Incident Reporting and Investigation Procedure

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1. Introduction

Swansea Bay University Health Board is committed to health, safety and welfare of its staff, patients, users, visitors and contractors across the health community, by being proactive in its approach to managing incidents and reducing risks.

The Incident Reporting and Investigation Procedure forms part of the Health Boards governance and risk management process for managing, reporting, analysing and learning from incidents that arise in the course of the Health Board conducting its business. The procedure will reflect the arrangements in place to facilitate the effective reporting of incidents, near misses and hazards by staff working in the health community and directly employed within the Health Board.

The aim of the Incident Reporting Procedure to ensure:

- A standardised mechanism for reporting when things did or could have gone wrong.
- The promotion of an open and fair learning culture.
- The necessary changes to support and promote safety for patients, staff and members of the public and to improve the quality of the service we provide.
- The identification of trends and areas of risk.
- A wider appreciation by staff of a system based approach in preventing, analysing and learning from incidents, which leads to improvements.

Adherence to the Procedure will ensure compliance with all relevant legal and internal requirements for reporting.

2. Purpose

This Procedure has been introduced to ensure that all incidents, near misses are reported, recorded, and an appropriate level of investigation undertaken. The reporting of incidents is the first important step in ensuring that action are identified and lessons are learnt and shared to avoid recurrence.

The primary purpose of incident reporting is to provide an opportunity for learning for the individual and for the Health Board, which in turn will contribute to continuous improvement. In addition incident reporting:

- Enables early actions to occur so that the likelihood of recurrence is reduced.
- Enables a review of what measures are in place to prevent incidents.
- Fulfils the Health Board's legal and statutory obligations to record and report certain defined incidents.
- Provides an early warning of potential complaints or litigation and helps identify any likely litigation cost to the Health Board.
- Alerts the Health Board to conditions of risk.
- Enables sharing of lessons learnt from appropriate levels of investigation.

3. Scope

This procedure applies to all Swansea Bay University Health Board employees and 'others' working within Swansea Bay University Health Board premises including temporary and agency staff, contractors, volunteers, students and those on work experience.

This document will deal with the incident reporting and investigation. The reporting and investigation elements are common to all incidents – both non-patient safety and patient safety.

There are specific steps and legislation which cover the subsequent management of patient safety incidents – these are described in the Putting Things Right Policy.

4. Principles

Incident reporting is a key aspect of the process of the identification of risks and is the responsibility of all staff. Accurate and concise completion of forms (on-line or hard copies) is essential to ensure the effectiveness of the system.

The Health Board seeks to promote an open reporting culture with a focus that encourages staff to look critically at their own action and those of their teams, with an emphasis on learning and not blame. However, serious breaches of professional practice, raised as part of an incident report cannot be ignored, but every effort will be made following an investigation, to utilise counselling and/or capability process rather than the disciplinary procedure. There are certain situations where the disciplinary procedure and associated actions may be necessary. Following this principle the Health Board will only consider disciplinary action in the following circumstances:

- Acts of gross misconduct / criminal acts.
- Professional malpractice.
- Abuse of clients, patients, or staff.
- Failure to report a serious incident in which the member of staff was either involved or aware of.

All incidents will be reviewed and if necessary investigated by the appropriate individual(s). The Putting Things Right Policy and Raising Concerns Procedure provide details of roles and responsibilities for the management of patient safety incidents and a similar approach will be adopted for non-patient incidents, with the Heads of Quality and Safety/Quality & Safety team supported by appropriate heads/experts as required. Non-clinical services managers/leads/supervisors will undertake investigations with the support from heads/experts for advice in relation to investigation.

5. Identifying of Incidents

The importance of implementing a comprehensive Incident Reporting Procedure to assist staff and ensure a corporate approach to the management of all incidents has been recognised. An incident may be identified by:

- A member of staff at the time of the incident.
- A member of staff retrospectively when an unexpected outcome is detected.

- A patient and/or their carers who express concern or dissatisfaction with the patient's healthcare either at the time of the incident or retrospectively (although these are not always reportable incidents).
- Incident detection systems such as medical records review.
- Other sources such as detection by other patients, visitors or non-clinical staff.

The process for incident reporting is summarised at Appendix A, you can also locate the on-line form using this link:
http://7a3b7svmdatixlv.cymru.nhs.uk/datix/live/index.php

Completion of the web based reporting form
All incidents should be reported using the Datix web incident form system. This can be found on the link above along with a user guide for completing the form. For those people that do not have access to the Health Board's Intranet, a paper copy of the form can be found in Appendix B (only to be used where DatixWeb reporting is not possible).

On clicking the "Submit" button, the reporter of the incident will receive an instant, on screen, acknowledgement that it has been submitted. If the reporter provides a valid email address, he/she will additionally receive an immediate email acknowledgement of the incident report having been received.

6. Equipment, Medical Devices & Furniture

If any incident involves equipment, medical devices or furniture, related items should be marked to indicate the defect. This should be dated and signed so that an engineer will know what the defect is and who to speak to about it. The item details; make and model should be recorded and the item withdrawn from use until declared safe to use and if necessary the incident reported to the MHRA, and kept for evidence and/or assessment. Where appropriate, these items should be photographed (these can be attached) and a note included indicating this on the incident report form. Electronic equipment will need to be reviewed and assessed either by in-house engineers or contractors, depending on contractual arrangements.

7. Investigation

Incidents should be thoroughly investigated as appropriate to ensure that lessons are learned and, the risk of recurrence removed if possible, or minimised. The level of investigation will depend on the severity of the incident.

The purpose of an investigation is to determine fully the issues involved, discover the cause, ascertain the circumstances, identify the consequences and implement improvements to ensure the risk of further similar incidents is minimal.

The Risk and Assurance Team are able to offer assistance and support with this process where appropriate and required.

The investigation of patient safety related incidents is detailed in the Putting Things Right Policy.
http://howis.wales.nhs.uk/sites3/Documents/743/PuttingThings%20Right%20Policy.Final.pdf

For non-patient incidents which are risk graded 9-15 (Moderate) or 16-25 (High) and all RIDDOR reportable incidents, an investigation must be undertaken by the responsible manager. Once the investigations have been completed or during the investigation relevant specialist in the organisation may be required to review them prior to be closed.

The level of investigation should be commensurate with the severity of the incident i.e. “moderate/amber” and “high/red” a detailed investigation using the relevant investigation form must be carried out. The Corporate Health and Safety Department and the Patient Risk & Engagement Team should be contacted for support and guidance on the approach and documentation.

