# INCIDENT MANAGEMENT POLICY

*June 2011*

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<td>Head of Health and Safety</td>
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<td>Responsible Director</td>
<td>Director of Human Resources</td>
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<td>Approved By</td>
<td>Health and Safety Forum</td>
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I. Scope of Policy Implementation

This policy is written in support of the general statements and principles as set out in the NHS Greater Glasgow and Clyde Health and Safety Policy.

II. Roles and Responsibilities

The framework of accountability and responsibility for managers and staff on the implementation of this policy follow that laid out within the Health and Safety Policy.

It is Local Managers and Head of Departments responsibility to ensure that actions are in place to ensure the implementation of the policy. In particular the timely and efficient use of the DATIXWEB Incident Reporting System.

1. INTRODUCTION

The reporting of incidents forms part of the Risk Management Strategy and should be recognised as a means of improving the quality of patient care and minimising risk. The open reporting of even minor incidents allows weaknesses to be identified in the system, customs and practices changed and retraining of staff where necessary. Investigation must be balanced with the need to counsel and support staff through any potential or actual incident, and to ensure appropriate support is given.

This is a guide for staff on how to report clinical and non-clinical incidents, including near misses and potential incidents. It covers all incidents, whether they involve patients, relatives, visitors, staff, contractors, volunteers or the general public. Due to the size and structure of the organisation incidents are generally reported up through two main streams with the non-clinical incidents reviewed by the Health & Safety Service and the clinical incidents reviewed by Clinical Risk. Examples of incident category under these main heading is given in appendix 4.3.

- An ‘Incident’ is any event or circumstance that led to unintended or unexpected harm, loss or damage.

- A ‘Near Miss’ is an event or occurrence which, but for skilful management or a fortunate turn of events, would have led to harm, loss or damage.

- A Serious Incident (sometimes known as a ‘Significant Incident’) is an event deemed at Director level to be sufficiently serious to warrant a formal investigation reportable to relevant Directorate/Partnership Senior Management with investigation monitored by the appropriate Health & Safety or Clinical Governance Forum. Usually it would involve the risk of death or serious injury / ill-health, major damage to property, loss of a service, create a major health risk, or are a threat to the strategic objectives of the NHSGGC. There is a policy on the Management of Significant Clinical Incidents for further information.

The NHSGGC recognises the importance of reporting incidents:

- The management of risk is the responsibility of all managers and staff throughout the NHSGGC. We aim to achieve this within a progressive, honest and open environment, where risks, incidents, accidents, mistakes and near misses are identified quickly and acted upon in a positive and constructive way.
- No disciplinary action will result except where, after a full investigation, there has been criminal or malicious activity, professional malpractice, or acts of gross misconduct. Disciplinary action may be considered where incidents or violations have not been reported.
- Staff will be provided with education, training and support to enable them to meet this responsibility.
NHSGGC promotes and seeks to encourage a culture of reporting so as to identify and learn from sources of error and risk which may lead to damage, loss or harm, complaint or legal claim for negligence.

Staff should report in the first instance to their line managers who will advise on action.

Understanding and learning from incidents is an important part of risk management. The occurrence of an incident or near miss might trigger a review of a risk assessment of a work area or of a particular practice, to work out how to minimise the chance of similar incidents in future. The type and frequency of incidents should also be taken into account when compiling risk registers.

The Health and Safety Service together with the Clinical Governance Support Unit, Occupational Health Service and other specialist departments can provide back up, advice and support on the investigation and handling of serious incidents.

2. REPORTING INCIDENTS

2.1 The reporting system

When an incident or a near miss occurs, the NHSGGC Incident Reporting System must be used.

- Web based incident reporting via a computer terminal – DATIX

NHSGGC has committed to the use of the web based incident reporting system DATIX. This allows incidents to be reported in real-time reducing delays experienced with paper systems. The web form divides the incidents into clinical and non-clinical with categories appearing in dropdown lists to make selection and completion straightforward.

Selection for separate recording of clinical and non-clinical incidents is made at the “Incident type” box on the DATIX report form.

2.2 Incident descriptions

- It is an incident which results in injury or ill health.
- It is contrary to the specified or expected standard of patient care or service.
- It places patient(s) or staff member(s), or visitor(s), contractor(s) or member(s) of the public at unnecessary risk.
- It puts the NHSGGC in an adverse position with potential loss of reputation.
- It puts NHSGGC property or assets in an adverse position or at risk of loss or damage.

