Pav Dental

Significant Events, Near Misses, and Incidents Policy

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Policy Statement

This policy relates to all adverse incidents (clinical and non-clinical) encompassing the whole spectrum of events from a ‘near miss’ to a serious untoward incident (SUI) and the importance of logging all events, whether a negative or positive outcome. This includes those incidents that occur on the premises, or when an employee is carrying out a work-related task not on the premises. It incorporates the reporting requirements of the Patient Safety Wales, the Health and Safety Executive (HSE).

Our practice is committed to investigating where appropriate and learning from all incidents in order to prevent a recurrence of a similar incident and to ensure that where required changes are identified, they become embedded in practice. We are also committed to sharing positive events as well.

For the purpose of this policy, the term SUI refers to Serious Untoward Incidents or Significant Events.

Purpose

The purpose of this policy is to outline the processes required to:

- Identify, record and report an adverse incident, including a near miss and general accidents.
- Minimise distress to staff, patients, family/carers and others involved
- Enable the practice to manage, review/audit and minimise future risk for staff, patients and others.
- Improve patient safety.
- Encourage wide learning and sharing of lessons learnt from clinical and non-clinical incidents.
- Encourage the logging and sharing of positive events alongside other events.

This policy is required in order to ensure the practice complies with relevant legislation including RIDDOR (Reporting of Injuries, Diseases & Dangerous Occurrences Regulations 2013) and that the practice meets the requirements of other organisations such as NHS Scotland and HIW.

Scope

The scope of this policy covers all adverse incidents, including near misses and significant events. This policy shall apply to all staff employed and self-employed by the dental practice (including bank and agency staff) students and volunteers and should be followed as our Standard Operating Procedure.

Definition of terms

Patient Safety

The reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment.

Incident/Accident: - Any event or circumstance arising during dental care that could or did lead to unintended or unexpected harm, loss or damage'

Near Miss: - Those incidents that did not lead to harm, but could have, are referred to as near misses

Significant Event (SUI)

Any event thought by anyone in the team to be significant in the care of patients or the conduct of the practice.

Significant Event Analysis (SEA)

A process in which individual episodes are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care, and to indicate any changes that might lead to future improvements.

Confidentiality

All reports relating to an incident should contain anonymised information. For example, the content of any reports relating to SUIs should not contain the names of performers or patients. Staff should be referred to by their job title where practical. Other individuals should be referred to by initials only.

Other requirements

When declaring an incident, significant event or near miss, it should also be borne in mind that certain incidents may also require investigation under separate procedures and should be reported accordingly. Such incidents would include those involving fraud, child protection and vulnerable adults' issues, Mental Health. Significant events should not be shortlisted to negative findings, positive impact events should also be logged and recorded.

Duties

For all staff who are involved in/witness or become aware of an adverse incident including SUI and near miss, must report all incidents, including positive, do not over focus on negative events.

An incident form must be completed immediately after the incident has occurred/been identified by the person involved/who first identifies it.

All staff have a responsibility to cooperate and assist fully with the investigation of incidents and serious untoward incidents and provide factually accurate witness, comprehensive statements if asked to do so. This applies to investigations which are conducted both internally and externally.

For reported incidents, all staff within the reporting lines must keep an updated chronology of the events which occurred and draft statements as soon as possible after the incident. When a member of staff becomes aware of the incident it is their responsibility to inform the manager of the service and to do what they can too make the situation as safe as possible.

All staff with responsibility for or who are involved in record keeping must ensure that there are contemporaneous notes in place which cover the events that have occurred. This should include all facts related to the incident when it was known that an incident occurred, the actions taken in response to the incident, the care and treatment provided to the patient, the major decision made and by whom.

Senior Manager/Clinician of area/service where the incident has taken place:

The senior clinician/manager who has been made aware of the adverse incident must:

- Ensure that all necessary remedial action has been taken to make the service safe and to prevent a recurrence of the event.

- Immediately collect basic background information after the incident, to inform any investigation.
- Consider if the incident involves or there is concern over child protection issues/adult at risk issues. If so, they must contact their local safeguarding board.
- Ensure that if a member of staff is involved, a referral to Occupational Health Department or Accident and Emergency should be made where this is deemed necessary.
- Use their discretion based on the nature of the incident in deciding if an investigation is required.

Completion of Incident Form/Significant Events Form

This section describes the reporting and recording procedures to be followed in the event of an adverse incident.

An incident/accident forms & Significant events forms must be completed for ALL adverse incidents including near misses, remembering to include both negative and positive events.

