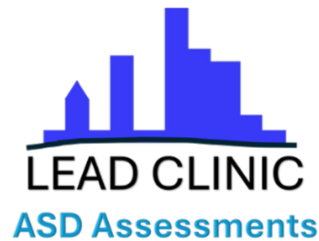

Incident Policy

Policy for the reporting, handling and management of incidents.

Document Detail	
Version	4
Owner & Responsible Lead	Manager LEAD
Effective from	1May 2018
Review	7/2/2026
Date of next review	February 2028
Review Criteria	This document will be reviewed prior to review date if a legislative change or other event dictates
Related documents	Safeguarding Children Policy Patient Safety Incident Response Policy (PSIRP)

This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

1. Scope

LEAD is committed to put patients first by ensuring that there is an embedded culture where reporting of, and learning from, all incidents, is both encouraged and welcomed.

This policy describes the process and provides instructions and guidance for the reporting, management and investigation of incidents, near misses and never events. It sets out the responsibilities for key individuals, immediate actions to be taken, communication both internally and externally if required, and the escalation process. Guidelines concerning the investigation of the incident and how incidents are categorised in terms of risk are also provided within this policy. The process combines proactive and reactive risk management.

LEAD is committed to fully investigate reported incidents, involve and provide feedback to patients and staff as appropriate within a timely manner. LEAD is dedicated to learning and changing practice based on our quality and safety indicators through assessments, data, and incident analysis.

The benefit of reporting incidents is to identify patterns and trends of when things go wrong, to undertake timely investigations, to pre-empt complaints and litigation, to target resources more effectively and to share learning within the organisation. In doing so LEAD is committed to developing a culture which promotes openness and honesty that supports staff to have the confidence to report incidents, and one which focuses on improving practice and patient and staff safety, not on deficiencies and blame. LEAD adopts a culture where the focus is balanced towards "how and why, rather than who".

2. Rationale

LEAD meets its obligations under the Duty of Candour in the incident management procedure.

LEAD is obliged by the Health and Safety at Work Act to report incidents covered by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

In all cases, LEAD needs a system for capturing details of, reporting, and managing such incidents, and a way of organising such information in order to support decisions and actions to reduce the likelihood of such incidents recurring.

This policy and associated documents set out the process for reporting,

managing and investigating incidents and identifying lessons learnt from incidents. Learning from what goes wrong in healthcare is crucial to addressing identified risks and reducing and preventing future harm. It requires a culture of openness and honesty to ensure staff, patients, families and carers feel supported to speak up in a constructive way.

This policy applies to all staff and it covers all types of incidents.

If you feel uncomfortable about speaking to the LEAD manager or trade union, you can call Protect on 020 3117 2520 or email whistle@protect-advice.org.uk

LEAD is committed to ensure each and every issue raised is followed up in a timely and confidential way. There should be no occasion where staff do not have support in order to report concerns, issues regarding a patient, staff or the safety of members of the public.

2.1 Definitions

The term incident includes clinical and non-clinical incidents, accidental injuries, near misses, serious incidents (SIs), never events, unusual and dangerous occurrences, damage to property or equipment and fires.

Incident - an unplanned event that has led to or could lead to injury, ill health, harm to person/s, damage to property, equipment or loss.

Patient Safety Incident - any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

Near miss - any event which had the potential to cause injury, ill health, damage, harm or loss.

Serious Incident (SI) - an event that causes unexpected major injury or death to a visitor or member of staff, or an event that has serious implications for LEAD e.g. an event that disrupts LEAD's ability to provide care to patients.

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

Never Events (NE) - Serious incidents that are wholly preventable because 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.

2.2 Grading Incidents

Low harm - any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons.

Moderate harm - any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons.

Severe harm - any unexpected or unintended incident that caused permanent or long-term harm to one or more persons.

Death - any unexpected or unintended event that caused the death of one or more persons.

3. Policy Objectives

The objectives of this policy are to:

- Ensure appropriate incident management.
- Act as a reference guide for reporting, investigating and managing incidents.
- Ensure that the process is set out clearly to support staff and the affected individuals identify and report incidents appropriately.
- Support staff to categorise and manage reported incidents according to severity.
- Support prompt responses/ action in response to incidents.
- Support LEAD's obligations to report particular incidents to external bodies within the required timescales.
- Ensure residual risks are managed through LEAD's risk management processes.
- Monitor remedial and preventative activity undertaken in response to reported incidents.
- Ensure that actions arising from incidents are being implemented and monitored.
- Ensure that any themes from incidents are recognised and learning is implemented.

4. Duties

Manager

- Responsible for:
- The management and reporting of incidents involving harm or risk of harm to patients, staff, visitors and contractors and has overall responsibility for implementing the policy.
- Investigations into all incidents are undertaken in accordance with this policy and appropriate resources and systems are provided.
- Root cause analysis methods are used to manage the investigation of incidents in which harm occurs.
- Arrangements are in place so that all staff are aware of their responsibilities to contribute and implement the policy and that incidents and near misses are reported.
- Ensure learning from incidents is shared across LEAD as appropriate
- Maintain accurate records of evidence of implementing actions arising from serious and moderate harm incidents and never events.
- Ensure that all incidents are reviewed and discussed every month, remedial and preventive actions are discussed and progressed, and that the meetings, actions and outcomes are minuted and auditable.
- Themes and trends arising from incidents are analysed and acted on

All staff - including contractors
Responsible for:

- Reporting incidents and near misses as soon as it is practically possible and required to assist with any incident/ near miss investigation that they have been involved in or have knowledge of

- In case of the death or serious harm/ impact on the services as the result of an incident, this must be reported immediately to the LEAD Manager

- If an incident occurs which causes, or threatens to cause harm, a safe environment should be re-established as soon as possible

- Any urgent clinical care that may reduce the harmful impact of the incident must be given immediately.

