London Ambulance Service **NHS** NHS Trust	
Incident Reporting Procedure	

DOCUMENT PROFILE and CONTROL.

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Sponsor Department: Health, Safety and Security

Author/Reviewer: Safety and Risk Advisor & Head of Governance and Assurance. To be reviewed by September 2019.

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Links to Related documents or references providing additional information		
Ref. No.	Title	Version
	Health and Safety at Work Act (1974)	
	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995	
TP003	Policy Statement of Duties to Patients	
TP004	Complaints and Feedback Policy and Procedure	
TP005	Risk Management Policy	
TP006	Serious Incident Policy and Procedure	
TP016	Habitual or Vexatious Complainants or Enquirers Procedure	
TP024	Managing Patient Confidentiality when Dealing with the Media	
TP034	Being Open and Duty of Candour Policy and procedure	
TP035	Risk Assessment and Reporting Procedure	
TP048	Information Security Policy	
TP054	The investigation and Learning from Incidents, PALS, Complaints and Claims Policy	
TP077	Security Management Policy	
OP010	Procedure for the Maintenance of the Location Alert Register	
OP025	Procedure for the Scheduled Maintenance and Exchange of Ambulance Equipment	
HR003	Freedom to Speak Up: Raising Concerns (Whistle Blowing) Policy	
	Prescription Only Medicines Act 1997	

HS012	Violence Avoidance and Reduction Procedure	
HS012b	Post Violence Support Procedure	
HS018	Stress Management Policy	
LA42	Crew Safety Assault Form	
LA52	Incident Report Form	
LA277	Abuse and High Risk Address Report Form	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

1.   Introduction

Effective accident and incident reporting is important for enabling the London Ambulance Service NHS Trust (LAS) to identify areas of risk. In order for the information to be used fully, it is vital that the management of incident reporting is consistent across the Trust, and that staff working at all locations, are made fully aware of this procedure.

The Care Quality Commission, Central Alert System and the NHS Protect place requirements on the LAS and all other NHS organisations, to have procedures in place for the reporting of incidents.

The aim of incident reporting is not to apportion blame, but to learn from experience and improve practice accordingly. Where errors have been made the preferred option is to provide guidance or retraining to those staff involved. Staff will only be disciplined where there is evidence of wilful negligence, acts of maliciousness or gross/repeated misconduct.

2.   Scope

This document covers all incident reporting aside from serious incidents and applies equally to incidents involving staff, patients, contractors, visitors and members of the public who are affected by the work of the Trust.

For serious incidents including fatalities, major injury, system breakdowns, and information security, managers and staff should refer to the Serious Incident Policy (TP/006). For concerns about colleagues working practices, staff should refer to the Freedom to Speak Up: raising concerns (whistleblowing) policy (HR003). This document should be read and implemented in conjunction with a number of other Trust policies detailed on page 3.

3.   Objectives

1. To provide a safe environment for staff, patients, visitors and contractors

2. To raise awareness of the importance of consistent and accurate incident reporting.

3. To ensure managers and staff at all levels are aware of their personal responsibilities in incident reporting investigation, and the actions that need to be taken following an incident.

4. To define the categories of incidents to be reported.

5. To describe the grading system to be used for assessing the impact of each incident, and the likelihood of recurrence, and to use the risk matrix score to establish the extent of the investigation to be undertaken.
6. To reduce the severity of incident reports by developing robust systems to

minimise the potential for recurrence.

7. To ensure that everyone in the organisation can learn lessons from both patient and staff health and safety incidents in order to prevent reoccurrence, so far as is reasonably practicable.

8. To reduce staff absence attributed to industrial injury.

9. To ensure that all staff are aware of what constitutes an information security incident and how to report any suspected or known incidents.

4. Responsibilities

4.1 The Trust Board

The Trust Board will have overall responsibility for monitoring incident outcomes.

4.2 Chief Executive

The Chief Executive has overall responsibility for risk management within the London Ambulance Service.

4.3 Director of Corporate Governance/Trust Secretary

Responsibility for health, safety and security and the Incident Reporting Procedure has been delegated to the Director of Corporate Governance/Trust Secretary.

4.4 Chief Information Officer

Responsibility for Information Security risks has been delegated to the Chief Information Officer.

4.5 Line Managers

It is the responsibility of managers at all levels to implement this procedure, and to ensure that all staff are aware of how to report an incident or risk, through Datixweb or by completing a paper form LA52 and LA277 which are made available in their area of work. It is important that managers make personal contact with all members of staff reporting incidents, in order to provide them with an opportunity to discuss the incident, and for managers to provide immediate support following an incident.

The London Ambulance Service NHS Trust uses Datixweb to capture and handle all incidents. Line managers are responsible for logging onto the Datixweb system to investigate all reported incidents within a timely manner and to feedback to staff on the outcome of that investigation. All staff have access to Datixweb for incident reporting purposes.

4.6   Managers' specific responsibilities include:

- To provide guidance to staff and to ensure measures are taken to prevent a recurrence of an incident.

- To refer staff for retraining as appropriate.

- To ensure all acts of physical abuse are reported to the Local Security Management Specialist as soon as possible after the incident.

- To offer support, and referrals for occupational health, welfare, counselling services & re-training as appropriate.

- Encourage staff to report risks and incidents via DatixWeb or through completion of a paper form: LA52 and LA277.
- Ensure that all information incidents graded as "High" are referred to the Information Governance Manager or Information Security Manager immediately by email or telephone.

- To report relevant RIDDOR Health & Safety incidents to the Health, Safety and Security Department , in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) see Section 4.18. The H,S&S Department will inform the Health and Safety Executive of relevant incidents.

4.7 Assistant Directors of Operations, Quality Governance and Assurance Managers, Head of Operations Centre, 111 Centre Operations Manager, Deputy Head of PTS,and Group Station Managers

- Are responsible for ensuring that Trust-wide, group station, sector and control room, 111 and PTS/NETS incident statistics are monitored and local trends are identified;

- Reports should be monitored at local/sector governance meetings ;

- Identified risks should be assessed for inclusion on the local risk registers.

4.8 Sector Delivery Managers, Clinical Team Leaders, PTS Site Managers, Group Station Managers, 111 Centre Operations Manager, Watch Managers, (Control), Training Officers, Department Heads and all appropriate Managers

- Are responsible for completing appropriate level of investigation and recording the outcome, including a pre- and post- risk grading, on the Datixweb system.

- Provide guidance to staff and to ensure measures are taken to prevent a recurrence of an incident. Where an incident has resulted in either a serious injury or fatality to either a member of staff a patient or serious loss of

information, managers should refer to the Serious Incident Policy (TP/006).

- To encourage the reporting of all Incidents, amongst their team and other operational staff;

- To ensure any equipment that has failed during the treatment of a patient is reported onto Datixweb or identified with an LA52, prior to being sent to Equipment Stores for repair/inspection as specified in Exchange in the Event of Equipment Failure Procedure (OP/025);

- To provide feedback to the member of staff reporting the incident, following completion of the investigation.

4.9 Quality Governance and Assurance Managers

- To make staff aware of the importance of incident reporting, and to encourage the reporting of patient safety and staff health and safety incidents through their day to day contact with staff.

- To oversee the investigation of patient safety incidents ensuring lessons learnt from incidents, are communicated to operational staff and appropriate training undertaken as required..

- To ensure that the results of equipment inspections are relayed to the member of staff who reported the fault.

- To logon to the Datixweb system in a timely manner and undertake the quality check of completed investigations in a timely manner.

- To identify areas of clinical risk in their group station or clinical area of responsibility.

4.10 Information Governance and Information Security Managers

- Review all Information Security incident reports.

- Ensure significant, major and critical Information Security incidents are reviewed by the Information Governance Group.

- The response to an incident will be determined by either the Information Governance or Information Security Manager.

- All *potential* incident investigations will remain confidential at all times.

4.11 Local Security Management Specialist, and the Health, Safety and Security department

The Local Security Management Specialist, and Health, Safety and Security department will identify reporting trends and themes, and provide Trust-wide guidance with regards to identified patterns and emerging risks. Specific

responsibilities include;

- Supporting staff who have been the victims of assaults in respect of liaison with the police and Crown Prosecution Service.

- Advising managers on their investigation of incidents

- Informing the Trust of trends in incident reporting and the issues raised in action plans resulting from incident investigations.

- Providing reports on incident levels to the Clinical Safety and Standards Committee, the Corporate Health and Safety Committee, and contributing the learning from experience reports and high level KPI dashboards used within the Trust.

