

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Incidents, Accidents and the Trust Disciplinary Process - Guidelines for Managers, Clinical Directors and Employees

Effective: March 2006

Reviewed: March 2009

Review: March 2012

1. Introduction

This guidance is intended to clarify for managers, Clinical Directors and employees, a number of general principles for follow-up of individual incidents and accidents. The guidance aims to help promote the development of a positive open and fair reporting culture in support of effective risk management within the Trust, while also clarifying the minority of situations where formal investigation and the possibility of subsequent action under the disciplinary procedure might be appropriate.

2. Promoting effective reporting

- 2.1 Errors, incidents and accidents in clinical practice can result in serious harm to patients, staff and visitors and it is therefore essential to ensure that all possible steps are taken to minimise the risk of their occurrence.
- 2.2 The first step in this process is to ensure that all incidents, accidents and near misses are reported promptly by the employees involved. This can only be achieved where members of staff reporting the incident feel confident that they will not automatically be punished or blamed.
- 2.3 The Kennedy Report (2001) into the Bristol Royal Infirmary Inquiry recommended that every effort should be made to create an open and non-punitive environment in the NHS in which it is safe to report and admit incidents. The Government has since made it clear that being open and fair must become a top priority in healthcare.
- 2.4 When incidents do occur, it is vital in the first instance that prompt action is taken to minimise their potentially harmful effects. In addition, it is subsequently necessary to consider carefully the circumstances in which the incident occurred, so that we can learn from the events and take action to reduce the risk of recurrence in the future.
- 2.5 All staff should report incidents, accidents or near misses as soon as possible following the procedure outlined in the Operational Policy for Accident/Incident Reporting.

3. Individual incident arising from systems failures

In a highly pressurised environment such as a hospital ward or department, it is inevitable that incidents, accidents and near misses will occur as a result of systems failures and Trust managers must recognise this.

- 3.1 It is often difficult for managers to decide whether the incident involved a reckless, malicious or repeated violation and to help managers make their decision the National Patient Safety Agency and the NHS Confederation has developed the Incident Decision Tree. An on-line dynamic Decision Tree is available at the NPSA's website www.npsa.nhs.uk an adapted copy of the Decision Tree is attached as Appendix I.
- 3.2 Although every incident and its consequences need to be considered individually, as

a general principle an isolated incident or near miss caused by simple human error which is promptly reported, will not normally be considered to require automatic action via the disciplinary procedure. The preferred response will be for the manager, or clinical director (where a member of medical staff is involved), to investigate the incident and to discuss practice issues informally with the employee to ensure that lessons have been learned both by the employee and the organisation as a whole. This discussion may in turn, result in the identification of a systems problem that will require a full root cause analysis investigation.

- 3.3 Although individual incidents may not in themselves be serious, additional concerns may emerge if an individual employee's practice has contributed to more than one clinical incident or accident. In such circumstances, the clinical director or manager will wish to discuss this in detail with the individual involved and to identify any underlying causes and support required to prevent recurrence. In some circumstances it may be appropriate to consider such issues with the individual under the Trust's policies for the management of sub – standard performance, for example Concerns Relating to the Performance, Professional Behaviour and Personal Conduct of Medical and Dental Staff or Disciplinary Policy/Procedure.

4. Situations where more formal action under the disciplinary procedure may be required.

- 4.1 More formal action may be deemed appropriate in situations caused by reckless disregard of safety, procedure or protocol likely to cause damage.

- 4.2 Where incidents and accidents are not promptly reported and appropriate action not taken to protect patients, visitors or staff from harm, this will be viewed as a serious breach of the terms and conditions of employment and will consequently always be investigated formally with the possibility of subsequent disciplinary proceedings against the employee concerned.

- 4.3 Employees witnessing incidents and accidents also have a responsibility to ensure that the event is promptly reported and failure to carry out this responsibility may also merit formal investigation as in paragraph 4.2 above.

5. Monitoring and review

- 5.1 This guideline will be reviewed regularly as indicated. Comments on the content or implementation of the document should be directed to the Manager Clinical Governance and Risk Department

6. Definitions

- 6.1 These definitions **must always** be considered in line with the National Patient Safety Agency **Incident Decision Tree** (See Appendix I)

6.2 Causes of Error

6.2.1 Slip, trip, lapse, fumble

The plan is correct but the action fails (failure of action or memory) this can be due to tiredness, failure to check or similarity of subject matter.

6.2.2 Rule Based Mistake

Misapplying a good rule due to assumptions or applying bad rules leading to bad habit formation.

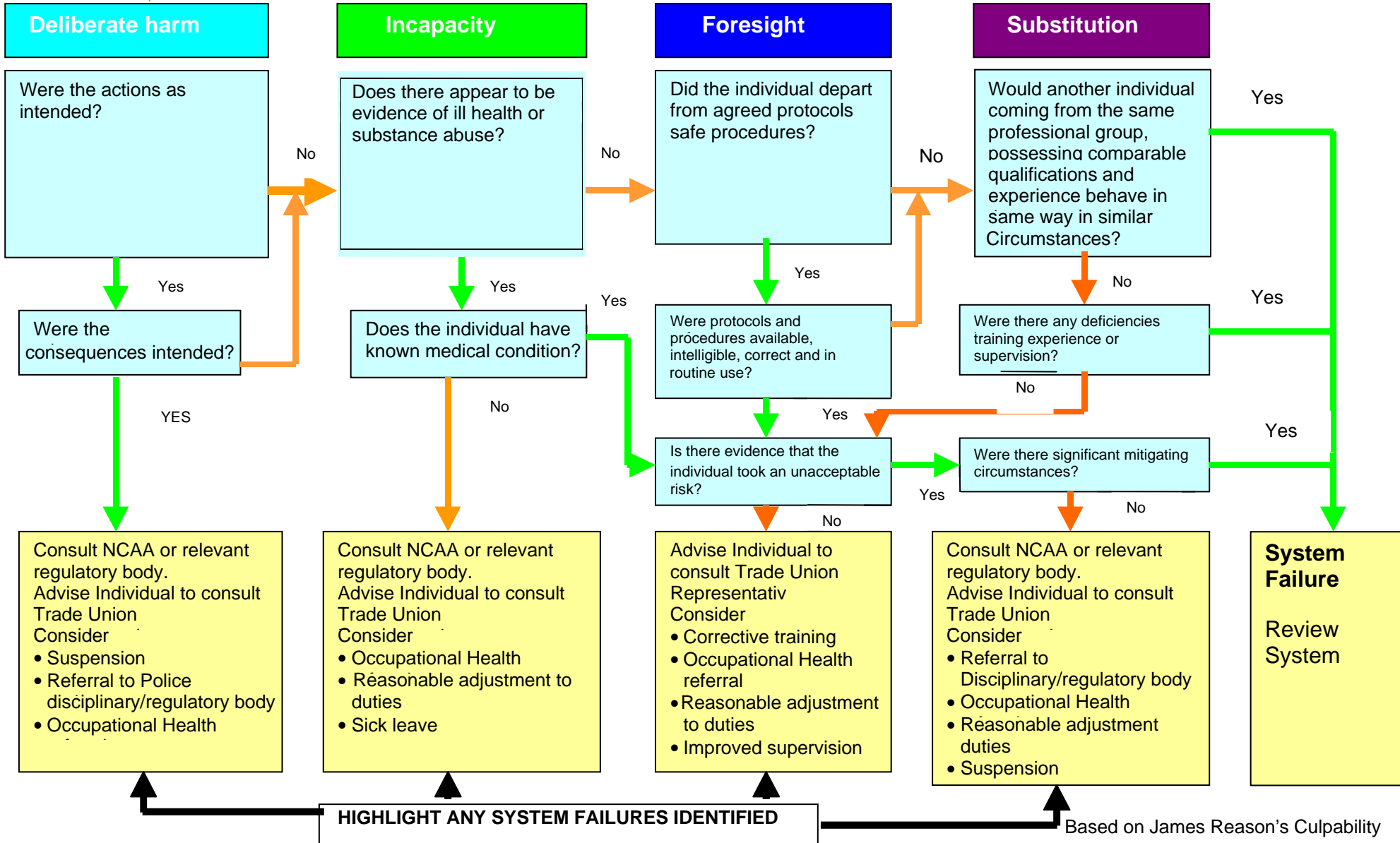
- 6.2.3 **Knowledge Based Mistakes**
Wrong action is chosen due to lack or inappropriate knowledge base.
- 6.2.4 **Routine Violations**
Deliberate deviations from accepted codes of practice. Used to avoid unnecessary effort or to work quicker e.g. failing to check a patients wristband when you have known the patient for some time.
- 6.2.5 **Situational (Reasoned) Violations**
When the procedure is impractical due to time constraints, unusual situations or thought to be in the best interest of a third party e.g. crossing the road against the 'red man'.
- 6.2.6 **Reckless and Repeated Violation** – these are deliberate deviations from accepted behaviour, practices and procedures. There will be foreseeable negative consequences and the employee has deliberately chosen to ignore laid down guidance provided by management via the Trust's Policies and Procedures.
- 6.2.7 **Malicious Violations** – these occur when there is a deliberate intention to cause harm to an individual or individuals or damage to property or the reputation of the Trust. Investigation of this type of incident should follow the Trust's Disciplinary Policy.
- 6.3 **This Statement must be read in conjunction with the Trust's Disciplinary Rules.** There may be rare occasions where legal action, either criminal or civil, has been taken against an individual employee of the Trust. This can be by the Police, Health and Safety Executive or a member of the public. Where internal investigation has shown that there was a systemic failure within the Trust and the employee is not guilty of a Reckless, Repeated or Malicious Violation or Gross Misconduct, that individual will be supported until such times as it is impossible to do so e.g. removal of Registration results in inability to perform contracted duties.
- 7. Monitoring and Review**
- 7.1 Review of adherence to this policy will be carried out by the Manager – CEGARD by auditing the response of managers to incidents within the sphere of authority. This will be carried out on a two yearly basis.

Author: Manager, Clinical Governance and Risk

INCIDENT DECISION TREE

NPSA & NHS Confederation

Start Here for each individual involved



Based on James Reason's Culpability