# Incident Reporting & Management Policy and Procedure v6.0

**Policy Statement:**
This policy describes the Trust's approach to incident reporting, management and investigation. It defines the types of incidents that may occur and describes the derivation of incident grade.

**Key Points**

- What and why to report
- Guidance for staff and managers in the management of an incident
- Reporting Requirements
- Timeframes

**Paper Copies of this Document**

- If you are reading a printed copy of this document you should check the Trust's Policy website (**http://sharepoint/policies**) to ensure that you are using the most current version.

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|---|---|
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# Meta Data

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## Revision History

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| 1.1 | Review | July 2008 | Healthcare Governance | Review to ensure compliance with practice and healthcare standards | Policy reviewed and updated |
| 2.0 | Review | October 2008 | Healthcare Governance | Review to ensure compliance with practice and NHSLA requirements | Policy reviewed and updated |
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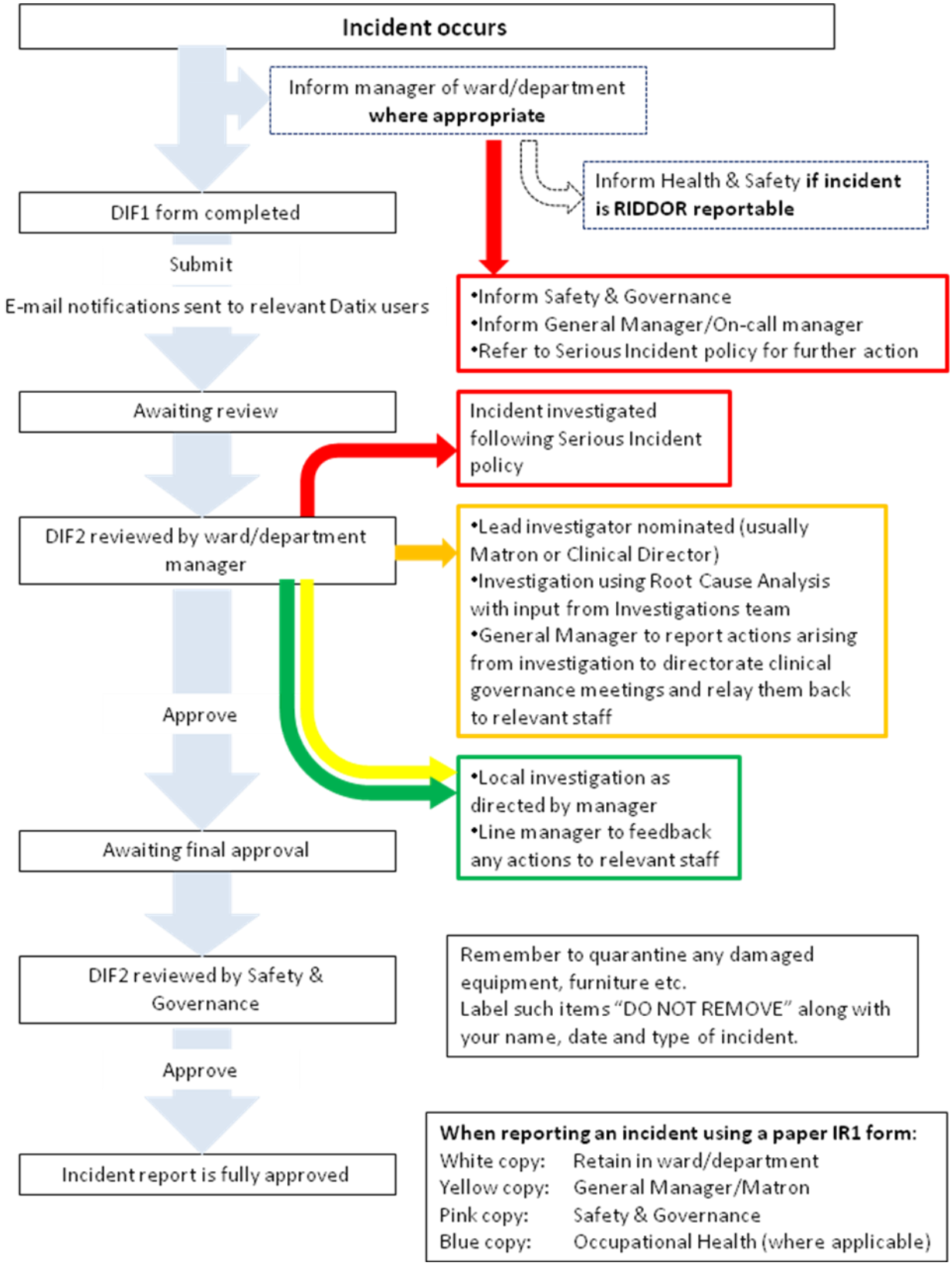
## Process for Reporting an Incident



## 1 Circulation

This Policy applies to all staff in a permanent, temporary, voluntary or contractor role acting for or on behalf of HEFT.

## 2 Scope

**Includes**

- This policy describes the Trust's approach to incident reporting and management. It defines the types of incidents that may occur and clarifies the process of reporting and classification of incident grading.

- This document provides the framework for the management of incidents which all members of staff must follow if they occur on Trust property or as a result of any work activity conducted by or on behalf of the Trust.

**Excludes**

- This policy and the procedure excludes the management of incidents that are deemed to be Serious Untoward Incidents or Major Incidents. For information on these incidents, please refer to the Serious Untoward Incident Policy and the Major Incident Plan which can be found on the Trust Intranet.

## 3 Definitions

An Incident is defined as an untoward event which causes or has the potential to cause any of the following:

- Harm to an individual
- Financial loss to an individual or the Trust
- Damage to the property of an individual or the Trust
- Disruption to services provided by the Trust
- Damage to the reputation of the Trust

This definition also encompasses all prevented incidents i.e. where none of the above occurred either by good fortune or due to the intervention of staff. These can also be referred to as 'near miss' incidents.

## 4 Reason for development

Heart of England NHS Foundation Trust recognises the importance of reporting all accidents and incidents as an integral part of its risk identification and risk management strategy. The Trust is committed to ensuring the safety of everyone who uses its healthcare services, to improving the quality of care to patients and the safety of staff and members of the public, through the consistent monitoring and review of incidents which result, or had the potential to result in injury, damage or other loss.

The investigation of an incident forms part of a wider strategy for risk management, which advocates the use of root cause analysis to understand why an incident has occurred. The emphasis is upon critical exploration of the underlying and contributory factors which, if allowed to persist, could create the potential for the same error to be repeated again. Organisational learning and remedial action must be at the heart of any risk management approach and the reporting of all incidents is a key factor in enabling this.

The Trust, in its approach to incident investigation, aims to develop a non punitive culture, so long as there has been no flagrant disregard of the Trust Policies, fraud or gross misconduct. It is therefore essential that this policy be read in conjunction with the other linked policies stated in the Meta Data at the beginning of this document.

