group policies and procedures

# Incident Policy

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| Category | Corporate Governance |
| Author | Castleman Healthcare Ltd |
| Responsible Director | Dr Christina Hawkins |
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**Related policies and guidance**

**Document revision and approval history**

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# introduction

Castleman Healthcare Ltd is committed achieving a high standard of health, safety and welfare for all patients, members of the public, employees and others engaged in or affected by the activities and services of Castleman Healthcare Ltd.

The reporting and management of incidents is a critical tool in assisting the organisation to effectively manage risk. The reporting of incidents and near misses provides valuable data, which can help improve safety, prevent the recurrence of incidents and facilitate wider organisational and cross-organisational learning.

NHS England has published two patient safety documents which form the basis of this policy. In 2015 a revised Never Events Policy and Framework and a revised Serious Incident Framework, were implemented on the 1st April 2015.

Serious Incident Framework builds upon previous guidance, to ensure that a systematic process for responding serious incidents in NHS-funded care is in place for all organisations. This framework replaced the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and NHS England’s Serious Incident Framework (March 2013).

Both frameworks require action to be taken by providers that ensure local policies and procedures remain aligned with national policy frameworks.

# Aim of policy

The aim of this policy is to ensure that the organisation is compliant with all relevant regulations and guidelines and to support staff in reporting, investigating and managing incidents.

This Policy applies to all members of Castleman Healthcare Ltd staff, including independent contractors.

All managers and staff (at all levels) are responsible for ensuring that they are viewing and working to the current version of this procedural document. If this document is printed in hard copy or saved to another location, it must be checked that the version number in use matches with that of the live version on the Castleman Healthcare Ltd documents repository.

All staff are responsible for implementing procedural documents as part of their normal responsibilities, and are responsible for ensuring they maintain an up-to-date awareness of procedural documents.

# SCOPE

This document explains the processes involved in managing Serious Incidents within the activities of Castleman Healthcare Ltd.

The definition of ‘Serious Incident’ is as per the NHS England Serious Incident Framework (March 2015) (see Section 5 – Definitions).

# castleman healthcare ltd Roles & Responsibilities

All staff are responsible for being aware of the requirements of this policy, reporting an incident when it occurs and participating in incident investigation processes,

**Castleman Healthcare Ltd Board**

The Board has overall responsibility and decision-making powers with regard to incident handling within Castleman Healthcare Ltd.

**Directors**

The designated Director for overall responsibility for risk management is Dr Christina Hawkins and the Clinical Governance Director is Dr Dominic Hennessy. The Director is responsible for ensuring that the appropriate support and advice is provided by the Castleman Healthcare Ltd Managers to fulfil the Policy.

Castleman Healthcare Ltd Director will provide the strategic lead on incidents issues and will be responsible for ensuring that incidents information is reported through to the appropriate committees and that the Managers are monitored for compliance with the objectives of the Incidents Process.

**Directors are responsible for:**

1. Ensuring all staff are informed of the need to report incidents which arise.
2. Ensuring all directly employed staff understand the incident reporting system and receive feedback from incidents reported.
3. Ensuring sessional staff are aware of the Incident Reporting Policy.
4. Initiating any investigations required following an incident.
5. Allocating sufficient resources (both financial and human) for incident investigation and follow up.
6. Ensuring any recommendations made as a result of investigations are put into place.

**Castleman Healthcare Ltd Line Managers**

Line Managers are responsible for ensuring that their staff receive appropriate training to ensure they are fully aware of the procedures for reporting and formally recording all incidents relating to their work or workplace. Following any incident or injury, Line Managers must ensure that there is an appropriate investigation or root cause analysis of the circumstances as soon after the event as possible.

# Purpose of the procedure

This purpose of this procedure is to run in parallel with the NHS England Serious Incident Framework (March 2015) and Revised Never Events Policy and Framework rather than duplicate it. This procedure explains the processes utilised by Castleman Healthcare Ltd. to ensure these frameworks are followed and therefore the objective of this document and is to establish a procedural document for managing Serious Incidents, to document the different types of serious incidents, to ensure

Serious Incidents that occur are reported and investigated within the parameters of the Serious Incident Framework, to ensure all Castleman Healthcare Ltd staff understand the procedures and to document the lessons learned to inform learning and improvement.

This document is set out in three parts:

**Part One: Definitions and Thresholds.** This section describes what a serious incident is and how serious incidents are identified.

**Part Two: Underpinning Principles.** This section outlines the principles for managing serious incidents. It also clarifies the roles and responsibilities in relation to serious incident management, makes reference to legal and regulatory requirements and signposts to tools and resources.

**Part Three: Serious Incident Management Process.** This section outlines the process for conducting investigations into serious incidents for the purposes of learning to prevent recurrence. It covers the process from setting up an investigation team to closure of the serious incident investigation. It provides information on timescales, signposts tools and resources that support good practice and provides an assurance Framework for investigations.

# PART ONE – DEFINITIONS AND THRESHOLDS

**What is a Serious Incident? (ref NHS Serious Incident Framework source document)**

Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation’s ability to deliver ongoing healthcare.

