



INCIDENT MANAGEMENT POLICY

June 2014

Lead Manager	Head of Health and Safety
Responsible Director	Director of Human Resources
Approved By	Health and Safety Forum
Date Approved	June 2014
Date for Review	June 2017
Version	Version 3 (Version1 – 2008, Version 2 - 2011)

CONTENTS

I. Scope of Policy

II. Roles and Responsibilities

1. INTRODUCTION

2. REPORTING INCIDENTS

- 2.1 The reporting system
- 2.2 Incident descriptions
- 2.3 Near miss reporting
- 2.4 Your duties as an employee
- 2.5 Steps to take following an incident.
- 2.6 Reporting
- 2.7 Timescales for DATIX Reporting
- 2.8 RIDDOR Reportable Incidents
- 2.9 The Line Manager's role
- 2.10 Severity rating of incidents
- 2.11 Follow-up action
- 2.12 Communicating with patients and families
- 2.13 Good practice notes
 - a. Why complete a form?
 - b. Other means of reporting an incident
 - c. Equipment
 - d. Assurance
 - e. Training
- 2.14 Role of the Health and Safety Service and/or Clinical Governance Support Unit

3. SUMMARY of ROLES AND RESPONSIBILITIES

4. APPENDICES

- 4.1 Incident flow diagram
- 4.2 Root Cause Analysis
- 4.3 Examples of incident types to be reported
- 4.4 Risk Matrix & Severity impact definitions
- 4.5 RIDDOR (Reporting of Injuries, Diseases & Dangerous Occurrences Regulations)
- 4.6 Roles within DATIX WEB

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 headings are 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.**

This would also include **Reportable** incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. Such incidents are reported to the Health and Safety Executive (HSE) by the Health and Safety Service. The Health and Safety Service will also undertake investigation of all RIDDOR incidents and provide a report on their findings to the appropriate level of Management.

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. (Hyperlink to Risk Register policy)

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

The Health and Safety Service will conduct investigations into all RIDDOR Reportable Incidents. This investigation will be separate from any local investigations undertaken by local management.

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.

It is recognized that on occasion access to IT systems may be compromised. It is recommended that local managers print a few copies of the [paper version](#) to be used in such circumstances, that will then require to be input to DATIX.

2.2 What is an “Incident”

- is an event which results in injury or ill health.
- is contrary to the specified or expected standard of patient care or service.
- places patient(s) or staff member(s), or visitor(s), contractor(s) or member(s) of the public at unnecessary risk of harm.
- places NHSGGC in an adverse position with potential loss of reputation.
- places 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 Section 3 of 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.

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. Make a record of the equipment's serial number. 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 2.10)

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. A Datix must also be completed.

Those noted in the table above may carry out investigations into the incident. It should be noted that such action does not remove the need for local management to investigate the 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 the line manager's job to review the form, to complete further sections of the form such as severity and submit for **final approval within 7 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.

2.8 RIDDOR Reportable Incidents

The **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations** place a statutory duty on NHSGGC to report certain incidents within prescribed timescales. Specified **Injuries** and **Dangerous Occurrences** require immediate reporting to the Health and Safety Executive. An Incident which resulted in an employee being unable to attend work or unable to carry out their normal duties for 7 days, must be reported within 15 days to the HSE.

All RIDDOR reporting is the responsibility of the Health and Safety Service. Incidents which are covered by these Regulations are listed in [Appendix 4.6](#).

If in doubt whether an incident falls within RIDDOR or not, guidance should be sought from the Health and Safety Service.

2.9 The Line Manager's Role

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

- Ensure the correct Category has been selected, where at all possible avoiding using "Other"
- Ensure names of persons involved are not included in the free text sections.
- Record on the form what action was taken, or will be taken, including an indication of whether further investigation is required by them.
- Ascertain if any sickness absence has occurred due to the incident.

- Ensure contact has been made with any identified Investigators
- Submit the form for final approval
- Attach any relevant related papers. Including witness statements.
- **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 and must be recorded on DATIX**
- 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.

It should be noted that Manager's do have the access rights to be able to generate incident statistics data for their areas of responsibility. Specific training for this is available from the DATIX Support Team.

2.10 Severity Rating of incidents

5 or 4	Extreme or Major	Management level investigation required, record and analyse investigation results retrospectively.
3	Moderate	Local investigation required, record and analyse investigation results retrospectively.
2 or 1	Minor or Negligible	Consider local investigation, record and analyse investigation results retrospectively.

