Nottinghamshire Hospice
adding life to days

POLICY INFORMATION	
Subject	**Reporting of Incidents and Accidents Policy** (This policy is subject to periodic review and will be amended according to service development needs)
Applicable to	This policy applies to all staff, volunteers, service users, visitors and contractors who work for Nottinghamshire Hospice.
Target Audience	
Date issued	March 2022
Next review date	March 2024
Lead responsible for Policy	Chief Executive Officer
Policy reviewed by	Director of Care
Notified to (when)	Corporate Management Team March 2022 Senior Management Team March 2022
Authorised by (when)	Quality and Safety Committee March 2022 (pending)
CQC Standard if applicable	
Links to other Policies	Disciplinary Policy Whistle blowing Risk Management Managing Staff Performance/Capability Policy
Summary	This document aims to provide a clear understanding of Nottinghamshire Hospices Reporting of Incidents and Accidents Procedure.
This policy replaces	Reporting of Incidents and Accidents 2020

VERSION CONTROL		
Status	**Date**	**Reviewed date**
Original policy written by John Gibbon, Director of Care but never ratified	March 2014	March 2016
Policy reviewed by Director of Care Services, Jo Polkey and Executive Assistant, Katie Watson	Jan 2018	
Authorised by Quality and Safety Group	Jun 2018	June 2020
Updated control sheet and published on Policy Doc App	July 2018	
Updated logo and published on website	December 2020	
Reviewed by Director of Care services and Chief Executive Officer and authorized by Quality and Safety Group	March 2022	
Next review due	March 2024	

INDEX

APPENDICES

1. INTRODUCTION

Nottinghamshire Hospice promotes a positive and non-punitive approach towards incident reporting and is committed to ensuring that all staff have a good understanding of the reporting system, thereby promoting opportunities to learn from adverse incidents, or accidents reported.

The effective reporting and management of incidents and accidents is a key component of effective risk management and clinical governance and will help to ensure the safety of patients, staff, visitors and contractors through learning where things have gone wrong.

The Hospice recognises the value of risk assessment and risk prevention and will ensure that it will provide resources for investigation and feedback to prevent or minimise the recurrence of incidents and accidents.

This policy applies to incidents and accidents involving any person on or off Hospice premises. It covers both incidents that occur within the clinical setting and those that occur within non-clinical areas.

This policy is applicable to all hospice premises or places of work and covers all incidents and near misses involving patients, staff, volunteers, service users, visitors, contractors or any others to whom the hospice owes a duty of care.

2. STATEMENT OF INTENT

The Hospice recognises its duties under the *Health and Safety at Work Act 1974* and other Health and Safety legislation to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all its employees. The business of the Hospice should be conducted in such a way as to ensure that patients, their relatives, contractors, voluntary workers, visitors and members of the public who may be affected by the activities of the Hospice, are not exposed to risk.

The Hospice acknowledges that certain accidents, illnesses and dangerous occurrences must be reported to the Health and Safety executive as required by the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.* (See Appendix 1 for link to the Reporting Guidance).

The Hospice also acknowledges the requirement to report accidents and incidents to various other stakeholders or external organisations including relevant CCG (all serious incidents) The Care Quality Commission (CQC) and others as required from time-to-time.

The Hospice is committed to an open and fair culture. The purpose of accident/incident reporting is not to apportion blame to individuals but to identify problems or potential problems in the system or process that may have contributed to the incident occurring and to learn from the experience and improve practices accordingly. Equally, employees need to be aware that there may be clearly defined occasions where further action will need to be taken, namely where there is evidence of a breach of the law, professional misconduct or conduct that fulfils criteria in the Hospice's Disciplinary Policy.

An effective accident/incident reporting process provides the following benefits:

- A clear record of facts should reference be needed in the future
- Identification of factors contributing to accidents, incidents and near misses to assist in implementing risk reduction strategies to reduce recurrence
- A means to analyse trends in accident and incidents and to take immediate and appropriate action
- Assistance in minimising risk to staff, patients, visitors and contractors
- A means to identify any necessary policy or procedural changes that may be required
- Ensures that the Hospice complies with statutory compliance
- Assists in the review of the health and safety management systems as recommended by the Health and Safety Executive (HSE)
- Identifies opportunities for continuous improvement

This policy contributes to:

- Minimising the risk of untoward/serious incidents
- Ensuring that all possible lessons are learned and shared as appropriate
- Supporting staff and patients through potentially distressing situations

3. **DEFINITIONS**

Accident – an unplanned event resulting in injury to people or damage to property

Incident - is any event or circumstance planned or unplanned which could have or did lead to unintended or unexpected harm, loss or damage to a patient, member of staff, volunteer or visitor, the hospice, its property assets, its reputation or the environment.

Near Miss - a set of circumstances which, while not resulting in an incident, damage or injury may have done so if circumstances had been different e.g. the recognition of incorrect drugs being prescribed but not dispensed so no accident has occurred.

The outcome or potential consequences of some incidents are so serious that they are classed as Serious Untoward Incidents. These are defined as any event or circumstance where a patient, member of staff, volunteer or member(s) of the public suffers unintended or unexpected significant harm such as serious injury, major permanent harm or unexpected death (or the risk of death or injury), loss or damage; where the actions of any employee are likely to cause significant public concern; any event which may seriously impact upon service delivery and / or may attract negative media attention.

4. **ROLES AND RESPONSIBILITIES**

The Chief Executive has ultimate accountability for all aspects of governance including effective incident management. For the purpose of this policy the delegated responsibilities are as follows:

The Director of Care is responsible for ensuring all patient and clinical incidents and near misses are managed and reported appropriately.

The Executive Assistant is responsible for ensuring all non-clinical incidents, accidents and near misses are recorded appropriately.

Heads of Department are responsible for ensuring:

- Employees and volunteers are aware of and have access to this policy
- Incident and accident forms are completed accurately
- Appropriate action/escalation and follow up is taken depending on the severity of the incident
- Take all measures possible to minimise adverse incidents within their area of control
- Take all necessary action to prevent re-occurrence
- Promote and encourage staff to report all incidents and near misses to their line manager
- In line with the level of their responsibility and depending on the severity of incident, ensure that the recommendations are implemented
- Consistent feedback is given to local staff to maintain the momentum of incident reporting and its benefits to patients and staff safety.

All Employees, Volunteers and Contractors are responsible for reporting incidents and near misses as soon as is possible and to cooperate in any accident, incident or near miss investigation.

It is the responsibility of employees to carry out the following:

- Verbally report all accidents/incidents to their line manager as soon as possible
- Report any near miss situation that had the potential to cause significant injury to a person or financial loss to the Hospice
- Where possible, the person involved in the incident/accident should complete the Incident Report Form. If this is not possible the form must be completed on that person's behalf by any other who has the relevant facts of the incident
- Complete the form as soon as is reasonably practicable
- Comply with any actions required to reduce the risk of a similar accident/incident should these be identified in the subsequent investigation

5. REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS 1995 (RIDDOR)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) require employers and others to report specific accidents and some diseases that arise out of or in connection with work. These reports enable the enforcing authorities to identify where and how risks arise and to investigate serious accidents.

It is the responsibility of all Managers to ensure that all incidents are reported in line with the statutory requirements. Guidance can be gained from www.hse.gov.uk/riddor/index.htm

6. STAFF TRAINING

Training regarding the incident reporting procedures will be delivered in various forms for all staff and will be covered in:

- Staff Induction
- Workshop sessions

Where managers identify the need for some specific training in this policy and procedure they should contact the relevant Director.

7. MONITORING

The Hospices Quality and Safety Committee and Strategy and Corporate Governance Group will monitor and review relevant incidents/ accidents.

8. INCIDENT AND ACCIDENT REPORTING PROCESS

Report Forms and Process

Hospice Incident Report forms will be completed for all incidents. Where a person has been injured, an accident form should also be completed.

All incidents are to be recorded immediately after the incident has occurred. All forms recorded must be seen by the line manager or other designated person who will complete the manager's section indicating what actions have been taken to minimise the risk of the incident happening again. In the event of a serious incident the relevant Director would advise on further reporting requirements. Incident and Accident forms are available from the Executive Assistant in non-clinical instances and the Director of Care for clinical instances.

Staff completing an Incident or Accident form must record only the facts as they know them and not opinions.

Record Keeping

All copies of Incident and Accident forms will be treated as confidential. These will be retained by either the Executive Assistant or Director of Care Services. A record of the incident will be entered onto the Hospice Incident Recording Database. All information held will be dealt with in accordance with the Data Protection Act 1998. Any employee or their authorised representative has the right to see any record relating to them. All third party details will be redacted from these reports where necessary.

Patients and Visitors

Where patients or other visitors are involved in an untoward incident, it is the responsibility of Hospice staff to ensure that a form is completed and contains all the relevant information.

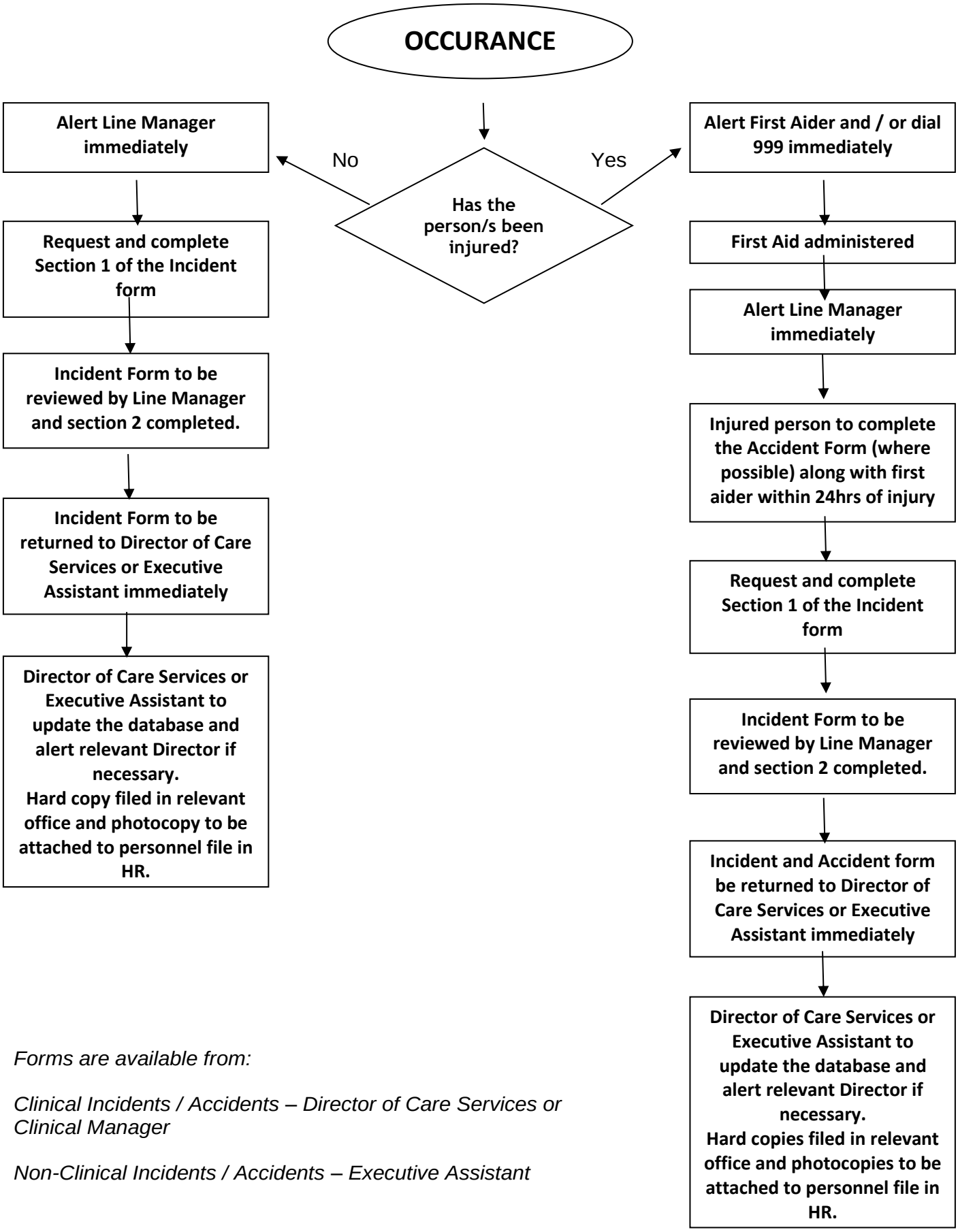
The manager of the department will ensure that the patient/visitor is kept informed of the outcome of any investigation into the incident as appropriate.

Contractors

There is a joint responsibility for the health and safety of contractors working for the hospice. There is a requirement for anyone engaging the services of a contractor to ensure that arrangements for health and safety are in place. These arrangements will include:

- The reporting of accidents/incidents involving the contractors
- Who will be responsible for completing RIDDOR reports where required.
- Who will carry out any investigation into accidents.
- Notwithstanding the above, all serious or major accidents involving contractors must be reported on the Hospice Incident forms by the person responsible for employing the services of the contractor or project/contract manager

Incident Management FlowChart



Forms are available from:

Clinical Incidents / Accidents – Director of Care Services or Clinical Manager

Non-Clinical Incidents / Accidents – Executive Assistant

INCIDENT INVESTIGATION AND ACTION PLANNING

The primary purpose of an investigation is to establish the facts and sequence of events leading up to the adverse incident (whether an incident, complaint or claim) to determine what happened, how it happened, why it happened, who was involved and to determine the impact on patients and/or staff.

The escalation of investigation where necessary will be determined by the Director of Care and/or the Chief Executive.

The Directors will review all incidents that have occurred within their jurisdiction on a monthly basis, with appropriate links being made to ensure actions and learning for the Hospice.

The various grades of investigation and action planning are as follows:

1. Very Low 'Green Incidents'. - These incidents generally do not have ongoing serious consequences and can be managed promptly on the spot. The Head of Department will undertake any review which may identify learning points or safety improvements. Any identified control measures should be implemented immediately and recorded on the incident report form

2. Low 'Yellow Incidents'. - These incidents should be reviewed in the department where the event occurred. The Head of Department will undertake any review but the nature of the incident and possible implications would require a more senior manager to be informed. Any identified control measures should be implemented promptly and recorded on the incident report form.

3. Moderate 'Amber Incidents'. - These should be subject to a review and if necessary an investigation and all learning points and safety improvements should be appropriately identified, implemented and recorded. Where an investigation takes place a report detailing outcomes should be presented to the relevant Director by the person identified to lead the investigation

4. High 'Red Incidents'. - Where major (i.e., permanent injury) or catastrophic harm (avoidable death or significant shortening of life expectancy) has occurred, an investigation led by the relevant Director or Chief Executive will be carried out. The recommendations from the investigation report will be included in Senior Management Team briefings and reported to the Board of Trustees.

APPENDIX 1

INCIDENT GRADING MATRIX

LIKELIHOOD	*CONSEQUENCE*				
	Insignificant 1.	**Minor 2.**	**Moderate 3.**	**Major 4.**	**Catastrophic 5.**
5. Certain	**Moderate Amber**	**Moderate Amber**	**High Red**	**High Red**	**High Red**
4. Likely	**Low Yellow**	**Moderate Amber**	**Moderate Amber**	**High Red**	**High Red**
3. Possible	**Very Low Green**	**Low Yellow**	**Moderate Amber**	**High Red**	**High Red**
2. Unlikely	**Very Low Green**	**Very Low Green**	**Low Yellow**	**Moderate Amber**	**High Red**
1. Rare	**Very Low Green**	**Very Low Green**	**Low Yellow**	**Moderate Amber**	**Moderate Amber**

Likelihood Rating / Grading	Description
5. Certain	Will undoubtedly recur, possibly frequently
4. Likely	Will probably recur, but is not a persistent issue
3. Possible	May recur occasionally
2. Unlikely	Do not expect it to happen again, but it is possible
1. Rare	Cannot believe that this will ever happen again

APPENDIX 2

MEASURES OF CONSEQUENCES

	1	2	3	4	5
Consequence	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury or Harm Physical or Psychological	Minor injury to individual. No requiring first aid	Minor injury to several people. First aid required	Major injury to individual	Major injury to several people. Death of individual	Death of several people
Quality of the Patient Experience / Outcome	Reduced quality of patient experience not directly related to the delivery of clinical care	Unsatisfactory patient experience directly related to clinical care – readily resolvable	Mismanagement of patient care, short term effects (less than a week)	Mismanagement of patient care, long term effects (more than a week)	Totally unsatisfactory patient outcome or experience
Business/ Finance & Service Continuity	Minor loss of non-critical service Financial loss of up to £10K	Service loss in a number of non- critical areas <2 hours or 1 area or <6 hours Financial loss of £10k - £50k	Loss of services in any critical area Financial loss of £50K to £500K	Extended loss of essential service in more than one critical area Financial loss of £500K to £1 million	Loss of multiple essential services in critical areas Financial loss of above £1 million
Potential for Complaint or Litigation	Unlikely to cause complaint or litigation	Complaint possible Litigation unlikely	Litigation possible but not certain High potential for complaint	Litigation expected	Litigation certain
Employees and Volunteering Competence	Short term low employee and volunteer level (<1 day) where there is no disruption to patient care/service	Ongoing low employee and volunteer level results in minor reduction in quality of patient care/service	Late delivery of key objective/service due to lack of employees and volunteers. Minor error due to ineffective training. Ongoing problems with levels of staffing	Uncertain delivery of key objective/service due to lack of employees and volunteers. Serious error due to ineffective training	Non-delivery of key objective/service due to lack of employees and volunteers. Loss of key staff. Critical error due to insufficient training
Reputation or Adverse Publicity	Within unit Local press 1 day of coverage Not the front page	Regulatory concern Local media <7 day of coverage Makes the front page	National media <3 day of coverage Department executive action	National media >3 day of coverage MP concern Questions in the House	Full public enquiry
Inspection / Audit	Small number of recommendations with focus on minor quality/process improvement issues	Minor recommendations made which can be addressed by low level of management action	Challenging recommendations but can be addressed with appropriate action plan	Enforcement action. Low rating. Critical report.	Prosecution. Zero Rating. Severely critical report.

These are only examples and to be used as a guide. Actual grading will depend on individual circumstances and engagement with relevant team members.