The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.

There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created, there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list.

The definition below sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis using the description below. Inevitably, there will

be borderline cases that rely on the judgement of the people involved (see section 1.1).

**Serious Incidents in the NHS include:**

Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

* Unexpected or avoidable death of one or more people. This includes
* Suicide/self-inflicted death; and
* Homicide by a person in receipt of mental health care within the recent past
* Unexpected or avoidable injury to one or more people that has resulted in serious harm;
* Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: — the death of the service user; or serious harm;
* Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where: healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.

**A Never Event** - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.

An incident (or series of incidents) that prevents, or threatens to prevent, an organisation’s ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues (see Appendix 2 for further information);

* Property damage;
* Security breach/concern
* Incidents in population-wide healthcare activities like screening13 and immunisation programmes where the potential for harm may extend to a large population
* Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS)
* Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services
* Activation of Major Incident Plan (by provider, commissioner or relevant agency)
* Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

# PART two – underpinning principles

**Seven Key Principles (Taken from the NHS Serious Incident Framework source document)**

This Framework endorses the application of 7 key principles in the management of all serious incidents:

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| Key Principle | Supporting Information |
| Open and Transparent | The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents.  The principles of openness and honesty as outlined in the NHS Being Open guidance and the NHS contractual Duty of Candour[[1]](#footnote-1) must be applied in discussions with those involved. This includes staff and patients, victims and perpetrators, and their families and carers. (Castleman Healthcare Ltd. have a Duty of Candour Policy).  Openness and transparency (as described in ‘Being Open’) means:   * Acknowledging, sincerely apologising and explaining when things have gone wrong; * Conducting a thorough investigation into the incident, ensuring patients, their families and carers are satisfied that lessons learned will help prevent the incident recurring; * Providing support for those involved to cope with the physical and psychological consequences of what happened[[2]](#footnote-2)   Saying sorry is not an admission of liability and is the right thing to do. Healthcare organisations should decide on the most appropriate members of staff to give both verbal and written apologies and information to those involved. This must be done as early as possible and then on an ongoing basis as appropriate.  The NHS Litigation Authority provides advice on saying sorry available online from: <http://www.nhsla.com/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf>  Part three; section 4.2 outlines the steps required to support this principle. |

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| Preventative | Investigations of serious incidents are undertaken to ensure that weaknesses in a system and/or process are identified and analysed to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again[[3]](#footnote-3).  Investigations carried out under this Framework are conducted for the purposes of learning to prevent recurrence. They are not inquiries into how a person died (where applicable) as this is a matter for Coroners. Neither are they conducted to hold any individual or organisation to account. Other processes exist for that purpose including: criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council. In circumstances where the actions of other agencies are required then those agencies must be appropriately informed and relevant protocols, outside the scope of this Framework, must be followed.  Organisations must advocate justifiable accountability and a zero tolerance for inappropriate blame. The Incident Decision Tree[[4]](#footnote-4) should be used to promote fair and consistent staff treatment within and between healthcare organisations. |
| Objective | Those involved in the investigation process must not be involved in the direct care of those patients affected nor should they work directly with those involved in the delivery of that care. Those working within the same team may have a shared perception of appropriate/safe care that is influenced by the culture and environment in which they work. As a result, they may fail to challenge the ‘status quo’ which is critical for identifying system weaknesses and opportunities for learning.  Demonstrating that an investigation will be undertaken objectively will also help to provide those affected (including families/carers) with confidence that the findings of the investigation will be robust, meaningful and fairly presented.  To fulfil the requirements for an independent investigation, the investigation must be both commissioned and undertaken independently of the care that the investigation is considering (see Appendix 3) |
| Timely and responsive | Serious incidents must be reported without delay and no longer than 2 working days after the incident is identified (Part Three; section 3 outlines the process for reporting incidents).  Every case is unique, including: the people/organisations that need to be involved, how they should be informed, the requirements/needs to support/facilitate their involvement and the actions that are required in the immediate, intermediate and long |

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|  | term management of the case. Those managing serious incidents must be able to recognise and respond appropriately to the needs of each individual case. |
| Systems based | The investigation must be conducted using a recognised systems-based investigation methodology that identifies:   * + The problems (the what?);   + The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and   + The fundamental issues/root cause (the why?) that need to be addressed.   Within the NHS, the recognised approach is commonly termed Root Cause Analysis (RCA) investigation.[[5]](#footnote-5) The investigation must be undertaken by those with appropriate skills, training and capacity. |
| Proportionate | The scale and scope of the investigation should be proportionate to the incident to ensure resources are effectively used. Incidents which indicate the most significant need for learning to prevent serious harm should be prioritised. Determining incidents which require a full investigation is an important part of the process (see Part One; section 1.1) and ensures that organisations are focusing resources in an appropriate way  Typically, serious incidents require a comprehensive investigation, but the scale and scope (and required resources) should be considered on a case by-case-basis. Some incidents may be managed by an individual (with support from others as required) whereas others will require a team effort and this may include members from various organisations and/or experts in certain fields. In many cases an internally managed investigation can fulfil the requirements for an effective investigation. In some circumstances (e.g. very complex or catastrophic incidents spanning multiple organisations and/or where the integrity of the investigation would be challenged/ undermined if managed internally) an independent investigation may be required (see Appendix 3 for further details). In exceptional circumstances a regional or centrally-led response may be required (see Part Three, section 3.2). |
| Collaborative | Serious incidents often involve several organisations. Organisations must work in partnership to ensure incidents are effectively managed.  There must be clear arrangements in place relating to the roles and responsibilities of those involved (see Part Two, section 2 and 3 below). Wherever possible partners should work collaboratively to avoid duplication and confusion. There should be a shared understanding of how the incident will be managed and investigated and this should be described in jointly agreed policies/procedures for multi-agency working. |

# PART three – roles and responsilbilties for managing serious incidents

**(Taken from the NHS Serious Incident Framework source document)**

The nature of the serious incident largely determines who has a role to play and what that role is. This section outlines the key roles and responsibilities of providers, commissioners, key regulatory and supervisory bodies.

The leadership at a provider organisation is ultimately responsible for the quality of care that is provided by that organisation. Serious incident management is a critical component of corporate and clinical governance, and providers are responsible for arranging and resourcing investigations and must ensure robust systems are in place for recognising, reporting, investigating and responding to serious incidents. The principles and processes associated with robust serious incident management must be endorsed within an organisation’s Incident Reporting and Management Policy.

There must be clear procedures for:

1. Timely reporting and liaison with their commissioning bodies (incidents must be recorded on STEIS within 2 working days of being identified). Particular types of incidents may require additional reporting to other systems.
2. Compliance with reporting and liaison requirements with regulators and other agencies/partners.
3. Mechanisms to support robust serious incident investigations, including processes to ensure the following:
4. Early, meaningful and sensitive engagement with affected patients and/or their families/carers, from the point at which a serious incident is identified, throughout the investigation, report formulation and subsequent action planning through to closure of the investigation process. A specific person should be assigned to engage with the family to provide a single point of contact.
5. Clear procedures for taking immediate action following a serious incident including the collection and retention of evidence i.e. notes/clinical records, written accounts/statements32 from those involved, equipment involved, information from the location (site visit) and interviews with relevant individuals.
6. Investigations are undertaken by appropriately trained and resourced staff and/or investigation teams that are sufficiently removed from the incident to be able to provide an objective view.
7. Investigations follow a systems-based approach to ensure any issues/problems with care delivery are fully understood from a human and systems factors perspective and that the ‘root causes’ are identified (where it is possible to do so) in order to produce focused recommendations that result in SMART (specific, measurable, attainable, relevant, time-bound) actions and learning to prevent recurrence.
8. Access to relevant specialists/ experts, communications expertise, administrative support and/or additional resources to support investigations where required.
9. Mechanisms to ensure that actions from action plans are monitored until implemented and there is evidence of whether or not the action plan has resulted in the practice / system improvement anticipated. This should include oversight of implementation by organisation leaders.
10. Mechanisms to support investigations being led by external agencies such as the police, HSE or local authority. Where required, providers must submit evidence to contribute towards external investigations.
11. Processes (including interagency investigation policy and/or memorandum of understanding with relevant organisations) to support collaboration and partnership working where joint investigations are required to avoid duplication of activity or confusion of responsibility.
12. Quality assurance processes to ensure completion of high-quality investigation reports and action plans to enable timely learning and closure of investigations and to prevent recurrence.
13. Mechanisms and effective communication channels to facilitate the sharing of lessons learned across the organisation and more widely where required.

**Never Events** are a subset of Serious Incidents that meet all of the following criteria:

1. They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers
2. Each Never Event has the potential to cause serious harm or death. However serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event
3. There is evidence that the category of Never Event has occurred in the past for example through reports to the National Reporting and Learning system, and a risk of recurrence remains
4. Occurrence of the Never Event is easily recognised and clearly defined – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.

For further information on Never Events, refer to the Revised Never Event Policy and Framework, NHS England, March 2015.

# Reporting

Castleman Healthcare Ltd recognises that incidents may occur because of problems with systems, processes or by individuals. Castleman Healthcare Ltd. promotes a positive approach to incident reporting throughout the organization in line with the Serious Incident Framework as detailed above. Staff are encouraged and will be supported to be open and honest about events and issues that have or could cause damage to people, property or the organisation. Castleman Healthcare Ltd operates an open and fair blame culture and will accept vicarious liability for the actions of staff as long as they were carrying out their duties in accordance with Castleman Healthcare Ltd policy, their professional standards, information, instruction, training and supervision they had received.

Castleman Healthcare Ltd. staff have a statutory duty to report any incident they are involved in immediately in line with the Serious Incident Framework. This includes hazard concerns and near misses that have the potential to cause harm or loss as well as other incident types as outlined in this document.

All incidents need to be reported to the Line Manager. The Incident Form (see Appendix 1) should be filled in and emailed to the Line Manager and details of incident logged in Castleman Healthcare

Ltd Quality Log and a robust procedure of investigation, recording and learning will be undertaken in line with the Serious Incident Framework as detailed above and within recommended timescales.

