Countess of Chester Hospital NHS
NHS Foundation Trust

POLICY FOR THE REPORTING OF INCIDENTS

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INTRODUCTION & EXECUTIVE SUMMARY

The Countess of Chester Hospital NHS Foundation Trust recognises that incident reporting, including near miss incident reporting, is essential in identifying where systems and processes may be improved in order to maintain patient and staff safety. The Trust is committed to appropriately managing and investigating all reported incidents; and to learn and make changes as a result of incidents in order to improve safety for patients, staff, visitors and contractors.

This document will outline the approved process for internal and external reporting of all incidents and near misses.

It aims to clearly explain:

- Who should report incidents
- What should be reported as an incident
- When incidents should be reported
- How to report an incident

It will also outline how staff can raise concerns for example, using the Trust's Speak out Safely (Raising Concerns About Patient Care) and Whistle Blowing Policy.

1.0 DUTIES – WHO SHOULD REPORT INCIDENTS

All Staff

- It is the responsibility of all staff to report all incidents and near misses on the organisations Datix system in a timely
- Staff are also required to participate in any investigation process and to assist with the implementation of changes instigated due to lessons learnt following any incident.
- All staff also have a duty to raise any concerns regarding care or other activities using the Speak out Safely (Raising Concerns About Patient Care) and Whistle Blowing Policy.

Managers must

- All managers are responsible for engaging all staff in the reporting and management of incidents.
- Managers are also responsible for ensuring that their staff receive the necessary level of incident reporting awareness/training in order to ensure that they are competent to identify, assess and report incidents (both actual and near miss) within their working environment.
- Managers must ensure that there are adequate systems in place for sharing the lessons learnt following incidents relevant to their areas.

Risk & Patient Safety Team must

- Ensure managers are alerted to all significant incidents or trends within their areas in a timely manner.
- Provide incident data and report progress against actions plans to all divisional and corporate forums as appropriate.
- Report incidents to appropriate external agencies including the Care Quality Commission (CQC), MONITOR, the relevant Clinical Commissioning Group (CCG) or health board, National Reporting and Learning System (NRLS), Medicines and Healthcare Regulatory Agency (MHRA), and other organisations as appropriate.

Divisional Boards must

- Receive governance reports which include Health & Safety issues, incident data, national guidance and other relevant governance/risk issues
- Receive serious incident investigation reports relating to their divisional activities and monitors progress against related action plans until completion.
- Review the action plans from sub groups and specialities throughout the Divisions to ensure progress and closure
- Receive and review escalated risks from the sub groups and specialties throughout the Division:
- Review the Divisional Risk Register and ensures appropriate development of treatment plans for remedial action
- Reviews minutes from sub groups and specialities throughout the Divisions which give assurance of effective risk management.

Quality, Safety and Patient Experience Committee

The Quality, Safety and Patient Experience Committee is a high level committee and it is a sub-committee of the Board of Directors. The Committee meets monthly and monitors the progress of all high risk issues including serious incidents and incident trend reports.

2.0 WHAT SHOULD BE REPORTED AS AN INCIDENT

Incident

An event or circumstance which could have resulted, or did result, in unnecessary damage, loss or harm to patients, staff, visitors or members of the public e.g:

- Clinical (i.e. affecting a patient) e.g investigation, diagnosis, treatment, medical equipment malfunction /misuse, decontamination issues, medicines management, confidentiality, consent
- Equipment: Including damage to equipment, equipment failure, unavailable equipment, user error.
- Fire Incident: Any incident, no matter how small, involving fire or fire alarm systems (including false alarms).
- Security Incident inc Violence and Aggression: Any untoward incident involving theft, loss or other damage to organisation, vehicles or personal property; intrusions, false alarms (but not fire alarms), absconded patients, verbal abuse, unsociable behaviour, racial or sexual harassment or physical assault, whether or not injury results.
- Health and Safety incidents

Near Miss

A near miss incident, event or omission that fails to develop further, whether or not compensating action was taken, and does not cause injury, harm or ill health. Such incidents may still have the potential to result in serious consequences e.g. prosecution.

3.0 WHEN TO REPORT AN INCIDENT

All incidents and near misses involving staff, patients and others must be reported within 24 hours of discovery.

4.0 HOW TO REPORT AN INCIDENT

There are a number of ways an incident can be reported. The preferred choice is the Datix Risk Management system:

Intranet Reporting

- From the Trust Intranet page click on the Datix icon to open up a new incident reporting form.
- Enter text into all of the relevant fields ensuring to add as much detail as possible, this will ensure a thorough investigation of the incident can be conducted. Give facts, not opinions. Do not use full upper case as this affects data transfer.
- Where the reporter has identified an actual harm of moderate or above, the duty of candour section must be completed to determine what information has been disclosed to the patient/family and their understanding of this.
- Enter the details of the persons involved in the relevant sections.
- An overview of the actions taken at the time of the incident must be completed to clearly state what you have done following the incident to minimise the incident happening again.
- Once all sections have been completed, you can submit the incident and print a copy for your own records.

With regard to safety, the Trust operates a fair and just culture. If a member of staff wish to report an incident anonymously they can do so by not completing the relevant section within the incident reporting form. The reporter may also wish to telephone the Risk & Patient afety Team to discuss the incident in confidence.

Reporting Potentially Serious Incidents

- All staff have responsibility to report any serious incidents (including serious incident near misses immediately on discovery to their Line Manager or Lead Consultant and/or to the Risk & Patient Safety Team (in person or by telephone). The incident must also be reported on the Trust's Datix Risk Management system as soon as appropriate.

- The manager or Lead Consultant has a responsibility to escalate any serious incidents (including serious near misses) which may require a serious incident investigation to the Director of Nursing, Quality and Environment, the Medical Director and/or the Head of Risk & Patient Safety.

- The Head of Risk & Patient Safety will oversee an initial overview (Situation, Background, Assessment, Recommendation (SBAR) report) of the potential serious

incident and this is escalated to the Executive Serious Incident Panel where it will be confirmed if the incident meets the criterion of the Serious Incident Framework.

Further details regarding serious incident reporting and investigations is found in the Policy for 'Investigating Incidents.'

5.0 NPSA NEVER EVENTS

All never events of near miss never events must be reported immediately to line manager/ Consultant.

The Senior Management Team must be informed as above.

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

The current Never Event List (2015/16) was published by NHS England in April 2015 and the never event list now includes:

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operative
4. Mis – selection of a strong potassium containing solutions
5. Wrong route administration of medication
6. Overdose of Insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis – seclection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients

6.0 INCIDENT GRADING SYSTEM

The degree of harm agreed by the National Reporting and Learning System (NRLS) is intended to record the actual degree of harm suffered by the patient as a direct result of the patient safety incident. However, this is not always the case. Sometimes reporters provide the potential degree of harm of an incident instead of the actual degree of harm that occurred. For example, in the case of 'near misses' (where no harm resulted as the impact was prevented) the resulting degree of harm is occasionally coded as 'severe'.

In addition, reporters may code the degree of harm as 'severe' when the patient is expected to suffer severe but temporary harm (for example, severe bruising), which conflicts with the NRLS definition of significant and permanent harm.

For incident grading, the Trust follows the NRLS coding of degree of harm as described below

	None (No Harm)	Low (Minimal Harm)	Moderate (Short Term Harm)	Severe (Permanent or Long Term Harm)	Death (Caused by the incident)
No Harm	X				
Near Miss	X				
Actual Harm		X	X	X	X

The Trust's Datix Risk Management system also enables the reporter to capture potential harm.

7.0 HOW STAFF CAN RAISE CONCERNS FOR EXAMPLE, WHISTLE BLOWING, OPEN DISCLOSURE, ETC

The Trust has a range of policies and procedures which deal with standards of behaviour at work notably, discipline, grievances, harassment and bullying, staff concerns about patient care, and the anti-fraud and corruption strategy. These documents provide a route by which staff can identify their concerns in the knowledge that there is a responsibility imposed on management team to investigate such concerns. In normal circumstances therefore, staff will be encouraged to use the provisions of those policies and procedures.

There may be times, however, when the matter is extremely sensitive and needs to be handled in a different way and when it is not felt appropriate to use normal management reporting channels. In those instances, the provisions of the Speak out Safely (Raising Concerns About Patient Care) and Whistle Blowing Policy may be more appropriate.

8.0 FEEDBACK TO STAFF

The divisions receive feedback regarding incident trends and specific lessons learned following serious incident reviews through the divisional forums.

Immediate lessons learned from incidents are shared by Ward Managers/Matrons, Departmental Leads and Medical Staff etc at safety briefings.

It is recognised that incident trend feedback to staff could be further improved and this is currently being explored.

9.0 REPORTING INCIDENTS TO EXTERNAL AGENCIES

Process for reporting incidents to external stakeholders such as North West Ambulance Trust, Cheshire & Wirral Partnership Hospitals NHS Foundation Trust and other care providers.

- Staff report the incident on the Datix Risk Management system
- Risk and Patient Safety Leads alert the team's Compliance Officer to the incident and the relevant external provider
- Incidents suggesting that an immediate review is required are forwarded on immediately by email otherwise incidents are forwarded on a monthly basis to the relevant external provider
- Feedback is requested for any incident graded as moderate or above and the reporter notified of this, if received.

Process for reporting Serious Incidents to West Cheshire Clinical Commissioning Group (CCG), Betsi Cadwaladr University Health Board (BCUHB), Care Quality Commission (CQC), MONITOR and NHS England Specialist Commisioning - please refer to the Policy for Incident Investigations for further details

- The Executive Serious Incident Panel will determine if an incident meets the criterion of the Serious Incident Framework and therefore requires reporting externally
- Where appropriate the Director of Nursing, Quality and Environment (or deputy) will discuss the incident with West Cheshire Clinical Commissioning Group (CCG) to provide assurances of the Trust's actions.
- The Head of Risk & Patient Safety will ensure that the incident is reported on the Strategic Executive Information System (StEIS) within 2 working days of the incident being confirmed as meeting the criterion of the Serious Incident Framework. This submission automatically notifies the West Cheshire Clinical Commissioning Group (CCG) and the Care Quality Commission (CQC) of the incident.
- Once a StEIS number has been generated, the Head of Risk & Patient Safety will also notify the relevant leads within the West Cheshire Clinical Commissioning Group (CCG) and the Care Quality Commission (CQC) of the incident by email. If the incident involves a service monitored by NHS Specialist Commissioning, the Head of Risk & Patient Safety will also notify the relevant lead for that service. If the incident involves a 'never event', the Head of Risk & Patient Safety will also notify the relevant contact within MONITOR.
- Monthly data is provided relating to serious incidents involving patients whose care is funded by Betsi Cadwaladr University Health Board (BCUHB) and discussed at the monthly quality contract meeting between both organisations.
- Once the investigation report has been finalised, the Head of Risk & Patient Safety will forward the report to the West Cheshire Clinical Commissioning Group (CCG) via the Clinical Support Unit. The timescale for submission of the final report is 60 working days following reporting on Strategic Executive Information System (StEIS). If the incident involves a service monitored by NHS Specialist Commissioning, the Head of Risk & Patient Safety will also forward the report to the relevant lead for that service. If the incident involves a patient whose care is funded by Betsi Cadwaladr University Health Board (BCUHB) the Head of Risk & Patient Safety will also notify the relevant contact within Betsi Cadwaladr University Health Board (BCUHB) .
- Completed serious incident reports and action plans are reviewed at the monthly West Cheshire Clinical Commissioning Group (CCG) Serious Incident Meeting.