Belfast Health and Social Care Trust
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Reference No: TP 08/08

Title:	**Adverse Incident Reporting and Management Policy**		
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	BHSCT General Health and Safety Policy (2018) TP 50/08 BHSCT Policy on the Data Protection and Protection of Personal Information (2018) TP 26/08 BHSCT Risk Management Strategy (2020) TP 58/08 BHSCT Medicines Code Policy (2020) SG 09/11

Date	Version	Policy Author	Comments
25/02/2008	1.0	M Bardgett	Adverse Incident Reporting and Management Policy
19/04/2010	2.0	CR Cairns	Revised Adverse Incident Reporting and Management Policy
April 2014	3.0	CR Cairns	Revised Adverse Incident Reporting and Management Policy
29/11/2017	4.0	G Moore	Interim update pending regional policy
January 2020	4.1	Regional Group	After a period of Regional consultation Department of Health issued a template for the management of incidents and requested all Trust to update their existing Trust Policy to reflect Regional template
May 2020	4.2	G Moore R Henry	Adoption of Regional template customised to reflect BHSCT arrangements

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

Belfast Health & Social Care Trust has had a Trust Policy that covers Incident management from 2008. Following recommendations of the Regional Learning System Project Report (August 2015), it was agreed to develop a regional policy on the reporting and management of adverse incidents to be used by all Health & Social Care Trusts, the Northern Ireland Ambulance Service (NIAS) and the Health & Social Care Board (HSCB) hereinafter called ("the organisation").

1.2 Introduction

This policy provides the framework for reporting and managing all adverse incidents which affect service users[1], staff and visitors to its premises or have an impact on the Belfast Health and Social Care Trust[2] (BHSCT), its reputation or its legal duty of care.

The manner in which an organisation manages and learns from adverse incidents is one of the key markers of success in relation to risk management, corporate and clinical and social care governance standards. Consistent identification, monitoring and review of incidents is central to the

organisation's strategic and operational processes to ensure it can achieve its vision for safe and effective care.

It recognises that no health and social care environment will ever be absolutely safe and, on occasions, errors or incidents will occur. Equally, it recognises that when incidents do occur it is important to identify causes to ensure that lessons are learned to prevent recurrence.

The organisation is committed to an open, honest and just culture and reporting of adverse incidents is encouraged so that the organisation can learn from incidents and take actions including changes in practice to reduce the risk of recurrence. It also will ensure that staff learn and are supported in making changes to their practice, post incidents, as required.

1.3 Purpose of policy

This policy provides guidance on the reporting and managing of adverse incidents which affect service users, staff and visitors to its premises or have an impact on the organisation, its reputation or its legal duty of care. It will also enable a robust and systematic approach to the management of adverse incidents that will be consistently applied across the organisation ensuring that it meets all relevant statutory[3] or mandatory responsibilities and reporting requirements thereby safeguarding the wellbeing of service users, staff and visitors.

It has been developed to ensure organisational wide learning takes place within a structured framework and that any lessons learned are disseminated widely throughout the organisation and to external agencies, as appropriate.

1.4 Policy Aims and Objectives

Adverse incident management systems assist organisations to ensure that systems are in place to secure service user, staff and visitor safety; ensure internal accountability and safeguard the organisation's assets and reputation. Learning from adverse incidents enables the organisation to proactively reduce risk and improve services. It recognises that most incidents occur because of problems with systems rather than individuals but may also on occasions be multifactorial in nature.

The objectives of this policy are:-

- To promote and provide a unified regional organisational wide system for the reporting, recording, review and analysis of all adverse incidents;

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[1] The term service user also refers to patients, clients, children and young people under 18 years and carers
[2] "the Trust"
[3] Health & Safety at Work Order 1978, Management of Health and Safety at Work Regulations (Northern Ireland) 2000 and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.

- To improve the safety and quality of care through reporting, analysing and learning from incidents involving service users, staff and visitors (including contractors);
- To comply with relevant legislation and standards relating to the reporting of incidents;
- To ensure all adverse incidents are dealt with appropriately and in a timely and consistent manner;
- To provide a means of analysing trends in incidents and identification of factors contributing to incidents to assist in implementation of service improvement and risk reduction strategies, thereby minimising risk to service users, staff and visitors and the organisation; and
- To support staff when mistakes happen and encourage staff to review and reflect on their practice post review of incidents.

1.5 Legislative Requirements

The key legislative reporting requirements for organisations in respect of adverse incidents are as follows:-

- Health & Safety at Work (NI) Order 1978;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1997;
- Social Security Claims and Payments Regulations 1979; and
- The Public Interest Disclosure Act 1998.

2.0 SCOPE OF THE POLICY

This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors, students, volunteers and bank and agency staff or locums and any others to whom the organisation owes a duty of care.

This policy excludes detailed arrangements in respect of the following areas, which are covered by separate regionally agreed policies:-

- Policy for Reporting Early Alerts to Department of Health;
- Being Open Policy;
- Policy for Reporting Adverse Incidents under RIDDOR Regulations;
- Supporting Staff Involved in Incidents, Complaint, Claims and Coroner's Inquests;
- Policy on Memorandum of Understanding (MOU) - Investigating Service User Safety Incidents

3.0 ROLES AND RESPONSIBILITIES

3.1 **Trust Board:** is responsible for ensuring that a robust system is in place for the reporting and management of adverse incidents and will receive regular management reports on this subject matter.

3.2 **Chief Executive**:is the Accountable Officer for the organisation and is responsible for ensuring that it meets its statutory and legal requirements in respect of adverse incident reporting and management. He/she will ensure that the Trust adheres to, and responds appropriately to, circulars and guidance issued by the Department of Health (DoH) in respect of adverse incident management. The Chief Executive has delegated these executive functions to the Medical Director.

3.3 **Medical Director:** is the lead Director responsible for the reporting and management of adverse incidents within the Trust. He/she will ensure that systems, policies and procedures are developed and implemented on an organisational basis including the onward reporting of relevant incidents to external agencies for eg, Health & Social Care Board (HSCB), Heath & Safety Executive for Northern Ireland (HSENI) and the Regulation, Quality Improvement Authority (RQIA). On a daily basis this function is delegated to the Co-Director for Risk & Governance

3.4 **Co Director for Risk & Governance:** will support the Medical Director in meeting his/ her responsibility for the management of adverse incidents throughout the BHSCT.

3.5 **Director/s:** are responsible for ensuring that the Trust's policy on adverse incident reporting and management is widely disseminated, promoted and implemented within their areas of responsibility.

3.6 **Co-Directors and Senior Clinicians:** are responsible and accountable to their respective Directors for ensuring that this policy and any associated procedures are effectively implemented within their areas of responsibility. They should also promote an open, honest and just reporting culture and ensure that appropriate reviews are carried out.

3.7 **Senior Manager, Corporate Governance Services:** will support the Co-Director Risk and Governance in meeting his/her responsibility for adverse incident management.

3.8 **Senior Manager responsible for RIDDOR (Corporate Standards and Risk):** will support the Co-Director Risk and Governance in meeting his/her responsibility for adverse incident management and will ensure that systems are in place for the appropriate management and reporting of Health and Safety incidents including the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR).

3.9 Head of Pharmacy and Medicines Management: as Controlled Drugs Accountable Officer must ensure there are safe systems in place for the management and use of controlled drugs. Adverse incidents and concerns involving controlled drugs are reported to the Accountable Officer.

3.10 Medicines Governance Pharmacist: is responsible for the expert review, quality assurance and identification of learning from reported medication incidents. In the event an adverse incident is categorised as a Serious Adverse Incident, they should be involved in the review. He /she is also responsible for submission of HSC Trust medication incident data for regional analysis by the Medicines Governance Teams.

3.11 Senior Information Risk Owner (SIRO): is the lead Director for ensuring that Information Governance (IG) incidents are reported and appropriately managed including reporting to Information Commissioner's Office, if necessary. He/she (or nominee) will provide advice and support to managers in respect of IG incidents, as appropriate.

3.12 Senior Managers, Heads of Departments/Services: are responsible for:

- ensuring that this policy and associated procedures are effectively implemented across their area of responsibility;
- promoting an open, honest and just reporting culture;
- ensuring that staff are appropriately trained in the reporting and management of adverse incidents;
- ensuring that appropriate review of adverse incidents is carried out;
- ensuring staff are given appropriate support following an adverse incident;
- ensuring communication with the service user and/or their relatives/carers as appropriate. (See Being Open Policy for guidance);
- trend analysis of incidents and identification of factors contributing to incidents to assist in service improvement and risk reduction strategies

3.13 Incident Approver

The Approver is responsible for reviewing, approving and/or escalation of incidents via DatixWeb, and for:

- ensuring that all possible remedial action is taken immediately following an adverse incident to prevent reoccurrence without compromising the investigation processes;
- ensuring the onward reporting of adverse incidents both internally and, where appropriate, externally and that their staff are aware of these particular local arrangements;
- securing all relevant evidence including materials, equipment, consumables, samples, records, witness details etc and ensuring that these are not compromised until appropriate investigation is complete. (See Procedure for Investigating an Incident);
- ensuring that where a death or a major injury has occurred, the security of the location and/or equipment/consumables, is maintained for inspection purposes by senior managers and/or statutory authorities (See Procedure

for Investigating an Incident);

- providing feedback and sharing learning with staff and ensuring that risk assessments and training needs are reviewed where relevant following adverse incident reviews.
- trend analysis of incidents and identification of factors contributing to incidents to assist in service improvement and risk reduction strategies

3.14 All staff: have a responsibility to:

- ensure the safety of individuals involved (service users, visitors and staff), the environment and equipment;
- avoid putting themselves and others in situations of danger;
- ensure their line manager/s and/or person in charge of the area is informed of the incident;
- record and report all adverse incidents using the organisation's reporting systems as soon as possible and ideally within 24 hours of the occurrence or becoming aware of the adverse incident; and
- co-operate with any review process including the provision of witness statements, if appropriate.

4.0 CONSULTATION

This policy was developed by the Regional Adverse Incident Work Group chaired by the Assistant Director, Risk Management & Governance, South Eastern Health & Social Care Trust. Consultation was completed via email with relevant Assistant/Co-Directors and staff within all organisations included in the working group. Further consultation within BHSCT was completed via email with relevant Co-Directors/Senior Managers.

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 Definitions

5.1.1 Adverse Incident: Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of a HSC organisation/Special Agency or commissioned service[4]. A suggested list of broad categories of adverse incidents to be reported is listed in Appendix 1, for guidance purposes.

5.1.2 Harm is defined as: "injury (physical or psychological), disease, suffering, disability or death".[5] In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient's/client's illness or underlying condition.

[4] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[5] Doing Less Harm, NHS, National Patient Safety Agency 2001

5.1.3 Serious Adverse Incident (SAI): is an adverse incident that must be reported to the Health and Social Care Board (HSCB) because it meets at least one of the criteria as defined by the HSCB within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAI's), Oct 2016[6].

5.1.4 Service User[7]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

5.2 Policy Statement

The Trust is committed to providing the best possible services for its service users, staff and visitors. It recognises that adverse incidents will occur and that it is important to identify causes to ensure that lessons are learnt to prevent recurrence. It is, therefore, essential that a responsive and effective incident recording, reporting and management system is in place to achieve this aim. Where learning from such adverse incidents is identified the necessary changes should be put in place to improve practice.

5.3 Policy Principles

5.3.1 The organisation's approach to Adverse Incident Reporting and Management: An open, honest and just culture[8]

As part of its proactive approach to risk management, the organisation promotes an open, honest and just culture in which errors or service failures can be admitted, reported and discussed without fear of reprisal. This will enable lessons to be identified and allow active learning to take place and the necessary changes made or reflected in policies, procedures and practices.

All staff must report and manage adverse incidents according to this policy (and any related operational procedures) for adverse incident reporting. Crucial to the effectiveness of adverse incident reporting and management is the organisation's commitment to the promotion of an open, honest and just culture where all staff can participate in reporting adverse incidents. Staff are encouraged to report incidents and to look critically at their own actions and those of their teams, to ensure the organisation can provide quality services for our service users, staff and visitors.

Ultimately, the organisation wants to encourage staff to report areas of concern and to foster a positive ethos around reporting. Staff who make a

[6] HSCB Policy and Procedure for the reporting and follow up of Serious Adverse Incidents, November 2016

[7] As per the draft Statement of what you should expect in relation to a Serious Adverse Incident Review, January 2019

[8] *a just culture focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviours, while maintaining individual accountability by establishing zero tolerance for reckless behaviour. Just organizations focus on identifying and correcting system imperfections, and pinpoint these defects as the most common cause of adverse events. Just culture distinguishes between human error (e.g., mistakes), at-risk behaviour (e.g., taking shortcuts), and reckless behaviour (e.g., ignoring required safety steps), in contrast to an overarching 'no-blame' approach" (Agency for Healthcare Research and Quality; Patient Safety Network 2016, US Department of Health).*

prompt and honest report in relation to an adverse incident should not expect to be subject to disciplinary action except under the following circumstances:-

- A breach of law;
- Wilful or gross carelessness or professional misconduct;
- Repeated breaches of Trust policy and procedure;
- Where, in the view of the Trust, and/or any professional registration body, the action causing the incident is far removed from acceptable practice; or
- Where there is failure to report a serious incident in which a member of staff was involved or about which they were aware.

Completion of an adverse incident report does not discharge staff of their duty of care and their risk management responsibility. There should be timely and appropriate follow-up of adverse incidents. Where preventative measures and/or procedural changes are identified these should be put in place to minimise the risk of the adverse incident recurring.

All employees must be honest, open and truthful in all their dealings with patients/clients and the public, and organisational and personal interests must never be allowed to outweigh the duty of openness, transparency and candour.

5.3.2 External reporting arrangements in respect of other incidents not covered by this policy

Depending on the nature of the adverse incident the organisation may be required to report relevant details to other statutory agencies and external bodies, for example, HSCB, RQIA, HSENI and NIAIC. Staff should ensure that they are aware of their local reporting requirements to other statutory agencies and external bodies as per their local policy/procedures. These incidents must also be recorded on the organisation's incident reporting system.

With regard to Independent Service Providers (ISPs) and contractors, they will be required under their contractual arrangements to maintain a system of reporting and recording of adverse incidents related to service users referred to them by the Trust for assessment, treatment or care. ISPs are also required to submit monitoring information to the organisation as required. Both adverse incidents and SAIs are discussed at contract meetings between Trusts and ISPs. As per the HSCB procedure for reporting SAIs (November 2016), the Trust will decide whether an ISP adverse incident meets the criteria for reporting as a SAI and is, therefore, responsible for reporting the SAI to the HSCB.

~~5~~.3.3 Operational Procedures for Reporting of Adverse Incidents

A summary of the process for reporting, recording and reviewing adverse incidents is detailed below and also included in diagrammatic format in Appendix 1. Detailed procedures for reporting and managing, grading and

investigating incidents are available and should be read in conjunction with this policy. Key points to remember are listed below.

5.3.4 What to do when an adverse incident occurs – immediate actions

The injured person or damaged property should be assessed immediately to ascertain extent of injury/damage and identify emergency or urgent treatment/action required. The situation must be made safe. Communicate with the service user and their relatives/carers, as appropriate following an adverse event. Ensure appropriate discussion with the service user and/or relatives/carers and give consideration to any additional support which may be required. (See the *Being Open Policy*). Any equipment involved in the adverse incident, even if not directly implicated, should be removed from use and the following action taken:-

- Clearly label “Do Not Use” including a short description of the nature of the fault, if possible;
- Retain any related evidence such as packaging (for batch or serial numbers) or consumables/accessories (e.g. giving sets for pumps etc.);
- Decontaminate any device that can be decontaminated without destroying evidence and attach a decontamination certificate to that effect (See the *Medical Devices Policy & Procedures*); and
- For medication – where packaging or labelling of a medicine is an issue, retain or photograph to facilitate further review and follow up with the pharmaceutical company/MHRA.

You must also follow the *Guidance on Actions to be Taken after a Patient’s Death in Hospital* in relation to immediate actions to be taken when finding a person deceased following a suspected incident.

5.3.5 Who should report?

Any member of staff can report an adverse incident. It is the responsibility of **ALL** staff who are involved in, witness to, or become aware of an adverse incident, to ensure it is reported using the organisation’s adverse incident reporting system. If the incident involves another area within the Trust, this area must be made aware of it and remedial actions agreed.

5.3.6 When to report?

It is important that all adverse incidents are reported as soon as possible and ideally within 24 hours of occurrence or becoming aware of the adverse incident. This supports effective review and timely learning, and ensures compliance with responsibilities for external reporting.

5.3.7 What types of incidents to report?

Any event which meets the definition in section 4.1.1 involving service users, staff and visitors must be reported promptly and action instigated, where necessary. Appendix 2 provides a list of broad categories of possible adverse

incidents which may assist reporters. This is not an exhaustive list but gives a broad indication of the types of adverse incidents to be reported.

5.3.8 How to report?

All incidents should be reported using the organisation's adverse incident reporting system (DatixWeb). This is accessed via the Hub (Trust Intranet).

In respect of incidents involving service users, please note that adverse incident reports are NOT health records and copies of any electronic reports (or paper forms) should NOT be filed in the service users' records. However, details of the incident (including the incident reference number, if available) that are relevant to the treatment and care being provided to the service user should be added separately within the service user's healthcare record.

5.3.9 Other Reporting Systems

Some departments have additional error and incident monitoring arrangements (e.g. Laboratories) as part of specific legal, accreditation or quality assurance framework requirements for these services. Staff using these systems must ensure that incidents which meet the organisation's definition of adverse incidents are also reported via the organisation's adverse incident reporting system.

5.3.10 Staff Support directly following an incident

The organisation recognises that it has a responsibility to support all staff following adverse incidents. All staff involved in an adverse incident will need an appropriate level of support consistent with the outcome of the incident. It is the line manager's responsibility to ensure that individuals are supported appropriately. Support can be provided by Occupational Health, Trade Unions and Staff Care. Staff involved should be kept informed of the progress of a review at all stages.

In addition, individuals who have been absent from work may require additional support and supervision to aid confidence when returning to work. Staff involved in the incident should also be involved in the review where appropriate, with feedback, when complete. Further guidance can be obtained via the Trust's policy on *Supporting Staff Involved in Incidents, Complaint, Claims and Coroner's Inquests*.

5.3.11 Arrangements for Incident Review & Grading

Deciding the level of review

Many organisations typically report thousands of incidents each year. It is therefore unrealistic to suggest that all incidents should be reviewed to the same degree, or at the same level, within the organisation. Furthermore, the outcome of an incident, including a 'near miss', at the time of occurrence is

sometimes a poor indicator of the level of review required. The application of a simple risk assessment process to incidents at the time of occurrence can enable the organisation to implement a much more structured approach to its incident management.

Organisations should grade all incidents in DatixWeb for severity (actual impact) at the time of reporting the incident. This is completed by the reporter of the incident using the Regional Risk Matrix (Impact Assessment Table) (see Appendix 3).

In addition, it is important to complete the potential risk grading also using the Regional Risk Matrix (Impact Assessment Table/ Likelihood Descriptors) on DatixWeb (See *Procedure for Grading an Incident*)

The Regional Risk Matrix is also used by a range of specialist advisers for grading of incidents. Not all incidents fit discreetly into individual categories within the matrix and therefore the grading/coding of incidents will be at the discretion of the relevant adviser.

5.3.12 Communication with Service Users and/or relatives

Harming a service user can have devastating emotional and physical consequences for the individuals, their families and carers, and can be distressing for the professionals involved. ***'Being Open'***[9] is a set of principles that health and social care staff should use when offering an explanation and apologising to service users and/or their carers when harm has resulted from an incident. **"Saying sorry is not an admission of liability".**

'*Being Open'* involves:

- acknowledging, apologising and explaining when things go wrong;
- keeping service users and carers fully informed when an incident has occurred;
- conducting a thorough review into the incident and reassuring service users, their families and carers that lessons learned will help prevent the incident reoccurring;
- providing support for those involved to cope with the physical and psychological consequences of what happened; and
- recognising that direct and/or indirect involvement in incidents can be distressing for health and social care staff. Staff are encouraged to seek emotional support.

The organisation is committed to improving the safety and quality of the care we deliver to the public. Our '*Being Open'* policy expresses this commitment to provide open and honest communication between health and social care staff and a service user (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance

by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven Steps to Patient Safety'*.

The main focus of the Being Open policy is for incidents with a severity of moderate and above. However, it is good practice to follow the principles for any incidents where service users have suffered harm.

Further guidance on communicating with service users and their relatives is available in the *Being Open* and/or *Serious Adverse Incident Policy*.

5.3.13 Communication with the Media

All media queries should be directed, in the first instance, to the Corporate Communications Dept.

5.3.14 Debriefing of Staff after Adverse Incidents

Co-Directors/Senior Managers and Heads of Department should ensure that local procedures are in place for the debriefing of staff after incidents. Agreed timescales for debriefing should be specified. The Line Manager should ensure that the staff member has access to appropriate help immediately post incident as necessary eg, referral for medical opinion in case of assault, counselling etc. Line managers should, where appropriate, seek medical advice as to whether it is advisable for the staff member to return to (or stay in) the workplace.

It should be standard practice at all debriefing sessions with staff to consider the contributing factors, which may have led to an incident. This should assist staff in reviewing practice and updating care plans, risk assessments etc. in order to minimise the risk of recurrence. Details of debriefing offered/arranged should be documented and retained in the staff member's local personnel file.

In the case of assaults on staff, line managers should discuss with the staff member whether or not they wish the police to be involved. Line managers should make staff aware of the availability of the services of Occupational Health Services and Staff Care.

5.3.15 Review, Monitoring and Analysis of Adverse Incidents

The organisation has in place mechanisms for the review, monitoring and analysis of adverse incidents both at Corporate and Divisional level. This involves production of reports for consideration and discussion at relevant governance related committees/sub committees and externally as required. Incidents should also be used with other sources of information to help inform the management of risks and effectiveness of actions taken following incident reviews, Quality Improvement projects and other quality and safety initiatives.

The Medicines Governance Pharmacist will lead on the multidisciplinary review, monitoring and analysis of medication related incidents and will link in

with the Regional Medicines Governance Team in respect of the production of regional Medication related governance reports.

5.3.16 Learning and Feedback

Learning from adverse incidents can only take place when they are reported and investigated in a positive, open and structured way. Where learning from such adverse incidents is identified the organisation will ensure that the necessary changes will be put in place to improve practice. Where learning from incidents is relevant to other areas across the organisation, and/or externally, the learning should be shared as per current organisational arrangements, e.g. established sub committees and groups. (See *Policy for Sharing Learning*)

Feedback to staff is vital in respect of incidents they report. Managers should ensure it occurs in their respective areas. This can be on a one to one basis or feedback can be given to all staff at regular Incident, Staff or Assurance / Governance Meetings.

5.4 Dissemination

This policy covers all areas of the organisation's business and applies to all incidents involving service users, staff and visitors, as well as those incidents where individuals are not affected. It also includes contractors, students, volunteers and bank and agency staff or locums and any others to whom the organisation owes a duty of care. All staff employed by the Trust should be provided with access to this policy. The latest version of this policy (and related documents) is available on the Trust's intranet.

5.5 Resources

5.5.1 Training

Adverse Incident Training is mandatory for all staff and appropriate training and guidance will be provided by the Corporate Governance Dept, to ensure that all Trust employees understand their responsibilities under this policy and are able to effectively fulfil their obligations to report adverse incidents. The organisation's training administration system should be used appropriately to record staff training. Senior Managers/Heads of Departments are responsible for ensuring that training on Incident Reporting is covered in local Directorate induction programmes.

5.6 Exceptions

There are no exceptions to this policy and to the organisation's commitment to learn from adverse incidents.

6.0 MONITORING AND REVIEW

An audit of the policy will be undertaken post implementation to ensure adherence to the principles and procedures outlined in this policy document. Changes will be made to the policy, as required. This policy will be reviewed on a regular basis in the light of best practice, changing legislation or new/updated policy guidance.

7.0 EVIDENCE BASE/REFERENCES

- Health & Safety at Work (Northern Ireland) Order 1978;
- Management of Health & Safety at Work Regulations (Northern Ireland) 2000;
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997;
- HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016;
- Six steps to Root Cause Analysis, 2002, Consequence UK Limited;
- National Patient Safety Agency;
- Seven Steps to Patient Safety (2004); and
- Being Open, Patient Safety Alert, November 2009.

8.0 APPENDICES

Appendix 1 – Incident reporting and review process flowchart
Appendix 2 – Examples of Adverse Incidents
Appendix 3 – Regional Risk Matrix

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient **in Adverse Incident Reporting and Management Policy** where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.

- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

Wording within this section must not be removed.

10.0 EQUALITY IMPACT ASSESSMENT

The Trust has legal responsibilities in terms of equality (Section 75 of the Northern Ireland Act 1998), disability discrimination and human rights to undertake a screening exercise to ascertain if the policy has potential impact and if it must be subject to a full impact assessment. The process is the responsibility of the Policy Author. The template to be complete by the Policy Author and guidance are available on the Trust Intranet or via this **link**.

All policies (apart from those regionally adopted) must complete the template and submit with a copy of the policy to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the equality screening for the policy is:

Major impact ☐
Minor impact ☐
No impact ☐

Wording within this section must not be removed

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

Completed Data Protection Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved ☐
A full data protection impact assessment is required ☐
A full data protection impact assessment is not required ☐

Wording within this section must not be removed.

12.0 RURAL NEEDS IMPACT ASSESSMENT

The Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. A screening exercise should be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this link.

If a full assessment is required the Policy Author must complete the shortened rural needs assessment template on the Trust Intranet. Each Directorate has a Rural Needs Champion who can provide support/assistance.

Completed Rural Impact Assessment forms must be returned to the Equality & Planning Team via the generic email address equalityscreenings@belfasttrust.hscni.net

Wording within this section must not be removed.

13.0 REASONABLE ADJUSTMENT ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended) (DDA), all staff/ service providers have a duty to make Reasonable Adjustments to any barrier a person with a disability faces when accessing or using goods, facilities and services, in order to remove or reduce such barriers. E.g. physical access, communicating with people who have a disability, producing information such as leaflets or letters in accessible alternative formats. E.g. easy read, braille, or audio or being flexible regarding appointments. This is a non-delegable duty.

The policy has been developed in accordance with the Trust's legal duty to consider the need to make reasonable adjustments under the DDA.

Wording within this section must not be removed.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

04/06/2020

_____ **Date:** _____

Chris Hagan
Medical Director

10/06/2020

_____ **Date:** _____

Cathy Jack
Chief Executive

Appendix 1 – Process for Reporting and Managing an Adverse Incident (including level of review based on severity and potential risk grading)

NOTE: For detailed guidance see the Procedures for Reporting and Managing, Grading and Investigating Incidents

INCIDENT

IMMEDIATE ACTION

1. Make person(s) / area safe.
2. Obtain medical aid if required.
3. Inform manager on duty ASAP.
4. Complete an incident form.
5. Consider level of communication with the patient.
6. Consider level of review required and action accordingly. If incident meets SAI criteria, follow relevant procedures.

GREEN INCIDENT (INSIGNIFICANT OR MINOR SEVERITY/LOW RISK)

Green incidents – Should normally be reviewed locally in the ward or department in which the event occurred. The review lead will normally be the Ward/Team/Department manager. It is the local team's responsibility to identify learning points, or safety improvement measures that are within the department's control, and ensure that those safety measures identified that are not within the control of the department are appropriately communicated to the relevant Management Team for consideration.

Incident types frequently falling into this grading should also be subject to aggregate analysis by the Ward/Team/Departmental Manager to identify any need for more targeted data collection. It is acceptable for the ward/departmental manager to close such incidents following review and recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 5 working days**.

YELLOW INCIDENT (MODERATE SEVERITY/MEDIUM RISK)

Yellow Incidents – These should also be reviewed locally, as for Green Incidents, but overseen by the Service Manager/Asst Service Manager for that area. It is the local team's responsibility to identify learning points, or safety improvement measures within the departments control and ensure that those which are not, are appropriately communicated to the relevant Management Team for consideration. Frequently occurring events of this grading should also undergo Trust-wide aggregate review to identify any need for more targeted data collection.

It is acceptable for the Ward/Team/Departmental Manager to close such incidents following review and proper recording of findings and lessons learned on Datix.

Review of this grade of incident should normally be completed and **closed within 4 weeks**.

AMBER INCIDENT (MAJOR SEVERITY/HIGH RISK)

Amber Incidents – The Co-Director is accountable for ensuring that all investigations are carried out appropriately. The incident should be investigated and reviewed locally by more than one person and the team may include someone independent from the specialty, if required. Where the incident crosses professional and/or managerial boundaries, team membership should reflect this.

It is the responsibility of the relevant management team to ensure that all learning points and safety improvements are appropriately identified and those not within the control of the local management team are communicated to the relevant person/s and committee/s, whichever is the more appropriate. Improvement strategies arising out of this group of events should be monitored as part of the Division's Governance arrangements.

Advice can be sought from Directorate Governance staff.

Review of this grade of incident should normally be completed and **closed within 12 weeks**.

RED INCIDENT (CATASTROPHIC SEVERITY/EXTREME RISK)

Red Incidents – The Co-Director is accountable for ensuring that all reviews are carried out appropriately. The incident should be investigated and reviewed locally by more than one person and the team may include someone independent from the specialty, if required. Where the incident crosses professional and/or managerial boundaries, team membership should reflect this.

It is the responsibility of the relevant management team to ensure that all learning points and safety improvements are appropriately identified and those not within the control of the local management team are communicated to the relevant person/s and committee/s, whichever is the more appropriate. All of the resulting reports and improvement strategies arising from these events should be monitored through Division/Trust Governance arrangements.

Advice can be sought from Directorate Governance staff.

Review of this grade of incident should normally be completed and **closed within 12 weeks.**

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR)
Report all RIDDOR reportable incidents to the Health & Safety team on 02895048722.

For advice on Medical Device incidents contact the Medical Devices Coordinator on [redacted] or email [redacted]

Open, Honest and Just Culture

This Trust welcomes knowledge of adverse events as an opportunity to learn for the benefit of our service users, staff and visitors. Unless there is clear evidence of flagrant malpractice, a complete disregard for the safety of others, maliciousness, intent to harm, theft or fraud, the disciplinary policy will not be used for review purposes. Incidents will be investigated for the purposes of learning and change and staff are required to engage as active participants of this.

Appendix 2 – Examples of Adverse Incidents that should be reported

Broad categories of possible adverse incidents are shown below and may assist reporters. This list is not comprehensive but gives a broad indication of what should be reported

- Violence, aggression, behavioural issues
- Delays or difficulties during appointments, admissions, transfers or discharges
- Accidents e.g. falls, medical sharps injuries, manual handling, exposure to hazardous substance, burn or scalds
- Cardiac arrests involving CPR and/or Defib
- Issues with clinical investigations, scans, x-rays, lab tests etc.
- Communication breakdowns between staff and/or with service users, issues with consent and confidentiality
- Event which caused the dignity and respect of a service user to be compromised
- Diagnosis, missed or delayed
- Financial loss to the Trust
- Infrastructure or Resources (staffing, facilities, environment) – for example, unsafe environment, waste issues, misuse, failure or theft of IT equipment or systems, lack of facilities, equipment or supplies, inadequate staffing levels
- Infection control issues, pressure sores, fluid maintenance, pain management, any other issues relating to implementation of care or ongoing monitoring / review
- Labour or delivery adverse incidents
- Medical device/equipment related Incidents – any preventable equipment related event that could have or did lead to patient harm, loss or damage. Includes incidents related to training, servicing, storage, disposal and suitability of the device, as well as failure of the equipment itself
- Medication incident (ie, any preventable medication related event that could have or did lead to patient harm, loss or damage).
- Patient Information issues e.g. records, documents, test results, scans. This may also include any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.
- Treatment, procedure – any adverse incident immediately before, during or immediately after
- Security – for example, fires and fire risks, theft or damage to personal property, premises or vehicles, intruders or break-ins

Appendix 3 – Regional Risk Matrix

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid. • Non-permanent harm lasting less than one month. • Admission to hospital for observation or extended stay (1-4 days duration). • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required.	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspection – recommendations can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e.g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory authority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest > 3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investigation or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interruption 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resulting in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affecting off-site with detrimental effect requiring outside assistance.

SET Risk Matrix – April 2013 (based on HSC Regional Risk Matrix - April 2013, updated June 2016) - Clean

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Risk Matrix/Consequence (Severity Levels)				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Belfast Health and Social Care Trust
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Weekly Governance Call Terms of Reference

PURPOSE	To act as an organisational sense check in facilitating discussion, identification of early learning and escalation of key governance issues that have occurred / been reported over the previous week (or are pending for report) in relation to: • Approved incidents (that have a catastrophic severity or an extreme risk grade) • Any new Serious Adverse Incidents (SAIs) reported to the SPPG • Key recommendations from finalised SAI reports • Any new Early Alerts or updates reported to the Department of Health • Ensuring awareness of Coroners Cases and Clinical Negligence cases scheduled for the week ahead • Complaints [This includes those newly graded as extreme or high risk; those with recommendations arising from NI Public Services Ombudsman final reports; and escalation of any required actions in relation to complaints that have a deadline for the week ahead] • Any new Corporate Risks identified or any new risks graded as extreme • RIDDOR Reportable Death, Major Injury and Dangerous Occurrence incidents • Any new incidents reported to the ICO within the last week. *Other key Governance issues that are felt to require discussion can also be tabled.* This will help to ensure that: • Incident details recorded on Datix are accurate and that detail of any follow-up is appropriately logged. • Key learning to be shared at the earliest possible occasion • There is a regular forum that governance issues can be flagged, discussed and escalated if necessary • There is a collaborative approach in ensuring good organisational governance	
MEMBERSHIP	**Chairs:**	Deputy Medical Director or Risk & Governance Co Director [*Senior R&G Manager, or Directorate Governance & Quality Manager in the absence of a Senior R&G Manager can deputise*]
	Members:	Directorate / Divisional Governance & Quality Managers (and / or nominated representative) Service Managers, R&G (x4) Governance Manager, Corporate Governance Datix & Admin Manager, Corporate Governance Medication Safety Representative Manager Central Nursing PCCS Senior Manager (or deputy) Social Work Governance Representative (or deputy) *From time to time other staff may need to attend to present certain agenda items. This should be agreed in advance of the call*
MEETINGS	**Secretary:**	Risk & Governance will oversee the setup of the teleconference, collation of initial report for review and upload of this report on MS Teams in advance of the teleconference. (The Risk & Governance team will also be responsible for ensuring an updated report is made available after the weekly governance call to the Safety Huddle membership who meet the next day).

	Appointments:	The membership of this group shall be determined by the Deputy Medical Director and / or Risk & Governance Co Director taking into account the skills and expertise necessary to deliver the groups remit.
	Quorum:	The quorum for the meeting will be the Chair (or deputy) plus no less than 50 % membership and must include, as a minimum, representations from 3 Service Directorates.
	Frequency:	This group will meet weekly. Conference time allotted will be 1 ½ hour (with aim to complete within 1 hr)
	Papers:	Agenda and report will be uploaded electronically on MS Teams the afternoon prior to the teleconference. (Finalised papers will be shared after tele-con with Safety Huddle membership)
REPORTING	In relation to approved incidents (i.e. a catastrophic severity or an incident with an extreme risk grade) the Governance manager for that service area would be expected to provide: • a brief overview of the incident and • confirm if further investigation/ review is ongoing, • if reporting as a SAI is being considered • if a 'hot debrief' was identified as necessary and if so had this been completed • Any important immediate learning for immediate wider sharing across the Trust If Governance manager not in attendance at the call or not all information able to be uploaded prior the weekly call, this would be carried forward as an outstanding action for discussion at next teleconference. If a quicker response is required, due to the nature of the incident, this should be followed up prior to the next teleconference. In relation to Serious Adverse Incidents (SAIs) the relevant Governance Manager would be expected to provide a brief overview of the incident and outline any additional information that may be useful to be shared with those on the teleconference. Confirmation if a 'hot debrief' was identified as necessary and if so had this been completed would be provided. Early Alerts reported to the Department of Health should be briefly discussed and confirmation provided if a SAI submission is also required For Coroners Cases, Clinical Negligence cases, a prompt is provided to confirm what is scheduled for the week ahead. (This information should have already been shared with the relevant Director) For Complaints, a prompt is provided to confirm what key actions are expected for the week ahead. (This information should already have been shared via the relevant senior manager for the service involved) For External Guidance, the weekly newsletter 'External Guidance Issued' will be included in the papers and listed on the agenda. This newsletter contains links to correspondence received in the previous week for sharing within Directorates by Governance Managers. In addition, a separate document highlighting which areas were included in original dissemination is included for information only. On the call this should include acknowledgement that all relevant areas have received a copy of the guidance. If not, any areas still requiring a copy should be highlighted. Attendance will be recorded via MS Teams.	
REVIEW	These terms of reference and operating arrangements will be reviewed on an annual basis.	