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.

2.11 Follow-up action

If the rating is a **4** or **5** there must be an investigation, following the principles of Root Cause Analysis.

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.

2.12 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.

2.13 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.
- In some cases such as Reportable Incidents it is a legal requirement.

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.
- As per the role of the Equipment Co-Ordinator as set out within the Safety Action Notice Policy, the Clinical Physics or the Health and Safety Service will be responsible for reporting any relevant device/ equipment related incidents to Health Facilities Scotland.

d) 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.
- 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, Needlestick Reduction etc.

e) 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

2.14 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 required 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 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.

3. SUMMARY of ROLES AND RESPONSIBILITIES

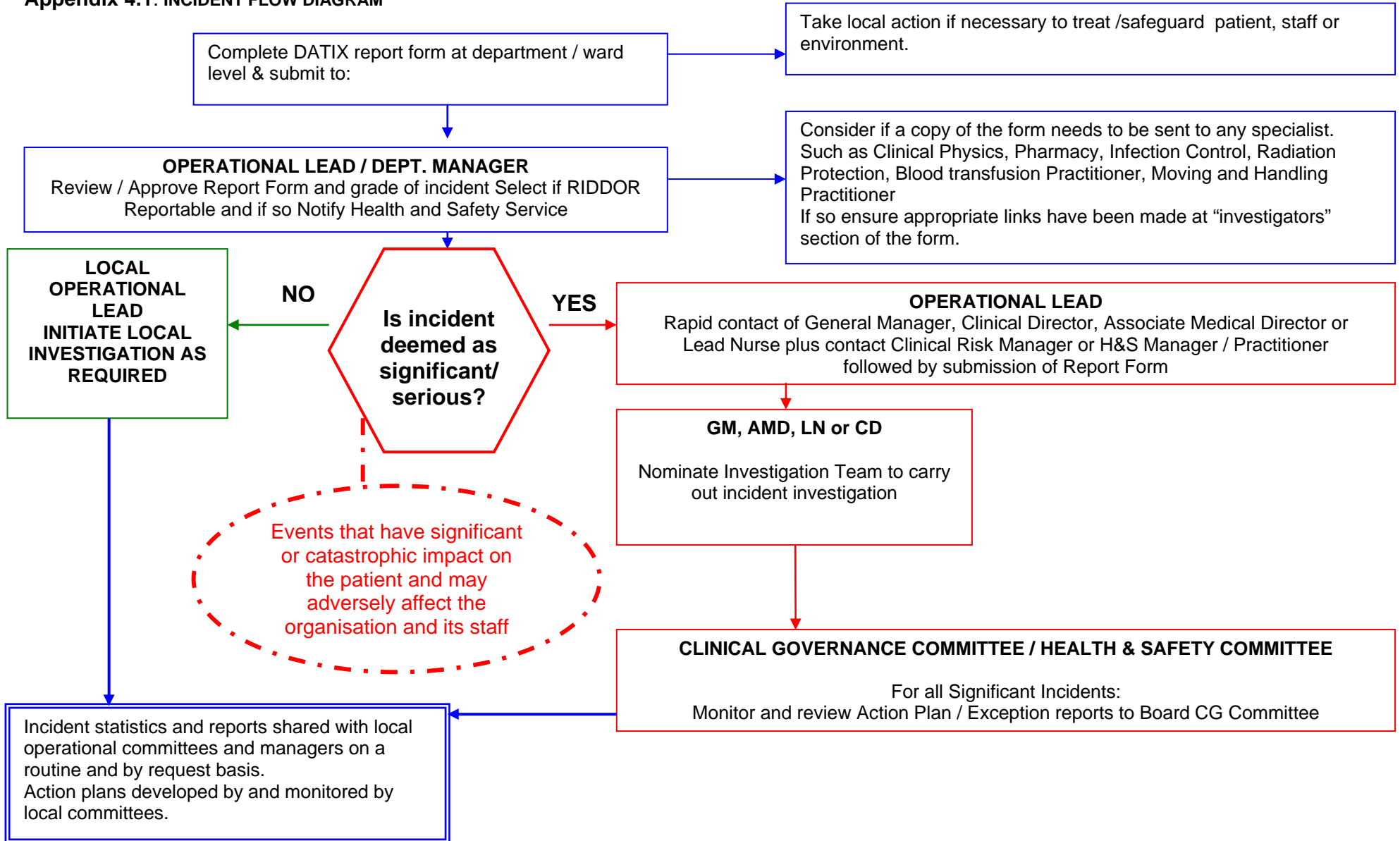
a) Every member of staff

Everyone in the organisation has a responsibility to:

- Maintain general risk awareness and accept personal responsibility for maintaining a safe 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 Reportable 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



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

Non-Clinical	<ul style="list-style-type: none">▪ Contact with moving machinery or material being machined▪ Hit by a moving, flying or falling object▪ Hit by a moving vehicle▪ Hit by something fixed or stationary▪ Injured while handling, lifting or carrying▪ Slipped, tripped or fell on the same level▪ Fell from height▪ Trapped by something collapsing▪ Drowned or asphyxiated▪ Exposed to or in contact with a harmful substance▪ Exposed to fire▪ Exposed to an explosion▪ Contact with electricity or an electrical discharge▪ Injured by an animal▪ Physically assaulted by a person▪ Stress▪ Verbal abuse
Clinical	<ul style="list-style-type: none">▪ Patient Absconds▪ Blood Transfusion issue▪ Consent issue▪ Diet inappropriate▪ Discharge or transfer problem▪ Imaging problem▪ Inappropriate behavior (related to clinical condition)▪ Infection Control issue▪ Medication Incident▪ Medical Device issue▪ Obstetric incident▪ Problem with records▪ Theatre Processes▪ Treatment problem▪ Self harm▪ Specimen issues▪ Suicide

Appendix 4.4 RISK MATRIX AND SEVERITY / IMPACT DEFINITIONS

<u>Likelihood</u>	<u>Impact/Consequences</u>				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience/clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience/ clinical outcome directly related to care provision – readily resolvable.	Unsatisfactory patient experience/ clinical outcome; short term effects – expect recovery <1wk.	Unsatisfactory patient experience/ clinical outcome; long term effects – expect recovery >1wk.	Unsatisfactory patient experience/ clinical outcome; continued ongoing long term effects
Objectives / Project	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significant project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury	Adverse event leading to minor injury not requiring first aid.	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significant injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints / Claims	Locally resolved verbal complaint.	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints.	Multiple claims or single major claim. Complex justified complaint

Service / Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality. Minor error due to ineffective training/implementation of training.	Late delivery of key objective / service due to lack of staff. Moderate error due to ineffective training/implementation of training. Ongoing problems with staffing levels.	Uncertain delivery of key objective/ service due to lack of staff. Major error due to ineffective training/ implementation of training.	Non-delivery of key objective/service due to lack of staff. Loss of key staff. Critical error due to ineffective training/ implementation of training.
Financial (including damage / loss / fraud)	Negligible organisational/ personal financial loss. (£<1k). (NB. Please adjust for context)	Minor organisational/personal financial loss (£1-10k).	Significant organisational/personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/personal financial loss (£>1m).
Inspection / Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity / Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/public attitudes.	Local media – long-term adverse publicity. Significant effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidence in the organisation undermined. Use of services affected.	National/international media/adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Inquiry/ FAI.

Appendix 4.5 RIDDOR REPORTING

To be reported to HSE via Health and Safety Services.

Staff Injury Injury arising out of work activity, which results in the person being incapacitated for work for more than 7 consecutive days, not counting the day of the accident but including any days which would not have been working days.	Must be reported to the HSE within 15 working days from the date of the incident.
Specified Injury Injury arising out of work activity which results in anyone suffering a specified major injury	Must be reported to HSE immediately.
Dangerous Occurrence Specified list of Dangerous Occurrences	Must be reported to HSE immediately.
Reportable Disease Must be diagnosed by a Medical Practitioner and confirmed in writing to Health and Safety Service Manager to then make RIDDOR Report.	Once HSSM notified

What is “an accident”?

In relation to RIDDOR, an accident is a discrete, identifiable, unintended incident which causes physical injury. This specifically includes acts of non-consensual violence to people at work.

Injuries themselves, eg “feeling a sharp twinge,” are not accidents. There must be an identifiable event, external to the body which causes the injury, eg being struck by a falling object. Cumulative exposures to hazards which eventually cause injury (eg repetitive lifting) are not classed as “accidents” under RIDDOR.

What is meant by “work-related”?

RIDDOR only requires accidents to be reported if they arise “out of or in connection with work.” The fact that an accident occurs at work premises does not, of itself, mean that the accident is work-related -there must be some indication that the work activity contributed to the circumstances of the accident. An accident should be considered as “work-related” if any of the following factors played a significant role:

the way the work was carried out;

any machinery, other plant, substances or equipment used for the work; or

the condition of the site or premises where the accident happened.

What are “reportable” injuries

The following injuries are reportable under RIDDOR when they result from a work-related accident:

Injuries to workers which result in their **incapacitation for more than 7 days**

Over-seven-day incapacitation of a worker

Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury. This seven day period does not include the day of the accident, but does include weekends and rest days. The report must be made within 15 days of the accident.

Non-fatal accidents to non-workers (eg members of the public)

Accidents to members of the public or others who are not at work must be reported if they result in an injury and the person is taken directly from the scene of the accident to hospital for treatment to that injury. Examinations and diagnostic tests do not constitute 'treatment' in such circumstances.

There is no need to report incidents where people are taken to hospital purely as a precaution when no injury is apparent.

If the accident occurred at a hospital, the report only needs to be made if the injury is a 'specified injury' (see Below).

Exemptions

Accidents during medical or dental treatment, or during any examination carried out or supervised by a doctor or dentist.

Accidents involving the movement of a vehicle on a public road (other than those associated with: loading or unloading operations; work alongside the road such as road maintenance; escapes of substances from the vehicle; and accidents involving trains.)

Specified Injuries to Workers

a. fractures, other than to fingers, thumbs and toes

Bone fractures include a break, crack or chip. They are reportable when diagnosed or confirmed by a doctor, including when specified on a GP "fit note." In some cases, there may be no definitive evidence of a fracture (e.g. if an X-ray is not taken), but the injury will still be reportable if a doctor considers that a fracture is likely to have occurred. Self-diagnosed "suspected fractures" are not reportable.

b. amputation of an arm, hand, finger, thumb, leg, foot or toe

Amputation includes both a traumatic amputation injury at the time of an accident, and surgical amputation following an accident as a consequence of the injuries sustained.

c. any injury likely to lead to permanent loss of sight or reduction in sight in one or both eyes

Any blinding and injuries causing reduction in sight are reportable when a doctor diagnoses that the effects are likely to be permanent.

d. any crush injury to the head or torso causing damage to the brain or internal organs

Injuries to the brain or internal organs within the chest or abdomen are reportable when caused by crushing as result of an accident.

e. any burn injury (including scalding) which:

- I. Covers more than 10% of the whole body's total surface area; or
- II. Causes significant damage to the eyes, respiratory system or other vital organs

Burns which meet the above criteria are reportable irrespective of the nature of the agent involved, and so include burns caused by direct heat, chemical burns and radiological burns.

Medical staff may indicate the approximate proportion of skin suffering burn damage, and charts are often available in hospital burns units. In adults of working age, the *Rule of Nines* can help estimate the body surface area (BSA) affected:

- Skin covering the head and neck: 9%
- Skin covering each upper limb: 9%
- Skin covering the front of the torso: 18%
- Skin covering the rear of the torso: 18%
- Skin covering each lower limb: 18%

If the BSA of a burn exceeds 15% in an adult, they are likely to require hospitalisation for intravenous fluid resuscitation.

Where the eyes, respiratory system or other vital organs are significantly harmed as a consequence of a burn, this is a reportable injury irrespective of the surface area covered by that burn. Damage caused by smoke inhalation is not included within this definition.

f. any degree of scalping requiring hospital treatment

Scalping is the traumatic separation or peeling of the skin from the head due to an accident, eg hair becoming entangled in machinery. Lacerations where the skin is not separated from the head are not included, nor are surgical procedures where skin removal is deliberate.

g. any loss of consciousness caused by head injury or asphyxia

Loss of consciousness means that the injured person enters a state where there is a lack of response , either vocal or physical, to people trying to communicate with them. The length of time for which a person remains unconscious is not significant in terms of whether an accident is reportable.

Asphyxia (lack of oxygen) may occur in situations where a person enters an oxygen-deficient atmosphere, such as a confined space, or are exposed to poisonous gases eg carbon monoxide.

h. any other injury arising from working in an enclosed space which:

- I. leads to hypothermia or heat-induced illness or
- II. requires resuscitation or admittance to hospital for more than 24 hours

An enclosed space includes any space which is wholly or partly enclosed to the extent that there is a significantly increased risk to the health and safety of a person within that space by virtue of its enclosed nature. This would include any confined space as defined by the Confined Spaces Regulations 1997, and would additionally include similar spaces where there is a foreseeable risk of hypothermia (eg a cold store.)

