How will learning be used to improve safety?

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

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

For each completed investigation report

- 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 service.

Can a complaint become a SAI?

Yes, if during follow up of a complaint we believe a serious adverse incident has occurred it will be reported as a SAI. You will be informed of this and updated on progress regularly.

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Further information

If you require any further information or have comments regarding this process the nominated link person will be happy to discuss these with you.

If not yet provided, the link person's name and contact details will be forwarded to you as soon as possible.

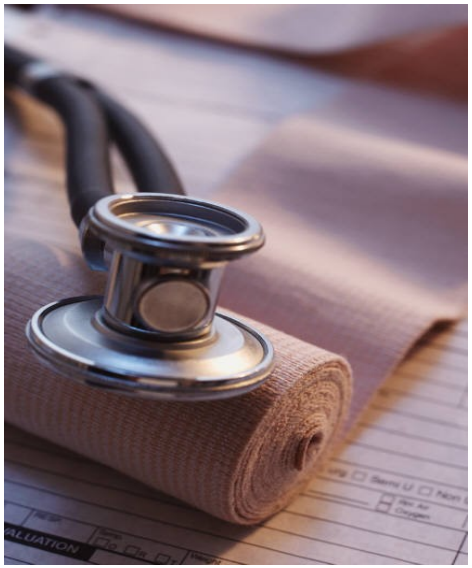
'We will foster an open and learning culture and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services' BHSCT Annual Report 2012/2013

HSC Belfast Health and Social Care Trust

HSC Belfast Health and Social Care Trust

'Committed to delivering safe and high-quality care in an environment that puts patients, clients, and their carers at the centre of everything we do' BHSCT Annual Report 2012/2013

What do I need to know about Serious Adverse Incidents? (SAI)



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What do I need to know about Serious Adverse Incidents (SAI)?

This leaflet is written for people who use our services, their families and/or carers.

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 from whatever cause of any child receiving health or social services (up to the age of 18 years).

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.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported and investigated. It may be:

- An incident resulting in serious harm;
- An unexpected/unexplained death;
- An unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital.
- When a child has died, even if expected.

The incident or event may affect service users, members of the public or staff.

How is the SAI investigated?

Depending on the circumstances of the incident an appropriate investigation will be undertaken. The investigation will take between 4 to 12 weeks. If more time is required you will be kept informed of the reasons.

We will discuss with you the method by which we investigate the incident and who will be involved.

You may also wish to contribute. We will try to accommodate your involvement as we believe your experiences may give vital insight into improving our care.

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.

What happens once the investigation is complete?

A copy of the report will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by Trust staff if acceptable to you.

How is the person affected or their family / carers involved in the investigation?

A link person will be identified to provide contact with you throughout the investigation process. This person will ensure as soon as possible that you:

- are made aware of the incident, the investigation and what this will entail;
- have the opportunity to express any concerns;
- will know how you can contribute to the investigation, for example share your experiences;
- are given an explanation of the investigation findings and/or receive a copy of the final report;
- are updated and advised if there are any delays;
- are offered media advice, should the media make contact.

Your link person is

Contact Number