2.3 Near miss reporting

This is an occurrence that might have led to harm or damage but did not happen due to discovery, chance or skilful management. Reporting a ‘near miss’ event is as important as reporting incidents that actually occurred and caused harm. Although a ‘near miss’ did not cause harm the potential for recurrence probably still exists and this needs to be managed effectively. The point for selection of a near miss is within the “Outcomes” box in the DATIX report form.
2.4 Your duties as a NHSGGC employee

NHSGGC aims to promote a culture in which all staff are individually conscious of their responsibility to reduce and prevent unsafe practices and routinely to raise concerns. There are many routes through which concerns can be effectively raised but these should include line managers. As a member of staff you are required to inform your line manager of incidents and near misses. Your duty to report applies even if you are not directly or potentially affected.

The NHSGGC Risk Management Strategy states:

“In order to ensure full reporting of incidents, a ‘just culture’ will be operated within which staff are free to report on incidents and concerns in the knowledge that they will be supported.”

2.5 Steps to take following an incident.

It should not be the responsibility of an individual member of staff to solely undertake any of the following actions. Support should be expected from colleagues and line management.

Immediate action.
Before the reporting system is commenced some incidents will require prompt and specific action to deal with the problem. This may involve:

Individual care of the person(s) affected by the incident

- Provide emergency medical/psychiatric treatment.
- Treat /care for others affected.
- Ensure that all patients, staff, visitors and others at risk, are moved to a safe area if there is an environmental threat.

Create a safe environment

- Summon assistance e.g. police, fire.
- Take immediate action if the incident could recur.
- If equipment /machinery is involved, remove it from service (marking it clearly out of order). Isolate any faulty equipment in a safe place for later inspection without altering its settings. You should record any settings that may be lost when the machine is turned off. Contact Clinical Physics or the Estates Department as appropriate.
- Appropriate records, materials and equipment, including disposable equipment used in conjunction with any device, must be retained

Communication

- Notify line manager for all incidents.
- Notify senior members of staff if incident is significant.
- Where appropriate, notifying next of kin for both patient and staff injury incidents.
- Consider the need to provide an explanation or an apology to the patient and family; an apology invariably improves relationships and communications and, note, is not an admission of liability.
- Record all actions taken.
Where death or serious injury has occurred or you regard the incident as very serious, **reporting must be immediate**, i.e. by telephone to senior managers, or on call managers outside normal working hours. Health and Safety Services should also be informed immediately during office hours or by leaving a message on the answering service outwith office hours.

The patient’s Consultant must be informed of serious/significant incidents especially if this resulted in an adverse outcome.

In some circumstances deaths of patients may require to be reported to the Procurator Fiscal. Further Guidance on this is covered by the Significant Clinical Incident Policy.

### 2.6 Reporting

Access to the DATIX reporting system via Staffnet. (under Applications)

If you have not completed the incident form before, read through it before you fill it in. Guidance on completion is available at the DATIX staffnet page, also via a link at the top of the online reporting form DIF1. At the initial time of completion not all the necessary information may be available. This should not delay the reporting process as missing information can be added later.

The key information you will be asked is:

- The location of where the incident occurred (Where)
- The date and time of the incident (When)
- Personal details relating to the person involved in the incident (victim / injured party)
- Description of the incident (What, Why and How)
- The outcome of the person involved (injury / result)
- The immediate treatment given to the person involved.
- Any immediate action taken
- Any remedial action taken to minimise risk of recurrence
- Others who were involved in observing or reporting the incident.
- The severity of the incident (see section 2.9)

It is imperative that the person(s) reporting the incident confine themselves to **issues of fact**. There is no place for any opinion or assumptions, however well intended. Merely state the facts as they are. Incident forms may have to be **disclosed** in the event of subsequent litigation. Therefore it is important that details are **accurate and factual**.

If staff are involved in an incident on other NHS employers’ premises, they must report and complete an incident form for that organisation. The member of staff should upon return to base inform their line manager of the incident. Staff involved in an incident elsewhere e.g. a patient’s home, should complete a NHSGGC Datix form as soon as they return to their place of work.

All staff with honorary contracts must complete a form if they are involved in an incident on NHSGGC property. Volunteers and students on work experience should similarly complete a form if they are involved in an incident whilst on NHSGGC property and also make a report to the organisation which has placed them in NHSGGC.

Presently it is not possible to operate an incident reporting system which can be utilised by two separate employers. Therefore the dual reporting systems in use within Partnerships will remain.

It is acceptable for staff to complete forms on behalf of other people if the need arises, after full establishment of the facts.
If the incident is an event, only one form is necessary as multiple forms providing different versions of the same incident lead to double counting of the incident. The most senior person present at the incident should ensure that at least one form is completed.

Where it is necessary to record more than one person involved or affected by the incident this can be done by using the repeating section of “persons affected” on the DATIX DIF1 reporting form.

Non-clinical example: A patient became violent in the ward area and three members of staff were injured. Each member of staff would be recorded on the single incident form relating to their involvement and injury. It would only be necessary to complete a form for the patient if he/she were also injured. The only exception to this would be where more than 1 persons involvement resulted in a RIDDOR report. In such circumstances separate reports would be required for each person.

Clinical example: Medication incident where patient A gets patient B’s drugs and as a result patient B does not receive any drugs. Although both incidents relate to the same initial error, patient A would be reported as wrong patient for medication and patient B would be reported as omission of medication.

To help improve safety at NHSGGC, the incident reporting process has to be pursued to a conclusion at the level of the local management team. This requires local ownership and commitment to action. Line managers and staff should work together to ensure that the specific concerns raised are acted upon and information about the event and the outcomes shared as widely as possible, seeking corporate advice if needed from relevant departments, e.g.:

- Clinical Risk
- Health and Safety Services
- Clinical Physics Department
- Estates
- Radiation Protection
- Infection Control Team,
- Occupational Health.
- Pharmacy
- Falls prevention

Notifying any of the above, while necessary is not a sufficient response to an incident.

2.7 Timescales for Datix Reporting

You should complete your part of the form as soon as possible after the event, within one working day, unless, exceptionally, there are reasons for delay. Do not delay reporting because some information is unavailable; this can be added later.

It is your line manager’s job to review the form, to complete further sections of the form such as severity and submit for final approval within 3 days. This includes identifying whether an incident is RIDDOR reportable or not. When it is believed that the incident is RIDDOR reportable the Health and Safety Service must be notified immediately.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations place a statutory duty on NHSGGC to report certain incidents within prescribed timescales. Specified Major Injuries and Dangerous Occurrences require immediate reporting to the Health and Safety Executive. All RIDDOR reporting is the responsibility of the Health and Safety Service. Incidents which are covered by these regulations are listed in Appendix 4.5

If in doubt whether an incident falls within RIDDOR or not, guidance should be sought from the Health and Safety Service.
2.8 The Line Manager’s Role

On receipt of notification from DATIX, the line manager’s role is to:

- Record on the form what action was taken, or will be taken, including an indication of whether further investigation is required.
- Submit the form for final approval
- Attach any relevant related papers.
- Inform the member(s) of staff who completed the incident form on what action you intend to initiate or to take. Providing feedback to staff is essential.
- For incidents that affect patients; ensure that relevant information is added to the patient’s notes.
- Ensure that staff preserve all relevant documents, equipment, devices, drugs or any other item that may be used to assist any subsequent investigation.

2.9 Severity Rating of incidents

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<th>Severity</th>
<th>Investigation Required</th>
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<tr>
<td>5 or 4</td>
<td>Extreme or Major</td>
<td>Management level investigation required, record and analyse investigation results retrospectively.</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>Local investigation required, record and analyse investigation results retrospectively.</td>
</tr>
<tr>
<td>2 or 1</td>
<td>Minor or Negligible</td>
<td>Consider local investigation, record and analyse investigation results retrospectively.</td>
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</tbody>
</table>

If the incident has a severity rating of 4 or 5 (Extreme or Major) consideration must be given to reporting it to senior staff within the Clinical Risk or Health and Safety Services. (See Significant Clinical Incidents Policy for more information).

Moderate rated incidents of 3 should be reviewed by the Local Management Teams and an action plan drawn up to eliminate or reduce the risk of recurrence.

Minor and negligible incidents of 1 and 2 should be investigated at the discretion of the line manager who receives the report.

