Incident Reporting Policy

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Ratified By	Quality and Safety Committee
Ratified Date	No date available
Review Date	December 2015
Version	2.1
Policy Consultation Period	21.01.2015 – 20.02.2015

Related Policies & Guidelines:

- Complaints Policy
- Information Governance Policy

Contents

Amendment History

Version	Status	Date	Reason for Change	Authorised
2.1		December 2014	Review and formatting	Q&SC

1. Introduction

Central London Healthcare has a responsibility to ensure the safety and wellbeing of patients and staff and to investigate when things go wrong. This policy informs staff on the process of reporting clinical and non-clinical incidents, including hazards, near misses and potential incidents.

The reporting and management of incidents is a critical tool in assisting the organisation to effectively manage risk. The reporting of incidents and near misses provides valuable data which can help improve safety, prevent the recurrence of incidents and facilitate wider organisational and cross-organisational learning.

The aim of this policy is to ensure that the organisation is compliant with all relevant regulations and guidelines and to support staff in reporting, investigating and managing incidents.

This Policy applies to all members of CLH staff, including independent contractors.

1.1 Objectives

The objectives of the policy are to ensure that the NPSA guidance on the Seven Steps to Patient Safety (2009) are followed by:

- Promoting a culture of learning through review and reflection of incidents and near misses,
- Ensuring a consistent approach across the organisation in the reporting and management of incidents,
- Enabling the effective reporting and provision of information on incident trends to ensure that lessons can be learnt and improvements made reducing re-occurrence of similar incidents,
- Improving the safety of service users, staff and visitors,
- Minimising the human, organisational and financial impacts of incidents through effective management,
- Enabling the identification and correction/ improvement of weaknesses in practices, systems or equipment,
- Ensuring the onward reporting of serious hazards and incidents to relevant stakeholders

2. Definition of Terms

2.1 Incident

An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors, members of the public or CLH itself.

2.2 Near Miss

An incident that did not lead to harm, loss or damage but had serious potential to do so and where lessons can be learnt from changes in procedures, processes and systems.

2.3 Hazard

Is any situation or physical factor which has the potential to cause an incident

2.4 Serious Incident Requiring Investigation (SIRI)

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public, or where the outcome requires lifesaving intervention or major surgical/medical intervention, or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm (Seven Steps, 2009);
- a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- allegations of abuse;
- security incidents;
- adverse media coverage or public concern for the organisation or the wider NHS; or
- one of the core set of Never Events;
- All apparent or actual suicides of people with an open episode of care (either community or inpatient) at time of death;
- Major outbreaks, serious incidents of communicable disease or exposure to environmental hazards caused by healthcare failures or other NHS system failures that have put patients/staff at harm/risk of harm or restrict service delivery;
- Information Technology incidents including systems failure leading to serious outcomes and data loss resulting in severe breach of confidentiality.

2.5 Never Events

Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Incidents are considered to be never events if:

- The incident either resulted in severe harm or death or had the potential to cause severe harm or death.
- There is evidence that the never event has occurred in the past and is a known source of risk (for example through reports to the National Reporting and Learning System or other serious incident reporting system).
- There is existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.

- Occurrence of the never event can be easily identified, defined and measured on an on-going basis.

2.6 Root Cause Analysis (RCA)

A systematic process whereby the factors that contributed to an incident are identified. As an investigation technique for patient safety incidents, it looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which an incident happened.

2.7 Significant Event Audit

An audit process where data is collected on specific types of incidents that are considered important to learn about how to improve patient safety.

2.8 Clinical Incident

Is any untoward event or near miss that involves a patient, e.g. drug errors, patients falling, patient complaint; this will include:

- Operation on the wrong patient/body part
- Surgical foreign body left in situ
- Intra operative problems
- Diathermy burns/reaction to prep agent/pressure sores
- Performance of operation that is not indicated
- Failure to warn (informed consent)
- Failure to act on abnormal test results
- Medication errors
- Infusion problems
- Problems with medical records
- Clinical Equipment malfunction
- Self-harm
- Unexpected death

2.9 Non-Clinical Incident

Is an untoward event that involves any person (e.g. member of staff, visitors, voluntary workers, contractors etc.). It may also involve a patient where the event relates to health & safety issues rather than clinical issues. A non-clinical incident may be an accident or a near miss. The following is a non-exhaustive list of non-clinical incidents:

- Physical or verbal aggression
- Slip, trip or fall
- Needlestick or sharps injury
- Any work related ill health including stress
- Burns or scalds
- Accidental exposure to electricity
- Accidental exposure to chemical agents
- Accidental exposure to biological agents

- Accidental exposure to radiation
- Manual handling injuries to staff
- Upper Limb Disorders/Repetitive Strain
- Struck or Trapped by any Object
- Failure of non-clinical equipment
- Theft, loss or damage of any property

3. Reporting

CLH recognises that incidents may occur because of problems with systems, processes or by individuals. CLH promotes a positive approach to incident reporting throughout the organisation. Staff are encouraged and will be supported to be open and honest about events and issues that have or could cause damage to people, property or the organisation. CLH operates an open and fair blame culture and will accept vicarious liability for the actions of staff as long as they were carrying out their duties in accordance with CLH policy, their professional standards, information, instruction, training and supervision they had received.

CLH Staff have a statutory duty to report any incident they are involved in immediately. This includes hazard concerns and near misses that have the potential to cause harm or loss.

All incidents need to be reported to the Line Manger/Quality Coordinator. Incident Form (see Appendix I) should be filled in and emailed to the Line Manager/Quality Coordinator and details of incident logged in CLH Quality Log.

IG incidents should be logged using the online toolkit:
https://nww.igt.hscic.gov.uk/home.aspx (See CLH Information Governance Policy)

Grading of incidents should occur as soon as possible after the incident and a review of grading should take place after the investigation has concluded – see Appendix 2

Grading	Action	Timescales
Minor incidents	Investigated by Line Managers, reviewed by Executive Manager. The principles of root cause analysis (RCA) or significant event audit (SEA) and relevant NPSA guidance (www.nrls.npsa.nhs.uk/resources) should be applied.	Logged in the CLH Quality Log within 24 hours. Resolved within 21 days.
Moderate	Investigated by Line Managers/ Executive Manager/ CLH Clinician. The principles of root cause analysis (RCA) or significant event	Logged in the CLH Quality Log within 24 hours. Resolved within 28 days.

	audit (SEA) and relevant NPSA guidance (www.nrls.npsa.nhs.uk/resources) should be applied.	
Major/Catastrophic	National SIRI guidelines to be followed. Serious Incident Reporting form to be emailed to london.sui@nhs.net	Logged in CLH Quality Log within 24 hours. Resolved within 45 days.

4. Serious Incidents

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

CLH must report SIs and potential SIs to the Quality and Patient Safety Team. This must be done by completing the Serious Incident Reporting form, Appendix III which must be sent by email to london.sui@nhs.net. The words 'Serious Incident Notification' must be used in the subject of the email (See Serious Incident Operating Model for Services Directly Commissioned by the NHS Commissioning Board in London).

SIs must be reported as soon as possible after the incident is detected and no later than two working days after the incident being identified. The report must not contain any patient or staff identifiable data (including initials of names) and the description should be concise.

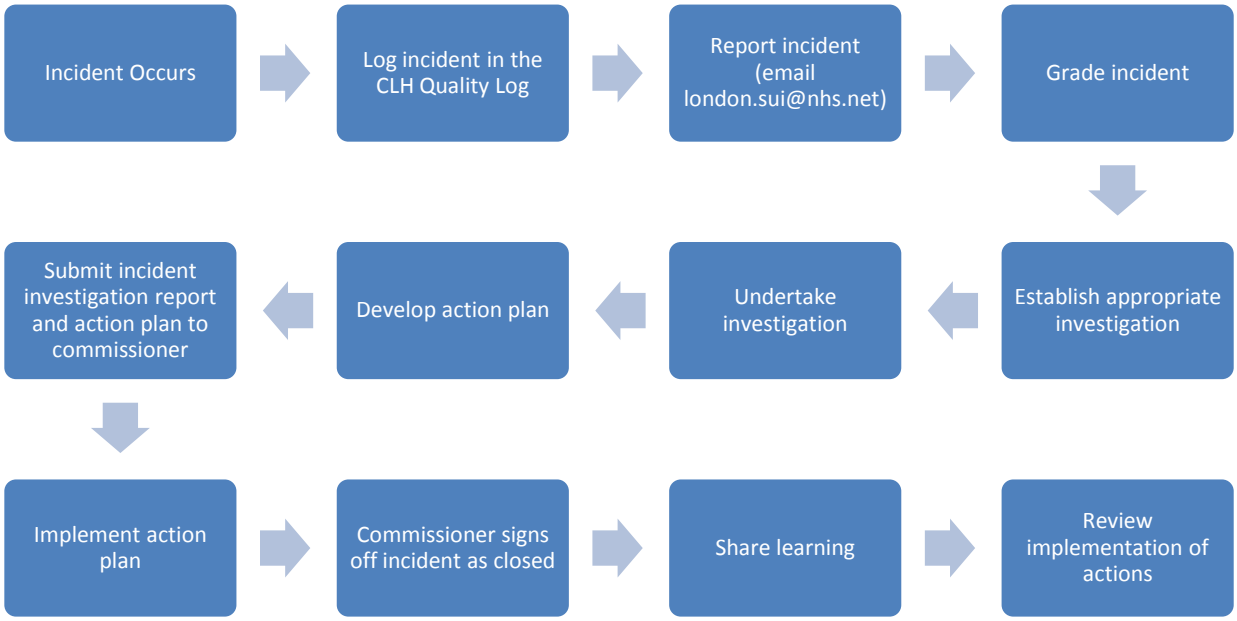
CLH must ensure that all serious incidents are disclosed to those affected in a timely manner, appropriately reported and investigated, with the findings being shared with those involved in accordance with the Being Open guidance and the contractual Duty of Candour requirements. Staff leading serious incident investigations should have up to date training and be competent in investigative methodology, techniques and analysis, report writing, and including human factors.

CLH is accountable for effective governance and learning following a serious incident.

CLH should ensure that:

- relevant policies and procedures are in place
- incidents are reported
- all incident investigations and action plans are reviewed
- data trends are monitored
- serious incidents are investigated and closed in a timely manner

4.1 Steps to be taken when a serious incident occurs – simplified flowchart



5. Investigating Incidents

Adverse incidents and near misses are subject to an appropriate level of investigation and root cause analysis and where relevant an action plan for improvements prepared. Not all events need to be investigated to the same extent or depth and the investigation and analysis should be relative to the seriousness, complexity of the event and/ or whether it resulted in actual harm and the potential for learning, such as those which are high frequency but may be of low severity

Any investigation should have the following aims:

- to ensure timely and appropriate follow-up
- to establish the facts
- to identify factors contributing to the events
- to determine what actions are to be taken to remedy any identified deficiency
- to prevent, as far as possible, similar occurrences in the future
- to meet national, regional and legal reporting requirements

To ensure the achievement of these aims is possible, an investigation should feature the following components:

- collection of evidence about what happened – to include clinical records (where relevant), correspondence, witness statements, etc.
- consideration of the evidence, including a comparison with relevant standards, protocols or guidelines, whether national or local

- establishment of the facts and, based upon these, the drawing of conclusions and making of recommendations for action to minimise risk
- the drawing up of an action plan with prioritised actions, responsibilities, timescales and strategies for measuring effectiveness of actions
- the implementation of the improvement strategy and track progress; including the effectiveness of actions

6. Responsibility and Accountability

6.1 All CLH Staff and CLH contractors

All staff are responsible for being aware of the requirements of this policy, reporting an incident when it occurs and participating in incident investigation processes.

6.2 CLH Management Board

Has overall responsibility and decision making powers with regard to incidents handling within the CLH.

6.3 CLH Managing Director

Is responsible for ensuring that the appropriate support and advice is provided by the CLH Quality and Line Managers to fulfil the Policy. The CLH Executive Manager will provide the strategic lead on incidents issues and will be responsible for ensuring that incidents information is reported through to the appropriate committees and that the Quality/Line Managers are monitored for compliance with the objectives of the Incidents Process.

He/She will also be responsible for reviewing all incidents investigation reports. His/Her 'signed off' findings will be formally communicated to the parties concerned.

6.4 CLH Quality Manager/Line Manager

Have the overall responsibility and accountability for the implementation of the policy and for the managing of the incidents process across the CLH.

Line Managers are responsible for ensuring that their staff receive appropriate training to ensure they are fully aware of the procedures for reporting and formally recording all incidents relating to their work or workplace. Following any incident or injury, Line Managers must ensure that there is an appropriate investigation or root cause analysis of the circumstances as soon after the event as possible.

7. Learning

The sharing of the lessons learnt post investigation is a critical part of incident management. Learning from incidents is a collaborative, decentralized and reflective process that draws on experience, knowledge and evidence from a variety of sources. The learning process is a process of

change evidenced by demonstrable, measurable and sustainable change in knowledge, skills, behaviour and attitude. Learning can be demonstrated at organisational level by changes and improvements in process, policy, systems and procedures relating to patient safety within healthcare organisations. Individual learning can be demonstrated by changes and improvements in behaviour, beliefs, attitudes and knowledge of staff at the front line of healthcare delivery.

