Policy Name	**Incident Reporting Policy**
Policy Purpose	**Policy to promote the prevention of injury, loss and damage through the development of safer working practices across the Organisation. To support implementation of the BEMS' Patient Safety Incident Reporting Framework (PSIRF) plan**
Created by	**Operations Manager**
Created date	**October 2010**
Amendment dates	**November 2011, February 2013, March 14, March 15, July 17, Oct 18, August 19, May 2024**
MEC Authorisation dates	**November 2025**
Current Status	**Live**
Next Review Date	**November 2026**

BANES ENHANCED MEDICAL SERVICES

INCIDENT REPORTING POLICY

The organisation will ensure that all accidents and incidents are formally documented and thoroughly investigated. Remedial action will be based on investigation findings and recommendations. The goal is to promote the prevention of injury, loss and damage through the development of safer working practices across the organisation. The thrust of investigation and reporting procedures is to promote safe performance not to apportion blame, and the organisation is committed to developing a culture encompassing fair and just treatment of all staff.

Definitions

After Action Review (AAR)
An After Action Review (AAR) is a learning response method that supports organisations to respond to a safety event or other event for the purpose of learning and improvement.

Hazard
Anything with potential to cause harm, loss, damage or injury.

Incident
Any event that occurs which results in (or has the potential to result in) damage, loss or harm to persons, property, equipment, assets etc also known as Patient Safety Incidents.

Near Miss
Any event that occurs that does not result in damage or injury but had the potential so to do..

Patient Safety Incident (PSI)
Any unplanned or unintended event or circumstance which could have resulted or did result in harm to a patient

Patient Safety Incident Investigation.
An investigation process, undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation, based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Risk
The likelihood of harm, loss, damage or injury occurring.

Risk Profile
The relationship between the hazard, the risk and the severity of the outcome of the accident/incident. The risk profile is categorised on a risk matrix, which is shown in 5.3.

1. Purpose

1.1. To establish a framework to support identification and grading of incidents.

1.2. To provide a clear procedure for reporting and managing incidents.

1.3. To ensure BEMS complies with Duty of Candour

2. Key Principles

2.1. Accessibility.

2.2. Action appropriate to level of risk.

2.3. Fair and just treatment.

2.4. Continuous improvement in quality, effectiveness and efficiency of services.

3. Supporting Objectives

3.1. To provide easy access for all staff to report untoward incidents.

3.2. To have a thorough approach to investigation based on assessed risk.

3.3. To ensure fair treatment of staff, clinicians and patients.

3.4. To separate incident reporting from disciplinary procedures.

3.5. To effectively record, audit and cross-reference data to other quality and risk management processes across BEMS.

3.6. To extract lessons learned from incidents, to improve services, reduce the risk of future incidents and to improve quality.

3.7. To provide written evidence of actions undertaken as a result of any incident.

4. Process

4.1. All incidents and near misses should be reported using the Teamnet Significant Event reporting form as soon as possible after occurrence.

4.2. Immediate action should be taken where necessary to reduce or eliminate risk to patients, staff or resources.

4.3. Any incidents that are risk categorised red, or as ‘catastrophic’ or ‘major’ on the risk rating chart should immediately be reported to the BEMS CEO and the BEMS Clinical Governance Director. This includes Duty of Candour notifiable incidents. See section 7 below for details.

4.4. Incident forms should be forwarded to the Operations Director for administrative incidents or to the Clinical Governance Director for clinical incidents for review and sign-off.

4.5. The Operations Director or Service Clinical Governance Lead will ensure development and implementation of appropriate action plans, including whether to initiate a formal investigation, to mitigate any future risks.

4.6. The Operations Director or Service Clinical Governance Lead will be responsible for completing an anonymised report, including lessons learnt, and forwarding to the BEMS Clinical Governance Director for review.

