Incident Reporting 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 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, no matter how minor are reported, recorded, and an appropriate investigation undertaken. The reporting of incidents is the first important step in ensuring that lessons are learnt and action is identified 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 will contribute to continuous improvement. In addition incident reporting:

- enables early action to occur so that 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

3. Scope

This policy 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** aspect only. The reporting element is common to all incidents – both patient safety and non-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 Concerns Policy and Procedure provides details of roles and responsibilities for the management of patient safety incidents. The Corporate Risk Team is responsible for managing non-patient safety incidents and can provide advice in relation to investigating these.

5. Definitions

INCIDENT	Any unintended or unexpected occurrence that: could have resulted in harm, damage or loss but fortunately there was no harm, damage or loss did result in harm, damage or loss
PATIENT SAFETY INCIDENT	Previously been defined by the National Patient Safety Agency as "any unintended or unexpected incident which could have or did lead to harm for one or more persons **receiving NHS care**"
PREVENTED INCIDENT	A PREVENTED incident is one where there was an unintended or unexpected occurrence, which could have led to harm, damage or loss but an intervention prevented any harm, damage or loss. **These are still reportable incidents**
HARM	HARM is considered to be any injury (physical or psychological), disease, suffering, disability, impairment of normal function or death.
NO HARM	Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.
DAMAGE	DAMAGE is considered to be an impairment of the normal function or appearance of an item or physical property
LOSS	LOSS is considered to be a monetary loss or reduction in monetary value or the deprivation of use/presence of an item of physical property
LOW	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.
MODERATE	Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS funded care.
SEVERE	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care.
DEATH	Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

6. 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

Trigger lists can be a helpful tool for aiding staff to recognise incidents. Departments may wish to develop their own trigger lists to assist staff; and example of a trigger list for Children and Young People, and Neonates is provided at Appendix B.

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 C – are SBUHB going to adopt this?.

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.

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 and a note included to indicate 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.

Reporting via an electronic or paper form
In exceptional circumstances where it is not possible to use the web based reporting system, and for Primary Care contractors and Commissioned Services, an electronic (attached to an email) or paper based version should be completed and forwarded to the Line Manager and emailed to the dedicated incident reporting email address: (Insert email addresses)

Patient Safety Incidents: XXX@wales.nhs.uk (Does SBUHB have a generic email?)

Non Patient Incidents: XXXYY@wlaes.nhs.uk

Copies being emailed should be sent using PII email form. The incident form template is provided at Appendix C and the user guide for completing the form at Appendix F. (Need to check this for SBUHB)

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

6.1 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.

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 **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 Corporate Risk Team (as appropriate) should also be informed. Is this name/title correct?

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 Director of Nursing and Patient Experience for patient safety incidents. The Director of Nursing and Patient Experience will inform the remaining members of the Executive Team as appropriate, and the Chief Executive.

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.

The Team (patient safety incidents) or Corporate Risk Team (non-patient safety incidents) must be informed by phone or email on the next working day.

Timescales

Incident forms should be completed and submitted within **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.

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

Incidents identified via reviews

For incidents detected through the clinical coding process for patient records and/or as a result of 1000 Lives Plus Programme patient record reviews, the need for a retrospective incident report and investigation should be discussed with the Patient Safety Team (Patient Safety Investigations)

Incidents involving the independent Contractor Service and Commissioned Services

There is no contractual obligation for Independent Contractor Services to report incidents to the Health Board. However, they are encouraged to work with the organisation in promoting safer working practices and sharing lessons learned.

Independent contractors and Commissioned Services are requested to:

- complete an incident report form;
- email or post the electronic / paper report form to the Primary Care Team and retain a copy for the practice records;
- investigate, and discuss if appropriate in the practice team meetings;
- implement change if appropriate;
- share lessons learned.

It is the responsibility of the Independent Contractor Service and Commissioned Service to have systems in place for reporting and managing patient safety incidents as part of their contractual arrangements. The Health Board is required to monitor this as part of their contractual arrangements.

