

**POL-CG-008**

## **DIGITAL HEALTH AND CARE WALES**

# **Incident Reporting and Investigation Policy**

The incident reporting policy outlines the process involved following all incidents, and near misses and provides guidance on the actions that need to be taken, to ensure a safe working environment is provided for staff, contractors and visitors.

<b>Document Version</b>	2.0
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<b>Status</b>	Approved
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Document author:	Julie Ash, Head of Corporate Services
Approved by:	Chris Darling, Board Secretary
Date approved:	06/06/2023
Review date:	06/06/2026

<b>STRATEGIC OBJECTIVE</b>	Delivering High Quality Digital Services
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<b>WELL-BEING OF FUTURE GENERATIONS ACT</b>	A healthier Wales
If more than one standard applies, please list below:	

<b>DHCW QUALITY STANDARDS</b>	ISO 9001
If more than one standard applies, please list below:	

<b>HEALTH CARE STANDARD</b>	Safe Care
If more than one standard applies, please list below:	

<b>EQUALITY IMPACT ASSESSMENT STATEMENT</b>	Date of submission: September 2013
Yes, applicable	Outcome: Completed
Statement: EQIA undertaken by Velindre NHS Trust to support Policy approval. Positive outcomes only. No significant changes at review.	

<b>APPROVAL/SCRUTINY ROUTE:</b>		
Person/Committee/Group who have received or considered this paper prior to this meeting		
<b>COMMITTEE OR GROUP</b>	<b>DATE</b>	<b>OUTCOME</b>
Management Board		
Audit and Assurance Committee		

<b>IMPACT ASSESSMENT</b>	
<b>QUALITY AND SAFETY</b> IMPLICATIONS/IMPACT	Yes, please see detail below
	Supports the Risk Management Process
<b>LEGAL</b> IMPLICATIONS/IMPACT	Yes, please see detail below
	Health & Safety responsibilities under legislation
<b>FINANCIAL</b> IMPLICATION/IMPACT	No, there are no specific financial implication related to the activity outlined in this report
<b>WORKFORCE</b> IMPLICATION/IMPACT	Yes, please see detail below
	Incident Reporting will contribute towards keeping the workplace safe for staff
<b>SOCIO ECONOMIC</b> IMPLICATION/IMPACT	No. there are no specific socio-economic implications related to the activity outlined in this report

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## 1 DOCUMENT HISTORY

### REVISION HISTORY

Date	Version	Author	Revision Summary
September 2013	1	Velindre NHS Trust	Approved Publication
6 June 2023	2	Michael McGrath Bethan Walters Julie Ash	Annual Review

### REVIEWERS

This document requires the following reviews:

Date	Version	Name	Position
6 June 2023	2	Chris Darling	Board Secretary

### AUTHORISATION

Signing of this document indicates acceptance of its contents.

<b>Author's Name:</b>	Julie Ash
<b>Role:</b>	Head of Corporate Services
<b>Signature:</b>	<p style="text-align: right;">06/06/2023</p> <p><b>X</b> Julie Ash</p> <hr/> <p>Julie Ash Head of Corporate Services Signed by: Julie Ash (NWIS - CSU)</p>

<b>Approver's Name:</b>	Claire Osmundsen-Little
<b>Role:</b>	Executive Director of Finance
<b>Signature:</b>	<p style="text-align: right;">07/06/2023</p> <p><b>X</b> Chris Darling</p> <hr/> <p>Chris Darling Board Secretary Signed by: Andrea Harris (An286780)</p>

### DOCUMENT LOCATION

Type	Location
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Electronic	Integrated Management System
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## 2. PURPOSE

All incidents should be reported into the Once for Wales RL Datix System in a timely manner, ideally on the day of occurrence.

To ensure all staff are aware of their responsibilities to report incidents and near misses

To ensure Managers are aware of responsibilities and guidance:

- to review and grade the incident
- to identify incidents that require investigation
- to provide feedback
- to share lessons learned
- Requirements for reporting to external agencies
- Promotion of incident reporting for all staff as part of their induction
- Internal reporting to the Committees

To set out the analysis and review process and the mechanisms for sharing lessons learned.

Digital Health and Care Wales is committed to ensuring the health, safety and welfare of its staff, visitors and all users of its premises and services, and its impact on the environment by being pro-active in its approach to reduce the number of incidents and near misses.