Nb. Hypothermia is not a specified risk within the meaning of the Confined Spaces

Regulations. Hypothermia and heat-induced illness include situations where a person suffers an adverse reaction (the physical injury) to intense heat or cold acting on the body, such that they require assistance from another person.

Situations where the extent of an injury is unclear

In some instances, employers and self-employed workers may not be in a position to know the full extent of an injury, eg when a prognosis has not yet been established in relation to an eye injury, or when efforts are being made to treat an injured limb which may ultimately require surgical amputation. In such situations, there is no requirement for reports of specified injuries to be made on a precautionary basis. It is likely that the accident will in any case require reporting due to the injured person being incapacitated for more than 7 days. The enforcing authority should be notified or updated as soon as a specified injury has been confirmed

Reportable Diseases

Diagnosis by a Doctor

A reportable disease must be diagnosed by a doctor. Diagnosis includes the identification of any new symptoms, or the identification of any significant worsening of existing symptoms. For employees, the diagnosis should be provided in writing to the employer. Doctors are encouraged to use standard wording when describing reportable diseases on written statements which they make out for their patients.

Where an employee who sustains a high risk needlestick injury subsequently sero-converts to a reportable disease, a RIDDOR Reportable Disease report will require to be submitted in addition to the report of the Dangerous Occurrence

Regulation 8 requires employers and self-employed people to report cases of certain diagnosed reportable diseases which are linked with occupational exposure to specified hazards. The reportable diseases and associated hazards are set out below.

Carpal Tunnel Syndrome: where the person's work involves regular use of percussive or vibrating tools.

Cramp of the hand or forearm: where the person's work involves prolonged periods of repetitive movement of the fingers, hand or arm.

Occupational dermatitis: where the person's work involves significant or regular exposure to a known skin sensitiser or irritant.

Hand Arm Vibration Syndrome: where the person's work involves regular use of percussive or vibrating tools, or the holding of materials which are subject to percussive processes, or processes causing vibration.

Occupational asthma: where the person's work involves significant or regular exposure to a known respiratory sensitiser.

Tendonitis or tenosynovitis: in the hand or forearm, where the person's work is physically demanding and involves frequent, repetitive movements.

Biological agents

All diseases and any acute illness which requires medical treatment must be reported when it is attributable to a work-related exposure to a biological agent. The term biological agent is defined within the Control of Substances Hazardous to Health Regulations 2002 [COSHH] and means a micro-organism, cell culture, or human endoparasite which may cause infection, allergy, toxicity or other hazard to human health. Work with hazardous biological agents is subject to specific provisions within COSHH.

Work-related exposures to biological agents may occur as a result of:

- Where an employee who sustains a high risk needlestick injury subsequently sero-converts to a reportable disease, a RIDDOR Reportable Disease report will require to be submitted in addition to the report of the Dangerous Occurrence. A report should be made whenever there is reasonable evidence suggesting that the disease was likely to have been caused by a work-related exposure. The doctor may indicate the significance of any work-related factors when communicating their diagnosis.
- An identifiable event, such as the accidental breakage of a laboratory flask, accidental injury with a contaminated syringe needle or an animal bite; or
- Unidentified events, where workers are exposed to the agent without their knowledge. (eg where a worker is exposed to legionella bacteria whilst conducting routine maintenance on a hot water service system.)

Further guidance on occupational illnesses associated with biological agents is provided at:
<http://www.hse.gov.uk/biosafety/infection.htm>

Minor infections which are common in the community such as colds, bronchitis or stomach upsets cannot generally be attributed to work-related exposures to biological agents, and thus are generally not reportable. However, where there is reasonable evidence of a work-related cause, such as inadvertent contact with the infectious agent during laboratory work, a report should be made. Acute illnesses requiring medical attention must be reported when they result from a work-related exposure to a biological agent, including its toxins or any infected material.