Refer to Appendix D for patient safety incident reporting process for primary care. Check for SBUHB process

A number of externa organisations/agencies must be contacted when a particular type of incident has occurred. The following section lists these organisations and gives brief information on the mechanisms for reporting.

Where indicated, further information and guidance can be found within relevant Appendices.

NHS Partners, Tertiary and Specialist Providers/Contractors, Social Services. Local Authority Departments

Except where other specific arrangements or requirements may exist, the Executive Team will consider and agree the level and nature of communications in respects of any

individual, patient safety incident and the extent of any involvement of such partners/stakeholders in the overall incident management and learning process.

Requirements for specific types of incidents, and those requiring external notification and reporting

Incidents involving fires

The Fire Service advises they are to be called to all fires.

All fires and false alarms must be formally investigated by the Health Boards Fire Officer. The Fire/False Alarm must be recorded on Datix **within 24 hours** of the fire incident/false alarm via the organisations intranet site using the link: http://7a3b7svmdatixlv.cymru.nhs.uk/datix/live/index.php By pressing the submit button an email is sent automatically to the fire officers to inform them of the incident. A copy of notification of the incident must be forwarded to Line/Ward/Department/Accommodation Manager where the incident occurred. The incident form (fire) should be completed by the Ward/Department Senior Person where the incident took place. The exception to this is if the site has a Fire Incident Coordinator available at the time of the incident (e.g. Senior or Acting up Nurse, site Manager, Hospital night coordinator, or Bed Manager).

Fire involving deaths, injuries or damage, need specific action for example, incidents of arson must be reported immediately to the Fire Safety Manager during normal working hours. Out of normal working hours, the On-Call Director must be informed via the switchboard.

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.

Information Governance Incidents

All incidents relating to information governance matters should be copied or notified to the Corporate Services Department. This will allow for consideration to be given as to whether the incident should be reported to the Information Commissioner and for accurate reporting of incidents to the Information Governance Group. For guidance purposes, information governance related incidents could include any of the following breaches.

- 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 to personal identifiable information (electronic or paper);
- inappropriate use of social media including websites, mobile phones and cameras;
- inappropriate use of email/internet;
- IT security breaches;
- records management breaches.

This list is not exhaustive and further advice should be obtained from the Corporate Services Department as required.

Incidents involving ionising radiation

The Ionising Radiation Regulations 2017 specify reporting requirements for a range if incidents including loss of radioactive sources and equipment faults resulting in a patient exposure 'much greater than intended'. Incidents involving exposure to ionising radiation to an extent which is 'much greater than intended' will be reported to the Health Inspectorate Wales (HIW) via the Medical Director on the advice of the Radiation Protection Adviser. This includes any incident where the wrong patient has had an X-ray or CT scan.

Drugs Reactions and Medicine Defects

These incidents need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA). The reporting of any suspected drug reaction can be made by any clinician using the Yellow Card system for reporting, which can be found on the back page of the British National Formulary or on-line http://yellowcard.mhra.gov.uk/ . The person making the report should also advise the Chief Pharmacist.

Medicine defects, such as cloudiness of liquid or discoloration of medicines, should be reported to the Chief Pharmacist who will advise the all Wales Medicines Quality Controller and complete an incident report if appropriate.

Medical Devices and Equipment

These incidents need to be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA). Where any incident relates to/involves the use of medical equipment, there should be contact with the Head of Clinical Engineering who will advise on or assist with the investigation of the incident, as appropriate and make a report to the MHRA.

Communicable Diseases and Inoculation Injuries

The Infection Control team will report notifiable incidents to the Centre for Communicable Diseases Control and will undertake EPINet (Exposure Prevention Information Network) reporting for inoculation injuries.

Serious Hazards of Transfusion (SHOT)

This is a voluntary reporting scheme to which the Health Board submits reports of relevant incidents. Automated email triggers from the on-line reporting system will alert the Blood Transfusion Practitioners of each such reported incident.

Safeguarding Adults

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.

Safeguarding Children

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

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.

External Reporting

National Reporting and Learning System (NRLS)
All NHS organisations are required to report patient safety incidents (with certain exceptions) to the NRLS. This is the responsibility of the Patient Safety Team – What do we have at SBHUB?, and is undertaken via an electronic export of data from the Datix System. This task will be undertaken on a fortnightly basis, apart from serious incidents.

Although the National Patient Agency has been dissolved, the requirement to report serious patient incidents through the NRLS, **within 36 hours**, is an ongoing requirement.

The Senior Manager for Investigations & Quality Improvement will ensure the necessary report is made at the same time as reporting any serious patient safety incident to Welsh Government (Who produces this for SBUHB), via an export from Datix system. This will be initial information only, at this stage and re-export of the record will be required when the investigation is concluded.

Welsh Government – Improving Patient Safety Team for serious patient safety incidents

All serious incidents must be reported to the Welsh Governments Improving Patient Safety Team in accordance with the 'Guidance on the Reporting and Handling of Serious Incidents and other Patient related Concern / no surprises' document.

The definition of a serious incident extends beyond those which directly impact on patients/staff. This definition is provided in section XX (definitions), and relates to those which result in severe harm or death. Those which need to be reported to the Welsh Government including broader criteria, and apply to those that occurred in relation to NHS funded services and care resulting in:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm);
- a scenario that prevents or threatens to prevent an organisations ability to continue to deliver health care services, for example , actual or potential loss or damage to property, reputation or the environment;
- a person suffering from abuse;
- adverse media coverage or public concern for organisation or wider NHS;
- the core set of "never events" as updated on an annual basis. A list is available at http://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/

The Senior Manager for Investigations & Quality Improvement (or nominated staff in the Concerns Team) will undertake the necessary reporting and communications with the Improving Patient Safety Team. Welsh Government will grade the incident and indicate the timescale for completion of the investigation; a closure form is sent to Welsh Government once the investigation is complete which will include lessons learned and action taken to make improvements.

Welsh Health Specialised Services

Serious patient safety incidents involving Forensic Psychiatry should be reported to Welsh Health Specialised Services at the same time as they are reported to Welsh Government. This should be done by a nominated person within the Mental Health Directorate.

Health & Safety Executive

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 Board Secretary/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

Where the incident relates to Patient Safety, the Chief Executive and Executive Team or their delegated officers will decide whether the Police should be notified of any incident and instigate the necessary actions.

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.

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.

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 Risk Department must be contacted with the incident reference number. A RIDDOR form will be sent to the Manager to fill in. This must be completed and returned to the Corporate Risk 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 E).

The Regulations require that the Health Board keeps a record of an incident if the employee has been incapacitated for more than **three** 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 Corporate Risk 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 Incident Reporting webpage.

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 Concerns Team, Corporate Risk Team, and Primary Care Team are able to offer assistance and support with this process where appropriate and required.

Patient Safety Incidents

The investigation of patient safety related incidents is detailed in the Concerns Policy & Procedure.

Non-Patient Safety Incidents

For non-patient safety incidents which are risk graded 8-12 (amber) or 15-25 (red) and all RIDDOR reportable incidents, an investigation must be undertaken by the responsible manager. There are also specific investigation forms which can found on the Health & Safety intranet page, including Staff Physical Assault, Manual Handling, Slip Trip or Fall and Road Traffic Collision. The investigation forms can be located on the Incident Investigation page of the intranet. Investigations will then be reviewed by the relevant specialist in the organisation.

All incidents should be investigated. However, the level of investigation should be commensurate with the severity of the incident i.e. investigation into

"green" and "yellow" incidents documented on the investigation page of Datixweb (DIF2) and the more detailed investigation into „amber" and „red" incidents documented using the relevant investigation form (DIF2). The Corporate Risk Team should be contacted for support and guidance on the approach and documentation.

8. 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 Corporate Risk Team.

9. 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.

