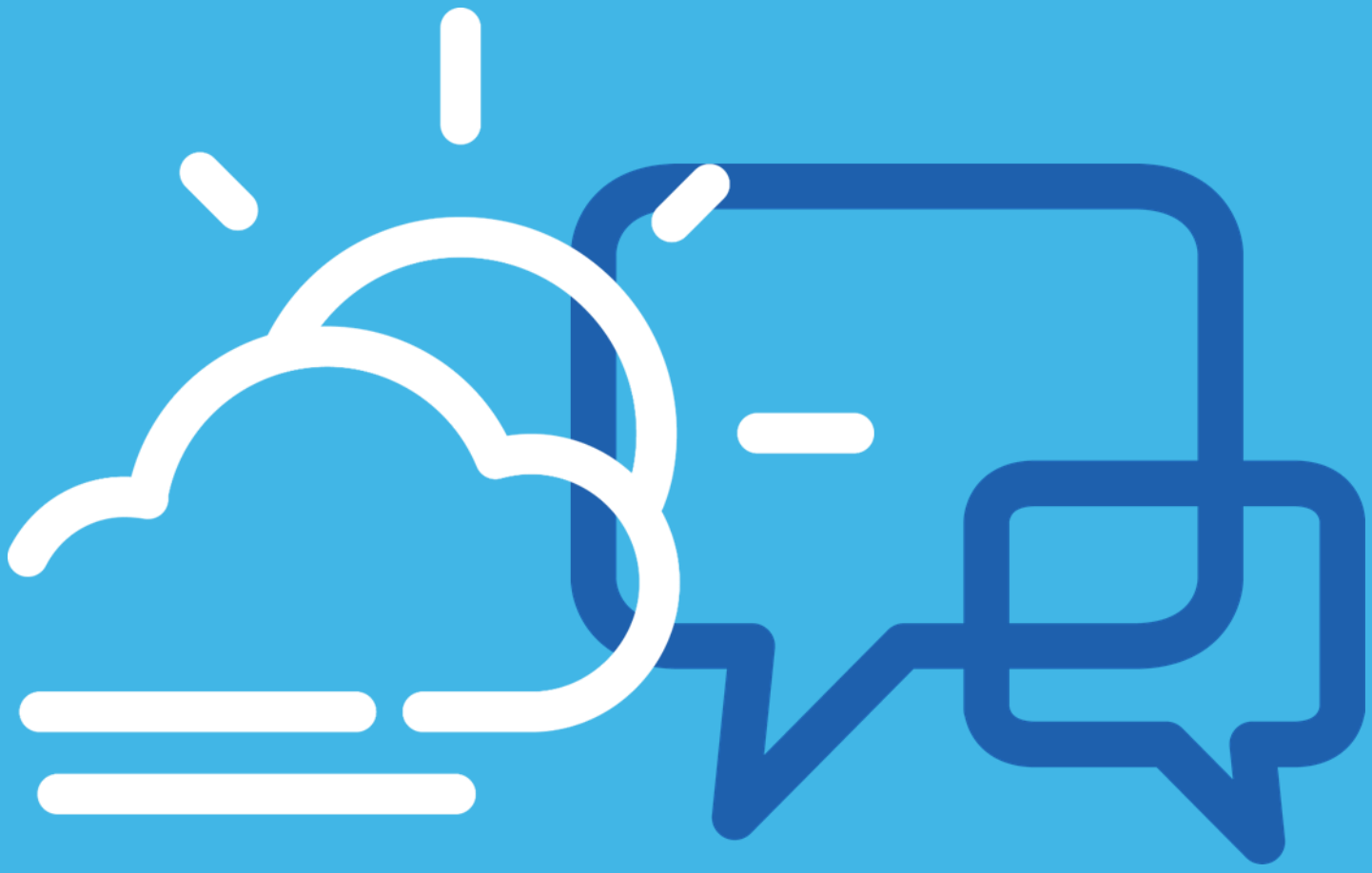
NHS
Greater Manchester Mental Health
NHS Foundation Trust

Incident, Accident and Near Miss Policy and Procedure

Greater Manchester Mental Health NHS Foundation Trust



Improving Lives

Document Name:	**Incident, Accident and Near Miss Policy and Procedure**
Executive Summary:	The purpose of this policy is to provide a framework for all Trust employees to ensure uniformity in reporting and investigating incidents, accidents and near misses and lessons are learned from these incidents in order to minimise the likelihood of such events occurring in the future.
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1. Introduction

'Serious Incidents within health care are rare but when they do occur everyone must ensure that there are systematic measures in place to respond to them. These measures must protect patients and staff and ensure robust investigations are carried out so that organisations learn from serious incidents to minimise risk of the incident happening again' Serious Incident Framework 2015 NHS Commissioning Board.

This policy covers the reporting, management and reviewing of incidents, accidents and near misses and explains the responsibilities and actions of staff when dealing with serious incidents. The policy highlights the importance of all staff in reporting any patient, staff or visitor safety incident in order that safety issues are identified and that investigation procedures are initiated in a timely manner. The Trust accepts that human errors occur and therefore does not seek to place unfair blame on individuals. The policy therefore explains the methodology and tools adopted by the Trust when investigating incidents, which focus on improving the systems and process that all staff work with, in order to reduce the likelihood of human error.

The policy has also been revised in accordance with Regulation 20, Duty of Candour within the CQC guidance for NHS bodies (2014) and Health and Social Care Act (2008) informing patients and or their carer where a patient safety incident resulting in Harm has occurred as a result of the care provided by the healthcare provider.

2. Definitions

Incident/accident: An event or circumstance that could have resulted or did result in unnecessary damage, loss or injury such as physical or mental injury to an individual.

Near Miss: An unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Only a fortunate break in the chain of events i.e. through staff vigilance which prevented an injury, fatality or damage; it is important that all near miss incidents are reported and thoroughly investigated where appropriate.

Patient safety Incident: An unintended or unexpected incident that could have or did result in harm to a patient receiving NHS funded care.

UNEXPECTED death- The death of a patient under the care of community or inpatient services, where the death was not expected and/or the patient was not subject to an end of life care plan.

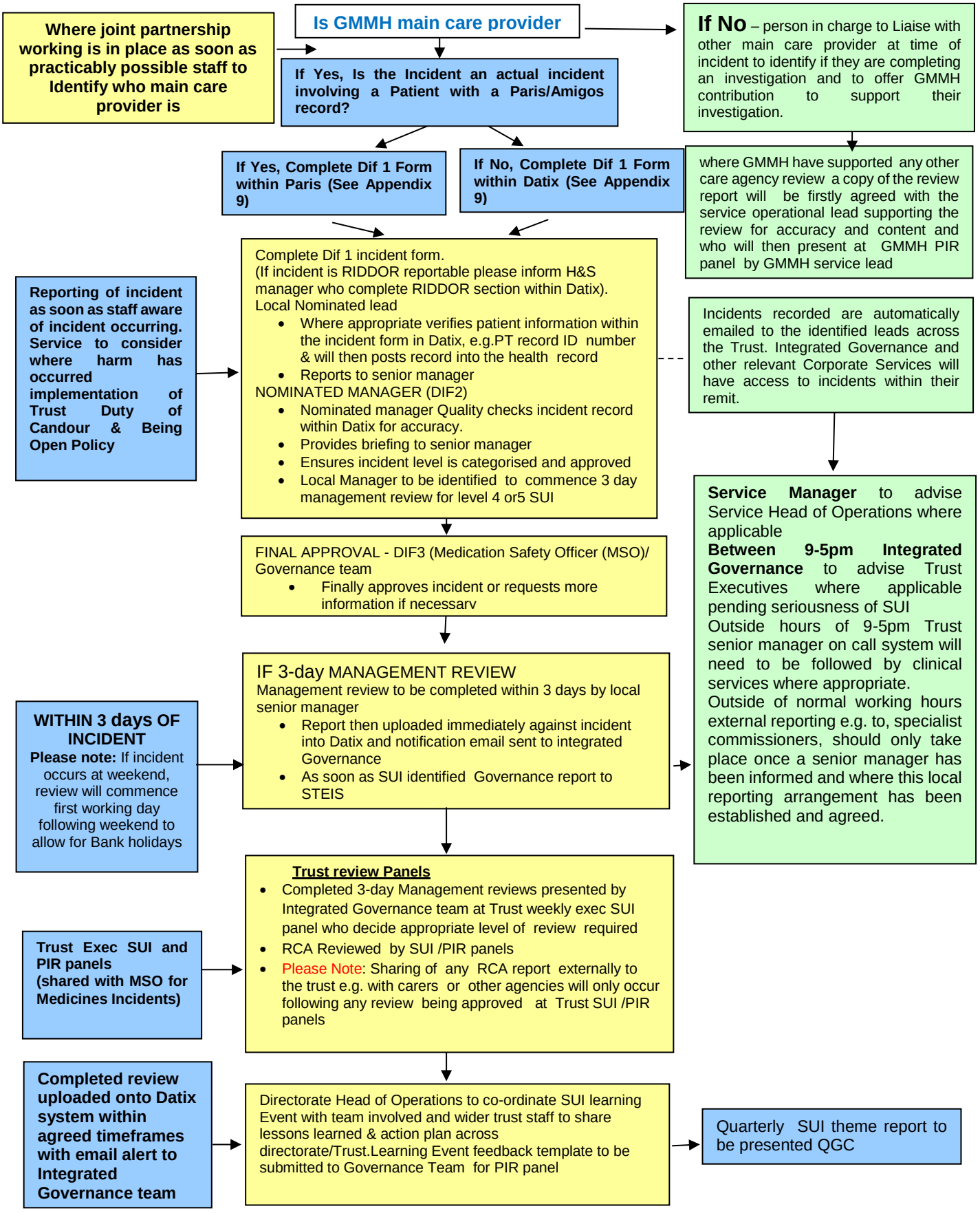
EXPECTED death- The death of a patient under the care of community or inpatient services, where there is an agreed end of life care plan in place.

Duty of Candour: Health care providers must be open and honest with patients if things go wrong during care and treatment. If a patient under your care has suffered harm or distress, you should: put matters right (if that is possible) offer an apology explain fully and promptly what has happened and the likely short-term and long-term effects

Incidents resulting in Moderate/Significant Harm: An incident that appears to have resulted in moderate harm to an individual where the harm is not deemed to be permanent e.g. a fall resulting in a fracture to a bone.

Incidents resulting Severe Harm or Death: A serious incident that may have resulted in an individual's death or where harm is deemed permanent e.g. affecting an individual's bodily, sensory, motor, physiologic or intellectual functions that is related directly to the incident and not related to any natural course of the an individual's illness or underlying condition.

2.1. Incident Management Flow Diagram



3. Duties

Please see Appendix 4.

4. Reporting and Responding to an Incident

All staff employed by the Trust will be actively encouraged and have a duty to report all incidents, accidents and near misses in a timely manner and as soon as possible after an incident has occurred. The Trust will work to develop a culture and climate where staff feel empowered to report incidents and learn from them without fear that they may be blamed or that the incident will not be taken seriously.

What to do when an incident/accident occurs

- Respond to the incident/accident with a sense of urgency and priority.
- Make an immediate assessment of the situation and take immediate action to minimise impact and secure the safety of any other persons potentially at risk at the scene.
- Ensure that in all cases the welfare of an individual is paramount, and ensuring they receive medical attention as soon as possible must be the first concern of staff. If an individual is injured staff should seek immediate medical treatment or phone for an ambulance.
- Assess an individual's physical condition for injuries such as possible fractures prior to moving the person. (For further information staff should refer to the Trust Falls Policy).
- If in doubt, staff should not move a person and contact an ambulance as soon as possible.
- In the event of a death please refer to the Trust 'In the event of death policy'

Being Open and Honest & Implementing a Duty of Candour

Where a patient safety incident has occurred resulting in moderate harm, significant harm or death to a service user as a result of the care provided by the Trust, staff are expected to demonstrate openness, honesty and candour, with the service user and/or their relevant carer or family as soon as is practicably possible. The service should offer an individual's carer/family the opportunity to meet with a senior member of the team within 10 operational days from staff becoming aware of the incident occurring. Staff should offer the service User/ Carer the opportunity to meet face to face with a local manager so that an honest account of the facts known at that time of the incident that has occurred. Support should be offered and information of what further enquires the trust is making e.g. Incident investigation. The service should then offer an apology and follow up all face to face Being Open meetings in writing and keep a copy of letters sent as a record in Datix against the incident record. Please see the Trust Being Open & Duty of Candour Policy for further information on the stages of the Being Open and Duty of Candour process. (see appendix 26 for quick overview of the stages)

What to do following incidents relating to a possible serious self-harm attempt by a service user where injuries are deemed to be life threatening or warrant emergency transfer to an acute Trust A&E department (e.g. ligature related incidents)

- Maintaining the safety and wellbeing of the service user will be paramount, and immediate life support should be the first concern and action of staff.
- **Communicating with emergency services:** It is important that the nominated person must telephone any emergency service e.g. NWAS or Police regarding any serious incident or sudden unexpected death, are aware of key information about the incident and any persons affected so the relevant emergency service can assess and prioritise their response.

  Possible questions staff may be asked when phoning any emergency service:
- Exact location of incident (staff will need address and postcode to hand)
- What the problem is (what has happened)
- Patients age and gender involved
- Status of Consciousness of individual affected
- Breathing status of the individual affected
- Supplementary questions would then be asked specifically aimed at the condition reported, e.g. is the individual having difficulty in breathing
- Have any observations been taken by staff e.g. pulse, BP if so, what are the results of these if known
- Is the individual fully alert?

Staff action to be taken if there are doubts that any injuries caused to a service user were self-inflicted and where third party involvement cannot be ruled out

- Alert the police immediately.
- Secure the area and potential evidence: The room/location must be preserved as soon as practicably possible by a locally designated manager to support any initial investigation by the police of the incident. This will involve closing, locking or cordoning off a room/area and securing for inspection any equipment, materials or documentation such as health records observations records, particularly paper records which should be secured away until the police arrive. In these circumstances the location would be at the very least photographed and examined by the police to ensure there is no indication of third party involvement. Preserving the location as far as possible by GMMH staff is important and allows for an assessment to be made by the police in order to eliminate a crime scene.

- In cases where the service user's injuries later prove to be fatal, the police will assess the circumstances of the incident to ascertain if there are any suspicious circumstances as to the incident occurring and will prepare a report for the coroner who will decide if a coronial inquest will take place.

- **Documents removed by police or any other investigatory body** – If GMMH staff are asked by the police for a service users medical records/documents (e.g. patients observation sheets, team handover records, staff duty sheets etc.), the senior nurse in charge should ask the police if staff can photo copy any paper records prior to the police removing them from the premises. The senior manager should pull together a written inventory list identifying all the documents taken off the premises by the police or any other investigatory agency e.g. Health and Safety Executive and ask the police/agency to sign the inventory list to show what documents they are removing from the ward as part of their investigation. This inventory may then be asked for at a later date by a coroner and will assist the trust to track what key documents have left the premises.

- **Obtaining witness statements**: It is the responsibility of the senior person in charge following a serious incident to ensure that all staff involved in or witnessing a serious incident complete a Trust statement using the trust statement template (See Appendix 5) as soon as practically possible following the incident ideally before going off duty. This will support any future internal or external Serious Incident Review and also inquest process.

- If a serious incident is suspected or has occurred whilst staff are visiting a service user's home and access into the premises is not possible, the police should be contacted immediately as they have a power of entry.

- Between the hours of 9-5pm staff should inform their immediate line manager that the incident has occurred. Outside normal working hours (between 5pm –9am) all serious incidents should be reported to the local manager (Bronze) on call who will when escalate to the trust Senior Manager (Silver) on call as necessary. The Senior Manager on call will then escalate where appropriate to the executive director (Gold) on call.

- All incidents, Accidents and Near Misses must be reported where possible during the same working shift of the incident being identified. A full and accurate account should be given when recording the incident within the DATIX incident form as this may later be required as evidence by the police or solicitor as part of the claim process or at a coroner's court.

  Following a sudden unexpected in patient death (please also see the Trust's 'In the event of death policy').

- The deceased should not be moved and the police should be informed immediately, the deceased should not be moved until the police have attended and given authorisation to do so (refer to Trust In the event of death policy). **The room/location where the incident occurred must be preserved and secured off as soon as practicably possible** by a nominated member of the team to avoid others entering the area in order to support any initial police investigation into the incident. This will involve closing, locking or cordoning off a room/area and securing for inspection any equipment, materials or documentation involved in the incident, including obtaining of witness statements. This is important as the site could be

designated as a crime scene by the police. Staff should be mindful they will have to remain on duty until the police have agreed it is safe for staff to leave the premises.

- Staff will follow same steps as mentioned previously re pulling together a document inventory list where records are taken by police from the ward.

- As per national guidance, the Integrated Governance Department will report to the relevant commissioners via STEIS, any unexpected inpatient death, and also to the CQC if the patient was detained.

Following an unexpected death in the community (please also see the Trust's 'In the event of death policy'):

- When making a community visit and there is clear evidence that a life is in danger or an unexpected death has occurred, contact the ambulance and police.
- Staff should risk assess the situation/environment to maintain health and safety (i.e. water/electrical hazards)
- If staff are able to enter the area where the service user is situated and suspected there has been an unexpected death as far as practicably possible no one should be allowed to move, touch or otherwise interfere with any article of furniture in a room or at a scene before the arrival of the police. This can be best achieved by closing and locking the door to an area or cordoning the area off.
- If it is necessary (for urgent reasons) for a member of staff to move anything at the scene before the arrival of the police for example to provide medical treatment to an individual – the first person at the scene should note their movements (including moving of persons) and their original position.
- If staff are unable to enter the area where the service user is situated, wait for the emergency services to gain entry and liaise with them.
- When absence of life is declared, inform your line manager/community team colleagues/responsible medical officer.
- Emergency services will need to have your contact details and you may be asked to give a statement which may result in you having to attend an inquest at a later date.
- Liaise with relevant agencies/family/chaplains etc.
- Complete DATIX form and electronic notes.
- On no account should staff talk to the media, the Communications Department are responsible for liaising with the media.

Additional requirement for the Unexpected Death of a Service User Under the Age of 18 (please also see the Trust's 'In the event of death policy').

When a death is 'Sudden and Unexpected' (defined in Chapter 7 of Working Together to Safeguard children) as:

"…the death of a child which was not anticipated as a significant possibility 24hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to death"

A group of key professionals should come together to evaluate the circumstances around that death.

In Greater Manchester there is a 24/7 consultant led on call Rapid Response service which will attend all unexpected deaths along with a Senior Investigating Officer from the Police. They will work closely with the hospital team, primary care and social services to gather as much information as possible surrounding the child's death and their family and their social circumstances. The Rapid Response role is:

- To help work out the cause of death, and identify any risk factors pertaining to that death
- To explicitly consider safeguarding issues for surviving siblings, or other associated children
- To signpost to appropriate help and support for family/friends where necessary
- To gather information for Child Death Overview Process

Communicating an unexpected death to the family/Carer, bereaved families and support;

- Following a serious incident such as an unexpected inpatient death, services should liaise with the police attending the ward of when and how staff should communicate with the service user's family and carers so this can be safely and sensitively managed. This should ideally be a senior member of the clinical team who may then accompany the police to break the bad news to the deceased's family at the family home.

- See appendix 6 link to Carers Leaflet for staff to share with Carers or Family members following an unexpected death which contains information on where to obtain advice, information and support in dealing with the processes that follow an unexpected death

- (See Trust policies 'In the event of death' and also Being Open policy for guidance)

  Following serious incidents such as a death of a service user the Trust is keen to demonstrate honesty and transparency by involving carers in the Trust SUI review process. Following a Trust investigation where harm has occurred to a service user as a result of the care provided by the trust, As part of the Being Open process the Trust will Engage with carers for them to contribute to the review/investigation process share a copy of any comprehensive investigation report with the identified carers.
  The Trust are currently developing a Bereavement support role for the trust who will support families following a death

- **Deaths of service users detained under the Mental health Act**
  The Trust will review all deaths of service users who die whilst detained under the Mental Health Act. We will complete a 3 day review and then the SUI Panel will

consider any care delivery problems/service delivery problems before agreeing if a Comprehensive Serious Incident Review (SIR) is required.

