Policy Document

Reference: HS23

NHS University Hospitals of North Midlands NHS Trust

Health and Safety Accident and Incident Investigation and External Reporting

Version:	**1**
Date Ratified:	**February 2023 by Executive Health & Safety Group**
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Policy Author:	**Senior Health and Safety Advisor**
Executive Lead:	**Associate Director of Corporate Governance**

Version Control Schedule

Version	Issue Date	Comments
1	March 2023	New Policy

Statement on Trust Policies

The latest version of 'Statement on Trust Policies' applies to this policy and can be accessed here

University Hospitals of North Midlands NHS Trust

Equality Impact Assessment (EIA)

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. The Equality Impact Analysis Form is designed to help consider the needs and assess the impact of each policy. To this end, EIAs will be undertaken for all policies.

Policy Reference, Title and Version Number	HS23 Health and Safety Accident and Incident Investigation Version 1
Summary of changes made on this review	New policy
Please list which service users, staff or other groups have been consulted with, in relation to this	Executive Health and Safety Group All Divisional Health and Safety Leads
Were any amendments made as a result? If yes, please specify	N/A
Does this policy involve the administration or control of medicines? If yes, have the Safe Meds Group been consulted with?	N/A
Which Executive Director has been consulted on?	Associate Director of Corporate Governance
Does this policy have the potential to affect any of the groups listed below differently - please complete the below. Prompts for consideration are provided, but are not an exhaustive list	

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	Actions taken to mitigate negative impact
Age (e.g. are specific age groups excluded? Would the same process affect age groups in different ways?)	No		
Gender (e.g. is gender neutral language used in the way the policy or information leaflet is written?)	No		
Race (e.g. any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)	No		
Religion & Belief (e.g. Jehovah Witness stance on blood transfusions; dietary needs that may conflict with medication offered)	No		
Sexual orientation (e.g. is inclusive language used? Are there different access/prevalence rates?)	No		
Pregnancy & Maternity (e.g. are procedures suitable for pregnant and/or breastfeeding	No		

Group	Is there a potential to impact on the group? (Yes/No/Unsure)	Please explain and give examples	Actions taken to mitigate negative impact
women?)			
Marital status/civil partnership (e.g. would there be any difference because the individual is/is not married/in a civil partnership?)	No		
Gender Reassignment (e.g. are there particular tests related to gender? Is confidentiality of the patient or staff member maintained?)	No		
Human Rights (e.g. Does it uphold the principles of Fairness, Respect, Equality, Dignity and Autonomy?)	No		
Carers (e.g. is sufficient notice built in so can take time off work to attend appointment?)	No		
Socio/economic (e.g. would there be any requirement or expectation that may not be able to be met by those on low or limited income, such as costs incurred?)	No		
Disability (e.g. are information/questionnaires/consent forms available in different formats upon request? Are waiting areas suitable?) Includes hearing and/or visual impairments, physical disability, neurodevelopmental impairments e.g. autism, mental health conditions, and long term conditions e.g. cancer.	No		
Are there any adjustments that need to be made to ensure that people with disabilities have the same access to and outcomes from the service or employment activities as those without disabilities? (e.g. allow extra time for appointments, allow advocates to be present in the room, having access to visual aids, removing requirement to wait in unsuitable environments, etc.)			**Yes/No**
			No
Will this policy require a full impact assessment and action plan? (a full impact assessment will be required if you are unsure of the potential to affect a group differently, or if you believe there is a potential for it to affect a group differently and do not know how to mitigate against this - please contact the Corporate Governance Department for further information)			**Yes/No**
			No

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1. INTRODUCTION

1.1 This policy outlines the procedures that are to be adopted when any accident / Incident that has resulted in or could have resulted in personal injury and any diagnosed occupational disease occurs within the Trust's undertaking.

1.2 The Trust recognises that the investigation of work-related accidents, incidents and ill health forms an essential part of the management of health and safety risk and acknowledges its duty to report to the enforcing authorities including the Health and Safety Executive certain accidents, incidents and occupational diseases.

1.3 In order to comply with its statutory duties, the Trust has put in place such arrangements as are necessary to ensure a good quality investigation into every adverse event leading to incidents and accidents is conducted in order to identify and mitigate any failure in control measures put in place under the sphere of UK health and safety legislation, or where a failure to put in place such control measures has resulted in an accident or incident and/or might indicate a likelihood of a breach of health and safety law.

1.4 All diagnosed cases of occupational disease will be investigated by an investigation team led by the Corporate Health and Safety Team.

1.5 The legal basis for this policy is as follows:

- The Health and Safety at Work etc. Act 1974
- The Management of Health and Safety at Work Regulations 1999 (MHSW)
- The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- The Social Security (Claims and Payments) Regulations 1979

1.5.1 **The Health & Safety at Work Act 1974** places a general duty on the employer to ensure so far as is reasonably practicable, the health, safety and welfare of its staff whilst they are at work.

1.5.2 **The Management of Health and Safety at Work Regulations 1999** place a number of duties on the Trust including having in place arrangements for the effective planning, organisation, control, **monitoring** and review of the preventive and protective measures that arise from the significant findings of a risk assessment.

1.5.3 **The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013** place a duty on the Trust to have in place arrangements which ensure all accidents and incidents involving healthcare sharps are investigated in accordance with the regulations and the guidelines published by the enforcing authority (HSE).

1.5.4 **The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (**RIDDOR) is the law that requires employers, and other people in control of work premises, to report (to the HSE) and keep records of work-related accidents which cause death; work-related accidents which cause certain serious injuries (reportable injuries) or inability to perform their normal work duties, for more than seven consecutive days as the result of their injury; diagnosed cases of certain occupational diseases; and certain 'dangerous occurrences' (incidents with the potential to cause harm).

1.5.5 **The Social Security (Claims and Payments) Regulations 1979** requires among other things that 'Every employer shall take reasonable steps to investigate the circumstances of every accident of which notice is given to him' and 'Every employed earner who suffers personal injury by accident in respect of which benefit may be payable shall give notice of such accident either in writing or orally as soon as is practicable after the happening thereof' and the requirement to 'keep readily accessible a book or books in a form approved by the Secretary of State in which the appropriate

particulars of any accident causing personal injury to a person employed by the employer may be entered by that person or by some other person acting on his behalf'.

1.6 The Trust acknowledges that an investigation is not merely a 'tick-box' exercise but rather a systems-based process for investigating accidents/incidents in order to identify and the factors that led to the event and to identify measures needed to prevent similar unplanned events, and undertakes to adopt the standards and principles of investigation set out in Appendix 1.

1.7 The Trust will adopt a 'just culture' and the philosophy that the primary aim of any health and safety accident/incident investigation is not to apportion blame by adopting a 'blame-shame-retrain' culture but rather to accurately and thoroughly identify what happened and why; and recommend strong/effective systems-based improvements to prevent or significantly reduce the risk of a repeat accident/incident and ensuring organisational memory is maintained whilst ensuring statutory duties are met.

1.8 A 'just culture' is founded on the following three principles:

- Human error is inevitable, and people must not be blamed for making genuine mistakes;
- The primary focus is on learning from mistakes and taking effective steps to reduce and mitigate them in the future; and
- Individuals at all levels are accountable for any intentional or reckless actions or decisions they take that cause or contribute to accidents and incidents.

1.9 The Trust recognises the importance of considering human factors in an investigation and the three interrelated aspects that must be considered: the job, the individual and the organisation. If the system factors are not identified and communicated throughout the organisation, this makes a recurrence more likely.

1.10 Organisational learning is a key aspect of health and safety management. If reporting and follow-up systems are not fit for purpose, for example if a blame culture is adopted, staff will be afraid to report incidents and valuable knowledge will be lost.

1.11 An effective investigation requires a methodical, structured approach to information gathering, collation and analysis with every investigation seeking to consider the following which is illustrated at Appendix 3:

- Work system factors and interactions between each: namely People, Organisation, Tasks, Tools and Technology, Environment (internal and external)
- Processes: Physical, Cognitive, Social/behavioural.
- Outcomes: People, Organisational.

1.12 The Trust recognises that for an investigation to be carried out to an acceptable standard that sufficient training, resources and time must be afforded those responsible for investigating accidents and incidents.

1.13 Investigations will be conducted and managed by persons sufficiently experienced in health and safety investigation and who are to be afforded resources and time commensurate with the requirement to align with legislation, the level of harm or potential harm and the value of any potential learning.

1.14 Use of Datix for reporting work related accidents shall be considered to be the equivalent of an accident book for the purpose of meeting the Trust's legal duty as specified in the Social Security (Claims and Payments) Regulations 1979.

1.15 Statutory RIDDOR notification and reporting deadlines are absolute in law with no latitude provided by the enforcing authority. Appendix 7 Standards of work specify the reporting requirements.

2. SCOPE

2.1 This policy applies to all Trust managers and employees operating on any of our sites, or within community settings, such as patients' homes; and to all work systems and tasks under the control of the Trust and its employees.

2.2 The policy's scope extends to the investigation of accidents/incidents and cases of diagnosed occupational disease in staff and involving work practices where duties exist under health and safety legislation.

2.3 The policy is not concerned with the conduct of any clinical operation, examination or other medical treatment, procedure or diagnostics being carried out by or under the supervision of a registered health profession however its remit does apply to any duties held under the relevant health and safety legislation whilst engaged in such healthcare activities.

3. DEFINITIONS

72 hour Health and Safety Report	Not to be confused with the 72 Hour report referred to in Policy RM07.
Accident	An accident is a separate, identifiable, unintended incident, which causes physical injury. This specifically includes acts of non-consensual violence to people at work.
Competence	The ability to perform a particular job in compliance with performance standards (that is suitably trained and with sufficient experience and understanding to safely perform the assigned work without supervision or with only a minimum degree of supervision).
Control measure	A measure taken to reduce exposure to a hazard (including the provision of systems of work and supervision, training, the cleaning of workplaces, premises, maintenance of plant and equipment, the provision and use of engineering controls and personal protective equipment etc.).
Dangerous occurrence	Any reference made to a dangerous occurrence in this policy shall be taken to be referring to a RIDDOR reportable dangerous occurrence.
Handler	Person responsible for ensuring an investigation is completed in accordance with Policy. The handler is not necessarily the lead investigator.
Hazard	Anything with the potential to cause harm, damage or loss.
HSE	Health and Safety Executive
Human factors	The scientific discipline concerned with the understanding of interactions among humans and other elements of a system, and the profession that applies theory, principles, data, and methods to design in order to optimize human well-being and overall system performance (International Ergonomics Association, 2000)
Immediate cause	The agent of injury or ill health e.g. the blade, the substance, the dust etc. And/or the most obvious reason why an adverse event happens, e.g. the guard is missing; the employee slips etc. There may be several immediate causes identified in any one adverse event.
Incident/adverse event	May be used to describe near misses and undesired circumstances and interchangeably to describe accidents.
Lesson/ learning	Should identify safety and environmental lessons that when published to the wider Trust/Division/Department will contribute to the development of safe systems of work. In this context a lesson is defined as: a. an experience, example or observation that imparts beneficial new knowledge or wisdom; and / or b. it is something that can be analysed to produce recommendations and / or actions. Lesson learning goes hand in hand with acting upon the findings of an investigation.
Local rationality	In relation to an adverse event, local rationality is about considering 'What they

	were thinking at the time and why, and at that time, knowing what they knew at that time, did the decision they made make sense to them?
Near miss	An event that, while not causing harm, has the potential to cause injury or ill health.
NHS 'Never event'	Defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.
Organisational memory	The knowledge that has been retained from past experiences, which resides in the organisation and can be used towards making decisions.
P.E.A.C.E.	The five stages of managing the interview process: 1. Preparation and Planning 2. Engage and Explain 3. Account 4. Clarification, Challenge • Closure 5. Evaluation.
RIDDOR	An acronym for the 'Reporting of Injuries, Diseases and Dangerous Occurrence Regulations'. A set of regulations which sit under the statutory umbrella of the Health and Safety at Work etc. Act 1974, and supplement the requirements under the Trust's Policy for Reporting of Adverse Incidents, in reporting those outlined in statute to the Health and Safety Executive.
Risk	The likelihood that the potential for harm to the health of a person will be attained under the conditions of use and exposure and also the extent of that harm.
Risk Assessment	The process of estimating the likelihood of occurrence of specific undesirable events (the realisation of identified hazards), and the severity of the harm or damage caused, together with a value judgement concerning the significance of the results. It therefore has two distinct elements: risk estimation and risk evaluation.
Risk control measure	Workplace precautions put in place to reduce the risk to a tolerable level.
Root cause	The failure from which all other failings grow, often remote in time and space from the adverse event e.g. failure to identify training needs and assess competence, low priority given to risk assessment etc.
SI	Serious incident (Patient)
Significant hazard	A hazard is significant if it can cause: Serious harm, or. any degree of non-trivial harm, depending on individuals' level of exposure to it, or Harm which does not usually manifest itself or become detectable until significant time has elapsed e.g. exposure to asbestos or other hazardous substances that might cause cancer or genetic mutations.
Systems approach/Systems thinking	Recognition that the performance of an enterprise depends on a dynamic and inter-related set of parts; the focus on systems as a route to safety and productivity.
Systems-based safety incident investigation process	Breaking down a complex arrangement into simple units to assist understanding of the complexity, interactive nature and interdependence of the various external and internal factors.
Underlying cause	Unsafe acts and unsafe conditions e.g. the guard removed, the ventilation switched off etc.
Undesired circumstance	A set of conditions or circumstances that have the potential to cause injury or ill health, e.g. untrained nurses handling heavy patients, pallet stacked too high. Not to be confused with 'near miss' or 'dangerous occurrence'.
Woolf Reforms	A programme of reforms to the civil justice system implemented in April 1999, based upon a report by Lord Woolf and known as the Woolf reforms.

4. ARRANGEMENTS

4.1 The Handler of a health and safety accident/ incident should in most cases be the line manager of an injured person and/or holding the greatest operational control over a work system and/or work process or a person, being suitably experienced nominated by them. In most cases, there is an expectation that the line manager, their deputy of a person nominated by them shall lead an investigation.

4.2 Where there is disagreement as to responsibility for investigating an instruction to nominate a handler will be passed by the Head of Health and Safety or in their absence the Associate Director of Corporate Governance or Deputy Associate Director of Corporate Governance to an appropriate divisional manager who should appoint a handler under the authority of this policy.

5. ROLES AND RESPONSIBILITIES

5.1 Chief Executive/Associate Director of Corporate Governance

5.1.1 The Chief Executive Officer (CEO) has overall responsibility for the health and safety of all persons who are affected by Trust work activities.

5.1.2 It is his/her duty, with on-going responsibility for delivery through the Associate Director of Corporate Governance, so far as is reasonably practicable to:

- Ensure that the relevant health and safety requirements and standards, both nationally and locally imposed, are met.
- Monitor the management of this policy and associated standard operating procedures, and ensure all recommended and agreed corrective actions are implemented.
- Set priorities against identified problems and ensure sufficient resources are allocated, in terms of human time, effort and finance.

5.2 Chief Operating Officer/Deputy Chief Operating Officer

5.2.1 In the event of a failure by Divisions to furnish the Corporate Health and Safety Team necessary information to enable timely notification of RIDDOR reportable incidents by them to the HSE, the Chief Operating Officer or their deputy will act as the corporate escalation point and take necessary steps to effect the provision of information required in by the Corporate Health and Safety Team, by responsible persons, to enable an informed decision to be made by them within the prescribed timescale, as to whether an incident is reportable to the enforcing authority under RIDDOR or not.

5.3 Executive Directors/Divisional Senior Managers/Heads of Service/Divisional Health and Safety Leads

5.3.1 Executive Directors/Divisional Senior Managers/Heads of Service and those deputising for them are responsible for enforcing compliance with this policy within their power of influence.

5.3.2 Provide such support as is necessary to enable those under their charge to fulfil duties including diverting resources necessary to ensure compliance.

5.3.3 In the event of a failure by Wards/Departments within their division to furnish the Corporate Health and Safety Team with necessary information within a 72 hour Health and Safety report to enable timely notification of RIDDOR reportable incidents by them to the HSE, will act as the final divisional escalation point and take necessary steps to effect the provision of information required by the Corporate Health and Safety Team, by responsible persons, to enable an informed decision to be made by them within the prescribed timescale, as to whether an incident is reportable to the enforcing authority under RIDDOR or not.

5.4 Line Managers/Deputy Line Managers

5.4.1 Line managers and those deputising for them are responsible for enforcing compliance with this policy and associated systems of work among those under their accountability.

5.4.2 Line managers and/or those deputising for them are to make every reasonable effort to ensure that all health and safety accidents and incidents occurring within their area of responsibility have been

reported using Datix within 24 hours of an incident and that the Datix is reviewed and investigation commenced in a sufficiently timely fashion with a view to identifying system and other causative factors. Where a member of staff under their command is for whatever reason unable to complete a Datix within 24 hours of an incident, the line manager or a person deputised by them shall ensure a Datix entry is made so far as reasonably practicable within 24 hours of an incident's occurrence.

5.4.3 All line managers are to ensure sufficient numbers of staff, having consideration of periods of absence, complete training in incident investigation delivered by the Corporate Health and Safety Team in order that all investigations can be commenced without undue delay.

5.4.4 Provide such cooperation as necessary to the Corporate Health and Safety Team to enable them to notify the enforcing authority (HSE) within legal deadlines.

5.5.5 Where it is not possible to fulfil duties specified in this policy, escalate through the management chain.

5.4.6 When requested by any investigation handler or lead investigator, line managers will make every reasonable effort to release staff from their duties to take part in health and safety investigations.

5.4.7 Managers should wherever possible accommodate any request by a Trade Union representative to be included in an investigation into an accident or incident.

5.4.8 Where lessons are learnt, managers should ensure that appropriate corrective action is taken, risk assessments reviewed and updated and monitor the effectiveness of new or revised control measures and ensure that all stakeholders are made aware of changes to existing management systems or processes.

5.5 All Trust employees

5.5.1 Trust employees have a duty to report the known details of all accidents or incidents that cause injury to them or with the potential to cause injury, to their line manager or a person deputised by them as soon as is practicable after the event and in any case before the end of a shift in which engaged at the time of the accident/incident.

5.5.2 Every reasonable effort should be made by the above-mentioned employee to report the details of the accident or incident using Datix within 24 hours of the event and/or where this is not practicable, to inform their line manager by any reasonable means.

5.5.3 No team or individual including contracted staff working on their behalf, are permitted to submit a RIDDOR report for which the Trust owns a statutory duty to notify, except those specifically authorised with such under the authority of this policy.

5.5.4 Every employee is expected to provide their full co-operation to enable the investigation of all health and safety incidents and the submission of accurate RIDDOR reports to the enforcing authority within the statutory deadlines.

5.6 Corporate Health and Safety Team

5.6.1 Provide specialist health and safety legislative advice across all tiers of Trust management hierarchy insofar as the investigation of accidents and incidents is concerned and the notification and reporting thereof to the Health and Safety Executive.

5.6.2 Review every Datix and 72 Hour Health and Safety report form relating to 'Incidents affecting the STAFF/ Accident / Incident that has resulted in or could have resulted in personal injury' and all patient falls resulting in an SI.

5.6.3 Make the final decision as to whether any accident or incident is reportable to the Health and Safety Executive under RIDDOR and IRR17.

5.6.4 Escalate through the prescribed management route in the event of a failure by Wards/Departments to furnish the Corporate Health and Safety Team with necessary information within a 72 hour Health and Safety report to enable timely notification of RIDDOR reportable incidents by them to the HSE.

5.6.5 Notify the Health and Safety Executive in the prescribed fashion all RIDDOR and IRR17 reportable accidents/incidents within the statutory timescales.

5.6.6 Manage all requests by the HSE to exercise its inspection and enforcement powers on Trust premises.

5.6.7 Develop information, instruction and training in accident and incident investigation and deliver such to Trust staff as required.

5.6.8 Health and safety professionals to maintain own competency though CPD.

5.6.9 Monitor compliance with the relevant regulations and Trust policy.

5.6.10 Provide support necessary to embed processes specified in Standards of Work at Ward/departmental level, providing information, instruction, training and on-going advice and guidance to persons responsible for investigation.

5.6.11 Assume the role of lead investigator where professional judgement deems it necessary.

5.7 Department of Nursing

5.7.1 Notify responsible persons including the Corporate Health and Safety Team, of the detection of Serious Incidents (SI) involving patient falls.

5.8 Contractors

5.8.1 Contractors and the Trust's partners remain responsible for fulfilling their legal duties under RIDDOR.

6. INFORMATION, INSTRUCTION AND TRAINING AND PLAN OF IMPLEMENTATION

6.1 All line managers who it is reasonable to expect will have responsibility for investigating a health and safety incident are required to attend 205 RIDDOR and Accident Investigation Workshop which can be booked via ESR.

7. MONITORING AND REVIEW ARRANGEMENTS

7.1 Monitoring Arrangements

7.1.1 The Corporate Health and Safety Team share with the Executive Health and Safety Group a monthly Incident Data Analysis Report plus associated safety statistics and learning one week prior to each monthly Executive Health and Safety Group meeting.

7.1.2 Monitor compliance with statutory reporting timeframes e.g. RIDDOR notification to HSE through Executive Health and Safety Group.

7.1.3 This policy is to be reviewed within one year of initial ratification, unless changes in national legislation override this or there has been a specific request to review sooner; and thereafter every three years unless changes in national legislation override this or there has been a specific request to review sooner.

7.1.4 RIDDOR reportable accidents/incident investigation governance is monitored through RCA panels for quality and content and shared learning.

8. REFERENCES

8.1 HSE (1999) The Management of Health and Safety at Work Regulations 1999 available at: https://www.legislation.gov.uk/uksi/1999/3242/contents/made (Accessed 28/09/2022)

8.2 HSE (2013) The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 available at: https://www.legislation.gov.uk/uksi/2013/1471/contents/made (Accessed 28/09/2022)

8.3 HSE (2013) Health Services Information Sheet. Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 available at: https://www.hse.gov.uk/pubns/hsis7.pdf (Accessed 15/10/2021)

8.4 HSE (2013) A brief guide to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) available at: https://www.hse.gov.uk/pubns/indg453.pdf (Accessed 28/09/2022)

8.5 HSE (2004) HSG245. Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals available at: https://www.hse.gov.uk/pubns/hsg245.pdf (Accessed 28/09/2022)

8.6 HSE (2013) Health Services Information Sheet No 1 (Rev4) Reporting injuries, diseases and dangerous occurrences in health and social care. Guidance for employers available at: https://www.hse.gov.uk/pubns/hsis1.pdf

8.7 BASHH (2021) UK guideline for the use of HIV post-exposure available at: prophylaxis 2021 http://www.bashhguidelines.org/media/1308/pep-2021.pdf (Accessed 20/10/2022)

APPENDIX 1

STANDARDS AND PRINCIPLES OF INVESTIGATION

STANDARDS

1.0 STRATEGIC

All managers ensure:

1.1 Oversight and Governance

1.1.1 An environment of just culture, learning and continuous improvement is encouraged by supporting and promoting these standards and principles.

1.1.2 Time and resources are invested in supporting investigations and subsequent delivery of improvement actions.

1.1.3 Ensure statutory external reporting compliance is analysed and reported on at divisional governance/health and safety meetings.

1.2 Planning

1.2.1 Investigation planning should follow the following format:

- Writing an initial incident statement (e.g. A staff nurse slipped on the corridor between A and B bay injuring her left shoulder) will aid the investigator in maintaining focus on relevant factors.
- Identify the investigation team membership including key people.
- Identify whether any specialist input is required e.g. Engineer.
- Put in place contingency measures to cover annual leave etc.
- Identify time objectives and deadlines e.g. meeting statutory reporting deadlines such as RIDDOR.
- Identify what resources are required e.g. meeting rooms.

1.3 Timely and Responsive

1.3.1 Investigations are started as soon as possible after the adverse event is identified and otherwise without undue delay.

1.4 Objective

1.4.1 If possible and practicable investigations are not conducted by people directly involved in an adverse event.

1.4.2 A team approach to investigation should be adopted and consist of more than one person (in addition to any panels) to provide multiple perspectives.

1.5 Resourced

1.5.1 All health and safety adverse event investigations should ideally be led by staff who have as a minimum attended the '205 RIDDOR and Accident Investigation' Course/Workshop.

1.5.2 Subject matter experts e.g. Clinical Technology, should have an appropriate level of knowledge and skills where their advice is sought and/or engineering reports etc. are requested. Investigation leads must confirm that the necessary knowledge and skills are held.

2.0 PREVENTATIVE

Managers and Investigators ensure:

2.1 Learning and prevention of recurrence

2.1.1 Investigations are conducted for the purpose of learning and identifying improvements which prevent or significantly reduce recurrence and to ensure statutory compliance.

2.1.2 Use of skilled analysis to move the focus of investigation from the acts or omissions of staff, to identifying the underlying causes of the incident and looking at what was wrong in the system will help the Trust to learn lessons that can actually make a difference to our safety culture and prevent similar incidents from recurring.

2.1.3 Development of a learning culture to establish a positive 'safety culture' with lessons learnt considered to be 'business as usual'.

2.1.4 Systemic, deep-seated, interconnected causal factors are identified and acted on to sustainably prevent or measurably reduce recurrence.

2.1.5 Investigation findings are shared, with preventative actions identified and acted upon.

2.1.6 Where an investigation identifies risks are that might have wider implications, this is appropriately escalated in line with the Trust's risk management processes.

3.0 COLLABORATIVE

Managers and Investigators ensure:

3.1 Collaboration and cooperation

3.1.1 Every reasonable effort is made to collaborate and cooperate with cross-departmental investigations.

3.1.2 Barriers where different departments operate in 'silos' inhibit organisational learning and are therefore avoided.

4.0 FAIR AND JUST

Managers ensure:

4.1 Fair and Just

4.1.1 Unfair blame i.e. 'blame – shame – retrain' culture is avoided. Referral for individual management/ performance review or disciplinary action is only appropriate for acts of gross misconduct, wilful harm or wilful neglect.

4.1.2 Phrases such as 'Staff to take more care' etc. and words to that effect should never be considered as appropriate actions to prevent accidents.

4.2 Open, Honest and Transparent

4.2.1 Persons involved in an adverse event are not to be excluded from the investigation process.

4.2.2 Persons involved in the adverse event are informed of the findings of the investigation.

4.2.3 Affected employees are offered/signposted to professional support services where required to further aid recovery.

5.0 PEOPLE FOCUSED

Managers ensure:

5.1 Support

5.1.1 Staff involved in accidents remain active and supported participants in any investigation.

5.1.2 The investigation should be carried out with the intent of adopting a non-hierarchical approach that gives everyone an equal opportunity to input and learn and values all viewpoints. The safety incident investigation focuses not on accountability but on learning.

6.0 EXPERT/CREDIBLE

Senior managers ensure:

6.1 Trustworthy

6.1.1 The professionalism of investigators is promoted and supported e.g. supporting attendance on Training.

6.2 Systems-based

6.2.1 Accuracy and credibility of investigations requires a methodical, structured approach to information gathering, collation and analysis and the investigation regards incidents as faults in a system in which individuals are present (as patients or staff), rather than individual fault.

6.2.2 Follow a planned and pre-determined process. See Appendix 3.

6.3 Adept

6.3.1 Investigations are conducted by teams with experience and knowledge of safety investigation and procedures to command the confidence of staff, patients and the public.

7.0 PRINCIPLES OF INVESTIGATION

7.1 Prioritise all of the People involved in the incident and seek multiple perspectives when attempting to understand system safety.

7.2 Avoid blaming individuals (departments & organisations), focus learning at the system level. Avoid a 'Blame – Shame – Retrain' culture.

7.3 Recognise that system safety is everyone's responsibility.

7.4 Safety incidents are often caused by multiple, interacting contributory factors from across the system.

7.5 Safety is an emergent property of systems; it does not reside in a person, device or department of an organisation or system.

7.6 Consider 'human error' as a symptom of a system problem, not its cause.

7.7 Recognise that there may be no single 'root cause' of a safety incident in highly complex systems.

7.8 Adopt a systems approach to investigation, learning and improvement.

7.9 Recognise the need to learn from everyday work as well as past safety incidents

7.10 Consider both the Context AND the Situation.

7.11 It is critical to explore and reconcile ‘work-as-imagined’ and ‘work-as-done’.

7.12 Consider Local Rationality when learning from previous safety incidents.

7.13 Explore performance variability (trade-offs and adaptations etc.)

7.14 Recommendations for improvement should focus on systemic change and redesign, rather than individual performance.

APPENDIX 2

PRIORITISATION OF RESOURCES

The resources released to an investigation including time, and the depth and scope of the investigation should be prioritised by hierarchy and investigation carried out to the commensurate depth and appropriately resourced.

The hierarchy is as follows:

- Regulatory alignment e.g. RIDDOR reporting deadlines.
- National never events e.g. falls from poorly restricted windows, chest/neck entrapment in bed or trolley rails, scalding of patients.
- Rare, unforeseen events with very high impact.
- Level of harm.
- Frequency of similar incidents.
- Miscellaneous.

There are three investigation levels

Level	**Definition**	**Minimum internal investigative depth and resources**
Level 1	Any accident/incident that is not reportable to the enforcing authority	Basic investigation. (Sharps investigations to statutory guidelines.)
Level 2	Any accident/incident that is reportable to an enforcing authority or deemed to require level 2 investigation on the professional judgement of the Corporate Health and Safety Team or on the judgement of Divisional or Corporate Management.	Basic investigation plus an in depth analysis of system factors. 'RCA' report. Lead investigator/Handler to present to a panel led by the Corporate Health and Safety Team.
Level 3	Any non-sharps related RIDDOR Dangerous Occurrence and any case of diagnosed Occupational Disease or deemed to require level 3 investigation on the professional judgement of the Corporate Health and Safety Team.	Basic investigation plus an in depth analysis of system factors. 'RCA' report. Investigation led by Corporate Health and Safety Team To be heard at a Corporate Health and Safety Team led panel.

Basic investigation

Minimum requirements:

- Identify the risk control measures which were missing, inadequate or unused.
- Compare conditions/practices as they were with that required by current legal requirements, codes of practice and guidance.
- Identify additional measures needed to address the immediate, underlying and system causes.
- Provide meaningful recommendations and/or actions which can be implemented. (Woolly recommendations such as 'staff must take care' show that the investigation has not delved deep enough in search of the real causes.

APPENDIX 3

INVESTIGATION PROCESS

1. Ensure a Safe System of Work is followed when managing all accidents and incidents. To achieve this, the following procedure should be adopted.

    - Ensure that the area and/or any plant/equipment is made safe and poses no risk to other persons.
    - If necessary use a barrier to restrict access and where deemed appropriate, undisturbed until advised otherwise by an appropriately qualified person).
    - Ensure first-aid is provided to persons who might have suffered injury.
    - Inform the injured person's manager (or a responsible person) of the incident.

2. Ensure the preliminary and basic details of the adverse event have been recorded using Datix, or if not readily available use pen and paper to record details that might be beneficial to a later investigation e.g. basic details of what happened (incident statement), times, names of witnesses, description of equipment involved etc.

3. Plan the investigation. Decide who will lead the investigation and what resources will be required.

4. Once the scope of the investigation has been established all investigations should follow the following process, the order of which does not require strict adherence:

    - Step one: Gathering the information.
    - Step two: Analysing the information.
    - Step three: Identifying risk control measures.
    - Step four: The action plan and its implementation.
    - Step five: Learning that ensures the maintenance of organisational memory.

5. Investigators should be prepared to gather information relating to the event from any number of sources including but not limited to the following:

    - Visiting the scene.
    - Making drawings and taking photographs.
    - Checking records e.g. training records and risk assessments.
    - Interviewing witnesses.
    - Taking written statements.
    - Requesting engineer reports.
    - Reconstructing.
    - Using a storyboard.
    - Developing time logs.

6. Once information has been gathered, the investigator will analyse the information with a systems approach mind-set that avoids a ‘blame-shame-retrain’ culture.

7. During analysis investigators should consider the four varieties of human work as follows when investigating and look to establish any differences:

    - Work-as-imagined (by national guidelines, legislation etc.)
    - Work-as-prescribed (local/Trust policies/SOPs)
    - Work-as-disclosed (How we’re told the work is done)
    - Work-as-done (How the work is actually done)

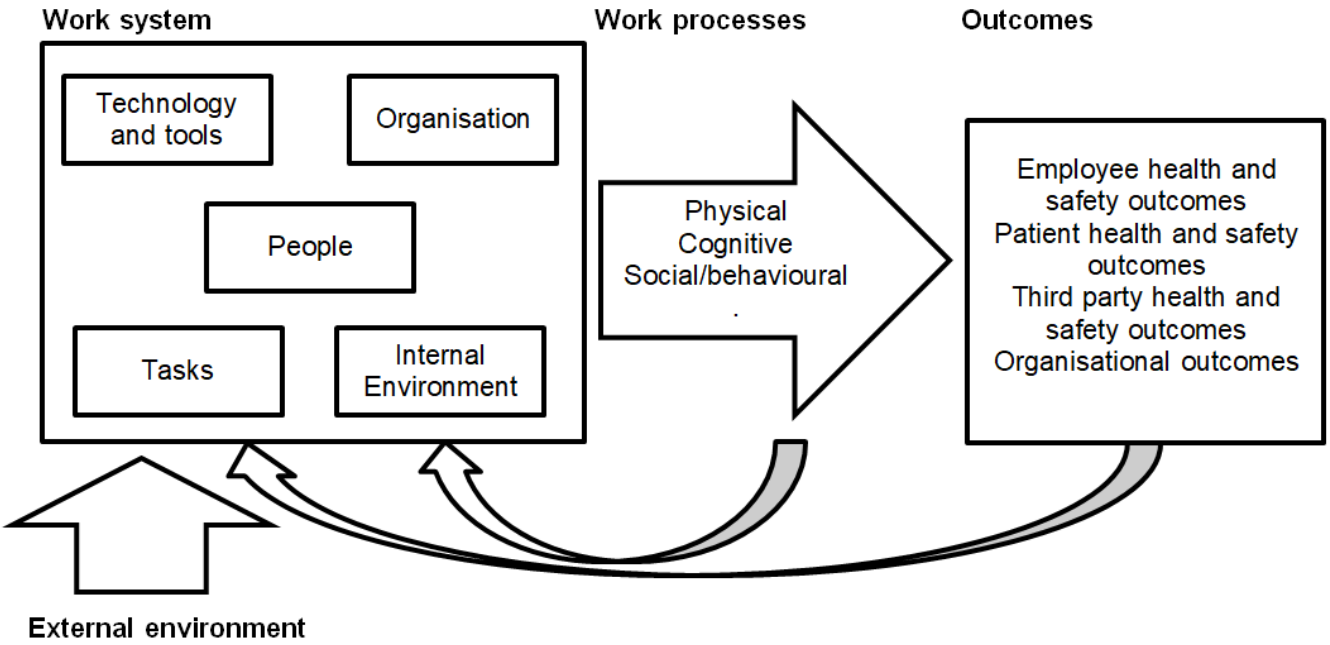


Figure 1.

8. An RCA Report is required for all RIDDOR reportable accidents/incidents with relevant line manager attendance at panels requested as appropriate.

9. As a minimum the following documents where relevant and available should be uploaded to the Datix:

- Risk assessment pre and post-accident/incident.
- Training records.
- Relevant policies and Standard operating procedures in place at time of incident.
- Witness statements.
- Maintenance and/or inspection records.
- RIDDOR report (where an accident/incident is RIDDOR reportable)
- Photographs, CCTV etc.

APPENDIX 4

INTERVIEWING

A health and safety accident/incident investigation interview should be considered to be and come across as a conversation between colleagues with the aim of solving a problem.

The investigator conducting an interview should follow the five stages of managing the interview process:

- **P**reparation and Planning
- **E**ngage and Explain
- **A**ccount
- **C**larification, Challenge, Closure
- **E**valuation.

Without good listening skills you cannot hope to gather all relevant information.

You should:

- Set your own opinions aside.
- Focus on what the person is saying, not what you will say.
- Don't be afraid to be silent.
- Check your understanding.
- Do not interrupt or finish the person's sentences.
- Avoid the jump to an instant solution.

Good responding

- Use plain English and avoid jargon.
- Use paraphrasing skills to feed back the key points.
- Demonstrate acceptance of the perspective the person has.
- Keep in mind that how you say things is just as important as what you say.
- Be clear on what you will do next.

Consider

- Giving verbal encouragers (e.g. 'mmm').
- Acknowledging any evident distress.
- Not providing information or signpost until you have listened.
- Not using clichés such as : "I understand how you feel."
- Not using statements that begin with "You should" "You will".

Good endings

- Summarise the conversation you have had
- Agree any next steps or action points
- Confirm what record of the conversation will be available?
- Advise if there will be more contact?
- Ensure relevant contact details are known?
- Establish if there any preferred method or route of contact?

KEY LISTENING SKILLS

- Pay attention - One goal of active listening is to set a comfortable tone and allow time and opportunity for the other person to think and speak. Pay attention to your frame of mind as well as your body language. Be focused on the moment and operate from a place of respect.

- Withhold judgment - Active listening requires an open mind. As a listener and a leader, you need to be open to new ideas, new perspectives and new possibilities. Even when good listeners have strong views, they suspend judgment, hold their criticism and avoid arguing or selling their point right away.

- Reflect - Learn to mirror the other person's information and emotions by paraphrasing key points. Don't assume that you understand correctly or that the other person knows you've heard them. Reflecting is a way to indicate that you and your counterpart are on the same page.

- Clarify - Don't be shy to ask questions about any issue that is ambiguous or unclear. Powerful, open-ended, clarifying and probing questions are important tools. They draw people out and encourage them to expand their ideas, while inviting reflection and thoughtful response.

- Summarize - Restating key themes as the conversation proceeds confirms and solidifies your grasp of the other person's point of view. It also helps both parties to be clear on mutual responsibilities and follow-up. Briefly summarize what you have understood, and ask the other person to do the same.

- Share - Active listening is first about understanding the other person, then about being understood. As you gain a clearer understanding of the other person's perspective, you can then introduce your ideas, feelings and suggestions. You might talk about a similar experience you had or share an idea that was triggered by a comment made previously in the conversation

APPENDIX 5

A MANAGERS' GUIDE TO THE REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS 2013 (RIDDOR)

This guide is aimed at line managers with responsibility for accident/incident investigation including inpatient falls and provides simplified information as to RIDDOR requires deaths and injuries to be reported only when:

- there has been an accident which caused the injury
- the accident was work-related
- the injury is of a type which is reportable

What is an 'accident'?

In relation to RIDDOR, an accident is a separate, identifiable, unintended incident/adverse event, which causes physical injury. This specifically includes acts of non-consensual violence to people at work.

Injuries themselves, e.g. 'feeling a sharp twinge', are not accidents. There must be an identifiable external event that causes the injury, e.g. a falling object striking someone. Cumulative exposures to hazards, which eventually cause injury (e.g. repetitive lifting), are not classed as 'accidents' under RIDDOR.

What is meant by 'work-related'?

RIDDOR only requires you to report accidents if they happen 'out of or in connection with work'. The fact that there is an accident at work premises does not, in itself, mean that the accident is work-related – the work activity itself must contribute to the accident. An accident is 'work-related' if any of the following played a significant role:

- the way the work was carried out
- any machinery, plant, substances or equipment used for the work or
- the condition of the site or premises where the accident happened

Example 1: A nurse has just finished his shift and decides to run down a corridor towards the exit to get home quicker. As he is running he inverts his ankle causing an injury that results in him being off work for more than 7 days.
Although the member of staff has suffered an accident at his place of work and is unable to perform his duties for more than 7 days, this is not RIDDOR reportable.
Rationale: The nurse was not on duty albeit at his place of work and therefore the way the work was carried out was not a factor. No Trust machinery, plant, substances or equipment played a significant part in the event and there is nothing to indicate that the condition of the site or premises where the accident happened in any way contributed.
Example 2: A Nursing Assistant is asked to go to the other end of a ward to fetch a piece of equipment and decides to run down a corridor due to the perceived urgency. As she is running she twists her ankle causing a soft tissue injury as she turns the corner resulting in a 10 day period of sickness absence.
This accident is deemed to be RIDDOR reportable as an over-7-day injury.
Rationale: The nurse was on duty and therefore way the work was carried out (running down the corridor) played a significant part in the accident.

What are 'reportable' injuries?

The following injuries are reportable under RIDDOR when they result from a work-related accident:

- The death of any person.
- Specified Injuries to workers.
- Injuries to workers which result in their incapacitation for more than 7 days.
- Injuries to non-workers which result in them being taken directly to hospital for treatment, or specified injuries to non-workers which occur on hospital premises e.g. fractured neck of femur following an in-patient fall.

Specified Injuries

- Fractures, other than to fingers, thumbs and toes.

- Amputation of an arm, hand, finger, thumb, leg, foot or toe.
- Any injury likely to lead to permanent loss of sight or reduction in sight in one or both eyes.
- Any crush injury to the head or torso, causing damage to the brain or internal organs.
- Burns which cover more than 10% of the whole body's total surface area or cause significant damage to the eyes, respiratory system or other vital organs.
- Scalping requiring hospital treatment.
- Loss of consciousness caused by head injury or asphyxia.
- Injury arising from working in an enclosed space which
  - leads to hypothermia or heat-induced illness or
  - requires resuscitation or admittance to hospital for more than 24 hours

Over-7-day incapacity/injury
Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury.

Dangerous Occurrences
These tend to be incidents with a high potential to cause death or serious injury, but which happen relatively infrequently. The following incidents are reportable as dangerous occurrences:

- The collapse, overturning or failure of any load-bearing part of any lifting equipment (e.g. patient hoist), other than an accessory for lifting (e.g. sling).
- The failure of any closed vessel, its protective devices or of any associated pipework (other than a pipeline) forming part of a pressure system as defined by regulation 2(1) of the Pressure Systems Safety Regulations 2000, where that failure could cause the death of any person.
- Any plant or equipment unintentionally coming into:
  - contact with an uninsulated overhead electric line in which the voltage exceeds 200 volts; or
  - close proximity with such an electric line, such that it causes an electrical discharge.
- Any accident or incident which results or could have resulted in the release or escape of a biological agent likely to cause severe human infection or illness. Sharps injuries where the source is known to be positive for a blood borne virus of either Hepatitis B, C and/or HIV) shall be classed as dangerous occurrences.
- The malfunction of:
  - a radiation generator or its ancillary equipment used in fixed or mobile industrial radiography, the irradiation of food or the processing of products by irradiation, which causes it to fail to de-energise at the end of the intended exposure period; or
  - equipment used in fixed or mobile industrial radiography or gamma irradiation, which causes a radioactive source to fail to return to its safe position by the normal means at the end of the intended exposure period.
- Certain incidents involving the complete or partial collapse (including falling, buckling or overturning) of scaffolding.
- Certain incidents resulting in structural collapse.
- Any unintentional explosion or fire resulting in the suspension of normal work in those premises, for more than 24 hours.
- Release of flammable liquids and gases where the quantity exceeds a quantity specified by the HSE.
- Unintended release or escape of any substance which could cause personal injury to any person other than through the combustion of flammable liquids or gases.

APPENDIX 6

RIDDOR REPORTING STANDARD OF WORK

RIDDOR REPORTING STANDARD WORK					
Last updated:	[Insert]	**Owner:**	Head of Health & Safety	**Performed by:**	Health & Safety Team
Duration:		**Revised By:**	Head of Health & Safety	**Revision #:**	3
		Trigger:	Executive Routine Meetings	**Done:**	

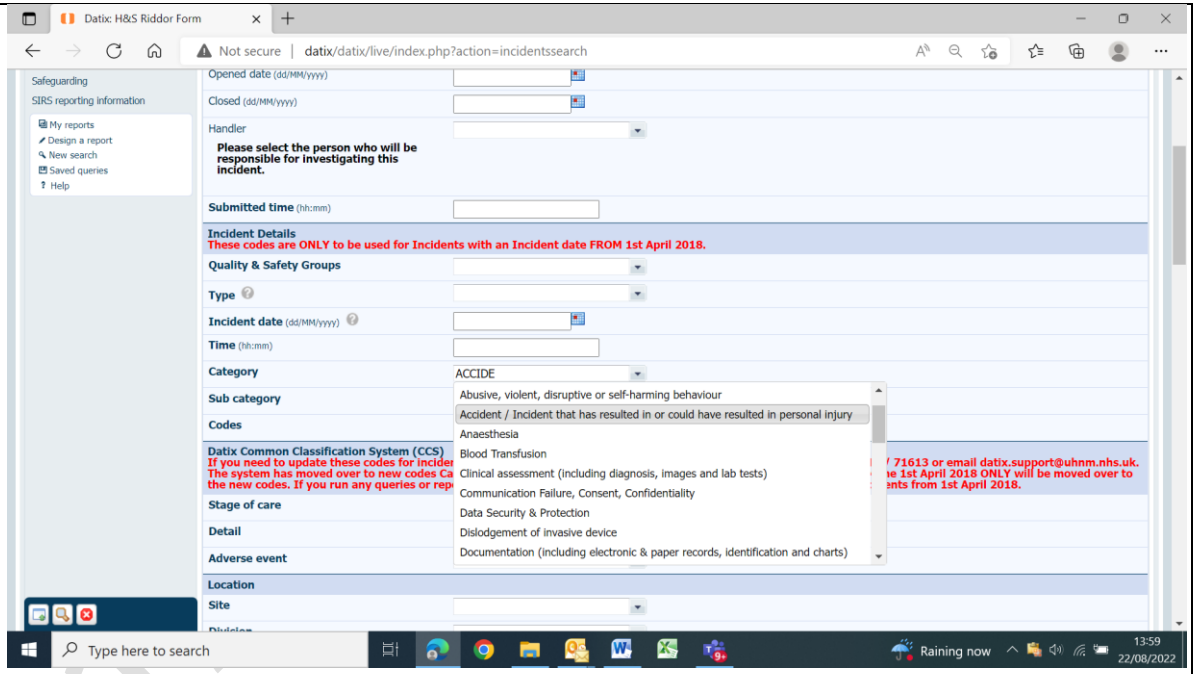
Purpose: The standard of work detailed below specifies the reporting requirements to ensure that the Trust is in compliance with its regulatory duty under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, (RIDDOR).

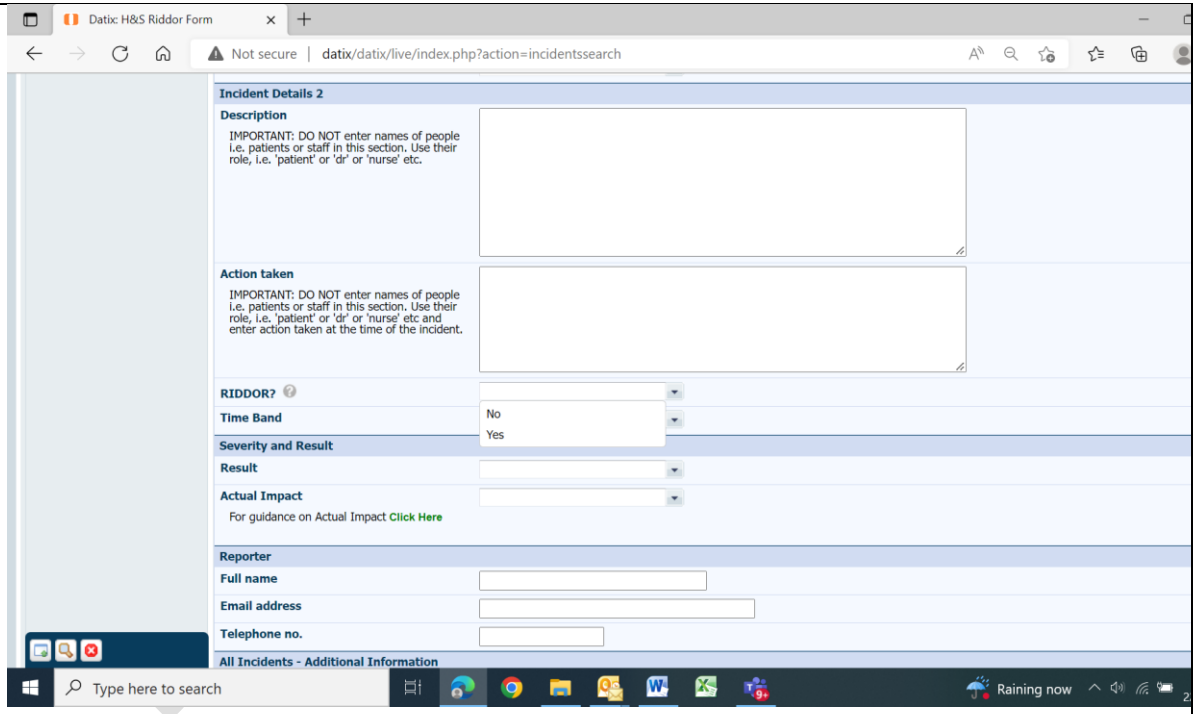
The RIDDOR Regulations determine that incidents that occur at work and in connection with the way in which work is carried out must be reported to the Enforcement Agency, Health and Safety Executive, within the following timeframes:-

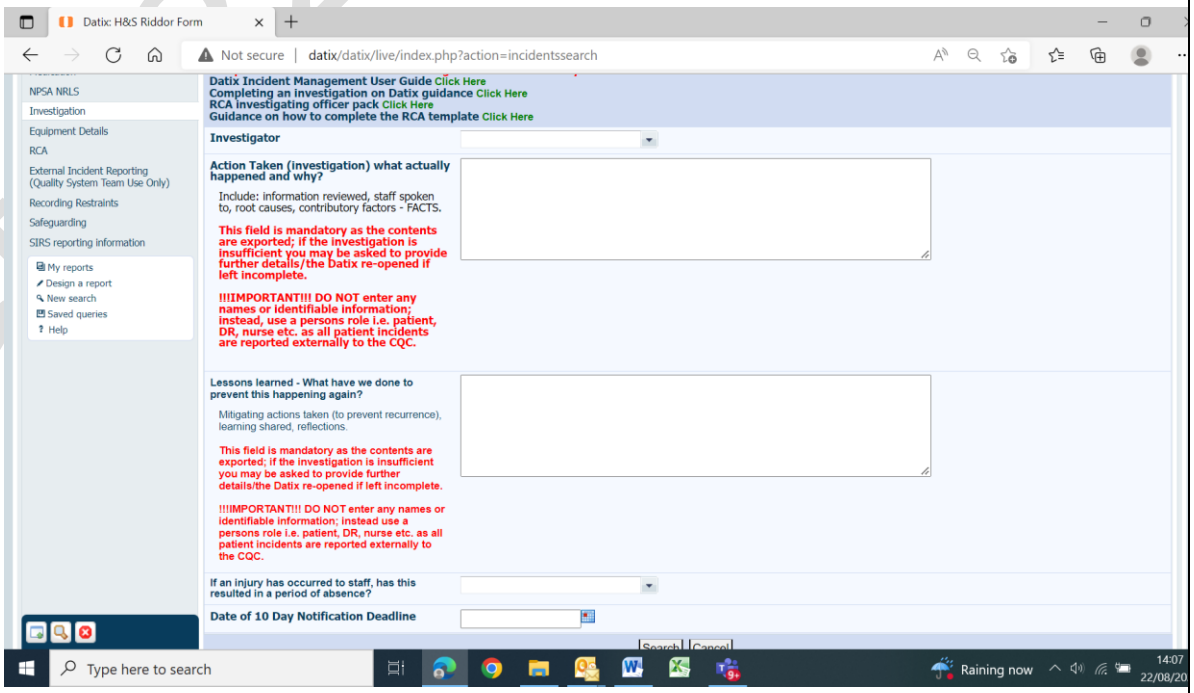
- Dangerous Occurrence, such as a dirty sharp or occupational exposure, report within **10 days of the incident**.
- Occupational Disease, as soon as a registered medical practitioner confirms diagnosis and the work related element has been established.
- Specified Injury, such as a fracture or dislocation (excluding fingers, toes and thumbs), this requirement includes patients and staff, immediate notification by phone with a report to be made **within 10 days.**
- Over 7 day incapacity, as a result of a work related injury, which can also include formally determined light duties, report within **15 days of the incident date**.

The Trust must ensure that suitable and sufficient arrangements are in place to ensure the reporting of incidents within the regulatory timeframes.

#	Major Steps	Details / Responsibility	Time	Diagram, Workflow, Picture, Time, Grid
1	**Incident Occurrence**	Immediate corrective action to be taken by Manager / Supervisor of the area the incident occurred to maintain the safety of staff and patients.	Immediately	In accordance with RM07 Incident Reporting and HS23 Health and Safety Accident/Incident/ Investigation and External Reporting Policy.

2	**Incident Reported via Datix**	The incident must be reported via Datix.	Within 24 hours of the incident occurring	 When completing the Datix report it must be categorised as an “Accident / Incident that has resulted in or could have resulted in personal injury” this will ensure that the Health and Safety Team are aware of the incident.

				 Initially the report can be logged as RIDDOR, however the determination and final assignment of this will be by the Health and Safety Team, once the 72 hour Health and Safety report has been received.
3	**Incident Reviewed by Health & Safety Advisor**	**During Normal Working Hours (Mon – Friday 8am – 5pm):** • Health and Safety Advisor to review the incident to determine whether the incident is or has the potential to be a RIDDOR reportable incident **Out of Hours: (Evenings and Weekends)**	Within 24 hours of the incident being reported (Normal Working hours) Out of hours the incident will be reviewed	

		• The HSE consider weekends as part of the 10 and 15 day deadline for reporting. Incidents that occur during the evening will be reviewed the following day, incidents that occur over weekend periods will be reviewed on Monday morning and prioritised for escalation.	on the Monday morning.	
4	**Outcome of Health & Safety Advisor Review**	**If the incident is deemed to be / potentially be RIDDOR Reportable:** • Health & Safety Advisor to notify the ward / department manager, with a copy to the responsible Matron and Divisional Nurse Director, requesting a 72 Hour Health and Safety Report that should be produced and submitted to the Health and Safety Team within 72 hours. **If the incident is not deemed to be RIDDOR Reportable:** • Feedback given by Health & Safety Advisor to local ward/ department manager to complete local incident	72 hours from request from H&S Advisor Datix incident to be completed and closed in accordance with RM07	Link to 72 hour Health and Safety Report template. http://uhnm/media/23839/72-hour-report-staff-and-3rd-party-v1.docx 

		investigation in line with Trust Policy RM07		If the incident is determined as not RIDDOR Reportable the investigation page must be completed by the handler of the incident.
5	**Completion of Initial 72 Hour Health and Safety Report**	Ward / Department Manager (or person nominated by them) to complete 72 hour Health and Safety report and submit to Health & Safety Advisor.	Within 72 hours of the request from the Health and Safety Advisor	
6	**If 72 hour Health and Safety report not received within 72 hours**	**This step can be skipped if the 72 hour Health and Safety report has been received.** **Escalation Point 1:** Health & Safety Advisor to escalate to Matron and Divisional Nurse Director, via email and if possible with a follow up telephone call to confirm the delay and to seek assistance in obtaining the report.	4 days after initial request for 72 hour report requested by H&S Advisor.	

7	**If 72 hour Health and Safety report not received as agreed with Matron & Divisional Nurse**	**This step can be skipped if the 72 hour report has been received.** **Escalation Point 2:** Health & Safety Advisor to escalate Chief Operating Officer to pick up with Divisional Operational Director and Divisional Nurse Director for immediate action.	5 days after initial request sent from H&S Advisor	
8	**Receipt of 72 hour report**	Health and Safety Advisor to review 72 hour Health and Safety report and determine whether a RIDDOR report is required.	Within 8 Hours of receipt decision will be made.	
9	**Reporting of RIDDOR**	**If a decision to report to RIDDOR is determined:** • Health and Safety Advisor to advise Senior H&S Advisor or Head of Health and Safety to report the incident to HSE using the RIDDOR portal • Copy of RIDDOR Report will be saved to the Datix for information. • Senior Health and Safety Advisor or Head of Health and Safety to escalate the notification to the Associate Director of Corporate Governance and relevant Executive	Immediate notification once RIDDOR Report has been submitted to the HSE	Link to HSE RIDDOR Reporting Portal: How to make a RIDDOR report - RIDDOR - HSE RCA Template Intranet address http://uhnm/a-z/business/health-and-safety/incident-investigation-riddor/

		Lead/s for information • Senior Health and Safety Advisor or Head of Health and Safety to inform the ward / department manager , with a copy to the responsible Matron and Divisional Nurse Director**, requesting that a full Root Cause Analysis is required to be completed.** **If the incident is not deemed to be RIDDOR Reportable:** Feedback given by Health & Safety Advisor to local ward/ department manager to complete local incident investigation in line with Trust Policy RM07		
10	**Liaison with HSE following RIDDOR report**	Senior Health and Safety Advisor or Head of Health and Safety to liaise with HSE as appropriate, providing updates on progress with the investigation and to determine any next steps, including whether the RIDDOR can be withdrawn if further information deems this to be the case.	In accordance with timeframes requested by the HSE Inspector.	