

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Management and Reporting of Accidents and Incidents Policy

Effective: January 2010

Review: January 2012

1. Introduction

The Newcastle upon Tyne Hospitals NHS Foundation Trust actively supports the promotion of a positive and non-punitive approach to incident, accident and near miss reporting in a culture of openness and learning.

The promotion and development of a positive and fair blame incident reporting culture is pivotal to effective risk management within the Trust and will provide information, which will enable us to learn from adverse events and facilitate action to prevent recurrence.

Errors, incidents and accidents in all areas of clinical and non-clinical activity can result in serious harm to patients, staff and other personnel as well as to Trust property and reputation.

It is essential that all possible steps are taken to minimise the risk of initial incident occurrence and subsequent recurrence and that when an incident, accident or near miss occurs, that an incident form is completed. The Trust operates a web-based incident reporting system (DatixWeb) to facilitate the incident reporting and investigation process.

This policy covers the reporting of all incidents, accidents and near misses and the process for investigation of such incidents (clinical and non-clinical). Please refer to Appendix 1.

2. Definitions

For the purposes of this policy the following definitions apply:

- **Accident/Incident** :- An unexpected, unplanned event which causes an injury (either physical or psychological) to staff patients, visitors, volunteers, or contractors which results in damage to equipment, buildings, assets or structures. It is not consistent with the desired operation of the organisation and may lead to a formal complaint and/or litigation.
- **Harm**: - An injury (physical or psychological), disease, suffering, disability or death including all instances of potentially preventable harm.
- **Near Miss**: - An unplanned or uncontrolled event, which did not cause injury to persons or damage to property, but had the potential to do so.
- **Person**: - A member of staff or patient in any location and visitors, contractors, or any member of the public whilst on Trust premises.
- **Serious Untoward Incidents**: - Incidents that are categorised as major or catastrophic on the incident grading matrix should be considered as potential Serious Untoward Incidents and be managed in accordance with the Trust

policy - Serious Untoward Incidents (SUIs) Reporting and Management Policy”.

- **Adverse Event:** - an incident/accident which results in actual harm.

N.B. For the purposes of this Policy the word Incident will apply to incidents and accidents unless specifically stated otherwise.

3. Responsibilities

3.1 Individual Employees

- Every employee has a responsibility to maintain safe systems of work, to take care of their own safety and that of colleagues and all other persons who may be affected by their acts or omissions. Any incident or near miss should be reported to the person in charge, supervisor or senior manager as soon as possible. The person in charge, supervisor or senior manager is the person with responsibility for the area concerned at the time that the incident or near miss takes place. An incident report should be completed as soon as possible after the event.
- In the case of a member of staff suffering an incident or near miss whilst in the course of their duties, on the premises of another organisation, the reporting procedures for that organisation should be followed in addition to the Trust procedure.
- Reporting of incidents does not absolve responsibility to identify action and prevent recurrence; there is a duty of care on the part of all staff to report any situation which they think is potentially dangerous or harmful.

3.2 Ward / Department Managers/Supervisors

- All staff must be made aware of the existence and content of this Policy.
- All managers, or those acting in that capacity, have the responsibility for ensuring that all incidents and near misses are reported according to the procedure indicated in this policy.
- All managers are responsible for the initial investigation of incidents and near misses to the degree appropriate to the severity of the incident and for the identification of action required to prevent recurrence.
- Where appropriate this will involve liaison and consultation with managers in other areas, senior managers and specialist staff e.g. Risk Management, Health & Safety Advisors, Infection Prevention and Control Team, Fire Officers.
- All managers and supervisors must be aware that an incident may progress to a claim in negligence and as such must ensure that the process of incident investigation is followed as outlined within this policy.

3.3 Senior Managers (Reporting, Investigation and Risk Registers)

- Managers should ensure that the on line incident report is completed

within 24 hours of the incident or near miss occurring.

- Managers are responsible for investigating incidents within their areas of responsibility and for ensuring that where necessary actions are completed following investigation. Where an action is outstanding the manager must ensure that where appropriate this is reported on the risk register and risk reduction measures identified.
- Managers are responsible for liaising with Risk Management, Health and Safety, Fire and Security Officers or other specialist staff where necessary in completing the investigation.
- Managers are responsible for undertaking trend analysis to ensure that where there are potential “hot spots”, appropriate action plans are in place to reduce the level of risk of recurrence of such incidents.
- Managers are responsible for ensuring organisational learning through the dissemination of Directorate incident data and aggregated data to the Directorate Clinical Governance or Risk Groups and via department/ward level meetings.

3.4 Clinical Directors

In addition to ensuring that all incidents and near misses are reported through the incident reporting mechanisms, the Clinical Director has a responsibility to ensure that issues highlighted through investigation are addressed within the Directorate and that potential Serious Untoward Incidents are reported to the Medical Director.

3.5 Risk Management and Safety Manager

It is the responsibility of the Risk and Safety Manager to maintain a central database of all reported incidents and near misses on behalf of the Medical Director.

This responsibility functions in order to:

- Ensure that information from incident and near miss reports informs the Trust Risk Management priorities as outlined within the [Trust Risk Management Strategy](#) and that issues arising are addressed within the overall Risk Management function.
- Monitor Trust wide incident data including trend and statistical analysis as part of the systematic aggregation of incidents, complaints and claims.
- Provide appropriate and timely reports for the Trust Board and associated committees in order to facilitate effective risk management.
- Provide support to managers and clinicians in identifying and addressing specific risks arising from either individual incidents or from analysis of wider trends.
- Ensure that appropriate reports are submitted to external agencies as

detailed in section 9 in relation to reportable incidents.

3.6 Health and Safety Advisors

The Health and Safety Advisors are responsible for:

- Coordination of investigations into any incidents involving or potentially presenting a health and safety risk including the follow up of incidents, in association with the Risk Management and Safety Manager
- Advising managers on current Health and Safety Legislation and Trust Policy and Procedure for accident prevention purposes
- Providing appropriate and timely reports to the Trust Health and Safety Committee
- Liaison with the Health and Safety Executive with regard to reportable incidents (Appendix 2).

3.7 Fire and Security Officers

The Trust Fire and Security Officers are responsible for monitoring incident data for all fire and security incidents in conjunction with the relevant Directorate Manager and providing appropriate and timely information to the Health and Safety Committee.

3.8 Executive Responsibilities

The Chief Executive is ultimately accountable for Risk Management within the Trust and for ensuring that the Trust meets all of its obligations under Health and Safety legislation and NHS Directives.

4. Reporting of Incidents and Accidents

A flowchart of the Accident/Incident process and Near Miss reporting process can be found in Appendix 1.

4.1 On becoming aware of an Incident the employee concerned must take the following actions:

- Arrange immediate treatment for any injured person.
- Summon emergency services if appropriate.
- Take action to remove the hazard or to protect others from it if it is safe to do so. Occasionally the site of the incident will require cordoning off to ensure that staff and visitors do not put themselves at risk.
- Complete any notation required in the patient's clinical record.
- Inform the person in charge of the area or department or senior manager immediately, particularly where a serious incident or near miss has occurred. Out of normal working hours the Patient Services Coordinator

should be contacted.

- **Complete an on line incident report via the Trust incident reporting system, DatixWeb, and where relevant attach witness statements and supporting documents to the incident record.**
- **Following a potential Serious Untoward Incident an incident report must be completed and the Risk and Safety Manager or in his/her absence a Patient Safety Advisor, should be contacted by telephone to ensure that such a severe incident is reported to the Executive Team as soon as possible.**
- In the event of system downtime or unavailability of IT systems a paper incident form must be completed and the appropriate procedure followed as outlined in Appendix 3.

4.2 Once informed of the incident, the person in charge or manager will take the following actions:-

- Start the investigation in consultation with appropriate specialist staff or relevant departments.
- Visit the scene and establish the facts of the incident.
- Check that any injured person has received treatment and that any hazard has been made safe.
- Obtain statements from witnesses (see Appendix 4 for guidance) and attach to the relevant on line incident report. Where a paper form is used (as in the case of system downtime or unavailability of IT systems) the statements should be attached to the form.
- In the event of a Catastrophic or Major injury or dangerous occurrence, consider the Trust's Policy on the "[Serious Untoward Incidents \(SUIs\) Reporting and Management Policy](#)".
- In the case of an incident involving a patient, an entry must be made in the clinical notes. Where appropriate discussion should also take place with the patient and the family in accordance with the Trust policy on [Being Open](#) and the discussion recorded in the clinical notes.
- If a complaint or claim highlights an incident or near miss occurrence, an incident report should be completed via the Trust online incident reporting system, DatixWeb. The information should include reference to the complaint; however the complaint or claim itself should be managed through the Trust's [Claims Management Policy](#) or the [Concerns and Complaints Policy](#) .
- The individual designated as the Final Approver should then ensure that the incident report has been completed appropriately. It is essential that the information documented for the incident is comprehensive and objective and provides accurate detail of the occurrence.
- The Senior Manager, Directorate Manager or Head of Department is responsible for ensuring that any follow up action is taken.
- Staff side appointed Health and Safety Representatives are encouraged to contribute to any investigation and will have access to documentation where necessary, together with the right to inspect the workplace after

any occurrence of a notifiable disease or incident.

- 4.3 Each ward and department should have easy access to the on line incident reporting system. In the event of system downtime, then a paper incident form must be completed. Paper incident forms are available through the Hospital General Offices.
- 4.4 Copies of all documentation relating to the incident will be retained by the Trust for 20 years in accordance with the Trust procedure for documentation retention.

5. Reporting of Incidents Retrospectively

Occasionally an incident or injury comes to light a considerable length of time after it occurred. Where this is the case the incident should be reported via the online incident reporting system as usual, although the manager should note clearly any time delay in the report and the reason for the delay.

6. Whistle Blowing and Open Disclosure

There may be occasions when an incident may raise concerns about malpractice or inappropriate behaviour. The "[Whistleblowing: Policy on voicing concerns about malpractices, misdemeanours, inappropriate behaviour or actions](#)", should be referred to in such circumstances.

7. Incident Investigation

The level of investigation will differ dependent on the severity of the incident; see Appendix 1.

7.1 Investigation and Follow Up

- The initial investigation of incidents should be undertaken as above by the relevant Ward or Department Manager or designated deputy, in consultation with specialist personnel as appropriate.
- Occasionally the initial investigation may highlight the need for further investigation by a designated lead investigator. This will include incidents such as:
 - Suspected fraud
 - Possible complaint or claim against the Trust
 - Situations in which the conduct of staff may require investigation under the disciplinary procedure
 - Serious Untoward Incidents

These further investigations will only be initiated following discussion with the Director of Quality and Effectiveness, the Medical Director, Nursing and Patient Services Director or designated operational lead. All communication from external agencies should be referred to the Director of Quality & Effectiveness or the Medical Director.

7.2 Incident Grading

Each incident is graded according to the damage caused, based on the

criteria listed in Appendix 4. These consequences are listed in three columns based on: Impact on the Individual, Impact on the Organisation and the Number of People affected by the event. Using the listed criteria the investigator identifies a description that matches most closely the consequence of the incident, reviewing each column individually. The overall consequence of the incident is based on the highest level scored in each column. For example, should an incident have a major impact on an individual, a moderate impact on the organisation and only one person was affected, the consequence of the incident would be major.

7.3 Investigation procedure

7.3.1 All designated investigators must have completed the Trust training for Lead Investigators. Training on Incident Investigation will be delivered on a nominated person basis to staff identified by their Directorate Management team before being given access to the Datix Investigation Module.

Additional on line training in Incident Investigation is available and provided by the National Patient Safety Agency at http://www.npsa.nhs.uk/health/resources/root_cause_analysis.

7.3.2 Any equipment that was involved in the incident should be isolated until it has been reviewed by either the Health and Safety Advisor or EME Services Officer in the Estates Department. Photographs should be taken to support analysis of the incident. Health and Safety Advisors, Risk Management and Patient Services Coordinators all have access to digital cameras.

Where an incident involves a piece of bio-medical equipment:

- Do not alter any dials or settings
- Record the settings for future reference
- Retain any disposables e.g. giving sets, in a yellow biohazard bag within a sealed and clearly labelled clear polythene bag
- Quarantine the equipment in an area where it cannot be accessed by staff who may inadvertently put the equipment back into service
- Do not allow the kit to be returned to the manufacturer without the clear agreement of either the Works Department, Manager, Medical Electronics, Health and Safety Department or Risk Management
- Ensure that there is a secure environment to store any evidence to prevent loss or tampering.

7.3.3 Case notes should be reviewed in the case of a clinical incident to ensure that all records are completed appropriately. Staff should not record the reasons for any incident within the clinical record. The clinical record

exists to record the clinical care of the patient and all other information should be recorded in the appropriate incident report and supplementary documentation.

- 7.3.4 Where a patient death or injury could be perceived as suspicious the police may seize the records. To allow the Trust to start its own investigation the senior officer on site at the time should obtain a photocopy of the records at the outset and retain in safe keeping for future reference.
- 7.3.5 The investigating officer and line manager must consider if it is possible that there was any negligence, deliberate or malicious intent involved, and act in accordance with Trust Policy "[Incidents, Accidents and the Trust Disciplinary Process – Guidelines for Managers, Clinical Directors and employees](#)".
- 7.3.6 In the event of a serious incident, the severity of the incident and investigation should be determined and agreed as outlined in the SUI Policy.

If it is decided that an incident should be reported as a Serious Untoward Incident (SUI) it will be reported and investigated as per the Trust policy and procedure on "[The Reporting and Management of Serious Untoward Incidents](#)".

- 7.3.7 Interviews should be arranged with all key staff involved in the incident.

Where possible staff members should write statements immediately following an incident. Statements can be marked draft until the staff member is satisfied with the content. All statements must be dated and signed with the name clearly printed in black ink on Trust headed paper and then attached to the on line incident report.

- 7.3.8 Involvement in a critical incident can be extremely upsetting for staff and the emotional state of the employee must be considered at all times. Support by Staff Counsellors can be arranged through Occupational Health if required. Please refer to Trust document "[Supporting Staff Involved in Traumatic/Stressful Incident or Claims Policy](#)". Early implementation of this process will demonstrate strong support for staff involved.

Prior to the interviews the investigating officers should meet to agree the areas of information to be obtained and the methods of discussion. An interview preparation form may be used.

Ensure staff members are supported and that they are informed that they may bring a supportive friend, professional advisor or union representative to the interview if they wish.

Following the investigation the investigating officer must complete all relevant sections of the on line incident report including the contacts before sending the form for final approval.

7.4 Root Cause Analysis

- The following may be required:
 - a) Incident report and relevant appendices.
 - b) Other relevant written documentation as appropriate or available at the time (e.g. case notes or written policy documents).
 - c) Statements from all relevant staff immediately following incident (availability will depend on nature of incident).
- Following incident investigation an Action Plan for remedial action may be necessary.

7.5 Closing or approving the Investigation

- Senior Officers from the department/s involved should agree the factual basis of the report and remedial action required.
- Staff involved should be informed that the investigation is closed, bearing in mind that this is likely to be a difficult time for some and that support may be required.
- It is the responsibility of the Clinical Director of the department where the incident occurred to ensure, with the support of the Directorate Manager and Matron, that remedial action is implemented and that where appropriate learning from the incident is shared throughout the organisation.
- Ideally lessons learned should be shared with the group of staff directly involved.
- It must be remembered that the report can be disclosed during litigation.
- Where necessary ongoing audit of the proposed changes should be agreed.
- Learning from incidents should be directed through the Directorate Clinical Governance and Risk Groups. Where there is thought to be an opportunity for Trust wide learning the issue should be discussed at the Integrated Governance Group and the Clinical Risk Group for wider dissemination.

7.6 Risk Identification

- Following some incidents the investigating officer will identify that there is a residual risk to the organisation. To ensure that this risk is managed correctly the risk should be added to the Trust Risk Register.

It is the responsibility of the Directorate or Department manager with access to the Risk Register to ensure that the hazard or threat is recorded.

- To ensure that the risk is managed correctly the Trust policy on “[Risk Register – Management and Use](#)” should be followed.

8. Internal Reporting

Incident Report	Committee	Frequency	Person responsible
Serious Untoward Incident	Corporate Governance Committee	Bi-Monthly	Director of Quality and Effectiveness
Quality Account	Trust Board	Monthly	Risk Management and Safety Manager
Monthly Incident Report	Women’s Services Clinical Improvement Risk Group (CIRG)	Monthly	Risk Management and Safety Manager

Incidents involving the Cervical Screening Programme (NHSCSP) should be handled in accordance with protocol documentation to *Interim Guidelines for Managing Incidents in the NHS Cervical Screening Programme* “NHSCSP Publication No. 11 Dec 2010”

9. Reporting Mechanisms to External Agencies

All NHS organisations are expected to communicate with the relevant external bodies in accordance with appropriate reporting requirements. There are a number of external bodies to which certain incidents should be reported as and when they occur; these are included in Table 1.

Table 1. Key External Stakeholders / Reporting Schemes

Incident Type	External Agency Reported	Frequency	Person/Department Responsible for Reporting to External Agency	Internal Reporting Committee
Patient Safety Incidents	National Patient Safety Agency (NPSA) – National Reporting Learning Service (NRLS)	Ongoing rolling programme	Risk Management and Safety Manager	Integrated Governance Committee, Trust Board
Serious Untoward Incident/Serious Adverse Event	National Patient Safety Agency (NPSA)	Ongoing rolling programme	Risk Management and Safety Manager	Trust Board
	Primary Care Trust	As they occur	Risk Management and Safety Manager	Trust Board

Radiation Protection	Health and Safety Executive, Care Quality Commission	As they occur	Director of Quality and Effectiveness	Trust Board
Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (1995) RIDDOR	Health & Safety Executive	As they occur	Risk Management and Safety Manager	Trust Health and Safety Committee
Medical Devices	Medicines and Healthcare products Regulatory Agency (MHRA)	As they occur	Risk Management and Safety Manager	Medical Devices Steering Group
Blood products	Serious Adverse Blood Reactions and Events (SABRE)	Within 24 hours and investigated within 5 days	Transfusion Practitioner/Blood Bank Manager	Hospital Transfusion Committee

10. Training

The Trust will ensure that appropriate training is provided on the reporting and investigation of incidents and near misses, using the web-based incident reporting system, DatixWeb. All staff receive training on incident reporting as part of the Trust Induction Programme. A prospectus detailing the programme of training sessions for

various staff groups is available on the Trust Intranet on the Clinical Governance and Risk Department webpage and on the Learning Zone. As outlined in the Mandatory Training Policy, training on Incident Investigation will be delivered on a nominated person basis to staff identified by their Directorate Management Team before being given access to the Datix Investigation Module.

11. Monitoring

As outlined above, incident and near miss data is reported and monitored both through internal and external committees and agencies on a regular basis. Overall responsibility for monitoring lies with the Trust Board via the Quality Account.

Incident data, as part of the systematic aggregation of incidents, complaints and claims, will be reviewed by the Integrated Governance Group. This group will review the data and identify trends, themes and learning points to be reported to the Clinical Risk Group Quarterly. The Clinical Risk Group will identify any deficiencies, develop action plans and monitor these through to completion.

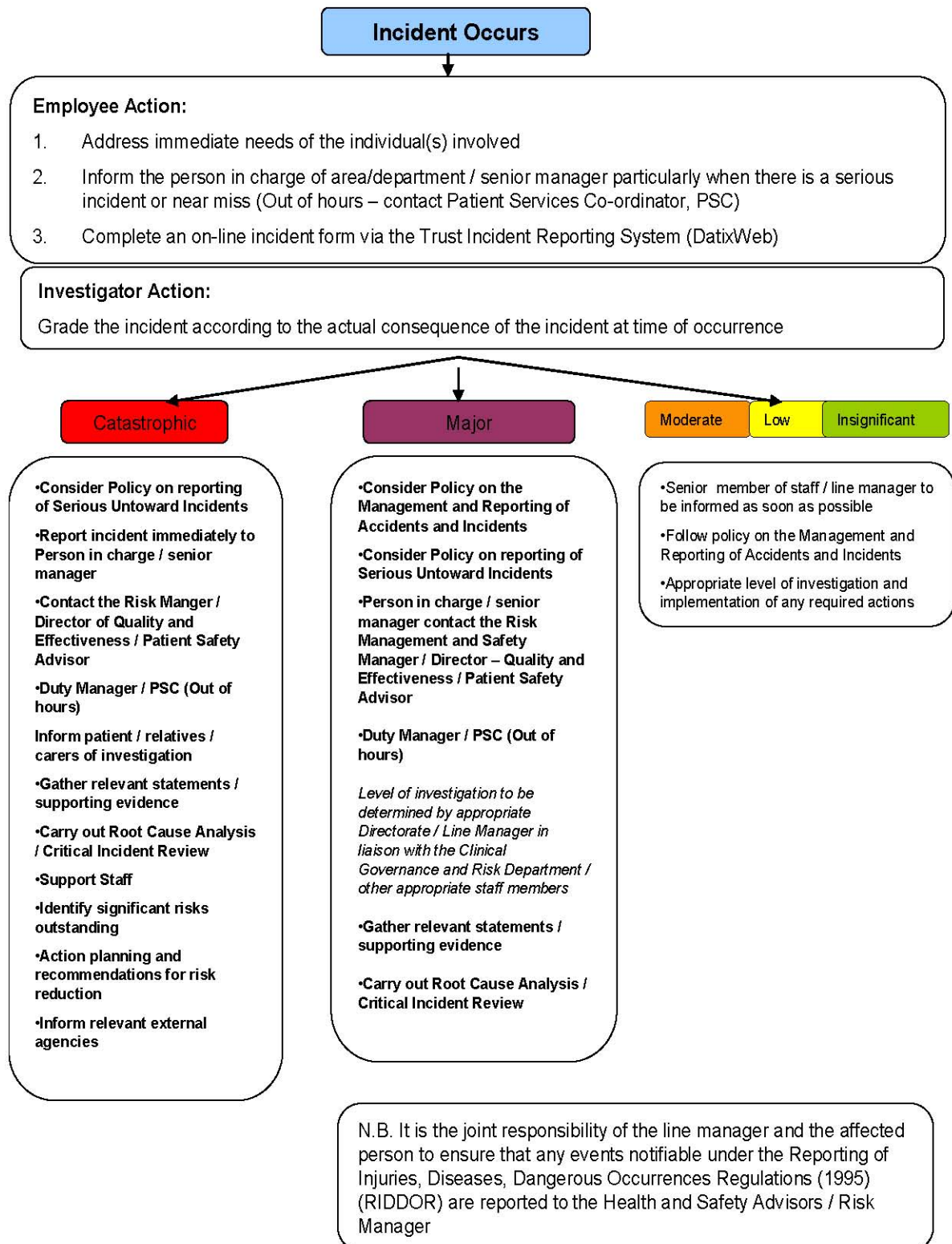
12. Policy Review

This policy will be formally reviewed by the Risk Management and Safety Manager on a two yearly basis or when changes in practice warrant updates to this policy.

Ongoing review will be carried out by the Risk Management and Safety Manager.

Policy Author: Risk Management and Safety Manager, Clinical Governance and Risk Department

Flowchart on the Management of Incidents within the Trust



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

All RIDDOR reportable incidents will be submitted to the Health & Safety Executive through the Clinical Governance & Risk Department.

Normally clinical incidents are not reportable under RIDDOR. However where an injury (as defined by the regulations) has occurred to a patient or visitor that is thought to have occurred through a failure of safe systems of work this should be considered for reporting under RIDDOR.

For the purposes of reporting the regulations define major injuries and dangerous occurrences as indicated below.

1. Major Injuries

- 1.1 Fracture of the skull, spine, pelvis and any bone in the arm or leg, but not bones in the hand or foot.
- 1.2 Amputation of a hand or foot; or a finger, thumb or toe where the bone or joint is completely severed.
- 1.3 Loss of sight in an eye or a penetrating injury, or a chemical or hot metal burn to an eye.
- 1.4 Injury requiring medical treatment or loss of consciousness due to electric shock. Loss of consciousness due to lack of oxygen.
- 1.5 Decompression sickness.
- 1.6 Acute illness or loss of consciousness caused by absorption of any substance.
- 1.7 Acute illness believed to be the result of exposure to a pathogen or infected material.
- 1.8 Any other injury which results in the person being admitted to hospital for more than 24 hours.

2. Dangerous Occurrences

- 2.1 The collapse, overturning, or failure of a load bearing part of a lift, hoist, crane, derrick or mobile platform, or an excavator, or a pile-driving frame with an operating height of over seven metres.
- 2.2 The collapse or failure of a load bearing part of a passenger carrying amusement device or any safety arrangement connected with it.
- 2.3 The explosion, collapse or bursting of any closed vessel.

- 2.4 Electrical short-circuits or overload causing fire or explosion.
- 2.5 Any explosion or fire resulting in the suspension of normal work for more than 24 hours.
- 2.6 The collapse or partial collapse of any scaffold over five metres high.
- 2.7 Any unintended collapse of any building or structure under construction, alteration or demolition involving a fall of more than five tonnes of material or of a wall or floor in a place of work.
- 2.8 An uncontrolled or accidental release or escape of any pathogen or substance from any apparatus or equipment.
- 2.9 Any unintentional ignition or explosion of explosives.
- 2.10 Failure of any freight container or a load bearing part thereof.
- 2.11 Bursting, explosion or collapse of a pipeline.
- 2.12 Any incident in which a road tanker overturns or suffers serious damage catches fire or causes the release of dangerous substances.
- 2.13 Any incident in which a dangerous substance being conveyed by road is involved in a fire or where there is an uncontrolled release or escape of the dangerous substance.
- 2.14 Any incident where breathing apparatus malfunctions in such a way as to deprive the wearer of oxygen.
- 2.15 Any incident in which plant or equipment comes into contact with overhead power lines exceeding 200 volts.

3. Three Day Absence

Any employee requiring three days or more absence from work following a work related incident must be reported under the RIDDOR rules.

This rule applies even if the absence does not take place immediately following the incident.

Guidance for Preparing Statements and Reports

1. Introduction

There are occasions when staff will be required to write a statement following a complaint and/or incident.

Staff must be supported in statement writing following an incident. All statements must be dated and signed with the name clearly printed in black ink on Trust headed paper. As staff may be traumatised by having witnessed or being involved in an incident, it is not always possible to obtain statements immediately. In such cases they will need to undertake supported statement writing at a later time. In extreme cases it may be necessary to visit a member of staff at home, with their agreement, to assist in statement provision. If this is necessary it is essential that consideration is given to who should undertake this task.

2. Purpose of the Statement

The aim of the statement is to establish the facts about the events which resulted in an incident. Accurate and concise reporting ensures that the organisation is in the best position to satisfy a complainant or deal with potential claims for negligence at the time or in the future.

Good record keeping is of paramount importance in both complaints handling and incident reporting as many of the complaints received arise from failures in communication.

The need for statements to amplify the clinical record is greatly reduced where the quality of clinical documentation is high. It is therefore in everyone's interests to continually maintain a high standard of record keeping.

3. Content of Statements and Reports

There are six main instances in which clinical staff may be requested to provide a written statement or report. These are:

- to supplement the clinical record
- to be used by the Trust for an internal enquiry or an independent review
- requested by HM Coroner
- to assist the Trust in relation to a complaint
- to assist the Trust in relation to a legal claim
- to assist the Trust in relation to an incident/accident report.

The core content of each of these types of statement is likely to be similar, but there are levels of detail which may be more or less appropriate for inclusion depending on the purpose for which the statement is being requested.

Common to every type of statement is the need to record the facts and not to present opinion, belief or blame. Opinion and belief may need to be

transmitted to other staff within the Trust, but initially this is best done verbally. If it becomes necessary to put it in writing, this should be done as a letter with a defined recipient and circulation and should not be part of a formal report or statement.

Points to note:

- Only the facts should be documented
 - The statement should be full, frank and honest
 - The statement should be clear and unambiguous
 - Statements relating to clinical care should be written with reference to the clinical notes.

This makes it essential that in any statement opinions should not be included. Advice on the content of statements can be obtained from the Clinical Governance and Risk Department.

4. Writing the Statement

4.1 General Points:

- The report does not form part of the medical record
- Timing is important; write a statement as near as possible to the event
- The final version of the report should retain the date of the first draft and state the date of the final version
- The first page of the final version should be on Trust headed stationery
- In a case involving a patient, the patient's full name, date of birth and hospital record number should be stated. (In the case of a baby, this should include the baby's full name, date of birth and hospital number followed by the words 'Baby of' and then the mother's full name, date of birth and hospital number).

4.2 First Paragraph

This should state your full name, status and relevant qualifications. Professional staff should state their registration number and duration of employment with the Trust. It is helpful in addition to state dates, such as date of qualification and date of obtaining a postgraduate qualification, as well as the duration of work at your present grade. For example: "I am Dr Joseph Onions, MB BS, MRCOG. I qualified in 1992 and have worked as a specialist registrar for 2 years. I have worked in the Directorate xxxxxxxxxx at the xxxxxxx hospital for 5 months.

4.3 Second Paragraph

This should state who has requested the report or statement, and the purpose for which the statement or report has been requested. For example: "This statement has been prepared as a supplement to the clinical record at the request of".

4.4 Third Paragraph

This should state the basis of your statement or report. The report might be based on the clinical record, relevant charts, your own observations, or relevant information from any other member of staff who should, where relevant, be named. For example: "This report is

based on my own observations and the charts from the night of 9th /20th June which recorded observations made by A.N. Other (post).

4.5 Fourth Paragraph

This should state your role in relation to the patient and/or the incident in question. In the unlikely event of your being a personal friend or relative of the patient, this should also be stated clearly. Example: "I was involved in the care of this patient from the start of my shift at 2100 on 19th June 1999 until she was transferred to intensive care at 0300 on 20th June".

4.6 Subsequent Paragraphs

- All staff should state the names and grades of their colleagues on duty at the time.
- Events should be chronologically ordered, starting from when you came on duty or when you first took charge of the patient, as appropriate.
- Avoid abbreviations.

4.7 Checking the Statement or Report

- Check for correct spelling and grammar.
- Check that the information you have is accurate, objective and complete.
- Finish – "I believe that the facts stated in this witness statement are true" (not "to the best of my knowledge and belief").
- Sign and date the report.

4.8 Reports for the Coroner

Unlike internal statements for use within the Trust, or reports or statements which may ultimately be cited in court proceedings, reports to the HM Coroner become public documents. It is therefore Trust policy that all reports requested by HM Coroner are seen by the Trust's solicitors before the final report is submitted to HM Coroner. The presentation of such reports to the Trust's solicitor will be coordinated by the Legal & Committee Services Officer on behalf of the Medical Director.

Incident Grading Matrix

Level	Descriptor	Actual/ Potential Impact on Individuals	Actual/ Potential Impact on Organisation	Number of persons affected at one time
5	CATASTROPHIC	Suicide or homicide or a death that would generate immediate media attention Any alleged rape or other serious violent assault on an NHS patient or member of staff Infant abduction	National adverse publicity NHS Investigation STEIS Healthcare Commission Visit Criminal Prosecution, RIDDOR Extended service closure Cost greater than £500K Litigation Expected	Excess of 50 e.g. cervical screening disaster, mass evacuations
4	MAJOR	Invasive procedures being carried out on the wrong patient or body part. Any unexpected death of a patient whilst under the direct care of a health care professional or within one month of being seen by a health care professional Haemolytic transfusion reaction; Removal of wrong body part. Infant discharge to the wrong family Permanent injury Loss of body part, Mis-diagnosis – poor prognosis. Patient receiving radiation dose much greater than intended whilst undergoing a medical exposure	Service closure, H&S Investigation reportable, Long term sickness. Claim expected – indefensible. Temporary service closure. Increased Pt. Stay >15 days Cost greater than £250K RIDDOR reportable injury MHRA reportable STEIS reportable	16 - 50 Moderate number – e.g. loss of specimens, vaccination problem
3	MODERATE	Semi-permanent Injury/ Damage e.g. injury takes up to one year to resolve Short term sickness more than 3 days	Needs careful PR, Local Adverse publicity RIDDOR reportable MHRA reportable Hospital stay increased < 15 days	Small number 3-15
2	LOW	Short term Injury/ Damage e.g. injury that has been resolved within one month	Minimal risk to the organisation	One
1	INSIGNIFICANT	No injury or adverse outcome Near Miss	No Risk at all to the organisation	None

**THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A**

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Management and Reporting of Accidents and Incidents Policy	Policy Author:	Nicolle Croft, Risk Manager, CGARD
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy does not discriminate against any individual or group on the basis of race, ethnicity, nationality, gender, culture, religious belief, sexuality, age or disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	N/A	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d)	Can we reduce the impact by taking different action?	N/A	

Comments:	Action Plan due (or Not Applicable):
	N/A

Name and Designation of Person responsible for completion of this form: Nicolle Croft, Risk Manager, CGARD Date: 12/04/2010

Names & Designations of those involved in the impact assessment screening process: Integrated Governance Group and Clinical Risk Group
(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)