Incident Management Policy and Guidance

|  |  |
| --- | --- |
| Author (name): | Matthew Emerson  |
| Author (designation): | Head of Quality Assurance and Improvement |
| Date approved by QGB | 5/09/2017 |
| Date uploaded to intranet: | 27/09/2017 |
| Review Date | September 2018 |
| Key words |  |

**Version control**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Version** | **Author of changes** | **Date** | **Revisions from previous issues** | **Circulation** |
| 1.0 | Matthew Emerson | 03/07/2014 | Initial draft |  |
| 1.1 | Matthew Emerson | 07/01/2015 | Review |  |
| 1.2 | Gail Wheatley-Yates | June 2017 | Review - departmental name change |  |
| 2.0 | Policy, Strategy and Partnerships Team | 5/09/2017 | Policy approved for publication at Quality Governance Board | Via Intranet and Staff Bulletin |

# contents

|  |  |  |
| --- | --- | --- |
|  |  | **Page Nos** |
| **1.** | **Introduction** | **5** |
| **2.** | **Background** | **5** |
| **3.** | **Aims** | **5** |
| **4.** | **Definitions** | **5** |
| **5.** | **Guiding Principles** | **6** |
| **6.** | **Reporting an incident, near-miss or hazard** | **7** |
| **7.** | **Grading** | **7** |
| **8.** | **Validation** | **9** |
| **9.** | **Response** | **9** |
| **10.** | **Choosing the right level of investigation** | **10** |
| **11.** | **High Level Investigation Reports** | **11** |
| **12.** | **Disclosure** | **12** |
| **13.** | **Monitoring** | **12** |
| **14.** | **Safeguarding** | **13** |
| **15.** | **Corporate Health and Safety Reporting** | **13** |
| **16.** | **CQC Notifiable Incidents for Adult Social Care Providers** | **13** |
| **17.** | **OFSTED Notifiable Incidents for Children’s Social Care Providers** | **13** |
| **18.** | **Disciplinary Proceedings** | **14** |
| **19.** | **Whistleblowing** | **14** |
| **20.** | **Learning and Improvement** | **14** |
| **21.** | **Roles and Responsibilities** | **15** |
| **22.** | **People Services Quality Governance Board** | **16** |
| **23.** | **Quality Assurance and Improvement Team (QA Team)** | **16** |
| **24.** | **Health and Safety Team** | **17** |
| **25.** | **What competences will staff who are implementing this policy need?** | **17** |
| **26.** | **Implementation and Review** | **17** |
| **Appendices** |
| **1.** | **People Services: Guidance for managing incidents, near-misses and hazards** | **18-25** |
| **2.** | **Standard Investigation Record** | **26-27** |
| **3.** | **High-Level Investigation Record** | **28-31** |
| **4.** | **Statement Template** | **32** |
| **5.** | **People Services Improvement Plan** | **33-34** |

**Introduction**

1. This policy sets out the Department’s requirements for responding to incidents, accidents, near misses and hazards in People’s Services.
2. This policy does not replace the Corporate Accident and Incident Reporting policy which should be followed on discovery of an accident or incident. This policy is about how the Department investigates, learns and improves as a result of incidents occurring.
3. This policy should be read in conjunction with the Corporate Accident and Incident Reporting Policy and guidance, Children’s and Adults Incident Response Guidance (see appendix), CQC Statutory Notifications Guidance, Ofsted Notification Guidance.

**Background**

1. The Department delivers services to thousands of people every day. The circumstances of the people who receive these services – children, people with disabilities, older adults - means there is a heightened risk of unintentional or unexpected harm occurring to them whilst in the service.
2. The Department acknowledges that whilst risk exists and that incidents can occur, the organisation will seek to minimise the number of incidents and the severity of their outcome.
3. In order to minimise the severity of incidents, the Department must have systems in place to ensure incidents are reported, investigated, analysed, that learning from investigations is captured, improvement actions implemented and then shared effectively.
4. The Department will strive to learn from incidents by identifying trends at a service and strategic level, which will assist in the prevention and recurrence of adverse incidents in the future.

**Aims**

1. The aims of this policy are:
* To safeguard service users and staff from unintended or unexpected harm
* To ensure all staff know their role in the management of accidents, incidents, near-misses and hazards
* To promote a culture of continuous improvement
* To assist the Department to learn from incidents and improve services as a result.

**Definitions**

1. **Accident** – any unplanned occurrence that leads to the injury of a person or other persons involved in our activities, including diseases or medical conditions contracted as a result of our activities.
2. **Incident** - An act of violence or aggression both verbal and physical or any unplanned occurrence that leads to damage to property, plant or equipment
3. **Near miss** - A near miss is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.
4. **Harm** – the term ‘harm’ refers to injury (physical or psychological), disease, suffering, disability or death occurring to any person on Council premises caused by an incident within the Council's buildings, or occurring outside of the Council's buildings or in the community in the course of the employee's work for the Council. Harm of this nature will not be related to any known existing injury or ill health.
5. **Hazard** - the potential of something to do harm to people or damage to property.

