Western Health and Social Care Trust

Adverse Incident Policy
June 2021

Western Health and Social Care Trust

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Western Health & Social Care Trust

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Western Health and Social Care Trust

Contents

1.0 INTRODUCTION/PURPOSE OF POLICY

1.1 Background

Arising out of the recommendations of the Regional Learning System Project Report (August 2015), it was agreed to develop a regional policy on the reporting and management of adverse incidents to be used by all Health & Social Care Trusts, the Northern Ireland Ambulance Service (NIAS) and the Health & Social Care Board (HSCB). For the purposes of this policy, hereinafter the Western Health & Social Care Trust will be referred to as ("the organisation").

1.2 Introduction

The manner in which an organisation manages and learns from adverse incidents is one of the key markers of success in relation to risk management, corporate and clinical and social care governance standards. Consistent identification, monitoring and review of incidents is central to the organisation's strategic and operational processes to ensure it can achieve its vision for safe and effective care.

It recognises that no health and social care environment will ever be absolutely safe and, on occasions, errors or incidents will occur. Equally, it recognises that when incidents do occur it is important to identify causes to ensure that lessons are learned to prevent recurrence.

The organisation is committed to an open, honest and just culture and reporting of adverse incidents is encouraged so that the organisation can learn from incidents and take actions including changes in practice to reduce the risk of recurrence. It also will ensure that staff learn and are supported in making changes to their practice, post incidents, as required.

1.3 Purpose of policy

This policy provides guidance on the reporting and managing of adverse incidents which affect service users, staff and visitors to its premises or have an impact on the organisation, its reputation or its legal duty of care. It will also enable a robust and systematic approach to the management of adverse incidents that will be consistently applied across the organisation ensuring that it meets all relevant statutory[1] or mandatory responsibilities and reporting requirements thereby safeguarding the wellbeing of service users, staff and visitors.

It has been developed to ensure organisational wide learning takes place within a structured framework and that any lessons learned are disseminated widely throughout the organisation and to external agencies, as appropriate.

1.4 Policy Aims and Objectives

Adverse incident management systems assist organisations to ensure that systems are in place to secure service user, staff and visitor safety; ensure internal accountability and safeguard the organisation's assets and reputation. Learning

[1] Health & Safety at Work Order 1978, Management of Health and Safety at Work Regulations (Northern Ireland) 2000 and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.

from adverse incidents enables the organisation to proactively reduce risk and improve services. It recognises that most incidents occur because of problems with systems rather than individuals but may also on occasions be multifactorial in nature.

The objectives of this policy are:-

- To promote and provide a unified regional organisational wide system for the reporting, recording, review and analysis of all adverse incidents;
- To improve the safety and quality of care through reporting, analysing and learning from incidents involving service users, staff and visitors (including contractors);
- To comply with relevant legislation and standards relating to the reporting of incidents;
- To ensure all adverse incidents are dealt with appropriately and in a timely and consistent manner;
- To provide a means of analysing trends in incidents and identification of factors contributing to incidents to assist in implementation of service improvement and risk reduction strategies, thereby minimising risk to service users, staff and visitors and the organisation; and
- To support staff when mistakes happen and encourage staff to review and reflect on their practice post review of incidents.

1.5 Legislative Requirements

The key legislative reporting requirements for organisations in respect of adverse incidents are as follows:-

- Health & Safety at Work (NI) Order 1978;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1997;
- Social Security Claims and Payments Regulations 1979; and
- The Public Interest Disclosure Act 1998.

2.0 SCOPE OF POLICY

2.1 This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors, students, volunteers and bank and agency staff or locums and any others to whom the organisation owes a duty of care.

2.2 This policy excludes detailed arrangements in respect of the following areas which are covered by separate regionally agreed policies:-

- Policy on the reporting of Early Alerts;
- Policy of Being Open;
- Policy on Reporting of Adverse Incidents under RIDDOR Regulations;
- Policy on Supporting Staff involved in Incidents, Complaints, Claims and Coroners Inquests;

- Policy on Liaison and Effective Communications with PSNI and HSENI when investigating Patient Safety Incidents involving Unexpected Death and Serious Untoward Harm; and
- Policy on Mortality & Morbidity Guidance.

3.0 ROLES AND RESPONSIBILITIES

3.1 Trust Board: is responsible for ensuring that a robust system is in place for the reporting and management of adverse incidents and will receive regular management reports on this subject matter.

3.2 Chief Executive: is the Accountable Officer for the organisation and is responsible for ensuring that it meets its statutory and legal requirements in respect of adverse incident reporting and management. He/she will ensure that the Trust adheres to, and responds appropriately to, circulars and guidance issued by the Department of Health (DoH) in respect of adverse incident management.

