Belfast Health and Social Care Trust
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Reference No: TP 42/08

Title:	**The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) policy**		
Author(s)	Philip Boyle, Health and Safety Manager [redacted] Regional Working Group		
Ownership:	Dr Chris Hagan, Medical Director		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	04 June 2020 10 June 2020
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Version No.	5	**Supersedes**	V4 - May 2018
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Links to other policies	• BHSCT Adverse Incident Reporting and Management Policy (2018) TP 08/08 • General Health and Safety Policy (2018) TP 50/08 • BHSCT Policy & Procedural Arrangement for the Prevention and Management of Slips, Trips and Falls (2018) TP 69/11 • BHSCT Zero Tolerance Approach To The Prevention And Management Of Aggression & Violence Towards Staff In The Workplace (2019) TP 02/08 • BHSCT Management And Prevention Of Adult Inpatient Falls In A Hospital Setting (2020) SG 45/09 • BHSCT The Prevention & Management of Patient, Client and Service Users with Identified Choking Risks (2019) TP 106/17 • BHSCT The Control of Substances Hazardous to Health (COSHH) Trust Policy & Procedural Arrangements (2018) TP 35/08 • BHSCT Policy & Procedural Arrangements relating to the Prevention and Management of Latex Sensitisation (2018) TP 67/10 • BHSCT Safe Use of Bed Rails (2011) SG 09/08 • BHSCT Manual Handling Policy and Procedural Arrangements (2018) TP 34/08 • BHSCT Prevention of the spread of Blood Borne Virus (BBV) Infection and the Management of patients with BBV infection in the Department of Nephrology & Transplant (2016) SG 43/11		

Date	Version	Author	Comments
03/01/2018	4.1	Philip Boyle	3 year review and consultation. Policy revised to enhance the Managers, Health & Safety Managers and staff responsibilities section; “Major Injuries” section updated to reflect version in RIDDOR NI Regulations, reference to Patient Falls/ Bed Rails and Prevention and Management of Patient/Client and Service Users with Identified Choking Risks. Include

			an appendix on “HSENI Correspondence and Belfast Trust CEO Flowchart”
08/11/2018	4.2	Irene Low	RIDDOR policy was subject to a review by a Regional HSC Trusts. Comments from July 2018 consultation process
31/03/2020	4.3	Philip Boyle Laota McQuitty	Adapted Regional RIDDOR policy to the Belfast Trust and added appendices
28/05/2020	4.4	Laota McQuitty	Comments from Trust Wide Consultation detailed

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

The Belfast Trust (herein referred to as “The Trust”) recognises its statutory obligations under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997. RIDDOR relates to a defined process enshrined in law, which must be completed within a stipulated timeframe (ie within 10 days of the occurrence of specified “incidents”).

RIDDOR legislation requires employers to report certain types of injury, some occupational diseases and dangerous occurrences that *‘arise out of or in connection with work’* to either the Health Safety Executive Northern Ireland (HSENI) or the respective local authority. The regulations cover (in summary):

- Accidents which result in death of any person;
- Accidents which result in an employee (or self-employed person) suffering a major injury (See Appendix 1);
- Accidents which result in an employee (or self-employed person, eg self-employed contractor) being absent from work or unable to undertake their normal duties for more than three days following the date of the incident (including nights);
- Accidents which result in a person not at work (eg patient, service user, visitor) suffering an injury (eg as a result of an incident/accident within Trust premises) and being taken to hospital (or if the accident happens at a hospital, suffering a major injury which would otherwise have required hospital treatment);
- Specified dangerous occurrences (See Appendix 2), which may not result in a reportable injury but have the potential to do significant harm (eg collapse, overturning or failure of load-bearing parts of lifts and lifting equipment);
- An employee (or self-employed person) suffering from a specified work related disease (See Appendix 3).

1.2 Failure to report a reportable injury, dangerous occurrence, or disease in accordance with the requirements of RIDDOR, is a criminal offence, and may result in prosecution. Reporting an incident is not an admission of liability.

The prompt and accurate reporting of all such incidents is therefore essential in ensuring that the Trust fulfils its legal obligations and in turn avoids potential prosecution for failure to comply with the aforementioned legislation. The Trust aims to comply with RIDDOR legislation and to submit timely returns to the appropriate enforcing authorities

1.3 Intrinsic to this is an onus on all staff members to ensure that fully completed incident report forms are completed and approved on the Trust incident reporting system within 7 days following an incident. In the event of a major injury or fatality, the Trust Health & Safety Department **must be notified immediately** by telephone.

1.4 Purpose

This policy has been developed to meet the statutory requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) which sets out the need to have a system of formal reporting of specified incidents to the appropriate enforcing authority (ie the relevant District Council and/or the Health & Safety Executive for Northern Ireland). This policy also aims to give assurance to the Trust Board of continued statutory compliance with regards to the above listed legislation. This document is intended to provide managers and staff with guidance on RIDDOR reportable incidents. It contains details of the types of incidents that are RIDDOR reportable and the methods by which they should be reported (See Appendices 1, 2, 3, 4).

1.5 Objectives

The objective of this policy is to ensure that all managers and staff are aware of their responsibilities under the RIDDOR Regulations.

2.0 SCOPE OF THE POLICY

2.1 This policy provides guidance on the arrangements for the reporting and management of incidents under RIDDOR within the Trust's owned, leased or managed premises/property and when its staff (staff for the purposes of this policy will include Bank staff), self-employed persons and Contractors are working within the remit of their employment (including whilst volunteering) for the Trust, patients/clients and members of the public. .

2.2 The Trust recognises that some staff may be required, as part of their employment, to work at locations outside of Trust premises (eg Peripatetic working in the community). Such working also falls within the remit of this policy and is reportable under RIDDOR legislation.

2.3 Incidents involving agency workers should be reported by their respective agency to the HSENI. The Health & Safety team will discuss Agency worker RIDDOR reportable incidents with the Service Area Manager who will be requested to notify the Agency. If there is no confirmation that the Agency will report to the HSENI, the Health & Safety team will complete the RIDDOR form to the HSENI.

3.0 ROLES & RESPONSIBILITIES

3.1 Risk & Governance Department: Will review all incident report forms on a regular basis and the Health & Safety and Estates will undertake to report incidents which are subject to RIDDOR to the Health & Safety Executive, Northern Ireland (HSENI) in compliance with the regulations using the relevant extant pro formas. It is the responsibility of Health & Safety and Estates to complete and submit this form through the HSENI on-line system and it is included within this policy for reference purposes only. It should be noted that since 1 April 2013, employers have the option to report all work related incidents to HSENI, regardless of which jurisdiction (and local enforcing authority area) the incident occurred in.

3.2 **Managers (Approving Managers):** It is the responsibility of all managers to ensure that incident report forms are completed and approved on the Trust's incident reporting system, submitted to Risk & Governance Department and that any death, major injury and dangerous occurrence incidents are communicated to the Health & Safety department by the fastest possible means (e.g. telephone). It is essential that all parts of the incident report forms are completed in their entirety.

3.3 **Staff**: It is the responsibility of all staff to ensure that incident reports are completed promptly and that all parts of the incident report are completed in their entirety.

3.4 It should be noted that reporting to the HSENI as a requirement under RIDDOR is a function of the Health & Safety and Estates and should not be undertaken at local level.

3.5 **Health and Safety Managers:**
To liaise with HSENI and the Service Area in relation to the subsequent incident investigation following the procedure outlined in Appendix 6.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

4.1.1 **RIDDOR:** Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997.

4.2 Guidance Notes – General Points

4.2.1 All incidents must be reported as soon as practicable to Risk & Governance Department. This must typically be no later than the next working day following the incident.

4.2.2 These forms will be evaluated by the Risk & Governance Department in order to decide whether they meet the reporting requirements under RIDDOR.

4.2.3 If applicable the Health & Safety and Estates will complete form NI2508 and submit it to the appropriate enforcing authority. This is completed via the HSENI On-line reporting system.

4.2.4 All incidents and associated reporting are recorded in the Trust's Datix database. Records of all RIDDOR reportable incidents are maintained by the Risk & Governance Department or a period of ten years (in accordance with The Trust's Retention & Disposal Schedule).

4.2.5 All RIDDOR reportable incidents will be subject to an investigation.

4.3 Incident types which must be reported

4.3.1 Death or Major Injury (Appendix 1)

If there is an accident connected with the workplace and a staff member, patient/client or self-employed person working on Trust premises is killed or suffers a major injury (including as a result of physical violence); or there is an accident connected with the workplace and a member of the public is killed or taken to hospital; then the HSENI must be notified without delay (e.g. telephone). Within 10 days of the incident, a completed NI2508 form must be sent to the HSENI as required under RIDDOR legislation. Both of these actions

will be carried out by Health & Safety and Estates upon the incident being reported to them by the respective manager concerned.

In the event of an incident involving a contractor the employer will report the incident to the enforcing authority and notify the Trust of the incident.

4.3.2 Over 3 Day Injury

If there is an accident connected with work (including as a result of physical violence) and a staff member or self-employed person working on Trust premises, or within the remit of their employment, suffers an injury which prevents them from carrying out their duties for more than 3 days, a completed report form, NI2508, must be sent to the enforcing authority within 10 days by Health & Safety Department staff. This type of injury is not classified as major but results in the injured person being away from work or unable to conduct their normal duties for more than three days (including non-work days but not including the day on which the incident occurred). **If an injury is detected subsequent to an incident report being submitted, (which gives rise to the aforementioned absence from work) it is the responsibility of the manager of the facility where the incident occurred to provide details of the injury (via email, providing incident report number) to the [Health & Safety Department].**

In the event of an incident involving a contractor the employer will report the incident to the enforcing authority and notify the Trust of the incident.

4.3.3 Dangerous Occurrence (Appendix 2)

If an incident occurs which does not result in a reportable injury, but clearly could have done, then it may constitute a dangerous occurrence (see examples in Appendix 2) and must therefore be reported without delay (e.g. telephone) and supplemented by a notification to the HSENI within 10 days (using form NI2508). This action is carried out by the Health & Safety and Estates. This is completed via the HSENI Online system.

If the Health and Safety Department is notified by a doctor (eg GP or Occupational Health) that a staff member suffers from a contaminated blood born virus (BBV) biological Hazard group 3 or 4 needlestick injury** (*eg hepatitis B or C or HIV*) the Health and Safety managers must then complete a NI2508 form and forward to the HSENI.

4.3.4 Disease** (Appendix 3)

If the Health and Safety Department is notified by a doctor (eg GP or Occupational Health) that a staff member suffers from a reportable, work related disease (e.g. dermatitis, a sharps injury and a BBV acquired by this route sero-converts), the Health and Safety managers must then complete a disease report form NI2508A and forward to the HSENI. (This form is available online and can be accessed as necessary).

** Sharing of information with the Health and Safety Executive NI for legal RIDDOR requirement on Disease and Dangerous Occurrence biological Hazard Group 3 or 4 is detailed in Occupational Health Privacy Notice.

See Patient/Service User Falls and Choking Incidents for guidance in Appendix 4.

See RIDDOR reporting flowchart for further guidance in Appendix 5.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

5.1.1 This policy is applicable to all staff within the Trust. This policy will be made available to all staff via the Trust's intranet site.

5.2 Resources

5.2.1 Training on the application of this policy for relevant managers and staff will be facilitated and delivered by the Trust's Risk & Governance Department as part of wider training on incident reporting.

5.3 Exceptions

5.3.1 There are no service areas exempt from the operation of this policy.

6.0 MONITORING

It is the responsibility of the Health & Safety Department to monitor the implementation of and assess the level of compliance with this policy.

7.0 EVIDENCE BASE/REFERENCES

- Health & Safety at Work (NI) Order 1978
- RIDDOR (NI) 1997
- NI2508 Report Form
- NI2508A Report Form
- Health & Safety Executive "A Guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995" (L.73)
- Health Services Information Sheet No 7 (revision 3), 1 October 2013 - Reporting Injuries Diseases and Dangerous Occurrences in Health & Social Care – Guidance for Employers
- Memorandum of Understanding. Investigating patient or client safety incidents (Unexpected death or serious untoward harm): Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health and Safety Executive for Northern Ireland. March 2013

8.0 CONSULTATION PROCESS

Via the Regional Working Group on Adverse Incidents consultee list.

The policy has been developed in consultation with the Trust's Occupational Health Service, Health & Safety Team, Risk & Governance Department Estates Department and members of the Joint Health & Safety Committee.

Consultation with employees and their trade union representatives is a legal requirement, ref: Health & Safety (Consultation with Employees) Regulations (NI) 1996 and The Safety Representatives and Safety Committee Regulations (NI) 1979.

9.0 APPENDICES/ATTACHMENTS

Appendix 1 – Definitions of Major Injuries
Appendix 2 – Reportable Dangerous Occurrences
Appendix 3 – Reportable Diseases
Appendix 4 – Examples of Patient/Service User Falls and Choking Incidents
Appendix 5 – RIDDOR Reporting Flowchart
Appendix 6 – HSENI Correspondence and Belfast Trust CEO Flowchart

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 policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this 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 ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

09 June 2020

_____ **Date:** _____

Name: Philip Boyle
Title: Lead Health & Safety Manager

10 June 2020

_____ **Date:** _____

Name: Chris Hagan
Title: Medical Director

10 June 2020

_____ **Date:** _____

Name: Dr Cathy Jack
Title: Chief Executive

Appendix 1

DEFINITIONS OF MAJOR INJURIES

Reportable major injuries are:

- Fracture other than to fingers, thumbs or toes;
- Amputation;
- Dislocation of the shoulder, hip, knee or spine;
- Loss of sight (temporary or permanent);
- Chemical or hot metal burn to the eye or any penetration injury to the eye;
- Injury resulting from an electric shock or electrical burn leading to unconsciousness or requiring resuscitation or admittance to hospital for more than 24 hours;
- Unconsciousness caused by asphyxia or exposure to harmful substances or biological agent;
- Acute illness requiring medical treatment where there is reason to believe that this resulted from exposure to a biological agent or its toxins or infected material;
- Any other injury leading to hypothermia, heat induced illness or to unconsciousness, or requiring admittance to hospital for more than 24 hours;
- Acute illness requiring medical treatment or loss of consciousness which results from the absorption of any substance by inhalation, ingestion or through the skin.

Further information in respect of Appendices 1, 2 and 3 is available at https://www.hseni.gov.uk/publications/riddor-guidance - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997

Appendix 2

REPORTABLE DANGEROUS OCCURRENCES

[Note – each Trust to modify this list as they wish ie, consider excluding non-healthcare related dangerous occurrences]

- Collapse, overturning or failure of load-bearing parts of lifts and lifting equipment;
- Explosion, collapse or bursting of any closed vessel or associated pipework;
- Failure of any freight container in any of its load-bearing parts;
- Plant or equipment coming into contact with overhead power lines;
- Electrical short circuit or overload causing fire or explosion;
- Any unintentional explosion, misfire, failure of demolition to cause the intended collapse, projection of material beyond a site boundary, injury caused by an explosion;
- Accidental release of a biological agent likely to cause severe human illness;
- Failure of industrial radiography or irradiation equipment to de-energise or return to its safe position after the intended exposure period;
- Malfunction of breathing apparatus while in use or during testing immediately before use;
- Failure or endangering of diving equipment, the trapping of a diver, an explosion near a diver, or an uncontrolled ascent;
- Collapse or partial collapse of a scaffold over 5 meters high, or erected near water where there could be a risk of drowning after a fall;
- Unintended collision of a train with any vehicle;
- Dangerous occurrences at a pipeline;
- Failure of any load-bearing fairground equipment, or derailment or unintended collision of cars or trains;
- A road tanker carrying a dangerous substance overturns, suffers serious damage, catches fire or the substance is released;
- A dangerous substance being conveyed by road is involved in a fire or released.

The following dangerous occurrences are reportable except in relation to offshore workplaces:

- Unintended collapse of: any building or structure under construction, alteration or demolition where over 5 tonnes of materials fall; a wall or floor in a place of work; any false work;

- Explosion or fire causing suspension of normal work for over 24 hours;

- Sudden, uncontrolled release in a building of : 100kg or more of flammable liquid; 10kg of flammable liquid above its boiling point; 10kg or more of flammable gas; or of 500kg of these substances if the release is in the open air;

- Accidental release of any substance, which may damage health.

Appendix 3

REPORTABLE DISEASES

1. Occupational Diseases

Conditions due to physical agents and physical demands of work

- Inflammation, ulceration or malignant disease of the skin due to ionising radiation;
- Malignant disease of the bones due to ionising radiation;
- Blood dyscrasia due to ionising radiation;
- Decompression illness;
- Barotrauma resulting in lung or other organ damage;
- Dysbaric osteonecrosis;
- Cramp of the hand or forearm due to repetitive movements. *Activity – work physically involving prolonged periods of handwriting, typing or other repetitive movements of the fingers, hand or arm;*
- Subcutaneous cellulitis of the hand (beat hand). *Activity – physically demanding work causing severe or prolonged friction or pressure on the knee;*
- Bursitis or subcutaneous cellulites arising at or about the knee due to severe or prolonged external friction or pressure at or about the elbow (beat elbow*). Activity – physically demanding work causing severe or prolonged friction or pressure on the elbow;*
- Traumatic inflammation of the tendons of the hand or forearm or of the associated tendon sheaths. *Activity – physically demanding work, frequent or repeated movements, constrained postures or extremes of extension or flexion of the hand or wrist;*
- Carpal tunnel syndrome. *Activity – work involving the use of hand-held vibrating tools;*
- Hand-arm vibration syndrome. *Activity – work involving:-*
    - The use of chain saws, brush cutters or hand-held or hand-fed circular saws in forestry;
    - The use of hand-held rotary tools in grinding material or in sanding or polishing metal;
    - The holding of material being ground or metal sanded or polished by rotary tools;
    - The use of hand-held percussive metal working tools or the holding of metal being worked upon by percussive tools in connection with riveting, caulking, chipping, hammering, fettling or swaging;
    - The use of hand-held powered percussive drills or hand-held powered percussive hammers in mining, quarrying or demolition, or on roads or footpaths (including road construction);

- The holding of material being worked upon by pounding machines in shoe manufacture.

2. Conditions due to biological agents

- Anthrax
- Brucellosis
- Avian Chlamydiosis
- Ovian Chlamydiosis
- Hepatitis
- COVID-19
- Legionellosis
- Leptospirosis
- Lyme disease
- Q fever
- Rabies
- Streptococcus suis
- Tetanus
- Tuberculosis
- Poisonings
    - Acrylamide monomer
    - Arsenic or one of its compounds
    - Benzene or a homologue of benzene
    - Beryllium or one of its compounds
    - Cadmium of one of its compounds
    - Carbon Disulphide
    - Diethylene dioxide
    - Lead or one of its compounds
    - Manganese or one of its compounds
    - Mercury or one of its compounds
    - Methyl bromide
    - Nitrochlorobenzene, or a nitro –or amino- or chloro-derivitive of benzene or a homologue of benzene
    - Oxides of nitrogen
    - Phosphorous or one of its compounds

- Cancer of a bronchus or lung
- Primary carcinoma of the lung
- Cancer of the urinary tract
- Bladder cancer
- Angiosarcoma of the liver
- Peripheral neuropathy
- Chrome ulceration
- Follicilitis
- Acne
- Skin cancer
- Pneumoconiosis
- Byssinosis
- Mesothelioma

- Lung Cancer
- Asbestosis
- Cancer of the nasal cavity or associated air sinuses
- Occupational dermatitis
- Extrinsic Alveolitis
- Occupational Asthma

Appendix 4

Patient/Service User Falls and Choking Incidents

Please refer to the Trust's Patient Falls & Bed Rails Policies

In the event of a death or major injury arising due to a patient/service user fall or choking incident, in connection with the Trust's work activities and it could have been prevented through risk assessment, identifying and implementing control measures or failure to do any of these, this should be reported under RIDDOR.

- A patient fall incident would be reportable if:-

    - The fall protection measures identified in the falls assessments were not in place at the time of the incident including arrangements for supervision, assistance, access to call and use of mobility aids etc;
    - There was an environmental factor which may have contributed to the fall for example defective flooring, wet floors, housekeeping issues etc.

Examples of Patient Falls:

- A confused patient falls from a hospital window on an upper floor and is badly injured;
- A service user falls in the lounge area, there is previous history of fall incidents, but reasonably practicable measures to reduce the risks have not been put in place;
- A service user falls out of bed, is injured and taken to hospital. The assessment identified the need for bedrails but they, or other preventative measures, had not been provided;
- A service user trips over a loose or damaged carpet in the hallway.

(Source: HSE Reporting injuries, diseases and dangerous occurrences in health and social care: Guidance for employers Health Services Information Sheet No 1 (Revision 3).

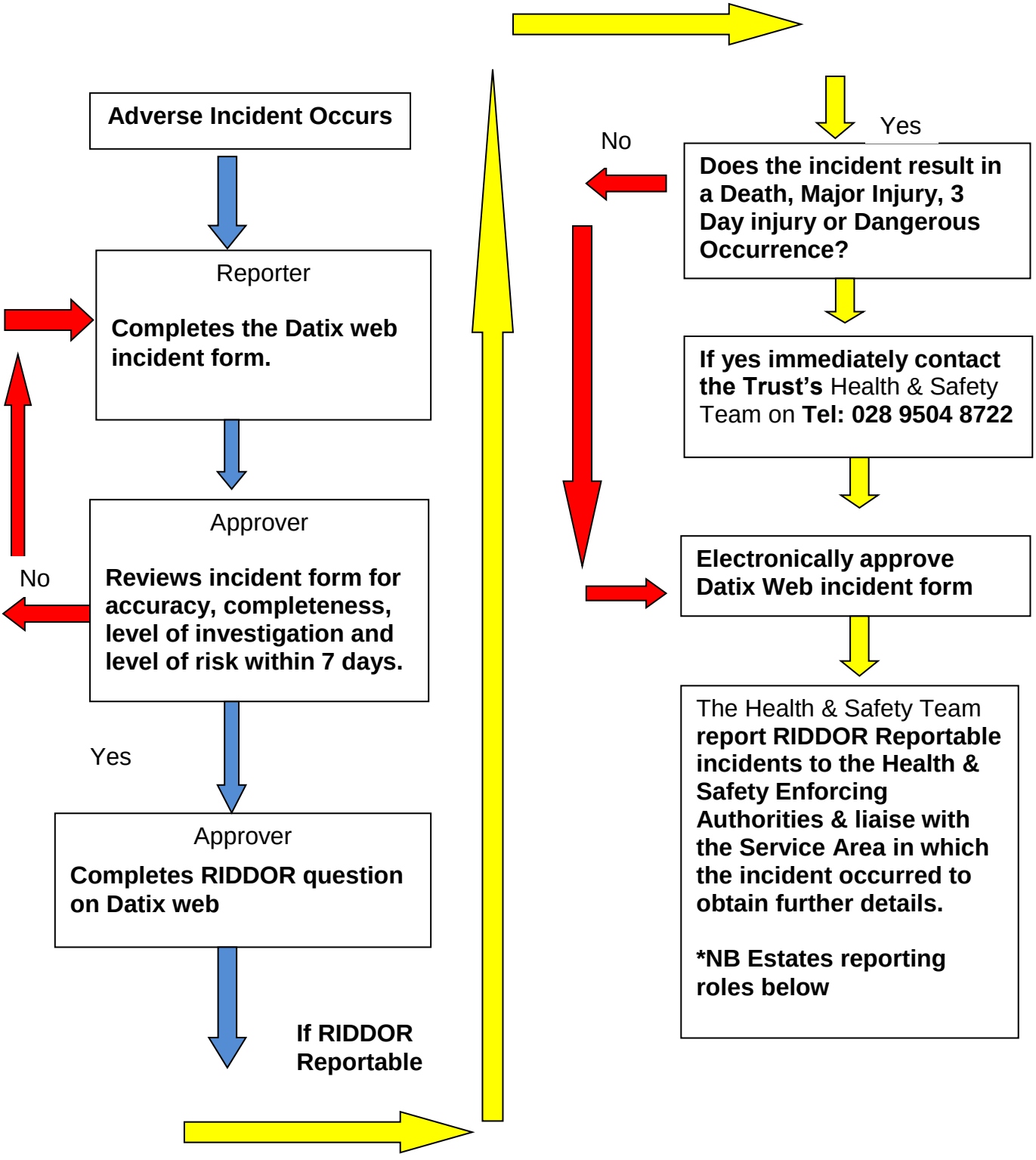
Patient Choking

Please refer to the Trust's policy on The Prevention & Management of Patient, Client and Service Users with Identified Choking Risks.

- A patient choking incident would be RIDDOR reportable if measures in place at the time of the incident as per patient assessment were not in place for example supervision at meal times, personal placemat, safe eating strategies and staff training in swallowing, eating, drinking assessments.

Appendix 5

RIDDOR Reporting Flowchart



***If an Estates related** Dangerous Occurrence **immediately contact the** Estates Risk Manager **on Tel: 028 9504 8838 who reports such incidents under RIDDOR.**

Appendix 6

HSENI Correspondence and Belfast Trust CEO Flowchart

EXTERNAL SOURCE (HSENI) TO THE BHSCT
RIDDOR and ANONYMOUS COMPLAINT INVESTIGATONS

Health & Safety Executive for NI (HSENI) sends correspondence to the Chief Executive's Office (CEO)
(These are often copied to Risk & Governance – but this process relates to actions to be taken by the primary addressee)

CEO forwards correspondence (via email) to Lead / & Health & Safety Managers (H&SM)- Health and Safety Partnered Arrangements (on the Hub)

↓

Risk & Governance Health and Safety Department

Action: Lead/Partnered Health & Safety Manager (directly liaise with Governance Manager / Senior Service Area Manager):

- **Identify Directorate/Service Area affected / actions required**
- **Communicate actions required to identified Director**
- **Copy to relevant Co Director/Governance Mgrs/ASM +, Medical Director, Deputy Medical Director, Risk & Governance Co Director, Corporate Risk and Standards Senior Manager, & Lead Health and Safety Mgr for information**
- **Confirm with the Directorate the commitment to meet the timeline for reply outlined by the HSENI**

→ **Lead/Partnered Health & Safety Manager acknowledges receipt to HSENI of the correspondence and confirms date for reply.**

↓

Action by Lead Director/Responsible Lead & H&SM

- **Identify 'Responsible Lead' within the Directorate.**
- **Where necessary: set up a group to prepare a response and consider any actions e.g. learning, change in practice with consideration to the date for reply.**
- **'Responsible Lead' escalate as a matter of importance to Lead Director if timeline not being met and notify H&SM. H&SM liaise with the HSENI and informs Directorate accordingly.**
- **Partnered Health and Safety Manager to request a minimum of 2 updates from Responsible Lead to provide assurance the response is kept on track**

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Action by Responsible Lead

Forwards formal response to partnered Health &Safety Manager approved by the Directorate at least 4 days before the agreed response time limit.

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Action by Lead/Health and Safety Manager

Lead H&SM forward response to Corporate Risk and Standards Senior Manager and Co-Director for review.

Response forwarded to the CEO 3 days of the agreed response time limit by the Lead/Partnered Health & Safety Manager.

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Action: CEO sends formal response (signed by CEO) via email to the HSENI in accordance with timescale.
Copy: Directorate Director/ Co-Director, Governance Manager, Service Manager, Medical Director, Deputy Medical Director, Risk & Governance Co Director, Corporate Risk and Standards Senior Manager, Lead/ Partnered Health & Safety Manager.

NB Lead/ Partnered Health & Safety Manager attach relevant correspondence to the Datix record for the incident

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP094/14

Title:	**Procedure for Reporting and Managing Adverse Incidents**			
Author(s)	Claire Cairns, Senior Manager Corporate Governance [redacted], Admin & Datix Manager			
Ownership:	Medical Directorate			
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Version No.	V2	**Supercedes**	V1 – 2014-2017	
Links to other policies/ procedures	**Adverse Incident Reporting and Management Policy** Procedure for Reporting and Managing Serious Adverse Incidents Procedure for Grading an Incident Procedure for Investigating an Incident The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements Guidelines for Writing a Statement following an Incident Being Open Policy Whistleblowing Policy			

Date	Version	Author	Comments
24/04/2013	0.1	[redacted]	Initial Draft
03/06/2013	0.2	[redacted]	Comments from Corporate Governance team
09/09/2013	0.3	[redacted]	Comments from Corporate Governance team
15/11/2013	0.4	[redacted]	Comments from Corporate Governance team
20/11/2013	0.5	[redacted]	Comments from Corporate Governance team
25/11/2013	0.6	[redacted]	Comments from Corporate Governance team
04/12/2013	0.7	[redacted]	Comments from Directorate Governance colleagues
December 2013	0.8	Claire Cairns [redacted]	Revised version
June 2014	1.1	Claire Cairns [redacted]	Revised version
29th November 2017	1.2	[redacted]	Interim update pending regional policy / procedures

1.0 INTRODUCTION

1.1 Background

This procedure provides guidance on 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 Trust is committed to an open and fair culture and reporting of adverse incidents is encouraged so that the organisation can learn from incidents and take actions to reduce the risk of reoccurrence.

1.2 Purpose

This procedure is one of a number of procedures directly associated with the Adverse Incident Reporting and Management Policy.

The purpose of this procedure is to enable a robust and systematic approach to the reporting and management of adverse incidents that will be consistently applied across the Trust. This will contribute to ensuring that the Trust meets all relevant statutory or mandatory responsibilities and reporting requirements and safeguards the wellbeing of service users, staff and visitors.

2.0 WHEN AN ADVERSE INCIDENT OCCURS

The injured person or damaged property should be assessed immediately, to ascertain extent of injuries / 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 incident. Ensure appropriate discussion with the service user and/or relatives/carers and give consideration to any additional support which may be required. See 'Being Open Policy' for guidance.

Any equipment involved in the adverse incident, even if not directly implicated, should be removed from use and:

- clearly labelled **"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 Trust Management of Medical Devices Policy and Procedures and Guidelines for further details

[1] The term service user also refers to patients, clients, children and young people under 18 years and carers
[2] "the Trust"

3.0 WHO SHOULD REPORT

Any member of staff can report an adverse incident. It is the responsibility of **ALL** staff who are involved, witness to, or become aware of an adverse incident, to ensure it is reported. If the incident involves another area within the Trust, this area must be communicated with (see Investigation procedure for further guidance).

4.0 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 investigation and timely learning, and ensures compliance with our responsibilities for external reporting.

5.0 WHAT TO REPORT

5.1 All adverse incidents must be reported. The definition of an adverse incident is as follows:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation"[3].

5.2 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, 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
- 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 devices/equipment/non-medical device problems

[3] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

- Medication adverse incidents
- 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

5.3 External Reporting

5.3.1 Depending on the nature of the adverse incident the Trust is required to report details to other statutory agencies and external bodies. Staff should ensure that they are aware of their local reporting requirements to other statutory agencies and external bodies.

Please remember that a Trust Incident Report form must always be completed in the first instance.

5.3.2 It is not practicable to list all relevant agencies/external bodies; however, the table and list below indicate the most common.

External Organisation	Incidents to report	Who reports	Form to use
Health & Social Care Board (HSCB)	Incidents meeting SAI (Serious Adverse Incident) criteria	Corporate Governance Department	HSC Serious Adverse Incident Report Form
Health and Safety Executive Northern Ireland (HSENI)	Injuries, diseases, conditions and dangerous occurrences that arise out of or in connection with work	Health & Safety / Occupational Health/ Estates Dept only. Trust staff / service users should not report directly to HSENI.	On-line RIDDOR report
Northern Ireland Adverse Incident Centre (NIAIC)	Incidents relating to medical devices, non-medical equipment, plant and building items	Trust staff	NIAIC Adverse Incident Report Form
Regulation & Quality Improvement Authority (RQIA)	Various incidents depending on the service. (See RQIA guidance for further details)	Trust staff	RQIA Statutory Notification of Events

Others:

- Counter Fraud and Security Management Service (CFSMS)
- Department of Justice (NI)
- DoH ("the Department")
- DoH Health Estates
- DoH Northern Ireland Head of Inspection and Enforcement (Pharmaceutical Branch)

- General Medical Council (GMC)
- Her Majesty Coroner (HMC) (NI)
- Human Fertilisation and Embryology Authority (HFEA)
- Human Tissue Authority (HTA)
- Information Commissioner Office (ICO) NI office
- Medicines and Healthcare Regulatory Agency (MHRA)
- Northern Ireland Environment Agency (NIEA)
- Nursing & Midwifery Council (NMC)
- Pharmaceutical Society of Northern Ireland (PSNI)
- Police Service of Northern Ireland (PSNI)
- Public Health Agency (PHA)
- Serious Hazards of Transfusion (SHOT)

6.0 HOW TO REPORT

6.1 All adverse incidents must be recorded on an electronic Trust incident form (Datixweb). (Paper incident forms may be used in areas which do not yet have access to Datixweb, or in the rare event that Datixweb is unavailable for a prolonged period of time.)

6.2 **In respect of incidents involving patients/service users, please note that incident report forms are not health records and copies should not be filed in patients'/service users notes.**

6.3 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 Trust definition in 5.1 of this procedure are also reported on a Trust incident form.

6.4 Responsibilities of the Reporter

- Gather the relevant facts to enable a Trust incident Report Form to be completed.
- Complete a Trust Incident Report Form, documenting fact only, not opinion. The electronic incident form is accessed via the Hub home page under '**I Want To…..**Report an Incident (Datixweb)'. Guidance on completion of forms is available on the electronic (Datixweb) form itself, or in the paper incident book.
- Send the incident form for approval, by either clicking 'Submit' on the electronic form or passing the white and green copy of the paper form, along with any attachments, to the approving / line manager for your area.
- Report the incident to your line manager as soon as possible after it has occurred. The line manager may well have already received

notification via Datixweb however it is important that staff do not rely solely on this for communication.

- Inform any other relevant bodies / persons as appropriate.

6.5 Responsibilities of the Approving Manager / Line Manager

As soon as possible after receipt of the incident form, or becoming aware of the incident:

- Ensure section 2.0 of this procedure has been actioned as appropriate.
- Review the incident form to ensure that all relevant sections are complete and accurate and make amendments if required. It is good practice to discuss any amendments with the incident reporter.
- Complete the investigation and approval sections. Note: the mandatory fields should be completed as soon as possible and no later than 7 days after the reported date. Any review / investigation information, and/or updates to current information, can be added to the record at a later date (see Grading and Investigation procedures for further guidance).
- Click 'Save' on the electronic form, or forward the white copy of the paper form to Corporate Governance, 6th floor, McKinney House, Musgrave Park Hospital, Belfast, BT9 7JB.
- Inform any other relevant bodies / persons as appropriate.
- Ensure that appropriate feedback is given to the reporter of the incident and the wider staff team as appropriate.
- Consider whether a hot debrief is required. A hot debrief is a review carried out as soon as possible after the incident. This is to identify any immediate learning that could influence future events as well as supporting staff involved.

Review and approval of incident forms should take place in a timely manner in accordance with the Escalation Protocol (Appendix 1).

7.0 STAFF SUPPORT DIRECTLY FOLLOWING AN ADVERSE INCIDENT

7.1 The Trust recognises that it has a responsibility to support all staff following adverse incidents.

7.2 All staff who are involved in an adverse incident will need the appropriate level of support. It is the line manager's responsibility to ensure that individuals are supported appropriately.

7.3 Support can be provided by Occupational Health and the Staffcare Service.

7.4 Staff involved must be kept informed of the progress of an investigation at all stages.

7.5 Individuals who have been absent from work may require additional support and supervision to aid confidence when returning to work.

See the Investigation procedure for further guidance.

SIGNATORIES

24 January 2018

_____ **Date:**

Name Dr Cathy Jack
Title Deputy Chief Executive/ Medical Director

24 January 2018

_____ **Date:**

Name Martin Dillon
Title Chief Executive

Appendix 1

Escalation Protocol for Datixweb Incident Reporting

Timely reporting of incidents is vital in ensuring that incident data is as robust and accurate as possible. Incidents that remain unapproved for excessive periods of time do not appear in reports used throughout the Trust, or those requested by external bodies, such as the DHSSPS, the Assembly, FOI requests etc.
Furthermore it is easier and less time consuming to investigate incidents as near to the time of occurrence as possible.
The following action will therefore be taken regarding incidents overdue for approval.

1. Any incident remaining unapproved after 7 calendar days (excluding day reported) is deemed to be overdue. For overdue incidents, the manager responsible for DIF2 approval (the handler) will be sent a reminder email from the Risk & Governance Department.
   This email will be sent on a weekly basis until the incidents are approved.

2. If the incident remains overdue for a further 7 calendar days an email will be sent to the appropriate Service Manager.

3. If after a further 7 calendar days the incident/s still remain overdue, an email will be sent to the appropriate Service Manager and Senior Manager for Governance and Quality.

It would be expected that the managers copied into reminder emails would take the appropriate action to ensure outstanding incidents are approved.
The above process is summarised in the table below:

Incident remains unapproved after being reported (number of days)	Reminder sent to applicable		
	Approving Manager	Service Manager	Senior Manager for Governance & Quality
7 days	x		
14 days	x	x	
21 days	x	x	x

All managers responsible for approving incidents should ensure that there is a deputy identified to take over this role in their absence.

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Reference No: TP095/14

Title:	**Procedure for Grading an Incident**			
Author(s)	Claire Cairns, Senior Manager Corporate Governance [redacted], Admin & Datix Manager			
Ownership:	Medical Directorate			
Approval by:	Policy Committee Executive Team		**Approval date:**	11th January 2018 24th January 2018
Operational Date:	January 2018		**Next Review:**	January 2023
Version No.	V2	**Supercedes**	V1 – June 2014 - 2017	
Links to other policies/ procedures	**Adverse Incident Reporting and Management Policy** Procedure for Reporting and Managing Adverse Incidents Procedure for Reporting and Managing Serious Adverse Incidents Procedure for Investigating an Incident The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements Guidelines for Writing a Statement following an Incident Being Open Policy Whistleblowing Policy			

Date	Version	Author	Comments
20/06/2013	0.1	[redacted]	Initial Draft
27/06/2013	0.2	[redacted]	Comments from Corporate Governance team
30/10/2013	0.3	[redacted]	Comments from Corporate Governance team
20/11/2013	0.4	[redacted]	Comments from Corporate Governance team
06/03/2014	0.5	[redacted]	Comments from Directorate Governance colleagues
29th November 2017	1.1	[redacted]	Interim update pending regional policy / procedures.

1.0 INTRODUCTION

All adverse incidents should be investigated commensurate with the severity (actual harm, loss or damage) and/or the potential risk grading. The grading will assist in deciding what level of investigation is required and at what level within the Trust the investigation should be conducted. An initial assessment of the incident severity and risk grade should be undertaken to allow staff to progress appropriately. This can be reviewed following further investigation and amended accordingly.

Tables 1, 2 and 3 below have been agreed regionally to assist in assessing severity and risk grade as objectively and consistently as possible, however it is inevitable that the process will involve a degree of subjectivity. It is recognised that not all incident scenarios fit neatly into one or other of the domains but staff should use their judgement, and view the tables 1and 2 as a guide to assist them towards effective and consistent grading.

The severity and risk grade will be decided initially by the reporting area but may be subject to review by the Corporate Governance Department as part of the quality assurance process. As a result of this, the reporting area may be contacted and asked to review the grading.

2.0 SCOPE OF THE PROCEDURE

This procedure applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency, contractors and volunteers.

3.0 ROLES/RESPONSIBILITIES

3.1 Responsibilities of the Incident Reporter

Determining the Severity (actual harm, loss or damage)

3.1.1 Ensure you have included **all** the relevant facts in the description on the incident form. This will assist in accurately grading the incident at the time and will allow for a clear understanding of the basis for the grading decision, either at a later date or for other staff viewing the incident.

3.1.2 Based on the perceived outcome of the incident **at the time**:

- Using table 1 (Appendix 1), choose the most appropriate domain(s) for the adverse incident from the left hand side of the table.
- Work along the columns in the row to assess the most applicable severity. If the incident could fall into more than one domain and the severity differs between these, a general rule of thumb is to choose the highest severity.

3.1.3 Enter this severity on the incident form

3.2 Responsibilities of the Approving / Line Manager

3.2.1 Review the severity grading on the incident form. If you feel it is incorrect, discuss this with the reporter and change the severity as required.

Determining the Risk Grade

3.2.2 Using table 1 (Appendix 1), choose the most appropriate domain for the adverse incident from the left hand side of the table.

3.2.3 Work along the columns in the same row to assess the most probable potential consequence if this type of incident were to happen again. If the incident could fall into more than one domain and the consequence differs between these, a general rule of thumb is to choose the highest consequence.

3.2.4 Using table 2 (Appendix 1), and based on your knowledge of your own area, determine the likelihood of this type of incident happening again under similar circumstances. The frequency column is the one most often used however the time framed descriptions of frequency or the probability can be used instead, if considered more appropriate.

3.2.5 Plot the consequence and likelihood on the risk matrix in the incident form (Datixweb), (also illustrated in table 3, Appendix 1) to determine the risk grade – low (green), medium (yellow), high (amber) or extreme (red). (For areas still using paper incident forms complete section 12 of the form.)

The severity and/or risk grade now determines the level of investigation required. See the Investigation procedure for full guidance.

3.2.6 If following investigation, the severity and/or risk grading requires amendment, the approving / line manager should action this on the incident form. (For locations still using paper incident forms, contact the Corporate Governance Dept at incident.reporting@belfasttrust.hscni.net to amend the record on your behalf.)

SIGNATORIES

24 January 2018

_____ **Date:** _____

Name Dr Cathy Jack
Title Deputy Chief Executive/
Medical Director

24 January 2018

_____ **Date:** _____

Name Martin Dillon
Title Chief Executive

Table 1 **Appendix 1**

DOMAIN	SEVERITY / 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.

Table 2

Likelihood Scoring Table				
Likelihood Scoring Descriptors	**Score**	**Frequency** (How often might it/does it happen?)	**Time framed** Descriptions of Frequency	**Probability**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily	75%+ More likely to occur than not
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly	50-74% Likely to occur
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly	25-49% Reasonable chance of occurring
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually	10-24% Unlikely to occur
Rare	1	This will probably never happen/recur	Not expected to occur for years	<10% Will only occur in exceptional circumstances

Table 3

	Consequence 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**

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Reference No: TP093/14

Title:	**Procedure for Investigating an Incident (excluding SAIs)**			
Author(s)	Claire Cairns, Senior Manager Corporate Governance [redacted] Admin & Datix Manager			
Ownership:	Medical Directorate			
Approval by:	Policy Committee Executive Team		**Approval date:**	11th January 2018 24th January 2018
Operational Date:	January 2018		**Next Review:**	January 2023
Version No.	V2	**Supercedes**	V1 – June 2014 - 2017	
Links to other policies/ procedures	**Adverse Incident Reporting and Management Policy** Procedure for Reporting and Managing Adverse Incidents Procedure for Reporting and Managing Serious Adverse Incidents Procedure for Grading an Incident The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements Guidance on Writing a Statement following an Incident Policy for Sharing Learning Being Open Policy Whistleblowing Policy			

Date	Version	Author	Comments
29/08/2013	0.1	[redacted]	Initial Draft
21/03/2014	0.2	P Keenan	Comments from Corporate Governance team
24th April 2013	1	Claire Cairns [redacted]	Final version
04/04/2014	0.3	[redacted]	Comments from Directorate & Corporate Governance colleagues
12/05/2014	0.4	[redacted]	Comments from Directorate & Corporate Governance colleagues
28/05/2014	0.5	[redacted]	Comments from Directorate & Corporate Governance colleagues
June 2014	0.6	Claire Cairns [redacted]	Revised version
29th November 2017	1.1	[redacted]	Interim update pending regional policy / procedures

1.0 INTRODUCTION

This procedure applies to ALL incidents which are considered *not* to meet Serious Adverse Incident (SAI) criteria. Please see SAI procedure for further guidance on SAIs.

All incidents should be subject to some level of review or investigation. The severity and / or risk grade of the incident will determine the level of review or investigation required.

For the purposes of this procedure the term 'investigation' will be used throughout to mean either informal review or formal investigation.

This procedure outlines the process of adverse incident (excluding SAIs) investigation including determining what level and type of investigation to adopt, a guide through the investigation process itself, subsequent action planning, sharing of lessons learned and audit to assure appropriate compliance with lessons learned.

2.0 PURPOSE

The purpose of this procedure is to enable a robust and systematic approach to the investigation of adverse incidents that will be consistently applied across the Trust.

3.0 SCOPE

This procedure applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency, contractors and volunteers.

1.0 INTRODUCTION TO INVESTIGATING AN INCIDENT

Many people feel that errors are random occurrences that are unpredictable and beyond control. It is true that chance will play a part in causing some incidents but a large majority of incidents are caused by systemic failures that follow a recurrent pattern. Moreover, if the cause of the incident can be identified, preventative changes can take place and true learning encouraged and shared.

The definition of an adverse incident is as follows:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation"[1].

It is the responsibility of all staff who are involved in, witness to, or become aware of an adverse incident to ensure that this is reported and to complete a Trust Incident Report form.

The Belfast Health and Social Care Trust is committed to staff and service user safety and cooperation with statutory agencies with regard to the response to/and investigation of all incidents up to and including suspicious / unexpected death and serious untoward harm.

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

2.0 LEVEL OF INVESTIGATION REQUIRED

The grading of an incident by severity and risk will determine the requirements for investigating that incident. All incidents will therefore be graded according to severity (actual harm/impact) and risk. (See Procedure for Grading an Incident for further guidance.)

An immediate assessment of the incident grade should be undertaken to allow staff to progress appropriately, if in doubt staff should always grade the incident at the higher level. The incident severity and/or risk grade may require to be amended after further investigation.

Depending on the grade of incident an appropriate level of investigation should be carried out. All levels of investigation require some degree of evidence gathering, making sense of data, analysing problems, identifying cause(s), drawing up conclusions, identifying learning and actions to prevent reoccurrence.

A hot debrief should be considered. This is a review carried out as soon as possible after the incident. This is to identify any immediate learning that could influence future events as well as supporting staff involved.

Investigations should be carried out in accordance with the grading as follows:

2.1 Green – Insignificant or Minor Severity / Low Risk

Who investigates?
The investigation will be commissioned by the incident form approver. It should be investigated locally in the ward/facility in which the event occurred by the incident approver and/or their staff.

Methodology
The outcome of the investigation should be recorded on the investigation and learning section of the incident form. This should include any causes identified, further action taken or planned and any learning. Where no learning or actions are identified, this should be explained as it may be necessary to justify the reasoning behind the decisions at a later date. The investigation should normally be completed no later than 7 working days after the event.

If the investigation identifies any factual inaccuracies with the original incident details, these should be updated accordingly.

Once the investigation is complete and the incident record updated, the approving manager should code the approval status of the incident on Datixweb as ‘Approved, investigation complete’. This is not dependent on actions being outstanding.

Actions & Learning
The incident approver is responsible for ensuring all actions are completed and any learning shared as appropriate (see Policy for Sharing Learning for further guidance). Any actions which are not within the local team’s control or remain uncompleted should be communicated to a more senior manager for consideration.

2.2 Yellow – Moderate Severity / Medium Risk

Who investigates?
The Service Manager or Assistant Service Manager is accountable for ensuring that all investigations are carried out appropriately. The incident can be investigated and reviewed locally in the ward/facility in which the event occurred by the incident approver and their staff, however where the incident crosses professional and/or managerial boundaries, team membership should reflect this.

Methodology
As a first step consider use of Significant Event Audit (SEA) methodology which is an appropriate technique for this level of investigation. The investigation details should be recorded on the SEA template (Appendix 1) which should be attached to the incident record. A note that the template has been attached should be added to the investigation and learning section of the incident form.

If SEA methodology is deemed not appropriate, the outcome of the investigation should be recorded on the investigation and learning section of the incident form. This should include any causes identified, further action taken or planned and any learning. Where no learning or actions are identified, this should be explained as it may be necessary to justify the reasoning behind the decisions at a later date. The investigation should normally be completed no later than 4 weeks after the event.

If the investigation identifies any factual inaccuracies with the original incident details, these should be updated accordingly.

Once the investigation is complete and the incident record updated, the approving manager should code the approval status of the incident on Datixweb as 'Approved, investigation complete'. This is not dependent on actions being outstanding.

Actions & Learning
The Service Manager or Assistant Service Manager are responsible for ensuring all actions are completed and any learning shared as appropriate (see Policy for Sharing Learning for further guidance). Any actions which remain uncompleted should be communicated to a more senior manager for consideration.

2.3 Amber – Major Severity / High Risk (and not an SAI)

Who investigates?
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 should include someone independent from the specialty. Where the incident crosses professional and/or managerial boundaries, team membership should reflect this. More guidance on team membership is available in the Significant Event Audit (SEA) guidance.

Methodology
As a first step consider use of Significant Event Audit (SEA) methodology which is an appropriate technique for this level of investigation. The investigation details should be recorded on the SEA template (Appendix 1) which should be attached to the incident record. A note to this effect should be added to the investigation and learning section of the incident form.

If during the SEA process, it is felt that further analysis is required, the process should transfer to Root Cause Analysis (RCA) methodology. A summary of the results of the investigation should be recorded on the investigation and learning section of the incident form. This should include any causes identified, further action taken or planned and any learning. The investigation report should also be attached to the incident record. Where no learning or actions are identified, this should be explained as it may be necessary to justify the reasoning behind the decisions at a later date. The investigation should normally be completed no later than 12 weeks after the event.
If the investigation identifies any factual inaccuracies with the original incident details, these should be updated accordingly.

Once the investigation is complete and the incident record updated, the approving manager should code the approval status of the incident on Datixweb as 'Approved, investigation complete'. This is not dependent on actions being outstanding.

Actions & Learning
The Co-Director is responsible for ensuring all actions are completed and any learning shared as appropriate (see Policy for Sharing Learning for further guidance).

2.4 Red – Catastrophic Severity or Extreme Risk (and not an SAI)

Who investigates
The Co-Director or 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 should include someone independent from the specialty. Where the incident crosses professional and/or managerial boundaries, team membership should reflect this. More guidance on team membership is available in the Significant Event Audit (SEA) guidance and RCA guidance.

Methodology
Depending on the nature of the incident it may be subject to specific formal Trust investigation process e.g. Case Management Review (CMR), Morbidity & Mortality (M&M) meeting or Cardiac Arrest review. If this is not the case the incident should be subject to SEA or RCA methodology as per Amber section.

A summary of the results of the investigation should be recorded on the investigation and learning section of the incident form. This should include any causes identified, further action taken or planned and any learning. The investigation report should also be attached to the incident record. Where no learning or actions are identified, this should be explained as it may be necessary to justify the reasoning behind the decisions at a later date. The investigation should normally be completed no later than 12 weeks after the event.

If the investigation identifies any factual inaccuracies with the original incident details, these should be updated accordingly.

Once the investigation is complete and the incident record updated, the approving manager should code the approval status of the incident on Datixweb as 'Approved, investigation complete'. This is not dependent on actions being outstanding.

Actions & Learning

The Co-Director or Director are responsible for ensuring all actions are completed and any learning shared as appropriate (see Policy for Sharing Learning for further guidance). This should include any actions or learning identified as a result of other formal Trust investigation processes e.g. M&M, Cardiac Arrest review.

2.5 Summary Table: Level of Investigation

Severity / Risk Grade	Insig. / Minor	Moderate	Major	Catastrophic
	Low	Medium	High	Extreme
Investigation Commissioner	Incident form approver	Service Manager / Asst Service Manager	Co-Director	Director / Co-Director
Investigation duration (guide)	No more than 7 working days	No more than 4 weeks	No more than 12 weeks	No more than 12 weeks
Form	Incident Form	Incident Form (Consider use of SEA template)	SEA template / RCA template (and attach to Datixweb incident record)	SEA template / RCA template (and attach to Datixweb incident record)
Actions	Local implementation / record on incident form.	Local implementation / record on incident form.	Formally monitored.	Formally monitored.
Learning	Record on incident form / shared locally. Patient / Service User / Family informed as appropriate	Record on Datixweb incident form / shared locally. Patient / Service User / Family informed as appropriate	Record on incident form. Shared locally within Directorate. If learning applicable beyond Directorate, Co-Director to share through appropriate Assurance sub-committee. Patient / Service User / Family informed as appropriate	Record on incident form. Shared locally within Directorate. If learning applicable beyond Directorate, Co-Director to share through appropriate Assurance sub-committee. Patient / Service User / Family informed as appropriate

2.6 Incidents involving Non-HSC Organisations

Where incidents are of a serious nature and may include required involvement from other organisations, the Memorandum of Understanding Investigating patient or client safety incidents (Unexpected Death & Serious Untoward Harm) should be used to ensure appropriate investigation on the part of the Trust. This document will guide on which organisation leads and the roles of each in the investigation. Certain investigations or aspects of them may be for others to take forward and therefore the scope of the Trust investigation may be affected.

2.7 Potential Disciplinary / Performance Issues

Incident investigation is designed principally to identify and draw out learning in order that this can be shared, however where an incident involves potential disciplinary or performance issues it is important to follow Human Resources policy and procedures at an early stage. The NPSA Incident Decision Tree can be helpful in identifying these issues early in the investigation process.

3.0 HOW TO INVESTIGATE

The investigation should focus on five key areas:

- **WHAT** - this is detail / specifics in relation to incident / investigation, the actual event and its impact and consequences if any
- **WHERE** - the location / site / area of the incident/ significant in that it may be important in securing evidence / making the scene safe for others and protecting any evidence that may contribute to the investigation
- **WHEN** - the timings / event / notification / resolution from the time of the actual event to the reporting and remedial action, the arrival of assistance and / or other persons involved.
- **WHO** - all persons involved in the incident / investigation, injured parties / witnesses and any others person who have a material contribution to make in terms of the investigation process (remembering that the person(s) affected may also be witnesses)
- **WHY** - findings of the investigation / cause identification / learning to be shared

Of the five areas the WHY is the last to be considered as this will reduce likelihood of jumping to an initial conclusion without due consideration of the facts and causes.

The following sections (3.1 to 3.6) outline the requirements for investigating an incident. The level of detail required should be proportionate to the grading and complexity of the incident.

3.1 Record keeping

Appropriate documentation, including written submissions of witness from staff (see Guidelines on Writing a Statement following an Incident) is required to be recorded and retained in line with good record keeping guidance.

A thorough record of all the investigation activity should be recorded in the appropriate field in Datixweb or added as an attachment to the incident record. Investigators should be aware that the investigation documentation will be covered by the Data Protection Act and will potentially be disclosed to persons outside of the organisation, including the subject of any report.

Once complete, the investigation file should be referenced and filed locally, together with a copy of the final report and completed action plan in accordance with the Trust's Records Retention Schedule. A copy of the final report and action plan, where available, should be attached to the Datixweb record.

3.2 Communicating with and involving patients / service users / families / carers

Staff should follow the Being Open Policy in relation to communicating with patients / service users/ families / carers.

It is important that teams involved in investigations of any incidents where harm occurred, ensure sensitivity to the needs of the patients/service user/relatives/carers involved and agree communication arrangements, where appropriate.
The accountable person should ensure the appropriate level of involvement of patient / service user / family / carer throughout the investigation including discussion / sharing of the final report with the patient / service user / family / carer. The level of involvement clearly depends on the nature of the incident and the patient/service users/relatives/carers wishes to be involved.

3.3 Securing evidence & gathering information

Investigators may find it helpful to consider information from a range of sources including:

- The people involved in or witnessing the event
- The place or environment in which the event took place
- The equipment or objects involved in the event
- The paper work related to the event (e.g. policies, procedures, clinical records, incident reports, risk assessments, maintenance records, clinical audits, training records)
- The widely held beliefs about the normal work processes, team relationships and adequacy of leadership in the workplace.

This list is not exhaustive.

Where required the immediate area should be secured and access be limited until such time as to allow an opportunity to access the scene and record any relevant observations (this may include taking photographs of the scene or measurements).

All material evidence, including written documentation (or copies of), relating to the incident should be gathered and secured as soon as possible after the event. This is particularly important in relation to the timely seizing of CCTV where available, as such evidence may be on a time limited system.

3.3.1 Time Period to be Investigated

From the initial assessment, decide on the time period (start and end dates) that needs to be investigated. This is essential as it determines the information and evidence required. You may therefore need to consider the lead up to and aftermath, as well as the incident itself.
Describe what happened with facts, not opinions, using tools such as a chronology narrative and/or tabular timeline. Avoid the use of abbreviations and medical terms as this may form part of the investigation report which may be read by service users / families/ carers etc. Investigators are encouraged not to pre-judge which events are significant / insignificant in advance of compiling a timeline.

3.3.2 Obtaining Personal Accounts of the Incident

Witnesses to the event and those involved in the incident should be given the opportunity to provide a personal account as to what has occurred.
The PEACE model can be utilised for structured discussion with staff to obtain accounts, if considered appropriate (Appendix 2).
This structured discussion should be carried out in a supportive way, to ascertain the following:

- the role of the witness or those involved in the event and the extent of their involvement.
- The patient and/or relatives/carers account of the incident should be obtained if appropriate.
- the chronology and details of the incident time period
- what problems, action(s), inaction(s) resulted in the incident
- what records, guidelines, equipment were involved
- any other contributory factors e.g. where custom and practice may have deviated from policy and procedure.

3.3.3 Witness statements

Once statements have been received, the lead investigator may wish to speak to staff in person to help clarify part of a statement or account. Any written evidence may become "disclosed" in the event of subsequent legal action and care should be taken in its formulation to include only relevant facts of what actually happened, not what people thought happened. There should be no opinion on who is at fault or any speculation on causes. Forms should be fully completed and all information requested completed.

For further details on Witness Statements please see Guidelines on Writing a Statement following an Incident.

3.3.4 Equipment
For some incidents site visit(s) and liaison with manufacturers and/or suppliers, contractors and/or other agencies/individuals involved may be needed. Any piece of equipment involved in the incident should be removed and preserved as evidence where possible. For further information see Medical Devices Procedures and Guidelines.

3.3.5 Environment – The place in which the incident occurred
Investigators should visit the actual area, if relevant, where the incident took place, preferably before any changes are made and note the layout. A sketch of the area and its layout may be useful particularly if annotated with the location of persons involved in the incident, and other witnesses to the incident. Photographic evidence of the environment can be invaluable.

3.3.6 Evidence storage
Any non-clinical evidence gathered should be attached to the Datixweb incident record e.g. documents, photographs, emails, letters, faxes etc., in order to maintain a complete record of the investigation. If attaching clinical evidence to the Datixweb incident record, the Data Protection Policy must be adhered to. Alternatively this evidence may be retained in a separate file and the location and holder of the file should be clearly recorded on the Datixweb record.

3.4 Identifying problems

A number of tools can be used for identifying the problems e.g. Multidisciplinary meeting, brainstorming / brainwriting, Nominal group technique etc. Please see the Corporate Governance Hub site and SEA and RCA methodology for further guidance regarding these tools.

Problems may relate to the direct provision of care e.g. actions or omissions by staff or absence of guidance to enable action to take place – failure to monitor, observe or act, incorrect decision with hindsight, not seeking help when necessary.

Problems may be identified which are not associated with direct provision of care e.g. issues with decisions, procedures and systems – failure to undertake risk assessment, equipment failure.

3.5 Analysing the incident

The investigator (and/or team) should analyse the problems to identify contributory factors and root causes. For more detailed investigations an analytical tool such as fishbone, 5 Whys may be used to assist. Please see the Corporate Governance Hub site and SEA and RCA methodology for further guidance regarding these tools.
Contributory factors may be:
a) Communication factors (including verbal, written and non-verbal between individuals, teams and/or organisations)
b) Education and training factors (e.g. availability of and attendance at training)
c) Equipment and resource factors (e.g. clear machine displays, poor working order, size, placement, ease of use)
d) Medication factors (where one or more drugs directly contribute to the incident)

e) Organisation and strategic factors (e.g. organisational structure, contractor / agency use, culture)
f) Persons affected factors (e.g. clinical condition, social / physical / psychological factors, relationships)
g) Task factors (includes work guidelines / procedures / policies, availability of decision making aids)
h) Team and social factors (includes role definitions, leadership, support, and cultural factors)
i) Work and environment factors (e.g. poor/excess administration, physical environment, work load and hours of work, time pressures)

Root causes/causal factors

These are failures which had a direct causative affect on the incident. There may be more than one root cause in any incident although care should be taken to distinguish root causes from issues which merely contributed to the incident.
A root cause is a problem which, if resolved, will significantly reduce the risk of reoccurrence of the incident if not eliminate that risk entirely.

3.6 Generating solutions – Conclusions & Actions

3.6.1 Conclusions
Following analysis the key findings should be summarised along with issues that need to be addressed. Include any good practice identified as well as actions to be taken.
Formulate conclusions based upon available evidence.

3.6.2 Actions
Develop actions to help prevent or minimise recurrences thus reducing risk of future harm and ensuring patient safety is improved. Where appropriate include details of any ongoing engagement / contact with service users, family members or carers.
Actions should be SMART i.e.:

- Specific (is it clear what is being asked and of who?);
- Measurable (ask yourself whether the action is auditable);
- Accountable (who is responsible for implementing the action);
- Realistic (consult with those persons able to deliver the action);
- Time-bound (there should be a clear timeframe for implementation).

Avoid actions such as *remind staff* or *promote awareness,* but if they have to be used, explain how this will be done e.g. a poor action would be – *share updated policy with staff*. Be more specific – *send staff the specific section which has changed highlighting the change and drawing their attention to it*.
Investigators should aim to have no more than 4-5 key actions (although it may be less); the important thing is that the actions reduce the likelihood of a reoccurrence of the incident.

3.6.3 Report and dissemination
The report should be clear, free of jargon, acronyms and names and using plain English. Where technical terms are necessary a glossary may be required.

It is important to note that unless there are specific exceptions, the patient / service user or family of a patient / service user have a right to the full investigation report under the Data Protection Act 1998 (ref NPSA Guidance on Writing and Investigation Report. Aug 08). The findings of the report should be shared with all other stakeholders as appropriate and ensuring confidentiality.

3.6.4 Action Plans

Action Plans should be generated for incidents graded as major or catastrophic severity and high or extreme risk. Lower grades than this may also use action plans where the actions require monitoring closely due to their complexity and/or cross service responsibility.

The individual accountable for the investigation has responsibility for ensuring the preparation of an action plan.

Developing an action plan

- Overall responsibility for the action plan must be with the individual who commissioned the Investigation.
- Where an action identified is outside the area of responsibility of the individual accountable for the investigation, discussion and agreement must be reached with the relevant manager for taking that action forward.
- Timescales for each action must be agreed with the person responsible for implementing the action.
- Every action plan should include the following:
    - The reference number of the incident
    - Date Investigation completed
    - Date of the latest version of the action plan
    - Version number

Monitoring

The individual accountable for the investigation is responsible for setting up directorate level monitoring and review processes to ensure actions are progressed as planned.

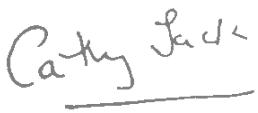
Learning

Where learning has been identified, this should be shared as appropriate (see the Policy for Sharing Learning)

3.7 The Investigation process, where an Incident is also a Complaint.

When an adverse incident is being investigated and is also a complaint, the investigation will continue and the outcome of the investigation may form part of the complaint response.

SIGNATORIES



24 January 2018

_____ **Date:** _____

Name Dr Cathy Jack
Title Deputy Chief Executive/
Medical Director

24 January 2018

_____ **Date:** _____

Name Martin Dillon
Title Chief Executive

Belfast Health and Social Care Trust

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT

TITLE:	
DATE OF SIGNIFICANT EVENT:	
DATE OF SIGNIFICANT EVENT MEETING:	
SEA FACILITATOR/ LEAD OFFICER:	
TEAM MEMBERS PRESENT:	

WHAT HAPPENED?

WHY DID IT HAPPEN?

WHAT HAS BEEN LEARNED?

WHAT HAS BEEN CHANGED?

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

Where a Level two or three investigation is recommended please complete the sections below

THE INVESTIGATION TEAM :

INVESTIGATION TERMS OF REFERENCE:

LEVEL ONE – SIGNIFICANT EVENT AUDIT REPORT GUIDANCE

TITLE: *Insert unique identifier number*	*Self- explanatory*
DATE OF SIGNIFICANT EVENT:	*Self- explanatory*
DATE OF SIGNIFICANT EVENT MEETING:	*Self- explanatory*
SEA FACILITATOR/ LEAD OFFICER:	*Refer to guidance on Level one investigation team membership for significant event analysis –Appendix 9*
TEAM MEMBERS PRESENT:	*Self- explanatory*

WHAT HAPPENED?

(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user, the team, organisation and/or others).

WHY DID IT HAPPEN?

(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)

WHAT HAS BEEN LEARNED?

(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)

WHAT HAS BEEN CHANGED?

(Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.

Action plans should be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan).

RECOMMENDATIONS FOLLOWING THE LEVEL ONE SEA:

(Following the SEA it may become apparent that a more in depth investigation is required. Use this section to record if a Level two or three investigation is required).

P.E.A.C.E. Interview Model

Planning & Preparation	**E**ngage & Explain	**A**ccount Clarification & Challenge	**C**losure	**E**valuation
•Plot events on a timeline for information retention •What is known about interviewee and what needs to be established •Points to prove, facts and issues •Practical issues (5 W's) •Aim & objectives •Written Plan	•Engage in a conversation •First impressions •Explain purpose of interview •Reasons, routines, outline, expectations •Assess needs of the interviewee	•Uninterrupted account •High use of questions summaries •Expanding & clarifying the account •Question loop.. Open, probe, summarise as appropriate, link •Done chronologically, methodically •Lock the person down into their account •Challenge the inconsistencies & contradictions •Use the words of the interviewee, words of others and contradictory information / evidence •Non accusatorial •Ask the interviewee to explain the differences between their account and the evidence	•Summarise account for mutual understanding •All areas fully covered •Explain future activities •Facilitate positive attitude of accurate and reliable information •Review needs of interviewee •Maintain professional style	• Evaluate information obtained • Aims & objectives reached • Re-evaluate evidence in investigation • Evaluate own performance • Evaluated by lead • Identify areas of improvement

Belfast Health and Social Care Trust
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Reference No: TP096/14

Title:	**Guidelines for Writing a Statement following an Incident**			
Author(s)	Claire Cairns, Senior Manager Corporate Governance			
Ownership:	Medical Directorate			
Approval by:	Policy Committee Executive Team		**Approval date:**	11th January 2018 24th January 2018
Operational Date:	January 2018		**Next Review:**	January 2023
Version No.	V2	**Supercedes**	V1 – June 2014 - 2017	
Links to other policies/ procedures	**Adverse Incident Reporting and Management Policy** Procedure for Reporting and Managing Adverse Incidents Procedure for Reporting and Managing Serious Adverse Incidents Procedure for Grading an Incident Procedure for Investigating an Incident The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements Being Open Policy Whistleblowing Policy			

Date	Version	Author	Comments
24th April 2013	0.1	Claire Cairns [redacted]	Final version
December 2013	0.2	Claire Cairns [redacted]	Revised version
June 2014	1	Claire Cairns [redacted]	Revised version
29th November 2017	1.1	[redacted]	Interim update pending regional AI policy / procedures

Guidelines for Writing a Statement following an Incident

1. There are many circumstances in which you may be called upon to provide a written statement. This may be as a result of being asked to give an opinion as a health care professional, or as part of an investigation into an adverse incident, complaint or claim. Reports may be of a factual nature, such as a description of the events surrounding an adverse incident, or an opinion, which is an interpretation of facts such as an evaluation of a patient's prognosis. The report should be directed to the purpose for which it is required, it is therefore important that you recognise what type of statement you are being required to give.

2. These guidelines aim to provide you with some simple advice on preparing a statement of fact, which has been requested for an investigation into an untoward event that has occurred during the course of your employment.

3. You must assume that the reader of your statement knows nothing of the facts of the case, of the patient/service user's medical history or of hospital routines. The statement will thus form a story which will tell an intelligent lay person (the coroner in the case of a death) the circumstances of the adverse incident as you remember them.

4. If you were the witness to an adverse incident, the Witness Statement form (Appendix 1) is provided for your use.

5. Use good quality A4 paper. Do not use scraps of paper, pages from notepads, medical records sheets, or the backs of documents designed for other purposes.

6. Statements should be typed using only one side of each page. Wide margins and double line spacing are recommended. If it is not possible to have your statement typed you must write neatly using black ink.

7. Each page should be numbered consecutively in the right hand corner and all of the pages should be securely fastened together.

8. Each page should include the adverse incident, complaint or claim reference number.

9. Begin the statement with your name, professional qualifications, length of service and what post you hold within the Trust.

10. Be clear about the times you were on and off duty on the days in question and about what you saw and heard. Put events in the order in which they happened giving precise dates and times (using am or pm or the 24 hour clock). Explain what was happening at the time of the incident and describe the environment in which the incident occurred.

11. State your location at the time of the adverse incident and name any other witnesses who were present. When referring to other people in your statement give their full names and job titles.

12. Stick to facts and avoid expressing opinions. Only include facts or conversations you have actually witnessed or taken part in. Do not include things that other people told you happened or conversations reported to you.

13. Write the statement in simple terms and avoid using jargon or abbreviations. Be as brief as possible while covering all essential points.

14. All numbers, including dates, should be expressed in figures, not words.

15. If you include in your statement any information you have read in professional records, documents, papers or notes you should include references as to where it can be found e.g.: "It is recorded on 23/9/2002 on Mrs Smith's communication sheet that a request for a CT scan had been sent to Radiology."

16. Your statement should be written in the first person i.e.: "I was asked by Staff Nurse Jane Smith to record Mr Green's blood pressure."

17. Any alterations to your statement should be made by drawing a single line through the words you wish to change. This should then be initialled.

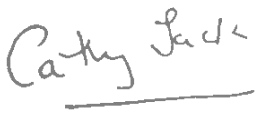
18. The final paragraph of your statement should read: "This statement is true to the best of my knowledge and belief."

19. Your statement should be signed and dated. You should also print your full name and job title.

20. Double check your statement before signing it. It is recommended that you keep a copy of your statement for your own records.

21. Remember that statements should be factual and accurate and you should make sure that you are happy for others to read it. If you need help or advice in writing a statement, ask your manager.

SIGNATORIES



24 January 2018

_____ **Date:** _____

Name Dr Cathy Jack
Title Deputy Chief Executive/
Medical Director

24 January 2018

_____ **Date:** _____

Name Martin Dillon
Title Chief Executive

Appendix 1

Belfast Health and Social Care Trust
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WITNESS STATEMENT FORM										
Surname (PRINT)										
Forename (PRINT)										
Title	Dr.		Mr.		Miss.		Ms.		Mrs.	
Job Title(PRINT)										
Directorate/Area										
Home Address										
Contact phone no:										

INCIDENT DETAILS			
I was a witness to an incident that occurred:			
Site:			
Exact locations – section room etc			
Date		Time	
Incident form reference no:			
Factual description of the incident			
I confirm that the contents of this, my statement, are true to the best of my knowledge, information and belief.			
Signed		**Date**	