Livewell Southwest

Incident Reporting and Investigation Policy

Version No 3.7

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Corporate Risk and Compliance Team**

Asset Number: **49**

Reader Information

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	• Management of Health and Safety at Work Regulations, 1999 • NPSA improving patient safety • Health and Safety Executive http://www.hse.gov.uk/ • Investigating Accidents and Incidents http://www.hse.gov.uk/managing/delivering/check/investigating-accidents-incidents.htm
Associated documentation	• Risk Management Strategy (including Risk Assessment Process) • Health and Safety Policy • Incident Reporting & Investigation Policy and Procedure • Sickness Policy • Serious Incident Requiring Investigation Policy • **Immediate Notification of Serious Incident & 72hr report** commonly known as Appendix A. • Whistle-blowing Policy • Bullying and Harassment Policy • Equality and Diversity Policy • HSG65 – Managing for Health and Safety • Six Steps to Root Cause Analysis – Maria Dineen
Supersedes document	Incident Reporting & Investigation Policy and Procedure V3.6
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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
For previous review history please contact the PRG secretary.				
V3:0	Full review	Jan 2011	A Wadley	Comprehensively updated to reflect NHSLA, NPSA and NHS Plymouth standards.
V3.1	Extended	March 2013	A Wadley	Extended no other changes
V3.2	Extended	August 2013	K Spencer	Extended no other changes
V3.3	Extended	Dec 2013	K Spencer	Extended no other changes
V3.4	Extended	June 2014	K Spencer	Extended no other changes
V3.5	Extended	December 2014	K Spencer	Extended no other changes
V3.6	Reviewed	January 2016	S Adams	Major review
V.3.7	Amended	May 2016	S Adams	Amendments following PRG Meeting April 2016

Incident Reporting and Investigation Policy

1 Introduction

1.1 Livewell Southwest has a responsibility to identify, record and control, so far as is reasonably practicable, any hazards and associated risks within the organisation. This policy describes the process for the reporting, investigation and management of incidents, accidents and near misses to ensure compliance with statutory and regulatory requirements.

1.2 The reporting of incidents will allow the organisation to learn from and improve the health, safety and wellbeing of all staff, contractors, visitors and people accessing services promoting a positive Health and Safety culture throughout Livewell Southwest.

Statement of Policy

1.3.1 Livewell Southwest has a responsibility to respond at an appropriate and proportionate level to any incident that occurs within the organisation. This policy details how to report and investigate all incidents and near-misses, whether clinical or non-clinical. It applies to all incidents whether it involves a person(s), premises, property, assets, information or any other aspect of the organisation.

1.3.2 This policy describes what processes need to be undertaken including timescales required for incident identification, investigation and reporting purposes. It describes how to report and who is responsible within the incident reporting and investigation process.

2 Purpose

2.1 The purpose of this policy is to detail arrangements on how to report incidents, investigate and identify trends including reporting arrangements to ensure that Livewell Southwest can demonstrate that they have addressed any Health, Safety and Wellbeing risks and ensure that there is a positive reporting culture across the organisation.

3 Definitions

3.1 **Accident** - an unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury. Incidents can be minor, major, severe or in some circumstances fatal.

3.2 **Incident** – is any unintended or unexpected event which could have or did lead to harm. Incidents include hazards (anything which has the potential to cause injury, illness or harm), accidents (direct results of unsafe activities or conditions), near misses, dangerous occurrences and significant events. Examples of incidents include:

a) Any event that resulted in an adverse effect (however minor) on a person(s);
b) Failure of equipment, whether or not injury occurs;
c) Serious damage to the estate (e.g. buildings);
d) Serious damage / loss / theft of assets / data protection breach (e.g. equipment);

e) Damage to personal property;
f) Loss / theft of personal property;
g) Fire;
h) Violence;
i) Breaches of security;
j) Lost records;
k) Illegal acts;

3.3 **Near Miss** – is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.

3.4 **Serious Incidents Requiring Investigation (SIRI)** – defined as an incident that has occurred in relation to NHS-funded services and care resulting in further investigation. Any SIRI has to be reported as an incident but also on an **Immediate Notification of Serious Incident & 72hr report** commonly known as Appendix A. Please refer to Serious Incidents Requiring Investigation (SIRI) Policy for further information.

4 Duties & Responsibilities

4.1 All staff have a responsibility to identify risks, report incidents and participate in investigations and implement subsequent changes identified. In addition there are some specific duties commensurate with their roles and responsibilities.

4.2 The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

4.2.1 The general responsibilities of the **Board and Chief Executive** are described in Livewell Southwest Health and Safety Policy.

4.3 The **Director of Professional Practice, Safety and Quality** has corporate responsibility for Health and Safety Management and, therefore, takes specific responsibility for:

4.3.1 Advising the Board on the review of existing policy arrangements.

4.3.2 Advising the Board on the allocation of resources to implement health and safety procedures.

4.3.3 Referring matters of a critical nature to the Board for resolution via the SIRI process, Incident Grading and Investigation Process and the Corporate Risk Register.

4.3.4 Ensuring adequate safety arrangements exist within Livewell Southwest.

4.4 The **Head of Corporate Risk and Compliance** is responsible for:

4.4.1 Specialist Health and Safety advisory and co-ordinating functions which reach across all levels of management. It includes direct access to the Chief Executive and the Board.

4.4.2 Ensuring that incident reports received are analysed in order to identify trends and make recommendations, sharing lessons learned from incidents reported, based on

the collation of information therein and will submit relevant reports to the appropriate committees as standing agenda items.

4.4.3 Developing, implementing and monitoring the systems and processes for reporting, investigation and management of all incidents

4.4.4 Ensuring that appropriate reports are made to external enforcing and other statutory agencies.

4.4.5 Ensuring that incident data is included in the internal and external assurance frameworks.

4.4.6 Ensure that outstanding incident action plans are monitored at Risk Moderation and Monitoring Group (RMMG).

4.5 The **Health and Safety Competent Advisor** is responsible for:

4.5.1 Providing an expert advisory service to Livewell Southwest in matters of health and safety.

4.5.2 Providing a co-ordinating service for health and safety matters to all levels of management.

4.5.3 Following up any incident with the potential for a civil claim.

4.6 The **Senior Service Managers and Service Managers** are responsible and accountable for:

4.6.1 Ensuring that all incidents, accidents or near misses that occur within their services are reported.

4.6.2 Ensuring that immediate action is taken where there is direct risk to a person's health, safety and welfare including reporting to external agencies such as Police, Devon and Somerset Fire and Rescue, SWAST in emergency situations.

4.6.3 Assessment, triage and investigate proportionally, all incidents/accidents/near miss reports according to the level of risk identified and through root cause analysis identify trends to ascertain immediate or underlying causes.

4.6.4 Providing appropriate support for employees involved in incidents/accidents and/or their investigation, which may include referral to Occupational Health and Wellbeing.

4.6.5 Ensuring that incident action plans following investigation are completed where appropriate and monitored at Service business meetings.

4.6.5 Monitoring and reviewing all incidents, accidents and near misses and subsequent action plans to ensure that appropriate risk assessments are undertaken with controls and actions identified.

4.6.6 Ensuring the implementation of the Incident Reporting and Investigation Policy with assurance that staff are trained on how to complete incident reports on the online incident reporting (Safeguard) system, investigate incidents and escalation

procedures.

4.6.7 Based on size of the team nominate additional members to attend Risk Assessor Training and support Manager.

4.6.8 Informing the Corporate Risk and Compliance Team of any changes to the team so that the reporting structure can be changed on the Safeguard system.

4.7 The **Local Health and Safety Risk Assessors** will be responsible for:

4.7.1 Reporting any incidents, accidents and near misses.

4.7.2 Taking appropriate action in the event of an incident/accident or near miss.

4.7.3 Ensuring that the local risk register is populated following investigation with appropriate risk assessments including controls and actions.

4.7.4 Attending any investigations if requested to do so.

4.8. **Information Governance (IG) Incidents**

4.8.1 All incidents will be reviewed by IG Lead or SIRO (Senior Information Risk Owner).

4.8.2 Serious IG Incidents requiring Investigation will follow the process outlined in Information Governance Serious Incident Requiring Investigation (SIRI) Policy and Procedure. V1.

4.8.3 For serious IG incidents requiring investigation, the IG Lead or SIRO should be informed within 24 hours of awareness of the incident.

4.9 All **Employees** are responsible for:

4.9.1 Correctly reporting and completing incidents/accidents and near misses on the online incident reporting (Safeguard) system. When reporting staff must ensure that:

a) Fact only is recorded – opinions or hearsay must not be expressed.
b) **All** relevant sections are completed, including grading the actual impact caused by the incident.
c) Unexpected death or serious injury (death/severe incidents) must be reported on the online incident reporting (Safeguard) system in addition to staff completing **Immediate Notification of Serious Incident & 72hr report** commonly known as Appendix A.

4.9.2 Taking appropriate action in the event of an incident/accident or near miss.

4.9.3 Providing reports as part of the investigation process.

4.10 The **Communications Team** are responsible for:

4.10.1 Managing all media enquiries relating to incidents. Senior Service Managers/Service Managers must inform the On-Call Director (via Mount Gould Switchboard on 0845 155 8100).

4.11 The **Local Security Management Specialist (LSMS)** is responsible for:

4.11.1 Investigating security incidents, including physical and non-physical assaults, and breaches in a fair, objective and professional manner so that appropriate sanctions can be applied and preventative action considered and implemented where necessary.

5 Process for Reporting Incidents

5.1 Incident / Accident / Near Miss Report Form

5.1.1 Completing the Incident Form

a) Support in completing and managing the incident form can be found on the intranet under forms entitled "Guidance on Entering an Incident on Safeguard eForm"

b) To access incident reporting system go onto the intranet and click onto Incident Reporting, Risk Register and Assets (Safeguard) link using the same ID and password that you use to log onto the computer.

c) Complete the **New Incident** report form within **24 hours** or as quickly as possible after the event. Where further information is required the incident may be saved for later.

d) The form is then escalated to the completer's line manager. The manager will assess the incident, re-grade if appropriate, counter-sign and enter any management actions required or already implemented **within 72 hours** or sooner if possible. Appendix G - The incident notification chart depicts who in addition to the manager are informed of any incidents reported.

e) If further investigation is required the incident form may be put 'under review' until actions are completed.

5.2. Process for Raising Concerns

5.2.1 Whilst Livewell Southwest is clear that all incidents must be reported in line with this policy, it fully supports a culture of safety and openness, therefore, staff may also raise matters of concern (where appropriate) through Livewell Southwest's Whistle-blowing Policy, Bullying and Harassment Policy, Equality and Diversity Policy and through other agencies such as NHS Protect.

5.2.2 Staff reporting and involved in incidents are assured that any investigations will be carried out fairly, without prejudice and with the aim of identifying and correcting underlying causes to prevent recurrence.

5.2.3 Staff will not be subject to disciplinary action or suffer any material loss or disadvantage unless they have been negligent in their acts or omissions or willfully failed to comply with professional standards and codes of practice. Managers should be mindful of the needs of the individuals concerned, which may need support and / or

counseling, to help them through difficult situations. Managers must ensure staff support is put in place, where necessary and in consultation with the individuals concerned, at the start of any investigation.

6 Immediate Actions

6.1 **General incidents** - the immediate responsibility for managing an incident falls to the most senior person on duty at the time the incident occurs. It is the responsibility of that person on duty to:

a) Make the situation safe (contact emergencies services if appropriate). In the event of an issue with the estate also contact Estates Helpdesk on 435100 or PCHCIC.EstatesHelpdesk@nhs.net.

b) Provide or arrange any first aid or medical care as needed.

c) Inform the patient / person affected of the incident if he/she is not already aware.

d) Decide who else needs to know for example a relative, carer (taking into account issues of confidentiality).

e) Where police have been involved ensure you enter any Police Log Number on the incident report form.

f) If unable to inform people who need to know, ensure appropriate person(s) are delegated to inform people who need to know.

f) Complete incident form on Intranet under Incident Reporting, Risk Register and Assets (Safeguard) link.

6.2 Where accidents / incidents occur due to defects and failures in Livewell Southwest Estates and Facilities, the area should be made safe/cordoned off, preserving any evidence of defects or failures wherever possible. The Corporate Risk and Compliance Team should be informed as soon as possible and the incident report form is to be completed.

6.4 Some accidents at work constitute a RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) and consequently require reporting to the Health & Safety Executive (HSE) by the Corporate Risk and Compliance Team. The following **work-related** incidents/accidents are RIDDOR reportable:

a. The death of a person
b. Specified injuries to workers (such as amputations, serious burns).
c. Over seven day incapacitation of a worker.
d. Non-fatal accidents to non-worker (e.g. members of the public) where the person is taken directly from the scene of the accident to hospital for treatment to that injury. Occupational Diseases (such as occupational cancer, hand arm vibration syndrome).
e. Dangerous occurrences - specified near-misses (such as the collapse, overturning or failure of load-bearing parts of lifts and lifting equipment).
f. Gas Incidents.

6.5 **Medical Devices and Community Equipment Incidents** – the relevant manager is required to take equipment out of use immediately. The relevant manager is required to fill out an incident form and **must** ensure that the Corporate Risk and Compliance Team are notified of the defective equipment to enable them to report this incident directly to the Medicines and Healthcare Products Regulatory Agency (MHRA).

6.6 The Corporate Risk and Compliance Team will ensure any incident / accident requiring specialist investigation, i.e. radiation, fire, pharmacy, asbestos will be forwarded to the relevant Responsible Person for appropriate involvement in the investigation.

6.7 Some information governance incidents need to be reported to the ICO, HSCIC and Commissioners via the Incident Reporting Tool on the Information Governance Toolkit. This will be managed by the Information Governance Lead and SIRO in line with the Information Governance Serious Incident Requiring Investigation (SIRI) Policy and Procedure. V1

7 Determining Level of Grading

7.1 Livewell Southwest grades its incidents using the following criteria:

7.1.1 **Death** – any incident that directly result in the death of one or more persons.

7.1.2 **Severe** – any incident that appears to have resulted in permanent or long term harm to one or more persons where the outcome requires lifesaving intervention, major medical /surgical intervention, will shorten life expectancy, result in prolonged pain or physiological harm or where there is a risk of enforcement action, national media coverage, risk of claims, business interruption resulting in non-compliance with standards or service delivery.

7.1.3 **Moderate** – any incident that caused short term harm requiring further treatment or procedure to one or more persons or where there is risk of enforcement action, local media coverage, risk of claims, business interruption impacting standards and/or service delivery.

7.1.4 **Low** – any incident that required extra observation, minor treatment or caused minimal harm, to one or more persons or where there is risk of enforcement action, short term local media coverage, risk of claims, business interruption resulting in the reduction of standards or service delivery

7.1.5 **No harm**:

a) Impact prevented – any incident that had the potential to cause harm but was prevented, resulting in no harm to people;
b) Impact not prevented – any incident that ran to completion but no harm occurred to people.

7.1.6 **Near miss -** is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.

7.2 **Information governance** has a separate level of grading in line with the HSCIC recommendations and requirements of the Information Governance Toolkit. These incidents will be graded by the Information Governance Lead or SIRO in line with

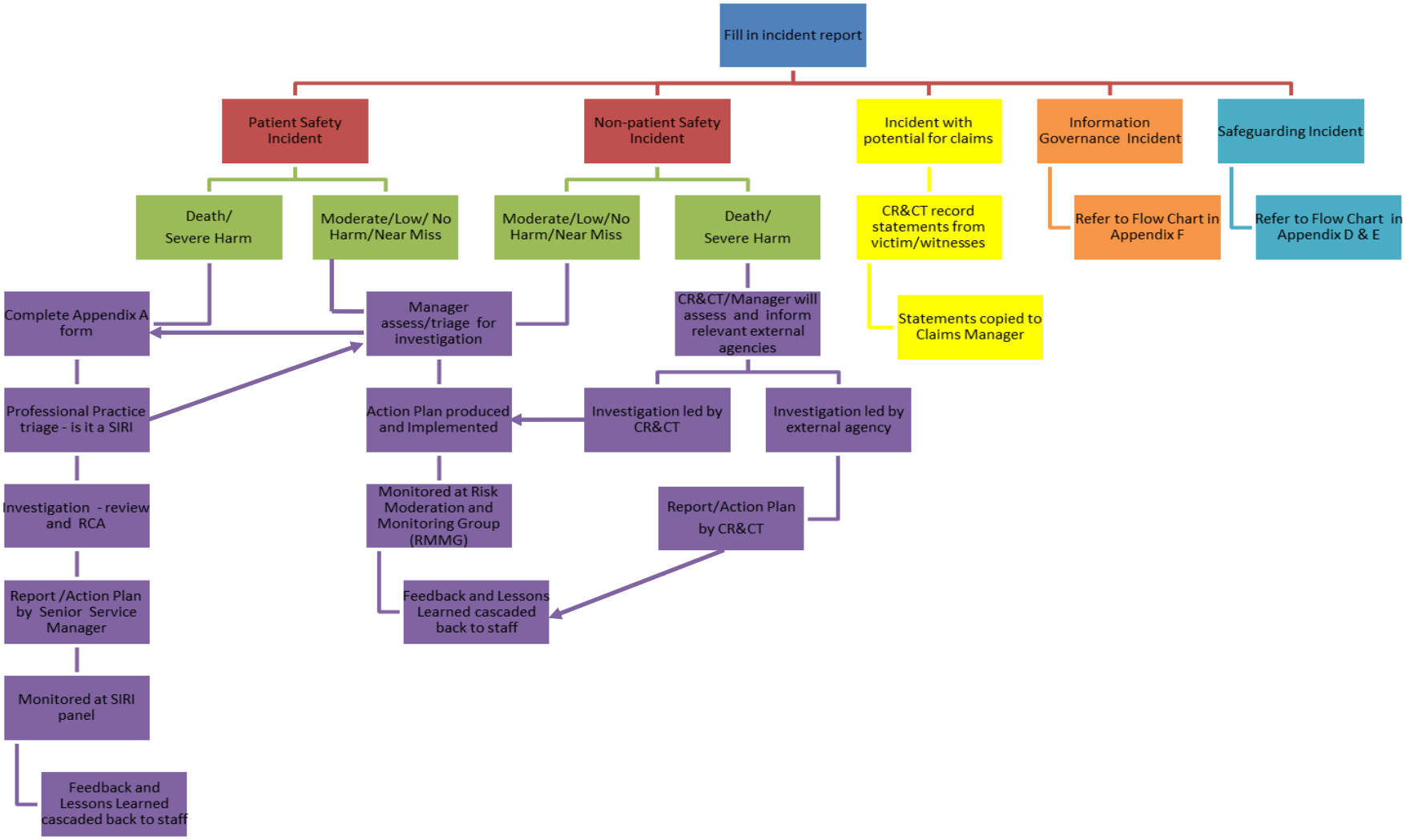
Information Governance Serious Incident Requiring Investigation (SIRI) Policy and Procedure. V.1

7.3 There are 5 levels attributed to incident investigations:

- L1 - All incidents
- L2 - Moderate/Severe/Death (non-SIRI)
- L3 - Information Governance (separate policy) see Appendix D for process.
- L4 - SIRI Investigation (separate policy)
- L5 – Safeguarding Adult/Children Investigation (separate policies) see Appendix E and F for process.

8 Investigation Process

8.1 In the event of an incident the following flow chart should be used to determine the appropriate routes of investigation:



8.2 Why Investigate?

8.2.1 Investigations form an essential part of the monitoring processes and can inform organisations of any breaches of health, safety and welfare issues and legal compliance. The primary purpose for investigating an incident is to ascertain:

- What happened?
- How did it happen?
- Why did it happen?

so that the appropriate recommendations can be made and actions implemented to prevent future occurrence, or at the very least, mitigate the impact of the event.

8.2.2 By investigating an incident Livewell Southwest is able to take remedial actions and identify trends to prevent further occurrences and demonstrate a positive attitude to health and safety.

8.2.3 Investigation findings will help identify what existing controls have failed, identify additional control measures required, improve the management of risk in the future, learn lessons and examine all causes of workplace incidents, accidents and near misses.

8.2.3 Investigation findings will provide essential information for insurers in the event of a claim and will assist Livewell Southwest in determining the true cost of incidents.

8.3 Incident Investigation Guidance for Managers

8.3.1 The manager must be proportionate in their investigation which will depend on the level of incident and the actions that are required.

The following levels are advised:

- L1 - For all low harm / no harm / near miss incidents a proportionate investigation should be undertaken by the Manager and complete the 'Please describe what actions have been taken' box and for any further actions required complete the 'action plan' section of the Managers' form on the incident reporting (Safeguard) system (see Appendix A - Investigation Process for Managers)

- L2 - For all moderate / severe / death incidents Managers are required to complete the 'RCA' process of the incident reporting (Safeguard) system if the incident is not classed as a SIRI (see Appendix B - Investigation Process for Managers – Root Cause Analysis (RCA) process)

- L3 - For SIRI's Managers are advised to refer to the Serious Incidents Requiring Investigation Policy and are required to complete the **Immediate Notification of Serious Incident & 72hr report** commonly known as Appendix A.

- L4 - For Information Governance incidents Managers are required to complete the IG Incident Reporting Tool see process in Appendix D.

- L5 – For Safeguarding Adult/Children complete the incident report and follow processes in Appendix E and F.

8.3.2 **Lesson Learned/Sharing of Information**

The level of incident will dictate the information sharing from lessons learned as a result of the investigation process. For all incidents the following information sharing process should be undertaken:

1. Manager to speak with individual concerned and brief them on the outcome of the investigation.

2. Where the team manager feels that the team could benefit from the investigation outcomes then the lessons learned need to be shared with the team in a team briefing/meeting.

3. Where team manager feels that the learning from the incident could benefit other teams within the locality this information should be shared with Senior Service Manager/Service Manager so that they can disseminate information in the Business/Performance Meetings.

4. Where Senior Service Manager/Service Manager consider the lessons learned should be shared across services this should be shared in the Locality Business Meeting so the information can be disseminated accordingly.

5. Where lessons learned from an incident need to be highlighted and discussed with external agencies, such as Commissioners, Executive Directors will agree a plan on how to share this information.

8.3.3 The Corporate Risk and Compliance Team oversee all incidents, where an incident is considered to need escalating prior to the completion of the investigation process they will ensure that this is disseminated to the Executive Team/Board who will agree a plan on how to share this information across the Organisation.

9. **Duty of Candour**

9.1 The Duty of Candour Regulation ensures that health and social care providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment, staff and any other relevant persons. Livewell Southwest has to report on whether Duty of Candour was applied to any incident and therefore must be considered as part of the investigation process.

9.2 Duty of Candour must be applied to any incident where there is a level of harm or distress to the individual or people acting lawfully on their behalf.

9.3 Appendix C describes to Duty of Candour process for managers to complete during the managing incident process.

10 Training

10.1 Incident Investigation Training for managers is available through Professional Training and Development, provided by the Corporate Risk and Compliance Team.

10.2 Risk Assessor Training is available through Professional Training and Development,

provided by the Corporate Risk and Compliance Team.

10.3 Additional support is available by contacting the Corporate Risk and Compliance Team.

11 Reporting to External Agencies

11.1 Reporting to the following agencies are carried out centrally by the Corporate Risk and Compliance Team:

a) Health & Safety Executive
b) Care Quality Commission
c) National Patient Safety Agency
d) Clinical Commissioning Group
e) Specialist Commissioning Group
f) Plymouth City Council
g) Devon and Somerset Fire and Rescue Service
h) Environment Agency
i) Department of Health
j) MHRA
k) Coroner
l) Police

12 Monitoring Compliance and Lessons Learned

12.1 The Corporate Risk and Compliance Team will undertake an annual review of risk, health, safety and security management processes.

12.2 Managers can request scheduled incident reports.

12.3 The Health, Safety & Security Committee will monitor all incidents by:

- Reviewing all incidents, identify trends; agree corrective actions and dissemination of lessons learned across Livewell Southwest through meetings, different media such as posters/intranet etc.
- To develop and monitor the Risk Management Strategy in line with incidents.
- Assess the extent of compliance with health, safety and security management arrangements in line with incidents
- To ensure that health, safety and security risk issues are dealt with and escalated through the approved process.
- Learning and feedback from incident investigations will be disseminated through this forum and any exceptional issues will be escalated to SQP.

12.4 The Risk Moderation and Monitoring Group (RMMG) will monitor incident action plans generated from the Manager's form and RCA process.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

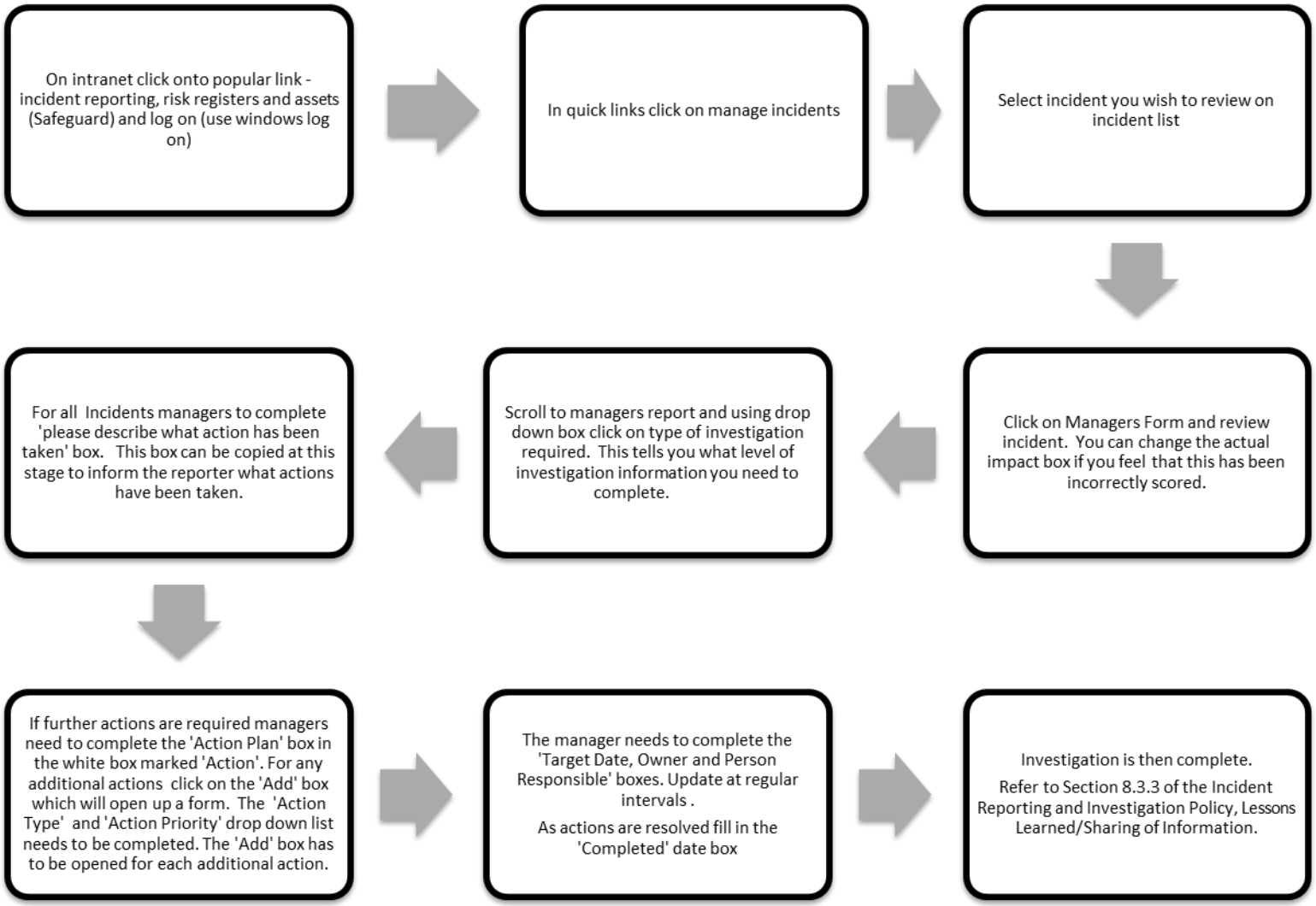
The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

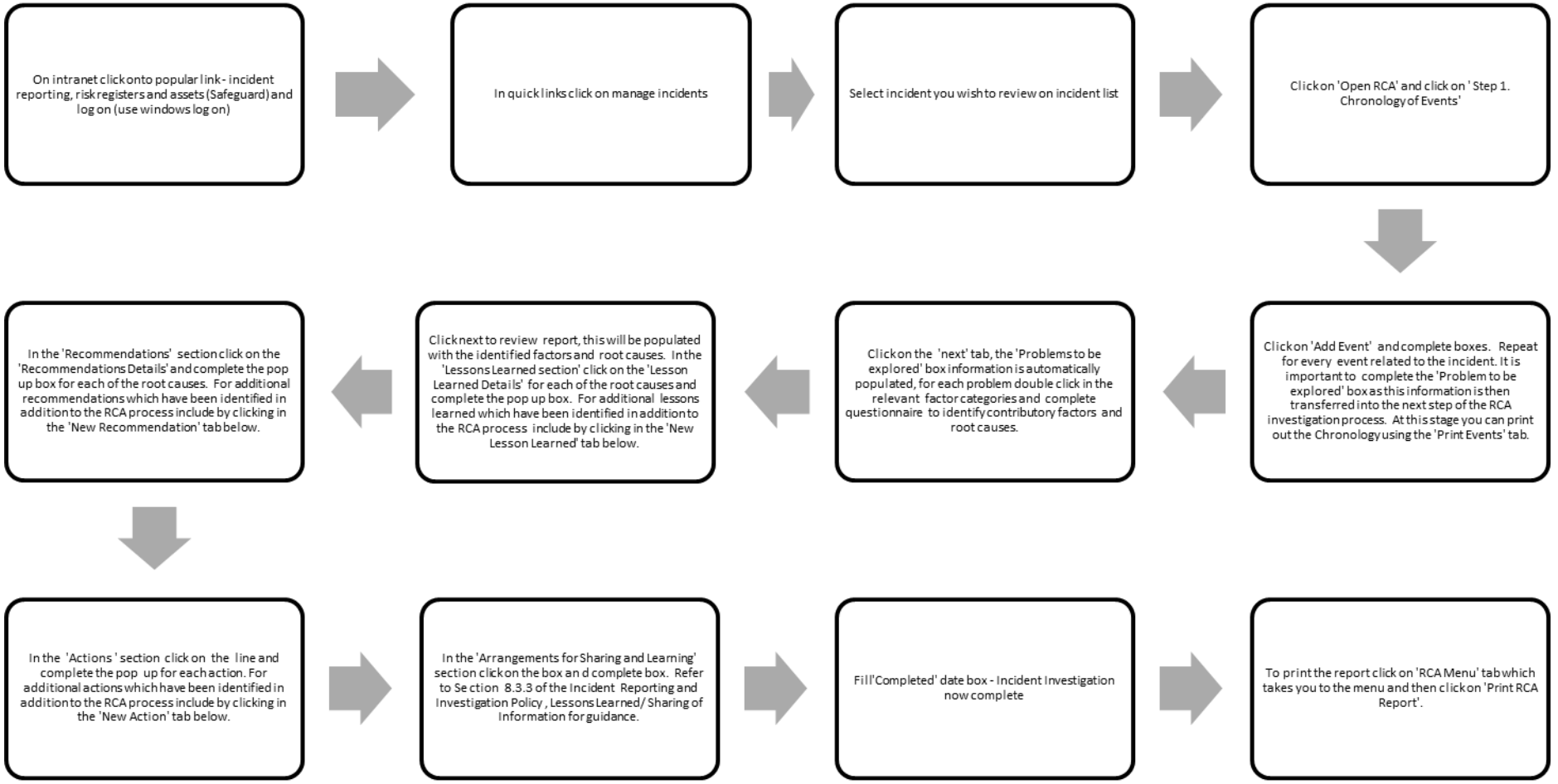
Signed: Director of Professional Practice, Safety and Quality

Date: 19th May 2016

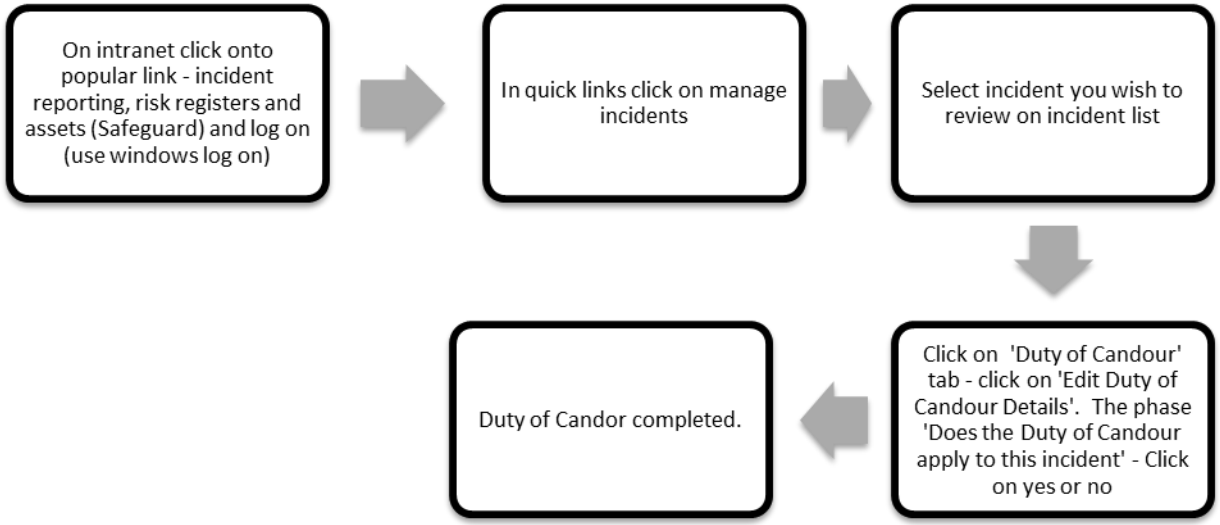
Appendix A - Investigation Process for Managers – Action Plan Process



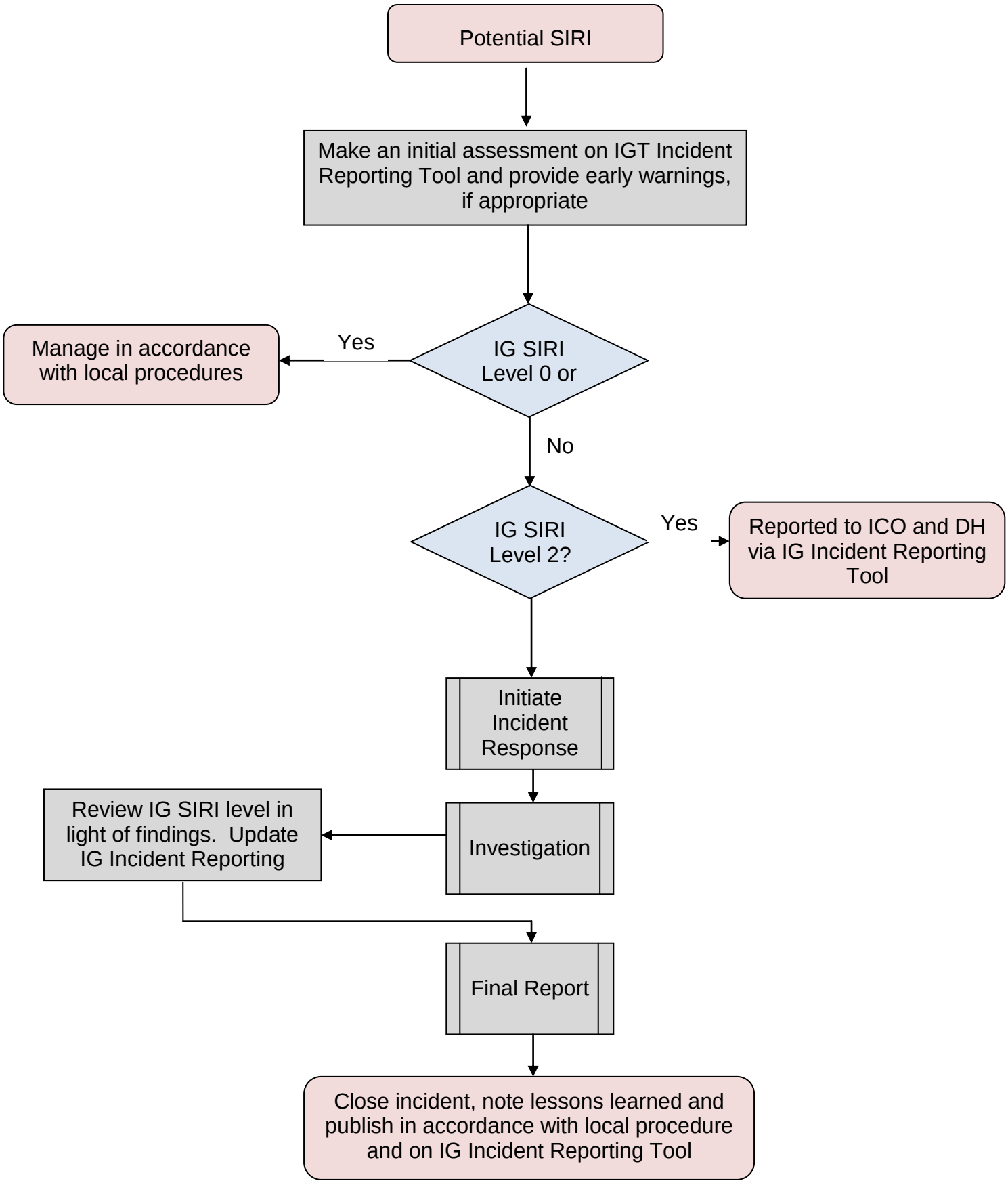
Appendix B - Investigation Process for Managers – Root Cause Analysis (RCA) Process



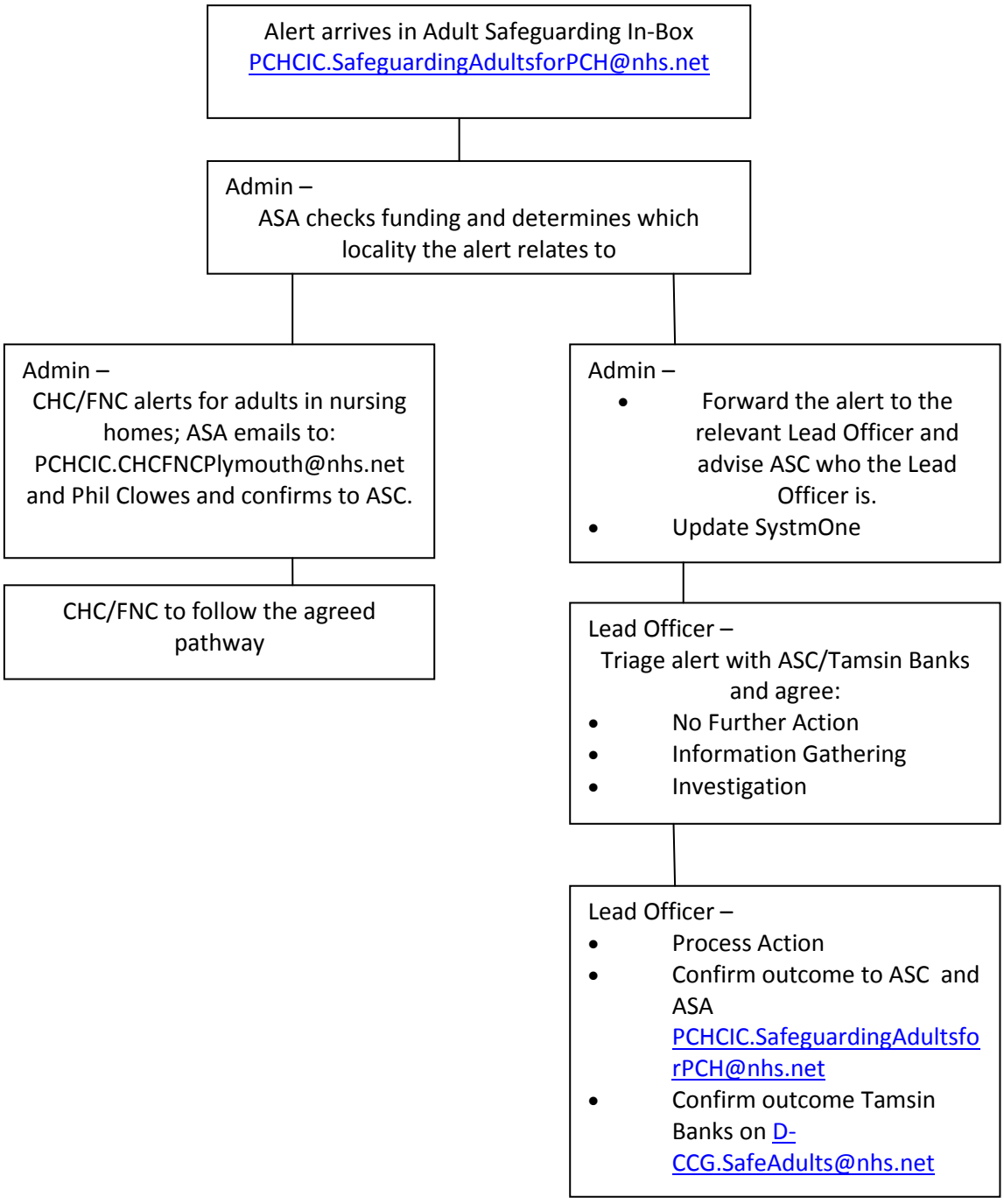
Appendix C – Investigation Process for Managers – Duty of Candour



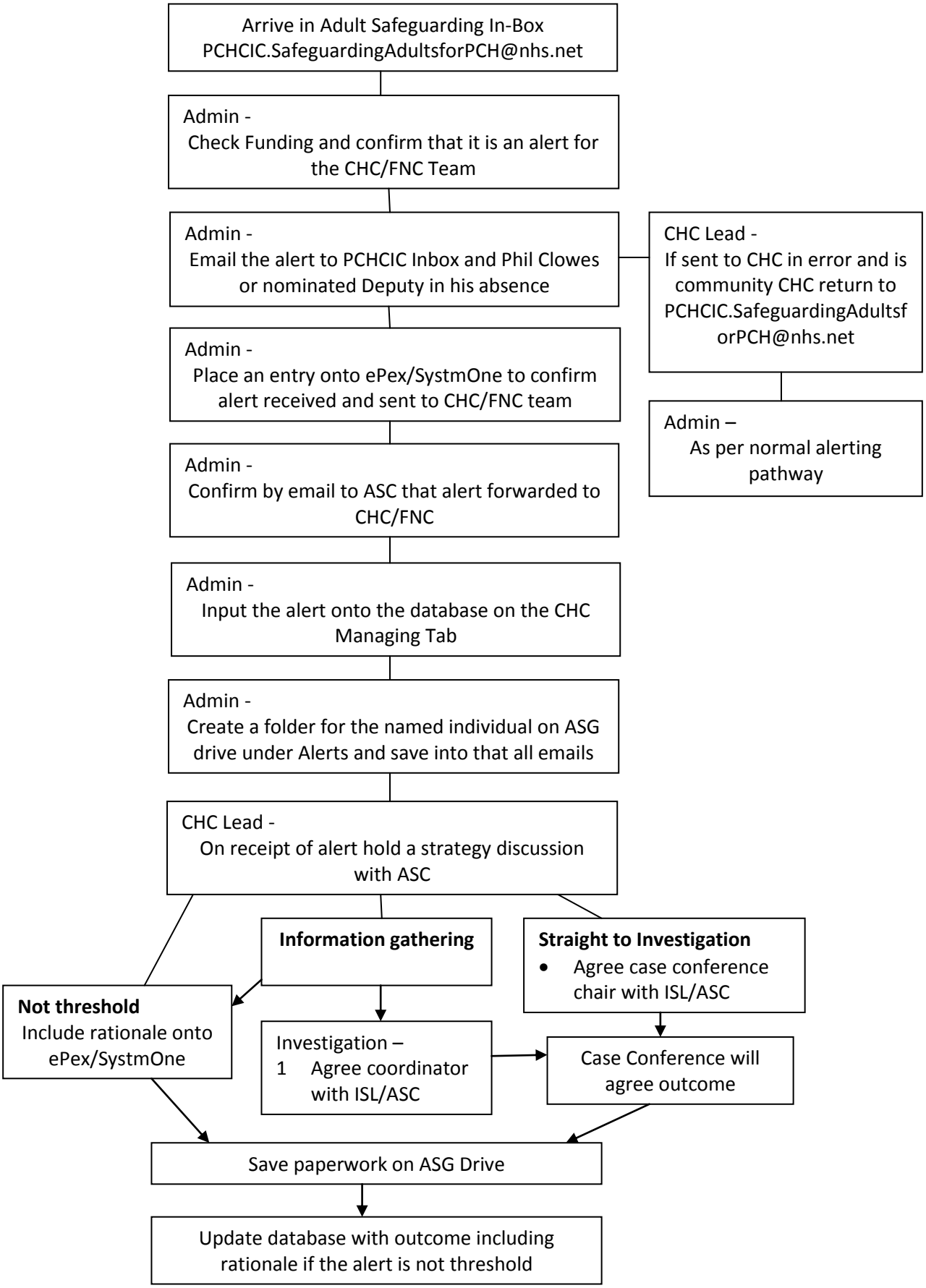
Appendix D - IG SIRI High Level Process



Appendix 4 - Adult Safeguarding Alerts Pathway



Appendix 5 - CHC/FNC Team Alerts Pathway



Appendix G – Incident Notification Flow Chart