Parish Nursing
Ministries UK

Heath United Reformed Church

Parish Nursing – Adverse Incident Policy

1. Aim of the Policy

Although parish nursing does not involve the provision of medical treatments or direct nursing care, it does involve activities intended to improve, maintain or regain health, or to provide additional support to those who are isolated, frail and nearing the end of life. As a result there is a viable risk that adverse incidents will occur. The aim of this policy is to outline the processes for :-

- Identifying adverse incidents relating to the organisations parish nursing service including Near Misses and Serious Incidents
- Recording and Reporting adverse incidents
- The management of adverse incidents including investigation, follow up and closure of incidents
- Managing, reviewing, auditing and minimising all risks to parish nursing staff and service users
- Promoting and improving service user safety
- Encouraging learning from incidents and promoting high quality care and best practice in parish nursing

This policy incorporates the reporting requirements of NHS England – Revised Serious Incident Framework, the Health and Safety Executive and the Charities Commission.

2. Scope of the Policy

This policy applies to any staff involved in the leadership governance management and delivery of the organisation's parish nursing service.

The policy does not cover Incidents related to corporate risks to the organisation such as Fraud or misuse of funds, massive utility failures, theft or damage to property.

3. Definitions

Service users People who access or are in receipt of support from the parish nursing service or their carers,

Adverse incident Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the provision of parish nursing. Adverse incidents can be categorised as near misses or serious incidents.

- **Near Miss** An event or circumstance occurring during the course of parish nursing that did not result in injury, illness or damage but had the potential to do so.
  It may be appropriate for a 'near miss' to be categorised as a serious incident

(see below), and this decision should be made based on assessment of risk that considers: -

- The likelihood of the incident occurring again if current systems/ process remain unchanged and
- The potential for harm to staff, patients and the organisation should the incident occur again. A near miss should be reported as a serious incident where there is a significant existing risk of system failure and serious harm.

Serious Incidents An event where the potential for learning is so great, or the consequences to patients, families, their carers, staff or the organisation are so significant that they warrant using additional resources to mount a comprehensive response.

Serious incidents can extend beyond incidents, which affect service users directly and include incidents, which may indirectly impact service user safety or the organisations ability to deliver parish nursing in the future.

The occurrence of a serious incident demonstrates a weakness in a system or process that needs to be addressed to prevent future incidents leading to avoidable serious harm to service users or staff, future incidents of abuse to service users or staff, or future significant reputational damage to the organisation and parish nursing more widely.

Each serious incident is considered on case-by-case basis. Examples of serious incidents in parish nursing may include the following (this list is not considered to be exhaustive):

- Incidents related to provision of wholsitic health screening information advise and support
- Accidents and incidents involving the emergency services
- Child/vulnerable adult protection issues (see Safeguarding Policies)
- Confidential information breach – e.g. loss of patient notes or unencrypted portable data, storage device (e.g. laptop or memory stick containing unencrypted parish nursing notes: (see confidentiality and or Data Protection policies)
- Health device/equipment failure/misuse
- Service user complaint (see Compliments Concerns Complaints Policy)
- Physical or Verbal Abuse/ Threatening Behaviour; Physical Violence; Sexual Assault (service user or parish nursing staff – see Dignity in the workplace policy)
- Professional misconduct/non-compliance/whistle-blowing issues which pose a risk to service user safety, organisational reputation or wider reputation of parish nursing
- Suicide or Unexpected death whilst on the organisations premises / or when consulting with the parish nursing service

Root Cause Analysis (RCA): - RCA is a systematic process whereby the factors that contributed to an incident are identified. RCA as an investigative technique for patient safety incidents is used routinely by the NHS. It aims to look beyond the individuals

concerned and seek to understand the underlying causes and environmental context in which an incident happened.

4. Responsibilities

The organisation will ensure that an electronic or paper based incident reporting database is available and that parish nursing staff are trained in its use.

All parishes nursing staff will receive training in incident reporting and investigation (this can be provided by PNMUK)

Recognises that all incidents, especially Serious Incidents, are potentially stressful for personnel and service users chair of the leadership team and line manager will make decisions about support and communications to staff and service users following adverse incidents. The leadership team should ensure that appropriate support is available to staff post the incident, and will be responsible for decisions about leave of duty or referral for post incident support.

All staff have a responsibility to co-operate and assist with any internal and external investigations of incidents and to provide witness statements if asked to do so

The organisation should ensure that handling and processing of data pertaining to the adverse incidents complies with GDPR regulations. All incident reports and action plans should be treated as strictly confidential and should not include full names of any service users or personnel concerned. Information should only be shared on a ‘need to know’ basis, and monitoring reports to the Leadership Team should be anonymised

The Leadership Team or group responsible for the strategic oversight and governance of the parish nursing service will receive information at their meetings on the number of near missed or serious incidents in a quarter and information about incidents will be available to the public for inspection

Serious incidents may require additional reporting and investigation involving statutory agencies – e.g. fraud, child protection, vulnerable adults and mental health issues. Decisions about responding to Serious Incidents and onward reporting will be made by the Chair of the leadership team in consultation with the line manager and parish nurse. PNMUK will advise where appropriate.