- The risk of recurrence should be considered immediately and actions taken to mitigate this.

5. Managing specific and externally reportable incidents

Please refer to the Incident report form (appendix 1) which should be used to document all incidents and may be used as a report of the incident.

When an incident is reported that is classed a Serious Incident/ potential Serious Incident or Never Event then it needs to be reported to the commissioners within 48 hours.

For incidents that do not meet the SI/NE criteria but have resulted in moderate harm or above, or the potential for learning is so great an internal investigation should be considered.

5.1 Health & Safety Incidents (RIDDOR)

Where harm or the threat of harm has arisen out of or in connection to work, particularly to staff, contractors and visitors, such incidents are reported as non-clinical.

The primary guidance for Health and Safety incidents is the Health and Safety Executive (HSE) publication 'Reporting injuries, diseases and dangerous occurrences in health and social care' guidance (Health Services Information Sheet No 1 (Revision 3)). This defines the types of incident which must be reported to HSE under the RIDDOR regulations. The publication defines 'specific injuries', which must be reported for both staff and patients and incidents which become reportable as a result of a staff member being incapacitated for seven days or more. The manager is responsible for identifying whether an incident is reportable under RIDDOR regulations. Where no harm has occurred, or the incident is not reportable, the Manager is responsible for investigating the incident and completing a risk assessment and management plan.

Joint investigations with police and HSE involvement

On rare occasions it will be obvious, or may emerge as LEAD carries out its own investigations that the police and/or the HSE should be contacted. The decision to report an incident to the police should be made by the Manager.

Onward management of the incident will be advised on a case-by-case basis.

The following types of incident may prompt referral to the police and/or the HSE in the course of investigation:

- Evidence or suspicion that harm was intended;
- Evidence or suspicion that adverse consequences were intended;
- Evidence or suspicion of gross negligence and/or recklessness in a

serious safety incident.

5.2 Managing Security Incidents

A security incident is an unexpected or unplanned event or circumstance that causes harm, has the potential to cause harm, or presents a risk to a patient, member of staff, student, visitor or contractor:

- An event or circumstance in which damage is caused or risk presented to LEAD premises and equipment;
- An incident that may constitute criminal behaviour
  If a security incident has been found to have taken place, but does not need urgent assistance, this should be reported. The individual reporting the incident should consider contacting the Waldron Health Centre Security team via the Security control desks who will advise if the incident is reportable to the Police and assist the member of staff accordingly. If the incident is reportable, a crime number must be obtained from the Police. This number will be required should a subsequent insurance claim be made by the individual in respect of any personal loss that might have occurred.

Responding to security incidents:
In the event of an individual finding themselves involved in a security incident, immediate assistance should be sought by contacting the Waldron Health Centre Security team, by contacting the Police by dialling 999 or by the use of local procedures.

Security staff will respond and assess the situation and if required the Police will be called.

5.3 Managing Safeguarding Incidents

If the incident involves a child or young person who has sustained possible harm and whereby abuse or neglect is suspected it should be raised with the Manager.

A decision will be made on whether this requires a referral to external agencies of social care and / or police. The Manager will determine if the criteria for a referral to the Local Authority Designated officer (LADO) has been met. The LADO must be contacted within one working day in respect of all cases in which it is alleged that a person who works with children has:

- Behaved in a way that has harmed, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Following any SI in relation to children a decision needs to be made on whether the case needs to be referred to the Local Safeguarding Children Board (LSCB) for consideration of a Safeguarding Review.

5.4 Managing Infection Prevention and Control (IPC) Related Incidents

All infection prevention and control (IPC) incidents should be reported to the Manager. All IPC incidents will be reviewed on an individual basis. If there is a potential serious incident or more immediate advice is required the local hospital should be contacted directly.

5.5 Managing Information Governance (IG) Incidents

Information governance incidents are broadly defined as any actual or suspected breach of confidentiality, integrity or availability of information, and should be reported and investigated

External notification of information governance incidents is implemented by the Manager if needed.

5.6 Escalation of incidents causing severe harm, death and never events

For any incident involving severe harm or death, the staff member must immediately notify the Manager providing the available details of the incident. The Manager will forward anonymised details to CQC, or the relevant CCG within three working days.

This policy supports LEAD in meeting the following obligations:

Document title	Publisher	Date	Comments
Health and Safety at Work Act	HM Government	1974	HSWA mandates Health and Safety Executive to regulate employers. HSE requires employers to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses).
National framework for reporting and learning from serious incidents requiring investigation	National Patient Safety Agency (NPSA) now subsumed by National Reporting and Learning Service (NRLS) http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173	March 2010	Defines reporting, and investigation processes.
Serious Incident Framework	NHS England http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf	2015	Does not alter framework set out by NPSA, but sets out what commissioners must require from providers.
Reporting injuries, diseases and dangerous occurrences in health and social care 2013: Health Services Information Sheet No 1	Health and Safety Executive HSIS1(rev3) http://www.hse.gov.uk/pubns/hsis1.pdf	2013	Defines incidents reportable under RIDDOR regulations, and associated requirements.

Document title	Publisher	Date	Comments
Memorandum of Understanding Investigating patient safety incidents (unexpected death or serious untoward harm): a protocol for liaison and effective communications between the National Health Service, Association of Chief Police Officers and Health & Safety Executive	Department of Health http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4084861.pdf	2004	Defines how NHS, police and HSE work together investigating serious incidents. Although document is archived, it is still the only guidance for these circumstances.

6. Appendix 1

INCIDENT REPORT FORM

Incident details

Date and time of incident

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What happened?

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Patient details

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Resolution

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Supervisor comments

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Supervisor signature

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Date and Time

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