10. Non Conformance

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

11. Equality Impact Assessment

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

12. References

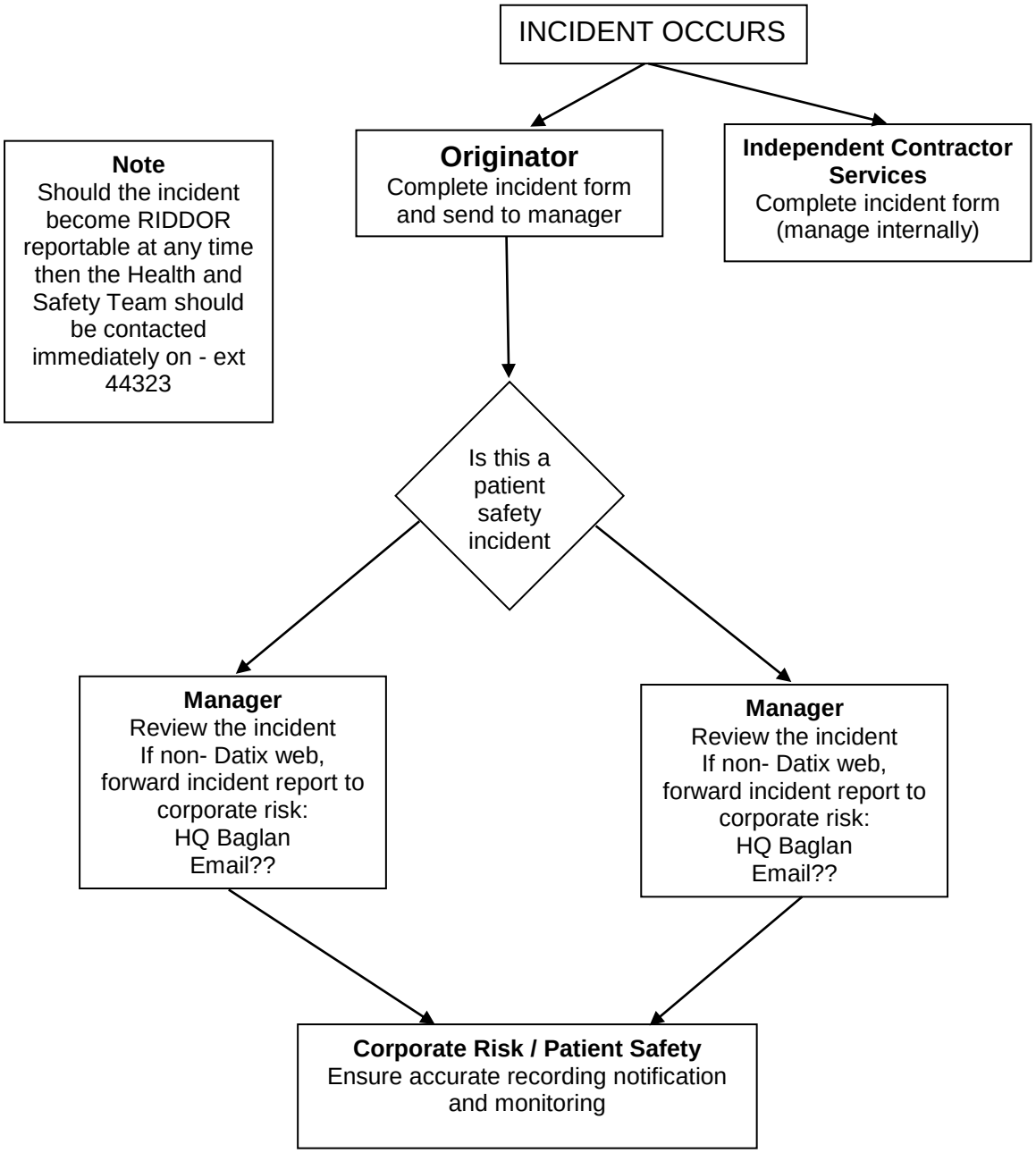
- Health and Safety at Work etc. Act 1974
- Management Regulations, 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 HSE (1995) The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. (RIDDOR)
- NPSA (2004) Seven Steps to Patients Safety
- 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

