Lincolnshire Community Health Services NHS Trust

Incident Reporting Policy and Procedure

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Lincolnshire Community Health Services NHS Trust

Version Control Sheet

Incident Reporting Policy

Version	Section/Para/ Annex	Version/Description of Amendments	Date	Author/Amended by
1		New Document		
2	Entire Document	Full review and update	January 2012	D Bainbridge
3	Entire Document	Full review – updates to reflect current organisational structure and arrangements for incident reporting, new process of Flash Alerting and inclusion of flash alert form	July 2014	D Bainbridge
4	Entire Document	Full review – updates to reflect current organisational structure and investigation procedures	April 2016	K Rossington/Jo Gooch
5	5.2	Removal of Datix as the recording of the Risk Register	June 2018	K Rossington/Jo Gooch
6	7.5	Removal of SIRS	June 2018	K Rossington/Jo Gooch
7	12	Updated Committee structure	June 2018	K Rossington/Jo Gooch
8	Appendix 5	Updated Committee structure	June 2018	K Rossington/Jo Gooch
9	Appendix 6	Amended Grading in line with datix	June 2018	K Rossington/Jo Gooch
10	Appendix 10	Addition of Pressure Ulcer investigation Standard Operating Procedure	July 2018	K Rossington/Jo Gooch
11	Appendix 11	Pressure Ulcer Reporting instructions	July 2018	K Rossington/Jo Gooch
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Incident Reporting Policy and Procedure

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Policy Statement

Background

This policy is consistent with guidance issued by the Department of Health in June 2000 entitled *An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS,* which drew attention to the scale of potentially avoidable events within the NHS and *Building a safer NHS for Patients published in April 2001*, which sets out the Government's plans for promoting patient safety.

'Doing Less Harm', (NPSA 2001) provided a framework for incident reporting which has underpinned the development of systems and processes in the Lincolnshire Community Health Services NHS Trust.

Statement

The organisation accepts that things may go wrong and incidents will occur. When this happens, the organisation will respond quickly and positively to ensure the wellbeing of patients, staff and the public. We shall investigate incidents to ensure that we learn the lessons and hence improve the quality of our services and promote a safer environment for all.

All staff have a role to play in identifying and minimising all kinds of risks. The organisation is committed to promoting an open and fair culture where staff feel able to report incidents or near misses and learn from mistakes without fear of recrimination.

Responsibilities

All staff have a responsibility to report near misses, adverse incidents and serious incidents, to ensure that the Lincolnshire Community Health Services NHS Trust Risk Management Strategy is effective and that all statutory reporting requirements are met.

Any member of staff who is involved in an incident or near miss must complete a Datix Incident Report Form (IR1) immediately (i.e. within one working day) for each relevant incident according to the attached procedure.

Managers must ensure that they, and the staff for whom they are responsible, are fully aware of the Lincolnshire Community Health Services NHS Trust Incident Reporting Policy and that access to Datix incident reporting forms are readily available to all employees at all times.

Training

All new members of staff will be introduced to the principles of risk management, including incident reporting procedures and serious incident reporting, during the Lincolnshire Community Health Services NHS Trust Induction programme.

All staff will also receive an annual update on incident reporting through mandatory training.

The organisation will identify an appropriate interval for training updates. Thereafter it is the responsibility of the staff member to identify their training needs on an ongoing basis, including the need for training updates.

Dissemination

The policy will be disseminated to all staff via Team Brief and be available on the Lincolnshire Community Health Services NHS Trust website.

Resource Implications

The successful implementation of incident reporting requires robust staff training and access to appropriate information systems and analytical tools.

A) POLICY

1. BACKGROUND

This policy is consistent with guidance issued by the Department of Health in June 2000 entitled *An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS,* which drew attention to the scale of potentially avoidable events within the NHS and *Building a safer NHS for Patients published in April 2001*, which sets out the Government's plans for promoting patient safety.

'Doing Less Harm', (NPSA 2001) provided a framework for incident reporting which has underpinned the development of systems and processes in the Lincolnshire Community Health Services.

Incident Reporting Compliance Requirements and Professional & Health Service Guidelines and Standards are shown in Appendix 1.

2. INTRODUCTION

The Lincolnshire Community Health Services' NHS Trust Board recognise that the delivery of healthcare is complex and sometimes things can go wrong. The organisation is committed to ensuring the safety of patients, staff, volunteers, contractors and visitors and this is taken seriously at every level in the organisation. The Trust Board supports open and transparent systems of patient and staff safety, and it is unacceptable to prioritise other objectives at the expense of safety. The organisation actively supports the promotion of a positive and fair blame approach to incidents and near miss reporting in a culture of openness and learning, which is fundamental to effective risk management and quality improvement. The organisation supports the view that the response to incidents should not be one of blame but of organisational learning to encourage participation in the overall process. The organisation is committed to developing a just culture, encouraging a willingness to admit mistakes without fear of punitive measures. Every incident report is seen as a learning and quality improvement opportunity. Incident reporting is more likely to take place in an organisation where there is a well developed safety culture and where there is strong leadership. Refer to the Trust Being Open Policy and Duty of Candour Policy for further information.

The completion of an incident report does not constitute an admission of liability. The organisation believes that incident investigation and reporting should only trigger or contribute to any disciplinary procedure where one of the following applies:

- Where there are repeated occurrences involving the same individual, despite retraining;
- Where the incident results in a police investigation;
- Where, in the view of the organisation or any professional registration body, the action causing the incident is far removed from acceptable practice;
- Where there is a failure to report an incident in which a member of staff was either involved or about which they were made aware.

In these cases a full investigation will be undertaken to determine the appropriate action.

It is the policy of this organisation to record all incidents that have resulted in harm or loss or have the potential to do so, and staff are to report these incidents to the appropriate person and in a timely manner. This applies to incidents affecting patients, directly employed staff and others including visitors, contractors and volunteers who are visiting or

working on the premises. This policy and procedure describes the organisation's approach to the recording, reporting and the management of incidents and is the first step in the process. It also defines the types of incidents that may occur and clarifies the process of classification of incident severity. The Procedure for the Investigation of Incidents, Complaints and Claims describes the next step in the process in more detail.

The organisation's approach to incident management is designed to achieve the following objectives:

- A standardised approach to incident management;
- To ensure that learning from incidents is an integral part of the organisation's culture;
- To provide an analysis of trends which may identify the further need for intervention;
- To improve patient, staff and visitor safety by addressing systematic errors;
- To promote a culture of accountability with 'fair blame'.

This policy should be read and used in conjunction with the Lincolnshire Community Health Services NHS Trust Risk Management Strategy, Major Incident Policy, Serious Incident Policy and related policies identified in paragraph 17.

3. PURPOSE AND SCOPE

This policy describes how the organisation intends to ensure that all incidents, whether they have caused actual harm, or where a near miss, are reported by staff in a timely manner.

This policy covers all adverse, serious incidents and near misses and the following reporting systems:-

- Adverse Incidents
- RIDDOR reportable incidents
- Medical Devices
- Violence and Aggression
- Serious Incident Reporting Policy

The policy applies to all patients, staff, contractors and visitors to Lincolnshire Community Health Services NHS Trust premises where injury, damage, loss or harm occurs in connection with Lincolnshire Community Health Services NHS Trust undertaking. This may be at premises owned and operated by the Organisation, or at other locations where work is carried out by, or on behalf of, the Organisation. The policy also applies where employees are required to travel between locations as part of their job.

This policy describes how incidents will be identified, managed and investigated and ultimately used to learn lessons and promote future best practice. Lincolnshire Community Health Services NHS Trust is committed to developing a learning culture consistent with *Seven Steps to Patient Safety, 2004.*

4. WHAT IS AN INCIDENT?

An incident (adverse incident) is an untoward or adverse event that gives rise to, or has the potential to produce, unexpected or unwanted effects which could be detrimental to the safety of service users, other persons, staff or the organisation.

4.1 **Adverse Incidents** are defined as:

- personal accident
- fire
- violence/abuse/harassment
- security
- incidents involving a vehicle
- relating to a clinical issue
- ill health
- infection control related incident (see Appendix 8 for more detail)

'Near miss', means any incident, which could have lead to harm but did not, because intervention or evasive action was taken.

'Harm' means, "injury, ill-health, damage, theft or loss relating to persons, property, income or reputation".

4.2 **Serious Incident**

Some incidents have serious outcomes that require formal investigation and are reportable to the Department of Health. These are known as serious incidents.

In the interest of clarity a serious incident is defined as:

- unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
- a never event – all never events are defined as serious incidents although not all never events necessarily result in severe harm or death (See *Never Events Framework* (DoH);
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- allegations, or incidents, of physical abuse and sexual assault or abuse;
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

The detailed procedure for reporting a serious incident and full set of serious incident definitions is reflected within the Serious Incident Policy.

4.3 **Major Incident**

A major incident is any emergency that requires the implementation of special arrangements by one or more of the emergency services, the NHS or the local authority. For the purposes of Lincolnshire Community Health Services NHS Trust is defined as:

"Any occurrence which presents a serious threat to the health of the community, disruption to the service, or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented."

4.4 **Near Miss**

"An avoided set of circumstances which had the potential to cause harm"

5. WHY DO INCIDENTS NEED TO BE REPORTED?

Reporting all incidents, however trivial they may appear, enables a profile to be built of the risks to staff, clients and the business of the organisation, from which a strong and factual basis for targeting resources effectively can be developed. By reviewing patterns and trends of incidents, services are therefore better placed to manage the underlying risks.

Lincolnshire Community Health Services has a statutory duty to report certain types of incidents including The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) which require the organisation to notify the Health and Safety Executive of accidents at work; and incidents concerning medical devices, food, medicines, serious equipment failings and fire as well as serious incidents involving staff, service users or members of the public.

5.1 **Risk Evaluation**

Evaluation of risk is a key component of incident reporting and all incidents, actual or near miss, should be assessed to determine the level of risk and the type of action to be taken to reduce or eliminate any risk. All staff have a responsibility to identify and (within their level of authority) respond to or escalate the risk to promote its effective mitigation.

When an incident occurs the staff member who reports it should take action to manage any immediate safety concerns, escalating the incident to their line manager (or relevant other individual as determined by the nature of the incident) immediately, if risk to patient / staff / organisation remain uncontrolled.

The line manager and Quality Assurance Manager are responsible for checking that all necessary steps have been taken to manage the incident and its aftermath. Once the incident has been investigated, a further risk assessment is undertaken to re-assess the grading in the light of control measures instituted. This will be reported via the on-line Datix IR2 system.

Risks which cannot be mitigated sufficiently should be considered for inclusion on the organisation risk register.

5.2 **Risk Registers**

Lincolnshire Community Health Services NHS Trust holds its own Risk Register (refer to the Risk Management Strategy) and reports significant risks and risks with a corporate impact to the Corporate Risk Register.

6. DUTIES WITHIN THE ORGANISATION

6.1 **Lincolnshire Community Health Services** NHS **Trust Board**

The Trust Board supports a fair and open culture in the reporting and management of incidents and are responsible for ensuring there are effective incident reporting, learning and quality improvement arrangements within the organisation.

The Trust Board formally receive a monthly report describing incident reporting, key risks identified and actions taken to enable them to be informed and assured that the Incident Reporting Policy is working effectively.

6.2 **Quality and Risk Committee**

The Quality and Risk Committee have overarching responsibility for the management of risk.

Implementation of this policy and related procedures by employees and managers will be monitored and reviewed by the Quality and Risk Committee and Trust Board. The Policy and Procedure will be reviewed on a bi-annual basis.

6.3 **The Chief Executive of Lincolnshire Community Health Services NHS Trust**

The Chief Executive has ultimate responsibility for the incident reporting, and management of adverse and serious incidents. Operational oversight of the associated processes is delegated through the designated Trust Board member, the Director of Nursing and Operations.

6.4 **Director of Nursing and Operations**

The Director of Nursing and Operations has delegated responsibility for Clinical Risk Management, including the reporting and management of adverse incidents and associated investigations.

The Director of Nursing and Operations will, through the Deputy Nursing Directors, be responsible for receiving information and analysing trends and will identify and act on lessons learnt, reporting activity to relevant organisation strategic committees, including the Lincolnshire Community Health Services Trust Board and the Quality and Risk Committee.

6.5 **Quality Assurance Manager / Corporate Assurance Manager**

The Quality Assurance Manager / Corporate Assurance Manager will have operational responsibility for reporting to external agencies. The Quality Assurance Manager / Corporate Assurance Manager may request further clarification, investigation or action as a result of an incident and will advise the manager who reported the incident, accordingly. They will be responsible for collating and analysing data for presentation within required reports/associated trends analysis.

The Quality Assurance Manager / Corporate Assurance Manager supported by managers, will ensure that all incident reports submitted are correctly referenced, graded, data entered, collated, reported and archived in order to provide a permanent record of reported incidents for statutory and organisation purposes. They will monitor incoming incident reports to ensure that actions are completed in a timely way and risks escalated within the organisation.

6.6 **Head of Communications**

The Head of Communications will:

- Provide support to the Lincolnshire Community Health Services' NHS Trust Deputy Nursing Directors. Inform staff, patients and/or relatives and the public as appropriate.
- In liaison with Deputy Nursing Directors and senior management ensure that any such information is appropriately documented.
- In liaison with Deputy Nursing Directors and senior management, ensure that any affected patient(s) and staff are informed before the media.
- Receive all press enquiries and ensure that an alternative contact is identified in his/her absence.
- Issue press releases
- Act as gatekeeper for co-ordination of interviews with the media
- Tape broadcasts

6.7 **Investigating Manager**

An investigation manager will be identified by the Deputy Nursing Directors, in liaison with the Quality Assurance Manager for the relevant area, for incidents which rate extreme and Serious Incidents.

The identified Investigation Manager will be required to carry out an investigation using Root Cause Analysis (RCA) tools. The Investigation Manager is responsible for completing an initial management review (see paragraph 7.2 and detailed Serious Incident Policy) within three working days of the initial Serious Incident report. Thereafter a full investigation report should be completed, no later than forty-five working days after the initial Serious Incident report.

The investigation manager will collate relevant evidence and confirm the final investigation report and any associated recommendations. Completed investigation reports are to be sent to the Quality Assurance Manager.

6.8 **Line Managers**

Managers have a responsibility to manage risk within their own service.

Managers must ensure that they, and the staff for whom they are responsible, are fully aware of the Lincolnshire Community Health Services NHS Trust Incident Reporting Policy and that access to Datix incident reporting forms (IR1s) are readily available to all employees at all times.

Following every incident or near miss, managers must take immediate action to make the situation safe.

The manager will assess whether the incident is likely to be a serious incident by assessing it against the serious incident criteria, see 4.2 and refer to the Serious Incident Policy for full details. If the incident is judged to be a serious incident, the manager will report it immediately by telephone to the Deputy Nursing Directors. The detailed procedure is identified within the Serious Incident Policy.

Where an incident has resulted in, or has the potential to result in, significant harm, and there is a possibility that it could occur within other areas of the organisation, the manager will contact their Service Clinical Lead/Locality Lead who will complete an Incident Flash Alert (IFA) form and distribute as required (Appendix 9).

The line manager, supported by the relevant Quality Assurance Manager, will be responsible for determining when there is a need to involve relevant external agencies in the investigation (see Appendix 4).

Managers will review the incident forms submitted to them by their staff, and will be responsible for completing the Datix investigation form (IR2) related to the initial incident report, completing it within one month of receipt and taking all necessary steps to escalate and mitigate risk associated with the incident or its aftermath.

Managers are responsible for reviewing the grading of the incident according to the severity of the actual outcome, as soon as possible after the incident. Escalating incidents with an outcome graded as high or extreme, for consideration as a Serious Incident requiring more detailed investigation using root cause analysis. Refer to Serious Incident policy for further detail regarding the management of serious incidents.

The manager to whom the incident was reported would commonly be responsible for undertaking the investigation of non serious incidents. This responsibility may however, be delegated to an alternative individual or team if the original manager does not have the specific expertise required to investigate the incident, or where there is a potential conflict of interest. In this circumstance the Head of Clinical Service will nominate an alternative individual / team.

The manager responsible for the investigation will be responsible for completion of the Datix investigation form (IR2).

The manager is responsible for notifying the Quality Assurance Manager, in advance of the 31 day deadline, if the investigation is not going to be completed within the designated timescale. In this circumstance the manager is responsible for advising / negotiating an alternative completion date.

6.9 All Lincolnshire Community Health Services NHS Trust Staff

All staff have a responsibility to report near misses, adverse incidents and Serious Incidents, to ensure that the Lincolnshire Community Health Services NHS Trust Risk Management Strategy is effective and that all statutory reporting requirements are met.

Staff should be fully open and co-operative with any investigation process.

Staff have a responsibility to highlight any risk issues which could warrant further investigation

Any member of staff who is involved in an incident or near miss must complete a Datix Incident Report Form (IR1) immediately (i.e. within one working day) for each relevant incident according to the attached procedure

All staff must ensure that “Serious Incidents” are reported immediately to their Line Manager or, if not immediately available, to the On call Manager. Staff working out of hours should report Serious Incidents and RIDDOR incidents to the On call manager.

A flowchart describing the timescales for incident reporting is attached at Appendix 3.

B) PROCEDURE

7. PROCEDURE FOR REPORTING, RECORDING, INVESTIGATING AND LEARNING FROM INCIDENTS

7.1 Adverse Incident Reporting Process

All incidents should be reported, recorded and investigated. A flowchart describing timescales for incident reporting is attached at Appendix 3. Reporting should take place immediately using the Datix Incident Report Form (IR1). Staff must be aware how to access Datix incident reporting forms, and as such this should form part of staff orientation when they work at a new site.

7.2 Serious Incidents

Serious Incidents as defined in 4.2 must be reported immediately to your line manager / senior manager or director. If none of these officers are available please contact the Quality Assurance Manager, stating that you wish to report a Serious Incident.

If the incident occurs out of hours, please report the incident to the manager on call. The Director on call will report the Serious Incident in accordance with the Serious Incident policy and notify the relevant Deputy Nursing Directors at the earliest opportunity.

Serious Incidents should, at the same time, be reported on the Datix Incident Report form (IR1) and investigated according to the procedure. The Deputy Nursing Directors will monitor the progress of the investigation and provide follow up reports to the relevant Commissioner either to Clinical Commissioning Group using the STEIS reporting system or Lincolnshire County Council. Any lessons learned from a Serious Incident will be disseminated as appropriate.

7.3 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents

Full compliance with the RIDDOR regulations will be met.

RIDDOR regulations require the organisation to report and keep records of all work related deaths, serious injuries, certain diseases and dangerous occurrences.

RIDDOR reportable incidents will be reported to the Health and Safety Executive after discussion with the Corporate Health and Safety team. RIDDOR reportable incidents should, at the same time, be reported on the Datix Incident Report form (IR1) and investigated according to the procedure.

Full guidance is available on the Trust website ‘Health and Safety’ section and by contacting the Corporate Health and Safety Team.

7.4 Incidents involving medical devices or equipment, medication or blood reactions/events (SABRE)

Incidents which involve any fault, failure, defect, or unreliability of a medical device must be reported to your line manager. Your line manager will inform the Medical Device Liaison Officer.

The Medical Device Liaison Officer supported by Quality Assurance Manager will provide immediate advice and support for reporting the incident to the Medicines and Healthcare Products Regulatory Agency (MHRA) as appropriate. A Datix Incident Report form (IR1) should be completed and the incident investigated according to the procedure. The Investigation Manager should consult the following departments for support and advice for the types of medical devices indicated below:-

Procurement

The Procurement Manager should be contacted for all incidents involving medical consumable goods, e.g. syringes, catheters, catheter bags, etc.

Medical Physics

Medical devices and associated equipment, e.g. ventilators, monitors, infusion pumps, etc.

Estates

All other ancillary equipment used in the care of patients, e.g. beds, hoists, wheelchairs, etc.

Any equipment involved in an incident should be retained in safe keeping for future examination. Configuration and settings on equipment must not be altered before the preliminary examination has been completed. If possible, do not turn off or reset any medical device until the medical electronics staff have approved clinical operation. However, the first consideration must always be patient or staff safety and welfare.

Such equipment should not be re-used without the approval of either the Medical Physics Department, Estates Department or MHRA.

7.5 Security and Violence and Abuse

All such incidents must be reported using the Incident Reporting System and a Datix Incident Report form (IR1) completed. A copy of the Incident Report form will be forwarded to the Local Security Management Specialist who will support the staff and manager. In serious incidents the line manager should contact the Local Security Management Specialist immediately for advice.

7.6 National Patient Safety Agency - National Reporting and Learning System

The National Reporting and Learning System (NRLS) is a national system of reporting anonymous incidents to the National Patient Safety Agency (NPSA). The System is designed to collect information on patient safety errors and systems failures with a view to identifying national patient safety trends and priorities in order to develop practical solutions to these. The overall aim of the NRLS is to support the NHS to learn from things that go wrong. The responsibility for the investigation and management of the incidents, however, remain firmly with Lincolnshire Community Health Services NHS Trust.

Lincolnshire Community Health Services NHS Trust reports patient safety incidents anonymously to the National Patient Safety Agency (NPSA) through the electronic extraction of data from the Datix incident reporting system. Anonymised data will be

uploaded to the National Reporting and Learning System (NRLS) on at least a monthly basis.

Staff are able to report independently to the NRLS should they wish through completing an online electronic reporting form, details of which may be found on the NPSA website: www.npsa.nhs.uk

7.7 **Major Incident**

Major Incidents should be managed according to the Major Incident reporting policy.

7.8 **Media Involvement**

All communication is to be undertaken through the Communications Team. The Head of Communications and Deputy Nursing Directors to be made aware of media interest as soon as possible.

7.9 **Procedure for responding to an incident**

Before completing the Datix Incident Report form (IR1), staff must determine whether the incident is a Serious Incident or RIDDOR reportable, or involves a medical device or equipment. Assistance can be sought from the Quality Assurance Manager and Health and Safety Manager if staff are unsure. See also 7.2 above and Appendix 3 within this policy.

Following every incident or near miss, staff member must take immediate action to make the situation safe. This may include the wearing of protective clothing, removal of similar pieces of equipment, undertaking/reviewing risk assessments and change of clinical procedures. This action should be entered on the Datix Incident Report form (IR1). The line manager should be informed of the incident within a maximum of one working day, immediate notification is required if the incident is assessed as serious, falls within the Serious Incident criteria or where the staff member requires line management support.

7.10 **Completing the Datix Incident Report Form (IR1)**

If the person involved in an incident is unable to complete the Datix incident report form (IR1) for any reason, then a witness or colleague should do so on their behalf.

All information given, including written statements, must accurately state the facts, without expressing personal opinion or allocating blame.

All sections of the Datix Incident Report form (IR1) should be completed as fully as possible and the online prompts should be followed.

7.11 **Managers role on receipt of the Datix Incident Report Form (IR1)**

Upon receipt, the line manager will review the Datix Incident Report forms (IR1s) submitted to them by their staff. Managers will be responsible for completing and recording the incident investigation in line with the Datix IR2 Quick Guide, available on Lincolnshire Community Health Services NHS Trust website, completing it within 31 days of receipt and taking all necessary steps to escalate and mitigate risk associated with the incident or its aftermath.

Managers will re-grade the incident according to the severity of the actual outcome, as soon as possible after the incident. Escalating incidents to the Deputy Nursing

Directors graded as high or extreme, for consideration as a Serious Incident requiring more detailed investigation using root cause analysis tools.

The line manager, supported by the Quality Assurance Manager, will be responsible for determining when there is a need to inform / involve relevant external agencies in the investigation (see Appendix 4). See also section 7.4 for involvement of external stakeholders in the investigation phase.

If the incident is judged to be a Serious Incident, the manager will report it immediately by telephone to the Deputy Nursing Directors. The detailed procedure is identified within the Serious Incident Policy.

8. INVESTIGATION

All incidents must be investigated and the responsibility for undertaking the initial investigation rests with the line manager.

The Datix Incident Investigation form (IR2) should be completed by the appointed investigator (usually the line manager).

Line managers will review the grade of all incidents as soon as possible after the event. The grading will reflect the actual impact of the incident and the risk to the organisation (likelihood x outcome). The level of local investigation and analysis will be dependent upon this grading.

- All serious incidents, and those which are classified as extreme, will automatically trigger a higher level of investigation.

- Some of the above will, on further assessment against the Serious Incident criteria, be Serious Incident reportable. All Serious Incidents will require a full investigation to be carried out by an individual nominated by the relevant Deputy Nursing Directors. Where there is no direct conflict of interest and where the manager holds the relevant expertise to investigate the incident, this may be carried out by the manager subject to the agreement of the Deputy Nursing Directors.

- Incidents where the potential for learning, but which may otherwise be of low severity, should also at the manager's discretion, be considered for this level of investigation or a thematic review.

All other incidents reported on the Datix Incident Report forms (IR1s) (ie incidents **not** achieving a grading of extreme using the risk assessment matrix), should be investigated by the local manager and the actions completed to reflect analysis of the incident and lessons learnt. Completion of the Datix Incident Investigation form (IR2) in these instances will be undertaken within 31 days of the incident being reported. This responsibility may however, be delegated to an alternative individual or team if determined to be appropriate by the manager.

The higher level investigation will be carried out according to the principles of root cause analysis. This will look past the immediate causes or active failures, digging deeper for the underlying or latent failures. Managers are advised to consult the Procedure for the Investigation of Incidents, Complaints and Claims; the RCA tool kit and support and assistance is also available from the Quality Assurance Manager. See also training section 14.

If the investigation has not been completed within the designated timescale the manager to whom the incident was reported / identified will advise the relevant Quality Assurance Manager of progress / anticipated date of completion.
Where the necessary investigation or remedial action falls outside the authority of the manager, the investigation and action planning will be delegated to an appropriate manager by the relevant Deputy Nursing Directors.
The Incident decision Tree provides a quick decision support tool for managers to assist them to focus on organisational issues. The Incident Decision Tree may be referred to assist in determining future action (NPSA Website www.npsa.nhs.uk).

8.1 Involvement of external agencies

The line manager, supported by the Quality Assurance Manager and Health and Safety Manager, will be responsible for determining when there is a need to involve relevant external agencies in the investigation (see Appendix 4). Examples of where this is necessary could include:-

- Where the incident falls within the definitions and time frames of the external agency, e.g. RIDDOR reportable incidents to the Health and Safety Executive
- Where an external agency is involved in the incident.
- Where there is a high probability of litigation
- Where there is insufficient expertise or test equipment within the organisation
- Where there are political considerations
- When there is a need to eliminate bias

When the incident indicates the involvement of external agencies, the manager will alert the Quality Assurance Manager. The operational management of incidents will be managed by the Head of Clinical Service.

9. CLOSING THE LOOP - Debriefing Staff

Communication with staff when an incident occurs and on completion of the investigation, is essential to promote a positive response to the investigation recommendations, to positively influence culture and practice and minimise the possibility of a similar incident occurring in the future.
The line manager will provide feedback to staff regarding the outcome of the investigation at the earliest opportunity following completion of the investigation. Where possible every effort will be made for the staff who have contributed to an investigation, to review elements of the report which relate to them, to provide an opportunity to check for accuracy.

10. REVIEW, UPDATING AND ARCHIVING OF THIS DOCUMENT

This policy will be reviewed every two years. Policies will be held centrally by the designated senior managers. Superseded policies will be archived according to the Lincolnshire Community Health Services NHS Trust Records Management Policy.

11. REPORTING AND LEARNING FRAMEWORK

Lincolnshire Community Health Services NHS Trust has a standard reporting system that complies with A/NZS/4360/1999. Incidents are entered onto a secure database. This data base provides comprehensive reports and trend analysis for Lincolnshire Community Health Services NHS Trust and for audit and research purposes. Lincolnshire Community Health Services NHS Trust has a Learning from Experience framework which links the

various reporting strands and supports learning outcomes. It is described in more detail in Appendix 5.

Learning will be identified through the investigation of incidents. Action plans will be developed in response to incidents and these action plans will be monitored in the first instance by the line manager to whom the incident was first reported. The Quality Assurance Manager will monitor the completion of action plans, ensuring that lessons learnt are captured and shared within the service area and where appropriate, with relevant other stakeholders to promote patient safety and quality.

The Quality Assurance Manager will disseminate incidents and lessons learnt through the local Clinical Governance forums and the Quality and Risk Committee to reflect learning and promote patient safety and service quality. Deputy Nursing Directors/Senior Managers will be responsible for ensuring learning is disseminated.

Learning with regard to practice/changes in practice will be supplied to Deputy Nursing Directors/Senior Managers and professional leads and Workforce Development who will ensure that the learning is appropriately reflected in both training commissioned externally and delivered in-house and in policies and procedures.

Lessons will also be disseminated through relevant strategic committees and professional forum.

Learning outcomes will also be generated from Independent Reviews and National Enquiries.

Learning will be reflected within the monthly report considered by the Quality and Risk Committee and presented to the Trust Board. Learning actions will be communicated to staff through briefings, discussions at staff meetings, and through newsletters.

Lincolnshire Community Health Services NHS Trust will also take the opportunity to share lessons learnt across the health community through professional and care pathway networks and co-operation with partner organisations.

12. MONITORING

Process for monitoring effectiveness

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/ audit	Responsible individuals/ group/ committee (multi-disciplinary) for review of results	Responsible individuals/ group/ committee for development of action plan	Responsible individuals/ group/ committee for monitoring of action plan
Reporting of incident types and Incidents investigation timescales	Reports to Governance Committees	Quality Assurance Manager and Health and Safety Manager	Monthly	Quality and Risk Committee, Safeguarding and Patient Safety Group	Deputy Nursing Directors/local clinical governance forums	Quality and Risk Committee Safeguarding and Patient Safety Group

12.1 Key performance indicators

Lincolnshire Community Health Services NHS Trust will review / monitor the minimum requirements within the relevant National Health Service Litigation Authority (NHSLA).

13. TRAINING

All new members of staff will be introduced to the principles of risk management, including incident reporting procedures and Serious Incident reporting, during the Induction program.

All staff will also receive an annual update on incident reporting through mandatory training.

A programme of investigation using Root Cause Analysis training will be established for managers to enable them to fulfil their investigatory responsibilities. Managers working within higher risk services will be prioritised for training, and training will be rolled out to all managers identified by their Senior Manager as requiring it, within 12 months of the date of this policy.

It is the responsibility of every staff member supported by their line manager, to ensure that they are familiar with the Lincolnshire Community Health Services NHS Trust Incident Reporting Policy and to identify training needs in relation to these policies. Such training needs should be reported through staff members line management.

14. STAFF FOLLOW UP / SUPPORT

Adverse incidents and near misses can have a significant impact on staff who are either involved in it or witness it, consequently, when an adverse incident occurs, the needs of those affected by the incident need to be the primary concern.

Clearly incidents and near misses vary significantly in their nature and the appropriate action to be taken in response will vary accordingly. No single one method of support is ideal for all staff members, so staff should be informed of the different types of help available to them and told how to access these readily. In terms of basic principles, the following is advocated:

14.1 Duties / referral process

- Immediate support should be provided by the **staff member's line manager**.

- In the absence of the line manager an **alternative senior manager** should be identified to provide immediate support to the staff member. Thereafter necessary steps will be taken (by the alternative senior manager) to ensure that the staff member's line manager is informed of the incident to enable any ongoing support needs to be identified and responded to.

- **Staff members** may access ongoing support through a number of different channels, including :

    - Occupational Health Service;
    - Independent counselling Service

  The above may be accessed directly or by referral through the staff member's line

manager. Staff may also seek support from:

- Own GP,
- Relevant Professional Body or Union. The contact details of the Staff Side Representatives are described on Health and Safety Law Posters found on all Health and Safety notice boards.

- Line managers will assess the effectiveness of the support measures through management reviews with their individual staff member.

14.2 **Support for staff called as a witness**

- Staff may be requested to write statements or appear as witnesses as a result of being involved in or witnessing an incident. In these instances, the organisation will provide appropriate immediate and ongoing support to the staff member.

- Staff members will usually be supported by their line manager in the first instance.

- The line manager will contact the Practitioner Performance Manager to alert them to the information request and thus enable a nominated lead within that team to provide specialist support. A statement template is available on request.

- The staff member may also contact their professional Body / Union, to secure additional personal support.

14.3 **Monitoring Staff Support**

- The effectiveness of the support measures will be assessed through management review between the line manager and the individual staff member.

15. INVOLVING AND COMMUNICATING WITH PATIENTS AND PUBLIC

"The active role of patients in their care should be recognised and encouraged. Patients have a key role to play in ensuring that treatment is appropriately administered, monitored and adhered to, and in identifying adverse events and taking appropriate action" (Vincent C. and Coulter A. (2002) *Patient Safety: what about the patient?* Quality and Safety in Healthcare, 11: 76-78)

.

Consistent with "Being Open" and Duty of Candour guidance, patients should be informed when things have gone wrong and they have been harmed as a result.

Staff should liaise with the Information Governance Manager and adhere to the Caldicott principles before the transfer of patient identifiable information from Lincolnshire Community Health Services NHS Trust. Where disclosure of information is essential within the organisation or to the partner agencies, staff shall follow the local protocols governing the protection of and use of patient identifiable information.

Support for patients can be obtained through PALS

The organisation will acknowledge, provide appropriate support and apologise for failings in the care it delivers, re-assuring patients and their families that the right lessons have been learnt from patient safety incidents consistent with the Lincolnshire Community Health Services NHS Trust Being Open Policy and Duty of Candour Policy. See also point 7.8 media involvement.

16. DISSEMINATION

The policy will be disseminated to all staff via Team Brief and available on the Lincolnshire Community Health Services NHS Trust web site.

17. RELATED POLICIES / PROCEDURES

Other related policies to which reference should be made include:-

- The Risk Management Strategy and Policy
- The Serious Incident Policy
- Whistle Blowing Policy
- Media Protocol
- Organisation Emergency Plan
- Health and Safety Policy
- Medical Devices Policy
- Policy on the Management of Violence and Aggression
- Being Open Policy including Duty of Candour
- Procedure for the Investigation of Incidents, Complaints and Claims

INCIDENT REPORTING COMPLIANCE REQUIREMENTS

Health & Safety at Work etc Act 1974 (Available from Health and Safety Resource Library)

Health & Safety (Consultation with employees) regulations 1996

Safety Representatives & Safety Committees regulations 1977

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

PROFESSIONAL & HEALTH SERVICE GUIDELINES AND STANDARDS

Dept of Health – *An Organisation with a Memory* (Report of an expert group on learning from adverse events in the NHS, chaired by CMO) 2000

EPL(95)16 Reporting of incidents involving Buildings and Plant

HS(G) 65 (1991) Successful Health & Safety Management

HS(G) 96 The Cost of Accidents at Work

HSC 1999/123 Controls Assurance Statements 1999/2000 : Risk Management and Organisational Controls

HSG(93)13 reporting adverse incidents and reactions, and defective products relating to medical and non-medical equipment and supplies, food, buildings and plant, and medicinal products

L73 Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

National Patient Safety Agency – '*Seven Steps to Patient Safety*', 2004

NHSLA Risk Management Standard for Organisations

A/NZS /4360/1999

Trust Board Statement on Incident Reporting in an Open and Fair Culture

Lincolnshire Community Health Services NHS Trust accepts that things may go wrong and incidents will occur. When this happens, the Lincolnshire Community Health Services NHS Trust will respond quickly and positively to ensure the wellbeing of patients, staff and the public. We shall investigate incidents to ensure that we learn the lessons and hence improve the quality of our services and promote a safer environment for all.

All staff have a role to play in identifying and minimising all kinds of risks. The Lincolnshire Community Health Services NHS Trust is committed to promoting an open and fair culture where staff feel able to report incidents or near misses and learn from mistakes without fear of recrimination.

Exceptional cases may arise where there is clear evidence of repeated poor performance, despite intervention or support, or wilful or gross neglect in contravening the Lincolnshire Community Health Services NHS Trust Policies and Procedures and/or professional codes of conduct. In these cases, action will be taken through the appropriate channels.

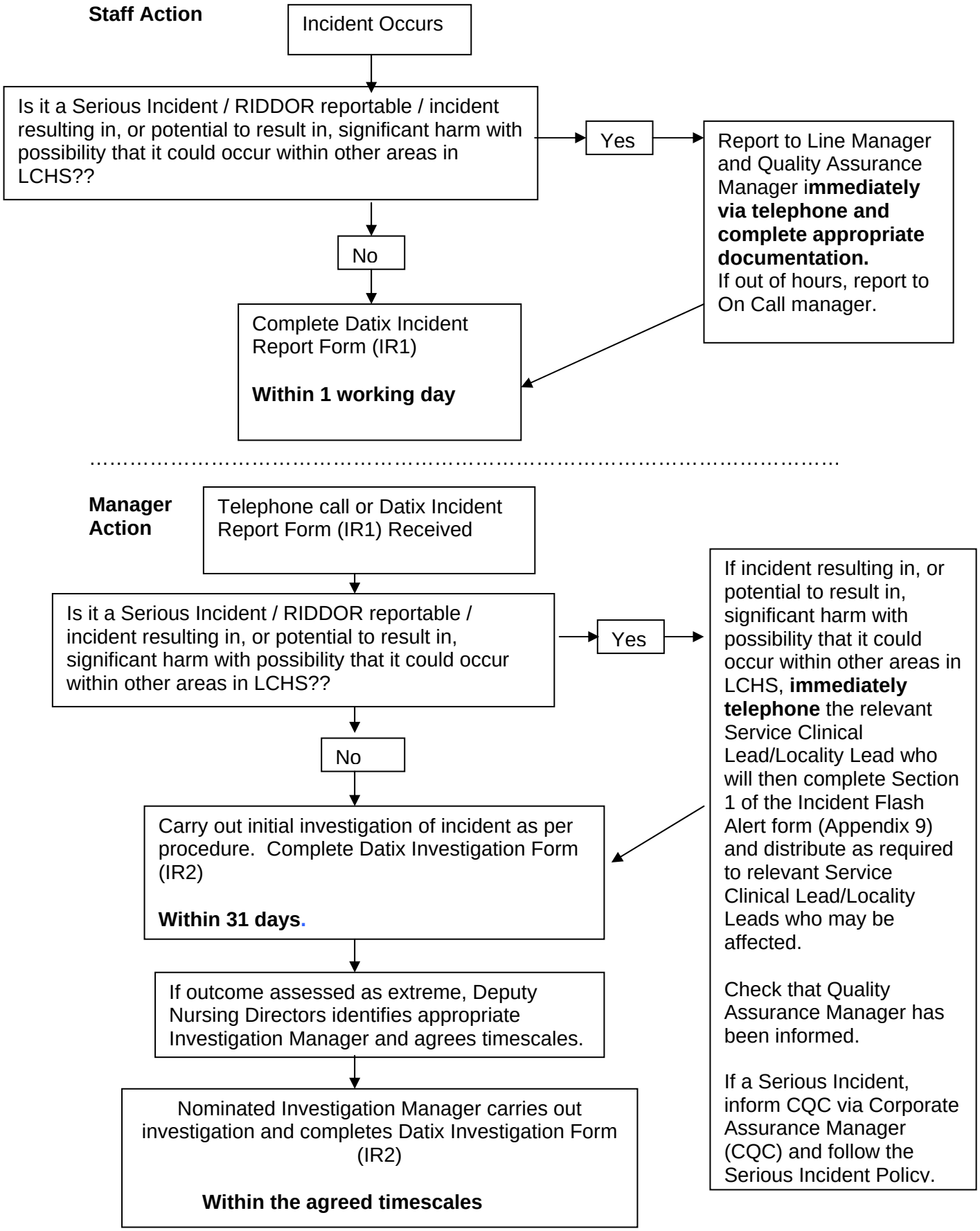
The Lincolnshire Community Health Services NHS Trust has a whistle blowing policy which supports staff in sharing any concerns without fear of recrimination.

Signed …… Date……

Lincolnshire Community Health Services NHS Trust Board, Chair

APPENDIX 3

INCIDENT REPORTING FLOWCHART



APPENDIX 4

LIST OF EXTERNAL AGENCIES TO WHOM INCIDENTS MAY BE REPORTED

Area Child Protection Committee

Care Quality Commission

Centre for Communicable Disease Control

Clinical Commissioning Groups

Confidential Inquiries

Coroner

Department of Health

Environmental Health

Food Standards Agency

Health and Safety Executive

Health Protection Agency

Home Office

Lincolnshire County Council

Medicines and Healthcare Products Regulatory Agency (MHRA)

Medicines Control Agency

National Patient Safety Agency

NHS Estates

NHS Litigation Authority

Other Organisations

Police

Professional regulatory bodies (e.g. GMC, UKCC, etc.)