PNMUK can provide their partner organisations with hands on support and advice in the investigation of incidents.

The presence and effectiveness of the adverse incident policy will be reviewed by PNMUK as part of the service accreditation scheme and adverse incidents reviewed at the annual quality visit. Any lessons or actions that may reduce the risk of a similar incident elsewhere in the country, will be shared with other parish nursing services and incorporated into national education, standards and guidance.

5. The Management of Adverse Incidents

The management of adverse incidents must comply with the 7 key principles for the management of all serious incidents, as documented in the NHS England: Serious incident Framework and should be: -

- Open and Transparent;
- Preventative;
- Objective;
- Timely and Responsive;
- Systems Based – consider other agencies involved;
- Proportionate;
- Collaborative.

5.1 Procedure for Managing Adverse Incidents

It is mandatory for parish nurses and volunteers to report any adverse incidents that involve themselves and service users.

The reporter of an incident should record notes on the incident as soon as possible after the incident. This should include what happened, when, where and if there were any witnesses. Reports should be made even if the reporter is unsure whether the event constitutes an 'incident' or is unclear about all the facts relating to the incident

The lead parish nurse (in consultation with the any witness/reporter) completes an incident report. (an exemplar is provided in Appendix A) If the incident occurs out of hours, parish-nursing staff should use their discretion as to whether reporting can wait until the next working day or whether to inform the line manager immediately.

The lead parish nurse should ensure that the line manager is aware of the incident as soon as possible.

The parish nurse(s) and line manager will assess the incident and determine whether it constitutes a Near Miss or a Serious Incident (This in turn will determine the level of investigation required. Parish Nursing Ministries UK may provide advice if required.

5.1 a. Near Miss – The parish nurse/line manager enters the incident on an Incident Report database. They then lead a small-scale investigation with relevant staff. Parish Nursing Ministries UK can be asked to lead or support the investigation.

5.1.b. Serious Incident - The parish nurse/line manager enters the incident on database and put in place an investigation team involving relevant staff and other agencies that might have been involved. Incidents involving serious safety and/or clinical governance issues should involve a representative of Parish Nursing Ministries UK will may be asked to lead the team.

If Parish Nursing Ministries UK are not involved in the investigation, the regional coordinator should be informed of a near miss or adverse incident within 1 week of its occurrence. Following the investigative process, a final report and action plan is written by the investigative lead and the incident logged on the incident register.

A serious incident involving a service user must be recorded on the parish nursing record.

The Incident investigation action plan and reporting should be completed with a 12 weeks of the incident.

The incident register is presented at quarterly leadership team meetings, and incidents occurring in that quarter presented by the parish nurse &/or line manager. The chair of the leadership team closes the investigation and confirms the time scales for monitoring the action plan where actions / improvements are still being implemented.

If the investigation highlights unsafe practice or misconduct by a member of regulated profession such as nursing or midwifery, the Leadership team will consider a referral to the regulator. If it involves a parish nurse, the line manager should advise Parish Nursing Ministries UK who will provide the professional advice regarding handling and referral to the Nursing and Midwifery Council.

6 Breach of Policy

All personnel will receive a copy of this policy and training, and will be required to comply.

Breaches of the policy in terms of reporting, recording and communicating incidents or implementing recommendations arising from incident reports may constitute professional misconduct and could lead to disciplinary action or referral to regulatory bodies.

Appendix A Adverse Incident Reporting Form.

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DO NOT INCLUDE PERSON IDENTIFIABLE INFORMATION OR THAT OF INDIVIDUALS OTHER THAN THOSE OF THE REPORTER FOR COMMUNICATION PURPOSES.

In your opinion is this incident a Serious Incident (SI) ☐
or Near Miss ☐

When, Where and Your Details

Type of Incident	**Name of Organsiation**
Date of Incident:	**Reporter Name:**
Time of Incident:	**Reporter Job title/Role:**
Location of Incident:	**Reporter Tel No:**
Date Incident Identified:	**Reporter Email:**
Name of other Organisations or agencies Involved (where relevant):	
Any other people involved (carers, friends relatives, volunteers etc)	

Details of the Service User or Subject of the Incident

Consent for collection of this information is required to enable the incident to be reported. If more than one service user/subject was involved copy and paste the boxes below and add their details

Service User/Subject Name & Date of Birth:	**Their Gender:**
Role (service user staff member other)	**Ethnic Group:**

What Happened?

Description of What Happened including how the was identified as an adverse incident
Immediate Action Taken:
Any Further Information:
Details of any Police, Media Involvement/Interest: