NHS
Coventry and Warwickshire Partnership NHS Trust

Incident Reporting Policy (Reporting, Managing and Investigating Incidents)

(Including Serious Incidents Requiring Investigation (SIRIs))

Version:	V11.0
Policy Author:	Mandy Jenner
Designation:	Head of Patient Safety
Responsible Director:	Chief Nurse, Chief Operating Officer and Deputy Chief Executive
Target Audience:	All Staff
EIA Assessed:	01/05/2018
Approved By:	Policy Review Group
Approval Date:	02/05/2018
Ratified By:	Policy Review Group
Ratification Date:	02/05/2018
Review Date:	02/05/2021

CONTENTS

1. Introduction 3
2. Purpose 4
3. Definitions 5
4. Duties / Responsibilities 10
5. Process 17
6. Consultation 31
7. Implementation 31
8. Training Needs 31
9. Review 31
10. Monitoring Compliance 32
11. References 33
12. Trust Associated Documents 33
13. Version Control 34
14. Equality Impact Assessment Form 37

Appendix 1 38
Appendix 2 39
Appendix 3 40
Appendix 3A 42
Appendix 3B 43
Appendix 3C 45
Appendix 4 46
Appendix 5 47
Appendix 6 49

1. Introduction

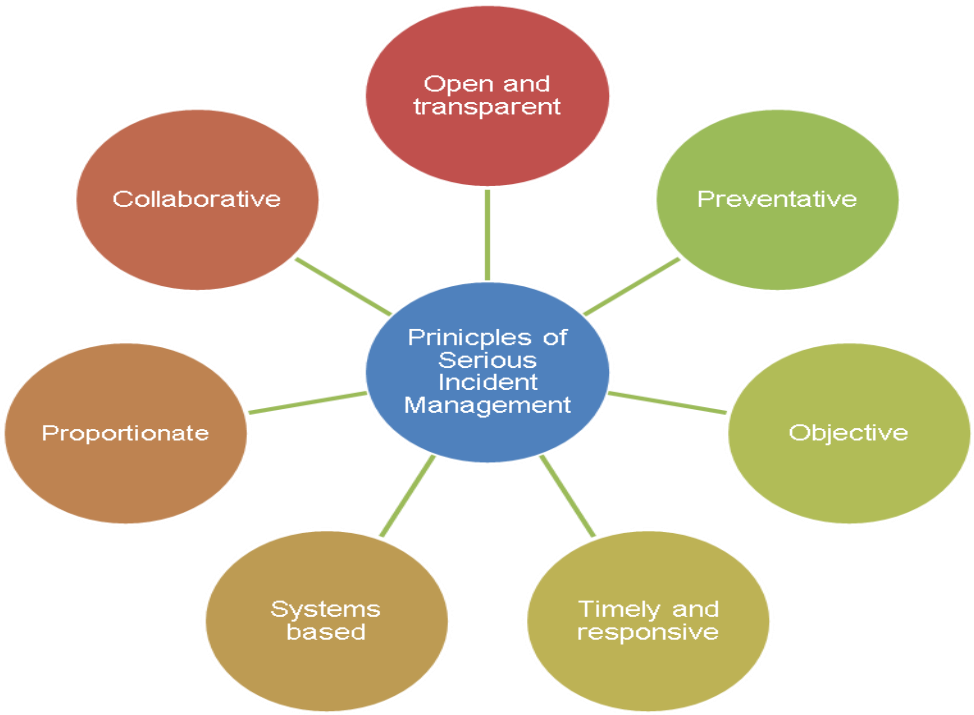
The Trust acknowledges that the provision of health care is, by its very nature, susceptible to risk from a variety of sources. The Coventry and Warwickshire Partnership NHS Trust (CWPT) is committed to providing a safe and secure environment for patients, staff and visitors.

Incident reporting and follow up forms part of the strategy of the Trust for the management of risks. The procedures for incident reporting, management, review and learning need to be clear and easily followed. If an incident is not reported then the risk remains unrecognised and the incident can recur. This is not an acceptable position for the Trust and all staff are expected to play their part in using the incident reporting system to improve safety for all.

The Trust recognises that it is essential that the Trust has an open and learning culture for the safety of patients and staff to be maximised. This will ensure that staff feel motivated to report incidents and that staff and service users affected by incidents receive appropriate feedback and support about what has happened and the learning from this.

This policy reflects national policies and procedures around reporting of incidents, in particular the Serious Incident Framework[1] and Never Events Framework[2], published by NHS England, both of which came into effect on 1 April 2015 and the requirements of the statutory Duty of Candour which came into effect on 27 November 2014.[3]

NHS England has identified the 7 principles shown in the diagram below as underpinning the Serious Incident Management process across the NHS.



1 Serious Incident Framework 2015/16, NHS England, 27 March 2015
2 Revised Never Events Policy and Framework, NHS England, 27 March 2015
3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

2. Purpose

The purpose of this policy is to set out clear management policy and procedure for incident reporting, management review and organisational learning.

The responsibility of individuals in this process is explained and guidance is provided for those involved in such events.

This policy encompasses all clinical and non-clinical incident reporting, regardless of grade, including medication errors and data/information losses and breaches.

The following are the main Trust policies which complement the processes described within this policy document; staff should familiarise themselves with their content and utilise where appropriate. Other policies may cover other specific situations (i.e. medication errors, safeguarding issues, absences without leave/failure to return from leave) and should be referred to as required.

Policy:	Relevant When:
Complaints Policy Raising Concern (Freedom to Speak – Whistleblowing) Policy	A service user/carer wishes to raise issues around how specific care or a service is delivered.
Raising Concern (Freedom to Speak – Whistleblowing) Policy	A member of staff, in good faith, wishes to raise concerns about work practice of colleagues. The policy sets out the processes to be followed.
Being Open Policy (Duty of Candour)	A service user has suffered moderate or severe harm or death as a result of care provided (or where care should have been provided and has not). The policy explains how to communicate with those affected in line with the Trust's responsibilities under the statutory Duty of Candour.
Coping with a Stressful Incident/Event Policy	Staff involved in an incident, complaint or legal claim are affected by the events and how they should be supported.
Camera Photographic Imagery Policy - Use of Cameras in the Clinical Care Setting	Consideration is being given to taking photographs to document aspects of investigations (i.e. room layout, equipment).

2.1 Policy Objectives

- To set out clearly what is meant by incidents and the harm that arises from them so that all know exactly what to report.
- To ensure that all incidents are reported and that reports contain accurate factual information.
- To set out the respective responsibilities and roles of designated persons and groups with regard to management of all types and severity of incidents and respective investigation procedures.
- To facilitate good communication between Trust departments and specialist groups on incidents and their outcomes.
- To ensure that the incident management process results in timely internal reporting to fulfil obligations for external reporting to enforcing authorities and other bodies.

- To demonstrate to all stakeholders that the Trust incident reporting, management, investigation and learning processes provide reasonable assurance that the Trust Governance procedures are robust.

3. Definitions

3.1 Incident (Also Referred To As Adverse Events Or Accidents)

Any event or circumstance that led, or could lead to, unexpected (and generally unintended) harm, loss or damage to a service user, staff, member of the public or Trust property.

3.2 Serious Incident Requiring Investigation (SIRI) – Formerly Known As Serious Untoward Incidents (SUIs)

The Trust adopts the definition of serious incidents as set out by the Serious Incident (SI) Framework (March 2015).

In line with the Serious Incident Framework, the Trust does not have a prescribed list of serious incidents and adopts the definition from the SI Framework as set out below. Any incident meeting this threshold should be escalated as a potential serious incident:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    - Unexpected or avoidable death[4] of one or more people. This includes:
        - Suicide/self-inflicted death; and
        - Homicide by a person in receipt of mental health care within the recent past (6 months given as a guide but will depend on facts).
    - Unexpected or avoidable injury to one or more people that has resulted in serious harm.
    - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
        - The death of the service user; or
        - Serious harm.
    - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
        - Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or
        - Where abuse occurred during the provision of NHS-funded care.

[4] Caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS-funded care caused/contributed towards the incident

A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. (The 2018 list is set out below, however advice should be sought from the Safety and Quality Department around the specific facts of each incident).

SURGICAL

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-procedure.

MEDICATION

4. Mis–selection of a strong potassium solution
5. Administration of medication by the wrong route
   The patient receives one of the following:
   - Intravenous chemotherapy by the intrathecal route
   - Oral/enteral medication or feed/flush administered by any parenteral route
   - Intravenous medication that was intended to be administered by the epidural route
6. Overdose of insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis–selection of high strength midazolam during conscious sedation.

MENTAL HEALTH

9. Failure to install functional collapsible shower or curtain rails.

GENERAL

10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients
15. Unintentional connection of a patient requiring oxygen to an air flowmeter.

- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

  - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues (see 5.10 for further information)
  - Property damage
  - Security breach/concern
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population

- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS)
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
- Activation of Major Incident Plan (by provider, commissioner or relevant agency).

- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

3.3 Investigation

An investigation is an inquiry into circumstances surrounding an allegation, or incident which seeks to establish the facts and circumstances (what happened) and identify any contributing factors (how the incident happened) and underlying/root causes (why it happened). The key is to identify learning/actions to prevent recurrence and wider issues for learning. This does not seek to attribute blame.

The main types of formal investigation used by the Trust are: -

- Initial Management Review (IMR) – undertaken within 48 hours of the incident to identify immediate actions and set the scope of any level 1-3 investigation which may also be required
- NPSA Level 1 – Concise Investigation (i.e. incidents risk rated as "high" and serious inpatient falls and pressure ulcers grade 3 and 4)
- NPSA Level 2 – Comprehensive Investigation (i.e. all SIRIs except serious inpatient falls and pressure ulcers)
- NPSA Level 3 – Independent Investigation (led by an external investigator)

The investigation process in this policy covers incidents, complaints and claims.

Incident report templates should be used to ensure consistency across the Trust. Report templates incorporating the requirements of NHS England concise/comprehensive/independent reports and other documentation required for investigations are held on the Patient Safety page of the intranet (SIRI button - access via Ctrl/click on this link: http://cwptintranet.covwarkpt.nhs.uk/business-units/quality/nursing/Pages/SIRI.aspx and will be updated in line with local need/national requirements.

3.4 Case Note Review / Structured Judgement Review (SJR)

A structured desktop review of a patient's health record (in the event of death) carried out by clinicians to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely in the absence of any particular concerns about care, to learn and improve. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when the

bereaved or staff raise concerns about care. Please refer to the Mortality Review Policy for further information.

3.5 Near Miss

An undesired happening / incident / accident which could have resulted in an accident, incident or harm but did not do so. Reported and managed as an incident.

3.6 Grading Incidents

All incidents must be graded low, medium, high or serious using the Trust matrix (as contained within the Ulysses Incident Report) by the person in charge of the area at the time. The grade determines the action to be taken, which should be proportionate to the severity of the incident.

3.7 Harm, Loss or Damage

Harm is defined as injury (physical and psychological) disease, suffering, disability or death. In most instances, harm can be considered to be unexpected, if it is not related to the nature of a person's illness or underlying condition.

Actual harm must also be graded in line with definitions set out by the NPSA and in incidents where there is moderate or severe actual harm or a death a "Duty of Candour" conversation must be considered – see Being Open Policy (including Duty of Candour) for further details.

Loss or damage includes loss or damage to personal or Trust property, damage to the Trust's reputation or an inability to deliver services.

3.8 Never Event

A list of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented issued by NHS England. See 3.2 for the current list. Follow up will be as for other SIRIs however, specific additional steps must be taken to manage never events (i.e. immediate escalation by Director on-call to NHSI, early reporting of HR information, inclusion of details on CWPT internet) and these will be co-ordinated by the Quality and Safety Department.

3.9 Root Cause Analysis

A systematic process whereby the factors that contributed to and/or caused an incident are identified. As an investigation technique for patient safety incidents, it looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which an incident happened. This is the approach adopted by the NHS and should be used for all investigations into incidents, complaints and claims.

3.10 Working Day

Days that exclude weekends and bank holidays.

3.11 Ulysses

Ulysses is the name of the incident reporting system used at CWPT. Following a transition from paper to electronic reporting, it is expected that incidents will be recorded through the electronic reporting (e-reporting) system. Paper forms should only be used as a last resort. Any staff member can log into the Ulysses

System by using their normal log in details (on intranet select “Systems” then “Incident Reporting System”).

3.12 Abuse

The Care Act (2015) has identified abuse in the different categories below: -

3.12.1 Physical Abuse

When an adult is subject to assault, hitting, slapping, pushing, misuse of medication, restraint, or inappropriate physical sanctions.

3.12.2 Sexual Abuse

Can include; rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

3.12.3 Psychological Abuse

Can include; emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

3.12.4 Financial or Material Abuse

Can include; theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

3.12.5 Modern Slavery

Encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

3.12.6 Discriminatory Abuse

Including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

3.12.7 Organisational Abuse

Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

3.12.8 Neglect and Acts of Omission

Including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational

services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

3.12.9 Self Neglect

This covers a wide range of behaviour neglecting to care for one's personal hygiene, health, or surroundings and includes behaviour such as hoarding.

3.12.10 Domestic Abuse

Including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

4. Duties / Responsibilities

4.1 Chief Executive

The Chief Executive has ultimate accountability for incident reporting, management and investigation within the Trust. The Chief Executive delegates responsibility for establishing required systems and monitoring processes to the Chief Nurse, Chief Operating Officer and Deputy Chief Executive.

4.2 Chief Nurse, Chief Operating Officer and Deputy Chief Executive

The Chief Nurse, Chief Operating Officer and Deputy Chief Executive has lead operational responsibility to ensure that the structures, processes and systems are in place to support staff to implement this policy.

4.3 Trust Board

The Trust Board will ensure that appropriate structures are in place to implement effective incident reporting, management, review and learning. Trust Board will be responsible for committing resources necessary to facilitate this.

4.4 Safety and Quality Committee

The Safety and Quality (S&Q) Committee is a formal sub-committee accountable to the Trust Board and receives delegated authority to implement governance policies and actions.

The S&Q Committee has the responsibility for ensuring that reported incidents are managed and investigated as described within this policy document and will therefore: -

- Receive reports pertaining to reported incidents on a monthly basis
- Receive reports pertaining to serious incidents on a monthly basis
- Will ensure that incidents are reported, managed and investigated appropriately
- Will ensure that lessons learned are implemented within required defined time scales
- Advise the Trust Board with regards the above.

4.5 Serious Incident Group (SIG)

The Serious Incident Group is a sub-group of the Safety and Quality Operational Group and is responsible for assuring that reported serious

incidents are managed, investigated, reviewed and acted upon appropriately and that lessons learned are implemented and monitored.

The group will: -

- Act as the principal source of advice and expertise to the Trust Board on significant incidents.
- Provide updates on the status of significant incidents to the Safety and Quality Operational Group as part of the Trust Assurance Framework and Risk Management Strategy.
- Oversee the implementation of actions and dissemination of lessons learned from concise/comprehensive investigations (as per Lessons Learned Policy).

4.6 Service Safety and Quality Groups

The Service Safety and Quality Groups will meet on a monthly basis and will monitor incident trends, investigation and management locally, considering other risk management / safety issues arising, and escalating any areas of concern to the S&Q Committee as required. These groups will ensure there are mechanisms in place for feedback of learning to staff and for monitoring implementation of lessons learned.

4.7 Affected / Involved Staff Member

Immediately on becoming aware of the incident the member of staff will: -

- Complete a report of known facts using the electronic incident reporting function within Ulysses Risk via the Trust intranet.
- If a paper Incident Report Form is used this should be completed using a **dark ink ball point pen;** the completed form must be handed to or faxed immediately to the line manager/person in charge, or, in his/her absence, to the Operational Manager
- Where possible and required, take appropriate action to address the situation that has caused the incident; provide aid to staff, patients, visitors who are the subjects of an incident; act reasonably and appropriately to their level of skill and responsibility; and be mindful of the potential need for protective clothing in undertaking the same
- Summon medical aid if indicated
- Where the incident is a SIRI, or is considered "serious" **the scene of the incident, including equipment and records, should be preserved as much as is practicable**
- Verbally report the incident to the line manager/person in charge or, if not available, the relevant senior manager or operational manager on call out of hours.

4.8 Line Manager

The Line Manager/person in charge (For example: the staff member "in charge" e.g. Home Manager, Ward Manager, Senior Nurse,) immediately on becoming aware of the incident will: -

- On receipt of the electronic or paper Incident Report Form, ensure that all sections are completed and undertake a preliminary grading of the incident and of actual harm to determine the approach to be taken in terms of

immediate action, onward reporting, duty of candour and subsequent investigation.

- Where possible, take appropriate action to address the situation that has caused the incident; provide aid to staff, patients, visitors who are the subjects of an incident; act reasonably and appropriately to their level of skill and responsibility; and be mindful of the potential need for protective clothing in undertaking the same.

- Ensure that the subject of the incident receives appropriate medical attention, reassurance, advice and information, in line with the Trust's Policy on Being Open and that this is documented within Ulysses Risk and the IMR report as appropriate.

- Where appropriate, remove equipment from service and preserve/retain for inspection if relevant; inform the Head of Health, Safety and Security where a medical device-related incident has occurred.

- Sign off completed electronic forms and communicate completed paper Incident Reports, regardless of grade, to the Safety and Quality Department on a **daily basis.**

- Where an incident is deemed to be a **Serious Incident/red graded incident** (as described in Section 3) or where any incidence gives cause for concern or is considered serious, **regardless of grade assigned to the incident**, the Line Manager must inform the senior manager (in hours)/ operational manager on call (out of hours) and the Head of Patient Safety **immediately.**

4.9 Senior Manager (in hours) / Operational Manager On Call (out of hours)
In the event of a reported **Serious Incident** the senior/operational manager must:

- Assess the incident from the brief provided by the line manager
- Escalate in line with local on call rotas to ensure the Associate Director (in hours) and Director on call (out of hours) are informed of the incident
- Confirm that medical attention/support has been provided to those involved if indicated
- Commence a timed incident log in which information received, action taken, advice given etc. should be accurately recorded.
- Attend the site of the incident/service involved (if required)
- Collect witness statements (Appendix 1 and 2) where required
- Ensure that any affected service users/carers are supported and kept informed as appropriate and in line with the Being Open Policy (including Duty of Candour).
- Provide advice and support to staff
- Liaise with Police where required
- Initiate the investigation process if/where required.

4.10 Associate Director (in hours)/Director On Call (out of hours)
In the event of a reported **Serious Incident** the **Associate Director (in hours)/Director On Call (out of hours)** will ensure the following steps are taken: -

- Assess the incident, bearing in mind the requirements of the Trust Business Continuity Plan.
- Ensure the following people have been contacted as soon as practicable if they have not already been contacted ie via internal incident escalation email from Safety and Quality (it is recognised that the time of contact will depend upon the exact nature of the incident and the time of day): -
    - Chief Executive (the Chief Executive will inform the Partnership Trust Chairman as appropriate)
    - Relevant Director of Public Health (in the event of a public health related incident)
    - Director/Director on call with the responsibility for the area/service concerned
    - Director of Finance, Performance and Information (where there are financial implications)
    - Chief Nurse and Director of Operations / Medical Director for serious clinical incidents and for serious information incidents
    - Chief Nurse and Director of Operations for serious information incidents
    - Head of Marketing and Communications
    - Deputy Director of Governance
    - Head of Patient Safety/Head of Health, Safety and Security
    - Operational managers as appropriate
    - Commence a timed incident log in which information received, action taken, advice given etc. should be accurately recorded. Either retain or assign responsibility for the co-ordination and management of the initial situation to the most appropriate director e.g. the director with responsibility for the service area. This decision will depend upon the exact nature of the incident and the time of day.
    - Co-ordinate the management of the incident with the assistance of other Directors and Managers as appropriate.
    - Liaise with the Head of Patient Safety to ensure that the incident is reported to the CCG/LAT via the UNIFY system.
    - Out of hours the Director will:
        - Telephone the on-call executive director for the relevant CCG if the SIRI meets one of the following criteria:
            - Significant risk of media or public interest
            - The Serious Incident is likely to go beyond local capacity/capability to manage and external support may be required.
            - The Serious Incident is likely to impact upon another LAT/NHS organisation/health care provider
            - Never event.

- Verbally inform other key agencies e.g. the Health & Safety Executive if the incident is RIDDOR reportable, the MHRA if a medical device (s) was involved in the incident; the Police or professional regulatory bodies as appropriate.

- Verbally inform the commissioner of the service involved.

- The **Associate Director (in hours)/Director On Call (out of hours)** will :

  - Ensure a Chair is assigned for the Initial Management Review (to be held within 48 hours of knowledge of the incident) (see template on Patient Safety intranet page).
  - Ensure the Investigating Officer is appointed.

4.11 Investigating Officer

In the event of a reported **Serious Incident** an Investigating Officer will be appointed. Where possible, a Supporting Investigating Officer will also be appointed. The Investigating Officer will: -

- Have received relevant Investigating Officer training.
- Where possible attend the IMR.
- Commence the appropriate investigation, following the investigation process outlined in Section 5 of this policy, including the Being Open (including Duty of Candour) requirements.
- Liaise throughout the investigation with the Head of Patient Safety, keeping them abreast of the investigation process and informing them of any potential delay in meeting time scales.
- Where evidence of fraud is identified or suspected details should be provided to the Local Counter Fraud Specialist who will provide advice and guidance on further investigation.

- Produce a detailed written report following the appropriate templates (see Patient Safety page on intranet for templates and guidance).

4.12 Head of Patient Safety

The Head of Patient Safety will:-

- In conjunction with the Head of Health, Safety and Security, ensure that all incidents are reported centrally via the Ulysses Risk System.
- Act as the Trust central point of contact with the coroner's offices.
- Facilitate the production of monthly aggregate data reports (detailing incident trends and emerging themes.
- Advise staff members with regards the incident reporting, investigation and follow up process.
- Facilitate any external reporting requirements.

In the event of a reported **Serious Incident** the Head of Patient Safety will:-

- Ensure that the Ulysses electronic reporting form has been completed correctly and advise the LAT within 48 hours (or next working day) of knowledge of the incident occurring
- Ensure the commissioner of the service receives verbal notification via the SIRI mobile. Ensure there is a system in place for the investigation of the incident which is appropriate to the grade assigned
- Provide a report on the details of the incident, management and progress of the investigation to the Directors, Serious Incident Group, Safety and Quality Committee and the Trust Board as soon as it is feasible to do so
- Ensure a 72 hour update is provided, as required.
- Report on the outcome of any subsequent investigation to both internal and external stakeholders
- Ensure that the incident is reported to other agencies as required; these may include Health and Safety Executive, Medicines and Healthcare Products Regulatory Agency, Area Child Protection Committee
- Liaise with the Trust Health and Safety Manager and Local Security Management Specialist (LSMS) and other staff with key roles in the management of specialist types of incidents (i.e. Safeguarding, Infection Control, Resuscitation, Information Governance) where required
- Liaise with HM Coroner's Office(s) regarding the outcome of Post Mortem and/or Inquest
- Ensure that any medical devices involved in the incident are inspected by the appropriate internal and external agencies
- Provide support to the Investigating Officer during the investigation
- Assist the Investigating Officer in compiling the final report
- Ensure the LAT and Commissioner receives details of outcome of investigation, recommendations, lessons learned and actions taken
- Provide monthly reports on SIRIs to allow performance and trends to be monitored.

4.13 Safety and Quality Department

The Safety & Quality Department ensures that all incident management activity is co-ordinated throughout the Trust, and that a systematic and focused approach is adopted. They provide:-

- Training to staff on how to report and manage incidents.
- Necessary support to the investigating officers, line managers and other staff members involved in SIRIs.
- Reports to Trust Board and the business units on the ongoing risk profile of the Trust, the changing trends in risks, and priorities for action/lessons learned.

- A mechanism to capture incident details and learning via the incident database.

4.14 Head of Health, Safety and Security

The Head of Health and Safety will: -

- In conjunction with the Head of Patient Safety, ensure that all incidents are reported centrally via the Ulysses Risk System.
- Advise staff members with regard to the incident reporting process.
- Be responsible for the maintenance and provision of the incident reporting system.

In the event of a reported **Serious Incident** the Head of Health and Safety will:-

- Liaise with other Health and Safety personnel as appropriate
- Ensure that the incident is/has been reported to other agencies as required; these may include the Health and Safety Executive, Medicines and Healthcare Products Regulatory Agency, National Patient Safety Agency, (NPSA), and as appropriate, Area Child Protection Committee
- Ensure that any medical devices involved in the incident are inspected by the appropriate internal and external agencies
- Provide support to the Director and Investigating Officer during the investigation
- Provide advice to appropriate forums in relation to the SIRI as required.

4.15 Head of Marketing and Communications

In the event of a reported **Serious Incident** the Head of Marketing and Communications will: -

- Act as the main point of contact between the partnership Trust and the media
- Liaise with the Chief Nurse and Director of Operations and ensure that staff, patients, family and any directly involved members of the public are informed of the incident by the most appropriate person and that this takes place before the media is informed.
- Prepare and deliver appropriate briefings for the media in close collaboration with key directors/managers involved.
- Liaise with other agencies (including external) such as the Police, LAT etc in collaboration with the key directors/managers involved.
- Liaise with the partnership Trust solicitors where circumstances indicate this is appropriate.
- Where indicated, establish an emergency control centre in the Communications Office at the partnership Trust headquarters, and:-
  - Arrange for appropriate administrative and specialist staff to take the calls

- Complete a staff rota so that calls may be taken over a period of time if necessary
- Provide appropriate documentation to maintain a record of calls: time received, caller details, purpose of call, advice given and subsequent action taken in response to the call
- Secure IM&T support as required
- Arrange for communication bulletins via Partnership Trust website as appropriate
- Identify administrative staff to handle large mail outs if required and/or additional incoming post
- Refer to procedural arrangements detailed in Appendix 3 of this policy document in the case of incidents involving multiple enquiries.

4.16 All Staff

All staff are responsible for ensuring that they report any incident of which they become aware and for assisting with managing and following up an incident promptly and in line with the Trust approach of fair blame.

5. Process

5.1 Management of Incidents

When an incident occurs, the immediate safety or well-being of the patient, staff member or visitor affected or involved in the incident is paramount. The Line Manager/person in charge or the on-call manager, if out of hours, is responsible for ensuring that appropriate action has been taken to make the area safe.

The Safety and Quality Department ensures that all incident management activity is co-ordinated throughout the Trust, and that a systematic and focused approach is adopted. They provide:-

- Training to staff on how to report and manage incidents.
- Necessary support to the investigating officers, line managers and other staff members involved in SIRIs.
- Reports to Trust Board and the business units on the ongoing risk profile of the Trust, the changing trends in risks, and priorities for action/lessons learned.
- A mechanism to capture incident details and learning via the incident database.

5.2 Reporting Incidents

The reporting of incidents has two key purposes: -

1. To provide a formal record that an incident has occurred.
2. To trigger an investigation with recommendations to managers to prevent reoccurrence and to ensure trust wide learning, thus embedding a fair and just culture across the trust.

Reporting timescales: All clinical and non-clinical incidents, including "near misses", (regardless of grade or severity), must be reported

electronically on Ulysses Risk within 24 hours of discovery. Only facts, not opinions, should be documented.

Stating the facts of an event on an Incident Report does not constitute an admission of liability of any kind on any person and staff reporting or involved in an incident should not be treated unfairly because of this. Nevertheless, completed forms may be requested for legal proceedings and so must be completed **legibly, comprehensively and carefully.** Incomplete Incident Reports will be returned to line managers for completion.

Any member of staff may report an incident and this is usually the person who is aware of all the available facts (e.g. victim, witness,). If a victim is too traumatised to complete the form then someone else should complete on their behalf. Only facts, not opinions, must be documented.

Report submission: Incidents should be submitted where possible via the web based incident reporting system. Where, by exception, a paper form is used completed Incident Reports must be returned to the Safety and Quality Department, Wayside House, Wilsons Lane, Coventry, CV6 6NY **on a daily basis or the next working day**; alternatively Incident Reports can be faxed Fax: 024 7653 6809.

Late reports: There may be instances where an incident does not come to light for a period of time after the event, in which case it should be reported **as soon as it is discovered.** If an incident is reported by phone, due to its serious and urgent nature, **then a follow-up Incident Report is still required and must be completed and submitted as described above.**

Report grading: The Line Manager/person in charge is required to complete the grading section of the Incident Report prior to submission and therefore **has responsibility for grading the incident and the actual harm** based on the information provided. **All incidents must be graded via Ulysses Risk prior to submitting the report.** The risk scores, and associated guidance notes detailing how to assign grading scores and actions to take depending on the grade, can be found in section 5.15.1 of this policy.

Actions/feedback
It is the responsibility of the line manager to provide feedback to staff in that area on actions taken and to be taken in response to incidents reported within that area. In some cases it may be appropriate to arrange feedback via another route (i.e. investigating officer if appointed). The line manager is also responsible for ensuring actions are implemented (or added to the local risk register and appropriately escalated if local implementation is not possible).

Anonymous reporting/raising concerns: It is recognised that some staff may wish to provide a report in strict confidence and in such cases staff may do so by sending their report directly to the Medical Director, Chief Nurse and Director of Operations or a member of the Safety and Quality Team (contact 024 7653 6887). In such cases, staff may wish to familiarise themselves with the Trust Raising Concerns (Freedom to Speak Up / Whistleblowing) Policy and/or contact the Trust Freedom to Speak Up Guardian.

5.3 Reporting Serious Incidents

Refer also to section 4 of this policy (Staff duties).

Where an incident:-

- is graded as serious/red on the Trust Matrix or
- fulfils the SIRI criteria (see 3.2) **regardless of grade assigned**

Then this must be reported immediately to the relevant line manager/person in charge who must then inform the relevant and appropriate Operational Manager, Executive Director, (or Manager /Executive On-call if out of hours), and the Safety & Quality Team (as defined in Section 4.7- 4.9 of this policy).

Staff members who are in doubt as to whether an incident is considered to be an SIRI should seek clarification from their Operational Manager and/or the Head of Patient Safety as soon as possible. It may be appropriate to gather further information, hold an IMR and liaise with commissioners to allow a decision around SIRI reporting to be made.

5.4 Incidents Involving Drugs

Incidents of drug errors, e.g. omissions, errors in recording, wrong dosage (amount and interval), wrong administration, dispensing error etc. should be reported as an incident as detailed within this policy in addition to the reporting requirements detailed within the Trust Medicines Policy. The grading applied will determine how the incident will then be managed.

Adverse drug reactions should be reported in line with the recommendations from the Committee of Safety of Medicines (CSM) using the yellow card system (see current British National Formulary (BNF)) and the Trusts Medicines Policy.

However, when an adverse drug reaction becomes an incident as defined in Section 3.1 e.g. patient suffers harm as a direct result of an adverse drug reaction, then such incidents should also be reported as detailed within this policy document.

If a serious incident involves medication, the medication should be quarantined, clearly labelled and stored safely, with details recorded on the Incident Report, in case this is required as evidence in the investigation.

5.5 Incidents Involving Equipment

Any equipment involved in an incident should be withdrawn from use by the line manager / person in charge and must be retained, labelled and kept in a safe place for examination. The exact location of the incident must be identified and the asset number of the equipment must be written on the Incident Report.

5.6 Incidents Involving a Work Related Injury to Staff or the Public

Any incident on a CWPT premises or in the course of undertaking a CWPT work activity, which results in a physical injury to a member of staff or member of the public, must be reported and should be flagged as potentially RIDDOR reportable. If, as a result of the incident, a member of staff is off work for over 7 days (one week) then the Health, Safety and Safety Team must be advised via emailing the incident number, staff name and duration of absence to

HealthandSafety@covwarkpt.nhs.uk. Incident reporting must not be delayed due to staff absence – an incident report must be created within 24 hours of the incident occurring either by a witness or line manager on behalf of the staff member if the incident was unwitnessed.

5.7 Physical and Non-physical Assaults

All assaults on staff / patients, including those which are the result of a clinical cause i.e. dementia or confusion due to the individual's medical problem, must be reported as an incident.

5.8 Security Incidents

Security related incidents resulting in loss or damage to property or assets of the Trust, staff or patients, whether accidental or non-accidental, must be reported via Incident Reports.

5.9 Safeguarding Incidents

The Trust recognises that its patients are more likely to be vulnerable than other population groups and that ensuring safeguarding processes are effective is essential. Staff should also refer to the Trust Safeguarding Children and Adults Policy.

The national framework requires that all incidents involving allegations of abuse are investigated as SIRIs. This may include where there has been a failure to take a complete history, gather information from which to base care plan/treatment, assess mental capacity and/or seek consent to treatment, or fail to share information when to do so would be in the best interest of the client in an effort to prevent further abuse by a third party and/or to follow policy on safer recruitment. See section 3.11 for further details and definitions, in line with the Care Act 2015.

All child protection SIRIs must be managed as Grade 2 SIRIs.
Any incident where a patient makes an allegation of abuse, whether by someone outside the Trust (i.e. carer), another service user or a member of staff must be reported as an incident. Managers reviewing Incident Reports must be alert to safeguarding issues. If an Incident Report raises a safeguarding issue the manager must decide if there is a safeguarding concern. If there is such a concern a safeguarding alert must be raised with the local Safeguarding Team promptly so that this issue can be investigated. A safeguarding concern can come to light at any point of an investigation process and must be dealt with in line with this section and related policies whenever it is identified.

For further information contact the Safeguarding Team at Wayside House.

5.10 Information Governance, Caldicott and Data Protection/Information Incidents

An information incident can be any real or potential breach which may affect the confidentiality of information that is processed by the Trust. The Trust holds large amounts of confidential information about service users and staff. The format can be in hard copy (i.e. patient records, clinic lists), electronic (laptops, emails) or both. An information incident can vary between:

- “personal data” and “sensitive personal data” (as defined by current Data Protection legislation) left unattended on a desk in an open plan office
- “stolen laptop” containing personal data and sensitive personal data about service users
- “unauthorised” access by members of the public into an area where confidential information is stored
- “passwords” and “login” written down and stuck on the back of the screen and an unauthorised person has gained access to your account.
- “bcc” option is not utilised when sending emails to more than one service user, using their personal email addresses about specific services.

If a member of staff believes that an information incident has occurred they MUST report it to their line manager IMMEDIATELY. The line manager MUST report the incident via the incident reporting system without any delay as the current data protection legislation requires the Trust to report certain information breaches to the Information Commissioner’s Office (ICO) within 72 hours.

When reporting serious incidents, staff must comply with Caldicott, Data Protection and Information Governance requirements. Where incidents relate to Information Governance (IG) issues they MUST be reported within the IG toolkit / successor toolkit, in line with the Health and Social Care Information Centre Guidance Checklist (HSCIC Page 20 of 46).

The Central Log of all Information Incidents will be retained by the Information Governance Team and assessed on a case by case basis and in accordance with the scale and severity factors outlined within the HSCIC guidance. All incidents which reach the threshold for a level 2 IG related serious incidents are reported publicly via the NHS Digital reporting tool and MUST be reported to the ICO within 72 hours. All such incidents will be investigated as serious incidents under this framework. Serious incidents relating to Information Governance have to be reported on the NHS serious incident management system, STEIS or its successor, as well as the Data Security and Protection Toolkit. Organisations must be registered to access the HSCIC IG toolkit / successor toolkit. Login details will be provided when the organisation undertakes the initial IG assessment which is a dual functionality of the toolkit and provides NHS organisations with a means of self-assessing performance against key aspects of information governance. For further information relating to the assessment and reporting process please refer to the HSCIC guidance or updated guidance as appropriate or contact your regional information governance lead.

Organisations must be aware that the information reported to the IG toolkit successor toolkit will be published within the public domain. Consequently, the transfer of STEIS reports to the IG toolkit / successor toolkit is not recommended unless the content has been approved for publication and a separate report is typically required. It is acknowledged that reporting to both Data Security and Protection Toolkit and STEIS represents duplication of reporting, however the IG toolkit / successor toolkit does not currently provide a mechanism for informing relevant commissioners of IG serious incidents and so STEIS reporting is required to ensure that information is shared.

5.11 Absence Without Leave (AWOL)/ Failures to Return from Leave

If a patient absconds from in-patient care without agreement from clinicians (i.e. formally under s17 or informally) or fails to return from a period of agreed leave this constitutes a clinical incident and must be reported as such.

If the patient is detained or liable to be detained under a section of the Mental Health Act and/or where there is a significant risk to the patient and/or others, this must be reported immediately to Safety and Quality Department and an IMR undertaken. A decision will then be made by the operational team and Safety and Quality Department as to whether this will be reported and managed as a SIRI.

The Care Quality Commission (CQC) must also be informed immediately if a detained patient is AWOL from a low, medium or high secure service

Reporting to the CQC will be via Mental Health Act Administrators and the Safety and Quality Department.

Staff dealing with a patient who absconds or fails to return from leave should refer to the appropriate Trust Missing Absent from a Care Setting (JSOP) Policy for operational management of the incident.

5.12 CQC Notifications

The Trust has a legal obligation to report certain categories of information to the CQC. Those categories that relate to abuse, events that stop/may stop services, serious injuries and certain deaths of service users are reported via the incident reporting database upload to the National Reporting and Learning Service (NRLS) managed by NHS England. It is important that staff involved in these incidents in these categories report them promptly as the CQC requires that these incidents are reported “without delay”.

5.13 Pressure Ulcers

If a patient is found to have a pressure ulcer which is graded using Trust approved tools as grade 2, 3 or 4 an Incident Report must be completed, in line with the Trust Pressure Ulcers Grade 3 and 4 - Decision Making Process for Referring Patients into Adult Safeguarding (Coventry) (JSOP).

The report should include details of whether the patient had become open to CWPT services within the last 72 hours and if they have recently been discharged from acute care or transferred in from another area, so it can be established whether the pressure ulcer arose under CWPT care or not.

A grade 2 pressure ulcer will be reviewed using root cause analysis techniques to identify any learning. This is completed via the web based incident reporting systems.

A grade 3 or 4 pressure ulcer must be reported and consideration will be given by the Tissue Viability Team and Safety and Quality Department as to whether this should be investigated as a SIRI, to identify any learning, and safeguarding authorities will be notified where required.

Specialised advice on management of pressure ulcers is available from the Tissue Viability Team and Pressure Ulcer policies and guidelines.

5.14 Incidents Causing Moderate/Severe Actual Harm or Death/Duty of Candour

Incidents where a patient has suffered moderate or severe actual harm or death invoke additional responsibilities around ensuring an open discussion takes place with the patient and/or family and that this is appropriately documented. For full details and timescales see the Being Open Policy (Duty of Candour).

5.15 Incident Investigation Process

5.15.1 Level of Investigation by Grading of Incident

Investigations should be conducted at a level appropriate and proportionate to the incident, claim, complaint or allegation etc. **The Level of Investigation for complaints and claims differs to those of incidents; therefore please refer to the Complaints Policy and Claims Management Policy for details on investigation.**

The level of investigation for incidents are detailed below: -

- The grading applied to the incident is a guide to determining what level of investigation will be required.

- The table below provides a guide to the level of investigation required. Any Line Manager who feels, after review of the Incident Report, **that an incident warrants an investigation, regardless of grading applied** should seek further advice from the Head of Patient Safety.

Risk Grade	Level of Investigation	By Whom
Low	No formal investigation usually needed – carry out local review and note actions taken on Incident Report.	Line Manager
Medium	Local review by a Line Manager – note actions taken on Incident Report. Consider for concise investigation where appropriate (i.e. persistent issue, near miss)	Line Manager

High	Local review by Line Manager with reference to Matron/Service Co-ordinator – note actions taken on Incident Report. If appropriate (i.e. moderate/severe actual harm or death significant care issues or outcome) consider an IMR and commence Level 1/ Investigation (report template on Patient Safety intranet page) within 7 days of incident. Compliance with Being Open Policy (including Duty of Candour) required for appropriate cases. Reports to be signed off via local governance processes within 8 weeks.	Line Manager
Serious	**Initial Management Review** (IMR)/Structured Judgement Review (SJR) to be undertaken within 48 hours of incident using template on Patient Safety intranet page to identify immediate actions and if further investigation is required. In line with the outcome of IMR/SJR proceed to a comprehensive investigation or note no further action. In all cases note learning points identified All SIRIs require root cause analysis comprehensive investigation using template on Patient Safety intranet page unless otherwise agreed with Safety and Quality Department.	IMR – IMR Chair RCA investigation – Assigned Investigating Officer

5.15.2 Initial Management Review (IMR)

An Initial Management Review (IMR) is the initial step in following up any incident which may require a comprehensive investigation, in particular if the duty of candour may apply (ie moderate/severe actual harm or death). An IMR must be held when a serious incident (SIRI) has occurred or for a "high" risk incident. It must be noted that this review will not apportion blame and should not be treated as a staff debrief.

The IMR should be held as soon as possible **but no more than 2 working days** after the incident**.** The Associate Director responsible for the service area involved or Executive Director on call out of hours is responsible for ensuring a Chair is assigned for the IMR (see Section 4 for staff duties and responsibilities).

Detailed guidance notes for conducting IMRs and accompanying templates can be found on the Patient Safety intranet page. All IMRs must be documented using the templates provided.

A verbal update must be provided within 2 working days to the Head of Patient Safety to allow a decision to be made regarding SIRI grade.

Completed IMR report templates and any accompanying documentation must be submitted to the Head of Patient Safety within 7 days of the incident.

The purpose of IMR is to:-

- Ensure due process has been followed.
- Identify any immediate root causes and high risks.
- Instigate immediate actions to minimise these risks.
- Agree a time frame for immediate actions.
- Agree responsibility for implementing immediate actions.
- Identify an Investigating Officer (if not already appointed) and alert the Investigating Officer to potential concerns.
- Identify staff involved (including those who can offer specialist advice ie pharmacy, infection control, clinical specialists) and ensure support has been offered and statements are being obtained – i.e. does a separate debrief need to be arranged?
- Identify any additional evidence that may be required (i.e. medical records, records not contained within the clinical records – i.e. observation sheets, ward audits, rotas, photographs of relevant locations in particular if these may be helpful at subsequent legal proceedings.
- Recommend whether a more detailed root cause analysis investigation is required.
- Recommend whether a potential Serious Incident should be: -
    - Downgraded and closed or
    - Investigated in line with Trust policy.
- If investigation is required, set the scope of the Root Cause Analysis Investigation (i.e. period of time and issues to be covered).
- Identify what communication is required and who will manage it (in particular "Being Open/Duty of Candour" discussions with the service user/family/carers, staff support to meet Duty of Candour requirements i.e. discussion within 10 working days – see Being Open Policy (including Duty of Candour) for further details).
- Ensure any competency issues identified for individual staff members are passed to the relevant line manager to review, together with HR. (liaise with Quality and Safety for specific information required for a Never Event).
- Recommend whether the Partnership Trust's solicitors should be advised of the incident.
- Assess any potential safeguarding issues and make a referral if required.

- Assess the need for other agency involvement e.g. police, GP, Third Sector Agency if the need has not already been recognised and ensure their input is obtained.
- Identify an appropriate person to provide a written statement for the Coroner in the event of an Inquest being held.

5.15.3 Concise Investigations

A level 1 / concise investigation is most commonly used for incidents, complaints, claims or concerns that resulted in minimal or moderate harm to the patient. The Trust has dedicated level 1 templates for the use in investigating inpatient falls and pressure ulcers. In the Trust a level 1 / concise investigation will generally be used for an incident scoring "high" on the matrix. It can also be used for clusters of low/medium incidents or near miss incidents with potential for more serious harm.

The concise investigation includes the essentials of a thorough and credible investigation conducted in the briefest terms and summarised using a standardised structured approach.

Dedicated templates for undertaking level 1 / concise investigations have been developed and can be accessed via the Trust Intranet site or by telephoning the Safety and Quality Department direct (Tel: 02476536887). The template should be utilised by staff at all times when conducting level 1 / concise investigations (see template as a guide to completion) for serious inpatient falls and Pressure ulcers Grade 3 and 4. This will include the development of an action plan, which should be undertaken by the Investigating Officers, with input from relevant operational staff.

For the purposes of complying with the duty of candour, the report should be signed off through local governance purposes within 8 weeks of the incident being notified and a copy provided to the patient/family as appropriate.

Copies of completed templates from concise investigations undertaken must be communicated to the Head of Patient Safety within 28 days of the incident occurring. If the investigation is ongoing at that time then a status update and an anticipated completion date for the completion of the concise investigation must be provided by the Investigating Officer.
A concise investigation may be adequate for an incident which has been reported as a SIRI (i.e. patient fall or Pressure Ulcers), but this should be agreed in advance with Safety and Quality.

5.15.4 Comprehensive Investigation (to include Root Cause Analysis (RCA) methodologies)

A Level 2 / Comprehensive investigation is required for all SIRIs graded at Grade 1 or 2 and (in most instances) for more serious incidents e.g. actual or potential "severe harm" or "death". These investigations are conducted to a high level of detail and will include all elements of a thorough and credible investigation.

Such investigations will normally be undertaken by a multi-disciplinary team and are likely to involve experts/expert opinion/independent advice or specialist investigators.

Level 2 / Comprehensive investigations will be led by staff not involved in the incident, division or service in question, will involve staff experienced in Root Cause Analysis (RCA) techniques and will be overseen by SIG.

Reports should be written using the comprehensive investigation template. This will include the development of an action plan, which should be undertaken by the Investigating Officers, with input from relevant operational staff. **The template and RCA guidance will be supplied to Investigating Officers and can be found on the Trust Intranet site or upon request from the Safety and Quality Department Tel: 024 76 536887 (see Patient Safety Intranet page).**

To comply with external reporting requirements, copies of completed templates from level 2 / comprehensive investigations must be approved by SIG within 60 working days of the incident being reported. If the investigation will not be completed by that date a status update and an anticipated completion date must be provided by the Investigating Officer as soon as the delay is identified.

Once approved the investigation report should be provided to the patient/family within 10 working days to meet duty of candour requirements, as appropriate.

5.15.5 Independent Investigation

An internal comprehensive investigation will generally be required, pending the decision to hold an independent investigation. **An independent investigation** will normally also be utilised in the following situations:-

- Certain SIRIs (including Mental health homicides which meet Department of Health Guidance. www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculard/Dearcolleagueletters/DH_076535)
- Incident, claims, complaints or concerns of high public interest or attracting media attention.
- Where article 2 of the European Convention on Human Rights is, or is likely to be, engaged.

An independent investigation is likely to utilise the methodologies and report template adopted in a Level 2 / comprehensive investigation, but it must be **commissioned and conducted by those independent to the Trust and the decision will be made by the LAT.**

Where an independent investigation is recognised as being required or where there is likelihood that an incident will require an independent investigation, the Responsible Director must refer the matter to the Chief Nurse and Director of Operations and/or the Medical Director immediately who will facilitate the required actions.

5.15.6 SIRI Investigation Timescales

In line with the National Framework, time for completing an SIRI investigation is calculated from the date the CCG/LAT is informed of the incident. The investigation must be completed:-

- Within 60 working days/12 weeks of notification
- Except for an independent investigation which must be completed within 26 weeks/6 months.

An investigation will only be considered to be completed once there has been approval of the report/action plan by SIG (Serious Incident Group). Safety and Quality Department will confirm the date the report is required from Investigation Officers when they are appointed to ensure this performance indicator can be met.

Appendix 6 sets out an overview of the SI process, from the SI Framework 2015.

5.15.7 Statements and Conducting Staff Interviews

Listening to the first-hand accounts from those involved in an incident as soon as possible after it has happened will help the investigation team start to build a picture of what happened and potentially highlight what information will be required.

The optimum time for holding an interview is between 2 and 72 hours after the incident (Milne & Bull, 1999; Vincent et al, 1999; NPSA, 2008b) and therefore the Investigating Officer must establish who they want to interview and make arrangements to do so as soon as possible. For incidents where the timescales and numbers of people involved are limited and there do not appear to be contentious issues (i.e. competency) a table top review format may support wider learning.

Guidance for conducting interviews is detailed within Appendix 5 of this policy and a template for collecting Witness statements where required can be found in Appendix 1 and 2.

5.15.8 Action Plans

It is expected that if recommendations are identified following the review of a SIRI that these will be addressed in an action plan. The action plan will generally be prepared by the Investigating Officer(s) with input from operational staff, to ensure effective action planning and maximum local ownership of the outcomes of the incidents.

Once a report has been signed off by SIG and sent to commissioners, the actions will be monitored by an action tracker, held within Safety and Quality. This will record the status of each action (i.e. in progress, completed etc.) and will be updated on receipt of information from operational areas. This should include the date of completion, work done to achieve the action and copies of any supporting evidence, which will be kept on file within Safety and Quality.

Each operational area will monitor implementation of actions, generally through a business group/ Safety and Quality Forum. Updates will also be monitored at SIG, where action implementation will be a standing agenda item. Any actions which are not being progressed to timescale will be reviewed and escalated to the Safety and Quality Operational Group or other appropriate committee/staff member in line with discussions.

A report will be provided to each meeting of the Safety and Quality Committee which shows actions from SIRIs as reported to the Safety and Quality Committee in previous meetings (generally 4 months/2 meetings before). This report will show the present position of each action. Once actions have been reported as completed to Safety and Quality Committee they will be considered to have been closed off.

All overdue SIRI actions will be reviewed at EPG.

5.15.9 Sharing of Lessons Learned / Good Practice from investigations
Feedback to staff involved in/directly affected by incident: It is essential that information from incident investigations is shared with staff involved in/directly affected by the incident and any action plan.

The responsibility is as per the table below:-

• Low/medium risk incidents	Feedback to be provided by local manager
• High risk incidents • Concise/level 1 investigation • Serious incidents/SIRIs • Comprehensive/level 2 investigation	Feedback via the Investigating Officer/S&Q. This will usually be by circulation of the report and action plan, but for more complex incidents a face to face feedback session with one or more staff may be appropriate

Feedback to staff indirectly affected by an incident: Information pertaining to lessons learned / good practice post investigation will be shared within and across the organisation using a number of media and approaches, depending on content. These will primarily involve:-

- Communication to the relevant committees/groups as described in the duties section of this policy.

- Communications with staff at all levels via:-

    - Team Brief
    - Practice Development Newsletter/Learning Alert
    - Patient Safety Portal
    - Dedicated Educational Sessions.

- Utilising lessons learned / good practice data to influence training provision and business planning.

Reports from level 1 / concise and level 2 / comprehensive investigations should be considered on a regular basis by the business unit affected to ensure lessons learned are disseminated and that actions identified are completed. This process will be overseen by SIG.

Feedback to external stakeholders: As stakeholders' needs vary widely each incident should be considered on its own facts to establish what feedback will be appropriate and advice can be sought from the Head of Patient Safety.

Key external stakeholders who are involved with incidents include the patient/carers/relatives, commissioners, LAT, other healthcare providers (i.e. GPs, acute Trusts), Social Services, third sector agencies, the police, Safeguarding Boards, the Coroner.

A distinction should be made between stakeholders who are involved as part of a separate process and stakeholders who have a specific interest in the incident investigation. The first category includes, for example, police contact as a result of a police investigation where CWPT staff are involved, contact with the coroner as part of his/her enquiries for an inquest, Safeguarding Board reviews. Information given as part of these processes will not constitute feedback from an incident investigation.

The second category will constitute feedback and should consist of:

Patient/carers/relatives – feedback as agreed with the Investigating Officer as part of the investigation process (this will generally be through feeding back outcomes from the investigation) either verbally or in writing and in line with the Being Open Policy (including Duty of Candour) requirements.

Commissioners/LAT – the investigation report will be provided to CWPT's main commissioners and key details of issues identified/actions will be posted on STEIS. Specific arrangements for feeding back to specialist commissioners should be made, generally through contract monitoring meetings. The local health economy receives feedback on relevant incidents via commissioners.

Other healthcare providers/Social Services/third sector agencies – staff from these types of organisations who have assisted in the investigation should receive feedback as agreed with the Investigating Officer.

5.16 Communication and Notification

In the event of a SIRI / Serious Incident or any other incident or circumstance that requires formal notification and communication management e.g. with media, then this will be managed by the Head of Marketing and Communications as described in Section 4.

Some incidents occurring in the Trust or elsewhere in the Health Service, but impacting on the Trust, may require the establishment of 'Hot-line' arrangements to answer multiple enquiries from the public. Appendix 3 details the procedure for establishing such arrangements.

Communication (standard required notification) with LAT and Commissioners will be managed by the Head of Patient Safety as detailed within Section 4.

5.17 Record Keeping

All incident reports received will be entered onto the Ulysses Risk System. Original forms will be filed by the Safety and Quality Department and retained in line with the Trust policy for the retention of records.

Details of the investigation report and action plan for each incident investigated will be held centrally by the Head of Patient Safety who will update Ulysses, local databases etc. ensuring that progress status recorded is accurate and incidents are closed in a timely and appropriate way.

6. Consultation

This policy has been developed in conjunction with Associate Directors of Operations and Service Leads, Safety and Quality staff members, relevant committees e.g. Safety and Quality Committee and Serious Incident Group (SIG). Trust wide consultation via the Intranet has also been undertaken.

7. Implementation

It is the responsibility of managers to ensure that staff are aware of Trust policies and where necessary implement changes to working practice.

8. Training Needs

Training in the application of this policy and the application of the risk matrix will be provided via Trust Induction and local training sessions in line with the Trust Training Needs Analysis.

Investigating Officer training, including more specialist root cause analysis training, will be provided in addition where required (i.e. as identified by KSF/PDP) in line with the Trust Training Needs Analysis.

9. Review

This policy will be reviewed annually by the policy lead.

10. Monitoring Compliance

MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT					
Aspect of compliance or effectiveness being monitored	**Monitoring method**	**Individual department responsible for the monitoring**	**Frequency of the monitoring activity**	**Group / committee which will receive the findings / monitoring report**	**Group / committee / individual responsible for ensuring that the actions are completed**
Duties remain relevant	Review of Policy	Safety and Quality	At least 3 yearly (at each review if earlier)	N/A	N/A
The incident reporting process is being followed:- - All staff are reporting Incidents - Incidents are reported in a timely manner - Incidents are graded - External agencies are reported as appropriate	Incident reporting performance dashboards	Safety and Quality	Monthly	Service Governance Forums / Pertinent sub committees / Safety & Quality Operational Committee	Safety and Quality Operational Group
Different levels of investigation appropriate to the severity of the event(s)	Ulysses Risk Audit (random sample)	Safety and Quality	Annually	Safety and Quality Operational Committee	Safety and Quality Committee
Process for involving and communicating with internal and external stakeholders to share safety lessons	External – Performance Dashboards Internal – SIG minutes re Investigation Reports	Safety and Quality	Monthly Fortnightly	Serious Incident Group	Safety and Quality Operational Group
Process for following up relevant action plans	SIG minutes	Safety and Quality	Fortnightly	Serious Incident Group / Safety and Quality Groups	Safety and Quality Operational Group

11. References

- Milne R and Bull R, (1999). Investigative Interviewing-Psychology and Practice. Wiley, Chichester
- NHS West Midlands, (2008). Good Practice Guidance: 10 steps To Successful RCA Reports
- NPSA, (2010). National Framework for Reporting and Learning from Serious Incidents Requiring Investigation.
- NHS Commissioning Board, Serious Incident Framework, (2013)
- NHS England (formerly NPSA, (2008)). Root Cause Analysis Investigation Tools: Three Levels of RCA Investigation-guidance.
- NHS England (formerly NPSA, (2008b)). Root Cause Analysis Investigation Tools: Investigative Interview Guidance (cognitive type interview): Taking A First-hand Account Of Individuals Involvement In A Patient Safety Incident.
- Vincent c et al, (1999). A protocol for the investigation and analysis of clinical incidents. RSM
- NHS West Midlands in Serious Incidents (SI) Reporting Policy and Procedure (April 2010)
- Connecting For Health, Information Governance Incident Classification

12. Trust Associated Documents

- Pressure Ulcers Grade 3 and 4 - Decision Making Process for Referring Patients into Adult Safeguarding (Coventry) (JSOP)
- Admitting a Young Person to an Adult Ward Policy
- Risk Management Strategy
- Raising Concern (Freedom to Speak – Whistleblowing) Policy
- Complaints Policy
- Being Open Policy (including Duty of Candour)
- Coping with a Stressful Incident/Event Policy (Supporting Staff)
- Medicines Policy
- Mortality Review Policy
- Violence and Aggression RPI Policy (Management via Restrictive Physical Intervention and Positive Behaviour Approaches)
- Retention and Disposal of Records Policy
- Camera Photographic Imagery Policy - Use of Cameras in the Clinical Care Setting

13. Version Control

Version	Date	Author (name and designation)	Status (Draft/Approved)	Comments
V1.0	Dec 2008	Lisa Cummins Asst Director Governance	Draft	Modified previous policy document
V2.0	Dec 2008	Lisa Cummins Asst Director Governance	Draft	Modified post consultation – complaints team
V3.0	Dec 2008	Lisa Cummins Asst Director Governance	Draft	Reviewed and modified in line with NHSLA format
V4.0	Jan 2009	Lisa Cummins Asst Director Governance	Draft	Amended to reflect DH guidance re: admission of young persons
V5.0	Jan 2009	Lisa Cummins Asst Director Governance	Draft	Consultation period
V6.0	Jan 2009	Lisa Cummins Asst Director Governance	Draft	Amendments to contact details
V7.0	Feb 2009	Lisa Cummins Asst Director Governance	Draft	Amendments post SIG consultation
V8.0	Feb 2009	Lisa Cummins Asst Director Governance	Draft	Amendments post consultation
V9.0	Mar 2009	Lisa Cummins Asst Director Governance	Approved	Ratified at S&Q 20th March with final amendments / cross referencing
V10.0	Nov 2010	Ruth Gibson Head of Patient Safety	Draft	Annual Review
V10.1	Nov 2010	Becky Keough NHSLA Co-ordinator	Draft	Format Changes
V10.2	Nov 2010	Lisa Cummins Deputy Director Governance	Draft	Minor amendments
V10.3	Jan 2011	Ruth Gibson Head of Patient Safety	Draft	Minor amendments / Policy Review Group
V10.4	Feb 2011	Ruth Gibson Head of Patient Safety	Approved	Amendments from Policy Review Group

Version	Date	Author (name and designation)	Status (Draft/Approved)	Comments
V10.5	May 2011	Ruth Gibson Head of Patient Safety	Approved	Minor amendment to 5.2.2 to include GP & Third Sector Agency
V10.6	Feb 2012	Ruth Gibson Head of Patient Safety	Approved	Minor amendment to update Never Event definitions and follow up requirements, to clarify investigation of high incidents and to report templates
V10.7	Mar 2012	Ruth Gibson Head of Patient Safety	Approved	Minor amendment to Section 8 on IMR Form (appendix 3).
V10.8	15 June 2012	Ruth Gibson Head of Patient Safety	Approved	Amendment to Appendix 3 – IMR form
V10.9	July 2012	Ruth Gibson Head of Patient Safety	Draft	Amendments following consultation
V10.10	August 2012	Ruth Gibson Head of Patient Safety	Approved	Policy Review Group amendments
V10.11	June 2013	Ruth Gibson Head of Patient Safety	Draft	Amendments to update and to incorporate Duty of Candour requirements
V10.12	October 2013	Ruth Gibson Head of Patient Safety	Draft	Amendments following consultation
V10.13	November 2013	Ruth Gibson Head of Patient Safety	Draft	Amendments following PRG
V10.14	November 2013	Ruth Gibson Head of Patient Safety	Draft	Policy Review Group Amendments
V10.14	January 2014	Ruth Gibson Head of Patient Safety	Approved	Policy Review Group virtual approval
V10.15	March 2014	Ruth Gibson Head of Patient Safety	Approved	Minor amendment to include RIDDOR reporting process (Section 5.6)
V10.16	15/09/2014	Ruth Gibson Head of Patient Safety	Approved	PRG Chair approval to minor amendment (correct naming of policy – supporting staff involved in an incident, complaint or claim policy)

Version	Date	Author (name and designation)	Status (Draft/Approved)	Comments
V10.17	20/01/2015	Ruth Gibson Head of Patient Safety	Approved	Amended IMR Form (appendix 3)
V10.18	31/05/2015	Ruth Gibson Head of Patient Safety	Draft	Amended following updates to national guidance.
V10.19	04/06/2015	Ruth Gibson Head of Patient Safety / Nicola Corbett Head of Registration and Compliance	Draft	Policy Review Group amendments / formatting
V10.20	13/08/2015	Becky Keough, Standards and Compliance Coordinator	Approved	Amendment to Section 5.15.3 and 5.15.4 to remove reference to Level 1 and Level 2. Change review period to annually.
V11.0	13/03/2018	Mandy Jenner Head of Patient Safety	Draft	Changed Policy details Added EPG details Changed NPSA to NHS England Added SJR details Updates made to data protection references.
V11.0	02/05/2018	Nicola Corbett Head of Registration and Compliance	Approved	Following Policy Review Group amendments.

14. Equality Impact Assessment Form

DOCUMENT/ PROJECT NAME: Incident Reporting Policy (Reporting, Managing and Investigating Incidents)(Including Serious Incidents Requiring Investigation (SIRIs))			
		Yes / No	**Comments**
1.	**Does the document affect one group less or more favourably than another on the basis of: -**		
	Race	No	
	Religion or Belief	No	
	Gender reassignment	No	
	Sex	No	
	Sexual Orientation	No	
	Age	No	
	Disability (learning disabilities, physical disability, sensory impairment and mental health problems)	No	
	Marriage and civil partnership	No	
	Pregnancy and maternity	No	
2.	**Is there any evidence that some groups are affected differently?**	**No**	
3.	**If you have identified potential discrimination are there any expectations valid, legal and / or justifiable?**	**N/A**	
4.	**Is the impact of the document / guidance likely to be negative?**	**No**	
5.	**If so, can the impact be avoided?**	**N/A**	
6.	**What alternative is there to achieving the document / guidance without the impact?**	**N/A**	
7.	**Can we reduce the impact by taking different actions?**	**No**	
8.	**Who has consultation taken place with?**	**Safety and Quality Committee, Serious Incident Group (SIG) All Trust wide intranet consultation**	
9.	**EIA Team:** Names and designations of the 3 people who contributed to this assessment	**1. Mandy Jenner, Head of Patient Safety 2. Jagdish Guru, Patient Safety Co-ordinator 3. Nicola Corbett, Head of Registration and Compliance**	
10.	**Head of Equality and Diversity**	**Rano Bains**	
11.	**Date of the Assessment: (dd/mm/yyyy)**	**01/05/2018**	

If you have identified a potential discriminatory impact on this procedural document, please refer it to the author of the policy or strategy, together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please refer to the guidance notes**. If the document affects one group less or more favourably, you MUST complete the full EIA form (i.e. if you have answered 'Yes' to any of the above).** The full EIA form can be obtained from the Equality and Diversity Department/website.

This policy, strategy, procedure or function has to go to the Head of Equality and Diversity for final sign off.

Please return a copy to the Equality and Diversity Department: rano.bains@covwarkpt.nhs.uk

APPENDIX 1 - Preparing a Witness Statement for Complaints / Incidents

When an incident occurs you should prepare a statement of your involvement as soon as possible, while events are still fresh in your mind.

The information contained within your statement will enable the Safety & Quality team to respond to the concerns that have been raised / investigate a reported incident. Any information provided is retained on file and may be disclosed (where required) to other Senior Partnership staff and third parties e.g. Police, Independent Investigation Team etc.

It is important that your statement is an accurate and factual account of your involvement in the complaint / incident. It should be focused on:

- **What you said**
- **What you did**
- **What you saw**
- **What you didn't do and why**

Statements should be factual, accurate, concise, relevant to the questions asked, clear - absent of jargon, and legible.

It is important that you make it clear in the statement when you are relying on information from the patient's records or any other documentary evidence rather than your recollection of events.

Your statement should be a full and complete account of your involvement in the events leading up to and during the incident.

Provide the detailed chronological narrative of your involvement set out in paragraphs. If the statement is to answer a complaint, ensure that it answers all of the issues raised.

Detail each visit to the patient, examinations and treatment performed stating the date and time at which these contacts occurred.

Say precisely what care you gave to the patient including any observations carried out and whether or not these were within normal limits.

If you liaised with other members of staff for advice, or to discuss care state who these persons were and their designation e.g. Dr John Smith (duty SHO).

For further advice and information please contact the Safety and Quality Team on:

Tel: 024 7653 6887
Fax: 024 7653 6809

Appendix 2

STATEMENT SHEET FOR STAFF PROVIDING INFORMATION IN RESPONSE TO A FORMAL COMPLAINT / SUPPORTING INVESTIGATION OF AN INCIDENT

(Please read guidance notes provided)

PATIENT DETAILS

Name of patient:	
Location of complaint / incident:	
Complaint / Incident Ref: (official use)	
Date complaint received / incident reported: (official use)	

Where more than one patient is affected please provide details on a separate sheet

STAFF MEMBER COMPLETING STATEMENT FORM

Full name:		
Designation:		
Department:		
Professional qualifications (list)	**Year obtained**	**PIN/GMC etc. number**
Relevant training/experience		
Statement/Response (continue on a separate sheet if required)		
Signature:	**Date:**	
Name (please print your name clearly):		

APPENDIX 3 – Procedure for Dealing with Multiple Enquiries in the Case of a Serious Incident Requiring Investigation

'Hot-line' Arrangements

- The process will be managed by the Chief Nurse and Director of Operations and Head of Marketing and Communications who will be the "Responsible Directors" for activating the procedure.

- The Responsible Director(s) shall hold a meeting with those to be involved in the 'hot-line' arrangements e.g. Head of Marketing and Communications, Telecommunications Manager, Heads of Service, Hospital Chaplains.

- An appropriate room or rooms shall be designated as the 'incident room'. This maybe in the rooms designated for use in the Major Incident Procedure or alternative arrangements may be put in place depending on the incident e.g. more appropriately sited.

- The Responsible Director(s) will inform the Telecommunications Manager of the requirement for a 'hot-line' as soon as possible after the incident. The Telecommunications Manager will arrange for the necessary and appropriate telecommunication equipment to be installed in the designated incident room(s).

- The Head of Marketing and Communications may give the necessary numbers to the media in order to broadcast them to the public alongside approved material released in press statements.

- The Responsible Director(s) will make an assessment of the likely number of enquiries and will organise a rota of a suitable number of volunteers. The Responsible Director(s) will need to take account of the nature and sensitivity of the calls and decide on any specific skills and knowledge that may be required by those operating the 'hot-line'.

- There must always be one more volunteer available to take calls than the available lines, i.e. one line – two volunteers – this is to ensure appropriate support is available, the necessary breaks can be taken and the volunteer can be replaced if they have dealt with a particularly difficult or distressing call.

- The Responsible Director(s) will decide the appropriate 'hot-line' operating hours according to the nature of the incident e.g. 8.00 a.m. to 8.00 p.m. and the possibility of a recorded answering machine message outside of the designated manned hours.

- The Responsible Director(s) will decide the initial period for the 'hot-line' to be in place, this will normally be a minimum of three days in the first instance.

- The Responsible Director should ensure that daily bulletins are prepared and issued to volunteers and any changes to procedures communicated appropriately. The bulletins will include any relevant media statements that the Trust has issued and also copies/transcripts of any press stories that callers may quote when calling the 'hot-line'.

- Volunteers commencing a new shift should be briefed accordingly by the Responsible Director(s) or colleague before manning the 'help-line'.

Staff Support

- The Responsible Director will ensure that members of staff operating the 'hot-lines' have the availability of a short training programme to cover the following:

    - Preparation of scripts of possible questions and answers
    - Help on dealing with the difficult or distressed caller
    - Details of other help that may be available to callers e.g. counselling services
    - Access to information sources e.g. media statements,
    - Mechanism to seek expert or more senior advice and support
    - Mechanism to refer callers to clinical or technical expert if required.

- 'Hot-line' volunteers should be briefed at regular intervals by the Responsible Director(s), have appropriate supervision, rest periods of 20 minutes at least every 2 hours away from the telephone and time for adequate refreshment. Shift periods should be no more than 7 hours in any 24-hour period.

- The Responsible Director(s) will arrange de-brief sessions with all those involved in the incident for reflection and discussions on the lessons to be learnt from the experience.

- It is the responsibility of the Responsible Director(s) to arrange any subsequent action planning meetings and to ensure staff have access to any additional support they may require.

Other Issues

- Arrangements for postal and Internet enquiries should also considered ensuring consistency with the telephone 'hot-line' arrangements.

Specimen forms to be used to:

Appendix 3A. Record actions in initiating this process,
Appendix 3B. Record calls from patients, their relatives or the public, and;
Appendix 3C. Record media enquiries.

APPENDIX 3A

ACTION CHECKLIST

Action Checklist	Action By Whom	Actioned Initial/Date/Time
Meeting to be called to include all involved as follows: • Telecommunications Manager • Head of Marketing and Communications • Consultants from specialty involved • Service Manager(s) • Senior Nurse(s) • 'Hot-line' volunteers • Hospital Chaplain • Medical Director.	Responsible Director (s)	
Determine room, operating hours and telecommunication requirements.	Responsible Director (s)	
Determine script and process for dealing with enquiries.	Responsible Director(s) Head of Marketing and Communications	
Organise rota of volunteer staff.	Responsible Director(s)	
Brief staff and identify any training requirements.	Responsible Director(s)	
Install relevant equipment and advise responsible director.	Telecommunications Manager	
Prepare daily bulletins to all concerned.	Responsible Director(s) Head of Marketing and Communications	
Arrangements for dealing with media determined and press statements produced.	Responsible Director(s) Head of Marketing and Communications	
Arrange follow-up action planning and de-briefing meeting.	Responsible Director(s)	

APPENDIX 3B –

Form to Record Calls
From Patients, Relatives and / or Members of the Public

'HOT-LINE' Information from Callers

Patient Information

Name ……

Previous name (if changed since last attendance) ……...

Date of Birth ……...

Address ……..

……

……

Previous Address (if changed since last attendance) …….

……...

……

Hospital Number ……..

GP Surgery ……

Contact Number (Home) ……. (Work) ……...

Patient Treatment Information (continue overleaf if necessary)

Seen by ……..

Date of last attendance ……See overleaf

Condition treated ……..

Concerns expressed ……See overleaf

Details of Person Taking the Call

Name ……...

Date/time of call …….

Treatment Information (continued)

Concerns expressed (continued)

Status (please tick)

☐ No further action required

☐ Referred to relevant clinician

☐ Referred to Responsible Director

☐ Hoax/malicious call

Other:……

Response provided to caller/patient

Specified Action Taken

_____

APPENDIX 3C

FORM TO RECORD CALLS FROM THE MEDIA

NATIONAL/LOCAL MEDIA ENQUIRIES

Date:	
Time:	
Journalist:	
Organisation:	
Telephone:	
Facsimile:	
Deadline:	
Taken by:	

Issues raised:

Enquiry comment sought from:

APPENDIX 4 – Examples of Contributory Factors to SIRIs

CONTRIBUTORY FACTOR	EXAMPLES
Patient factors	▪ Pre-existing core-morbidity ▪ Complexity/seriousness of condition ▪ Trauma ▪ Existing mental disorder ▪ Interpersonal relationships with staff, family, patients
Task	▪ Guidelines/procedure/policies: up-to-date, available, understandable, relevant ▪ Access to senior/specialist advice ▪ Complete information available
Communication	▪ Ambiguous information ▪ Style of delivery ▪ Relevant people informed ▪ Written information: legible and comprehensive ▪ Body language
Team/social	▪ Roles defined and understood ▪ Effective leadership ▪ Support networks for staff ▪ Team openness ▪ Perception of team (Uni or multi-professional)
Equipment	▪ In good working order and well maintained ▪ Correctly placed and stored ▪ Clear controls ▪ Legible displays
Educations / Training	▪ Adequate knowledge/skills/experience ▪ Adequate supervision/mentorship ▪ Availability, accessibility and appropriateness of training
Working environment	▪ Efficiency of administrative system ▪ Availability of medical records ▪ System for ordering drugs ▪ Office/area design ▪ Cleanliness/temperature/lighting/noise ▪ Staff skill mix, staff: patient ratio, retention/turnover
Strategic management	▪ Hierarchical or other structure ▪ Accountabilities ▪ Financial balance focused versus quality ▪ Local/agency policy ▪ Loaned equipment, forward ▪ Culture: thinking/developmental/experimental culture
Individual Staff	▪ General health, fatigue, stress, specific mental health illness ▪ Impairment (illness/drugs/alcohol/pain) ▪ Motivation, cognitive factors ▪ Domestic/lifestyle problems ▪ Confidence ▪ Risk taker/averse

Appendix 5

Investigative Interview Guidance (cognitive type interview): Taking a First-Hand Account Of Individuals' Involvement In A Patient Safety Incident

An investigative interview is designed to help interviewees retrieve from memory the events associated with a patient safety incident.

A cognitive interview is an interviewing technique based on psychological theory and research for examining the retrieval of information from memory.[1]

The interview style recommended for Root Cause Analysis (RCA) investigations is a modified approach of the formal cognitive interview. It involves actively listening to someone who recalls their first-hand account of an event they have either witnessed, or been involved in, as soon after it has happened as possible.

Preparation

Listening to the first-hand accounts from those involved in an incident as soon as possible after it has happened will help the investigation team start to build a picture of what happened and potentially highlight what other information will be required. The optimum time for holding an interview is between two[1] and 72 hours after the incident.[2]

The interviewer needs to establish who they want to interview and make arrangements to do so as soon as possible. The identified staff should be invited to attend; told the purpose of the interview; what to expect; and what preparation they need to do. It is essential that the interviewer and the room are prepared prior to the interview.

Inviting the member of staff to attend for an interview

Where appropriate, a written invitation to the interview can be provided and the details below included. Where this is not practical due to the need to see staff as soon as possible after the incident, staff should be advised in advance and be given the following information verbally:

- The purpose of the interview and details of the incident being investigated;
- The time, place and estimated length of the interview;
- Who will be conducting the interview and their role;
- How the cognitive interview will be conducted and the first-hand account recorded (e.g. the interview will be informal, notes will be taken to inform the investigation, but these will not act as a formal witness statement and do not need the interviewee's signature);
- What documentary evidence will be available to them during the interview;
- The fact that they can bring a friend or colleague for support (explanations need to be given regarding the role of this friend/colleague e.g. confidentiality, their involvement);
- Advice on what will happen after the interview.

Interviewer preparation

- The interview should take place in a quiet, relaxed setting and, if possible, away from the interviewee's usual place of work and not at the scene of the incident.
- The room should be set out informally with refreshments available and steps taken to ensure, where possible, no interruptions occur (e.g. telephones, bleeps).

- Where possible, the interviewee should have the opportunity to attend the interview in work time and arrangements may need to be made with their line manager to ensure this.
- Depending on the nature of the case or the interviewee's personal involvement, they may find the process of recounting the events either upsetting or disturbing. The interviewer will need to have information available on staff support/counselling.
- The interviewer should ensure they have all the relevant documentation available at the interview.
- It is important to remember in the cognitive interview to only interview one staff member at once.

Conducting the interview
Introductions (where appropriate) should be made of those present in the room. Include details on roles and an explanation of the sequence of the interview and approximate length. The RCA process should be explained and an estimate given of how long it will take to complete.

It is important to reinforce that this is not part of a disciplinary process. The interviewer should explain that notes will be taken throughout, for the purpose of informing the investigation. It must be stressed that these notes will not act as a formal witness statement and therefore do not need the interviewee's signature.

If, following the interview, the interviewer feels that the individual staff member should write a formal statement, guidance and support should be given by a union representative or trust solicitor as applicable.

The interviewee should be asked to confirm they have understood all of the above and should be reminded that they should offer only factual information, but include everything regardless of whether they think it is relevant or not. The interviewee should be discouraged from making 'off the record comments'. The interviewee should also be advised that the first-hand account and the final report will be written with due anonymity to staff and the patient.

NPSA cognitive interviewing process
For detailed guidance on the NPSA cognitive interviewing process, go to:
www.msnpsa.nhs.uk/rcatoolkit/resources/word_docs/Guidance/Guidance_Undertaking_an_Investigative_Interview.doc

Completion of the interview
On completion, the interviewer should ensure the interviewee feels appropriately supported and that any further support required is organised. The interviewer should reconfirm what will happen with the information gained from the interview and how this will be used in the RCA process.

[1] The cognitive interview is based on work undertaken by two American cognitive psychologists, Ed Geiselman and Ron Fisher. For more information: R Milne, R Bull (1999), Investigative Interviewing – Psychology and Practice. Wiley, Chichester

[2] Vincent C et al (1999). A Protocol for the Investigation and Analysis of Clinical Incidents. RSM
Ref: www.npsa.nhs.uk/nrls Root Cause Analysis Investigation Tool.

Appendix 6 SI Framework - Overview of Process