THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL HEALTH AND SOCIAL SERVICES TRUST

Trust Policy

TP 9/00

Adverse Incident Reporting

Rationale

Adverse events can be defined as "any unexpected or untoward event that has a detrimental effect on an individual patient, member of staff or public." This definition includes near miss reporting. Events related to clinical treatment and outcomes patient care, working practices, health, safety, fire, security (including data protection) and events involving property (1,2,) are covered by this policy.

Incident and near miss reporting can be used as a means of identifying the risks to which patients, staff and members of the public may be exposed.

Objectives

- To provide staff with an opportunity to participate in and effect changes in practice and procedures
- To provide information to allow effective evaluation and monitoring of patient care and procedures
- To provide formal documentation to assist in the management of complaints, claims and investigations by statutory bodies.

Policy

This policy applies to all staff and any other employers whose activities may directly or indirectly affect patients, staff or visitors.

All staff must report adverse events as outlined in the procedure for adverse events reporting (3).

Line managers are responsible for implementing the policy within each ward and department and staff must follow the recognised procedures. These are summarised as follows:

- ensuring all staff are aware of the policy and procedures
- ensuring incident documents and reports are available
- acting appropriately on all reports received liasing with Risk Management and others as necessary.

The Risk and Occupational Health Directorate is responsible for.

- reviewing incidents and actions taken by wards and departments
- following up on actions taken as deemed necessary
- notifying appropriate persons or government agencies where required (4)
- ensuring information is up to date and available to relevant personnel
- managing incident information on behalf to include the evaluation and monitoring of incidents and maintaining a central record of events
- maintaining records, database and archive files.

The monitoring and review of adverse event reporting will form part of ward and department audit activities in line with Clinical Governance and Controls Assurance.

Chief Executive

Hullan Nykec

May 2000

Review Date

Authors: John Orchin, Health & Safety manager June Champion, Clinical Risk Manager

REFERENCES

- Fire Precaution Policy TP 4/00
- 2 Information Systems Security TP 26/98
- 3 Procedure for Adverse Incident Reporting April 2000
- Reporting of Injuries, Diseases and Dangerous Occurrence (NI) 1997