**Guiding principles**

1. It is important to note that the Department supports a ‘no-blame’ culture. This means that whilst staff are accountable for their actions, the process of incident reporting is not about apportioning blame but identifying practice which has or could lead to harm so that it does not happen again.
2. The Department recognises that in the majority of cases incidents are not attributed to individual error. Most incidents are caused by ‘system or process failures’. It is only by reporting and investigating such incidents that their underlying causes can be addressed and then acted upon.
3. Continuous improvement is everybody’s business. The safety of service users and staff depends on all staff putting the quality of the service they deliver at the heart of their work.
4. How you can do it:
5. **LEARN** so that we know why something went wrong and what can be done to stop it happening again
6. **IMPROVE** something in your service to avoid the same thing happening twice
7. **SHARE** what you have done so that your colleagues and our partners can learn and improve what they do too
8. **REPEAT** points I-III because improving quality is what we do

**Reporting an incident, near-miss or hazard**

1. The reporting of incidents is covered in the Corporate Accident and Incident Reporting Policy Guidance which can be found [here](http://teamsites.bolton.gov.uk/sites/ce/CorporateOD/INTRANET%20Health%20and%20Safety/Accident%20Reporting%20Guidance%20and%20Procedures%20to%20be%20Followed.pdf). Staff should refer to this policy for guidance on reporting.
2. The Department encourages staff to report as much as possible. If in any doubt, staff should report it. All staff have a responsibility to report accidents, incidents, near-misses or hazards. This must be done as soon as is practicable following the event.
3. Accidents, Incidents, near-misses and hazards should be reported via the Ulysses Incident Reporting System. Guidance on how to use this system is available via the Quality Assurance and Improvement intranet page [here](http://portal.bolton.gov.uk/ChildrensServices/PlanningPerformanceandresources/QualityAssuranceandImprovement/Pages/default.aspx). If you do not have access to a computer, you should complete an incident report form and hand it to your supervisor.
4. For accidents, incidents, near misses or hazards occurring in the Integrated Services only one report will be made, if the incident is related to the care given by Council Staff then the incident will be reported by Council staff on the Council Ulysses system. If the incident is related to care given by Health staff then this will be reported by Health staff on the Foundation Trusts Ulysses system.
5. **NB If reporting on Ulysses, it is not necessary to complete a Health and Safety Report as the Ulysses report replaces this requirement.**

**Grading**

1. When reported, all incidents, near-misses and hazards must be graded. This is a specific requirement for People’s Services. Grading an incident means scoring the severity of the harm caused. Grading should be carried out by the member of staff making the report but must be validated by a Service Manager, Head of Service or Assistant Director.
2. Where near misses or hazards are reported, they should be graded for the potential to cause harm. In these circumstances the highest grade that can be given is Grade 3.
3. The grade depends on the level of the harm. The decision on grading is a judgement to be made by the reporting and validating officers. The validating officer will check the initial grading and may decide to alter it. The table overleaf is to be used as a guide only:

|  |  |  |
| --- | --- | --- |
| **Grade** | **Descriptor** | **Examples** |
| **1** | **Low** | No or minimal harm requiring no or minimal treatment. * Grade 1 pressure ulcer
* Non-physical or physical assault which causes negligible offence or harm
* Fire alarm activated but false alarm
* A near miss or hazard with potential to cause low no or minimal harm.
 |
| **2** | **Minor** | Minor harm or illness requiring first aid* Fall resulting in sore knee, small cut
* Incorrect medication dispensed but not given
* Non-physical or physical assault that causes minor offence or harm
* Broken piece of specialist equipment e.g. hoist
* Minor fire, no injury, no loss of service or damage to property
* A near miss or hazard with potential to cause minor harm
 |
| **3** | **Moderate** | Moderate harm requiring professional intervention such as GP, A&E * Slip, trip or fall resulting in injury e.g. fracture, dislocation, large cut
* Grade 3 or 4 pressure ulcer,
* Wrong medication or dosage given
* Non-physical or physical assault that causes moderate offence or harm (see slip, trip, fall above)
* Damage to equipment/property resulting in loss of service
* Fire causing moderate injury, some loss of services and/or some damage to property
* A near miss or hazard with potential for moderate, major or catastrophic harm.
 |
| **4** | **Major** | Major harm requiring professional intervention and stay in hospital* Slip, trip or fall resulting in significant injury e.g. long-term incapacity/disability
* Physical assault that causes major harm or non-physical assault which causes major offence and may be criminal (racially or religiously aggravated)
* Fire with major injuries or significant loss of services
 |
| **5** | **Catastrophic** | Incident leading to unexpected death or permanent incapacity e.g. loss of a limb |

**Validation**

1. Validation of the incident grade must be made by a Service Manager, Head of Service or Assistant Director. The validation process is to ensure that the appropriate grade has been assigned and the appropriate response actioned.
2. A validating officer must ensure that the grade recorded fits the severity of the incident. This is a judgement to be made by the validating officer but the above table can be used as a guide. The validating officer can change a grade if they believe it has been graded wrongly.
3. For incident grades 1-3, validation must take place within 5 working days by the Service Manager. Grade 4 and 5 incident validation must take place within 24hrs by the Head of Service or Assistant Director.
4. Where a validating officer is not available, validation must be carried out by another manager of similar or higher seniority.

**Response**

1. Investigating an incident, near-miss or hazard is the primary response to incidents and the way in which services will learn and improve.
2. Investigations are the way in which the Department can evidence it has taken the necessary steps to understand why something has gone wrong and to put things right so as to avoid future safety issues. By not investigating, the Department may place service users and staff at increased risk and expose the organisation to avoidable adverse publicity, litigation and criticism.
3. The response should be proportionate to the incident. Investigations should follow a standard process using the Investigation Document in the appendix (please refer to Children’s and Adults Incident Management Guidance) [this will eventually be electronic on the Ulysses system].
4. There are four different levels of response:
5. No further action required
6. Review risk assessment – service user’s and/or other risk assessments
7. Standard investigation – captures summary information about the incident, immediate actions taken, investigation activity, learning and anything to be shared.
8. High-Level Investigation – where a more in-depth investigation is required. Root cause analysis techniques should be used and the findings recorded in the report. Lessons should be noted and an action plan put in place. Means of sharing learning should be identified including legal sign-off if being shared beyond the organisation.
9. The level of investigation to be undertaken should be recorded on the incident record by the Validating Officer.
10. If the incident is graded level 3 or above and a decision is taken not to investigate then the reason for that decision must be noted on the incident record by the Validating Officer.

**Choosing the right level of investigation**

*Grade 1 and 2 (Green)*

1. Validation from the Service Manager should be within 5 working days.
2. Incidents of this level may not require any further action or they may require a review of the risk assessment(s) for that service or service user.
3. A recurring ‘Green’ incident could require a Standard investigation if the recurrence is affecting service delivery and could ultimately affect the safety of service users, members of the public or staff.

*Grade 3 (Amber)*

1. Validation from the Service Manager should be within 5 working days and the investigation and report should take no longer than 20 working days.
2. A Standard Investigation should be completed. The nature of the incidents may require further risk assessments to be carried out in order to monitor the situation.
3. Teams may find it useful to carry out a High-Level Investigation if they feel a more in-depth analysis would be of benefit. Forming an investigation team is not a requirement of the policy but services may find this helpful to aid the investigation process.

*Grade 4 and 5 (Red)*

1. The validation of ‘Red’ incidents should take place within 24hrs. Validation should be undertaken by the Head of Service and a notification sent to the Assistant Director.
2. All ‘Red’ incidents will trigger a High-Level Investigation (HLI).
3. An HLI Team should be established headed by an Assistant Director or delegated to a Head of Service (this would usually be done at the AD’s discretion depending on the nature and severity of the incident). The investigation team should involve officers relevant to the incident but ideally the lead investigator should be independent of the area where the incident occurred.
4. All HLIs should carry out root cause analysis. The investigation should be undertaken in collaboration with the Quality Assurance and Improvement Team to help guide the investigation team through the process.
5. Following a level 4 or 5 incident, statements should be taken soon after the event from witnesses.
6. The investigation and report should take no longer than 40 working days.

**High Level Investigation Reports**

1. When an investigation has been completed a final report will be prepared that will provide a chronology and the detail of the root cause analysis, learning, recommendations and actions to be taken.
2. HLI reports will be signed-off by the Assistant Director heading up the investigation. By signing-off, the Assistant Director is confirming the outcome of the investigation, the learning, the improvement actions and who the report should be shared with.
3. The Director should sign-off HLI reports where it is recommended that the report is shared with Legal Services or other third parties.
4. Under certain circumstances final draft reports must be sent to the Legal Services Department for review prior to being sent to other groups either internally or externally. The criteria are as follows (not exhaustive):
* An incident likely to generate substantial compensation
* An incident that is media sensitive or likely to generate publicity
* Fatal incidents
* Serious professional misconduct
1. It is important that incident investigation reports must not contain any comments which are tantamount to admissions of breach of duty and/or causation without first seeking advice from the Legal Services Department.

**Disclosure**

1. Those involved in investigations should be aware that all documents generated in the course of the investigation (including internal memos/comments/emails etc.) are generally disclosable in any subsequent legal claims. They may also be disclosable by virtue of the provisions of the Data Protection Act 1998 or the Freedom of Information Act 2000. All reports should be prepared containing only factual information and not opinion.
2. Information obtained in an investigation would also be disclosable to any subsequent disciplinary or safeguarding investigation.

**Monitoring**

1. The responsibility for implementing actions will depend on the level of the action. Unless otherwise agreed, service level actions should be implemented by the Service Management Team and Departmental actions should be implemented by DMT and the Quality Governance Board. The progress of implementing recommendations and actions for all incidents will be monitored by the Quality Governance Board and Quality Assurance and Improvement Team.
2. The progress of High-Level Investigations will be monitored by the Quality Governance Board. Regular progress updates should be submitted to the Quality Assurance and Improvement Team.
3. The Quality Assurance and Improvement Team will carry out audits of incident records to ensure policy and procedure is being complied with and improvement activity is taking place.

**Safeguarding**

1. Incidents which involve a safeguarding concern should be reported to the Safeguarding team in the normal way. Where safeguarding issues are present, the Safeguarding investigation will normally take precedence over any other investigation.
2. Being Open and Honest when things go wrong - Duty of Candour
* If in the application of this policy it is identified that harm (grade 3-5) occurred to a service user then our policy of Being Open and Honest (also known as the Duty of Candour) may also apply. Please refer to the Duty of Candour policy.
* The Duty of Candour policy is based on the Duty of Candour which is enshrined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It is a legal requirement for Registered Persons to inform service users or their relatives if they have been caused harm resulting from an incident.
* Investigations must document whether service users, or their relative, have been informed about an incident which cause them harm under the Duty of Candour policy.

**Corporate Health and Safety Reporting**

1. Reporting accidents and incidents should be done in line with the Corporate Accident and Incident Reporting Policy.

**CQC Notifiable Incidents for Adult Social Care Providers**

1. It is a statutory requirement to notify the Care Quality Commission of certain incidents that occur in Adult Social Care Services. Guidance on the type of incident and the process is available on the CQC website <http://www.cqc.org.uk/>
2. Where relevant, registered managers should continue to report notifiable incidents to CQC as normal as well as responding in line with this and corporate policy.

**OFSTED Notifiable Incidents for Children’s Social Care Providers**

1. It is a statutory requirement to notify Ofsted of certain incidents that occur in some children’s and family’s services. Guidance on the type of incident and the process is available on the Ofsted website [www.ofsted.gov.uk](http://www.ofsted.gov.uk)
2. Where relevant, managers should continue to report notifiable incidents to Ofsted as normal as well as responding in line with this and corporate policy.

**Disciplinary Proceedings**

1. Where the incident also relates to disciplinary proceedings, investigations should remain separate.
2. Where relevant, information obtained through incident investigations should be made available to subsequent disciplinary investigations.

**Whistleblowing**

1. Whistle blowing should follow the corporate policy and process. The Corporate Whistleblowing policy encourages anyone with an issue to raise it with the relevant service manager in the first instance. Alternatively, they may report the matter to the Office of the Borough Solicitor if they feel this is more appropriate. The policy is available via the Council’s intranet site [here.](http://portal.bolton.gov.uk/Home/Policies/Pages/default.aspx)

**Learning and Improvement**

1. It is expected that all responses to incidents note what has been learnt and what will be improved as a result. For incident grades 3-5, this is mandatory and will be followed up by the Quality Assurance and Improvement Team.
2. Outcomes of investigations, lessons learned and actions should be shared (if appropriate) through established management structures such as Quality Governance Board, Service Management Meetings, team meetings and supervisions.
3. Individual members of staff who are involved in incidents should receive feedback from their line manager. This should be coordinated by the Investigating Officer or Assistant Director.
4. Outcomes of investigations, lessons learned and actions should be shared with the Quality Assurance and Improvement Team so that selected learning points can be approved for publication on the Quality Improvement intranet site and newsletter.
5. An investigation final report (or abridged version) may be shared with the service user/family involved subject to approval by the Assistant Director.
6. In certain circumstances Investigation Reports may be authorised by the Director to be shared with external organisations. Such organisations may include the NHS, CCG, Police, Coroners, CQC, Ombudsman.
7. More information on sharing learning can be found in the Children’s and Adults Incident Management Guidance (see appendix).

**Roles and Responsibilities**

*Director*

1. The Director maintains overall responsibility for this policy and for the Department’s response to incidents, near-misses and hazards. The Director will hold Assistant Directors to account for the response to incidents in their services and ensure the Department is learning and improving. The Director may liaise with the Borough Solicitor in relation to incidents which are particularly sensitive or have the potential to have reputational or financial impact for the Council. The Departmental Management Team will receive quarterly quality reports from the Quality Governance Board about the management of incidents and make decisions accordingly.

*Assistant Directors*

1. Assistant Directors (ADs) will manage the response to incidents through their Heads of Service. They will be responsible for forming and leading High-Level Investigation teams to investigate ‘Red’ incidents and signing-off final reports. Where appropriate, ADs will liaise with the Director on incidents and investigations which are particularly sensitive or have the potential to have reputational or financial impact for the council. ADs will be responsible for ensuring that investigations are taking place (where appropriate) and that services are identifying and implementing actions. ADs will report to the Departmental Management Team progress and outcomes of investigations.

*Heads of Service*

1. Heads of Service (HoS) will validate ‘Red’ incident reports. The HoS may be tasked by the AD with investigating ‘Red’ incidents. The HoS will liaise closely with their service managers and other staff on the number and severity of incidents in the service and the progress of the response. The HoS will be required to attend the Quality Governance Board to discuss the progress of investigations and overall performance. The HoS will be responsible for ensuring staff in their service know about this policy and related guidance and have received necessary training. In particular, the HoS will emphasise the guiding principles outlined above. HoS will ensure that learning is shared within their service and with the Quality Assurance and Improvement Team.

*Service Managers*

1. Service Managers will validate ‘Green’ and ‘Amber’ incident reports. The Service Manager will ensure that all necessary immediate actions to all incidents have taken place. The Service Manager will be responsible for implementing the right level of response. It is expected that, unless otherwise agreed, the Service Manager will lead any investigatory work (if required) into ‘green’ and ‘Amber’ incidents. The Service Manager may be tasked by the Head of Service to investigate ‘Red’ incidents. The Service Manager will be responsible for ensuring all staff in their service know about this policy and related guidance and have received necessary training. The Service Manager will manage incidents through their monthly Service Management meetings. The Service Manager will be required to attend the Quality Governance Board to discuss the progress of investigations and overall performance. The Service Manager will ensure that learning is shared within their service and with the Quality Assurance and Improvement Team.

*All staff*

1. All staff must ensure that any incidents, near-misses or hazards are reported in line with corporate policy. Staff must be aware of how they can learn and improve their services as a result of incidents. Staff must inform their line manager if they have any concerns about incidents or with the implementation of this policy.

**People Services Quality Governance Board**

1. The Quality Governance Board (QGB) will be responsible for ensuring the policy is being implemented appropriately and will hold services to account by conducting annual reviews. The QGB will monitor incident data and ensure that investigations are being carried out in line with this policy. The QGB will be responsible for ensuring any Department-wide learning is shared across the Department and wider if appropriate. A quarterly incident report will be made to DMT by the QGB.

**Quality Assurance and Improvement Team (QA Team)**

1. The QA Team will provide support to managers and teams in implementing this policy. A member of the QA Team will support High Level Investigation Teams in the investigation process. The QA Team will follow-up with Heads of Service/Service Managers on the progress of investigations and the implementation of actions. The QA team will conduct regular audits of incident reports,

**Health and Safety Team**

1. The Corporate Health and Safety Team are responsible for the overarching Corporate Accident and Incident Reporting Policy and will continue to collate data for their statutory reporting processes e.g. RIDDOR. The Health and safety Team will usually be involved with investigations into more serious incidents.

**What competences will staff who are implementing this policy need?**

1. All staff
* should know how to report an incident.
* should know about this incident management policy.
1. All Managers
* should know how to validate an incident.
* should know how to conduct a Standard Investigation.
* should have a basic knowledge of root cause analysis techniques and their application.
* should know how learning and improvement activity can be shared.
1. All Senior Managers
* should know how to conduct a High-level Investigation.

**Implementation and review**

1. The policy will be stored and accessible to all staff on Bolton Councils’ intranet site and within the service settings where there is limited access to IT. It will be communicated via the internal bulletin that this policy has been reviewed together with a link to access it from the intranet and a paper copy where required.
2. The policy will be reviewed in September 2018.
3. Competencies will be checked by managers through supervision, team meetings and PDRs and observed practice.

**Appendix 1: People Services: Guidance for managing incidents, near-misses and hazards**

**1. Introduction**

1.1 This guidance is to assist People Services staff to investigate incidents according to the policy. Separate corporate guidance is available to staff on reporting incidents. This should also be read in conjunction with the *Ulysses Guidance for Reporters* and *Ulysses Guidance for Managers.*

1.2 Investigating incidents is important so that we can establish why something happened and so that we can put measures in place to prevent the same thing happening again.

1.3 The response should be proportionate to the incident that occurred. The following guide should be used to determine the level of response required.

|  |  |  |
| --- | --- | --- |
| Incident Grade | Minimum response required  | Timescale |
| 1 and 2 | No further action or Review risk assessment(s) | 5 working days |
| 3 | Standard Investigation | 20 working days |
| 4 and 5 | High-level Investigation | 40 working days |

**2.** **Review Risk Assessment (Grades 1 and 2)**

2.1 A grade 1 or 2 incident is classed as something low-level where no or only minimal harm has occurred. On some occasions, there is genuinely no further action required. This should be recorded on Ulysses and the reasons for this.

2.2 The primary response to a grade 1or 2 incident should be to review relevant risk assessments. This includes those relating to service users, staff, public or property. Your review of the risk assessments should take into account the nature of the incident and how likely you think that it could happen again.

2.3 For some services and, depending on the incident, you may also need to consider whether a review of the service user’s needs is required.

2.3 You should document the actions you have taken resulting from this incident on the Ulysses system.

NB. A recurring grade 1 or 2 incident may require a more robust response to identify the reasons for the recurrence. A Standard Investigation should be implemented in these circumstances (see below).

**3.** **Standard-Level Investigation (Grade 3)**

3.1 A grade 3 incident means that moderate harm occurred requiring professional intervention. The minimum response to such an incident should be a Standard Level Investigation (SLI). The Standard Investigation requires the investigating officer to record what they have done to investigate the incident, what learning they have identified, what actions are to be taken to prevent this from happening again and how this will be shared with others.

**4. High-Level Investigation (Grade 4 and 5)**

4.1 For grade 4 and 5 incidents where major injury or death has occurred, the minimum response should be a High-level Investigation (HLI). The HLI goes into more depth than the SLI and it is a requirement of this policy to form an Investigation Team, to undertake root cause analysis (RCA) and to obtain Assistant Director sign-off. As with the SLI, the HLI should record what has been done to investigate the incident, what learning and improvement actions have been identified and how this will be shared. HLI reports potentially require legal and Director sign-off (see policy).

**5. Tips for Investigating Officers**

5.1 The purpose of an incident investigation is to establish the facts about:

* What happened (i.e. chronology of events);
* Who it happened to;
* When it happened;
* Where it happened;
* How it happened (i.e. what went wrong);
* Why it happened (i.e. what underlying, contributory or deep-rooted factors caused things to go wrong);
* How the same thing can be prevented from happening again.

5.2 Your report should be clear and logical and demonstrate that an open and fair approach has taken place.

5.3 You should consider the following in your investigation:

* Review relevant paperwork such as case notes, observations, communication sheets, emails
* Talk to staff, service users, partners, any relevant party
* Visit the scene of the incident
* Conduct formal interviews (normally as part of an HLI)
* Obtain statements from key witnesses soon after the event (a requirement for level 4 and 5 incidents)
* Complete a chronology of events (a requirement for an HLI)
* Conduct root cause analysis ( a requirement for an HLI)
* Review relevant policies and procedures to compare what should happen with what did happen.

5.4 Some general principles of investigation:

* Was the investigation process conducted with the appropriate level of independence?
* Was the investigation proportionate to the incident and any associated risks?
* Did the investigation begin and end in a timely manner?
* Was the investigation process open and transparent?
* Did the investigation team keep relevant parties appropriately informed?
* Was the investigation based on evidence?
* Did the investigation look for improvements and not to apportion blame?

**6. Root Cause Analysis**

6.1 You are required to undertake Root Cause Analysis (RCA) as part of a High-Level Investigation. RCA techniques can also be used in Standard Investigations if the nature of the incident warrants closer analysis of the underlying causes.

6.2 As part of a HLI, a member of the Quality Assurance and Improvement team will support the Investigation team to undertake RCA.

6.3 The purpose of RCA is to identify the contributory factors and underlying causes of an incident.

6.4 There are a number of techniques that can be used in Root Cause Analysis. More than one of these techniques would normally be used.

* Brainstorming – when everyone in a group puts their ideas forward in a structured or unstructured fashion. These are then prioritized and grouped together.
* Brainwriting – as above but written down anonymously.
* Fishbone Analysis – Used for analyzing the contributory factors to one specific problem or issue.
* ‘Five Whys’ – Developing a questioning attitude and never accepting the first reason given.
* Barrier analysis – A review of the barriers (controls) which were in place and which should have stopped the problem occurring or mitigated its impact

6.5 Further guidance about RCA is available on the Quality Assurance and Improvement Intranet page [link] or, for more help, please contact the QA Team quality@bolton.gov.uk .

**7. Obtaining a witness statement**

7.1 For grade 4 and 5 incidents, statements should be obtained from key witnesses. Statements should be obtained as soon after the event as possible. The Validating Officer should ensure that statements have been taken.

7.2 Statements should be uploaded to the incident record on Ulysses. If handwritten, these should be scanned and uploaded and then the original shredded.

7.3 A statement should be an account of what the witness saw, heard, did and said.

7.4 Statements are a confidential document for use in the investigation. However, they may be used in other processes such as a disciplinary or criminal investigation.

7.5 Use the statement template attached to this guidance.

**8. Validating an incident**

8.1 Validation must be undertaken for all incidents. This is to ensure they have been graded appropriately and the right response instigated.

8.2 Validation should take place in line with the following framework

|  |  |  |
| --- | --- | --- |
| Grade | Validating Officer | Timescales |
| 1 and 2 | Service Manager | Within 5 working days |
| 3 | Service Manager | Within 5 working days |
| 4 and 5 | Head of Service | Within 24 hours |

8.3 Validating officers will be sent a notification from Ulysses to say that an incident requires validating.

8.4 In order to validate an incident, validating officers should refer to the grading table in the policy and make a judgement about whether they agree with the initial grading.

8.5 If the grading needs to be amended, the manager should do this via the Manager’s Form on Ulysses (please refer to Ulysses Guidance for Managers).

**9. Learn, Improve, Share**

9.1 All incident responses should record what was learnt and what has been improved as a result. For grades 3-5 it is mandatory that the learning and improvement section of the investigation form is completed and plans to share the learning outlined.

**What is learning?**

9.2 Learning is what we identify through investigation that could have been done better or differently. The act of learning should be seen by staff as a positive because it will lead to a better service and better outcomes for our service users.

9.3 Learning is not what we *did* after the incident although each bit of learning should lead to an improvement action or actions.

9.4 Learning should be specific and not generalised. If learning is specific it means that improvement actions can be more targeted. Your learning should describe the problem and what impact this has on the service. For High-level investigations, your learning is most likely to be identified via Root Cause Analysis.

9.5 Although often similar, learning should be different from the root cause. The root cause will tell you what the underlying reason was for the incident but perhaps not identify all of your learning. This will come though discussing the root causes and other issues.

**What is improvement?**

9.6 Improvement is the activity we undertake to rectify what we have learnt though the investigation process.

9.7 Improvement recommendations or actions should:

* address all of the root causes and key learning points;
* be designed to significantly reduce the likelihood of recurrence and/or severity of outcome;
* be clear and concise and kept to a minimum wherever possible;
* be Specific, Measurable, Achievable, Realistic and Timed (SMART) so that changes and improvements can be evaluated;
* be prioritised wherever possible

9.8 You should add improvement actions to your service improvement plan and regularly monitor their progress in management meetings. A standard service improvement plan can be found at appendix 5.

**Worked example of root cause, learning and SMART improvement actions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Incident | Cause | Root Causes | Learning | SMART Improvement Action |
| Service user collapsed after medication administered and admitted to hospital | Medication wrongly administered by untrained staff | Staff do not have the right skills to administer medicationOur medication training records are not kept up to date which means we don’t know who can administer medication and who can’t. We have no process or designation for updating records | We do not have a robust process to ensure our staff are trained appropriately and that training is kept up to date.  | All staff responsible for administering medication in the service to receive medication training by the end of January 2015. Service dashboard to be updated with staff training data by end of January 2014. Training compliance to be reviewed monthly at management meetings and supervisions from February 2015 onwards. Admin to update dashboard.  |

**What is sharing?**

9.9 Sharing learning is an important aspect of continuous improvement. By sharing learning with others, we are maximising the opportunities to improve and reduce harm overall.

9.10 It is common to assume incidents are unique or only relevant to your own service or organisation. In reality, patterns recur and are consistent across multiple services.

9.11 It is important to detail the mechanisms by which lessons have been or will be shared.

9.12 How learning is shared and who with will depend on what has been learnt. The below table should be used as a guide.

|  |  |  |  |
| --- | --- | --- | --- |
| **Learning potential** | **Significance** | **Sharing** | **Method** |
| Specific | Local | Shared within the area where the incident happened | Service Management meetingSupervisionsTeam MeetingsEmail to staffTeam newslettersQuality Assurance and Improvement Team |
| Common | Organisational | Shared across the organisation involved | Quality Governance BoardQuality Assurance Intranet siteNewsletters – such as Customer Voice, Learn and Improve or service specificManagement Teams |
| Broad | Multi-agency | Shared across organisation and with partners e.g. NHS, CCG, Police etc. | Board meetingsMulti-agency meetings – such as safeguarding boards, partnership groups |

9.13To share something via *Customer Voice* or the QA intranet page email quality@bolton.gov.uk or add it to the forum.

**10. Expected Workforce Competencies**

10.1 **All staff**

* All staff should know how to report an incident
* All staff should know about this incident management policy

10.2 **All Managers**

* All managers should know how to validate an incident
* All managers should know how to conduct a Standard Investigation
* All managers should have a basic knowledge of root cause analysis techniques and their application
* All managers should know how learning and improvement activity can be shared

10.3 **Senior managers**

* All senior managers should know how to conduct a High-level Investigation

**Appendix 2: Standard Investigation Record**

|  |
| --- |
| 1. Division
 |
|  |
| 1. Service and Unit
 |
|  |
| 1. Incident severity – Level 1-5
 |
|  |
| 1. Incident number (Ulysses number if known)
 |
|  |
| 1. Investigating Officer
 |
|  |
| 1. Incident type
 |
|  |
| 1. Description of incident – Provide a clear, concise description of the incident and its effect on (or outcome for) the service user, the staff, the service and any other stakeholders. You should answer the following questions: What? Who? Where? When? How?
 |
|  |
| 1. Details of investigation - outline what information you have looked at, who you have spoken to and what your findings are. Here you should try and answer the following question: Why did it happen?
 |
|  |
| 1. Details of Risk Assessments Reviewed - List the risk assessments reviewed and what has changed
 |
|  |
| 1. Learning identified
 |
|  |
| 1. Improvement Action plan – i.e. what will you change to avoid this happening again?
 |
| What | Who | When |
| 1. Arrangements for sharing learning– tell us how you will share this learning. Use the below guide to help
 |
|

|  |  |  |  |
| --- | --- | --- | --- |
| **Learning potential** | **Significance** | **Sharing** | **Method** |
| Specific | Local | Shared within the area where the incident happened | SupervisionsTeam MeetingsTeam newsletters |
| Common | Organisational | Shared across the organisation involved | Quality Governance BoardIntranetQ-mailManagement Teams |
| Broad | Multi-agency | Shared across organisation and with partners e.g. NHS, CCG, Police etc. | Board meetingsMulti-agency meetings e.g. Safeguarding Board |

 |

**Appendix 3: High-Level Investigation Record**

For help with root cause analysis or completing this form, please contact the Quality Assurance and Improvement Team quality@bolton.gov.uk tel ext 8845

Incident Investigation Record for Root Cause Analysis investigation

Please send a copy of the completed form to quality@bolton.gov.uk.

|  |  |
| --- | --- |
| 1. Service Type
 | 1. Scheme/Centre/Property/Establishment
 |
|  |  |
| 1. Cause of Incident –( picklist option chosen in Ulysses)
 | 1. Date of Incident
 |
|  |  |
| 1. Incident severity – (Level 4 or 5)
 | 1. Incident number (from Ulysses)
 |
|  |  |
| 1. Lead Investigating Officer
 | 1. QA Officer supporting
 |
|  |  |
| 1. Investigation Team – (list the staff involved in the investigation)
 | 1. Investigation meeting date
 |
|  |  |
| 1. Description of incident – (Please include WHAT happened, WHO it happened to, WHEN and WHERE did it happen)
 | 1. Actions taken –( Please describe what happened immediately following the incident and any follow up actions completed prior to this investigation)
 |
|  |  |

|  |
| --- |
| **Chronology (timeline) of events** |
| **No** | **Time** | **Date** | **Event** | **Is this following policy, procedure or guidance?****Yes/no/Na** | **Is this evidence of good practice?****Yes/no/Na** | **Is this a care or service delivery problem?****Yes/no/Na** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| 1. Findings **Please complete the chronology above to help complete this section** – (Include HOW and WHY this happened, use the areas identified above as a ‘care or service delivery problem’, or where something happened that was ‘outside of process’)
 | 1. Conclusion of investigation:- (what is the conclusion of the investigation? This section should include a statement about responsibility or liability if any fault was found)
 |
|  |  |
| 1. Learning identified – (what was the root cause or contributory factors that led to or contributed to this incident)
 | 1. Action plan – (ie what will you change to avoid this happening again? These should be linked to the learning points)
 |
|  | **What** | **Who** | **When** |

|  |
| --- |
| 1. Arrangements for sharing learning – (tell us how you will share this learning e.g. through team briefings, Customer Voice, Intranet etc)
 |
|  |
| 1. Head of Service sign-off
 | 1. Date signed-off
 |
|  |  |
| 1. Assistant Director sign-off
 | 1. Date signed-off
 |
|  |  |

**Appendix 4: Statement Template**



|  |
| --- |
| **Serious Incident Witness Statement** |
| Name: |
| Position: |
| Ext: |
| Statement details: in your own words please describe what happened  |
| Signed: |
| Date:  |

This statement will be used for the purpose of the investigation. However, it could also be used as evidence in subsequent disciplinary investigations and/or criminal investigations.

**Appendix 5: People Services Improvement Plan**

Service………………………………….

Owner…………………………………...

Last updated……………………………

This is the Departmental standard improvement plan – a rolling record of your improvement activity.



Improvement Plan

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Number | Source of action E.g. Audit, inspection, complaint, incident, customer feedbackFor reference include dates of audits or links to reports etc.  | Action | Responsible person | Date to be completed | Status (RAG) G – on target, A – risk to target date R– off-target | CompletedY/N | Comments |
| 1 |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |