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NHS Dorset Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

Procedure for the management of Adverse Incidents



Supporting people in Dorset to lead healthier lives

PREFACE

This procedural document outlines the processes to be adopted to ensure the thorough investigation of adverse incidents reported to, and by, NHS Dorset CCG.

All managers and staff (at all levels) are responsible for ensuring that they are viewing and working to the current version of this procedural document. If this document is printed in hard copy or saved to another location, it must be checked that the version number in use matches with that of the live version on the CCG intranet.

All CCG procedural documents are published on the staff intranet and communication is circulated to all staff when new policies or changes to existing procedural documents are released. Managers are encouraged to use team briefings to aid staff awareness of new and updated procedural documents.

All staff are responsible for implementing procedural documents as part of their normal responsibilities, and are responsible for ensuring they maintain an up to date awareness of procedural documents.

A	SUMMARY POINTS

- Following the publication of the new Serious Incident Framework by NHS England (March 2015) a decision was made to separate the 'Policy and Procedure for Recording, Reporting and Managing Adverse Incidents' into two procedural documents:
  - Procedure for the management of Serious Incidents (ID Ref 80)
  - Procedure for the management of Adverse Incidents (this document)
- This procedure documents the document the different types/sources of adverse incidents managed by the CCG
- This procedure explains the CCG internal processes for the management of adverse incidents for CCG staff and Providers of NHS funded care to follow.

B	ASSOCIATED DOCUMENTS

- Procedure of the development and management of procedural documents, 2015
- Risk Management Framework, 2015
- Whistleblowing Policy, 2014
- Procedure for reporting adverse drug reactions, 2015

C	DOCUMENT DETAILS

Procedural Document Number	49
Author	Suzie Hawkins
Job Title	Patient Safety and Risk Manager
Directorate	Quality Directorate
Recommending committee or group	n/a
Approving committee or group	Director's Performance Meeting
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Sponsor	Sally Shead, Director of Quality
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D	**CONSULTATION PROCESS**		
Version No	**Review Date**	**Author and Job Title**	**Level of Consultation**
2	18.08.2015	Suzie Hawkins, Patient Safety and Risk Manager	Quality Directorate Leadership Team, Patient Safety and Risk team, Safeguarding teams, Professional Practice Lead, Internal Audit

E	**VERSION CONTROL**				
Date of issue	**Version No**	**Date of next review**	**Nature of change**	**Approval date**	**Approval committee /group**
19/10/2015	2	21.09.2017	Comprehensive re-write to reflect the decision to separate the management of Serious Incident and the management of adverse incidents from one, to two, procedural documents.	05/10/2015	Director's Performance Meeting

F	**SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES**	
Evidence	**Hyperlink (if available)**	**Date**
The Health and Safety at Work Act	http://www.legislation.gov.uk/ukpga/1974/37	1974
Reporting of Injuries, Diseases and Dangerous Occurrence Regulations	http://www.legislation.gov.uk/uksi/1995/3163/contents/made	1995
Management of Health and Safety Regulations	http://www.legislation.gov.uk/uksi/1999/3242/regulation/3/made	1999
Serious Incident Framework, NHS England	http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-	2015

	incidnt-framwrk-upd.pdf	
Working together to safeguard children, MH Government	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf	2015

G	DISTIBUTION LIST		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
✓	✓	✓	✓

PROCEDURE FOR THE MANAGEMENT OF ADVERSE INCIDENTS

1.0 RELEVANT TO

1.1 This procedure is relevant to all individuals interested in the procedure for the management of adverse incidents by NHS Dorset Clinical Commissioning Group. This includes (but is not limited to) staff employed by the CCG, NHS England, providers of NHS funded healthcare for Dorset residents and members of the public.

2.0 INTRODUCTION

2.1 NHS Dorset Clinical Commissioning Group (hereafter known as the CCG) is committed to the achievement of a high standard of health, safety and welfare for all patients, members of the public, employees and others engaged in or affected by the activities and services of the CCG.

2.2 The Health and Safety at Work Act 1974, the Management of Health and Safety Regulations 1999 and the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 1995 require organisations to have a procedure in place for the recording and reporting of all adverse and serious incidents.

2.3 All adverse and serious incidents including accidents, near miss incidents, property damage, equipment failure, lost or stolen equipment, breaches of confidentiality, verbal abuse and dangerous occurrence etc. should be reported as soon as possible after their occurrence. Not only is this a legal requirement in some cases (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)), but factual information must be gathered as soon as is practicable after the event by accurately determining the causes and contributing factors and taking all reasonably practicable action to prevent a recurrence.

3.0 SCOPE

3.1 This procedural document explains the processes involved in managing adverse incidents which occur within NHS funded healthcare in Dorset or involve staff employed by the CCG. The definition of an ‘adverse incident’ can be found in **Section 5 – Definitions**.

3.2 The previous CCG procedural document ‘Policy and Procedure for Recording, Reporting and Managing Adverse Incident’, which incorporated the management of Serious Incidents has now been split into two procedural documents:

- Procedure for the management of Serious Incidents (ID Ref 80)
- Procedure for the management of Adverse Incidents (this document)

3.3 This document does not include:

- the management of incidents which meet the 'Serious Incident' definition; the process which details how to manage Serious Incidents is explained in a separate policy (ID Ref 80).

- the management of 'GP intelligence' (information or issues which GPs/practice staff wish to report to the CCG about an issue and/or Provider, however aren't serious enough to warrant submitting as an adverse incident and don't meet the criteria of a Serious Incident). A document detailing how to submit GP intelligence is available from the Patient Safety and Risk team.

- the management of incidents relating to pharmacies, Dentists and Optometrists; these incidents should be submitted to NHS England (Wessex).

4.0 PURPOSE

4.1 The objective of this document and its effective implementation is to:

- Establish a procedural document for managing adverse incidents

- Clearly document the different types/sources of adverse incidents (see **Section 5 - Definitions**) managed by the CCG

- Ensure the CCG internal processes for the management of adverse incidents are clearly documented for CCG staff and Providers of NHS funded care to follow.

- Ensure that there is a system in place, within the CCG, to enable:

    - all adverse incidents, to be reported and investigated;

    - causal factors to be identified;

    - any faults to prevent re-occurrence to be identified;

    - lessons to be learnt across the organisation and other partner organisations;

    - feedback to be provided to the individual/organisation raising the incident, if appropriate

    - the provision of support/counselling where necessary.

5.0 DEFINITIONS

5.1 This procedural document is a procedure as it provides a clear explanation of what must be done, once an adverse incident is identified by and/or reported to the Patient Safety and Risk team within Dorset CCG.

5.2 Within **Appendix A** is a glossary of terms; all items under the heading 'Adverse Events' are reportable. Users of the reporting system should consider the definitions within the glossary when deciding to submit a report, and work to the premise: '*if in doubt, report*'.

5.3 Adverse incidents are also known as ‘Significant Events’ within Primary Care.

5.4 Adverse incidents can occur in many different locations, and can be identified and reported by a range of organisations. Examples are provided below (other locations, sources and/or reporters are possible):

Where the incident happened	**Reported by a member of staff employed by…**	**Example(s)**
An adverse incident internally within the CCG	CCG	It is reported that a member of staff slips whilst walking down the stairs and fractures their wrist
		An information governance breach is reported by a member of staff.
An adverse incident which occurs within a GP practice or relates to the practice of a GP or a member of the practice staff	The GP practice	It is reported that a GP receptionist left a message on the home phone of a patient stating that she had missed an appointment. The patient had not told her husband that she had booked an appointment and he listened to the answerphone message.
	An Acute Hospital, Community/Mental Health Trust or within an Urgent Care Service	It is reported that a GP did not alert a hospital that a patient being admitted had been having ‘watery stools’. This is a potential infection control issue.
	Another NHS funded Provider (e.g. hospice, nursing home)	It is reported by a key worker that a prescription has been incorrectly written and therefore the patient is taking an incorrect dose.
An adverse incident which occurs within an Acute Hospital, Community/Mental Health Trust or within an Urgent Care Service	CCG (CHC staff)	It is reported that a patient with a funded package of care has been discharged home from an Acute Hospital and CHC is not informed of the discharge. The patient is therefore discharged without sufficient support at home, which cannot be restarted for three days as no notice of discharge was given.
	A GP Practice	It is reported that a physiotherapy discharge form, received by fax to the GP practice, requests urgent action re: a possible joint infection. There was no attempt to alert the practice by phone or any indication on the fax that the form was anything other than routine correspondence. It was only due to fortuitous circumstances that the fax was read upon receipt and not left to be read during admin time.

	Another Acute Hospital, Community/Mental Health Trust or within an Urgent Care Service	It is reported by an Acute Hospital that a patient was transferred from a community Provider and there was no reference to the Grade 3 pressure ulcer on their sacrum
	Another NHS funded Provider (e.g. hospice, nursing home)	It is reported that a patient is discharged from an Acute Hospital to a nursing home with no discharge paperwork or medication.
An adverse incident which occurs within another NHS funded Provider (e. g. hospice, nursing home)	The NHS funded Provider at which the incident occurred	It is reported that a resident of a nursing home with dementia threw coffee at another resident. A small amount of coffee hit the resident's chest.
	CCG (CHC staff)	It is verbally reported by a nursing home that a resident with epilepsy has had two seizures in the two weeks prior to their CHC assessment. There is no evidence in their notes of this, and no seizure chart. The last recorded seizure was over 12 months ago.
	GP Practice	It was reported by a GP practice that, following a visit to a nursing home, that the GP had concerns about administration of medication.
	An Acute Hospital, Community/Mental Health Trust or within an Urgent Care Service	It is reported that paperwork relating to another nursing home resident was provided to staff upon admission to hospital.
	Another NHS funded Provider (e.g. hospice, nursing home)	It is reported by a hospice that transport to transfer a patient for respite (from their home to the hospice) did not arrive.
An adverse incident which relates to packages of care commissioned by Continuing Healthcare (CHC) team	CCG (within CHC team)	It is reported that a Provider commissioned to provide care to a patient overnight did not arrange for a member of staff to fill the shift. There was therefore no-one available to provide the required care and care had to be provided by the family.
	A GP Practice	It is reported that a patient has been discharged home on a Friday with a package of care expected to start on a Saturday. The expected carer did not arrive on the Saturday and the patient's wife contacted the GP practice over a weekend stating that they are unable to cope.

	An Acute Hospital, Community/Mental Health Trust or within an Urgent Care Service	It is reported that a patient cannot be discharged from an acute medical bed, despite being medically fit, due to lack to resource to provide a care package in their home.
	Another NHS Funded Provider (e.g. hospice, nursing home)	It is reported by a hospice that a request for an increase in care was made to facilitate a patient to be discharged home. Despite numerous contact and requests, lack of resources meant that the patient has not been able to leave the hospice.

6.0 ROLES AND RESPONSIBILITIES

Director of Quality

6.1 The Director of Quality is the designated lead within the CCG, and is responsible for:

- ensuring that appropriate structures are in place to manage all adverse incidents which occur within NHS funded health care in Dorset;
- ensuring that appropriate structures are in place to manage all adverse incidents which involve staff employed by the CCG;
- monitoring the effectiveness of this procedural document.

On-call Director

6.2 The on-call Director has a duty to notify the Patient Safety and Risk team of any adverse incidents of which they are contacted about during the 'on-call' period.

All Directors

6.3 All Directors have a duty to ensure that there is full compliance with this procedure and that all areas within their Directorate are reporting adverse incidents.

Line managers

6.4 CCG Line managers have a responsibility to:

- ensure that all adverse incidents within their area of responsibility are reported using the Staff Adverse Incident Report form (**Appendix B**)
- ensure the Chief Officer is made aware any RIDDOR reportable incidents which involve a member of their staff
- feedback to the person reporting the adverse incident details of the action taken to prevent recurrence and any feedback from the organisation of

learning outcomes; this is essential to motivate staff to report. Other members of the team may also need to be provided with this feedback:

- ensure that adverse incident reporting mechanisms is included in local induction for all staff (permanent, temporary and contract).

Head of Patient Safety and Risk

6.5 The Head of Patient Safety and Risk is responsible for:

- the overall management of this procedure;
- ensuring the processes and procedures within this document are correctly adhered to.

Patient Safety and Risk Manager

6.6 The Patient Safety and Risk Manager is responsible for:

- the day to day management of this procedure;
- ensuring this procedure is reviewed within the required timeframe;
- reviewing all Standard Operating Procedures referred to within this procedure prior to publication;
- ensuring that the Standard Operating Procedures referred to within this procedure are up to date and adhered to at all times;
- reporting trend/theme information to the CCG Quality Safety Information Group (QSIG) on a monthly basis;
- reporting theme/trend/incidence information to the Quality Group on a quarterly basis;
- ensuring that any learning identified is shared to a wider audience, as appropriate;

Patient Safety and Risk Facilitator and Patient Safety and Risk Co-ordinator

6.7 The Patient Safety and Risk Facilitator and Patient Safety and Risk Co-ordinator are responsible for:

- writing and maintaining the Standard Operating Procedures referred to within this procedure;
- following the Standard Operating Procedures referred to within this procedure;
- supporting small Providers (e.g. care homes/nursing homes) to undertake RCA investigations, if required;

- liaising with 'subject experts' within the CCG (e.g. infection control, medicines management, safeguarding) with regards to adverse incidents, as appropriate;

- working with Providers to achieve timely responses to adverse incidents;

- closing adverse incidents when a satisfactory response has been received in relation to the incident, which includes steps being taken to prevent a recurrence;

- producing theme/trend reports for internal and Provider use, as per an agreed schedule.

- reviewing all submitted Adverse Incident forms for completeness and accuracy and ensure that an investigation appropriate to the level of risk has been undertaken

- ensuring that the data is entered on Ulysses within three working days of receipt

- ensuring the procedure for reporting any RIDDOR reportable incidents is followed (**Appendix D**)

Professional Practice Lead

6.8 The Professional Practice Lead is responsible for:

- providing clinical and professional practice advice to the Patient Safety and Risk team, as appropriate;

- being a formal link with the CCG Quality Safety Information Group (QSIG) as the QSIG Chair.

Head of Information Governance and Customer Care

6.9 The Head of Information Governance and Customer Care is responsible for:

- having oversight of all Information Governance and Cyber Related incidents;

- considers whether reported incidents meet the threshold of declaring and Information Governance or Cyber Related Serious Incident;

- ensuring themes and trends are identified and that there is organisational learning from Information Governance and Cyber Related Incidents.

All staff

6.10 All staff have a duty to follow this procedure by reporting all adverse incidents promptly and completing an Adverse Incident Report (**Appendix B** or **C**) form in

line with the procedures outlined within Standard Operating Procedure 4-PS&R-01 and 4-PS&R-02.

7.0 PROCESS FOR REPORTING AND MANAGING ADVERSE INCIDENTS

7.1 There are two different forms to be used to report an adverse incident, depending on who is reporting the incident.

- **Appendix B**: CCG staff Adverse Incident form (only to be used if a member of CCG staff is reporting an Adverse Incident)
- **Appendix C**: Significant Event/Adverse Incident form (to be used if the individual reporting the incident does not work for the CCG)

Completing and submitting an Adverse Incident form

7.2 As soon after the incident as possible, an Adverse Incident form (**Appendix B** or **C**) must be completed.

7.3 It is important that all incidents should be given a consequence and likelihood grading. This will be checked (and amended if appropriate) by the Patient Safety and Risk team for consistency.

What was the CONSEQUENCE of what happened as a result of the incident? (circle)				
None/Negligible (no harm)	Minor (low harm)	Moderate (moderate harm)	Major (serious harm)	Catastrophic (death)

What is the LIKELIHOOD of the incident occurring again? (circle)				
Rare	Unlikely	Possible	Likely	Almost certain
This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Using the risk matrix below, what is the risk score?					
Consequence score =		Likelihood Score =		C x L =	

Risk Matrix

Likelihood / ***Consequence***		Rare	Unlikely	Possible	Likely	Almost certain
		1	2	3	4	5
1	No harm	1	2	3	4	5
2	Low harm	2	4	6	8	10
3	Moderate harm	3	6	9	12	15
4	Serious harm	4	8	12	16	20
5	Death	5	10	15	20	25

Low Risk Green 0-5	Moderate Risk Yellow 6-8	Significant Risk Orange 9-12	High Risk Red 15-25

7.4 When either **Appendix B** or **Appendix C** has been completed, the completed form must be sent to the Patient Safety and Risk team via email or in the post.

Receiving, acknowledging and logging adverse incidents

7.5 Upon receipt, all incidents are recorded on the electronic risk management system (Ulysses), by the Patient Safety and Risk team.

7.6 Standard Operating Procedures (SOPs) are in place within the Patient Safety and Risk team to ensure that processes are consistently applied. These are available on request (CCG staff only) from the Patient Safety and Risk team.

7.7 The process for receiving, logging and acknowledging adverse incidents can be found in Standard Operating Procedure 4-PS&R-01.

7.8 Some adverse incidents require either the involvement of a member of the Safeguarding team (Adult and/or Children's) or for a member of the team to be notified. The process for identifying the need for safeguarding involvement can also be found in Standard Operating Procedure 4-PS&R-01.

7.9 Adverse incidents relating to Information Governance issues are managed directly by the CCG Information Governance Officer. The incidents are logged onto a Caldicott log, as well as logged onto Ulysses for investigation, management and subsequent closure.

7.10 The Caldicott Log facilitates bi-monthly reporting to the Information Governance Group and the identification of information governance risks to the organisation.

RIDDOR reporting (CCG staff only)

7.11 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) require employers, the self-employed and those in control of premises to report specified workplace incidents.

7.12 For general guidance on the requirements of RIDDOR, such as, who should report, how to report and when to report, please visit the HSE RIDDOR website.

7.13 The HSE (Health and Safety Executive) has also developed an information sheet helps clarify how RIDDOR applies to the health and social care sector and whether certain types of incident are reportable (including examples): http://www.hse.gov.uk/pubns/hsis1.pdf

7.14 Appendix D provides a summary of the requirements to report certain incidents to the HSE; failure to meet the reporting criterion is a breach of Health and Safety Regulations and could lead to prosecution.

7.15 Further advice can be sought from the Patient Safety and Risk team during working hours, or via the HSE web site http://www.hse.gov.uk/

Medical attention and support (CCG staff only)

7.16 In cases of physical injury members of staff should attend the nearest Emergency Department or Minor Injuries Unit Department as soon as possible. They should be accompanied by a Manager or colleague so that details, records and, where appropriate photographs may be taken. The member of staff will be requested to give a written or verbal account of the incident as soon as possible. This may be used for further inquiries by the CCG and support the adverse incident report.

7.17 Immediate support should be in the nature of practical and emotional support from colleagues and/or from anyone requested to provide this (family or friend). Staff are strongly advised to keep Line Managers/Human Resources informed of contact details of those whom they wish to be contacted should the occasion arise.

Terms of Reference

7.18 On infrequent occasions, usually when multiple Providers are involved, it is helpful for a clearly determined Terms of Reference to be agreed ahead of any investigation. This is led by the Patient Safety and Risk team.

Undertaking investigations

7.19 The expected methodology to be used to investigate adverse incidents is 'Root Cause Analysis' (RCA). This is a systematic approach to investigating an incident to identify whether there were any care/service delivery problems or contributory factors which led to the incident, and what the root cause of the incident was. This will lead to lessons learnt, recommendations and the formation of an action plan.

7.20 The Patient Safety and Risk team are willing and able to work alongside any Provider who needs to undertake an RCA and requires support to do so. Additionally, staff training on RCA methodology is available from the Patient Safety and Risk team on request (if deemed appropriate to do so).

Whistleblowing

7.21 Whistleblowing occurs when an employee or worker provides certain types of information, usually to the employer or a regulator, which has come to their attention through work. The disclosure may be about the alleged wrongful conduct of the employer, or about the conduct of a fellow employee, client, or any third party. The whistleblower is usually not directly, personally affected by the danger or illegality, although they may be. Whistleblowing is therefore 'making a disclosure in the public interest' and occurs when a worker raises a concern about danger or illegality that affects others, for example members of the public.

7.22 The CCG is committed to creating a safe working environment where people feel comfortable in raising their concerns. The CCG Whistleblowing Policy seeks to guide people through the process in a fair and transparent manner and is available on the CCG intranet.

Investigation timeframe

7.23 The CCG requests that responses to adverse incidents are received within 40 working days (8 weeks) of the incident being reported to the CCG.

7.24 The Patient Safety and Risk team maintain regular contact with the Risk Departments at each of the Providers, requesting updates in relation to when investigations are past their due date.

7.25 The CCG is realistic that the 40 day timeframe, whilst aspirational, cannot always be achieved. This timeframe can be particularly challenging for complex investigations. In these circumstances, the CCG requests that the investigator regularly updates the CCG with progress in relation to the investigation and outcome timeframes.

Subject experts

7.26 The Patient Safety and Risk Facilitator and Patient Safety and Risk Co-ordinator can draw on subject expertise within the Quality Directorate, and throughout the CCG, if necessary. This could be following receipt of an Adverse Incident form and/or receipt of a response in relation to the incident.

Working with Providers to achieve timely reporting and closure

7.27 On a monthly basis, the Patient Safety and Risk Facilitator emails a list of 'outstanding adverse incidents' (i.e. sent to a Provider over 20 working days ago) requesting an update on the investigation progress.

7.28 On occasion, if required, the Contract Lead for each Provider will be provided with a report of outstanding responses to raise at the informal monthly meeting with Director/Deputy Director of Nursing at the Provider organisations.

7.29 The CCG also requests that all incidents are reported to the CCG in a timely manner. This will allow for the organisation that needs to undertake the investigation to do so within timeframes which will allow for staff to clearly recollect the incident. If reports are frequently not submitted in a timely manner, this will be raised by the CCG Quality Contract Lead with the Provider, with supporting examples.

Closing Adverse Incidents

7.30 Adverse incidents will only be closed on Ulysses following receipt of a response which addresses the issues identified within the initial report.

7.31 The process for closing an adverse incident can be found in Standard Operating Procedure 4-PS&R-04. This includes the process for feeding back to the individual/team who raised the adverse incident with the outcome of the investigation.

7.32 There will also be instances when an adverse incident can be closed upon receipt by the Patient Safety and Risk team. This could include an injury to a

staff member sustained in the workplace; if the Adverse Incident form included full details of what was done at the time of the incident to treat the staff member, this could be closed on receipt.

Reporting

7.33 The Patient Safety and Risk team is responsible for gathering information from all adverse incidents reported to the CCG and for preparing routine and ad hoc reports as required.

7.34 Information is provided to the monthly information sharing group, the Quality and Safety Information Group (QSIG), a forum for the triangulation of information about serious and adverse incidents with other information and intelligence, as per the requirement of the Serious Incident Framework (NHS England, March 2015).

7.35 Additionally, a full summary of activity in relation to adverse incidents will be included in the annual risk management report. This would include the number of adverse incidents, by type, the number of closed, the timeframes for closure etc.

CCG Group/Committee reporting

7.36 The following table summarises the formal CCG groups/committees which receive adverse incident information, the frequency and format.

7.37 A detailed theme/trend paper relating to adverse incident occurrence and Provider is provided in the Patient Safety and Risk paper for each Quality Group meeting by the Patient Safety and Risk Manager.

	QUALITY GROUP	AUDIT AND QUALITY COMMITTEE	GOVERNING BODY	DIRECTORS PERFORMANCE
Frequency	Quarterly	Quarterly	n/a	n/a
Format	Word	Word	n/a	n/a
Title	Patient Safety and Risk Report	Quality Group proceedings	n/a	n/a
Content	Narrative and graphic	Narrative	n/a	n/a

8.0 TRAINING

8.1 There are no identified training needs in relation to this procedure. This procedure is already in place for the management of adverse incidents.

8.2 Plans are in place to incorporate risk management and adverse incident training into the new staff induction programme/mandatory training process via an online module.

9.0 CONSULTATION

9.1 Those consulted during the development of this revised procedural document were:

- Quality Directorate Leadership team;
- Patient Safety and Risk team;
- Safeguarding Leads;
- Professional Practice Lead;
- Internal Audit.

9.2 Regarding the need for an Equality Impact Assessment, following due consideration it has been determined that an Equality Impact Assessment is not required for this procedural document.

10.0 RECOMMENDATION AND APPROVAL PROCESS

10.1 As a 'Risk Management' procedural document, this procedure is to be approved by the Director's Performance Meeting.

10.2 This requirement reflects the process for recommendation and approval of procedural documents outlined in **Appendix F** of the Procedure of the development and management of procedural documents.

11.0 COMMUNICATION/DISSEMINATION

11.1 Following approval, this procedure will be distributed via the CCG newsletter to all CCG staff and a copy will be uploaded to the CCG intranet.

11.2 A copy of the procedure will also be provided to Providers at the Patient Safety Event meeting in September 2015.

12.0 IMPLEMENTATION

12.1 This procedure is already in place for the management of adverse incidents by the Patient Safety and Risk team.

12.2 Work is planned for the remainder of 2015 and during 2016 to raise awareness of adverse incident reporting to the CCG, with the intention of increasing reporting. Currently, (July 2015) 94 of the 100 GP practices have submitted at least one adverse incident form, however 77 of these have submitted five or less forms over two years since the commencement of the CCG.

13.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THE DOCUMENT

13.1 This procedure will be subject to an audit by Internal Audit on a cyclical basis. Dorset CCG has a three year strategic plan, so this topic is likely to be subject to internal audit once every three years.

13.2 Any areas of concern or non-compliance identified in the internal audit will result in the production of an action plan. This will be reviewed by Audit and Quality Committee. Actions will be recorded in the committee/group minutes.

13.3 Any areas of concern or non-compliance identified in the biennial audit will result in the production of an action plan. This will be reviewed by Audit and Quality Committee. Actions will be recorded in the committee/group minutes.

14.0 DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

14.1 This procedure is reviewed every two years to take account of any changes in national guidance. Necessary changes throughout the year will be issued as amendments to the procedure. Such amendments will be clearly identifiable to the section to which they refer and the date issued. These will be clearly communicated via the CCG.

APPENDIX A

GLOSSARY: ADVERSE EVENTS

Below is a glossary of terms. Users of the reporting system should consider the definitions within the glossary when deciding to submit a report, and work to the premise: '*if in doubt, report'*.

Adverse Incident (also known as a Significant Event)	Any incident, occurrence or accident, related to clinical or non-clinical care, which has or could have resulted in an injury, or near miss to a patient, visitor or member of staff. The incident may be of property or equipment damage only, equipment failure, physical aggression or verbal threats.
Adverse Incident Report (AIRS form)	The document that is used to report all adverse incidents. This is referred to in GP Practices as a "Significant Event Report". There are no great fundamental differences, with the exception of significant event, which sometimes encompasses 'good' events as well as 'adverse' events.
Root Cause Analysis (RCA)	A systematic approach to investigating an incident to identify the cause and possible lessons to be learnt. It is a problem solving methodology for discovering the real causes of the problems, or difficulties, identified via a range of activities including incident management

Users of the reporting system should consider the definitions below when deciding to submit a report, and work to the premise: '*if in doubt, report'*.

Accident	An unplanned event, which may or may not result in injury or damage. It is clear from this definition that it is not essential for injury to have been sustained or for damage to have occurred for an accident to happen.
Information Incident	Any event or occurrence that has resulted or could have resulted in either the disclosure of confidential information to an unauthorised individual, put at risk the integrity of the system or data, or put at risk the availability of the system.
Near Miss (or No Harm)	An incident which should be regarded as a warning that a problem exists and that positive action is required. With a near miss the potential for harm exists if the event had occurred under slightly different circumstances. This means that the same immediate and basic potential causes of the accident are in place but on this occasion the outcome is limited to the events occurrence without resultant injury or damage. Because of the potential for harm, all these incidents should be investigated at

	department level in the same way as accidents.
Information Governance' incident	Any incident which involves actual or potential failure to meet the requirements of the Data Protection Act 1998 and / or the Common Law of Confidentiality. This includes unlawful disclosure or misuse of confidential data, recording or sharing of inaccurate data, information security breaches and inappropriate invasion of people's privacy. This definition applies irrespective of the media involved and includes both electronic media and paper records.
Patient Safety Incident	Any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS funded care. This also includes patient safety incidences which were prevented or near misses
Violence	In the context of healthcare, violence is defined as any incident where a healthcare worker is abused, threatened or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, well-being, or health.
Violence and Aggression at work	any incident in which a person working in the healthcare sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment.

APPENDIX B

Ulysses No:

MEMBER OF STAFF ADVERSE INCIDENT FORM

Serious/Major incidents should be reported immediately. Complete this form and send it to the Patient Safety and Risk team within 24 hours: avril.brown@dorsetccg.nhs.uk or laura.limm@dorsetccg.nhs.uk Please complete all of the form; if not completing electronically, please use black ballpoint pen and block capitals.

PERSON AFFECTED BY INCIDENT			
Full name			
Title			
Date of birth			
Gender			
Department			
Ethnic origin code			
Staff ☐	Visitor ☐	Contractor ☐	Patient ☐

WHO HAS BEEN NOTIFIED?	
Next of kin ☐	Doctor/GP ☐
Police ☐	Occupational Health ☐
Director ☐	Line Manager ☐
Estates ☐	Risk team ☐

DID THE PERSON RECEIVE ATTENTION?	
None ☐	First Aid ☐
Occupational Health ☐	Emergency Department ☐
Doctors signature (where appropriate)	

WHAT DESCRIBES THE INCIDENT?	
Accident ☐	Confidentiality breach ☐
Fire/false alarm ☐	Information breach ☐
Physical assault ☐	Security incident ☐
Near miss ☐	Serious Incident ☐
Other ☐	

Other person(s) involved (complete for information breach)	
Full name:	

RIDDOR (Reporting of injuries, diseases or dangerous occurrences regulations)		
Is hospitalisation for more than 24 hours likely (or additional, if patient)		
Yes	No	N/A
Has there been a dangerous occurrence?		
Yes	No	N/A
Has death or major injury occurred?		
Yes	No	N/A
Is there a work related illness/condition		
Yes	No	N/A
Incapacity for work for more than three days?		
Yes	No	N/A

DID THE PERSON SUFFER PHYSICAL INJURY, ILL HEALTH OR OTHER ADVERSE EFFECTS?	
Yes ☐	No ☐
If yes, which part of the body was affected (e.g. back, left shoulder)	
What was the nature of the injury sustained? (e.g. laceration, bruising)	
Identify nature of ill health or adverse effect (e.g. wound, headache)	

TO BE COMPLETED BY THE MEMBER OF STAFF WHO DISCOVERS, WITNESSES OR IS NOTIFIED OF THE INCIDENT					
Full name				Signature	
Designation				Department	
Date completed		Line manager signature		Date signed	

DETAILS OF WHAT HAPPENED (were there any contributory factors e.g. training, equipment failure) – RECORD FACT NOT OPINION							
Date of incident		Time of incident (24 hour clock)		Location of incident		No of people involved	
Description of incident Use separate sheet if necessary							

Immediate action taken

Risk Matrix (please circle)	Likelihood					
	Impossible	Rare	Unlikely	Moderate	Likely	Certain
	0	1	2	3	4	5
Consequence						
Prevented harm – 0	0	1	2	3	4	5
No harm (near miss) – 0	0	1	2	3	4	5
Minor – 1	0	1	2	3	4	5
Serious 2	0	2	4	6	8	10
Major – 3	0	3	6	9	12	15
Fatality – 4	0	4	8	12	16	20
Multiple fatalities - 5	0	5	10	15	20	25

ETHNICITY CODES			
1	White British	10	Bangladeshi
2	White Irish	11	Other Asian
3	White – Other White	12	Black Caribbean
4	Mixed White/Black Caribbean	13	Black African
5	Mixed White/Black African	14	Other Black
6	Mixed White/Asian	15	Chinese
7	Other Mixed	16	Other ethnic category
8	Indian	17	Note stated
9	Pakistani		

APPENDIX C

ADVERSE INCIDENT/SIGNIFICANT EVENT INCIDENT FORM

Patient details	
Patient name	
Identifying number on system for patient:	
NHS No. (if known)	
Hospital No. (if known)	
Date of Birth	
Gender	
Ethnicity of patient (if known)	

Incident details	
Date of incident	
Time of incident	
Date of reporting	
Reported by	
Job title	
Name of surgery or pharmacy	
Address	

Description of incident *Record fact and not opinion. Include a description of any medicines involved / injuries sustained / equipment problem / tests given.*

Persons involved (witnesses or attending staff)			
	Person 1	**Person 2**	**Person 3**
Name			
Status			
Job title			

Additional considerations		
Person directly affected by incident (harmed or prevented harm)	☐ Yes	☐ No
Does this incident have child protection/vulnerable adult issues?	☐ Yes	☐ No
Does this incident involve controlled drugs?	☐ Yes	☐ No

What was the CONSEQUENCE of what happened as a result of the incident? (circle)				
None/Negligible (no harm)	Minor (low harm)	Moderate (moderate harm)	Major (serious harm)	Catastrophic (death)

What is the LIKELIHOOD of the incident occurring again? (circle)				
Rare	Unlikely	Possible	Likely	Almost certain
This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Using the risk matrix below, what is the risk score?					
Consequence score =		Likelihood Score =		C x L =	

Risk Matrix

Likelihood / ***Consequence***		Rare	Unlikely	Possible	Likely	Almost certain
		1	2	3	4	5
1	No harm	1	2	3	4	5
2	Low harm	2	4	6	8	10
3	Moderate harm	3	6	9	12	15
4	Serious harm	4	8	12	16	20
5	Death	5	10	15	20	25

Low Risk Green 0-5	Moderate Risk Yellow 6-8	Significant Risk Orange 9-12	High Risk Red 15-25

Actions taken			
Signature:		Date:	

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RIDDOR REPORTABLE INCIDENTS **APPENDIX D**

A, B, C and D are immediately reportable by telephone
E, F and G are reportable in writing within 10 days

	**A**	The death of any person whether or not they are at work, as a result of an accident arising out of, or in connection with work.
	Senior Manager/Director or Patient Safety & Risk Manager (where available) (On-call Director /Manager out of hours)	

	**B**	Someone at work is unable to do their normal work for more than 7 days as a result Any person suffering a specified major injury as a result of an accident arising out of, or in connection with work.
	Senior Manager/Director or Patient Safety & Risk Manager (where available) (On-call Director /Manager out of hours)	

	**C**	Someone who is not at work (e.g. member of the public) suffers an injury **as a result of an accident arising out of or in connection with the work of the CCG** and is taken from the scene to a hospital for treatment, or, if the accident happens at a hospital, suffers a major injury).
	Senior Manager/Director or Patient Safety & Risk Manager (where available) (On-call Director /Manager out of hours)	

	**D**	One of a list of **specified** dangerous occurrences takes place. Dangerous occurrences are events, which do not necessarily result in a reportable injury, but have the potential to do significant harm.
	Senior Manager/Director or Patient Safety & Risk Manager (where available) (On-call Director /Manager out of hours)	

	**E**	Someone at work is unable to do their normal work for more than 7 days as a result of an injury (an 'over 7 day' injury) caused by an accident at work (including as a result of physical violence). The 7 day period does not include the day of the accident/incident but does include weekends and rest days.
	Senior Manager/Director or Patient Safety & Risk Manager (where available) (On-call Director /Manager out of hours)	

	**F**	The death of an employee if this occurs some time after a reportable injury which led to that employee's death, but no more than one year afterwards (Reg. 4).
	Patient Safety and Risk team	

	**G**	A person at work suffers one of a number of specified diseases, provided that the doctor diagnoses the disease and the person's job involves a specified work activity.
	Patient Safety and Risk team	

Patient Safety and Risk team	**HSE Info line (08:00 – 18:00)**
T: 01305 368052/36/56	**T:** 0845 3009923
Email: matt.wain@dorsetccg.nhs.uk	**Website:** http://www.hse.gov.uk/riddor/report.htm