2.10 Follow-up action

If the rating is a 4 or 5 there must be an investigation.

In consultation with the Clinical Governance Department or Health and Safety Service consideration should be made whether the severity of the incident is such that it merits formal classification as a “Significant / Serious Incident”. This will not necessarily be the case for all these incidents. These incidents should also be discussed with the Clinical Director or General Manager.

If the severity is moderate, there should at least be an informal investigation, led by the line manager, using if appropriate, a root cause analysis type approach.

If the severity is minor or low this does not mean that the incident can be ignored. These incidents represent small failures and vulnerabilities that may signal action to avoid repeat or escalation of a situation.
For incidents severity graded 3, 4 or 5 there should be a discussion at the appropriate Directorate / Partnership Management Forum. This could be done in a number of ways, depending on the issues arising from the incident and the subsequent investigation. One approach would be to make case presentations quarterly, but clearly, where there are serious and pressing issues, these should be brought to the next possible meeting.

It is important that all the facts of an incident are reviewed. Human error may seem to be the immediate cause, but an incident is rarely due to a single act or omission. Usually an incident occurs because of a combination of actions, events and the surrounding circumstances.

The line manager will communicate with colleagues, formally or informally and agree the level of requirements needed to resolve the issue and introduce preventive measures against recurrence of this or similar problems.

Reference should always be made to existing policies or procedures that relate to the incident and apply to local circumstances, as they may contain specific instructions on immediate action to be taken, e.g. Infection Control policies, Health and Safety policies, resuscitation, medical devices, manual handling, radiation safety and others listed in public folders and on the intranet.

2.11 Communicating with patients and families

When an incident has occurred, NHSGGC’s policy is to communicate the facts as openly and rapidly as possible with patients and their families or individuals close to the family. This should be done whenever possible by a senior member of staff in conjunction with a member of staff known to the person affected. It is particularly important in circumstances where external agencies may become involved, to inform those affected, including staff, before this happens.

If there is likely to be a need for continuing communication with a patient or family about an incident, it is essential that one member of the clinical team is nominated to act as the main point of liaison and that the family knows to whom to direct their concerns. This is usually the patient’s Consultant who will decide, considering the patient condition, the level of explanation given to the patient and how this explanation is recorded in the patient’s notes.

Experience shows that identifying this lead person as early as possible is essential in supporting the patient and family.

In some instances it may be prudent to inform NHSGGC Communications Team in preparation for media enquiries.

2.12 Good Practice Notes

a) Why it is necessary to complete an incident form.

The completion of an incident report matters because:

- It is a contemporaneous record of the event, which captures the basic information in one place and in a single system.
- It acts as a prompt for further action locally and, if necessary corporately – a need for more detailed investigation, development of a remedial plan, dissemination of the lessons that can be learned from the incident.
- It is a source of information that contributes to an analysis of patterns of events.
It may lead to identification of more serious problems or trends which need special attention.
It may form the first stage of documentation in a future legal claim of negligence.
Information on the form should always be clear and unambiguous, factual and without obscure abbreviations.

b) Other means of reporting an incident

The use of DATIX is the primary formal reporting system within NHSGGC. The exception being Radiation Incidents, which are reported via a different system within that service. (Q Pulse.)

It may be the case that in exceptional circumstances other forms of communication with the Clinical Risk Department or Health and Safety Service may be utilised e.g. email. However even in these circumstances, ultimately the matter will have to be formally recorded on DATIX.

c) Equipment

If any piece of equipment is involved in an incident:
- First of all, follow the advice under ‘Immediate Action’. (section 2.5)
- Retain the device/equipment involved in the incident, including packaging and instructions where appropriate.
- If it is a machine ensure the item is removed from use immediately and labelled to prevent further use. Try to leave all switches and controls as they were at the time of the incident unless it is not safe to do so, in which case make a note of all settings. Notify Health and Safety Service and/or Clinical Risk as either may require to instigate immediate investigation and require to record current condition of equipment.
- Contact, as appropriate, the Clinical Physics or Estates department to assess the equipment and organise repair if necessary. Consideration will be necessary as to whether the equipment may require decontamination. Advice can be sought from Infection Control.
- Clinical Physics or the Health and Safety Service will be responsible for reporting any relevant device/equipment related incidents to Health Facilities Scotland.

d) The role of the Health and Safety Services or Clinical Governance Support Unit

The Health and Safety Services and/or Clinical Risk regularly review the DATIX database. However it should not be assumed that all incidents will be discovered via this route and it is recommended that, as described above, direct contact should be made following serious incidents. Analyses are regularly fed back to Directorates/Partnerships and Departments. Additionally local managers are encouraged to interrogate Datix and produce their own reports and analysis of incidents within their areas of responsibility. The data is used both centrally to target risk reduction programs and within the Partnerships/Directorates.

