The Pennine Acute Hospitals NHS
NHS Trust

ACCIDENT AND INCIDENT REPORTING POLICY

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Chief Executive

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Contents

1 Introduction

This policy relates to the requirement of all personnel employed by the Trust to report all untoward events, including near misses, regardless of whether they involve patients, visitors, staff or contractors. They should be reported as soon as possible after the event, using the Trust's incident reporting form/system, and in all cases within 24 hours.

The reporting of untoward events is an integral part of the Trust's risk management strategy, which has a goal of identifying and then removing, or reducing to an acceptable level all risks across the organisation.

The Trust is committed to developing an organisational non-punitive culture that listens to staff and responds to what they say in a positive and supportive manner in accordance with Pennine Acute Hospitals NHS Trust Public Interest Disclosure Act (Whistle Blowing) Policy, this can be found in the Personnel Policies and Procedures Folder or under Documents, in the Personnel section of the Trust Web. It is important to state however that where incidents occur as a result of gross neglect or recklessness, these cannot be excused and appropriate action will be taken.

2 Definitions

Untoward events include all of the following:

Incident – an untoward or unexpected event, this would include verbal abuse, threats and gestures and harassment.

Accident – an incident that results in loss or damage, this would include violence resulting in actual harm.

Clinical Incident – an incident occurring to a patient during or because of treatment.

Clinical Accident – a clinical incident that results in actual harm to the patient during or because of treatment, this would include unexpected deaths and unexpected/unexplained clinical outcomes.

Serious Untoward Clinical Incidents – a situation in which one or more patients, staff or members of the public are involved in an actual, or alleged event, arising from the clinical process. The situation could lead to significant legal, media or other interest which if not properly managed may result in a loss of reputation or assets of the Trust and the professional standing of staff. This would include:-

- A number of unexpected/unexplained deaths or serious unexpected clinical outcomes.

- Equipment malfunction leading to equivocal test results.

Hazard – Anything with the potential to cause harm.

Near Miss – any of the above that were narrowly avoided or that are judged may happen in the future.

3 Accountabilities/Responsibilities

The Chief Executive has overall responsibility for Trust wide legislative compliance and management of risk.

The Medical Director has Board responsibility for all aspects of risk management including accident/incident reporting. This post also has delegated responsibility for keeping the Board fully informed about serious untoward events as well as general trends.

The Governance Director has responsibility for co-ordinating accident/incident reporting across the sites of the Trust, and in trend analysis of these reports and any associated trends common to complaints and/or claims. This post also has responsibility along with the Medical Director and Director of Nursing for instigating the correct level and form of investigation following any serious RED GRADED untoward event.

The Divisional Management Teams have responsibility to review accident/incident trends in their own divisions and develop action plans to prevent the recurrence of avoidable accidents/incidents. They also have a responsibility to conduct or assist in root cause analysis investigations of red graded untoward events as directed by the Governance Director. When untoward events are graded orange the team has responsibility for instigating the correct level and form of investigation.

The Governance Teams are site based, with a close working link to the Divisional Management Team based on their site. They vary on each site and can include Risk Co-ordinators, Health and Safety Advisors, Risk Management Assistants and clerical assistance. They are responsible for categorising incidents, entering them into the computerised recording system and retaining the original incident forms for at least 10 years. They are responsible for reporting, where appropriate, to outside agencies including the Health & Safety Executive (HSE), the Strategic Executive Information System (STEIS) and the National Patient Safety Agency (NPSA) and advising on, and being involved in, full investigations as directed. They should report internally to Executive Directors and liase with the Claims Manager when litigation may ensue. They shall review the effectiveness of action plans introduced to prevent recurrence of untoward events. They will also take the lead in developing and delivering training relating to untoward incident reporting, grading and investigation.

