Trust Policy and Procedure **Document ref. no: PP(17)105**

Incident Reporting and Management Policy

For use in (clinical areas):	All areas of the Trust
For use by (staff groups):	All Trust staff (Hospital and Community)
For use for (patients / treatments):	Adverse incidents and near misses
Document owner:	Governance Department
Status:	Approved

1. Scope

1.1 This policy is a Trust-wide document and applies to all West Suffolk NHS Foundation Trust (WSFT) staff. It should be read in conjunction with the Trust's Incident Reporting & Management Procedure.

1.2 This policy has been updated in the 2017 edition to incorporate the Suffolk Community Health policy '*Policy and procedure for the reporting of incidents and their management including Serious Incidents and Never Events'.* For all staff working in Community locations of the WSFT this updated policy now supersedes the use of that policy.

2. Introduction

2.1 The WSFT is committed to ensuring high quality healthcare in a safe environment. By providing a system for incident reporting and management, incidents can be reported and investigated. Incident trends can be analysed to understand where development and learning can improve patient experience and quality of care. Lessons can also be learned from incidents and shared across the organisation to prevent recurrence.

2.2 Effective incident reporting, investigation and the institution of appropriate control measures will reduce the likelihood of incidents recurring. This will help contribute to improved patient safety and service provision and make the hospital a safer place to work and visit for staff, patients and the public.

2.3 The Trust's Incident Reporting system must be used to report an incident which has given, or may give rise to, actual or possible injury. An incident that resulted in or could have resulted in harm to a patient, visitor or member of staff or if, as a result of the incident, there has been a loss to the Trust, either financially or by way of reputation.

2.4 The objective of incident investigation is to understand what happened, why it happened and to identify any actions that need to be taken to prevent a similar incident in the future. The depth and scope of the investigation will be proportionate to the incident grade (or potential grade).

2.5 Professional staff should also ensure they comply with their own professional guidelines (e.g. General Medical Council & Nursing & Midwifery Council) regarding the reporting and investigation of incidents. Members of Trust staff must ensure that incident reports are made promptly and accurately.

2.6 The Trust is committed to a culture which promotes openness, honesty and that focuses on improving practice, rather than focusing on individual deficiencies and blame. The board of directors accepts that fear of disciplinary action may deter staff from reporting incidents and has therefore chosen to adopt an open approach, where all reports are viewed as an

opportunity to learn rather than punish. Disciplinary proceedings will only result in exceptional circumstances, for example where there has been a breach of the law, gross negligence or professional misconduct.

2.7 The Trust may take action against an employee who knowingly has failed to report an incident of which they were aware.

2.8 The Trust advocates a fair and just system where staff are held to account for their actions / behavior, without being unduly blamed. Every effort will be made to ensure that reported incidents are managed and investigated positively as a way of improving safety through learning.

3. Definitions

3.1 **Incident**: any event or circumstance arising that could have, or did, lead to unintended or unexpected harm, loss or damage to a person, property or the organisation.

An incident can cover a wide range of situations but generally a reportable incident is an event that contains one or more of the following components:

- 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

3.2 **Harm:** Injury (physical or psychological), disease, suffering, disability or death.

3.3 **Near miss:** Any event or circumstance that did not result in harm, loss or damage, but had the potential to do so.

3.4 **Serious Incident Requiring Investigation (SIRI)**: Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. This is in accordance with NHS England : Serious Incident Framework (2015)

3.5 **Non–SIRI Trust led investigation**, these are incidents that don't meet the criteria of a SIRI (see above), but identify an area where there is significant learning that can be achieved and shared through doing a detailed investigation. These investigations may be related to areas of care where there has been changes to national reporting requirements and the Trust has taken the decision to continue to investigate them to ensure" Best Practice" is delivered.