Public Health Laboratory Service

Specialist advice may also need to be sought from:

- Legal advisors
- Local representative committees
- Medical Defence organisations

This list is not exhaustative and each individual case should be assessed by the relevant manager.

APPENDIX 5

LINCOLNSHIRE COMMUNITY HEALTH SERVICES NHS TRUST GOVERNANCE ARRANGEMENTS

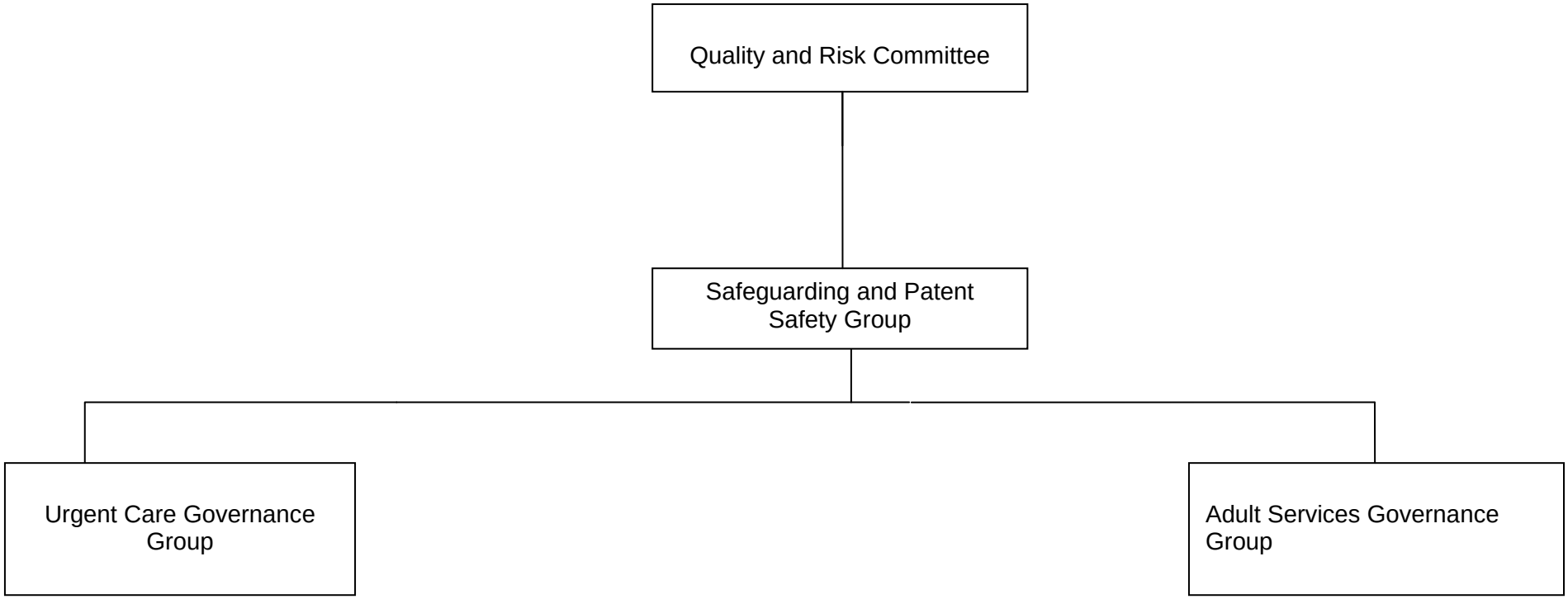


Table 1 Incident Definitions / Risk management Matrix - Consequence

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**No harm**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	No harm No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating

				Critical report	Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	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) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
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

Note: the above table can to be adapted to meet the needs of the individual Organisation.

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

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

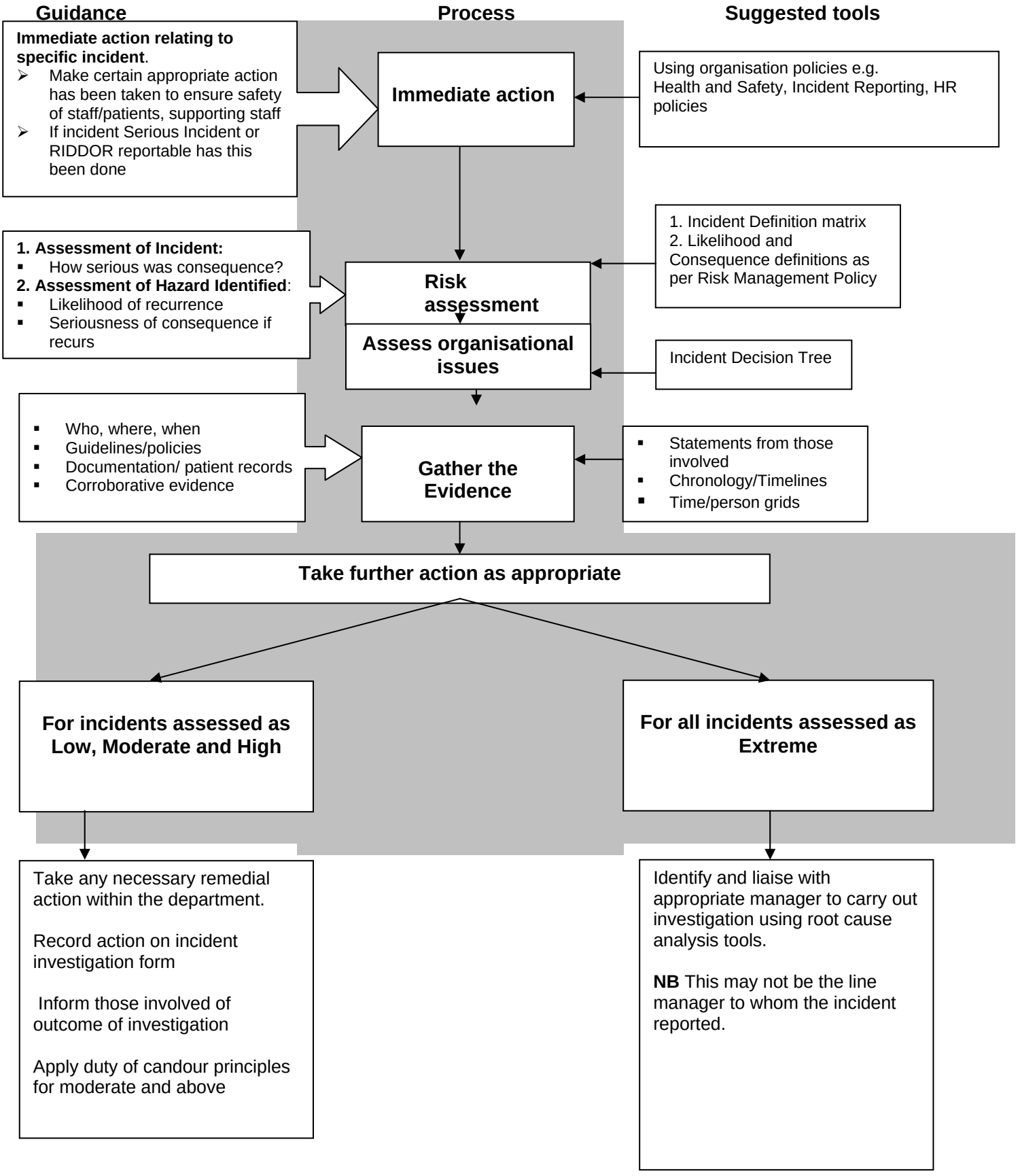
2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

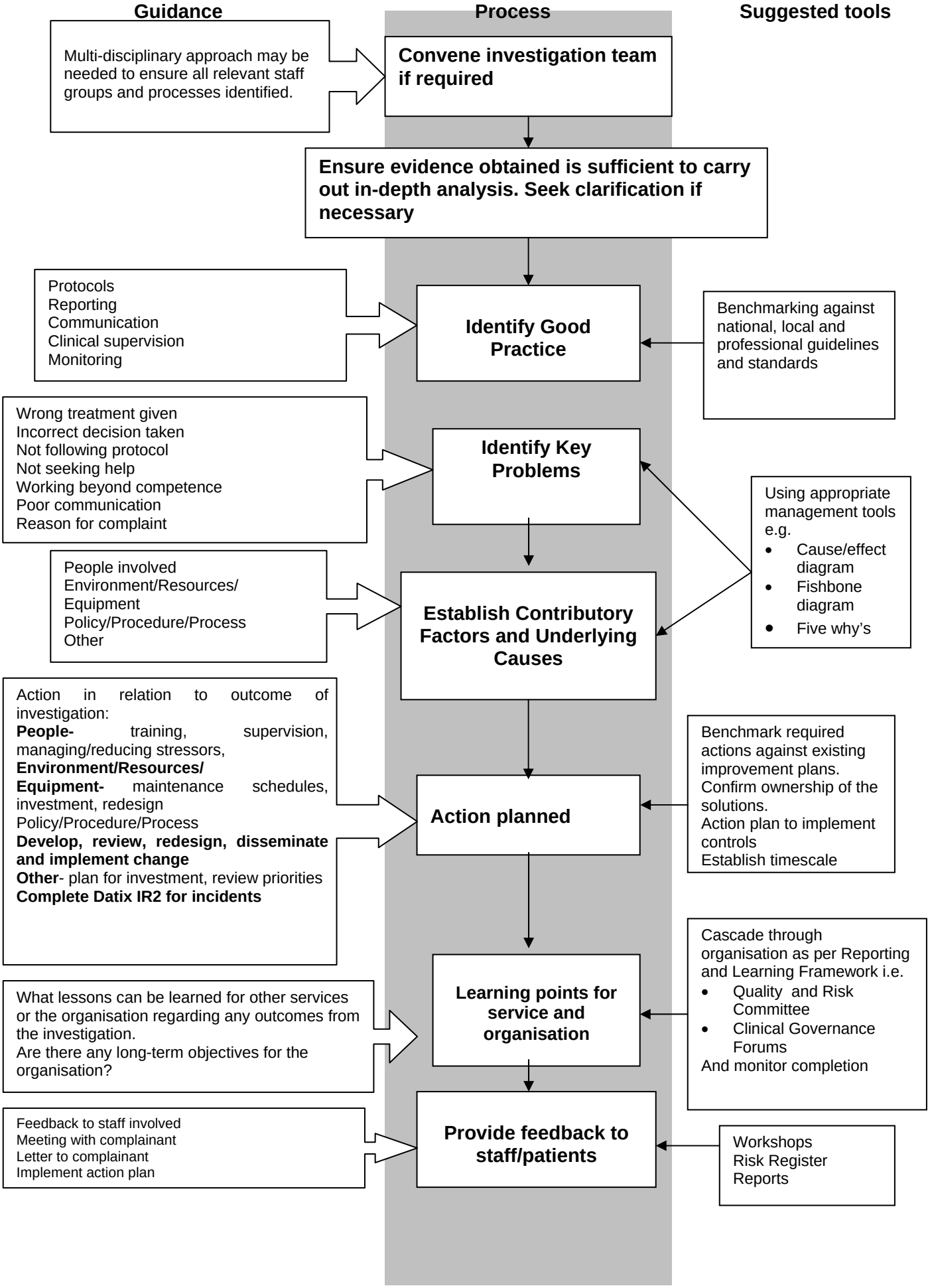
4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

INVESTIGATING AND LEARNING FROM INCIDENTS AND COMPLAINTS



HIGHER LEVEL INVESTIGATION FOR INCIDENTS AND COMPLAINTS



INCIDENTS RELATED TO HEALTHCARE ASSOCIATED INFECTIONS (HCAI)

Table 1: Trigger Prompts for reporting HCAI incidents
Death from HCAI
Serious illness due to HCAI – patients' health may suffer more than would otherwise be the case, and may have increased lengths of stay, re-admissions, returns to theatre or transfer to critical care.
Incorrect treatment
Failure to communicate infectious status
Delayed diagnosis of infection
Contaminated blood sample
Needlestick injury
Failure to follow protocols/procedures
Failure to follow policies and advice on hand hygiene
Failure to follow policies or advice about isolation
Failure to isolate patients owing to lack of isolation facilities
Admission to closed bays/wards
Transfer of patient for non-clinical reasons
Failure to comply with standard operating procedures on the management of beds and their allocation, particularly when patients are transferred between beds or admitted
Problems with aseptic technique/procedures
Concerns regarding poor practice/technical competency
Infected urethral/urinary catheter
Infection in clean surgery
Indwelling devices in situ and either no documentation or documentation that hasn't been maintained properly
MRSA patient whose pathway of care has been managed poorly
Post-operative surgical site infection
Reuse of devices designed to be used only once
Contamination of equipment
Any incident concerning the failure to decontaminate
Unsafe/inappropriate clinical environment, or inadequate environmental decontamination
New build or change of service without having sought advice on infection control
Inappropriate acquisition of equipment
Infected or infectious member of staff
Unusual antimicrobials resistance: infection not responding to treatment

Reference

Healthcare Commission Healthcare Associated Infection: *What else Can the NHS Do?*

Incident Flash Alert (IFA)

Section 1 – Completed by the Service Clinical Lead/Locality Lead

Service Clinical Lead:			Telephone no:		
Date of incident:		Time:		Location:	

Distribution (insert X to confirm)

Relevant Service Clinical Lead/Locality Lead:		Director of Nursing and Operations	
1)		Health and Safety Advisor	
2)		Quality Assurance Manager	
3)		Deputy Nursing Directors	

Incident details (do not enter any personal details)

Immediate Action Taken by originating Service Clinical Lead/Locality Lead

Section 2 – To be completed by the receiving Service Clinical Lead/Locality Lead

Action taken

Return form to originating Service Clinical Lead/Locality Lead and distribute as per distribution list above.

Name:	**Date returned:**

Appendix 10

Operating procedure for investigation of Pressure Ulcers

Background

All pressure ulcers are required to be reported using the Datix reporting system. The incident form has been adapted to collect detailed information regarding the patient care that is pertinent to a pressure ulcer. This is tailored according to whether the patient is an existing patient on the caseload or is new to care within LCHS.

The incident form is designed to capture a high level of information; this will enable the reported to capture any action planning and corrective actions that are necessary prior to the completion of the IR2.

Guidance, including screenshots, on how to complete the incident form has been produced to support the reporter.

Reporter

The reporter is responsible for completing the comprehensive history relating to the patient, reviewing pressure ulcer prevention strategies and identifying factors that have contributed to the development of the pressure ulcer.

Investigator

The investigator will be responsible for ensuring that the investigation is completed accurately and ensuring any lessons learned that have been identified are actioned within their team.

Matron

The matron will be responsible for collating any lessons identified relevant to teams outside of the incident and to report these to the local Quality Assurance Meeting for wider dissemination.

Timescales

Category 1,2,3 and 4 inherited pressure ulcers investigation to be completed within 31 days of incident being reported.

Category 1 and 2 pressure ulcers for existing patients investigation to be completed within 31 working days of incident being reported.

Category 3 and 4 pressure ulcers for existing patients to be completed within 10 days of incident being reported.

Thematic reviews

All Category 3 and 4 pressure ulcers that have been identified whilst the patient is under the care of LCHS (an existing patient) are to be investigated and the findings presented at thematic review.

Thematic reviews are undertaken monthly and review all of the pressure ulcers from the previous month (the thematic reviews take place at the beginning of each month and pressure ulcers reported at the very end of the month are reviewed the next month to allow adequate timescale for investigation). The findings are scrutinised by the group using the patient records. The group is chaired by a Tissue Viability Nurse Specialist or Matron and consists of representation from the teams presenting findings and where possible, a Clinical Educator.

The outcome-Avoidable/Unavoidable is established together with actions for the team and themes applicable to all services. The peer group scrutiny will identify best practice or lessons are learned to promote best practice in the future.

A summary report is completed at the thematic review and submitted within the required time frame for the local Quality Assurance meeting, Safeguarding and Patient Safety Group and Quality and Risk Committee each month to facilitate shared learning and assurance to the Trust. Once approved by the Safeguarding and Patient Safety Group, the report is shared with the CCG for review and challenge.

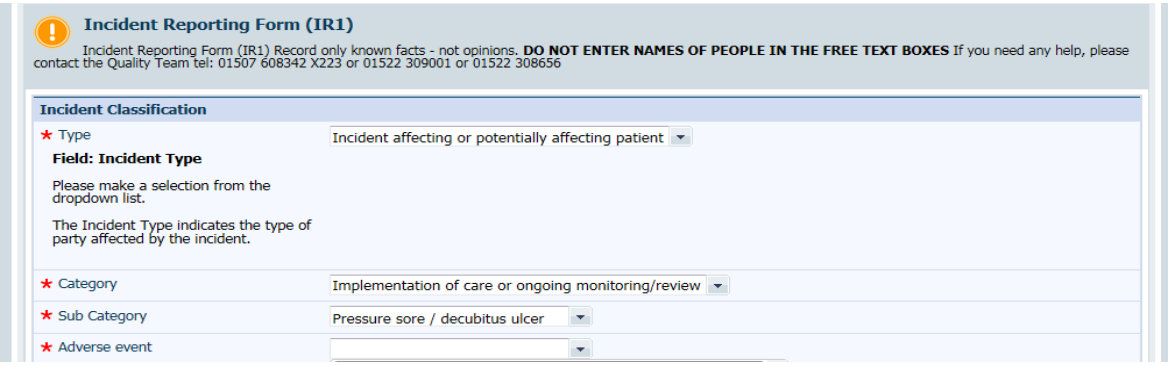
An ongoing action plan is reviewed and updated at each thematic review meeting. This is shared throughout LCHS, involving all staff involved in delivering patient care. Education is identified and delivered by TVN's , Case Managers, CTL's, Clinical educators to drive up standards of care. Evidence that action plans have been implemented are reviewed within the service lines.

Pressure Ulcer Incident Report guidelines

Within LCHS all pressure ulcers, categories 1 to 4 (EPUAP 2014) are required to be reported in line with NICE (2014) guidance. This is undertaken using Datix to both report and record details of the investigation. The local CCG request that all category 3 and 4 pressure ulcers are reported as a Serious incident (SI). These are then reported in the strategic Executive Information System (STEIS) and require investigation.

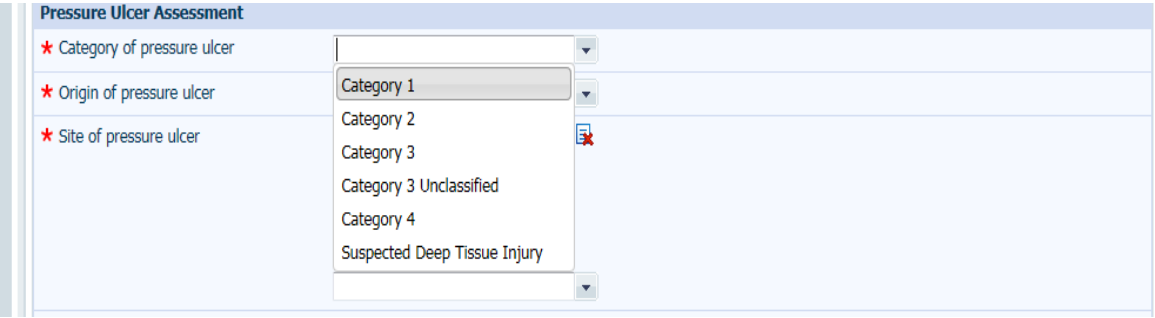
The **reporter** is responsible for completing the comprehensive history relating to the patient, reviewing pressure ulcer prevention strategies and identifying factors that have contributed to the development of the pressure ulcer. The **reviewer** will be responsible for ensuring that this is completed accurately and confirming the outcome and lessons learned prior to the Pressure Ulcer Thematic Review meeting the following month.

When reporting a pressure ulcer incident, these are the details you should select from the drop down menus.



Adverse event – Select the main factor that appears to have contributed to the development of pressure damage.

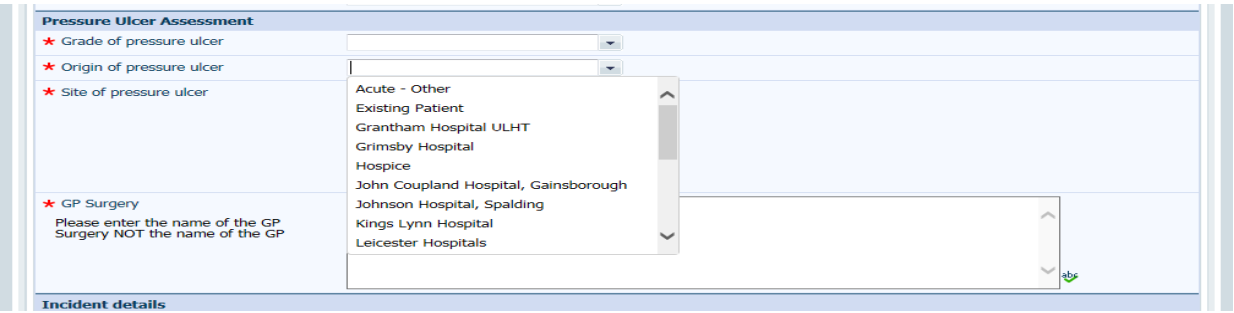
The pressure ulcer assessment fields will then appear:



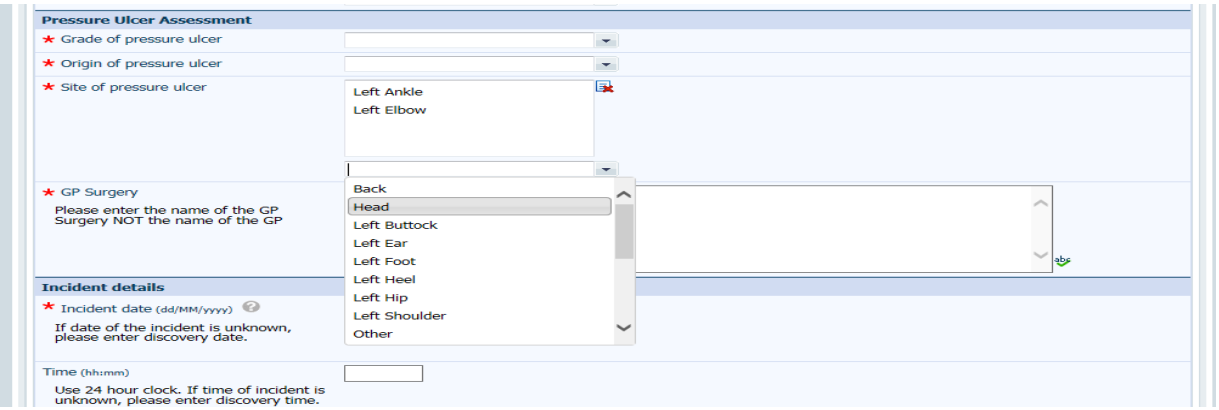
Grade/Category – select the grade of pressure ulcer from the drop down menu referring to EPUAP (2014) classification system. If in doubt of category always liaise with clinical colleagues or TVN.

Origin – see below drop down menu which enables you to select where the pressure ulcer originated. Ensure that you review the patient records to ascertain the origin.

Note: Patient is only **new** if they have not been known to any service in LCHS not just your own. A patient that has been discharged within the last month should be reported as **'existing'** and not as **'new'** patients.



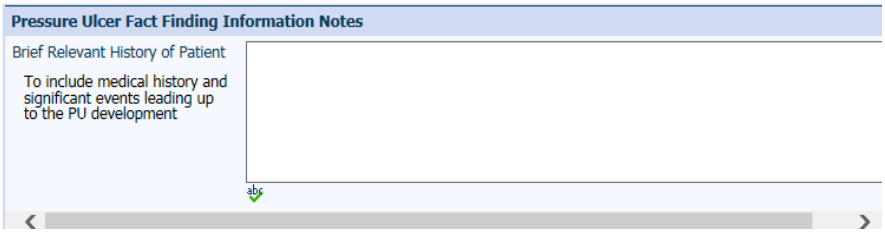
Site of pressure ulcer – see below drop down menu which enables you to select the site(s) of pressure ulcer. More than one site can be selected by holding down the CTRL key and using the mouse to click on more than one.



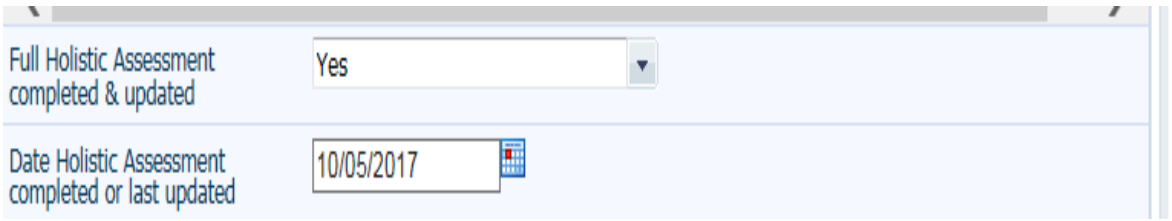
In the 'Description of incident' box, please type in details.

In the 'Immediate action taken' box, please type in details of action taken. This should include assessment and provision of pressure relieving equipment, wound management, and advice given re repositioning, nutrition and time spent in bed.

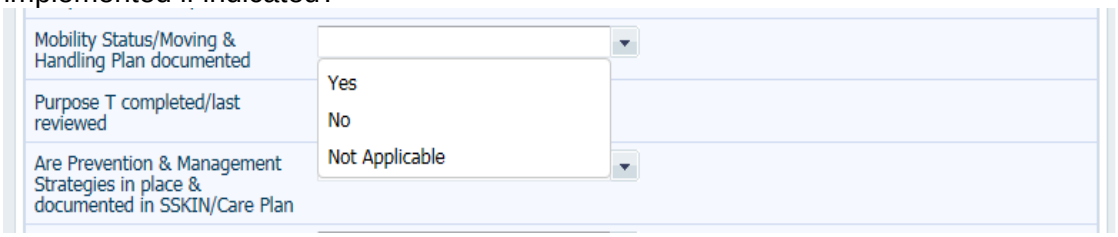
Complete Brief Medical History – This should include the medical history from the patients records and relevant information as to the patients overall condition and relevant treatment e.g If palliative was the patient receiving chemotherapy and or deteriorating?



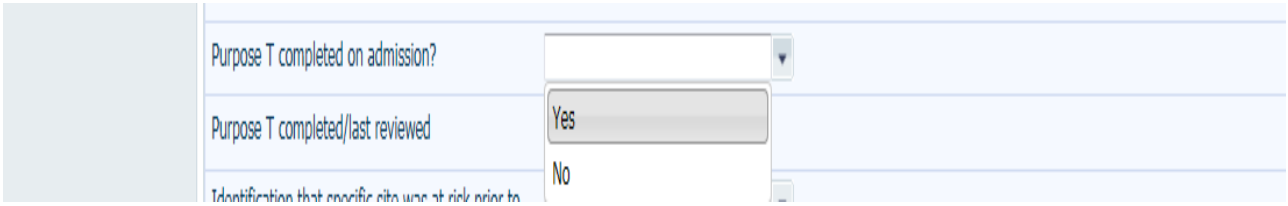
Holistic Assessment – This relates to a fully completed assessment and the date this was last completed or reviewed.



Mobility status – was this identified and recorded in the holistic assessment and a plan implemented if indicated?



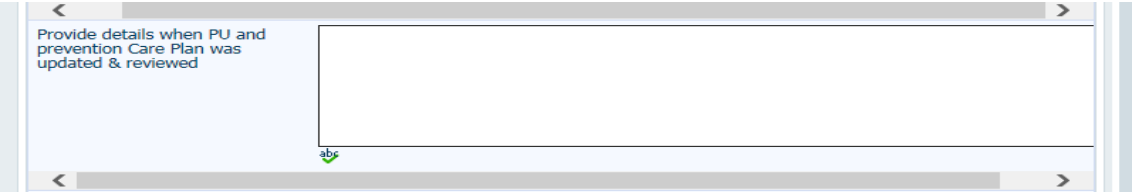
Purpose T – Indicate if this was completed on admission and record the date this was completed and the date this was most recently completed/reviewed.



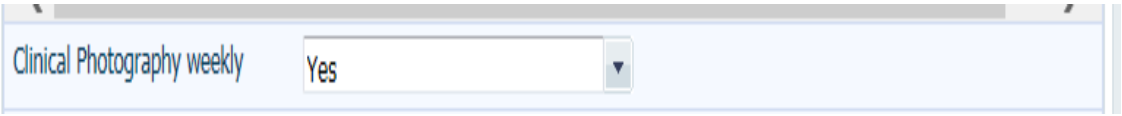
State if site of pressure ulcer had been documented as ‘at risk’ followed by details of specific equipment that was prescribed to reduce the risk of pressure damage

Care Plan – state when SSKIN care plan was instigated. Was this individualised to patients needs. Was SSKIN undertaken at each visit. Did skin inpection take place as indicated . Was the care plan

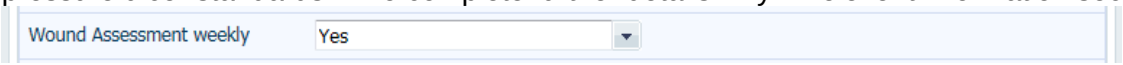
reviewed and ammended as required? If no complete further details why in relevent information section.



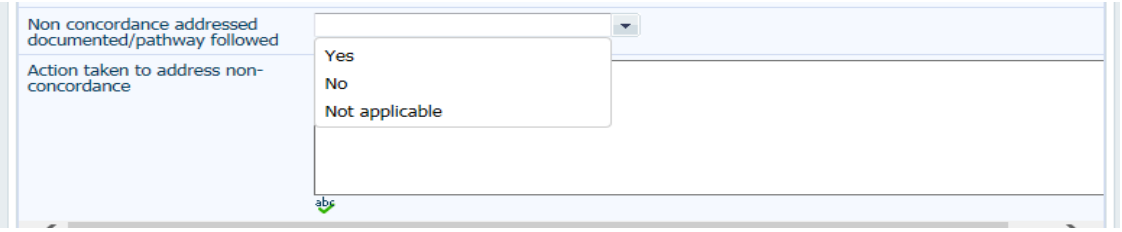
Clinical Photography – Indicate if clinical photography was undertaken weekly in line with LCHS pressure ulcer standards. If no complete further details why in relevent information section.



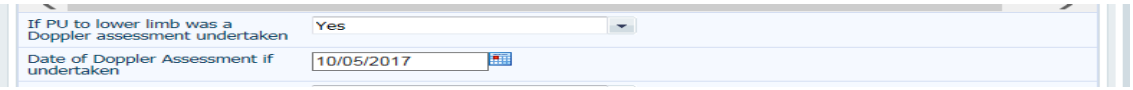
Wound assessment- Indicate if wound assessment was undertaken weekly in line with LCHS pressure ulcer standards**.** If no complete further details why in relevent information section.



Non concordance– Refer to LCHS non concordance pathway (J:\2017-2018\LCHS\TISSUE VIABILITY\Pressure ulcers) and record if actions are evidenced in the patient records. Examples of actions needed to be documented would include reasons why the patient is declining equipment/ repositioning, evidence the risk was discussed with patient and actions undertaken to meet the patients needs. If no complete further details why in relevent information section.



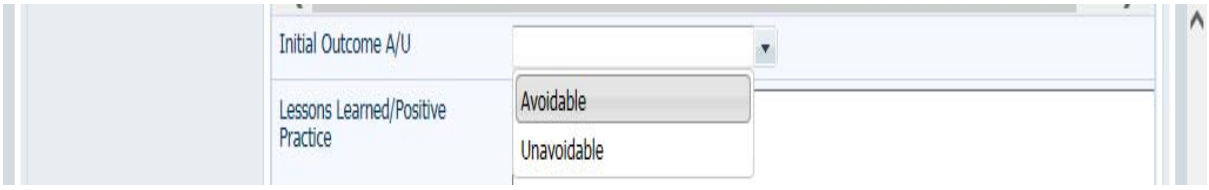
Doppler assessment – Record if a doppler assessment was undertaken if pressure ulcer was on lower limb or foot in line with LCHS standards. If no complete further details why in relevent information section.



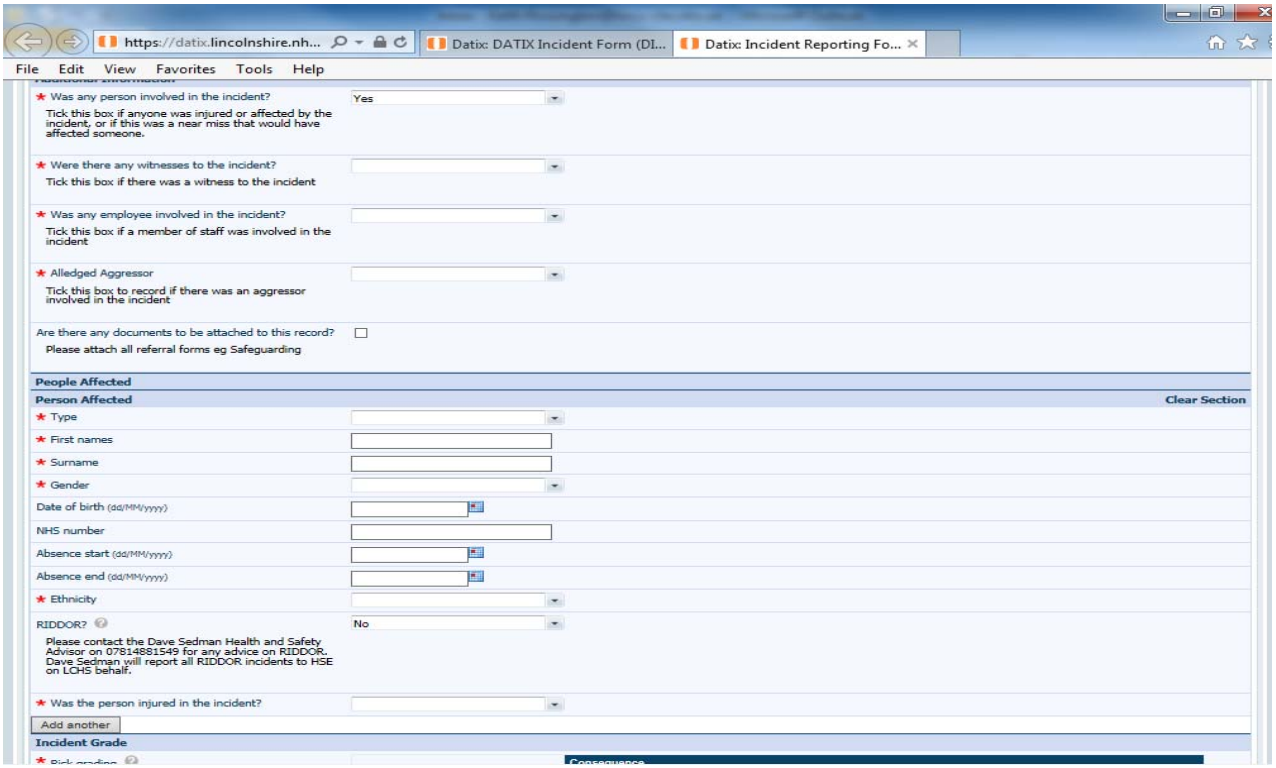
Leaflet

Relevent information- include further details that you think are relevent to the patients management that have not already been covered and reasons for any 'no' answers above

Outcome – Determine if the pressure ulcer was Avoidable/Unavoidable. For an unavoidable outcome the patient records must evidence best practice in line with NICE guidance (2014)

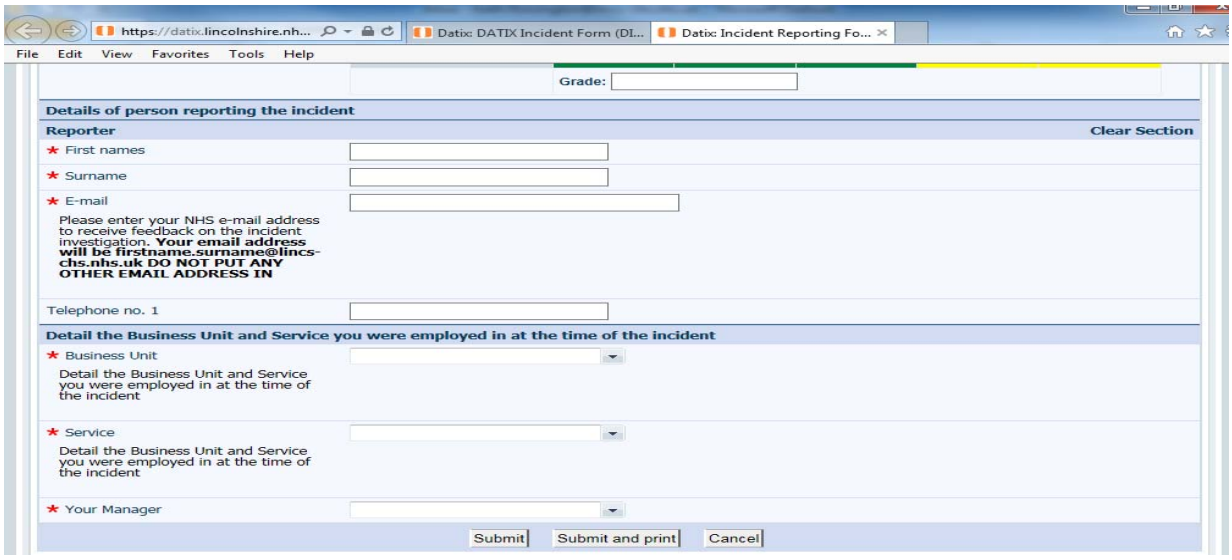


Was any person affected - Please select 'Yes' to this question which will open up the person affected details for you to complete **all sections .**



Was the person injured – please select No

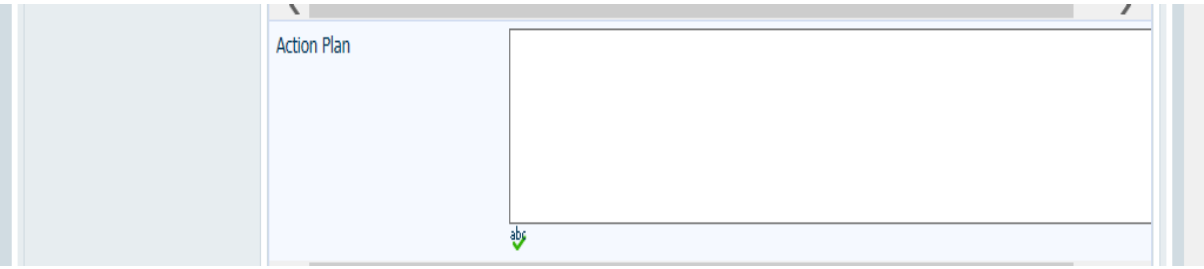
From the drop down menus, please enter the Business Unit and Service you are employed in and your line manager's name.



IR2 SECTION- This section needs to be completed by the reviewer (Team lead or Case

Manager) who is responsible for ensuring that all sections are completed correctly). This information will be collated to formulate the monthly pressure ulcer report.
Lessons learned will be based on the investigation outcomes and where best practice has not been evidenced. Always question why best practice was not achieved e.g. is this lack of knowledge (education) or a delay in provision of equipment etc.
Always record positive practice identified, for example where care planning has been individualised and reviewed, MDT involvement etc.

Record what actions will be undertaken to address lessons learned, how learning will be measured and name of person who will monitor this .



Themes- Identify the main themes that emerge following the investigation. If these are not listed add additional theme not previously identified.

Equality Analysis

Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them. This standard template is designed to help LCHS staff members to comply with the general duty.

Please complete the template by following the instructions in each box. Should you have any queries or suggestions on this template, please contact Qurban Hussain Equality and Human Rights Lead.

Name of Policy/Procedure/Function*	
Incident Reporting Policy and Procedure	
Equality Analysis Carried out by:	Keith Rossington
Date:	July 2018
Equality & Human rights Lead:	Rachel Higgins
Director\Deputy Nursing Directors:	Lisa Stalley-Green

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what its intended outcome is and who the intended beneficiaries are expected to be.	This policy outlines the arrangements for reporting, managing, analysing and learning from adverse incidents, accidents, and near misses (hereafter referred to as incidents) which arise from the LCHS activities. The policy is intended to benefit all population groups by improving the quality of patient care. The policy is designed to ensure the Trust responds quickly and positively to ensure the wellbeing of patients, staff and the public.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	No		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		X	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:	Keith Rossington			
Date:	April 2016			