Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Procedure for the Reporting and Management of Adverse Incidents**		
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Ownership:	[redacted] Medical Director [redacted] Director of Quality, Safety & Improvement		
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1.0 INTRODUCTION:

1.1 Background:

Arising out of the 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:

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:

This procedure 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[1] 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 Aims & 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

[1] Health & Safety at Work (Northern Ireland) 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.

most incidents occur because of problems with systems rather than individuals but may also on occasions be multifactorial in nature.

The objectives of this procedure are:

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

1.4 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.
- The Public Interest Disclosure Act 1998.
- Mental Health (NI) Order 1986.
- The Children (NI) Order 1995.

2.0 SCOPE OF PROCEDURE:

2.1 This procedure 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.

2.2 This procedure excludes detailed arrangements in respect of the following areas which are covered by separate regionally agreed policies:

- Procedure on the reporting of Early Alerts (pending);
- Policy of Being Open (pending);
- Procedure on Reporting of Adverse Incidents under RIDDOR Regulations (pending);
- Procedure on Supporting Staff involved in Incidents, Complaints, Claims and Coroners Inquests (pending);

- Policy on Liaison and Effective Communications with PSNI and HSENI when investigating Patient Safety Incidents involving Unexpected Death and Serious Untoward Harm (pending); and
- Policy on Mortality & Morbidity / Learning From Deaths (pending).

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.

3.3 **The Medical Director:** is the lead Director responsible for the reporting and management of adverse incidents within the Trust (structural review ongoing). 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 e.g., Health & Social Care Board (HSCB), Health and Safety Executive for Northern Ireland (HSENI) and the Regulation, Quality Improvement Authority (RQIA). On a daily basis this function is delegated to the **Risk Manager.**

3.4 **Directors:** are responsible for ensuring that the Trust's procedure on adverse incident reporting and management is widely disseminated, promoted and implemented within their areas of responsibility. Directors are also responsible for ensuring that staff are appropriately trained in the reporting and management of adverse incidents.

3.5 **Assistant Directors:** are responsible and accountable to their respective Directors for ensuring that this procedure 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.

3.6 **All Staff with Line Management Responsibility:** are responsible for:

- Ensuring that this procedure and associated procedures are effectively implemented across their area of responsibility.
- Promoting an open, honest and just reporting culture.
- Ensuring that appropriate review of adverse incidents is carried out.
- Ensuring staff feedback occurs in their respective areas. This can be via DATIX, on a one to one basis or at staff meetings.
- Ensuring appropriate support is offered to staff (see section 4.3.10 & 4.3.14).
- Reviewing, approving and/or escalation of incidents via DatixWeb.
- Challenging persistent misuse or deliberate over categorisation.

3.7 **Person/s who report an incident;** are responsible for reporting the incident using DatixWeb in line with Trust reporting criteria and timescales. Where DatixWeb is not available, paper/fax will be accepted by HQ.

3.8 Person/s who investigate/review incidents: are responsible for ensuring that incidents reported are in line with Trust reporting policies and procedures and the content of the report is appropriate. They will also be responsible for initiating any relevant investigations/reviews within agreed Trust timeframes. On completion of this process they are responsible for closing incidents.

3.9 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.

NOTE: Continual misuse, deliberate exaggeration (over categorisation) or unsubstantiated versions of events will be investigated by line management.

3.10 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.

3.11 Regional Training Officers: will provide advice and support to Line Managers in the event of clinical incidents, manual handling, managing aggression etc. Divisional/Clinical Training Officers are responsible for conducting training needs analysis, developing individual training plans and providing training and clinical supervision as required. Call reflections must be completed for all significant clinical incidents. Any issues/concerns should be escalated via line management structures. NOTE it remains the responsibility of the line manager to ensure DATIX is updated and incidents are closed.

4.0 KEY PRINCIPLES

NOTE: With regards to NIAS Policy and commitment to Learning From Incidents, please refer to the Learning From Incidents Policy.

4.1 Definitions

4.1.1 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[2]. A suggested list of broad categories of adverse incidents to be reported is listed in Appendix 1, for guidance purposes.

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

4.1.2 Harm is defined as: "injury (physical or psychological), disease, suffering, disability or death".[3] In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the service users' illness or underlying condition.

4.1.3 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[4]. **For higher impact incidents that meet the criteria, refer to separate Learning From Serious Adverse Incidents Procedure.**

4.1.4 Service User[5]: this term refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative / advocate.

4.2 Statement of Commitment

The Trust is committed to providing the best possible service 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.

4.3 Approach to Adverse Incident Reporting and Management: An open, honest and just culture[6]

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

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

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

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

[6] *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).*

- 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 service users and the public, and organisational and personal interests must never be allowed to outweigh the duty of openness, transparency and candour.

4.3.2 External reporting arrangements in respect of other incidents not covered by this procedure

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 and HSENI. 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.

This procedure does not cover the arrangements for the reporting of Early Alerts to the DoH as this is the subject of separate guidance/policy.

4.3.3 Operational Procedures for Reporting of Adverse Incidents

The process for reporting, recording and reviewing adverse incidents is detailed below and also included in diagrammatic format in Appendix 1. Key points to remember are listed below.

4.3.4 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. 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., defibrillator pads, giving sets for pumps etc.);
- Decontaminate any device that can be decontaminated without destroying evidence and attach a decontamination certificate to that effect (refer to IPC policy); 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.

4.3.5 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 incident reporting system. In the event of an incident with multiple crews attending, the lead clinician is ultimately responsible for reporting. If the incident involves another area within the Trust, this area must be made aware of it and remedial actions agreed.

4.3.6 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.

4.3.7 What types of incidents to report?

The incident reporting system will ensure that any event which meets the definition in section 4.1.1 involving service users, staff and visitors are 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.

4.3.8 How to report?

All incidents should be reported using the organisation’s adverse incident reporting system (DatixWeb).

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 with patient report forms. 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 to patient report forms / passed to acute Trusts as necessary.

4.3.9 Other Reporting Systems

Some directorates/areas have additional error and incident monitoring arrangements (e.g. Medical Directorate and Information Governance) as part of specific legal, regional, 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.

4.3.10 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, Peer Support, Inspire, Trade Unions etc. 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 must also be involved in the review, where appropriate, with feedback, when complete.

4.3.11 Arrangements for Incident Review & Grading

Deciding what to 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 actual impact at the time of reporting the incident. This is usually completed by the reporter of the incident using the Regional Risk Matrix (Appendix 3).

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 where there is any disagreement between the reporter and the Investigating Officer, the final decision will be taken by the Risk Manager.

4.3.12 Communication with Service Users and/or relatives

A member of staff within the line management structure of the lead member of staff responsible for the treatment and/or care will retain the responsibility for communicating with the service user and their relatives about the incident. However, there may also be a liaison person at a senior level identified to make contact with the family.

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'[7] 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.

The organisation is committed to improving the safety and quality of the care we deliver to the public. Our '*Being Open'* policy (pending) 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 Trust will adhere to these principles whilst complying with other applicable legislation such as Data Protection.

Further guidance on communicating with service users and their relatives is available in the Learning From Serious Adverse Incidents (SAIs) Procedure. **For higher impact incidents that meet SAI criteria, refer to separate Learning From Serious Adverse Incidents Procedure**.

4.3.13 Communication with the Media

All communications with the media should be co-ordinated by the Communications Team.

4.3.14 Debriefing of Staff after Adverse Incidents

Assistant Directors/Senior Managers should ensure that local procedures are in place for both the operational and psychological debriefing of staff after incidents (NOTE operational debriefing is dealt with under Emergency Planning Arrangements).

The Line Manager should assess individual incidents, liaise with staff and make arrangements for Peer Support as appropriate. Line Managers should note that to be effective, Peer Support should be able to offer a debrief within 14 days. In the event of cases with particularly significant outcomes / major incidents, etc. staff may be contacted directly by Peer Support. Staff can also avail of Peer Support services at any time.

The Line manager should also ensure that the staff member has access to appropriate help post incident as necessary e.g., referral for medical opinion in case of assault, counselling etc., NOTE it has been recognised that there is limited out of hours support for front line staff and a review of Operational Management Structure is ongoing. In the interim, every

[7] Insert details re Regional Being Open policy

effort will be made via On Call Officer / Senior On Call etc. to address any immediate concerns. 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.

In the case of assaults, line managers must encourage reporting to PSNI however discussions should take place with the staff member on whether or not they wish the matter to be taken forward (**note Appendix 5 the offence of Assaulting an Ambulance Worker**). Line managers should make staff aware of the availability of the services of Occupational Health Services, Inspire and Peer Support.

4.3.15 Review, Monitoring and Analysis of Adverse Incident Statistics

The organisation has in place mechanisms for the review, monitoring and analysis of adverse incidents and produces reports for consideration and discussion locally at relevant governance related committees/sub committees/team meetings, and externally as required. Incident statistics should also be used with other sources of statistics to help inform the management of risks and effectiveness of actions taken following incident reviews, Quality Improvement projects and other quality and safety initiatives.

Due governance of NIAS incident management is provided through several assurance functions, including:

- Trust Board – scrutiny of implementation of policy and procedures. As necessary reviews incidents / trends highlighted by Committees. Leads 'Just Culture'.
- Assurance Committee – receiving and reviewing reports of all of the Trust's incidents; monitoring trends, receives reports on all Trust Serious Adverse Incidents (SAIs), Interface Incidents, Intertrust Incident etc. Ensuring systems are in place for organisational learning.
- Learning Outcomes Review Group (LORG) – identification of themes across Directorates, implementation of corporate actions. The LORG provides a structured framework for the dissemination of learning.
- Medical Equipment Group – Medical equipment and medicines incidents.
- Health and Safety Committee – health and safety related incidents
- Emergency Preparedness & Business Continuity Group – EP / BCP related incidents.
- Infection Prevention and Control (IPC) Group – IPC incidents.
- Fire Compliance Group – Fire related incidents.
- Management of Aggression Working Group – work related violence incidents.

Committee / Group Terms of Reference and minutes are available on SharePoint. .

4.3.16 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.

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 meetings. In the event of major themes and trends, action may be taken

Directorate wide, and feedback provided via the likes of memos and Clinical Newsletters (for example, the thermometer replacement programme following a number of incident reports describing inaccurate readings). Levels of feedback will be monitored via performance management processes as deemed necessary.

5.0 IMPLEMENTATION

5.1 Dissemination

This procedure 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 procedure. The latest version of this procedure (and related documents) is available on SharePoint (Corporate Documents and Medical Directorate).

5.2 Resources

5.2.1 Training

Adverse Incident Training is mandatory for all staff and appropriate training and guidance will be provided by the Risk Management Team to ensure that all Trust employees understand their responsibilities under this procedure and are able to effectively fulfil their obligations to report adverse incidents. The Risk Management Team will use HRPTS to record staff training.

5.3 Exceptions

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

6.0 MONITORING

An audit of the procedure will be undertaken post implementation to ensure adherence to the principles and procedures outlined in this procedure document. Changes will be made to the procedure, as required. This procedure will be reviewed on a regular basis by the Risk Management Team 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 CONSULTATION PROCESS

This procedure 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 Directors and staff within all organisations included in the working group.

9.0 APPENDICES

Appendix 1 – Incident reporting and review process flowchart
Appendix 2 – Examples of Adverse Incidents
Appendix 3 – Regional Risk Matrix
Appendix 4 – Guidance for Incident Review and Grading

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this procedure should be subject to a full impact assessment was carried out on the 9th February 2020. The outcome of the Equality screening for this procedure is:

Major impact ☐

Minor impact ☐

No impact. ☒

[redacted]

Date: 27th May 2020

Lead Author

[redacted]

Date: 27th May 2020

Lead Director

APPENDIX 1 – PROCESS FOR REPORTING / MANAGING AN INCIDENT (INCLUDING LEVEL OF REVIEW BASED ON POTENTIAL RISK GRADING)

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 service user if required.
6. Consider level of review required and action accordingly. If incident meets SAI criteria, follow relevant procedures.

GREEN INCIDENT (LOW RISK)

Green incidents – Should normally be reviewed locally in the area in which the event occurred. The investigative lead will normally be the line manager. It is the local team's responsibility to identify learning points, or safety improvement measures that are within the areas 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 category should also be subject to aggregate analysis by Area Managers/Senior Management identify any need for more targeted data collection. It is acceptable for the line 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 (MEDIUM RISK)

Yellow Incidents – These should also be reviewed locally, as for Green Incidents, but reviewed by a more senior manager as necessary. Again it is the local team's responsibility to identify learning points, or safety improvement measures within the areas control and ensure that those which are not, are appropriately communicated to the relevant Management Team for consideration. Frequently occurring events attracting this risk category should also undergo Trust-wide aggregate review to identify any need for more targeted data collection.

It is acceptable for the line 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 (HIGH RISK)

Amber Incidents – These incidents should be subject to the appropriate level of review. The line manager should discuss with the relevant Area Manager / **Assistant Director**, who is going to take the lead. 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.

Note – Improvement strategies arising out of this group of events should be monitored as part of the organisation's Governance arrangements.

Where necessary advice can be sought from the **Risk Management Team.**

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

RED INCIDENT (EXTREME RISK)

Red Incidents – Where major (i.e., long-term permanent harm/disability [physical/emotional injuries/trauma]) or tragic harm (i.e., permanent harm/disability [physical/emotional trauma] or incident leading to death) has occurred the relevant Director, with the support and advice of the Risk Management Team, should appoint a team led by a trained facilitator in SEA/root cause analysis. All of the resulting reports and improvement strategies arising from these events should be monitored by the organisation's Learning Outcomes Review Group.

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

The Health and Safety Advisor will monitor DATIX and complete reports under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR)

The Risk Manager will monitor DATIX and report all Medical Device Events to NIAIC.

Ensure all staff sickness precipitated by an accident is reported to Occupational Health and recorded on GRS

If in doubt contact the Risk Management Team.

For higher impact incidents that meet SAI criteria, refer to separate Learning From Serious Adverse Incidents Procedure.

Open, Honest and Just Culture

NIAS 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

- Abusive, violent, disruptive, challenging or self-harming behaviour
- Delays or difficulties during appointments, admissions, transfers or discharges
- Accidents e.g. falls, sharps injuries, manual handling, exposure to hazardous substance, burn or scalds
- Issues with clinical investigations
- Communication breakdowns between staff and/or with service users, issues with consent and confidentiality
- 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
- 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 service user harm, loss or damage. Includes incidents related to training, servicing, disposal, storage, and suitability as well as failure of the equipment itself
- Medication incident (i.e., any preventable medication related event that could have or did lead to service user harm, loss or damage).
- Service user Information issues e.g. records, documents etc. 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**

APPENDIX 4 – GUIDANCE FOR INCIDENT REVIEW & GRADING

This section is a general guide to the review of incidents. **It is recognised that each organisation will have different organisational arrangements and therefore it is acceptable to replace this appendix with local arrangements provided they are based on the undernoted principles.**

Deciding what to review

Organisations should grade all incidents on DatixWeb for actual impact at the time of reporting the incident. This is usually completed by the reporter of the incident using the Regional Risk Matrix (see Appendix 3). The Investigating Officer should update the risk grading is necessary following investigation also using the Regional Risk Matrix (Impact Assessment Table /Likelihood Descriptors) on Datix Web.

The organisation's on-line reporting system allows staff to input this information directly into the electronic system.

What is the actual impact/severity of the event?

Use the Impact Assessment Table at Appendix 3 to determine the **actual impact/severity** of the event by considering the outcome of the incident in terms of harm to: People, Quality & Professional Standards/guidelines, Reputation, Finance, Information & Assets, Resources or Environmental issues.

If two or more domains (see Appendix 3) have been affected by the incident, consider which has been affected the most to assist in your judgement of the impact/severity of the incident. The impact/severity categories are as follows: Insignificant, Minor, Moderate, Major or Catastrophic. This information should be recorded within the "Actual Impact/Severity" field within Datix.

Action required based on the Incident Grading

The Table in Appendix 1 details the actions required with regard to the level of review based on the potential risk grading.

APPENDIX 5 – OFFENCE OF ASSAULTING AN AMBULANCE WORKER

When PSNI bring a prosecution, the charge more often than not relates to 'Common Assault'. All staff are reminded to advise the PSNI Officer that the charge should be Assaulting an Ambulance Worker. See below for your reference.

Justice Act (Northern Ireland) 2016

2016 CHAPTER 21

PART 3

Miscellaneous

Assaulting ambulance workers etc

Offence of assaulting ambulance workers etc

54.—(1) A person commits an offence if he or she assaults—

(a) an ambulance worker in the execution of that ambulance worker's duty;

(b) a person who is assisting an ambulance worker in the execution of that ambulance worker's duty.

(2) "Ambulance worker" means a person who provides ambulance services (including air ambulance services) under arrangements made by or at the request of—

(a) the Northern Ireland Ambulance Service Health and Social Care Trust,

(b) St. John Ambulance (NI),

(c) the British Red Cross Society, or

(d) the charity registered in the Republic of Ireland known as the Order of Malta Ireland.

(3) A person guilty of an offence under subsection (1) shall be liable—

(a) on summary conviction, to imprisonment for a term not exceeding 6 months or to a fine not exceeding the statutory maximum, or to both; or

(b) on conviction on indictment, to imprisonment for a term not exceeding 2 years or to a fine, or to both.