3.6 **Never Event** - all Never Events are defined as serious incidents although **not all Never Events necessarily result in serious harm or death.** Never Events are a particular type of serious incident that meet **all** the following criteria:

'They are **wholly preventable**, where guidance or safety recommendations that provide strong systemic protective barriers **are available at a national level, and should** have been implemented by all healthcare providers'

The current Never Events List includes the list below:

1. Wrong Site Surgery
2. Wrong implant /prosthesis

3. Retained foreign object post-procedure
4. Mis-selection of a strong potassium-containing solution
5. Wrong administration route of medication
6. Overdose of insulin due to abbreviations (e.g. iu) or incorrect device
7. Overdose of Methotrexate for non-cancer treatment
8. Mis-selection of high-strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails (Mental Health only)
10. Falls from poorly-restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients

3.7 **Root Cause Analysis (RCA)**: A structured investigation to determine what, how, and why an incident happened. Which through analysis can then be used to identify areas for change, develop recommendations and look for new solutions to minimise the risk of a similar incident occurring in the future. These can take the format of a concise or comprehensive format as described within the Incident Reporting and Management Procedure.

3.8 **Aggregated RCA**: These investigations consist of more than one incident of any grading that relate to similar thematical issues or repetitions of near miss incidents. These incidents may relate to incidents that occur within particular specialities, divisions or applicable to a number of areas across the Trust.

4. Responsibilities

4.1 Corporate responsibilities

4.1.1 Chief Executive and Executive Chief Nurse

The overall responsibility for effective risk management in the Trust, including incident reporting and management lies with the Chief Executive. At an operational level, the Executive Chief Nurse is the Director designated with responsibility for governance and risk management. Accountability for management of financial (business) risk including the correct application of Standing Financial Instructions and Standing Orders lies with the Executive Director of Resources. The Executive Chief Nurse will liaise with the Executive Medical Director for medical issues relating to clinical risk management, patient safety and staff concerns regarding service delivery.

The Executive Chief Nurse's key responsibilities in respect of incident reporting and management are:

- Assessing incidents reported as major or catastrophic harm to determine whether they meet the definition for a SIRI. This is undertaken in conjunction with the Executive Medical Director, and other Directors as appropriate.
- Considering whether a level 3 external independent inquiry needs to be established in accordance with NHS England Serious Incident Framework. Obtaining Chief Executive approval if an inquiry is considered to be appropriate.
- Notifying the Board of Directors and Chief Executive of SIRIs.
- Notifying the Board of Directors of incidents reported as major or catastrophic harm not assessed as SIRIs with the rationale for the decision.
- Being kept appraised of developments in relation to SIRIs by Directors and/or General Managers (or equivalent) and/or Clinical Directors and/or Governance Department.

4.1.2 Executive Directors

Responsible for ensuring that risk, including incident reporting and management, is managed appropriately in their area of responsibility. Key responsibilities include:

- In conjunction with the Executive Chief Nurse assess incidents reported as major or catastrophic harm to determine whether they meet the definition for a SIRI and /or Never Event. This role is primarily undertaken by the Executive Chief Nurse and Executive Medical Director.
- Co-ordinating and managing SIRI investigations in conjunction with the General Manager/ Clinical Director/Governance Department and in accordance with the Red Incident Procedure
- Ensure any significant concerns/issues arising from incidents are reported to the Trust Board, Trust Executive Group (TEG) Clinical Directors Group and Clinical Safety & Effectiveness Committee (CSEC).
- Ensure that they are kept appraised by their General Managers; Clinical Directors of developments in relation to Non-SIRI Trust led incidents.

4.1.3 Board of Directors

The Board of Directors has delegated authority for incident reporting and management to the Clinical Safety & Effectiveness Committee. The Board of Directors will be directly appraised of:

- New SIRIs claims, complaints graded as ‘red’ and dated inquest hearings.
- Never Events
- Performance against agreed Key Performance Indicators as part of the agreed performance monitoring arrangements.
- Receive an aggregated report of incidents and complaints.

4.1.4 Clinical Safety & Effectiveness Committee (CSEC)

The committee has responsibility for ensuring that the Trust’s procedures and practices are effective in protecting patients, visitors and staff, by ensuring that they comply with national requirements, promote best practice and are effective in the identification and elimination or reduction of hazards.