3.3 Medical Director: is the lead Director responsible for the reporting and management of adverse incidents within the Trust. He/she will ensure that systems, policies and procedures are developed and implemented on an organisational basis including the onward reporting of relevant incidents to external agencies for e.g., Health & Social Care Board (HSCB), Heath & Safety Executive for Northern Ireland (HSENI) and the Regulation, Quality Improvement Authority (RQIA). On a daily basis this function is delegated to the Head of Quality & Safety**.**

The Medical Director as co-Chair of the Rapid Review Group holds delegated responsibility for holding other Directors to account in ensuring Serious Adverse Incidents and incidents graded as EXTREME risk (Red incidents) are managed in accordance with relevant systems, policies and procedures.

3.4 Director/s: are responsible for ensuring that the Trust's policy on adverse incident reporting and management is widely disseminated, promoted and implemented within their areas of responsibility.
Directors are ultimately responsibility for ensuring incidents reported within their directorates are managed in accordance with this policy and where deficits in incident management performance are identified they take remedial actions and ensure systems and processes are effective.

3.5 Assistant Directors and Professional Leads: are responsible and accountable to their respective Directors for ensuring that this policy and any associated procedures are effectively implemented within their areas of responsibility. They should also promote an open, honest and just reporting culture and ensure that appropriate reviews are carried out.

Assistant Directors are specifically responsible for ensuring Serious Adverse Incidents (SAIs) and Post Falls Reviews are reported, reviewed and the Directorate learning shared and actions taken as appropriate.

3.6 Senior Managers, Heads of Departments/Services: are responsible for:

- ensuring that this policy and associated procedures are effectively implemented across their area of responsibility;

- promoting an open, honest and just reporting culture;
- ensuring that staff are appropriately trained in the reporting and management of adverse incidents;
- ensuring that appropriate review of adverse incidents is carried out; and
- reviewing, approving and/or escalation of incidents via DatixWeb.

3.7 Person/s who report an incident (Reporter):

The Reporter is responsible for reporting the incident using DatixWeb in line with Trust reporting criteria and timescales. Where DatixWeb is not in use in some areas within the Trust then the reporter must report using the Trust Incident form which can be supplied by Risk Management department.

3.8 Person/s who review incidents (Reviewer / Handler):

The Reviewer is the staff member assigned by the manager responsible for the incident (Handler) to review the incident. Note that the Handler may assign a Reviewer or carry out the review themselves depending on the grading and review requirements. The handler is responsible for ensuring that incidents reported and reviewed are in line with Trust reporting policies and procedures and the content of the report is appropriate including review of incident grading to ensure it is reflecting the risk based on latest information. They will also be responsible for initiating and completing reviews within agreed Trust timeframes. On completion of this process they are responsible for moving the incident to 'awaiting final approval' stage.

3.9 Person/s who approve incidents for closure (Handler):

The person approving the incident for closure is responsible for ensuring the incident reporting and review process have been followed and that all information and/or actions contained within the report and review have been acted upon appropriately prior to agreeing 'final approval' and closure of the incident within agreed Trust timeframes.
The person approving the incident should be the incident Handler and for Low (Green) and Medium (Yellow) incidents the handler should have management responsibility for the relevant area/service to which the incident relates. For High (Amber) incidents the person approving the incident must be either the relevant responsible Professional Lead or Service Manager.
The above applies with the exception of incidents graded as Extreme (Red) where it is the responsibility of the Assistant Director to ensure appropriate review of these incidents but they cannot be closed without final approval from the Rapid Review Group (see 3.13 below)

3.10 Medicines Governance Pharmacist (MGP): is responsible for the expert review, quality assurance and identification of learning from reported medication incidents. In the event a Medication incident is categorised as a Serious Adverse Incident, the MGP should be involved in the review. He /she is also responsible for submission of HSC Trust medication incident data for regional analysis by the Medicines Governance Teams.

3.11 All staff: have a responsibility to:

- ensure the safety of individuals involved (service users, visitors and staff), the environment and equipment;
- avoid putting themselves and others in situations of danger;
- ensure their line manager/s and/or person in charge of the area is informed of the incident;
- record and report all adverse incidents using the organisation's reporting systems as soon as possible and ideally within 24 hours of the occurrence or becoming aware of the adverse incident; and
- co-operate with any review process including the provision of witness statements, if appropriate.

3.12 Senior Information Risk Owner (SIRO): is the lead Director for ensuring that Information Governance (IG) incidents are reported and appropriately managed including reporting to Information Commissioner's Office, if necessary. He/she (or nominee) will provide advice and support to managers in respect of IG incidents, as appropriate.

3.13 Rapid Review Group

Rapid Review group is responsible for monitoring and assessing the review of SAIs and Red Incidents to maximize the potential for identifying and sharing learning as quickly as possible for sharing across the Organisation and where appropriate the Region.

