London Ambulance Service NHS
NHS Trust

Incident Reporting Procedure

DOCUMENT PROFILE and CONTROL.

Purpose of the document: Procedure to be carried out when reporting incidents.

Sponsor Department: Safety and Risk

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Links to Related documents or references providing additional information		
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	Health and Safety at Work Act (1974)	
	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995	
TP/006	Serious Untoward Incidents Policy	
OP/025	Exchange in the Event of Equipment Failure	
	LAS Whistle Blowing Policy & Procedure	
TP/004	Complaints Procedure	
	POMs Act	
H&S / 012	LAS Staff Safety Policy	
H&S / 012a	LAS Violence Prevention Procedure	
H&S / 012b	LAS Post Violence Support Procedure	
	Information Security Policy	

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.

1.0 Introduction

Effective Accident and Incident Reporting is important for enabling the London Ambulance Service (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 Standards for Better Health, Clinical Negligence Scheme for Trusts, National Patient Safety Agency, Risk Pooling Scheme for Trusts, Safety Alert Broadcasts and the Counter Fraud Security Management Service place requirements on the London Ambulance Service (LAS) and all other NHS Trusts, to have procedures in place for the reporting of Incidents.

Staff should be aware that this procedure 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 untoward incidents including fatalities, major injury, system breakdowns, and information security, managers and staff should refer to the Serious Untoward Incidents Policy (TP/006). For concerns about colleagues working practices, staff should refer to the Whistle Blowing Policy & Procedure.

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.

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 for describing Patient Safety Incidents/Near Misses, Health and Safety Events/Near Misses, all acts of Violence or Verbal Abuse and any breach of information security.

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. Further examples are detailed later in the procedure. Clinical Governance encourages the reporting of all Patient Safety Incidents in order to identify and reduce clinical risk. The National Patient Safety Agency (NPSA) has been established as a central point for NHS Trusts to report Patient Safety Incidents in order for the wider NHS to learn lessons from events on a national basis

Physical Violence includes any event where 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 victimization 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.

2.0 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, and investigation, and the actions that need to be taken following an incident.
4. To define the categories of incidents that need 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 score for establishing the extent of the investigation to be undertaken.
6. To reduce the level of untoward incident levels by developing robust systems for minimising the potential for recurrence.
7. To ensure that everyone in the organisation can learn lessons from Health and Safety and Patient Safety Incidents
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.

3.0 Reporting Incidents

3.1 All incidents involving either Physical Violence or Non-Physical Abuse will be reported on the Abuse and Risk Address Information Form LA277 (2005) and

all other Health and Safety and Patient Safety (including Sharps/self inoculation) Incidents should be reported on an Incident Report Form LA52, (2005) following the guidance given in Appendix A. The report should be completed within twenty four hours, of the event occurring. When a member of staff is unable to complete the form due to ill health or injury, their line manager should complete the form on their behalf. The report, together with any associated investigation, should be forwarded to the Safety and Risk Department within seven days.

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

3.3 When reporting any incident, staff should report only facts, rather than offering opinions.

3.4 Injuries resulting from Road Traffic Accidents should be reported on an LA52. However damages resulting from Road Traffic Accidents should continue to be reported on form LA420.

4.0 Reporting Physical or Verbal Abuse

4.1 All acts of Physical Violence or Non-Physical Abuse should be reported by completing a LA277 (2004/2005) – see Appendix 2.

4.2 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, within 48 hours of the incident. 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 Staff Safety Officer to liaise with the Counter Fraud and Security Management Service, Police, and Crown Prosecution Service.

4.3 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.

5.0 Reporting Patient Safety Incidents

5.1 When reporting Personal 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 Personal Safety Incidents should be brought to the attention of the Senior Training Officer, or the Senior Emergency Operations Centre Training Manager.

5.2 All equipment that fails during use, or drug packs with out of date drugs etc., should be taken out of use immediately. Staff should complete an LA52, and

attach the yellow copy of the report to the equipment, or the drugs pack and then follow the Exchange in the Event of Equipment Failure Procedure (OP/025), or return the drugs and LA52 to the used drugs locker as appropriate. Guidance on equipment classified as a medical device can be obtained from the Safety and Risk Department.

5.3 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/ UOC/ UOC.
- Suspected or proven adverse outcome from Clinical Telephone Advice.

5.4 Delays caused by system failures in EOC/ UOC/UOC, in either call taking, or vehicle allocation should be reported, by the Senior Officer in charge of the Control Room (AOM or OCM), at the time of the incident.

6.0 Health and Safety and Patient Safety near Misses

6.1 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.

6.2 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.

7.0 Reporting Information Security Incidents

7.1 Once becoming aware of a potential information security incident, staff are required to inform their manager and fill in a LA 52 form. This form should be sent to Safety & Risk who will pass onto the Information Security Manager as soon as possible.

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

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

8.0 Grading of Incidents

8.1 All reported 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 3.

9.0 Responsibilities

9.1 Chief Executive

The Chief Executive takes overall responsibility for Risk Management within the LAS.

9.2 Director of Human Resources and Organisational Development

Responsibility for Health & Safety and the Incident Reporting Procedure has been delegated to the Director of Human Resources.

9.3 Director of Information Management &Technology and Medical Director

Responsibility for Information Security risks has been delegated to the Director of Information Management & Technology and the Medical Director (Caldicott Guardian).

9.4 Line Managers

It is the responsibility of managers at all levels to implement this procedure, and to ensure that a book of LA52/LA277 (2005) incident reporting forms 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. Incident Reports should be forwarded to the Human Resources, and Safety and Risk Departments, within seven days of the event occurring. Copies of the Abuse and Risk Address Information Reports should be forwarded to the Operational Information, Safety and Risk Department and your HR Department.

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 by telephone to the Safety and Risk Adviser (LSMS) as soon as possible after the incident.
- To offer support, and referrals for occupational health, welfare, counselling services & re-training as appropriate.
- To ensure LA52/LA277 (2005) are completed in full, prior to distribution to the Safety & Risk, Operational Information, Info Sec and Human Resources Departments.
- Ensure that all incidents graded "High" are referred to Complaints Department or Information Security Manager if an Information Security incident within 48 hours of the incident occurring.

- To report all Health & Safety incidents to the Health and Safety Executive, in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) see Section 14.

9.5 Ambulance Operations Managers, Regional Operations Managers (PTS) Senior Operations Manager – Planning and Risk

Ensuring that Service wide, Complex, Regional and Control Incident Statistics are monitored, local trends are indentified, and that proactive actions are taken when individual members of staff report disproportionately high levels of incidents.

9.6 Duty Station Officers, PTS Site Managers, Ambulance Operations Managers, (Control), Training Officers & Department Heads

Ensuring that incidents are graded and investigated, identifying contributory factors pertinent to the event, in accordance with Appendix 2 - *Grading and Learning from Incidents*. To 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 or a patient or serious or large scale loss of information, managers should refer to the Serious Untoward Incidents Policy (TP/006).

9.7 Ambulance Operations Managers & EOC/ UOC Training & Training Officers

- To make staff aware of the importance of incident reporting, and to encourage the reporting of Patient Safety and Health and Safety Incidents all incidents through day to day contact with staff.
- To oversee the investigation of Patient Safety Incidents ensuring lessons learnt from the reporting of incidents, are passed to operational staff through training initiatives etc.
- To ensure that the results of equipment inspections are relayed to the member of staff who reported the fault.
- To ensure the patients clinical outcome is identified as part of the investigation into clinical untoward incidents.
- To identify areas of clinical risk in their Complex or area of responsibility.

9.8 A&E Team Leaders, PTS Crew Team Leaders and Control Quality Assurance Advisers

- A&E and PTS Team Leaders, Control Quality Assurance Advisers have the following specific responsibilities in clinical and non-clinical incident investigation. It is expected that they will assist in investigations led by Ambulance Operational Managers, Duty Officers and PTS Site Managers;
- 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 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.

9.9 Information Security Manager

- Review all Information Security LA52s.
- Ensure significant, major and critical Information Security incidents are reviewed by the Information Governance Group.
- Responding to Incidents:
  Upon receiving reports of an incident, the Information Security Manager will classify the incident according to the following grades:

  - Low
  - Moderate
  - Significant
  - High

  The response to the incident will subsequently be determined by either the Information Security Manager or a senior member of staff.

  All potential incident investigations will remain confidential at all times.

9.10 Safety & Risk Adviser (LSMS), and Safety and Risk Adviser (Manual Handling)

The Safety & Risk Adviser (LSMS), and Safety and Risk Adviser (Manual Handling) will review all LA52s to identify reporting trends, and to ensure appropriate follow up action, grading and investigation has been taken following an incident. 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 untoward incidents or accidents.
- 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 Risk Group, and the Corporate Health and Safety Committee.
- Developing procedures and strategies to achieve a reduction in incidents.
- Informing the Counter Fraud Security Management Service of all Physical Assaults (see Section 15)

9.11 All Staff

All staff are required to:

- Report accidents, incidents (including Information Security incidents), near misses, or dangerous occurrences that affect themselves, patients or members of the public.
- Remove immediately from use any piece of faulty equipment.
- Co-operate in the investigation of Incidents, providing witness statements and any other information that will assist with an investigation.

10.0 Central Alerting System (CAS)

The Central Alerting System (CAS) is an electronic system developed by the Department of Health (DOH), National Patient Safety Agency (NPSA), 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 Safety and Risk Adviser is 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.

11.0 Counter Fraud Security Management Service (CFSMS)

The CFSMS are tasked with reducing levels of physical abuse to NHS staff. The Staff Safety Officer will report all incidents of Physical Abuse to the CFSMS. The Violence Prevention Manager is the nominated manager responsible for notifying the CFSMS of all reported incidents where violence is a factor.

12.0 National Patient Safety Agency (NPSA)

The NPSA 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.

13.0 National Health Service Litigation Service Authority (NHSLA)

The NHSLA is a special Health Authority that promotes good risk management and assurance as part of assessment against risk management standards.

14.0 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 three days (not including the day of the incident) that results from an industrial injury.
- Any fracture (other than to fingers, thumbs, or toes).
- Any amputation.
- Any dislocation of the shoulder, hip, knee or spine.
- Loss of sight (whether temporary or permanent) burns (chemical/heat) or other penetrating injuries to the eye.
- Injuries due to electric shock or burns, which require resuscitation, or which result in hospitalisation for more than twenty four hours.
- Unconsciousness due to asphyxia or exposure to a harmful substance.
- Acute illnesses that require medical treatment or that result in unconsciousness due to chemical or biological substances being inhaled, ingested or absorbed through the skin.
- Acute illnesses requiring medical treatment, which are believed to be due to infected material or to biological agents or their toxins.

Managers are responsible for reporting incidents to the HSE on form F2508 within seven days of the event occurring. A further copy of the form should be forwarded to the Safety and Risk Department. F2508s can be forwarded to the HSE via e-mail www.riddor.gov.uk.

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 & Information Security training Incident reporting awareness sessions and guidance Training guidance in the use of documentation is provided in the section 25 page II of this policy and the rear cover of LA 52 and LA 277 pads. Health, Safety and Awareness training module – incident investigation provide specific (1 day) training. The training will be evaluated as part of the Training Needs Analysis (TNA) and revised on an annual basis.
Monitoring	Audit of LA52/LA277 forms This policy will be monitored in line with NHS best practice guidance. The Trust will undertake specific monitoring by reviewing:- LA 277 incident reports – collated from completed and approved LA277's that are sent to the Sector Commander (CAC) at Headquarters. The Sector Commander (CAC) is responsible for making arrangements to collate all completed LA277's and for arranging an update to the database on a regular basis. LA52 incident reports - Incident Reporting Data is tabled at the Corporate Health and Safety Meeting, which are held on a quarterly basis, chaired by the Director of HR Feedback from RIDDOR – learning and obtaining guidance on risk management within the workplace, from reported incidents related to injuries, disease and dangerous occurrences Serious Untoward Incident (SUI) – decisions arrived at by the Trust on incidents that arise are passed to the national Patient safety Agency TP/004 Complaints Procedure HR/07/22 Whistle Blowing Procedure

Appendix 1

Incident Reporting Procedure

Important: Serious injuries/fatalities to staff or patients must be verbally reported immediately, either directly to the Safety & Risk Department, or via Control.

The LA52 (2005) report form must be completed as soon as possible after the event and be accurate and detailed.

The LA52 (2005) replaces all previous versions of the LA52.

On completion of the form:
TOP COPY (White) goes to Safety & Risk Dept, Pocock Street, SE1 (External Mail)
MIDDLE COPY (Gold) goes to Sector/Dept HR Office
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.

All incidents involving physical or non-physical abuse must be reported on an LA277 (2005).

Guidance on Completion

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.

13. 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. It is the duty of the Manager investigating the incident to complete a Health & Safety Form F2508 in accordance with the Reporting of Incidents Diseases and Dangerous Occurrences Regulations (RIDDOR) where an employee has been absent for a period greater than three days not including the day of the occurrence, following the incident. Copies of the form should be sent to the Health & Safety Executive within 10 days, with a further copy forwarded to the Safety & Risk Department.

Appendix 2

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

Important: Serious injuries/fatalities to staff or patients must be verbally reported immediately, either directly to the Safety and Risk Department or via EOC/ UOC.

The LA277 (2005) replaces all previous versions of the LA277 and LA52 in terms of reporting Physical and Non-Physical Abuse, and adding addresses to the High Risk Address Register.

The LA277 (2005) report form must be completed as soon as possible after the event, and should be accurate and detailed.

On completion of the form:
TOP COPY (White) goes to the Operational Information Department, Headquarters (External Mail)
SECOND COPY (Pink) goes to Safety & Risk Department, Pocock Street, SE1
THIRD COPY (Gold) goes to Station/Department HR Office
FOURTH 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 accident and probable cause.

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 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. It is the duty of the Manager Investigating the incident to complete a Health & Safety Executive form F2508, when a member of staff has been absent for a period greater than 3 days not including the day of the occurrence. Copies of the form should be sent to the Health & Safety Executive, with a further copy forwarded to the Safety & Risk Department.

Appendix 3

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, LA52s, LA400s 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 and causal analysis 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 members 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 Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to

		internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	rating Critical report	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)

	Likelihood Score				
Impact 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 LA52, 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 manual (also on the Intranet).

Category	**Actions** **AOMs. DSOs, PTS Site Managers, OCMs (Control), Senior/Training Officers & Department Heads**	**Analysis**	**Outcome**
Green (Low)	Support and discuss incident with staff member Check that 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 incident Database	Carry out immediate Remedial Action
Yellow (Moderate)	Cross reference LA52/LA277 with PRF's and other documentation Carry out Actions as for category yellow	As for category yellow General Analysis of cause and contributory factors	Immediate Remedial Actions, and Recommendations where appropriate
Orange (Significant)	Carry out Actions as for category yellow and green Carry out thorough investigation and	As for category yellow and green General Analysis of cause and	Immediate Actions, or Recommendations and Action Plan

	consider referring to Complaints Dept. for RCA	contributory factors which may lead to RCA	
Red (High)	Full investigation by PALs or nominated Investigating Officer	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 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. Copies of the action plans should be forwarded to the Staff Safety Officer, together with a copy of the LA52/LA277 (2005), and the findings of the associated investigation. Action plans that have Trust wide implications will be reported to the Clinical Risk Group and Corporate Health and Safety Group.

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. Adverse 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.

Full Root Cause Analysis will in the majority of circumstances; be undertaken by PALs, with the assistance of other managers with expertise in specific areas. Where necessary, this group will also seek advice from external experts and organizations e.g. the NPSA, NHSLA, HSE.

The purpose of the analysis exercise is to identify the Immediate, Contributory and Root causes of the incident.

RCA would normally include the following steps:

- Identify the incident.
- Preserve direct evidence from the scene & make detailed records / complete LA52/LA277 (2005)/F2508.
- Provide a chronology.
- Gather documentary and other evidence.
- Arrange and carry out interviews.
- Identify related factors.
- Analyse related factors.
- Use NPSA RCA models.
- Decide on and cost the options for improvement controls.
- Provide a report.
- Ensure implementation of improvement strategy, phased if necessary.

Communication of Learning Points

Implementing recommendations and Improvement Strategies, 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 organization.

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