## POLICY FOR THE MANAGEMENT OF ADVERSE INCIDENTS

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<tr>
<td>Contents</td>
<td>Page Number</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>1.0 Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2.0 Definitions</td>
<td>3/4</td>
</tr>
<tr>
<td>3.0 Purpose and Aims</td>
<td>4</td>
</tr>
<tr>
<td>4.0 Policy Statement</td>
<td>4/5</td>
</tr>
<tr>
<td>5.0 Scope of the Policy</td>
<td>5</td>
</tr>
<tr>
<td>6.0 Responsibilities</td>
<td>5/6/7</td>
</tr>
<tr>
<td>7.0 Legislative Compliance, Relevant Policies Procedures &amp; Guidance</td>
<td>7</td>
</tr>
<tr>
<td>8.0 Equality and Human Rights Considerations</td>
<td>8</td>
</tr>
<tr>
<td>9.0 Policy Approval</td>
<td>8</td>
</tr>
<tr>
<td>10.0 Policy Implementation, Training and Education</td>
<td>8</td>
</tr>
<tr>
<td>11.0 Review of Policy</td>
<td>9</td>
</tr>
<tr>
<td>12.0 Sources of Advice and Further Information</td>
<td>9</td>
</tr>
</tbody>
</table>
1.0 Introduction

1.1 This policy describes the Southern Health and Social Care Trust’s (hereafter referred to as ‘The Trust’) management of adverse incidents.

1.2 The arrangements within this policy set out the processes for reporting and recording adverse incidents, investigation, minimising risk and sharing lessons learned.

1.3 This policy has been developed in accordance with the Trust’s key principles for policy development.

1.4 This policy has been developed in consultation with internal stakeholders.

1.5 The principles of this policy apply to the management of all adverse incidents across the Trust regardless of which Directorate is charged with responsibility for administering those adverse incidents.

2.0 Definitions

2.1 For clarity of the purpose and scope of this policy, the following definitions are provided:

2.1.1 Adverse Incident - An ‘adverse incident’ is defined as event, circumstance or departure from acceptable standards of practice that could have or did lead to unintended or unexpected harm, loss or damage to people, property, environment or reputation of the Trust. This definition incorporates previously used terms such as accidents, clinical incidents, non clinical incidents, near misses, critical incident, medication incidents and adverse events.

2.1.2 Serious Adverse Incident - In line with the definition outlined in the DHSSPSNI circular HSS (PPM) 06/04 a ‘Serious Adverse Incident’ is “any event or circumstance arising during the course of the business of a HSS organisation/Special Agency or commissioned service that led, or could have led, to serious unintended or unexpected harm, loss or damage.” The Trust has to consider whether the incident should be reported to the Department of Health Social Services and Public Safety where it is likely to
(i) Be serious enough to warrant regional action to improve safety and / or care.
(ii) Be of public concern (such as serious media interest) or
(iii) Require an independent review.

A suicide must be reported to DHSSPS and the Southern Health and Social Services Board as a Serious Adverse Incident.
2.1.3 R.I.D.D.O.R. Reporting Mechanism - The term ‘R.I.D.D.O.R Incident’ relates to any incident or dangerous occurrence that is defined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (N.I.) 1997. There are four main classifications and these include:

- Major Injury Incidents / Conditions.
- Adverse incidents that result in more than three consecutive day’s incapacity from work.
- Dangerous Occurrences.
- Occupational Diseases.

3.0 Purpose and Aims

3.1 The purpose and aims of this policy are as follows:

3.1.1 Ensure that the Trust has in place a suitable, robust and standardised policy for the reporting and recording of all adverse incidents thereby ensuring that all adverse incidents are responded to in a timely and methodical manner.

3.1.2 Ensure that the Trust meets its statutory obligations in reporting certain adverse incidents to the appropriate regulatory authority.

3.1.3 Ensure that all adverse incidents are investigated to an appropriate level.

3.1.4 Inform the establishment of local arrangements to fulfil the requirements of this policy.

3.1.5 Ensure that all employees of the Trust understand and fulfil their responsibilities for the reporting of adverse incidents.

3.1.6 Identify clearly what an incident is and what adverse incidents should be reported.

3.1.7 Learn from the incident experience and transfer that learning across the entire organisation in order to facilitate the enhanced development of robust policies, procedures and systems in order to prevent a similar adverse incident happening again.

4.0 Policy Statement

4.1 The Trust promotes an open and positive approach to adverse incident management so as to ensure that the Trust learns from the adverse incident and participates in regional arrangements to minimise or prevent the recurrence of that adverse incident.

4.2 Learning from an adverse incident takes priority over any investigation or disciplinary purpose, except in the following rare circumstances where there is evidence of the following:
4.2.1 Gross professional misconduct or personal misconduct;
4.2.2 A breach of criminal or other law;
4.2.3 Falsified information about an incident.

4.3 Repeated breaches of acceptable behaviour or practice despite the Trust having provided all necessary training, counselling and supervision to prevent a reoccurrence.

4.4 With the implementation of this policy the Trust will ensure the following standards are met:

4.4.1 Statutory and other requirements for reporting adverse incidents to external organisations and bodies shall be fulfilled;
4.4.2 All adverse incidents shall be reported in an accurate and timely manner in accordance with supporting procedures;
4.4.3 All adverse incidents shall be reported within the Trust using a single specified data information system;
4.4.4 All adverse incidents shall be subject to regular review for the purpose of identification of action required to prevent recurrence.
4.4.5 All adverse incident investigations/reviews are reported in accordance with the Health and Social Care Regional Template for Guidance for Investigation/Review Reports, DHSSPS, September 2007.

5.0 Scope of the Policy

5.1 All Trust employees must adhere to this Adverse Incident Policy and associated procedures. This policy outlines the approach to adverse incident management which must be adopted when any employee, patient, contractor or visitor experiences an incident during the course of their work and / or whilst on Trust premises and / or receiving services from the Trust.

6.0 Responsibilities

6.1 Responsibility of the Chief Executive

6.1.1 The Trust’s Chief Executive, as “Accountable Officer” is responsible for ensuring sufficient resources are in place to ensure the effective reporting, recording, investigation and treatment of adverse incidents.

6.1.2 The Chief Executive delegates the day to day responsibility for establishing and monitoring the implementation of this policy to Directors.
6.1.3 The Chief Executive is responsible for ensuring periodic review of the Trust Adverse Incident Reporting system and associated processes.

6.2 Responsibility of the Risk Manager and Patient/Client Liaison, Safety and Risk Managers

6.2.1 The Trust will designate a senior member of staff to act as the Risk Manager and Patient/Client Liaison, Safety and Risk Managers. The Risk Manager and Patient/Client Liaison, Safety and Risk Managers will promote this incident policy, will oversee the training agenda and will assist other Managers to ensure that the Trust meets its obligations under this policy. The Trust’s Risk Manager and Patient/Client Liaison, Safety and Risk Managers will coordinate any information regarding reporting to external bodies and ensure the relevant timescales for reporting such adverse incidents are adhered to. The risk management function of the Trust is under the direction of the Medical Director. The Medical Director is responsible for the following:

6.2.1.1 Ensuring that all reported adverse incidents are recorded on the Trust’s Risk and Adverse Incident Management System;

6.2.1.2 Ensuring the effective management of adverse incidents that have been referred by front-line staff and managers using the appropriate line management channels.

6.2.1.3 Providing support and advice to staff responding to adverse incidents.

6.2.1.4 Managing the Trust’s Serious Adverse Incident Investigation process.

6.2.1.5 Having access to all relevant records (including personal medical records) which are essential to any serious adverse incident.

6.2.1.6 Having authority to review Trust procedures where these are found to be contributing to a serious adverse incident.

6.2.1.7 Ensuring that relevant regulatory and other bodies are provided with the necessary information on specific adverse incidents within the specified timescales.

6.3 Responsibility of Senior Management

6.3.1 All Trust Directors, Assistant Directors, Heads of Service and Senior Managers have responsibility for the management of adverse incidents within the areas of their remit and control and for ensuring that the learning that is gained from the investigation process is fully implemented and monitored as part of the Trust’s integrated governance requirements.
6.3.2 All Trust Directors, Assistant Directors, Heads of Service and Senior Managers have responsibility for ensuring that information required in relation to affecting this policy is provided in an accurate and timely manner.

6.3.3 All Directors are responsible for developing and implementing local arrangements and for monitoring those arrangements to ensure effective incident management.

6.4 Responsibility of Trust Staff

6.4.1 All Trust staff have a responsibility to adhere to the principles and aims of this policy and ensure that they operate in accordance with its supporting procedures.

7.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

7.1 There are a number of statutory bodies which have a legislative requirement to investigate specific types of adverse incidents and to provide information where appropriate to organisations on how to minimise the chance of reoccurrence.

Their legislative powers also extend to providing evidence to the courts for prosecution purposes where there have been serious breaches in legislation. Such bodies include Health and Safety Executive (N.I.), Police Service Northern Ireland, local Councils, Mental Health Commission, Health Estates on behalf of the Department of Health Social Services and Public Safety and the Regulation and Quality Improvement Authority.

7.2 Each of the above bodies has specific procedures in place for reporting adverse incidents to them. These will be followed by the Risk Manager and Patient/Client Liaison, Safety and Risk Managers where there is occasion to report information outside of the Trust.

7.3 Staff must take cognisance of relevant professional standards and guidance and other Department of Health, Social Services and Public Safety publications including but not exclusively or exhaustively the following:

7.3.1 Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (NI) 1997
7.3.2 Serious Adverse Incident Reporting DHSSPSNI Circular HSS (PPM) 06/04
7.3.3 Reporting of Medical Devices and Trust’s relationship with the Northern Ireland Adverse Incident Centre (N.I.A.I.C.).
7.3.4 Reporting of Incidents involving use of Medicines and Healthcare Products.
7.3.5 The Children (Northern Ireland) Order 1995 and Protection of Vulnerable Children and Adults (POCVA) requirements.

7.3.6 Reporting of Violence against staff.

7.3.7 Serious Adverse Blood Reactions and Events (SABRE) / Serious Hazards of Transfusion (S.H.O.T.).

8.0 Equality and Human Rights Considerations

8.1 This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

8.2 Using the Equality Commission’s screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

8.3 This policy has been considered under the terms of the Human Rights Act, 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

8.4 This policy will be included in the Trust’s register of screening documentation and maintained for inspection whilst it remains in force.

8.5 This document can be made available on request in alternative formats, e.g. Braille, disc, audio cassette and in other languages to meet the needs of those who are not fluent in English.

9.0 Policy Approval

9.1 During development, this policy was considered in draft form by the Senior Manager-Patient & Client Safety, Medical Directorate and circulated for consultation to Trust Directors and Assistant Directors.

9.2 This policy was presented in final draft and approved by the Trust Board at its meeting on 30th October 2007.

10.0 Policy Implementation, Training and Education

10.1 Following approval by the Trust Board, this policy was circulated to all Trust staff by the Senior Manager, Medical Directorate on ..............

10.2 The Risk Manager and Patient/Client Liaison, Safety and Risk Managers will provide any necessary training with regard to this policy.

10.3 A copy of this policy was placed on the Trust’s intranet on ...........

10.4 All Trust managers must ensure that their staff have access to this policy, understand its content, and are aware of its aims and purpose immediately upon its release.

10.5 All Trust staff must comply with this policy.
11.0  **Review of policy**

11.1 The Trust is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

11.2 This policy will be reviewed by the Senior Manager-Patient & Client Safety, Medical Directorate in December 2008, or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

12.  **Sources of Advice and Further Information**

12.1 Further advice and information regarding this document can be obtained from the Risk Manager and Patient/Client Liaison, Safety and Risk Managers.