Guidance on Dangerous Occurrences

The list of dangerous occurrences in [Schedule 2](#) of the RIDDOR Regulations (which lists a total of 27 different DO's) is designed to obtain information primarily about incidents which have a high potential to cause death or serious injury, but which happen relatively infrequently *for example, an employee is injured by a sharp known to be contaminated with a blood borne virus*. Collecting the information gives the enforcing authorities the opportunity to learn about the circumstances in which they occur and about their causes. This provides valuable information which both regulators and business can use to help prevent accidents.

Several types of dangerous occurrence require reporting in circumstances where the incident has the potential to cause injury or death. This assessment does not require any complex analysis, measurement or tests, but rather for a reasonable judgement to be made as to whether the circumstances gave rise to a real, rather than notional, risk. Such judgement allows for prompt reporting, and ensures that valuable information is not lost.

For clarity, the guidance below is focussed to those DO's most likely to occur in our premises. It is also worthy to note the majority are related to Facilities / Estates related activities and therefore that Directorate will deal with reporting requirements:

Lifting equipment

The collapse, overturning or failure of any load-bearing part of any lifting equipment, other than an accessory for lifting.

The definition covers the collapse or overturning of any lifting equipment, or the failure of any load-bearing part, whether used for lifting goods, materials or people. It does not cover the failure of ancillary equipment, such as electric operating buttons or radius indicators, or failures of lifting accessories, such as chains and slings.

Failure in this context refers to components which suffer mechanical breakdown during the normal operation of the lifting equipment, as opposed to accidental or deliberate damage.

Incidents involving cranes must be reported irrespective of the nature of the work being done, and reports must not be restricted to those involving lifting and lowering. For example, a collapse or overturning when a machine is being used for demolition activities must be included.

Lifting equipment includes machinery such as bored piling rigs and percussion pilings rigs

Pressure systems

The failure of any closed vessel, its protective devices or of any associated pipework (other than a pipeline) forming part of a pressure system as defined by regulation 2(1) of the Pressure Systems Safety Regulations 2000, where that failure could cause the death of any person.

The definition covers the failure of a pressure system (other than a pipeline) with the potential to cause the death of any person. It applies to any such vessel whatever its contents.

Incidents requiring notification due to having 'the potential to cause the death of any person'. This includes scaldings or burns arising from contact with steam, hot water, other hot liquids, liquors, hot products or hot substances, and immersion in liquids or splashing with toxic chemicals.

Other examples of incidents which might be notifiable as having 'potential to cause death' would be those where a person was either struck by, or could have been struck by, a projectile emitted from the failure of a closed vessel or pipeline under pressure. In the event of an explosion, this might be a fixture or component, the vessel or pipeline itself, or a secondary projectile arising from the destruction of structures close to the vessel, for example falling debris such as masonry or window glass, or shrapnel from buildings or other structures.

Overhead electric lines

Any plant or equipment unintentionally coming into:

- a. contact with an uninsulated overhead electric line in which the voltage exceeds 200 volts; or
- b. close proximity with such an electric line, such that it causes an electrical discharge

Examples of the kinds of incident which are covered and which must be notified and reported are:

- (a) accidental contact of a mobile crane or a vehicle with an overhead line;

- (b) accidental contact with an overhead line by something being carried or lifted; and
- (c) the collapse of something (eg an engineering structure) across an overhead line.

Electrical incidents causing explosion or fire

Any explosion or fire caused by an electrical short circuit or overload (including those resulting from accidental damage to the electrical plant) which either:

- a. results in the stoppage of the plant involved for more than 24 hours; or
- b. causes a significant risk of death.

Where the failure of an item of electrical equipment (including as a result of accidental damage) results in a fire or explosion, the failure is reportable as a dangerous occurrence if the equipment concerned is rendered unusable for over 24 hours, or if the occurrence was one with the potential to cause the death of any person. The incident is reportable even if the system in which the damaged equipment was installed is put back into service using new equipment within 24 hours. In such a case an assessment should be made of how long a repair to the damaged equipment would have taken had it been attempted.

Repair time does not include incidental time delays such as those associated with travelling to repair plant in remote locations, or with sourcing parts.

Biological agents

Any accident or incident which results or could have resulted in the release or escape of a biological agent likely to cause severe human infection or illness.

Severe human infection or illness can be regarded as that caused by biological agents in Hazard Groups 3 and 4 as defined in COSHH 2002 Schedule 3, paragraph 2(2) and as set out in the latest edition of the Management, design and operation of microbiological containment laboratories¹¹ or otherwise being agents classified provisionally by an employer as being in one of those groups (COSHH Schedule 3, paragraph 2(2)). More specialised guidance on the application of this and other aspects of RIDDOR in the healthcare sector is available from HSE.

