

Policy I8

Incident Reporting and Management Policy

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Equality & Diversity statement

The Trust aims to design and implement services, policies and measures that meet the diverse needs of its services, population and workforce, ensuring that none are placed at a disadvantage over others.

The development/review of this policy has undergone an Equality Impact Assessment [EIA], as per the guidance in the Trust Policy Development Monitoring & Review [P3].

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Version Control Sheet

Version	Date	Title of Author	Status	Comment
I8/01	Dec 07	Associate Director Patient Safety	New policy	
I8/02	Dec 07	As above	Trust wide consultation	Endorsed by TCRGE. Policy consultation period ending 22.02.08

I8 Incident Reporting and Management Policy

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1. INTRODUCTION

- 1.1 Working in any organisation, both staff and service users, will encounter a range of events as part of their daily lives. Some of these events will fall outside of what might be considered normal or an every day occurrence. These events can be considered to be adverse incidents and fall within the scope of this policy.
- 1.2 This policy covers the reporting, management and review of adverse and serious adverse incidents in West London Mental Health NHS Trust (WLMHT).
- 1.3 The purpose of this policy is to provide the framework that ensures incidents are identified and reviewed, and the lessons learnt are promptly applied. The policy also ensures that reported incidents are analysed to seek to identify root causes and likelihood of repetition, taking into account *Building a safer NHS for patients: implementing an organisation with a memory* (DoH, 2001).
- 1.4 WLMHT's intent is to ensure that any adverse incident is properly recorded and that appropriate action is taken to minimise the risk of a recurrence. Staff are also encouraged to report 'no harm' incidents as they also help guide procedures to avoid recurrences. Through reviewing incidents, WLMHT also aims to:
- Provide feedback and information to those involved
 - Improve practice as a result of review findings and share learning
 - Set priorities for investment in training and/or other resources.
- 1.5 WLMHT has a fair-blame ethos in reviewing incidents. Part of reviewing any incident is a focus on staff behaviour and actions, however, their proceedings should be kept separate from any disciplinary proceedings that may have arisen from the incident. Where such disciplinary proceedings occur, human resources advice should be sought and consideration given to the need to involve regulatory bodies (i.e. GMC, NMC).
- 1.6 WLMHT has an obligation to report serious incidents to NHS London in accordance with the *Serious Untoward Incident (SUI) Reporting* Guidance, NHS London (October, 2007) within 24hrs or as soon as is practicable and then to update on progress.
- 1.7 As part of High Security Services, Broadmoor Hospital is required to comply with the *Policy Framework for the Reporting and Briefing of Incidents and Issues in High Security Hospitals* (June 2007).
- 1.8 To support this policy an incident reporting, review and management resource pack is available on the Risk and Safer Services Page of the Exchange containing documentation relevant to and referenced in the policy. This pack includes:
1. WLMHT Management Guideline *Undertaking Incident Reviews*
 2. *Serious Untoward Incident (SUI) Reporting* Guidance, NHS London

(October, 2007)

3. *Policy Framework for the Reporting and Briefing of Incidents and Issues in High Security Hospitals* (June 2007)
4. Guidance on the completion of incident forms (paper)
5. Guidance on the completion of incident forms (electronic)
6. Critical Incident Debrief letter template
7. Being Open - NPSA
8. Staff support information

1.9 The Policy must be read, understood and actively supported by all staff employed by the Trust. It is consistent with and should be read in conjunction with other policies and guidance governing the management of specific incidents. Including:

- Complaints Procedure (Trust Policy C1)
- Cardiopulmonary Resuscitation (Trust Policy C4)
- Child Protection Policy (Trust Policy C18)
- Vulnerable Adults Policy (Trust Policy V7)
- Disciplinary Procedure (Trust Policy D4)
- Policy on Death of a Patient (Trust Policy D6)
- Fire Policy (Trust Policy F1)
- Health & Safety Policy (Trust Policy H3)
- Hostage Policy (Broadmoor Hospital Policy H7)
- Medicine Policy (Trust Policy M2)
- Media Relations (Trust Policy M4)
- Patients Absent without Leave (Trust Policy P1)
- Prevention and Management of Violence (Trust Policy P7)
- Risk Management Strategy (Trust Policy R1)
- Seclusion Policy (Site-specific Policy S2)
- Whistle Blowing (W1)

2 Incident Definition, Categorisation & Levels of Review

As describe in the introduction staff and service users will encounter a range of events that fall outside of what might be considered a normal or an every day occurrence. These events can be considered to be adverse incidents or serious adverse incidents. To aid understanding of the implications of these events, these definitions are further categorised to establish the need for a formal review and if appropriate the level of review.

2.1 Definitions

2.1.1 Adverse Incident:

- Any event that has given or may give rise to actual or personal injury, patient dissatisfaction, or to property damage or loss.

2.1.2 Serious Adverse Incident:

- An adverse incident when a patient, member of staff, or member of the public suffers serious harm or unexpected death on trust premises,

premises where health care is provided, including in a patient's own home or anywhere in the community

- Where actions of trust staff are likely to cause significant public concern
- Any event that might seriously impact upon the delivery of service plans and/or may attract media attention and/or result in a settlement following litigation and/or may reflect a serious breach of standards of service

2.2 Categories

2.2.1 WLMHT categorises Adverse Incidents through the use of the National Patient Safety Agency (NPSA) terms and definitions (modified) for the grading of incidents. This involves using the categories:

Death – Any death

Severe – Any incident that appears to have resulted in permanent harm to one or more person and/or has had a severe outcome. Examples include:

- Attempted suicide
- A serious sexual assault
- A serious physical assault
- A serious accident or injury
- Actual or attempted escape from a secure setting
- Major Fire
- Serious self-harm
- Significant outbreak of health care associated infection.

Moderate – Any incident that resulted in a moderate increase in treatment and/or which caused significant but not permanent harm, to one or more persons. Examples include:

- Physical/verbal assault
- Moderate/minor self-harm
- Sexual assault
- Fire
- Accident/injury
- Medication errors
- Absconson from a 'non-secure' setting.

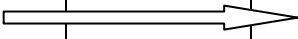
Low – Any incident that required extra observation or minor treatment and/or caused minimal harm, to one or more persons. This category includes prevented incidents, near misses and no harm incidents.

2.2.2 WLMHT and other related organisations categorise incidents differently and the language used within, and between organisations can be confusing. The table below (Fig 1) gives a broad comparison of categories used.

2.2.3 Incident categorisation influences the type of review required and all incidents categorised in WLMHT as Death, Severe or Moderate **must** be considered for further formal review.

- 2.2.4 It is only if a death is established to be by natural causes that it will not be subject to a formal investigation, unless there are lessons to be learnt about the care received prior to death.

2.2.5 Fig 1.

	Highest level				Lowest Level
WLMHT	Death	Severe	Moderate	Low	-
NHS London	Serious Untoward Incident	-	Untoward Incident	-	-
Mental Health Act Commission	Class A	Class B	Class C	Class D	Class E
High Secure Hospital Reporting	Category A - Major Incident	Category B- Serious Incident	Category C- Untoward Incident	-	-
National Patient Safety Agency	Death	Severe	Moderate	Low	None

2.3 Levels of Incident Review

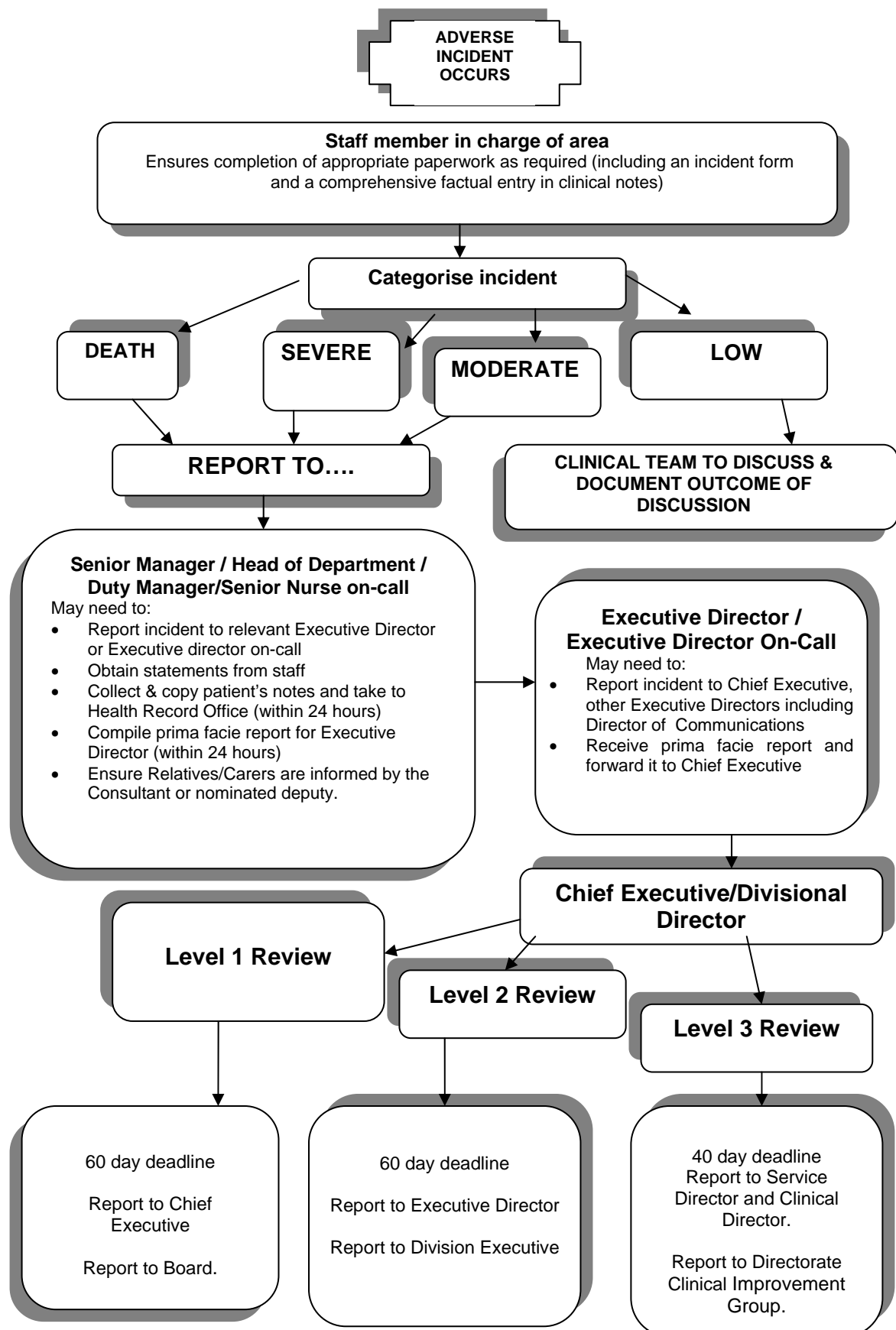
2.3.1 Following an incident categorised in the trust as Death, Severe or Moderate there are three levels of review that can be undertaken:

- **Level 1 Review** - This is the highest level of review undertaken within the trust. It will always involve a non-executive director and may involve members of the review team who are external to the trust. Level 1 reviews must be completed within 60 working days of the incident. The majority of these reviews will be complex and therefore may take longer to complete, but this needs to be agreed with the strategic health authority.
- **Level 2 Review** - This level of review will always involve the majority of the review team being from another directorate. Level 2 reviews must be completed within 60 working days of the incident.
- **Level 3 Review** - This level of review will always involve the majority of the review team from the directorate where the incident has taken place. Level 3 reviews must be completed within 40 working days of the incident.

2.3.2 Clusters of similar 'lower level' incidents may warrant formal review and should be given due consideration.

2.4 Undertaking Incident Reviews

2.4.1 The detailed trust procedure for conducting incident reviews is described in the management guideline complements and expands on this policy.



3 Reporting Incidents

3.1 Internal Requirements

- 3.1.1 All incidents as defined in section 2 must be reported using WLMHT Incident Reporting Form (IR1) or by the electronic incident reporting form by a member of Trust Staff who was witness to or involved in the incident.
- 3.1.2 Detailed guidelines for the completion of incident forms can be found in the incident reporting, review and management resource pack that is available on the Risk and Safer Services page of the Exchange.
- 3.1.3 For an incident that is categorised as Death, Severe or Moderate, a 24 Hour Report must be completed by the Senior Manager to whom the incident was reported **Appendix**.
- 3.1.4 Staff on duty and directly involved in an incident will be required to provide a written statement of their involvement in the incident **prior to going off duty** unless they are medically unfit to do so.
- 3.1.5 It is the responsibility of the Senior Manager to whom the incident was reported to produce, within 72 hours, a report of the incident covering the prima facie facts (including who, what, where, when and how), a description of the action taken following the incident, and any initial assessment of the causes of the incident. Any information sought but not available in the timescale should be identified in this report. This prima facie report should be reviewed by the relevant Executive Director and forwarded immediately to the Chief Executive. A check list for immediate action is attached at **Appendix**.
- 3.1.6 It may be the case that remedial action is required to reduce the likelihood of a recurrence of a similar incident. This action must not be delayed awaiting the outcome of the incident review and the person receiving the 24/72 hour report must consider this requirement.
- 3.1.7 Incidents involving adverse drug reactions or incorrect administration of medication, as well as completing the Trust incident form, must be reported to the Pharmacy/on-call Pharmacy personnel **immediately** (Ref: Medicine Policy M2)
- 3.1.8 For incidents judged to be of potential media interest (e.g. involving high profile patients), the Communications Department must be notified via site specific procedures.
- 3.1.9 From time to time some incidents will need to be reported to the police. Actual or potential legal action or investigation of a particular incident by the police should not necessarily be regarded as grounds for deferring an incident investigation or implementing any necessary clinical/managerial action, although advice should be sought in these circumstances from the relevant Executive Director who will seek advice from Trust's solicitors in conjunction with local police or Crown Prosecution Service.

- 3.1.10 The procedure outlined at **Appendix** should be followed for any serious incident or assault requiring the involvement of the Police, including sexual assault.
- 3.1.11 Incidents involving the death or serious harm of a child will usually lead to multi agency investigation and review under the procedure of a Serious Case Review. The initial incident investigation and necessary clinical managerial action should not necessarily be deferred. Advice should be sought in these circumstances from the relevant Executive Director and Named Doctor for Safeguarding Children in conjunction with the local safeguarding children group. The procedure to be followed is outlined at **Appendix**.
- 3.1.12 For incidents involving other agencies or Trusts, the possibility of jointly commissioning a singly inquiry will be considered by the relevant Executive Director in conjunction with representatives of the other agencies/trusts involved. The aim is to enable local inquiry to proceed as soon as possible and for lessons to be learned, whilst ensuring coordination of procedures and avoiding duplication of inquiry processes. Robust communication is vital when more than one agency is involved in an incident.
- 3.1.13 The Divisional Executive Director will always report significant patient safety incidents to the Medical Director and Nursing Director, usually on the next working day, but immediately if very serious.
- 3.1.14 All severe and death incidents should be reported by the Executive Director or on-call Executive Director to the Trust's Director of Public Relations & Communications who will ensure they are routinely reported to NHS London's Communications Team.
- 3.1.15 If the incident has occurred on a facility or property not managed by the Trust, the relevant facility's manager should also be informed.
- 3.1.16 In addition to incidents that involve physical assault, certain incidents may need to be referred to the Police due to their nature (e.g. sexual assault or child protection issues). Reporting should be carried out by the Senior Manager or Head of Department in conjunction with the Executive Director. The Service Manager or Head of Department will also ensure the scene of the incident is isolated pending the arrival of the Police. **(See Appendix)**.
- 3.1.17 Any individual (patient, staff, visitor) subject to a criminal act must be advised of their right to report the incident to the Police, and of the process of doing so. Staff must assist any patient or an inpatient in the reporting of an incident.
- 3.1.18 Where other agencies or organisations are involved, for example the Police or Health and Safety Executive, an early meeting of the Executive Director and senior staff of the other agencies will be required to agree an approach to nature and timing of investigations, and the sharing of information.
- 3.1.19 Serial incidents are extremely rare within mental health services but, in the event of one occurring, the Chief Executive will initiate a response plan which, if appropriate will include the establishment of an "information hotline" for service users, relatives/carers, staff and/or the public to call. External expertise may be engaged by the Chief Executive for this purpose.

- 3.1.20 The Serial Incident Protocol can be accessed through the Risk and Safer Services Page on the Exchange.

3.2 NHS London

- 3.2.1 As described in the introduction WLMHT has an obligation to report certain serious incidents to NHS London in accordance with the *Serious Untoward Incident (SUI) Reporting Guidance*, NHS London (October, 2007). This guidance is available as part of the incident reporting, review and management resource pack that is available on the Risk and Safer Services Page of the Exchange.

- 3.2.2 The reporting pathway is appended to this policy at **appendix**.

- 3.2.3 Notification within 24hrs or as soon as is practicable to NHS London is coordinated directly through the Local and Forensic Divisions. Therefore, prompt notification, as outlined in this policy, through WLMHT's own systems is essential.

3.3 Broadmoor Specific

- 3.3.1 As described in the introduction, as part of High Security Services, Broadmoor Hospital is required to comply with the *Policy Framework for the Reporting and Briefing of Incidents and Issues in High Security Hospitals* (June 2007).

- 3.3.2 This notification is coordinated directly from Broadmoor Hospital. Therefore, prompt notification, as outlined in this policy, through WLMHT's own systems is essential. This guidance is available as part of the incident reporting, review and management resource pack that is available on the Risk and Safer Services Page of the Exchange.

3.4 Other External Notification Requirements

- 3.4.1 The Trust is required to notify other organisations of certain incidents.
- 3.4.2 HM Coroner: Sudden and/or unexpected and/or unnatural deaths are notifiable to HM Coroner. In the event of a sudden death on a ward, the Coroner is informed as quickly as possible. The Death of a Patient Policy should also be consulted.
- 3.4.3 Health & Safety Executive: Incidents notifiable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). The Risk Management Department undertakes this role and reports these incidents on forms F2508 and F2508A to the Health and Safety Executive. Suicides are not reportable to the HSE.
- 3.4.4 Medicines & Healthcare Products Regulatory Agency: Suspected adverse reactions to drugs are notifiable by doctors and pharmacists through the Yellow Cards system. Advice and Yellow Cards are available from the Medicines Control Agency, CSM Freepost, London SW8 5BR (0800 731 6789) and are included in the British National Formulary. Suspected defective medicinal products are notifiable by doctors and pharmacists to The

Defective Medicines Report Centre, Medicines Control Agency, Room 1801, Market Towers, 1 Nine Elms Lane, London SW8 5NQ.

- 3.4.5 Medical Devices Agency: Adverse incidents relating to medical devices are notifiable under SN1999 (01). The Risk Management Department undertake this role.
- 3.4.6 Local Authority: Confirmed reports of food poisoning are notifiable to the relevant local authority Environmental Health Department by the Director of Nursing and Facilities.
- 3.4.7 NHS Estates: Fire incidents and adverse incidents involving buildings or plant are notifiable to NHS Estates by the Director of Nursing and Facilities.
- 3.4.8 NHS Litigation Authority: The Trust Secretary notifies the NHSLA when clinical negligence claims are received. The Finance Governance Manager notifies third party claims.
- 3.4.9 Mental Health Act Commission: In the event of the death of a Service User detained under the Mental Health Act, the Mental Health Act Commission must be advised using form MHAC3. The Medical Records/ Patients Services Manager will undertake this role. **Appendix**
- 3.4.10 NHS Counter Fraud and Security Management Service: The NHS CFSMS has policy and operational responsibility for the management of security within the NHS. Their remit is the protection of people and property so the highest standards of clinical care are available to service users. Incidents of physical assault against staff must be reported to NHS SMS via Patient Assault Reporting System (PARS). The Risk Management Department has responsibility for ensuring this happens. In cases of suspected Fraud, the Director of Finance assumes responsibility for Liaison with NHS CFSMS.
- 3.4.11 National Patient Safety Agency (NPSA): The NPSA gathers data in the NRLS (National Reporting and Learning System) on patient safety incidents that occur in NHS Trusts across the country. WLMHT has an electronic gateway that reports all patient safety incidents to the NPSA via the risk department.

4.0 Responsibilities for Managing and Reporting an Incident

4.1 Responsibility of staff present

- 4.1.1 Any Member of Trust staff present at, or responding to, an incident on Trust property must, to the best of their ability, carry out the following.
- 4.1.2 Respond in the first instance according to the nature of the incident, their assessment of risk involved and the advice given by the person in charge of the area.
- 4.1.3 For the management of some incidents it will be necessary to raise the alarm (e.g. emergency/fire alarms/radio/telephone) in order to gain more assistance from additional medical and other support staff.
- 4.1.4 At all times the preservation of life, safety and security of service users, staff

and visitors is paramount.

- 4.1.5 When faulty equipment is involved, it must be retained by the person in charge of the area for inspection. The equipment must be clearly labelled with appropriate information stating that it is out of use.
- 4.1.6 Take appropriate emergency action in the case of fire, explosion, toxic or electrical hazard, etc. This may include contacting emergency services directly (9999), ensuring that location details are correct.
- 4.1.7 Ensure that any casualties receive appropriate medical attention.

4.2 Responsibility of Person in-charge of immediate area

- 4.2.1 The immediate responsibility for managing an incident falls to the most senior person on duty in the relevant area at that time. This person is responsible for ensuring that:
- 4.2.2 Those directly involved in the incident receive the immediate care and assistance required in order to reduce any further untoward impact.
- 4.2.3 The risk to staff, service users and visitors is minimised as far as possible.
- 4.2.4 A Trust incident form is completed. The person completing the form must record facts only, not their opinion.
- 4.2.5 The Unit coordinator/site manager is aware of all aspects of the incident.
- 4.2.6 Where one or more service users are involved, the appropriate clinical staff must make comprehensive entries in the health records, giving a full description of events, interventions used and post incident care planned, as soon as possible after an incident.
- 4.2.7 All documentation is cross referenced. For example, incident forms are referenced in the service user's clinical notes.
- 4.2.8 If the service user is not aware that they have been involved in or affected by an incident, for example, in the case of a medication error, they must be informed at the earliest opportunity by the Ward Manager or Person in charge of the area.

4.3 Responsibility of Unit coordinator/Site Manager

- 4.3.1 The unit coordinator/site manager is responsible for ensuring that:
- 4.3.2 The Manager/Department Head and the service users Responsible Medical Officer are informed at the earliest possible opportunity. Outside business hours the duty Consultant and Manager/Senior nurse on-call for the area is informed.
- 4.3.3 The area is made safe, including redeployment of additional staff/resources if necessary.

- 4.3.4 All paperwork (incident forms/health records/statements) is completed. Additional staff may be required to ensure that the individuals are relieved of other responsibilities to allow this to happen.
- 4.3.5 Support is provided to staff, including facilitating access to the staff support and counselling service.
- 4.3.6 The police are contacted, and briefed, if in the opinion of the unit coordinator/site manager their attendance is necessary. Examples of this include, but are not restricted to, a service user with a weapon; a disturbance involving a number of service users; a hostage situation; assault.
- 4.3.7 Whenever there is a serious adverse or adverse incident, they must document exactly which staff responded and from where.

4.4 Responsibility of Senior Manager

- 4.4.1 The most senior person on duty is responsible for ensuring that appropriate action has been taken to manage the incident and to initiate additional action as necessary. This may include, but is not restricted to:
- 4.4.2 The Service/Department Manager or on-call Director is informed immediately where appropriate e.g. if it is viewed that the incident is potentially a Serious Adverse Incident.
- 4.4.3 The management of the incident is escalated to the Service/Department Director, Director on Call, or the Chief Executive, if necessary.
- 4.4.4 Liaison with the police in the event of suspected criminal activity or suspicious circumstances.
- 4.4.5 That staff and service-users have access to appropriate support.
- 4.4.6 Produce a report within 24 hours, when the incident is viewed as a potential Serious Adverse Incident, covering the prima facie facts (including who, where, what, when and how), a description of the action taken following the incident and an initial assessment of the causes of the incident. The 24 hour report is accessed through the Risk and Safer Services page of the Exchange. Completion guidelines are also contained on the Exchange.
- 4.4.7 If the incident is potentially a serious adverse incident, obtain a written statement from each member of staff involved unless medically unfit to do so.

4.5 Responsibility of the Consultant (Duty Consultant)

- 4.5.1 The doctor who is present at the incident (e.g. the Consultant Psychiatrist, the Duty Consultant or Duty Psychiatrist) is responsible for informing the patient's relatives/carers of what has happened, having obtained consent from the patient when possible. **This must be done promptly.** If another member of the multi-disciplinary team, who is well known to the relatives/carers, is present, the Consultant may delegate this responsibility to them, recording this in the patient's notes. The relatives/carers must be given the name and contact details of someone who can answer any further questions or concerns they might have after the initial contact. This is a central contact

number in each Division. (020 8354 8052 for Local Services & 01344 754678 for Forensic Services)

5 Post Incident Management

5.1 Preserving the Scene

- 5.1.1 The priority during any incident is the preservation of life. Following the administration of any basic life support and/or the removal of any immediate hazards or broken equipment, it may be necessary to preserve the scene of the incident.
- 5.1.2 The relevant Senior Manager (or Police if attending) will determine, having inspected the area when access may resume. Important evidence, such as broken equipment, weapons, etc. should not be destroyed or disposed of, but taken out of service and kept safely by the Senior Manager, pending an investigation.
- 5.1.3 Every effort should be made to ensure that the scene and any evidence are secured for future possible police investigation.
- 5.1.4 Any items removed from the scene should be placed in an evidence bag and a record made of the contents. This should then be stored in a secure place where access is restricted to the Senior Manager.
- 5.1.5 There will be occasions when it is necessary to disturb evidence to ensure a safe environment or to prevent further harm occurring. If this transpires, a written record detailing this is prepared by the most senior person on duty to assist any future investigation.

5.2 Care and Support for Staff

- 5.2.1 In all situations managers have the responsibility to make appropriate and timely arrangements to ensure that support is provided to all staff and patients involved in serious incidents*. Examples of this may include:
 - review of fitness to continue to work
 - medical treatment as necessary
 - post-incident 'Diffusion'
 - critical incident stress debriefing
 - assistance in escorting staff home where appropriate
 - involvement of staff Counseling and Support service
 - involvement of the Occupational Health Department
 - clinical team support to service users
 - support for relatives and carers
 - Inviting staff in writing to arranged Critical Stress Debriefings

** Further information is available as part of the incident reporting, review and management resource pack that is available on the Risk and Safer Services Page of the Exchange.*

5.3 Support for Staff called to give evidence at Court

- 5.3.1 Occasionally Staff will be required to give evidence to a Court; Civil, Criminal or Coroner's Court. This can be a particularly daunting experience, especially

for those that have never gone through this experience before. In order to support staff and minimise anxiety it is vital that any member of staff called to give evidence is:

- Allocated a named manager who will ensure they have access to any support options available, keep them informed of progress throughout the process and accompany (or arrange) them to the court hearing.
- Afforded the opportunity to discuss this with the Trust solicitor, if appropriate, prior to the day of giving evidence.
- Offered the opportunity to access the Staff Support and Counselling Service throughout the process including after the conclusion of the court case.
- Given the opportunity to view proceedings in a Court prior to giving evidence themselves, whenever possible.

5.4 Support for service-users involved in or witness to a distressing Incident

- 5.4.1 The nurse in charge should decide on the most appropriate method of supporting service-users (taking into account such issues as the time of day/night the Incident occurred and whether other service-users are aware of it etc). This should be done in discussion with other members of the Clinical Team/on-call personnel. Service-users can exhibit a wide range of emotional response when they are affected by serious incidents and it is not unusual for such emotionally charged situations to result in conflict between patients or patients and staff.
- 5.4.2 The nurse in charge should consider whether a ward community meeting, involving all service-users and staff, should take place. All questions surrounding the nature and circumstances of the incident should be answered truthfully and information only withheld if it is necessary to do so due to the legal process, maintenance of safety or matters of confidentiality.
- 5.4.3 If the incident is serious, such as the suicide of a fellow service-user, the clinical team should consider the effect this has on others, paying particular attention to their level of risk.
- 5.4.4 The Manager of the service must ensure that service users have access to other support/advice services such as Advocacy, PALS and Bereavement Counsellors.

5.5 Communicating with Relatives

- 5.5.1 **It is essential to ensure relatives are always kept informed of progress of the review and related events; this will be as appropriate but must happen following any death or serious incident.**
- 5.5.2 Good communication is vital to allay the anxiety and fears of relatives and carers. Communication must be open, honest and accurate, ensuring that the right information is given to the right people and that they have ample opportunity to ask questions.
- 5.5.3 Face to face contact is always preferable to other indirect communication media in these circumstances.

- 5.5.4 Sharing of information about the incident and subsequent investigation is important to reassure relatives and carers that the incident is being investigated and that measures are being taken to ensure that a recurrence of the incident is prevented.
- 5.5.5 The principles and concepts of Being Open - communicating patient safety incidents with patients and their carers (NPSA, 2006) should be considered. This document is available as part of the incident reporting, review and management resource pack that is available on the Risk and Safer Services Page of the Exchange.
- 5.5.6 It is both natural and desirable for those involved in the care which produces and adverse outcome to sympathise with the person's relatives and to express sorrow and regret at the outcome. Such expressions of regret do not normally constitute an admission of liability, either in part or full, and this policy does not prohibit them.
- 5.5.7 As part of apologising it is the intent of this policy to encourage the sharing of information related to the incident with relatives whether informally, formally or through mediation. The NHS litigation authority is clear that it will not take a point against anyone offering a factual explanation offered in good faith before litigation is in train. They consider the provision of facts, as opposed to opinions to constitute good practice, should form the basis of any explanation
- 5.5.8 Immediately after a death or serious incident the responsibilities for communicating with relatives is described above in section 4.5.1.
- 5.5.9 In the event of a death a letter of condolence must be considered. These can be signed by the Chief executive.
- 5.5.10 Medium to longer term communication with relatives is essential. The frequency of contact and person responsible must be described in the terms of reference of the incident review. However, the person identified may not be on the panel but must be a senior member of staff i.e. Head of Service/Service Director for the directorate where the incident happened.
- 5.5.11 Relatives should be presented with the conclusions of any review and offered the opportunity to discuss this with the panel Chairperson. Consideration should be given as to the best way to do this as the report may contain sensitive and distressing detail. When sharing information with relatives and carers, care must be taken to protect the identity of third parties involved in the incident.

5.6 Records Management

- 5.6.1 Where it is clear that a Level 1 or 2 review may be convened, all the service users clinical records, in the case of a clinical incident, or all other relevant Trust records, must be collected and photocopied within 24 hours and the "originals" taken by the Duty Manager to the Mental Health Act and Health Records Office in Broadmoor or at the London end of the trust to the Ealing site Medical Records department immediately after the incident. Requests for release of case notes, for example, requests from Police, should be considered by the Executive Director. The Trust will retain a photocopy of the full case notes should it be agreed to release the original case notes.

- 5.6.2 Copies will be made available as required for internal or external investigations. Any access to the original file will be recorded for future reference.
- 5.6.3 In very rare circumstances, an Executive Director may direct that an original or copied file be taken directly to Trust HQ, In which case no separate copies will be retained in either records department.
- 5.6.4 The Information Department must also take steps to secure electronic records within the same 24hr timescale. The Senior Manager on duty is responsible for advising the Information Department regarding this.
- 5.6.5 All records related to level 1 reviews will be archived by the risk management department and retained in line with NHS records management schedule. All other reviews will be archived by the person commissioning the review and retained in line with NHS records management schedule.
- 5.6.6 All copies of draft reports held by review panels will be destroyed following submission of the report to its commissioner.

5.7 Involvement of the Trust's Solicitors

- 5.7.1 Some incidents may result in legal action being taken against the Trust. Where this is the case the Chief Executive will seek legal advice on the evidence to be collated and the issues to be considered, so that the Trust may obtain advice on anticipated future legal claims or liabilities.
- 5.7.2 In order to ensure that the Trust obtains early legal advice the Board Secretary will notify the Trust's solicitors of the incident as soon as practical.

6 Incident & Causal Factor Analysis

- 6.1 Responsibility for Incident Analysis
 - 6.1.1 The quantitative and qualitative analysis of incident data will be conducted each month.
 - 6.1.2 Incident data is collated and stored by the Risk Department and month end reports are sent to a designated mailing list across WLMHT.
 - 6.1.3 Specific data, reports, etc. can be requested from the Risk Department when required. This can be tailored to meet the parameters of the requesting team, individual, etc.
 - 6.1.4 Operational managers of all levels are responsible for monitoring incident levels in their respective areas. This knowledge should inform their practise and management strategies in their place of work. When necessary, they should seek advice and guidance from specialist services.
 - 6.1.5 All incidents are reported quarterly to the Risk Committee by the Risk Department.

6.2 Responsibility for Causal Factor Analysis Post Review

- 6.2.1 **Level 1** – The Trust Clinical Governance executive will consider all ‘clinical’ level 1 review reports and action plans and agree how learning will be shared. For non-clinical incidents the Trust Executive will fulfil this function.
- 6.2.2 **Level 2** – The Trust Clinical Governance executive will consider all ‘clinical’ level 2 review reports and action plans and agree how learning will be shared. For non-clinical incidents the Trust Executive will fulfil this function.
- 6.2.3 **Level 3** – The Divisional executive will consider all level 3 review reports and action plans and agree how learning will be shared. For non-clinical incidents the Trust Executive will fulfil this function.
- 6.2.4 **Reviews of other Organisations & National Findings** – The Trust Clinical Governance executive will consider significant review reports from other organisations and the findings of national inquiries and agree how learning will be shared. For non-clinical incidents the Trust Executive will fulfil this function.

7 Training

- 7.1 Following an assessment need the training requirements... **to be undertaken in context of final agreed policy**

8 References

Building a safer NHS for patients: implementing an organisation with a memory (DoH, 2001)
To be finalised