Ward/Departmental Managers are responsible for ensuring that an accident/incident book is available within their ward/department, and that it is accessible for staff at all times. When untoward events are graded yellow, the manager has responsibility for instigating the correct level and form of investigation. They should ensure that all staff know how to use the reporting system and know what should be reported. They must also ensure that any staff who may be in charge of their ward or department at any time are trained in basic accident/incident investigation and grading to allow them to complete sections 6,7,8 and 9, and when appropriate, optional boxes A, B, C and D of the form.

All staff must ensure that any untoward event is promptly reported using the incident reporting system, and that the person in charge at the time of the incident is informed to allow them to promptly investigate the incident and complete their sections of the form.

Immediate action following an incident.

Following every incident, whether a near miss or an incident resulting in injury, all managers must take and record immediate and/or preventative actions. Immediate action taken should be recorded on the Incident Form (Box 6 – Action Taken to Prevent a Recurrence).

A list of policies that contain immediate action to be taken following an incident are listed in Appendix 2. This list is not exhaustive and will be added to as policies are produced or amended. Some examples of actions that they need to take are:

- referral of a member of staff to Occupational Health following a needlestick or manual handling injury
- the removal of equipment from service
- the review of existing risk assessments
- the taking of witness statements at the earliest opportunity
- the counselling of patients, relatives and staff

4 Procedure

- The accident/incident book should be available in every ward/department at all times and must NOT be removed. Replacement books are available as a stock item from Supplies. The name of the designated line manager to whom blue copies of the incident form should be sent, should be marked on the front of the book.

- All sections must be completed as fully as possible, using block capitals, in black ink.

- The book should be used to report incidents, accidents, clinical incidents, unexpected/unexplained clinical outcomes, violence/aggression including verbal or racial abuse, security breaches suspected or proven, intranet abuse, theft and near misses.

- In the case of a staff incident, the member of staff involved should complete sections 1 to 4. If this is not possible, then completion by a colleague on their behalf is desirable - this may mean dictation by telephone. In the case of a patient, a member of staff should complete these sections. Incidents occurring off site must be reported.

  The member of staff completing sections 1 – 4 should sign the form in section 5.

- When completing section 2 the information should be accurate and complete, only FACTS and KNOWN contributory factors should be recorded. Avoid the use of 'may have', 'must have', or 'apparently' etc.

- Section 4 should be fully completed with name and designation. Witnesses should only be listed if they actually witnessed or were involved in the incident.

- Sections 1 - 5 should be completed at the time of the accident/incident or as soon as possible afterwards. The book should then be passed to the person in charge as soon as possible and always within the shift/day.

- The person in charge should now complete sections 6 – 8 and when appropriate the optional boxes A – D.

- Section 6 relates to accident/incident investigation - confirming the circumstances relating to the event, any action taken to prevent immediate recurrence, and any further action required.

- Section 7 relates to the grading of incidents, this section MUST be completed for all incidents/accidents using the guidance in section 5 below.

- Section 8 relates to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). The completion of the form should not be delayed in order to fill in this section, if in any doubt tick the 'unsure at this time' box. Additional guidance on RIDDOR reporting is provided in Appendix 2 of this policy.

- Unexpected deaths and serious accidents, particularly those known or thought to be reportable under RIDDOR should be reported immediately to the Governance Department.

- The white copy should now be removed from the book and sent to the site-based Governance Department within 24 hours.

- The blue copy should be removed and sent to the line manager as designated on the front cover of the incident book. In the case of staff accidents/incidents the blue form will be filed in their personal records.

- Should a ward/department wish to do so a photocopy of the incident form may be retained provided that these are securely stored.

Further information/guidance can be obtained from the Governance Departments based on each site.

5 Guidance on Grading Untoward Events

The following matrix can be used to grade all types of untoward events. It involves determining the consequences of the particular untoward event and then the likelihood of a recurrence of the accident/incident. Grading of incidents must be completed as soon as possible after the event and in any event within 24 hours in line with Section 4 above.

Consequence

Determine the consequences of the untoward event from table 1 below. All columns that are appropriate should be used to determine the consequences with the highest score becoming the actual consequence used in the matrix. Where there is more than one consequence the most serious one should be used to grade the incident in the matrix.