A guide to incident investigation is provided in appendix F.

7.1 Incident investigation auditing and quality monitoring

Staff incident investigations will be reviewed at each local health & safety/governance meeting (frequencies of investigations reviewed/audited shown in table 1.), to capture learning for both the process and for the individuals/teams undertaking the original investigations.

Within each of the service group’s managers will be identified to undertake reviews/audits of staff incident investigations to ensure the quality of the investigations and that investigation process for the levels of incidents is consistent throughout the organisation. Examples of the categories and percentages of investigations to be reviewed/audited are shown in table1.

Table 1.

Incident Category	Audit Process	Quality Check
RIDDOR	Health and Safety Department (100%)	Health & Safety Operational Group
Lost Time Injury	Quality & Safety Leads (50%)	Health and Safety Operational Group
Moderate Injury	Local Management Meetings (10%)	Health and Safety Operational Group

In addition a review/audit will be undertaken by the investigation audit team lead by the Lead Serious Incident Investigator/Assistant Director of Health and Safety/Lead Quality & Safety Manager, with the assistance of co-opted experts on incidents in the categories listed in table 1.

The quality assurance of staff incident investigation to be facilitated by the investigation team is provided in appendix G. Frequencies of these will be based on the level and category of incidents, with the target of 50% of RIDDORS; 20% of lost time incidents and 10% of moderate incidents.

8. Definitions – Level & Descriptor

Step 1:
The envisaged or actual consequences and likelihood are analysed in the context of any risk controls that have already been put into place using Table 1. It is acknowledged that in practice, both Steps 1 and 2 are subjective and will depend on the knowledge and expertise of

the person(s) involved in the risk assessment process. To mitigate this, risk assessment is most appropriately conducted as a group/multidisciplinary activity. Descriptor

Table 1.

Descriptor	Actual or potential unintended impact on individual(s) - Patient, family member, visitor, contractor, staff	Actual or potential impact on the Health Board
1 NEGLIGIBLE Green	No harm, harm prevented or very minor harm. Example(s): Cut or bruise. First-aid treatment only required. Some extra observation required. Unsatisfactory patient experience not related to patient care.	No damage or very minor damage. No direct financial loss or financial loss up to 1k Very minimal impact. No service disruption. Example(s): Wastepaper basket fire
2 MINOR Yellow	Avoidable short-term, non-permanent harm or impairment of health – full recovery in up to 1 month. Example(s): Minor healthcare associated infection. Temporary avoidable increase in pain experience. Unsatisfactory patient experience – readily resolvable	Short-term damage, remedial within 1 month. Increased length of hospital stay/level of care – between 1 and 7 days. Single failure to meet internal quality standards. Damage or direct financial loss up to £10,000. Staff sickness < 3 days. Low risk of complaint.
3 MODERATE Amber	Avoidable semi-permanent injury or impairment of health or damage - recovery in up to 1 year. Additional interventions required or treatment needed to be cancelled. Necessary to transfer to another centre for treatment/care. Example(s): Temporary loss of mobility Temporary loss of vision Healthcare associated infection taking up to 1 year to resolve e.g. MRSA Further/new surgical intervention required Mismanagement of patient care	Damage remedial in up to 1 year. Direct financial loss/cost up to £100,000. Increased length of hospital stay/increased level of care – 8 to 15 days. Temporary restrictions on service(s) / service disruption. Repeated failures to meet internal quality standards. Staff sickness > 3 days. Local adverse publicity / moderate loss of confidence in organisation. Risk of litigation with cost up to £500,000. MHRA Reportable. Mental Health Act Commission Assessment. HSE Improvement Notice issued.
4 SEVERE Red	Irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well-being. **Example(s)/including:** Procedures involving wrong patient/ body part. Loss of major body part(s). Retained instrument/material after surgery. Healthcare associated infection, which may result in major permanent harm e.g. Hepatitis C. Haemolytic transfusion reaction. Radiation dose much greater/less than intended, whilst undergoing a medical	Adverse national publicity. Loss of confidence in the Health Board. Ability of Health Board to provide a service adversely affected / temporary service closure/resources needed to remedy situation – up to £1M. Increased length of stay or care over 15 days. Risk of litigation with cost up to £1M. Prohibition Notice /

	exposure. Misdiagnosis with poor prognosis of return to health. Infant abduction or discharge to the wrong family. Serious concerns re patient experience or clinical service requiring escalation to executive level for investigation/action.	Executive Officer fined. Failure to meet national and professional standards of quality. Example(s): Trust-wide PAS/PIMs failure.
5 MAJOR Red	Avoidable loss of life or unnecessary shortening of life expectancy. Example(s)/including: Unexpected death of a patient whilst under the direct care of a healthcare professional. Healthcare associated infection resulting in or with potential to result in death, e.g. hospital acquired legionellosis. Suicide or homicide committed by a patient being treated for a mental health condition. Unacceptable patient experience which would lead to an investigation by external bodies e.g. Mid Staffordshire	Significant adverse national / international publicity. Severe loss of confidence in the Health Board. Extended service closure. Risk of litigation with cost over £1M. Criminal prosecution. Direct financial cost over £1M. Example(s): Major loss of healthcare facilities due to fire. Loss/destruction of medical records department and all patient records Screening errors and failure to recall.

Step 2:

Measure of Likelihood Table 2 Level and Descriptor Description Example 1 RARE would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again. 10 Yearly 2 UNLIKELY Not expected to occur/reoccur but there is some possibility.

Table 2.

