Brigstock Skin and Laser Centre

13. Risk Management

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13.1 Risk Management

13.1.1 Introduction

Brigstock Skin and Laser Centre faces a range of risks associated with carrying out its functions, including risks to its capacity and capabilities, staffing, reputation and finances. All actions contain inherent risks and risk management is central to the effective running of any organisation. At its simplest, risk management is good management practice: being both proactive and reactive in the management of risks. It is not seen as an end in itself by the organisation, but as part of an overall management approach.

13.1.2 Purpose

The purpose of this policy is to confirm the clinic's approach to risk management and set out it's responsibilities in developing robust systems and processes for implementation.

13.1.3 Scope

This policy applies to all activities undertaken by the organisation and responsibilities for independent contractors and employees directly managed by the clinic.

The clinic will collaborate with: organisations from whom it commissions services, suppliers of goods and materials, clients and the public, to proactively manage risks and to review and learn from adverse events.

The clinic will refine systems and processes as required in response to the Care Quality Commission and external standards as they evolve and are published.

13.1.4 Our intent

The Clinic's Partners are committed to leading the organisation forward to deliver high quality services, delivering care in a safe environment and achieving excellent results. The

The Clinic's Partners recognises that risk management is an integral part of good management practice and to be most effective should become part of the clinic's culture.

The Clinic, therefore, is committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than viewed or practiced as a separate programme and that the responsibility for implementation is accepted at all levels of the organisation.

The Clinic will ensure that risk management receives priority and the necessary resources within affordable limits in order to achieve the objectives of the organisation. Risk management therefore links with the Standards for Better Health, Health and Safety, Infection Control, Security and Monitoring Quality.

Risk management is a fundamental part of the total approach to corporate and clinical governance and the overall aim is to build upon the high quality of care already being

provided through the prevention, control and management of risks within the organisation and in partnership with others, risks external to the organisation.

14.1.5 Key Objectives for Risk Management

The key objectives for risk management are to

- develop and implement robust risk management educational programmes to ensure that staff at all levels of the organisation, including the partners, have the knowledge, skills, support and access to expert advice to implement the risk management systems, processes, policies, procedures and guidelines;

- establish a risk profile across the clinic, identifying common risk areas and share expertise on ways of managing and controlling them;

- facilitate the clinic to undertake analysis of risks when undertaking sizeable projects, or service developments in order to make the right decisions at the appropriate stages. A risk assessment is required as a fundamental part of any business case and should seek to demonstrate value for money and affordability of the scheme, to identify how any residual risks will be managed;

- facilitate the clinic to undertake risk assessments as part of its commissioning process and as part of its corporate risk reduction. The process should ensure that identified risks are actively managed and responsibilities are clearly assigned whether within the clinic or external to it;

- facilitate the development and implementation of the monitoring requirements the clinic should include within Service Level Agreements and contracts; governance, clinical governance and quality indicators and targets / activity levels;

- in conjunction with Health and Safety representatives ensure the development and implementation of risk assessment processes throughout the clinic;

- maintain a robust significant event reporting system ensuring management reviews are undertaken in a timely fashion and facilitate the registered manger to monitor trends and generate reports from the available data.

- encourage sharing of information to ensure lessons are learned and improvements can be made.

13.1.6 Accountabilities, Responsibilities and Organisational Framework

The clinic’s partners are responsible for pursuing the aims and objectives of risk management. The Responsible Individual has overall responsibility for risk management throughout the clinic and is accountable to the partners for ensuring there is an effective risk management system in place. The Registered Manager is accountable for the overarching operational risk management processes. Accountabilities and responsibilities will be met in a variety of ways:

- **through delegated responsibility** for implementation of risk management;

• **an organisational structure** to help manage this delegated responsibility for implementing risk management systems within the clinic; Appendix 3

13.1.7 System for Managing Risk

Framework
The systems, processes and risk management tools put in place to facilitate the proactive and reactive management of risk throughout the organisation will be based on the Australian/New Zealand Standard [AS/NZS 4360:1999 – Appendix 38] Is an exemplar for good risk management practice.
The clinic's systems and processes are outlined in this policy and the significant events and Learning Opportunities Policy (See Monitoring Quality; 4.6).

13.1.8 Risk Assessment Process (pro Active Risk Management)

Risk assessments should be undertaken as a minimum as required by the Heath and Safety at Work Act. In addition the clinic should undertake risk assessments whenever necessary as part of day to day activity to maintain safe systems of work both clinical and non-clinical.

All risks should be graded according to the risk matrix, consequence and likelihood charts see below and Appendix 39) and recorded on a Risk Assessment form (Appendix 40). Any risk graded amber or red should be added to the clinic's Register and have an associated action plan

All proposed service developments or changes, business planning and commissioning should involve risk assessments. These should demonstrate how they will help reduce the risks to the organisation and whether any additional risks may arise. It is important that decisions are based on accurate risk evaluation including the analysis of the potential benefits, and that the available evidence can be used to justify such decisions.

13.1.9 Grading Risk

Systems put in place will use the same risk grading process (risk assessment matrix Table 3) to assess risk in terms of likelihood and severity of outcome. A consequence chart (Table 1) and likelihood chart (Table2), will aid such grading.

Table 1 Consequence Chart

Seriousness	Description
Low	Unsatisfactory service or experience not directly related to care. No impact or risk to provision of care. **OR** Unsatisfactory service or experience related to care, usually a single resolvable issue. Minimal impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
Medium	Service or experience below reasonable expectations in several ways, but not causing lasting problems. Has potential to impact on service provision. Some potential for litigation.

High	Significant issues regarding standards, quality of care and safeguarding of or denial of rights. Complaints with clear quality assurance or risk management issues that may cause lasting problems for the organisation, and so require investigation. Possibility of litigation and adverse local publicity. **OR** Serious issues that may cause long-term damage, such as grossly substandard care, professional misconduct or death. Will require immediate and in-depth investigation. May involve serious safety issues. A high probability of litigation and strong possibility of adverse national publicity.

Table 2 Likelihood Chart

Likelihood	**Description**
Rare	Isolated or 'one off' – slight or vague connection to service provision.
Unlikely	Rare – unusual but may have happened before.
Possible	Happens from time to time – not frequently or regularly.
Likely	Will probably occur several times a year.
Almost certain	Recurring and frequent, predictable.

Table 3 Risk Assessment Matrix

Seriousness	**Likelihood of Recurrence**				
	Rare	Unlikely	Possible	Likely	Almost Certain
low	Low	Low	Low	Moderate	Moderate
	Low	Moderate	Moderate	High	High
Medium	Low	Moderate	High	High	Extreme
	Moderate	Moderate	High	High	Extreme
High	Moderate	High	High	Extreme	Extreme
	Moderate	High	Extreme	Extreme	Extreme

13.1.10 Significant Events Reporting System (reactive risk management)

All individuals involved directly or indirectly in patient care, including the organisational delivery of healthcare services, are aware of what constitutes an adverse incident.

Incident reporting, grading and root cause analysis is part of the induction training for new staff. Training is also provided for those conducting investigations. Updates will be available.

Lessons will be learned from individual adverse patient incidents, from local aggregate reviews and from wider experiences, including feedback from the National Patient Safety Agency, other agencies/bodies, and benchmarking. Improvement strategies aimed at reducing risk will be implemented and monitored. Where appropriate, local staff will learn lessons and change practice in order to improve the quality of care for patients and the safety for patients, staff and organisation.

13.2 Internal Reporting Arrangements

Flow charts directing the handling and reporting of adverse incidents occurring within Brigstock Skin and Laser Centre are detailed in Appendix 2. These charts should be laminated for display in all service delivery areas so they are available for immediate reference.

An Incident Reporting Form (see Appendix 26) must be completed for all incidents relating to clinic's clinical services and organisational business. All identified risks will be added to the Risk Register and subsequently removed when all necessary action has been taken to eliminate or minimise to prevent future recurrence.

All reported incidents are graded either Red, Amber, yellow or green, according to the actual impact on the patient(s), potential future risk to patients and to the organisation, and reviewed to establish stakeholder reporting requirements e.g. MDA. The individual reporting the incident will carry out the grading.

Patient(s) and/or relatives must be informed of any incident which directly affects their care or well-being. This should be carried out by the most senior or experienced member of the team who is caring for the individual. In cases where there are many involved this many be delegated to a number of experienced individuals.

All incidents will be subject to an appropriate level of investigation and causal analysis and, an action plan will be prepared and implemented. With the exception of red incidents and some amber incidents, this process will take place at first line

13.3 External Reporting Arrangements Including Staff Suspensions

The organisation will report any significant incident, clinical, organisational or financial, to the appropriate external agency within the required timescale.

It is the responsibility of the organisation to report significant incidents to the appropriate external agency, for example Medical Devices Agency, Health and Safety Executive. See Health and Safety Policy; 14.15 Accident Reporting, for further details.

Where appropriate the Care Quality Commission and national professional bodies such as the GMC will be notified about staff who have been suspended on clinical or professional grounds, or practitioners whose practising privileges have been suspended, restricted or withdrawn on professional or clinical grounds.

Patient incidents graded as red are reported to the National Patient Safety Agency within 3 working days of the date of occurrence. For category red adverse events only (i.e. where serious actual harm has resulted), this information is also reported to the Care Quality Commission. (This should be read this in conjunction with the major incident policy.)

For all category red incidents, a full root cause analysis will be undertaken reported to appropriate agency and the SHA within 45 working days of occurrence of the incident.

Patient(s) and/or relatives as a priority must be kept up to date with any investigation process, outcomes or action.

13.4 Information Alerts and Hazard Notices

All information alerts and hazards notices received by the clinic will disseminated via an agreed cascade to all relevant members of staff within the required timescale. Actions taken in response to alerts will be monitored by the Registered Manager to ensure the clinic has taken all reasonable steps to mitigate identified risks.

13.5 Key Performance Indicators

A key element of effective and progressive risk management is performance monitoring and review. The effectiveness of the risk management system must be measured by its success in controlling, limiting and, where possible, eliminating risks which threaten or harm the clinic and its clients, staff and others affected by it.

Performance will be monitored and be subject to internal and external assessment by the Care Quality Commission. An Annual audit will be produced concerning significant events. audits will be reviewed by the clinic’s responsible individual and registered manager and action plans produced to address frequently occurring issues and developing trends.

13.6 Serious Untoward Incidents

13.6.1 Background

This policy applies only to those events which are categorised as a serious untoward incident (SUI): all other adverse events should be managed as per the Incident and Near Miss Event Reporting Policy

In general terms, a SUI is something unexpected or likely to attract public and media interest and may involve a large number of patients, poor clinical or managerial judgement, a serious service failure or an unexpected death of a patient in the care of BSL.

BSL recognises that in a service as large and as complex, SUIs will occur. When they do, BSL supports the view that the response should not be one of blame and retribution but of organisational learning with the aim of encouraging participation in the overall process and supporting staff, rather than exposing them to recrimination. Therefore, BSL is committed to developing a just culture and to encouraging a willingness to admit mistakes without fear of punitive measures. In support of this, BSL accepts that reporting a SUI does not constitute an admission of liability and will not result in automatic disciplinary action. There are occasions, of course, when it may be necessary to apportion blame: acts of maliciousness or criminal or gross/repeated professional misconduct.

13.6.2 Principles

Staff are expected to operate according to specific standards specified in this policy.

13.6.3 Purpose

This policy sets out the reporting arrangements and actions to be taken, and by whom, in the event of a SUI involving patients, staff, visitors or contractors and ensures that the lessons learned inform future practice.

It will ensure that there is a consistent approach to the management of SUIs and that staff at all levels are aware of their roles and responsibilities in the reporting and management of such events.

13.6.4 Definitions

Serious Untoward Incident
There is no single definition of a SUI but in general terms, it is any event which:

a) Involves a patient, a service user, a member of the public, contractors, staff or other providers of healthcare involved in the process of treatment, care or consultation on BSL premises and;

b) Results in, or could have resulted in, one or more of the following:

- Serious Injury
- Unexpected death
- Permanent harm
- Significant public concern
- Significant media concern
- Significant disruption to health care services.
- A serious situation which is associated with, or is a result of, an infection control / communicable disease.
- Recordable as specified within the Health & Safety Act

If in doubt, it is better to report an incident as a potential SUI, as this can then be confirmed by the Information Governance Steering Group (IGSG).

Initial Management Report (IMR)
The IMR gives a brief outline of the incident and immediate actions taken and is completed and forwarded to the IGSG within 24 hours of the SUI occurring. The IMR template can be found at Appendix B.

National Patient Safety Agency (NPSA)
An arm's length body of the Department of Health which leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.

Root Cause Analysis
A formal, well recognised way of investigating incidents, claims and complaints, which offers a framework identifying what, how and why an event happened. Analysis can then be used to identify areas of change, develop recommendations and look for new solutions.

13.6.5 Scope

This policy applies to all permanent, locum, agency, bank and voluntary staff of BSL, whilst acknowledging that for staff other than those directly employed by BSL the appropriate line management or chain of command will be taken into account. Whilst the policy outlines how BSL will report, manage, analyse and learn from all SUIs and serious untoward near misses, implementation does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance.

> *'In the event of an infection outbreak, flu pandemic or major incident, BSL recognises that it may not be possible to adhere to all aspects of*

this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety

13.6.6 Roles and Responsibilities

Chief Executive
The Responsible Manager has overall responsibility for ensuring there are appropriate processes in place for the management of any SUI but delegates this responsibility through the Clinical Director.

Clinical Lead
The CD has responsibility for ensuring that appropriate processes for the management of any SUI are in place.

SIRO
The SIRO has management responsibility for delivering the Governance Agenda, including Risk Management. The SIRO also has responsibility for reporting all level 3 SUIs to the Information Commissioner via the IGTK SIRI submission tool.

All Managers
Managers are responsible for ensuring there are operational systems in place within their teams to fulfil the requirements of this policy. Within that context, managers must ensure that their staff are released for training, are fully assisted and supported throughout the handling of an SUI and receive feedback on the outcome of any investigation. Where staff experience particular difficulties associated with an SUI, managers should consider referring the staff member or members to an Occupational Health Service. Managers should contact the Operations Lead to make the necessary arrangements.

All Staff
It is mandatory for all staff to

- Be aware of what constitutes a SUI
- Report any SUI, which they witness or in which they are involved.

The Reporter must:

- Ensure the immediate safety of those directly affected by the SUI
- Complete an adverse incident form
- Immediately inform the appropriate senior member of staff/line manager

BSL Leadship Team
The leadership team has overall responsibility for ensuring appropriate SUI processes are in place and, as part of the Quality Exception Report, receives a monthly update prepared by the Clinical Director, on the status of any SUIs.

Information Governance Steering Group (IGSG)
The IGSG provides a high level forum in which to oversee and monitor the reporting and review of serious untoward incidents, ensuring that recommendations arising from SUI investigations are implemented as required and that organisational learning has taken place. In addition the Group will escalate any appropriate risks for inclusion on the Risk Register.

Management Team
The Management Team have a responsibility for ensuring that this policy is adhered to and to ensure actions to reduce error arising out of SUI investigations are implemented and monitored, as part of the monthly Performance Reviews. The Teams also have a responsibility to ensure that they foster an ethos of learning.

13.6.7 Care Quality Commission Outcomes

Include Care Quality Commission Outcomes applicable and impact on policy.
Outcome 17

Procedure/course of action required

13.6.8 Investigation of Serious Untoward Incidents

We have adopted the NPSA 'Seven Steps To Patient Safety' guidance into our incident and Serious Untoward Event policies.

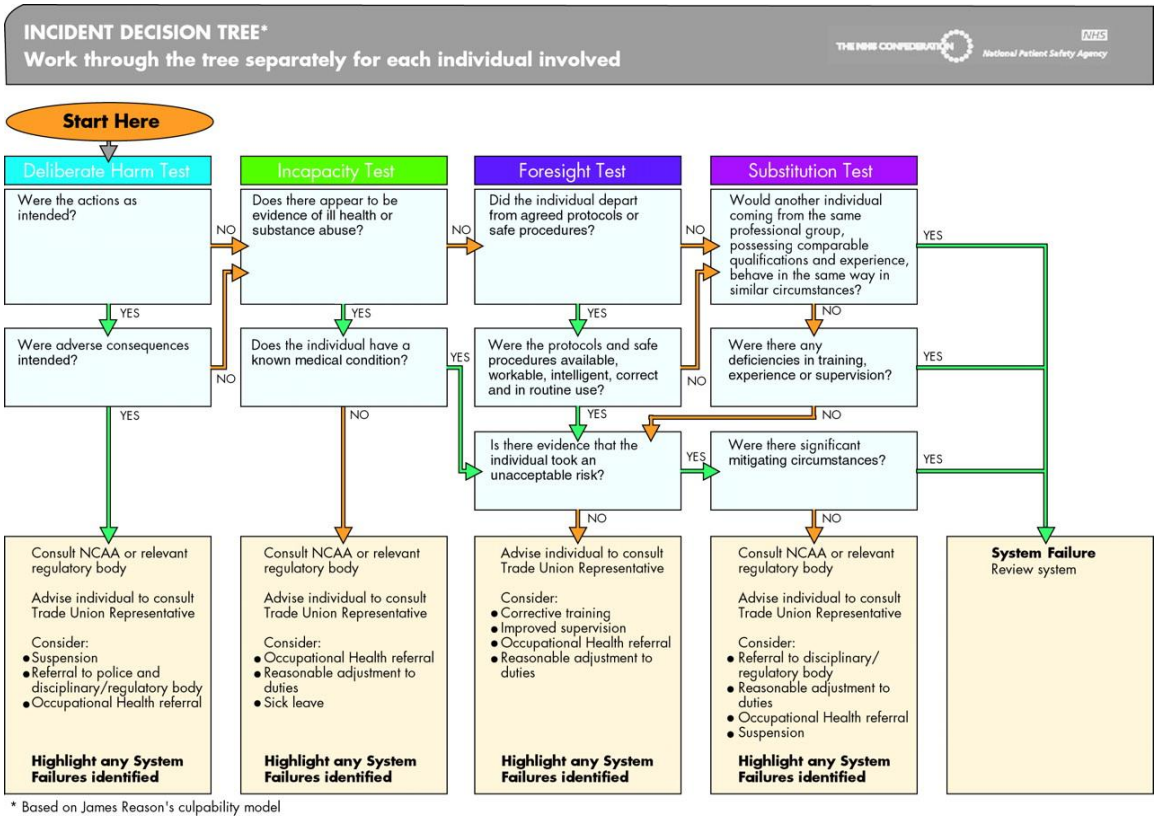
- **Step 1** Build a safety culture Create a culture that is open and fair
- **Step 2** Lead and support your staff. Establish a clear and strong focus on patient safety throughout your organisation
- **Step 3** Integrate your risk management activity. Develop systems and processes to manage your risks and identify and assess things that could go wrong
- **Step 4** Promote reporting. Ensure your staff can easily report incidents locally and nationally
- **Step 5** Involve and communicate with patients and the public. Develop ways to communicate openly with and listen to patients
- **Step 6** Learn and share safety lessons. Encourage staff to use root cause analysis to learn how and why incidents happen
- **Step 7** Implement solutions to prevent harm. Embed lessons through changes to practice, processes or systems

Once a reported incident is confirmed as a SUI, by the IGSG, the IG Lead will immediately report it via the IGTK Serious Incident Requiring Investigation (SIRI) reporting tool.

The person delegated to manage the incident should appoint an investigation team and ensure that an investigation is undertaken as soon as possible. The investigation should be documented.

In the case of SUIs that are clinical incidents, the investigation will take the form of a full root cause analysis. The root cause analysis must be undertaken by an individual who has undertaken appropriate training.

For individuals involved the Incident Decision Tree can be used to identify issues and understand the nature of the problem and actions required.



An investigation into a SUI is entirely separate from BSL' Disciplinary procedures. The investigation will be carried out under the requirements of the Fair Blame culture. However, if matters come to light during an internal enquiry which necessitate disciplinary action in respect of members of BSL' staff, then these matters will be dealt with separately under BSL' Disciplinary Procedures.

If a SUI is likely to give rise to a legal claim against BSL legal advice should be sought via an **Executive Director.**

Statements should be obtained from all relevant staff as soon as possible after an incident, and also from patients and members of the public if required.

In exceptional circumstances a formal enquiry may be conducted by one or more Senior Manager/ consultant of BSL. An enquiry of this nature might be considered if BSL had received a very serious complaint and it was considered that an investigation by one or more Senior Manager/ consultant was the most appropriate way to investigate the matter.

In very exceptional circumstances the BSL Executive leadership team may consider it advisable to ask an independent person or panel to investigate a SUI. The circumstances where this may be applicable are:

- when there have been a series of problems of a very serious nature or a number of problems that cause suspicion of something very serious not yet uncovered
- extremely serious and rare circumstances
- when there are problems at a very senior level in the organisation.

13.6.9 Internal Reporting

All adverse incidents and near misses and the outcome of any investigations are inputted onto the standard organisational forms and reported to the Quality Assurance Team to initiate investigation include in the service Risk Register. Incidents and the Risk Management Register Risk with any action plans will be reviewed at service Clinical Governance and IGSG Meetings. The Risk Register and action plans are reviewed by IGSG to analyse and feed back key themes and organisational learning to local services and the leadership team.

Following the investigation phase, all incidents deemed to be critical are reported as follows:

- Internally to the lead clinician and senior management
- Externally to the IGTK SIRI reporting tool and to the Commissioner
- Externally via the eForm NPSA website
- Externally to the Medicines and Healthcare products Regulatory Agency (MHRA)
- Externally to the HSE through RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

Within each service and at organisational level we aim to track the following KPIs:

- Number of incidents reported per annum: reviewed monthly and target for numbers to increase as this shares a culture of patient safety

- Number of incidents reported per employee: reviewed monthly and target to reduce numbers per employee with appropriate, targeted staff training
- Number of Serious Untoward Incidents (SUIs) reported per annum: reviewed monthly
- SUIs will have a root cause analysis review: reviewed annually and a target of 100%
- Root Cause Analysis will be undertaken within 10 working days of the incident being reported: reviewed annually and a target of 100%
- SUIs should have action plans with associated delivery dates and be followed up via a Root Cause Analysis (RCA) register: reviewed annually and a target of 100%
- Number of RIDDOR reportable incidents: reviewed quarterly and annually with a target for numbers of decrease
- Completion and submission of incident reports within 7 days: reviewed annually and a target of 100%
- Incidents are reported to external agencies when required by a nominated Lead: reviewed annually
- Root Cause Analysis is recorded in the appropriate documentation: reviewed annually and a target of 100%
- RCA pro-forma record support offered: reviewed annually and a target of 100%
- Records of Occupational Health support given to staff involved in stressful incidents: reviewed annually
- RCAs are communicated and to internal and external stakeholders and agencies in accordance with the organisation's policy and all communication is documented: reviewed annually and a target of 100%

SUIs are communicated to the patient when applicable in accordance with the organisation's policy and all communication including additional support offered is documented, in line with the NPSA Being Open Framework

No near miss event policy will be effective unless there is organisational learning and feedback on the lessons learned and any required changes in practice implemented.

13.6.10 Communication

Where staff, patients or the members of the public are involved in the serious incident it is essential that the staff, patient(s), the members of the public and/or relatives are informed as quickly as possible by an appropriate person. In clinical incidents this will normally be the lead health professional. This is particularly important if there is potential media interest where every possible effort will be made to inform the staff, patient/s and/or relatives prior to the media. This should also include the appropriate clinician(s). The designated individual will determine who to inform.

BSL has procedures in place to establish an “incident hotline” at short notice to provide information to patients, their carers and the general public in the event of a serious incident. Arrangements are detailed in Procedure. It is the responsibility of the Chief Executive, to decide if a hotline needs to be established for the incident concerned.

The service commissioner will be informed by telephone and in writing, either by the IG Lead or the individual designated to manage the incident.

The senior manager on duty at the time of the incident will determine whether any external agencies need to be informed of the SUI immediately. Responsibility for informing other organisations will then become the responsibility of the designated individual managing the incident.

The individual managing the incident will determine, in conjunction with the Chief Executive and others as appropriate, what information should be provided to staff, patients, and the public. A record of the decision to provide information and the details provided must be retained.

All contact with the media will be made through an Executive Director who with the approval of the Chief Executive will also ensure that an appropriate person is designated to act as a media spokesperson for any incident which has potential /actual wider public interest.

After the investigation into the incident has been concluded the lessons learned will be considered and disseminated to others in BSL as appropriate.

Memorandum of Understanding

The Memorandum of Understanding protocol has been agreed between the Department of Health on behalf of the National Health Service, the Association of Chief Police Officers and the Health & Safety Executive modifications.
BSL holds a copy available on-line and this will be used in discussions with local Commissioner arrangements in our handling of reporting SUIs to local organisations

Reporting to Police or Coroner’s Office

BSL will use the Memorandum of Understanding as the basis of communication with the police.
Staff who come across deaths that are sudden and unexpected or, caused by violence, including self-harm, and which are suspicious and unexplained must report them to the Police where it is clearly appropriate. The IG Lead should be contacted immediately if there is any doubt.
The Police will inform the Coroner’s Office if the death is a matter for their consideration.

13.6.11 Reporting to CCG/Commissioner

The SIRO will be responsible for notifying the commissioners of all SUIs. The IGSG will act as the liaison link between BSL and the CCG/Commissioners during all stages of the incident investigation process. BSL will keep the CCG informed of any significant developments in internal/external investigations, as appropriate.

If employee is unsure whether an issue should be reported they must phone the IG Lead or the Senior Manager on call.

Access to on line incident reporting will be provided through IGTK. The incident will be reported via the on line incident reporting form.

How to access IGTK SIRI reporting tool.

IG Incident Reporting Tool User Guide.pdf

Reporting to RIDDOR

The Reporting of Injuries, Dangerous Occurrence and Diseases (RIDDOR) 1995 requires certain categories of injury, disease or dangerous occurrence to be reported to the Health and Safety Executive (HSE) within specified times of their occurrence. In addition, the Genetically Modified Organisms (Contained Use) Regulations 2000 require the separate reporting to HSE of any incident involving a significant and unintended release of genetically modified organisms (including micro-organisms) that presents an immediate or delayed hazard to human health or to the environment.

It is BSL' policy to ensure that incidents at work are recorded, investigated and reported in order to meet the BSL' legal obligations for Health and Safety at work, including RIDDOR. BSL will aim, through its reporting and monitoring procedures, to assist the development of a proactive and positive response to incidents at work. Responsibility for implementing this Policy rests with the Chief Executive. Day-to-day responsibility for implementation lies with Directors and Managers.

13.6.12 Reporting timescales

It is critical the completed incident form reaches the next in line manager by the next working day. So it can be forwarded to the SIRO with the management actions section completed as soon as possible. All incident forms should be with the SIRO within 3 days of the incident.
If the form was completed on line as soon as the form is submitted a copy will go the next in line manager and the SIRO, after investigation the management

actions should be entered on the management section of the form and submitted as soon as possible (maximum 3 days)

Sections A to J of the paper form must be completed by the person in charge or the member of staff as appropriate at the time of the incident. (*Completion Guidelines see appendix 2b*).

In addition to the accident/incident form, where appropriate, all medical and nursing records must be completed. The facts of an incident should be recorded in the case notes / communication sheet by the clinician or care provider involved.

Subjective material should not be included (*record **facts** only*).

Record equipment failure and any notification of such to appropriate persons.

If any of the above cannot be reported on the present form paper form due to lack of space, please continue on a separate sheet (numbered e.g. 1of 3, *signed and dated*) and record the fact one is included on the form.

Investigate the incident bearing in mind the following points, particularly if the incident is serious

- Visit the scene of the incident
- Consider and implement action needed to prevent recurrence
- Establish the facts
- Take statements from any witnesses
- Make appropriate arrangements to withdraw from service any piece of equipment where necessary, and arrange for its inspection.
- Make a sketch or arrange for photographs to be taken
- If a Patient or member of the Public is involved in the incident it is important they are kept informed on the progress of the investigation and any finding or outcome if appropriate
- Should any enquires be received from the Media they should be referred to an Executive Director or outside normal office hours to the Operations Lead on Call.

13.6.13 Whistleblowing

All staff are encouraged to raise concerns and to report all incidents. BSL has a separate whistle blowing policy (HR 20) which is intended to help employees who have concerns about wrongdoing in the organisation, which they have not been able to address through normal management reporting routes.

13.6.14 Examples of Serious Untoward Incidents

The following examples should be considered when determining whether an incident is serious:

- Where there is suspicion that a patient was potentially at risk of serious harm as the result of possible negligence or error by a member of staff or service.
- Where a death or serious injury to a child has occurred which results in a Part 8 review under the Children's Act 1989.
- Where death or serious injury to a vulnerable adult has occurred which may result in an inquiry
- Where there is suspicion that a patient may have suffered injury as the result of a deliberate act by a member of staff, another patient or member of the public.
- Where there is suspicion that a patient may have suffered serious harm as the result of faulty procedures, a lack of proper procedures, or failure to follow proper procedures.
- Where there is suspicion of serious harm to a patient, member of staff, or member of the public, resulting from faulty equipment, drugs or unsafe environment.
- Where a patient or member of staff attempts serious harm to themselves on BSL premises.
- Where there has been a violent attack or serious injury or death of a member of staff or contractor in the course of their duties
- A fire, where damage has occurred and where patients and staff have been put at risk and / or the circumstances are suspicious.
- Where incidents involve infectious diseases that cause profound difficulties.
- Incidents that would be coded "RED" in line with the National Patient Safety Agency guidance
- Where an incident poses or may pose a significant threat to public health and / or safety including microbiological and chemical contamination incidents or releases into the environment
- Where an incident is likely to lead to public concern and / or significant media attention.
- Inadvertent circulation of confidential information
- Thefts of computers, laptops or tablet computers that contain patient sensitive material.
- Suspension of clinical or managerial staff in highly unusual circumstances.
- Where an incident may seriously prevent BSL from meeting its objectives or compromise the provision of services
- Any other serious untoward incident which would not be included within any of the above categories

13.6.15 Supporting Staff

BSL values it's staff and will support them following traumatic or stressful incidents. BSL recognises that the counselling support that is normally available to staff may need to be augmented following a major traumatic

incident and will utilise appropriate external agencies in such cases. It is BSL' aim to reduce untoward incidents to staff and to minimise these through risk assessment and appropriate actions.

This applies to all employees and sub-contractors of BSL who may have to deal with a traumatic or stressful incident. This also applies to employers from external agencies who in the course of their duties may be may be involved in traumatic or stressful incidents which require further support.

The Human Resources Designate will be responsible for ensuring that a counselling service is available to staff and for authorising the use of external agencies to meet demand following a traumatic or stressful incident.

The Human Resources Designate will be responsible for monitoring the use and the effectiveness of the counselling service and also for quality assuring any external agencies used. The Human Resources Designate will be responsible for identifying in a timely manner of the need for external support.

Service Managers must:

- Undertake risk assessments
- Promote good practice and refer their staff on to the Human Resources Designate as necessary
- Arrange for the de-briefing of staff following traumatic incidents and deal with any consequent absence in a compassionate manner
- Complete or ensure timely completion of the relevant forms:

Appendix A for further advice on supporting staff involved in SUIs.

Implementation Plan

Consultation
Stakeholders and sub-contractors have been made aware of this policy and offered the opportunity to comment or advise on content.

Ratification
The leadership team ratification has been sought and given for this policy.

Dissemination

The policy will be made available on the Intranet and will be available to all staff.

Training/Awareness
The policy will be introduced to all staff at induction and reviewed at annual appraisal or supervisory session.

Audit and/or Monitoring
The policy will be monitored, assessed and reviewed through incident reporting and supervisory sessions. The leadership team is responsible for review and the frequency that this review will be carried out.

Directors are responsible for ensuring that this procedure is followed throughout their directorate and that adequate arrangements are in place for recording and managing SUIs and learning and disseminating lessons from those incidents.

The Leadership team monitors this procedure through monthly reports on the number of SUIs reported and performance against reporting and investigating targets.

The SIRO and IGSG oversee the arrangements for reporting and managing SUIs and report non-compliance or concerns to the leadership team.