Examples of learning:

- solutions to address incident root causes which may be relevant to other teams, services and provider organisations;
- identification of the components of good practice which reduced the potential impact of the incident, and how they were developed and supported;
- systems and processes that allowed early detection or intervention which reduced the potential impact of the incident;
- lessons from conducting the investigation which may improve the management of investigations in future; and
- documentation of identification of the risks, the extent to which the risks have been reduced, identified and how this is measured and monitored.

Learning points should be grouped or themed to help the reader(s) identify those points applicable to their team, service, speciality, division or wider.

Appendix 1 – Incident Form

INCIDENT FORM

Patient/CLH staff details:	**Your details:**
Name:	Name:
Department:	Department:
UBRN:	Date of incident:
NHS:	Time of incident:
Contact details:	Location of incident:
Incident details: **Immediate Action taken:** **Managers' Name** (form sent to)**:**	
Comments:	

Appendix 2 – Grading of Incidents

Assessing and grading an incident's risk severity in a consistent way provides the CLH with a way of identifying levels of risk and the actions to deal with them. A risk severity grade is achieved by using the 2-dimensional risk grading matrix (as below) (***consequence*** and ***likelihood***) to identify a severity score/colour.

Risk Grading Matrix		Likelihood score				
		1	2	3	4	5
Consequence score		Rare	Unlikely	Possible	Likely	Almost certain
	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

For grading risk the scores obtained from the risk matrix are assigned colour grades:

Green	1 - 3	Low risk
Yellow	4 - 6	Moderate risk
Amber	8 - 12	High risk
Red	15 - 25	Extreme risk

Assessing and grading Consequence and Likelihood to grade incident severity and risk

To establish the overall risk grading of an incident, we need to first assess and grade the incident in terms of the consequence/impact, followed by an assessment of the likelihood or reoccurrence.

Consequence Grading for Incidents

Consequence is defined as the severity of the actual or potential harm or outcome of an incident. Where there is more than one consequence of a single incident, use the most severe to grade the severity. Consequence scores and grades are:

1 Negligible
2 Minor
3 Moderate
4 Major
5 Catastrophic

These are shown below in a table with some descriptors of incidents. Work along the columns to assess the consequence of the harm or outcome of an incident (actual or potential), on the scale of 1 to 5. The score is the number given at the top of the column, the grade is the colour.

Table 1	Consequence grading/scoring (severity levels)				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical or psyhcological harm)	No injury or minimal injury but no first aid required	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Major injury leading to long-term incapcity/disability	Serious injury or harm eg. very serious suicide attempt
	No time off work	Requiring time off work for >3 days	Requiring time off work for 4-14 days (RIDDOR reportable incident)	Requiring time off work for >14 days	Incident leading to death
			An event which impacts on a small number of service users	Mismanagement of care with long-term effects	An event which impacts on a large number of patients
					Meets the definition of an SI
					A Never Event
Quality/complaints/audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service
	Informal complaint/inquiry	Formal complaint (stage 1)	Formal complaint (stage 2) complaint	Multiple complaints/ independent review	Inquest/ombudsman inquiry
		Single failure to meet internal standards	Repeated failure to meet internal standards	Critical report	Gross failure to meet national standards
		Minor implications for patient safety if unresolved	Major patient safety implications if findings are not acted on	Low performance rating	Gross failure of patient safety if findings not acted on
		Local resolution	Local resolution (with potential to go to independent review)	Critical report	
		Reduced performance rating if unresolved			
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Unsafe staffing level or competence (>1 day)	Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
			Late delivery of key objective/ service due to lack of staff	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
			Poor staff attendance for mandatory/key training	No staff attending mandatory/ key training	No staff attending mandatory training /key training on an ongoing basis
			Low staff morale	Very low staff morale	Loss of several key staff
				Loss of key staff	
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation	Single breech in statutory duty	Multiple breeches in statutory duty	Multiple breeches in statutory duty
		Reduced performance rating if unresolved	Challenging external recommendations/ improvement notice	Low performance rating	Zero performance rating
				Improvement notices	Complete systems change required
				Enforcement action	Prosecution
				Critical report	Severely critical report
Adverse publicity/ reputation	Rumours	Local media coverage – short-term reduction in public confidence	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
	Potential for public concern	Elements of public expectation not being met			Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget	5–10 per cent over project budget	Non-compliance with national 10–25 per cent over project budget	Incident leading >25 per cent over project budget
		Schedule slippage	Schedule slippage	Schedule slippage	Schedule slippage
				Key objectives not met	Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget	Loss of 0.25–0.5 per cent of budget	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget	Non-delivery of key objective/ Loss of >1 per cent of budget
		Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Claim(s) >£1 million
				Purchasers failing to pay on time	Loss of contract / payment by results
					Failure to meet specification/ slippage
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility

Likelihood of re-occurrence scoring

The likelihood score should only be assessed once the consequence or impact of an incident has been graded.

The likelihood score is an assessment of how likely it is that an adverse incident will re-occur:

a. That the same incident or event will happen again ***and***
b. With the same level of consequence (the same impact)

For example, if the incident was a fall in which someone sustained a fracture, how likely is it that the fall will happen again (consider place and person), and how likely is it that if a fall does recur that the injury will again be a fracture.

It is important to take into consideration the control measures already in place to stop the event occurring again at the same level, including any actions taken after the incident.

As with the assessment of 'consequence', the likelihood of the incident re-occurring is assigned a number from '1' to '5' - the higher the number the more likely it is to re-occur and is based on frequency:

1. Rarely
2. Unlikely
3. Possibly
4. Likely
5. Almost certainly

Table 2 provides definitions of descriptors to help score the likelihood of an incident risk being realised by assessing frequency.

Table 2	**Likelihood score**				
	1	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Very Likely**
Frequency **How often might it or does it happen (at the same level)**	Extremely unlikely to happen/recur – may occur only in exceptional circumstances – has never happened before and don't think it will happen (again)	Unlikely to occur/reoccur but possible. Rarely occurred before, less than once per year. Could happen at some time	May occur/reoccur. But not definitely. Happened before but only occasionally once or twice a year	Will probably occur/reoccur. Has happened before but not frequently – several times a month. Will occur at some time.	Continuous exposure to risk. Has happened before regularly and frequently – is expected to happen in most circumstances. Occurs on a daily basis

Example incident:

A member of staff slips and falls down some steps, injuring their hand, requiring first aid. The incident graded by the person who fell, it is their assessment of the severity:

Consequence: Minor (injury, impact) – scores 2
Likelihood: Unlikely (to re-occur)– scores 2
Overall incident grading would be 2x2 = 4 = Yellow

Risk Grading Matrix		Likelihood score				
		1	2	3	4	5
Consequence score		Rare	Unlikely	Possible	Likely	Almost certain
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	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	2	4	6	8	10
	1 Negligible	1	2	3	4	5

Appendix 3 – Serious Incident Reporting Form

NHS Commissioning Board

Serious Untoward Incident Documentation			
Reporting Organisation:		Date & Time Reported:	
When, Where & Your Details			
Date of Incident:		Reporter Name:	
Time of Incident:		Reporter Job Title:	
Site of Incident:		Reporter Tel. No.:	
Location of Incident:	Please Select	Reporter Email:	
Clinical Commissioning Group of Reporting Organisation:	Please Select		
Who			
Care Sector	Please Select	Type of Patient	Please Select
Clinical Area (more than one can be selected):	Please Select	Gender	Please Select
Date of Birth (dd/mm/yyyy, N/A or Not Known):		Ethnic Group:	Please Select
CCG of Patient's GP:	Please Select		
What Happened?			
Type of Incident:	Please Select	Actual / Near miss:	Please Select
Incident Grade:	Please Select	Never Event:	Please Select
Pressure Ulcer Detected on First Contact with the Patient or Within 72 Hours of Admission (*this applies to all care settings*):	Please Select	Media Interest:	Please Select
Description of what happened:			
Immediate action taken:			
Further Information:			
Report to Health Protection Agency:	Please Select	Line being taken by Trust/ PCT:	Please Select
Externally reportable:	Please Select	Externally reportable to (more than one can be selected):	Please Select
Apparent outcome of incident:			
Likelihood of recurrence:			
Most likely consequences:			
Potential risk to future patients:			
Trust File Details:			
Lead Officer at Trust:		Lead Officer Tel No.:	
Further Information:			
Please add any further information (whch is not addressed above) here:			

Appendix 4 – References

NPSA guidance on the Seven Steps to Patient Safety (2009)
http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

NHS Serious Incident Framework
http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf