BHSCT Serious Adverse Incident (SAI) Procedures – April 2014

This procedure includes the following:-

1. Reporting a SAI
2. Investigating a SAI
3. Developing & Monitoring SAI Action Plans

1. Reporting a Serious Adverse Incident (SAI)

1.1 What is a SAI?

A SAI is an adverse incident that must be reported to the Health & Social Care Board (HSCB) because it meets at least one of the following criteria:

- Serious injury to, or the unexpected/unexplained death of:
  - a service user (including those events which should be reviewed through a significant event audit)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility.
- any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a Looked After Child or a child whose name is on the Child Protection Register;
- unexpected serious risk to a service user and/or staff member and/or member of the public
- unexpected or significant threat to provide service and/or maintain business continuity
- serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;
- serious self-harm or serious assault (including homicide and sexual assaults)
  - - on other service users,
  - - on staff or
  - - on members of the public

by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;

- suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident;
- Serious incidents of public interest or concern relating to:
    - any of the criteria above
    - theft, fraud, information breaches or data losses
    - a member of HSC staff or independent practitioner

Any adverse incident which meets one or more of the above criteria should be reported as a SAI.

1.2 How to Report a SAI

If an adverse incident occurs which meets or seems to meet any of the above criteria it should be reported immediately through the reporters management line and ultimately to Director or Co-Director for consideration for reporting as a SAI (the directorate Governance & Quality Manager or equivalent, should also be included in any communication). This should be done urgently and in the form of verbal as well as email communication.

When Director/Co-Director agrees to report the incident as a SAI, the relevant Manager or Governance & Quality Manager should then complete the SAI Notification form report, send it to the Director / Co-Director for approval and forward the approved copy (including details of who approved it) to the Corporate Governance Department SAI mailbox (address below) for onward reporting to the Health & Social Care Board (HSCB). This form can be found on the Trust Intranet at the following link:-

Link to be set up

The form can also be obtained by emailing your request to Serious Adverse Incident mailbox SeriousAdverseIncident@belfasttrust.hscni.net (Also in Outlook address book) or by contacting Corporate Governance Services on Tel: 028 950 48098.

(The Serious Adverse Incident mailbox should also be used for all SAI correspondence with Corporate Governance and external bodies.)

Corporate Governance will then check and redact the SAI Notification form and give it a BHSCT SAI reference number. The form will then be forwarded to the HSCB and if applicable to the Regulation and Quality Improvement Authority (RQIA).

A Trust Incident Report Form should also be completed as soon as possible (if not already done so) as per Trust procedures.
(All Adverse Incident policies and procedures can be found in Policies & Guidelines page of Trust Intranet under the Medical Directorate/Risk & Governance sub folders.)

1.3 Timescale

All SAIs are required to be reported to HSCB within 72 hours of the incident being discovered.

1.4 General guidance on completing the SAI Notification form

Guidance on completing the SAI Notification for can be found at Appendix 1. The following points should be read in conjunction with those procedures:-

Sections to complete

Complete all of the following sections (Corporate Governance will complete the remainder)

Sections 3, 4, 5, 6, 8 (excluding CCS coding), 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18.

Section 8: Incident Description:

- Provide a brief factual description of what has happened and a summary of the events leading up to the incident. Please ensure sufficient information is provided so that the HSCB/PHA is able to come to an opinion on the immediate actions, if any, that they must take.
- Where relevant include D.O.B, Gender and Age.

- All reports should be anonymised – the names of any practitioners or staff involved must not be included. Staff should only be referred to by job title.

1.5 Informing the service user / family / carer

The principles of the Being Open policy must be adhered to when communicating to service users, their families or carers regarding the reporting of a Serious Adverse Incident. Where it is clear or suspected that a SAI has resulted in unexpected serious harm or death to a service user rapid and open disclosure and emotional support should be given.

The Co-Director responsible for the SAI is also responsible for ensuring the service user / family / carer is communicated with appropriately regarding the SAI and subsequent investigation. They will nominate the appropriate person to speak with the service user / family / carer initially and also ensure the service user / family / carer has a link person to contact throughout the SAI process as required. An information leaflet[1] covering "What do I need to know about Serious Adverse Incidents" should be given to the service user / family / carer to include contact details for the link person. **NB -This leaflet should only be used when it is confirmed that a SAI has been reported.**

If the Service User/Family/Carer has been notified of the incident before completing the SAI notification form, the appropriate date of notification must be included in section 15 of the form (see appendix 1). If notification is planned and not yet complete at the time of reporting, or not planned, the reason(s) should be explained in the "Others" free text field in section 15 of the form, or where relevant in any updated form the HSCB subsequently issues.

1.6 Coroner Involvement

Details of involvement with the Coroner should be included in the description section 8 of the Notification form. It is also important to include date of notification of the Coroner if applicable in section 17. When it is known that a death is to be investigated as an SAI the Coroner must be notified of this even if previously notified of the death.

[1] There are two Trust leaflets informing service users / family / carers about SAIs. One is specifically for Adult Social and Primary Care and the other is general and should be used in all other areas.

Ensure the form is forwarded by email to the Trust SAI email address seriousadverseincident@belfasttrust.hscni.net along with confirmation of approval by the relevant Director or Co-Director (name of whom must be provided).

1.7 "Query Serious Adverse Incidents" (QSAIs)

The responsibility for identifying and decision to report an SAI lies primarily with the relevant directorate responsible for that incident. To support directorate incident review processes and to act as a further barrier to delayed reporting, the Corporate Governance department may query any incident report where an SAI criteria seems to have been met but where the date for reporting the incident as an SAI is overdue and with no indication that it is being reported or considered. This is known as a Query SAI (QSAI) and "QSAI" is added to the incident reference until closed.

Once an incident is identified as being a query SAI (QSAI) it is forwarded to the relevant Governance manager or alternative for consideration for reporting as a SAI. The incident will remain open as a QSAI until Corporate Governance receives either:-

- A completed approved SAI Notification form relating to the incident, or
- An investigation report or summary as necessary which includes a clear explanation of why the incident does not meet the criteria for reporting as an SAI. This should also include any learning and actions taken to prevent re-occurrence where applicable. Please note that the decision not to report as an SAI may be subject to challenge from the Medical Directorate's office.

  The response to the QSAI should be sent to the Trust SAI mailbox and any report should also be included within the Datixweb incident record and referenced in the investigation section.

2. Procedure for investigating Serious Adverse Incidents (SAI)

The following procedures for investigation of Serious Adverse Incidents (SAI) are based on, and should be read in conjunction with, the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013.

When reporting a SAI, the responsible Director / Co-Director (in conjunction with the Medical Director if considering a level 3) must decide on the level of investigation required and this must be indicated on the SAI Notification form (section 18). There are 3 levels of investigation available for SAIs and these are explained below with a summary table for quick reference.

2.1 Level of SAI Investigation

SAI investigations should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning of all SAIs reported, it is important the level of investigation focuses on the complexity of the incident and not necessarily on the significance of the event.

SAIs will be investigated using one or more of the following:

Level 1 Investigation – Significant Event Audit (SEA)

A level 1 investigation requires the use of Significant Event Audit (SAE) investigation methodology to investigate the incident. For guidance on using SEA methodology please see *NPSA SEA guidance link*.

SAI notifications which indicate a level 1 investigation will enter the investigation process at this level and a SEA will immediately be undertaken to:

- assess why and what has happened
- agree follow up actions
- identify learning

The possible outcomes may include:

- no action required
- identification of a learning need and actions
- sharing the learning
- Requires Level 2 or 3 investigation.

The SEA report must be completed, approved by the relevant Director or Co-Director and sent to the Trust SAI mailbox for onward reporting to the HSCB within 4 weeks of the SAI being reported.

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If during or on completion of the SEA the investigating team determines the SAI is more complex and requires a more detailed investigation, the investigation will move to either a level 2 or 3 investigation.

If a Level 2 RCA is required, the SEA report will still be forwarded to the HSCB within 4 weeks of the SAI being reported along with completed sections 2 and 3 of the RCA template to include Team Membership and Terms of Reference of the team completing the level 2/3 investigation. The level 2 RCA process will then need to be initiated (see below). It may be possible to retain the same team but the level of independence needs to be considered and the Co-Director will need to contact Corporate Governance who oversee a pool of level 2 investigators (see below).

In most circumstances, completed SEA investigations at this level will be adequate for incidents involving no harm and low harm and/or where the circumstances are of a less complex nature. In these instances it is more proportionate to use a concise SEA to ensure there are no unique factors and then focus resources on implementing improvement rather than conducting a comprehensive investigation that will not produce new learning.

Any learning from these investigations should be shared as appropriate within the Directorate governance structures and in accordance with the Trust Sharing Learning procedure (appendix 2). If there is significant learning at any stage of the SEA process which requires urgent sharing outside the directorate, this should be brought to the next SAI Group meeting by the relevant Co-Director on a Transferrable Learning Template (see appendix 2).

Level 2 – Root Cause Analysis (RCA)

Level 2 Investigations will most likely be conducted for incidents of actual or potential serious harm or death and/or where the circumstances involved are relatively complex and may involve multiple processes/teams/disciplines.

The investigation should include use of appropriate RCA analytical tools (see paragraph 2.3 below and NPSA Guidance on RCA methodology on hub *insert link*) and will normally be conducted by a multidisciplinary team (not directly involved in the incident) with a degree of independence determined by the complexity of the incident. The investigation should be chaired by someone independent to the service area involved as a minimum. The investigation report should be completed using the HSCB RCA report template (see appendix 6 & 7 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013).

Team membership for level 2 investigations is the responsibility of the commission Director / Co-Director. Members will be selected from an established pool of investigators and will be proposed by Corporate Governance to include members independent of the directorate concerned, with agreement from the Commissioning Director / Co-Director. Where the Commissioning Director / Co-Director requires team member(s) external to the Trust, Corporate Governance will liaise with the commissioning Director / Co-Director to propose an appropriate independent member(s) for inclusion on the team.

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Level 2 SAI investigations may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to the final investigation report. Corporate Governance will liaise with the other organisation(s) to propose a team member(s).

Sections 2 and 3 of the RCA template will be completed and forwarded to the HSCB by, or on behalf of the Director / Co-Director within 4 weeks of the SAI being notified, detailing the membership and Terms of Reference for the level 2 investigation.

Any learning from these investigations should be shared as appropriate within the Directorate governance structures and in accordance with the Sharing learning procedure (appendix 2). If there is significant learning at any stage of the SEA process which requires urgent sharing outside the directorate, this should be brought to the next SAI Group meeting by the relevant Co-Director on a Transferrable Learning Template (see Sharing Learning procedure).

Level 3 – Independent Investigation

Level 3 investigations will be considered for highly complex SAIs where a high degree of external/independent representation on the investigation team is required. In some instances all team members may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting, Chair and membership of review team will be agreed with the HSCB/PHA Designated Review Officer (DRO) at the outset. The Commissioning Director / Co-Director and Medical Director should liaise with the DRO through Corporate Governance to agree timescales, team membership and terms of reference.

Level 3 investigation reports will take the same format as level 2 and use the same template structure for the final report.

Any SAI which involves an alleged homicide perpetrated by a service user known to/referred to mental health and/or learning disability services will be investigated as a level three incident. In these instances, the Protocol for Responding to a SAI in the Event of a Homicide, issued in 2010 and revised in 2013 should be followed (see appendix 13 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013).

2.2 Timescales

Notification

Any adverse incident that meets the criteria of a SAI must be reported within 72 hours of the incident being discovered using the SAI Notification Form.

Investigation Reports

- Level 1 – SEA

SEA reports must be completed using the SEA template and submitted to the HSCB within 4 weeks (6 weeks by exception) of the SAI being notified.

Note: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to HSCN to allow for redacting and final checks.

- Level 2 – RCA

RCA investigation reports must be completed using the level 2 & 3 report template and submitted to the HSCB 12 weeks from the initial notification of the SAI to HSCB or, if previously a SEA, 12 weeks from submission of the SEA report.

Note: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to HSCN to allow for redacting and final checks.

- Level 3 – Independent Investigations

Timescales for completion of level 3 investigations will be set by the HSCB/PHA lead officer and/or DRO.

Note: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to HSCN to allow for redacting and final checks.

Investigation Report Extensions

- Level 1 Investigations – SEA

HSCB and PHA will not accept extension requests for this level of investigation. When reporting the SEA, an additional 2 weeks can be sought by exception only with reason given.

- Level 2 Investigations - RCA

In most circumstances, all timescales for submission of RCA investigation reports must be adhered to. However, it is acknowledged there may be some occasions where an investigation is particularly complex, perhaps involving two or more organisations. In these instances the reporting organisation may request an extension to the normal timescale i.e. 12 weeks from timescale for submission of interim update report. However, this request must be approved by the DRO and should be requested when submitting the interim update report.

- Level 3 Investigations – Independent

As per above, all timescales (including possible extensions) must be agreed with the DRO at the outset of the investigation.

DRO Queries

- Level 1 Investigations – SEA

DRO queries must be responded to within 1 week of the query being received

- Level 2 Investigations - RCA

DRO queries must be responded to within 4 weeks of the query being received

- Level 3 Investigations – Independent

DRO queries must be responded to within 4 weeks of the query being received

Monitoring

The investigation progress will be monitored by the SAI Group and the responsible director/ Co-director to ensure timetables are met. A performance report will be tabled at each SAI Group identifying any areas where targets are not being met. The relevant Co-Director will be required to provide explanations for any delays.

When the draft final report is complete, the Investigation team chair is advised to share the report with a Trust colleague independent to the directorate to review. The reviewer may have comments/feedback which will then be considered by the Investigation team before finalisation of the report for approval by relevant Director/Co-director.

Actions

The RCA template (appendix 6 & 7 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013) indicates that an action plan should be included within the Final report for submission to HSCB. This should be done as far as possible with a final draft Action Plan forwarded as soon as approved. Actions do not need to be complete when submitting the action plan to the HSCB. Further details on the Action Plan can be found in paragraph 3.0 below.

2.3 Completion of SEA & RCA templates

Guidance on completing the SEA and RCA templates for can be found at Appendix 5 & 6 respectively of the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013. The following points should be read in addition to those procedures:-

- Jargon or unexplained abbreviations must not be used within the report. Although clinical shorthand would be understandable to other clinicians, a SEA or RCA report is a formal report and not a clinical record. As such it should be understandable to non-clinicians including the service user / family members / carers and the Coroner.

- All reference to services, organisations, facilities etc should be explained fully if not otherwise obvious to the reader e.g. including the name of a housing association building without explaining what it is would not suffice.
- The HSCB RCA template is in tabular form. This may cause formatting difficulties. It is acceptable to use a blank word document instead but the HSCB section headings from the RCA template must be included.

2.4 Service User/Family/Carer involvement

HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013 Paragraph 5.4 should be adhered to and states the requirement for service user / family / carer involvement in SAI investigations is as follows:-

"It is important that teams involved in investigations in any of the above three levels ensure sensitivity to the needs of the service user/relatives/carers involved in the incident and agree appropriate communication arrangements, where appropriate. The Investigation Team should provide an opportunity for the service user / relatives / carers to contribute to the investigation, as is felt necessary. The level of involvement clearly depends on the nature of the incident and the service users/relatives/carers wishes to be involved."

The Co-Director responsible for the SAI should ensure the appropriate level of involvement of service user / family / carer throughout the investigation including discussion / sharing of the final report with the service user / family / carer and this should be agreed with the investigation team from the outset.

The Co-Director responsible for the SAI should ensure the completion of a SAI Investigation Report checklist (appendix 3) when submitting Investigation reports to HSCB. This checklist will explicitly describe the involvement (and if not, the circumstances where it has not happened) of Service Users/Relatives/Carers in the Investigation and whether they received a final report.

Approved SAI final reports should be shared or talked through with the service user/relatives/Carer as appropriate and where this is not done, an explanation must be submitted within the SAI checklist and if pending, this should be included as an action in the subsequent Action Plan for that SAI (see below).

In all cases the principles of consent and patient confidentiality must be upheld.

For guidance on how to involve families in the SAI investigations please refer to the RCA Guidance on the hub.

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Involvement specific to SEA reports

Under the HSCB timeframe for completing SEAs it may not be possible to involve the service user / family / carer in the investigation process before the final report is submitted to the HSCB. In such cases, where family involvement is deemed appropriate, the approved report should be discussed / shared with the family at a date as soon as possible after submission of the report and any issues addressed and those requiring material changes to the SEA report should be added as an addendum and forwarded to Corporate Governance for sending to HSCB in a revised report.

Where a SAI is also a Complaint

Where a Serious Adverse Incident is also a Complaint, the investigation under the SAI process will take precedence and the Complaints investigation will be put on hold until the SAI investigation is complete. The Complainant must be notified of this as soon as possible. An information leaflet along with an explanation of the change in process should be given to the Complainant.

Note that communication through the complaints process with the Complainant should continue regarding timescales and any associated delays. The SAI investigation process as per above will also have a link person identified to communicate with the service user / family / carer and will communicate through this process as appropriate. When complete the SAI final report will be shared with the Complainant and the complaints process remains open until the complaint is formally closed with all complaints issued addressed.

2.5 Coroner engagement

Reports should also routinely include in their chronology details of all engagements with the Coroner where a death has occurred and if the Coroner has not been involved this should be stated and the decision explained.

The Co-Director responsible for the SAI should also ensure the completion of a SAI Investigation Report checklist (appendix 3) when submitting Investigation reports to HSCB. This checklist will explicitly ask if the Coroner has been notified and if the case has been closed.

2.6 Child Protection and Adult Protection

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Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the investigation of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as a SAI.

It should be noted that, where possible, safeguarding investigations will run in parallel as separate investigations to the SAI process with the relevant findings from these investigations informing the SAI investigation and vice versa. However, all such investigations should be conducted in accordance with the processes set out in the Protocols for Joint Investigation of Cases of Alleged or Suspected Abuse of Children or Adults.

In these circumstances, the DRO should liaise closely with the HSC Trusts on the progress of the investigation and the likely timescales for completion of the SAI Report.

On occasion the incident under investigation may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

If a CMR is being considered the SAI process may be suspended and the HSCB notified of this whilst a notification and decision regarding CMR is made.

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							Responsible officer			
SAI type *(guide only)*	**Inv. level**	**Inv. tool/ Template**	**Timescale**	**Chair**	**Team**	**Extension**	**Approval**	**Action Plan**	**Learning**	**DRO Queries timescale**
Mostly Low/no harm, not complex, minimal learning envisaged at outset	Level 1	SEA	4 weeks	Outside Service Area. SEA trained	Local multi-disciplinary.	No (2 additional weeks when reporting SAI, by exception)	Director/Co-Director	Director/Co-Director	To SAI group if sharing beyond Directorate	1 week
SEA not sufficient, more complex and/or serious outcome	Level 2	RCA	12 weeks from SAI Notification or completion date of SEA. ToR & Team membership by 4 weeks	Outside Service Area/Dir. or Trust. RCA trained	Multi-disciplinary / Trust independent input possible.	1 extension by exception, sought at 4-6 weeks.	Director	Director/Co-Director & SAI Group	To SAI group if sharing beyond Directorate	4 weeks
Particularly complex/ multiple orgs involved; requires significant degree of independence; high profile.	Level 3	RCA	To be agreed with HSCB	Outside Dir or Trust. RCA trained	Highly independent multi organisational	To be agreed with HSCB	Director/ Chief Executive	Director & SAI Group	To SAI group if sharing beyond Directorate	4 weeks

Table 1: SAI Investigation process – Teams, tools and timescales

For further details please see HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013

3. Action Plans - Procedure for developing & monitoring SAI Action Plans

3.1 Introduction

These procedures outline the responsibilities and requirements to ensure appropriate actions are taken to prevent/minimise re-occurrence and share learning.

The individual who commissioned the SAI investigation has responsibility for ensuring any recommendations and lessons learned are incorporated into a plan of appropriate and realistic actions (SAI Action Plan).

An Action Plan is an important tool to improve systems and implement recommendations from investigations into Adverse Incidents:

Action Plans for SAIs should be approved by the individual who commissioned the Investigation (usually Director). When all actions are completed they should be signed off by the Director/ Co-Director and in the case of Level 2 & 3 SAIs noted as closed at SAI Group.

A robust Action Plan should be:-

- explicit
- time bound
- deliverable
- assign responsibility for the action
- measurable

Avoid actions such as *remind staff* or *promote awareness,* but it they have to be used, explain how this will be done e.g. a poor action would be – *share updated policy with staff*.

Be more specific – *send staff the specific section which has changed highlighting the change and drawing their attention to it*.

SAI Action Plans should include actions for sharing lessons learned from SAI investigations as appropriate.

3.2 Generating actions from the Final Report

Whilst recommendations in a final report are drawn up and are the responsibility of the Investigation team, the corresponding actions are the responsibility of the relevant Director or Co-Director. Action Plans must address all recommendations within the Final Report as deemed appropriate. Where actions are at variance with what has been recommended within the Investigation report a reason should be given to justify the differing course of action or no action.

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If Recommendations include actions external to the Trust, the Action Plan should address who will take these forward and how they have been notified.

Additional actions

- An action should be included in the Action Plan in relation to sharing the Action Plan with the service user / family / carer as appropriate and the progress of this should be monitored until complete.
- An action should be included which outlines how the learning from the SAI is being shared as appropriate.

3.3 Developing an Action Plan

- Overall responsibility for the SAI Action Plan must be with the Director / Co-Director who commissioned the SAI Investigation.
- The Director / Co- Director who commissioned the investigation must determine who draws up the actions.
- Where the action identified is within the area of responsibility of the Director / Co-Director who commissioned the investigation, the person identified to take the action forward must be instructed to do so and have the capacity required.
- Where a recommendation is outside the area of responsibility of the Director / Co-Director who commissioned the investigation, discussion and agreement must be reached with the relevant manager for drawing up and taking any action(s) forward.
- Timescales for each action must be agreed with the person/area responsible for implementing the action.
- A draft Action Plan should be submitted as far as possible with the Final Report to the HSCB with a final draft submitted when approved. Actions do not need to be completed when submitting to the HSCB.

3.4 Documentation

- Every Action Plan must be documented using the “SAI Monitoring / Tracking Report template” LINK which complies with the minimum standard for Action Plans appendix 8 HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013.

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- The SAI Monitoring / Tracking Report template for recording Action Plans includes the following:-
    - The reference number of the SAI
    - Date of the SAI Investigation report
    - Date of the latest version of the Action Plan
    - Version number and how often the Action Plan is to be reviewed
    - Who will monitor the implementation of the Action Plan.
    - Who will sign off the Action Plan when all actions are complete
- Each action on the "SAI Monitoring / Tracking Report template" must include:-
    - An associated recommendation, Contributory factor or lesson learned from the Investigation report.
    - A reference or sub-reference number.
    - The current position – this should provide the latest position in relation to progressing the action to date.
    - A description of the action to be taken.
    - Name of the responsible lead for that action (not only their job title).
    - A timescale for completion (if unknown an estimate should be made).
    - Evidence of progress/completion (including any intended Action Plan reviews or audits).
    - Indication of current status which must be one of the following:-
        - RED – Action agreed but not yet commenced
        - AMBER – Action in progress
        - GREEN – Action complete

3.5 Monitoring

- The Director / Co-Director who commissioned the investigation is responsible for setting up directorate level monitoring and review processes to ensure actions are progressed as planned.
- Where actions cannot be completed, the Director / Co-Director who commissioned the investigation is responsible for ensuring that any associated risks are identified and managed in line with the Trust Risk management strategy and brought to the SAI Group for consideration, along with any other unresolved issues.
- The relevant Co-Director responsible for the SAI should notify the SAI Group of the closure of any Action Plans which are complete and have no outstanding issues. Action Plans will not normally be required to be tabled at SAI Group.
- The SAI Group will in respect of its provision:-
    - Provide independent review to agree learning points for sharing;
    - Note closure of action plans through exception reporting;
    - Directorate membership will provide assurance of appropriate debriefing and sharing of learning at Directorate level;
    - Agree appropriate escalation of learning to the Learning from Experience Steering Group;
    - Review status reports from external bodies, such as HSCB/RQIA/HSCNI, as and when required;
    - Members will report on identified risks/issues associated with SAIs and agree appropriate escalation to the Learning from Experience Steering Group;
    - Make recommendations to corporate and operational risk registers as appropriate.
- The Corporate Governance department of the Medical Director's directorate will have responsibility for administering a central monitoring process to facilitate SAI Group monitoring.
- Directorate senior managers responsible for governance are responsible for ensuring Corporate Governance has the latest version of action plans held centrally.
- The Corporate Governance department will have responsibility within the central monitoring process for providing a final check on Action Plan progress and will provide liaison with external organisations as required.

4.0 Closure of the SAI

The SAI is closed when signed off by the SAI Group. This will be done when the Action Plan is complete and no outstanding issues remain and will usually include ensuring that the HSCB has also closed the SAI (which they do via email to Corporate Governance and notification of this will be forwarded to the commissioning Director / Co-Director). When closed, a confirmation email is sent to the Director / Co-Director to include a final version of the Final report and Action Plan. Up until this stage, the version used will be a “final approved draft” and subject to change due to further material changes for example after comments received from family members. Any change will be under strict version control through Corporate Governance, approved by the commissioning Director / Co-Director and presented as an addendum to the report and forwarded to HSCB and any other relevant stakeholders.

APPENDIX 1

Guidance Notes
HSC SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

All Health and Social Care Organisations, Family Practitioner Services and Independent Service Providers are required to report serious adverse incidents to the HSCB within 72 hours of the incident being discovered It is acknowledged that not all the relevant information may be available within that timescale, however, there is a balance to be struck between minimal completion of the proforma and providing sufficient information to make an informed decision upon receipt by the HSCB/PHA.

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB/PHA to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *(to be completed by Corporate Governance department)*	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REF NO.** *(to be completed by Corporate Governance department)*
3. HOSPITAL FACILITY *where the incident occurred*	**4. DATE OF INCIDENT: DD / MMM / YYYY** *Insert the date incident occurred*
5. DEPARTMENT / WARD: *where the incident occurred*	
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7. PROGRAMME OF CARE:** *(to be completed by Corporate Governance department)*

8. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Child Protection Committee have been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*

whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(to be completed by Corporate Governance department)*	**DETAIL:** *(to be completed by Corporate Governance department)*	**ADVERSE EVENT:** *(to be completed by Corporate Governance department)*

9. IMMEDIATE ACTION TAKEN TO PREVENT RECURRANCE:

Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

10. CURRENT CONDITION OF SERVICE USER:

***Where relevant** please provide details on the current condition of the service user the incident relates to.*

11. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	**YES**	**NO**	**N/A**
12. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please select and specify **where relevant**)*	**YES**	**NO**	**N/A**

13. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*

Serious injury to, or the unexpected/unexplained death of: • a service user • a staff member in the course of their work • a member of the public whilst visiting a HSC facility.	
Any death of a child (up to eighteenth birthday) in a hospital setting.	
Unexpected serious risk to a service user and/or staff member and/or member of the public	
Unexpected or significant threat to provide service and/or maintain business continuity	
Serious self-harm or serious assault (*including homicide and sexual assaults*) by a service user, a member of staff or a member of the public within a healthcare facility	
Suspected suicide of a service user known to Mental Health services (including Child and Adolescent Mental Health Services, (CAMHS) and Learning Disability (LD) within the last year.	
Serious self-harm / serious assault (including homicide and sexual assaults) by a service user in the community who is known to mental health services (*including CAMHS*) or learning disability services within the last year. ▪ on themselves ▪ on other service users, • on staff or • on members of the public	
Serious incidents of public interest or concern relating to: • any of the criteria above • theft, fraud, information breaches or data losses • a member of HSC staff or independent practitioner	

14. IS ANY <u>IMMEDIATE</u> REGIONAL ACTION RECOMMENDED? *(please select)*	**YES**	**NO**

if 'YES' *(full details should be submitted):*

15. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING INVESTIGATED AS A SAI	**YES - Date informed**	**No – Specific reason?** *If the service user suffered harm but was not informed of the SAI, or if the SAI involves the death of a Service User and their family / carer were not informed, please include here the reason for this.*

16. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? ***where there appears to be a breach of professional code of conduct***	**YES**	**NO**

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH PROFESSIONALS COUNCIL **(HPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
OTHER – PLEASE SPECIFY BELOW

if 'YES' ***(full details should be submitted including date notified):***

17. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	**DATE INFORMED:**	**OTHER:** *(please specify where relevant).*
DHSS&PS EARLY ALERT		**Date informed:**
SERVICE USER / FAMILY		
HM CORONER		
INFORMATION COMMISSIONER OFFICE **(ICO)**		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE **(NIAIC)**		
NORTHERN IRELAND HEALTH AND SAFETY EXECUTIVE **(NIHSE)**		
POLICE SERVICE FOR NORTHERN IRELAND **(PSNI)**		
REGULATION QUALITY IMPROVEMENT AUTHORITY **(RQIA)**		

18. Level of investigation	Level 1 *SEA*	Level 2 *RCA – Can be Trust and/or independent*	Level3 *RCA Complex / Multi organisational*

19. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

20. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further investigation may not meet the criteria of a SAI. Use this section to request that a SAI be de-escalated. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further investigation under the SAI process.

The HSCB/PHA will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full investigation report is required.

Use this section also to provide updates on progress with investigations – e.g. where the reporting organisation knows that the investigation report will not be submitted within the 12 week timeframe, this will be communicated to HSCB via Corporate Governance Dept with the unique incident identification number/reference in the subject line and provide the rationale for the delay and revised timescale for completion .

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED INVESTIGATION REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO THE 12 WEEK TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED

Additional information submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

Draft - SHARING LEARNING PROCEDURE Appendix 2

Belfast Health & Social Care Trust

Introduction

When an adverse incident occurs or a patient/client has sub-optimal experience in our service or in another Trust we owe it to our service users and ourselves to learn from such events and reduce the chance of similar experiences happening again.

Sir Liam Donaldson, speaking on patient safety, said in 2007: -

"To err is human, to cover up is unforgivable and to fail to learn is inexcusable"

Learning obtained from incidents can be defined as safety, practice and process issues which have contributed to the incident but from which others can learn.

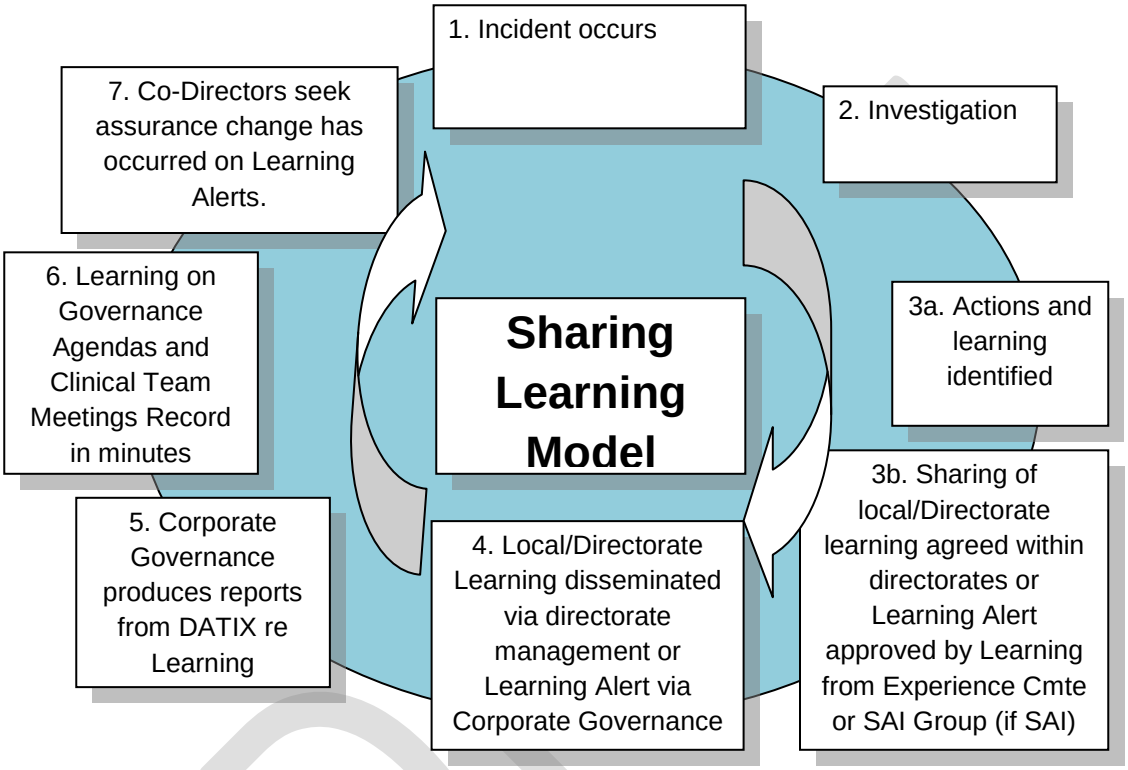
Examples of learning are:-

- Solutions to address incident root causes which may be relevant to other teams, services and provider organisations.
- Good practice which reduced the potential impact of the incident.
- Early detection or intervention which reduced the potential impact of the incident.
- Lessons from conducting the investigation which may improve the management of investigations in future.

Staff are learning from incidents every day but there needs to be an approved procedure for ensuring learning is shared with all parts of the organisation to which it applies. This includes

the need to have a learning repository for staff to refer to. The Trust "Safety Matters" newsletter exists to support this role. This paper will outline how learning should be captured and shared in the Belfast Health & Social Care Trust.

Shared Learning Model



Sources of Learning

This procedure concerns primarily the learning from Adverse Incidents including those resulting in a near miss. Please note that the learning may also be derived from a complaint, litigation, or an audit finding in the Belfast Trust

Events in other Trusts sometimes result in a learning letter from that Trust, HSCB or the DHSSPS. In this case the learning cycle will be initiated by the Trust Corporate Governance Department.

Incident Investigation

All SAIs must be investigated as per the HSCB Procedure for the reporting and follow up of SAIs October 2013, using the investigation report templates contained within that procedure. The templates for Level 1and Level 2&3 type investigations include a section on Learning.

Within investigation reports it is important that: -

- Learning is clearly identified and addressed by the recommendations and relates to the findings.
- A learning section should indicate to whom learning needs to be communicated.

Action Plans

SAI action plans should include actions for sharing of lessons learned from SAI investigations as appropriate.

Local learning (ward/department)

Learning deemed relevant only to the ward or department where the incident occurred should be recorded on the Datix system. The incident approver on Datixweb should ensure the learning is entered in the appropriate field within the Investigation section of the incident form along with any investigation completed and action taken.

Local Learning from incidents reported on paper forms should be forwarded along with any investigation/action taken to Corporate Governance department quoting the incident reference number for inclusion on the Datix system with that incident. These will then be available for sharing electronically as appropriate with the ability to cross-reference to the incident for context and coding of themes.

Shared Learning

Often learning from incidents will be relevant to other areas across the specialty or directorate where the incident occurred. In these circumstances the learning should be shared via Directorate assurance structures and Governance groups as well as using the Datix system

as above to ensure learning is captured. The learning should all be included in directorate governance agenda and discussion/action noted in minutes (for audit trail).

Where learning is relevant beyond the directorate responsible, a Learning Alert may be used in addition to the methods above. This should be used within the functions of the assurance framework and reported through to the learning from Experience sub-committee who provide assurance that learning is shared appropriately.

Learning Alert

A learning alert notice is a communication tool, to enable one service to share the learning from an adverse incident, with other relevant services. The learning alert will be usually a one page document recorded on a Transferrable Learning Template below. This can be easily read, displayed and filed.

The drafting of the Learning alerts will be the responsibility of the person who leads the investigation into the incident and who also prepares the action plan.

Learning Alerts should not name staff or the specific unit where the learning event occurred.

Learning that is deemed relevant to other directorates should be tabled by the relevant Director / Co-Director at the Learning from Experience Committee for a decision for sharing as a learning alert. If approved for sharing, the Learning Alert will then be disseminated by Corporate Governance to the relevant directorates for confirmation of action taken within 3 months. Please see flowchart below.

All learning alerts disseminated will be inserted into a folder in the Corporate Governance webpage in the Hub for easy reference.

Learning from SAIs

Members of the SAI Group (Co-directors/ Governance & Quality Managers) will provide a report on any learning from their current SAIs for sharing beyond their directorate (or other issues to be raised).

The learning alert template should also be used for this purpose. The SAI Group will be responsible for the final wording and dissemination of the alert both Trust wide and regionally.

Regional shared learning

The Trust receives and is expected to act upon learning letters from HSCB, DHSSPS or other agencies and in external/regional audit findings.

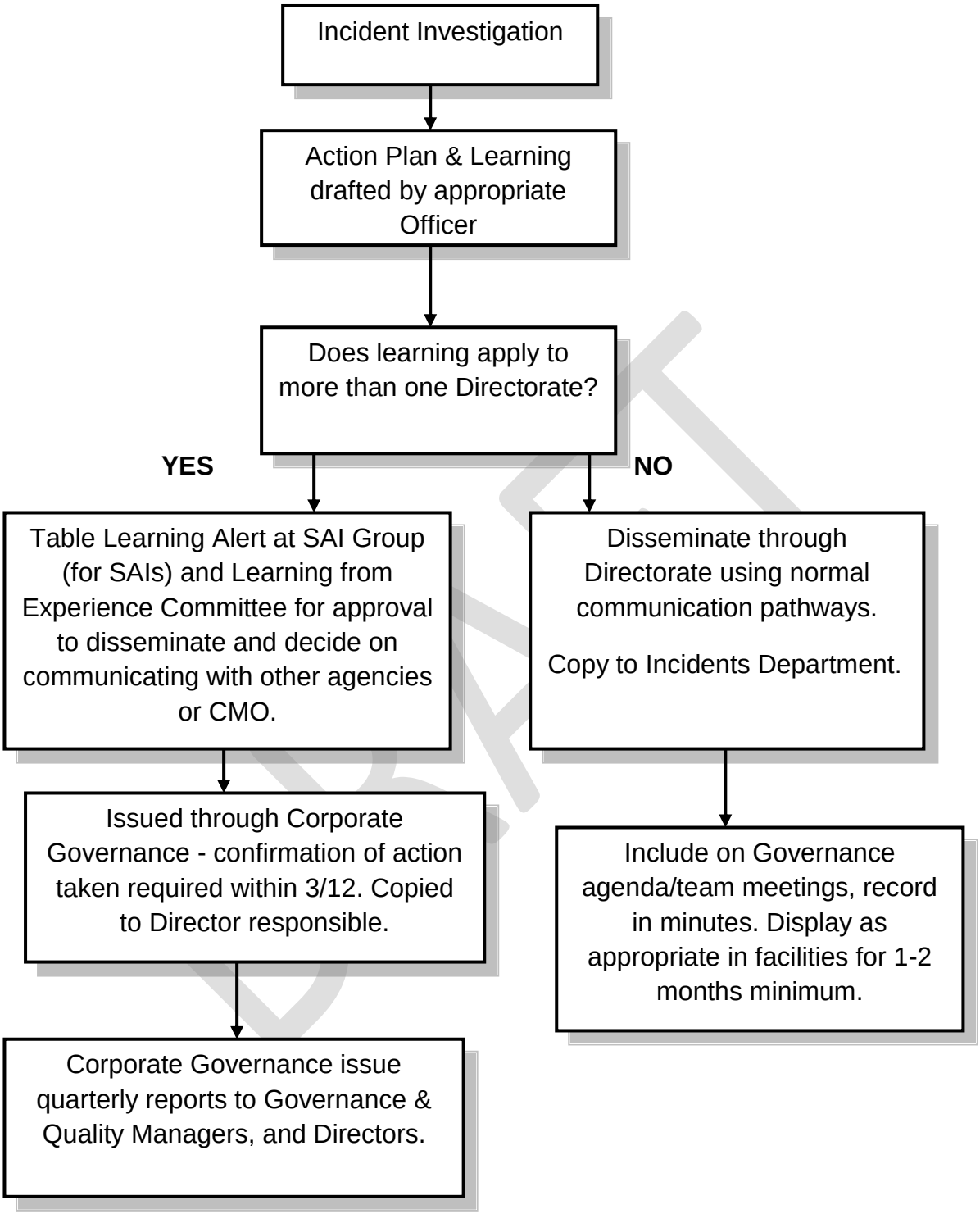
The HSCB has a responsibility to share learning across relevant agencies from Trust SAI Investigation reports and associated action plans.

However, if the Trust has identified Learning that other Trusts should be alerted to either urgently or outside the SAI process, if possible this should be shared promptly from Trust to Trust. The Learning Alerts will be used for this purpose and a decision on sharing the learning will be made by the SAI Group/ Medical Director. The Learning Alerts will be shared externally through the Corporate Governance Department.

Shared Learning Template Belfast Health and Social Care Trust	**Incident/SAI Ref:**	**Date:**
Directorate		
Service Area		
Summary of event		
Learning for sharing beyond directorate		
Learning applicable to:		
Specific Directorate(s)		Trust wide	
		Regional	
Action required (*for discussion and agreement at Learning from Experience/SAI Group*)		
Date:	Signed:	Designation:

SAI Procedure: Draft 5: April 2014

DISSEMINATION OF BHSCT TRUST LEARNING ALERTS



SAI Procedure: Draft 5: April 2014

Serious Adverse Incident Investigation Report Checklist **Appendix 3**

1. FAMILY INVOLVEMENT

(a) Notification

What was the level of Service User /Family involvement at the time the SAI was notified to HSCB
(This should reflect what was reported on notification form)

Additional Comments:

(b) Review Process

i. Were the Terms of Reference of the Review Team shared with the Service User / Family	Yes ☐ No ☐	**Date shared:** **……../……/…….....** **If No - Please comment:**
ii. Were Service User / Family given the opportunity to attend the review and/or meet with the chair and/or members of the review team	Yes ☐ No ☐	**Date attended:** **……../……/…….....** **If No - Please comment:**

(c) Investigation Report

i. Has the investigation report been shared with Service User / Family	Yes ☐ No ☐	**Date shared:** **……../……/…….....** **If No - Please comment**
ii. Has Service User / Family been given the opportunity to meet with member/s of the review team to discuss the	Yes ☐	**Date attended:**

findings of the report	No ☐	……../……/……..... **If No - Please comment**

2. CORONER'S OFFICE

i. Was the Coroner notified of this SAI	Yes ☐ No ☐	**Date notified:** ……../……/……..... **If No - Please comment**
ii. If the Coroner was notified of this SAI, has this case been since closed by the Coroner	Yes ☐ No ☐ N/A ☐	**Date closed:** ……../……/……..... **If No - Please comment**

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