## 5 Aims and Objectives

- To provide staff with an agreed method of reporting, investigation and management of incidents and development of action plans, where appropriate.
- To ensure that each department, and the Trust as a whole, has accurate information on incidents so that trends can be identified, learning from events takes place and steps taken to prevent similar incidents from occurring in the future.
- Where appropriate, to support the investigation of complaints and provide evidence in pursuance of litigation claims, both for and against the Trust.
- To identify all losses including those for which the Trust has insurance cover.

## 6 Standards

### 6.1 General

In the event of an incident occurring staff will:

Reporting

- Complete an online incident report form, or an IR1 form in the event of the online system being unavailable.
- Include details of the remedial actions taken on the incident form.
- Document, on the incident form, events from the time the incident occurs to ensure that details surrounding the incident are accurate.

Management

- Take appropriate remedial actions at the time of the incident to prevent further harm to the patient, member of staff or to the general public.
- Carry out incident investigations according to the severity of the event **(Attachment 4a)** to identify any deficiencies in care (which may include Root Cause Analysis) to learn lessons from these for the benefit of future patients.

### 6.2 Who Should Report Incidents

Any person who is employed by the Trust on a permanent or temporary basis may complete an incident form. Ideally the person who was directly involved in the incident should complete the incident form as soon as possible after the event. Where this is not possible a witness or supervisor may complete the form.

### 6.3 Process for staff who wish to raise concerns

Staff have a right, and a duty, to raise with their employer any matters of concern they may have about health service issues associated with the organisation and delivery of care.

The Trust Whistle Blowing Policy and procedure should be used by any Trust employee who wishes to express concerns about malpractice/wrongdoing. Any related incidents should be reported in the usual way. If a member of staff is aggrieved about their personal position, they should refer to the Trust Grievance Procedure.

## 6.4 Process for reporting to external agencies

The Trust has a statutory duty to report certain kinds of accidents, violent incidents, dangerous occurrences and occupational ill health under the Health and Safety at Work Act 1974 and in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.
It is also a requirement to report certain incidents to other national organisations, as outlined below:

| Organisation | Responsible | Frequency |
|---|---|---|
| HSE | Health and Safety Manager | As appropriate, but within 10 days of the incident occuring |
| NPSA | Governance Information Manager | Weekly |
| MRHA | Medical Devices Manager | As appropriate |
| NHS Protect | Local Security Management Specialist | As appropriate |

The following process is to be followed:

1. Incident is reported via Trust incident reporting system
2. Relevant manager (as per table ablove) is notified of the incident
3. Relevant manager (as outlined in table above) is responsible for informing the relevant agency as per external agencies own notification arrangements

## 6.5 Process for following up action plans

Formal action plans, as a result of incidents, will not always be required. If action plans are developed they must be monitored by the Directorate (ward or department manager) to ensure the actions are implemented and minimise the potential of reoccurrence **(Attachment 4b).** Action plans for some incidents (where the case is the subject of a high profile coroners inquest or the incident is graded as red) will be followed up by the Safety and Governance Directorate.

## 6.6 Learning

Where an incident has occurred it is incumbent upon the Trust to learn lessons that minimise the risk of similar incidents taking place. As a minimum safety lessons will be communicated both internally and externally as follows:

<u>Internally</u>
- Direct feedback to ward staff from the local manager
- Safety lessons will be included on quarterly Directorate Governance Reports
- Closedown reports for red incidents will be available on the Trust's intranet site.

<u>Externally</u>
- The outcome of red/SUI investigations will be fed back to patients and their relatives
- The outcome of red/SUI investigations will be fed back to Commissioners
- Safety Sit Rep (with safety lessons) will be presented to Clinical Quality Review Group
- Safety lessons will be included in the Safety and Governance Annual Report.

# 7 Roles and Responsibilities

## 7.1 Individual Responsibilities

### 7.1.1 All Staff

- To report, where appropriate, any accident or incidents to their line manager or to the person in charge of the ward/department at the time (including First On-Call out of hours).
- If an incident relates directly to the performance of a colleague, staff should also consider implementing the Trust's Whistle Blowing Policy, which is available on the Trust Intranet.
- To assist in the investigation of any incident (e.g. providing witness statements **Attachment 6**).

### 7.1.2 Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to report and manage incidents. The Chief Executive delegates responsibility for the Trust's governance arrangements to the Director of Safety & Governance.

### 7.1.3 Director of Safety & Governance

The Director of Safety & Governance is responsible to the Trust Board and Chief Executive in relation to Incident management and will provide regular reports to the Trust Board in this regard. He / she is also responsible for providing expert advice to the Trust in relation to Incident investigation and management.

### 7.1.4 Director of Medical Safety

The Director of Medical Safety has a particular role in supporting the Trust to understand and act upon clinical risk management and safety information and is also responsible for the provision of internal clinical advice in relation to risk and incident management.

### 7.1.5 Directorate Management Team (Clinical Director, Matron and General Manager)

- To inform the Safety & Governance Directorate immediately by telephone of any incidents whose grade, following an initial assessment, is red. To undertake an investigation into orange incidents utilising root cause analysis (RCA) and, where appropriate, the gaining of witness statements.
- To produce an action plan outlining the required actions to be implemented to ensure lessons are learned
- To provide the Investigations Team with the investigation paperwork, which should include the RCA, action plan, statements and any correspondence with the patient / family.
- To manage any red status incidents in line with the Trust's Serious Untoward Incident (SUI) policy and be involved with the investigation of red incidents.
- To feedback the outcome of investigations to directorate staff as appropriate.
- Ensure that staff receive appropriate support in line with the Supporting Staff policy
- Ensure that the patients, relatives or carers are informed about the incident in a timely manner in accordance with the Trust's Being Open Policy.

- To formally monitor, at Directorate meetings, action plans produced as a result of incident investigations.
- To ensure that any actions, highlighted as a result of an incident investigation and which cannot be completed, are placed on the Directorate Risk Register.

### 7.1.6 Ward/Department Manager

- To review all online incident report forms including their grades and to take appropriate remedial action, where possible, to prevent a future occurrence.
- Where appropriate, feedback the investigation outcome/preventive actions to staff.
- Immediately inform member of the directorate management team of any incident graded red.
- Immediately inform any members of staff from other departments who need to be aware of the incident.
- Document remedial action on the incident report to complete the approval process.
- Ensure that staff are provided with appropriate support, in line with the Supporting Staff policy.
- Ensure that the patients relatives or carers are informed about the incident, where appropriate, in a timely manner in accordance with the Trust's Being Open policy
- To inform the Health & Safety Manager within 24 hours of the incident (see flowchart) occurring to enable the prompt reporting to the Health and Safety Executive if an incident is RIDDOR reportable

Details relating to RIDDOR reportable incidents are included in **Attachment 3**.