Patient safety bulletins are produced, drawing out any lessons and action points arising from incidents. Internal safety notices may also be produced if communication of a particular issue requires to be rapidly shared with the organisation. Data is also used to assist in compliance with Health and Safety legislation.

e) Assurance

In order to ensure that this system of reporting is working well, the following arrangements are in place as a check and balance:
- Local managers / health and safety committees must review the incidents occurring within their area to ensure any required actions have been completed.
- An audit program is in place to ensure measures undertaken as a result of incidents are being followed.
- The NHSGGC’s Risk Management Steering Committee reviews the overall system of incident reporting to ensure it is a robust and effective method.
- Board wide committees review and discuss incidents pertaining to their area of responsibility to ensure lessons have been learned and the likelihood of reoccurrence is reduced e.g. Clinical Governance Committee, Health & Safety Forum, Safer Use of Medicines, Blood Transfusion, Infection Control, Medical Devices etc.
- Wherever a patient has been harmed, a single clinician should be nominated to act as a liaison with families, ensuring that good channels of communication remain open.

f) Training

Topics where the Clinical Risk or Health and Safety Services can provide briefings or links to external sources of training include the following topics:

- Incident reporting
- Incident investigation
- Health and Safety requirements
- Root Cause analysis
- Introduction to risk management
- Risk registers
- Risk assessments

3. SUMMARY of ROLES AND RESPONSIBILITIES

a) Every member of staff

Everyone in the organisation has a responsibility to:

- Maintain general risk awareness and accept personal responsibility for maintaining a safer environment, notifying line managers of any identified risks.
- Report incidents, accidents, mistakes and ‘near misses’ and action taken using the incident reporting system - DATIX.
- Comply with NHSGGC rules, regulations and guidance to protect the health, safety and welfare of anyone working in, using, staying within, or visiting NHSGGC premises.
- Maintain confidentiality of patient and NHSGGC information.
- Be aware of emergency procedures, e.g. resuscitation, first aid, evacuation and fire precautions, as relevant to the employee’s particular work area.
- Co-operate in the investigation and review of incidents to improve future services and reduce future risks.

b) Local Managers and Departmental Heads

Every Local Manager and Departmental Head has a responsibility to:

- Review and / or approve incidents and near misses reported to their department.
- Undertake initial categorisation of the type of event and seriousness on the incident form.
- Foster an environment in which staff are encouraged to report incidents and discuss the implications constructively and openly.
- Maintain departmental policies and procedures and ensure staff are aware of them and are trained to follow them.
- Contribute to directorate and corporate discussions and reviews (both on own initiative and when asked to do so).

c) Directors / Partnership Management Team and other Senior Staff
Each directorate/partnership has a clear risk management responsibility and is responsible for:

- Reviewing all serious incidents and a sample of the less serious ones.
- Ensuring that the required actions have been taken and are followed through.
- Ensuring that there is a regular multidisciplinary governance meeting which reviews the serious incidents and actions arising and all relevant policies and procedures.
- Deciding who should lead the review of incidents and investigations and when this should be escalated beyond the departmental level.

d) Clinical Governance Support Unit
This department has a number of support responsibilities in relation to NHSGGC wide risk management arrangements. These include:

- Advising on external reporting requirements.
- Maintaining and monitoring the reporting system of clinical incidents within the NHSGGC.
- Analysing trends to inform directorate/partnerships decisions and corporate management decisions.
- Supporting reviews of serious incidents.

e) Health and Safety Service
This department, part of the Corporate HR Department, includes responsibility for the provision of competent health and safety advice to assist in ensuring compliance with applicable health and safety law and guidance:

- Liaising with the Health & Safety Executive in the establishment and maintenance of procedures for reporting, investigating, recording and analysing accidents and incidents where appropriate.
- Ensuring reporting of accidents and ill health is undertaken in accordance with statutory requirements, e.g. RIDDOR.
- Investigating RIDDOR incidents
- Conducting / Assisting other investigations where appropriate.
Appendix 4.1: INCIDENT FLOW DIAGRAM

Complete DATIX report form at department / ward level & submit to:

OPERATIONAL LEAD / DEPT. MANAGER
Review / Approve Report Form and grade of incident

LOCAL OPERATIONAL LEAD INITIATE LOCAL INVESTIGATION AS REQUIRED

Is incident deemed as significant/serious?

NO

Events that have significant or catastrophic impact on the patient and may adversely affect the organisation and its staff

YES

OPERATIONAL LEAD
Rapid contact of General Manager, Clinical Director, Associate Medical Director or Lead Nurse plus contact Clinical Risk Manager or H&S Manager / Practitioner followed by submission of Report Form

GM, AMD, LN or CD
Nominate Investigation Team to carry out incident investigation

CLINICAL GOVERNANCE COMMITTEE / HEALTH & SAFETY COMMITTEE
For all Significant Incidents:
Monitor and review Action Plan / Exception reports to Board CG Committee

Consider if a copy of the form needs to be sent to any specialist. Such as Clinical Physics, Pharmacy, Infection Control, Radiation Protection, Blood transfusion Practitioner.
If so ensure appropriate links have been made at “investigators” section of the form.

Take local action if necessary to treat /safeguard patient, staff or environment.

Incident statistics and reports shared with local operational committees and managers on a routine and by request basis.
Action plans developed as required and monitored by local committees.
Appendix 4.2 Root Cause Analysis

Root cause analysis is a structured investigation that aims to identify the true cause(s) of a problem, via its contributory factors, and the actions necessary to eliminate it. The principles are useful in the investigation of any incident but it is particularly important in the formal investigation of a Serious/Significant Incident which requires a more comprehensive and structured approach.

A root cause is a fundamental cause which if resolved will eradicate, or significantly contribute to the resolution of the identified problem to which it is attached, both within the local department and more widely across the organisation.

A variety of management ‘tools’ such as ‘cause and effect charts’ a ‘fishbone diagram’ can be applied to this process but the simplest, traditional approach is known as the ‘Five Whys’ Model. This can be used:

- For general analysis of the cause of any incident
- More formally, usually in a multi-disciplinary team setting, when contributory factors are discussed and in depth causal factors are written down and traced back until a clear understanding of the root cause is reached.

What are the benefits of root cause analysis?

- Dangerous assumptions are avoided
- Investigators avoid jumping to conclusions
- The logic required highlights questions, and facts that need to be obtained
- The investigation is unavoidably thorough
- It reduces the temptation to blame
- It identifies action steps or recommendations
- Conclusions can be presented in a rational manner

The lead Investigator must either trained in or is directly supported by someone who been trained in RCA techniques.
Appendix 4.3 EXAMPLES OF INCIDENT AND NEAR MISS TYPES TO BE REPORTED
(Incident: is any event or circumstance that led to unintended or unexpected harm, loss or damage.)

The list is not exhaustive

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<tr>
<td>• Contact with moving machinery or material being machined</td>
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<td>• Hit by a moving, flying or falling object</td>
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<td>• Hit by a moving vehicle</td>
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<tr>
<td>• Hit by something fixed or stationary</td>
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<tr>
<td>• Injured while handling, lifting or carrying</td>
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<td>• Slipped, tripped or fell on the same level</td>
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<td>• Fell from height</td>
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<td>• Trapped by something collapsing</td>
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<td>• Drowned or asphyxiated</td>
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<td>• Exposed to or in contact with a harmful substance</td>
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<td>• Exposed to fire</td>
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<td>• Exposed to an explosion</td>
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<td>• Contact with electricity or an electrical discharge</td>
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<td>• Injured by an animal</td>
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<td>• Physically assaulted by a person</td>
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<td>• Stress</td>
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<td>• Verbal abuse</td>
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<td>• Other</td>
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<tr>
<td>• Patient Absconds</td>
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<td>• Blood Transfusion</td>
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<td>• Consent</td>
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<td>• Diet inappropriate</td>
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<td>• Discharge or transfer problem</td>
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<td>• Imaging problem</td>
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<td>• Inappropriate behavior (related to clinical condition)</td>
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<td>• Infection Control</td>
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<td>• Medication Incident</td>
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<td>• Medical Device issue</td>
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<td>• Patient Observations</td>
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<td>• Obstetric incident</td>
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<td>• Problem with records</td>
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<td>• Theatre Processes</td>
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<tr>
<td>• Treatment problem</td>
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<tr>
<td>• Self harm</td>
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<tr>
<td>• Specimen issues</td>
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<td>• Suicide</td>
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## Appendix 4.4 SEVERITY / IMPACT DEFINITIONS

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<th>Extreme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives / Project</strong></td>
<td>Barely noticeable reduction in scope, quality or schedule.</td>
<td>Minor reduction in scope, quality or schedule.</td>
<td>Reduction in scope or quality of project; project objectives or schedule.</td>
<td>Significant project overrun.</td>
<td>Inability to meet project objectives; reputation of the organisation seriously damaged.</td>
</tr>
<tr>
<td><strong>Injury</strong></td>
<td>Adverse event leading to minor injury not requiring first aid.</td>
<td>Minor injury or illness, first aid treatment required.</td>
<td>Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.</td>
<td>Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.</td>
<td>Incident leading to death or major permanent incapacity.</td>
</tr>
<tr>
<td><strong>Complaints / Claims</strong></td>
<td>Locally resolved verbal complaint.</td>
<td>Justified written complaint peripheral to clinical care.</td>
<td>Below excess claim. Justified complaint involving lack of appropriate care.</td>
<td>Claim above excess level. Multiple justified complaints.</td>
<td>Multiple claims or single major claim. Complex justified complaint</td>
</tr>
<tr>
<td><strong>Service / Business Interruption</strong></td>
<td>Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.</td>
<td>Short term disruption to service with minor impact on patient care.</td>
<td>Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.</td>
<td>Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.</td>
<td>Permanent loss of core service or facility. Disruption to facility leading to significant “knock on” effect</td>
</tr>
<tr>
<td><strong>Staffing and Competence</strong></td>
<td>Short term low staffing level temporarily reduces service quality (&lt; 1 day).</td>
<td>Ongoing low staffing level reduces service quality.</td>
<td>Late delivery of key objective / service due to lack of staff. Moderate error due to ineffective training/implementation of training.</td>
<td>Uncertain delivery of key objective/ service due to lack of staff. Major error due to ineffective training/ implementation of training.</td>
<td>Non-delivery of key objective/service due to lack of staff. Loss of key staff. Critical error due to ineffective training/ implementation of training.</td>
</tr>
<tr>
<td><strong>Financial</strong></td>
<td>Negligible organisational/personal financial loss. (£&lt;1k). (NB. Please adjust for context)</td>
<td>Minor organisational/personal financial loss (£1-10k).</td>
<td>Significant organisational/personal financial loss (£10-100k).</td>
<td>Major organisational/personal financial loss (£100k-1m).</td>
<td>Severe organisational/personal financial loss (£&gt;1m).</td>
</tr>
<tr>
<td><strong>Inspection / Audit</strong></td>
<td>Small number of recommendations which focus on minor quality improvement issues.</td>
<td>Recommendations made which can be addressed by low level of management action.</td>
<td>Challenging recommendations that can be addressed with appropriate action plan.</td>
<td>Enforcement action. Low rating. Critical report.</td>
<td>Prosecution. Zero rating. Severely critical report.</td>
</tr>
<tr>
<td><strong>Adverse Publicity / Reputation</strong></td>
<td>Rumours, no media coverage. Little effect on staff morale.</td>
<td>Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/public attitudes.</td>
<td>Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.</td>
<td>National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected.</td>
<td>National/international media/adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Inquiry/ FAI.</td>
</tr>
</tbody>
</table>
Appendix 4.5  RIDDOR REPORTING

To be reported immediately to HSE via Health and Safety Services.