Specific responsibilities in relation to Incident management are:-

- Review Red incidents (or other incidents escalated to RRG for consideration as potential SAIs) reported in preceding week, assess progress of review and give direction on level and type of review required.
- Escalate to the Chief Executive delayed reporting of incidents identified at RRG as SAIs.
- Consider Review team membership of new SAIs and recommend degree or independence and appropriate Chair / experts
- Review progress on SAI and Red incident investigations and seek explanations for delay in process and escalate issues relating to system performance through C&SCG Sub-Committee, CMT and Chief Executive as required.
- Escalate any serious risks identified through the incidents reviewed (triangulated with any other information provided e.g. complaints) to Risk leads, CMT, C&SC/Corporate Governance sub-committees or any other persons or forum identified as appropriate to ensure onward management.
- Peer review SAI reports approved by Assistant Directors and pending final approval by Directors.
- Identify learning for sharing corporately and/or regionally including referring for clinical audit, quality improvement projects and training plans
- Receive assurances from Directorates on progress on SAI action plans and family engagement.
- Provide a summary report to the Trust's Clinical and Social Care Governance Sub Committee of Governance Committee.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

4.1.1 Adverse Incident: Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of a HSC organisation/Special Agency or commissioned service[2]. A suggested list of broad categories of adverse incidents to be reported is listed in Appendix 1, for guidance purposes.

4.1.2 Harm is defined as: "injury (physical or psychological), disease, suffering, disability or death".[3] In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient's/client's illness or underlying condition.

4.1.3 Serious Adverse Incident (SAI): is an adverse incident that must be reported to the Health and Social Care Board (HSCB) because it meets at least one of the criteria as defined by the HSCB within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAI's), Oct 2016[4].

4.1.4 Service User[5]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

4.1.5 Post Falls Review: is required following an adverse incident where an Adult patient has fallen whilst an inpatient within a Trust Hospital and who has suffered Moderate or above harm/ death as a direct result.

4.2 Policy Statement

The Trust is committed to providing the best possible services for its service users, staff and visitors. It recognises that adverse incidents will occur and that it is important to identify causes to ensure that lessons are learnt to prevent recurrence. It is, therefore, essential that a responsive and effective incident recording, reporting and management system is in place to achieve this aim. Where learning from such adverse incidents is identified the necessary changes should be put in place to improve practice.

4.3 Policy Principles

4.3.1 The organisation's approach to Adverse Incident Reporting and Management: An open, honest and just culture[6]

As part of its proactive approach to risk management, the organisation promotes an open, honest and just culture in which errors or service failures

[2] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[3] Doing Less Harm, NHS, National Patient Safety Agency 2001

[4] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[5] As per the draft Statement of what you should expect in relation to a Serious Adverse Incident Review, January 2019

[6] *a just culture focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviours, while maintaining individual accountability by establishing zero tolerance for reckless behaviour. Just organizations focus on identifying and correcting system imperfections, and pinpoint these defects as the most common cause of adverse events. Just culture distinguishes between human error (e.g., mistakes), at-risk behaviour (e.g., taking shortcuts), and reckless behaviour (e.g., ignoring required safety steps), in contrast to an overarching 'no-blame' approach" (Agency for Healthcare Research and Quality; Patient Safety Network 2016, US Department of Health).*

can be admitted, reported and discussed without fear of reprisal. This will enable lessons to be identified and allow active learning to take place and the necessary changes made or reflected in policies, procedures and practices.

All staff must report and manage adverse incidents according to this policy (and any related operational procedures) for adverse incident reporting. Crucial to the effectiveness of adverse incident reporting and management is the organisation's commitment to the promotion of an open, honest and just culture where all staff can participate in reporting adverse incidents. Staff are encouraged to report incidents and to look critically at their own actions and those of their teams, to ensure the organisation can provide quality services for our service users, staff and visitors.

Ultimately, the organisation wants to encourage staff to report areas of concern and to foster a positive ethos around reporting. Staff who make a prompt and honest report in relation to an adverse incident should not expect to be subject to disciplinary action except under the following circumstances:-

- A breach of law;
- Wilful or gross carelessness or professional misconduct;
- Repeated breaches of Trust policy and procedure;
- Where, in the view of the Trust, and/or any professional registration body, the action causing the incident is far removed from acceptable practice; or
- Where there is failure to report a serious incident in which a member of staff was involved or about which they were aware.

Completion of an adverse incident report does not discharge staff of their duty of care and their risk management responsibility. There should be timely and appropriate follow-up of adverse incidents. Where preventative measures and/or procedural changes are identified these should be put in place to minimise the risk of the adverse incident recurring.

All employees must be honest, open and truthful in all their dealings with patients/clients and the public, and organisational and personal interests must never be allowed to outweigh the duty of openness, transparency and candour.

4.3.2 External reporting arrangements in respect of other incidents not covered by this policy

Depending on the nature of the adverse incident the organisation may be required to report relevant details to other statutory agencies and external bodies for eg, HSCB, RQIA and HSENI. Staff should ensure that they are aware of their local reporting requirements to other statutory agencies and external bodies as per their local policy/procedures. These incidents must also be recorded on the organisation's incident reporting system.

With regard to Independent Service Providers (ISPs) and contractors, they will be required under their contractual arrangements to maintain a system of reporting and recording of adverse incidents related to service users referred

to them by the Trust for assessment, treatment or care. ISPs are also required to submit monitoring information to the organisation as required. Both adverse incidents and SAIs are discussed at contract meetings between Trusts and ISPs. As per the HSCB procedure for reporting SAIs (November 2016), the Trust will decide whether an ISP adverse incident meets the criteria for reporting as a SAI and is, therefore, responsible for reporting the SAI to the HSCB.

This policy does not cover the arrangements for the reporting of Early Alerts to the DoH as this is the subject of separate guidance/policy.

4.3.3 Operational Procedures for Reporting of Adverse Incidents

The process for reporting, recording and reviewing adverse incidents is detailed below and also included in diagrammatic format in Appendix 1. Key points to remember are listed below.

4.3.4 What to do when an adverse incident occurs – immediate actions

The injured person or damaged property should be assessed immediately to ascertain extent of injury/damage and identify emergency or urgent treatment/action required. The situation must be made safe. Communicate with the service user and their relatives/carers, as appropriate following an adverse event. Ensure appropriate discussion with the service user and/or relatives/carers and give consideration to any additional support which may be required. Refer to the organisation's Being Open Policy. Any equipment involved in the adverse incident, even if not directly implicated, should be removed from use and the following action taken:-

- Clearly label "Do Not Use" including a short description of the nature of the fault, if possible;
- Retain any related evidence such as packaging (for batch or serial numbers) or consumables/accessories (eg, giving sets for pumps etc);
- Decontaminate any device that can be decontaminated without destroying evidence and attach a decontamination certificate to that effect (refer to local Trust policy); and
- For medication – where packaging or labelling of a medicine is an issue, retain or photograph to facilitate further review and follow up with the pharmaceutical company/MHRA.

You must also follow **Verification of Life Extinct Policy** in relation to immediate actions to be taken when finding a person deceased following a suspected incident.

4.3.5 Who should report?

Any member of staff can report an adverse incident. It is the responsibility of **ALL** staff who are involved in, witness to, or become aware of an adverse incident, to ensure it is reported using the organisation's adverse incident reporting system. If the incident involves another area within the Trust, this area must be made aware of it and remedial actions agreed.

4.3.6 When to report?

It is important that all adverse incidents are reported as soon as possible and ideally within 24 hours of occurrence or becoming aware of the adverse incident. This supports effective review and timely learning, and ensures compliance with responsibilities for external reporting.

4.3.7 What types of incidents to report?

The incident reporting system will ensure that any event which meets the definition in section 4.1.1 involving service users, staff and visitors are reported promptly and action instigated, where necessary. Appendix 2 provides a list of broad categories of possible adverse incidents which may assist reporters. This is not an exhaustive list but gives a broad indication of the types of adverse incidents to be reported.

4.3.8 How to report?

All incidents should be reported using the organisation's adverse incident reporting system (DatixWeb).

In respect of incidents involving service users, please note that adverse incident reports are NOT health records and copies of any electronic reports (or paper forms) should NOT be filed in the service users' records. However, details of the incident (including the incident reference number, if available) that are relevant to the treatment and care being provided to the service user should be included within the service user's healthcare record.

4.3.9 Other Reporting Systems

Some departments have additional error and incident monitoring arrangements (e.g. Laboratories) as part of specific legal, accreditation or quality assurance framework requirements for these services. Staff using these systems must ensure that incidents which meet the organisation's definition of adverse incidents are also reported via the organisation's adverse incident reporting system.

4.3.10 Staff Support directly following an incident

The organisation recognises that it has a responsibility to support all staff following adverse incidents. All staff involved in an adverse incident will need an appropriate level of support consistent with the outcome of the incident. It is the line manager's responsibility to ensure that individuals are supported appropriately. Support can be provided by Occupational Health, Trade Unions and local Staff care Services **Inspire Workplaces**. Staff involved should be kept informed of the progress of a review at all stages.

In addition, individuals who have been absent from work may require additional support and supervision to aid confidence when returning to work.