The Committee’s key responsibilities in respect of incident reporting and management are:

- Approving the Trust’s policy and procedure for incident reporting and management
- Reviewing summary investigation reports of Red incidents (including SIRIs) to ensure appropriate escalation, effective investigation and appropriate learning.
- Review of incidents reported as Red and subsequently downgraded, with the rationale for the decision.
- Monitoring implementation of individual actions for red incidents (including SIRIs), clinical risks arising from investigations and reviewing the results of compliance audits.
- Review of benchmarking information including: overall rates, levels of harm and SIRI rates.
- Reviewing incidents reported to external agencies as defined in the Incident Reporting and Management Procedure
- Monitoring that effective learning takes place from individual and aggregated analysis of incident, complaint and claim data.
- Escalating any outstanding issues or concerns to the Board of Directors.

4.1.5 Trust Executive Group

The Trust Executive Group (TEG) is corporately responsible for the formulation, implementation and delivery of the Trust's strategy, service aims and objectives as approved by the Board. Their key responsibilities in relation to incident reporting and investigation include:

- Consider the resource requirements to address risks identified through incident reporting in accordance with the Trust's Standing Financial Instructions.
- Escalating any significant concerns to the Board.

4.1.6 Clinical Directors Meeting

The key responsibilities in relation to incident reporting and investigation include:

- Providing a degree of challenge in relation to individual incidents and/or themes
- Agreeing any lessons to be shared Trustwide or externally
- Escalating any outstanding concerns or issues to the relevant Division for action as appropriate
- Follow up of overdue investigations for green / amber incidents where a member of medical staff is the handler.
- Escalating any outstanding issues or concerns to TEG.

4.1.7 Specialist advisory committees

A number of specialist advisory committees are identified in the Trust Risk Management strategy & policy PP093 with responsibility for incident management. Their key responsibilities in relation to incident reporting and investigation include:

- Review incident trends according to the defined function to ensure organisational learning takes place.
- Escalating any outstanding issues or concerns to the committee they report to.

4.1.8 Governance Department

The Governance Department is responsible for communicating and co-ordinating the process of risk management throughout the Trust. Their key responsibilities in relation to incident reporting and investigation include:

- Managing the Trust's system for reporting incidents and near misses and encouraging prompt reporting of all incidents.
- Liaising with statutory and other official bodies, for example the Health & Safety Executive, Care Quality Commission, NHS England, the Information Commission, the NHS Litigation Authority and the Clinical Commissioning Group (CCG).
- Supporting the review of incident trends and providing information and analysis on incident trends to assist responsible committees and individuals.
- Supporting the review of incidents reported as major or catastrophic harm to determine whether the incident meets the definition for a SIRI.
- Supporting the investigation of SIRI and Non-SIRI Trust led incidents through root cause analysis.
- Supporting the review of incidents reported as moderate, major or catastrophic harm to ensure statutory requirements for Duty of candour are complied with.
- Reporting of SIRIs through the Strategic Executive Information System (STEIS) to NHS Suffolk, providing progress reports regarding investigation and learning.

- Reporting of all patient related incidents through the National Reporting and Learning System (NRLS) via an online portal.
- Providing Root Cause Analysis training to relevant staff
- Promoting lessons learned and initiatives which can be used to reduce incident causes.
- Identify issues arising from incident investigations for inclusion in the Trust clinical audit programme.

4.2 Divisional responsibilities

4.2.1 Divisional Quality & Performance Meetings

Responsible for reviewing quality, financial, service performance and human resources within the division. Their key responsibilities in relation to incident reporting and investigation include:

- Consider issues for escalation from divisions
- Escalating any significant concerns to TEG and/or Trust Board.

4.2.2 Divisional Governance Steering Groups / Quality Boards

Responsibility for considering quality and clinical governance issues within the Division regarding incidents. Their key responsibilities in relation to incident reporting and investigation include:

- Reviewing incident data and trends
- Addressing any significant concerns or issues.
- Communicating any lessons learnt locally.
- Informing the Governance Department of any lessons to be shared both Trustwide and in the wider health community.
- Escalating any significant concerns to General Manager/Clinical Director and/or the Divisional Quality & Performance Meeting.

