Serious Untoward Incidents Procedure

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Approved by: Care and Support Executive Team

Lead Director: Director of Quality and Improvement

In consultation with: Operational teams, Quality and Improvement, Health and Safety

Link to Procedure: Death of a Customer Procedure

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Contents

1. Procedural Context

Riverside is committed to enhancing the safety of our customers, their families and carers, our colleagues and the public by ensuring that we have robust systems in place to enable reporting on and learning from adverse events. This procedure sets out the systems, processes and requirements for serious and untoward incident reporting, management, investigation and learning. The procedure aims to facilitate learning by promoting an open and learning culture, avoiding blame.

This procedure is based on the following principles:

- A culture of learning and openness is required to improve safety.
- All incidents should be reported and managed efficiently and effectively.
- Serious Incident Investigations are conducted for the purposes of learning to prevent or reduce the likelihood of recurrence. They are not conducted to hold any individual or organisation to account.
- The needs of those affected should be the primary concern of those involved in the response to and the investigation of incidents. Customers, their families and carers and victims' families must be involved and supported throughout the investigation process in an open and honest way.
- Information from incidents should be made available to all levels of the organisation to inform improvements to service delivery.
- Riverside will cooperate with other providers, commissioners and regulators to support the investigation of incidents and subsequent learning.

All Procedures referred to for Care and Support can be found on the RIC here:
Care and Support - Care and Support Policies and Procedures - All Documents

2. Definitions

Incident - an incident is an event or circumstance that resulted in, or could have resulted in, unnecessary damage, loss or harm such as physical or mental injury to customers, colleagues, visitors or members of the public and damage to the organisation.

Near Miss - a near miss is an unplanned event that did not result in injury, illness, or damage but had the potential to do so. Only a fortunate break in the chain of events, either deliberate or inadvertent, prevented an injury, fatality or damage.

Serious Incident - acts or omissions by individuals that result in:

- Unexpected or avoidable death including suicide.
- Unexpected or avoidable injury that has resulted in serious harm.
- Unexpected or avoidable injury requiring treatment by a healthcare professional in order to prevent death or serious harm.
- Sexual or physical abuse.
- Psychological ill-treatment.
- Neglect.

- Exploitation, financial or material abuse, discriminative and organisational abuse.
- Major loss of confidence in the organisation, including prolonged adverse media coverage or public concern about the quality of the service.

Classification of incidents

Incidents are classified as:

Minor	• Minor injuries with no first aid treatment required • No property damage • Minor abuse or threats
Moderate	• Injuries requiring first aid treatment • Damage to equipment within building • Small leak of substance hazardous to health • Threat causing distress
Major	• Major injuries requiring hospital treatment or a Fatality • Structural damage to buildings or loss of building • Harm to the environment or irreversible damage • Very Harmful or Potential Threat to the Business

A more detailed explanation of incident classification can be found in ***'Appendix 1 – Incident Classification'.***

3. Application

This procedure applies to all incidents and near misses. It applies to all employees of Riverside Care and Support, including Supported Housing, Retirement Living and Care services.

All colleagues should read and understand this procedure along with the Death of a Customer Procedure which provide guidance and support on how to deal with the death of a customer and serious untoward incidents.

4. Duties and responsibilities

The table below sets out responsibilities for tasks relating to Serious Untoward Incidents:

Role	Responsibilities
Executive Director of Care and Support	• Commissioning the development of relevant policies and procedures and delegating responsibility for delivery to the Director of Operations. • Leadership and oversight of Incident reporting to the Care and Support Committee including: ○ Ensuring that individual Incident reports are reported to the committee where required.

	○ Ensuring the committee takes appropriate actions in response to incidents. ○ Ensuring the committee receives an annual thematic review of learning from Serious Incident investigations *(to be completed by the Head of Quality and Improvement)*
Director of Operations	• Ensuring that robust procedures, systems and processes are in place for the reporting, investigation, management and learning from incidents. • Ensuring the Care and Support management structure develop effective relationships locally with commissioners and regulators to provide confidence in the organisation's ability to report, investigate, manage and learn from incidents. • Determining whether an incident meets the criteria for external reporting. • Reviewing and approving Investigation reports (or nominating a deputy to do this) ensuring that learning has been identified and an action plan has been developed in response to recommendations.
Head of Operations	• Reviewing all major incidents (level 3) in consultation with the relevant Regional Operations Manager to decide what type of investigation is needed. • Authorising closure of Serious Incidents on SAW-IT that have resulted in an investigation.
Regional Operations Managers (ROM)	• Ensuring compliance with this procedure, systems and processes. • Reviewing all moderate and major incidents (levels 2 and 3) to: ○ Review the level of classification given to an incident ○ Appoint an Incident Investigator. • Reviewing Incident Investigations – upon completion of the investigation, the report must be reviewed and approved by the appropriate ROM who will then ensure that any learning is identified and that recommendations are developed into action plans which are then implemented.
All Managers	• Ensuring compliance with this procedure and relevant systems / processes. • Ensuring incidents are reported on the Safety At Work – Information Tool (SAW-IT) by colleagues as soon as possible and within one working day of the incident occurring. • Reviewing any applicable incident reports generated within SAW-IT that have been allocated to them, and reviewing the level of classification given. • Communicating any moderate and major incidents reported to relevant ROM for their attention. • Reporting Serious Incidents (where required) to appropriate commissioners *(usually done by an Area Manager)* within 48 working hours of the incident occurring or Riverside becoming aware of the incident occurring.

	• Taking immediate action following an incident to support people who are affected, preserving any evidence for future investigation and implementing any required immediate safety measures. • Ensuring all colleagues are supported post incident by contacting them directly to identify if any specific support is required; including providing feedback on the outcome of an incident report and investigation. • Ensuring the learning from incidents is implemented, making improvements to service delivery and ensuring their teams are fully engaged in the reporting and learning from incidents.
Incident Investigators	• Ensuring investigations are conducted in accordance with the procedures, systems and processes and that they are completed within the required timescales. • Developing robust recommendations that are based on the identified learning and which will seek to prevent recurrence of the incident and promote safety and quality. • Consulting all relevant stakeholders in developing recommendations. • Developing observations which are not directly related to the incident but are other opportunities for learning and improvement identified through the investigation process.
All colleagues	• Taking responsibility for their own safety, and the safety of others. • Reporting all incidents on SAW-IT as soon as possible (within one working day). • Cooperating fully with management and any other person conducting an investigation into the incident.

5. Incident Reporting

All incidents and near miss incidents must be reported through SAW-IT, as soon as is reasonably practicable, and no later than:

- **72 hours for Minor or Moderate incidents**
- **24 hours for Major incidents**

Upon discovering a death the relevant ROM and Head of Operations should be informed immediately so they are aware of the incident.

Information and guidance about the SAW-IT system can be found on the RIC: Riverside (effective-software.com)

Incidents which are particularly serious and/or may attract immediate media attention should be escalated through the line management structure, and the marketing and communications team informed where required. If the incident occurs during out of hours, the On-Call procedure should be followed to ensure it can be escalated

appropriately. Please note where out of hours, a marketing colleague is available through the Customer Service Centre.

In the event that the SAW-IT system is unavailable, paper records will be used and retrospectively entered. Once entered onto the system the paper records will then be destroyed.

6. External Incident Reporting

The Director of Operations will be responsible for determining whether an incident meets the criteria for external reporting and ensuring this takes place as per below:

- **Commissioning** - where required, Serious Incidents will be reported to appropriate commissioners, usually done by an Area Manager, within 48 working hours of the incident occurring or Riverside becoming aware of the incident occurring. *Note - timescales for reporting incidents may vary for certain services depending on any contractual requirements from your Local Authority so these should be considered.*
- **Care Quality Commission (CQC) -** Registered Care Managers to notify the CQC of specific incidents as required and a record kept locally. Riverside's nominated lead on CQC services to be informed. Notification forms can be accessed at: http://www.cqc.org.uk/content/notifications
- **RIDDOR Incidents -** The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) requires employers to report deaths, certain types of injury, some occupational diseases and dangerous occurrences that 'arise out of or in connection with work'. Generally, this covers incidents where the work activities, equipment or environment (including how work is carried out, organised or supervised) contributed in some way to the circumstances of the incident. It is the responsibility of the Health, Safety and Environment (HSE) team to report any RIDDOR related incidents which come through SAW-IT. For further advice or guidance please contact the HSE team on: health_safety_and_environment_team@riverside.org.uk
- **Data Protection** - where an incident involves the destruction, loss, alteration, unauthorised disclosure of, or access to personal data this may constitute a data breach. It is important that all colleagues report a data breach, or suspected data breach, to the Data Protection Team using the data breach webform as soon as possible.

  From discovery, we have a maximum of 72 hours to establish what has happened; determining the nature, size, and severity of the breach and whether we need to notify the Information Commissioner's Office (ICO). We may also be required to inform a number of other parties, contractually or through statutory or other obligations. More information on our, and your, obligations in relation to data breaches can be found in Riversides Group Data Breach Playbook.

7. Police Involvement

The police should be immediately notified of all incidents where it is suspected criminal activity has taken place. This may include:

- Evidence or suspicion that the actions leading to harm (including acts of omission) were reckless, grossly negligent or wilfully neglectful.
- Evidence or suspicion that harm/adverse consequences were intended.
- A suspicious or accidental death.

Where the police conduct an investigation into an incident, Riverside's own investigation would normally continue unless the police request that the investigation is suspended until the police investigation is complete.

Please note where the police first attend the scene, they may ask any colleagues present for a statement on what has taken place. In these instances colleagues are encouraged to defer making a statement at this time and inform the police that they must first take legal advice as per Riverside's internal procedure. Colleagues should then liaise with their line manager to prepare a statement on what has taken place and engage with our in-house legal team to sign this off before sending back to the police where necessary. For guidance on how to access support and advice from our legal team please refer to our Legal User Guide which can be found on the RIC here: Care and Support - Legal Services - User Guide - All Documents (sharepoint.com)

8. Informing a Next of Kin or 'Third Party'

Wherever a serious untoward incident has occurred, colleagues should make time, as soon as is reasonably practical, to speak to the customer(s) involved and ask them if they would like to inform their next of kin (NOK) or a named 'third party' on what has taken place.

For example, there may be instances where a customer has been involved in an incident and may be willing to let their NOK know what has happened who may then be able to offer any appropriate support to the customer. This could be the customer speaking to their NOK themselves or giving permission for a Riverside member of staff to inform them.

If the customer asks us to disclose any information, colleagues should always obtain the customer's consent both verbally and in writing, before doing this. The Disclosure Form in ***'Appendix 5 – Consent to Disclose Form'*** should be completed by customers and saved onto the customer's file for reference.

If a customer does not want us to share information about the incident with their NOK or a third party, this should always be respected.

Please note, if a serious incident occurs and a customer is admitted to hospital in an emergency situation, colleagues are able to inform a customer's NOK that they have been admitted to hospital without completing this form.

9. Incident Management

All incident reports submitted through SAW-IT will be reviewed by the line manager of the individual who reported the incident. They will receive an automated email from the system to notify them there is an incident to investigate. They are responsible for undertaking any initial investigation to review what happened and speak with any individuals involved to record their version of events.

Any notes taken or evidence found at this stage should be saved onto the incident record on SAW-IT and could be used as part of any potential future HR processes, e.g. disciplinary investigations. Any such HR process will be carried out in accordance with the HR procedure and will be in addition to the investigation set out in this procedure.

Upon completing the initial review line managers should then classify the incident which should be done using ***'Appendix 1 – Incident Classification'*** for guidance and update the incident record on SAW-IT.

All incidents classified as Level 2 – 3 (Moderate / Major) should be reviewed by the relevant Regional Operations Manager who will:

- Review the level of classification given *(see Appendix 1 – Incident Classification)*
- Appoint an Incident Investigator where required to carry out any incident investigations. The individual should be from a different service to which the incident occurred to ensure it can be completed objectively.

All incidents classified as Level 3 (Major) should be managed in consultation with the relevant Head of Operations so they are aware of these incidents.

All colleagues should refer to ***'Appendix 1 – Incident Classification'*** for guidance on how incidents should be graded to the appropriate level and what type of investigation should be carried out, if this is required.

Responsibility for the closure of Serious Incidents on SAW-IT that have resulted in an investigation can only be authorised by the relevant Head of Operations.

Incidents that have **not** resulted in an investigation (e.g. Level 1 – Minor) can be closed on the authority of the line manager who is initially assigned to review it.

10. Incident Investigation Principles

The following are key issues regarding the Incident investigation process. A more detailed investigation process is provided in ***'Appendix 2 - Incident investigation Process'.***

For incident investigations, those leading the investigation process must not be involved in the service in which the incident occurred. Demonstrating that an investigation will be undertaken objectively helps to provide those affected (including

customers, families and carers, and commissioners) with confidence that the findings of the investigation will be robust, meaningful and fairly presented.

Actions in response to the recommendations must be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions and **not** by the Incident Investigator. This will normally be the appropriate Regional Operations Manager.

Consideration also should be given as to whether to investigate a Near Miss where the consequences would have been classified as MODERATE or MAJOR (see '***Appendix 1 – Incident Classification'***).

All Incident investigations should be completed and approved *within 30 working days* of the incident occurring.

If an Incident investigation is being conducted by the NHS into an incident involving a Riverside customer the Executive Director of Care and Support can decide not to commission an internal investigation providing the NHS investigation report is made available to Riverside for the purpose of learning and is satisfied that no further learning would be gained from an internal investigation. The reasons for not commissioning an internal investigation should be recorded on SAW-IT.

11. Regulatory Investigations

In the event of a regulatory investigation the Executive Director of Care and Support or nominated deputy will coordinate with the appropriate regulator.

12. Coroners Inquests

When a death is unexpected, violent or unnatural, the coroner will decide whether to hold a post-mortem and, if necessary, an inquest. The coroner's court is a court of law, and accordingly the coroner may summon witnesses to attend and give evidence.

Where a coroner's verdict is not known at the time of the investigation report being completed, the final investigation report will be submitted within the appropriate timescale and not delayed in order to incorporate the coroner's verdict. It must be made clear in the report that a coroner's verdict is awaited. If the verdict presents issues not covered in the final report, Riverside will revise the report in order to incorporate these issues.

Where there is a Coroner's Inquest, Riverside will share its final approved investigation report with the coroner.

For further information, and support for colleagues around Coroner's Inquests, please refer to '***Appendix 3 – A short guide to Coroners Inquests'*** which can be found within the ***Death of a Customer Procedure.***

13. Safeguarding Incidents

Safeguarding concerns, follow a different recording and reporting process specified by the particular Local Authority Safeguarding Team, which should be completed in addition to the internal Safeguarding concern form. Please refer to the Safeguarding Procedures for further guidance which can be found on the RIC: Safeguarding - Home (sharepoint.com)

14. Learning from Incidents

The overall aim from investigating incidents is to identify if there are any areas of learning for the organisation. An action plan will be developed in response to the report recommendations that ensures the learning is turned into tangible improvements in service delivery.

Managers should ensure learning is shared within their team. This must include providing feedback to the person who recorded the incident and facilitating reflective practice where appropriate as this encourages further incident reporting and learning.

The timeframe for being able to feedback learning may vary, e.g. involvement from a coroners court as a result of a death, but where possible this should be shared and fed back to relevant colleagues without any undue delay.

The Director of Operations and Senior Management Team are responsible for ensuring the learning from incidents is implemented, making improvements to service delivery, and sharing learning with other areas as appropriate.

15. Being Open (Duty of Candour)

Whilst the principles of Being Open and the Duty of Candour relate to NHS patient safety incidents and Care Quality Commission (CQC) registered services, Riverside expects the same principles to be applied to all incidents that occur within the organisation irrespective of whether they are regulated by the CQC, including staff incidents.

Riverside has a moral and legal duty to be open with customers, their families and carers when a serious incident has occurred. This duty is detailed in CQC Regulation 20: Duty of Candour and must be applied in all circumstances. Further information can be found in the link below:
Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk)

Early, meaningful and sensitive engagement with affected customers, their families and carers should be established from the point at which an incident is identified and throughout the investigation process.

16. Support for colleagues

Riverside recognises that colleagues who are involved in an incident may be affected by the event both in their work and on a personal level. Riverside is committed to supporting colleagues and will provide timely and appropriate support.

Following an incident, including the death of a customer, colleagues should be met face-to-face (wherever possible) by a manager who will ensure any support needs are identified and addressed.

More information about support available can be found in ***'Appendix 4 – Support for colleagues'*** within the ***Death of a Customer Procedure.***

Appendix 1 - Incident Classification

Appendix 1 - Incident Classificatic

Appendix 2 - Incident Investigation Process

Appendix 2 - Incident Investigatic

Appendix 3 – Investigation Template

Appendix 3 - Investigation Templ

Appendix 4 – Contributory Factors Fishbone Diagram

Appendix 4 - Contributory Factor

Appendix 5 – Consent to Disclose Form

Appendix 5 - Consent to Disclose

Version	Date	Changes Made	By Who	Authorised
1.1	21.07.20	**Appendix 1 – Incident Classification** New header inserted into the table entitled **"Death of a Customer"** to support colleagues classify a death as level 1, 2 or 3.	Mark McKean	Simon Allcock
1.2	13.10.21	**Appendix 3 – Investigation Template** There is now one Investigation Template to be used for all incidents requiring an investigation which can be found in Appendix 3	Mark McKean	Simon Allcock
1.3	22.03.21	**Section 8 – Informing a Next of Kin or 'Third Party'** Additional section added which provides guidance for colleagues on informing a Next of Kin or 'Third Party' after a Serious Incident has occurred **Appendix 5 – Consent to Disclose Form** Added additional Appendix for colleagues to complete with a customer if there is a need to disclose any information to a Next of Kin or Third Party in relation to a serious incident that may have taken place.	Mark McKean	Stella Hughes
2.0	14.08.23	Formal review of the procedure undertaken in consultation with Operational colleagues and Quality and Improvement team. **Section 6 – External Incident Reporting** Additional information on all individuals' obligations in relation to data breaches and reporting requirements as part of this. **Section 7 – Police Involvement** Additional information provided for colleagues where police attend a scene and ask for a statement and the steps colleagues should take including seeking advice from our in-house legal team. **Sections 12, 15 and 16** Information in these sections reduced down and colleagues signposted to additional information and guidance provided within the Death of a Customer Procedure to reduce duplication. **Appendices**	Mark McKean	C&S Executive Team

		All other appendices moved into separate documents which have been embedded into the procedure to reduce the overall length.		