Level and Descriptor	Description	Example
1 RARE	Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen/happen again	10 Yearly
2 UNLIKELY	Not expected to occur/reoccur but there is some possibility.	Yearly
3 POSSIBLE	May occur/reoccur at some time / occasionally.	Monthly
4 PROBABLE	Will probably occur/reoccur but will not be a persistent issue.	Weekly
5 EXPECTED	Will occur/reoccur and likely to be frequent.	Daily

Step 3: Risk Rating

Multiply the consequence and likelihood together to provide the Risk Rating which determines the overall risk ranking and priority of the risk for action (risk treatments), in accordance with the Risk Matrix:

Risk Matrix					
CONSEQUENCES	1 Rare	2 Unlikely	3 Possible	4 Probable	5 Expected
1 Negligible	1	2	3	4	5
2 Minor	2	4	6	8	10
3 Moderate	3	6	9	12	15
4 Major	4	8	12	16	20
5 Critical	5	10	15	20	25

1 – 4 LOW	This level of risk is considered acceptable and no additional action is required over and above existing management measures
5 – 8 Manageable	This level of risk is marginally acceptable and efforts should be made to reduce the risk although the cost of reduction must be carefully considered. Risk reduction actions should be completed within 12 months.
9 – 15 Amber Moderate	This level of risk should be discussed and actions agreed by the Service Delivery Unit. Risk reduction action to reduce the risk should be completed in 6 months.
16 – 25 HIGH	Board level notification/attention of this level of risk is required, via the Health and Safety Forum. Urgent attention to the risk is required by the Unit with actions to reduce the risk commencing within 1 month. Close monitoring required. Immediate action may be required, including halting the process although before doing so the risk must be assessed to ensure it is safe to do so.

9. Reporting via an electronic or paper form

In exceptional circumstances where it is not possible to use the web based reporting system, and for contractors and Commissioned Services, a paper copy (scanned & attached to an email) or paper based version should be completed and forwarded to the Line Manager to arrange to be uploaded to the DatixWeb system or emailed to the unit generic governance email address.

Staff should only complete one incident form per incident. Details provided should be factual and not opinions.

9.1 Notifications/Initial Contacts

Each Unit, Directorate, Department and leads should define its specific arrangements and ensure compliance with the following requirements, and communicate these to all staff.

9.2 Incidents occurring within normal working hours (Monday-Friday, 09.00 - 17.00)

The staff member who identifies the incident should report this to their line manager; subsequent escalation will depend on the nature of the incident, it may be appropriate to inform the senior person on duty.

In the event of a **critical (serious) incident**, the senior person at the scene should inform the Directorate/Unit Lead, by telephone, of the situation and actions taken so far. The Patient Risk and Engagement Team for patient related incidents and the Health and Safety Team for staff related incidents (as appropriate) should also be informed.

The Directorate/Unit Lead informed of a serious incident, must ensure that all actions outlined in this document are taken. They will also advise the Chief Operating Officer who will inform the remaining members of the Executive Team as appropriate, and the Chief Executive.

9.3 Critical (serious) Incidents occurring outside of normal working hours

The senior person in charge within that clinical area must notify the On-Call Manager of the Incident and the action being taken.

The On-Call Manager must notify the Executive Director On-Call of the incident and discuss the action already being taken and to be taken.

The On-Call Manager and Executive Director On-Call should contact the Chief Executive and a decision will be made on whether to contact the designated On-Call Professional at Welsh Government.

All non- patient (staff) incidents must be reported to the Health and Safety team. The Patient Risk & Engagement team must be contacted in relation to (patient safety incidents) they must be informed by phone or email on the next working day.

9.4 Timescales

Incident forms should be completed and submitted as soon as possible after discovering the incident (**recommended 2 working days**) of the occurrence of the incident unless there are exceptional circumstances.

If the matter is serious, the on-line incident report must be completed **within 24 hours** of the occurrence.

As far as possible, the person most directly involved in the incident should complete the incident report.

9.5 Additional record keeping requirements for patient safety incidents

A record of a patient safety incident should be written in the patients' clinical notes in addition to completion of an incident report. However, the incident report itself and any subsequent investigation notes do not form part of the patients clinical notes.

When an inpatient has been subject of a patient safety incident, the discharge letter sent to the patients GP should summary details of:

- The nature of the incident and continuing care and treatment.
- The current condition of the patient.
- Recent results.
- Prognosis.

9.6 Incidents involving clinical students on placement in the Health Board

Incidents involving clinical students are reported in the same way as any other incident. In addition, for student nurses, the Pre-Registration Course Leader at the University must be notified and a copy of the incident sent to them. If the incident is RIDDOR reportable it is the responsibility of the University to report it to the Health and Safety Executive. For other clinical students, the appropriate Course Leader should be informed.

10. Information Governance Incidents

Data protection legislation requires that the Health Board consider certain data breaches for notification to the Information Commissioner's Office (ICO) as the regulatory body for data protection in the UK. For incidents that involve data breaches or other Information Governance (IG) elements, it is essential that the IG Team are informed to allow an assessment to be undertaken. The Health Board are at risk of significant fines for non-compliance with ICO notification requirements. When completing an IR1 DATIX form, ticking the box that asks "Do the IG Team need to be made aware of this incident?" ensures that the IG Team are informed of any newly reported breaches.

Generally an IG incident can be described as an incident that adversely affects an individual's rights and freedoms. It may cause an invasion of privacy, distress, embarrassment, risk of harm, financial loss, fraudulent activity or clinical risk. A breach may affect the confidentiality, integrity or availability of personal data. This may result in accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed. As a guide, the scope of an IG incident could include:

- Breaches of data protection, confidentiality or Caldicott principles (patients or staff information).
- Loss/compromise of personal identifiable information (electronic or paper).
- Theft of personal identifiable information (electronic or paper).
- Inappropriate access/disclosure to personal identifiable information (electronic or paper).
- Inappropriate use of social media including websites, mobile phones and cameras.
- IT security breaches.
- Records management breaches.

Please refer to the "Information Governance Incident and Near Miss Procedure" for further breach examples and details on how they should be handled.

11. Safeguarding Adults and Children

The Health Board's Safeguarding Team should be contacted for advice on all incidents relating to Safeguarding Adults to ensure reporting and management in accordance with the all-Wales procedure.

12. Incidents involving Bank Staff

If an incident involves a member of staff working for the Bank at the time of the incident, then the line manager should be informed who will determine whether the Bank Manager should be informed.

13. External Reporting

RIDDOR

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) requires employers and others to report certain types of injury, some occupational diseases and dangerous occurrences that "arise out of or in connection with work". Generally, this covers incidents associated in some way with work activities, equipment or environment, including how work is carried out, organised or supervised.

The Assistant Director of Health and Safety / Head of Health and Safety will consider any necessity to make contact with the Health and Safety Executive and will inform the Director of Corporate Governance/Director of Nursing and Patient Experience who will in turn inform the Chief Executive, the identified Health & Safety leads, and the Executive Team accordingly.

Police

For incidents of non-patient safety Violence and Aggression, a person affected has the right to contact the Police to make a complaint but are encouraged to work with their line managers in accordance with Health Board policies.

14. Action Plans and Learning

Where lessons have been identified, action plans may need to be developed to facilitate improvement.

