Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Incident Management Policy

This procedural document incorporates:

CORP/RISK 4 v.3 – Policy for Supporting Staff Involved in Incidents, Complaints and Claims;
CORP/RISK 13 v.2 – Policy for the Reporting and Management of Incidents and Near Misses;
CORP/RISK 20 v.1 – Learning from Incidents, Complaints and Claims;
CORP/RISK 24 v.1 – Investigating Incidents, Complaints and Claims.

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Executive Sponsor(s):	Sewa Singh- Medical Director
Author/reviewer: (this version)	Louise Povey-Head of Patient Safety & Experience Lisette Caygill-Acting Deputy Director of Quality & Governance
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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 1 (amended 22 May 2018)	22 May 2018	• A link relating to Public Health England Screening Programmes has been added within section 8.	Lisette Caygill
Version 1	12 October 2017	• This new procedural document incorporates: CORP/RISK 4 v.3 – Policy for Supporting Staff Involved in Incidents, Complaints and Claims; CORP/RISK 13 v.2 – Policy for the Reporting and Management of Incidents and Near Misses; CORP/RISK 20 v.1 – Learning from Incidents, Complaints and Claims; CORP/RISK 24 v.1 – Investigating Incidents, Complaints and Claims. Please read in full.	Louise Povey Lisette Caygill

Contents

Page No.

1 INTRODUCTION

Incident reporting is a fundamental tool of risk management. The ultimate aim is to reduce the risk of harm to patients, staff and other users of Trust premises through improving the safety culture and quality of services and the environment. This will be addressed by undertaking qualitative and quantitative data analysis of incidents to highlight any trends.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) recognises that in a service as large and complex as the NHS things go wrong. When they do, the Trust supports the view that the response should not be one of blame and retribution but of organisational learning with the aim of encouraging participation in the overall process and supporting staff, rather than exposing them to recrimination. Therefore, the Trust is committed to developing a just or fair blame culture and to encouraging a willingness to admit mistakes without fear of punitive measures. In support of this, the Trust accepts that reporting an incident via Datix does not constitute an admission of liability and will not result in automatic disciplinary action.

2 PURPOSE

This policy will cover the following areas:

- When and how to report an incident
- Investigation of incidents
- Learning from incidents
- Support to staff when affected by an incident

3 DUTIES AND RESPONSIBILITIES

These are the individual and departmental roles and levels of responsibility for incident management within the Trust.

3.1 All Staff

All staff have a responsibility for ensuring that incidents and near misses are reported. All staff should be aware of what constitutes an incident or near miss and the process for reporting and management of such incidents.

3.2 The Incident Reporter

The reporter must:

- Ensure the immediate safety of the patient/staff/visitor involved in the incident.
- Report the incident on Datix (DIF1).
- Ensure that the team leader or department manager is informed of the Incident as soon as possible after the incident.

- When it is a patient that has been affected by the incident, the relevant medical team should be informed and the event should be recorded in the patient record.
- If there has been any harm impact on a patient then the patient should be informed in line with duty of candour principles. Where the patient cannot be informed, then their named contact should be informed.

3.3 Incident Approver

Each department will have an incident approver, which will typically be the ward or department manager. Patient safety leads or facilitators, clinical governance leads and the Patient Safety and Legal Services team may also undertake incident approval where required in order to progress initial investigation and allocation of responsibility. They will:

- Assess the content of the incident form to determine:
  - The outcome of the incident, updating the result field on the DIF2 form on Datix.
  - The actual harm caused by the incident and update the severity field of the DIF2 form as required. ***(See Appendix 1)***
- Where the information is insufficient to determine the outcome and harm caused, undertake initial investigation into the outcome and harm.
- Undertake a risk grading based on the potential consequence and likelihood.
- If there is evidence of harm, then proportional investigation of the cause of the incident should be undertaken.
- Where there is no harm caused and there is a high risk grade, then proportional investigation should be undertaken.
- The current status field should be updated to reflect the stage of approval and completion.
- If an incident has not caused harm, and is classified as low or moderate risk, then local investigation is discretionary, but the incident can be finally approved and closed at this point.
- Complete DIF2 with the findings of the initial and any subsequent proportional investigation.
- Record details of the actions necessary to reduce or eliminate the risk of recurrence and communicate with the relevant manager with responsibility to undertake the actions required. All agreed actions must be undertaken within 3 months, or an exception report be provided through the local specialty or department governance meetings.
- Update actions planned by the deadline set.
- Complete RIDDOR form when applicable and following advice from Health & Safety Manager.
- Seek advice from relevant specialist staff to investigate and manage the incident, such as Pharmacists, Medical Technical Services, Resuscitation & Manual Handling Lead, Local Security Management Specialist, Information Governance team, Radiation Protection advisor and Counter Fraud Specialist.