Incidents are those unplanned or uncontrolled events or a sequence of events that lead to or result in injury, damage or loss. Near misses are similar but no harm, injury or loss has occurred. The SHA has a duty to protect its assets from all threats whether internal, external, deliberate or accidental.

It is essential that all incidents near misses and hazards are reported in a consistent manner, this policy outlines the overarching process that all Directorates will follow. However, further local procedures that support this policy may be in place where additional guidance for staff is required.

The SHA encourages an open and fair culture where staff are comfortable with reporting incidents, near misses and hazards. The aim of reporting and investigating incidents is to identify the root cause and not to blame individuals. This policy also outlines the management responsibilities for reviewing and identifying appropriate investigation and feedback mechanisms to the incident reporter and for sharing lessons learned.

The Policy also highlights the reporting arrangements required for the SHA to comply with its statutory duty in notifying external agencies including the Welsh Government, Delivery Unit, Medicines and Healthcare products Regulatory Agency and the Health and Safety Executive.

Digital Health and Care Wales are committed to ensuring the health, safety and welfare of all its staff, patients and service users, by providing a safe and secure environment and safe systems of work in which staff can deliver safe and effective services to their patients, donors and services users.

All staff are required to report any incident or near miss that occurs during their normal working

activities. When an incident occurs that causes an injury the staff member should seek first aid or medical advice where required. Also the incident must be reported to the Manager/supervisor prior to leaving site. The Manager will discuss the incident and identify appropriate action. E.g. Send the staff member home or advise to attend A&E or organise transport home and will ensure that action is taken to make the area safe.

### 3. SCOPE

This policy applies to all employees who work for Digital Health and Care Wales (The SHA). The SHA encourages an open and fair culture, where there is a willingness to report incidents, near misses and hazards, so that lessons can be learned and risks reduced as far as is reasonably practicable.

It aims to provide a structure for the management of incidents, near misses and hazards and to ensure a single system for reporting, investigation and feedback is implemented across the organisation.

- To ensure that all incidents, near misses and hazards are reported and managed appropriately and effectively within a supportive framework.
- To promote a culture in where incidents are reported and investigated appropriately and to ensure lessons learnt are shared across the SHA.
- To ensure that the SHA is able to effectively manage the risks to which it is exposed, which may arise from hazards or result in incidents and near misses.
- To enable the SHA to comply fully with legislation and mandatory requirements in relation to incident reporting.

The SHA encourages all staff to report incidents without fear of personal reprimand or detriment. The emphasis is on the "how" and "why" rather than the "who".

To achieve this, the incident investigation process must be :-

- Fair and equitable
- Consistent and systematic
- Focused on learning and change
- Focused on identifying contributory factors and root causes

In accordance with the principles of clinical governance, disciplinary action would not normally result from reporting incidents, mistakes or near misses but other procedures may apply.

However issues which may lead to disciplinary action would include:

- Criminal activity (e.g. theft, assault)
- Malicious activity (e.g. making false allegations against a colleague)
- Acts of gross misconduct or gross negligence
- Repeated unreported errors or violations of procedures

### 4. DEFINITIONS

**Accident:** Any unplanned, unwanted event that results in injury or ill-health to employees or results

in property damage.

**Incident:** Incidents are those unplanned or uncontrolled events or a sequence of events that lead to or result in injury, damage or loss.

Please note: Only incidents that are related to, or in connection with the SHA activities should be reported. Throughout the policy the term 'incident' covers all incidents, serious untoward incidents and near misses that affect the whole of the SHA.

**Serious Incident:** In general terms an SI is defined as: "Something out of the ordinary or unexpected or likely to attract public or media interest." An incident may be declared as an SI if it involves a large number of service users, there is a question of poor clinical or management judgment, a service has failed, a patient/service user has died under unusual circumstances or there is a perception that any of these has occurred.

Examples of Serious Incidents and the procedure to be followed in the event of such an incident occurring appears in Appendix 1.

**Near Miss:** A 'near miss' as defined by the HSE, is any incident, accident or emergency which did not result in an injury but has the potential to do so.

**HSE:** Health and Safety Executive

**Hazard:** Anything with the potential to cause harm, injury or loss as defined by the HSE

**Risk:** A risk is the chance, high or low, of somebody being harmed by the hazard, and how serious the harm could be, as defined by the HSE. Impact x Likelihood= Risk Rating.

**RIDDOR:** Abbreviation for Reporting Injuries, Diseases and Dangerous Occurrences Regulations. (2013)

**Root cause analysis:** A method used in investigation process to identify underlying causes of an incident. E.g. Incident Decision Tree, 5 WHYS, Fishbone, Fault Tree Analysis, Failure Modes and Effect analysis.

**Risk Assessment:** A careful examination of what in the workplace could cause harm, a documented process that uses a numerical calculation to identify the risk rating.

**Competence:** The person must have the appropriate and relevant qualification, knowledge, skills and experience to perform their duties.

## 5. ROLES AND RESPONSIBILITIES

### Chief Executive

The 'Chief Executive', carries overall accountability for ensuring compliance with the Health and Safety at Work Etc Act 1974 and associated legislation and for ensuring that the risk management, governance and incident reporting systems are in place and functioning effectively.

### Executive Directors

Executive Directors have Board level responsibility for ensuring that a robust and effective risk management function and incident reporting system is in place and for the promotion of the SHA policies.

This includes:

- Advising the Chief Executive and other Executive Directors regarding incidents that may constitute a Serious Incident
- Ensuring the relevant external agency is notified when required
- Ensuring that incident trends are monitored and reviewed at the SHA wide Safety Health and Environmental (SHE) Group

Directors are responsible for ensuring an effective risk management function and system is in place within their area.

### **The SHA Risk Management Group**

The SHA Risk Management Group is responsible for:

- Providing support in relation to the maintenance of the Datix System
- Checking that appropriate reporting to external organisations occurs
- Providing assistance, support and advice on the investigation process
- Ensuring that SHA wide incident analysis and identification of trends are reported and shared via the SHA SHE meetings and Incident Review and Learning Group.
- Providing appropriate training for key staff (as required)

### **Managers**

Managers are responsible for ensuring that their area is a safe environment for staff, visitors and service users and also where incidents have been reported for ensuring any faulty equipment and estate defects are reported to the appropriate personnel for remedial action to be implemented.

Managers should encourage the reporting of incidents, hazards and near misses and promote the use of the Datix System.

Manager's responsibility:

- to review any incidents occurring in their area
- to identify any remedial action required
- to identify and record the severity of actual injury or harm
- to identify if an investigation is required and who will perform it
- to identify any lessons learnt that can be shared with other departments or committees
- to review in a timely manner
- to record all outcomes and feedback to staff

### **All Staff**

All staff are responsible for reporting incidents that occur during their normal working activities in a timely manner via the approved procedure and for making the area safe unless they are injured. Where an injury occurs the staff member should seek first aid or medical advice and also report the incident to their Manager. The Manager will discuss the incident and identify the best course of action and also will ensure that action is taken to make the area safe.

## **6. AWARENESS INDUCTION AND TRAINING**

All staff as a minimum should be trained to report incidents as part of local induction programmes. A range of training is available across the SHA. Further specific training is provided within IOSH

managing safely and working safely upon request. Competence to deliver training must be in line with core skills framework.

All staff who will be required to facilitate an investigation or a root cause analysis should receive training.

## 7. INCIDENT REPORTING

### **Immediate Action following an incident**

The first priority following an incident is to deal with the immediate needs of any injured persons and others involved and to make sure the area is made safe. Seek first aid assistance when required, if no injury has occurred staff must make the area safe. The incident must be reported verbally to the Manager or other appropriate Senior Manager. When an injury occurs the Manager will seek assistance to make the area safe and decide on the best course of action, to send staff home or advise to go to A&E etc.

### **Incident reporting mechanism - Datix System**

All incidents are recorded into a single incident reporting system (Once for Wales RL Datix). Any staff member may report directly into an online web based form, which is available via the DHCW intranet. Please note that all incident information recorded in the Datix Once for Wales System constitutes the SHA's "Accident Book" and a copy of the incident form may be requested as evidence in litigation or prosecution.

### **What to and how to report**

All incidents, near misses and hazards must be reported in a timely manner or within 3 working days. Where a staff member has an injury that prevents them returning to work, the Manager will ensure that the basic information is input into the Datix System.

The Datix online incident form is available on DHCW intranet. Please complete the form with as much relevant information as possible and do so as soon as possible following the incident.

All sections of the form with an \* are mandatory and must be completed - failure to do so before you submit the form will revert you back to the required section. Once you have input and submitted your form an automatic notification is issued to the relevant Manager of the incident area.

### **Types of incidents**

Select a TYPE of incident, there are a range available, if you are unsure of the correct TYPE, please contact the Estates and Compliance Team.

Please note: Within the description of the events, no staff names must be recorded, staff names are to be recorded in the contacts section. E.g. John Jones fell down stairs is not acceptable.

Staff member fell down stairs is acceptable and the name John Jones is added to the contact list as staff member or injured person.

### **Manager's responsibility and guidance**

The Manager is responsible for incidents occurring in areas under their direct control, e.g. office, department etc. In certain circumstances the Estates Compliance Manager will be responsible for the area but not the staff. E.g. Staff member has a fall on the stairs, this is not normally related to their own area, it is a shared communal space any investigation will be done by the Estates Compliance

Manager or appointed person.

The staff member may report an incident verbally or will input the information into Datix. The staff member may have had first aid assistance, or where no injury has occurred staff will have made the area safe. The Manager will ensure that staff and the environment are safe and that relevant personnel are contacted if there is a fault that needs repair and that the incident is logged on Datix.

The Manager will discuss the incident with the staff member and establish if any further action is needed to ensure their safety and ensure that the area is made safe. E.g. Send staff member home or advise A&E or GP referral etc.

The Manager of the incident area should receive an automated notification from Datix System that an incident has occurred, once an incident has been submitted into the system. The Manager will discuss the incident with the staff member and review the incident, ensuring it is factual and any remedial action is input into the report.

Witness statements should be completed by any witnesses to an incident, the information should be uploaded into Datix System. A guidance document is available for completing a witness statement see details in Appendix 1.

## 8. REPORTING A SERIOUS INCIDENT (SI)

Initially, Serious Incidents (SI's) are also reported in the same way as all other incidents but they must be escalated to the Executive Lead who will liaise with Corporate Governance if the SI is deemed reportable. Guidance is available on categorisation of an SI although the list is not exhaustive see Appendix 2.

It is important that SI's are identified quickly for an investigation to commence, in some circumstances an SI will not be initially identified, but may later be re-categorised. This is a preferred option rather than delaying until an investigation has been completed. Exceptionally an incident may only be recognised as an SI some time after the event. In such cases the member of staff for whom such evidence comes to light must report it immediately.

SI's will be scored for severity on the potential impact and the potential likelihood, due to their nature. All SI's will require full investigation using an appropriate root cause analysis technique.

It is important to emphasise that the benefits of the investigation process are to prevent further incidents from occurring. The investigation process will identify failings and underlying causes without apportioning blame and by putting appropriate control measures in place will ensure a safe working environment and improve staff morale.

The Manager will determine the severity of the incident based on actual harm using the matrix in Appendix 3 and will also identify the level of investigation required and identify a competent Investigating Officer (IO) or will investigate the incident themselves.

A full investigation may not be needed for all incidents, where incidents have no injury or harm the Manager will discuss the incident with the person affected and identify if any remedial action is required and ensure it is implemented. This information will be recorded in the Datix System.

Full guidance is available on Investigation see Appendix 4.

The Manager will collect physical evidence immediately or may identify an appropriate person to do so. This is particularly important where incidents are serious, complex or could result in litigation or prosecution. Evidence to be collected may include physical, documentary and supporting information, and is not limited to the following:

- Photographs of the environment where the incident occurred and of any items contributing to the incident E.g. equipment, machinery, labels on medicines or substances, warning signs etc.
- Maintenance records, for equipment
- Relevant pages of patient notes
- Material safety data sheets
- Documented risk assessments
- Safe systems of work and written instructions given to staff
- Training records
- Observations noted at the time of the incident e.g. weather, lighting, wet floors
- Comments from witnesses who overheard an incident, but may not have seen it

A systematic process is advised when performing an investigation, to assist with this an investigation report template has been developed, investigating officers are encouraged to utilise this form to gather information for entry on to Datix to ensure a consistent investigation is completed.

For general investigations see details in Appendix 5

For patient safety investigations see details in Appendix 6

All information collected must be scanned or uploaded into the investigation section of the incident report within Datix System. These will include all the correspondence, photographs and documents related to the incident as well as the investigation report.

## 9. STAFF SUPPORT

All staff involved in an incident must be offered appropriate support or guidance to ensure staff well being is maintained.

Staff involved in or witnessing significant incidents may become distressed and suffer psychological harm and become anxious when returning to work. Staff may need support and counselling - there are a number of support mechanisms in place across the SHA.

Managers and colleagues may offer informal support. Where staff may need professional help, advice and support is available from Occupational Health, there are two ways to access this service either by speaking to your Manager who may refer you or self referral is available. The SHA has subscribed to Workplace Options who provide the Employee Assistance Programme which offers a range of counselling services 24/7 and is a free and confidential service.

For more advice on staff support see your local procedure/notice boards and the SHA intranet site.

## 10. REPORTING

The SHA Safety Health and Environmental (SHE) Group will monitor a range of health and safety topics and receive a quarterly health and safety incident report for discussion and review. Clinical Incidents are managed by the Clinical Directorate. All incidents are reviewed by the Incident Review and Learning Group.

### **External Agencies**

All incidents reported to external agencies must be raised and discussed at the appropriate Group to ensure incidents are appropriately discussed internally and any lessons learned can be identified and disseminated.

Health and Safety Executive (HSE)  
Medicines and Healthcare Products Regulatory Agency (MHRA)  
Information Commissioner  
National Cyber Security Centre  
Welsh Language Commissioner

### **Welsh Government/Delivery Unit**

The SHA are required to respond to national reporting requirements.

## 11. LEARNING FROM INCIDENTS

It is important that learning from incidents is shared throughout the SHA. Incident information and trends relating to health & safety/information governance incidents are reported to the Incident Review and Learning Group. Clinical Incidents are reviewed and managed by the Clinical Directorate.

## 12. FEEDBACK

It is the Manager's responsibility to feedback on any outcome or action to any person reporting and involved in an incident. It is essential to thank them for reporting the incident and also to report on any action proposed or taken, to demonstrate that their incident was taken seriously.

The feedback process will highlight any repair, replacement or changes to working practices and any outcome of an investigation. This will demonstrate that the learning process is being completed. The Manager may complete the feedback process by either:

- discussing the incident with the staff member informally
- or by sending a formal feedback communication explaining the outcome

Both these feedback mechanisms are acceptable and should be recorded on the feedback form and input into the incident record within Datix Once for Wales System as a supporting document. Refer to Appendix 7.

## 13. MONITORING

It is necessary to ensure that this policy is disseminated and promoted across the SHA to ensure that a standard approach to incident reporting and investigation is implemented.

## 14. REVIEW

The incident reporting policy will be subject to review within DHCW every three years, unless major legislative change takes place.

## 15. EQUALITY IMPACT ASSESSMENT

The SHA is committed to ensuring, as far as is reasonably practicable, the way it provides services to the public and the way it treats its staff reflects their individual needs and does not discriminate against individuals or groups. An equality impact assessment was completed and found that there was no negative impact against individuals or groups.

## 16. IMPLEMENTATION

The SHA will actively promote awareness and understanding of this policy, linking to existing organisational development programmes, where possible. Additionally, there will be supporting guidance available the intranet site and information disseminated via newsletters, posters and campaigns and dedicated awareness training available upon request.

## 17. DISTRIBUTION

The Incident Reporting and Investigation Policy will be available via the SHA intranet and internet sites. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.



## SERIOUS INCIDENTS (SIs)

The reporting of SIs to the Welsh Government and NPSA does not exclude the requirement to report to other bodies, e.g. Healthcare Inspectorate Wales, Health & Safety Executive (RIDDOR), Information Commissioner's Office, Police, Coroner, as appropriate and as required by each individual body.

The definition of a Serious Incident in this context extends beyond those which impact directly on patients. The NPSA has suggested the following definition which we would wish to adopt in NHS Wales:

A SI requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public; permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm);
- a scenario that prevents or threatens to prevent an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- a person suffering from abuse;
- adverse media coverage or public concern for the organisation or the wider NHS;

Managers are responsible for identifying when an incident falls into this category and ensuring that the investigation is completed. Where appropriate the manager may discuss their concerns with the Patient Safety Manager.

The serious incident will then be raised with the Chief Executive who will identify the action to be taken.

The Corporate Governance Directorate is responsible for reporting all serious incidents and other concerns/early warning notifications to the Welsh Government.

## Appendix 3

### RISK MATRIX

Please record in Datix Once for Wales System. - The Actual severity level of the injury sustained. Where there is no injury sustained please record no injury.

Severity Rating =	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical or psychological harm)	Minimal injury Requiring no minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR reportable incident. An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

### Likelihood – MATRIX

#### LIKELIHOOD DESCRIPTION

<b>5 Almost Certain</b>	<b>Likely to occur, on many occasion</b>
<b>4 Likely</b>	<b>Will probably occur, but is not a persistent issue</b>
<b>3 Possible</b>	<b>May occur occasionally</b>
<b>2 Unlikely</b>	<b>Not expected it to happen, but may do</b>
<b>1 Rare</b>	<b>Can't believe that this will ever happen</b>

#### Risk Rating Matrix = Impact x likelihood

IMPACT	LIKELIHOOD				
	Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
<b>5 Catastrophic</b>	<b>25</b>	<b>20</b>	<b>15</b>	<b>10</b>	<b>5</b>
<b>4 Major</b>	<b>20</b>	<b>16</b>	<b>12</b>	<b>8</b>	<b>4</b>
<b>3 Moderate</b>	<b>15</b>	<b>12</b>	<b>9</b>	<b>6</b>	<b>3</b>
<b>2 Minor</b>	<b>10</b>	<b>8</b>	<b>6</b>	<b>4</b>	<b>2</b>
<b>1 Insignificant</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>

### Risk score and Action timetable

Risk Score	Risk Level	Action and Timescale
1-3	LOW	No action required providing adequate controls in place.
4-6	MODERATE	Action required to reduce/control risk within 12 month period
8-12	SIGNIFICANT	Action required to reduce/control risk within 6 month period
15-25	CRITICAL	Immediate action required by Senior Management

## Investigation Process – Guidance

It is important to emphasise that the benefits of the investigation process is about preventing the incident from happening again and identifying the failings and underlying causes and not apportion blame. Reviewing the Safe Systems of Work with the underlying causes will identify any gaps. Sharing the findings is as important as ensuring the quality of the investigation.

The Manager will determine the level of severity of the incident and will identify a competent Investigating Officer (IO) and in some cases will perform the investigation themselves.

The IO will lead the investigation and will facilitate any assistance required where necessary identifying who will make up the investigation team depending on circumstances the following should be considered:

- Someone familiar with the work location
- Supervisor or Manager of the work location
- Senior manager with authority or influence
- Health and safety expert and or technical expert
- Employee representative
- Person involved if possible

The IO or team will collect any further information and will complete any interviews with witnesses, patients, service users and staff. Ensuring documented statements are taken.

The IO or team will analyse of all evidence collected as part of the immediate response and ensure where required that an appropriate specialist examines any equipment thought to be faulty and that a report is provided by the specialist on the outcome.

The IO or team will analyse all the evidence collected and using an appropriate root cause analysis tool e.g. Incident Decision Tree, 5 WHYS, Fishbone, Fault Tree Analysis, Failure Modes and Effect analysis. The IO will use the best tool for the incident and identify direct causes and any underlying causes.

Where the incident is general the IO will produce a report based on Appendix 5 Where the incident is clinical or patient safety related the report will be based on Appendix 6.

The aim of the report is to identify any immediate or underlying causes and consider any gaps in the process or procedures and recommend remedial action and share information to learn lessons from the incident.

The IO will feed back the documented report to the Manager, and the report will be added to the Datix incident report. The initiating Manager will feedback outcomes to the persons involved in the incident using the feedback form in Appendix 7

## Appendix 5

<b>INCIDENT INVESTIGATION REPORT</b>	
<b>Datix Incident Number:</b>	
<b>Date of Incident:</b>	
<b>Investigated by: (all involved in the investigation)</b>	
<b>Date(s) of investigation:</b>	
<b>Department/Area:</b>	
<b>Name of Personnel involved in the incident. (if applicable):</b>	
<b>Contact details of Personnel involved in the incident :</b>	
<b>Please record any external reporting e.g. RIDDOR, Welsh Gov, Environmental Agency etc.</b>	

<b>1. INCIDENT DETAILS - What happened? Gather the facts.</b>
<b>1.1 What are the circumstances &amp; sequence of events to be investigated?</b>
<b>1.2 Was there any injury / ill health / damage? What treatment was given?</b>
<b>1.3 Details of plant / equipment / substances / location (include photographs and sketches</b>
<b>1.4 Documentary Evidence - Please list all evidence reviewed(policies &amp; procedures, training records, method statements, risk assessments, equipment logs, maintenance sheets etc.</b>
<b>1.5 Witnesses to the incident(attach statements)</b>
<b>1.6 Was any immediate action taken?</b>
<b>2. INVESTIGATION FINDINGS – Why did the incident happen?</b>

<b>2.1 What are the immediate cause(s)?</b>			
<b>2.2 Are there underlying and or contributory factors?</b>			
<b>2.3 Is there any further action required?</b>			
<b>2.4 Recommendations/ actions planned (what action is needed, by when and by whom?)</b>			
<b>Action</b>	<b>Date Due</b>	<b>Responsible Person</b>	<b>Progress</b>
<b>3. Lessons Learned Identified:</b>			
<b>3.1 Lessons Learned: How are these being shared is there documented evidence?</b>			
<b>3.2 Lessons Learned - Circulation list:</b>			
<b>Investigation Report Author:</b>			
<b>Investigation Report Date:</b>			

**Appendix 6**

<b>CLINICAL/PATIENT SAFETY INCIDENT INVESTIGATION REPORT</b>	
<b>Datix Incident Number:</b>	
<b>Incident Date:</b>	
<b>Incident Type:</b>	
<b>Ward, Speciality &amp; Location (exact)</b>	
<b>Investigated by: (all involved in the investigation)</b>	
<b>Date/s of the investigation:</b>	
<b>Scope &amp; level of investigation</b>	
<b>Injured Patient contact details (if not already provided on Incident Report Form):</b>	
<b>External reporting please identify: NPSA/RIDDOR/WG etc</b>	

<b>1. Summary Incident Description</b>
<b>2. Actual Effect on the Patient or Service</b>
<b>3. Severity of the Incident</b>
<b>4. Pre-Investigation Risk Assessment</b>
<b>5. Scope and level of Investigation</b>
<b>6. Involvement and support of Patient and Relatives</b>
<b>7. List of Information Gathered</b>

<b>8. Chronological order of events</b>			
<b>9. Identification of Human and other Contributory Factors</b>			
<b>10. Analysis to identify common underlying Root Causes: Organisational, Procedures, Processes, Human Error: Identified via a series of 5 why questions and answers.</b>			
<b>11. Is there a link between Cause and Effect?</b>			
<b>12. Lessons learned identified</b>			
<b>13. Lessons learned – How are these being shared is there documented evidence?</b>			
<b>14. Lessons learned circulation list:</b>			
<b>15. Recommendations/ actions planned</b>			
<b>Action</b>	<b>Date Due</b>	<b>Responsible Person</b>	<b>Progress</b>

**INVESTIGATION FEEDBACK**

The Feedback mechanism following an incident is important, it ensures staff are aware of the investigation process and know that their incident will be followed up.

It is the Manager's responsibility to complete the investigation or to identify a competent person to do so. Following an incident and an investigation it is essential that feedback to the staff member is given. This can be formal or informal feedback: See form below: **ALL feedback must be recorded.**

<b>FORMAL FEEDBACK</b>
<p><b>The Manager should: Discuss the incident and any outcome of an investigation with the person involved and send a formal feedback note.</b></p> <p><b>Managers name:</b></p> <p><b>Person involved in the incident:</b></p> <p><b>Outcome of the incident/investigation:</b></p>  <p><b>Manager confirms formal feedback: Sign &amp; Date:</b> _____</p>
<b>VERBAL FEEDBACK</b>
<p><b>Manager name:</b></p> <p><b>Person involved in the incident:</b></p> <p><b>Summary of the verbal feedback given:</b></p>  <p><b>Manager confirms verbal feedback: Sign &amp; Date:</b> _____</p>