If in doubt grade up NOT down.

TABLE 1

Consequence	Impact on individual(s)	Impact on the Trust	Number of persons affected at one time
Catastrophic	DEATH Permanent brain damage	International adverse publicity HSE investigation Extended Closure	Many e.g. cervical screening disaster
Major	PERMANENT INJURY Loss of body part(s) Mis-diagnosis – poor prognosis	Temporary Service closure DOH reportable National adverse publicity	Moderate number e.g. loss of specimens vaccination problems
Moderate	SEMI-PERMANENT INJURY / DAMAGE e.g. injury that takes up to 1 year to resolve RIDDOR reportable injury	Needs careful PR MDA reportable Local adverse publicity RIDDOR reportable	Small numbers e.g. 3-10
Minor	SHORT TERM INJURY / DAMAGE e.g. injury that will be resolved within 1 month	Minimal risk to organisation	One
Insignificant	NO INJURY OR ADVERSE OUTCOME	No risk to organisation	None

TABLE 2

Likelihood

Determine the likelihood of a recurrence using the following guidance in table 2.

Likelihood	Description
Almost Certain	Likely to re-occur on many occasions, a persistent issue
Likely	Will probably re-occur but is not a persistent issue
Possible	May re-occur occasionally
Unlikely	Do not expect it to happen again but it is possible
Rare	Can't believe that this will happen again

Grading

Put the likelihood and consequence through the following matrix (table 3) to determine the grade of the untoward event.

TABLE 3

Likelihood	Consequence				
	Insignificant	Minor	Moderate	Major	Catastrophic
Almost Certain	MODERATE	MODERATE	SIGNIFICANT	HIGH	HIGH
Likely	MODERATE	MODERATE	SIGNIFICANT	HIGH	HIGH
Possible	LOW	MODERATE	SIGNIFICANT	HIGH	HIGH
Unlikely	LOW	LOW	MODERATE	SIGNIFICANT	HIGH
Rare	LOW	LOW	MODERATE	SIGNIFICANT	HIGH

6. Action Following Grading

6.1 Re-grading of Incident

There is the facility to re-grade incidents following completion of the incident form.

6.1.1 If following an incident, immediate action has been taken by a manager to reduce the likelihood of reoccurrence the incident may be re-graded accordingly. In such instances a detailed description of the steps taken/lessons learned in order to prevent reoccurrence must be included on or appended to the incident form. The person re-grading the incident should document how they have arrived at the new grade and sign and date that document, clearly indicating their designation.

6.1.2 If following investigation of the incident the initial risk grading is found to be either too high or too low, the incident must be regarded accordingly. In such instances a detailed description of the rationale for re-grading must be included on or appended to the incident form, the person re-grading the incident should sign and date the document, clearly indicating their designation.

6.2 Near Misses

All near misses should be graded according to the above criteria according to their potential outcome. However, they should not trigger the Divisional reporting process outlined below for Red or Orange incidents. The Governance Team will initiate the Divisional process on receipt of the incident form. All near misses graded yellow or above should follow the reporting process detailed at paragraph 6.4 below.

6.3 Red (HIGH) Graded Untoward Events

6.3.1 The person in charge at the time of the incident who has graded the untoward event, must inform their immediate manager, a member of the site management team/or on call manager and the Governance Department. The incident form should be sent to the Governance Department as soon as possible, and in all cases within 1 working day. The Governance Department to immediately notify the Medical Director, the Director of Nursing or the Chief Executive as appropriate. Out of normal office hours red graded incidents should be reported to the incident reporting hot line on 0161 627 8808.

6.3.2 The Site Management Team or on call manager to notify the Divisional Management Team (DMT), and provide a copy of the incident form and a single A4 sheet confirming the facts/circumstances of the incident and related issues as soon as possible, and in all cases within 1 working day.

6.3.3 The Governance Teams on receipt of the accident/incident form to confirm that the Governance Director is aware of the untoward event, and following review and confirmation of the grade, to report to the appropriate outside agencies, e.g. the Health and Safety Executive (HSE), Strategic Health Authority or the National Patient Safety Agency (NPSA).