4.2.3 General Managers and Clinical Directors

Responsible for ensuring that risk, including incident reporting and management, is managed appropriately in their area of responsibility. Key responsibilities include:

- Addressing significant concerns/issues from incident investigation escalated by Lead Clinicians, Heads of Department, Service Managers and Matrons or by Divisional Governance Steering Groups.
- Ensuring that actions from SIRI and Non-SIRI Trust led incidents are implemented within given timescales.
- Concerns/issues that they are unable to resolve are escalated to the appropriate Director, and/or the Divisional Quality & Performance Meeting, Trust Executive Group.
- Attending Root Cause Analysis training to assist in the investigation of SIRI and Non-SIRI Trust led incidents.
- Ensure appropriate action is taken to deliver Divisional KPI relating to incident reporting and management.

4.2.4 Lead Investigators

Individuals identified as a Lead investigator for a SIRI or Non-SIRI Trust led Incident Procedure are responsible for:

- Leading an investigation into the specific incident

- Producing an RCA report using the Trust templates.
- Ensuring National and local practice is reflected within the investigation

4.2.5 Managers/Matrons (including Ward Managers, Community Team leads, Local area Managers and Departmental managers)

All managers are responsible for:

- Ensuring that all incidents that occur in their area of responsibility are reported in a timely manner and in accordance with Trust Policies and Procedures.
- Receiving all Datix reports occurring in their area(s) of responsibility and ensuring that immediate action has been taken to manage the incident.
- Identifying causes of incidents and putting in place measures to minimise the likelihood of recurrence by establishing any lessons to be learnt and implementing these locally.
- To review investigation of incidents reported for their area(s) of responsibility.
- Informing their Head of Department or Service Manager / Local area Manager) of any lessons to be shared both Trustwide and in the wider health community.
- Escalating any significant concerns to their Head of Department, Service Manager / Local area Manager or Matron.
- Ensuring that staff are adequately supported following an incident and as required during an investigation (in accordance with Supporting staff during an investigation of an adverse incident, complaint or claim PP198). Support can either be provided via their manager, their GP, the Trust's counselling Service and/or by referring the member of staff to the Trust's Occupational Health Service.
- Liaising with the Human Resources Department regarding any precautionary measure, capability or disciplinary action proposed regarding a member of their staff following an incident.

4.2.6 Senior member of staff on duty when a Red incident occurs

The senior manager must immediately:

- Inform the General Manager/ Deputy Directors (or equivalent)/Clinical Director. If out-of-hours contact the Senior Manager on-call via switchboard who will manage the incident until the next working day (see Section 4 below).
- Contact the consultant/medical team if the incident has involved a patient. The consultant must take any necessary clinical action to minimise the effect of the incident and also inform the patient and/or patient's relatives of what has occurred. In cases of death or serious injury, the consultant/medical team must contact the patient's next-of-kin. Where there is difficulty in locating the next-of-kin, the Police may be contacted to assist. It is the responsibility of the patient's clinician to notify the Coroner of all cases of death as a direct result of an incident. If the consultant is unavailable, another consultant in the same specialty should be advised of the incident and asked to attend immediately.
- Preserve the scene to prevent unauthorised entry or tampering with evidence, this may include taking photographs (consider whether consent is required) and recording the position of equipment and people involved in the incident.
- Isolate/retain all evidence i.e. medical records, equipment, drugs and other documentation. This is particularly important where foul play is suspected/has been confirmed.

4.2.7 All staff

Staff responsibilities include:

- Reporting incidents and near misses promptly. Staff working in the Trust on a locum or agency basis, or as a contractor or volunteer must also report incidents. Where a member of the public has been involved in an incident, staff must complete an incident form on their behalf.
- If a witness to or directly involved in an incident, addressing the immediate health needs of the person(s) involved in an incident, ensuring that the situation is made safe, informing their Manager and completing a Trust incident on Datix.
- Undertaking immediate action to manage the incident and identifying actions needed to minimise the chances of recurrence.
- Co-operating in the investigation of incidents and providing a witness statement if required.

