INCIDENT REPORTING POLICY

Policy Title:	**Incident Reporting Policy**
Executive Summary:	Pioneer Healthcare Limited (PHL) is committed, through its Health and Safety and Risk Management Policies, to the maintenance of safe working practices and the provision of an environment, which is safe for staff, patients and others; in accordance with good clinical practice and the requirements of Health and Safety, Fire Safety, Security and Environmental Legislation. This policy applies to all staff employed by PHL. This policy relates to the requirement of all personnel employed in all areas of PHL to report all untoward events, including near misses, regardless of whether they involve patients, visitors, staff or contractors. The reporting of untoward events is an integral part of PHL risk management strategy, which has a goal of identifying and then removing, or reducing to an acceptable level all risks across the organisation. The reporting and subsequent management of the incidents reported will allow PHL to put measures in place to reduce or eliminate the likelihood of recurrence and allow the organisation to learn from previous incidents and experiences.
This policy will impact on: All staff working within PHL	

Policy Area:	Organisation wide	**Document Reference:**	IRP1
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Author:	P Godbole, CEO		

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Ratified by:	Board of Directors	17th January 2018
Reviewed 3.0	January 2020 V Dugdale	No changes
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Reviewed 6.0	May 2026 P Godbole	Legislative and Governance Updates

1. INTRODUCTION

Pioneer Healthcare Limited is committed, through its Health and Safety and Risk Management Policies, to the maintenance of safe working practices and the provision of an environment, which is safe for staff, patients and others; in accordance with good clinical practice and the requirements of Health and Safety, Fire Safety, Security and Environmental Legislation.

This policy applies to all staff employed by Pioneer Healthcare Limited. This policy relates to the requirement of all personnel employed in all areas of PHL to report all untoward events, including near misses, regardless of whether they involve patients, visitors, staff or contractors.

The reporting of untoward events is an integral part of PHL's Risk Management Strategy, which has a goal of identifying and then removing, or reducing to an acceptable level all risks across the organisation. As an organisation we can also transfer the risk to another stakeholder or accept the risk as it is. The reporting and subsequent management of the incidents reported will allow PHL to put measures in place to reduce or eliminate the likelihood of recurrence and allow the organisation to learn from previous incidents and experiences.

PHL is committed to developing an organisational just culture in which front-line operators and others are not punished for actions, omissions or decisions taken by them which are commensurate with their experience and training.

PHL will listen to staff and respond to what they say in a positive and supportive manner. Concerns can be raised by staff via the incident reporting process (covered by this policy).

Pioneer Healthcare Limited will align incident management processes with current NHS England Patient Safety Incident Response Framework (PSIRF) principles where applicable and proportionate to organisational size and activity.

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2. OBJECTIVE

This policy and associated standard operating procedures sets out the process for reporting and management of clinical and non-clinical incidents, accidents and near miss events reported via the incident reporting and Datix risk management system. This includes the reporting of incidents, accidents, and near miss events related to patients, staff, volunteers, contractor, visitors and assets and including the investigation of serious incidents.

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3. SCOPE OF POLICY

All staff, including agency staff, student learners, volunteers and contracted staff are required to report incidents, accidents and near misses (hereafter referred to collectively as incidents) in line with this policy and procedure.

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4. ROLES AND RESPONSIBILITIES

4.1 Chief Executive

Has overall accountability for PHL wide legislative compliance and management of risk.

4.2 Medical Director

Has delegated accountability for ensuring PHL has robust risk management arrangements in place, including processes for reporting, responding and commencing investigations into clinical and non-clinical incidents. This person also has responsibility for keeping the Board fully informed about serious untoward events as well as general trends.

4.3 All Executive Directors

Have operational responsibility for the implementation and monitoring of the risk management systems in place in PHL. This includes provision of specialist advice and support, implementation of independent scrutiny process and representing PHL at relevant Integrated Care Board/NHS Trust/Independent Sector Hospitals/Other Commissioner or Regulator serious incident review meetings. Acts as the designated Liaison Officer for patients and families in relation to serious incidents as required.

4.4 Director of Operations

The Director of Operations has operational responsibility for the implementation and monitoring of the incident reporting and management systems in place in PHL, including ensuring that PHL fulfils its statutory and contractual duties to report incidents externally via national serious incident reporting systems and the Learn from Patient Safety Events (LFPSE) service where applicable. Provides specialist advice to operational teams to support effective clinical and non-clinical risk issues associated with incidents, including analysing and reporting on learning from trends and serious incidents. This post holder is the Information Asset Owner for integrated risk management system and has overall responsibility for the management of the system.

4.5 Specialist Advisers eg Fire Safety, Health & Safety, Manual Handling, Safeguarding Team etc.

The specialist advisors within Pioneer Healthcare Limited will have oversight of incidents within their scope of practice. Each specialist advisor will receive an email notification from Datix when an incident within their speciality is reported.

4.6 Risk Management Team

The Risk Management Team has responsibility to review and approve each incident reported and assign each incident to the appropriate person. Each member of the team can

review any incident that is reported but each has their own specialist area in which they can provide advice to the incident handler.

4.7 Clinical Leads

Clinical Leads have the responsibility to ensure that incidents are reviewed at monthly governance meetings and receive assurance that actions are implemented and this can be evidenced.

4.8 Heads of Service

The Heads of Service in each Service Line have operational responsibility for ensuring staff within their respective service line adheres to this policy and associated procedures. The Heads of Service are responsible for embedding individual and system learning as a result of incidents reported within PHL. Each Head of Service is responsible for all incidents being investigated appropriately and any actions arising from an investigation are implemented within timescales and evidence of completion forwarded to the risk management team to upload to Datix.

4.9 Service and Departmental Managers/Matrons

Have a responsibility to review incident forms pertaining to their area and to ensure that accidents/incidents within their area of responsibility are investigated and managed effectively. They must escalate any concerns up to the Head of Service immediately.

4.10 Managers/Team Leaders

Have a responsibility to review incident forms pertaining to their area and to ensure that accidents/incidents within their area of responsibility are investigated and managed effectively. They must escalate any concerns up to their Manager immediately.

4.11 All staff

All staff employed by PHL have a legal, professional and moral duty to report accidents/incidents and near misses as soon as reasonably practical. They have a duty to assist with any accident/incident or near miss investigation that they have been involved in or have knowledge of.

Staff must report any hazards they identify to their manager/the appropriate person to be resolved before any accidents or incidents occur. They must also take all reasonable steps to minimise risks to patients, colleagues and others. They have a duty to follow any changes in any policy, procedure or practice that has been identified as a result of an incident review or lessons learnt.

Where death or serious injury occurs as a result of an incident or there is a significant impact on the delivery of services, this must be reported immediately to a senior manager and the risk management team in hours or to the senior manager on call, out of hours.

Staff wellbeing, fatigue, psychological safety and workload pressures should also be considered during incident review and learning processes.

5. POLICY

5.1 Recording Incidents (All must be entered on DATIX or local Incident reporting system)

All incidents must be reported via the host organisation Datix system where applicable, or via Pioneer Healthcare Limited incident reporting arrangements including IR1 forms where used outside hospital settings.

All staff must be encouraged to report incidents appropriately and should refer to the relevant standard operating procedure and guidance entitled: How to report an incident.

5.2 Definitions

Accident/incident

An unplanned and uncontrolled event that has led to or could lead to injury, ill health, harm to persons, damage to property, equipment or loss.

Patient safety incident

Anything associated with the patient and their clinical treatment or care which has or could lead to ill health or harm.

Non patient safety incident (non-clinical)

An accident/incident involving anyone (staff, patient relative or visitor, contractor or visitor to PHL) or item or equipment, property or premise that is not directly associated with patient treatment or care.

Serious Incident Requiring Investigation

A serious incident requiring investigation is any incident on an NHS site or elsewhere whilst in NHS funded or NHS regulated care involving patients, relatives, visitors, staff, contractors, building, equipment or property and which may or has:

- caused death (including suicide) or serious injury or was life threatening;
- contributed to reduced standards of care;
- involved a hazard to public health;
- caused serious disruption to services;
- caused significant damage to NHS assets;

- caused significant damage to the reputation of an NHS organisation or its staff;
- involved fraud or suspected fraud;
- given rise to a significant claim for damages;
- raised concerns following an inquest;
- caused a serious breach in confidentiality;
- involved an attack on a member of staff, visitor or patient.

Near Miss

Any event which had the potential to cause injury, ill health, damage, harm or loss but did not.

Never Event

Never Events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The current NHS England Never Events list and framework applies and should be referenced via current NHS England guidance.