- **Deaths in custody**
  GMMH will complete a 3 day review for any death of a service user in prison then the SUI Panel will consider any care delivery problems/service delivery problems before agreeing if a Comprehensive Serious Incident Review (SIR) is required. GMMH will support all prison and probation ombudsman investigations following the service users death in prison.

- **Deaths of a service user with a learning disability (LD) diagnosis**
  Once the Incident has been reported via the Datix system (within policy timeframe) the reporting service is to complete the LeDeR notification form that will be sent to them by the incident team (See appendix 7). Once this has been completed, service to email this to the incident team (incidents@gmmh.nhs.uk) within 5 working days for any deaths (unexpected/expected) of a service user with a diagnosed or suspected learning disability. This will then be reported to the LeDeR programme by the Incident Team.

  The incident team will then liaise with the LeDer team at Bristol University to obtain notification reference number, which the incident team will then upload to Datix and inform the service.

  See appendix 8 for process flow chart

  Please note: As this is a new national programme this process may be subject to change as and when required.

4.1. Reporting an Incident via the Web Based Datix Reporting System

- Datix is a web based risk management system that can be accessed by any Trust computer via the Trust home page. All staff can access training through the Trust learning team either by accessing the hub or by telephone.
- Please see roles and responsibilities around staff Datix roles in (Appendix 9).
- The key organisational responsibilities for incident management lie with the organisation in which the incident took place.
- Staff should where reasonably possible report an incident on the same day the incident occurred or when they were made aware of the incident.
- A comprehensive and factual account of the incident and the actions taken must be entered into the Datix incident form. Staff should ensure correct details are recorded such as the patient's electronic healthcare record number, date of birth etc. (see below for contingency plans if intranet system not accessible).
- The Datix Dif1 form can be accessed within the Paris system, this Paris form should be used for incidents that involve a patient that has a Paris record. The following are incidents that are NOT recorded on Paris, instead requiring reporting on the Datix Dif 1 form (See Appendix 10 for more information and guidance).
    - Information Governance Incidents
    - All "Near Miss" Incidents

  - All Prescribing and Dispensing errors that were intervened before administration to the patient
  - Highly Sensitive Incidents (HSI) allegations of staff abuse
  - Informed of former Patient Death 3 months or more following discharge
- For all incidents that involve a service user that does not have a PARIS record e.g. prison services, and service users with only an Amigos record are to report the incident thought the Datix Dif1 form available via the Trust home page.

- Each service has identified a designated Manager who is responsible for quality checking the details within the Datix incident form and amending as required. The designated Manager will then have responsibility for grading the incident level within the Datix system and confirming what level of review is required.

- The MSO reviews all medicines related incidents and acts as a DIF3, finally approving the incidents to send to the National Reporting and Learning Service (NRLS). This process is further supported by the role of the Lead Nurse for Medicines Management, who provides advice and guidance to the directorate where required

Please see appendix 11 for further examples of serious incident reporting criteria

4.2. Identification of the Incident Level and Degree of Harm

When an incident occurs and is reported it needs to be categorised within DATIX with the appropriate incident level. See appendix 12 indicating the severity of the incident and the level of harm caused. This approach is used for consistency across all:

Trust Risk Management Modules e.g. Incidents and Trust Risk Registers. The incident level is determined by designated DIF 2 managers within each service as previously mentioned.

This is confirmed or amended by the DIF3.

Once finally approved by the DIF3 any changes can only be implemented by the governance team.

The degree of harm suffered by an individual following an incident is also required to be captured by staff.

PLEASE NOTE: Contingency plans in the event of the Intranet not being accessible for Datix reporting for more than 24 hours.

In the event of an incident occurring and Datix Web being out of action for 24hrs due to technical issues, all staff will need to revert to completing the paper version of the “Incident and near miss reporting form” this template requires completing within same working shift of the incident occurring and emailing, password protected, to the incidents@gmmh.nhs.uk . Please also report any difficulties to IM&T.

Staff are required to save a paper version of the Incident and Near Miss Reporting Form in the event of the Trust IT systems not being accessible (as mentioned above) and submitted through the Datix system once access is reinstated. (See appendix 13)

In the event of Datix being out of action as above all staff need to ensure an account of the incident and the actions taken is recorded in the patient's health record.

4.3. Safeguarding Concerns

For Multi-Agency Procedures for Safeguarding Children and Vulnerable Adults (Please refer to Trust Safeguarding Policies).

In the event of a safeguarding event, staff are required to link in with their local safeguarding lead and to follow the Trust safeguarding policies and procedures and complete the relevant Safeguarding section in Datix describing what action has been taken.. Staff are required to notify safeguarding leads

GMMH staff should work effectively with the safeguarding teams whilst a safeguarding investigation is taking place in order to secure the safety of individual patient and assess any risks still posed by the perpetrator. It is important for GMMH staff to liaise with safeguarding teams before conducting any internal review so as to avoid conflicting with any other investigatory process.

4.4. Reporting to External Agencies

The Trust recognises that for certain types of incidents there will be a need to involve external bodies in the investigation process, such as the Police, HSE, local authority safeguarding teams, Fire Services, NHS counter Fraud, Security Management Services, Clinical Commissioning group, Information Commissioners Office, The Medicines and Health Products Regulatory Agency, Channel, etc. is an immediate and statutory duty.

Reporting Incidents via the National Reporting and Learning System (NRLS)
Via the Trust incident risk management system (Datix) the Integrated Governance Team will inform the National Reporting and Learning System (NRLS) weekly of specific patient related incidents.

Reporting RIDDOR incidents to the Health and Safety Executive (HSE)
GMMH Risk and Safety Manager, on notification of RIDDOR incidents, will process the relevant reports to HSE. Services **should not** report RIDDOR incidents direct to HSE.

Reporting Controlled Drug incidents
The MSO alerts the Controlled Drug Accountable Officer (CDAO) of all CD incidents, which the CDAO reports to the Local Intelligence Network (LIN).

4.5. Reporting to the Care Quality Commission (CQC):

There is a requirement under the Mental Health Act monitoring functions for NHS Trusts to report specific serious incidents to the CQC. Reporting to the CQC should be undertaken within the agreed timescales. Please see Appendix 14 for more information.

For further information go to the CQC Website; http://www.cqc.or.uk

NHS bodies to notify the CQC following:

- The death of people detained under the Mental Health Act.
- The unauthorised absence of people detained under the Mental Health Act in a hospital designated as low or medium security.
- A service user who is under 18 years of age admitted to an adult psychiatric ward

The notifications of above must be submitted using the standard CQC form which is incorporated into the Datix system. Once the CQC form has been completed within Datix. Staff should notify Clinical Governance who will submit the completed form to the CQC on behalf of the service.

Timeframes for submitting to the CQC for the above see appendix 14

4.6. Reporting Information Governance incidents

The Trust is expected to inform the Department of Health for Information Governance incidents as follows:

1. The Information Governance Manager will be responsible for informing the DoH and Information commission officer of the following:

    - Details of the incident and how the information was stored: paper, memory stick, disc or laptop etc.
    - Details of any safeguards such as encryption that would mitigate the risk.
    - Details of the number of individuals whose information is at risk.
    - Details of the type of information demographic, clinical or bank details etc.

4.7. Investigation Process and Timeframes Following an Incident

The purpose of any investigation is to understand exactly what happened, how it happened, why it happened and to explore in detail any care or service delivery problems and to learn lessons to prevent re-occurrence. When investigating a serious incident the Trust adheres to the 'NHS England 'Serious Incident Framework (2015). The key principles of any incident investigation are openness, honesty and transparency. The Root Cause Analysis (RCA) approach is the NHS preferred methodology for the investigation of all serious incidents. RCA is system-focused and is geared towards exploring the human factors, contributory and causal factors that may underpin service and care delivery problems. (See Appendix 15).

In order to support the above incident management process the Trust has established a weekly senior level Serious Untoward Incident panel. This panel review completed 3-day Review reports following serious incidents, to determine the level of investigation/review and review team required. The monthly Trust Post Incident Review Panel (PIR) review completed RCA investigations/reports and action plans. For more information about the role and membership of these panels, see Appendix 16 & 17.

Please Note:, ***Where a service user was no longer under care of the Trust. i.e. service user had been discharged from the care of the trust for more than 3 months prior to death.*** Depending on the specific circumstances of the SUI services may be asked to complete a 3DR for the SUI panel.

External agencies such as the safeguarding teams, police, counter fraud, security management services, or Health and Safety Executive can investigate incidents that have occurred within the Trust. The Trust will work closely with these agencies in assisting with any investigation. Trust staff should liaise with the external investigation team prior to commencing any internal investigation e.g. internal review so as to avoid conflicting with any other investigatory process.

Please note: It is a Trust expectation that all members of Trust staff are to participate in any aspect of the Trust investigation process as requested.

Types of Incident Investigation/Review

- Individual Staff Review (ISR), locally managed and usually implemented for lower level incidents where no harm has occurred but where individual learning of a member of staff is required.
- 3 Day Review, including cluster reviews, (initial fact finding process by local manager)
- Concise Serious Incident Review. (SI 1, previously known as RCA 1) following incidents where No harm or Low harm occurs at the discretion of the SUI Panel and/or commissioning bodies.
- Comprehensive Serious Incident Review (SI 2, previously known as RCA 2) following serious incidents e.g. Serious Harm, Care/Service Delivery Concerns, Death, Where the 3 day review has indicated learning for the Trust and as deeper investigation is required to capture and address this.
- Independent investigation commissioned by NHS England.

Each process and the actions staff need to take are described below.

4.8. Individual Staff Review (ISR)

An Individual Staff Review is a service locally managed review between an individual member of staff and their line manager. This should take place following the occurrence of a lower level incident where no harm has occurred usually as a result of an individual member of staffs actions or omission e.g. following a low level medication error where no harm has occurred but where individual lessons need to be learned. The ISR is a face to face meeting between the member of staff member and their line manager. The ISR should be completed as soon as practically possible following the incident being identified. The ISR will explore reasons for incident e.g. any contributing factors and lessons learned by the member of staff and any managerial actions required. Following meeting with the individual staff the line manager must record the purpose, outcome and agreed actions from the meeting and retain a written record to save in the staffs local personnel file with a copy being shared with the member of staff. This will assist managers in the monitoring of

an individual staff practice and may highlight staff training or supervision needs. Any lessons learned can then be shared within the team where relevant.
(See Appendix 18 for example ISR template).

4.9. 3-Day Management Review (3DR)

A 3-day Management Review which is the initial fact finding process completed by a local manager following incidents that are graded 4 and 5 within the Trust incident guidance (please note depending on the incident scenario services may be asked to complete a 3DR for lower level incidents where more information may be required by the executive team, Governance & Nursing Team or Trust MSO). The 3 day review will identify the chronology of events leading up to the incident occurring and will identify if there have been any care or service delivery problems identified requiring immediate action taken by the service to maintain staff and patient safety. Witness accounts (statement) from those involved in or witnessing the incident should be sought ASAP where possible as part of the 3-day management review process. Once completed the 3 day review report will be uploaded into DATIX and Integrated Governance incident management team informed. The report will then be presented by a senior member of the Clinical Governance team to the Trust weekly executive Serious Untoward Incident Panel. This group will then consider if a further investigation is required by the Trust. (See Appendix 19 for 3DR template). All reviews (including Concise Serious Incident Reviews and Comprehensive Serious Incident Reviews) will be shared with a multidisciplinary panel including the MSO, governance, senior nursing and medical staff.

Timeframe: 3 day review to be completed within three working days of the incident

Please note: If an incident occurs on a Friday evening after 5pm to allow mangers time to review circumstances leading up to the incident the 3-day management review may commence on the first working day after the weekend and to also take into account Bank holidays.

PLEASE NOTE: Services to notify Clinical Governance Team at the earliest opportunity from the service being made aware of the incident in the event of potential homicide, a sudden unexpected inpatient death, escape of a service user from a medium secure services or any incident which attracts significant media attention is likely to become high profile and/or is likely to be of public concern
A service may be asked to complete the 3DR more quickly or the earliest possibility as requested either by one of the executive team or clinical Governance team who will also liaise with the Trust Communications team this will assist the trust in completing any press release and communications with our commissioners and regulators.

4.10. Concise Serious Incident Review (SI 1, previously known as RCA 1)

(See appendix 20 for template)

This form of review is a concise review using root cause analysis methodology. This review may be indicated for incidents where no harm or low harm has occurred and where harm is not deemed to be permanent or where a cluster of similar incidents has occurred and more detailed analysis of the incident is required than that provided in the 3-day review. This type

of review will be confirmed after consideration by the weekly Trust Serious Untoward Incident review panel.

The Concise SIR 1 will be completed by a nominated Manager within the service and will involve the further gathering of information regarding the events leading up to the incident, including a review of care delivery and all relevant documents e.g. Care plan, risk management plan, handover records observation records etc.

A Concise review is the opportunity for the local Multi-Disciplinary team (MDT) to explore the events leading up to the incident and identifies any potential lessons to be learned within the team or for the service. The manager completing the review must make every attempt to gather facts from as many key professionals involved in an individual's care. The service will then be able to demonstrate lessons that have been learned.

The Concise Review and action plan must be completed within the agreed timeframes and submitted via Datix to the Trust incident team within 40 working days in order for the Trust to achieve the national timeframes to be submitted to our clinical commissioning group. The completed report should then be attached as a document within the Datix system and a confirmation email then sent to the Clinical Governance incident team. The review will then be presented to the weekly Executive SUI panel.

Examples of types of incident that is likely to result in Concise review as per the National SUI framework

- A Near Miss incident where through the actions or vigilance of staff prevented an incident occurring or an Individual becoming harmed where a team can learn lessons in order to prevent a serious incident occurring in the future.
- Hospital acquired infection outbreak.
- In-patient self-harm or cluster of self-harm incidents resulting in minor harm that may require local first aid by the team but not deemed serious enough to warrant transfer to A&E or for emergency treatment
- Level 2 Data loss and information security breaches.
- Cluster of AWOLs of detained patients who leaves a particular ward without permission of staff but where no harm occurs to any individual.
- Near Misses or Clusters of medication incidents on a ward/service where no harm has occurred to a service user but where systems/practices need to be reviewed.
- Some RIDDOR incidents (dependant on severity of harm and contributory factors).
- MHA lapses in statutory paperwork leading to invalid detentions, treatment

4.11. Comprehensive Serious Incident Review (SI 2, previously known as RCA 2)

This form of review takes a comprehensive Root Cause Analysis approach and will be conducted for specific serious untoward incidents (SUIs) that are categorised as level (4 - 5) within Datix at the discretion of the SUI Panel in keeping with local policy and/or commissioning bodies. The SUI panel will agree on the type and the level of review /investigation depending on the circumstances of the serious untoward incident. Comprehensive Reviews will usually consist of a nominated review lead who is deemed to be of sufficient seniority and have the relevant skills and experience.

Please Note: The Comprehensive Review lead should be supported by another practitioner/clinician who can offer expertise and support relating to the clinical area where the incident occurred. Depending on the circumstances of the serious Incident e.g. sudden unexpected in-patient death or unexpected community patient (where the death is not deemed to be due to natural causes) it will be agreed at the weekly executive SUI panel who will agree on whether the SIR will be led by a senior manager internally to the trust or independent to the trust.

Any Comprehensive review must be completed and submitted to the Clinical Governance Team within 40 working days in order for the Trust to achieve the national timeframes to be submitted to our clinical commissioning group
(See Appendix 21 for Comprehensive Serious Incident Review Template (SI 2).

Examples of incident types that may result in a Comprehensive Serious Incident reviews:

- Avoidable or unexplained death of a service user where GMMH was main care provider and ***where cause of death was not due to natural cause's*** *e.g*. Suspected suicide (to include those unexpected deaths where an inpatient is on leave or has gone AWOL or missing. Death of a service user with a learning disability
- Self-harm or Suicide attempt by service user resulting in moderate harm/serious harm requiring hospital treatment
- Medication incidents leading to moderate- severe harm or death of a GMMH services user.
- Escape of a patient from medium secure services.
- Allegations of physical misconduct or harm to a services user by another service user.
- Poor discharge planning by a GMMH service causing moderate, severe harm or death to a service user.
- A Never Event (DH Policy framework on Never Events for use in the NHS 2012).

4.12. Case note review structured judgment review;

- Since 2014 hospitals in Yorkshire and the Humber have been working together with the AHSN Improvement Academy to refine a mortality review method, called Structured Judgement Review (SJR), a method proposed for all acute hospitals in England
- SJR for Mental Health Services are currently being developed and when the pilot has been completed, GMMH will implement SJR's as an additional approach of serious incident investigation.

4.13. Monitoring of comprehensive investigation action plans

The implementation and management of any action plan arising from any Concise and Comprehensive Serious Incident investigation will be the responsibly of the directorate where the SUI occurred. The Clinical Governance team will monitor outstanding 3 day reviews and Serious Incident Review supporting actions plans within the agreed timeframe of 6 month of the review completion and liaise with services for updates where required in order to provide progress reports to our Trust Post Incident Review panel and also our Clinical Commissioning Groups/NHSE (CCG).
Outstanding actions are monitored and progress reports are sent to each Head of Ops for progressing

4.14. Level 3 NHSE Independent Investigations

These reviews will be commissioned and led by an external independent investigation team appointed by NHS England for the following SUIs

- Homicide where the perpetrator was a GMMH service user with a mental illness or other mental disorder and who has been in contact with specialist mental health services within the last 6 months.

  Following any Homicide where the perpetrator was a GMMH service user who has been in contact with GMMH services within the last 6 month GMMH will complete its own internal SIR review as mentioned previously. This report will then be shared with and reviewed by our CCG who in consultation with NHS England will then agree to commission a further independent Homicide review in line with the process laid out in the National Serious Incident Framework (2015)

All Trust staff are required to actively engage in any independent investigation process as requested and will be supported by the Trust to do so.

4.15. Disciplinary Process/Personal Responsibilities Framework

As previously mentioned GMMH promotes a fair blame ethos in the reviewing of incidents however there may be exceptional circumstances as a result of an individual member of staffs actions or omissions during an incident that gives cause for concern. Disciplinary proceeding
s might be considered appropriate where there are grounds for believing an employee:

- Has acted criminally or maliciously.
- Is responsible for professional malpractice.
- Has acted with gross misconduct.
- Has a record of significant repetition of mistakes, or,
- Has knowingly not reported an incident or accident they are aware of that have potentially put service users and staff at risk.

A senior manager within the service will be nominated via the HR team and their Service Director/Head of service to investigate these concerns and will liaise with the Trust Human Resource Department regarding the appropriate course of action to follow as soon as possible i.e. Disciplinary Process or Personal Responsibilities Framework. This element of investigation will be carried out in accordance with Trust's Human Resources procedures.

4.16. Completion of staff witness accounts following a Serious Incident

Where possible, any individual involved with or witnessing a serious incident should complete a Trust witness account template see template within this policy as soon as practicably possible ideally before they go off duty and hand this to a local Manager, keeping a copy of the signed account for themselves. Staff should be aware that any witness account they provide may be requested to support any Trust investigation or

external agency investigation e.g. NHSE, CQC, HSE or Coroners. See Guidance for completing a witness account in Appendix 5.

4.17. Completion of Chronological Timelines following a Serious Incident

The designated manager within the service should ensure that each staff member who witnessed or were involved in a serious incident completes a timeline as soon as practicably possible following a serious incident ideally before they go off duty, along with relevant staff statements. A full chronology of the incident can then be compiled by the relevant manager who will lead the review.

4.18. The Importance of Good Record Keeping During Any Investigation

The keeping of accurate data is imperative during the course of an investigation. The senior manager leading a Trust investigation is therefore responsible for the security and accuracy of all information appertaining to the incident. Details of the incident must be recorded immediately following any incident. However it is recognised in certain circumstances especially if the event unfolds rapidly, that contemporaneous notes may be taken and updated as soon as possible.

As with all record keeping it is essential to keep accurate, legible and contemporaneous records. Records, must therefore be written in consecutive order detailing dates and times as necessary and must only record fact, not opinion. All records must be signed and dated. Records must be stored safely and securely.

Clinical staff should familiarise themselves with the Trusts 10 golden rules of clinical record keeping, these can be found within the trust ‘Standards and structure of clinic records policy’.

4.19. Communication with Carers

When informing patient’s relatives of a Patient Safety Incident please refer to the Trust ‘Being Open & Duty of Candour’ policy and also In line with ‘In the event of Death policy’.

4.20. Staff Support

Debriefing and Support for Staff following a Serious Incident
Following any serious incident Managers should offer immediate support to the team through appropriate debriefing with the team and re-assurance to staff.

PIDS
Senior managers may feel it appropriate to refer individual staff or a team to the Post incident debrief service (PIDS) delivered by the Trust psychology team (see appendix 22 referral to the PIDS)

Occupational Health support
Where appropriate the incident may be brought to the attention of the Occupational Health service in order that they can ensure that the relevant resources are in place to support the staff concerned.

PAM Assist

PAM Assist Is a confidential support service provided to Trust employees. The service is staffed by experienced and professional advisors 24/7, 365 days a year to answer calls. Through PAM Assist employees will have access to clinical and professional expertise that gives individuals a chance to talk about all kinds of work and personal issues. PAM Assist can also provide telephone counselling, face to face counselling or Cognitive Behavioural Therapy (CBT).
visit www.pamassist.co.uk

Psychological first aid support for staff

The Trust Chaplaincy/Spiritual Care Department have in Psychological First Aid (PFA), and chaplains are available to conduct sessions in PFA or Defusing in the aftermath of a traumatic incident use email spiritualcare@gmmh.nhs.uk.

Hotline Arrangements following a major incident affecting multiple persons

The Chief Executive or the Executive Director on call is responsible for making the decision to establish a Hotline as required. The Communications Lead will make practical arrangements for this. Please refer to Trust Major Incident Plan.

Communication with the Media

The decision to inform the media of any incident without exception must be taken by the Chief Executive or the relevant Executive Director on call. Following any decision to act the Communication Lead will be responsible for informing the media. Any liaison required with the Communications Manager within the CCG and NHS England will be agreed by the Director of Nursing and Governance, Medical Director or Executive Director on call.

4.21. How the Organisation Can Learn from Incidents (Internally)

The purpose of carrying out reviews of incidents is for the Trust to learn lessons in a positive manner and ensure that actions that did or could have led to patient or staff harm are not repeated.

Some examples of how the Trust shares the learning following serious incidents:

- Positive Multidisciplinary Lessons Learned events coordinated by a senior service lead following the findings from any Trust investigation. It is an opportunity for key staff from the service or other areas across the trust will be invited to attend this event. The team will then reflect on the investigation findings.
- Positive Learning splash screens used to distribute learning themes from incidents/.complaints /inquests
- Risk Management Group discussions where directorates get to share information about adverse events and near misses.
- Local and Trust Medicines Management Group information sharing.
- Sharing via the Board, Quality Governance Committee, and Operational Leadership Committee, Senior Leadership Team meetings to local operational, team meetings, and specialist groups that report to the Quality Governance Committee.

- Annual Thematic Reviews of incident/Serious Incident Review themes and Trend analysis reports
- Medicines management prescriber and nurse newsletters

The Trust monitors that lessons have been learned following incidents via a variety of processes such as:

- Improved working practices and culture through evidence of Trust wide increased reporting figures around incidents and Near Misses with the overall aim of reducing the severity of incidents that have occurred.
- Evidence will also be provided through staff and service user/carer surveys, families and friends test
- Positive MDT Learning Events feedback Templates (see appendix 23 & 24)
- Trust wide audits completed by services and Trust audit team. All of which will be presented to the relevant committees of the Trust Board.
- Trend analysis reports

4.22. Regional Learning (Externally)

In order to share the learning from serious incidents the Trust will:

- Share and receive information relating to serious incident alerts between other providers
- Work closely with our CCG in raising awareness around emerging themes/trends from our incident data
- Participate in Benchmarking events with key partners to inform regional learning with partner Trusts and agencies to improve patient safety within mental health services.

4.23. Performance Management and Data Collection

Some untoward events in isolation may be graded as a low risk but may be indicative of a higher risk trend analysis. Analysis of incident data is monitored via the Trust Risk Management Strategy Group through the presentation of NRLS data, which is published bi-annual for all NHS trusts.

Aggregated data will also be presented to the RMG on the following:

- Untoward events and any emerging trends.
- Moving and handling related events.
- Patient safety events.
- Violence and aggression related events.
- Medication incidents
- Clinical events.
- Loss or potential loss of person identifiable information.
- Claims and litigation.

In addition to being presented to the RMG the above data will also be presented at the relevant Trust sub committees.

All information governance incidents will be aggregated and reported via the Integrated Governance annual report.

4.24. RIDDOR Incidents (The Reporting of Injuries, Diseases & Dangerous Occurrence Regulations)

See Appendix 25 for information on RIDDOR reporting.

4.25. DATIX Incident Management System Roles of Staff

- **DIF1 (Datix Incident Form):** Any member of staff can complete a DIF1 form. No password or login details are required.

- **Linking the incident into the patient health care record:** Staff, including ward and community nurses, have been identified and trained to ensure incidents are posted into the health care record within a timely manner.

- **DIF2:** Ward Managers, Matrons and other Senior Managers have been identified and trained to review incidents to ensure all details are accurately completed and investigations and action plans carried out.

- **DIF3:** Final approvers of incidents

- **DUAL ROLE:** Team Managers and Governance Leads working with community.

- **SUPER USERS:** Senior administrative staff have been identified within Directorates to provide the main link to the DATIX Governance team. Super users provide support to DATIX users within their area or service across all specified modules. They maintain local protocols, processes and reporting requirements.

4.26. Safeguarding Children

This policy should be considered in conjunction with the Trust Safeguarding Children Policy. The safeguarding leads within the Trust work closely with the local safeguarding boards where an incident raises a concern that a child has been harmed or an offence has been committed against a child or staff have behaved in a way that indicates that they may be unsuitable to work with children.

4.27. Safeguarding Adults

This Policy should also be read in conjunction with the Trusts Adult Safeguarding Policies. The safeguarding leads within the Trust work closely with the local safeguarding board where an incident raises a concern that a patient of adult age has been harmed or an offence has been committed by a member of staff that warrants a referral to the Local Adult Safeguarding Team.

5. Training Requirements

- All new staff to attend training on how to report an incident and also risk management training via the Learning Department which will include the process for incident reporting on the trust risk management system and refresher training will be provided as scheduled by the Incident Team.
- Serious Incident RCA training is available quarterly to Trust staff who as part of their role will lead Trust SUI reviews
- Being Open & Duty of Candour workshops are delivered to senior staff as required by services by the Head of Patient Safety & Governance.
- Being Open and Duty of Candour is also delivered as part of the Junior Doctors induction programme
- Datix refresher training and support will also be provided in-house by designated Directorate Super-users (see local Directorate protocols).
- Training needs in relation to incident reporting and investigation are detailed in the Organisation Wide Training Needs Analysis (TNA).

6. Monitoring

Minimum Requirement	Frequency	Process for monitoring	Evidence	Responsible Individual(s)	Response Committee(s)
Non-clinical incident or near-miss analysis.	Quarterly		Datix Report or Minutes		Health & Safety Committee, SIRO, IGOG
Medicines management incident or near-miss analysis	Bi-monthly		Datix Report or Minutes		Medicines Management Group
SIR review progress report	Monthly		Datix Report or Minutes		PIR Panel
SIR & 3-day report updates	Weekly		Minutes		Trust weekly SUI meeting
Aggregated Incident, Complaints and Claim report	Bi Monthly		Datix Report or Minutes		RMG
Incident management Performance Report	Monthly		Datix Report of Minutes		Board
Number of staff trained in RCA	Quarterly		In Trust TNA held by learning and Developmen t team		Workforce Education Governance Committee

Minimum Requirement	Frequency	Process for monitoring	Evidence	Responsible Individual(s)	Response Committee(s)
External agency reports e.g. CCG,CQC, NRLS, HSE etc.	As required		Datix Incident/Risk Report/Data Quality Checks		Head of Patient Safety & Governance /Incident Administrator
Sharing of incident, investigation data and lessons learnt to CCGs	as required		Report and minutes		Head of Patient Safety & Governance/ Incident team

7. Resource/Implementation Issues

Staff will require access to a computer in their working environment to report an incident via PARIS and Datix systems.

8. Risk Issues

In the absence of the Trust failing to provide frameworks for the reporting of all incidents there would be safety risks to both patients and employees of the organisation and potential risks to the Trust reputations and assets. All significant risk will be risk rated and will inform the Trust risk assurance framework received by the board.
Failure to report a reportable injury, dangerous occurrence or disease in accordance with the requirements of the RIDDOR regulations is a criminal offence and could result in the Trust being prosecuted by the Health and Safety Executive (HSE).

9. Requirements, Supporting Documents and References

9.1. Requirements

Board Objective Reference:	4
CQC Reference:	4, 7, 9, 16, 18, 19 & 20 CQC Reg 20

9.2. Supporting Documents

It is felt that this policy should be read in conjunction with the following policies:

- Risk Management Strategy.
- Health and Safety Policy.
- Whistle-Blowing Policy.
- Care Programme Approach Policy.
- Major Incident Plan.
- Infection Control Procedures.
- Disciplinary Procedure.
- Personal Responsibility Framework.
- Compliments and Complaints Policy.
- Claims Policy.
- NHS Code of Conduct.
- Confidentiality Policy.
- Supporting staff following a Traumatic and stressful incident.
- Safeguarding and Protecting Children Procedure.
- Safeguarding Adult Policy.
- Information Governance Policy.
- In the event of Death Policy.
- Being Open & Duty of Candour policy.

9.3. References

The following references are essential background for readers of this policy:

- NHS England Serious Incident Framework March 2014
- CQC Regulation 20 duty of candour Guidance for NHS providers 2014
- National Guidance on Learning From deaths March 2017

10. Subject Expert and Feedback

Should you wish to discuss any aspects of this policy or have any areas for concern please in the first instance contact the Policy Author, Head of Patient Safety & Governance on: Telephone (0161) 358 2096 or Email: julie.bodnarec@gmmh.nhs.uk

11. Review

This policy will be reviewed in 5 years or sooner in light of organisational, legislative or other amendments.

Equality Impact Assessment Tool Sept 2017

This policy should not affect any individual or group less or more favourably than any other

Appendix 1 – Checklist for the Review and Approval of Policies

To be completed and attached to any policy which guides practice when submitted to the appropriate committee for approval.

	Title of policy being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
2.	**Rationale**		
	Are reasons for development of the policy stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the policy clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the policy identified explicitly?	yes	
	Are key references cited?		
	Are the references cited in full?		
	Are supporting documents referenced?	Yes	
6.	**Approval**		
	Does the policy identify which committee/group will approve it?	yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the policy?	yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	yes	Via RMG

	Title of policy being reviewed:	Yes/No/ Unsure	Comments
	Does the plan include the necessary training/support to ensure compliance?	yes	
8.	**Document Control**		
	Does the policy identify where it will be held?	yes	
	Have archiving arrangements for superseded policies been addressed?		On Trust intranet with other policies.
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the policy?	yes	
	Is there a plan to review or audit compliance with the policy?	yes	
10.	**Review Date**		
	Is the review date identified?	yes	
	Is the frequency of review identified? If so is it acceptable?	yes	
11.	**Overall Responsibility for the Policy**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the policy?	yes	

Committee Approval RMG			
If the committee is happy to approve this policy, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the policy and the person who is responsible for maintaining the Trust's database of approved policies.			
Name	Gill Green	Date	21/11/17

Appendix 2 - Monitoring Criteria

Monitoring Criteria	Yes/No
Are all members of staff trained accordingly to carry out the requirements of the policy?	**Yes**
Are all members of staff aware of the existence and details of the policy?	**Yes**
Are all new starters made aware of this policy during local induction processes?	**Yes**
Have all old versions of this policy stored locally (either electronically or as a hard copy) been removed?	**Yes**
Are the processes contained in the policy followed correctly?	**Yes**

Appendix 3 – Communication/Training Plan

Communication/Training Plan	
Payments to Service Users and Carers	
Goal/purpose of the communication/training plan	To ensure that policy is implemented successfully.
Target group for communication/training	All Trust Staff.
Target Numbers	All Trust Staff.
How will the communication/training be carried out?	The document will be available on the intranet. Training will be provided when requested by services.
Who will carry out the Communication / training?	Incident Team
Funding	
Measurement of Success	Compliance with training needs in relation to incident reporting and investigation as detailed in the Organisation Wide Training Needs Analysis (TNA).
Effectiveness	Year on Year incident data
Issue date of original policy	July 2010
Start and completion date of communication/training plan	N/A
Support from Training Services	N/A

Appendix 4 - Roles and Responsibilities

Quality Governance

- Receive and note the learning from Positive Learning reports

Risk Management Strategy Group (RMG)

- The RMG is the Trusts lead group for the monitoring and approval of this policy.

Health and Safety Committee

- Receipt, scrutiny and analysis of monthly Performance Reports in relation to non-clinical incident data.

Trust Board

- Receipt and scrutiny of monthly Performance Reports in relation to incident data.

Chief Executive

- Provide strong leadership to ensure that patient safety is fully supported by the Trust Board.
- Demonstrate support of a learning non-punitive culture.
- Ensure that the Trust Board receives the relevant information on incident management including the management of serious untoward incidents.
- Ensure that reporting to external agencies is embedded within the organisation e.g. Clinical commissioning groups, Department of health, Information commission office (ICO) Care Quality Commissioning etc.

Director of Finance and IM&T

- Ensure that any issues that impact on Standing Financial Instructions are managed in accordance with this policy and associated Finance Procedures.
- Ensure that any incidents involving fraud are reported accordingly to Mersey Internal Audit Agencies (MIAA) Counter Fraud Department.

Director of HR

- Ensure any disciplinary action required following a Trust investigation is carried out within agreed time frames.

Director of Nursing and Governance

- Ensure that immediate concerns are reported directly to the Chief Executive.
- Ensure all safeguarding incidents are recognised and reported immediately to the relevant agencies.
- To ensure the sharing of lessons learned following safeguarding reviews takes place.

- Ensure that Directors, Heads of Operations, Non-Executive Directors and senior managers are kept informed of specific incidents.
- Ensure investigation into a serious incident is carried out and reported on within agreed timescales, this includes to external organisations.
- Ensure that those incidents that are required to be externally reported have been received by the appropriate people e.g. Local Safeguarding Board.
- Deputy Chair of Trust Post incident review panel.

Medical Director

- Provide clinical leadership to ensure that the trust has a culture whereby patient safety and the principles of a Duty of Candour are fully embedded across the Trust and that all senior clinicians promote a patient safety culture within their practice and support any Serious Incident review as required.
- Ensure that immediate concerns are reported directly to the Chief Executive.
- Ensure investigation into a serious incident is carried out and reported on within agreed timescales.
- Ensure that those incidents that are required to be externally reported have been received by the appropriate people.
- Represent the executive team on the Trust Post Incident Review Panel and weekly serious incident panel.
- Ensure that senior clinicians, Heads of Operations, Non-Executive Directors and senior managers are kept informed of specific incidents.
- Ensure investigations into serious incident are carried out and reported on within agreed timescales, this includes to external organisations.
- Report to external agencies e.g. Medicines & Health products regulatory agency where appropriate.
- Chair of PIR Panel

Medication Safety Officer

- Review all medicines management incidents via the Datix system.
- Review Team Management review reports and action plans relating to medication incidents and support services in the implementation of safer medicines management systems and process.
- Contribute to the Trust quarterly Lessons Learned newsletter around medication incidents.
- Raise issues of Trust-wide significance at the Trust's Medicines Management Group as this group has a key role in looking at clusters, themes and errors across the Trust.
- Report to external agencies e.g. Medicines & Health products regulatory agency where appropriate.
- Liaise with external partner's e.g. Community pharmacy leads regarding Trust lessons learned around medicine management.
- Present themes from medicine management incidents via the Trust Quality Governance Committee chairs report.

Deputy Director of Governance

- Maintain effective system for managing all Trust wide incidents.
- Ensure incidents are communicated to the relevant members of the EMT e.g. Director of Governance, HR, Director of Nursing, Operations and Medical Director.
- Comply with the external reporting requirements of the trust regulators and partners
- Provide analysis of data and reports to the relevant forums and directorates.
- Initiate joint working arrangements where applicable under the Memorandum of understanding.
- Provides support to Head so of service around the facilitation of learning events following a Post incident review.
- Is a member of the Trust Post incident review panel and weekly SUI panel.

Head of Patient Safety & Governance

- Maintain effective system for managing clinical incidents and near misses.
- Ensure incidents are communicated to the relevant executive directors.
- Comply with the external reporting requirements to trust regulators and key partners
- Review and analyse incidents, liaise with managers for further information, also give final approval to incidents reported via Datix and monitor SUI review reports and action plans.
- Provide analysis of data and reports to the relevant forums and directorates.
- Provide support to managers in monitoring improvement actions, including population of the DATIX risk register of significant risks.
- Support a process to share learning across the Trust.
- Initiate joint working arrangements where applicable under the Memorandum of Understanding.
- Develops and Coordinates Positive lessons learned splash screens.
- Delivers Trust wide investigation and RCA training
- Provides 1-1 Support to nominated investigation leads around the review process following a serious Incident
- Will pursue ‘beyond date’ SIR directly with review leads and Heads of services
- Share lessons learned at the relevant Trust wide committees following national enquiries.
- Provides support to service leads around the sharing of Learning following serious Incidents and Trust investigations
- Is a member of the Trust SUI and Post Incident Review Panels.

Head of Corporate Affairs and Communications

- Ensure that the Chair and Non-Executive Directors are kept informed of specific incidents.
- Manage the interface with the media and the Strategic Health Authority Communications team.
- Manage the interface with leads for communication and media within other stakeholder group’s Department of Health, Information Commissioners Office and Police Authority) with regards to media handling.

Associate Directors/Head of Operations and Service Managers

- Ensure the developing and implementation of appropriate action plans following SIR reviews.
- Ensure where appropriate serious incidents are reported as soon as possible to the relevant Trust staff e.g. Director of Nursing, Medical director. Head of communications, this should be done before alerting external partners e.g. CCG
- Outside of normal working hours where appropriate respond to incidents as per Trust on call process and alert executive on call of a serious incident as appropriate.
- Following a serious incident where serious harm or death occurs to nominate a member of staff at an appropriate level to implement Duty of Candour in line with Being Open& Duty of Candour policy and directly inform service users / carers when a serious incident has occurred
- To ensure staff complete 3DRs /SIR reviews within agreed timeframes
- That a system is in place to monitor the effectiveness of any risk reduction measures introduced.
- Ensure lessons learned arising from SUI's are shared across the Directorate and Trust through the coordination and facilitation of Directorate Learning events following all SUI reviews
- To ensure their directorate continues to be represented at Trust wide committees such as Medicine management committee in order to share lessons learned following mediation incidents.
- To nominate senior managers to lead newly commissioned SUI reviews as quickly as possible so the trust achieves national timeframes required by our CCGs

Local Ward/Team Managers

- Ensure that reporting procedures are complied with in the event of any incident affecting any service user, member of staff, visitor or premises for which they are responsible.
- Ensure where appropriate serious incidents are escalated to the relevant senior manager/department where appropriate
- Respond to incidents as per Trust on call process.
- In the event of an unexpected inpatient death to ensure the incident scene and evidence is secured for police examination
- Ensure statements are collected following all SUIs ideally within 24hrs of the incident occurring
- (Undertake initial investigation of incidents and near misses in liaison with other managers where necessary.
- Provide support to any investigating team and chair Team Management Reviews when requested.
- Ensure 3-day management reviews are completed within expected timeframes and are emailed to Integrated Governance via Datix system.
- Provide the opportunity for staff to review and receive feedback on specific incidents.
- Provide the opportunity for staff to meet to discuss and participate in a meeting following an incident, particularly serious untoward incidents soon after the event.

- Ensure facilitation of attendance at the appropriate level for training events and monitor attendance of staff on mandatory courses.
- Monitor trends on incidents and near misses within the area of responsibility.
- Contribute to dissemination of lessons learned and implementation of improvement actions.
- Report incidents via the appropriate channels.
- Review monthly all reported incidents within their areas and agree any further necessary actions or improvements required.
- Provide feedback on incident reviews to their respective service.
- Initiate the safeguarding procedures where applicable.
- Monitor the progress of action plans for their service and the implementation and effectiveness of lessons learned and improvement actions. Make staff aware of the importance of taking care of their own safety and that of service users, colleagues and others on Trust premises.
- For ensuring staff use the arrangements in place to report all incidents accident or near misses within the given timescales.
- Ensure serious incidents are escalated appropriately to a directorate senior manager and trust senior manager on call out of hours.
- Ensure that staff carry out their nominated roles as per this policy and as agreed within their local Datix incident management protocols (see appendix 18 for guidance on Datix roles).

Head of Risk Management

- Provide analysis of data and reports to the relevant groups and directorates on staff related incidents e.g. reportable to RIDDOR
- Provide support to managers in monitoring improvement actions.
- Support a process to share learning.
- Co-ordinate a risk management training programme.
- Comply with the external reporting requirements, e.g. NHSLA, HSE, NHSSMS and MHRA for Medical Devices.
- Initiate joint working arrangements where applicable with other relevant agencies
- Review all Health & Safety related incidents, accidents and near misses.
- Liaise with the HSE regarding RIDDOR related incidents and provide reports to the relevant Trust forums on staff safety incidents.
- Provide specialist advice to staff.
- Report relevant incidents to Health & Safety Executive Participate in the risk management training programme.

Information Governance Manager

- Ensure that reporting procedures are complied with in the event of any incident involving the theft or potential loss of person identifiable information.
- Ensure the reporting of information Governance incidents to relevant agencies e.g. ICO
- Ensure the severity of the incident is recorded correctly in line with the Department of Health's Checklist for Reporting, Managing and Investigation of IG serious incidents and amend if necessary or appropriate.

- Provide support to any investigating team.
- Review weekly all reported Information Governance incidents and agree where necessary the level of review required with the service involved and any further necessary action or improvements required.
- Ensure the senior information risk owner (SIRO) is kept informed of IG SUI incidents.
- Ensure lessons learnt arising from IG SUI incidents are shared across the Directorate and Trust.
- Ensure directorate Information Governance Leads are kept informed of incidents via the Information Governance Monthly meeting.
- Provide analysis of data and reports to the above Meeting quarterly.
- Facilitate any identified Information Governance Training requirements.

Security Management Specialists

- Receive and review all violence, aggression and harassment incidents and near misses directed towards staff.
- Provide specialist advice in relation to security and management of violence towards staff.

Clinical Governance Incident Administrators

- Manage the DATIX Incident module and provide timely reports as requested e.g. Care Quality commission, CCG
- STEIS report incident within 48hrs of recognition of SUI
- Provide overview reports of timescales for the management of incidents including reporting both internally and externally.
- Provide overview reports of incidents by monitoring action plans in conjunction with Service Leads, for significant risk areas liaise with the Risk Manager to ensure that they are populated onto the risk register.
- Liaise with services regarding progress around Investigation reviews
- Minute taker at monthly PIR panels.

All Trust Staff

- Take care of their own safety and that of service users, colleagues and others on Trust premises.
- In line with this policy ensure all incidents, accidents and Near miss are reported via Datix or to a senior manager as soon as they have become aware an incident has occurred.
- Use the correct reporting templates (enclosed within this policy).
- To complete a witness statement where requested by their manager following serious incidents as soon as practically possible
- To participate in any Trust investigation, and contribute to solutions and improvements.

Appendix 5- Guidelines & Template for staff statement

Guidelines and Template for staff producing a written statement following a serious untoward Incident

When a serious incident has occurred e.g. following the unexpected death of a service user, staff are required to complete a written accounts ideally before going off duty or as soon as practically possible. The information contained in your statement will support any Trust investigation to follow.

Any information you give will be treated as confidential and will be stored in a secure place. Disclosure of the content of your statement to anyone outside of the investigation or safeguarding team will not occur without your consent (except where the Trust is required to by law) – this would include disclosing your statement to the Police and Coroner as we are required by law to do this. As part of this process your statement may be shared with the family and/or Trust Solicitors. Your statement may also be used in any claims that could be brought against the Trust.

Please note in the statement you will be asked to provide the following information;

- Your full name.
- Ward/Team/directorate, were you are based and the relevant contact details for that area.
- Qualifications (including dates).
- Your PIN or GMC number where relevant.
- Any relevant training and experience you have had.
- Job role.
- Whether or not you are the patient's Key worker or care coordinator.
- Patient's name.
- Patient's date of birth.
- Patient's address.
- Patient's NHS number.

Guiding Principles

When preparing a statement following an incident the following points should be followed;

1. Obtain a copy of the information you will need e.g. patient's notes, off-duty, personal diary, policies and procedures etc. If at all possible no Witness accounts should be written entirely from memory. Make it clear in the statement where you are relying on information from the patient's records or any other documentary evidence rather than your own memory in any issue.

2. Be completely honest and open.

3. Avoid using abbreviations, ambiguity, and jargon. Where possible adopt a short, readable sentence structure.

4. Include a detailed chronological account of your involvement in the patient's care both leading up to the incident and at the time of the incident, also split the statement into short paragraphs.

5. Keep the account simple and focused.

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

7. Say precisely what you did and what you saw e.g. Care you gave to the patient and/or the nature of the involvement you had with them including any observations carried out and whether or not they were within normal limits.

8. If you liaised with any other members of staff for advice or to discuss care and state who these persons were and their designation e.g. Dr Joe Bloggs (Duty SHO). Please ensure full names are used within the statement and not initials.

9. Statements should be factual, focus on;

    - What you said.
    - What you were told.
    - What you did.
    - What you saw.
    - What you didn't do.
    - And why (consider your application of the Therapeutic Positive Risk Taking guidance)

10. Statements should be written in first person e.g. "I gave Mr Smith an injection of….at 9am" rather than passive "Mr Smith was injected with…."

11. State any exceptional circumstances e.g. ward in process of redecoration.

12. Do not include opinions; value judgments or speculations; only state the facts.

13. Should be typed if possible or completed handwritten in black ink.

14. Include your full name, designation, and date on each sheet of paper.

15. **Please note:** You should retain a signed copy of your statement.

16. All Witness accounts should be signed and dated.

17. Complete your written Witness accounts using the Trust's pro-forma below.

Statement Template	
Statement Provider Information	
Name in full	
Contact details	
Professional PIN/GMC number (if relevant)	
Qualifications and Year qualified	
Current Post / Role held	
Brief summary of your role and responsibilities	
Post occupied at the time of the incident	
Current Post / Role held (if different)	
Relationship to the Service User	
Where your information has been drawn from:	☐Medical Records ☐Personal Experience ☐Direct Knowledge

Service	
Name of service/ward	*e.g. Beech Ward, Bolton Directorate*
Brief summary of type of service and function	*e.g. 28 bedded female later life ward for patients with physical/mental health needs relating to dementia*

Service User Details	
Name in full	
Date of Birth	
Address	

Details of statement provider's contact, in chronological order

Signed:_____**Date:**_____

Please Note: Remember to keep a copy of your signed witness account when completed

Appendix 6 – Information leaflet for Carers or Family on information and guidance following an unexpected death

Information leaflet for Carers or Family on information and guidance following an unexpected death

Link to the leaflet:

http://intranet/integratedgovernance/clinicalgovernance/Inquests/InquestDocuments/HelpandinformationforthebereavedleafIet.pdf

Printer settings for leaflet: Print on both sides – flip on short edge

Appendix 7 – LeDeR Programme Notification Template

Learning Disability Mortality Review (LeDeR) Programme Notification

This template will be sent by the incident team to service leads to complete as specified as part of the national LeDeR programme following a service user with a learning disability and who has died. Services will asked to complete and then send back to the Incident team for submission via the national LeDeR online reporting process

1. Name of the person notifying the death

Name: Click and type your name here.

2. Role and agency of person notifying the death

Details: Click here to enter text.

3. How the reporter knew the person who has died

Relationship: Click here to enter text.

Reporter's contact details (if they are happy to be contacted)

4. Telephone number: 0161 358 20199
5. Email address: incidents@gmmh.nhs.uk
6. Postal address and postcode: Knowsley Building, Prestwich Hospital, M25 3BL
7. Reporter's preferred method for contact: Email

8. Who else has been notified about the death? (Tick all that apply)

☐ To the reporter's knowledge, no one else has been notified

☐ Coroner
☐ Child Death Review
☐ Care Quality Commission
☐ I don't know
☐ Safeguarding Team
☐ Police
☐ Someone else

If someone else has been notified about the death, please provide their contact details if you have them.

Contact details: Click here to enter text.

Details about the person who died

9. FIRST (GIVEN) NAME of the person who died

Name: Click here to enter text.

10. LAST NAME (i.e. family name or surname) of the person who died

Name: Click here to enter text.

11. Was the person known by any other name? If so, what was it?

Name: Click here to enter text.

12. Date of BIRTH (This should be in the format dd/mm/yyyy)

Date: Click here to enter text.

13. Date of DEATH (This should be in the format dd/mm/yyyy)

Date: Click here to enter text.

14. Age at death

Age: Click or tap here to enter text.

15. Gender

☐ Male ☐ Female ☐ Other

16. Deceased person's ethnic group

White

☐ British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Any other White background (please give details in box below)

Mixed / multiple ethnic groups

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other Mixed / multiple ethnic background (please give details in box below)

Asian / Asian British

☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Any other Asian background (please give details in box below)

Black / African / Caribbean / Black British

☐ African
☐ Caribbean
☐ Any other Black / African / Caribbean background (please give details in box below)

Other ethnic group

☐ Arab
☐ Any other ethnic group (please give details in box below)

Details of person's ethnic group: Click here to enter text.

17. Marital Status of the person who died

☐ Single (never married)
☐ Married / civil partnership
☐ Separated (but still legally married / in a civil partnership)
☐ Divorced
☐ Widowed
☐ I don't know

18. In which area of England was the person registered with a GP?

☐ North: Yorkshire & the Humber
☐ North: Lancashire & Greater Manchester
☐ North: Cumbria & the North East
☐ North: Cheshire & Merseyside
☐ Midlands & East: North Midlands
☐ Midlands & East: Central Midlands
☐ Midlands & East: West Midlands
☐ Midlands & East: East Midlands
☐ South: South West
☐ South: South East
☐ South: Wessex
☐ South: South Central
☐ London Region
☐ I don't know
☐ Not registered with a GP

19. NHS Number (This should be in the following standard format: 000 000 0000)

NHS number: Click here to enter text.

20. Did the person who died have any known medical conditions or health problems?

Details: Click here to enter text.

21. What level of learning disability did the person who died have?

☐ Mild
☐ Moderate
☐ Severe
☐ Profound / multiple
☐ I don't know

22. Usual address and postcode of the person who died

Address: Click here to enter text.
Postcode: Click here to enter text.

23. Did the person who died usually live alone?

☐ Yes ☐ No ☐ I don't know

24. Was the person who died placed out-of-area, either in a residential / nursing placement or in a supported living tenancy?

☐ Yes ☐ No ☐ I don't know

If yes, please state which area was their original 'home': Click here to enter text.

25. Was the person subject to any restrictive legislation?

☐ None

☐ Deprivation of Liberty Safeguards (DOLS) - approved
☐ Deprivation of Liberty Safeguards (DOLS) – applied for
☐ Section of the Mental Health Act
☐ Detention in police custody/imprisonment
☐ Other: Click here to enter text.
☐ I don't know

If the person was subject to any restrictive legislation, please describe more fully (e.g. dates, reason for restriction)
Click here to enter text.

26. Someone who knew the person who died

Name: Click here to enter text.
Telephone number: Click here to enter text.
Email address: Click here to enter text.
Address and postcode: Click here to enter text.

27. How did they know the person who died?

Click here to enter text.

28. Name of and contact details of the person's GP surgery

GP name: Click here to enter text.
Surgery contact details: Click here to enter text.

Details of the Death

29. What was the place of death?

☐ Hospital
☐ Usual place of residence
☐ Hospice / palliative care unit
☐ Home of relative or friend
☐ Residential / nursing home that was not usual address
☐ I don't know
☐ Other: Click here to enter text.

Please provide the address of the place where the person died:
Click here to enter text.

30. What was the cause of death as described on the Cause of Death Certificate? (If you do not know, please leave blank)

I	(a) Disease or condition leading directly to death	Click here to enter text.
I	(b) Other disease or condition, if any, leading to I(a)	Click here to enter text.
I	(c) Other disease or condition, if any, leading to I(b)	Click here to enter text.
II	Other significant conditions contributing to death but not related to the disease or condition causing it	Click here to enter text.

31. What did reporter think the cause of death was?

Perceived cause:

32. Will there be a post mortem?

☐ Yes ☐ No ☐ I don't know

33. Will there be a Coroner's inquest?

☐ Yes ☐ No ☐ I don't know

34. Will there be any other investigation or review of the death?

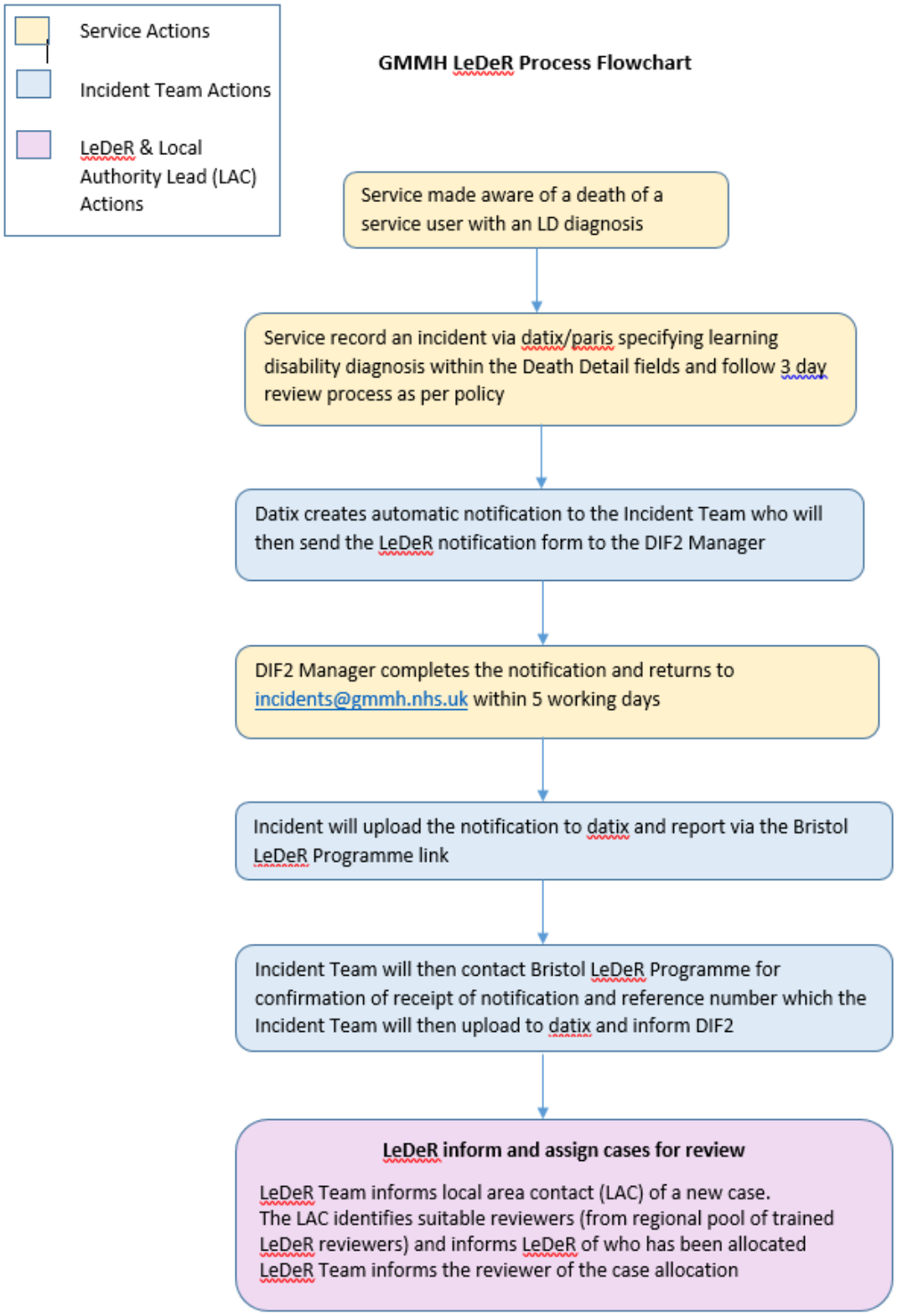
☐ Yes ☐ No ☐ I don't know

If YES please describe: Click here to enter text.

35. Reporter's comments about the death:

END OF DEATH NOTIFICATION – Please email to the Incidents Team (incidents@gmmh.nhs.uk) who will then upload to the incident and report to the LeDeR programme.

Appendix 8 – GMMH LeDeR Process Flowchart



Appendix 9 - DATIX Roles for Managing Incidents

DIF1: Any member of staff can complete a DIF1 form (dependent upon local protocol) No password or login details are required.

Linking into Patient record: Staff Nurses working with Inpatient Services have been identified and trained to ensure incidents are posted into the patient electronic health care record within a timely manner.

DIF2: Ward Mangers, Matrons and other senior managers have been identified and trained to review incidents to ensure all details are accurately completed and investigations and action plans carried out.

DUAL ROLE: Team Managers and Governance leads working with Community

SUPER USERS: Senior Administrative staffs have been identified within Directorates to provide the main link to the Datix Governance team. Super users provide support to Datix users within their area or service across all specified modules. They maintain local protocols, processes and reporting requirements and attend User group meetings and other associated meetings as required.

Linking into the patient health care record Person:

Refer to the Quick Help Guide for step-by-step instructions.

In order to ensure that the incident is posted into the patient records in a timely manner all staff nurses have been identified for this Link role". They will be responsible for accessing the incident from the "Incidents in the holding area awaiting review" folder. They will be responsible for removing any patient or staff identifiable information from the Description and Action Taken fields. They will enter the "Degree of Harm" also verify all contacts (e.g. Patient or witness, etc). Once all Contacts have been verified they will click on the Link Section" and select "Yes" so that the record is posted in the patient record Once they select "Yes" they will be asked to check the patient's record details and record ID to post the incident into the correct patient's record.

The staff identified in this role will be working at ward level this will enable them to ensure the incident is posted into the patient records immediately.

The Link person can also use the email communication section within the incident to alert other DIF2 manager(s), Super users or Clinical care groups that the incident has taken place and that it has been posted in the patient records if required.

Individual or group email addresses can be added here (multiple addresses can be separated by a single comma). The user can then copy and paste the description of the incident into the body of the message so that managers are aware of what the incident is about. A record of all these email communication messages is stored within Datix and is accessible to Managers accessing Datix.

After changing the heading to **"being reviewed"** this user is then able to log out of Datix having completed their role.

Role of the DIF 2 Manager

Refer to Incident DIF2 User Guide for step-by-step instructions.

The DIF2 manager will have received an email notification from the staff member who has linked the datix record in stating that they have posted the incident into the patient records To access the incident the DIF2 Manager can click on the email link or log into Datix via the Trust Intranet home page.

Once successfully logged in, the DIF2 Manager will click on Incidents folder and access an incident in the folder named "being reviewed". Incidents can be displayed differently by clicking on the title headings.

DIF2 Manager is responsible for reviewing the incident and making amendments as required e.g. removing identifiable information from the description, adding any information missing, classifying the incident level and indicating if a Safeguarding or SIR review is required. Once completed the DIF2 Manager then changes the Approval status to "Awaiting final approval" by DIF3.

Appendix 10 – DIF1 Incident Reporting Pathway V4

The incident module sits within Datix Integrated Risk Management system. The Incident module provides a platform on which to report and review incidents, which have been identified within the organisation. An Incident can be recorded by any member of staff (DIF1) before being reviewed and managed by the appropriate Ward or Operational Manager (DIF2) and finally approved by Governance (DIF3).

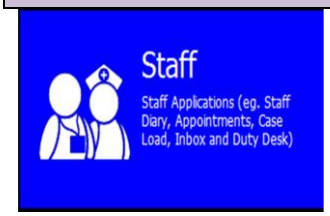
DIF1 Datix Incident Form (Stage 1)
Any member of staff can complete a DIF1 form via access to PARIS or DATIX

There are two separate pathways for completing a DIF1 Form:-

PARIS DIF1

The PARIS DIF1 form **MUST** be used for all Incidents & Accidents **involving a Patient with a PARIS Record**

HOW TO ACCESS PARIS DIF1



Log into PARIS and click on the STAFF tile, then select the PARIS DIF1 form.

STAFF COMPLETE AND SAVE PARIS DIF1 FORM

ANY Staff Member can complete a DIF1 form

Some staff may need to access **CITRIX** first before being able to access GMMH systems

DATIX DIF1

The DATIX DIF1 form **MUST** be used to record all Incidents & Accidents where there is **NO patient involved or for patients that do not have a PARIS Record**

HOW TO ACCESS DATIX DIF1

Greater Manchester West NHS
Mental Health NHS Foundation Trust

Datix

Click on the Intranet to open GMMH staff page, click on DATIX link in the top middle of page

STAFF COMPLETE AND SUBMIT DATIX DIF1 FORM

Once completed the DIF1 Form sends automatic emails to notify relevant managers that incident has occurred.

A summary section is available within the PARIS Incident that updates automatically

DIF2 REVIEW
ALL incidents are reviewed and managed within DATIX once they have been reported at DIF1 Stage

All incidents will be reviewed and finally approved by Governance DIF3

PATIENT RELATED INCIDENTS THAT MUST NOT USE PARIS DIF1		
There are 7 main types of Patient related incidents that MUST NOT USE PARIS DIF1		
NO	**TYPE**	**DESCRIPTION**
1	Incidents involving Prisoners	The majority of Prisons employing GMMH services use their own system "system one", therefore Prison incidents must **NOT USE** the PARIS DIF1 form and all incidents **MUST** be recorded using DATIX DIF1
2	Information Governance Incidents	All information Governance breeches both patient and non-patient related must **NOT** be recorded within the PARIS record, therefore all IG incidents **MUST** be recorded using DATIX DIF1
3	All "Near Miss" Incidents	All incidents have a classification of Actual Incident or Near Miss. Any incidents classified as Near Miss did not affect the patients care and treatment therefore they must **NOT** be recorded within PARIS and **MUST** be recorded using DATIX DIF1
4	All Prescribing and Dispensing errors that were intervened before administration to the patient	All Prescribing and Dispensing Medication incidents that were intervened before administration to the patient and therefore the patients care and treatment was not affected in any way must **NOT** be recorded within PARIS and **MUST** be recorded using DATIX DIF1
5	Highly Sensitive Incidents (HSI) allegations of abuse by Staff	Highly Sensitive incidents involve allegations of abuse by Staff and are added by Governance in order to avoid email notifications being sent out and are "locked" down with access limited to specified managers. **STAFF MUST CONTACT GOVERNANCE AND MUST NOT USE PARIS DIF1 OR DATIX DIF1**
6	Informed of former Patient Death 3 months or more following discharge	Former Patient Deaths occurring 3 months or more after discharge are **NOT REPORTABLE INCIDENTS AND MUST NOT USE PARIS DIF1 OR DATIX DIF1**

Appendix 11 – further examples of serious Incident reporting Criteria

- Unexpected or avoidable death of one or more patients, staff, visitor or member of the public.

- Serious harm to one or more patients, staff, visitor or member of the public or where the outcome requires lifesaving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm.

  E.g. suspected attempted suicide of an in-patient or community patient (incudes where patients are on leave or have gone AWOL)

  E.g. self-harm attempts made by a service user where the self-harm attempt is a significant change or escalation from the services users normal presentation for which there is a Multi-disciplinary care plan in place. Or cluster of self-harm incidents within the same ward and by same service user over the period of a day.

- A scenario that prevents or threatens to prevent a provider organisations ability to continue to deliver health care services e.g. Actual or potential loss of personal/ organisational information due to IT failure, damage to property or reputation.

- Allegations of abuse E.g. Suspicions, concerns or allegation of abuse experienced by a patient when the alleged abuser is a member of staff or volunteer or the alleged abuser is another service user.

- Adverse media coverage or public concern about the organisation or the wider NHS.

- The occurrence of a Never Event -All Never Events are defined as serious incidents e.g. patients who escape from medium secure

- Patients detained under the Mental Health Act who go AWOL (absent without leave) or abscond from mental health services who present a serious risk to themselves and/or to others or attract media attention and/or who commit an offence whilst at large.

- All medication related incidents to also include the prescribing and administration of Oxygen**.** All medication incidents and near misses must be reported and categorised appropriately depending on the potential degree of harm and risks to the patient as with any other clinical incident.

- Outbreak of infectious diseases in hospital (e.g. food poisoning, MRSA etc), also the transmission of infectious disease between employees of the Trust and patients.

- Grade 1 and above Pressure ulcers and VTE which are either present on admission or develop during an inpatient stay will be reported via Datix. Pressure

ulcers graded 2 and above will require a pressure Ulcer Serious Incident Review review (PUSIR) completed. Pressure Ulcers graded 4 and above will also warrant a 3 day review report see physical Health care policy for further information. The PUSIR template can be found in DATIX.

- Under 18 admission to an adult ward

- Any incident, which attracts significant media attention is likely to become high profile and/or is likely to be of public concern.

- A pattern emerging that is causing local concern, such as a high number of complaints regarding a member of staff, a particular service that may warrant further investigation and action.

- Theft or loss of Trust IT (information technology) equipment such as computers or laptops that contain patient sensitive data and any incident involving the actual loss of personal identifiable information.

- Where a cluster of very similar incidents within a Service has been identified within a relatively short period of time.

- A system error e.g. loss of the patient electronica patient record system DATIX or Outlook failure from which may result in lost data or a period of unexpected ‘down time’ of clinical information.

- A ‘Near Miss’ incident, which if not realised could have caused harm to an individual service user or staff member.

- Thefts, loss of and/or deliberate damage to Trust assets and property.

- Loss of a service users clinical records.

Appendix 12 – Incident Level Guidance

INCIDENT LEVEL GUIDANCE (Version 12) - UPDATED VERSION FOR POLICY

Being Open & Duty of Candour policy to be implemented for patient Safety Incidents resulting in moderate harm, significant harm or death

Face to face meeting to be offered/take place with service User /carer and outcome of meeting/conversation recorded and shared with service user/Carer & then uploaded into Datix

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
INVESTIGATION	**MANAGE LOCALLY / CARE PLAN RISK PLAN ETC.**		**Being Open & Duty of Candour to be implemented**	**3 DAY REVIEW REQUIRED RCA LEVEL 2 REQUIRED** **STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**	**STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**
DEATH	Not applicable	Not applicable	EXPECTED deaths of a patient under the care of community or inpatient services where there is an agreed end of life care plan in place	Unexplained/unexpected death of a patient currently under the care of community services	Unexplained/unexpected Inpatient or Prisoner death or Inpatient AWOL/Abscond resulting in Death - this includes any Inpatient death whilst on authorised leave NEVER EVENT - Suicide using non-collapsible rails
ACCIDENTS	Accident with no HARM Not RIDDOR reportable	Accident with minor harm e.g.: LOCAL First Aid Required or absence from work for less than 7 days. Not RIDDOR reportable	Accident with moderate harm (ie requiring medical treatment, Staff needle stick injuries or accident resulting in absence from work for over 7 days or occupational disease (ie carpet tunnel syndrome or dermatitis). Potentially RIDDOR reportable	Accident with significant harm (i.e. requiring urgent or major treatment including fractures or loss of consciousness or significant occupational disease BUT NOT DEEMED PERMANENT RIDDOR reportable	LEVEL NOT APPLICABLE Accident resulting in death needs reporting as a "Death" category incident. ALL NEVER EVENTS FOR ACCIDENT CATEGORY

Being Open & Duty of Candour policy to be implemented for patient Safety Incidents resulting in moderate harm, significant harm or death

Face to face meeting to be offered/take place with service User /carer and outcome of meeting/conversation recorded and shared with service user/Carer & then uploaded into Datix

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
INVESTIGATION	**MANAGE LOCALLY / CARE PLAN RISK PLAN ETC.**		**Being Open & Duty of Candour to be implemented**	**3 DAY REVIEW REQUIRED RCA LEVEL 2 REQUIRED** **STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**	**STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**
VIOLENCE, AGGRESSION, AND ALL ASPECTS OF ABUSE & DISCRIMINATION	Incident with no direct harm.	Incident with low harm that may require ,local first aid or support required from a member of staff Not RIDDOR reportable	Incident causing moderate harm or psychological harm (experienced for up to 28 days but not deemed permanent but requiring medical or psychological intervention) Potentially RIDDOR if staff injured and absent from work for more than 7 days.	Incident causing serious harm that may require urgent treatment and transfer to another care provider e.g. A&E (i.e. loss of consciousness). allegation of abuse/physical misconduct or harm to a service user by a member of GMW staff RIDDOR reportable	Patient safety incident as a result of the care provided by the trust casuing serious harm that could be permanent Act of violence causing Death by a GMW Patient to a member of the public (ie Homicide)
ESCAPE (Patient from Medium or Low Secure Services who has left without the permission and knowledge of staff)	Not applicable	Not applicable	Not applicable	Patient escapes from Low Secure adult services.	Patient escapes from Medium (adult or adolescent services). NEVER EVENT - Escape of a transferred prisoner
AWOL/ where patient does not return from agreed leave on time **ABSCOND** when a patient absconds from an escort or leaves the ward without staff knowing **Missing** community patient is missing from a known address and cannot be contacted	Where Patient assessed as posing no risk of harm to self or others **REPORT AS "LATE BACK" IF PATIENT HAS NOT RETURNED WITHIN 5 HOURS**	Patient - assessed as posing LOW risk of harm to self or others but where the staff are aware of whereabouts or are in contact with the patient **REPORT AS "LATE BACK" IF PATIENT HAS NOT RETURNED WITHIN 5 HOURS**	Not applicable	Where Patient - assessed as posing as a significant risk of harm to self or others. Report immediately as AWOL/ABSCOND/MISSING	LEVEL NOT APPLICABLE If patient dies whilst AWOL/Abscond report incident under "Death" category

Being Open & Duty of Candour policy to be implemented for patient Safety Incidents resulting in moderate harm, significant harm or death

Face to face meeting to be offered/take place with service User /carer and outcome of meeting/conversation recorded and shared with service user/Carer & then uploaded into Datix

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
INVESTIGATION	**MANAGE LOCALLY / CARE PLAN RISK PLAN ETC.**		**Being Open & Duty of Candour to be implemented**	**3 DAY REVIEW REQUIRED RCA LEVEL 2 REQUIRED**	
				STEIS REPORTABLE Being open & Duty of Candour to be implemented	**STEIS REPORTABLE** Being open & Duty of Candour to be implemented
UNDER 18 ADMISSION	Not applicable	Not applicable	Under 18 Admission to adult ward. If more than 48 Hrs CQC notification required	Under 18 Admission to adult ward. If more than 72 Hours upgrade to Level 4 complete RCA level 2 reviews to include rationale for admission and immediate management, forward planning and reasons for length of stay.	Not applicable
MEDICATION Also refer to other Medication guidance	No potential to cause harm to patient, no breach of policy	Isolated incident potential to cause low/minor harm e.g. additional dose of correct meds, minor breach of policy but no legal infringement	Incident resulting in moderate harm to a patient or Cluster of similar minor incidents demonstrating high risk of reoccurrence, isolated incident with potential to cause moderate harm, significant breach of policy/professional standards	Incidents resulting in significant harm but not deemed to be permanent harm Cluster of moderate harm incidents, isolated incident with potential to cause significant harm e.g. change of care setting, prolonged additional observations, legal breach	NEVER EVENT MEDICATION ERRORS Extensive Permanent harm caused. If patient dies as a result of a Medication error report incident under "Death" category
SELF HARM	Self-harm as part of Service users known Clinical presentation, No physical treatment or intervention required CAN BE REPORTED AS A CLUSTER ON ONE INCIDENT FORM PER INPATIENT SHIFT OR PER COMMUNITY CONTACT	Self-harm deemed to be as part of Service users known clinical presentation where minor treatment / intervention is required i.e. local first aid.CAN BE REPORTED AS A CLUSTER ON ONE INCIDENT FORM PER INPATIENT SHIFT OR PER COMMUNITY CONTACT	Actual Self harm/suicide attempt assessed as requiring further intervention or treatment via A&E dept.	Actual act of Self harm/or attempted suicide that could be deemed as life-threatening that requires urgent medical intervention to preserve life.	LEVEL NOT APPLICABLE Self-Harm resulting in death needs reporting as a "Death" category incident.

Being Open & Duty of Candour policy to be implemented for patient Safety Incidents resulting in moderate harm, significant harm or death

Face to face meeting to be offered/take place with service User /carer and outcome of meeting/conversation recorded and shared with service user/Carer & then uploaded into Datix

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
INVESTIGATION	**MANAGE LOCALLY / CARE PLAN RISK PLAN ETC.**		**Being Open & Duty of Candour to be implemented**	**3 DAY REVIEW REQUIRED RCA LEVEL 2 REQUIRED** **STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**	**STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**
PATIENT CARE	Reduced quality of patient experience/clinical outcome not directly related to delivery of clinical care	Unsatisfactory patient experience/clinical outcome directly related to care provision - readily resolvable.	Unsatisfactory patient experience relating to the poor care delivery by a GMW service that may result in moderate harm being caused to a service users, relapse of their mental health symptoms or may warrant an extended admission or re-admission back into hospital	Unsatisfactory patient experience relating to the poor care delivery by a GMW service that may result in significant harm occurring to the service user clinical outcome: long term impact - expected recovery longer than1wk.	Unsatisfactory patient experience/ clinical outcome: continued ongoing long term mental /physical effects.
PRESSURE ULCERS & VTE	Not applicable	Not applicable	Grade 1 Pressure Ulcer or Hospital acquired VTE that requires VTE RCA Completing in Datix	Grade 2 Pressure Ulcer requires PURCA completing in Datix and safeguarding alert if community acquired.	Grade 3&4 Pressure Ulcers requires PURCA and Safeguarding alert.
SECURITY & ILLICIT SUBSTANCES (including legal highs)	Security concern/breach with no significant impact Suspicion of illicit substance use on an inpatient setting	Security concern/breach with minor impact Use of illicit substances on an inpatient setting	Security concern/breach with moderate impact (i.e. disruption for up to 24 hours) Use of illicit substances requiring medical treatment of an inpatient or dealing of illicit substances on Trust premises	Security concern/breach with significant impact (to include loss of keys for medium secure services) Significant harm (i.e. requiring urgent or major treatment) from use of illicit substances	Secuity conern/breach with major impact resulting in overwhelming disruption if Patient Dies from the use of illicit substances record under "Death" category
SERVICE DISRUPTION / FAILURE (May relate across several categories. eg: IT, environmental, flooding, heating, infection or contractual failure)	Disruption / failure of services for a brief period of time - no significant impact	Small scale localised disruption / failure of services that threatens to compromise the continued delivery of critical business functions - disruption for up to 8 hours	Larger scale disruption / failure of services that threatens to compromise the continued delivery of critical business functions - disruption for 24 hours	Significant disruption / failure of critical business functions for more than 24 hours triggering the Trust Business Continuity Plan, includes loss of keys for medium secure services.	Overwhelming disruption / failure of critical business functions resulting in declaration of a major incident or business continuity incident that involves multiple stakeholders.

Being Open & Duty of Candour policy to be implemented for patient Safety Incidents resulting in moderate harm, significant harm or death

Face to face meeting to be offered/take place with service User /carer and outcome of meeting/conversation recorded and shared with service user/Carer & then uploaded into Datix

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
INVESTIGATION	**MANAGE LOCALLY / CARE PLAN RISK PLAN ETC.**		**Being Open & Duty of Candour to be implemented**	**3 DAY REVIEW REQUIRED RCA LEVEL 2 REQUIRED** **STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**	**STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**
FIRE	Fire not started deliberately and confined to item first ignited with no fire or smoke spread and no one affected	Fire not started deliberately and confined to item first ignited. with minor smoke damage in the room of origin only and no one affected	Fire not started deliberately and confined to item first ignited. with moderate smoke damage confined to the room of origin only and no one affected	Fire was started deliberately with fire or smoke spread beyond room of origin or Fire involving bottled gasses, aerosols, dangerous chemicals. Full evacuation of the unit/building or Persons effected by fire/smoke or Major failure of local fire procedures,or fire warning systems or back up emergency lighting	Fire was started deliberately with fire/smoke spread to adjacent rooms/areas or Fire involving bottled gasses, aerosols, dangerous chemicals Full evacuation of the unit/building Fatalaties or injuries requiring hospitilisation and/or Major failure of local fire procedures, fire warning systems or back up emergency lighting
FALSE ALARM	Disruption / failure of services for a brief period of time - no significant impact Fire procedures followed	Small scale localised disruption / failure that threatens to compromise the continued delivery of critical business functions - disruption for up to 3 hours Fire procedures followed	Larger scale disruption / failure of services that threatens to compromise the continued delivery of critical business functions - disruption for 3 - 8 hours. Fire procedures not followed More than one false alarm in 24 hours from same ward/department /area	Significant high number of false alarms resulting in improvement notice from enforcing authority Incident had potential to cause a serious fire	Significant high number of false alarms resulting in enforcement action/prosecution by enforcing authority Incident had potential to cause seroius fire

Being Open & Duty of Candour policy to be implemented for patient Safety Incidents resulting in moderate harm, significant harm or death

Face to face meeting to be offered/take place with service User /carer and outcome of meeting/conversation recorded and shared with service user/Carer & then uploaded into Datix

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
INVESTIGATION	**MANAGE LOCALLY / CARE PLAN RISK PLAN ETC.**		**Being Open & Duty of Candour to be implemented**	**3 DAY REVIEW REQUIRED RCA LEVEL 2 REQUIRED** **STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**	**STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**
INFORMATION GOVERNANCE	Fax sent internally to wrong location and intercepted by staff that contain no identifiable data	Fax sent internally to wrong location and intercepted by staff that contained limited demographic data e.g. name and address equivalent to a telephone directory	Fax sent internally /externally to wrong location that contained limited clinical data e.g. clinic attendance, ward handover sheet	Fax sent internally and intercepted by staff that contained sensitive personal data that would cause significant distress e.g. mental health assessments, CPA or Star V.2	Fax sent externally and intercepted by member of the public that contained sensitive personal data that would cause significant distress e.g. mental health assessments, CPA or Star V.2
	Lost ID badge found in an office within a secure area	Lost ID badge found in reception area	Lost ID badge in non-clinical public area e.g. Staff car park	Lost ID badge found in public / Ward	Lost ID badge found in public / ward and unauthorised access to restricted area / Patient absconds
	Internal email sent to wrong staff member within GMW that contains no identifiable information	Email sent internally to wrong staff member that contained limited demographic data e.g.name and address equivalent to a telephone directory	Email sent internally/externally to wrong person that contained limited clinical data e.g. appointment time and location of appointment	Email sent internally to GMW staff member in error that contained detailed personal information e.g. supervision record, sickness record, diagnosis, medication	Email sent externally to member of the public that contained sensitive personal information likely to cause significant damage and distress e.g. medical history, family background, criminal record, history of abuse,
	Inaccurate information that has no adverse effect to a patient e.g.	Inaccurate information that doesn't indirectly affect patient e.g. wrong staff member on letter	Inaccurate information that affects the patient e.g. incorrect appointment time/ appointment location	Inaccurate information that affects the patient's care/treatment e.g. wrong name on letter, incorrect address	Inaccurate information that could cause significant harm to the patient e.g. wrong medication, wrong diagnosis
	Encrypted media lost/stolen/misplaced on site	Encrypted media lost/stolen/misplaced externally	Unencrypted media lost containing no clinical/personal data e.g. presentation notes, Internet pages, statistics	Unencrypted media lost/stolen/misplaced containing detailed clinical information e.g. name, address, appointment	Unencrypted media e.g. laptop, PC, mobile phone, USB stick containing sensitive personal data that is lost/stolen/misplaced which would cause significant damage and distress to affected individual/s

Being Open & Duty of Candour policy to be implemented for patient Safety Incidents resulting in moderate harm, significant harm or death

Face to face meeting to be offered/take place with service User /carer and outcome of meeting/conversation recorded and shared with service user/Carer & then uploaded into Datix

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
INVESTIGATION	**MANAGE LOCALLY / CARE PLAN RISK PLAN ETC.**		**Being Open & Duty of Candour to be implemented**	**3 DAY REVIEW REQUIRED RCA LEVEL 2 REQUIRED** **STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**	**STEIS REPORTABLE** **Being open & Duty of Candour to be implemented**
INFORMATION GOVERNANCE cont.	Letter sent to wrong location internally that has no adverse effect to patient/staff	Letter sent to incorrect location internally opened and only containing limited demographic data e.g. name and address equivalent to a telephone directory	Opened letter sent to wrong address that contained limited clinical data e.g. appointment time/appointment location (the recipient does not know patient affected)	Letter sent to wrong address containing detailed clinical information e.g. name, diagnosis, treatment etc (patient doesn't know affected individual)	Letter sent to wrong address containing sensitive personal data e.g. CPA, Star V.2 opened by neighbour and taken round to client which causes significant harm and distress to client as a result e.g. threats/harrassment made
	Confirming the name of a patient internally in an open planned office	Confirming limited demographic data to recipient of patient e.g. name and address without consent	Disclosing information to the Police or other NHS trust without following safe haven procedure e.g. Confirming identity	Disclosing information externally that identifies an individual and releasing detailed clinical information e.g. diagnosis, medication without consent	Disclosing information on the phone likely to attract media attention / police attention e.g confirming if a VIP or offender was in GMW
	Clinical information breached that doesn't directly identify an individual e.g. report only containing clinical number	Clinical information breached which contain limited demographic data e.g. name and address equivalent to a phone book	Limited clinical data breached e.g. appointment time and location of appointment via any method	Detailed clinical information breached e.g. case notes, report lost in the public domain	Detailed clinical information lost likely to attract media or police attention e.g. celebrity record breach or clinical information sold for profit

Medication Level Guidance

Examples	Incident Level Guidance	Incident Level Guidance	Incident Level Guidance	Incident Level Guidance	Incident Level Guidance
	Level 1	Level 2	Level 3	Level 4	Level 5
Finding a loose tablet on a bedroom or clinic floor	✓	X	X	X	X
Search of service user on admission recovers medication	✓	X	X	X	X
The wrong volume/amount of medication which is then corrected on a second check (near miss)	✓ If a colleague picks up this error	✓ If the service user picks up this error	X	X	X
Service user reporting loss of CD prescription	✓	X	X	X	X
Missing prescription	✓ Service user loses GMW Prescription	✓ GMW Staff	X	X	X
Service user reports hoarding or secretion of medication administered on the ward	✓	✓ Long term unnoticed by staff	X	X	X
Incorrect storage conditions for medication	✓ Short term	✓ Long term	✓ Large financial or clinical implications	X	X

Infringement of security around storage and delivery of medication (in staff only areas)	X	✓	X	X	X
Medication administered before start date/after stop date (causing potential or actual minor harm, this depends on medication)	X	✓ If no harm to the service user	✓ If extra observation is required	✓ Potential/ actual harm to service user of, change of care setting	✓ Permenant Harm or Death

Examples	**Incident Level Guidance**	**Incident Level Guidance**	**Incident Level Guidance**	**Incident Level Guidance**	**Incident Level Guidance**
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Service user brings in medication from home and continues to use it in the in-patient setting	X	✓ e.g. eye drops or inhaler	✓ Potential Harm	✓ Double dose of medication such as paracetamol e.g. actual harm	✓ Permenant Harm or Death
Prescribing, transcribing, dispensing or administration error resulting in service user receiving incorrect dose of the correct medication	X	✓	✓ Potential Harm or parental administration	✓ Actual Harm	✓ Permenant Harm or Death
Prescribing, transcribing, dispensing administration error resulting in service user receiving an incorrect type of medication	X	X	✓ Potential Harm	✓ Actual Harm	✓ Permenant Harm or Death
Service user not receiving intended medication due to a breakdown in order/supply chain	X	✓ Short term <48 hrs	✓ Long term >48 hrs	✓ Actual Harm	✓ Permenant Harm or Death
Administering medication from an unsigned medication card	X	✓ Short term <48 hrs	✓ Long term >48 hrs	X	X
Omission of depot to a service user due to staff error	X	✓ Short term <48 hrs	✓ Long term >48 hrs	X	X

Examples	**Incident Level Guidance**	**Incident Level Guidance**	**Incident Level Guidance**	**Incident Level Guidance**	**Incident Level Guidance**
	Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Legal infringement of CD policy	x	✓ Minor	✓ Moderate	✓ Major	x
Illegible Prescription resulting in administration of wrong drug or wrong dose	✓ Amended before administration	✓ Minor	✓ Moderate	✓ Major	✓ Permanent harm or death
Student nurse administering medication without supervision	x	x	✓	✓ Change of care setting	✓ Permanent harm or death
Prescribing, dispensing or administering a medication where the service user has clearly identified allergy to it	x	x	✓	✓ Change of care setting	✓ Permanent harm or death
Service user reporting loss of CD medication	x	✓	x	x	x
Administration of a dose of Clozapine following: - A red result - >48 hour period without Clozapine	x	x	x	✓	✓ Permanent harm or death
Never Event- Maladministration of Insulin, Opioid Overdose of an opioid-naïve service user	x	x	x	✓	✓
Medication error resulting in extensive permanent injury of death	x	x	x	x	✓

DATIX INCIDENT AND NEAR MISS REPORTING FORM (DIF1)

V2

ONLY USE THIS FORM IF DATIX SYSTEM IS INACCESSIBLE FOR MORE THAN 24 HOURS
COMPLETE IN FULL AND E-MAIL TO incidents@gmmhH.nhs.uk

If you require any assistance please contact the Incidents Team
On: Tel: (0161) 358 2099

Incident Details (DIF1)	
Date of Incident:	
Time of Incident: 24hr (hh:mm)	
Directorate:	
Location of Incident:	
Exact Location: i.e. bedroom, Corridor	
Incident Category & Description	
Incident Type: (Person affected: Patient, Staff etc)	
Incident Category: (Accident, Violent & Agg etc)	
Incident Subcategory:(Slip / Verbal abuse etc)	
Incident Classification: (Actual or Near Miss)	
Description of Incident: Please be factual / **DO NOT** use full names of people. Initials **CAN** be used.	
Immediate Action taken	

PLEASE ENSURE THAT STATEMENTS AND TIMELINES HAVE BEEN TAKEN FROM ANY STAFF PRESENT AT THE INCIDENT BEFORE THEY LEAVE THE WORKPLACE WHERE POSSIBLE					
Constraints & Alerts Section					
Was Seclusion used:	Yes / No	Was PMVA Used:	Yes / No	Was PMVA used: (older adults)	Yes /No
If PMVA used please describe names of staff and holds used:					
Was Safeguarding Alert Instigated?	Yes / No	If Yes what action taken:			
PARIS Section					
PARIS Client ID:			PARIS Case ID:		
Consultant / Responsible Practitioner (if applicable)					

Person(s) Affected by Incident (if applicable)	**Person 1**	**Person 2**	**Person 3**
Name			
Type (i.e. patient, staff, visitor)			
Subtype (i.e. Inpatient or nurse)			
Was person physically Injured	Yes / No	Yes / No	Yes / No
Type of injury: (please describe)			
Body part affected: (describe)			
Treatment received			

All Other Persons Involved	**Role 1**	**Role 2**	**Role 3**
Role played within Incident i.e. Perpetrator, Witness etc			
Name in Full			
Type (i.e. patient or staff)			
Subtype (i.e. Inpatient, nurse etc)			

Were police called:	Yes / No If Yes, Complete details	Time Called:	
		Time Arrived:	
		Officers Name:	

Reporter Details

Reporter Name:		Reporter Job Title :	
Reporter Phone Number:		Date Reported :	

The section below **MUST** be completed by the DIF2 Manager before emailing/faxing to Governance

DIF2 SECTION			
Degree of Harm to person involved This relates to physical or psychological harm Tick		**Incident Level:** Refer to Guidance Tick	
Not Applicable – No person directly involved		**Level 1**: (Grey)	
Unknown – Patient still missing		**Level 2**: (Green)	
Insignificant – no obvious harm		**Level 3**: (Yellow)	
Minor – Minor harm may require first aid/support		**Level 4**: (Amber)	
Moderate – Moderate harm requiring treatment		**Level 5**: (Red)	
Major – Major Permanent or long term harm			
Investigation Details			
Please indicate type of investigation required:	Tick	If none required please give rationale below:	
Care Plan updated			
Managed Locally			
Risk assessment completed			
3 day Review			
SIR 1 / 2 Local			
Individual Staff Review (ISR)			
DIF2 Manager	Name:	Signature:	Date:

Appendix 14– Definition of CQC Requirements for the Reporting of Detained Patient

DEFINITION OF CARE QUALITY COMMISSION (CQC) REQUIREMENTS FOR THE REPORTING OF DETAINED PATIENT DEATHS & AWOLS			
CATEGORY	**CQC STATUTORY REPORTING REQUIREMENTS**	**TIMESCALES**	
DETAINED PATIENTS ONLY	**All CQC Forms to be attached as a Document to the Datix Incident and an Email Communication sent to incidents@gmmh.nhs.uk within the required timeframes.** **Services DO NOT send Notifications directly to CQC. This is the responsibility of Clinical Governance**	**Services to Send CQC Form to Governance**	**Governance to Submit CQC once Quality Checked**
LOW, MEDIUM SECURE SERVICES **AWOL, Escape Abscond**	Services that are designated as low, medium or high security should use the form to notify **GOVERNANCE** of **all incidences of absence without leave (AWOL)**. Services should complete the CQC Notification Form **attach to the Datix Incident and inform Clinical Governance using the Email Communication.**	DIF2 Manager to complete by **9.00AM Next Working Day**	Governance to send to CQC by **10.00AM Next Working Day**
ALL SERVICES **Unexpected Death of Sectioned patient**	From 1 April 2010, NHS service providers will be required to make notifications about the death of a patient who is **detained** or liable to be detained as a condition of registration under the Health and Social Care Act 2008. Services should use the CQC Death Notification form to notify **Clinical Governance** of **all incidences of Deaths of Detained Patients, attach to the Datix Incident and inform Clinical Governance using the Email Communication.**	DIF2 Manager to complete by **9.00AM Next Working Day**	Governance to send to CQC by **10.00AM Next Working Day**
All SERVICES **Admission of under 18 onto an adult ward**	When a child or young person under the age of 18 is admitted to an adult psychiatric ward or unit and where the placement lasts for a continuous admission for a period of 48 hours or longer. Services should complete the CQC Notification Form **attach to the Datix Incident and inform Clinical Governance using the Email Communication.**	DIF2 Manager to complete by **9.00AM Next Working Day**	Governance to send to CQC by **10.00AM Next Working Day**

Appendix 15 – Root Cause Analysis Tool Kit

All types of incidents need to be investigated; the level of the investigation is dependent on the severity of the incident and whether the incident was actual or potential. The underlying principle for all investigation is Root Cause Analysis.

Root Cause Analysis is a structured investigation to;

- Enable the right questions to be asked to reveal the cause of actual or potential incidents.
- Identify any further contributing factors.
- Produce the appropriate recommendations for a change in practice.
- The identification of the root causes of an incident, enable them to be addressed to ensure that the same situation does not arise in the future. The most basic form of Serious Incident Review would be to ask the questions 'What?', 'How?' and 'Why?'
- Root Cause Analysis involves the interviewing of all the staff members involved in the incident to enable them to develop ideas about why an incident took place, rather than taking a formal written statement that would not allow the causes of the incident to be fully explored.

The Trust provides training courses eg how to chair a Serious Incident Review training for Senior Managers and Line Managers; this will ensure that there is a consistent quality of investigation. The Head of Patient Safety & Governance will also be available to assist with any issues that arise with the investigation.

Serious Incident Review - The Process

Mapping the Events

Once all the information has been gathered the SIR investigation team will piece this together to establish the chain of events that led up to the incident itself. This process will also be helpful in developing ideas about how to adapt the system to prevent repeated incidents. Where possible staff directly involved in the incident will be included in the mapping team.

Analysis of Information

Once the data analysis has been completed the information needs to be analysed to identify the root causes, contributing factors and lessons that can be learned.

At this stage of the investigation the investigation team must not allow any bias from the outcome or hindsight to influence their conclusions. The team will use a variety of Root Cause Analysis techniques to assist in the analysis of information gathered including;

- Diagrammatic time lines: This process can provide a greater degree of clarity about the stages of the event chain and are useful to view the incident as a whole.

- Five 'Whys': This technique is used to delve ever deeper into a problem asking 'why' for each primary cause that is identified until there are no more causes forthcoming.
- Brainstorming: This technique can help the investigation group identifying issues they believe need further exploration and can be linked to the Five Whys.
- Fishbone: This is where a long horizontal line is drawn and at the head of this is the problem to be explored. Spines are then added to the arrow, each representing the main areas to be explored for contributory factors.
- Barrier Analysis.
- A barrier is a defence or control measure put in place to prevent harm to vulnerable or valuable objects for example people, buildings, organisational reputation and the wider community.
- There are four main types of barrier, which are:
- Physical barriers: These are the most reliable barriers such as locked or controlled doors, mandatory fields on computer programmes, double locked cupboards with separate individuals holding the keys necessitating both to be present to unlock them.
- Natural barriers: These are barriers of distance time or place such as pre and post-operative swab counts, giving Methotrexate and Vincristine on separate days by different people and 10 minute break between a pharmacist's first check and the dispensing of a drug.
- Human action barriers: Such as checking a patient's identification before administering treatment and surgical site marking.
- Administrative barriers: Such as protocols and procedures, checklists, alert notices and professional registers.

Identifying which incidents, complaints or claims need to be investigated

All types of incidents need to be investigated. The level of the investigation is dependent on the severity of the incident and whether the incident was actual or potential. The underlying principle for all investigation is Root Cause Analysis.

Serious Incident Review (SIR) a structured investigation to;

- Enable the right questions to be asked to reveal the cause of actual or potential incidents.
- Identify any further contributing factors.
- Produce the appropriate recommendations for a change in practice.

The identification of the root causes of an incident enables them to be addressed to ensure that the same situation does not arise in the future. The most basic form of Serious Incident Review would be to ask the questions 'What?', 'How?' and 'Why?'

Serious Incident Review involves the interviewing of all the staff members involved in the incident to enable them to develop ideas about why an incident took place, rather than taking a formal written statement that would not allow the causes of the incident to be fully explored.

The Trust provides specific incident management training to senior managers around Serious Incident Review and how to lead a SIR review this will ensure managers that there is a consistent quality of investigation. The Assistant Director of Clinical Governance will also be available to assist with any issues that arise with the investigation.

Gathering Information

The person leading the investigation will be responsible for ensuring that statements are obtained from everyone involved in the incident and that the statements are written detailing fact not opinion. They will also be responsible for ensuring that all statements include the relevant dates and times and are signed and dated. The investigation officer must also ensure that copies are made of any records relating to the incident and that these are stored safely and securely to prevent any breach of confidentiality.

Data collection prior to the investigation will be required and may include the following;

- Copies of the Datix incident form and 3DR
- Copies of incident forms from related adverse incidents.
- Examination of the physical environment including non-digital photographs and other evidence from the incident scene including any equipment involved.
- Medical records including test results.
- Copies of environmental or individual risk assessments, Health and Safety inspections and/or clinical audit reports relevant to the investigation.
- Copies of policies and procedures, national and professional guidance relevant to the incident.
- Duty Rota's for staff and managers involved.

Conducting Interviews

From time to time it will be necessary to conduct more in depth interviews with staff, patients and/or relatives to find out what happened and why it happened.

An interview increases both the quality and quantity of information obtained and establishes a chronology of events, which can be compared with the responses made by other staff that will be interviewed.

The interview must always be conducted in private and should be conducted by the lead investigator. The Interview should be supportive and non-judgemental and **tape recorders or Dictaphones are not encouraged** as this raises staff anxieties. In some circumstances staff involved may wish to have a colleague attend and support them at the interview. Staff may require additional support and/or counselling following an adverse incident and this should be offered at this stage if it has not already been offered. Please refer to 'supporting staff following a traumatic event' policy.

Analysis of Incidents, Complaints and Claims

Greater Manchester Mental Health NHS Foundation Trust value the effective reporting and management of incidents, complaints, and claims, as a key component of not only Risk Management but also of Clinical Governance and essential for the delivery of high quality safe patient care. Effective reporting and management of incidents, complaints and claims will also ensure the health and safety and well-being of staff, contractors and visitors to the Trust.

Aims and objectives

The key objectives of the Trust's Incident Reporting Procedure are that;

- An over-view of all incidents, complaints and claims is obtained throughout the whole Trust by analysis of data.
- Any lessons which can be learned from what has gone wrong in one part of the Trust can be applied generally across the whole Trust.
- Effective reporting to statutory agencies occurs from a centralised managed point.
- A learning and fair blame culture is fostered.
- Loss of reputation, assets of the Trust and its staff is minimised and there is effective implementation of the Trust's Risk Management Strategy.

As stated above the over-riding emphasis of the incident reporting procedure is to solve and learn from problems but not to attribute individual blame. It is important that all the facts of incidents, complaints, and claims, are reviewed. It is rarely one person's fault that an incident has occurred but usually a combination of events, systems and organisational failures.

Learning & Sharing

The Trust is keen to learn from incidents and is always exploring how lessons following SUIs and inquests can be shared trust wide. The Trust has therefore established a quarterly Lessons Learned Newsletter which is distributed across all services.

Systems such as the National Reporting and Learning System, also help us to identify hazards and evaluate why patients safety incidents may occur compared against our other neighbouring trusts , Together with our internal Risk Management System Datix data collected is used to aggregate and analyse our incidents in order to improve patient safety.The data is then reported to the RMG

Appendix 16 – Post Incident Review Group (PIR) Terms of Reference

Membership:
Medical Director (Chair)
Director of Nursing and Governance (Vice Chair)
Associate Director of Nursing & Governance
Deputy Director of Governance
Head of Patient Safety & Governance
Head of Investigations
Senior Nurse for Integrated Health Care
Clinical Governance Leads
Incident Administrator (Minute taker)

Frequency of meetings:

- Monthly

Role:

- To review Serious Incident Review investigation reports, commissioned by the SUI panel, where the investigating panel is independent of the directorate in which the incident occurred
- To agree further action, amendments or additional information be added to the Serious Incident Review ahead of CCG submission.
- To receive assurances from investigation team and Head of Operations/Senior Manager that the investigation addresses Terms of Reference set and actions to address learning
- To sign off completed final Serious Incident Review reviews
- To seek assurance on care provision or working practices that need discussion with the Service Head of Operations or Associate Medical Director with respect to on-going care management.
- To establish patterns and themes from SUIs.
- To receive progress reports from the Nursing & Governance Department about the timeliness of Serious Incident Review reviews in line with national timeframes.
- To commission and receive progress reports on Directorate Positive Learning Events
- To appraise the Chief Executive of any major concerns of patterns or severity of individual incidents.
- To receive reports from the Nursing & Governance Team on actions from Serious Incident Reviews
- Nursing & Governance Team to share lessons learned from the panel through the Positive Learning splash screens, positive learning events and other methods as appropriate.
- Deputy Director of Governance / Head of Patient Safety & Governance to report concerns raised by the PIR panel to the Trust Risk Management group for discussion and action. Deputy Director of Governance / Head of Patient Safety & Governance to report back to the PIR Panel on actions taken as a result of concerns raised.

- For identified local or corporate risks from reviews to be recorded in the Trust Risk Register and action taken to resolve the risk
- RCA review themes and positive learning to be presented to the Quality Governance Committee (QGC) by the Deputy Director of Governance
- To receive Inquest report from the Nursing & Governance Team of forthcoming inquests where concerns have been found in the serious incident report and where coroners recommendations are anticipated
- To receive progress reports from the Nursing & Governance Department in regards to Regulation 28.

- **Safeguarding/Domestic Homicide Independent Management Reviews (IMRs)**
- Director of Nursing and Governance/Deputy Director of Governance to inform the Panel of requests for Independent Management Reviews and provide a brief summary of GMMH involvement and if known/relevant who will be representing GMMH on the Serious Case Review panel
- On completion the IMR the author and Head of Service to present findings and action plans as if for a RCA review and progress a learning event as appropriate
- On completion of the Serious Case Review/Domestic Homicide Review, the Director of Nursing & Governance/ Deputy Director of Governance will discuss the significant findings of the report, its implications for GMMH and the action plan produced
- The IMR/Serious Case Review GMMH action plan will be monitored by the PIR Panel
- Director of Nursing and Governance/ Deputy Director of Governance will inform the Joint Safeguarding Group of the findings from the IMR/SCR
- Key findings from the IMR/SCR will be presented to the Quality Governance Committee (QGC) and the Trust Board by the Director of Nursing and Governance/ Deputy Director of Governance

Quorum:

- Chair or Vice Chair
- Associate Director or Deputy Director of Governance
- Senior Governance Representative
- Minute Taker

Reporting to: Quality Governance Committee

Accountable to: The Trust Board

Review: Terms of reference to be reviewed every 12 months within the Post Incident Review panel and in line with this policy or following any changes to national guidance relating to the reporting and reviewing of incidents.

Appendix 17 – Serious Untoward Incident Group Terms of Reference

1. PURPOSE:

1.1 To review 3DRs completed following Serious Incidents

1.2 To review and approve locally led Incident reviews prior to sharing with CCGs

1.3 To agree on review teams to lead an SUI review e.g. if a review will be locally lead or independently lead from where the incident occurred

1.4 To monitor where clusters or trends emerge following the reviewing of 3DRs and RCA reviews and agree where action required.

1.5 Advise on remedial actions if required

1.6 To agree Terms of Reference for Comprehensive Reviews commissioned by the panel

1.7 To escalate any risks and concerns to the Chief Executive

1.8 To review weekly unexpected death data escalating to mortality group

1.9 To review and agree Comprehensive Reviews e.g. in-patient unexpected deaths, that require presentation to the PIR panel which fall outside of CCG/Coroner timeframes

1.10 To review RCA 2's that don't meet the timeframe/capacity for PIR Panel in order to meet CCG or coroner deadlines

1.11 To feedback to investigating team and review updated report

1.12 To ensure that the learning is captured within the lessons learnt process

2. FREQUENCY OF MEETINGS:

2.1 Weekly.

3. REPORTS TO:

3.1 SUI Panel members weekly

4. MEMBERSHIP:

- Medical Director
- Director of Nursing & Governance
- Associate Director of Nursing & Governance
- Deputy Director of Governance
- Head of Patient Safety & Governance
- Head of Investigations
- Senior Nurse Integrated Care
- Clinical Governance Leads
- Member of the Incident Team

5. QUORUM:

5.1

- Chair or Vice Chair
- Associate Director or Deputy Director of Governance
- Senior Governance Representative

6. AGENDA:

6.1 The panel base report will be sent out weekly post review by the representative from Clinical Governance

7. REPORTING MECHANISMS:

7.1 The progress report and positive learning will then be incorporated into the PIR panel chairs report for the Quality Governance committee.

8. REVIEW:

8.1 The functioning of the Group will be reviewed every 12 months within the Post Incident Review Panel and in line with this policy or following any changes to national guidance relating to the reporting and reviewing of incidents

Appendix 18 –Example of an Individual Staff Review template that may assist teams

EXAMPLE TEMPLATE TO ASSIST IN COMPLETING A
INDIVIDUAL STAFF REVIEW (ISR)
FOLLOWING THE OCCURRENCE OF A PATIENT SAFETY INCIDENT E.G.
MEDICATION ERROR WHERE NO HARM HAS BEEN CAUSED

Datix number:

Name of member of staff having ISR:

Name of line manager conducting ISR:

Date ISR completed

Date incident occurred or was identified:

Summary of incident occurring:

- Individual staff account of any identified reasons, contributory factors, including human factors for occurrence of incident
- Identified lessons learned
- Any remedial action/individual objectives required and agreed
- Review date planned

Staff member signature: _____

Line Manager signature: _____

Appendix 19 - 3 Day Management Review Report

Datix number:

3 Day Review

Directorate:		**Service/Ward:**	
Patient Details			
Initials of Patient/staff member incident is related to:		**MHA Status: e.g. Detained/Informal**	
D.O.B:		**MHA Section:**	
		Diagnoses:	
		Learning Disability Diagnosis (primary/secondary)	
Incident Details			
Date & Time Incident occurred if known:		**Incident category:** *e.g. unexpected Death*	
when service were made aware of incident and by whom:			
Actual Incident Description (Summary of what happened)			
Describe harm/injuries caused to any individual involved:			
Date service user was last seen or discharged by GMMH Services:		**List all other providers & any other GMMH Service within the last 3 months of the incident occuring** *e.g. other Trusts involved in service users care or substance Misuse services i.e. Cumbria CMHT*	
Review Findings			
Describe where Care provided was in line with Trust policies and procedures (please include where notable practice was identified)			
Care and Service delivery concerns identified whilst under care of GMMH e.g. *staff lack of adherence to local & trust policies and procedures, missed opportunities by professionals during care pathway, gaps in care e.g. long delays in appts resulting in patient not being following up, or identified weaknesses in local systems & processes. please also consider Human factors that may have influenced individual behaviors resulting in e.g. staff error, actions or omissions during care delivery e.g. staff member was distracted due to noise in clinic resulting in drug error being made*			

Reasons as to <u>WHY</u> concerns during GMMH care have occurred e.g. *Reason why staff deviated from trust polices, reasons for gaps in care or missed opportunities by care team or errors occurring and any identified human factors that may have influenced individual staff behaviour leading up to incident occurrence.*

Identify if any of the problems/concerns identified above could be deemed to have been contributory or causal in any way to incident occurrence e.g. *Staff member new to role and had not yet accessed trust induction in risk management or local operational procedures, local operational procedure unclear as to frequency of face to face contact with patients*

Conclusions

SMART Recommendations -Please provide SMART recommendations with identified lead and realistic completion dates in response to any identified concerns found

Example of SMART recommendations -

- *CMHT operational procedure should be revised by the Team Manager before end of the month in order to emphasis frequency of face to face therapeutic sessions between Care Coordinator and patients. This then needs to be discussed at the next MDT Team meeting with each staff member signing to say they have read revised Operational procedure*
- *Bi monthly audits of care plans to be completed by Team Manager over the next 6 month and findings to be reported via Directorate Governance forum. Care plans will then be re-audited to demonstrate improvement in record keeping*

Remember each recommendation must include

Who? Identify a lead to complete the action

When? Include a date for the action to be completed

How? E.g. change to operational policy? Monitoring via line management supervision?

Arrangements for shared learning e.g. via MDT Positive learning Event

Being Open/Duty of Candour (Statutory obligation CQC Regulation 20)

Does this incident trigger the Trust Being Open process	Yes /No	**Please provide rational if not is indicated**	
If yes indicated please state if Service user and or carer have been informed face to face of incident and Being Open process implemented as per Trust policy **Please note: It is the offer of a face to face meeting that should take place within 10 operational days the meeting may occur after this time frame**	Yes/No	**Please provide rational if not**	

Name & Role of Investigating Manager:		**Report Completion Date:**	
Electronic Signature of Head of Operations approving this report		**Date Head of Operations approved:**	

Appendices (to include the following)

- Chronological Timeline of events
- Please ensure staff involved are asked to prepare Statements in preparation for any future review or inquest

Chronology of Events: Please do not use staff or service user names only roles

Date:	Time (24hrs):	Roles of individuals involved:	Description of Events:

Appendix 20 – Concise Serious Incident Review Template (SI 1)

Datix number:

Concise Serious Incident Review

Section One –	**Patient & Incident Details**		
Directorate:		**Service/Ward:**	
Patient Details			
Initials of Patient/staff member incident is related to:		**MHA Status: e.g. Detained/Informal**	
D.O.B:		**MHA Section:**	
		Diagnoses:	
Incident Details			
Date & Time Incident occurred if known:		**Incident category:** *e.g. unexpected Death*	
when service were made aware of incident and by whom:			
Actual Incident Description (Summary of what happened)			
Describe harm/injuries caused to any individual involved:			
Date service user was last seen or discharged by GMMH Services:		**List all other providers** *e.g. other Trusts involved in service users care or substance Misuse services i.e. Cumbria CMHT*	
Section Two –	**Review Findings**		
Describe where Care provided was in line with Trust policies and procedures (please include where notable practice was identified)			
Care and Service delivery concerns identified whilst under care of GMMH e.g. *staff lack of adherence to local & trust policies and procedures, missed opportunities by professionals during care pathway, gaps in care e.g. long delays in appts resulting in patient not being following up, or identified weaknesses in local systems & processes. please also consider Human factors that may have influenced individual behaviors resulting in e.g. staff error, actions or omissions during care delivery e.g. staff member was distracted due to noise in clinic resulting in drug error being made*			
Reasons as to <u>WHY</u> concerns during GMMH care have occurred e.g. *Reason why staff deviated from trust polices, reasons for gaps in care or missed opportunities by care team or errors occurring and any identified human factors that may have influenced individual staff behaviour leading up to incident occurrence.*			

Overall Root Causes to problems identified *Please include here evidence of root cause analysis methodology e.g. contributory factors headings (classification framework available on staff intranet / Integrated Governance / How to complete a Serious Incident Review' using RCA tools Guidance) N.B. Please address each root cause within the SMART recommendations and populate fishbone diagram at the end of the report*
Identify if any of the problems/concerns identified above could be deemed to have been contributory or causal in any way to incident occurrence e.g. *Staff member new to role and had not yet accessed trust induction in risk management or local operational procedures, local operational procedure unclear as to frequency of face to face contact with patients*
Section Three – Conclusions
Conclusions
Section Four – SMART Recommendations
SMART Recommendations - Please provide SMART recommendations with identified lead and realistic completion dates in response to any identified concerns found (SMART recommendations must mirror root causes identified) *Example of SMART recommendations* • *CMHT operational procedure should be revised by the Team Manager before end of the month in order to emphasis frequency of face to face therapeutic sessions between Care Coordinator and patients. This then needs to be discussed at the next MDT Team meeting with each staff member signing to say they have read revised Operational procedure* • *Bi monthly audits of care plans to be completed by Team Manager over the next 6 month and findings to be reported via Directorate Governance forum. Care plans will then be re-audited to demonstrate improvement in record keeping* **Remember each recommendation must include** Who? Identify a lead to complete the action When? Include a date for the action to be completed How? E.g. change to operational policy? Monitoring via line management supervision?
Section Five – Shared Learning
Arrangements for shared learning e.g. via MDT Positive learning Event
Section Six – Being Open/Duty of Candour (Statutory obligation CQC Regulation 20)

Does this incident trigger the Trust Being Open process	Yes /No	**Please provide rational if not is indicated**	
If yes indicated please state if Service user and or carer have been informed face to face	Yes/No	**Please provide**	

of incident and Being Open process implemented as per Trust policy		**rational if not**	

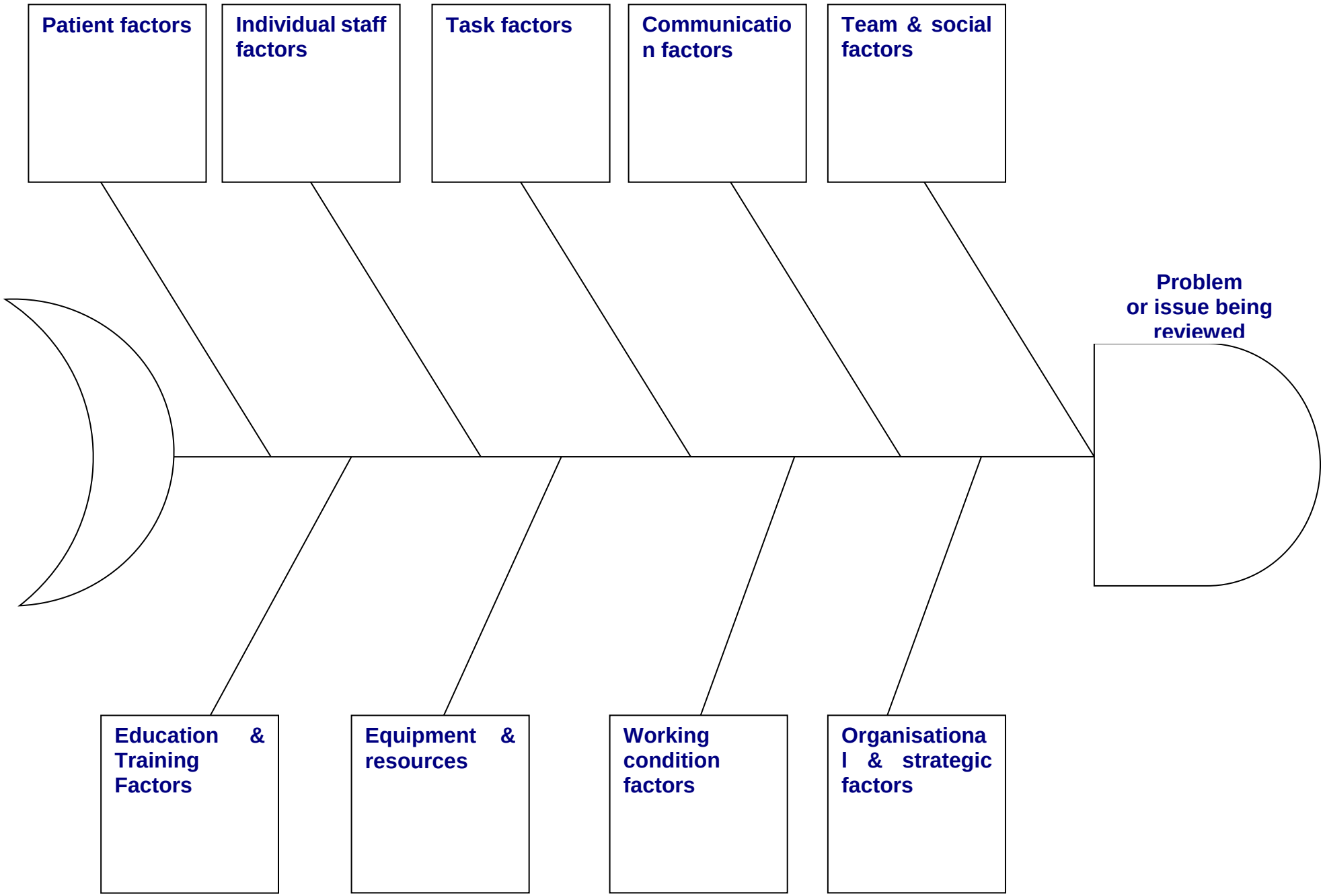
Section Seven –	**Investigator Details**		
Name & Role of Investigating Manager:		**Report Completion Date:**	
Electronic Signature of Head of Operations approving this report		**Date Head of Operations approved:**	

Section Eight - **Appendices (to include the following)**

- Chronological Timeline of events
- Fishbone Analysis
- Action Plan
- Staff interviews notes/statements
- Please ensure staff involved are asked to prepare Statements in preparation for any future review or inquest

Chronology of Events: Please do not use staff or service user names only roles

Date:	Time (24hrs):	Roles of individuals involved:	Description of Events:


Patient factors
Individual staff factors
Task factors
Communicatio n factors
Team & social factors
Problem or issue being reviewed
Education & Training Factors
Equipment & resources
Working condition factors
Organisationa l & strategic factors

Key to action plan categories

1. Policies & Procedures *e.g. these are relating to where Trust or local policies and procedures have not been adhered to or where local policy or procedure is unclear or requires strengthening*

2. Physical environmental *e.g. recommendations suggesting modifications are required to the environment in some way e.g. removal of ligature a specific ligature point in all bedroom areas on a ward*

3. Human factor *e.g. following human error, oversight or omission in care recommendations that may be around reminding a staff member to remember to follow a specific procedure*

4. Communication processes *e.g. recommendations relating to where there has been a lack of communication between staff e.g. between transitions of care and how these can be strengthened or records/assessments not kept up to date (records management)*

5. Training & Education *e.g staff not up to date with resus training or not accessed CRT*

6. Carer and Family engagement *e.g Carer or Family not engaged with service user's pathway.*

Example of Recommendation and Action Layout

Recommendation - *CMHT operational procedure should be revised by the Team Manager before end of the month in order to emphasis frequency of face to face therapeutic sessions between Care Coordinator and patients. This then needs to be discussed at the next MDT Team meeting with each staff member signing to say they have read revised Operational procedure*

Action No	Category of Action (Select category from the below) 1. Policies & Procedures 2. Physical environmental intervention 3. Human factor 4. Communication processes 5. Training & Education 6. Carer and Family engagement	Action Required	Responsible Lead (Initials & Role)	Action Lead	Planned Completion Date	RAG	If completed, Actual Completion Date
1	*Policies and Procedures*	*CMHT operational procedure to be revised in relation to face to face therapeutic sessions between care coordinator and service user*	*XX – Assistant Director*	*XX – Team Manager*	*31/01/2017*		
2	*Policies and Procedures*	*Revised CMHT operational procedure to be on the MDT meeting agenda (staff to sign once read)*	*XX – Assistant Director*	*XX – Team Manager*	*07/02/2017*		
3	*Policies and Procedures*	*Staff to sign that they have read revised CMHT operational procedure*	*XX – Assistant Director*	*XX – Team Manager*	*07/02/2017*		

Action Plan

Review leads will enter their recommendations into the action plan template prior to sharing report with the Head of Operations. Heads of Operations will then add responsible leads and completion dates prior to signing off the report and then send the Report and action plan back to the review lead who will submit to Governance

Investigation Report Action Plan Created Date_____

Please indicate if the action is a local team action or trust action. Heads of Operations are to incorporate actions for all reviews into the Datix action plan module and not using word documents.

Recommendation -							
Action No	**Category of Action** (Select category from the below) 1. Policies & Procedures 2. Physical environmental intervention 3. Human factor 4. Communication processes 5. Training & Education 6. Carer and Family engagement	**Action Required**	**Responsible Lead (Initials & Role)**	**Action Lead**	**Planned Completion Date**	**RAG**	**If completed, Actual Completion Date**
1							
2							
3							
4							

Appendix 21 – Comprehensive Serious Incident Review Template (SI 2)

Please indicate Level of Review
Comprehensive

DATIX NUMBER

STRICTLY CONFIDENTIAL
Serious Incident Review Template

PATIENT INITIALS & DATE OF BIRTH	
DIAGNOSES	
BRIEF DESCRIPTION OF INCIDENT:	
INCIDENT DATE:	
WARD/SERVICE:	
DIRECTORATE:	
REPORT COMPLETION DATE:	
REVIEW TEAM:	

Being Open & Duty of Candour (Important please complete all sections)

Where incident triggers the Being Open process
Has the Service User/Identified family member or Carer been informed of incident occurrence
Yes☐ No ☐
Please provide rational if indicated No_____

Has the Service user/ family/Carer been asked if they would like to contribute to this review and receive a copy of the final report via a face to face meeting with the Review team

Yes☐ No ☐

Please give rational if No to any of the above_____

Please Note: Only Indicate Head of Operations name in box below when they have read and agreed report

Electronic Signature of HOPs_____

Date approved by HOPs_____
Following this report will a written apology be provided by the service Head of Operations to the service users/carer/family member in line with Being Open Policy
If No, please say why_____

Main Report

Report headings

1. Section 1

1.1 Introduction

introduction to include statement: The purpose of this investigation is for the local team and trust to review the circumstances and events leading up to the incident occurrence with the aim of the trust identifying what happened, why it happened and identifying where lessons can be learned in order to prevent similar type incidents occurring in the future.

1.2 Brief description of Incident

2. Section 2

2.1 Review Team Names / Roles

3. Section 3 Investigation Process

3.1 Investigation process & Methodology
(Please state RCA tools used and provide evidence of these in appendices section)

3.2 Terms of Reference agreed for review

4. Analysis & Review findings

4.1 Identify where elements of care or service delivery were in accordance with the expected Trust standards and identify where the use of Therapeutic Positive Risk Taking was considered as part of service users agreed care and treatment. Please also highlight where notable practice by individual staff or team was identified

4.2 Identify any significant Problems/Concerns relating to the care delivered by GMMH staff
Such as: Were there any significant lapses in care by staff e.g. Actions or Omissions by staff involved, deviation from Trust policies by individual staff. Missed opportunities during the service users care or weaknesses in local processes and systems

4.3 What were the reasons as to WHY the Care delivery concerns occurred - *Identify what were the fundamental reasons e.g. as to why there may have been deviations by staff from trust policies and procedures identified in 4.2 that will then need addressing by the service or Trust (Please consider where Human factors played a role in any staff behaviours relating to any of the concerns found e.g. human error or oversight)*

4.4 What were the overall Root Causes found in 4.3 and consider whether these could be deemed to have been contributory or causal in any way to incident occurrence - Please include here evidence of RCA methodology e.g. complete this section under contributory factors headings (classification framework available on staff intranet / Integrated Governance / How to complete a Serious Incident Review' using RCA tools Guidance)
Example 1: Education and Training Factor – staff had not received training into how to complete assessment tool
Example 2: Task Factor - Local operational policy did not say how often service user should have been seen face to face by care coordinator
N.B. Please address each root cause within the SMART recommendations and populate fishbone diagram at the end of the report

5 Sharing Lessons Learned from this review - Identify arrangements for how Lessons Learned from this review will be shared *e.g. Positive Learning Event*

6 Conclusions to summarise key findings and overall root causes to concerns found

7. Recommendations (Which need to be SMART and will effectively address all root causes identified in 4.3 and reduce the likelihood of the incident re-occurring again *e.g. the local operational policy will be reviewed by the Team Manager by 31st January 2017 to ensure that clarity is provided as to the frequency of face to face meetings with the service by the care coordinator*

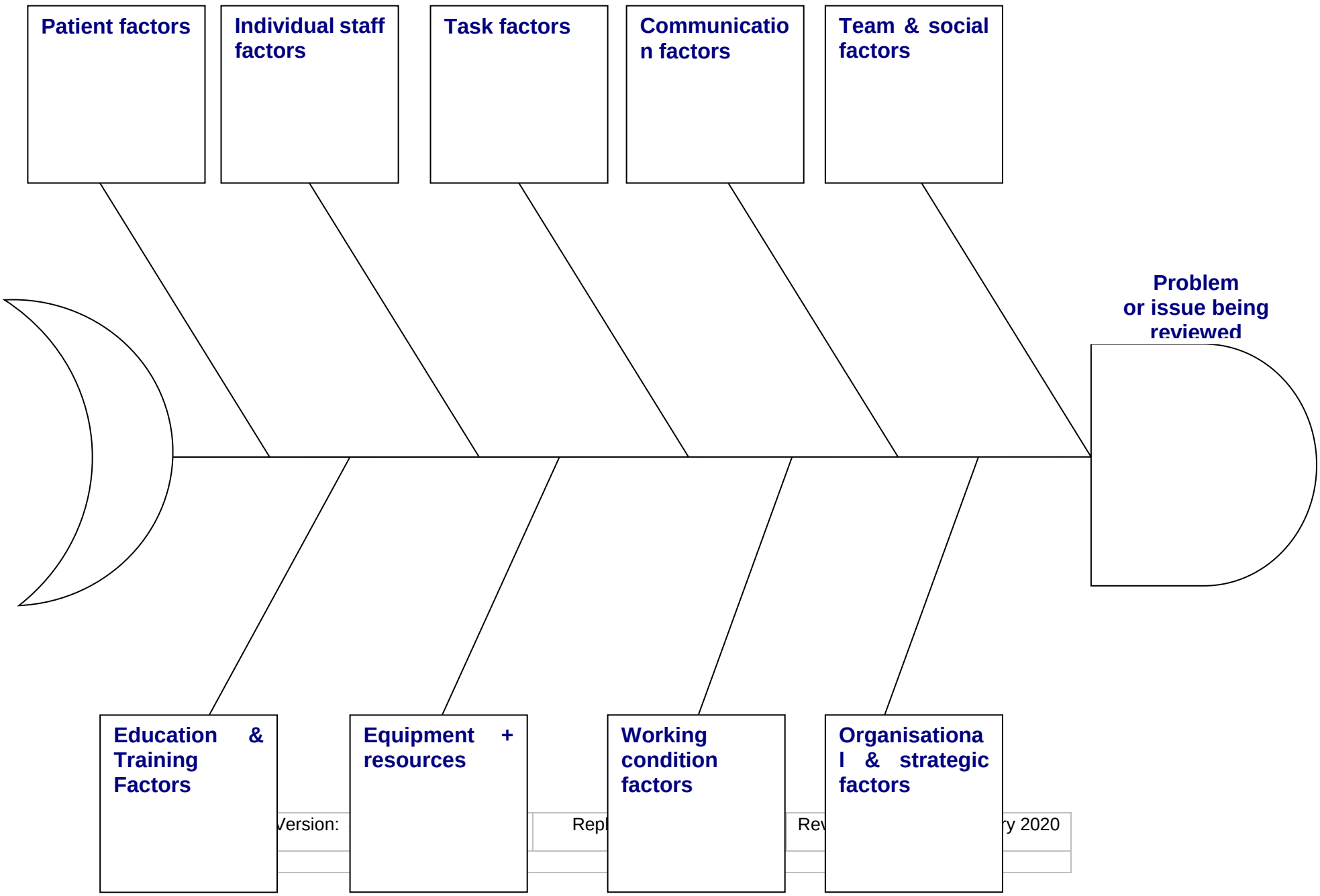
Mandatory Recommendation 1. The findings from this review will be presented by the local Team manager at a MDT Positive Learning Event within 2 months of the investigation concluding.

8 APPENDICES
To include the following
1. Chronological Timeline of events
2. Copies of RCA Tools used eg to include diagrams used with evidence recorded
3. Action plan generated from recommendations
4. Letters of correspondence in relation to this review e.g. to other agencies, GP, Carer/family
5. Statements from staff involved (use Inquest statements please if already completed): New statements should not be made if inquest statement have been completed however additional info obtained from staff during interview process should be attached with existing statement within the appendices section highlighting this

PLEASE NOTE: Please do not: embed documents into the report please attach each document at end of report. Please ensure correct report format is used with all headings above and the report has been quality checked for grammatical errors before submitting to Governance Team. Please submit all appendices at same time when submitting report to Governance team

Appendix 1 - Chronological Timeline of events

Date	Time (24hrs)	Initials & Roles of individuals involved	Description of Events


Patient factors
Individual staff factors
Task factors
Communicatio n factors
Team & social factors
Problem or issue being reviewed
Education & Training Factors
Equipment + resources
Working condition factors
Organisationa l & strategic factors

Key to action plan categories

1. Policies & Procedures *e.g. these are relating to where Trust or local policies and procedures have not been adhered to or where local policy or procedure is unclear or requires strengthening*

2. Physical environmental intervention *e.g. recommendations suggesting modifications are required to the environment in some way e.g. removal of ligature a specific ligature point in all bedroom areas on a ward*

3. Human factor *e.g. following human error, oversight or omission in care recommendations that may be around reminding a staff member to remember to follow a specific procedure*

4. Communication processes *e.g. recommendations relating to where there has been a lack of communication between staff e.g. between transitions of care and how these can be strengthened or records/assessments not kept up to date (records management)*

5. Training & Education *e.g staff not up to date with resus training or not accessed CRT*

6. Carer and Family engagement *e.g Carer or Family not engaged with service user's pathway.*

Example of Recommendation and Action Layout

Recommendation - *CMHT operational procedure should be revised by the Team Manager before end of the month in order to emphasis frequency of face to face therapeutic sessions between Care Coordinator and patients. This then needs to be discussed at the next MDT Team meeting with each staff member signing to say they have read revised Operational procedure*

Action No	Category of Action (Select category from the below) 1. Policies & Procedures 2. Physical environmental intervention 3. Human factor 4. Communication processes 5. Training & Education 6. Carer and Family engagement	Action Required	Responsible Lead (Initials & Role)	Action Lead	Planned Completion Date	RAG	If completed, Actual Completion Date
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Action Plan

Review leads will enter their recommendations into the action plan template prior to sharing report with the Head of Operations. Heads of Operations will then add responsible leads and completion dates prior to signing off the report and then send the Report and action plan back to the review lead who will submit to Governance

Investigation Report Action Plan Created Date_____

Please indicate if the action is a local team action or trust action. Heads of Operations are to incorporate actions for all reviews into the Datix action plan module and not using word documents.

Recommendation -							
Action No	**Category of Action** (Select category from the below) 1. Policies & Procedures 2. Physical environmental intervention 3. Human factor 4. Communication processes 5. Training & Education 6. Carer and Family engagement	**Action Required**	**Responsible Lead (Initials & Role)**	**Action Lead**	**Planned Completion Date**	**RAG**	**If completed, Actual Completion Date**
1							
2							
3							

Appendix 22 – Post Incident Debriefing for staff

POST INCIDENT DEBRIEFING SUPPORT (PIDS) TEAM

OPERATING FRAMEWORK FOLLOWING SIGNIFICANT AND DISTRESSING EVENTS

The Post Incident Debriefing Support (PIDS) Team has been established to provide debriefing support to GMMH staff following significant and distressing incidents at work, in accordance with Trust policies (Supporting Staff Involved in Traumatic/Stressful Incident, Inquest, Complaint or Claim Policy; Policy for the Management of Violence and Aggression; Incident, Accident and Near Miss Policy and Procedure). However, debriefing support is not part of a Post-Incident Review process.

Debriefing Support refers to the opportunity for a group of colleagues to meet together to discuss the impact on staff of a workplace incident in an organised and structured way. It usually takes the form of a single meeting within 3-14 days of the incident, led by facilitators trained in a particular approach to debriefing. Attendance at Debriefing Support meetings is voluntary and matters discussed in the meeting are confidential.

It is not treatment for trauma. Rather it is an opportunity to discuss what has happened, to consider the likely reactions to such an event and to provide immediate support and guidance. Overall the aim is to facilitate normal recovery through promoting the person's own coping mechanisms and support structures.

Incident Levels – managers should consider requesting PIDS team input for all incidents at Level 4 (major) and Level 5 (catastrophic) as defined in the GMMH Incident, Accident and Near Miss Policy and Procedure. Some Level 3 (moderate) incidents may also be considered.

Referral procedure –

- Incident occurs – local manager undertakes immediate staff support, and if appropriate makes PIDS referral, by contacting :

  Steph kennedy (PIDS Coordinator) stephanie.kennedy@gmmh.nhs.uk

- A record is taken by the PIDS team member contacted of the teams affected, the directorate, who is involved, who is the contact person, contact details and nature of the incident
- The referral is then allocated to two PIDS team members
- Allocated team members then liaise to arrange a telephone assessment with the referring manager

- Phone assessment made by the PIDS team

Debriefing Support Process –

- If during assessment it is agreed that Debriefing Support is appropriate, it will be agreed who will be invited to attend the core debrief (usually only those directly involved in the incident).
- Where large numbers are involved in an incident, secondary Debriefing Support groups may be established, and additional facilitators contacted to undertake these.
- While it is usual for Debriefing Support to be offered in groups, there may be occasions when individual Debriefing Support is also appropriate.
- The referring manager is responsible for booking a suitable room, facilitating staff availability, and providing the facilitators with a list of names of those attending
- Pre-information sheet will be provided to attendees by the PIDS facilitators
- Following the meeting evaluation sheet and further information will provided to attendees, including information to sign-post individual to further support if required
- Follow-up meetings (usually 4-6 weeks after the first Debriefing Support meeting) may also be offered

Evaluation and Audit –

- Evaluation sheets collected by facilitators are returned to the PIDS coordinator for analysis
- An annual audit of PIDS uptake and outcomes will be prepared by the PIDS coordinator

Supervision, Support and Continued Skills Development for PIDS Facilitators –

- A 3rd PIDS team member will be identified at the referral stage to offer support to the two allocated facilitators
- 6 monthly PIDS review meetings wil be held, including skills-based role play opportunity
- 6 monthly reviews may also provide an opportunity to train up new PIDS facilitators should any current team members be unable to continue in that role.

- Update training to be arranged as appropriate
- New literature to be disseminated to all team members

Confidentiality - exceptional circumstances -

- Matters discussed in the Debriefing Support meetings follow usual NHS boundaries of confidentiality, and there may be exceptional circumstances therefore where it is deemed appropriate to breach confidentiality. Consultation will be sought from the 3rd facilitator to support decision-making under such circumstances.

Appendix 23 – Positive Learning Feedback Template

Datix number:	
Managers name and role completing this template	
Category of SUI e.g. Unexpected Death:	
Service:	
Directorate:	
Date Learning Shared:	
Venue:	

Staff in attendance

Staff Name	**Role**	**Service**
Please include Staff Names and roles in attendance from other Trust services(This is to demonstrate learning is shared trust wide)	**Role**	**Service**

Format of Shared Learning: Please describe below how review findings were shared with those in attendance and say how the Gibbs Reflection tool in the guidance provided was used for Team and individual Reflection post incident /inquest review.

Highlight specific Individual/Team Reflections following the incident
Eg Feedback from staff during the Learning Event where specific practices may require change. Also include where professional codes of practice have been discussed as part of the learning event

Feedback from staff attending event re how supportive they found the Learning Event Process
Key actions for the team following Learning Event (please note any actions agreed must be entered into the Datix action plan highlighted as Learning Event actions

Appendix 24 – Individual Staff Reflection Template

POSITIVE LEARNING EVENT INDIVIDUAL STAFF REFLECTION TEMPLATE FOR PROFESSIONAL REVALIDATION

Staff Name: _____

Staff Signature: _____

Role: _____

Line Managers name: _____

Datix number:	
Category of SUI e.g. Unexpected Death	
Service	
Directorate	
Date of Positive learning Event	
Venue:	

Brief Description of the Serious Incident under review

- If you were involved or witnessed the serious Incident what was your role at the time?
- What happened?

You're Feelings & Thoughts.

- How did I feel at the time?
- How do I feel now?

Evaluation and Personal judgments

- Consider what went well, what didn't go so well
- What were your positive experiences, Negative experiences of the Incident

For staff from other areas of the Trust invited to this positive learning Event

- If you have been invited to this Positive Learning Event what are your thoughts and feelings following hearing the review findings
- What learning will you take back to your service
- Is there any aspect of your own practice which you feel from attended this review you would like to change

Analysis Explore each stage of the Serious Incident under review and choose which themes from the 4 boxes below you feel are relevant to your individual reflections.

Ask yourself the following:

- Do I feel I displayed a commitment to my professionals standards of practice and behaviour
- Do I feel I worked effectively with my colleagues to deliver the fundamentals of care expected of me
- Do I feel my practice was in line with best practice and current evidence
- Did I act in the best interest of others and maintain the safety of those around me

Conclusion

- ask yourself What could I have done differently:
- Would I act differently or do the same if faced with the same situation?

- Ask yourself what changes do I need to make to improve my practice

Action plan
What immediate action do I need to take What support do I require from my line manager to make any changes to my practice

Appendix 25 - The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

PLEASE NOTE: the Risk and Safety Team within the Governance Department will report all RIDDOR incidents to the Health and Safety Executive. It is therefore vitally important that all incidents are promptly and accurately recorded in Datix and relevant RIDDOR fields completed. Failure by the Trust to report RIDDOR incidents within the prescribed timescales is a criminal offence and could lead to the Trust being prosecuted.

Managers may consult the Risk and Safety Team on 0161 358 2440 for further guidance.

These Regulations require the Trust to report the following incidents:

- **The death of any employee, or person on GMMH premises** (i.e. self-employed persons, members of the public, service users or patients), caused by a work-related accident;
- **Specified injuries** (see list below) to employees, or self-employed persons working on GMMH premises, caused by a work-related accident;
- **Absence from work or inability to perform normal duties for over 7 days** by employees, or self-employed persons working on GMMH premises, caused by a work-related accident (see guidance below);
- **Dangerous occurrences** on GMMH premises or by GMMH work activities (see list below);
- **Occupational diseases** contracted by GMMH employees linked to their work (see guidance below);
- **Injuries to people who are not at work** (i.e. members of the public, service users or patients) where they are taken from the scene of a work-related accident to hospital by whatever means; or if the work-related accident happens at a hospital, suffering a **specified injury** (see list below).

<u>Reportable specified injuries (caused by a work-related accident):</u>

- fractures - other than to fingers, thumbs and toes;
- amputation of an arm, hand, finger, thumb, leg, foot or toe;
- any injury likely to lead to permanent loss of sight or reduction in sight in one or both eyes;

- any crush injury to the head or torso, causing damage to the brain or internal organs;
- any burn injury (including scalding) which covers more than 10% of the whole body's total surface area or causes significant damage to the eyes, respiratory system or other vital organs;
- any degree of scalping requiring hospital treatment;
- any loss of consciousness caused by head injury or asphyxia;
- any other injury arising from working in an enclosed space which leads to hypothermia or heat-induced illness or requires resuscitation or admittance to hospital for more than 24 hours.
- if an employee dies after some delay, as a result of a specified injury, then the Trust must report the death provided that it occurs within a year of the date of the original incident.

Over 7 day injuries

An injury becomes reportable if an accident at work results in an employee or self-employed person working on GMMH premises being away from work (i.e. sickness absence) or unable to perform their normal work duties (i.e. on light or restricted duties) for more than seven consecutive days (not counting the day of the accident but including weekends, rest days and holidays).

Occupational diseases

An occupational disease becomes reportable when a written diagnosis from a doctor is provided that an employee is suffering from an occupational disease specified in the Regulations **and** the employee has been doing work activities specified in the Regulations that could cause or contribute to the illness. Managers should consult the Risk and Safety Team on 0161 772 3611 for all circumstances of potential occupational disease in addition to completing a Datix incident report.

The list of reportable occupational diseases includes:

- Carpal Tunnel Syndrome where the person's work involves regular use of percussive or vibrating tools;
- Cramp of the hand or forearm where the person's work involves prolonged periods of repetitive movement of the fingers, hand or arm;
- Occupational dermatitis where the person's work involves significant or regular exposure to a known skin sensitizer or irritant;
- Hand Arm Vibration Syndrome where the person's work involves regular use of percussive or vibrating tools, or holding materials subject to percussive processes, or processes causing vibration;
- Occupational asthma where the person's work involves significant or regular exposure to a known respiratory sensitiser;
- Tendonitis or tenosynovitis the hand or forearm, where the person's work is physically demanding and involves frequent, repetitive movements;

- Cases of cancer must be reported where there is an established causal link between the type of cancer diagnosed, and the hazards to which the person has been exposed through work;
- All diseases and any acute illness needing medical treatment must be reported when it is attributable to a work-related exposure to a biological agent.

Dangerous occurrences

Dangerous occurrences are serious near-miss events specified in the Regulations, for example:

- collapse, overturning or failure of load-bearing parts of lifts and lifting equipment other than an accessory for lifting;
- any accident or incident which results or could have resulted in the release or escape of a biological agent likely to cause severe human infection or illness (i.e. sharps injury by a sharp known be contaminated with a blood-borne virus (BBV) e.g. hepatitis B, C or HIV);
- electrical short circuit or overload causing fire or explosion which results in the stoppage of the plant involved for more than 24 hours or causes a significant risk of death;
- failure of industrial radiography or irradiation equipment to de-energise or return to safe mode;
- explosion, collapse or bursting of any closed vessel or associated pipe work;
- collapse or partial collapse of a scaffold over five metres high, or erected near water where there could be a risk of drowning after a fall.

This list is not exhaustive but reflects the likely dangerous occurrences the Trust may encounter.

Appendix 26 – Quick overview of Stages of Being Open & Duty Candour process

Where a patient safety incident has occurred resulting in Moderate harm, significant harm or death to a GMMH service user

Stage 1

Identification of serious Incident resulting in harm or death to service user

Stage 2

Preliminary review to take place as quickly as possible by local manager to ascertain facts and circumstances to incident occurring and completion of 3DR template

Stage 3

Nominated service lead to offer first Being Open face to face meeting to service user/carer/relative as soon as possible within 10 days of incident occurring. This meeting **should** be followed by a written account of all face to face being open meeting/conversation arranged thereafter with service user/carer with evidence of apologies and support offered. Copies of all letters **must** be uploaded into Datix against the incident record and also sent to service user/carer and relative.

Stage 4

Follow up meetings with service user/carer/relative should be offered at regular intervals and recorded in writing as above and uploaded onto the Datix documents section. Following the outcome of the Trust Investigation the service user/carer/relative will be offered a supportive reading and full copy of the Trust Investigation report and appendices by investigation lead.

The final Being Open letter back to the service user/Carer/relative will be a letter of apology from the Head of Operations or nominated senior manager for the concerns identified during care delivery and further offer of any support where required.

A copy of this letter needs to be uploaded onto datix as final Being Open meeting

Stage 5

If the service user/carer/relative are satisfied with any actions being taken by the trust this completes the Being Open process.