3.4 Care Group Director, Head of Nursing/Midwifery/Therapies & Heads of Departments

Care Group senior management teams and department heads must ensure they have delegated the responsibility of incident management to appropriate individuals within their areas of responsibility, such as Matrons, Ward and Department Managers, Assistant Care Group Directors and Clinical Governance Leads. They are responsible for promoting effective risk management and ensuring there are operational systems in place within their teams to fulfil the requirements of this policy.

The Care Group management team are also responsible for agreement on the content of action plans from serious incident (SI) investigations, and the Care Group approval of serious incident investigation reports.

3.5 Care Group Clinical Governance Leads

These posts will provide oversight of the incident reporting process and ensure the provision of analysis of incident reporting, to be triangulated with other activities to determine quality and clinical governance and reporting to the Care Group Clinical Governance meetings. The monitoring of action plan completion is a key function which will be reported through clinical governance committees for each specialty and Care Group.

3.6 Patient Safety Team

The Patient Safety Team will ensure they have systems in place to review all incidents categorised as moderate, severe or death and confirm accuracy of severity. They will provide advice, assistance and support to Line Managers and other employees as appropriate. The Datix Administrator & Analyst will provide reports to the Patient Safety Review Group, Clinical Governance Committee and Health and Safety Committee as laid down in those committees' terms of reference.

3.7 Patient Safety Leads

The Patient Safety Leads will be involved in leading and facilitating investigation, supporting Care Group clinicians and managers to undertake investigations and will track and monitor the status of the care group serious incident investigation.

These posts are well positioned to work with the Clinical Governance Lead and Care Group management team to provide analysis of incident and risk data, producing monthly and quarterly reports for the care group and specialties, as required.

3.8 Medical Director and Director of Nursing, Midwifery and Quality

The Medical Director is the Executive lead for quality and the Director of Nursing Midwifery and Quality supports and deputises as required. Their teams provide the day to day oversight of decision making with regard to SI reporting and investigation approaches. The directors and deputies also provide the organisation sign off of SI investigation reports.

3.9 Chief Executive

The Chief Executive has ultimate responsibility for patient safety and risk management across the Trust and will ensure that all incidents are dealt with appropriately and that the just culture of fair blame is upheld.

3.10 Senior Incident Risk Owner (SIRO)

Is responsible for ownership of information risk across the Trust and for ensuring the Board is adequately briefed on information security risks and incidents.

4 COMMITTEES WITH RESPONSIBILITY FOR INCIDENT MANAGEMENT PROCESSES

4.1 Serious Incident Panel

The serious incident panel members include the following roles:

- Deputy Medical Directors (Governance)
- Deputy Director of Nursing, Midwifery and Quality
- Deputy Director of Quality and Governance
- Head of Patient Safety and Experience
- Education Quality and Governance Manager
- Patient Safety Co-ordinator

The above also includes the Director of Nursing, Midwifery and Quality and Medical Director, who attend and contribute when there are high profile or specific cases.

The panel meet predominantly on a weekly basis, with exceptions when bank holidays or other commitments prevent the panel meeting. Additional panel meetings are arranged when there are peaks in activity in report scheduling.

4.2 Patient Safety Review Group (PSRG)

PSRG will receive a monthly, quantitative and qualitative report on incident reporting activities incorporating a trend analysis of incidents and near misses and serious incident reporting patterns, in line with the national Serious Incident Framework. The PSRG will recommend actions required to ensure the reduction of risk in patient safety and prevent future reoccurrence.

PSRG's role is to ensure actions are taken as a result of trend analysis, and the cascading of information throughout the organisation.

PSRG will monitor the Trusts compliance to action plans completion targets generated from all serious incidents and duty of candour regulation compliance.

4.3 Clinical Governance Committee (CGC)

CGC will receive a monthly exception report of all serious incidents. They will receive assurance that systems and processes are in place to address and learn from all incidents and near misses and to ensure effective Risk Management across the Trust.

4.4 Care Group Clinical Governance Groups and Specialty Clinical Governance Groups

Must have systems and processes in place to ensure that:

- All incidents are reviewed and investigated at a level appropriate to the incident, using root cause analysis methodology when indicated.
- Any recommendations made following investigations are carried through to a SMART action plan which is monitored for completion
- The Statutory Duty of candour is complied with in all cases of "moderate" "severe" and "death" incidents
- Local and organisational learning takes place.
- Report to PSRG and CGC as defined in the terms of reference.

4.5 Staff Side Partnership Forum

The Forum will receive the quarterly DATIX report and note the Health and Safety section. They will consider the themes and agree further actions and audits.

5 PROCEDURE FOR INCIDENT REPORTING

5.1 Reporting the Incident: Completing an incident Report Form DIF1

When an incident occurs, the first response must be to make the situation safe and ensure the patient and/or staff member receive appropriate treatment and ongoing management. All evidence should be protected and secured, e.g., damaged equipment retained, IT activity logs copied, etc, in case of the need for further investigation.

The Incident must then be reported onto Datix (DIF1) recording all the facts as are known at the time and categorising the known harm to the person affected or harmed. An incident should be reported to the most senior member of the department at the time, for their consideration of escalation to senior managers in respect of any management action or potential serious incident management.

5.2 Duty of Candour (DoC)

Duty of Candour is a statutory requirement has been introduced to ensure health care providers operate in a more open and transparent way. The regulation for Duty of Candour applied to health service bodies from 27 November 2014. This regulation requires an NHS body to:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person in person as soon as reasonably practicable after becoming aware that a 'notifiable safety incident' has occurred, and provide support to them in relation to the incident. This should be carried out within 2 working days and a letter should be sent/given to the patient/family or carer within 10 working days.
- Provide an account of the incident which, to the best of the health service body's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the health service body believes are appropriate.
- Offer an apology. Follow this up by giving the same information in writing, and providing an update on the enquiries. Keep a written record of all communication with the relevant person. On conclusion of the investigation the findings will be shared with the patient/family/carer unless they decline to be informed of the outcome.
- See Appendix 1 for flowchart.

5.3 Reviewing the incident (DIF2)

Each section within Datix needs to be completed fully in order to provide clear evidence of acknowledgement, investigation, actions and learning. Each of the sub menus (list on the left hand side of the screen), need to be completed. See Appendix 2 detailing the process.

5.4 Investigation Process

Proportional investigation and analysis

The following table provides the expected standard for investigation detail.

Harm	Low Risk	Moderate Risk	High or Extreme Risk	Potential Severe Harm	Incident linked to death
No harm	Trend analysis.	Trend analysis	DIF2 standard investigation	Internal RCA	SI process
Low	DIF2 standard investigation	DIF2 standard investigation	DIF2 standard investigation	Internal RCA	SI process
Moderate	DoC process Moderate investigation	DoC process Moderate investigation	DoC process Moderate investigation	DoC process + Internal Moderate RCA investigation	SI process
Severe	SI process	SI process	SI process	SI process	SI process
Death	SI process	SI process	SI process	SI process	SI Process

In order to identify the appropriate level of investigation, the severity and level of risk must be considered and based on what is known at the time of reporting and subsequent review. Fact finding initial investigation steps may be required to determine the appropriate level of investigation decision. The Patient Safety Team will work with clinical colleagues to establish the relevant details to aid decision making and where thresholds for investigation fall into the potential for Serious Incident reporting, the SI panel will make the decision.

In the case of Serious Incidents the investigation method of choice is Root Cause Analysis (RCA). This ensures that the underlying or latent failures are identified.

The lead investigator appointed by the Patient Safety Team will establish the key facts, determine the staff members who were involved in the Serious Incident and request statements. The staff key template will be completed and kept in the investigators file.

A copy of the clinical records should be taken as soon as possible (original clinical records are often required by pathology or other clinicians).

The lead investigator will gather all the relevant information required to perform a comprehensive investigation and conduct interviews with staff as appropriate. The lead investigator along with allocated independent Care Group representative will attend 2 serious incident panel review meetings, the dates of which will be provided by the Patient Safety Team.

5.5 Action Plans

Action plans should be produced post investigation ensuring they are:

Specific

Measurable

Achievable

Realistic

Timed

These must be agreed by all parties involved in the investigation.

Action plans must be monitored by the local clinical governance groups. Any actions that have wider organisation implications will be reported by the Head of Patient Safety & Experience to the Patient Safety Review Group.

Completion of action plans may be the responsibility of a line manager, nominated individual or a group/ committee.

6 SUPPORT FOR STAFF

The Trust is committed to developing a working environment that promotes the health and well-being of its employees.

The health of staff can be affected if they are involved in traumatic incidents. Staff may be distressed, anxious and concerned about their own involvement in what happened, the consequences of this for the patient, family, themselves and their colleagues. Some staff may recover their equilibrium more quickly than others, but for some the distress and loss of confidence involved can seriously affect the individual's ability to continue to work and maintain a normal home life.

Examples of traumatic incidents, may include the following (though not exhaustively):

- Serious incidents
- Unexpected patient death
- Allegations of gross negligence/manslaughter
- Dealing with a major incident (eg a serious road traffic accident)
- Assaults
- Suicide
- Any other situation that the member of staff considers to be of a traumatic nature.

The first line of support is the line manager who should be involved as soon as possible. Much of the reassurance required by the staff member can be given by the manager, informing the staff member of the process and referring them to appropriate resources.

Dependent on the nature of the incident it may be necessary for the manager to provide support to staff during the incident, for example where patients or relatives may be getting increasingly disruptive or are unwilling to listen or cooperate with staff.

The line manager should be aware of those members of staff who may be especially vulnerable perhaps due to similar past experiences or who have particularly close involvement with the incident or with those involved in it. Staff should be seen individually and extra support provided if required.

The fitness of staff to undertake or continue their full range of duties following a stressful event should be risk assessed and consideration given to appropriate adjustments to duties or responsibilities should this be necessary.

It is the responsibility of the line manager to provide staff with immediate support and information on how to access the Trust support services. These may include access to counselling services through the HELP Employee Assistance Programme, clinical supervisor/college tutor, Chaplaincy department or professional bodies.

Staff may decide that they do not wish to access support services at the time of the incident. However there is a possibility that it may become apparent at a later date that they require additional support and it is the responsibility of the line manager to ensure that they can access support services retrospectively.

Following the conclusion of the incident investigation a debrief will be offered where appropriate. Staff will be kept informed by their line manager and/or lead investigator of the incident.

6.1 Staff who are involved in a complaint

At the beginning of the investigation any member of staff involved in a complaint will be informed immediately of any serious allegations made against them i.e. safeguarding issues, theft or cases which may have medico legal implications. They should in the first instance seek advice from their line manager. In cases where there may be a conflict of interest between the member of staff and the Trust, staff should be advised of their rights to seek help from their professional association or trade union. In most cases staff will be asked for a written report of events.

6.2 Staff who are involved in a claim

The Trust recognises the importance of ensuring that staff are appropriately supported during what can be a lengthy and stressful litigation process. Staff will receive the necessary support from their line manager and will be kept regularly informed via the Patient Safety and Legal Team of any developments during the process.

7 LEARNING FROM INCIDENTS

The outcome of any investigation is designed to identify learning points and take steps to change practice, leading to improvements in safety and quality of the care and services we provide, in line with the Trust Values. In order to achieve this, the outcome of investigation will need to detail that there are no learning points or that there are learning points requiring action. These may be local or wider impact actions depending on the nature of the incident or cause identified. This aspect should be evidence in the investigation reports produced or on the DIF2 incident reports and will be tracked.

In addition to the learning from individual cases, analysis of trends and themes may provide wider learning points and identify areas to focus on initiatives to improve the safe provision of care, or promote reporting of specific incidents.

The patient safety team will oversee the implementation of the actions within the designated Care Group and will provide support in respect of the learning.

All incidents and actions taken are entered onto the Trust management information system (DATIX).

This allows the Trust to analyse incidents and identify trends in a number of different ways. A monthly risk management report is produced and available to all Care Groups in respect of incident reporting and lessons learned are shared from closed serious incidents.

It is essential that staff receive appropriate feedback via their line management route on reported incidents and any actions taken. A ‘lessons learned bulletin’ is now produced on a monthly basis, this will be embedded through the Trust’s Lessons Learned Group.

8 INVOLVEMENT OF RELEVANT STAKEHOLDERS

NRLS: All patient safety incidents are reported by the risk department via the National Reporting and Learning System (NRLS) to NHS England.

HSE: Those specific incidents that are reportable to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR) are reported by the Head of Department 12.

MHRA: Notifiable incidents10 are reported by the Trust's Medical Devices Manager. Health and Safety incidents are reported to the Health and Safety Executive by the Trust's Health & Safety Manager.

The Senior Information Risk Officer (SIRO) is responsible for notifying the Department of Health of any category 1-5 information security incident.

Consideration should be made regarding reporting relevant incidents to the Human Tissue Authority. (See link for guidance) - https://www.hta.gov.uk/policies/post-mortem-hta-reportable-incidents.

Where other external bodies such as the Department of Health, the Police or Environmental Health Agency need to be informed, the Chief Executive will determine who should contact the relevant body.

Consideration should be made regarding reporting relevant incidents relating to Public Health England Screening Programmes. (See link for guidance)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672737/Managing_safety_incidents_in_National_screening_programmes.pdf

9 RAISING CONCERNS

Staff must be aware of how to raise concerns regarding all incidents and near misses without a fear of recrimination. Please refer to Raising Concerns: 'We Care. We Listen, We Act' - CORP/EMP 14.

10 TRAINING/SUPPORT

All staff will receive awareness training on incident reporting through local induction. Managers should ensure that all members of their staff receive sufficient training to enable them to fulfil their individual responsibilities under this policy.

The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead.

Investigation of incidents, complaints and claims, including root cause analysis will be provided to all patient safety leads, matrons, clinical governance leads and ward/department managers.

11 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
The rate of reporting trends. The Serious Incident reporting rate. The level of compliance with Duty of Candour Regulations. The provision of analysis reports at care group and trust wide committees and groups The rate of avoidable harm following investigation.	Patient Safety team	Monthly Integrated Risk management report	Reported to PSRG & CGC
The upload of NRLS data and benchmark data provided through the 6 monthly external reporting reports.	Patient Safety team	6 monthly	Reported to PSRG & CGC

12 DEFINITIONS

Throughout this policy, the word 'incident' should be taken to include 'near-misses' unless otherwise specified.

Death – when the incident was avoidable and has impacted on the death of the patient.

DIF2 – The incident reporting form accessible following reporting from the web-based risk management system, Datix. (Datix Incident Form 2).

DIF2 standard investigation is essentially the local management investigation process, which should be sufficient to feed back to the reporter and satisfy the management team that sufficient proportional learning takes place in each ward and department.

DoC process is the Duty of Candour, specified in the Duty of Candour regulations issued by the Care Quality Commission. This requires open disclosure of the incidents that may have caused death, severe, or moderate harm.

Incident – any accident, event or circumstance that led to harm, loss or damage to people, property, reputation, or other occurrence that could impact on the organisation's ability to achieve its objectives.

Incident Report form (DIF1) - The incident reporting form, openly accessible on the intranet (Datix Incident Form 1).

Low harm – harm with less than a week recovery time.

Moderate harm – harm with an impact for more than one week, but not permanent or typically longer than 1-3 months.

Moderate Internal RCA is a Trust investigation that does not meet the Serious Incident reporting criteria, but would benefit from a detailed investigation.

Near-miss – an incident that did not lead to harm, loss or damage.

No harm – where no actual harm occurred and there was the potential for harm.

Root cause analysis – the investigation process to identify underlying cause(s) of incidents.

Severe harm – when an incident results in avoidable permanent harm, chronic pain (continuous or for more than 12 weeks) or psychological harm for more than 28 days.

SI process is the externally reportable process for Serious Incident reporting following the NHS England framework.

Trend analysis is a process where all incidents are considered by category and any themes, variation in trends from frequency month to month are considered. This process analysis enables investigation of statistical significant changes in reporting from the historical patterns of reporting. Using statistical process control charts, rolling 12 month rates and other benchmarking tools, the Trust is able demonstrate effective monitoring systems. Low to moderate risk, no harm incidents can also benefit from local investigations depending on the context and so is at the discretion of the designated manager to review and investigate those that may require further exploration.

13 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 3).

14 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

Complaints, Concerns, Comments and Compliments: Resolution and Learning - CORP/COMM 4
Claims Handling Policy - CORP/RISK 5
Risk Identification, Assessment and Management Policy – CORP/RISK 30
Being Open and Duty of Candour Policy - CORP/RISK 14
Serious Incidents (SI) Policy - CORP/RISK 15
Maternity Services Risk Management Strategy - CORP/RISK 16
Information Management and Technology Strategy - CORP/ICT 5
Health and Wellbeing Policy – CORP/EMP 31
Raising Concerns: 'We Care, We Listen, We Act' - CORP/EMP 14
Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) - PAT/PA 19
Privacy and Dignity Policy - PAT/PA 28
Information Risk Management Policy - CORP/ICT 21
Fair Treatment for All Policy – CORP/EMP 4
Equality Analysis Policy – CORP/EMP 27.

15 REFERENCES

Health and Safety Executive Riddor
http://www.hse.gov.uk/riddor/

Never Event Frame Work
https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf

NHS Digital Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation (2015)
https://www.igt.hscic.gov.uk/KnowledgeBaseNew/HSCIC%20SIRI%20Reporting%20and%20Checklist%20Guidance.pdf

Regulation 20 Duty of Candour
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

Serious Incident Framework
https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

APPENDIX 1 – LEGAL - DUTY OF CANDOUR PROCESS

Applies to incidents in which a patient suffers a "moderate" or "severe" harm or death, with an outcome or psychological harm lasting over 1 month*

- Patient Safety Incident resulting in moderate/severe harm or death
- Provide prompt appropriate clinical care and prevention of further harm
- Information given to patient and/or carer by appropriate healthcare professional and verbal apology offered
- A full record of the incident and immediate actions taken should be recorded in the patient's notes
- Complete a Datix Incident Form, ensuring that the verbal apology has been recorded. Consider whether the incident should be reported as a Potential Serious Incident
- Identify a single point of contact for on-going communication (usually the Lead investigator on the ward/department)
- Arrange support for patient and/or carers and any staff involved
- Ensure **1st Duty of Candour Letter** has been sent to the patient and/or carer and that this is uploaded to Datix. This should be within **10 days** of the incident being reported
- `Investigation of Incident - investigator should consider face-to-face meeting with staff, patient and/or carer to ensure all parties' recollections and comments are captured
- Agree any points of learning, further actions and communication plan
- Ensure 2nd Duty of Candour Letter has been sent to the patient and/or carer explaining the results of your investigation. This letter should be uploaded to Datix and a resolution meeting offered.
- Upload the incident report to Datix and monitor the implementation of any actions identified - Care Group specific.

- Seek prompt Consultant / Matron advice if there are concerns that the patient and / or relatives may suffer significant harm when informed of the potential patient safety incident; **OR** an adult or child safeguarding incident is suspected; **OR** it is not possible to inform patient / relevant other (capacity issues / no relatives).
- If it is uncertain whether an error or omission led to the harm suffered or the level of actual harm caused by the incident is unclear, follow the ***Duty of Candour*** process and seek further advice from the **Patient Safety Team** on extension 662276
- All other incidents: Apologise immediately and explain the process.

APPENDIX 2 – REVIEWING THE INCIDENT (DIF2)

Reviewing the Incident (DIF2)

Each section within Datix needs to be completed fully in order to provide clear evidence of acknowledgement, investigation, actions and learning. Each of the sub menus (list on the left hand side of the screen), need to be completed as follows:

Name and Reference

- **ID** and **Reference Number** identify the individual incident
- **Name** - ensure that this is the name of the person affected by the incident, or if it is an organisation incident, succinctly describes the event e.g. Staffing issues
- **Handler** - This is the person with overall responsibility for ensuring that the incident is investigated and finally approved
- **Department Manager** - The person who is aware of the incident but will not investigate or close
- **Investigator** - Person responsible for investigating the incident
- **RIDDOR** - State "Yes" if this is a staff injury and they have been off work ***MORE THAN*** 7 days
- **Report to NRLS** - If the incident affects a patient, this is "Yes"
- **Approval Status** - Click on the drop down box and change the status - ensure that ALL incidents are moved from "Holding Area" within 3 days
- **Closed** - If Investigation / Incident Summary / Duty of Candour / Action Plans are completed, the Incident can be Finally Approved and closed

Incident Details

This contains all of the details of the incident. Make sure you check:

- Accuracy of **Location**
- **Diabetes** and **Dementia** says Yes or No
- Correct **Category** of Incident compared with the description
- **Result** and **Severity** is accurate - does it need to be downgraded or escalated? Remember this is ACTUAL HARM if the incident occurred or POTENTIAL HARM if the incident is a NEAR MISS
- **Additional Questions** - Identifying if the incident is an SI or Never Event - hyperlinks to policies
- **Reporter** - the name of the person reporting the incident, ensure you let them know the outcome of your investigation
- **Other Specialties Affected** - other areas you may need to involve in your investigation, and notify of your outcome

If any of the details are incorrect - you have the authority to **CHANGE** them

Duty of Candour
If the incident severity grading is Moderate, Severe or Death, the Duty of Candour section will appear. • If this is an incident involving a patient, either the patient or when a patient lacks capacity, a relative/carer must be informed of the circumstances of the incident offering a verbal apology • Ensure that the verbal apology is recorded on Datix and documented in the case notes • Duty of Candour Letter 1 should confirm this apology and be sent out within 10 days of the incident. • Duty of Candour Letter 2 should be sent with a copy of the final investigation report
People directly and indirectly involved in the incident
• Ensure all contacts are approved • Add in any contacts that have not been identified
Investigation Process (Actions)
• Ensure ALL actions and recommendations arising from the investigation are recorded on this section (including SI and Moderate report action plans) • This section can be used to send reminders to yourself or actions to others in the course of your investigation
Incident Summary
This is where you demonstrate the findings of your investigation, every section is MANDATORY • **Root Causes** or contributory factors leading to the incident. This is free text, record all your findings • **Summary Root Causes** A drop down list of root causes from the NRLS, click in the smaller of the 2 boxes, you can single click as many as are applicable and then double click one you have highlighted to add them to the main box above. • **Action Taken (Investigation)** a free text box to describe the actions you took during your investigation and what subsequent actions are required in order to minimise the risk of this incident occurring again • **Action Taken Codes** A drop down list, use as per the summary root case • **Key Findings** This is for SERIOUS INCIDENTS only and is filled in by the Patient Safety Team Administrator • **Risk Grading** All incidents need to be risk graded on likelihood of occurrence and the consequence should it occur • **Outcome of Investigation** identify whether the incident was avoidable or unavoidable and whether there are further actions which need to be actioned (ensure they are on the action plan)

Serious Incident Details

This section summarises the processes involved and timeline for completion of the Serious Incident report. If you are involved in a Serious Incident and need an explanation on this section please call the Patient Safety Team on extension 642276

Inquest Details

This section summarises the processes and details of an Inquest. If you are involved in an Inquest and need an explanation on this section please call extension 642167

Communication and feedback

This is the email facility within Datix. If you need to contact a member of staff or respond to a message on an incident, please ensure that this is completed in this section.

- **Recipients**—This is your equivalent to the "To" box in Outlook. The top section will state the names of the Handler and Reporter; the middle box holds the names of all staff that have a Datix login and the third box is a free-text box so you can add any other member of staff. Please note you may only add NHS email addresses and you may email any number of staff at the same time
- **Message**—the first box has a default subject heading, the larger box has some text already in—please leave this text—and enter your message after the prompt "The feedback is:"
- Remember to feedback your findings to the reporter
- Press the "Send message "box
- **Notifications** these show the people who were notified of this incident when it was reported

Documents and Templates

- **Documents** this is where you add documents as evidence of your investigation, these could be reports (SI reports) , letters (Duty of Candour), photographs (NEVER attach any photographs of patients) or general supporting evidence. Click on "Attach a new document" to start the process, identify the type of document, give it a short title and press "Browse" to look for the file on your computer.
- **Templates** the drop down box contains templates of Duty of Candour letters, witness statements, scoping and report templates. Click on the document required and press "Merge in MS Word"

Progress Notes

This is where you can document findings, progress and general notes on the incident you are investigating. All you need to do it type in the large text box and then press "Save". Datix will Date and Time stamp the note with the name of the person logged in to Datix.

Linked Records

In order to help the Datix User, Incidents can be linked to Complaints and to Claims. This is carried out by the Patient Experience Team and the Patient Safety & Legal Teams.

For further information on any of the above sections, please contact the Datix Administrator on extension 642275

APPENDIX 3 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
CORP/RISK 33 v.1 – Incident Management Policy		Louise Povey	New Policy	September 2017

1) Who is responsible for this policy? Name of Care Group/Directorate:

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes?

3) Are there any associated objectives? Legislation, targets national expectation, standards:

4) What factors contribute or detract from achieving intended outcomes? –

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] -

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken]

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: September 2020

Checked by: Lisette Caygill **Date: September 2017**