5. Risk categorisation of Incidents

Categorisation of incidents should occur as soon as possible after the incident, using the matrix at section 5.3 of this policy, and a review of the risk category should take place after the investigation has concluded.

5.1. Risk Categorising Matrix (Consequence)

Risk ratings and Descriptions				
1	**2**	**3**	**4**	**5**
Minimal	**Low**	**Moderate**	**Major**	**Catastrophic**
No injury. Minimal financial impact. No service disruption.	No medical treatment or intervention required. First aid treatment delivered. Minimal or no disruption to service delivery. No litigation. Low – medium financial loss or cost. Minor impact on level of care.	Medical treatment required. Reduced capacity to deliver service(s). Likelihood of litigation. High financial cost/loss. Moderate impact on level of care. Local adverse publicity/loss of confidence in the organisation.	Serious injury. Serious property damage. Litigation. Major financial loss/cost. Increased level of care. National adverse publicity. Major loss of confidence in the organisation. Temporary service closure.	Death. Severe loss of confidence in the organisation. Extended service closure/substantial disruption of service provision. Extensive injuries. Litigation >£1m. Substantial financial impact. International/national adverse publicity.

5.2. Risk Categorising Matrix (Likelihood)

1	**2**	**3**	**4**	**5**
Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
The event may only happen in exceptional circumstances.	The event could occur (recur) at some time.	The event may well occur (recur) at some time.	The event is expected to occur (recur) in mist circumstances.	The event will occur (recur) in most circumstances.

5.3. Risk Categorising Chart

Likelihood of Recurrence	Risk Level/Consequence and Weighting				
	Catastrophic (5)	**Major (4)**	**Moderate (3)**	**Low (2)**	**Minimal (1)**
Almost certain (5)	25	20	15	10	5
Likely (4)	20	16	12	8	4
Possible (3)	15	12	9	6	3
Unlikely (2)	10	8	6	4	2
Rare (1)	6	4	3	2	1

In terms of categorising and managing risks the following categories will then be applied:

	Green	Managed by staff
	Amber	Managed by Service Delivery Manager, Service Delivery Project Manager, Operations Director & Service Clinical Governance Leads
	Red	Managed by Clinical Governance Director, immediate action required

All incidents will be considered for inclusion on the Risk Register and investigation using the After Action Review (AAR) methodology

6. Incidents categorised as category 12 or above

6.1. For all incidents, but particularly in the event of a Patient Safety Incident (PSI), contemporaneous record keeping is an essential component of incident management. In addition to informing relevant patients/relatives/staff and the public of any incidents that involve them, all communications must be accurately documented.

6.2. The lead investigating officer will be BEMS Clinical Governance Director. The lead will be fully conversant with investigation procedures and, where appropriate, will have relevant expertise in, or understanding of, the work area. The lead will ensure that actions comply with the NHS Contract Incident Process requirements (Appendix 1), where applicable. The lead will use the incident investigation template outlined in Appendix 2.

6.3. The investigating officer will be responsible for ensuring that all relevant individuals are involved in the analysis, that an investigation team is brought together within two working days of the incident to agree and document any actions required, and that resource requirements are identified and highlighted as appropriate.

6.4. A full examination of the circumstances of the incident must be undertaken, and a report prepared indicating the contributory factors of the event and identifying remedial action (Appendix 2).

6.5. All evidence including witness statements, training records, risk assessment documentation, photographic material and equipment information should be gathered, reviewed and kept secure, in adherence with the NHS Records Retention Policy, as part of the investigation procedure.

6.6. A managed response should be agreed, and remedial action timetable implemented. For incidents risk categorised as 12 or above this will be reported to the commissioner within 45 working days; for incidents risk categorised as between 6 and 10 this will be reported within 60 working days.

7. Duty of Candour

7.1. As from 1 April 2015 Duty of Candour is a new statutory obligation for all health service providers. This requires BEMS by law:

a. To be open and transparent with any patient who is harmed by an incident for which BEMS are responsible, in other words to inform the patient of the fact and offer an apology and an appropriate remedy, regardless of whether the patient has made a complaint

b. To notify any such incident to the Learning From Patient Safety Events (LFPSE) service.

7.2. A notifiable incident is any intended or unexpected incident that could result in, or appears to have resulted in, death, severe harm, moderate harm, or prolonged psychological harm to the patient. Moderate harm includes any extension to treatment, e.g. extra unplanned hospital stays. Prolonged means for at least 28 days.

7.3. The statutory Duty of Candour is organisational; it therefore applies to everyone who works for BEMS not just to clinicians who already have a professional duty of candour under General Medical Council/Nursing Midwifery Council registration.

7.4. This regulatory information is set out in new Care Quality Commission regulation. Enforcement will normally be through Care Quality Commission inspection.

7.5. The Learning from Patient Safety Events (LFPSE) system is an online reporting system that does not record the organisation or the patient name. BEMS' nominated individual will record the incident online via the online portal: https://record.learn-from-patient-safety-events.nhs.uk/ The incident will need to be categorised in one of the following ways:

a. Medication

b. Documentation

c. Clinical assessment (diagnosis, tests etc)

d. Hospital admission

e. Consent/confidentiality

f. Behaviour of patients towards clinician, staff or other patients

g. Infection control

h. Patient accidents

i. Pressure ulcers

j. Self-harm

k. Treatment/procedures

8. Individual Responsibilities

8.1. The Operations Director/Service Clinical Governance Leads

a. To be responsible for ensuring that staff are fully aware of the procedures for reporting and formally recording all accidents and incidents that arise from the work activity, and to ensure that all staff receive training appropriate to their responsibilities.

b. For remote sites, to ensure that effective incident reporting systems are in place and that any incidents related to BEMS services are fully reported.

c. To ensure that, where incidents occur, the area has been made safe, that where necessary, calls have been put through to emergency services as appropriate, and that immediate action has been taken. This will include but not be confined

to removal of equipment from service, review of risk assessments, referral of staff to Occupational Health services.

d. To ensure that all incidents are reported, and progress is logged using the TeamNet Significant Event Reporting Form and are appropriately categorised.

e. To review all reports categorised up to Amber Level and be responsible for the security of all documentation, and to ensure that appropriate action plans are developed and implemented.

f. To report all incidents using the TeamNet Significant Event reporting form and

g. To immediately refer incidents categorised Red, or as ‘major’ or ‘catastrophic’ to the Clinical Governance Director and CEO.

h. If the incident is notifiable under Duty of Candour, then the Clinical Governance Director will send a letter to the patient apologising and explaining what steps are being put in place to prevent a recurrence.

i. Unless otherwise directed by the Clinical Governance Director or CEO, to be responsible for clarifying and reviewing event circumstances, developing and delivering appropriate remedial action recommendations, and ensuring appropriate debriefing support.

j. To work closely with the Clinical Governance Director, Health and Safety Advisers and other specialist advisers to ensure that incidents are effectively managed, and to liaise with external agencies where appropriate.

k. To report to BEMS Management Executive Committee all incidents on a monthly basis. To report to the BEMS Clinical Governance Committee all incidents on a quarterly basis.

l. To ensure that all clinical and/or patient-related incidents, including information security incidents, are reported to the commissioner’s agreed contact within the required timescales. Patient Safety Incidents (PSI) will be reported within 48 hours and all other incidents within 5 working days unless otherwise agreed.

m. To ensure that RIDDOR reports are made where necessary if someone has died or has been injured because of a work-related accident. This may have to be reported using the appropriate form (accessed from HSE website, http://www.hse.gov.uk/riddor/ or tel. 0845 3009923 (Monday to Friday 8:30am to 5:00pm).

n. To report all incidents risk categorised as 15 or above, and any identified trends, to the BEMS Council.

o. To ensure that any potential or actual media interest is dealt with in line with BEMS’ Media and Communications Policies.

p. To ensure that, when an incident occurs involving a patient, the patient and/or carer is informed of the nature of the incident and any actions taken. To ensure that the incident, side effects, injury and any treatment given are recorded in the patient records.

q. To ensure that all incident information is securely maintained.

8.2. All Employed and Contracted Staff

a. To immediately report any accident/incident they are involved in, or are aware of, to the Operations Director or Service Clinical Governance Lead. This includes hazard concerns and near miss situations that have the potential to cause injury, loss or damage.

b. To co-operate fully with accident/incident investigation procedures providing written statements as appropriate to their involvement in the accident/incident.

c. The Occupational Health service will provide confidential care to staff.

8.3. Quality and Clinical Governance Director

a. To support the Operations Director and Service Clinical Governance Leads and other staff in implementing incident reporting procedures.

b. To ensure that appropriate ongoing training is provided to staff with respect to incident reporting and investigation.

c. To develop systems for recording and monitoring of incident information via a central database, incorporating complaints data and other information related to risk.

d. To ensure that there are systems in place to provide meaningful information to the BEMS Council, MEC and to the CEO in relation to risks.

e. To audit information from incident reports, identify trends arising from reports and share relevant learning across the organisation.

f. To alert the commissioner of a PSI within 48 hours so it can be reported on the Learning From Patient Safety Events (LFPSE) service using the NHS contract incident process described in Appendix 1.

g. To undertake investigations of PSI where appropriate using the template described in Appendix 1.

h. To ensure that all incident information is securely maintained.

9. Management Executive Committee Responsibilities

a. To review all incidents, and any identified trends, and ensure that appropriate remedial action has been taken.

b. To regularly monitor the progress of any investigation conducted as the result of a Patient Safety Incident and ensure that remedial action is taken within agreed timescales.

c. To receive audit reports on incident reporting and advise on any action required locally.

d. To ensure that any concerns are raised with the CEO.

e. To receive summaries of incident reports, advise on identified trends and ensure that any learning is shared across the organisation.

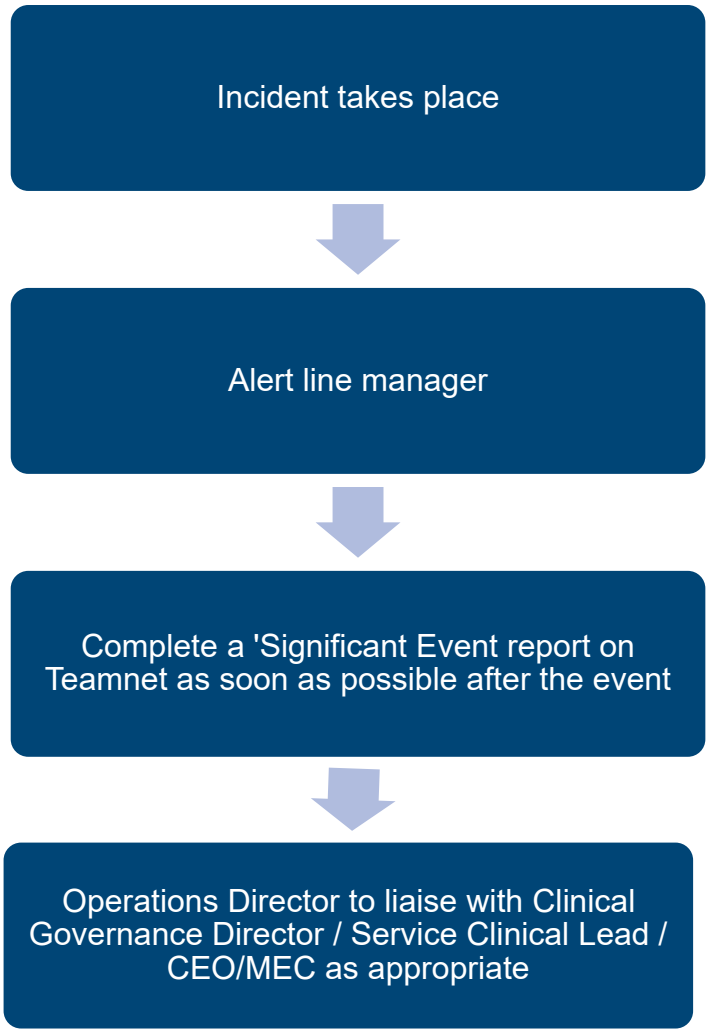
f. To review the effectiveness of incident management procedures and the training in place to support the development of safer working practices.

g. To provide reports as agreed for the commissioner.

h. To receive and consider reports from the Clinical Governance Director on issues of significant concern, including incidents categorised as PSI and significant trends.

i. To report to the Council any issues that may present significant risk (category 15 or above) to the safe operation of the organisation.

10. Incident reporting flowchart



11. Training Requirements

11.1. The Organisation will ensure that all staff are appropriately trained to enable them to carry out their responsibilities with regard to accident/incident management. The Operations Director and Service Clinical Governance Leads who are responsible for investigating the circumstances of accidents/incidents will be trained in investigation techniques together with reporting and recording skills.

12. References

Patient Safety Incident Response Framework August 2022

Appendix 1: CONTRACT INCIDENT PROCESS REQUIREMENTS

Providers will demonstrate a learning culture and systems in line with the Patient Safety Incident Response Framework (PSIRF) and their Patient Safety Incident Response Plan (PSIRP).

The provider to produce a monthly update on any Patient Safety Incident Investigations that they are currently undertaking.

PSIRF is a key part of the NHS Patient Safety Strategy published in July 2019 (www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/). It supports the strategy's aim to help the NHS to improve its understanding of safety by drawing insight from patient safety incidents.
Under PSIRF, each provider must:

- engage compassionately with affected patients, carers and staff following any patient safety incident;
- respond in a proportionate way to such incidents, undertaking investigations where appropriate; and
- ensure that improvements to services are implemented following responses to incidents.

Provider to have in place a PSIRP and associated policy which has been agreed with commissioners.

Provider to share learning, trends and themes and engage with System Quality Group and the BSW Health and Care Professional Leadership Group where appropriate.

Provider to have an identified Patient Safety Specialist who will engage in the BSW Community of practice for Patient Safety Specialists.

The provider will demonstrate evidence of Learning from patient safety incidents and will identify priorities for Quality improvement.

Appendix 2. Patient Safety Incident Investigation (PSII) process – After Action Review principles

A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can.

The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

An After Action Review (AAR) is a learning response method that supports organisations to respond to a safety event or other event for the purpose of learning and improvement. AARs are structured around four questions:

1. **What was expected?** Participants describe what they would expect to happen in situations such as this.
2. **What actually happened?** Participants describe what they did, saw or experienced during the event.
3. **Why was there a difference?** Participants explore what got in the way of expectations being met and what enabled expectations to be achieved or exceeded. This includes consideration of the work environment, technology and tools, tasks, people, organisation and external influences.
4. **What has been learnt?** Participants describe what they have learnt – this may be about themselves, about the team(s) and/or about the wider organisational context that influenced the event.

AARs are led by trained facilitators and follow the guidance set out in the Patient Safety Incident Response Framework and in the national patient safety incident response standards.

When should an AAR be initiated? An AAR should be used at any point where there has been an unexpected outcome – whether it be positive or negative. It is usually focused on task-based events during a project.

Who should participate in an AAR? Everyone who was involved in the particular task / activity / event which is to be reviewed, has a role to play.

Developed by the US Army, the AAR should be carried out with the intent of 'leaving the stripes at the door' so everyone has an equal opportunity to input and learn. The AAR focuses not on accountability but on learning.

A facilitator is also required to introduce the task and assist participants.

How should an AAR be carried out?

The overall time required for the session is around 30 minutes to an hour.

A facilitator should introduce the session and aim to create a space everyone feels comfortable in to openly and honestly share their views and experiences. A prerequisite of an AAR is that everyone feels they can equally contribute without fear of blame or retribution.

Firstly, the group should define together what the intended outcome was as 'what was meant to happen'.

Then, the group should define what actually happened and whether this contributed to either the success of failure of the task – again, this is about identifying unexpected events both positive and negative, not those who are responsible for them.

Then the group should aim to understand the differences between the intended and actual outcomes and what can be learned – should the outcomes be avoided or aimed for in the future?

The facilitator keeps track of time and can play a role in recording centrally what emerged from the activity. Review of the notes / key points is completed at the end for further discussion. The notes should then be captured by the team as part of a knowledge asset for the project to be shared within the wider organisation.

Things you need:

• Facilitator

• An open, safe space for discussion and movement

• Flipcharts/sticky notes and pens

Further information on AARs are provided in the table below.

AAR is	AAR is not
A method for enabling an open and honest conversation about an event that can be used on its own or as part of a wider suite of methods	The same as an investigation
A debrief for those involved, led by a skilled facilitator	A meeting undertaken by an untrained person
Primarily for those directly involved in an event although others may attend if helpful to aid learning	A managerial meeting about an event without those directly involved present
A conversation structured around four AAR questions that is allowed to evolve for the purpose of learning	A bureaucratic documentation exercise to collect information about an event to be reported through governance structures
An opportunity to involve patients, families and carers in the learning conversation providing doing so maintains a psychologically safe space for all those affected	A space where patients, families and carers are expected to attend without considering the psychological safety and welfare of all those affected
A psychologically safe space where people can speak openly without fear of blame or judgement	A debrief that drifts into a scrutiny of people's actions and decisions

A space where all those present are heard and all contributions are valued equally, irrespective of rank or status	An opportunity for a few individuals to 'have their say' and dominate the conversation
Focused on exploring 'work as done' by asking 'What would you **expect** to happen?	Focused on what **should have** happened (for example, as described in policy and protocols)
A debrief that **may** result in a written document that summarises collective learning and is written in the third person (we learnt that….)	A minuted meeting where information shared by participants in the AAR is detailed in a written report
An opportunity to talk about everyday work and the lived reality and experiences of participants	A place where people are judged or blamed for the expectations and experiences that they describe
A space to understand the perspectives and experiences of those in the room	A space for rigid exploration and theming of different elements of a 'work system' (that is, organisation, work environment, task, technology and tools, external influences, person)
An opportunity to develop and agree actions that can be agreed and enacted by people participating in the review	An opportunity to dictate actions for others to complete
A space to highlight concerns about the wider system that may need to be shared with and taken forward by relevant safety/governance groups	A place to decide actions outside the sphere of control of those present

The template below standardises the reporting of AARs. The template has been co-designed with staff leading AARs in a range of healthcare organisations. The structure is purposefully simple so that AARs can focus on reflective conversation and do not become a bureaucratic documentation exercise. See notes on writing an AAR at appendix 3.

Safety event ID:	
Date of ARR	
Facilitator name	
AAR participants	If sharing externally it may be appropriate to record roles only instead of names

Safety event summary

Scope of AAR

Key learning points

Outputs

Who else needs to know about this learning?

Person/organisation	Responsible lead/BEMS contact

Individual and/or team actions within the sphere of control of participants

Action	Responsible lead

Areas for improvement outside the sphere of control of participants to be shared with oversight groups

Action	Responsible lead

Attach the ‘Essentials of AAR’ when sharing this report.

Appendix 3: Notes on writing an AAR report.

General writing tips

An AAR report must be accessible to a wide audience and make sense when read on its own. Assume the report may be shared both internally and externally.

Refer to the Learning response review and improvement tool when reviewing this summary report.

The report should:

- use clear and everyday English whenever possible
- explain or avoid technical language
- use lists where appropriate
- keep sentences short
- avoid including tick boxes to demonstrate compliance (for example, with Duty of Candour).

Notes on writing the 'Safety event summary'

Add a brief, plain English description of the safety event.

Use third person language and do not include people's names.

Notes on writing the 'Scope of AAR'

Add a brief, plain English description of why the AAR was held. This may be no more than one or two sentences or a bullet point.

In some cases, multiple AARs may be called in relation to a single safety event, and the scope of the AAR may change over time.

For example:

- The AAR was called to learn from a patient fall that resulted in a late diagnosis of a hip fracture.
- The AAR was called to learn from family engagement following a patient's fall that resulted in a complaint.

Notes on writing the 'Key learning points'

This section can be completed as text or using a bullet point list.

The discussion will have been structured by the four questions, but it is not necessary to capture verbatim the discussion under each question.

Do not use language that directly or indirectly infers blame of individuals, teams, departments or organisations and/or focus on human failure – for example, the nurse failed to follow policy. Instead use system focused language – for example, we learned that there were challenges in following the policy in practice, because…, we learned that out of hours a number of factors affect the quality of escalation, including…

Focus on what happened and how it happened, and **not** what people, departments or organisations could or should have done during or before the event.

Include adaptations, trade-offs or behaviours that helped everyday work.

Notes on documenting 'Outputs'

It may be helpful to share insight gathered during an AAR with other groups across the organisation (for example, at a monthly governance meeting, weekly team meeting etc.) The person taking responsibility for sharing insight and at which meeting should be defined in the first table below.

No actions may arise from an AAR. However, when **actions within the sphere of control** of the participants are agreed, these should be described and a responsible lead named.

Any areas for improvement **outside the sphere of control** of the participants to be shared with oversight groups should also be defined.

As well as these outputs, participants may identify learning for themselves (for example, about their behaviour or way of interacting with colleagues). These are valuable outputs from an AAR but do not need to be detailed in the AAR report.

Refer to the safety action development guide for further information on developing actions.

General Tips

Capture multiple perspectives to reduce bias

Bias can significantly change the way data is used or interpreted. Once people know the outcome of an incident, it will be impossible for them to be without bias when looking back at what happened. For this reason, it is important to avoid forming conclusions too early.

Remember that the recollections of individuals will already be filtered through their own bias, mental models, and rationalisation. Investigation team members are not objective observers of reality – they will also be making sense of an incident and introducing biases and heuristics when doing so.

The narrative should showcase the incident from as many perspectives as appropriate. Differences in perspective do not need to be resolved in one ‘correct’ narrative. All perspectives need to be valued and this is likely to result in a complex narrative.

Capture the ‘view from inside the tunnel’

Focus on understanding the actions as they appeared to the people ‘inside the situation’.

Strive to enable readers to ‘walk in the shoes’ of the incident’s key players. At a minimum, the narrative should use the information known at the time to show how the decisions taken made sense within the social and cultural context.

The investigation team should seek to understand how the incident was perceived by those involved and why their actions/decisions made sense at the time they were taken.

Do not use the term cause

In legal contexts the term cause is strongly associated with blame and liability. There are also semantic difficulties with the term; many complicated philosophical arguments surround what constitutes a cause.

Avoid ranking contributory factors by degree of ‘contributory-ness’

Avoid differentiating contributory factors in terms of degree of connection or perceived importance in relation to the incident. Ranking in terms of degree of contribution can be perceived as a way of differentiating the level of responsibility or blame for the incident. In most situations, it is not possible to specify that a factor was contributory with absolute certainty. Those that can be specified with more certainty are usually those most closely connected in terms of time or physical proximity, e.g. individual actions.