Staff involved in the incident should also be involved in the review where appropriate, with feedback, when complete. Further guidance can be obtained via the Trust's policy on **Supporting Staff Involved in an Incident.**

4.3.11 Arrangements for Incident Review & Grading

Deciding what to review

Many organisations typically report thousands of incidents each year. It is therefore unrealistic to suggest that all incidents should be reviewed to the same degree, or at the same level, within the organisation. Furthermore, the outcome of an incident, including a 'near miss', at the time of occurrence is sometimes a poor indicator of the level of review required. The application of a simple risk assessment process to incidents at the time of occurrence can enable the organisation to implement a much more structured approach to its incident management.

Organisations should grade all incidents in DatixWeb for actual impact at the time of reporting the incident. This is usually completed by the reporter of the incident using the Regional Risk Matrix (Impact Assessment Table) (see Appendix 3).

In addition, it is important to complete the potential risk grading also using the Regional Risk Matrix (Impact Assessment Table/ Likelihood Descriptors) on DatixWeb (see appendix 4)**.**

4.3.12 Communication with Service Users and/or relatives (for incidents resulting in moderate to catastrophic harm incidents)

The lead member of staff responsible for the treatment and/or care will retain the responsibility for communicating with the service user and their relatives about the incident. However, there may also be a liaison person at a senior level identified to make contact with the family.

Harming a service user can have devastating emotional and physical consequences for the individuals, their families and carers, and can be distressing for the professionals involved. ***'Being Open'***[7] is a set of principles that health and social care staff should use when offering an explanation and apologising to service users and/or their carers when harm has resulted from an incident. **"Saying sorry is not an admission of liability".**

'*Being Open'* involves:

[7] WHSCT Being Open policy

- acknowledging, apologising and explaining when things go wrong;
- keeping service users and carers fully informed when an incident has occurred;
- conducting a thorough review into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident reoccurring;
- providing support for those involved to cope with the physical and psychological consequences of what happened; and
- recognising that direct and/or indirect involvement in incidents can be distressing for health and social care staff. Permission will be given to seek emotional support.

The organisation is committed to improving the safety and quality of the care we deliver to the public. Our '*Being Open'* policy expresses this commitment to provide open and honest communication between health and social care staff and a service user (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven Steps to Patient Safety'*.

Further guidance on communicating with service users and their relatives is available in the Being Open and/or Serious Adverse Incident Policy.

4.3.13 Communication with the Media

All communications with the media should be co-ordinated by **the Head of Communications.**

4.3.14 Debriefing of Staff after Adverse Incidents

Assistant Directors/Co-Directors/Senior Managers and Heads of Department should ensure that local procedures are in place for the debriefing of staff after incidents. Agreed timescales for debriefing should be specified. The Line Manager should ensure that the staff member has access to appropriate help immediately post incident as necessary eg, referral for medical opinion in case of assault, counselling etc. Line managers should, where appropriate, seek medical advice as to whether it is advisable for the staff member to return to (or stay in) the workplace.

In the case of assaults, line managers should discuss with the staff member whether or not they wish the police to be involved. Line managers should make staff aware of the availability of the services of Occupational Health Services and other staff care services E.g. Critical Incident & Stress Management (CISM).

It should be standard practice at all debriefing sessions with staff to consider the contributing factors, which may have led to an incident. This should assist staff in reviewing practice and updating care plans, risk assessments etc. in order to minimise the risk of recurrence. Details of debriefing offered/arranged should be documented and retained in the staff member's

local personnel file. See Trust policy of Supporting Staff involved in an Incident.

4.3.15 Review, Monitoring and Analysis of Adverse Incident Statistics

The organisation has in place mechanisms for the review, monitoring and analysis of adverse incidents and produces reports for consideration and discussion locally at relevant governance related committees/sub committees and externally as required. Incident statistics should also be used with other sources of statistics to help inform the management of risks and effectiveness of actions taken following incident reviews, Quality Improvement projects and other quality and safety initiatives.

The Medicines Governance Pharmacist will lead on the multidisciplinary review, monitoring and analysis of medication related incidents and will link in with the Regional Medicines Governance Team in respect of the production of regional Medication related governance reports.

4.3.16 Learning and Feedback

Learning from adverse incidents can only take place when they are reported and investigated in a positive, open and structured way. Where learning from such adverse incidents is identified the organisation will ensure that the necessary changes will be put in place to improve practice. Where learning from incidents is relevant to other areas across the organisation, and/or externally, the learning should be shared as per current organisational arrangements, eg, established sub committees and groups.

Feedback to staff is vital in respect of incidents they report. Managers should ensure it occurs in their respective areas. This can be on a one to one basis or feedback can be given to all staff at regular Incident, Staff or Assurance / Governance Meetings.

5.0 IMPLEMENTATION OF THE POLICY

5.1 Dissemination

This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors, students, volunteers and bank and agency staff or locums and any others to whom the organisation owes a duty of care. All staff employed by the Trust should be provided with access to this policy. The latest version of this policy (and related documents) is available on the Trust's intranet.

