (e.g. by act of violence or by fire) but would include road traffic incidents.

RIDDOR

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

SAFEGUARD INCIDENT REPORTING SYSTEM (IR1 SYSTEM)

Risk Management software utilised by the Trust to record and manage all adverse events.

SECURITY, THEFT, LOSS OR DAMAGE INCIDENT

Any untoward incident involving theft, loss or other damage to organisation or personal property, intrusions, false alarms, absconded patients and other security incidents (but not fire alarms)

SERIOUS INCIDENT (SI)

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified

VIOLENT INCIDENTS

The following definitions are those provided by the NHS Protect and will be applied within this Trust:

Physical assault

This is the intentional application of force to another without lawful justification, resulting in physical injury or personal discomfort.

Verbal/Non-physical assault

The use of inappropriate words or behaviour causing distress to an individual and/or constituting harassment
INCIDENT REPORTING FLOW CHART

1. **INCIDENT**
   - Manage incident safely
   - Comply with ‘Being Open’
   - Complete IR1 and report significant incidents to Manager (Band 7 or above)

2. **Department / Service Manager (Band 7 or above)**
   - Examines and moderates the incident report to ensure it reflects the correct level of risk and harm

3. **Subject Matter Expert** (notified automatically)
   - Examines the Incident report and provides support and advice to the department / service manager

4. **Corporate Patient Safety Team**
   - Ensure report has the correct categorisation and liaise with the Department / Service Manager if required

5. **IS THE DUTY OF CANDOUR TRIGGERED?**
   - NO
   - IS IT A SERIOUS INCIDENT OR NEVER EVENT?
     - NO
     - Investigate incident appropriately
     - Close the Incident on the IR1
   - YES
     - Close the Incident on the IR1 form, stating that the incident is subject to an SI investigation

6. **NOTE:** Not all Serious Incidents will trigger the Duty of Candour.

7. **IS THIS A SERIOUS INCIDENT OR NEVER EVENT?**
   - NO
     - Investigate incident appropriately for a Duty of Candour triggering incident.
     - Provide the Relevant Person with a copy of the Duty of Candour Report
     - Record all actions and upload all papers on to the Safeguard system
   - YES
     - Comply with the Serious Incident Policy, in particular:
       - Assess seriousness of incident
       - Carry out an investigation

8. **Comply with the Serious Incident Policy**

9. **ALL LESSONS LEARNT FROM INCIDENTS SHOULD BE SHARED TO PREVENT REOCCURRENCE**

10. **RELEVANT PERSON** means the patient or a person lawfully acting on their behalf if the patient is deceased or lacks capacity

**COLOUR KEY**
- DECISION BOX
- SI SECTION
- NORMAL SECTION
- REPORTERS SECTION
- MANAGERS SECTION
- DOC SECTION