Procedure For Reporting & Managing an Incident

Once an incident has been identified, an incident form should be completed. It will be up to the discretion of the manager concerned to determine if an investigation should be carried out into the incident. Where an investigation is carried out, the level of investigation will need to be determined.

Procedure For Reporting & Managing A Near Miss

Once a near miss has been identified, an incident form should be completed. It will be up to the discretion of the manager concerned to determine if an investigation should be carried out into the incident.

The results of the investigation and lessons learnt will be shared at the monthly practice meetings.

Significant Event Analysis

Put simply, an SEA is a ‘qualitative’ method of clinical audit. These audits tend to deal with larger-scale ‘quantifiable’ patient data sets and involve defining criteria and setting standards which can be measured and compared against. However, SEA should involve a systematic attempt to investigate, review and learn from a single event that is deemed to be ‘significant’ by the practice team.

Often, these types of ‘significant events’ will not be highlighted through ‘normal’ audits, but they still offer practices valuable opportunities to improve the quality and safety of healthcare. An SEA provides us with a structured framework which can guide the practice when discussing and investigating a chosen significant event.

There are seven steps to a significant event analysis;

Step 1 - Identify and prioritise the significant event.

- Staff should be confident in their ability to identify and prioritise a significant event when it happens. The Practice should be fully committed to the routine and regular analysis of significant events.

Step 2 - Collect the facts.

- Collect and collate as much factual information on the event as possible from personal testimonies, written records and other healthcare documentation. For more complex events, an in-depth analysis will be required to fully understand causal factors.

Step 3 - Arrange a meeting to discuss.

- The Practice should appoint a Lead who will structure the meeting, maintain basic ground rules, and help with the analysis of each event. The team should meet regularly to discuss, investigate, and analyse events. These meetings are often the key function in co-ordinating the SEA process and they should be held in a fair, open, honest, and non-threatening atmosphere. Agree any ground rules before the meeting starts to reinforce the educational spirit of the SEA and ensure opinions are respected and individuals are not 'blamed'. Minutes of the meeting should be taken, and action points noted. These should be sent to all staff, including those unable to attend the meeting. An effective SEA should involve detailed discussion of each event, demonstration of insightful analysis, the identification of learning needs and agreement on any action to be taken.

Step 4 - Undertake a structured analysis.

- The analysis of a significant event can be guided by answering four questions:

    1. What happened?
    2. Why did it happen?
    3. What has been learned?
    4. What has been changed or actioned?

- The possible outcomes may include:
    - no action required
    - a celebration of excellent care
    - identification of a learning need
    - a conventional audit is required
    - immediate action is required
    - a further investigation is needed
    - sharing the learning

Step 5 - Monitor agreed change.

- Any agreed action should be implemented by staff designated to co-ordinate and monitor change in the same way the practice would act on the results of 'traditional' audits.
- Progress with the implementation of necessary change should always be monitored by placing it on the agenda for future team or significant event meetings.
- Where appropriate, the effective implementation and review of change is vital to the SEA process. To test how well the SEA process has gone, practices should ask themselves 'What is the chance of this event happening again?'.

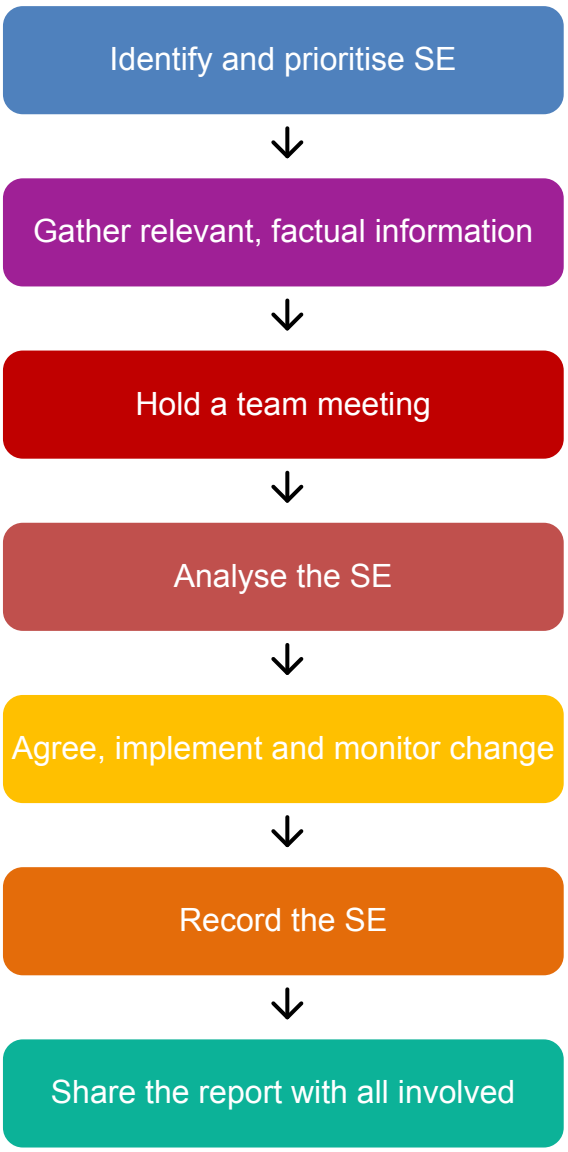
Step 6 - Write it up.

- It is important to keep a comprehensive, anonymised, written record of every SEA, as external bodies will require evidence that the SEA was undertaken to a satisfactory standard. The SEA report is also a written record of how effectively the significant event was analysed

Step 7 – Report, share & peer review.

- Reporting when things go wrong is essential in general practice, but rarely happens. The practice should look to formally report and notify (via regional requirement) those events where patient safety has, or could have been, compromised. Where a mechanism exists, practices should share knowledge of important significant events with local clinical governance leaders so that others may learn from these.

Flowchart for Significant Event Analysis



Reporting to External Bodies;

Statutory Notifications

Wales

If you are a registered provider or a registered manager, you are required to notify the HIW of certain incidences, events or changes to your service.

These incidences would include;

- Death of a person who uses the provider service
- Deaths and unauthorised absences of people who are detained or liable to be detained under the Mental Health Act 1983
- Serious injuries
- Deprivation of liberty applications and their outcomes
- Abuse and allegations of abuse
- Incidents reported to, or investigated by, the police
- Events that stop, or may stop, the registered person from running the service safely and properly
- The admission of a child or young person under 18 to an adult psychiatric ward or unit

The relevant notification form is found on the HIW website;

https://hiw.org.uk/notify-us-event

Practices providing NHS care may also need to use the Incident Reporting Tool:

https://nwssp.nhs.wales/a-wp/pcir/

England

Registered providers must notify the CQC regarding certain events and incidents that may affect their service or the people who all use it, more information can be found via the following link: https://www.cqc.org.uk/guidance-providers/notifications

The following is guidance on reportable events, the full list can be seen by accessing the link above:

- Death of a person using the service
- Death of a registered provider
- Allegations of abuse (Safeguarding)
- Police Involvement in an Incident
- Serious Injury to a person using the service

Scotland

Practices in Scotland are expected to follow RIDDOR guidelines of reportable incidents such as-

- Death of a person using the service
- Specified injuries to workers
- Non-fatal accidents to non-workers (eg members of the public)
- Certain Occupational diseases
- Gas related incidents
- Over 7 day incapacitation of a worker

RIDDOR reportable incidents

Injuries include those that lead to, or that if untreated are likely to lead to:

- Permanent damage (or damage that lasts or is likely to last more than 28 days) to:
    - a person's sight, hearing, touch, smell or taste
    - any major organ of the body (including the brain and skin)
    - bones
    - muscles, tendons, joints or vessels
    - the development after admission of a pressure sore of grade 3 or above that develops after the person has started to use the service
    - any injury or other event that causes a person pain lasting, or likely to last, for more than 28 days
    - intellectual functions, such as
        - intelligence
        - speech
        - thinking
        - remembering
        - making judgments
        - solving problems
- Injuries or events leading to psychological harm, including:
    - post-traumatic stress disorder
    - other stress that requires clinical treatment or support
    - psychosis
    - clinical depression
    - clinical anxiety

These lists are not exhaustive.

Notifications to the Local Area Team (If NHS)

The contractor must notify their local health board in writing, as soon as reasonably practicable or any serious incident that in the reasonable opinion of the contractor affects or is likely to affect the contractor's performance of its obligations under the contract.

Audit and/or monitoring

The monitoring and audit of policies and procedures is a requirement of clinical governance.

Breach of this policy

A breach of this policy could lead to adverse consequences in relation to patient/staff safety and in other areas related to the incident where an incident is not reported or is reported but does not adhere to the process as outlined. In certain circumstances, a breach of this policy could also lead to disciplinary action.

Document Control

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