Information on developing and progressing action plans for patient safety related incidents is provided in the Concerns Policy and Procedures.

Further information on developing and monitoring action plans relating to non-patient safety incidents can be obtained from the Patient Risk & Engagement Team.

15. Monitoring and Feedback

All incidents will be recorded on the central database (Datix Risk Management System), where they will remain open until all corrective action has been fully implemented. There should be timely feedback to patients and staff directly involved in the incident wherever possible and practical by the responsible manager.

Reports will be produced and presented to the appropriate Governance Committee for analysis, action and monitoring.

16. Non Conformance

Non-conformance with the Incident Reporting and Investigation Procedure may be dealt with under the Health Boards disciplinary processes, following a related investigation.

17. Equality Impact Assessment

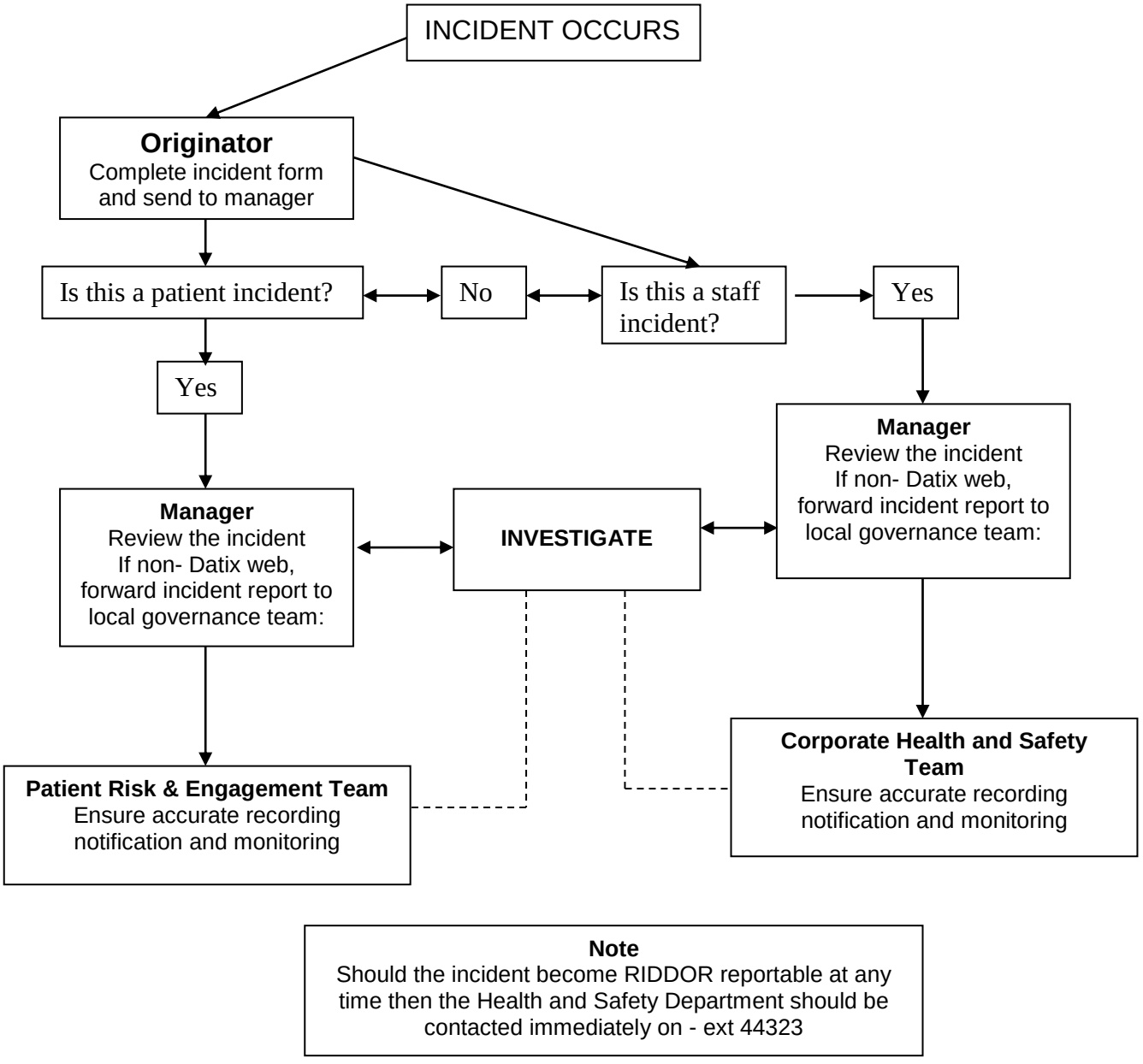
This Procedure has been subject to a full equality assessment and no adverse impact has been identified.

18. References

- Health and Safety at Work etc. Act 1974
- Management Regulations, 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 HSE (1995) The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. (RIDDOR)
- NPSA (2004) Seven Steps to Patients Safety
- NPSA (2005) Building a Safer NHS: Preventing harm Reducing Risks and Protecting Patients Safety Doing less harm. National Patient Safety Agency
- NPSA (2005) Patients Briefing Saying Sorry When Things go Wrong
- NPSA (2005) Being Open Alert http://www.nrls.npsa.nhs.uk/resources/
- NPSA (June 2009) Seven Steps to Patient Safety in General Practice
- Standards for Health Services in Wales. Welsh Government 2010
- Putting Things Right Guidance on dealing with concerns about the NHS from 1 April 2011. Welsh Government
- Investigating accidents and incidents (HSG245) http://www.hse.gov.uk/pubns/hsg245.pdf

Appendix A - Incident Reporting Flowchart

The following flowchart should be followed for the reporting of all incidents (NB: Datix-web must be used in all but exceptional circumstances)



Appendix B - Incident Reporting Form

(NB – Only to be used where DatixWeb reporting is not possible)

DATIX REFERENCE

INCIDENT REPORT FORM

NHS WALES GIG CYMRU

PLEASE COMPLETE ELECTRONICALLY & EMAIL TO YOUR MANAGER/ CLINICAL LEAD/SENIOR NURSE

A. WHEN & WHERE

Date of Incident		**Time (24hr clock)**	
Directorate			
Specialty			
Site Location Details (e.g. Morriston, Singleton Hospital etc…)			
Exact Location of Incident (e.g. Ward and room etc..)			
Origin of Incident (e.g. if a sharp was found in sheets in laundry, where did they come from?)			

B. INCIDENT TYPE

Patient Safety ☐ **Non-Patient Safety** ☐ **Organisational** ☐

Please ✓ Incident Category

Slip, Trip, Fall				Violence & Aggression	
Delays		Work Related Ill Health		Security	
Pressure Damage		Food Hygiene & Safety		Information Technology	
Treatment Error		Manual Handling		Vehicles, Machinery & Equipment	
Unexpected Outcome		Communication			

Other – Please State

Incident Outcome

Was the Person Harmed?	Yes No ☐	Near Miss	Dangerous Occurrence
If Yes - Please give details of injury/body part affected			
Treatment Received	None First Aid Own G.P. Occ Health A&E Admitted to Hospital Detailed in Patients Notes Seen by Doctor		

C. PERSON INVOLVED/AFFECTED

Staff		**State Job Title**					
Patient		**State Hospital Number**					
Contractor		**Visitor**		**Other**		**– Please state**	
Name						**Male**	**Female**
Date of Birth			**Ethnic Origin**				
Address							
Post Code			**Contact Tel**				
Have the Next of Kin Been Informed?	Yes		No		Not Applicable		

D. BRIEF DESCRIPTION OF INCIDENT: WHAT HAPPENED – FACTS ONLY

Immediate Action Taken Following Incident	
Was Equipment involved?	Yes ☐ – Complete below No ☐ Type of equipment/consumables Equipment Identifiers
Has the Equipment Been Sent to EBME/Estates?	Yes ☐ No ☐

E. WITNESS DETAILS – If more than one please add their details in Section D above			
Forename		**Surname**	
Job Title		**Contact Details**	

F. DETAILS OF PERSON COMPLETING REPORT			
Forename		**Surname**	
Job Title		**Date**	
Have you informed the Manager/Clinical Lead?	Yes ☐ No ☐ N/A ☐		

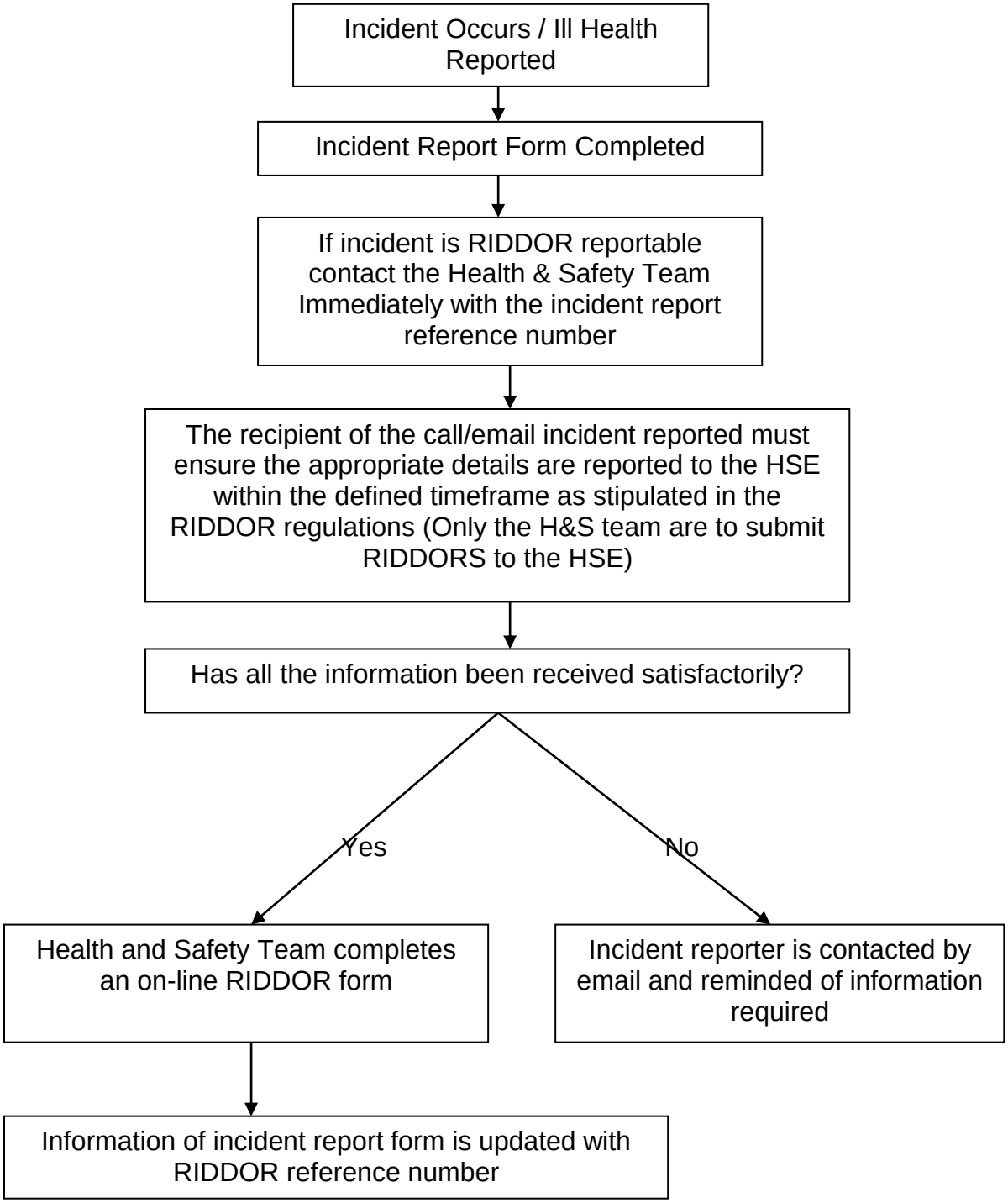
G. DESIGNATED MANAGER ACTION					
CONSEQUENCE – (**ACTUAL** Harm to the Individual – as defined in the Procedures document)					
Negligible ☐	Minor ☐	Moderate ☐	Major ☐	Critical ☐	
Risk Grading (Please refer to Risk Matrix)					
Consequence (Table 1)	☐ 1- Negligible	☐ 2-Minor	☐ 3-Moderate	☐ 4-Major	☐ 5-Critical
Likelihood (Table 2)	☐ 1-Rare	☐ 2-Unlikely	☐ 3-Possible	☐ 4-Likely	☐ 5-Almost Certain
Risk Score – (Table 3) Consequence x Likelihood	**Score**		☐ 1-3	☐ 4-6	☐ 8-12 ☐ 15-25

INVESTIGATION			
Results of Initial Investigation/Preventative Measure/Lessons Learnt			
No Further Investigation Needed and Feedback Given - ☐			
Further Investigation Needed and Feedback Required - ☐			
Have Witness Statements Been Taken?	Yes ☐ No ☐ N/A ☐ Declined to Give Statement ☐		
If a Member of Staff Was Affected, Did They Go Off on Sick Leave?	Yes ☐ No ☐		
Expected Date of Return to Work			
Completed By		**Date**	

For Official Use Only			
Date Received		**Received By**	
RIDDOR Reportable Yes ☐ **No** ☐		**Date Reported**	

Appendix C - RIDDOR Reporting Flowchart

RIDDOR REPORTING FLOWCHART



Appendix D - Reporting of Injuries Diseases and Dangerous Occurrences Regulations (Categories)

RIDDOR places a legal duty on employers, self-employed people and people in control of premises to report:

- **Death** – the death of any person, whether or not they are at work if it results from a work accident or occupational injury.
- **Major Injury** – accidents or incidents which result in an employee or a self-employed person suffering a major injury.
- **Over-seven-day injuries** - accidents or incidents which result in an employee or a self-employed person dying, suffering a major injury, being absent from work or unable to do their normal duties for more than seven consecutive days (not counting the day of the accident but including non-work days such as weekends, rest days or holidays).
- **Injuries to people not at work** - accidents or incidents which result in a person not at work (e.g. a patient, service user, visitor) suffering an injury and being taken to a hospital, or if the accident happens at a hospital, suffering a major injury which would otherwise have required hospital treatment.
- **Occupational Diseases** - an employee or self-employed person suffering one of the specified occupational diseases.
- **Dangerous Occurrences** - specified dangerous occurrences (near miss accidents or incidents), which may not result in a reportable injury, but have the potential to do significant harm.

When there has been an incident which is RIDDOR reportable the Corporate Health and Safety Department must be contacted with the incident reference number. A RIDDOR form will be completed by the Corporate Health and Safety Department as soon as possible so that the Health and Safety Executive (HSE) can be informed. Over-seven-day injuries must be reported to the HSE within fifteen days but all other RIDDOR reportable injuries must be reported to the HSE within a maximum of ten days of the incident occurring. (Refer to Appendix C).

The Regulations require that the Health Board keeps a record of an incident if the employee has been incapacitated for more than **seven** consecutive days (absent from work or unable to do their normal duties for over-three- days). This is recorded via the incident reporting system. It is important that the Health and Safety Department is notified of the length of time an employee is off work or has been incapacitated.

More detailed information can be found on the access to the online incident/compliment reporting intranet pages. http://howis.wales.nhs.uk/sites3/page.cfm?orgid=743&pid=36595

Appendix E - User Guide for Completing a Non DatixWeb Form

GUIDANCE NOTE FOR COMPLETING AN INCIDENT REPORT FORM (non Datix web)

NB: A non Datix web form should only be used where access to the Datix web reporting is not available.

A: WHEN & WHERE

- **Date of Incident**: Actual date of when incident occurred – (DD/MM/YY)
- **Time**: Time incident occurred (using 24 hour clock)
- **Directorate**: Relevant to the area where the incident occurred
- **Speciality**: The relevant speciality within the Directorate where the incident occurred
- **Site Location**: i.e. the Hospital site, Clinic, Patients Address
- **Exact Location**: Name of Ward/Room etc…
- **Origin of Incident** – i.e. if a sharp was found in sheets in laundry, where did they come from?

B: INCIDENT TYPE

- **PATIENT SAFETY** - Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care
- **NON-PATIENT SAFETY** - An event or omission causing physical or psychological injury to a member of staff, visitor, contractor, student etc.
- **ORGANISATIONAL** - An event or omission which causes disruption, loss or damage to the Health Board or which has the potential to cause disruption, loss or damage

Incident Category

- **Slip, Trip, Fall:** Any slip, trip or fall incident that occurred to a patient, staff member, or any other person
- **Delays:** Any incident that resulted in a delay to a patients treatment
- **Treatment Error:** Any incident where a patient receives incorrect treatment
- **Pressure Damage:** Where a patient is identified with grade 2 or above pressure damage
- **Unexpected Outcome:** e.g. adverse reaction, unplanned return to theatre, readmission, etc.
- **Personal Incident:** – any incident that occurred to an individual that is not covered in other categories
- **Work Related Ill Health**: Work related illness, disease, infection etc…

- **Food Hygiene and Safety**: An incident occurred as a result of or due to e.g. food poisoning, food out of date food, dirty crockery/utensils
- **Manual Handling:** Any incident involving patient or load handling
- **Violence & Aggression**: An incident occurred as a result of or due to e.g.: assault either physical verbal/sexual, racial/religious hate crime
- **Security**: Loss/damage/theft of personal/Health Board property
- **Vehicles, Machinery & Equipment**: An incident occurred as a result of or due to e.g. Road Traffic Collision (RTC – work related), inappropriate use of vehicle or machinery, damage to a vehicle or machinery or availability of machinery
- **Information Technology**: An incident occurred as a result of or due to system failures, problems with access, IT equipment, confidentiality
- **Communication**: An incident occurred as a result of or due to e.g.: communication failure between departments, staff to staff/relatives, language or disability barriers, telecommunications, switchboard
- **Other**: e.g. Missing/unavailable patient records, patient misidentification, transfusion error

Incident Outcome

- **Was the Person harmed**: **choose YES or NO.**
  If **YES,** - give brief details of injury/body part e.g. fracture to right ankle.
- **Near Miss**: i.e. Needles or sharps found in clinical waste bag
- **Dangerous Occurrence**: i.e. Accidental release of any substance which may damage health
- **Treatment received**: choose as applicable (this could be more than one), e.g. if attended A&E/Occupational Health

C: PERSONINVOLVED/AFFECTED

- **Choose as applicable:**
  - If a **staff** member include their job title
  - If a **Patient** include their Hospital Number
  - **Other** to include students, student nurses, volunteers, work experience etc…
- **Details of Person affected** – name, address, date of birth, contact number, ethnic origin (see appendix) (required by WG) and indicate whether next of kin have been informed (if applicable)

D: DESCRIPTION OF INCIDENT

- This should be a **brief account** of what happened. e.g., whilst disposing of needle in sharps box, member of staff sustained a needlestick injury.
  If the incident involved an assault by a patient you must include the patients name and Hospital number
- **Immediate action taken following incident**: this may include clearing

up spillages, first aid treatment, medical review of patient, reporting to senior member of staff.

- **Was equipment involved**: If **YES:**
  - **State the type of equipment/consumable**
  - **Equipment Identifiers** i.e. serial number/batch number etc....where possible record all

E: WITNESS DETAILS

Complete only if incident was witnessed

F: DETAILS OF PERSON COMPLETING REPORT

- The person who completed the incident report form must complete this section.

G: DESIGNATED MANAGER ACTION

- The Designated Manager of the area where the incident occurred should complete this section

Using the Risk Grading Matrix identify:

- Consequence (Table 1) - Identify the actual harm to the patient/person
- Risk Grading & Risk Score – (Tables 1, 2 & 3)
- Investigation - Please complete as appropriate
- Have Witness Statements Been Taken? – Either Yes, No Not Applicable or Witness Declined to give statement
- **If a Member of Staff Was Affected, Did They Go Off On Sickness Leave?** Either Yes or No.
- Expected Date of Return to Work (if applicable) – Enter estimated date (if known).

Appendix F - Guide for Incident Investigations

Investigation levels will depend on the seriousness of the incident and potential for learning lessons from either one or similar incidents across the organisation.

Levels of investigation:

- In a minimal level investigation, the relevant supervisor/manager will look into the circumstances of the event and try to learn any lessons which will prevent future occurrences.
- A medium level investigation will involve a more detailed investigation by relevant supervisor/manager and employee representative and will look for the immediate underlying and root causes.
- A high level investigation will involve a team-based investigation, involving supervisors/managers and employee representatives. It will be carried out under supervision of senior management or directors and will look for immediate, underlying, and root cause.

The urgency of an investigation will depend on the magnitude and immediacy of the risk involved (major accident). In general, adverse events should be investigated and analysed as soon as possible. This is good practice and capturing things early while memory is best and motivation is greatest immediately after an adverse event.

Immediately after the adverse event or as soon as safe to do so provide an emergency response:

- Ensure any casualties receive appropriate medical attention (first aid).
- Make the area safe.

Safety Investigation:

- Preserve the scene or items of evidence if practicable to do so.
- Take photographs if appropriate and record times.
- Review/investigate as close to the time of the incident as possible.
- Note the names of people, equipment involved and names of witnesses.
- Explore all reasonable lines of enquiries.
- Take witness statements.

Steps of the investigation:

Step one **Gathering the information**

Find out what happened and what conditions and actions influenced the adverse event. Begin straight away, or as soon as practicable.
It is important to capture information as soon as possible. This stops it being corrupted, e.g. items moved, guards replaced etc. If necessary, work must stop and unauthorised access be prevented.
Talk to everyone who was close by when the adverse event happened, especially those who saw what happened or know anything about the conditions that led to it.

The amount of time and effort spent on information gathering should be proportionate to the level of investigation. Collect all available and relevant information. That includes opinions, experiences, observations, sketches, measurements, photographs, check sheets, permits-to-work and details of the environmental conditions at the time etc. This information can be recorded initially in note form, with a formal report being completed later. These notes should be kept at least until the investigation is complete.

STAGE 1 – Gathering the information:

Where, when, who, how and what?

- Where and when did the adverse event happen?
- Who was injured/suffered ill health or was otherwise involved with the adverse event?
- How did the adverse event happen?
- Note any equipment involved.
- What activities were being carried out at the time?
- Was there anything unusual or different about the work conditions?
- Were there adequate safe working procedures and were they followed?
- What injuries or ill health effects, if any, were caused?
- If there was an injury, how did it occur and what caused it?
- Was the risk known?
- If so, why wasn't it controlled?
- If not, why not?
- Did the organisation and arrangement of the work influence the adverse event?
- Was maintenance and cleaning sufficient?
- If not, explain why not.
- Were people involved competent and suitable?
- Did the workplace layout influence the adverse event?
- Did the nature or shape of the materials influence the adverse event?
- Did difficulties using the plant or equipment influence the adverse event?
- Was the safety equipment sufficient?
- Did other conditions influence the adverse event?

STAGE 2 – Analysing the information:

- What were the immediate, underlying and root causes?
- What happened and why?
- What if 'human failings' (errors and violations) are identified as a contributory factor?
- Skill-based error – a slip or lapse of memory
- Mistakes – errors of judgement
- **Job factors** - distractions / time etc
- **Human factors** – physical / competence / fatigue
- **Organisation factors** – work pressures / resources / safety culture / communication
- **Plant, Equipment factors** – clear and simple instructions – design and suitability of equipment - layout

STAGE 3 – Suitable risk control measures

- What risk control measures are needed / recommended?
- Do similar risks exist elsewhere?
- If so where?
- Have similar adverse events happened before? Provide details.

STAGE 4 – Action plan and its implementation

- Which risk assessments and safe working procedures need to be reviewed and updated?
- Have the details of the adverse event and the investigation findings been recorded and analysed?
- Are there any trends or common causes which suggest the need for further investigation?
- What did the adverse event cost?

There are a number of techniques/tools that can be used to assist in the investigation.

One such tool is the five whys technique and this has be used for a hypothetical violence and aggression incident, which resulting in harm to a new staff member (mental health).

- *Why didn't we send the employee on the training?* Their induction includes going on the training within 12 weeks.
- *Why does it take up to 12 weeks?* Because the training team only schedule so many courses/spaces per year and not every month.
- *Why are there insufficient courses provided?* There are so many cancelations/no shows at late notice, courses are shown as undersubscribed by the training team.
- *Why are there so many cancelations/no shows?* Staffing shortages on the wards, therefore, can't release staff.
- *Why are staff numbers not sufficient?* Because of vacancies, sick absence and annual leave.

Using the 5 whys throughout the various stages can assist in identify not only the root cause, it will outline the contributory factors. From investigation lessons can be highlighted and shared across the organisation. It is important that safe systems of work and process are changed to reflect the lessons learnt as this will reduce the likelihood of such occurrences.

Quality Assurance of Incident Investigation

Questionnaire

Contents

Introduction

Incident investigation is important part of the learning cycle from events and auditing to assess the

quality of the investigation will provide learning points for the investigators and the organisation. It will provide a quality check on the methods used and the way in which they have been applied as part of the initial investigation. This will provide the organisation with assurance that the investigation are being reviewed to ensure the investigations are being undertaken to appropriate standards and lesson identified, shared and included in future investigation training.

Where practicable to do so trade union representatives will be invited to participate in these audits.

The responsible officers (Lead Serious Incident Investigator – Lead Head of Quality & Safety Manager – Assistant Director of Health & Safety) (Investigation Audit Team) are accountable for the quality assurance of the investigation audits and governance of the organisations systems. Improving these systems will support investigators in developing their investigation processes more effectively, which will add to the safety and quality of future investigations.

Other experts will be co-opted on to the investigation audit team where particular expertise is required to ensure a thorough review is completed to maximise learning.

What is quality assurance?

Quality assurance refers to the engineering activities implemented in a quality system so that requirements for a product or service will be fulfilled. It is the systematic measurement, comparison with a standard, monitoring of processes and an associated feedback loop that confers error prevention. In the context of responding to incident investigations and the management of the process of investigations, providing the opportunity to improve outcomes, benchmark good processes in investigations and to improve training.

Two principles included in quality assurance are:

- ‘fit for purpose’ – the product should be suitable for the intended purpose; and
- ‘right first time’ – mistakes should be eliminated.

(The product is the service offered by individuals/teams investigating incidents)

Feedback about all stages of the investigation will enable individuals/teams to learn and further improve the quality of the investigations to capture key learning points.

"Feedback is the breakfast of champions"
Ken Blanchard (author and management consultant)

Process
The processes by which feedback can be obtained should be considered. Information can be collected in several ways but it is important to capture learning points along the way and actively at the end of the process. The responding to concerns team should keep a record of issues which can be improved upon during the process. Feedback from the doctor and the witnesses may arise spontaneously during the investigation. All of this should be logged contemporaneously. Active feedback should be formally sought at the end of the process.

Purpose and context

This document provides sample questionnaires to aid the quality assurance of an investigation. The report template is an example of how the outcome of the quality assurance process can be formatted. The investigation audit team involved in an audit should learn from each investigation so that the process can be improved for the next investigation in the organisation. It is also important to reflect on what happened for the personal learning of individuals. This will ensure consistency and equity of approach.

The questionnaires need to be administered soon after the investigation is completed (ideally within 3 months) by a nominated member(s) of the incident investigation audit team. Any learning captured during the process should also be reviewed by the team member(s). The responding to concerns team may have collected information on a feedback log which should be reviewed and considered in the report. This team member should then compile a report of learning outcomes from the investigation with action plans for the organisation and individuals. When the report is available it should be circulated to the responding to concerns team and a meeting to discuss it would also be helpful. The report should be kept confidentially and each organisation should have relevant information management systems to explain how the report is circulated/stored etc.

Primary audience

This document is aimed at all those responsible for undertaking incident investigations at corporate and local levels and could be part of the investigation audit team. It is the responsibility of each Service to ensure a percentage of investigations are reviewed internally, with a 50% of all investigations for RIDDOR and lost time incidents and 5-10% of moderate incidents.

Service Groups and Directorate/Departments ae to review investigations locally and report findings to the Health Board Health and Safety Operational Group.

Identified staff to undertake reviews include, but are not limited to, the following:

- Quality & Safety Managers
- Support Service Managers/Supervisors (Portering/Catering/Cleaning – Estates)
- Human resource managers

Quality assurance of incident investigation
Questionnaire to be completed by identified

Name of organisation:

Incident reference number investigated:

Name of original investigator(s):

Name of reviewing/audit investigator(s):

	Please write or type your answers below
1. What was the profession of the case investigator?	[clinician/HR/general manager/other]
2. Was the most appropriate case investigator selected?	[Yes/No]
3. If you think an alternative case investigator would have been more appropriate, please say why	[e.g. It would have been better to have a HR professional in this case.]
4. Had the investigator received appropriate training?	[Yes/No]
5. How long did the investigation take from the start until the final report received/closed on Datix?	[State in weeks and days]
6. Did the investigator act objectively throughout?	[Yes/No. If no, please give examples]
7. Did the investigator manage the investigation in a professional manner?	[Yes/No If no, please give examples]
8. Did the investigator ask for appropriate specialist opinions (if appropriate)?	[Yes/No, If no state any deficiencies.]
9. Was the report clear and understandable?	[Totally/Partially/Not at all. Include any relevant comments for feedback.]
10. Did the report contain appropriate evidence?	[Yes/No. If no, please explain]
11. Did the report answer the questions in the terms of reference?	[Totally/Partially/Not at all. If not totally, please explain any deficiencies.]

12. What was the overall quality of the report?	[Excellent/Good/Average/Poor]
13. Was the individual(s) supported appropriately?	[Yes/No. If no, please explain.]
14. Did you have access to the key subject?	[Yes/No. If no, please explain.]
15. Were there any witnesses and were statements taken?	[Yes/No. If no, please explain.]
16. Did the investigator understand the level of investigation required at the start of the investigation?	[Yes/No. If no, please explain.]
17. Was support available to the investigator?	[Yes/No. If no, please explain.]
18. Are there any other comments you would like to add which would improve the process of this investigation or the skills/knowledge of the case investigator and others in the responding to concerns team?	[Yes/No. If no, please explain.]

Quality assurance of incident investigation
Evaluation of the investigation report (report template)

Cover page should contain the following information:

Strictly confidential

Evaluation of the investigation process of incident reference number: ( )

Organisation's name:

Report author:

Date:

Side headings of report are as follows:

Contents

Background
[Give a brief explanation of the incident investigated and the outcome. The outcome needs to be described (e.g. no learning points identified, detail causal factors and root cause if identified, learning points etc.)

The investigation audit/review to team (Individual)
[List the names of the team and their designation (e.g. A N Other; Estates Manager etc.)

Methods
[Give a brief description of how the questionnaires were answered. Describe any other feedback received in the process not actively sort.

Results
[How long did the incident investigation audit/review take? What was the quality of the report? Did the report allow a decision to be made?

Conclusions
[Brief summary of overall conclusions]

Recommendations
[This is an important section and should include reports/action plans, as follows:

- *Service group/department Action Plan*
- *Report for the Health & Safety Operational group*
- *Recommendations for training updates and learning*
- *Anonymise for potential use in case studies within the training package*
- *Feedback through the H&S governance structure*
- *Synopsis for H&S newsletter (key points only)*