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| **Grading** | **Action** | **Timescales** |
| Minor Incidents | Investigated by managers and Castleman Healthcare Clinical Governance lead  Investigated as per the Serious Incident Framework detailed above. | Logged in Castleman Healthcare log within 24 hours  Resolved within 21 days |
| Moderate Incidents | Investigated by managers and Castleman Healthcare Clinical Governance lead  Investigated as per the Serious Incident Framework detailed above. | Logged in Castleman Healthcare log within 24 hours  Resolved within 28 days |
| Major/Catastrophic Incident | Investigated by managers and Castleman Healthcare Clinical Governance lead  Investigated as per the Serious Incident Framework detailed above.  National SIRI guidelines to be followed  Serious Incident Reporting form to be emailed to NHS | Logged in Castleman Healthcare log within 24 hours  Resolved within 45 days |

# Process for reporting an incident

Initiate any **immediate actions** required to prevent a recurrence (e.g. isolate defective equipment);

Complete an **Incident Report Form** as soon as possible (within 24 hours of the event), ensuring that where appropriate **Severity Grading** is allocated;

Complete any **supporting documentation** (further details, witness statements etc);

**‘Extreme’** Incidents (i.e. those involving death, serious injury etc) **must be reported immediately**, as Dorset Diagnostics is required to notify these to the Commissioners as SUI’s

Incident / Near Miss occurs

Send Incident Form to Manager

Use trend data to inform Quality Improvement and Patient safety activity

Manager to assess incident, and ensure immediate **preventative actions have been taken**

Manager to liaise with Director or Operations to decide **appropriate investigation methodology** (depending on severity);

Incident form sent to Director of Operations

Retain Incident Report Form in **secure** location and **circulate copies** to relevant staff if relevant;

**Initiate investigation** as advised;

Ensure that Director of Operations is kept appraised of internal investigation;

Notify Clinical Governance board of any identified organisational learning

Director of Operations to update CCG

**Review incident data** at appropriate meetings;

**Minutes** of meetings to summarise issues;

**Feedback to staff** by line managers;

**Assess trends** on a quarterly basis and develop action plans to address key issues

Incident data review

Feedback to Service and Clinical Governance Board

# Serious Incidents

Castleman Healthcare Ltd must ensure that all serious incidents are disclosed to those affected in a timely manner, appropriately reported and investigated, with the findings being shared with those involved in accordance with the Being Open guidance and the contractual Duty of Candour requirements. Staff leading serious incident investigations should have up to date training and be competent in investigative methodology, techniques and analysis, report writing, and including human factors as well as being fully conversant with the NHS Serious Incident Framework as outlined above.

Castleman Healthcare Ltd is accountable for effective governance and learning following a serious incident and will do so in line with the NHS Serious Incident Framework as outlined above. Castleman Healthcare Ltd will also ensure that:

* Relevant policies and procedures are in place
* Incidents are reported in line with the framework
* All incident investigations and action plans are reviewed in line with the framework
* Data trends are monitored in line with the framework
* Serious incidents are investigated and closed in a timely manner in line with the framework

**Notifying the CQC of incidents reported to, or investigated by the Police**

Castleman Healthcare Ltd is required to notify the CQC without delay of incidents reported to, or investigated by the Police.

# Steps to be taken when a serious incident occurs:

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| Steps | Details |
| 1 | Incident Occurs |
| 2 | Log incident on Quality Log |
| 3 | Report incident email Patient Safety and Risk Team |
| 4 | Grade incident |
| 5 | Establish appropriate investigation |
| 6 | Undertake investigation |
| 7 | Develop action plan |
| 8 | Submit incident investigation report and action plan to commissioner |
| 9 | Implement action plan |
| 10 | Commissioner signs off incident as closed |
| 11 | Share lessons |
| 12 | Review implementation of actions |

All Serious Incidents must be declared as soon as possible and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation.

Serious Incidents should be disclosed as soon as possible to the patient, their family (including victims’ families where applicable) or carers.

For certain types of Serious Incidents, the CCG must be informed via STEIS (and verbally if required) of a Serious Incident within two working days of it being discovered.

This must be done by completing the Serious Incident Reporting form, Appendix III which must be sent by email. The words ‘Serious Incident Notification’ must be used in the subject of the email.

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| **Patient Safety and Risk team** | **HSE Info line (08:00 – 18:00)** |
| T: 01305 368052/36/56 | T: 0845 3009923 |
| Email: [matt.wain@dorsetccg.nhs.uk](mailto:matt.wain@dorsetccg.nhs.uk) | Website: <http://www.hse.gov.uk/riddor/report.htm> |

SIs must be reported as soon as possible after the incident is detected and no later than two working days after the incident being identified. The report must not contain any patient or staff identifiable data (including initials of names) and the description should be concise.

Other regulatory, statutory and advisory bodies, such CQC, Monitor or NHS Trust Development Authority, must also be informed as appropriate without delay.