6.3.4 Following appropriate consultation with the Medical Director, the Director of Nursing or other specialist officers as appropriate, the Governance Director to inform the DMT of the type of investigation to be carried out, this should be within 1 working day of receiving the form and confirmation of the facts/circumstances.

Options include:

Full investigation and Root Cause Analysis (RCA) by the Division. Normally 2 senior managers from within the Division would carry out the investigation/RCA.

Full investigation/RCA with expert involvement when the incident involves issues outside the Division. Normally the investigation would be carried out by a senior manager from the Division and a specialist advisor, e.g. Risk Co-ordinator, Health and Safety Adviser or specialist from a particular discipline e.g. Physiotherapy etc.

Full investigation/RCA with HR involvement if there is an indication that there may be disciplinary action required. Normally a manager from the Division and a representative from HR would carry out the investigation/RCA. This should be very rare, when following the Trust's non-punitive culture, and would not be used for system failures.

NOTE: Regular training on how to perform a Root Cause Analysis is provided through the Governance Department, see also Pennine Acute Hospitals NHS Trust Procedure for the Root Cause Analysis Of Serious Untoward Incidents, Complaints and Claims.

During the course of an investigation it may be necessary to call upon external agencies to assist in the investigation process, for example the Trust Solicitors, Police, Coroner or Strategic Health Authority for independent advice. The decision to refer to an outside agency lies with the Medical Director or other designated Director in his absence.

6.3.5 Where the red graded untoward event has involved a patient, then the patient and/or relatives must be informed, normally by the patient's Consultant. Relatives should only be informed with the patient's consent, if this is possible. In all cases the patient and/or relatives MUST be informed before any other agency or the press. The patient's Consultant will also normally inform the patient's GP.

6.3.6 Where there is media involvement, all statements must be made by, or with the approval of the Communications Manager, the Director of Human Resources or the Chief Executive.

6.3.7 If the incident is a serial event that is likely to generate a large amount of public interest and enquiries, then telephone hotlines should be set up in accordance with the policy for the follow up of a Serious/Major Clinical Incident. The length of time that the hotlines are to be in place and the hours that they are staffed will be determined by the investigation team, following consultation with the Governance Director and other relevant Executives, Directors, Senior Officers and external agencies as appropriate.

6.3.8 All red graded incidents must be notified to the Head of Claims who in turn will determine whether the NHSLA need to be notified at that stage. Specialist legal advice can also be sought at this stage, if appropriate, via the Head of Claims.

6.3.9 The completed investigation/RCA written report to be submitted to the Governance Director within 1 month, and reported to the Trust Governance Committee.

6.3.10 The Governance Director, the Medical Director, the Director of Nursing and any other appropriate Director to review and action the report accordingly, e.g. sharing with staff groups, other outside agencies or Divisions within 1 week, and to monitor progress with implementation.

6.4 Orange (SIGNIFICANT) Graded Untoward Events

6.4.1 The person in charge at the time of the incident who has graded the untoward event must inform their immediate manager, and a member of the site management team or on call manager, and send the incident form to the Governance Department as soon as possible, and in all cases within 1 working day.

6.4.2 The site management team to advise the DMT and following consultation with the appropriate agencies/departments to decide on the type of investigation within 1 working day. Normally this would be an internal investigation carried out by 2 senior managers from within the Division. Occasionally it may involve expert input e.g. Governance, HR, Physiotherapy etc. There is the option of the DMT to re grade the incident and then take the appropriate action.

6.4.3 Where the orange graded untoward event has involved a patient, then the patient and/or relatives must be informed, normally by the patient's Consultant. Relatives should only be informed with the patient's consent, if this is possible. In all cases the patient and/or relatives MUST be

informed before any other agency or the press. The patient's Consultant will also normally inform the patient's GP.

6.4.4 The investigation to be completed and a written report submitted to the DMT within 1 month.

6.4.5 The DMT to review the report and action accordingly.

The above will be subject to an audit of the results and time targets as part of the Divisional Performance Review.

6.5 Yellow (MODERATE) Graded Untoward Events

6.5.1 The person in charge at the time of the incident who has graded the untoward event, must notify the ward/departmental manager and send the incident form to the Governance Department as soon as possible, and in all cases within 1 working day.

6.5.2 The Ward/Departmental Manager to decide on the type of investigation within 1 working day. Normally this will be a simple incident investigation carried out by the Ward/Departmental Manager or nominated representative. The Ward/Departmental Manager does have the option to re-grade the incident and follow the appropriate procedure for the new grade.

6.5.3 A short report is to be produced and reviewed with the Ward/Departmental team within 2 weeks.

The above will be subject to an audit of the results and time targets by the DMT as part of the Divisional review of the Ward/Department. The results of the audit will form part of the Divisional Performance Review.

6.6 Green (LOW) Graded Untoward Events

6.6.1 The incident form is to be forwarded to the Governance Department as soon as possible, and in all cases within 1 working day of the incident. The Governance Department has the option following appropriate consultation to re-grade the incident and instigate the appropriate action identified above.

7 The Reporting of Incidents to External Agencies

The Trust will work with the NPSA to progress the link to the NRLSA in order that all incidents are reported to an external agency. In addition individual incidents will be reported under the STEIS guidance to the Strategic Health Authority, under RIDDOR to the Health and Safety Executive and defective equipment to the MHRA. All instances to be reported via the Governance Directorate. In other instances it may be necessary to contact the Police, the coroner, the NRLS or other organisations. The decision to do so should be made in conjunction with the Medical Director or Chief Executive.

8 Incident Investigation and Root Cause Analysis

8.1 As part of the Accident/Incident Reporting Policy, the Governance Directorate requires a root cause analysis (RCA) of all red graded untoward events to be undertaken.

Regular training on how to perform a Root Cause Analysis is provided through the Governance Department. See also Pennine Acute Hospitals NHS Trust Procedure for the Root Cause Analysis Of Serious Untoward Incidents, Complaints and Claims.

An Incident investigation should:

- Identify reasons for substandard performance
- Identify underlying failures in management systems
- Learn from incidents and make recommendations
- Implement improvement strategies to help prevent or minimise recurrences, thus reducing future risk of harm
- Satisfy mandatory and reporting requirements.

Investigations should be led by someone with the status and knowledge to make authoritative recommendations. In most instances this will be a senior clinician or manager. A Risk Management Co-ordinator, Health and Safety Advisor, clinical, managerial, or technical staff, or equipment suppliers may need to be involved if events have serious or potentially serious consequences.

9 REFERENCES

The Health and Safety at Work etc Act 1974

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

The Management of Health and Safety at Work Regulations 1999

Clinical Negligence Scheme for Trusts (CNST) Standards 1 and 2

Risk Pooling Scheme for Trusts (RPST) Criterion 4

Department of Health (DOH) and National Patient Safety Agency (NPSA) – Doing Less Harm

Greater Manchester Strategic Health Authority Guidance on Reporting and Management of Serious Untoward Incidents using the Strategic Executive Information System (STEIS)

The Pennine Acute Hospitals NHS Trust Whistle public Interest disclosure Act (Whistle Blowing) Policy

The Pennine Acute Hospitals NHS Trust Procedure for Root Cause Analysis of Serious Untoward Incidents, Complaints and Claims

The Pennine Acute Hospitals NHS Trust Procedure for the Follow-up of Serious/Major Clinical Incident

BMA Patient Safety & Clinical Risk

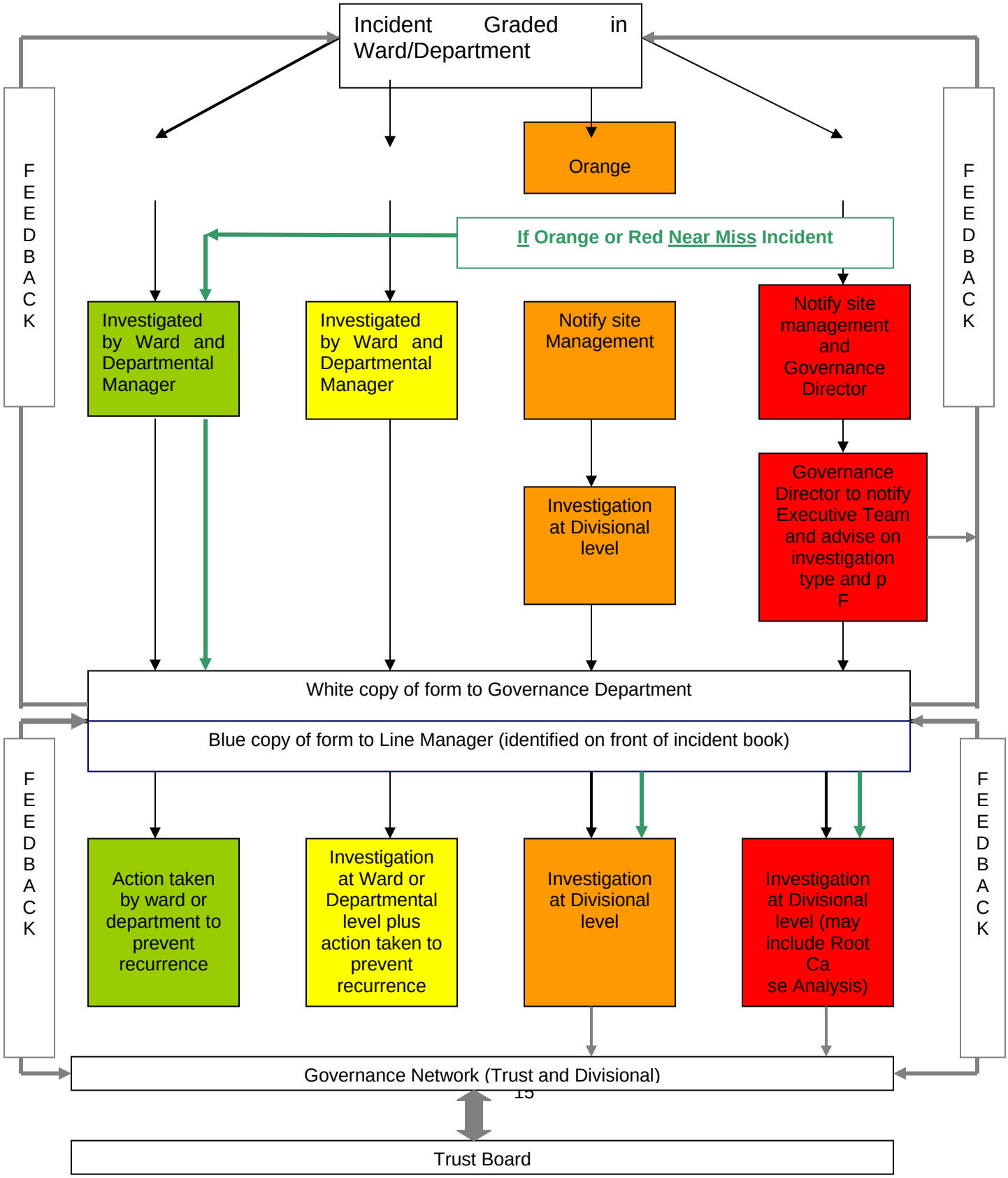
Journal of the Royal Society of Medicine 2001;94:322-330 Exploring the Causes of Adverse Events in NHS Hospital Practice.

DOH HSC 1999/053 – For the Record

Full protocol and case examples available at www.patientsafety.ucl.ac.uk

APPENDIX ONE

Incident Investigation Pathway



Appendix 2

Policies that contain immediate action to be taken following an incident are listed below:

Needle stick/inoculation injury Policy

Manual Handling Policy

Infection Control Manual

Health and Safety Policies