Collapse of scaffolding

The complete or partial collapse (including falling, buckling or overturning) of:

- a. a substantial part of any scaffold more than 5 metres in height;
- b. any supporting part of any slung or suspended scaffold which causes a working platform to fall (whether or not in use); or
- c. any part of any scaffold in circumstances such that there would be a significant risk of drowning to a person falling from the scaffold.

The incidents covered here are those involving any 'scaffold'. This includes any tower, trestle, slung or suspended scaffold.

The figure of 5 metres used in relation to the height of scaffolding refers to the height of the scaffolding itself from whatever base and not necessarily to the distance between the top of the scaffold and the ground.

Incidents involving the failure of the suspension arrangements of slung or suspended scaffolds are covered if the failure causes a working platform or cradle to fall. Reportable failures of suspension arrangements would include failures of outriggers, roof rigs or suspension ropes or winches.

Structural Collapse

The unintentional collapse or partial collapse of:

- a. any structure, which involves a fall of more than 5 tonnes of material; or
- b. any floor or wall of any place of work

arising from, or in connection with, ongoing construction work (including demolition, refurbishment and maintenance), whether above or below ground.

The unintentional collapse or partial collapse of any falsework.

Only structural collapses associated with ongoing construction, maintenance and demolition work are required to be reported under paragraph 23. However, the paragraph 24 requirement to report unintentional collapses of falsework applies whether construction work is taking place or not.

'Falsework' means any temporary structure used to support a permanent structure during its erection and until that structure becomes self-supporting.

Explosion or fire

Any unintentional explosion or fire in any plant or premises which results in the stoppage of that plant, or the suspension of normal work in those premises, for more than 24 hours.

This definition covers serious fires and explosions at work premises. Examples of the type of incident which would be reportable are:

any fire at a factory or office building, causing the suspension of work activities for more than 24 hours; or

an explosion involving dust in a pneumatic conveying system, causing stoppage of the conveying plant for more than 24 hours.

Release of flammable liquids and gases

The sudden, unintentional and uncontrolled release:

- a. inside a building
 - i. of 100 kilograms or more of a flammable liquid;
 - ii. of 10 kilograms or more of a flammable liquid at a temperature above its normal boiling point;

- iii. of 10 kilograms or more of a flammable gas; or
- b. in the open air, of 500 kilograms or more of a flammable liquid or gas.

This definition is designed to cover releases of flammable liquids or gases (eg due to the sudden failure of a storage vessel) where the release, if ignited, would cause a major explosion or fire. "Flammable" includes those substances classified as highly flammable or extremely flammable.

Hazardous escapes of substances

The unintentional release or escape of any substance which could cause personal injury to any person other than through the combustion of flammable liquids or gases.

The substances covered by this definition may be in any form: liquid, solid (eg powder), gaseous or vapour and may include, for example:

substances which may be hazardous to health (eg asbestos, phosgene, toluene diisocyanate);

substances which may be either corrosive or potentially hazardous by virtue of their temperature or pressure (eg nitric acid, molten metal, liquid nitrogen);

This definition includes incidents which present a fire or explosion hazard (eg combustible powders,) but not in relation to releases of a flammable liquids or gases, where the relevant thresholds in paragraph 26 above are not exceeded.

Examples of the kinds of incident covered by the definition are escapes arising from the failure or breakage of plant, pipes, equipment or apparatus; failures of process control; the operation of a relief valve or bursting disc where the escaping substance is not safely controlled or directed; and spillages from containers and equipment.

Releases from plant etc during the normal course of operation or maintenance (eg during sampling, packaging or draining of lines) that are sufficiently well controlled to ensure that no person is put at risk would not be reportable.

In some cases, the decision as to whether or not an incident is reportable will be straightforward, for example if the incident results in a person being exposed to a hazardous substance at a level which exceeds established safe limits. (eg a Workplace Exposure Limit.)

However, most incidents will require judgement. Various factors are relevant including: the nature of the substance and its chemical, physical and toxicological properties, the amount which escaped and its dispersal, and whether people were or could foreseeably have been exposed to a significant risk as a consequence of the escape.

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.

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

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. The Form is designed to be user friendly, so if you do use the internet for any reason at home then the layout and functionality of the form will be familiar.

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.