1 Introduction

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.

It is often difficult for managers to decide whether an incident has involved a reckless, malicious or repeated violation that may warrant subsequent action under the Disciplinary process. To help managers make their decision the National Patient Safety Agency and the NHS Confederation has developed the Incident Decision Tree. This guidance is therefore intended to clarify for managers, Clinical Directors and employees, a number of general principles for follow-up of individual incidents and accidents.

2 Scope

This policy covers the investigation of all incidents, accidents and near misses (clinical and non-clinical).

3 Aims

The guidance aims to support 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.

4 Duties (Roles and responsibilities)

4.1 Clinical Director/Directorate Manager

The responsibility for ensuring consistent application of this policy lies with the Clinical Director of each Directorate supported by the Directorate Manager. They are responsible for reviewing all Directorate incidents to ensure consistent application of the Incident Decision Tree by line managers/investigators.
4.2 Incident investigators/ Final Approvers  
Incident investigators must ensure that a thorough investigation is carried out which establishes the cause(s) of the error so that decisions can be made with regard to the most appropriate course of action.

4.3 Patient Safety and Risk Lead  
The Patient Safety and Risk Lead has a responsibility to raise awareness of the requirements of this policy as part of incident investigator training.

4.4 Human Resources  
Human Resources managers must ensure that staff are offered support, but if appropriate, disciplinary action is implemented in line with the Incident Decision Tree recommendations.

4.5 All Staff  
Staff have a responsibility to report incidents, accidents or near misses as soon as possible following the procedure outlined in the Management and Reporting of Accidents and Incidents Policy.

5 Definitions  
These definitions must always be considered in line with the National Patient Safety Agency Incident Decision Tree (See Appendix 1)

5.1 Causes of Error  
5.1.1 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.

5.1.2 Rule Based Mistake  
Mis-applying a good rule due to assumptions or applying bad rules leading to bad habit formation.

5.1.3 Knowledge Based Mistakes  
Wrong action is chosen due to lack or inappropriate knowledge base.

5.1.4 Routine Violations  
Deliberate deviation from accepted codes of practice. Used to avoid unnecessary effort or to work quicker e.g. failing to check a patient’s wristband when you have known the patient for some time.

5.1.5 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’.
5.1.7 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.

5.1.8 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 Reporting of incidents and accidents and the Trust disciplinary process

6.1 Promoting effective reporting

6.1.1 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.

6.1.2 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.

6.1.3 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.

6.1.4 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.

6.1.5 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.

6.2 Individual incident arising from systems failures

6.2.1 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.

6.2.2 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 1.

6.2.3 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.

6.2.4 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.

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

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

6.3.2 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.

6.3.3 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.
6.4 **Statement to 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 **Training**

All employees receive training on incident reporting at induction, and are shown how to report incidents and near misses. Relevant managers receive incident investigation training to ensure investigations are compliant with Trust policies and procedures.

8 **Equality and Diversity**

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9 **Monitoring compliance**

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of adherence to this guidance</td>
<td>Audit of response of managers to incidents within their sphere of authority</td>
<td>Patient Safety and Risk Lead/Human Resources</td>
<td>The report will be presented to the Clinical group</td>
</tr>
</tbody>
</table>

10 **Consultation and review**

10.1 This guidance will be reviewed every three years by the Patient Safety and Risk Lead and Clinical Risk Group, before being submitted to Internal Audit and Counter Fraud for assurance that it is fraud proofed.

10.2 A decision will be made by the Clinical Risk Group on the appropriateness of involvement of any other group depending on the significance of changes made to the guidance.
11 Implementation (including raising awareness)

This guidance is available to all Trust employees through the intranet, where associated policies can also be found.

The updated policy will also be disseminated to all staff who have a responsibility for implementing the guidance.

12 References

National Patient Safety Association and NHS Confederation- Incident Decision Tree

13 Associated documentation

The following Trust documents should be considered in conjunction with these guidelines:

- Disciplinary Policy/Procedure
- Management and Reporting of Accidents and Incidents Policy
- Serious Incidents – reporting and management policy
- Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims Policy
- Whistleblowing: Policy on Voicing Concerns About Suspected Wrongdoing in the Workplace
Appendix 1

INCIDENT DECISION TREE
NPSA & NHS Confederation

Start Here for each individual involved

Deliberate harm

Were the actions as intended?

Yes

No

Were the adverse consequences intended?

Yes

Consult NCAA or relevant Regulatory body.
Advise Individual to consult Trade Union
Consider  
• Suspension
• Referral to Police and disciplinary/regulatory body
• Occupational Health referral

No

Incapacity

Does there appear to be evidence of ill health or substance abuse?

Yes

Consult NCAA or relevant regulatory body.
Advise Individual to consult Trade Union
Consider  
• Referral to Police and disciplinary/regulatory body
• Occupational Health referral

No

Does the individual have a known medical condition?

Yes

Advise Individual to consult Trade Union Representative
Consider  
• Corrective training
• Occupational Health referral
• Reasonable adjustment to duties
• Improved supervision

No

Foresight

Did the individual depart from agreed protocols or safe procedures?

Yes

Were protocols and procedures available, intelligible, correct and in routine use?

Yes

Consult NCAA or relevant regulatory body.
Advise Individual to consult Trade Union
Consider  
• Corrective training
• Occupational Health referral
• Reasonable adjustment to duties
• Improved supervision

No

Was there evidence that the individual took an unacceptable risk?

Yes

No

Substitution

Would another individual coming from the same professional group, possessing comparable qualifications and experience behave in the same way in similar circumstances?

Yes

Consult NCAA or relevant regulatory body.
Advise Individual to consult Trade Union
Consider  
• Referral to Disciplinary/regulatory body
• Occupational Health referral
• Reasonable adjustment to duties
• Suspension

No

Were there any deficiencies in training, experience or supervision?

Yes

No

Were there significant mitigating circumstances?

Yes

No

System Failure

Review System

Based on James Reason's Culpability Model

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

<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Incidents, Accidents and the Trust Disciplinary Process - Guidelines for Managers, Clinical Directors and Employees</th>
<th>Policy Author:</th>
<th>Jackie Moon. Patient Safety and Risk Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does the policy/guidance affect one group less or more favourably than another on the basis of the following: (* denotes protected characteristics under the Equality Act 2010)</td>
<td>Yes/No?</td>
<td>You must provide evidence to support your response:</td>
</tr>
<tr>
<td></td>
<td>Race *</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
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<tr>
<td></td>
<td>Nationality</td>
<td>No</td>
<td></td>
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<tr>
<td></td>
<td>Gender *</td>
<td>No</td>
<td></td>
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<tr>
<td></td>
<td>Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Religion or belief *</td>
<td>No</td>
<td></td>
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<td></td>
<td>Sexual orientation including lesbian, gay and bisexual people *</td>
<td>No</td>
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<td></td>
<td>Age *</td>
<td>No</td>
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<tr>
<td></td>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health problems *</td>
<td>No</td>
<td></td>
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<tr>
<td></td>
<td>Gender reassignment *</td>
<td>No</td>
<td></td>
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<td></td>
<td>Marriage and civil partnership *</td>
<td>No</td>
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<tr>
<td>2.</td>
<td>Is there any evidence that some groups are affected differently?</td>
<td>No</td>
<td></td>
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<tr>
<td>3.</td>
<td>If you have identified potential discrimination which can include associative discrimination i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic, are any exceptions valid, legal and/or justifiable?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>4(a).</td>
<td>Is the impact of the policy/guidance likely to be negative? (If &quot;yes&quot;, please answer sections 4(b) to 4(d)).</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4(b).</td>
<td>If so can the impact be avoided?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4(c).</td>
<td>What alternatives are there to achieving the policy/guidance without the impact?</td>
<td></td>
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<tr>
<td>4(d).</td>
<td>Can we reduce the impact by taking different action?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Name and Designation of Person responsible for completion of this form: Jackie Moon, Patient Safety and Risk Lead Date: 1st June 2013

Names & Designations of those involved in the impact assessment screening process: Jackie Moon, Patient Safety and Risk Lead

(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.)

For advice on answering the above questions please contact Frances Blackburn, Head of Nursing, Freeman/Walkergate, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk, together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.