Leicester Event Medical LTD

Incident Reporting Procedure

DOCUMENT PROFILE

Purpose of the document: Procedure to be carried out when reporting incidents.

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Document Status: Final

Date	Author/Contributor	Amendment Details

1. Introduction

Effective accident and incident reporting is important for enabling Leicester event medical (LEM) to identify areas of risk. In order for the information to be used fully, it is vital that the management of incident reporting is consistent across the Trust, and that staff working at all locations, are made fully aware of this procedure.

The Care Quality Commission, Central Alert System and the NHS Protect place requirements on the LEM, to have procedures in place for the reporting of incidents.

The aim of incident reporting is not to apportion blame, but to learn from experience and improve practice accordingly. Where errors have been made the preferred option is to provide guidance or retraining to those staff involved. Staff will only be disciplined where there is evidence of wilful negligence, acts of maliciousness or gross/repeated misconduct.

2. Scope

This document covers all incident reporting aside from serious incidents and applies equally to incidents involving staff, patients, contractors, visitors and members of the public who are affected by the work of the Company.

For serious incidents including fatalities, major injury, system breakdowns, and information security, managers and staff should refer to the Serious Incident Policy For concerns about colleagues working practices, staff should refer to the Freedom to Speak Up: raising concerns (whistleblowing) policy (HR003). This document should be read and implemented in conjunction with a number of other Trust policies detailed on page 3.

3. Objectives

1. To provide a safe environment for staff, patients, visitors and contractors

2. To raise awareness of the importance of consistent and accurate incident reporting.

3. To ensure managers and staff at all levels are aware of their personal responsibilities in incident reporting investigation, and the actions that need to be taken following an incident.

4. To define the categories of incidents to be reported.

5. To describe the grading system to be used for assessing the impact of each incident, and the likelihood of recurrence, and to use the risk matrix score to establish the extent of the investigation to be undertaken.
6. To reduce the severity of incident reports by developing robust systems to minimise the potential for recurrence.

7. To ensure that everyone in the organisation can learn lessons from both patient and staff health and safety incidents in order to prevent reoccurrence, so far as is reasonably practicable.

8. To reduce staff absence attributed to industrial injury.

9. To ensure that all staff are aware of what constitutes an information security incident and how to report any suspected or known incidents.

4. Responsibilities

4.1 The Managing Director

The Managing Director will have overall responsibility for monitoring incident outcomes.

4.2 Line Managers

It is the responsibility of managers at all levels to implement this procedure, and to ensure that all staff are aware of how to report an incident or risk, through Casus which is made available in their area of work. It is important that managers make personal contact with all members of staff reporting incidents, in order to provide them with an opportunity to discuss the incident, and for managers to provide immediate support following an incident.

Leicester event medical uses casus to capture and handle all incidents. Line managers are responsible for logging onto the casus system to investigate all reported incidents within a timely manner and to feedback to staff on the outcome of that investigation. All staff have access to casus for incident reporting purposes.

4.3 Managers' specific responsibilities include:

- To provide guidance to staff and to ensure measures are taken to prevent a recurrence of an incident.
- To refer staff for retraining as appropriate.
- To ensure all acts of physical abuse are reported to the Local Security Management Specialist as soon as possible after the incident.
- To offer support, and referrals for occupational health, welfare, counselling services & re-training as appropriate.
- Encourage staff to report risks and incidents via casus.
- Ensure that all information incidents graded as "High" are referred to the Information Security Manager immediately by email or telephone.
- To report relevant RIDDOR Health & Safety incidents to the Health, Safety and Security Department , in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) see Section 4.18. The H,S&S Department will inform the Health and Safety Executive of relevant incidents.

4.4 Director of Operations, Quality Assurance Manager, Centre and line Managers

- Are responsible for ensuring that company-wide, sector and control, incident statistics are monitored and local trends are identified;

- Reports should be monitored at local/sector governance meetings ;

- Identified risks should be assessed for inclusion on the local risk registers.

4.5 Clinical Team Leaders, Team leaders, Department Heads and all appropriate Managers

- Are responsible for completing appropriate level of investigation and recording the outcome, including a pre- and post- risk grading, on the casus system.

- Provide guidance to staff and to ensure measures are taken to prevent a recurrence of an incident. Where an incident has resulted in either a serious injury or fatality to either a member of staff a patient or serious loss of information, managers should refer to the Serious Incident Policy.

- To encourage the reporting of all Incidents, amongst their team and other operational staff;

- To ensure any equipment that has failed during the treatment of a patient is reported onto casus, prior to being sent to Equipment Stores for repair/inspection as specified in Exchange in the Event of Equipment Failure Procedure.

- To provide feedback to the member of staff reporting the incident, following completion of the investigation.

4.6 Quality Assurance Manager

- To make staff aware of the importance of incident reporting, and to encourage the reporting of patient safety and staff health and safety incidents through their day to day contact with staff.

- To oversee the investigation of patient safety incidents ensuring lessons learnt from incidents, are communicated to operational staff and appropriate training undertaken as required..

- To ensure that the results of equipment inspections are relayed to the member of staff who reported the fault.

- To logon to the casus system in a timely manner and undertake the quality check of completed investigations in a timely manner.

- To identify areas of clinical risk in their group or clinical area of responsibility.

4.7 Security Managers

- Review all Security incident reports.

- Ensure significant, major and critical Security incidents are reviewed by the security Group.

- The response to an incident will be determined by the Security Manager.

- All *potential* incident investigations will remain confidential at all times.

4.8 Local Security Management Specialist, and the Health, Safety and Security department

The Local Security Management Specialist, and Health, Safety and Security department will identify reporting trends and themes, and provide company-wide guidance with regards to identified patterns and emerging risks. Specific responsibilities include;

- Supporting staff who have been the victims of assaults in respect of liaison with the police and Crown Prosecution Service.

- Advising managers on their investigation of incidents

- Informing the company of trends in incident reporting and the issues raised in action plans resulting from incident investigations.

- Providing reports on incident levels to the Clinical Safety and Standards Committee, the Corporate Health and Safety Committee, and contributing the learning from experience reports.

- Developing procedures and strategies to achieve a reduction in incidents.

- Informing the managing director via the Incident Reporting System of all security related incidents, including physical assaults

- Report all RIDDOR Reportable events to the HSE, ensuring a copy of the completed F2508 form is sent to the line manager for their records.

4.9 Head of Health, Safety and Security

It is the responsibility of the Head of Health, Safety and Security to ensure the company is providing regular and timely updates on all patient safety incidents.

4.10 Risk Systems and Development Manager

It is the responsibility of the Risk Systems and Development Manager to maintain the casus system, to provide technical support in its use to all levels of the company, and to make changes as necessary to the system.

4.11 All Staff

All staff are required to:

- Report incidents (including Information Security & Governance incidents), near misses, or dangerous occurrences that affect themselves, patients or any one affected by their acts.
- Remove any piece of faulty equipment from use immediately once identified.
- Co-operate in the investigation of incidents, providing witness statements and any other information that will assist with an investigation.

4.12 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995

There is a statutory duty on all employers, to report notifiable incidents to the Health and Safety Executive. Incidents to be reported include;

- Any absence over seven days (not including the day of the incident) that results from an industrial injury.

- A Major Injury (as defined by the HSE in Regulation 4 of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.)

- A Dangerous Occurrence (as defined by the HSE in Schedule 2 of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.)

- An Occupational Disease that is deemed by a healthcare professional as attributable to the person's work (as defined by the HSE in Schedule 2 of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.)

- Exposure to carcinogens and mutagens (as defined by the HSE in Regulation 9 of The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.)

Managers are responsible for reporting incidents all RIDDOR incidents to the Health, Safety & Security Department RIDDOR Reporting Form. A member of the team will review the information contained within, and if it meets the criteria for a RIDDOR report they will complete the appropriate report to the HSE. A copy of this will be sent to the line manager for their records.

5. Definitions

Patient Safety Incident includes any unintended or unexpected incident which could have or did lead to harm for one or more patients. Examples of such incidents include clinical error, equipment failures affecting the treatment of a patient, and delays in providing patient treatment. Clinical Governance encourages the reporting of all patient safety incidents in order to identify and reduce clinical risk.
A Health and Safety Incident can be defined as an event or omission that has caused injury or ill health to staff, visitors, or members of the public who are affected by the activities of the Trust. Such events include; work related accidents, ill health brought on by work-related activity, injuries sustained as a result of road traffic accidents, and equipment failings. Staff should also report incidents that occur at home where an injury has been sustained. The term Incident in this procedure, is

used to describe Patient Safety Incidents/Near Misses, Health and Safety Events/Near Misses, all acts of Violence or Verbal Abuse and any breach of information security.

Physical Violence includes any event where a physical assault has been suffered by a member of staff. This includes violence that can be attributed to patients' clinical condition, and sexual assault

Non-Physical Abuse includes any act of intimidation, verbal abuse anti-social behaviour, homophobia, sexism, racial abuse or victimisation of disabled people.

Patient Safety Near Miss is a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as a result of compensating action, thus preventing injury to a patient.

Non Clinical Near Miss includes any event where injury or loss has been avoided, but there is potential for the event to reoccur. Such events include health and safety incidents or dangerous occurrences involving the Trust's fleet or estate.

Hazard includes anything with the potential to cause harm

Information Security includes any event which may result in:

- Loss or release of confidential information
- Loss of personal information

Examples of information security incidents include:

- Loss of electronic or paper documents containing confidential information.
- Loss of portable electronic media such as laptops, PDAs, CD ROMs, or memory sticks which contain personal or confidential data.
- Unauthorised disclosure of user account details.
- Providing information to unauthorised persons.
- Use of another user's account to access resources.
- Identifying that a fax, printout or email containing confidential information was sent out to an incorrect recipient.
- Identifying a physical breach of a secure area.
- Introduction of a computer virus or worm.
- Identification of inappropriate websites.

6. Reporting Incidents

6.1 All incidents and near misses are to be reported using casus to which all staff have access; via salus.

6.2 It is important that names and contact details of witnesses to all incidents are recorded to assist with subsequent investigations.

6.3 When reporting any incident, involving staff, patients or others, only facts are to be documented not opinions.

6.4 Injuries resulting from Road Traffic Accidents must be reported via Casus

6.5 Some staff with access to the Broadnet radio system will be able to report an incident via a talkgroup. In this situation, the Casus record will be completed by a member of the control staff. Upon completion of the electronic form, a notification will also be sent to the appropriate line manager for investigation. Staff will be notified when this reporting method becomes open for use.

7. Reporting Physical or Verbal Abuse

7.1 All acts of Physical Violence or Non-Physical Abuse should be reported by completing a report on casus.

7.2 Where incidents involving physical violence or other serious occurrences (such as threats with fire arms) has occurred the investigating manager should notify the local Security Management Specialist (LSMS), as soon as possible. This will allow early liaison with the police, in an attempt to obtain a successful prosecution against the perpetrators of assaults against staff. A major factor for the police when deciding whether to charge someone for an offence is the body of evidence available. This includes independent witnesses to the assault. It is important that contact details for the police officers attending the incident are obtained, in order for the LSMS to liaise with the Police, and Crown Prosecution Service.

7.3 The police should be informed of all physical assaults where there is an intentional application of force without justification, resulting in physical injury or personal discomfort. When liaising with the police, keep the LSMS notified of any developments such as charges issued, court dates, crime reference numbers being given etc.

8. Reporting Patient Safety Incidents

A patient safety incident is defined as any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving care..

8.1 When reporting patient safety incidents, staff should provide as much detail as possible about the treatment provided to the patient, both prior and subsequent to an incident occurring. Where known, the outcome should be recorded in respect of how the incident has affected the patient's clinical condition. In the first instance the incident should be reported to the line manager who will decide the appropriate person to undertake the

investigation. All patient safety incidents must be assessed for their impact under Duty of Candour by a registered Healthcare Professional.

8.2 All equipment that fails during use, or out of date drug packs etc., should be taken out of use immediately. Staff should report the incident as detailed in section 6 above, and then follow the Equipment Failure Procedure. Guidance on equipment classified as a medical device can be obtained from the Health, Safety and Security department.

8.3 Other examples of patient safety incidents that should be reported include:

- Patient injuries sustained as a result of equipment failure, mishaps or falls whilst in LEM care.
- Drug administration errors.
- Concern about treatment provided by other Health Care Professionals
- Delays in providing treatment that result in an adverse effect on the patient's clinical outcome.

8.4 Delays caused by system failures in control, in either call taking, or vehicle allocation should be reported, by the manager in charge of the Control Room.

9. Near Misses (Clinical and Non-Clinical)

9.1 The need to report near misses is as important for the LEM as the reporting of incidents that have caused actual injury, ill health, or loss.

9.2 Examples of near misses that should be reported include:

- The failure of clinical or non-clinical equipment during a patient care episode.
- Mistaken clinical judgment.
- Procedures, clinical guidelines, protocols or practices, found to be unsafe.
- Hazards associated with the company's estate or fleet.

10. Reporting Information Security Incidents

10.1 Once becoming aware of a potential information security incident, staff are required to inform their manager and report the incident as per section 6.

10.2 Staff may contact the Security Manager for advice or to report the incident directly.

10.3 Staff must not discuss any matters regarding the incident with anyone except their immediate line manager, the Security Manager or a law enforcement officer.

11. Reporting to External Agencies

Incidents are reported to external agencies using the following protocols;

MHRA – Incident data will be submitted to the MHRA by the Health, Safety and Security department.

RIDDOR – Local managers are responsible for reporting incidents to the Health, Safety and Security Department via the LA473. This department will be responsible for reporting appropriate RIDDOR incidents to the HSE. Reporting procedures are detailed above in section 4.18.

12. Grading of Incidents

12.1 All reported incidents are graded by the investigating officer. All incidents will be graded according to the actual impact, and also the potential future risk to patients, staff and the organisation should a similar incident occur again. This will help to establish the level of local investigation and causal analysis that should be carried out. Guidance on how to grade Incidents is given in Appendix 2 .

13. Raising Concerns

Staff can refer to the HR003 Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy for the processes to raise concerns.

IMPLEMENTATION PLAN	
Intended Audience	For all staff
Dissemination	Available to all staff on salus
Communications	Revised Procedure to be announced in salus and a link provided to the document
Training	Health & Safety and Information Security training. Incident reporting awareness sessions and guidance. Managing Safety and Risk training (1 day) includes incident investigation training, which is refreshed every 3 years.

Monitoring:

Aspect to be monitored	Frequency of monitoring AND Tool used	Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported	Committee/ group responsible for monitoring outcomes/ recommendations	How learning will take place
Duties including how all incidents and near misses involving staff, patients and others are reported (Paragraphs 610)	Quarterly report Extracted from Datix	Health, Safety and Security Team report to the local Health and Safety Meetings	Clinical Safety and Standards committee and Corporate Health and Safety Committee	Lessons learned and improvements made are disseminated by the Clinical Safety and Standards committee and Corporate Health and Safety Committee
How the organisation reports incidents to external agencies (Paragraph 11)				

How staff can raise concerns (Paragraph 13)				

Appendix 2

Guidance on Grading, Investigation and Root Cause Analysis of Incidents

Introduction

This document provides guidance to staff within the LEM on how and when investigation processes should be undertaken following an incident.

Whilst incidents almost automatically lead to reactive risk management i.e. damage limitation and immediate remedial action. They should also be seen as an opportunity for proactive risk management i.e. learning from what has happened and looking ahead to see how such incidents can be prevented from reoccurring; thereby reducing future risk to the Trust.

In order to learn from these events it is necessary to obtain the facts and details of the incident. These must be recorded as soon after the incident as reasonably possible. Further, more detailed information can be gathered and collated as the investigation progresses. The depth and level of investigation will be dictated by the severity of the event/incident. When the key facts of the incident have been identified, then measures can be taken to prevent, or reduce the likelihood of similar circumstances combining again, with adverse results.

All staff therefore have a part to play in this area of risk management, whether it is in terms of completing accurate records (on PRFs, Casus,,) or if it is acting as an Investigating Officer/manager conducting the investigation and analysing the outcomes.

Definitions

For the purpose of this guidance the term Incident refers to any untoward events relating to Health and Safety, Patient Safety, physical or non-physical violence, near miss (clinical or non-clinical), or information security.

Immediate Cause is defined as the factor(s) which triggered the actual incident.

Contributory Factor is defined as the circumstance(s) which contributed to the occurrence of the incident, but which, by itself or themselves would not have caused the incident to arise.

Root Cause is defined as the underlying cause(s) to which the incident could be attributed and if corrected would prevent or minimise the likelihood of recurrence.

Incident Grading

All reported incidents will be graded according to the severity of the actual impact, and also the likely future risk to patients, staff and the organisation should a similar incident occur again. This grading will also help to establish the level of local investigation that should be carried out.

Incidents will be graded by individuals (identified in the procedure) using the matrix below. The level of investigation and analysis required for individual events should be dependent upon the incident grading and not whether the incident is an actual incident or a near miss.

Risk Scoring

Not all incidents need to be investigated to the same extent or depth. To assess the level of investigation required the impact of the incident and the likelihood of a recurrence both need to be considered. For incidents where Physical Violence, Non-Physical Abuse or Lifting, Handling and Carrying are factors, the likelihood should be based on the staff member's previous reporting history. For all other categories the likelihood should be based on general reporting trends. To assess the likelihood of recurrence, managers responsible for grading should refer to the Quarterly Incident Statistics, Complex Statistics and the levels of similar incidents that have been reported. Having assessed each incident against the risk grading matrix, the amount of investigative and analysis effort should be in relation to the risk scoring (see below).

Table 1 Impact Score

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Impact score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/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/ agency reportable incident An event which impacts on a small number of patients	Major injury leading to longterm incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with longterm effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/audit	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Noncompliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Noncompliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/ interruption of >1 hour Minimal or no impact on the environment	Loss/ interruption of >8 hours Minor impact on environment	Loss/ interruption of >1 day Moderate impact on environment	Loss /interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood Score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur annually.	Expected to occur at least annually.	Expected to occur at least every 6 months.	Expected to occur at least monthly.	Expected to occur at least weekly.
Probability	< 1%	1-5%	6-25%	25-60%	>60%
	Will only occur in exceptional circumstances.	Unlikely to occur.	Reasonable chance of occurring.	Likely to occur.	More likely to occur than not.

Table 3 Risk Score = Impact x Likelihood (I x L)

	Likelihood Score				
Impact Score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1-3	Low risk
	4-6	Moderate risk
	8-12	Significant risk
	15-25	High risk

Level and Nature of Local Investigation and Analysis

Once the event has been graded the appropriate response should be actioned, in compliance with the table below. If the investigation reveals issues that were not at first apparent from the casus report, the incident should be re-graded and additional actions undertaken appropriate to the Risk Score.

Dependant on the nature of the incident, e.g.: Violence, Manual Handling; further guidance on additional actions to be taken can be obtained from the company's Health Safety & Security documents (located on salus).

Category	Actions **All Operational Supervisors and Managers :**	Analysis	Outcome
Low (1 – 3)	Support and discuss incident with staff member Check that Casus completed Identify previous reporting history for this staff member – have similar incidents been reported previously Consider whether appropriate to add this address to High Risk Register	Incident to be entered on to casus and relevant investigation completed by manager.	Carry out immediate Remedial Action
Moderate (4 – 6)	Cross reference casus with Patient Report Form's and other documentation Carry out Actions as for category green	As for category green Analysis of cause and contributory factors	Immediate Remedial Actions, and Recommendations where appropriate
Significant (8 – 12)	Carry out Actions as for category yellow and green Carry out thorough investigation..	As for category yellow and green Analysis of cause and contributory factors	Immediate Actions, or Recommendations and Action Plan
High (15 – 25)	Assurance Team	Root Cause Analysis	Action Plan and Improvement Strategy

General Guidance on Investigation Processes

Incident investigations should:

- Identify reasons for substandard performance.
- Identify underlying failures in management systems.
- Learn from the incident and make recommendations to help prevent or minimise recurrences, thus reducing future risk of harm.
- Satisfy mandatory and LEM reporting requirements.

The investigation needs to be prompt and thorough. Where possible, remedial action or solutions should be recommended. If the investigation is not undertaken as soon as practicable after the event, conditions and recollections fade and evidence is lost.

There are five components of any investigation:

I. Collect evidence about what happened.
II. Assemble and consider the evidence.
III. Compare the findings with relevant standards, protocols or guidelines, whether these are particular to LEM or National, to establish the facts, draw conclusions about causation.
IV. Make recommendations for action to minimise risk of recurrence. V. Implement the recommendations and track progress.

I) Collecting Evidence.

The sources of information and methods that can be used in investigation typically fall into the three following categories:

- **Direct observation** is crucial to avoid losing important evidence about the scene, equipment, environment, vehicles and machinery involved, etc. Where possible photographs should be taken, particularly when it is impractical to preserve evidence or maintain the scene of the incident in a permanent state.

- **Documentation** which identifies what occurred leading up to and at the time of the incident and this should be included as part of the investigation. Evidence of prior risk assessment, work place inspections, servicing and maintenance history may all be relevant to the investigation.

- **Interviews** should be undertaken with the personnel involved in the incident, and any witnesses identified and their full contact details and signatures as soon as possible after the event.

Adverse incidents seldom arise from a single cause; there are usually multiple underlying failures in management systems/procedures which have created the circumstances leading to the incident.

II) Assembling and Considering the Evidence

Investigations should identify both immediate and underlying causes, including human factors/errors. Immediate causes must take into account the patient, the task, the work environment and weather conditions, all the persons' involved (either individually or as part of a crew or team), time of day and any machinery, vehicles or equipment used. Underlying causes can be management and systems failures organisational, cultural, personal/health and contextual factors that all contribute to explain why the event(s) occurred. Getting to the root cause of the problem will help ensure the development of an effective improvement strategy and if the incident is properly and thoroughly investigated then this should prevent or significantly reduce the likelihood of recurrence.

III) Comparing findings with relevant standards & protocols

The next stage of the investigation is to compare the conditions and sequence of events against relevant standards, guidelines, protocols, approved codes of practice, etc. This will help to minimise the subjective nature of investigations and to generate recommendations which have the maximum impact and relevance. The objectives are to decide:

- Whether suitable and sufficient standards / procedures / controls / risk assessments, undertaken and were they being implemented to prevent untoward incidents occurring in the first place.
- If standards / procedures etc exist, are they appropriate and sufficient?
- If the standards / procedures were adequate, were they applied or implemented appropriately?
- Why any failures occurred.
- Were safe systems and procedures accidentally or deliberately breached?

IV) Make Recommendations

Where an investigation identifies immediate or underlying causes involved, recommendations should be made to take remedial action immediately or make

recommendations for possible solutions to prevent recurrence within an action plan.

V) Implement the Changes/Action Plan

Where an investigation has resulted in an Action plan being created or a change in working practice, progress should be monitored and recorded.

Root Cause Analysis

Unless the fundamental, or root causes of adverse events are properly understood, lessons will not be learned and suitable improvements will not be made to secure a reduction in risks. Incidents rarely arise from a single cause; there are usually underlying failures in management systems which have helped to create the circumstances leading to the incident.

The purpose of the analysis exercise is to identify the Immediate, Contributory and Root causes of the incident.

Communication of Learning Points

Implementing recommendations and, and monitoring the effectiveness of action taken, will provide a certain level of evidence to demonstrate that the LEM is learning from adverse events. This may be on an individual or company Wide basis. It is necessary to ensure that lessons are learnt and changes are made and communicated so that the company can demonstrate continuous improvement as an organisation.

It will be the responsibility of Managers and Investigating Leads to feed back to individuals with regard to lessons learned from Incidents and to monitor progress against action plans drawn up.