5.3 Incident Response and Management

Immediate Action

The immediate safety or well-being of the patient, staff member or visitor affected or involved in an incident is paramount.

Any remedial first aid or emergency treatment must be given and in the event of patient safety incidents the patient's medical team must be informed.

Incident Management

The response to an incident must be proportionate to the severity of impact or harm.

The most serious events will be rated as having a consequence that is severe harm or death (or a risk that is high in the case of near miss events). These must be reported, escalated and responded to immediately to the senior clinician involved in the patient's care and reported to the risk management team as soon as reasonably practical.

The risk management team will review each incident. Any incident which is graded no harm, low harm or a near miss will be assigned to the appropriate handler and discussed in governance meetings.

There are some incidents that even if graded no harm, low harm or a near miss still require an investigation. These are termed incident red flags (listed in Appendix 2).

The member of staff in charge of an area is responsible for ensuring that appropriate action has been taken to make the area safe following any incident and to ensure that the risk of the incident occurring again is reduced and that the incident is reported at the earliest opportunity.

Any equipment involved in the accident/incident must be made safe and retained for the purposes of further investigation by the appropriate medical devices or specialist team and where appropriate reported to the Medicines and Healthcare products Regulatory Agency (MHRA).

If a patient receives a radiation dose “much greater than intended” this is reportable to the Care Quality Commission under IR(ME)R requirements.

Any incidents that involve blood transfusions could be reportable to SHOT (Serious Hazards of Transfusion).

Serious Incident reporting policy

All staff are expected to put compassion at the forefront of their behaviour. The desire to offer expedient and efficient treatment should at all times remain secondary to providing empathetic care.

All actions should be caring towards patients, patient families and to staff.

A major purpose of this document is to help staff recognise when a serious incident has taken place and how to proceed if one has been detected.

Pioneer has a small team providing entirely elective care. We see few serious incidents, but all staff members should feel confident and prepared to report both positive and adverse patient events or where processes are though not to be ideal.

The senior team are readily available to discuss concerns and are proactive in their approach to bring about improvement in services to enhance patient safety, experience and efficiency.

To report positive experiences – please see the policy on staff feedback.

Any adverse event should be reported and staff should have a low threshold for reporting as a serious incident. The following circumstances should always be treated as a serious incident

- Avoidable death, serious injury and near misses for death or serious injury
- Safeguarding or abuse.
- Never event see below
- An event identified as in need of closer scrutiny according to Pioneer’s PSIRF policy.
- An event that needs to be reported externally – healthcare partners are likely to demand a high degree of scrutiny and it is best to approach this as early as possible.

- System or organisational threats, that threaten the organisation's ability to deliver safe healthcare. These may be external to the organisation e.g. activation of a Major Incident Plan by a host Trust.

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Never events

Wrong site surgery

Retention of a foreign object

Incorrect implant

Administration of medication via the wrong route

Mis-selection of strong potassium solution

Overdose of insulin due to abbreviations or incorrect device

Overdose of methotrexate for non-cancer patients

Mis-selection of high strength midazolam during conscious sedation

Failure to install collapsible shower or curtain rails

Falls from poorly restricted windows

Chest or neck entrapment in bed rails

Transfusion or transplantation of ABO incompatible blood components or organs

Misplaced nano or orogastric tubes

Scalding of patients

Unintentional connection of a patient requiring oxygen to air flow meter.

Pioneers PSIRF investigation priorities

Failure to follow process leading to patient harm
Post operative surgical site infection
Postoperative DVT
Readmission within 60 days of surgery

Please communicate to the team leader, service manager of operations manager immediately.

Serious incidents can also be reported directly to the Director of Operations, Medical Director or Chief Executive, if there is doubt as to how to proceed.

Pioneer are working towards recording serious incidents on the national LFPSE portal. The policy will be updated when this is in place. This portal is open to everyone to be able to report and incident. In addition Pioneer is establishing its own on line reporting service where any incident will be able to be reported. The policy will be updated when this is available.

Currently incidents are securely recorded on the Sharepoint drive which is managed by the service managers, it is therefore important that the details of the incident are clearly communicated to them.

If a serious incident has occurred directly involving patient care then please engage with the patient or their family as soon after detection of the incident as possible. Please inform the patient or family that the incident will be reported and investigated by the organisation. Explain that the purpose of the investigation is to identify causes for the incident and to address them. The primary purpose of the investigation is not to apportion blame. Please enquire if the patient or their family would like to be directly involved in the investigation or if they would like to be made aware of the investigations progress and outcome. It is important to record the outcome of this discussion and communicate it to the senior team.

Pioneer services are conducted in a wide variety of clinical settings. It is sometimes the case that we do not have automatic access to all clinical documents after the day of an activity. It is very helpful if documents can be copied and made available to our organisation. This can only be done with permission of the host organisation e.g. a Trust where insourcing work is being conducted, and any clinical records must be transferred securely e.g. sent via NHS.net email or logged onto the Share point drive. If it is not possible to transfer documents immediately please ensure they are kept in a safe place until they can be securely transferred.

Swarm

The purpose of a swarm meeting is to understand and record what has happened, assess if there are underlying causes that can be addressed and assess if the incident impacts on other parts of the organisation.

It is ideal that a Swarm meeting takes place as soon after an incident as possible. It may well be that such a meeting is held on the day of the event and must be held if clinical activity has been curtailed due the serious nature of what has happened. For instance a serious complication during surgery should lead to consideration of stopping the remainder of a list – automatically one would undertake a debrief at this point but this should be extended to the principles of a swarm.

Please note it is good practice to involve a patient or their family in a Swarm. Care must be exercised and there will be circumstances where such involvement may cause excess

distress or make the conduct of a meaningful meeting impossible, so do not consider this to be mandatory.

The Swarm meeting is a vital part of the investigative pathway after an event. The findings and outcome should be recorded and sent to the Operations manager as soon as possible after wards.

In some cases it may not be possible to conduct a Swarm on the day of the event, in which case a Swarm will be called for the next working day. It will be led by one of the operations manager, director of operations, medical director or chief executive officer. It is recognised that members of the team present at the time of the incident may not be available at the time of the Swarm. It is important that enough information has been recorded to allow the meeting to understand what has happened.

The initial findings from the Swarm will determine the type and level of investigation then required as well as the reporting required. It will consider if duty of candour applies.

Role of the organisation

Where a serious incident has been reported. The senior team – consisting of the service manager, Director of Operations, Medical Director or Chief Executive Officer and the relevant operations manager will meet as soon as is practically possible. This may be the following working day but can be done immediately if considered necessary. They will review the available documentation including statements and the outcome of a Swarm if already held. The meeting will represent an initial LFPSE meeting and will be documented according to those principles.

The initial LFPSE meeting will determine if a serious incident has occurred, the correct application of the duty of candour and external reporting. The meeting will also determine the level of investigation required to manage the event safely and develop strategy to avoid future events. It is recognised that in most incidents further investigation is required but the meeting will address any immediate concerns and act accordingly e.g. cessation of a certain activity until more is known.

The patient wishes regarding involvement in the process will be considered and if it is not known the patient will be contacted to explain the process and ascertain their wishes.

The meeting will determine the level of support required by staff members.

The incident will be allocated to one of 3 tiers of investigation.

The first tier is for serious incidents including, PSIRF priorities and externally reportable events. It is envisaged that these investigations will require multiple meetings and personal statements from those involved. It is recognised that staff members may need to be present at some meetings and that due care in the timing of these will be made. The investigation may require external opinion. The responsibility for leading the investigation will be given to one of the team members in the initial meeting. There will be a timeline for reporting

constructed. The responsibility for external reporting and ensuring completeness of duty of candour principles will be allocated to a team member in the same manner.

The final report will be made available to all members of the team involved with further opportunity to provide support.

The second tier of investigation will apply if it is considered that the incident does not fulfill the criteria of a serious incident. However it is felt that there is still a need to coordinate a report from multiple sources but the scope and detail is not that required following a serious incident. An example might be a patient who suffered a significant but recognised complication of surgery. Roles and time line will be allocated in the same way. If, as investigation proceeds, it is recognised that the the event should be categorised as a serious incident then the scope and detail will be extended. Any such change will be referred back to the senior team for oversight.

The third tier is where it is identified that the incident is of low harm and risk. Few reports will be needed to complete the assessment and the matter will be managed largely through one to one communication.

All LFPSE reports will be completed on Pioneer standard documentation to ensure completeness.

Following investigation of the incident, the outcome should be discussed with the patient and/or carers and a letter offered to detail the outcome in accordance with the Duty of Candour Policy and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

5.4 CHECK AND CHALLENGE

Once a report has been completed by the investigator and before executive approval, a check and challenge meeting is held.

The investigator will present the report to the check and challenge group.

The report is then scrutinised to ensure the contributory factors, root cause and learning have been identified appropriately to reduce the risk of recurrence.

5.5 HUMAN FACTORS

All staff involved in an incident, irrespective of whether they are reporting, investigating or being investigated, should consider the following aspects of Human Factors which may have contributed to the incident.

The acronym “IM SAFE” applies:

- Illness
- Medication

- Stress
- Alcohol
- Fatigue
- Eat (hungry)

Staff wellbeing, fatigue, psychological safety and workload pressures should also be considered during incident review and learning processes.

6. ASSOCIATED DOCUMENTATION & REFERENCES

- Standard operating procedure: How to report an incident.
- Standard operating procedure: How to document an investigation and close the incident.
- Duty of Candour – Being Open Policy.
- Duty of Candour Standard Operating Procedure.
- Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy.
- NHS England Patient Safety Incident Response Framework (PSIRF).
- NHS Patient Safety Strategy.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).
- UK GDPR.
- Data Protection Act 2018.

7. TRAINING & RESOURCES

When a new employee commences employment at Pioneer Healthcare Limited it is the responsibility of their manager to request appropriate access to Datix at the provider hospital or incident reporting forms in order to investigate incidents in their area.

8. MONITORING & AUDIT

The effectiveness of the implementation of this policy will be monitored by the Director of Operations and assurance provided via governance reporting to the Executive Board.

Key performance indicators:

- Percentage of serious incidents reported to the Integrated Care Board within required timescales.
- Percentage of initial reviews completed within required timescales.
- Percentage of investigation reports completed within agreed timescales.
- Number of patient safety incidents reported.
- Themes and trends identified from incident reporting.

9. EQUALITY & DIVERSITY

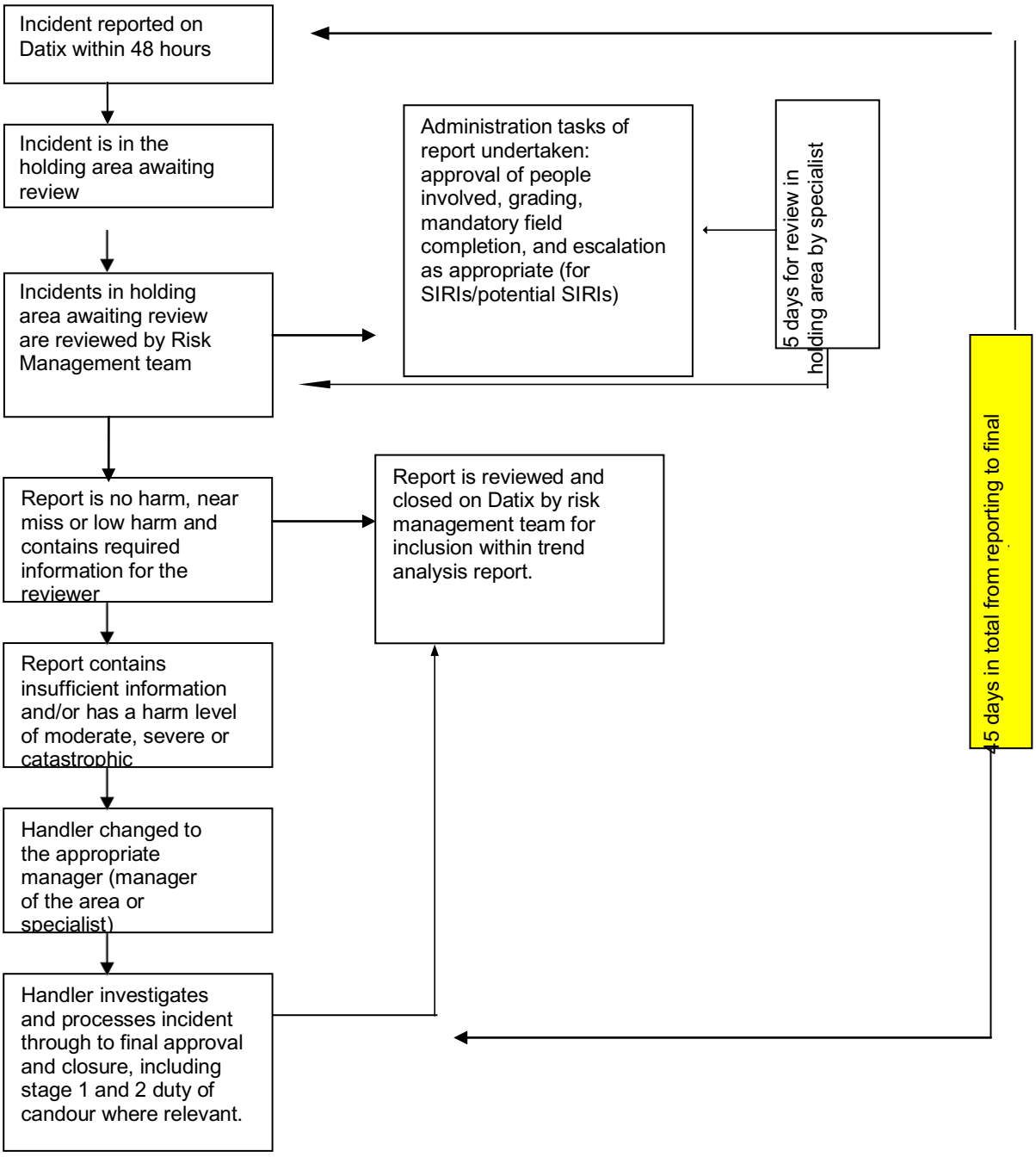
PHL is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider.

Pioneer Healthcare Limited is committed to fostering a just and learning culture that supports equality, diversity and inclusion.

This policy should be implemented with due regard to this commitment.

Appendices

Appendix 1 Procedure for the Reporting of incidents



Appendix 2

Incident red flags (Incidents which need to be investigated by the appropriate handler)

- One patient who has had numerous incidents reported.
- Controlled drug, insulin, anticoagulant, methotrexate, midazolam incidents to be assigned as normal and left open for the handler to investigate.
- Omissions/lapses in care which have altered the patient's journey.
- H&S (RIDDOR) incidents where a member of staff is injured.
- VTE (any patient developing a DVT or PE).
- C.Diff and MRSA bacteraemia
- Paediatric incidents
- Externally reportable incidents such as blood transfusions or medical device failures.
- Any incident where abuse/neglect to a patient is suspected.
- Never events (https://www.england.nhs.uk/patientsafety/never-events/).
- Moderate, severe or deaths all require investigation (and duty of candour stage 2).
- Mortuary incidents which include:

- Accidental damage to a body
- Discovery of an additional organ(s) in a body on evisceration for a second post-mortem examination, or during the repatriation or embalming process
- Discovery of an organ or tissue following post-mortem examination and release of body
- Loss, disposal or retention of a whole fetus or fetal tissue (gestational age greater than 24 weeks) against the express wishes of the family
- Loss, disposal or retention of a whole fetus or fetal tissue (gestational age less than 24 weeks) against the express wishes of the family
- Inadvertent disposal or retention of an organ against the express wishes of the family
- Incident leading to the temporary unplanned closure of a mortuary resulting in an inability to deliver services
- Loss of an organ (Post mortem)
- Major equipment failure in the mortuary
- Post-mortem examination conducted was not in line with the consent given or the PM examination proceeded with inadequate consent
- Post-mortem examination of the wrong body
- Release of the wrong body

Appendix 3

Assessment of quality in terms of investigation reports ref. Mazar's Independent Review (Dec 2015)

Excellent/good – no typographical; grammar; date; naming errors – report was easy to read, followed a logical flow and the evidence gathered clearly linked to recommendations and to action plans. The report could be shared with families as a robust piece of independent writing and with professionalism.

Adequate – showed most of the information needed was available but was presented in a manner that made understanding the issues difficult; often these had grammar; date; naming and typing errors. Could have caused distress to families if shared by showing a lack of respect and attention to detail. Probably had not been quality reviewed at any level or detail.

Poor/inadequate – these varied between having typographical errors to an unacceptable standard; naming the service user incorrectly; wrong dates; no flow and were either cursory or provided insufficient information to form good recommendations or action plans. These reports lacked challenge or effort in securing learning. Likely to cause distress to a family due to its cursory nature or lack of professionalism; and had most likely not been read properly during any phase of quality review.