### 7.1.7 Safety and Governance Directorate

- To establish and maintain an appropriate infrastructure for the management of incident reporting and investigation.
- To provide training and advice to all staff in the reporting, investigating and classification of incidents.
- To provide advice to directorate staff regarding the investigation of orange and red incidents.
- To report all relevant accidents and dangerous occurrences to the Health and Safety Executive and to ensure that appropriate remedial action is taken to prevent recurrence.
- Ensure that all incident documentation received from directorates is uploaded onto the Datix risk management database.
- To provide regular reports on Incident data in line with this policy (Attachment 4).
- To signpost staff to support mechanisms for staff involved in incidents, and those involved in the Being Open process.
- To review coding and grading of all incident reports received and to finally approve online incident reports once reviewed by ward/departmental managers.
- To notify the Director of Safety & Governance and the Director of Medical Safety of all serious untoward incidents.
- Where appropriate, to liaise with staff completing incident forms to gain further information.
- To upload patient safety incident data to the NPSA.

### 7.1.8 Senior Information Risk Owner (SIRO)

The SIRO will provide an essential role in ensuring that identified information security risks are followed up and incidents managed.

## 7.2 Board and Committee Responsibilities

### 7.2.1 Trust Board

The Trust Board is responsible for ensuring that appropriate systems are in place to enable the organisation to deliver its objectives in relation to this policy. It will delegate responsibility for the delivery of the policy to the Governance and Risk Committee.

### 7.2.2 Governance and Risk Committee

Governance and Risk Committee are responsible for assuring the Trust Board that SUIs are being investigated using RCA and any resulting risks are being addressed appropriately.

They are also responsible for ensuring that trends in incidents are being reviewed and managed on a Trust wide basis.

# 8 Training

Awareness of the role of all staff in reporting incidents forms a part of the Trust's mandatory training programme and all staff are informed of their responsibilities through the Trust's Corporate Induction process.

In addition the Safety & Governance Directorate will ensure provision of training as required to managers, supervisors and staff, to enable them to carry out their duties and responsibilities relating to incident management. For details of this please contact the Safety & Governance Directorate.

An online Root Cause Analysis training package is available to Staff at the link below:
http://sharepointap/governance/SitePages/Training.aspx

# 9 Analysis

In order that the Trust is able to identify emerging safety themes, an aggregated report (Safety Situation Report or SITREP) that includes data from incidents, complaints and claims will be produced on a quarterly basis. The Safety and Governance Directorate will be responsible for producing the SITREP and disseminating it to the following committees:

- Governance and Risk Committee (Trust Board level committee who will review themes and request further action as required)
- Clinical Quality Review Group (Commissioners and Trust Committee for information and assurance).

Reporting will occur 3 times a year as a minimum. The minimum requirements for reporting aggregated data in SITREP will consist of the following:

- Top 5 category themes for incidents, complaints and claims for the quarter being reported.
- Top 5 SUI themes for a 6 month period.
- Trust actions in response to identified themes.
- Quantitative analysis of incidents, complaints and claims by Trust site for the preceding 12 months.

The contents and frequency of aggregated reports provided to Committees will be subject to an annual review by the Safety & Governance directorate, to ensure the minimum reporting requirements are met.

## 10 Improvement

The Trust is committed to ensuring local and organisational learning from aggregated data of incidents, complaints and claims by producing and disseminating regular reports as described above.

The Trust will share safety lessons from the aggregated report across the local health economy with the Clinical Quality Review Group (via the SITREP report).

Governance and Risk Committee will review actions arising from the aggregated report to ensure lessons learnt make changes in organisational culture or practice. Progress against identified actions will be monitored by the Committee to ensure the implementation of risk reduction measures.

Where new risks are identified as a result of the aggregated report, they will be managed in line with the Trust Risk Management strategy and policy.

## 11 Monitoring and Compliance

| Criteria | Monitoring Mechanism | Responsible | Committee | Frequency |
|---|---|---|---|---|
| a)Duties | 'Being Open' audit of 25 relevant cases (5 from each clinical group) | Senior Investigations Manager | Quality & Safety Committee | Annual |
| b)process for reporting all incidents / near misses involving staff, patients and others | Incident volumes reported via Safety Metrics report. Incident trends reported via SITREP.<br><br>Actions identified to improve compliance as appropriate. | Governance Information Manager | Governance and Risk | Bi-monthly |
| c)process for reporting to external agencies | **NRLS**<br>6 monthly feedback report and upload history.<br>**HSE**<br>RIDDOR reports<br>**SIRS**<br>Upload history.<br>**MHRA**<br>Reports to MHRA.<br><br>and<br><br>To be included in the 'Being Open' audit as outlined above | **NRLS**<br>Governance Information Manager<br>**HSE**<br>Health & Safety Manager<br>**SIRS**<br>Local Security Management Specialist<br>**MHRA**<br>Medical Devices Manager | Safety Committee / Governance and Risk Committee<br><br>Quality and Safety Committee | Annual |
| d)reference to the processes for staff to raise concerns, e.g. whistle blowing / open disclosure | Whistle blowing and grievance monitoring tools | HR Director | HR Committee | Annual |
| e)different levels of investigation appropriate to the severity of the event(s) | Ongoing review of incident grading. | Governance Information Manager and Head of Governance and Safety Improvement | None | Ongoing |
| f)process for involving and communicating with internal and external stakeholders to share safety lessons | Annual review. To be included in the *Learning to be Safer Programme* | Head of Governance and Safety Improvement | None | Annual |
| g)process for following up relevant action plans | Action status report | Safety and Governance | Group Quality and Safety Committees | Bi-monthly |

In addition to the monitoring of the above citeria, the Trust will also monitor compliance with the mandatory training requirement detailed in section 8 of this policy. Please refer to the Trust's Mandatory Training Policy for further details.

## 12 Attachments

1: Process for reporting an incident
2: Incident grading
3: Details of RIDDOR reportable incidents
4: Minimum reporting requirements for incident data
5: Procedure for managing an incident
6: RCA tool
7: Guidance for staff in preparing statements
8: Procedure for the reporting and investigation of inappropriate access to electronic patient records
9: Equality and diversity – policy screening checklist

## 12.1 Attachment 1: Process for reporting an incident

All incidents, whether clinical or non-clinical must be reported to the Trust's Safety & Governance Directorate, using the DatixWeb online reporting form. This document is called a Datix Incident Form (DIF1). Staff are required to input the incident details on the DIF1 form. The incident report will then be quality assured by the ward/department manager or senior manager designated for this purpose, who will add extra further details to the incident report.

All incidents graded red will be alerted to senior managers via email, who can confirm whether it is a red incident and instigate the Serious Untoward Incident policy if appropriate. Guidance on how to complete the form is available on the Trust intranet and from the Safety & Governance Directorate.

**In the event of a failure of the online system, or in areas where the intranet unavailable or access is limited,** staff may report incidents by completing an IR1 form. Books of forms are held in each Ward/Unit/Department/Directorate in the Trust. All sections of the form should be completed as fully as possible. If appropriate, additional sheets with further information should be attached to the incident report form with either the patient ID number / staff name recorded on each additional sheet. The patient ID number or staff name should be recorded.

IR1 Forms are carbonated with 3 copies attached. One copy should remain in the department or ward, the second copy should be sent to the appropriate General Manager, or senior manager designated for this purpose, the third copy should be sent to the Safety & Governance Department. Where appropriate, a copy should also be sent to Occupational Health. Further details and guidance are contained on the relevant forms.

## 12.2 Attachment 2: Incident Grading

The classification of incidents can be scored using a simple risk matrix. The matrix used by the Trust has been adapted from an International Risk Management Standard (Australian Standard / New Zealand Standard 4360:1999) and recognised by the National Patient Safety Agency.

All incidents will be graded in order to determine the actions to be taken at Directorate and Trust level. The grading of the incident is determined by two factors:

- The **actual** consequence, outcome or severity of the incident
- The probability or likelihood of the incident occurring/reoccurring.

Both of these factors can be assigned a numerical score ranging 1 – 5. A detailed description of the numerical scoring is illustrated in table 1 and 2.

### Determining Consequence

**Table 1: Measure of Consequence / Incident Severity**

| Level | Descriptor | Description |
|---|---|---|
| 1 | Insignificant | No injury or adverse outcome |
| 2 | Minor | Short term injury/damage (e.g. resolves in a month); a number of people are involved |
| 3 | Moderate | Semi permanent injury (e.g. takes up to year to resolve) |
| 4 | Major | Permanent injury; major defects in plant, equipment, drugs or devices; the incident or individual involved may have a high media profile |
| 5 | Catastrophic | Death |

### Determining Likelihood

**Table 2: Measurement of Likelihood**

| Level | Descriptor | Description |
|---|---|---|
| 1 | Rare | The incident may occur only in exceptional circumstances |
| 2 | Unlikely | The incident is not expected to happen but may occur in some circumstances |
| 3 | Possible | The incident may happen occasionally |
| 4 | Likely | The incident is likely to occur, but is not a persistent issue |
| 5 | Almost Certain | The incident will probably occur on many occasions and is a persistent issue |

### Determining Incident Grading

Once the consequence and likelihood of an incident has been identified the grade of the incident must be determined utilising the risk quantification matrix (table 3, below). The grade of the incident is calculated by multiplying the consequence score by the likelihood score. This is done automatically on the online form once the consequence and likelihood have been entered. All incidents must be graded as soon as possible after an incident has occurred.

**Table 3: Grading Matrix**

| | CONSEQUENCE SCORE | | | | |
|---|---|---|---|---|---|
| **LIKELIHOOD SCORE** | **1 Insignificant** | **2 Minor** | **3 Moderate** | **4 Major** | **5 Catastrophic** |
| **1 – Rare** | 1 | 2 | 3 | 4 | 5 |
| **2 – Unlikely** | 2 | 4 | 6 | 8 | 10 |
| **3 – Possible** | 3 | 6 | 9 | 12 | 15 |
| **4 – Likely** | 4 | 8 | 12 | 16 | 20 |
| **5 – Certain** | 5 | 10 | 15 | 20 | 25 |

The incident score will be graded as a colour, as shown in the grading matrix, Incident scores above 15 are graded as Red incidents and are potential Serious Untoward Incidents.

**Consequence X Likelihood = Incident Score**

| | |
|---|---|
| **1 – 3** | Low |
| **4 - 8** | Moderate |
| **9 – 14** | Significant |
| **15 – 25** | High |

## 12.3 Attachment 3: Details of RIDDOR reportable incidents

**Death or major injury**
If there is an accident connected with work **and**:

- an employee, or a self-employed person working on Trust premises is killed or suffers a major injury (including as a result of physical violence); or
- a member of the public is killed or taken to hospital;
- you must notify the Health and Safety Manager and the Director of Governance & Standards without delay.

**Reportable major injuries are:**

- fracture other than to fingers, thumbs or toes;
- amputation;
- dislocation of the shoulder, hip, knee or spine;
- loss of sight (temporary or permanent);
- chemical or hot metal burn to the eye or any penetrating injury to the eye;
- injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
- any other injury: leading to hypothermia, heat-induced illness or unconsciousness; or requiring resuscitation; or requiring admittance to hospital for more than 24 hours;
- unconsciousness caused by asphyxia or exposure to harmful substance or biological agent;
- acute illness requiring medical treatment, or loss of consciousness arising from absorption of any substance by inhalation, ingestion or through the skin;
- acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material.

**Over-three-day injury**
If there is an accident connected with work (including an act of physical violence) and an employee, or a self-employed person working on your premises, suffers an over-three-day injury you must report it to the Health and Safety Manager in Healthcare Governance and Occupational Health department immediately.

An over-3-day injury is one which is not "major" but results in the injured person being away from work OR unable to do their full range of their normal duties for more than three days.

**Disease**
If a doctor notifies you that an employee suffers from a reportable work-related disease then you must report it to the Health and Safety Manager in Healthcare Governance immediately.

Reportable diseases include:

- certain poisonings;
- some skin diseases such as occupational dermatitis, skin cancer, chrome ulcer, oil folliculitis/acne;
- lung diseases including: occupational asthma, farmer's lung, pneumoconiosis, asbestosis, mesothelioma;
- infections such as: leptospirosis; hepatitis; tuberculosis; anthrax; legionellosis and tetanus;
- other conditions such as: occupational cancer; certain musculoskeletal disorders; decompression illness and hand-arm vibration syndrome.

**Dangerous occurrence**
If something happens which does not result in a reportable injury, but which clearly could have done, then it may be a dangerous occurrence which must be reported immediately to the Health and Safety manager in Healthcare Governance.

Reportable dangerous occurrences are:
1. collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
2. explosion, collapse or bursting of any closed vessel or associated pipework;
3. failure of any freight container in any of its load-bearing parts;
4. plant or equipment coming into contact with overhead power lines;
5. electrical short circuit or overload causing fire or explosion;
6. any unintentional explosion, misfire, failure of demolition to cause the intended collapse, projection of material beyond a site boundary, injury caused by an explosion;
7. accidental release of a biological agent likely to cause severe human illness;
8. failure of industrial radiography or irradiation equipment to de-energise or return to its safe position after the intended exposure period;
9. malfunction of breathing apparatus while in use or during testing immediately before use;
10. Failure or endangering of diving equipment, the trapping of a diver, an explosion near a diver, or an uncontrolled ascent;
11. Collapse or partial collapse of a scaffold over five metres high, or erected near water where there could be a risk of drowning after a fall;
12. Unintended collision of a train with any vehicle;
13. Dangerous occurrence at a well (other than a water well);
14. Dangerous occurrence at a pipeline;
15. Failure of any load-bearing fairground equipment, or derailment or unintended collision of cars or trains;
16. A road tanker carrying a dangerous substance overturns, suffers serious damage, catches fire or the substance is released;
17. A dangerous substance being conveyed by road is involved in a fire or released;
18. The following dangerous occurrences are reportable except in relation to offshore workplaces: unintended collapse of: any building or structure under construction, alteration or demolition where over five tonnes of material falls; a wall or floor in a place of work; any false-work;
19. Explosion or fire causing suspension of normal work for over 24 hours;
20. sudden, uncontrolled release in a building of: 100 kg or more of flammable liquid; 10 kg of flammable liquid above its boiling point; 10 kg or more of flammable gas; or of 500 kg of these substances if the release is in the open air;
21. Accidental release of any substance which may damage health.

## 12.4 Attachment 4: Procedure for management and investigation of an incident

The stages of incident management include investigation, analysis & reporting, follow-up, monitoring of actions and feedback to staff. Not all of these steps will apply to each incident.

Each category of incident (green, yellow, orange and red) will require specific action by the individual(s) involved in the incident, the Ward/Departmental Manager, the Directorate Manager / Senior Manager. In general:

- Green and yellow status incidents will be investigated and managed locally and require local remedial action by the ward and department concerned.
- Orange status incidents will be investigated, within the Directorate, utilising root cause analysis tools.
- Red status incidents will be investigated in line with the Serious Untoward Incident Policy.

### a) Investigation, Analysis and Reporting

***Green and Yellow Status Incidents***
Certain green status incidents will require further local investigation and may result in the development of an action plan. A summary of this investigation and any resultant action should be documented on the datix record. Staff should inform the General Manager as appropriate.

***Orange Status Incidents***
Once an incident has been finally approved as orange, a formal investigation using root cause analysis (RCA) must be undertaken. An RCA tool is available at appendix 7. The Ward Manager should begin by obtaining statements from all the staff involved in the incident and ensuring the Matron, General Manager and Clinical Director are aware of the incident and current actions.

When an incident is finally approved as orange, a member of the Investigations Team will formally request a root cause analysis and action plan from the Matron or Clinical Director within 20 days, who must ensure the incident is fully investigated. They must also instigate the Being Open process (please see the Being Open Policy for further details).

Upon completion of the investigation and Being Open process, the Matron or Clinical Director must forward the investigation paperwork (i.e. the completed RCA, action plan, statements, correspondence etc) to the Investigations Team who will store the documentation in line with the relevant retention dates. This will also help to inform potential future complaints, claims or an inquest in relation to the incident.

For further advice on how to investigate incidents or on the Being Open process, please contact a member of the investigations team.

For orange status incidents, the ward manager should also seek advice from an expert advisor, where appropriate. For example, in the case of a tissue viability incident contact the Tissue Viability nurse.

***Red Status Incidents***
All red incidents should be managed in line with the Trust's Serious Untoward Incident (SUI) Policy which can be found on the Trust Intranet.

### b) Follow up of Actions arising from all Incidents

For all incidents it is the responsibility of line managers to:

- Feedback to the individual(s) concerned, and any other staff who may have been affected by the incident, any action taken as a result of the incident or, where action cannot be taken, to feedback the reasons why this is so. Feedback, where appropriate, may be undertaken by a senior manager and may include representation from the Safety & Governance Directorate.
- Communicate any action resulting in changes affecting other individuals, or reasons for non-action, within the local ward / department.
- Ensure staff affected are made aware of and offered the opportunity to access appropriate support in line with the Supporting Staff policy
- Ensure that where incident follow up has identified a risk that cannot be resolved locally, that this is recorded and managed in accordance with the Trust Risk Management Policy (available on the Trust Intranet).

Formal action plans, as a result of incidents, will not always be required for low risk (green incidents) and where appropriate local and immediate actions may be recorded on the incident report form or other suitable record. Any follow up action will be the responsibility of the ward or department manager and will be monitored for progress at a local level. However if action plans are developed they must be monitored by the Directorate to ensure the actions are implemented and minimise the potential of reoccurrence.

The development of a simple action plan to prevent recurrence of the incident (where possible) is expected as a result of yellow status incidents. Where appropriate, these must be monitored by the Directorate to ensure the actions are implemented.

Action plans developed as a result of the root cause analysis investigation into an orange status incident will be reviewed by the Directorate to ensure that the agreed actions occur. The action plan should contain clear detail of what action is required, together with timescales and the name of the person responsible for the action. These must be monitored by the Directorate to ensure the actions are implemented.

For Red incidents the Group Medical Director and Executive Lead will take overall responsibility for ensuring implementation and monitoring of action plans through to completion by an appropriate committee. To support this the Safety and Governance Directorate will collect evidence and arrange for the final sign off of the action plan in line with the Trust's Serious Untoward Incident (SUI) Policy.

**Management Action**

| Incident Classification | Risk | Action |
|---|---|---|
| Green | Low | Manage locally – e.g. ward manager |
| Yellow | Medium | Manage locally – e.g. ward manager |
| Orange | Significant | Senior manager / clinical director / matron to lead |
| Red | Serious | Contact Safety & Governance to lead – e.g. Director of Medical Safety |

## 12.5 Attachment 5: Trust RCA Tool

### Root Cause Analysis

Root Cause Analysis is an investigative tool used to understand why an incident has occurred. RCA emphasises the critical exploration of underlying and contributory factors. The Trust has developed a Root Cause Analysis tool for the investigation of claims, complaints and incidents in line with NPSA guidelines.

### Purpose

The Trust has a statutory duty to report certain kinds of accidents, violent incidents, dangerous occurrences and occupational ill health under the Health and Safety at Work Etc Act 1974 and more specifically in accord with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995. It is also a requirement to report certain incidents to a national body (e.g. Medicines and Healthcare Regulatory Agency, NHS Estates, Department of Health, the Strategic Health Authority (St HA) and the National Patient Safety Agency (NPSA)) within a specific timeframe. Currently the timeframe for serious untoward incidents is 45 days.

### How to Complete This Document

1. This document is designed to be completed electronically.
2. Complete the right hand column for all sections relevant to the investigation.
3. Review the explanatory guidance text in the right hand column to understand the type of issues to consider and positively enter information. For example, in section 4, even if policies were followed and were in-date, state this otherwise there is no evidence that you have considered the possibility.
4. The examples given in the right hand column are not exhaustive but are provided as examples. Consider whether anything similar might be relevant to your particular incident investigation.
5. If you are unsure about any section, please contact the Risk Management Department on ext 42639 or 40285 for guidance.
6. Once you have entered your text into each section of the right hand column, delete the explanatory guidance.
7. Following completion of the RCA review any areas in which you have ticked “yes”. For each section with a “yes” you should consider an action to prevent or minimise the problem from recurring.

   In developing your actions consider the problem by way of the following hierarchy of controls, in order:

   1. **Eliminate**-can you eliminate the problem, for example stopping a high risk procedure altogether or not using a hazardous piece of equipment?
   2. **Substitute**-can you substitute the problem with something less harmful?. An example is the use of latex free gloves for staff allergic to latex
   3. **Isolate/distance**-can you isolate or distance the problem from people?
   4. **Safe Systems of Work**-can you create, or improve upon, safe operating procedures to minimise or eliminate the problem?
   5. **Training/knowledge/information/Supervision**-can you provide additional training or supervision to staff to minimise or eliminate the problem?

6. **Personal Protective equipment**-can you provide protective equipment to staff or patients to minimise harm to them. Examples include hip protectors for patients at risk of falls, eye protectors to prevent splash injuries, sharps boxes to prevent sharps injuries etc

7. For any actions identified, which cannot be managed locally, please document that these issues have been included in the Directorate Risk Register.

| | Questions | | Findings |
|---|---|---|---|
| **1** | Give a background history and description of the event | Issues to consider in this section include:<br>• The reason for the patient's admission (where the incident involves a patient)<br>• Relevant patient medical history including level of confusion, mobility etc (where the incident involves a patient)<br>• Where the incident involves a patient fall-the number of previous falls and details of falls risk assessments | |
| **2** | Confirm day, date, time of incident | | |
| **3** | Where did the incident occur? | | |
| **4** | Did deviation from current systems or processes contribute to the event? | Yes<br>No<br>(Delete as applicable) | Issues to consider in this section include:<br>• Whether any policies, procedures or protocols (or the lack of them) affected the incident. Were policies, procedures or protocols followed, out of date, ambiguous, unavailable? |
| **5** | Did staff actions contribute to the event? | Yes<br>No<br>(Delete as applicable) | Issues to consider in this section include:<br>• Staff motivation e.g. boredom, low job satisfaction<br>• Personality issues e.g.: low self confidence or overconfidence<br>• Domestic or lifestyle issues<br>• Physical ability, fatigue, stress, mental impairment due to illness, drugs, alcohol etc |
| **6** | Did inadequate staff training/skill contribute to the incident? | Yes<br>No<br>(Delete as applicable) | Issues to consider in this section include:<br>• The quality of any relevant training staff had undergone including local induction<br>• The level of experience of the staff<br>• Whether staff had adequate supervision and/or mentoring<br>• Had staff had refresher training to update themselves<br>• Were the staff subject to regular appraisal |
| **7** | Did inadequate staffing resources contribute directly to the incident? | Yes<br>No<br>(Delete as applicable) | Issues to consider in this section include:<br>• Skill mix<br>• Staff to patient ratio<br>• Use of agency/bank staff |

| | | | |
|---|---|---|---|
| **8** | Did poor communication or information contribute to the incident? | Yes<br>No<br>(Delete as applicable) | Issues to consider in this section include:<br>• Conflicting information, either verbally or within medical records etc<br>• Inaccurate information<br>• Poor communication due to language barriers, inappropriate medium (eg: email, fax etc)<br>• Relevant persons not included in communication<br>Poor/absent documentation within medical records |
| **9** | Did a malfunction or absence of equipment appear to contribute to the adverse event? | Yes<br>No<br>(Delete as applicable) | Issues to consider in this section include:<br>• Whether the equipment was subject to an up to date maintenance programme<br>• Whether the equipment was familiar to those using it and if they were competent to use it<br>• Whether a safety mechanism failed |
| **10** | Did controllable environment factors directly affect the outcome? | Yes<br>No<br>(Delete as applicable) | Examples might include water on the floor, a door that was locked preventing entry/exit, poor flooring, inadequate lighting, poor ventilation.<br><br>Has the area been subject to a risk assessment? If answering yes provide a copy. If answering no state why |
| **11** | Are there any uncontrollable external factors truly beyond the organisation's control? Give reasons why. | Yes<br>No<br>(Delete as applicable) | Examples might include an ambulance strike, a failure of BT systems rendering pagers inoperative etc |
| **12** | Are there any other factors that have directly influenced this outcome? | Yes<br>No<br>(Delete as applicable) | Please detail |

**Lead Investigator Name:** **Signature:**

**Designation**

**Date:**

## ACTION PLAN

| Action | Timescale | Person Responsible | Resource Implications | Local, Directorate or Trust wide | How will the completion of the action plan be measured? |
|---|---|---|---|---|---|
| Action point #1 | | | | | |
| Action point #2 | | | | | |
| Action point #3 | | | | | |
| Action point #4 | | | | | |
| Action point #5 | | | | | |

## 12.6 Attachment 6: Guidance for Staff in Preparing Statements

You should read the guide carefully before starting to prepare your statement. **Your statement is intended to be an accurate and factual account of your involvement in the care or treatment of the patient concerned.** For the main part it should be confined to facts you recall about the patient and your treatment, or facts which you are able to recall after refreshing your memory from entries made by you (or other staff) in the patient case notes.

1. Commence your statement by providing personal information such as: full name, business address, e.g. Department of Obstetrics & Gynaecology, Birmingham Heartlands Hospital and date of birth.

2. Set out your professional qualifications, which should include the year(s) obtained and an explanation of abbreviations, e.g. RN – Registered Nurse as well as your personal registration number. You should set out your current position and number of years in post and your position at the time of the incident. **Attach a copy of your curriculum vitae (if you have one).**

3. State whether you have an independent memory of the incident, patient or treatment, e.g. none, some or a good recollection and to what extent you are relying on refreshing your memory from the patient's records.

4. Now you should set out a detailed, chronological narrative (including dates and timings) of your involvement in the incident, which should be set out in paragraphs. If the incident involves a patient you should set out in detail each attendance on the patient including:

   - The history taken;
   - Examinations, referrals or advice taken from colleagues, any treatment ordered and administered, any advice or communications with the patient, GP or parents (if child) on discharge and any follow-up appointments made;
   - Any observations, test ordered and / or carried out and relevant findings, any diagnoses (including differential diagnoses);
   - Any referrals or advice taken from colleagues, any treatment ordered and administered, any advice or communications with the patient, GP or parents (if child) on discharge and any follow-up appointments made;
   - Time and recorded observations such as BP, pulse, temperature etc are extremely important, as are VE findings and CTG monitoring records in on obstetric cases.

   You should set out as much detail as possible for each attendance as even the most routine action can be critical or relevant.

5. Ask your line manager, supervising consultant, or a member of the Investigations team to review before submitting. If you wish, you can also ask your defence union to review.
6. Your statement may be used for a future complaint, claim or coroner's inquest. If you do not wish for your statement to be used for these purposes, you must express this on your form.

| | | |
|---|---|---|
| **Name of Patient Injured person (IP)** | | |
| **IPs Date of Birth** | | |
| **IPs PID No (if appropriate)** | | |
| **Date of Incident** | | |
| **Full Name of Person Providing Statement** | | |
| **Department you work in** | | |
| **Heart of England NHS Foundation Trust Site** | Heartlands | |
| | Solihull | |
| | Good Hope | |
| | Birmingham Chest Clinic | |
| | Other (please specify) | |
| | | |
| **GMC Number/Professional Registration Number** | | |
| **Professional Qualifications (including Year(s) obtained and an explanation of any abbreviations**<br><br>**Include Relevant Training / Experience** | | |
| **Current position and number of years in post** | | |
| **Your position at time of the incident** | | |
| **State whether you are writing the statement from independent memory of the incident alone or whether you have had access to the relevant medical records (see item 3 of guidance)** | | |

| **Chronological narrative of your involvement in the incident (as set out in item 4 of the guidance). Please include as much accurate detail as possible.** |
| --- |
| |

Statement of Truth:

I believe that the facts stated in this statement are true:

Signed (Full name) …….

Dated. …….

Contact Details …….

I agree to my statement being used for the purpose of a complaint, claim or inquest if instigated and relevant to this incident:

Signed (Full name) …….

Dated. …….

## 12.7 Attachment 7: Procedure for the Reporting and Investigation of Inappropriate Access to Electronic Patient Records

### 1. Introduction

Section 55 of the Data Protection Act 1998 discusses breach of the act and identifies the following as unlawful:

*A person must not knowingly or recklessly, without the permission of the data controller*

- *Obtain or disclose personal data or the information contained in personal data, or*
- *Procure the disclosure to another person of the information contained in personal data*

The Trust's solicitors have clarified this and explained that obtaining information should include inappropriate access to any records. Any breach should also be considered in relation to Common Law Code of Confidentiality and also Human Rights legislation that seeks to guarantee a private life.

The Trust is required to investigate all Incidents relating to inappropriate access to staff and patient information held on Trust I.T. systems. In doing this the Trust will attempt to identify the root cause of the incidents and address them to mitigate the risk of incidents reoccurring.

### 2. Aim

The purpose of this procedure is to outline the roles and responsibilities, of the Information Security Manager, HR Department and Information Governance Manager (IGM) in relation to the investigation and management of incidents relating to potential inappropriate access to electronic information by staff employed by the Trust.

The Management of incidents will follow a 3 step process

1. Report the Incident
2. Investigate the Incident
3. Resolve the Incident

### 3. Definition

Inappropriate access to a record is defined as:

*access undertaken for a purpose not in line with the specific duties of an individual member of staff or for the purpose for which the record is held*.

That means if accessing records does not form a legitimate part of your job then you should not do it and if you access a record then it should only be for the stated purpose for which that records is held i.e. a healthcare record should only be accessed for the purpose of healthcare.

### 4. Procedure

<u>Step 1. Reporting the Incident</u>

Incidents of suspected inappropriate access to electronic information should be reported according to the Trust's Incident Reporting Policy. This can either be online or using the IR1 form. The category of the incident should be "Governance", the sub category should be "Data

Protection/Confidentiality" and the grade of the incident should be "Orange". Reporting the incident is the trigger for this process to begin and anyone receiving verbal notification of potential inappropriate access should ensure that an incident report is completed.

Step 2. Investigating the Incident

The Trust's IGM will commence an investigation to ascertain if inappropriate access to records has taken place. After confirming the details of the incident the IGM will contact the Trust's Information Security Manager (or appropriate ICT staff) to confirm the details of the record access. This will include confirmation as to:

- what records were accessed
- who accessed the records,
- when the records were accessed,
- any amendments made to the record.

If access is not proven according to the incident report then the incident will be closed. If access is proven then the IGM will conduct an interview with the staff member concerned to establish whether or not access was appropriate.

If access is deemed appropriate then the incident will be closed.

If access is deemed inappropriate according to the definition included in this procedure then the IGM will proceed with the following:-

- Liaise with the appropriate HR consultant to determine whether a HR investigation and Governance investigation need to run in parallel(Reference NPSA [1]Incident decision tree);
- conduct further investigation to determine the root cause of the incident

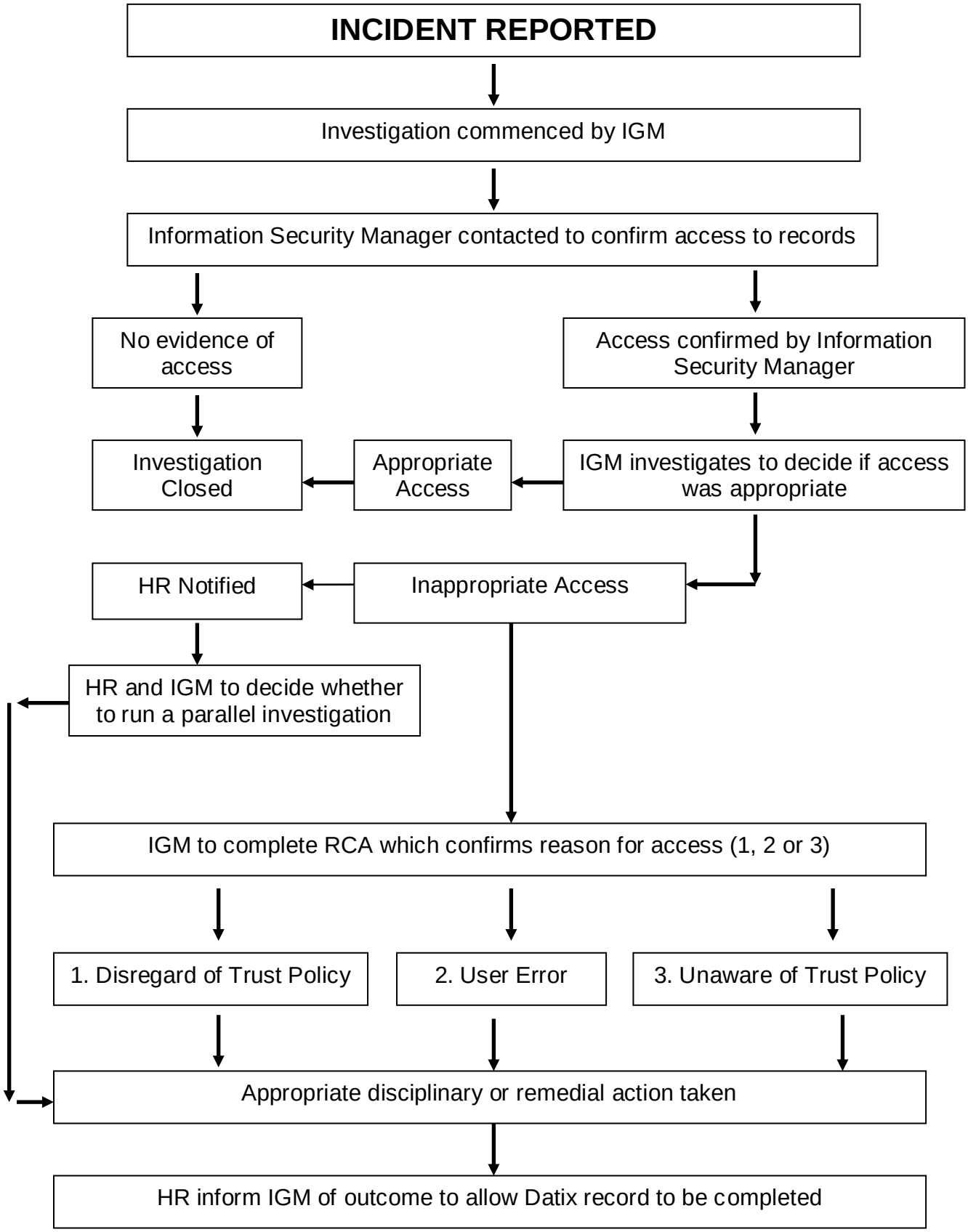
The HR Department will carry out appropriate action based on the individual circumstances of each incident. This may include arranging training sessions or undertaking disciplinary proceedings; report to the professional bodies of the staff member involved. Both the NMC and GMC have confirmed that they undertake fitness to practice hearings based on this subject and would also expect to be notified where the Trust confirm that a potential breach of the Data Protection Act 1998 has taken place. Once any actions are complete the HR department will notify the IGM.

Step 3. Resolving the Incident

Once the root cause of the incident is established the IGM will report the incident and findings to the Trust's Caldicott Guardian and the Information Governance Committee. Reporting to external agencies will be undertaken in accordance with the SUI Policy and Procedure

[1] The Incident Decision Tree helps NHS managers and senior clinicians to decide whether they need to suspend (exclude) staff involved in serious incidents and to identify appropriate management action. The aim is to promote fair and consistent staff treatment within and between healthcare organisations.

Procedure for the investigation of inappropriate access to electronic records



## Examples of Inappropriate Access

All of the following scenarios have been encountered in investigating inappropriate access to healthcare records. In these simple terms each would be deemed to be in breach of Trust Policy and may constitute an offence under the Data Protection Act 1998.

1. A work colleague is off sick and you decide to check their records to see if it is something serious so that you can send them a get well card.

   **No. Access to healthcare records should be for healthcare purposes only.**

2. You have attended the Trust as a patient and decide to check your records to see what has been recorded.

   **No. If you want to access information held about you then this should be done as a Subject Access Request under the Data Protection Act 1998. There are situations where you may not be entitled to access the complete record.**

3. The Trust's Communications Bulletin announces that a former member of staff has died; you access their record to see what they were suffering from.

   **No. Healthcare records remain confidential even after death. If access does not form a part of your job then do not do it**.

4. A colleague left the Trust a short time ago and you would like to invite them to a reunion so you check their records to find their telephone number.

   **No. Access to healthcare records should be for healthcare purposes only.**

5. A relative is due to attend the Trust; you check their record to make sure their details are correct and confirm their attendance.

   **No. If access does not form a part of your job then do not do it**.

6. A member of staff tells you that they are absent from work to attend a hospital appointment, you check their healthcare record to confirm this.

   **No. Access to healthcare records should be for healthcare purposes only.**

7. You know it is your colleague's birthday and would like to send a surprise gift to them at their home address so you check their records to find their address.

   **No. Access to healthcare records should be for healthcare purposes only**

8. Your child has been treated by the Trust and you check their records to have a look at the treatment they have received.

   **No. Access to healthcare records should be for healthcare purposes only. If you want to view any records then you must make an application to view records in line with the Trust's Access to Healthcare Records Policy.**

9. You think a colleague has looked at your records so you have a look at theirs in return.

   **No. If you think inappropriate access to any records has taken place then you should report it as an incident. This can either be online or using the IR1 form. The category of the incident should be "Governance", the sub category should be "Data Protection/Confidentiality" and the grade of the incident should be "Orange**

## 12.8 Attachment 8: Equality and Diversity - Policy Screening Checklist

| | |
|---|---|
| **Policy/Service Title: Incident Reporting Policy** | **Directorate: Healthcare Governance** |
| **Name of person/s auditing/developing/authoring a policy/service:** | |
| **Aims/Objectives of policy/service:** | |

### Policy Content:

- For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation?
- The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation.

**1. Check for DIRECT discrimination against any group of SERVICE USERS:**

| **Question:** Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of: | | **Response** | | **Action required** | | **Resource implication** | |
|---|---|---|---|---|---|---|---|
| | | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **1.1** | Age? | | X | | | | |
| **1.2** | Gender (Male, Female and Transsexual)? | | X | | | | |
| **1.3** | Disability? | | X | | | | |
| **1.4** | Race or Ethnicity? | | X | | | | |
| **1.5** | Religious, Spiritual belief (including other belief)? | | X | | | | |
| **1.6** | Sexual Orientation? | | X | | | | |
| **1.7** | Human Rights: Freedom of Information/Data Protection | | X | | | | |

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

**2. Check for INDIRECT discrimination against any group of SERVICE USERS:**

| **Question:** Does your policy/service contain any statements/functions which may exclude employees from operating the under the grounds of: | | **Response** | | **Action required** | | **Resource implication** | |
|---|---|---|---|---|---|---|---|
| | | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **2.1** | Age? | | X | | | | |
| **2.2** | Gender (Male, Female and Transsexual)? | | X | | | | |
| **2.3** | Disability? | | X | | | | |
| **2.4** | Race or Ethnicity? | | X | | | | |
| **2.5** | Religious, Spiritual belief (including other belief)? | | X | | | | |
| **2.6** | Sexual Orientation? | | X | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **2.7** | Human Rights: Freedom of Information/Data Protection | | **X** | | | | |
| If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation. | | | | | | | |
| **TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING DIRECT DISCRIMINATION =** | | | | | | | |
| **3. Check for DIRECT discrimination against any group relating to EMPLOYEES:** | | | | | | | |
| **Question:** Does your policy/service contain any conditions or requirements which are applied equally to everyone, but disadvantage particular persons' because they cannot comply due to: | | **Response** | | **Action required** | | **Resource implication** | |
| | | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **3.1** | Age? | | **X** | | | | |
| **3.2** | Gender (Male, Female and Transsexual)? | | **X** | | | | |
| **3.3** | Disability? | | **X** | | | | |
| **3.4** | Race or Ethnicity? | | **X** | | | | |
| **3.5** | Religious, Spiritual belief (including other belief)? | | **X** | | | | |
| **3.6** | Sexual Orientation? | | **X** | | | | |
| **3.7** | Human Rights: Freedom of Information/Data Protection | | **X** | | | | |
| If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation. | | | | | | | |
| **4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:** | | | | | | | |
| **Question:** Does your policy/service contain any statements which may exclude employees from operating the under the grounds of: | | **Response** | | **Action required** | | **Resource implication** | |
| | | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **4.1** | Age? | | **X** | | | | |
| **4.2** | Gender (Male, Female and Transsexual)? | | **X** | | | | |
| **4.3** | Disability? | | **X** | | | | |
| **4.4** | Race or Ethnicity? | | **X** | | | | |
| **4.5** | Religious, Spiritual belief (including other belief)? | | **X** | | | | |
| **4.6** | Sexual Orientation? | | **X** | | | | |
| **4.7** | Human Rights: Freedom of Information/Data Protection | | **X** | | | | |
| If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation. | | | | | | | |
| **TOTAL NUMBER OF ITEMS ANSWERED 'YES' INDICATING INDIRECT DISCRIMINATION =** | | | | | | | |

Signatures of authors / auditors: Date of signing: