Belfast Health and Social Care Trust
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Policy Code: BHSCT/Gen (14)

Title:	**Procedure for Reporting and Approving Adverse Incidents**				
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Responsible Director:	Dr George Gardiner, Acting Medical Director				
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Links to other policies	BHSCT Adverse Incident Reporting and Management Policy (2020) TP 08/08 BHSCT Procedure for Serious Adverse Incidents (2020) TP 97/14 BHSCT/Gen (13) (2024) Procedure for Grading an Adverse Incident BHSCT/Gen (12) (2024) Procedure for Reviewing/Investigating an Adverse Incident (excluding SAIs) BHSCT Guidelines for Writing a Statement following an Incident (2018) TP 96/14 BHSCT The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (NI) 1997 (RIDDOR) Procedural Arrangements (2020) TP 42/08 BHSCT Being Open Policy - Saying Sorry When Things Go Wrong (2020T) TP 80/11 BHSCT Your Right to Raise a Concern (Whistleblowing) Policy (2018) TP 22/08 BHSCT Core Statutory and Mandatory Training Policy (2020) TP 71/11				

1.0 INTRODUCTION / SUMMARY OF POLICY

This procedure provides guidance on reporting and approving 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, honest and just culture and reporting of adverse incidents is encouraged so that the organisation can learn from these and take actions to reduce the risk of reoccurrence.

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

2.0 SCOPE OF THE POLICY

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

3.0 ROLES AND RESPONSIBILITIES

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

It is the responsibility of all staff and managers involved in reporting and approving incidents to comply with this procedure alongside the Adverse Incident Reporting and Management Policy and other associated procedures.

4.0 CONSULTATION

This procedure has been reviewed by Directorate Governance and Quality Managers and their equivalent Senior Managers within Corporate Directorates.

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

5.0 POLICY STATEMENT/IMPLEMENTATION

5.1 When an Adverse Incident Occurs

The situation should be assessed immediately, to ascertain the extent of harm / risk / damage and to 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 the Being Open Policy for guidance.

Reasonable adjustments will be made in respect of disabled patients/service users/carers/visitors. This includes making all communication (in person, by phone, via email) and any information provided (in writing, verbally) accessible using alternative formats as required. Accessible/ Alternative formats can include, for example, information translated into Easy Read format or into Audio format - when a patient/service user/carer/visitor has a learning disability or is visually impaired. For advice on making information accessible for a person with a disability please refer to the staff guidance Making-Communication-Accessible.pdf

In addition, if a patient/service user/carer/visitor does not speak English as their first language or has poor English, the Trust has a statutory duty to provide an interpreter and to translate written information. This facilitates informed consent, better understanding and greater independence.

Staff may also require support following an adverse incident. See section 5.6 for further 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 Medical Devices Procedures and Guidelines for further details

5.2 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 Procedure for Reviewing/Investigating an Adverse Incident for further guidance).

5.3 When to Report

It is important that all adverse incidents are reported as soon as possible and ideally within 24 hours of occurrence or becoming aware of the adverse incident.

This supports effective review/investigation and timely learning, and ensures compliance with our responsibilities for external reporting (see section 5.4.1).

5.4 What to Report

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 arising during the course of the business of a HSC organisation/Special Agency or commissioned service"[3].

Types of possible adverse incidents are shown below.

- Accidents/Falls
- Administrative Processes – including issues with admission, discharge, handovers, referrals, transfers
- Anaesthesia Care
- Behaviour
- Blood/Plasma Products
- Communication
- Diagnostic Processes/Procedures
- Documentation
- Exposure to Environmental Hazards
- Fires, Fire Alarms and Fire Procedures
- Infection Control Incidents
- Injury of Unknown Origin
- IT Systems
- Maternity Care
- Medical Devices, Equipment, Supplies
- Medical Gases/Oxygen
- Medication/Biologics/Fluids
- Neonatal/Perinatal Care
- Nutrition Food/Meals from Kitchen
- Nutrition Pharmacy Products
- Personal Property/Data/Information
- Pressure Ulcers
- Property
- Public Order/Crowd Control
- Security of Organisation's Property, Data and Buildings
- Service Disruptions
- Terrorism
- Therapeutic Processes/Procedures
- Unexpected Deaths or Severe Harm

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

The trigger list of circumstances or events which may occur within service areas can also be referred to. The trigger list is available via a link on the incident report form.

5.4.1 External Reporting

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.

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

External Organisation	Adverse Incidents to report	Who reports	Form to use
Strategic Planning & Performance Group (SPPG)	Adverse incidents meeting SAI (Serious Adverse Incident) criteria	Corporate Governance Department	Regional 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)	Adverse 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 adverse incidents depending on the service (inc. those notifiable under (IR(ME)R) Regulations). (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/Dental Council (GMC/GDC)
- Health and Care Professions Council (HCPC)
- His Majesty's 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)

5.4.2 Independent Sector Providers

Independent sector providers e.g. private nursing homes, residential homes, domiciliary care providers, supported living providers and independent clinics/hospitals have a responsibility under their contract to report adverse incidents involving our service users to the Trust. These incidents are then transferred onto Datixweb by Trust staff and managed as per section 5.5 below.

5.5 How to Report

All adverse incidents must be recorded on an electronic Trust incident form (Datixweb). (In the rare event that Datixweb is unavailable for a prolonged period of time, services can record incidents on a form template downloadable from the Loop, and must communicate these to management. Services must transfer these incident details onto Datixweb when it becomes available)

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. However, details of the incident (including the incident reference number) that are relevant to the treatment and care being provided to the service user should be added separately within the service user's healthcare record.

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 5.4 of this procedure are also reported on a Trust incident form.

5.5.1 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 Loop under Digital Apps, Incident Reporting (Datixweb). Guidance on completion of forms, including links to other relevant procedures, is available on the electronic (Datixweb) form itself.

- Submit the incident form for approval, by clicking 'Submit' on the electronic form. Report the incident to the manager on duty as soon as possible after it has occurred. The 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, for example, the service user and/or family/carers.

5.5.2 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 5.1 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 ideally 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 Procedure for Grading and Adverse Incident and Procedure for Reviewing/Investigating Adverse Incidents for further guidance).
- Click 'Save' on the electronic form.
- Inform any other relevant bodies / persons as appropriate, for example, the service user and/or family/carers.
- Provide feedback to the reporter of the incident and the wider staff team as appropriate. Feedback can take a number of forms including automatic feedback email (Datixweb), one-to-one discussions with the reporter/involved staff member, discussions at team/assurance/governance meetings etc. This feedback should be documented.
- Consider whether an initial discussion, as soon as possible after the incident, is required. This may take the form of a hot debrief/learning conversation etc, which should be led by a manager/lead clinician and involve any other key staff. 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).

5.6 Staff Support Directly Following an Adverse Incident

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

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.

Support can be provided by Occupational Health, Staffcare Service and BeST (Belfast Support Team).

Staff involved must be kept informed of the progress of a review/investigation at all stages.

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

See the Procedure for Reviewing/Investigating an Adverse Incident for further guidance.

5.7 Dissemination

Following approval at Policy Committee this procedure will be made available on the Trust Intranet and forwarded to Directorate Governance and Quality Managers and their equivalent Senior Managers within Corporate Directorates, for cascading within their areas.

5.8 Resources

Staff will be informed that the updated procedure is available via Directorate Senior Managers as referenced in section 4.0 and the Trust Intranet.

5.9 Exceptions

This procedure applies to all staff and managers involved in reporting and managing incidents with no exceptions.

6.0 MONITORING AND REVIEW

This procedure will be monitored in conjunction with the Adverse Incident Reporting and Management Policy.

7.0 EVIDENCE BASE/REFERENCES

N/A

8.0 APPENDICES

Appendix 1 – Escalation Protocol for Datixweb Adverse Incident Approval

9.0 NURSING AND MIDWIFERY STUDENTS

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

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

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

10.0 EQUALITY IMPACT ASSESSMENT

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

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

The outcome of the equality screening for the policy is:

Major impact	☐
Minor impact	☐
No impact	☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection

Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to militate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this **link**.

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

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

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

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

12.0 RURAL NEEDS IMPACT ASSESSMENT

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

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

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

13.0 REASONABLE ADJUSTMENT ASSESSMENT

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

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

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

16/01/2024

[redacted]

_____ **Date:** _____
Policy Author

[redacted]

29/02/2024

_____ **Date:** _____
Director

Appendix 1

Escalation Protocol for Datixweb Adverse Incident Approval

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 Dept of Health (DoH), the Assembly, FOI requests etc. Furthermore it is easier and less time consuming to review/investigate incidents as near to the time of occurrence as possible.

Directorate Governance processes should ensure that there is regular monitoring of unapproved adverse incidents.

The following action will 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 approval 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.