- Developing procedures and strategies to achieve a reduction in incidents.

- Informing NHS Protect via the Security Incident Reporting System (SIRS) of all security related incidents, including physical assaults

- Report all RIDDOR Reportable events to the HSE, ensuring a copy of the completed F2508 form is sent to the line manager for their records.

4.12 Head of Health, Safety and Security

It is the responsibility of the Head of Health, Safety and Security to ensure the Trust is providing regular and timely updates on all patient safety incidents to the NRLS (*National Learning and Reporting System*).

4.13 Risk Systems and Development Manager

It is the responsibility of the Risk Systems and Development Manager to maintain the Datixweb system, to provide technical support in its use to all levels of the Trust, and to make changes as necessary to the system.

4.14 All Staff

All staff are required to:

- Report incidents (including Information Security & Governance incidents), near misses, or dangerous occurrences that affect themselves, patients or any one affected by their acts.

- Remove any piece of faulty equipment from use immediately once identified.

- Co-operate in the investigation of incidents, providing witness statements and any other information that will assist with an investigation (as outlined in *The Investigation and Learning from Incidents, PALS, Complaints, and Claims Policy TP054*).

4.15 Central Alerting System (CAS)

The Central Alerting System (CAS) is an electronic system developed by the Department of Health (DOH), NHS Estates and the Medicines and Healthcare Products Regulatory Agency (MHRA) to ensure that risks that arise from incident reporting can be highlighted to all Trusts

The Health and Safety Manager will be the nominated manager responsible for distributing Safety Alerts in the LAS and for reporting incidents where issues may have been raised that affect other NHS Trusts.

4.16 NHS Protect

NHS Protect are tasked with reducing levels of physical abuse to NHS staff. The Local Security Management Specialist will report all incidents of Physical Abuse to NHS Protect.

4.17 National Reporting and Learning System (NRLS)

The NRLS has established a central point for NHS Trust's to report Patient Safety Incidents. This is in order for the wider NHS to learn lessons from events on a National basis. It is the responsibility of the Head of Health, Safety and Security to ensure that regular and timely updates are made to the NRLS with details of all patient safety incidents.

4.18 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995

There is a statutory duty on all employers, to report notifiable incidents to the Health and Safety Executive. Incidents to be reported include;

- Any absence over seven days (not including the day of the incident) that results from an industrial injury.

- A Major Injury (as defined by the HSE in Regulation 4 of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.)

- A Dangerous Occurrence (as defined by the HSE in Schedule 2 of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.)

- An Occupational Disease that is deemed by a healthcare professional as attributable to the person's work (as defined by the HSE in Schedule 2 of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.)

- Exposure to carcinogens and mutagens (as defined by the HSE in Regulation 9 of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.)

Managers are responsible for reporting incidents all RIDDOR incidents to the Health, Safety & Security Department via the LA473 RIDDOR Reporting Form. A member of the team will review the information contained within, and if it meets the criteria for a RIDDOR report they will complete the appropriate report to the HSE. A copy of this will be sent to the line manager for their records.

5. Definitions

Patient Safety Incident includes any unintended or unexpected incident which could have or did lead to harm for one or more patients. Examples of such incidents include clinical error, equipment failures affecting the treatment of a patient, and delays in providing patient treatment. Clinical Governance encourages the reporting of all patient safety incidents in order to identify and reduce clinical risk.

A Health and Safety Incident can be defined as an event or omission that has caused injury or ill health to staff, visitors, or members of the public who are affected by the activities of the Trust. Such events include; work related accidents, ill health brought on by work-related activity, injuries sustained as a result of road traffic accidents, and equipment failings. Staff should also report incidents that occur at home where an injury has been sustained. The term Incident in this procedure, is used to describe Patient Safety Incidents/Near Misses, Health and Safety Events/Near Misses, all acts of Violence or Verbal Abuse and any breach of information security.

Physical Violence includes any event where a physical assault has been suffered by a member of staff. This includes violence that can be attributed to patients' clinical condition, and sexual assault

Non-Physical Abuse includes any act of intimidation, verbal abuse anti-social behaviour, homophobia, sexism, racial abuse or victimisation of disabled people.

Patient Safety Near Miss is a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as a result of compensating action, thus preventing injury to a patient.

Non Clinical Near Miss includes any event where injury or loss has been avoided, but there is potential for the event to reoccur. Such events include health and safety incidents or dangerous occurrences involving the Trust's fleet or estate.

Hazard includes anything with the potential to cause harm

Information Security includes any event which may result in:

- Loss or release of confidential information
- Loss of personal information

Examples of information security incidents include:

- Loss of electronic or paper documents containing confidential information.
- Loss of portable electronic media such as laptops, PDAs, CD ROMs, or memory sticks which contain personal or confidential data.
- Unauthorised disclosure of user account details.
- Providing information to unauthorised persons.
- Use of another user's account to access resources.
- Identifying that a fax, printout or email containing confidential information was sent out to an incorrect recipient.
- Identifying a physical breach of a secure area.
- Introduction of a computer virus or worm.
- Identification of inappropriate websites.

6.   Reporting Incidents

6.1   All incidents and near misses are to be reported using Datixweb, to which all staff have access; via the Emergency Bed Service (EBS); or by completing a paper form (LA 52 or LA 277). Please refer to Appendix 1.

6.2   It is important that names and contact details of witnesses to all incidents are recorded to assist with subsequent investigations.

6.3   When reporting any incident, involving staff, patients or others, only facts are to be documented not opinions.

6.4   Injuries resulting from Road Traffic Accidents must be reported via Datixweb. However damages resulting from Road Traffic Accidents should continue to be reported on form LA420.

6.5   Instead of using a paper LA52 and LA277, staff also have access to reporting incidents via Datixweb and the ability to report incidents via EBS between 8am and 8pm. Datixweb can be accessed from any service computer. Upon completion of the electronic form, a notification will also be sent to the appropriate line manager for investigation

6.6   Some staff with access to the Airwaves radio system will be able to report an incident via a talkgroup. In this situation, the Datixweb record will be completed by a member of the Emergency Bed Service. Upon completion of the electronic form, a notification will also be sent to the appropriate line manager for investigation. Staff will be notified via the RIB and the Pulse when this reporting method becomes open for use.

7.   Reporting Physical or Verbal Abuse

7.1   All acts of Physical Violence or Non-Physical Abuse should be reported by completing a paper LA277.

7.2   Where incidents involving physical violence or other serious occurrences (such as threats with fire arms) has occurred the investigating manager should notify the local Security Management Specialist (LSMS), as soon as

possible. This will allow early liaison with the police, in an attempt to obtain a successful prosecution against the perpetrators of assaults against staff. A major factor for the police when deciding whether to charge someone for an offence is the body of evidence available. This includes independent witnesses to the assault. It is important that contact details for the police officers attending the incident are obtained, in order for the LSMS to liaise with NHS Protect , Police, and Crown Prosecution Service.

7.3   The police should be informed of all physical assaults where there is an intentional application of force without justification, resulting in physical injury or personal discomfort. When liaising with the police, keep the LSMS notified of any developments such as charges issued, court dates, crime reference numbers being given etc.

8.   Reporting Patient Safety Incidents

A patient safety incident is defined as any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare.

8.1   When reporting patient safety incidents, staff should provide as much detail as possible about the treatment provided to the patient, both prior and subsequent to an incident occurring. Where known, the outcome should be recorded in respect of how the incident has affected the patient's clinical condition. In the first instance the incident should be reported to the line manager who will decide the appropriate person to undertake the investigation. All patient safety incidents must be assessed for their impact under Duty of Candour by a registered Healthcare Professional.

8.2   All equipment that fails during use, or out of date drug packs etc., should be taken out of use immediately. Staff should report the incident as detailed in section 6 above, and then follow the Equipment Failure Procedure (OP/025). Guidance on equipment classified as a medical device can be obtained from the Health, Safety and Security department.

8.3   Other examples of patient safety incidents that should be reported include:

- Adverse outcome due to failure to follow National Clinical Guidelines, protocols, procedures or instructions, including Medical Priority Dispatch System (MPDS).

- Adverse clinical outcomes as a result of following National Clinical Guidelines, protocols, procedures or instructions, including MPDS.

- Patient injuries sustained as a result of equipment failure, mishaps or falls whilst in LAS care.

- Drug administration errors.

- Concern about treatment provided by other Health Care Professionals

- Delays in providing treatment that result in an adverse effect on the patient's clinical outcome.

- Suspected or proven clinical risk resulting from delays in MPDS and allocation of calls in EOC or 111.

- Suspected or proven adverse outcome from clinical telephone advice.

8.4 Delays caused by system failures in EOC, in either call taking, or vehicle allocation should be reported, by the Senior Officer in charge of the Control Room.

9. Near Misses (Clinical and Non-Clinical)

9.1 The need to report near misses is as important for the LAS as the reporting of incidents that have caused actual injury, ill health, or loss.

9.2 Examples of near misses that should be reported include:

- The failure of clinical or non-clinical equipment during a patient care episode.
- Mistaken clinical judgment.
- Procedures, clinical guidelines, protocols or practices, found to be unsafe.
- Hazards associated with the Trust's estate or fleet.

10. Reporting Information Security Incidents

10.1 Once becoming aware of a potential information security incident, staff are required to inform their manager and report the incident as per section 6.

10.2 Staff may contact the Information Governance Manager or Information Security Manager for advice or to report the incident directly.

10.3 Staff must not discuss any matters regarding the incident with anyone except their immediate line manager, the Information Security Manager or a law enforcement officer.

11. Reporting to External Agencies

Incidents are reported to external agencies using the following protocols;

NRLS – Incident data is collated by the Governance department and exported to the NRLS by the department.

MHRA – Incident data will be submitted to the MHRA either by the Health, Safety and Security department, Logistics Department or Fleet Department if it meets their criteria

NHS Protect – Incident data related to assaults and other crime/security related incidents is collated by the Local Security Management Specialist, and is exported to the SIRS team in NHS Protect at least monthly.

RIDDOR – Local managers are responsible for reporting incidents to the Health, Safety and Security Department via the LA473. This department will be responsible for reporting appropriate RIDDOR incidents to the HSE. Reporting procedures are detailed above in section 4.18.

12.   Grading of Incidents

12.1   All reported incidents are graded by the investigating officer. All incidents will be graded according to the actual impact, and also the potential future risk to patients, staff and the organisation should a similar incident occur again. This will help to establish the level of local investigation and causal analysis that should be carried out. Guidance on how to grade Incidents is given in Appendix 2 .

13.   Raising Concerns

Staff can refer to the HR003 Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the processes to raise concerns.

IMPLEMENTATION PLAN	
Intended Audience	For all staff
Dissemination	Available to all staff on the Pulse
Communications	Revised Procedure to be announced in the RIB and a link provided to the document
Training	Health & Safety and Information Security training. Incident reporting awareness sessions and guidance. Guidance in the use of documentation is also provided on the rear cover of LA 52 and LA 277 pads. Managing Safety and Risk training (1 day) includes incident investigation training, which is refreshed every 3 years.

Monitoring:

Aspect to be monitored	Frequency of monitoring AND Tool used	Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported	Committee/ group responsible for monitoring outcomes/ recommendations	How learning will take place
Duties including how all incidents and near misses involving staff, patients and others are reported (Paragraphs 6-10)	Quarterly report Extracted from Datix	Health, Safety and Security Team report to the local Health and Safety Meetings	Clinical Safety and Standards committee and Corporate Health and Safety Committee	Lessons learned and improvements made are disseminated by the Clinical Safety and Standards committee and Corporate Health and Safety Committee
How the organisation reports incidents to external agencies (Paragraph 11)				
How staff can raise concerns (Paragraph 13)				

Completion of an Incident Report

Datixweb is the main incident reporting method within the Service. However, reporting an incident can be done via:
- **Datixweb, accessed on a Service computer using your 'User Name' and system password;**
- **EBS, using Airwave radio between 8am and 8pm**
- **Paper forms (LA 52 and LA 277)**

Important: Serious injuries/fatalities to staff or patients must be verbally reported immediately, to EOC.

All incidents must be reported as soon as possible after the event and be accurate and detailed.

Guidance on Completing form LA52

On completion of the form:
TOP COPY (White) goes to Health, Safety & Security Dept, Pocock Street, SE1 (External Mail)
BOTTOM COPY (Green) retained in originating Station/Office/Dept

If the incident victim as a result of their injuries (or any other reason) is unable to complete the Incident Report Form, it must be completed on their behalf, preferably by their Line Manager, with the outline details of the incident and probable cause.

(If using a paper form to report incident please be advised that all incidents involving physical or non-physical abuse must be reported on form LA277).

When completing the form:
1. Indicate the Station/Department where you are based and who you reported the incident to;

2. Record your personal details, including job title, age etc. Please confirm whether you give consent to a copy of the form being given to your Health & Safety Representative;

3. Cross the appropriate box highlighting the type of incident that occurred;

4. Record when and where the incident occurred, include map references as appropriate;

5. Describe what caused the incident giving factual details only. Continue on a separate sheet if required;

6. Indicate the relevant factors if the incident was of a non-clinical nature;

7. Supply the names and contact details for the incident, attaching witness statements where available;

8. Indicate the relevant factor for incidents of a clinical nature;

9. Confirm whether any Personal Protective Equipment was worn/in use at the time of the incident;

10. Detail any injuries or ill health suffered by anyone involved in the incident;

11. Specify any equipment involved in the incident; Trolley Beds, Chairs, Vehicle Patient Care Equipment etc, recording makes, models, fleet and serial numbers;

12. Provide your signature, record the date of completion and provide a contact telephone number;

For completion by the Line Manager – Managers investigating an incident should ensure all actions taken following an incident are recorded, by ticking the relevant boxes. Managers should grade the incident in accordance with the Incident Grading Matrix and confirm the results of investigations and actions taken to avoid a recurrence. The Manager investigating the incident should indicate how long an employee is known/likely to be unable to do their usual role. Guidance on Completing form LA 277

(Procedure for the Reporting of Abuse and Submission of Address to the High Risk Address Register)

On completion of the form LA 277:
TOP COPY (White) goes to the Management Information Department, Headquarters (External Mail)
SECOND COPY (Pink) goes to Health Safety & Risk Department, Pocock Street, SE1
THIRD COPY (Green) retained in originating Station/Office/Department

If the incident victim as a result of their injuries (or any other reason) is unable to complete the LA277 Report Form, it must be completed by the Line Manager, with the outline details of the incident and probable cause.

When completing the form:

1. Record where you are based and who you initially reported the incident to;

2. Record your personal details including job title, length of service etc. Please confirm whether you give consent to a copy of the form being provided to your Health & Safety Representative;

3. Record the category of incident by crossing the appropriate box;

4. Record when and where the incident occurred;

5. Describe what led up to the incident. All occurrences of physical abuse should be reported to the police in order to build up evidence against those who assault staff. Continue on a separate sheet if necessary;

6. Record the names and details of those involved in the above. Please also indicate what factors are relevant to the incident;

7. Record the names and contact details for any witnesses to the incident;

8. Was a stab vest or any other relevant Personal Protective Equipment in use at the time of the incident?;

9. Identify any injury, ill health, disease or emotional distress suffered as a result of this incident;

10. Provide your signature, record the date of completion and provide a contact telephone number;

11. For completion by the Investigating Manager. A discussion with the staff member reporting the incident must form part of the investigation. All actions taken following the incident should be recorded by ticking the relevant boxes. All incidents should be graded in accordance with the Incident Grading Matrix. You must also confirm whether the address of the perpetrator of the abuse should be added to the High Risk Address Register. Confirm whether any period of absence followed this incident. In all cases, it is the duty of the Manager investigating the incident to complete an LA473 where an employee has been absent for a period greater than seven days not including the day of the occurrence, following the incident. The Health Safety & Risk Department will report any RIDDOR Reportable incidents to the HSE.

Guidance on Grading, Investigation and Root Cause Analysis of Incidents

Introduction

This document provides guidance to staff within the LAS on how and when investigation processes should be undertaken following an incident.

Whilst incidents almost automatically lead to reactive risk management i.e. damage limitation and immediate remedial action. They should also be seen as an opportunity for proactive risk management i.e. learning from what has happened and looking ahead to see how such incidents can be prevented from reoccurring; thereby reducing future risk to the Trust.

In order to learn from these events it is necessary to obtain the facts and details of the incident. These must be recorded as soon after the incident as reasonably possible. Further, more detailed information can be gathered and collated as the investigation progresses. The depth and level of investigation will be dictated by the severity of the event/incident. When the key facts of the incident have been identified, then measures can be taken to prevent, or reduce the likelihood of similar circumstances combining again, with adverse results.

All staff therefore have a part to play in this area of risk management, whether it is in terms of completing accurate records (on PRFs, Datixweb, LA52s, or LA277s,) or if it is acting as an Investigating Officer/manager conducting the investigation and analysing the outcomes.

Definitions

For the purpose of this guidance the term Incident refers to any untoward events relating to Health and Safety, Patient Safety, physical or non-physical violence, near miss (clinical or non-clinical), or information security.

Immediate Cause is defined as the factor(s) which triggered the actual incident.

Contributory Factor is defined as the circumstance(s) which contributed to the occurrence of the incident, but which, by itself or themselves would not have caused the incident to arise.

Root Cause is defined as the underlying cause(s) to which the incident could be attributed and if corrected would prevent or minimise the likelihood of recurrence.

Incident Grading

All reported incidents will be graded according to the severity of the actual impact, and also the likely future risk to patients, staff and the organisation should a similar incident occur again. This grading will also help to establish

the level of local investigation that should be carried out.

Incidents will be graded by individuals (identified in the procedure) using the matrix below. The level of investigation and analysis required for individual events should be dependent upon the incident grading and not whether the incident is an actual incident or a near miss.

Risk Scoring

Not all incidents need to be investigated to the same extent or depth. To assess the level of investigation required the impact of the incident and the likelihood of a recurrence both need to be considered. For incidents where Physical Violence, Non-Physical Abuse or Lifting, Handling and Carrying are factors, the likelihood should be based on the staff member's previous reporting history. For all other categories the likelihood should be based on general reporting trends. To assess the likelihood of recurrence, managers responsible for grading should refer to the Quarterly Incident Statistics, Complex Statistics and the levels of similar incidents that have been reported. Having assessed each incident against the risk grading matrix, the amount of investigative and analysis effort should be in relation to the risk scoring (see below).

Table 1 Impact Score

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Impact score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/ agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/ interruption of >1 hour Minimal or no impact on the environment	Loss/ interruption of >8 hours Minor impact on environment	Loss/ interruption of >1 day Moderate impact on environment	Loss /interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood Score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	1	2	3	4	5
Descriptor	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur annually.	Expected to occur at least annually.	Expected to occur at least every 6 months.	Expected to occur at least monthly.	Expected to occur at least weekly.
Probability	< 1%	1-5%	6-25%	25-60%	>60%

	Will only occur in exceptional circumstances.	Unlikely to occur.	Reasonable chance of occurring.	Likely to occur.	More likely to occur than not.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk Score = Impact x Likelihood (I x L)

Impact Score	Likelihood Score				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1-3	Low risk
	4-6	Moderate risk
	8-12	Significant risk
	15-25	High risk

Level and Nature of Local Investigation and Analysis

Once the event has been graded the appropriate response should be actioned, in compliance with the table below. If the investigation reveals issues that were not at first apparent from the Datix report, the incident should be re-graded and additional actions undertaken appropriate to the Risk Score.

Dependant on the nature of the incident, e.g.: Violence, Manual Handling; further guidance on additional actions to be taken can be obtained from the Trust's Health Safety & Security documents (located on the Intranet).

Category	Actions **All Operational Supervisors and Managers (such as: QGAMs; GSMs; and CTLs), PTS Site Managers, Watch Managers (Control), Senior/Training Officers & Department Heads / Managers**	Analysis	Outcome
Low (1 – 3)	Support and discuss incident with staff member Check that Datixweb/LA52/LA277 completed Identify previous reporting history for this staff member – have similar incidents been reported previously Consider whether appropriate to add this address to High Risk Address Register	Incident to be entered on to Datix and relevant investigation completed by manager.	Carry out immediate Remedial Action
Moderate (4 – 6)	Cross reference Datix incident/LA52/LA277 with Patient Report Form's and other documentation Carry out Actions as for category green	As for category green Analysis of cause and contributory factors	Immediate Remedial Actions, and Recommendations where appropriate
Significant (8 – 12)	Carry out Actions as for category yellow and green Carry out thorough investigation. Incident to be considered by SI Group.	As for category yellow and green Analysis of cause and contributory factors which may lead to RCA	Immediate Actions, or Recommendations and Action Plan
High (15 – 25)	Governance & Assurance Team	Root Cause Analysis	Action Plan and Improvement Strategy

General Guidance on Investigation Processes

Incident investigations should:

- Identify reasons for substandard performance.
- Identify underlying failures in management systems.

- Learn from the incident and make recommendations to help prevent or minimise recurrences, thus reducing future risk of harm.
- Satisfy mandatory and LAS reporting requirements.

The investigation needs to be prompt and thorough. Where possible, remedial action or solutions should be recommended. If the investigation is not undertaken as soon as practicable after the event, conditions and recollections fade and evidence is lost.

There are five components of any investigation:
I. Collect evidence about what happened.
II. Assemble and consider the evidence.
III. Compare the findings with relevant standards, protocols or guidelines, whether these are particular to LAS or National, to establish the facts, draw conclusions about causation.
IV. Make recommendations for action to minimise risk of recurrence.
V. Implement the recommendations and track progress.

I)   Collecting Evidence.

The sources of information and methods that can be used in investigation typically fall into the three following categories:

- **Direct observation** is crucial to avoid losing important evidence about the scene, equipment, environment, vehicles and machinery involved, etc. Where possible photographs should be taken, particularly when it is impractical to preserve evidence or maintain the scene of the incident in a permanent state.

- **Documentation** which identifies what occurred leading up to and at the time of the incident and this should be included as part of the investigation. Evidence of prior risk assessment, work place inspections, servicing and maintenance history may all be relevant to the investigation.

- **Interviews** should be undertaken with the personnel involved in the incident, and any witnesses identified and their full contact details and signatures as soon as possible after the event.

Adverse incidents seldom arise from a single cause; there are usually multiple underlying failures in management systems/procedures which have created the circumstances leading to the incident.

II)   Assembling and Considering the Evidence

Investigations should identify both immediate and underlying causes, including human factors/errors. Immediate causes must take into account the patient, the task, the work environment and weather conditions, all the persons' involved (either individually or as part of a crew or team), time of day

and any machinery, vehicles or equipment used. Underlying causes can be management and systems failures organisational, cultural, personal/health and contextual factors that all contribute to explain why the event(s) occurred. Getting to the root cause of the problem will help ensure the development of an effective improvement strategy and if the incident is properly and thoroughly investigated then this should prevent or significantly reduce the likelihood of recurrence.

III)   Comparing findings with relevant standards & protocols

The next stage of the investigation is to compare the conditions and sequence of events against relevant standards, guidelines, protocols, approved codes of practice, etc. This will help to minimise the subjective nature of investigations and to generate recommendations which have the maximum impact and relevance. The objectives are to decide:

- Whether suitable and sufficient standards / procedures / controls / risk assessments, undertaken and were they being implemented to prevent untoward incidents occurring in the first place.
- If standards / procedures etc exist, are they appropriate and sufficient?
- If the standards / procedures were adequate, were they applied or implemented appropriately?
- Why any failures occurred.
- Were safe systems and procedures accidentally or deliberately breached?

IV)   Make Recommendations

Where an investigation identifies immediate or underlying causes involved, recommendations should be made to take remedial action immediately or make recommendations for possible solutions to prevent recurrence within an action plan.

V)   Implement the Changes/Action Plan

Where an investigation has resulted in an Action plan being created or a change in working practice, progress should be monitored and recorded.

Root Cause Analysis

Unless the fundamental, or root causes of adverse events are properly understood, lessons will not be learned and suitable improvements will not be made to secure a reduction in risks. Incidents rarely arise from a single cause; there are usually underlying failures in management systems which have helped to create the circumstances leading to the incident.

The purpose of the analysis exercise is to identify the Immediate, Contributory and Root causes of the incident. Guidance for using root cause analysis

techniques is in *TP054 The Investigation and Learning from Incidents, PALs, Complaints and Claims Policy.*

Communication of Learning Points

Implementing recommendations and, and monitoring the effectiveness of action taken, will provide a certain level of evidence to demonstrate that the LAS is learning from adverse events. This may be on an individual or Trust Wide basis. It is necessary to ensure that lessons are learnt and changes are made and communicated so that the Trust can demonstrate continuous improvement as an organisation.

It will be the responsibility of Managers and Investigating Leads to feed back to individuals with regard to lessons learned from Incidents and to monitor progress against action plans drawn up.