PATIENT SAFETY: ACCIDENT AND INCIDENT MANAGEMENT POLICY

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CONTENTS

1.0 INTRODUCTION
2.0 SCOPE OF POLICY
3.0 POLICY STATEMENT
4.0 LINKS WITH OTHER POLICIES
5.0 DEFINITIONS
6.0 AIMS OF THE POLICY
7.0 RESPONSIBILITIES
   7.1 Associate Director of Governance and Patient Safety
   7.2 Non Executive Director
   7.3 Director/Clinical Service group (CSG Chair)
   7.4 Deputy Director/Associate Director of Operations
   7.5 Associate Director of Nursing
   7.6 Head of Service
   7.7 Patient Service Manager
   7.8 Matrons
   7.9 Ward Sisters / Departmental Heads
   7.10 All staff
   7.11 Risk Management Departments
   7.12 Root Cause Analysis (RCA) Lead Investigator
8.0 TRAINING
9.0 MONITORING
10.0 GLOSSARY OF TERMS
11.0 EQUALITY IMPACT ASSESSMENT FORM
1.0  **INTRODUCTION**  
The Mid Yorkshire Hospitals NHS Trust (the Trust) actively supports the promotion of a positive approach to the reporting of incidents that occur within the hospital or its premises.

In order to manage risk effectively, improve the patient experience and meet the Trust’s statutory obligations it is necessary to ensure a rigorous system is in place to identify and report all incidents and prevented incidents within the Trust. Incidents and accidents in all areas of clinical and non-clinical activity can result in harm to patients, staff, visitors and other personnel as well as Trust property and reputation. It is, therefore, essential to ensure that all possible steps are taken to minimise the risk of initial incident occurrence and subsequent re-occurrence.

This policy should be read in conjunction with the Patient Safety: Accident and Incident Management Procedure.

2.0  **SCOPE OF POLICY**  
This policy applies to all the Trust’s premises, patients, visitors, employees and contractors and forms part of the Trust's Risk Management Strategy.

The content of this policy focuses on the patient safety agenda however the principles cover all accidents and incidents within the Trust.

3.0  **POLICY STATEMENT**  
The Trust is committed to the establishment of a supportive, open and learning culture that encourages staff to report mistakes through the appropriate channels. The aim is not to apportion blame but rather to learn from experience and improve practice accordingly. The Trust will take a systems approach to investigating incidents, as a focus solely on the failings of individual staff will miss important causes of incidents and hamper effective learning. The Trust's Risk Management Strategy supports this approach.

4.0  **LINKS WITH OTHER POLICIES**  
This policy does not operate in isolation and other policies / strategies link with the approach within this document such as:

- Adult Protection Policy and Procedures (Kirklees)
- Adult Protection Policy and Procedures (Wakefield & Pontefract)
- Agency Staff Policy
- Bank Staff Policy
- Blood Transfusion Policy
- Capability Policy
- Child Protection Policy & Procedures
- Claims Management Policy
- Consent policy
- Disciplinary Policy
- Emergency Planning and Major Incident Plan
- Fire Policy
- Equipment Management Policy
- Health and Safety Policy
- Health Records Policy
- Induction Policy
- Infection Control Policy
- Introduction of New Therapeutic Techniques
- Ionising Radiation Policy
- Locum Doctor Policy
- Policy on dealing with formal and informal complaints
- Policy on Maintaining the Registration of Professional Staff
Policy for Managing Aggression and the prevention of Violence in the Workplace
Procedure for dealing with NPSA Alerts, DH Alerts, Medical Devices alerts and reporting adverse incidents
Resuscitation Policy
Risk Management Strategy
Speaking Out Policy
Withholding Treatment from Violent and Abusive patients

5.0 DEFINITIONS
For the purpose of this policy the following definitions apply:

**Incident:** An adverse event or occurrence

**Accident:** An unplanned event that causes injury to persons, causes damage to property, or a combination of both.

**Near miss:** An unplanned event, which does not cause injury or damage but could do so.

**Never Events:** A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented.

6.0 AIMS OF THE POLICY
The aims of this policy are to:

- Safeguard patients and staff
- Improve the quality of care
- Promote a safety culture
- Facilitate a learning culture
- Demonstrate compliance with CQC Essential Quality Standards and Registration

7.0 RESPONSIBILITIES
The Chief Executive has overall responsibility for Risk Management. Prime responsibility and accountability for Risk Management must remain part of the Trust’s general management structure with Executive/Corporate Directors, Clinical Service Group (CSG) Chairs, Associate Directors of Operations (ADO), Associate Directors of Nursing (ADN), Heads of Service, Patient Service Managers, Matrons and other senior professional staff responsible for the maintenance of standards in their areas.

The Chief Nurse has the lead for Clinical Governance including Clinical Risk Management and the Associate Director for Governance and Patient Safety has the lead for operationalising the clinical governance arrangements. The Director of HDP Estates and Facilities has the lead for Non Clinical Risk Management including health and safety.

The CSG Chairs are responsible for operational risks across the Trust.

7.1 Associate Director of Governance and Patient Safety
Responsibilities:

- Reporting to the PCT via the STEIS system any serious untoward incidents.
- Ensure policies and processes reflect ‘Being Open’ policy.
- Ensuring that trends are identified.
- Ensuring that effective treatment plans are delivered for all ‘severe and fatality’ incidents
- Reporting any serious untoward incidents to Trust Board via Integrated Governance Committee.
- Ensuring that robust processes are in place to enable learning from incidents is cascaded across the organisation.
- Promoting NPSA initiatives
- Ensuring that robust processes are in place to enable any national initiatives, Department of Health guidance in relation to patient safety, risk etc are implemented within the Trust
- Reporting matters of professional concern to Medical Director of Chief nurse
7.2 Non-Executive Director
Responsibilities:
- Contributing to the development of the risk management strategy
- Ensuring the Trust is operating a safe sustainable service for the patients
- Contributing to the development of a robust Clinical Governance Framework, providing scrutiny and challenge when appropriate

7.3 Director/CSG Chair
Responsibilities:
- Clinical Governance of the Directorate/CSG working alongside the Deputy Director/ADO
- Ensuring governance arrangements are in place, for example Directorate/CSG Clinical Governance Committees and that these report to the Integrated Governance Committee.
- Promoting the reporting and investigation of incidents in a timely manner.
- Prompt investigation and response to receipt of CAS alerts
- Ensuring RCA investigations have appropriate leadership and participation.
- Ensuring actions from serious untoward incidents are completed and reported to the Governance Interface group
- Working alongside other managers in the directorate/CSG to develop a minimum list of incidents that should always be reported
- Monitoring incident themes and trends and ensuring action is taken as required.
- Ensure policies and processes reflect the ‘Being Open’ policy.
- Undertaking risk assessment ensuring that risks are minimised and appropriate action is completed including updating of the risk register.
- Ensuring that the reporting arrangements are in place in the Directorate/CSG and that learning is cascaded across the organisation following the investigation of an incident.
- Chair critical event control groups as appropriate.

7.4 Deputy Director/Associate Director of Operations
Responsibilities:
- Ensuring that patient safety incidents, non clinical incidents are managed in accordance with the Clinical Governance Framework and that non clinical risk / health and safety requirements are met at all times. This responsibility is shared alongside the Director/CSG Chair.
- Ensuring effective risk assessment and proactive health and safety management occur in the Directorate/CSG at all times.
- Receive Red (severe/fatality major/catastrophic) incidents reporting forms within 2 working days of the incident or knowledge of incident
- Ensure that processes are in place for reporting red incidents to Risk Management Department within 24 hours of receipt
- Making decision, with Director/CSG Chair (and/or ADN) to proceed to RCA within 2 working days
- Establishing RCA team and ensuring meeting occurs within 10 working days
- Develop culture (with Director/CSG Chair/ADN) to ensure RIDDOR requirements are adhered to.
- Working with the senior staff and senior clinicians to ensure that processes are in place for accident and incident reporting.
- Leading or participating in root cause analysis investigation team.
- Promoting the reporting of incidents.
- Ensure feedback is provided to staff following an incident.
- Ensure policies and processes reflect the ‘Being Open’ policy.
- Undertaking training needs analysis for all directorate staff in the management of risk and management of incidents.
- Work with Director/CSG Chair to ensure prompt investigation and response to CAS alerts.
7.5 Associate Director of Nursing
Responsibilities:
- Work with CSG Chair to lead and participate in RCA investigations
- Working with ADO and CSG Chairs on improving governance and risk management agenda across the Service Group
- Develop culture (with Director/CSG Chair/ADO) to ensure RIDDOR requirements are adhered to
- Promoting the reporting of incidents
- Ensure policies and processes reflect the ‘Being Open’ policy
- Ensuring that learning from incidents is cascaded across the organisation
- Supporting staff involved in serious incidents

7.6 Head of Service
Responsibilities:
- Leading or participating in root cause analysis investigation at the direction of the
- Promoting the reporting of incidents.
- Providing feedback to staff following an incident involving their service
- Ensure policies and processes reflect the ‘Being Open’ policy
- Ensuring that learning from incidents is shared at Service Group level.

7.7 Patient Service Manager
Responsibilities:
- Reporting any accidents or incidents under RIDDOR if appropriate
- Participating in Root Cause Analysis investigations.
- Quality assuring the closure of low harm, no harm incidents within service area.
- Monitoring trends and themes of incidents within service area.
- Supporting staff involved in an incident.
- Communicating with patients and relatives in accordance with the ‘Being Open’ policy.
- Supporting senior staff in ensuring that learning from incidents is cascaded across the service area.

7.8 Matron
Responsibilities:
- Ensure that all incidents are investigated and actions are implemented prior to closure of an incident in the service area.
- Leading and participating in Root Cause Analysis investigations at the direction of the CSG Chair.
- Monitoring trends and themes of incidents within their area of responsibility
- Providing feedback to staff following an incident.
- Supporting staff involved in an incident
- Communicating with patient and relatives in accordance with the ‘Being Open’ policy.
- Quality assuring the closure of incidents by Ward Sisters.
- Reporting any accidents or incidents under RIDDOR if appropriate

7.9 Ward / Departmental Head
Responsibilities:
- Investigating incidents and ensuring all actions are implemented before closure of an incident.
- Closure of no harm and low harm incidents.
- Participating in root cause analysis investigations as directed by CSG Chair.
- Monitoring trends and themes for area of responsibility and alerting Matron or Manager to any trend.
- Management of health and safety including risk assessment, regular inspections and monitoring of work activities
- Providing feedback to staff following incident
• Communicating with patients and relatives in accordance with the ‘Being Open’ policy.
• Ensuring all staff are trained appropriately in Risk Management and incident management
• Management of health and safety including risk assessment, regular inspections and monitoring of work activities.
• Reporting any accidents or incidents under RIDDOR if appropriate
• Work with Director/CSG Chair to ensure prompt investigation and response to CAS alerts.

7.10 All staff
All staff are responsible for:
• Reporting any accidents or incidents that occur on Trust premises
• Making a preliminary grading of the incident using the incident grading table
• Informing line manager of any reported incident and escalating the incident as appropriate
• Reporting any actions required to ensure the immediate and ongoing safety of patients, staff, visitors and others.
• Recording any discussions relating to the incident with the patient, relatives, and staff
• If required, completing statements within 48 hours of incident occurring.
• Identifying any training needs around risk management and incident management.

7.11 Risk Management Departments
The Risk Management Department is responsible for:
• Providing support and expert advice to staff
• Providing training on patient safety, accident and incident management policy, root cause analysis, patient safety and risk management
• Inputting incidents onto risk management system in a timely manner from receipt, pending web based reporting system.
• Checking initial grading of incident once incident report received in department.
• Reporting to external agencies as required.
• Providing reports on incidents to Directorates/CSG’s and other committees as required...
• Supporting in root cause analysis investigations.
• Advising and supporting managers in the reporting under RIDDOR / MHRA.
• Challenging the closure of incidents if action or evidence is not adequate.
• Providing a quarterly report for the Integrated Governance Committee.
• Capturing lessons learnt from incidents that have occurred and publishing them in the ‘Risky Business’ Bulletin.
• Co-ordinating the dissemination, monitoring and closure of safety alerts that come in via the CAS

7.12 Root Cause Analysis (RCA) Lead Investigator
The Root Cause Analysis (RCA) lead investigator is responsible for:
• Using RCA methodologies to investigate the incident
• Writing a RCA report and submitting it to the relevant committee / Clinical Governance Lead.
• Alerting the Director/CSG Chair to any actions that require immediate implementation and agreeing a strategy for this.
• Providing a copy of the RCA and all documents relating to an incident to the Risk Department for central filing.
• Submitting lessons learnt from an incident to the Risk Management Department for publication in the ‘Risky Business Bulletin’.

8.0 TRAINING
All staff have access to a range of learning and development opportunities covering a range of topics under the banner of risk management. Training needs are identified at appraisal and opportunities for the development of skills and knowledge range from training days, provision of written materials to shadowing a member of the risk team.
Training requirements are detailed in the Trust Mandatory Training Statement and Matrix which can be found on the Organisational Development section on the Trust Intranet.

Mandatory Training Statement

**Background and Rationale**
The Trust is continually working towards implementing the NPSA Seven Steps to Patient Safety 2004 and responding to the latest DH Safety First 2007 publication and Safety First Campaign which ensures patient safety is a priority for all Trusts. This statement is underpinned by the NHSLA Risk Management Standards 1 and 5 and CQC outcomes 18 and 20. The training includes how to investigate patient safety incidents. These methodologies can be used to investigate complaints and claims.

**Target Audience / Frequency of Attendance**
Every new permanent member of staff receives (as part of Corporate Induction) a 30 minute briefing on policies relating to Patient Safety.

Staff from the groups whose role requires them to have requires them to have regular patient contact or is connected to clinical governance must complete a training/study relating to those policies every two years.

**Mode of Delivery**
A 45 minute class room based interactive session on Patient Safety is available as a stand-alone workshop or as part of the Mandatory Health & Safety Training Day (Patient Handlers).

**Optional Training**
Root Cause Analysis Training
Risk Management Training

Throughout the year, at least two updates relating to patient safety will be provided for all staff through MY News and quarterly Risky Business newsletters will be produced. Specific training (but not mandatory) can be accessed through the Knowledge and Skills files relating to risk assessment, root cause analysis etc. Details of this training can be found on the Organisational Development pages of MY Intranet.

**Responsibility for monitoring compliance with this statement rests with the Clinical Service Group and Clinical and Performance Board (CPB).**

9.0 **MONITORING**
Monitoring the compliance of the implementation of this policy will be undertaken by the following methods.

- **Objective scrutiny**
  This will be evidenced by NHSLA assessments, CQC registration, Health and Safety Executive visits, Strategic Health Authority Review of Policy.

- **Bi-monthly/Quarterly reports** on a range of indicators on compliance with this policy to Integrated Governance Committee e.g.
  - Timeliness of decision making to proceed to RCA
  - Timeliness of reporting of incident

- Duties of individuals will be monitored by up to date job description
- Staff training will be monitored against mandatory training statement and matrix by Organisational Development
Different levels of investigation appropriate to severity of event will be monitored by RCA process, serious untoward incident process
Process for involving and communicating with internal and external stakeholders to share safety lessons will be monitored by publication of Risky Business
Process for follow up of relevant action plans will be monitored by Clinical Risk Co-ordinator
A co-ordinated approach to the management of risks identified through the aggregation of incidents, claims and complaints will be monitored by the Integrated Governance Committee
The frequency with which an aggregated analysis of incidents complaints and claims is to be completed is set and monitored by the Integrated Governance Committee.
Information required within the analysis report is set and monitored by the Integrated Governance Committee
The process for communicating this information to relevant individuals and groups is monitored by the Clinical Governance Lead
The process for monitoring the local and organisational learning from incidents will be via Clinical Risk Co-ordinator overseeing completion of action prior to closure of incident.
Monitoring of opportunities for sharing lessons from incidents, will be by Clinical Governance Operational Lead.
The process by which the organisation ensures that lessons learnt from analysis result in a change in organisational culture and practice is monitored by the Integrated Governance Committee.
Process for implementing risk reduction measures is monitored by Clinical Service Group’s local ownership of risk registers.
Process for reporting to external bodies will be monitored by the Risk Management Department.
Process for monitoring staff raising concerns will be by publication of quality reports and monitoring of Speaking Out Policy.

Where the monitoring identified deficiencies the Integrated Governance Committee and Clinical Performance Board will ensure action plans are developed and changes implemented accordingly.

10. Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADN</td>
<td>Associate director of nursing</td>
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<tr>
<td>ADO</td>
<td>Associate director of operations</td>
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<tr>
<td>CAS</td>
<td>Central Alert System</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CSG</td>
<td>Clinical service group</td>
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<tr>
<td>MHRA</td>
<td>Medicines and Healthcare Product Regulatory Agency</td>
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<td>NHSLA</td>
<td>National Health Service Litigation Authority</td>
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<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<td>RCA</td>
<td>Root cause analysis</td>
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<tr>
<td>RIDDOR</td>
<td>Reporting of Injuries, Diseases and Dangerous Occurrences Regulations</td>
</tr>
<tr>
<td>SUI</td>
<td>Serious untoward incident</td>
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</tbody>
</table>

Page 9 of 11
An impact assessment is a way of finding out whether an existing or proposed policy affects different groups of people in different ways and whether there is adverse impact on a group.

This form is to be used for new and existing policies and service developments, where a question is not applicable to your assessment, please indicate.

<table>
<thead>
<tr>
<th>Managers Name</th>
<th>Directorate</th>
</tr>
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<tbody>
<tr>
<td>Linda White</td>
<td>Directorate of Nursing, Governance and Patient Experience</td>
</tr>
</tbody>
</table>

Policy Title
The Patient Safety: Accident and Incident Management Policy

Policy Statement
The Patient Safety: Accident and Incident Management Policy has been developed to support the Trust in its reporting, investigating and learning from incidents that could affect patients, staff or contractors. The Policy is intended for the staff and contractor of Mid Yorkshire Hospitals NHS Trust.

Which groups does the policy benefit

Related polices that may be affected by changes

Names of staff and public (if applicable) who participated in the assessment, date of assessment
Linda White, Assistant director of governance and patient safety
<table>
<thead>
<tr>
<th></th>
<th>AGE</th>
<th>DISABILITY</th>
<th>RACE</th>
<th>RELIGION &amp; BELIEF</th>
<th>GENDER</th>
<th>SEXUAL ORIENTATION</th>
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<tbody>
<tr>
<td>Do different groups have different needs, experiences, issues</td>
<td>N</td>
<td>N</td>
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<td>and priorities in relation to the policy.</td>
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<td>Is there potential for, or evidence that the policy will</td>
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<td>promote equality of opportunity for all.</td>
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<td>Is there potential for, or evidence that, the policy will</td>
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<td>affect Different population groups differently (including</td>
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<td>possible discrimination against certain groups).</td>
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<td>Is there public concern in the policy area about actual,</td>
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<td>N</td>
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<td>received or potential discrimination against a particular</td>
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<td>population or groups.</td>
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<td>Is there doubt about answers to any of the above questions</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
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</table>

If the answer to any of the above is ‘yes’ an Intermediate assessment in the relevant area(s) is required.

**Intermediate Assessment**

Identify extra information/research to clarify whether there is an adverse risk