

INCIDENT AND SERIOUS UNTOWARD INCIDENT AND NEAR MISS REPORTING POLICY

Document Summary

To ensure incidents of all types that occur within Hospice at Home are consistently routinely reported, promoting a fair and just culture and enabling such incidents to be managed appropriately to minimise risk to all service users and staff.

This is the final version of this document and all other versions must be destroyed.

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1. SCOPE

This policy applies to all Hospice at Home Carlisle and North Lakeland services, patients, staff, volunteers and others who may be affected by incidents or near misses that occur in connection with Hospice at Home activity.

2. INTRODUCTION

The collation and analysis of data on incidents and near misses is an intrinsic part of risk management as it provides valuable opportunities to learn and improve. This policy describes Hospice at Home arrangements for reporting incidents of all types of any significance and actions expected to manage and follow up such incidents. This policy supports the Being Open Policy, and Dealing with Complaints and Comments.

3. STATEMENT OF INTENT

Hospice at Home is committed to supporting and embedding a positive reporting culture to enable learning when things have gone wrong. In particular Hospice at Home will:

- Ensure a culture is promoted, that assures Hospice at Home will have an open and just environment;
- Ensure all incidents are managed in a timely and organised manner;
- Ensure robust record keeping and reporting mechanisms are in place;
- Ensure clear lines of accountability and responsibility are identified for all elements of incident management;
- Ensure that all staff are aware of the communication systems in place for the management of all types of incidents, via induction and training;
- Establish key communication mechanisms with family and or carers in line with the Being Open Policy;
- Ensure all appropriate levels of debrief and publicity of lessons learned take place following incidents;
- Ensure all relevant regulatory bodies and external Stakeholders are engaged and involved and included in line with National guidelines;
- Ensure lessons are learned from reported incidents, and take appropriate action to avoid a recurrence, including making changes to practice and or the environment to improve patient and staff safety.

- Ensure no disciplinary action will result from reporting an incident (including near misses) unless there is evidence of:

Criminal or malicious activity;
Professional malpractice;
Act of gross misconduct;
Repeated mistakes; or
Where errors or violation have not be reported.

Under the circumstances, disciplinary action will be considered.

4. DEFINITIONS

4.1 Reportable Incident

The broad definition of a reportable incident is any situation or event:

- That led to an unexpected death;
- Where a person came to harm;
- Where a person could have come to harm;
- Which disrupts the normal running of the service;
- Which could lead to a complaint / claim.

4.2 Serious Untoward Incident (SUI)

Serious Untoward Incidents relate to reported incidents graded 15 on the risk matrix and one which may or has:

- Resulted in death (including deaths from suspected suicide or serious injury);
- Contributed to a pattern of reduced standards of care;
- Involved safeguarding incidents;
- Involved a hazard to public health;
- Caused serious disruption to services which involved invoking of the Business Continuity plan;
- Caused significant damage to the reputation of Hospice at Home or the staff;
- Resulting in a serious assault of staff;
- Caused significant damage to Hospice at Home assets;
- Involved fraud or suspected fraud;
- Given rise to a significant claim of damages;
- Involved the suspension of a member of staff;
- Resulted in involvement of external investigation agencies such as the Care Community Commission, Charity Commission or Health and Safety Executive;
- Resulted in a serious breach of confidentiality;

- Serious harm involving medical devices or medication error; or
- Raised severe criticism by an external body e.g. Coroner's inquest, Parliamentary and Healthcare Ombudsman.

4.3 Reporting of a Serious Untoward Incident (SUI)

An incident form should be completed within 24 hours of an SUI, or suspected SUI occurring. The manager where the incident occurred is responsible for ensuring the form is completed and is sent to the Chief Executive or Chair of Trustees within 24 hours.

4.4. 5 Day Clinical Review

A clinical review of an incident which is undertaken in the case of SUIs or when further information is required in order to determine whether an incident is an SUI. Reviews will be led by the Clinical Lead and Quality Facilitator. For non-clinical incidents relating to charitable activities will be led by the Head of Non-Clinical Services. Once a review has occurred, the completed 5 day review report should be sent to the Chief Executive.

4.5. Near Miss

Any event that occurred, but which was not anticipated or planned, which did not actually lead to harm, loss or damage, but under different circumstances could have done.

4.6 A Major Incident (to invoke Business Continuity Plan)

An unexpected event which overwhelms normal resources, and which requires special measures.

4.7 RIDDOR

The Reporting of Injury, Diseases and Dangerous Occurrences Regulations 1995 (HSF 1999). RIDDOR defines the type of incident, diseases and occurrences that must be reported to the Health and Safety Executive to comply with Statutory requirements. See Guidance in Appendix 1.

4.8 Incident Reports

All incidents are reported via the Incident Reporting Form (Appendix 2).

5. DUTIES

5.1 Chief Executive

The Chief Executive has overall responsibility for the management of incidents and associated reporting arrangements.

The Chief Executive or nominated individual will have responsibility for dealing with any media enquiries if required.

5.2 Managers: The Clinical Lead and Quality Facilitator and Head of Non-Clinical Services will:

- Ensure incident reporting arrangements are implemented within their service areas;
- Following an incident, take immediate action within the scope of their remit to prevent recurrence and/or eliminate or reduce any identified risks i.e. make the environment safe;
- In the event of an SUI make appropriate notifications internally to the Chief Executive or Chair of Trustees;
- 'Sign-off' incidents and near misses reported;
- Ensure incident reporting forms are completed with appropriate information;
- Conduct local investigation into all reported incidents;
- Notify the Health and Safety Executive for any incident that falls under RIDDOR;
- Conduct a risk assessment and notify the Chief Executive of identified risks highlighted by an incident or near miss if risks cannot be reduced to an acceptable level;
- Provide immediate and appropriate support to staff following incidents internally and if necessary externally;
- Encourage a positive reporting culture with Hospice at Home;
- Ensure 5 day clinical team post incident reviews for SUI are undertaken in a timely manner; and
- Nominate an individual to 'sign off' incident forms in their absence.

5.3 All Staff

All staff are responsible for adhering to this policy, in particular they will:-

- Report incidents and near misses using the incident reporting form;
- Raise any concerns about situations that led to, or could lead to, an incident or near miss with the line manager; and
- Participate and co-operate with post incident reviews and investigations.

5.4 Assurance committee

The Assurance Committee will receive reports utilising data from reported incidents, and seek further reports and assurances where they consider further action is required.

6. PROCESS AND ARRANGEMENTS FOR REPORTING ALL INCIDENTS AND NEAR MISSES

6.1 Immediate action to take following an Incident or Near Miss Event

Immediate action will depend on the individual circumstances of the incident or event. Wherever possible, action should address any faults or defects that expose staff, patients or others to imminent significant harm.

6.2 Incident Report Form

All sections of the incident form must be completed. Incident forms are a management document and originals or copies must not be filed in clinical records. These documents will need to be disclosed in the event of a claim against Hospice at Home. It is essential that fact, not opinion, is only being documented.

Completion of an incident form does not constitute an admission of liability or any kind to any person.

6.3 What to Report

It is not possible to be prescriptive about what should be reported, however Hospice at Home has the culture that all incidents or near misses should be reported in order to identify any trends and to learn from incidents or near misses.

All persons directly involved in an incident must be identified on the incident report forms.

Incident or Fraud, or Suspected Fraud

In the event of serious fraudulent activity, the Chief Executive or Chair of Trustees must be informed immediately.

Incidents of Violence and Aggression

Any incident of Violence or aggression (including verbal aggression) towards staff, patients or others acting on behalf of Hospice at Home, including incidents where the clinical condition of a patient may be a factor.

6.4 Notification of External Stakeholders, Agencies and Regulatory Bodies

Upon receipt of an incident report it may be necessary to submit notification to Care Quality Commission (CQC).

6.5 Involvement of Media following an Incident

Hospice at Home will not notify media before staff, patients or public specifically involved have been informed.

6.6 Investigation

All incidents and near misses will be subject to an investigation, depending on the severity. Incidents graded green will have a local level investigation completed at the time of the incident and reported on the incident form.

Hospice at Home has a statutory obligation to report and fully investigate Untoward Incidents (SUI). Hospice at Home will, if required, involve another organisation to undertake the investigation.

6.7 Feedback on Reported Incidents

It is the responsibility of the manager (or their nominated deputy) to provide feedback to the person who reported the incident on actions taken following the event. Feedback on incidents will be given at team meetings.

6.8 Requests to provide witness statements in relation to incident investigations or inquests

All correspondence in relation to inquests will be the responsibility of the Chief Executive.

7. TRAINING

Hospice at Home will provide training as required.

8. MONITORING COMPLIANCE WITH THIS POLICY

The table below outlines Hospice at Home's monitoring arrangements for this policy.

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Committee which will receive the findings/monitoring report
Incidents will be reported and managed in accordance with the policy including; <ul style="list-style-type: none"> duties process for reporting all incidents/near misses involving staff, service 	Analysis of reported incidents data. This report will be completed in conjunction with the review of	Chief Executive	Annual	Assurance Committee Workforce Committee

<ul style="list-style-type: none"> • users and others • process for reporting to external agencies • reference to the processes for staff to raise concerns, e.g. whistle blowing/open disclosure 	<p>investigations and of aggregation of incidents, complaints and claims</p>			
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9. REFERENCES/BIBLIOGRAPHY

Serious Untoward Incident Reporting Protocol, *NHS North West*, March 2008
 A Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, L73, *HMSO, 1999, Norwich*
 NPSA

10. RELATED POLICY/PROCEDURES

Whistleblowing Policy
 Policy on Prevention and Management of Violence and Aggression

Appendix 1 – Guidance on RIDDOR

Reporting accidents and incidents at work

A brief guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

What is RIDDOR?

RIDDOR is the law that requires employers, and other people in control of work premises, to report and keep records of:

- work-related accidents which cause death;
- work-related accidents which cause certain serious injuries (reportable injuries);
- diagnosed cases of certain industrial diseases; and
- certain 'dangerous occurrences' (incidents with the potential to cause harm).

There are also special requirements for gas incidents (see 'Reportable gas incidents').

This leaflet aims to help employers and others with reporting duties under RIDDOR, to comply with RIDDOR and to understand reporting requirements.

RIDDOR 2013 Changes

From 1 October 2013, RIDDOR 2013 comes into force, which introduces significant changes to the existing reporting requirements. The main changes are to simplify the reporting requirements in the following areas:

- the classification of 'major injuries' to workers is being replaced with a shorter list of 'specified injuries';
- the previous list of 47 types of industrial disease is being replaced with eight categories of reportable work-related illness;
- fewer types of dangerous occurrence require reporting.

There are no significant changes to the reporting requirements for:

- fatal accidents;
- accidents to non-workers (members of the public);
- accidents which result in the incapacitation of a worker for more than seven days

Recording requirements remain broadly unchanged, including the requirement to record accidents resulting in the incapacitation of a worker for more than three days.

Why report?

Reporting certain incidents is a legal requirement. The **report** informs the enforcing authorities (HSE, local authorities and the Office for Rail Regulation (ORR)) about deaths, injuries, occupational diseases and dangerous occurrences, so they can identify where and how risks arise, and whether they need to be investigated. This allows the enforcing authorities to target their work and provide advice about how to avoid work-related deaths, injuries, ill health and accidental loss.

What must be reported?

Work-related accidents

For the purposes of RIDDOR, an accident is a separate, identifiable, unintended incident that causes physical injury. This specifically includes acts of non-consensual violence to people at work.

Not all accidents need to be reported, a RIDDOR report is required only when:

- the accident is **work-related**; and
- it results in an injury of a type which is **reportable** (as listed under 'Types of reportable injuries').

When deciding if the accident that led to the death or injury is work-related, the key issues to consider are whether the accident was related to:

- the way the work was organised, carried out or supervised;
- any machinery, plant, substances or equipment used for work; and
- the condition of the site or premises where the accident happened.

If none of these factors are relevant to the incident, it is likely that a report will not be required.

See www.hse.gov.uk/riddor/do-i-need-to-report.htm for examples of incidents that do and do not have to be reported.

Types of reportable injury

Deaths

All deaths to workers and non-workers must be reported if they arise from a work-related accident, including an act of physical violence to a worker. Suicides are not reportable, as the death does not result from a work-related accident.

Specified injuries to workers

- The list of 'specified injuries' in RIDDOR 2013 (regulation 4) includes:
- a fracture, other than to fingers, thumbs and toes;
- amputation of an arm, hand, finger, thumb, leg, foot or toe;
- permanent loss of sight or reduction of sight;
- crush injuries leading to internal organ damage;
- serious burns (covering more than 10% of the body, or damaging the eyes, respiratory system or other vital organs);
- scalpings (separation of skin from the head) which require hospital treatment;
- unconsciousness caused by head injury or asphyxia;
- any other injury arising from working in an enclosed space, which leads to hypothermia, heat-induced illness or requires resuscitation or admittance to hospital for more than 24 hours.

Over-seven-day injuries to workers

This is where an **employee, or self-employed person, is away from work or unable to perform their normal work duties for more than seven consecutive days** (not counting the day of the accident).

Injuries to non-workers

Work-related accidents involving members of the public or people who are not at work must be reported if a person is injured, and is taken from the scene of the accident to hospital for treatment to that injury. There is no requirement to establish what hospital treatment was actually provided, and no need to report incidents where people are taken to hospital purely as a precaution when no injury is apparent.

If the accident occurred at a hospital, the report only needs to be made if the injury is a 'specified injury' (see above).

Reportable occupational diseases

Employers and self-employed people must report diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work. These diseases include (regulations 8 and 9):

- carpal tunnel syndrome;
- severe cramp of the hand or forearm;
- occupational dermatitis;
- hand-arm vibration syndrome;
- occupational asthma;
- tendonitis or tenosynovitis of the hand or forearm;
- any occupational cancer;
- any disease attributed to an occupational exposure to a biological agent.

Reportable dangerous occurrences

Dangerous occurrences are certain, specified 'near-miss' events (incidents with the potential to cause harm.) Not all such events require reporting. There are 27 categories of dangerous occurrences that are relevant to most workplaces. For example:

- the collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
- plant or equipment coming into contact with overhead power lines;
- explosions or fires causing work to be stopped for more than 24 hours.

Certain additional categories of dangerous occurrences apply to mines, quarries, offshore workplaces and certain transport systems (railways etc). For a full, detailed list, refer to the online guidance at: www.hse.gov.uk/riddor.

Reportable gas incidents

If you are a distributor, filler, importer or supplier of flammable gas and you learn, either directly or indirectly, that someone has died, lost consciousness, or been taken to hospital for treatment to an injury arising in connection with the gas you distributed, filled, imported or supplied, this can be reported online.

If you are a gas engineer registered with the Gas Safe Register, you must provide details of any gas appliances or fittings that you consider to be dangerous to the extent that people could die or lose consciousness or require hospital treatment. This may be due to the design, construction, installation, modification or servicing, and could result in an

- inadequate combustion of gas; or
- inadequate removal of products of the combustion of gas.
- An accidental leakage of gas

You can report online.

Exemptions

In general, reports are not required (regulation 14) for deaths and injuries that result from:

- medical or dental treatment, or an examination carried out by, or under the supervision of, a doctor or registered dentist;
- the duties carried out by a member of the armed forces while on duty; or
- road traffic accidents, unless the accident involved:
 - the loading or unloading of a vehicle;
 - work alongside the road, eg construction or maintenance work;
 - the escape of a substance being conveyed by the vehicle; or
 - a train.

Recording requirements

Records of incidents covered by RIDDOR are also important. They ensure that you collect sufficient information to allow you to properly manage health and safety risks. This information is a valuable management tool that can be used as an aid to risk assessment, helping to develop solutions to potential risks. In this way, records also help to prevent injuries and ill health, and control costs from accidental loss.

You must keep a record of:

- any **accident, occupational disease or dangerous occurrence** which requires reporting under RIDDOR; and
- any other occupational accident causing injuries that result in a worker being away from work or **incapacitated for more than three consecutive days** (not counting the day of the accident but including any weekends or other rest days). You do not have to report over-three-day injuries, unless the incapacitation period goes on to exceed seven days.

If you are an employer who has to keep an accident book, the record you make in this will be enough.

You must produce RIDDOR records when asked by HSE, local authority or ORR inspectors.

How to report

Online

Go to www.hse.gov.uk/riddor and complete the appropriate online report form. The form will then be submitted directly to the RIDDOR database. You will receive a copy for your records.

Telephone

All incidents can be reported online but a telephone service remains for reporting **fatal and specified injuries only**. Call the Incident Contact Centre on 0845 300 9923 (opening hours Monday to Friday 8.30 am to 5 pm).

Reporting out of hours

HSE has an out-of-hours duty officer. Circumstances where HSE may need to respond out of hours include:

- a work-related death or situation where there is a strong likelihood of death following an incident at, or connected with, work;
- a serious accident at a workplace so that HSE can gather details of physical evidence that would be lost with time; and
- following a major incident at a workplace where the severity of the incident, or the degree of public concern, requires an immediate public statement from either HSE or government ministers.

If you want to report less serious incidents out of normal working hours, you should complete an online form at www.hse.gov.uk/riddor/report.htm#online.

You can find more information about contacting HSE out of hours at www.hse.gov.uk/contact/outofhours.htm.

Industry-specific guidance

Accident book BL510 HSE Books 2012 ISBN 978 0 7176 6458 0
www.hse.gov.uk/pubns/books/accident-book.htm

Incident reporting in schools (accidents, diseases and dangerous occurrences) Education Information Sheet EDIS1(rev3) HSE Books 2013 www.hse.gov.uk/pubns/edis1.htm

Reporting injuries, diseases and dangerous occurrences in health and social care: Guidance for employers Health Services Information Sheet HSIS1(rev3) HSE Books 2013
www.hse.gov.uk/pubns/hsis1.htm

Further information

For information about health and safety, or to report inconsistencies or inaccuracies in this guidance, visit www.hse.gov.uk/. You can view HSE guidance online and order priced publications from the website. HSE priced publications are also available from bookshops.

This guidance is issued by the Health and Safety Executive. Following the guidance is not compulsory, unless specifically stated, and you are free to take other action. But if you do follow the guidance you will normally be doing enough to comply with the law. Health and safety inspectors seek to secure compliance with the law and may refer to this guidance.

This leaflet is available at: www.hse.gov.uk/pubns/indg453.htm.

APPENDIX 2 – INCIDENT REPORTING FORM

Employee Reporting Incident:

Name: _____ Title/Position _____ Date: _____

Incident

Date: _____ Time: _____

Patient/Staff/Volunteer/Participant Details:

Description of Incident

Witnesses

Action Taken

Was the Incident Reported to the Police? Yes No

By signing this document, you acknowledge that you have read and understood the information contained herein

Employee (Print Name)

Signature

Date

Management Section

Risk Matrix

		Consequences				
		<u>Insignificant</u> 1	<u>Minor</u> 2	<u>Moderate</u> 3	<u>Major</u> 4	<u>Catastrophic</u> 5
Likelihood	<u>Almost Certain</u> 5	5	10	15	20	25
	<u>Likely</u> 4	4	8	12	16	20
	<u>Possible</u> 3	3	6	9	12	15
	<u>Unlikely</u> 2	2	4	6	8	10
	<u>Rare</u> 1	1	2	3	4	5

Score on Risk Matrix:

Further Action Required/Taken by Whom/When

Risk Matrix

		Consequences				
		<u>Insignificant</u> 1	<u>Minor</u> 2	<u>Moderate</u> 3	<u>Major</u> 4	<u>Catastrophic</u> 5
Likelihood	<u>Almost Certain</u> 5	5	10	15	20	25
	<u>Likely</u> 4	4	8	12	16	20
	<u>Possible</u> 3	3	6	9	12	15
	<u>Unlikely</u> 2	2	4	6	8	10
	<u>Rare</u> 1	1	2	3	4	5

Score on Risk Matrix:

Does this incident meet Duty of Candour Requirement? (for completion by Manager)

Yes No

By signing this document, you acknowledge that you have read and understood the information contained herein

Manager (Print Name)

Signature and Date