BUDDIES COMMUNITY CARE LTD.

Incident Reporting and Management: Policy and Procedure

This Policy describes the **BUDDIES COMMUNITY CARE LTD** approach to incident recognition, investigation, response (including fulfilment of duty of candour) and learning from. It encompasses all types and levels of incidents and subsequent investigation.

Key Points

- What incidents should you report and why
- Guidance for staff and managers on incident management
- Reporting requirements and processes
- Duty of candour requirements
- Responding to and learning from incidents.
- Process for follow up of quality improvement plans.
- timescales for incident reporting and investigation

This Policy applies to all staff in a permanent, temporary, voluntary or contractor role acting for or on behalf of Buddies**.** It also applies to any subcontracted services). The Policy should be read in conjunction with the associated procedural document entitled Attachment 1 - Incident Reporting and Management Procedure and Attachment 2 - Incident Management Flowchart.

- This Policy describes Buddies approach to incident recognition, reporting and management (management includes investigation, Duty of Candour and learning).
- It defines the types of incidents that may occur and clarifies the process of reporting and classification of incident type and severity (level of harm)
- It defines the levels and process of investigation required for incidents according to their severity, complexity and potential for learning.
- It outlines the follow up of quality improvement plans arising from investigation and themes of incidents.

Scope of this Policy

Buddies is responsible for the safety of everyone who uses or works within its services and must ensure robust systems are in place to recognise, report, investigate and respond to incidents and to improve the quality of care provided to our service users – as well as the safety of staff and members of the public, through the consistent monitoring

and review of incidents which result, or had the potential to result in injury, damage or other loss.

Serious Incidents in healthcare are rare, but it is acknowledged that systems and processes have weaknesses and that errors will happen. A good organisation will recognise harm and the potential for harm and will seek to undertake swift, thoughtful and practical action in response, without inappropriately blaming individuals.

The investigation of an incident forms part of a wider strategy for risk management, and advocates the use of root cause analysis (RCA) as a systems based investigation process that explores the problem (what?) the contributing factors to such problems (how?) and the root cause(s) / fundamental issues (why?). Understanding these factors allows lessons to be learnt and actions to be developed to minimize the risk of the recurrence.

Organisational learning and remedial action must be at the heart of any risk management approach and the reporting of all incidents is a key factor in enabling this.

Staff have a right, and a duty, to raise with their employer any matters of concern they may have about health service issues associated with the organisation and delivery of care.

What should be reported, what is an 'Incident'?

Incident - An Incident is defined as an event or circumstance occurring during NHS funded care which causes or has the potential to cause any of the following:

- Harm to an individual
- Financial loss to an individual or organisation
- Damage to the property of an individual or the organisation
- Disruption to services provided by Buddies.
- Damage to the reputation of the organization.
- Non-compliance with regulation or Buddies Policy

Incident severity - This is the actual outcome of an incident (not what could have happened) according to the level of harm caused and is categorised as one of the following:

- No Harm
- Low Harm
- Moderate Harm

- Severe Harm
- Catastrophic/Death

Serious Harm - Any incident which appears to have resulted in severe harm or catastrophic harm, Chronic pain[1] or psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary[2]

Serious Incident (SI) - Serious incidents in health care are adverse events, including "near miss" incidents where the consequences to patients, families, and carers, staff or organisations are so significant or the potential for learning is so great that a heightened level of response is justified. Serious Incidents can be isolated, single events or multiple linked or unlinked events signalling systematic failures.

There is no national or local definitive list of events / incident that constitutes an SI as this can lead to inconsistency or inappropriate management of incidents. All incidents must be considered on a case-by-case basis using the guidance from the National Framework

Never Event - Is defined by the Department of Health as a "serious, largely preventable patient safety incident that should not occur if the available preventable measures have been implemented by healthcare providers". The management of Never Events is undertaken in line with the Never Events Policy Framework and the Never Events List[3].

Level of Investigation - The level of incident investigation required depends on the nature of the incident, the level of harm or the potential for learning. The level of investigation should be proportionate to the individual incident. Broadly speaking this can be summarised as follows:

- Local learning and optional RCA:
- Concise Investigation

No, low or moderate harm incidents which are not never events and do not fall within the definition of an SI.
Suited to less complex SI's and Never Events. Mandatory RCA managed by individuals or a small group at local level.

- Continuous, long term pain more than 12 weeks or after the time that healing would have been thought to have occurred in pain post trauma/surgery

- Has lasted, or is likely to last for a continuous period of at least 28 days
  The Never Events List 2013/14, NHS England, December 2013.

- Except where the incident is considered under the NHS England Serious Incident Framework 2013
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• Comprehensive Investigation: Suitable for more complex SI's and Never Events. Mandatory RCA which should be managed by a multidisciplinary team including experts or specialist investigations.

• Independent investigation: Suitable for incidents where the integrity of an internal investigation is likely to be challenged or where the size of the organisation, capacity / capability of the available investigators would make it difficult to conduct an objective internal investigation.

Details of the investigation requirements for each level of incident can be examined using the root cause analysis tool below. Root Cause Analysis: - A structured investigation that aims to identify the true cause of a problem, and the actions necessary to eliminate it.

A systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened (RCA toolkit NPSA).

Multi incident investigation root cause analysis moves the focus from repeated investigation to learning and improvement and can be used for the thorough investigation of reoccurring problems of a similar nature, setting or group of patients in order to identify the common problems, contributing factors, root causes and enables one action plan to be developed and monitored.

Duty of Candour - The statutory duty requires providers to notify anyone who has been subject (or someone lawfully acting on their behalf, such as families and carers) to an incident involving, moderate, severe or catastrophic harm or death. This notification must include an appropriate apology and information relating to the incident.

The aims and objectives of this policy are to:

- Promote an open, honest and fair approach to the identification, management and learning from errors and accident

- Provide staff with an agreed method of reporting, investigation and management of incidents and development of quality improvement plans, where appropriate

  - Enable collection and use of robust data to inform and promote organisational learning and improvement, providing appropriate assurance to internal and external stakeholders as required.

  - Use incident investigation and RCA to identify any deficiencies in care or service, learning from these findings through the development of safer practices and environments for the benefit of patients, staff and visitors

  - Establish an incident reporting and management framework which is proportionate to the incident being reported and fulfils statutory and contractual requirements in line with national best practice.

  - Support openness and transparency and assure patients / their representatives that appropriate review, investigation and learning from incidents are embedded within the organisation.

When an incident occurs the first action should be to make the situation safe, preserving the scene together with equipment or other items that may be used as evidence in an investigation. The standards that must be followed relate to the reporting, management and learning from incidents as follows:

Roles and Responsibilities

Individual Responsibilities

All staff are required to report and manage incidents in line with this policy. Where an incident occurs staff must take appropriate immediate remedial action at the time of an incident to prevent further harm to service users; staff; general public and the organization and its assets.

Chief Executive and Registered Manager

The Chief Executive is responsible for ensuring the infrastructure is in place to identify, report, manage, investigate and analyse incidents in order to learn lessons. The Chief Executive delegates responsibility to the registered manager.

The Impact on Quality Monitoring and the role of the Registered Manager

Buddies is cultivating a strong incident reporting culture in which incidents are promptly identified and reported.

- SI investigations are being appropriately identified, managed and investigated using RCA and any resulting risks are being addressed.
- Trends in incidents are being reviewed and managed on a Trust wide basis.
- Learning from incidents is being identified and improvements are implemented
- Reporting, managing and investigating incidents in line with this policy.
- Ensuring implementation of recommendations and quality improvement plans from serious incident investigations

They also have a role in the analysis of incident data, triangulating this information with other sources to identify trends and request assurance and improvement where required

- To review all online incident report forms within the timescales specified in this policy and take appropriate remedial action, where possible, to prevent a future occurrence.

- • Oversee the management of incidents reported within the ward /department, liaising with other disciplines / departments as required to ensure full, appropriate and timely response to all incidents.

- Immediately inform a member of the directorate management team and staff from other departments who need to be aware of any incident believed to be serious.

- Ensure that the patient's relatives or carers are informed about the incident, where appropriate, in a timely manner.

- Ensure local arrangements and support is in place to ensure statutory Duty of Candour requirements are fulfilled.

- Document remedial action on the incident report to complete the approval process and provide feedback where appropriate to the incident reporter.

- Reviewing and acting upon incident analysis themes and key learning points and triangulating with other risk information to inform improvement priorities.

- Provide appropriate feedback regarding the investigation outcome/preventive actions to staff.

- Ensure that staff are provided with appropriate support, in line with the Trust's Supporting

STAFF POLICY

- Enable the prompt reporting to the Health and Safety Executive if an incident is RIDDOR reportable.

TRAINING

The Safety and Governance Directorate will ensure provision of training as required to Directors, Managers, Supervisors, and any other staff groups to enable them to carry out their duties and responsibilities relating to incident report management and investigation. As a minimum this will include:

- Incident reporting training
- Incident management training
    - Managing investigations
- RCA training, resources and links
- Duty of Candour training and resources
- One to one support and guidance as required for SI investigation processes

LEARNING

Buddies is committed to ensuring local and organizational learning from incidents. Quality Improvement Plans will be developed that mitigate the risk of incidents reoccurring based on the outcome of incident investigations and RCA. These improvements will be shared with patients, relatives and staff as appropriate.

The Quality Improvement Plans will be agreed and owned by Buddies with the relevant person/s or manager responsible for the effective and sustained implementation of the Quality Improvement Plans.

To ensure improvements are completed, the action plan will be overseen by the registered manager.

INCIDENT REPORTING, MANAGEMENT AND LEARNING PROCEDURE

There are certain requirements that must be fulfilled when an incident occurs as follows:

Take Immediate Action:

When an incident occurs the first action should be to make the situation safe, preserving the scene and equipment or other items that may be used as evidence in an investigation.

Report the incident:

Staff will have appropriate access to report the incident by completing a Buddies incident report which should record the facts of the incident and immediate actions that have been taken.
Duty of candour will be fulfilled for all incidents graded moderate harm and above and this should also be reported on incident form.

(i) Management of the Incident – Escalation

Incidents will be escalated to senior management according to type, complexity and severity of the incident and in line with Attachment 2.
Severe Harm, Catastrophic incidents or Never Events should be notified to your line manager/senior person on shift and, for the most serious or urgent incidents, to the on-call management team. **07 999 16 17 18**

Incidents will be reported/escalated to external agencies in line with statutory requirements and as outlined in Attachment 6.

(ii) Management of the Incident - Initial management of incident report

• All incidents will be reviewed by the incident handler: o within 48 hours (for potential SI's). within a calendar week (for all other incidents).

- All incidents will be closed within a calendar month if appropriate (excluding SI's).

(iii) Management of the incident - Scoping

- Incidents that may be Never Events or Serious Incidents will be scoped within 72 hours of being reported to confirm the grading.
- Incidents will be scoped by clinical teams to determine the initial facts, level of harm, immediate action taken, and will be used to determine required level of investigation in collaboration with investigations team.

(iv) Management of the incident - Investigation

- Investigations will be carried out in line with Attachment 2 using RCA as a tool to understand the sequence of events and identify the root causes and contributory factors to the incident. Templates to support RCA investigation are at Attachment 7.
- Where statements are required from staff the guidance and proforma at Attachment 8 should be used.

(v) Management of the incident - Supporting Staff

Supporting staff involved in incidents should be undertaken in line with the Buddies' signposting access to support resources as needed.
Management of staff involved in incidents will be informed by application of the NPSA Incident Decision Tree.

Staff involved in the incident and investigation will be offered a debrief and opportunity to share the findings from the investigation.

(vi) Management of the incident - Quality Assuring the investigation report

Investigation reports will be quality assured at senior management level. SI's will be subject to Executive level sign off and/or under the commissioning groups guidance and instruction.

(Vii) Learning from the incident - Sharing findings

Patients / their representatives (where appropriate and in line with Duty of Candour) will be invited to meet with investigation leads to share the outcome of serious incident investigations and Quality Improvement Plans which have been developed in response to these investigations.

(ii) Learning from the incident - Follow up of Quality Improvements

Quality improvements from Comprehensive investigations will be monitored by commissioning group, management and director.
Quality improvements from Concise (local) investigations will be monitored through local divisional and governance processes.

(iii) Learning from the incident - Trends and Sharing Learning

All incidents will be subject to quarterly high-level analysis to identify trends/themes. In addition to this, trends and themes from serious incident investigations will be subject to bi-annual further analysis and monitoring via the quality monitoring policy. Both incident analysis reports will be provided to local teams, and commissioners for appropriate action / sharing.

DOCUMENTATION

Buddies incident reporting forms will act as document record for completed RCA's. with an audit sheet identifying key elements (seriousness/harm/potential harm/involvement of authorities/ use of restraint etc).
Supplementary documents may be stored and managed by directorates at a local level and kept in line with the GDPR Policy at operational address, as registered with CQC.

REPORTING TO EXTERNAL AGENCIES

Buddies has a statutory duty to report certain kinds of accidents, violent incidents, dangerous occurrences and occupational ill health under the Health and Safety at Work Act 1974 and in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.

It is also a requirement to report certain incidents to other national organizations, as outlined within the HSE Guidance:

https://www.hse.gov.uk/pubns/indg453.pdf

ROOT CAUSE ANALYSIS TOOL

Root Cause Analysis is an investigative tool used to understand why an incident has occurred. RCA emphasizes the critical exploration of underlying and contributory factors. Buddies has adopted the Root Cause Analysis tool for the investigation of claims, complaints and incidents in line with NPSA guidelines.

PURPOSE

Buddies has a statutory duty to report certain kinds of accidents, violent incidents, dangerous occurrences and occupational ill health under the Health and Safety at Work Act 1974 and more specifically in accord with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995.

All Severe and Catastrophic harm incidents need to be reported to the Clinical Commissioning Group (CCG) and it is also a requirement to report certain incidents to a national body (ie. Medicines and Healthcare Regulatory Agency, National Screening Programmes) within a specific timeframe. Currently the timeframe for serious untoward incidents is 45 days.

HOW TO COMPLETE THIS DOCUMENT

- This document is designed to be completed electronically.
- Complete the right hand column for all sections relevant to the investigation.
- Review the explanatory guidance text in the right hand column to understand the type of issues to consider and positively enter information. For example, in section 4, even if policies were followed and were in-date, state this otherwise there is no evidence that you have considered the possibility.
- The examples given in the right hand column are not exhaustive but are provided as examples. Consider whether anything similar might be relevant to your particular incident investigation.
- Once you have entered your text into each section of the right hand column, delete the explanatory guidance.
- Following completion of the RCA review any areas in which you have ticked “yes”. For each section with a “yes” you should consider an action to prevent or minimise the problem from recurring.

- In developing your actions consider the problem by way of the following hierarchy of controls, in order:

  - Eliminate-can you eliminate the problem, for example stopping a high risk procedure altogether or not using a hazardous piece of equipment?

  - Substitute-can you substitute the problem with something less harmful?. An example is the use of latex free gloves for staff allergic to latex.

  - Isolate/distance-can you isolate or distance the problem from people?

  - Safe Systems Of Work-can you create, or improve upon, safe operating procedures to minimise or eliminate the problem?

  - Training/knowledge/information/Supervision-can you provide additional training or supervision to staff to minimise or eliminate the problem?

- Personal Protective equipment-can you provide protective equipment to staff or patients to minimise harm to them. Examples include hip protectors for patients at risk of falls, eye protectors to prevent splash injuries, sharps boxes to prevent sharps injuries, etc.

ROOT CAUSE ANALYSIS TOOL

Did deviation from current systems or processes contribute to the event?	Yes No (Delete as applicable)	Issues to consider in this section include: • Whether any policies, procedures or protocols (or the lack of them) affected the incident. Were policies, procedures or protocols followed, out of date, ambiguous or unavailable?
Did staff actions contribute to the event?	Yes No (Delete as applicable)	Issues to consider in this section include: • • Staff motivation - ie. boredom, low job satisfaction. • • Personality issues - ie. low self-confidence or overconfidence. • • Domestic or lifestyle issues. • • Physical ability, fatigue, stress, mental impairment due to illness, drugs, alcohol, etc.

Did inadequate staff training/skill contribute to the incident?	Yes No (Delete as applicable)	Issues to consider in this section include: • • The quality of any relevant training staff had undergone including local induction. • • The level of experience of the staff. • • Whether staff had adequate supervision and/or mentoring. • • Had staff had refresher training to update themselves? • • Were the staff subject to regular appraisal?
Did inadequate staffing resources contribute directly to the incident?	Yes No (Delete as applicable)	Issues to consider in this section include: • • Skill mix. • • Staff to patient ratio. • • Use of agency/bank staff.

Did poor communication or information contribute to the incident?	Yes No (Delete as applicable)	Issues to consider in this section include: • • Conflicting information, either verbally or within medical records, etc. • • Inaccurate information. • • Poor communication due to language barriers, inappropriate medium (ie. email, fax, etc). • • Relevant persons not included in communication. • • Poor/absent documentation within medical records.
Did a malfunction or absence of equipment appear to contribute to the adverse event?	Yes No (Delete as applicable)	Issues to consider in this section include: • • Whether the equipment was subject to an up to date maintenance programme. • • Whether the equipment was familiar to those using it and if they were competent to use it. • • Whether a safety mechanism failed.
Did controllable environment factors directly affect the outcome?	Yes	Examples might include water on the floor, a door that was locked preventing

	No (Delete as applicable)	entry/exit, poor flooring, inadequate lighting and poor ventilation. Has the area been subject to a risk assessment? If answering yes, provide a copy. If answering no, state why.
Are there any uncontrollable external factors truly beyond the organisation's control? Give reasons why.	Yes No (Delete as applicable)	Examples might include an ambulance strike, a failure of BT systems rendering pagers inoperative, etc.
Are there any other factors that have directly influenced this outcome?	Yes No (Delete as applicable)	Please detail.

Guidance for Staff in Preparing Statements

You have been asked to write a statement following an incident that was reported to Safety and Governance. You may have been asked for a statement because you either:

- witnessed the incident or
- were involved in the patient's care or the incident

or you have relevant knowledge and/or experience to help the Investigator determine how the incident occurred.

The incident is being investigated to ascertain how it occurred, so that lessons can be learned and improvements made. The purpose is not to apportion blame on any staff members. Please do not include opinions in your statement unless you have been explicitly asked for an opinion.

Your statement is intended to be your accurate and factual account. It should be confined to facts you recall about the patient and your treatment, or facts which you are able to recall after refreshing your memory from entries made by you (or other staff) in the patient's medical notes.

Please note, in some circumstances, your statement may be disclosed to the Coroner, and/or used to respond to a formal complaint and claim.

Start your statement with personal information such as: full name, job title, work address, etc.

Set out your professional qualifications, which should include the year they were obtained and an explanation of abbreviations, ie. RN - Registered Nurse. You should set out your current position and number of years in post and your position at the time of the incident.

1. Include the source of the information you are providing, for example, is the information taken from your memory, or the medical records? Did you witness the incident? Do you have a good recollection of events?
2. Now you should set out a detailed, chronological narrative (including dates and timings where possible) of your involvement in the incident, which should be set out in paragraphs. Where applicable, describe the service users's condition and relevant details such as:

   - The service users history and presenting complaints.
   - The investigations carried out and subsequent results.
   - The diagnosis made and treatment provided.
   - What was communicated to the patient and their family.

   You should set out as much detail as possible for each attendance as even the most routine action can be critical or relevant.

STATEMENT PRO-FORMA

Name of Service User:
Service Users Date of Birth
SU Code, or identification number (might be initial or otherwise):
Date of Incident
Incident reference number

Full Name of Person Providing Statement

End of Policy Statement

This policy will be reviewed regularly to ensure it remains compliant with current legislation, regulatory standards, and best practice guidance.

The policy is subject to **annual review**, or sooner if there are:

- Changes to relevant legislation or regulation
- Guidance updates from the CQC or other regulatory bodies
- Changes in organisational structure or service provision
- Findings from internal audits or quality assurance processes
- Feedback from staff, service users, or stakeholders

All staff are responsible for ensuring they are familiar with this policy and apply it consistently in their roles. Updates will be communicated to all relevant personnel, and training will be provided as necessary.

Policy Review and Version Control

Version	Date Issued	Reviewed By	Next Review Due	Changes Made (Summary)
1.0	07/10/2025	James Pay	07/10/2026	Initial version issued

Approval:

Policy approved by: **James Daniel Pay - Registered Manager**

Signed: ..... (MANAGER)

Date: **7/10/2025**

Document Control:

- This document is a controlled policy. Once printed or downloaded, it becomes an uncontrolled copy and may not reflect the latest version. Please refer to the master version stored on the [policy management system / office file / care management software] for current policy.