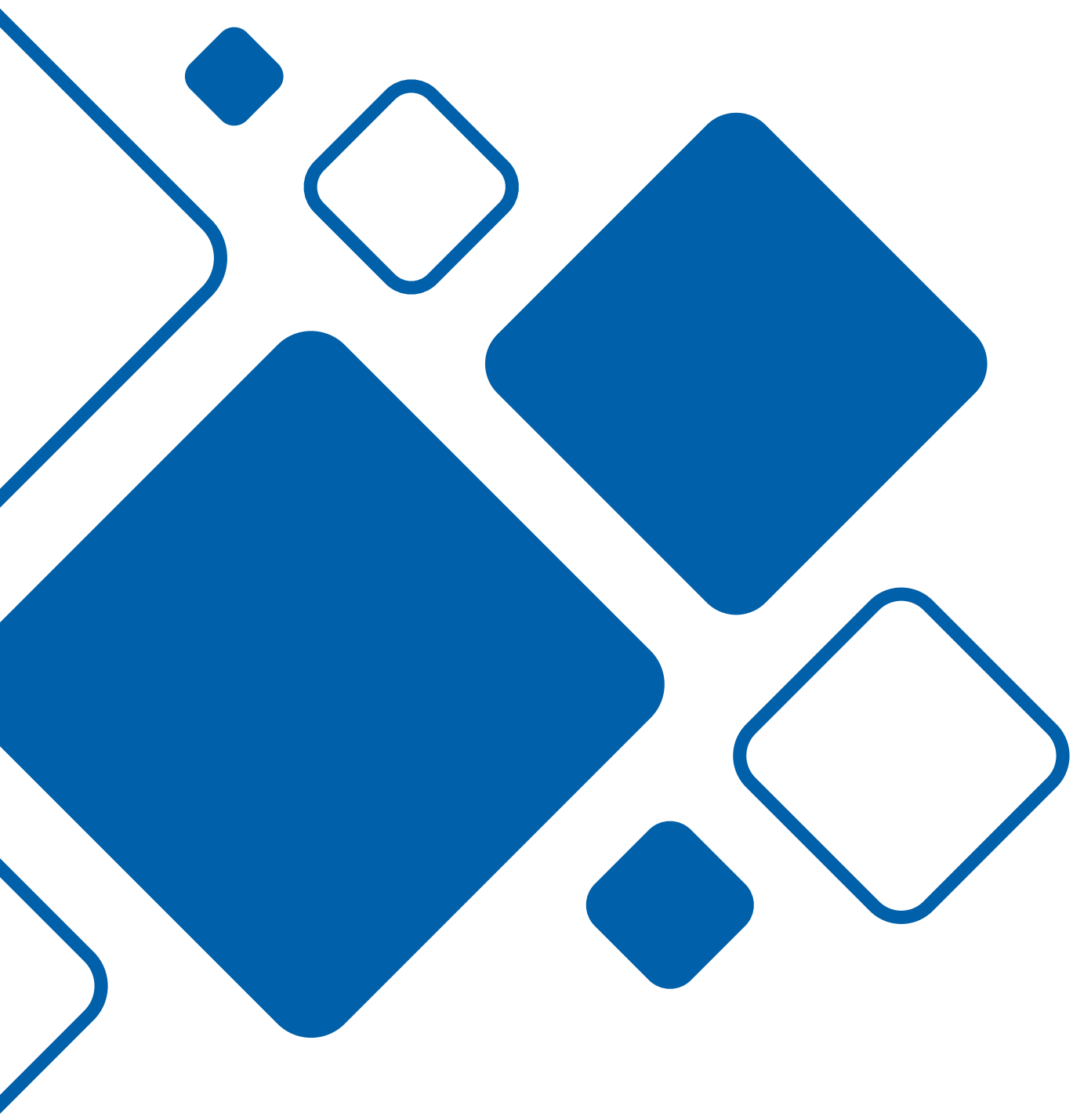
NURSDOC

# POLICY NUMBER: **90**

# POLICY TITLE: **INCIDENTS & SERIOUS INCIDENTS**

WHO MUST ABIDE BY THIS POLICY? **ALL STAFF**



# INCIDENTS AND SERIOUS INCIDENTS POLICY

## 1. INTRODUCTION

Providing healthcare is not a risk-free endeavour. Incidents, some of which may be serious incidents, will occur and there needs to be systematic measures in place to respond to them. The important things to ensure are that patients are protected; that systems for recording, reporting and classifying incidents are consistent and reliable and there is an appropriate escalation process for the more serious incidents identified.

Processes need to comply with the NHS Commissioning Board Serious Incident framework, and any statutory or regulatory requirements that may apply. It is also important that serious incidents are investigated robustly, that there is feedback to allow learning, to minimise the risk of similar incidents happening again. This policy sits alongside the network's risk management policy and other related policies and guidance on specific issues depending on the nature of the incident, for example Safeguarding Adults.

## 2. SCOPE AND PURPOSE

**The purpose of this policy is:**

- To provide a uniform approach to the reporting, management, investigation and learning in relation to incidents and Serious Incidents (SIs) across the network.
- To ensure that risks associated with serious incidents are identified and managed in accordance with best practice and in line with the expectations of the NHS Commissioning Board, The NHS Litigation Authority, the Health and Safety Executive, the CQC, Commissioners and the public.
- To ensure that, in dealing with serious incidents, there is clarity over roles and responsibilities, timescale for completing investigations and that the network complies with all requirements for serious incident reporting within the network and to relevant outside agencies.
- To ensure that recommendations are identified and implemented to prevent the recurrence of such incidents and that any relevant learning from the event is captured and disseminated.

## 3. RESPONSIBILITIES

**The Network Board**
The network board has responsibility for the approval of this policy and ensure that there are adequate governance arrangements in place for the effective reporting, management, investigation and learning from serious incidents within each of the network practices.

**Lead GP for Each Practice**
The Lead GP for each practice has overall responsibility to ensuring that appropriate and effective systems for the handling of incidents are in place within their practice. They also need to ensure that those systems meet all relevant statutory requirements and comply with best practice as described in guidance from the Department of Health, NHS Commissioning Body, CQC, Health and Safety Executive and any other relevant external body.

**All Practice Staff**
All staff are responsible for following this policy and for reporting incidents and near misses involving services, staff and others.

## 4. INCIDENTS AND SERIOUS INCIDENTS

### 4.1 Incidents

**4.1.1 Key Principles**
Incidents and near misses must be reported and managed in accordance with this policy. The key principles of the incident management process are:

- Any incident or near miss will be dealt with immediately by staff. The person discovering the incident or near miss must take immediate action to deal with the situation.
- A safe environment should be re-established as soon as possible and immediate action taken to ensure safety.
- The risk of recurrence should be considered immediately and actions taken to mitigate in advance of the investigation.
- Any urgent clinical care that may reduce the harmful impact of the incident must be given immediately.
- The incident or near miss must be reported by staff on the incident reporting template in Appendix 1.
- Careful attention should be paid to accurately recording details of the incident, the action taken and anything put in place to prevent or minimise a recurrence. Any witnesses to the incident should be identified.
- When equipment is involved, it must be retained by the person in charge of the area in case it requires inspection.
- The incident report will be reviewed by the designated lead in the practice who will add any information regarding any further action taken and review the severity or harm in accordance with Appendix 2.
- If the incident results in death or sever harm it must be reported to the Clinical & Corporate Governance Lead at the Clinical Commissioning Group (CCG) without delay and at most within 72 hours of the event.

**4.1.2 Reporting and Communication**
As soon as the incident has occurred the Practice Manager and/or Lead GP must be informed. The incident report should be made on the template in Appendix 1 within 2 hours of the incident being identified. In some cases this report may be required to be completed more quickly.

Within 24 hours the designated lead for the practice must review the incident and access for the severity grade for incident or harm (Appendix 2).

**The aim of the incident report is to:**

- Provide a summary of what happened and who was involved
- Identify any immediate action taken including clinical or managerial actions necessary to ensure safety
- Share the details with practice staff to support learning and continuous improvement

### 4.2 Serious Incident

When an incident occurs that might be considered a serious incident, it is important for practice staff to take immediate action to manage the incident, ensure that information is escalated to the most senior member of staff within the practice to take the lead and escalate to appropriate external agencies.

The principal definition of a serious untoward incident (SUI) is any incident on an NHS site, or elsewhere, whilst in NHS-funded or NHS regulated care involving:

1. Patients, relatives or visitors
2. Staff
3. Contractors working for the NHS, equipment, building or property **and which may or has:**
   - Resulted in death (this includes deaths from suspected suicide/suicide or homicide) or serious injury or was life-threatening
   - Contributed to a pattern of reduced standard of care
   - Involved a hazard to public health
   - Caused serious disruption to services
   - Caused significant damage to the reputation of an NHS organisation or its staff
   - Caused significant damage to NHS assets
   - Involved fraud or suspected fraud (the procedure in HSC 1999/062 and associated MOU (NHS CFS and ACPO, 2002) must also be observed in parallel)
   - Given rise to a significant claim for damages
   - Involved the suspension of a member of staff, or a student, on care/clinical, professional or managerial issues/when a 'healthcare professional alert' notice has been issued ("Healthcare Professionals Alert Notice Directions, 2006) or referral to a Professional Regulatory Body
   - Involvement of external investigation agencies ( Police, HSE, Healthcare Commission, CSCI)
   - Raised severe criticism by an external body e.g. Coroner's inquest, Parliamentary and Healthcare Ombudsman, Mental Health Act Commissions, Care Quality Commission
   - Raises concerns regarding Article 2 European Court of Human Rights (ECHR) (arguable breach of duty to protect life)

The above list is not exhaustive however by its shear nature it can be classed as far more serious than the more common **SIGNIFICANT EVENT**.

**4.2.1 Immediate Management of Serious Incidents**
All principles noted above in 4.1.1 need to be followed and additionally:

- The needs of the service users and their family/carers are the first priority.
- Support needs of any staff involved in the incident should also be considered any staff who have experienced a distressing or upsetting incident should be ordered support.

- All relevant physical and documentary evidence, such as the clinical notes or medical equipment should be secured. All relevant equipment or medication should be quarantined, labelled and isolate as appropriate.
- A contemporaneous and objective entry should be made in the patient's clinical records and measurements, drawings or photographs of the area where the incident occurred should be taken if necessary, appropriate and practical to do so.

**4.2.2 Support for and communication with the Service User/Family/ Carer**

- A designated staff member (normally the Practice Manager) will act a support person to the service user or carer/family and be a focal point for contact and information relating to the incident, the subsequent investigation and feedback on any action taken.
- The communication link is key to ensuring that the family receives accurate and relevant information in a timely manger by the most appropriate professional.

**4.2.3 Duty of Candour**

A statutory Duty of Candour was introduced in November 2014, which places a formal requirement on providers of health and social care to be open with their patients and families when they suffer harm related to care or treatment. This duty will apply at all times. Failure to comply is a criminal offence and the CQC can move directly to prosecution without first serving a warning notice.

The network practices must ensure that the service user and other "relevant persons" (people acting lawfully on their behalf) are notified as soon as is responsibly practicable when things go wrong with care and treatment, and that they are provide them with reasonable support and truthful information about the incident, keep them informed about ongoing enquiries and investigations, including the outcomes of any investigation and give a verbal and written apology.

**4.2.4 Reporting and Communication – Serious Incidents**

It is essential that there is timely and effective reporting, escalation and communication in dealing with any serious incident, within the following parameters. These deadlines must be adhered to:

- Within 1 hour of a serious incident notify the senior member of the practice and record the incident on the practice reporting form.
- Following the death of a patient consider whether the preservation of the scene of death is required and whether or not the police need to be notified.
- Identify witnesses, including staff and other service users, ensure they receive support and take statements as quickly as possible.
- Within 24 hours the designated practice lead must review the incident report including the severity grading.
- Within 72 hours of the event the Practice Manager or Lead GP must report the incident to the Clinical & Corporate Governance Lead at the Clinical Commissioning Group (CCG).
- Good practice is to make an initial phone call to the Clinical Governance Lead at the (CCG) to be followed up with a written report giving details of the incident, who was involved, when it happened and what action has already been taken. The CCG will give a DATIX number which acts as a reference to the case. (DATIX is an official piece of software used by many CCG's to report on risk)

The CCG should respond with a written acknowledgement within 48 hours. The practice should cooperate at all times with any investigation. Following assessment the CCG will consider the following options:

- No further action is needed and the CCG confirm that the incident is closed.
- The CCG may declare a particular incident to be a major incident and involve the National Reporting and Learning System
- The CCGs performance management of the incident and advises the practice as appropriate
- The incident meets the CCG's escalation criteria and is managed by the NRLS
- Any further action will be agreed with the CCG on a case by case basis as required. Once completed the incident may be recommended for closure.
- Within 72 hours the service user/carer/family needs to be contacted and updated.
- Within 10 days and in line with Duty of Candour requirements, initial feedback must be given to the service user (or relative/carer, as appropriate).

**4.2.5 Grading of Serious Incidents**

Once an incident is designated an SI and reported, the practice must identify an incident grade and agree it with the relevant commissioner in order to determine the correct investigation and monitoring approach.

Practice must also ensure where an incident is graded as an SI that the Clinical Lead for the Network is informed.

**4.2.6 Learning from Incidents and Serious Incidents**

Once investigations into incidents have taken place it is important to learn lessons and share the learning across the network. This will take place at the network board.

## 5. EXTERNAL INDEPENDENT INVESTIGATIONS

On occasion, external agencies may initiate inquiries or investigations following serious incidents. Such agencies may include, but are not limited to:

- Police
- HM Coroner
- Care Quality Commission
- Health and Safety Executive
- National Patient Safety Agency
- NHS Protect

All Practice and network staff are expected to co-operate fully with these investigations. Where issues of confidentiality arise, advice should be sought from the local Caldicott Guardian or professional registration bodies.

## 6. INFORMATION GOVERNANCE

The network practices need to ensure they comply with data protection, Caldicott and information governance requirements in all of its incident management procedures. Any details which could enable a patient to be identified should at all times be considered confidential and the consent of the patient sought before disclosing such information. Where this isn't practicable or an individual refuses consent to disclosure, disclosure may still be lawful if justified in the public interest or where those investigating the incident have statutory powers for obtaining the information. Particular care should be undertaken when a multi-agency approach to a serious incident investigation is taking place and the advice of the Caldicott Guardian should be sought whenever a situation arises that requires disclosure of personal or confidential information without consent.

# APPENDIX 1

## PRACTICE INCIDENT/SIGNIFICANT EVENT ANALYSIS FORM

**Practice Name and Address**

_____

_____

**Category of incident**

Personal Accident ☐

Violence Abuse or Harassment ☐

Ill Health ☐

Clinical Incident ☐

Fire Incident ☐

Security Incident ☐

Informal Complaint ☐

Other ☐

| | |
|---|---|
| Date of making this report | |
| Reporter's Name and details<br><br>Reported to - (name/names) | Name:<br><br>Name: |
| Persons involved/affected if a patient is involved, please add give their Emis id no. | Name/s or e.mis id no |
| Persons Notified? | ☐ Patient ☐ Carer<br>☐ Family |
| Degree of Harm | ☐ None ☐ Low ☐ Moderate<br>☐ Severe ☐ Death |
| When did the incident occur? | Date:<br><br>Time: |

| | |
|---|---|
| Where did the incident occur? | |
| What happened?<br><br>Give a factual account of the incident, including a description of:<br><br>• Any medical devices or equipment involved.<br>• Any medicines involved<br>• Any other relevant information | |
| Immediate Action Taken | |
| Result of investigation:<br><br>• learning points<br>• further action to be taken<br>• time frame for implementing | |
| Identify significant event | Adverse event / Near Miss |
| Who has been informed<br><br>(Circle appropriate response) | **Primary Care Trust / NPSA / HSE Social Services / Police / Other** |

Signatures
(anyone who has written on this form should sign)

Date

## GRADING OF SERIOUS INCIDENTS

**(Source: NHS Commissioning Board Serious Incident Framework)**

## APPENDIX 2

| INCIDENT GRADE | EXAMPLE INCIDENTS (THESE ARE SUGGESTIONS, NOT DEFINITIVE) | INVESTIGATION GRADE AND ACTION | TIMEFRAME | COMMISSIONER RESPONSIBILITY |
|---|---|---|---|---|
| 1 | **Grade 1 Incident Examples:**<br><br>Apparent suicide of people currently under the care of community mental health services.<br><br>Mental health inpatient attempted suicides.<br><br>Avoidable or unexplained death.<br><br>Failure to meet standards for ambulance service response times, resulting in patient death/severe harm<br><br>HCAI outbreaks.<br><br>Grade 3 and 4 pressure ulcers.<br><br>Data loss & information security (DH Criteria level 2)<br><br>Adult safeguarding incident | **Investigation Level 1**<br><br>Concise root cause analysis (RCA) for incidents involving No Harm and Low Harm and/or where the circumstances are very similar to other previous incidents. In these cases it is more proportionate to use a concise RCA to ensure there are no unique factors and then focus resources on implementing improvement than conducting comprehensive investigations that will not produce new learning. These will be a small minority of cases.<br><br>**Investigation Level 2**<br><br>Comprehensive RCA for incidents involving moderate and severe harm or death. This<br>should be the default level for most incidents | Following **initial** reporting within **2 working days**, the provider organisation must submit a completed investigation **within 45 working days** | Seek assurance and evidence from the provider that relevant policies and procedures are in place and implemented, for example by reviewing a sample of incident investigations and action plans as well as monitoring serious incident data trends.<br><br>Close incidents after receipt of evidence demonstrating that local monitoring arrangements are in place to ensure action points are going to be implemented. |
| 2 | **Grade 2 incident examples:**<br><br>Inpatient suicides (including following absconsion)<br><br>Maternal deaths<br><br>Child protection incidents<br><br>Never events<br><br>Accusation of physical misconduct or harm<br><br>Data loss and information security (DH Criteria level 3-5) | **Investigation Level 2**<br><br>Comprehensive RCA<br><br>(note NHS trusts should directly notify the NTDA of Grade 2 serious incidents) | Following **initial** reporting within **2 working days**, the provider organisation must submit a completed investigation **within 60 working days** | Likely to involve specific assistance with and contribution to the incident response and investigation.<br><br>Close incident after receipt of evidence demonstrating that each action point has been implemented is required |
| 3 | **Selected Grade 2 incidents:**<br><br>The need for independent investigations is identified and arranged by the commissioner or NHS CB, for example a major system failure with multiple stakeholders.<br><br>Homicides following recent contact with mental health services require an independent investigation. These will be commissioned by the relevant NHS CB area team. | **Investigation Level 3**<br><br>Independent RCA<br><br>(note NHS trusts should directly notify the NTDA of Grade 2 serious incidents) | Following **initial** reporting within **2 working days** independent investigators should be commissioned to complete an investigation **within 6 months** | As for Grade 2 above but in addition, commissioning the independent investigation. |