TOWER HAMLETS GP CARE GROUP (THGPCG) CIC
SERIOUS INCIDENT POLICY

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Title	Serious Incident Policy
Supersedes	All previous Policies
This policy will impact on	All staff
Related Documents	
Policy Area	Quality & Safety
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Context
Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents, including near misses, ill health and hazards, which will help to facilitate wider organisational learning. If incidents are not properly managed, they may result in a loss of public confidence in the organisation and a loss of assets. The THGPCG directors support open and transparent systems of patient and staff safety and that it is unacceptable to prioritise other objectives at the expense of patient safety

The purpose of this document is to describe how THGPCG intends to ensure that all incidents whether they have caused actual harm or where a near miss is reported by staff in a timely manner.

There are clear stages to overall incident management, whatever the grade or severity of the incident. :

i. ***Identifying an incident*** – ensuring staff are able to recognise and incident and know who to contact if they are unsure.
ii. ***Managing the incident*** - immediate actions to take to ensure the safety and wellbeing of those directly or indirectly involved, or to prevent immediate recurrence.
iii. ***Grading the severity of Incidents using the Risk Grading Matrix***- to ensure the incident is responded to appropriately.
iv. ***Reporting, recording and communication regarding the incident***
v. ***Reporting and managing Serious Incidents (Red incidents)***

This document applies to:

- Staff of any grades and role, in the THGPCG.
- Incidents that occur on any of the premises, including those that involve service users, employees, visitors or contractors.
- Incidents involving employees or service users that occur in any other setting, when an employee is carrying out his/her duties.
- Incidents that occur as a result of the care and treatment provided by service areas
- Serious Incidents (SI) such as a serious injury or a suspected suicide or homicide while a service user is receiving care and treatment from the service areas or has been in contact with services in the previous 6 months.
- Incidents that have actually occurred and those that were a 'near miss'.

Definitions

Abuse	A violation of an individual's human or civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological; it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation, of the person subjected to it. This is defined in *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (DH 2000), and *Working Together to Safeguard Children: A guide to inter-agency working* states that abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by 'inflicting harm' or by failing to act to prevent harm (DCSF 2006, p37).
Accident	An unplanned and unwanted event that results in a loss of some kind. An accident does not include near misses.
Adverse event	An adverse event could be an incident complaint or claim that requires investigation by the service areas to identify causal factors. An adverse event may not initially have been recognised and reported as an incident (and so may need reporting retrospectively).
Adverse Incident	Also referred to as an ***incident or untoward incident***. An unintended and/or unexpected event or a circumstance that actually leads to, or could have led to, harm, loss or damage to a service user, staff member, visitor/contractor or property. Harm may be physical or psychological.
Being open	Service users, relatives, carers, staff and partner agencies need to know when something has gone wrong and what the Service Areas is going to do to minimise harm and prevent recurrence. Service users, carers, relatives and staff can expect to be provided with appropriate information and support following any patient safety incident by the Organisations. See the THGPCG's' Being Open Policy for further guidance.
Causal Factors	A causal factor is something that led directly to an incident.
Just Culture	THGPCG aims to work within an open honest and just culture in which staff can be assured that they will be treated fairly and with openness