Specified Major Injury

- Any fracture, (including break, crack or chip) other than to the fingers, thumbs or toes
- Any amputation
- Dislocation of the shoulder, hip, knee or spine
- Loss of sight (whether temporary or permanent)
- A chemical or hot metal burn to the eye or any penetrating injury to the eye
- Any injury resulting from an electric shock or electrical burn (including electrical burn caused by arcing or arcing products) leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours
- Any other injury:
  - leading to hypothermia, or heat-induced illness or to unconsciousness
  - requiring resuscitation
  - requiring admittance to hospital for more than 24 hours
- Loss of consciousness caused by asphyxia or by exposure to a harmful substance or biological agent
- Either of the following conditions which result from the absorption of any substance by inhalation, ingestion or through the skin:
  - Acute illness requiring medical treatment
  - Loss of consciousness
- Acute illness which requires medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material.

Dangerous Occurrences

- collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
- explosion, collapse or bursting of any closed vessel or associated pipework;
- failure of any freight container in any of its load-bearing parts;
- plant or equipment coming into contact with overhead power lines;
- electrical short circuit or overload causing fire or explosion;
- any unintentional explosion, misfire, failure of demolition to cause the intended collapse, projection of material beyond a site boundary, injury caused by an explosion;
- accidental release of a biological agent likely to cause severe human illness;
- failure of industrial radiography or irradiation equipment to de-energise or return to its safe position after the intended exposure period;
- malfunction of breathing apparatus while in use or during testing immediately before use;
- collapse or partial collapse of a scaffold over five meters high, or erected near water where there could be a risk of drowning after a fall;
- unintended collision of a train with any vehicle;
- a road tanker carrying a dangerous substance overturns, suffers serious damage, catches fire or the substance is released;
- a dangerous substance being conveyed by road is involved in a fire or released;
- unintended collapse of; any building or structure under construction, alteration or demolition where over five tonnes of material falls; a wall or floor in a place of work; any falsework;
- explosion or fire causing suspension of normal work for over 24 hours;
- sudden, uncontrolled release in a building of: 100kg or more of flammable liquid; 10kg of flammable liquid above its boiling point; 10kg or more of flammable gas; or of 500kg of these substances if the release is in the open air;
- accidental release of any substance which may damage health

To be reported within 10 working days to HSE.

Injury at work which results in the person being incapacitated for work for more than 3 consecutive days, not counting the day of the accident but including any days which would not have been working days.

This only applies to staff injury.

If any doubt exists whether an incident is reportable or not please seek advice from the Health and Safety Service.
**Appendix 4.6 Roles within DATIX WEB.**

<table>
<thead>
<tr>
<th>Role</th>
<th>Tasks</th>
<th>Staff type</th>
<th>Needs Training?</th>
<th>Must login?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporter</td>
<td>Completes DIF1 form</td>
<td>Anyone</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Reviewer/Deputy Reviewer</td>
<td>Reviews data entered by Reporter, links contacts, marks incident as Reviewed</td>
<td>Team Lead / Ward Manager</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Approver/(optional) Deputy Approver</td>
<td>Checks investigation and actions are satisfactory, Approves and closes incident</td>
<td>Senior line manager – usually Lead Nurse or CSM</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Secondary Approver</td>
<td>Oversight of incidents in area of responsibility</td>
<td>Senior manager - GM, Head of Nursing, Clinical Director</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Investigator(s)</td>
<td>Can be named to allow view of any incident. May update/add details</td>
<td>Any Datix user as required</td>
<td>Possibly</td>
<td>Yes</td>
</tr>
</tbody>
</table>

There are 5 main roles within Datix

**Reporter** – the person that completes the DIF1 form (Datix incident form). This can be anyone who has access to staffnet and no login is required. The majority of staff can use this form without any training and if you can book airplane tickets or buy items over the internet then you can use the form without any problems.

**Reviewer/Deputy Reviewer** – usually a ward or dept manager the reviewer is responsible for reviewing the data that has been entered, complete some additional mandatory fields and link the contacts. Formal training is offered and must log into the system. Deputy provides cover when the reviewer is on annual leave/sick leave.

**Approver/Deputy Approver** – gives second check of data entered, checks any investigation information that has been entered and gives the incident final approval status and closure.

**Secondary approver** - has access to all incidents in area of responsibility. Usually senior management.

**Investigators** – can be added by a reviewer or approver to give access to incidents that are outwith their normal permissions. Used for investigations that may cross directorates. Also used for clinical nurse specialists i.e. Tissue Viability Nurse can be added to incidents as necessary.

END.