4.2.8 **On-Call Managers**

On-call managers are responsible for co-ordinating and managing incidents reported as major or catastrophic harm during out-of-hours and at weekends in accordance with the Incident Procedure.

5. External Independent Inquires

5.1 The NHS England Serious Incident Framework provides guidance on the criteria for establishing a Level 3 external independent inquiry.

5.2 External level 3 inquiries can only be established with the approval of the Chief Executive and must be based on a recommendation from the Executive Director leading the investigation.

6. External Reporting and Informing Key Stakeholders

6.1 Depending on the type of incident, it may require reporting to an external agency or key stakeholder, for example, the Care Quality Commission (CQC), NHS Improvement (NHSI) the Health & Safety Executive (HSE) or the local Clinical Commissioning Group (CCG). The Incident Reporting and Management Procedure lists the different external agencies / stakeholders and the types of incidents they need to be notified of, it also details who is responsible for undertaking reporting.

7. Incident Reporting and Management Training

7.1 All staff new to the Trust will receive mandatory Risk Management/Health & Safety Training as part of their induction which covers how to report incidents. Staff are also required to undertake three yearly updates as set out by the Trust's Policy and procedure for Mandatory and Statutory training (PP244).

7.2 Staff involved in investigating SIRI and Non-SIRI Trust led incidents will receive Root Cause Analysis Training. Root Cause Analysis Training provides high level investigative techniques to ensure that causes of incidents are identified and lessons are learnt. This includes:

- Directors
- General Managers/Deputy Directors and Clinical Directors
- Lead Clinicians, Heads of Department, Service Managers, Local area Manager and Matrons
- Specialist Leads

8. Investigations Involving the Police and/or HSE

8.1 Where an incident requires investigation by the police and/or HSE and information is required to be shared, the Trust will follow the guidance contained in the Trust Data Protection policy (PP110).

9. Duty of Candour

9.1 The Trust encourages all staff to be open and honest to any person affected by an incident and provide them with a full account of what happened and why it occurred. For incidents graded as actual moderate, major or catastrophic harm there is an additional statutory Duty of candour to inform the patient face to face and in writing. Please refer to the Trust's Duty of Candour policy (PP197) for further guidance and information.

10. Process for Staff to Raise Concerns i.e. Whistleblowing

10.1 Should a member of staff have legitimate concerns about someone's practice then this can be raised in accordance with the Trust's policy on Whistle blowing – Staff Concerns about patient care and other healthcare related matters (PP056).

11. Legal Proceedings

11.1 Reporting of an incident does not constitute an admission of liability by any person. However, incident report forms may be made available to all parties in the event of legal proceedings and it is therefore essential that they are completed accurately and factually. Never express opinions.

11.2 The Trust is vicariously liable for the acts and omissions of its employees whilst at work. Where it is considered that staff have acted in good faith, the Trust will take full responsibility in the event of any legal action arising from an incident.

12. Monitoring the implementation and effectiveness of the policy

12.1 The Trust's Incident Reporting & Management Policy will be monitored and reported to the Trust Board as part of the Trust Quality & Performance report and the quarterly Aggregated report to the Clinical Safety & Effectiveness committee The key measures are described below.

- Timeliness of SIRI submission on STEIS against national 2 working day deadline
- Completion of SIRI investigation within national 60 working day deadline
- % of 'Green' PSI incidents investigated
- Median NRLS upload 6 month rolling average against the National peer group (all acute trusts) benchmark.
- Completion of SIRI action plans including a 'deep dive' of evidence of implementation.
- Monitoring that effective learning takes place from individual and aggregated analysis of incident, complaint and claim data through analysis of incident trends and 'repeat incidents'

13. Document configuration information

Author(s):	Trust Secretary & Head of Governance, Associate Chief Nurse / Head of Patient Safety & Effectiveness, Compliance Manager
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