	and honesty when they report adverse incidents or mistakes
Management Fact Finding	Following initial reporting this is a further information gathering and 'risk scan' that will help determine what happened, any obvious gaps or failures in the systems (where immediate risk reduction measures may be needed) and identify the requirements of further investigation.
Hazard	A danger – something with the potential to cause harm
Incident	An event or circumstance which could have resulted, or did result, in unnecessary damage, loss or harm to patients, staff, visitors or members of the public. The harm may be physical or psychological. It is important to recognise and report ***all*** incidents, both clinical and non-clinical. The Service Areas uses the word **incident** because this is the term that staff recognise and use most frequently - although ***untoward Incident*** or ***adverse event*** may be technically more accurate
Investigation	A thorough, detailed, systematic inquiry, search or examination to discover facts. Usually results in recommendations, actions and sharing lessons learned as a result of the incident.
Likelihood	The possibility or probability that an incident will occur or reoccur
NPSA	The National Patient Safety Agency (NPSA) – an NHS body which supports the NHS to learn from patient safety incidents and develop solutions to prevent harm in the future. The NPSA: • Collects and analyses patient safety incident data via the NRLS • Issues information about identifies risks and solutions
NRLS	National Reporting and Learning System (NRLS) - a data base operated by the NPSA. All NHS organisations provide information about individual patient safety incidents, to enable the NPSA to analyse national incident data and support the NHS to improve patient safety.
Near-miss or **Close-Call**	An incident where an event or an omission does not develop further to cause actual harm - but did have the realistic potential to do so. These should be reported as incidents. **Near-misses** are ***free lessons*** and are as important in terms of the way we learn lessons as those events where actual harm, loss or damage has occurred. A '**near miss' incident** could be any severity grade.
Never event	Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. These are updated on an annual basis and are available on the Department of health website http://www.dh.gov.uk/health/2012/10/never-events/

Patient safety	The process by which an organisation makes patient care safer. This involves identifying, analysing and managing patient-related risks to improve and make services safer. Reporting, analysing and learning from incidents is an important part of this process.
Patient safety Incident	An incident related to patient care or treatment, which could have or did lead to harm for one or more patients receiving care from the Organisations. *National Patient Safety Agency (NPSA) definition.* Sometimes called an adverse healthcare event, a clinical error or incident.
CCG	Clinical Commissioning Group
Permanent harm	Harm directly related to the incident and not to the natural course of the patient's illness or underlying conditions; defined as permanent lessening of bodily functions, including sensory, motor, physiological or intellectual
Prolonged pain and/or prolonged psychological harm	Pain or harm that a patient has experienced, or is likely to experience, for a continuous period of 28 days.
Risk	How likely it is that the harm from one or more hazards/dangers will happen and the consequences or impact that it would have. The chance of something happening and the impact it would have.
Risk Assessment **Risk management and reduction**	A systematic way of: 1. Identifying hazards and risks 2. Deciding what harm could result, to who or what and how 3. Reviewing if these hazards/risks are adequately managed. 4. Taking action to control or limit the hazards or risks 5. Reviewing the effectiveness of the assessment and action plan 6. Recording this process
Risk Grading and the Risk Grading Matrix	Grading the severity of an incident to enable us to make informed decisions about subsequent actions and to analyse incident patterns and trends. The Organisations uses a Risk Grading Matrix to grade incident severity The grade of severity is based on the **likelihood** of something happening and the **impact** it would have if it did happen.
Risk Management	Systematically applying policies, procedures and practice (in the context of the Organisations' purpose and objectives) to: 1. Risk assess - based on identifying and evaluating hazards 2. Implement measures to control or manage the risk 3. Regularly monitor and review the risk This process can be recorded and monitored using a risk register (see Organisations' Risk Management Strategy)

Risk Reduction	Reducing the level of risk of recurrence by implementing identified actions e.g. as a result of lessons learned from an incident.
Risk Register	A risk management tool used by organisations to record, prioritise and monitor identified risks. See Risk Management Strategy.
Root Cause Analysis (RCA)	A systematic retrospective review of an incident undertaken to identify what, how, and why it happened. The analysis is then used to identify areas for change, recommendations and sustainable solutions, to help minimise the re-occurrence of the incident type in the future.
Safety Culture	A commitment to make the organisation as safe as possible for service users and staff by following policies related to risk and safety and openly reporting incidents and safety concerns.
Security incident	From April 2010 NHS Protect introduced a *Security Incident Reporting System.* This was developed to provide a clearer picture of security incidents across the health service in England, locally and nationally. This is a key step towards building a safer NHS where people and property are better protected. SIRS coincides with the extended requirements for reporting to NHS Protect. The following security incidents must be reported using SIRS: • any security incident involving physical assault of NHS staff; • non-physical assault of NHS staff (including verbal abuse, attempted assaults and harassment); • theft of or criminal damage (including burglary, arson, and vandalism) to NHS property or equipment (including equipment issued to staff); and • theft of or criminal damage to staff or patient personal property arising from these types of security incident.
Serious Incident **(SI)**	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: the unexpected or avoidable death of one or more patients, staff, visitors or members of the public; permanent harm to one or more patients, staff, visitors or members of the public, or where the outcome requires 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*, 2004, p100); 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; allegations of abuse; security incidents; adverse media coverage or public concern for the organisation or the wider NHS; or one of the core set of *Never Events*.
Severe harm	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS funded care.
Unexpected death	Where natural causes are not suspected; local organisations should investigate these to determine if the incident contributed to the unexpected death.

The Service Managers in each of the services is ultimately responsible for:

- Service user, staff and visitors health and safety
- Ensuring compliance with legal, statutory and national requirements in relation to health and safety, including effective incident management
- Ensuring that incident management processes are effective and are supporting robust safety, learning, just and open cultures within their Service areas.
- Ensuring the Partners/Directors receive relevant information regarding incidents and incident management including serious incidents.
- Incident management policies and procedures including any amendments are approved and ratified
- Implementation of this policy in their Service areas.
- The management and analysis of information and implementation of relevant learning.
- Working together with other Service Managers when necessary to address areas where a shared risk or learning action has been identified.
- Any trends or issues of concern are being analysed and investigated
- Ensuring that partner agencies and other stakeholders are informed of incidents as necessary.

Service Managers are also responsible for ensuring:

Policies, procedures and training:

- Staff are aware of this and other related policies and procedures and how to access them for reference.
- Staff access appropriate training/support for completing Incident Report Forms

Incident management:

- Incidents are managed to ensure the immediate safety and wellbeing of those involved.
- Support and information was/is offered to those affected directly or indirectly by an incident – service users, carers, visitors, staff or others.
- Witness statements are taken as required.
- All incidents and accidents are correctly recorded on Emis Web (where appropriate) in a timely manner. They are also responsible for ensuring that paper records relating to incidents are transferred and stored safely.
- All incidents are reported on the same or next working day via the Datix system. Datix will enable escalation as appropriate once the form has been completed.
- Liaise with the Health and Safety Manager regarding any member of staff who is unable to perform their normal job for more than three days as a result of an accident or incident at work.
- Liaise with the Named lead for Safeguarding Children where there is any concern about the welfare of a child.
- Follow the Vulnerable Adults procedure where the incident involves any allegation or suspicion of abuse of an adult in our care
- Liaise with information governance lead where there is a loss/ breach of person identifiable information
- Liaise with Human Resources where there are any concerns about staff capability, competence or behavior.
- Comply with external incident reporting requirements

Learning from Experience:

- Incidents in area of responsibility are investigated according to the severity of the incident, to identify what happened and why.
- Incident information is regularly reviewed and analysed to identify any patterns or trends that need to be investigated, this is done at Service Level by the Datix Approver. The Director of Quality & Assurance will review the organization Datix report monthly before noting any system issues and risks for the Governance Committee.

- Necessary actions and changes are implemented based on the findings of incident investigations and reviews
- Feedback from the review of an incident is provided to those staff involved

Staff responsibilities

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- All staff are responsible for ensuring that they have access via a personal log-in to the Datix system.
- It is your legal duty to report an incident or near miss as soon as it is reasonably practicable after the incident.
- Ensure you are familiar with this and other related policies and procedures.
- Ensure that when an incident has occurred, the immediate safety and welfare of all those involved or affected, directly and indirectly is acted upon, and that they take any necessary actions to prevent harm or further harm.
- Report all incidents immediately to the Service Managers Manager/Deputy Manager.
- Staff members should ask their manager for feedback on what happened as a result of reporting the incident
- Inform your manager of any period of sickness absence, or if you are unable to perform your normal job, for more than three days resulting from an accident or incident at work
- Follow the Safeguarding Adults procedure where the incident involves any allegation or suspicion of abuse of an adult in our care
- Liaise with the Named Lead for Safeguarding Children where there is any concern about the welfare of a child
- Ensure all breaches in confidentiality and other information governance issues are reported as incidents and that advice is sought from the Director of Quality & Assurance (who is the Caldicott Guardian).
- Volunteers, students, work experience placement etc. should report incidents to their supervisor, who is responsible for ensuring a Datix report form is completed in conjunction with the individual concerned.
- Ensure all breaches in confidentiality and other information governance issues are reported as incidents and that advice is sought from the healthcare records and information governance manager.

Managing an Incident –Immediate response

The first priority when an incident has occurred is to ensure the immediate safety and welfare of all those involved or affected, directly and indirectly, and to take any necessary actions to prevent harm or further harm.

The immediate responsibility for managing an incident falls to the most senior person on duty at the time the incident occurs, or is reported for the first time. The person managing or coordinating the response to the incident will ensure that all necessary actions are taken to make the situation safe, which may include:

- Arranging for assistance to deal with the situation e.g. sounding an alarm, calling for emergency services, asking for immediate help from another department
- Isolating or removing any risks to ensure the immediate safety of those involved, present or at risk, to prevent or minimize any injury or further injury to people.
- Providing immediate assistance to anyone injured
- Supporting any service users directly or indirectly involved.
- Considering the welfare of other service users, for example in a ward environment.
- Supporting staff who were involved
- Alerting senior managers to any serious incident

- Ensuring that service users and/or carers are provided with information about a patient safety incident (in which the service user has been harmed) as soon as possible.
- Contacting and liaising with the police if necessary.

Managing an Incident - next steps
When immediate actions necessary to manage the incident safely have been completed, there may be further actions required to ensure that the incident is effectively managed:

- Consider who needs to be informed and ensure that more people are aware of the incident as necessary
- Contact/liaise with the police as necessary
- Ensure that all potential evidence is retained intact and in safe-keeping for inspection. This may include clothing, equipment, messages and documents.
- Ensure that any potentially faulty equipment is withdrawn from use. Wherever possible it should be removed and/or locked away. If this isn't immediately possible it should be clearly labelled as unsafe and not for use
- Consider what further review, support and follow-up service users who were involved may need
- Consider what further review, support and follow-up staff may need e.g. staff going off duty may need support, advice or help

- Consider what information and support staff coming on duty may need – including staff returning to work from holiday or sickness absence
- It is not THGPCG policy to create paper healthcare records, however where these exist due to legacy arrangements these should be secured in the case of very serious incidents. Secured means removed from use and placed in a secure place where they cannot be tampered with or amended.

These responsibilities may be addressed by the person managing the incident, or passed to the Service Manager. When these have been addressed the incident should be formally recorded on using the Datix system.

Communication following incident

Communication with staff is key throughout the process and needs to take place both pre and post investigation. The manager is responsible for ensuring staff get support in line with Being Open and Supporting Staff policies. When investigations take place staff have the opportunity to read and agree notes taken in the meeting and factual accuracy check of draft reports.

TOWER HAMLETS GP CARE GROUP CIC

LOCAL PEOPLE. LOCAL HEALTH

SIGNIFICANT/CRITICAL EVENT TOOLKIT

INTRODUCTION

THGPCG aims to:

- foster an open and fair culture committed to learning
- ensure that lessons are learned as part of the Organisations's commitment to maintaining high quality services and supporting staff
- formalise roles and responsibilities to ensure that critical events are managed effectively and appropriately
- ensure the provision of feedback to all staff

The purpose of this toolkit is to provide staff with a procedure to follow in the recording and the review of Significant/Critical Events.

Definition of an Event

There is no single definition of a Significant Event. Service Managers acting prudently should record any incident or situation sufficiently out of the ordinary to warrant a permanent record, and perhaps with the potential to prompt action learning or change. Events may be adverse, or may be commendable incidents, and both require a record, a review, and appropriate acknowledgement.

Examples of significant or critical events

- Any incident that gives rise to actual or possible physical injury or patient dissatisfaction. This includes adverse clinical events.
- An injury sustained by a member of staff during the course of work or sustained as a result of an act of violence upon a person at work.
- Any near miss i.e. an incident which if it did not cause harm could do so if it happened again.
- Medication errors/issues
- Death on the premises
- New cancer diagnoses
- Deaths where terminal care has taken place at home
- Suicides
- Mental Health Act admissions
- Child protection cases
- Inaccurate or incomplete medical records

- Delayed or missed diagnosis
- Referral difficulties
- Failure in message handling
- Events which have resulted in a complaint
- Health and Safety issues or incidents
- Emergency situations involving patients or members of the public

Objectives of significant/critical event reporting

- To record adverse incidents effecting, or with the potential to effect patients or staff.
- To record "near misses" so that steps may be taken to prevent a recurrence.
- To learn from the event as a team, discuss, and put change or procedures in place to improve.
- To commend and acknowledge good practice.
- To provide a permanent record of events and evidence of remedial steps taken.
- To satisfy the requirements of QOF and nationally required incident reporting standards.
- To operate and discuss incidents in an open environment and within the safety of a "blame-free culture"

Recording of the event

It is the responsibility of all staff (including doctors, clinical and administrative staff, both temporary and permanent) to report significant/critical events.

Every person with a significant part in, or witnessing an incident should each complete a Datix report form independently and without conferring as soon as possible after the incident. This will ensure that each account of the proceedings is, as far as possible, as accurate as it can be and without the influence of a third party. Each statement will form part of the incident record. Event record forms are disclosable if legal proceedings follow and should not be stored or recorded in the patient's record.

Notes on completing report forms:
Each person involved in, or witness to, the event will complete a Report Form to record:
Date / time: The time of the incident may be a critical part of the record (e.g. in the case of a communication failure).

Brief description: This is the witness or staff statement of the events from their own perspective. This may disagree or conflict with other accounts of the event, and this is in order. No attempt should be made to influence a change to the statement although a written note of any points clarified may be made.

Where, during the course of the investigation or discussion of a Significant Event, it becomes apparent that further open discussion is not appropriate to the circumstances surrounding the incident; the matter will be reserved for individual action and investigation. It is envisaged that this will apply in exceptional circumstances only.

An event review meeting the following will be arranged after the sign off from the Datix approver has been completed:

Key risk issues:
The main elements of the incident will be identified - this will assist in the formulation of specific action points to address each of the risk areas (including actions to prevent recurrence). Also record actions which were taken during the event which were successful/satisfactory

Specific action required/Learning outcomes
Specific measurable action points should be agreed within a meeting of the clinical / management team, and documented to address the specific risk issues recorded within the form. The action points should be allocated to an individual to oversee and should be time-bound

Timescales and responsibilities
Record details of who is responsible for each action and the date by which it is to be completed

Review of actions
This will be carried out at a meeting of the clinical / management team at a later stage in the process when all action points have been completed. The review will focus on the causes of the incident (good or bad) and will focus on the adequacy of the response and the continuity of the learning points (again good or bad) which have arisen.

The meetings at which the events were discussed should be separately minuted and a detailed account of the discussion surrounding the event itself should be made within the body of the minutes which will be stored in the Datix system. These meetings may be multi-disciplinary.

The fully completed event forms, extracts of the minutes of the meetings, and perhaps a summary report can then form a complete file which can be examined by CQC inspectors if required via the Datix system.

Appraisal
Appraisal has a number of components and part of this is the presentation of evidence of a robust system of audit, significant event reporting and clinical risk assessment. One of the keys to this is the ability to demonstrate reflective practice – that issues have been identified, acted upon, and that resulting change has been successful. To this end it is recommended that an annual review of all significant events takes place where the various learning points and actions taken can be audited, validated and recorded, and the records of these can feed into the appraisal process.

It is likely that events arise from clinical, administrative and other areas of the business, and the validation and audit discussions may involve nursing, reception or other staff effected by either the original incident or by the subsequent changes. The effectiveness of the changes can then be evaluated.