



POLICY/PROCEDURE INFORMATION (Policy no OP002)	
Subject	Reporting of Incidents and Accidents Policy <i>(This policy is non-contractual and is subject to periodic review and will be amended according to service development needs).</i>
Applicable to	This policy applies to all staff and volunteers who work for Nottinghamshire Hospice.
Target Audience	Others such as agents, consultants and other representatives of Nottinghamshire Hospice may be required to comply with the policy as a condition of appointment.
Date issued	18 July 2023
Next review date	18 July 2026
Lead responsible for Policy	Chief Executive Officer
Policy reviewed by	Director of Care
Notified to (when)	Strategy and Corporate Governance Committee 18 July 2023
Authorised by (when)	Strategy and Corporate Governance Committee 18 July 2023
CQC Standard if applicable	Safe
Links to other Hospice Policies	Disciplinary Policy and Procedure HR0024 Whistle blowing Policy OP008 Risk Assessment Policy OP004
Links to external policies	
Summary	This policy outlines the legislation and regulations underpinning Incident and accident reporting and provides guidance on when and how to report.
This policy replaces	Reporting of Incidents and Accidents OP002 2022-2024

IMPORTANT NOTICE

Staff should refer to the Hospice website or Policies and Procedures folder on the 'N' drive for the most up to date Policy. If the review date of this document has expired it is still valid for 3 months.

After that staff should seek advice from their clinical lead or manager.

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	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	March 2024
Policy reviewed by Director of Care	June 2023	
Policy notified to Strategy and Corporate Governance Committee	18 July 2023	
Policy ratified by Strategy and Corporate Governance Committee	18 July 2023	18 July 2026
Updated control sheet and published on website	July 2023	

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1. Introduction

Nottinghamshire Hospice promotes a positive 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. Policy Statement/Aims

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, volunteers, 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 2013](#).

The Hospice also acknowledges the requirement to report accidents and incidents to various other stakeholders or external organisations including relevant

Commissioners (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 for future reference
- Identification of contributing factors to assist in implementing risk reduction strategies to reduce recurrence
- A means to analyse trends to enable appropriate action
- Assistance in minimising risk to staff, patients, visitors and contractors
- A means to identify any necessary policy or procedural changes
- Ensures that the Hospice complies with statutory regulations
- 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 aims to:

- Minimise the risk of untoward/serious incidents
- Ensure that all possible lessons are learned and shared as appropriate
- Improve patient safety
- Ensure staff and patients are supported through potentially distressing situations

<p>3.</p>	<p>Definitions</p> <p>Accident – an unplanned event resulting in injury to people or damage to property</p> <p>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.</p> <p>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.</p> <p>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.</p>
<p>4.</p>	<p>Responsibilities</p> <p>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:</p> <p>Director of Care is responsible for ensuring all patient and clinical incidents and near misses are managed, reported and recorded appropriately.</p> <p>Leadership Team are responsible for ensuring</p> <ul style="list-style-type: none"> • 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

- All measures possible are taken to minimise adverse incidents within their area of control
- All necessary actions are taken to prevent re-occurrence
- Staff are encouraged to report all incidents and near misses to their line manager That recommendations are implemented as directed
- Consistent feedback is given to staff to maintain the momentum of incident reporting and its benefits to patients and staff safety.

Staff, 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 staff to:

- 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 Reporting Form via Vantage (**Section 9**).
- If this is not possible (where staff or volunteers do not have a Hospice email) the form must be completed on that person's behalf by any other who has the relevant facts of the incident. This person must complete the form using the reporter's own words as much as possible.
- 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. Notifying External Organisations

The Hospice has a responsibility to report certain types of serious Incident/Accident to external bodies. This will be carried out by the Chief

Executive, Directors or their nominated Deputies. It is the responsibility of all Managers to ensure that all incidents are reported to their Director or deputy as soon as possible to ensure that the Hospice is in line with the statutory requirements.

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 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. [Riddor Reportable Incidents](#)

Care Quality Commission (CQC) Notifications

The Director of Care must report deaths and serious incidents affecting patients to the CQC within 48 hours of their occurrence.

The Director of Care must also report any incidents involving controlled drugs to NHS England.

Safeguarding Alerts

Some Incidents may trigger a safeguarding alert to the Multi-Agency Safeguarding Hub.

Police

For some incidents, the Police will have already been notified, if they have not, a Director may make the decision to inform them about the incident.

6. 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 or accident) 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 fortnightly, with appropriate links being made to ensure actions and learning for the Hospice.

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

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 Vantage incident report form

Low ‘Yellow Incidents’

These incidents should be reviewed in the department where the event occurred. The Head of Department will undertake a 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.

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

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 Leadership Team briefings and reported to the Board of Trustees.

<p>7.</p>	<p>Staff Training</p> <p>Training regarding the incident reporting procedures will be delivered in various forms for all staff and will be covered in:</p> <ul style="list-style-type: none"> • Staff Induction by their line manager • Managers can request a session on using the Vantage Incident reporting system from the Governance Lead
<p>8.</p>	<p>Monitoring</p> <p>The Hospice Quality and Safety Committee and Strategy and Corporate Governance Committee will monitor and review relevant incidents/ accidents.</p>
<p>9.</p>	<p>Incident and Accident Reporting Procedure (Appendix 1)</p> <p>Incident and Accident Reporting</p> <p>Incident Report forms will be completed for all incidents and accidents.</p> <p>All incidents/accidents are to be recorded as soon as possible after the incident has occurred via the online Vantage Incident Form. (Appendix 2, 3)</p> <p>All staff with a Hospice email will have a log-in and a password. Passwords can be reset if forgotten.</p> <p>Staff and volunteers without hospice email addresses must inform a nominated colleague who can complete the form on that person's behalf. This person must complete the form by putting the incident reporter's name in and using the reporter's own words.</p> <p>Within the Incident Form there are red fields – these must be completed before the form can be submitted.</p> <p>Once the form has been completed and submitted it will go to the Incident Reporter's manager who will investigate the Incident/Accident.</p> <p>Staff completing an Incident or Accident form must record only the facts as they know them and not opinions.</p>

Patients and Visitors

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

Managers Section/Investigation (Appendix 3)

Vantage will electronically alert the Manager that they have an Incident form on the system. Managers can put on an *Out of Office* if they are away for the Incident to be referred to another similar level manager.

On receiving the incident the Manager can see the form and can add to it. They also have a Managers/Investigation tab to complete (Appendix 2).

They will decide whether this needs a full investigation or more discussion and can, in consultation with their Director, allocate additional Investigators to the Incident/Accident.

Patient/Carer/Visitor

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

The Manager completes their section and then sends it onto the Incident Review Meeting.

Incident Review Meeting (Incident Closure Appendix 4)

At the Incident Review Meeting the incident/accident is reviewed by the Senior Leadership Team and Leadership Team.

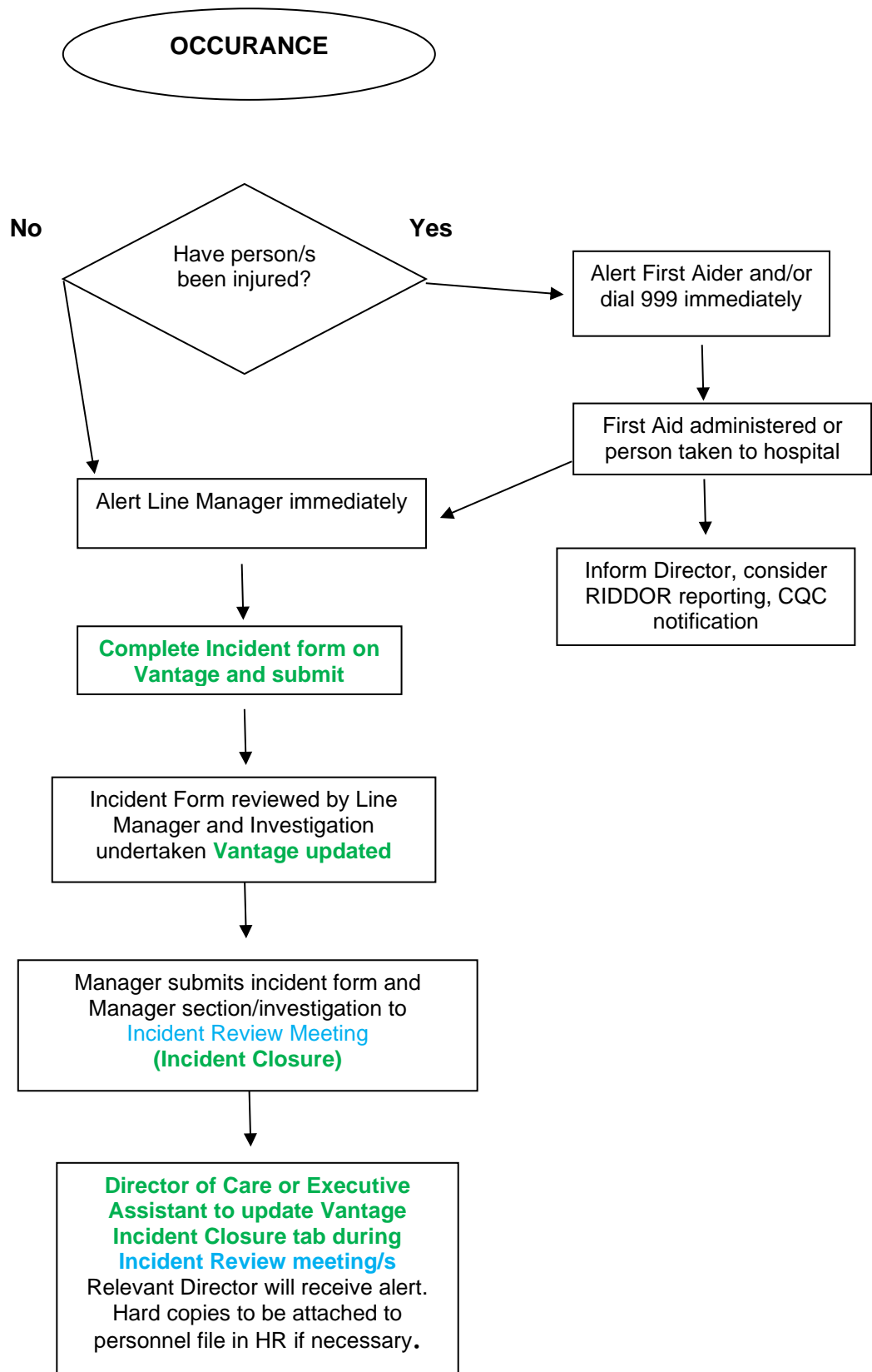
The Incident is Risk Scored within the tab (**Appendix 5**).

There is a check that all correct actions have been completed and agencies involved. An action plan tab is completed to look at if further actions are needed for individuals or the organisation.

The Incident may then be **Closed**, **Closed with action plan**, kept **In Progress** or

	by classed as <i>Investigation underway.</i>
10. Record Keeping	<p>All Incident and Accident records will be treated as confidential. Past records will be retained by either the Executive Assistant or Director of Care. All information kept 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.</p> <p>Information held on the Vantage system is subject to a complex encryption algorithm and not accessible to external individuals or agencies.</p> <p>Any identifiable data downloaded from the Vantage System will be anonymized as data only by the Administrators.</p>
11. Contractors	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>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</p>
12. References	<ol style="list-style-type: none"> 1. Health and Safety at Work Act 1974 2. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.

Incident Management FlowChart



Incident Form

Incident Reporting

Incident Reference No:

New Record (0 changes)

Record known facts only - do not record opinions; Completing this form does not constitute an admission of liability of any kind by any person; Any equipment involved in the incident should be retained in safe keeping for examination; If the incident is a Serious Incident (SI) this is to be reported IMMEDIATELY

Incident Reference No

Initial Details

Name of Person Reporting the Incident

Date of Incident



Time of Incident

Role

Department / Service

Location L1

Location L2

Location L3

Serious Incident, Incident or Near miss?

Full Incident Description

Any Injuries Sustained?

Immediate Action taken

Please describe what you did after the incident occurred

Reported to Department Line Manager/RN Leads

This should be reported immediately at all times to your Dept Line Manager/RN Lead


Incident Type - Main	[Please Select] ▼
Incident Type - Details	[Please Select] ▼
Was Any Person involved in the Incident?	[Please Select] ▼
Incident Type -Details	
Commissioner	[Please Select] ▼
Result	[Please Select] ▼
Outline any remedial or other action taken immediately following the incident	
	<i>Detail the steps taken to limit the spread of the incident. E.g. by isolating the area, communicating information to other staff or/and patients, cleaning the area</i>
In addition to the Dept. Mgr select any additional managers you wish to receive an alert	[Please Select]


Manager/Investigator Section

Manager Section

Line Manager's initial Findings/initial comments on Incident

Police Involved? [Please Select] ▼

Does Duty of Candour  apply to this incident [Please Select] ▼

Is this a safeguarding  incident? [Please Select] ▼
For Definitions of Safeguarding Concerns click the blue ? to the left

Has the referral met the threshold for investigation? [Please Select] ▼

Investigation Details

Actions and Learning

External Reporting

Underlying/Root Causes

Attach Document

Drop files here or

Incident Review Meeting

Incident Closure

Have you reviewed all Actions/Outcomes? [Please Select] ▼

Reputation Damage? [Please Select] ▼


Risk and Outcome Indicators

	Outcome					
Risk Grading	Negligible	Minor	Moderate	Major	Catastrophic	
Chances	Almost Certain Will undoubtedly happen/ recur, possibly frequently	5	10	15	20	25
	Likely Will probably happen/ recur but it is not a persisting issue	4	8	12	16	20
	Possible Might happen or recur occasionally	3	6	9	12	15
	Unlikely Do not expect it to happen/ recur but it is possible it may do so	2	4	6	8	10
	Rare This will probably never happen/ recur	1	2	3	4	5

What are the chances of the incident occurring again? [Please Select] ▼

What was the outcome of this incident? [Please Select] ▼

In Vantage the risk matrix is colour coded and clicking on a square will provide the narrative behind the risk score and populate the data in the boxes below.

Risk Colour	[Please Select]	▼
Risk Score	[Please Select]	▼
Date Risk Grading completed	<input type="text"/> 	
Are you happy to close this incident?	[Please Select]	▼
Incident closed by?	[Please Select]	▼
Current status of incident	In Progress	▼

Documents generated from templates

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

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.