5.2 Resources

5.2.1 Training

Adverse Incident Training is mandatory for all staff and appropriate training and guidance will be provided by **of the Risk Management Department** to ensure that all Trust employees understand their responsibilities under this policy and are able to effectively fulfil their obligations to report adverse incidents. The organisation's training administration system (HRPTS) should be used appropriately to record staff training. Senior Managers/Heads of Departments are responsible for ensuring that their staff avail of training on Incident Reporting.

All incident handlers are required to be trained in reviewing and approving incidents on Datix before being set up on the system as handlers.

All staff who are required to chair/lead Serious Adverse Incident reviews must be trained in (or have at least one SAI review team member who has been trained in) reviewing SAIs.

The AD responsible for an SAI must ensure that their nominee to liaise with the patient/family (where applicable) has experience or training in communicating with the service user / family.

Members of the review team for a Homicide reported under the SAI criteria, should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

5.3 Exceptions

There are no exceptions to this policy and to the organisation's commitment to learn from adverse incidents.

6.0 MONITORING

An audit of the policy will be undertaken post implementation to ensure adherence to the principles and procedures outlined in this policy document. Changes will be made to the policy, as required. This policy will be reviewed on a regular basis by the **Corporate Risk Manager** in the light of best practice, changing legislation or new/updated policy guidance.

7.0 EVIDENCE BASE/REFERENCES

- Health & Safety at Work (Northern Ireland) Order 1978;
- Management of Health & Safety at Work Regulations (Northern Ireland) 2000;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997;
- HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016;
- Six steps to Root Cause Analysis, 2002, Consequence UK Limited;
- National Patient Safety Agency;
- Seven Steps to Patient Safety (2004); and
- Being Open, Patient Safety Alert, November 2009.

8.0 CONSULTATION PROCESS

This policy was developed by the Regional Adverse Incident Work Group chaired by the Assistant Director, Risk Management & Governance, South Eastern Health & Social Care Trust. Consultation was completed via email with relevant Assistant Directors and staff within all organisations included in the working group.

9.0 APPENDICES

Appendix 1 – Incident reporting and review process flowchart
Appendix 2 – Examples of Adverse Incidents
Appendix 3 – Regional Risk Matrix
Appendix 4 – Guidance for Incident Review and Grading

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

SIGNATORIES

_____ **Date:**

Author

_____ **Date:**

Director

Appendix 1 – Process for Reporting and Managing an Adverse Incident (including level of incident review based on potential risk grading)

INCIDENT

IMMEDIATE ACTION

1. Make person(s) / area safe.
2. Obtain medical aid if required.
3. Inform manager on duty ASAP.
4. Complete an incident form.
5. Consider level of communication with the patient.
6. Consider level of review required and action accordingly. If incident meets SAI criteria, follow relevant procedures.

GREEN INCIDENT (LOW RISK)

Green incidents – Should normally be reviewed locally in the ward or department in which the event occurred. The investigative lead will normally be the Ward/Team/Departmental manager. It is the local team's responsibility to identify learning points, or safety improvement measures that are within the departments control and ensure that those safety measures identified that are not within the control of the department are appropriately communicated to the relevant Management Team for consideration.

Incident types frequently falling into this category should also be subject to aggregate analysis by the Ward/Team/Departmental Manager to identify any need for more targeted data collection. It is acceptable for the ward/departmental manager to close such incidents following review and recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 5 working days**.

YELLOW INCIDENT (MEDIUM RISK)

Yellow Incidents – These should also be reviewed locally, as for Green Incidents, by the **[Ward / Department Manager]** for that area. Again it is the local team's responsibility to identify learning points, or safety improvement measures within the departments control and ensure that those which are not, are appropriately communicated to the relevant Management Team for consideration. Frequently occurring events attracting this risk category should also undergo Trust-wide aggregate review to identify any need for more targeted data collection.

It is acceptable for the Ward/Team/Departmental Manager to close such incidents following review and proper recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 4 weeks**.

AMBER INCIDENT (HIGH RISK)

Amber Incidents – These incidents should be subject to the appropriate level of review. The **Professional Lead / Service Manager** should discuss with the relevant **Assistant Director**, who is going to take the lead. It is the responsibility of the Professional Lead / Service Manager to ensure that all learning points and safety improvements are appropriately identified and actioned and those not within the control of the local management team are communicated to the relevant person/s and committee/s, whichever is the more appropriate.

Note – Improvement strategies arising out of this group of events should be monitored as part of the organisation's Governance arrangements.

The Professional Lead / Service Manager should close such incidents following review and proper recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 12 weeks**.

RED INCIDENT (EXTREME RISK)

Red Incidents – Where major (ie, long-term permanent harm/disability [physical/emotional injuries/trauma]) or incident leading to death) has occurred the **Director and/or Assistant Director**), with the support and advice of the Rapid Review Group should appoint a team led by a trained facilitator in SEA/root cause analysis. All of the resulting reports and improvement strategies arising from these events should be monitored by the organisation's Rapid Review Group and escalated as appropriate through the Governance framework.

Red incidents should close following approval by the AD and subsequently the Rapid Review Group that appropriate review is complete and proper recording of findings with any lessons learned has been included and actions initiated.

Review of this grade of incident should normally be completed and **closed within 12 weeks.**

External reporting
Follow the guidance on the Datixweb incident reporting form for reporting RIDDOR reportable incidents incidents and Medical Device incidents to the Northern Ireland Adverse Incident Centre.

RIDDOR reportable events are:
Any fracture (not fingers or toes) | Amputations | Dislocation of Joint
Loss of sight | Chemical, hot burn to eye | Any electric shock requiring resuscitation | Hypothermia, or heat induced illness | Loss of consciousness – asphyxia | Acute illness caused by biological substance

If in doubt contact Risk Management at RskManager.ClericalOfficer@westerntrust.hscni.net_____

Open, Honest and Just Culture

This Trust welcomes knowledge of adverse events as an opportunity to learn for the benefit of our service users, staff and visitors. Unless there is clear evidence of flagrant malpractice, a complete disregard for the safety of others, maliciousness, intent to harm, theft or fraud the disciplinary policy will not be used for review purposes. Incidents will be investigated for the purposes of learning and change and staff are required to engage as active participants of this.

Appendix 2 – Examples of Adverse Incidents that should be reported

Broad categories of possible adverse incidents are shown below and may assist reporters. This list is not comprehensive but gives a broad indication of what should be reported

- Abusive, violent, disruptive, challenging or self-harming behaviour
- Delays or difficulties during appointments, admissions, transfers or discharges
- Accidents e.g. falls, medical sharps injuries, manual handling, exposure to hazardous substance, burn or scalds
- Cardiac arrests involving CPR and/or Defib
- Issues with clinical investigations, scans, x-rays, lab tests etc.
- Communication breakdowns between staff and/or with service users, issues with consent and confidentiality
- Diagnosis, missed or delayed
- Financial loss to the Trust
- Infrastructure or Resources (staffing, facilities, environment) – for example, unsafe environment, waste issues, misuse, failure or theft of IT equipment or systems, lack of facilities, equipment or supplies, inadequate staffing levels
- Infection control issues, pressure sores, fluid maintenance, pain management, any other issues relating to implementation of care or ongoing monitoring / review
- Labour or delivery adverse incidents
- Medical device/equipment related Incidents – any preventable equipment related event that could have or did lead to patient harm, loss or damage. Includes incidents related to training, servicing, disposal, storage, and suitability as well as failure of the equipment itself
- Medication incident (i.e., any preventable medication related event that could have or did lead to patient harm, loss or damage).
- Patient Information issues e.g. records, documents, test results, scans. This may also include any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.
- Treatment, procedure – any adverse incident immediately before, during or immediately after
- Security – for example, fires and fire risks, theft or damage to personal property, premises or vehicles, intruders or break-ins

Appendix 3 – Regional Risk Matrix

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid. • Non-permanent harm lasting less than one month. • Admission to hospital for observation or extended stay (1-4 days duration). • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest > 3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

SET Risk Matrix – April 2013 (based on HSC Regional Risk Matrix - April 2013, updated June 2016) - Clean

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Risk Matrix/Consequence (Severity Levels)				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Appendix 4 –

How to grade incidents (in relation to the Impact on the person affected)

The accurate grading of an incident is crucial to effective incident management. An incorrect grading can mask serious harm, risks and trends and can inappropriately prioritise valuable resources away from incidents of greatest risk, thus limiting our ability to help reduce those risks.

Every incident must be graded in terms of both the 'Actual Impact/Severity' (hereinafter Impact) and the 'Risk' to a particular 'domain'. The domain is selected from a list which includes People's health, safety and welfare; Professional standards; Organisational reputation; finance; and environment. The reporter should select the one most impacted by the incident.

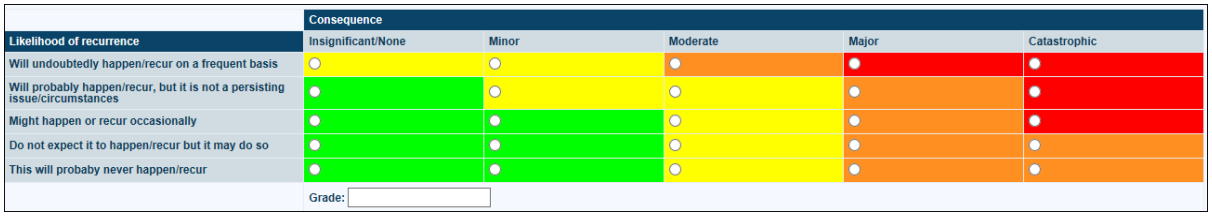
The majority of incidents that are reported primarily do (or could) impact people's health, safety or welfare and this is the domain we will focus on here. For guidance on grading against other domains (if more affected than the impact on people in an incident), please see Risk Management policy appendix 3.

Grading on Datix

Incidents are graded when reporting the incident by completing the following mandatory section on the Datixweb form. The handler must then review the grading (see below).

Select appropriate grade from drop down list

Select the appropriate grade by clicking the button which corresponds to your assessment of the Consequence and Likelihood at the coloured box where they meet, as per below:-



How to grade the Impact on people's health, safety or welfare

- Impact grading is the actual harm, not what it could have been.

Specifically for incidents where grading the impact on a person's health, safety or welfare, this is measured in terms of:-

- the duration of the harm/ injury or
- Any increased hospital stay as a direct result of the incident, regardless of the actual harm/injury itself, or
- Increase in treatment required as a result.

The following table should be used as a guide:

Table1: Guide to grading Impact or Consequence on a person

Impact / Consequence	Duration of Harm/Injury, or	Increased Hospital Stay required, or	Increase in treatment required	Emotional Impact
Insignificant	No Harm/Injury of note		None	None
Minor	Less than 1 month	Less than 5 days	Minor	Emotional distress – recovery within 1 month
Moderate	Between 1 month and 1 year	Between 5 and 14 Days	Moderate treatment e.g. Surgery required	Emotional injuries/trauma – recovery within 1 year
Major	Greater than 1 year	Greater than 14 days		Emotional injuries/trauma – recovery beyond 1 year
Catastrophic	Permanent - affecting more than one person / Death			Permanent Emotional trauma affecting more than 1 person

How to grade the Incident Risk

- Risk grading involves grading the potential future impact (known as consequence) if the incident were to happen again, in relation to the likelihood of the incident recurring (and with that impact being realised).

The Risk grading requires an estimate of

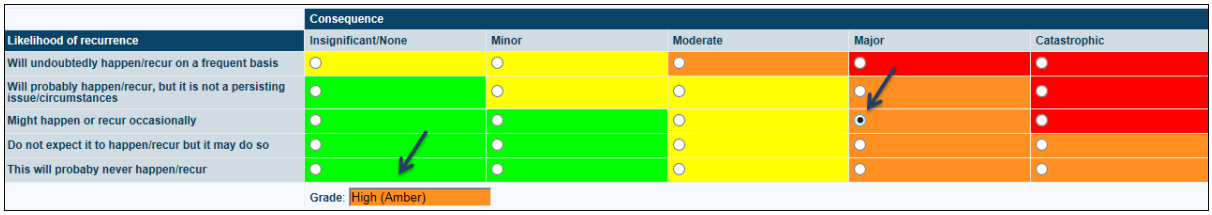
(1) The future potential Impact (Consequence). This should be done exactly as per the Impact grading above except it is an estimate on the most likely impact if that incident was to happen again, in relation to a similar person in the same circumstances and with current controls in place. It should be the most likely or typical impact for that incident.

(2) The likelihood of that incident impact reoccurring should then be graded. This should be an estimate based ideally on previous history e.g. incident reports of the frequency that such an incident with such an impact will occur. The following table can be used as a guide to estimating likelihood of occurrence

Table 2: Likelihood guide

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

When you select the appropriate coloured box in the grading matrix on Datix the system will produce the Risk Grading score for you as illustrated in example below. (If using the paper incident form, this should be marked manually on the grid provided)



For above example: *If* **Consequence** = Major *and* **Likelihood** = 'Might Happen…'

then **Risk Grading** = High (Amber)

The Risk grading determines the level of investigation required and therefore appropriately apportions resources to reviewing incidents in terms of the risk they present.

Review of Grading

The Manager (Handler) must review the Impact and Risk grading when approving the incident to ensure accuracy as they will have more information at that stage and have greater experience and oversight of similar incidents. They are also more detached from the immediate emotional impact, which may (understandably) influence the initial grading.

Where degree of impact is unclear

It may be difficult to estimate impact at the time of reporting / reviewing the incident so it should be estimated based on all evidence available. If / when further information becomes available regarding the harm/injury the incident handler should then re-grade the impact / and update the injury section under person affected. The Risk grading should also be re-considered. Further questions may need to be answered on Datix as a result.

Action required based on the Incident Grading

The Table in Appendix 1 details the actions required with regard to the level of review based on the potential risk grading.

For further details on how to do this refer to the **Risk Management Department.**