**72-hour review**

The Serious Incident Framework states that “an initial review (characteristically termed a ‘72-hour review’) should be undertaken and uploaded onto the STEIS system by the Provider. This should be completed within three working days of the incident being identified.”

Castleman Healthcare Ltd. has taken a pragmatic view on this requirement, as for some Serious Incidents, a 72-hour review will not ‘add value’. A 72-hour review will be provided only when:

* The Serious Incident is a Never Event;
* Independent investigations are to be undertaken;
* When additional information can be readily obtained, and may significantly expand early knowledge of the incident and why it occurred to quickly prevent further incidents.

72-hour review reports will not routinely be requested for Serious Incidents subject to concise and comprehensive investigations.

**Terms of Reference**

It is a requirement of the Serious Incident Framework that each Serious Incident investigation has a clearly determined Terms of Reference.

**Duty of Candour**

The NHS Constitution was updated in 2013 to include the requirements for NHS organisations under ‘Duty of Candour’ Communicating honestly and compassionately with patients and their families when things go wrong is a vital component in dealing effectively with errors or mistakes in their care.

The requirement in relation to applying Duty of Candour following Serious Incidents is clearly documented in the NHS England Serious Incident Framework.

**Investigation timeframe**

The Serious Incident Framework states that RCAs (concise and comprehensive investigations) must be completed within 60 working days of the incident being reported.

The 60-day timeframe, whilst aspirational, cannot always be achieved. This timeframe can be particularly challenging for certain investigations when additional meetings/panels need to be convened.

**Closing Serious Incidents on STEIS**

Serious Incidents will only be closed on STEIS following receipt of a robust investigation report that has been generated following a full root cause analysis with a time framed action plan.

Serious Incidents can only be closed following agreement from the Serious Incident Review Group investigating the Serious Incident.

If it is agreed during the Group or Panel meeting that the Serious Incident cannot be closed on STEIS due to outstanding information and/or assurance requirements, a member of the Patient Safety and Risk team will provide this information to the Provider in writing, within 48 hours of the Group or Panel meeting, detailing the requirements for closure (including expected timeframe for response).

**Deleting Serious Incidents from STEIS**

If a Serious Incident is declared but further investigation reveals that the definition of a Serious Incident is not fulfilled, the incident can be deleted.

Serious Incidents can only be deleted following agreement from the Serious Incident Review Group and the Governance Director.

# Investigating Incidents

Adverse incidents and near misses are subject to an appropriate level of investigation in line with the NHS Serious Incident Framework. Not all events need to be investigated to the same extent or depth however and the investigation and analysis should be relative to the seriousness, complexity of the event and/ or whether it resulted in actual harm and the potential for learning, such as those which are high frequency but may be of low severity

Any investigation should have the following aims:

1. To ensure timely and appropriate follow-up
2. To establish the facts
3. To identify factors contributing to the events
4. To determine what actions are to be taken to remedy any identified deficiency
5. To prevent, as far as possible, similar occurrences in the future
6. To meet national, regional and legal reporting requirements

**To ensure the achievement of these aims is possible, an investigation should feature the following components:**

1. Collection of evidence about what happened – to include clinical records (where relevant), correspondence, witness statements, etc.
2. Consideration of the evidence, including a comparison with relevant standards, protocols or guidelines, whether national or local
3. Establishment of the facts and, based upon these, the drawing of conclusions and making of recommendations for action to minimise risk
4. The drawing up of an action plan with prioritised actions, responsibilities, timescales and strategies for measuring effectiveness of actions
5. The implementation of the improvement strategy and track progress; including the effectiveness of actions

# sharing lessons

The sharing of the lessons learnt post investigation is a critical part of incident management. Learning from incidents is a collaborative, decentralized and reflective process that draws on experience, knowledge and evidence from a variety of sources. The learning process is a process of change evidenced by demonstrable, measurable and sustainable change in knowledge, skills, behaviour and attitude. Learning can be demonstrated at organisational level by changes and improvements in process, policy, systems and procedures relating to patient safety within healthcare organisations. Individual learning can be demonstrated by changes and improvements in behaviour, beliefs, attitudes and knowledge of staff at the front line of healthcare delivery.

The Practice maintains a register of all incidents occurring within the organisation. This register of incidents and the resulting actions taken are likely to impact upon other policies and procedures within the Practice.

All registered incidents are re-evaluated after a 6-month period to assess the effectiveness of the implemented actions, in ensuring that either the type of incident is no longer being reported or the volume of those types of incidents has reduced.

If there is no change in the volume of each type of incident, the Board is alerted and appropriate action taken.

To provide staff with an example of what could occur, how to respond to such events and how to avoid them, previous incidents are used in security and confidentiality training sessions.

Examples of learning:

* Solutions to address incident root causes which may be relevant to other teams, services and provider organisations;
* Identification of the components of good practice which reduced the potential impact of the incident, and how they were developed and supported;
* Systems and processes that allowed early detection or intervention which reduced the potential impact of the incident;
* Lessons from conducting the investigation which may improve the management of investigations in future; and
* Documentation of identification of the risks, the extent to which the risks have been reduced, identified and how this is measured and monitored.

Learning points should be grouped or themed to help the reader(s) identify those points applicable to their team, service, specialty, division or wider.

# appendix - Definition of Terms

**Incident**: An event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors, members of the public or Castleman Healthcare Ltd. itself.

**Near Miss:** An incident that did not lead to harm, loss or damage but had serious potential to do so and where lessons can be learnt from changes in procedures, processes and systems.

**Hazard**: Is any situation or physical factor, which has the potential to cause an incident.

**Serious Incident Requiring Investigation (SIRI):** A serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following:

1. The unexpected or avoidable death of one or more patients, staff, visitors or members of the public
2. Permanent harm to one or more patients, staff, visitors or members of the public, or where the outcome requires lifesaving intervention or major surgical/medical intervention, or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm (Seven Steps, 2009)
3. A scenario that prevents, or threatens to prevent, a provider organisation’s ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment
4. Allegations of abuse
5. Security incidents
6. Adverse media coverage or public concern for the organisation or the wider NHS; or
7. One of the core set of Never Events
8. All apparent or actual suicides of people with an open episode of care (either community or inpatient) at time of death
9. Major outbreaks, serious incidents of communicable disease or exposure to environmental hazards caused by healthcare failures or other NHS system failures that have put patients/staff at harm/risk of harm or restrict service delivery
10. Information Technology incidents including systems failure leading to serious outcomes and data loss resulting in severe breach of confidentiality.

**Never Events:** Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Incidents are considered to be never events if:

1. The incident either resulted in severe harm or death or had the potential to cause severe harm or death.
2. There is evidence that the never event has occurred in the past and is a known source of risk (for example through reports to the National Reporting and Learning System or other serious incident reporting system).
3. There is existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.
4. Occurrence of the never event can be easily identified, defined and measured on an on-going basis.

**Root Cause Analysis (RCA):** A systematic process whereby the factors that contributed to an incident are identified. As an investigation technique for patient safety incidents, it looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which an incident happened.

**Significant Event Audit:** An audit process where data is collected on specific types of incidents that are considered important to learn about how to improve patient safety.

**Clinical Incident:** Is any untoward event or near miss that involves a patient, e.g. drug errors, patients falling, patient complaint; this will include:

1. Operation on the wrong patient/body part
2. Surgical foreign body left in situ
3. Intra operative problems
4. Diathermy burns/reaction to prep agent/pressure sores
5. Performance of operation that is not indicated
6. Failure to warn (informed consent)
7. Failure to act on abnormal test results
8. Medication errors
9. Infusion problems
10. Problems with medical records
11. Clinical Equipment malfunction
12. Self-harm
13. Unexpected death

**Non-Clinical Incident:** Is an untoward event that involves any person (e.g. member of staff, visitors, voluntary workers, contractors etc.). It may also involve a patient where the event relates to health & safety issues rather than clinical issues. A non-clinical incident may be an accident or a near miss. The following is a non-exhaustive list of non-clinical incidents:

1. Physical or verbal aggression
2. Slip, trip or fall
3. Needle stick or sharps injury
4. Any work related ill health including stress
5. Burns or scalds
6. Accidental exposure to electricity
7. Accidental exposure to chemical agents
8. Accidental exposure to biological agents
9. Accidental exposure to radiation
10. Manual handling injuries to staff
11. Upper Limb Disorders/Repetitive Strain
12. Struck or Trapped by any Object
13. Failure of non-clinical equipment
14. Theft, loss or damage of any property

# Appendix 1 INCIDENT REPORTING FORM

|  |  |
| --- | --- |
| Incident Register Number | |
| **Reported by:** | **Date/time discovered:** |
| Incident details | |
| **Type of incident** *[tick a category]*:   |  |  | | --- | --- | |  | **Confidentiality**  e.g. breach due to unauthorised access, potential breach due to lost record, etc. | |  | **Integrity**  e.g. records altered without authorisation, etc. | |  | **Availability**  E.g. records missing, misfiled, theft etc. | | |
| **Incident details**,state the facts only, where it occurred; what information was involved etc. | |
| **Date reported**: | |
| **Initial action(s) taken**, (what did you do, who will / have you reported the incident to)**:** | |

|  |  |
| --- | --- |
| **Investigation and management** | |
| **\*\*\*Insert name and Position of person investigating the incident\*\*\*** | **Date investigation commenced:** |
| **Investigations, findings, actions and recommendations:** | |
| **Post-incident reporting** | |
| **Incident and investigation outcome reported to** [add any other relevant notes here, e.g. issue and outcome discussed at staff meeting]: | **Primary Care Trust**  **YES/NO** |
| **Information Commissioner**  **YES/NO** |
| **Practice Insurer**  **YES/NO** |
| **Other**  ***[Insert details]*** |
|  |  |

# Appendix 2 – Grading of Incidents

Assessing and grading an incident’s risk severity in a consistent way provides the Castleman Healthcare Ltd with a way of identifying levels of risk and the actions to deal with them. A risk severity grade is achieved by using the 2-dimensional risk-grading matrix (as below) (***consequence*** and ***likelihood***) to identify a severity score/colour.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Likelihood score** | | | | | | | |
| **Risk Grading Matrix** | | | **1** | **2** | **3** | **4** | **5** |
|  |  |  | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost** |
| ***Score*** | **Certain** |
| **5 Catastrophic** | | **5** | **10** | **15** | **20** | **25** |
| ***Consequence*** | **4** | **Major** | **4** | **8** | **12** | **16** | **20** |
| **3** | **Moderate** | **3** | **6** | **9** | **12** | **15** |
| **2** | **Minor** | **2** | **4** | **6** | **8** | **10** |
| **1** | **Negligible** | **1** | **2** | **3** | **4** | **5** |

For grading risk, the scores obtained from the risk matrix are assigned colour grades

|  |  |  |  |
| --- | --- | --- | --- |
| **Green** | **1** | **- 3** | **Low risk** |
| **Yellow** | **4** | **- 6** | **Moderate risk** |
| **Amber** | **8** | **- 12** | **High risk** |
| **Red** | **15 - 25** | | **Extreme risk** |

**Assessing and grading Consequence and Likelihood to grade incident severity and risk**

To establish the overall risk grading of an incident, we need to first assess and grade the incident in terms of the consequence/impact, followed by an assessment of the likelihood or reoccurrence.

**Consequence Grading for Incidents**

Consequence is defined as the severity of the actual or potential harm or outcome of an incident. Where there is more than one consequence of a single incident, use the most severe to grade the severity. Consequence scores and grades are:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 - Negligible | 2 - Minor | 3 - Moderate | 4 - Major | 5 - Catastrophic |

These are shown below in a table with some descriptors of incidents. Work along the columns to assess the consequence of the harm or outcome of an incident (actual or potential), on the scale of 1 to 5. The score is the number given at the top of the column, the grade is the colour.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table 1** | **Consequence grading/scoring (severity levels)** | | | | |
|  | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
|  | No injury or minimal injury | Minor injury or illness, | Moderate injury requiring | Major injury leading to long- | Serious injury or harm egg. |
| **Impact on the safety of**  **patients, staff or public**  **(physical or psychological**  **harm)** | but no first aid required | requiring minor intervention | professional intervention | term incapacity/disability | very serious suicide attempt |
| No time off work | Requiring time off work for  >3 days | Requiring time off work for 4-  14 days (RIDDOR reportable  incident)  An event which impacts on a  small number of service  users | Requiring time off work for  >14 days  Mismanagement of care with  long-term effects | Incident leading to death  An event which impacts on a  large number of patients  Meets the definition of an SL  A Never Event |
|  |  |
| **Quality/complaints/audit** | Peripheral element of  treatment or service  suboptimal | Overall treatment or service  suboptimal | Treatment or service has  significantly reduced  effectiveness | Non-compliance with  national standards with  significant risk to patient’s if  unresolved | Totally unacceptable level or  quality of treatment/service |
| Informal complaint/inquiry | Formal complaint (stage 1) | Formal complaint (stage 2) | Multiple complaints/ | Inquest/ombudsman inquiry |
| complaint | independent review |
|  | Single failure to meet | Repeated failure to meet | Critical report | Gross failure to meet |
| internal standards | internal standards | national standards |
|  | Minor implications fo patient safety if unresolved | Major patient safety  implications if findings are not acted on. | Low performance rating | Gross failure of patient  safety if findings not acted on |
|  | Local resolution | Local resolution (with |  |  |
| potential to go to | Critical report |
| independent review) |
|  | Reduced performance rating |  |  |  |
| if unresolved |
|  | Short-term low staffing level | Low staffing level that | Unsafe staffing level or | Unsafe staffing level or | Ongoing unsafe staffing |
|  | that temporarily reduces | reduces the service quality | competence (>1 day) | competence (>5 days) | levels or competence |
|  | service quality (< 1 day) |
| **Human resources/** |  |  | Late delivery of key | Uncertain delivery of key | Non-delivery of key |
| objective/ service due to lack | objective/service due to lack | objective/service due to lack |
| **organisational** |
| of staff | of staff | of staff |
| **development/staffing/** |
|  |  | Poor staff attendance for | No staff attending |  |
| **competence** | No staff attending mandatory |
|  | training /key training on an |
|  | mandatory/key training | mandatory/ key training |
|  | ongoing basis |
|  |  |  | Low staff morale | Very low staff morale | Loss of several key staff |
|  |  |  |  | Loss of key staff |  |
|  | No or minimal impact or | Breech of statutory  legislation | Single breech in statutory  duty | Multiple breeches in  statutory duty | Multiple breeches in  statutory duty |
|  | breech of guidance/ |
|  |
|  | statutory duty |
|  |  | Reduced performance rating  if unresolved | Challenging external  recommendations/  improvement notice | Low performance rating | Zero performance rating |
| **Statutory duty/** |
| **inspections** |  |  |  |
|  |  |  |  | Improvement notices | Complete systems change  required |
|  |
|  |  |  |  | Enforcement action | Prosecution |
|  |  |  |  | Critical report | Severely critical report |
|  | Rumors | Local media coverage – short-  term reduction in public  confidence | Local media coverage – long-  term reduction in public  confidence | National media coverage  with <3 days’ service well  below reasonable public  expectation | National media coverage  with >3 days’ service well  below reasonable public  expectation. MP concerned  (questions in the House) |
|  |
| **Adverse publicity/** |
| **reputation** |  |
|  |  |
|  | Potential for public concern | Elements of public  expectation not being met | Total loss of public  confidence |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Business objectives/ projects** | Insignificant cost increase/  schedule slippage | <5 per cent over project  budget | 5–10 per cent over project  budget | Non-compliance with  national 10–25 per cent over  project budget | Incident leading >25 per cent  over project budget |
| **Finance including claims** | Small loss Risk of claim | Loss of 0.1–0.25 per cent of  budget | Loss of 0.25–0.5 per cent of  budget | Uncertain delivery of key  objective/Loss of 0.5–1.0 per  cent of budget | Non-delivery of key  objective/ Loss of >1 per cent  of budget |
| remote |
|  | Claim less than £10,000 | Claim(s) between £10,000 | Claim(s) between £100,000  and £1 million | Claim(s) >£1 million |
| and £100,000 |
|  |  |  | Purchasers failing to pay on  time | Loss of contract / payment by  results |
|  |  |  |  | Failure to meet  specification/ slippage |
| **Service/business** | Loss/interruption of >1 hour | Loss/interruption of >8 hours | Loss/interruption of >1 day | Loss/interruption of >1 week | Permanent loss of service or  facility |
| **Interruption** |

**Likelihood of re-occurrence scoring**

The likelihood score should only be assessed once the consequence or impact of an incident has been graded.

The likelihood score is an assessment of how likely it is that an adverse incident will re-occur:

* 1. That the same incident or event will happen again ***and***
  2. With the same level of consequence (the same impact)

For example, if the incident was a fall in which someone sustained a fracture, how likely is it that the fall will happen again (consider place and person), and how likely is it that if a fall does recur that the injury will again be a fracture.

It is important to take into consideration the control measures already in place to stop the event occurring again at the same level, including any actions taken after the incident.

As with the assessment of ‘consequence’, the likelihood of the incident re-occurring is assigned a number from ‘1’ to ‘5’ - the higher the number the more likely it is to re-occur and is based on frequency:

* + 1. Rarely
    2. Unlikely
    3. Possibly
    4. Likely
    5. Almost certainly

Table 2 provides definitions of descriptors to help score the likelihood of an incident risk being realised by assessing frequency.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Table 2** | **Likelihood score** | | | | |
|  | **1** | **2** | **3** | **4** | **5** |
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Very Likely** |
| **Frequency**  **How often might**  **it or does it**  **happen (at the**  **same level)** | Extremely unlikely  to happen/recur –  may occur only in  exceptional  circumstances –  has never  happened before  and don’t think it  will happen (again) | Unlikely to  occur/reoccur but  possible. Rarely  occurred before,  less than once per  year. Could happen  at some time | May  occur/reoccur. But  not definitely.  Happened before  but only  occasionally once  or twice a year | Will probably  occur/reoccur. Has  happened before  but not frequently  – several times a  month. Will occur  at some time. | Continuous exposure to risk  Has happened  before regularly  and frequently – is  expected to happen  in most  circumstances.  Occurs on a daily  basis |
|  |
|  |
|  |  |  |  |  |  |

**Example incident:**

A member of staff slips and falls down some steps, injuring their hand, requiring first aid. The incident graded by the person who fell, it is their assessment of the severity:

Consequence: Minor (injury, impact) – scores 2

Likelihood: Unlikely (to re-occur) – scores 2

Overall incident grading would be 2 x 2 = 4 = Yellow

1. The Department of Health has introduced regulations for the Duty of Candour. It requires providers to notify anyone who has been subject (or someone lawfully acting on their behalf, such as families and carers) to a ‘notifiable incident’ i.e. incident involving moderate or severe harm or death. This notification must include an appropriate apology and information relating to the incident. Failure to do so may lead to regulatory action. Further information is available from <http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf> [↑](#footnote-ref-1)
2. National Patient Safety Agency, ‘Being Open: communicating patient safety incidents with patients, their

   families and carers’, November 2009, available at: <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=83726> [↑](#footnote-ref-2)
3. Maria Dineen (2011) *Six Steps to Root Cause Analysis* (third edition) ISBN:978-0-9544328-2-9 [↑](#footnote-ref-3)
4. The Incident Decision Tree (first published by the NPSA) aims to help the NHS move away from attributing blame and instead find the cause when things go wrong. The goal is to promote fair and consistent staff treatment within and between healthcare organisations. NHS England is planning the re-launch of the Incident Decision Tree during 2015/16. [↑](#footnote-ref-4)
5. 3 Tools and training resources to support robust systems investigation in the NHS are available to download from <http://www.nhs.npsa.nhs.uk/resources/collections/root-cause-analysis/> [↑](#footnote-ref-5)