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

Trigger List for Children, Young People, and Neonates

Children and Young People
Directorate Patient Safety
Incident Trigger List

Access, appointment, admission, transfer, discharge
Admission • *Unexpected readmission (readmission on the same day/within 12 hours)* • *Unplanned admission/ procedure* • *Ward closure* • *PAU closure* • *Admission of neonate (<28 days) due to feeding difficulties* • *Inability to provide high dependency care* • *Inappropriate placement of patients* ***Transfer*** • *Non clinical transfer of patient* • *Transfer of patient to PICU* ***Discharge*** • *Unable to discharge patient (social service unavailable, CAHMS assessment unavailable)* • *Delay/no discharge summery > 1 week*
Consent, confidentiality, communication
• Inadequate, poorly documented or no consent for procedure/ treatment • Breach of confidentiality • Communication failure - between team and outside of team
Patient information
• No access to patients" notes • Administrative failure impacting negatively on patient (system failure, delayed/lost pathology specimen/results) • Poor or inadequate documentation • Patient identification errors • Failure to access results of requested investigations • Failure to act on abnormal results • Failure of baby tagging system
Infrastructure, resources (staffing, facilities, environment)
Adverse events related to staffing • Lack of suitably trained/ skilled staff • Lack of medical and nursing support between both sites • Inability to provide HDU level care due to staffing issues • Closure of ward/PAU due to staffing issues • Nursing staff used special 1:1 patients with psychiatric/ self-harm • Cancellation of elective surgery/ procedure

Environment

- Unsafe/inappropriate clinical environment
- Lack of/ delay in availability of beds/ cubicles
- Medical equipment failure
- Lack of/ delay availability of facilities/ equipment/ supplies
- Loss of property/ theft

Allied services

- Unavailability of allied services e.g. physiotherapist
- Radiology procedure requested but refused or significant delay

Medication

Administration

- Medicine not administrated/ significant delay in administration (30 minutes for initial dose antibiotics, 1 hour for regular medications)
- Medication error
- Adverse reaction to medication

Prescription

- Prescribing error
- Weight/ allergy not documented

Injury, safety

- Incident or accident relating to actual or potential injury to member of staff or to the public including children
- Intruder on the ward
- Any act of violence or aggression
- Failure to follow safeguarding children guidance
- Failure to comply with the child protection policy/ pathways
- Child / baby abduction
- Missing or absconding patient

Treatment / procedure

Serious illness

- Unexpected death
- Cardio/ respiratory arrest
- Anaphylaxis
- Sudden collapse

Treatment management

- Failure to follow policy/protocols/ guidelines
- Incorrect documentation in the observation chart
- Failure to react/ interpret abnormalities on CRT chart
- Incorrect procedure/ treatment
- Wrong site surgery
- Inappropriate fluid management- failure to monitor fluid balance
- Chest drain
- Delay in surgery

Complications of treatment

- Blood transfusion error
- Postoperative bleed/apnoea
- Extravasation injury
- Aspiration following oral feeds
- Aspiration following NGT feeds
- Pneumothorax
- Peripheral intravenous line infection
- Central line infection/ blockage
- Return to theatre

Neonatal Clinical Incident Trigger List

Birth

- Still birth or neonatal death (less than 28 days postnatal age)
- Any birth injury (e.g. laceration or nerve injury)
- Significant perinatal compromise (cord pH <7.1 venous, 7.05 arterial)
- APGAR < 7 at 5 minutes

Medical problems

- Seizures
- Significant infection
- Pneumothorax
- Necrotising enterocolitis
- Neonatal encephalopathy
- Significant congenital anomaly not diagnosed antenatally
- Bleeding from umbilical cord
- Extravasation injury

Staff, equipment and organisation

- Notes unavailable
- Lack of suitably trained/skilled staff
- Unavailability of bed/neonatal cot
- Incidents relating to data protection/ breach of confidentiality
- Incidents relating to security
- Unavailability of facility or equipment
- Equipment failure
- Unavailability of allied services e.g. radiographer

Admission

- Unexpected admission
- Unit closure
- Term baby requiring admission
- Baby less than 28/40 (less than 30/40 twin)
- Hypothermia (< 36.5) on admission
- Baby requiring readmission
- Transport without heated resuscitaire or heated cot
- Baby transferred in from home
- Hypoglycaemia requiring admission
- Unsuccessful intubation
- Hypernatremia secondary to feeding problems

Others

- Procedure or intervention complication (e.g. long line complication)
- Pressure necrosis, NCPAP injury
- Incorrect plotting of bilirubin (affecting treatment)
- Medication error or adverse drug reaction
- Blood transfusion error
- Injury to staff or patient or visitor (e.g. needle stick injury)
- Violence and aggression

- Loss of property/ theft
- Communication issues
- Child protection
- Failure to notify health visitor/ community midwife of discharge from SCBU
- Failure to notify GP of discharge from SCBU within one week

Appendix C

Incident Reporting Form

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

DATIX REFERENCE

INCIDENT REPORT FORM

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. Royal Glamorgan, Prince Charles 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		Personal Incident (NPS)		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)						
No Harm ☐	Low ☐	Moderate ☐	Severe ☐	Death ☐		
Risk Grading (Please refer to Risk Matrix)						
Consequence (Table 1)	1- Negligible ☐	2-Minor ☐	3-Moderate ☐	4-Major ☐	5-Catastrophic ☐	
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 D

Primary Care Patient Safety Incident Reporting

Patient Safety Incident / near miss occurs in Primary Care

- Manage the immediate risks
- Inform lead GP / Nurse / Practice Manager
- Discuss within the practice to learn lessons
- Review and change practice if necessary
- Complete a Patient Safety Incident Report Form
- Provide patient details if incident requires investigating by secondary care

Did it result in severe harm or death?

- Report to Health Board within 24 hours by telephone
- Forward the Form to HB by email/Fax as soon as possible

Report to Health Board within 24 hours by telephone

- Local trend analysis and action
- To share lessons learned
- Report to NHS Improvement

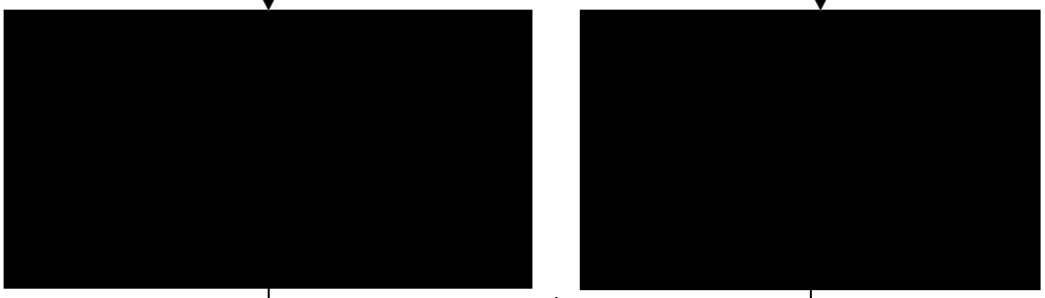
Report immediately to WAG as per procedure for Serious Incidents

Received in the HB by Primary Care Team

- Complete Datix from hard copy provided by practice
- Checked by Primary Care Manager

Regular & timely feedback – at locality groups or if necessary via additional working group

Does it need investigation?



Patient Safety Team to

- Direct secondary care team to investigate
- Obtain a response from Clinical area and forward to Patient Safety Team -* Escalate if required
- Feedback to Primary Care Manager as soon as possible within 1 month
- Report the incidents to the NPSA
- Check for any other reports needed – MHRA / Child Protection / POVA – advise and refer on as necessary
- Provide reports to the Primary Care Team on trends and lessons learned / action taken by secondary care

Appendix E

RIDDOR Reporting Flowchart

Appendix F

User Guide for Completing a Non DatixWeb Form