Health and Social Care Board

Public Health Agency

HSC Board and PHA Headquarters
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Chief Executives
HSC ALBs and Special Agencies

11 February 2015

Dear Colleague

Guidance on Engagement with Service Users, Families and Carers as part of the Serious Adverse Incident (SAI) Process

In April 2014, the HSCB and PHA established a group including representation from the PCC, RQIA and Trust Governance leads to develop guidance for the HSC on engagement with service users, families and carers as part of the SAI process.

Following consultation with a range of stakeholders, the guidance was subsequently updated, and has now been approved by the Department.

The attached final version of the Guidance refers to the principles of being open with service users/families/carers and details the various stages of engagement from recognition that a SAI has occurred to the conclusion of the process. It should be a valuable aid to HSC staff as it provides clear step by step advice on the procedures to be followed when they are communicating with service users/families/carers. In addition, a leaflet (appendix 2 of the guidance) will assist service users/families/carers who are involved in the SAI process.

We would ask that you arrange for this guidance to be disseminated to all staff in your organisation who have the potential to communicate with service users/families/carers following an incident.

The guidance will be reviewed after one year, taking account of feedback on its use, to ensure it remains fit for purpose.

If you require any further clarification on the guidance, please contact, Mrs Anne Kane, Governance Manger (HSCB) in the first instance.

Yours sincerely

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A Guide for

Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

January 2015

Contents

		Page
1.0	Introduction	5
2.0	Purpose	5
3.0	Principles of Being Open with the Service User / Family	6
3.1	Acknowledgement	8
3.2	Truthfulness, timeliness and clarity of communication	8
3.3	Apology / Expression of Regret	9
3.4	Recognising the expectations of the Service User / Family	9
3.5	Professional Support	10
3.6	Confidentiality	10
3.7	Continuity of Care	10
4.0	Process	10
4.1	Stage 1 – Recognition	11
	4.1.1 Preliminary Discussion with the Service User / Family	11
4.2	Stage 2 – Communication	12
	4.2.1 Timing of Initial Communication with the Service User / Family	12
	4.2.2 Choosing the individual to communicate	12
4.3	Stage 3 – Initial meeting with the Service User / Family	13
	4.3.1 Preparation Prior to the Initial Meeting	13
	4.3.2 During the Initial Meeting	13
4.4	Stage 4 – Follow up discussions	15
4.5	Stage 5 – Process completion	15
	4.5.1 Communicating findings of investigation / sharing investigation report	15
	4.5.2 Communicating Changes to Staff	17
4.6	Documentation	17
5.0	Supporting Information and Tools	18
	List of Acronyms and Abbreviations	19
	Appendix 1 Particular Service User Circumstances	20
	Appendix 2 Information Leaflet – What I Need to Know About a Serious Adverse Incident for Service users / Family Members / Carers	24

Appendix 3 Examples of communication which enhances the effectiveness of being open 30

Appendix 4 Before, During and After Communication / Engagement Documentation Checklist 33

Notes on the Development of this Guidance

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

Please note the following points:

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

A review / re-evaluation of this guidance will be undertaken one year following implementation.

1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to investigate the incident.

The purpose of a Serious Adverse Incident (SAI) investigation is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the investigation process, unless they wish otherwise.

2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (October 2013) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, investigation levels etc. *To view the SAI Procedure please* Click here.

The HSCB Process works in conjunction with all other investigation processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the investigation process to them, including timescales;
- Advising them how they can contribute to the investigation process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI investigation into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;

- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;
- Ensuring the service user / family have details for a single point of contact within the organisation.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The following principles underpin being open with the service user / family following a SAI.

3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / investigation team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI investigation checklist that is submitted to the HSCB.

It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI Investigations. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the investigation team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the investigation progresses. In these instances the HSCB must also be informed:

- **Level 1 Investigations - on submission of Investigation Report and Checklist Proforma**
- **Level 2 and 3 Investigations - on submission of the Terms of Reference and Membership of the review team.**

3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a

number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident investigation is undertaken, and that the service user / family will be kept informed, as the investigation progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family' sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident investigation process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the investigation and who the investigation report will be shared with.

3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions
- Stage 5 – Process Completion

The duration of this process depends on the level of SAI investigation being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

A Level 1 Investigation may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the investigation, provided they are content they have been provided with all information.

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.

4.2 Stage 2 – Communication

4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

4.2.2 Choosing the individual to communicate

The person[1] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the investigation team (if already set up).

[1] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*

4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI investigation is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI investigation, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;

- Advising who will be involved in the investigation before it takes place and who the investigation report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being investigated as a SAI, and knowing the organisation will continue to engage with them as the investigation progresses, so long as the service user / family wish to engage.

Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.

4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI Investigations);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

4.5 Stage 5 – Process Completion

4.5.1 Communicating findings of investigation / sharing investigation report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the investigation

- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and that the final investigation report will be shared with the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013) organisations may not have completed stage 5 of the engagement process prior to submission of the investigation report to HSCB. In these instances, organisations must indicate on the SAI Investigation checklist, submitted with the final Investigation report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of investigation / share investigation report.

4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.

Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at www.dhsspsni.gov.uk/sudden-death-guidance.pdf

List of Acronyms and Abbreviations

FPS	-	Family Practitioner Services
GMC	-	General Medical Council
HSC	-	Health and Social Care
HSCB	-	Health and Social Care Board
HSE	-	Health Service Executive
MDU	-	Medical Defence Union
MPS	-	Medical Protection Society
NIASW	-	Northern Ireland Association for Social Work
NISCC	-	Northern Ireland Social Care Council
NMC	-	Nursing and Midwifery Council
NPSA	-	National Patient Safety Agency
PCC	-	Patient Client Council
PHA	-	Public Health Agency
RC	-	Royal colleges
RCA	-	Root Cause Analysis
RQIA	-	Regulation and Quality Improvement Authority
SAI	-	Serious Adverse Incident
SEA	-	Significant Event Audit

Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.

1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).

1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using 'unofficial translators' and / or the service users family or friends as they may distort information by editing what is communicated.

1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the relationship between the service user / family and HSC staff breaks down and they may not be content with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;
- Ensure the service user / family are fully aware of the formal complaints procedures;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.

1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.

Appendix 2

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for

Service Users,

Family Members and Carers

Insert Name of Organisation

This leaflet is written for people who use Health and Social Care services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

In some circumstances events are reported as Serious Adverse Incidents (SAIs) to help identify learning even when it is not clear something went wrong with treatment or care. For example, we report the death of any child receiving health or social care services (up to the age of 18 years) regardless of the cause of death.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice are also highlighted and shared where appropriate.

What is a Serious Adverse Incident?

An SAI is an incident or event that must be reported to the Health & Social Care Board by the organisation where the SAI has occurred, and investigated. It may be:

- An incident resulting in serious harm;
- An unexpected or unexplained death;
- A suspected suicide of a service user who has a mental illness or disorder;
- An unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;
- When a child has died this includes any death of a child in receipt of HSC services (up to eighteenth birthday);
- The incident or event may affect services users, members of the public or staff.

Can a complaint become an SAI?

Yes, if during the follow up of a complaint (**insert name of organisation)** identifies a serious adverse incident has occurred it will be reported as a SAI. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is the SAI investigated?

Depending on the circumstance of the SAI an investigation will be undertaken. This will take between 4 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be investigated and who will be involved. The Trust will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family / carer involved in the investigation?

An individual will be identified to act as your link person throughout the investigation process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the investigation process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the investigation, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the investigation;
- Are offered the opportunity to meet and discuss the investigation

findings;
- Are offered a copy of the investigation report;
- Are offered advice in the event that the media make contact.

What happens once the investigation is complete?

The findings of the investigation will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By investigating a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed investigation:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a Health and Social Care Service. This may include help with writing letters, making telephone calls

or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the investigations.

Contact details:
Free phone number: 0800 917 0222
e-mail address: complaints.pcc@hscni.net

Do families get a copy of the report?

Yes;

- with the service users' consent;

- If the service user has died, families will get a copy of the report and an invite to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and investigation, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the

recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the investigation will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below: -

Your link person is ……..

Your link person's job title is……..

Contact number …….

Hours of work…….

Prior to any meeting or telephone call you may wish to consider the following questions

- Think about what questions and fears/concerns you have in relation to;

  (a) What has happened?
  (b) Your condition / family member condition
  (c) On-going care

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Examples of communication which enhances the effectiveness of being open	
Stage of Process	**Sample Phrases**
Acknowledgement	"We are here to discuss the harm that you have experienced/the complications with your surgery/treatment" "I realise that this has caused you great pain/distress/anxiety/worry" "I can only imagine how upset you must be" "I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you" "I understand that you are angry/disappointed about what has happened" "I think I would feel the same way too"
Sorry	"I am so sorry this has happened to you" "I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation" "I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment." "I am so sorry about the anxiety this has caused you" "A review of your case has indicated that an error occurred – we are truly sorry about this"
Story	**Their Story** "Tell me about your understanding of your condition" "Can you tell me what has been happening to you" "What is your understanding of what has been happening to you"

	Your understanding of their Story: (Summarising) "I understand from what you said that" xxx "and you are very upset and angry about this" Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.) "Am I right in saying that you……." **Your Story** "Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned? "Do you mind if I tell you what we have been able to establish at this stage?" "We have been able/unable to determine at this stage that……." "We are not sure at this stage about exactly what happened but we have established that ……. We will remain in contact with you as information unfolds" "You may at a later stage experience xx if this happens you should ……."
Inquire	"Do you have any questions about what we just discussed?" "How do you feel about this?" "Is there anything we talked about that is not clear to you?"
Solutions	"What do you think should happen now?" "Do you mind if I tell you what I think we should do?" "I have reviewed your case and this is what I think we need to do next" "What do you think about that?" "These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?" "I have discussed your condition with my colleague Dr x we both

	think that you would benefit from xx. What do you think about that?"
Progress	"Our service takes this very seriously and we have already started an investigation into the incident to see if we can find out what caused it to happen" "We will be taking steps to learn from this event so that we can try to prevent it happening again in the future" "I will be with you every step of the way as we get through this and this is what I think we need to do now" "We will keep you up to date in relation to our progress with the investigation and you will receive a report in relation to the findings and recommendations of the investigation team" "Would you like us to contact you to set up another meeting to discuss our progress with the investigation?" "I will be seeing you regularly and will see you next in….days/weeks. "You will see me at each appointment" "Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……" "If you think of any questions write them down and bring them with you to your next appointment." "Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services"

Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach

Before, During and After Communication / Engagement Documentation Checklist

BEFORE	***Note taking***
Service users full name	
Healthcare record number	
Date of birth	
Date of admission	
Diagnosis	
Key HSC professional(s) involved in service user's care	
Date of discharge (if applicable)	
Date of SAI	
Description of SAI	
Outcome of SAI	
Agreed plan for management of SAI	

Agreed professional to act as contact person with the service user / family	
Service user / family informed incident is being investigated as a SAI: • Date • By Whom • By what means (telephone call / letter / in person)	
Date of first meeting with the service user / family	
Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc)	
Person to be responsible for note taking identified	
Person Nominated to lead communications identified	
Colleague/s to assist nominated lead	
Other staff identified to attend the disclosure meeting	
Anticipated service user / family concerns queries	
Meeting agenda agreed and circulated	
Additional support required by the service user / family, if any?	

The service user / family has been advised to bring a support person to the meeting?	
The service user consented to the sharing of information with others such as designated family members / support person?	
It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made.	

Signature: _____

***Date*:** _____

DURING ***Note taking***

There has been an acknowledgment of the SAI in relation to the service user / family experience.	
An apology / expression of regret provided	
The service user / family was provided with factual information regarding the adverse event	
The service user / family understanding of the SAI was established	
The service user / family was provided with the opportunity to: - Tell their story - Voice their concerns and - Ask questions	
The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made.	
The service user / family was provided with information in relation to the supports available to them.	
Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided.	
Next meeting date and location agreed	

Signature: _____

***Date*:** _____

AFTER

Circulate minutes of the meeting to all relevant parties for timely verification.
Follow through on action points agreed.
Continue with the incident review.
Keep the service user included and informed on any progress made – organise further meetings.
Draft report to be provided to the service user in advance of the final report (if agreed within investigation Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA).
Offer a meeting with the service user to discuss the review report and allow for amendments if required.
Follow through on any recommendations made by the incident review team.
Closure of the process is mutually agreed.
When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process.

Signature: _____

***Date*:** _____