OPR/R2

PORTSMOUTH HEALTHCARE NHS TRUST
CORPORATE POLICY

RECORDING AND REVIEWING RISK EVENTS

1. Purpose

This Policy explains the system to be used by all staff for recording, reporting and reviewing all risk events or near misses, i.e. accidents, incidents, and untoward events or situations. The purpose of this system is to;

a) provide data which will alert the organisation as a whole to conditions of risk,
b) to promote action aimed at preventing further incidents from occurring,
c) to promote action aimed at minimising the actual or potential consequences of the event.
d) ensure other NHS organisations and external agencies who need to know, are made aware of the incident (e.g. Primary Care Trusts, Health Authority, Regional Office, Police, Social Services (Vulnerable People Policy

The reporting and reviewing of risk events is central to the agendas of Health and Safety and Clinical Governance. The purpose of recording, reporting and investigating incidents is therefore to learn from them, and to prevent their re-occurrence and not to apportion blame. Disciplinary action will usually not be taken except in extreme circumstances such as criminal behaviour, reoccurrence of incidents or unprofessional conduct

2. Scope

This policy covers;

- all staff who work within the Trust (Trust employees, agency staff, volunteers and work placements) as well as clients/patients, and
- all adverse events or situations that harm (or have the potential to harm) clinical and non-clinical services & activities. It also includes risks to Trust premises, Trust property and products.

The safest principle in risk reporting is that if in doubt, report the incident.

Risk assessment and management is *preventative*. Complaints, litigation and/or compensation claims are potential or actual *consequences* of risk events.

Separate Trust Policies exist for handling complaints and claims. Incidents reported as risk events AND claims and complaints routes should be logged on each respective system and investigated in line with the requirements of each system e.g. an incident that is reported as a complaint and a risk event should also be logged and reviewed via both systems. The managers of the respective systems are responsible for ensuring that outcomes of reviews and investigations are shared so that action plans, based upon the complete picture of events, can be developed to prevent reoccurence.

3. Definitions

The term **Risk Event** covers all types of accidents and incidents and it is acknowledged that a wide variety of terms are used to describe these:

(a) An **"Accident"** is an event that causes harm, injury and/or distress.
(b) **"Event"** and **"Incident"** are more global terms covering any clinical or non-clinical event which is a deviation from the pattern of ordinary or expected circumstances, and which adversely affects either the well-being of a person(s); or the smooth running of the Trusts services.
(c) A **Critical Incident** is a serious, untoward event i.e. accident or incident which is believed could severely harm a person(s), service, Trust premises or property, or the organisation as a whole.
(d) A **Near Miss** is a term used to describe a situation, which but for luck or skilful action could have resulted in an actual risk event occurring.
(e) A **Serious Adverse Incident** is a critical incident or series of critical incidents, which has the potential to involve other agencies such as the Health Authority, Social Services or the Police.

For consistency the term **"Risk Event"** refers to an event which could cause, or actually results in; harm, injury, distress, loss or damage. A **Risk Situation** refers to a set of circumstances or repeated events that are believed to harm (or have the potential to harm) the safety, well being and/or security of people, property, services or the Trust as a whole.

Regardless of the terminology used to describe situations or events, the most important principle is that risk events are recorded, reported and reviewed.

4. Procedure for Reporting and Reviewing Risk Events

IMPORTANT: ALL incidents involving patients should be fully recorded in their clinical records/notes; however, Risk Report Forms must not be filed in patient's notes.

Patients/clients should be made aware of any adverse incident which involves them, in a manner appropriate to their level of knowledge, understanding and personal circumstances. Wherever possible patients/clients should govern if, what, how and when information is released to their family, although clearly this will be dependent on the nature of their health problem, their age and personal circumstances.

Patients and/or their family should always be fully informed of any circumstances which involve them before any information is released to the media. Although the overriding principles of openness and honesty should prevail, patient confidentiality must be preserved when passing information to the media. Managers and Clinicians should work in unison to a) ensure the best interests of the patient/client are foremost in the management of the situation and b) to identify whether any, and if so, which external agencies should be notified (e.g. GP, purchasers, etc.).

One Risk Event form exists for the purpose of reporting all risk events with the exception of fire or fire alarm activation which should be reported using the Trust form 'Report of Fire or False Alarm' available from the Fire Safety Adviser

The Risk Event Report Book contains blank forms, detailed instructions for completion, timescales for completion, how to review the incident and where it should be forwarded following completion. The Continuation Sheet can be used to supply additional details about a complex incident or after the initial form has been completed and sent to the Service Manager.

Once the risk event report form is completed, it is dealt with according to the severity of the incident.

4.1 Reporting a Risk Event (any clinical or non-clinical incident)

A Risk Event form must be completed as soon as possible after the event has occurred. All information requested by the form should be entered using black ink and block capitals. A factual summary of the event must be recorded and immediate action taken to minimise the likelihood of the event re-occurring and to minimise the adverse effects of the event should be recorded and actioned. This might include review of a patient/client care plan, application of physical or psychological first aid or removal of an item of equipment from use.

NOTE - In the case of staff or visitors, these forms **do not replace local accident books** which should also be completed, either by the person who has had an accident or their advocate in compliance with health and safety legislation requirements.

The Risk Event form is forwarded to the nominated immediate line manager as soon as is practicable. They are responsible for ensuring that an immediate assessment of the circumstances of the event has been undertaken and that appropriate action has been taken to either minimise the likelihood of the event re-occurring or to minimise the adverse effects of the event.

Once the manager is satisfied that the form has been completed accurately and all necessary information is available, it is forwarded to the nominated Service or Senior manager who is responsible for a number of actions:

a) ensuring appropriate and effective action has been taken (as detailed above)
b) allocating a severity rating to the event
c) ensuring that the event is investigated at a level appropriate to the severity (See Appendix 2)
d) ensuring RIDDOR form has been completed and sent to the Health & Safety Executive
e) forwarding the completed form to the Risk Event Data Entry Clerk for entering into the CareKey™ database. The form should reach the Risk Event Data Entry Clerk within 5 days of the incident
f) **Ensuring that copies of the form(s) have been forwarding to Occupational Health and the Personnel Department (for staff events only).**

4.2 Reporting a Critical Incident - Rapid Reporting System

This system should be used for any event or situation where a person(s), Trust premise/property, equipment or service is very severely harmed, threatened or damaged, with or without the involvement of other agencies. In such cases local action to remedy and contain the situation should be taken *before* the Rapid Reporting System for Critical Incidents is used.

The Service Manager should establish a log detailing the times, dates and sequence of events leading up to, during and following the incident immediately after the incident. The log should include details of actions taken after the incident and up to the Critical Incident Review.

A Critical Incident Review should be convened in line with the Trust document ***"Guidelines for carrying out a Critical Incident Review"***. The outcome of which is documented in a Report, which includes lessons learned from the incident, and an Action Plan designed to prevent reoccurrence. The lessons learned will be shared within the service and where applicable, Trust-wide.

The Senior Manager or other Divisional Senior Manager, (or the Site Cover e.g. Sister Cover, 752 Bleepholder etc./Duty Manager if out of hours) should be contacted *immediately* for advice, action and support.

The definition of a Critical Incident is difficult to narrow down to specific types of incidents as often, it is a culmination of factors that determines the severity of an incident. However, the following incidents will always be classed as critical (this list is not exhaustive and is intended for guidance):

1. Any incident which is reported to the Police (see Section 4.3)
2. The unexpected death of any patient in the care of the Trust – residential, community, in-patient, out-patient, etc
3. The death of any member of staff whilst on duty – including volunteers, agency, contractors, etc
4. Any incident that might lead to criminal charges including violent attacks on patients, staff or hostage situations
5. Absconding by patients detained under the Mental Health Act or the confused elderly who may present a risk to themselves or others
6. Any significant damage, theft or loss of and to Trust property or premises (>£1,000)
7. Any incident that may attract local or national media attention

The Risk Event form should be completed immediately following the incident as usual, the significant difference in the process is the speed of communication. Completed forms should be faxed to the relevant Divisional Office and Trust Central Office on the day of the incident. Managers faxing a form can pre-empt/follow it up with a phone call to Trust Central Office if they think that more explanation is required. Out of office hours, the person in charge of the ward, area or department should contact their Duty Manager with details of the incident. This process is detailed in Appendix 1.

Once Trust Central Office have received sufficient information regarding the incident, any Executive Director can designate the reported incident as a Serious Adverse Incident if it is considered that the event has the potential for consequences external to the Trust. In such instances the Serious Adverse Incident Reporting Procedure, which is Appendix 3 of this policy should be followed.

4.3 External Reports

Some events have to be reported to external organisations/agencies, e.g. to the Health and Safety Executive (HSE), the Coroners office, the Medical Devices Agency (MDA), the NHS Executive for Estates-related incidents, and loss/damage exceeding £1,000 etc. These are listed below:

- RIDDORS to the HSE by Service/Senior Managers
- Coroner reports to Coroners Office by Responsible Medical Officer
- Accidents/Incidents involving medicinal products to Committee on Safety of Medicines/Medicines Control Agency by Responsible Medical Officer
- Accidents/Incidents involving a medical device(s) by Service Manager/Clinical Risk Adviser
- Adverse incidents involving food hygiene to Environmental Health Office by Catering Managers/Catering Adviser
- Accidents/Incidents involving non-medical equipment, engineering plant, installed services, buildings, & building fabrics to NHSE by Estates Department
- Reports to the Mental Health Act Commission by Mental Health Act Co-ordinator
- Damage/Special payments exceeding £500 (refer to the Trusts' Standing Financial Instructions) to NHSE by Finance Department
- Loss/theft/fraud exceeding £1,000 to NHSE by Deputy Finance Director
- Insurance reports e.g. claims/litigation issues to Trust insurers by Business Manager
- Reports to the Royal College of Psychiatrists' Confidential Enquiry into Suicides, and the local Suicide Prevention Group by Consultant Psychiatrist.

Reporting Incidents to the Police

The following incidents must be reported to the Police by the Service Manager. They should also be classed as a Critical Incident and reported to Divisional General Managers and Trust Central Office:

1. Loss, theft or damage to Trust property including petty cash (reporting incidents of loss or theft of personal property belonging to a member of staff or a patient is at the discretion of the individual concerned but should be encouraged)
2. Serious threats of violence towards members of staff including harassment, stalking, etc
3. Violent attacks on members of staff or patients
4. Absconscion by patients detained under the Mental Health Act or confused elderly people who may present a risk to themselves or others
5. At the discretion of the individual concerned, allegations or complaints of harassment, sexual assault, etc, from patients or staff perpetrated by other patients or staff
6. Drug offences on Trust premises

Incidents that are reported to the Police must be internally investigated by following the Critical Incident Review procedure. The Trust investigation is independent to the Police investigation and how the Trust deals with the incident should not be swayed by the outcome of the Police investigation. For example, the Police may find that there are no criminal charges to answer however the Trust may wish to pursue internal action such as following the disciplinary procedure for staff-related incidents and in the case of professional misconduct.

5. Reviewing Risk Events

All Risk Events must be reviewed (both in isolation and in relation to other incidents) to ensure that the objectives of the risk reporting process are achieved (see Section 1 of this policy). The format and vigour of the review process for *specific* events/incidents should be determined by the severity of the incident or event as per Appendix 2. Wider review of specific *categories or groups* of events/incidents are conducted by wider analysis of trends from summary and statistical reports provided from the CareKey system each quarter on request.

Trust-wide reports will be provided to the Risk Management Group, Clinical Governance Panel and the Trust Board each quarter. Service specific reports will also be provided to each Division.

6. Roles and Responsibilities.

A number of roles and responsibilities are referred to within this Policy. The following list clarifies these responsibilities, in particular for ensuring that forms have been completed, that appropriate reports have been made, that reviews of events are carried out, and that remedial and preventative action has been taken. See also section 4.3 for individual responsibilities relating to external reports.

It is acknowledged that each Division/Service may delegate different aspects of the process to particular individuals and these local arrangements should be sufficiently formalised to ensure all staff are aware of their responsibilities and line management channels:

It is the responsibility of all staff to report all risk events

All Trust staff should remain vigilant whilst undertaking their duties in identifying risk, taking action to eradicate/minimise potential risk and potential harm. Staff will take all appropriate immediate action following an actual risk event to record and report all concerns without delay and to minimise adverse effects of events. Any member of staff can report an incident by completing Sections A to H of the Risk Event form.

Person In Charge Of Shift/Area/Department completes section I of the form & ensures immediate remedial action is taken, the local accident book is completed for staff/visitors, & relevant other individuals/departments notified to minimise harm and, wherever possible, prevent re-occurrence.

Nominated Line Managers (nominated by Divisional General Manager for all services/areas within each Division) receive forms, ensure follow up action has been taken and monitored, and completes section J. Line Managers are responsible for ensuring that external reports are completed and sent (e.g. RIDDORS), and that copies of forms are forwarded without delay to Occupational Health and Personnel Departments. NOTE - adequate local arrangements should be in place to ensure the reporting process is not unduly delayed at times of annual or other leave.

Service Managers are responsible for checking that all parts of the form have been completed, allocating a severity code to the incident and confirming that if appropriate, the Health & Safety Executive have been notified of the incident by completion of a RIDDOR form. As the Service Manager will be notified of all incidents which occur in their area, there are responsible for monitoring trends and following-up on serious incidents or those which have service-wide implications.

Divisional General Managers ensure that appropriate systems are in place and followed to comply with this Policy; all staff are aware of their own and others responsibilities; and those people with specific responsibilities are clearly identified and communicated to all services and staff. Provide quarterly commentary/summary of all divisional events for the Divisional Review Reports, & ensures these are shared with local management teams and that any appropriate review and remedial actions are instigated.

Corporate Risk Adviser/Clinical Development Adviser produces summarised Trust wide information on trends and patterns for Risk Management Group, Health & Safety Committees and for specific samples on request. Provides advice where appropriate on minimising risks associated with reported events.

Quality Manager ensures standards are in place for reporting and reviewing all risk events, and that quality monitoring and audit systems are used to evaluate progress in reducing the number and adverse consequences of such events. Includes summary of all events in quarterly Quality Reports to the Board and Health Commission. Ensures wider service implications are shared and action taken by relevant Executive Directors & Managers.

Executive Director/s will be notified about all Critical Risk Events and liaise with the media if required. They will also designate serious adverse incidents in line with Appendix 3 of this Policy. The Director designated with the lead for the serious adverse incident will oversee the process to ensure all relevant action has been taken.

Nursing and Medical Directors take a lead role in providing advice and guidance on safe working practices in relation to clinical events e.g. patient accidents or incidents related to their treatment, and the analysis of patterns and trends.

Specialist/Trust Advisers provide specialist advice and support for specific events and overall trends, ensuring that standards of best practice are maintained, e.g. Handling Advisers, Catering Adviser, Specialist Clinical Advisers.

Risk Information Assistant receives risk event forms and ensures accurate entry into the Carekey™ database to agreed time scales.

7. Analysing and Auditing Risk Events

The analysis of all risk events - including critical incidents - is carried out at a number of levels; by each Division for local patient and staff accidents and incidents; by Occupational Health Departments for staff accidents; by the Risk Adviser for a Trust-wide review of all accidents, incidents and critical events; and by the Quality Director within the Trusts Quality Report.

Examples of the formal and informal methods for monitoring, reviewing and auditing risk events and reporting systems across the Trust are given below:

- By Divisional Managers, locally and through the Divisional Review process;
- By Divisional and Trust Health and Safety Committees;
- By the Corporate and Clinical Risk Advisers and Risk Management Group;
- By the Clinical and Service Audit Groups;
- By the Contract Reference and Lead Groups.

8. References

CNST Standards 2 (Clinical Incident Reporting) & 3 (Response to Major Clinical Incidents) (June 2000)
Controls Assurance Standard on Risk Management Systems (2000)
Critical Incident Review – Management Response to Fair Oak Incident Action Plan (November 2000)
Portsmouth Health Authority District Adverse Incident Policy (June 1999)
South East Regional Office – Serious Untoward Incident Guidance (August 2000)
An Organisation with a Memory - Learning from adverse events in the NHS (June 2000)

9. Circulation

All Corporate Policy Holders for communication and dissemination to all Trust staff
Appendix 3 – Executive Directors and Divisional General Managers,
Isle of Wight, Portsmouth, South East Hampshire Health Authority
Portsmouth Hospitals NHS Trust
Chief Executives of Primary Care Trusts in Portsmouth & East Hampshire

9. Policy Review Date

Policy produced by Helen Bowers, Risk Adviser 1994

Updated by Steve King, Clinical Risk Adviser, December 1999

Updated by Julie Jones, Corporate Risk Adviser, April 2001

Due for update January 2002

Where do Risk Event Forms go ?

TIMESCALE : Form should reach Data Entry Clerk within 5 days of the incident

Could it be a Critical Incident?

NO

YES

FAST-TRACK SYSTEM FOR CRITICAL INCIDENTS

1. Form completed by any member of staff
2. Retain bottom copy in Risk Event pad
3. Send/give top copy immediately to

The Risk Event form must be completed as described in the section opposite and faxed/phoned to the relevant Divisional Office and Trust Central Office that day.

Ward / Dept / Team / Manager for Action who then...

1. States action taken to prevent reoccurrence
2. If **STAFF INCIDENT** photocopies form to Personnel & Occ Health

Sends top copy immediately to

During normal office hours the person in charge of the ward, area or department where the incident occurred must **also** telephone their Line Manager with details of the incident.

The Line Manager will in turn telephone their Line Manager with details, and so on, until all relevant personnel have been informed. This includes the Service Manager, Divisional Manager and Trust Central Office as appropriate.

Senior / Service Manager for Action who then ...

1. Quality checks form (all action taken, all boxes completed, etc.)
2. Decides **SEVERITY** (low, med, high, critical incident, etc.)
3. Takes **RIDDOR** action if appropriate
4. Checks staff accident forms copied to Occ Health and Personnel

Posts original within 24 hours of receipt to

Out of Hours (evenings, weekends and bank holidays), the person in charge of the ward, area or department where the incident occurred will telephone the Duty Manager with details of the incident.

The Duty Manager will notify the On-Call Manager who in turn will decide whether it is appropriate to notify the Divisional Manager and the Executive Director On-Call.

Risk Event Data Entry Clerk who ...

1. Enters details on Risk Event Database
2. Requests Critical Incident Review Report (if applic) from Senior Manager
   2 weeks after event

Risk Event Form

For all Critical Incidents, Divisional Offices and Trust Central Office will take follow-up action as necessary and will require a copy of the report generated by the Critical Incident Review.

TIMESCALE : Details should reach Trust Central Office the same day as the incident

Appendix 2

Incident Severity and Review Levels

Code	Incident Severity		Review Level
L NM/L	**Low Severity** • No injury or only minor or moderate discomfort resulted. Little clinical intervention needed (bandage, reassurance, support, etc). • A false fire alarm activation. • A **near miss** which but for luck or skilful management would have resulted in a low severity incident	• Property losses of £1 - £100.	**Level I :** All Low, Medium and High Severity incidents must have at least this level of review. An immediate local review of the incident and its consequences by the Manager of the area where it happened. Action taken to prevent re-occurrence is noted in Section I. of the Risk Event form and passed to the Senior/Service Manager. Some High Severity incidents may warrant a Level II review at local/service level only (see below).
M NM/M	**Medium Severity** • A temporary injury which required moderate clinical intervention such as sutures, minor surgery, etc. • An actual fire with no injuries or property damage. • Attempted suicide. • Aggression and threats. • A **near miss** which but for luck or skilful management would have resulted in a medium severity incident	• Property losses of £100 - £1,000	
H NM/H	**High Severity** • An unexpected death of a member of staff on duty or a patient • A major fire (property damaged or people injured) • A patient absconscion or missing patient where the Search & Alert procedure was activated. • A major staff or patient injury such as coma, blindness, amputation, or an injury requiring more than 5 days stay in hospital. • An injury requiring resuscitation. • A serious infection control outbreak affecting high numbers of patients and/or staff • A serious aggressive or violent incident with potential or actual injuries. • A **near miss** which but for luck or skilful management would have resulted in a high severity incident	• Property losses of more than £1,000.	
CI NM/ CI	**Critical Incident** A High Severity incident, which requires a formal review and production of a full review, report regardless of the consequences. This type of incident must be notified to the relevant Divisional General Manager and Trust Central Office the same day the incident happens. A **near miss** which but for luck or skilful management would have resulted in a critical incident		**Level II :** All Critical Incidents must have a Level II Review. This is a formal review led by a Service or Senior Manager. The outcome of this review will be a final report detailing the full sequence of events, risk issues identified and Action Plan. This report will be copied to the relevant Divisional General Manager and Trust Central Office and a summary report included in Divisional Reviews.

Appendix 3

SERIOUS ADVERSE INCIDENT (SAI) REPORTING PROCEDURE

This procedure combines the guidance produced by Portsmouth & South East Hampshire Health Authority (June 1999) and the South East Regional Office (August 2000). It sets out the criteria for identifying serious adverse incidents that may occur within Portsmouth HealthCare NHS Trust, the reporting procedure, and ongoing communication, reporting and support arrangements.

1. Definition

1.1 There is no single definition however in general terms, it is **something likely to attract public or media interest**. Perhaps because it involves a large number of patients, there is a question of poor clinical or management judgement, a service has failed or a patient has died under unusual circumstances.

Examples of serious untoward incidents

(a) Suspected or known serious deficiencies in the delivery of any aspect of health care which have led to significant harm to patients, staff or the public
(b) Serious error/s by a member of staff or a contractor which may give rise to serious public concern
(c) Serious concern about an individuals clinical performance where this may have led to the significant harm of patients or staff
(d) Serious deviation from the requirements of clinical governance
(e) A number of unexpected/unexplained deaths including apparent clusters of suicides of patients receiving psychiatric care
(f) Impending litigation on suspicion of large-scale theft or fraud
(g) Any incident that might lead to serious criminal charges including violent attacks on either staff or patients or hostage situations
(h) Repeated serious complaints about a member of staff or a contractor
(i) A serious breach of confidentiality
(j) The suicide of any person on NHS premises or under the care of a specialist team in the community
(k) Accidental or suspicious death of or serious injury to any individual (staff, patient, student, visitor) on NHS premises
(l) Serious damage or equipment failure which occurs on NHS premises particularly relating to injury or disruption of services (e.g. fire, flood, power or water failure)
(m) Escapes or absconding by patients detained under the Mental Health Act
(n) Absconscion by voluntary patients such as confused elderly patients who present a risk to themselves or others or who may be on close observation
(o) Actual or suspected homicides and suicides committed by a person in receipt of or known to specialist psychiatric services
(p) A serious outbreak of an infectious disease, food poisoning or transmission of an infectious disease from a member of staff to a patient and vice versa, or any incident involving a member of staff/patient infected with HIV or Hepatitis B
(q) Serious chemical or microbiological contamination or radiation incident
(r) Any major incident
(s) Suspension of a doctor, GP, nurse or any clinician on the grounds of clinical malpractice
(t) Serious incidents of defective medicines or medical devices

2. Reporting procedure

2.1 Incidents of this nature must be reported as Critical Incidents using the Risk Event reporting procedure and notified to the Divisional General Manager and Trust Central Office, the day the incident happens.

2.2 The Critical Incident Review procedure should be invoked locally (as described in Section 4.2) by the Service concerned as soon as the incident happens.

2.3 Once details of the incident have been received at Trust Central Office, an Executive Director will determine whether the incident is to be designated as a Serious Untoward Incident and if so, invoke this procedure.

2.4 A nominated Executive Director will take the lead in managing the incident, with support from other Executive Directors, Quality Manager, Divisional General Managers, Senior Managers and Risk Advisers as required.

2.5 From the date of notification of the incident/s, the nominated Executive Director will ensure records are kept of all subsequent action taken as part of the process of managing the incident/s.

2.6 Depending on the nature of the incident, the following is a list of action which may require consideration. The nominated Executive Director will decide which action is appropriate and oversee the process by liaising with and delegating to relevant staff as required:

WHEN THE INCIDENT HAPPENS

(a) Ensure details are communicated immediately to other Executive Directors and Divisional General Managers

(b) Ensure details are communicated immediately to the Health Authority, Regional Office and where appropriate, Portsmouth Hospitals, Primary Care Groups and Primary Care Trusts. **(Contact numbers in each organisation are on a separate page at the end of this procedure).** The nominated Executive Director and the Health Authority lead will agree which organisation will report the incident to the Regional Office.

(c) Ensure details of the incident are communicated to the Chairman and Non-Executive Directors of the Trust Board

(d) Where appropriate, make arrangements for details of the incident/s to be passed on to other involved parties – patients, relatives, the Police, Social Services, GPs, Community Health Council, etc.

WITHIN 48 HOURS

(e) Agree the lead responsibility for the review with other agencies that may be involved. Where it is agreed the Trust will not be the lead agency, ensure that the Trust is represented on the Review Team and that relevant Trust staff are advised to give their full co-operation to the investigation

(f) Deal with any media or press enquiries concerning the incident/s, ensuring that any patients and relatives who may be effected by the incident are informed before the media

(g) As appropriate and in liaison with the Health Authority and other agencies as required, agree arrangements for dealing with multiple enquiries from members of the public (e.g. which may arise from serial incidents) such as establishing telephone hot lines

WITHIN A WEEK AND LONGER TERM

(h) Arrange for legal advice to be sought if applicable

(i) In liaison with (as appropriate) Divisional Manager/s and the Health Authority, convene a Review Team and appoint a suitably senior and experienced person to lead/chair the Review process

(j) If and when appropriate (possibly at the end of the investigation), liaise with the Personnel / Medical / Nursing Director to ensure professional bodies are notified (e.g. UKCC, GMC)

UNTIL INCIDENT CONCLUDED

(k) Keep all relevant parties informed of investigation developments and review timescales

(l) Ensure the outcome of the CIR/Investigation is communicated to relevant parties including the Trust Board, Health Authority and Regional Office

(m) Ensure that action plans arising from the Review are implemented within agreed timescales

3. Review Procedure

3.1 A Review Team will be convened and a person of suitable seniority and experience appointed to chair the review and co-ordinate the investigation process. The Review Team will comprise of internal staff and if appropriate, external staff where their input would be useful and relevant.

3.2 Where court proceedings relating to the incident have begun, legal advice should be sought to ensure the investigation does not prejudice those proceedings.

3.3 Internal reviews should also be sensitive to the timing of any coroners inquests. However, delay in receiving the Coroners findings is not a reason for delay in setting up and conducting a review.

3.4 The Review Team should:
(a) be established within 2 weeks of notification of the incident
(b) begin sitting within 4 weeks of notification of the incident
(c) have the active co-operation and participation of other agencies (e.g. social services, criminal justice agencies and private providers), with representation depending on the weight of the agency's involvement in the case
(d) have clear terms of reference
(e) report within ten weeks of notification of the incident

3.5 The Review Team Chair should refer to the Trust documents ***"Guidelines for carrying out a Critical Incident Review"*** and ***"Guidelines for Conducting Investigations"*** when convening review meetings, arranging for witness statements to be taken, producing the review report, etc.

4. Concluding the Serious Adverse Incident

4.1 A single report on the incident presented to the Trust Board, Health Authority and Regional Office will conclude the Serious Adverse Incident Reporting Procedure.

4.2 Whilst, this concludes external reporting requirements, the nominated Executive Director remains responsible for leading the incident until all actions recommended as a result of the review have been completed and the incident will continue to feature in internal reports (e.g. at Divisional Review) until that happens.

5. Role of the Health Authority

5.1 The role of the Health Authority is to:

(a) to offer support and guidance to the NHS Trust in carrying out their local investigation of the incident
(b) to liaise with the nominated Trust Director in agreeing the terms of the review where appropriate
(c) where appropriate, to agree arrangements for dealing with enquiries from the media, making press statements and setting up Hot Line facilities
(d) to receive and where necessary, comment upon review reports and action plans
(e) to ensure follow-up action is taken and that lessons learned are usefully shared with the whole health economy

6. Role of Regional Office

6.1 The role of the Regional Office will vary according to the nature of the incident but in general it will be to:
(a) offer support and guidance to the NHS (e.g. public health, media and communication, Mental Health Act requirements, etc)
(b) where appropriate agree the general remit of the review with the Trust and the Health Authority
(c) receive and where necessary, comment upon review reports and the action plan to implement recommendations
(d) ensure follow-up action is taken both locally and on a wider basis as appropriate
(e) prepare briefings for Ministers, the NHS Executive and Department of Health Headquarters, the Social Services Inspectorate and relevant policy branches on the facts of the incident and action being taken

SERIOUS ADVERSE INCIDENT REPORTING CONTACTS (at April 2001)

South East Regional Office

All Serious Adverse Incidents	Office Hours - (020) 7725 2534 Out of Hours – Pager (020) 8345 6789 quote **SER 101**
In addition: Actual or suspected homicides and suicides by patients in the care of mental health services must be reported to the Confidential Inquiry into Homicides and Suicides by Mentally Ill People:	Telephone: (020) 7823 1031 Fax: (020) 7823 1035
Patients who abscond under home office restrictions should also be reported to the Home Office Mental Health & Criminal Cases Unit:	Telephone: (020) 7273 4000 Fax: (020) 7273 2937 / 3411

Isle of Wight, Portsmouth & South East Hampshire Health Authority

Serious Adverse Clinical Incidents	Mr Peter Old, Director of Public Health
Serious Adverse Non-Clinical Incidents	Mrs Sue Robson, Director of Strategey & Performance Development Telephone: (023) 9283 5000 Fax: (023) 9273 3292
Portsmouth HealthCare NHS Trust	Mr Max Millett, Chief Executive Tel: (023) 9289 4378 Fax: (023) 9229 3437
Portsmouth Hospitals NHS Trust	Mr Mark Smith, Chief Executive Telephone: (023) 9286 6400 Fax: (023) 9286 6413
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Portsmouth HealthCare NHS
NHS Trust

GUIDELINES FOR CARRYING OUT A CRITICAL INCIDENT REVIEW (CIR)

These guidelines provide a Trust-wide template for dealing with critical and serious Incidents.

These Guidelines supplement the Trust Policy on Recording and Reviewing Risk Events. Persons involved in reviewing a critical incident may also wish to refer to the Trust Guidelines for carrying out an investigation.

Services such as Mental Health and Learning Disabilities, have developed their own guidelines which follow this model but are more specific to reflect the needs of their Service and Client Groups. All other Services should follow these guidelines.

1. What is a Critical Incident ?

An all-embracing definition is difficult to define and will vary from Service to Service . The following will always be classed as a critical incident (this list is not exhaustive and is intended for guidance):

1. Any incident which is reported to the Police (see Section 4.3)
2. The unexpected death of any patient in the care of the Trust – residential, community, in-patient, out-patient, etc
3. The death of any member of staff whilst on duty – including volunteers, agency, contractors, etc
4. Any incident that might lead to criminal charges including violent attacks on patients, staff or hostage situations
5. Absconding by patients detained under the Mental Health Act or the confused elderly who may present a risk to themselves or others
6. Any significant damage, theft or loss of and to Trust property or premises (>£1,000)
7. Any incident that may attract local or national media attention

It would be useful for lead managers, lead clinical and medical staff from each Service/Division to discuss and agree what types of incidents would be classed as critical within their Service and communicate this to front line staff.

2. What is the purpose of a Critical Incident Review (CIR)?

To reflect on the incident and:

a) explore and understand what happened
b) improve clinical and other working practices
c) identify helpful outcomes for service users and staff after an incident
d) identify issues of significance and make sure they are appropriately followed-up
e) enhance staff and service user's safety
f) minimise the occurrence of a similar incident
g) identify staff who may require additional support
h) provide a learning experience for staff
i) support the Trust's Risk Event Policy

3. Who decides a CIR is needed ?

a) All critical incidents should be notified immediately (same day) to Divisional Managers and Trust Central Office by the Manager of the area where the incident happened.

b) The Divisional Manager and Trust Central Office will agree where a CIR is to be convened - this will often follow discussion and agreement with staff at ward or department level and, if appropriate, the Service Manager.

c) In very serious cases it may be that an independent external review is called for.

4. How soon after the incident should it happen ?

The CIR should take place as soon as possible but no later than 10 days after the incident. Trust staff requested to attend a CIR must give it priority and re-arrange diaries to accommodate the CIR meeting/s.

5. Who should chair the CIR ?

a) The Chair could be any member of staff (not involved in the incident) with the appropriate seniority, objectivity and skills to be able to facilitate the CIR process.

b) As CIRs should be conducted immediately after the incident, the choice of Chair will also be influenced by availability and in some instances, experience of the environment (clinical or otherwise) under review.

6. Who else should be involved ?

a) All Portsmouth HealthCare NHS Trust staff involved or a witness to the incident and staff from other agencies as appropriate - Police, Social Services, Contractors, etc.

b) All sub-Consultant medical staff should discuss any incidents and their attendance at a Critical Incident Review meeting with their Consultant.

c) In some circumstances it may be helpful to involve an objective professional from outside the Service directly involved.

d) A standard CIR invitation letter is attached.

7. Who else (not directly involved in the CIR) needs to know it's happening ?

a) Divisional General Managers (for inclusion in Divisional Reviews)
b) Trust Central Office (Executive Directors and Risk Advisers)
c) Occupational Health (for staff accidents only)
d) Consultant/Responsible Medical Officer - to be notified by Divisional Manager if a patient under their care has been involved in an incident leading to a Review

8. How should a CIR be conducted ?

A combination of any of the following:-

a) individuals may be asked to provide a statement which sets out their recollection of events before any meetings
b) all people involved in the incident are invited to attend the same meeting at the same time in the first instance
c) the one-off meeting may suffice in completing the Review however, it could be followed series of meetings to clarify ambiguities that may subsequently arise

d) all staff involved in an incident should make it their priority to attend the CIR if invited however, if certain individuals not able to attend (owing to annual leave or sickness for example) they may be asked to provide written statements

9. What should happen during a CIR ?

a) Chair person makes an introduction stating the purpose of the review
b) all individuals are asked to provide a detailed account of what happened
c) factual chronological sequence of events is established
d) causal factors (breakdown in procedures, communications, equipment, systems, etc.) identified
e) the practicality and effectiveness of relevant policies and procedures is assessed

10. Identify the Root Cause/s

The occurrence of any incident is rarely attributable to a single factor but usually the culmination of a number of factors. To determine the root cause of an incident, a combination of organisational elements, local circumstances and errors or mistakes need to be considered:

a) Latent failures – management decisions, organisational structure, culture, etc
b) Conditions of work – workload, supervision, staffing levels, communication, equipment, knowledge, training, ability, etc
c) Active failures – unsafe acts, mistakes, omissions, etc, by groups or individuals
d) Controls/defences – were policies, guidelines or procedures in place? were they followed? were they ineffective?

11. Outcome of CIR ?

a) A CIR report is produced within 7 working days of the last review meeting
b) The report is produced in a standard Trust-wide format (sample attached) which includes:
   (i) introduction including relevant background information which may help to set the scene (i.e. summary of patient medical history for patient related incidents)
   (ii) name, job title and location of the person chairing the Review
   (iii) names, job titles, locations of all persons involved in the incident and CIR (this information can be anonymised if the Report is to be shared outside the Service for learning purposes)
   (iv) chronological sequence of events
   (v) the outcome of the incident
   (vi) the root cause/s of the incident identifying organisational, environmental, individual and procedural factors which may have contributed to occurrence of the incident
   (vii) key learning points - learning points which may have relevance beyond the immediate ward or service should be highlighted in the Report
   (viii) action plan which may identify individual/team training requirements, policies/procedures which may need to be reviewed or established, where resources need to be diverted, how communications systems can be strengthened, etc. For each action point a lead person and timescale for completion will be identified.
c) The Action Plan will be followed up through the Divisional Review process.

12. Who receives copy of the CIR report ?

a) A copy of the full report should be forward to the relevant Divisional General Manager/s so that a summary can be included in Divisional Reviews; the Corporate Risk Adviser at Trust Central Office for sharing with relevant Executive Directors; relevant Service Manager/s.

b) A summary of the learning points and action will be forwarded to external agencies involved in the CIR such as the Police, Social Services, Fire Service, etc.

c) Appropriate feedback will be provided to the Occupational Health Department (for staff accidents only).

d) Where appropriate, the Report will also be circulated to the Trust Board, the Health Authority and Regional Office.

13. Supporting staff after a critical incident

The CIR process may identify teams and individuals who require additional support however provision of support is separate to the CIR process. Support is available from :

a) In some Services specific de-briefing arrangements/policies are in place which should be followed.

b) the Trust's Occupational Health Department can provide advice and support to staff during and after a period of sickness absence following any kind of incident at work. Professional counselling and support is available from the Employee Assistance Programme.

c) the Employee Assistance Programme provider can facilitate team de-briefing and organise individual support sessions for staff as required. Team de-briefings can be arranged by the Team/Service Manager directly with the EAP or via Occupational Health. Individual members of staff can approach the EAP individually (and confidentially) or via their Manager or occupational health.

14. Follow-up to ensure CIR Action Plan is implemented

a) Service Managers have direct responsibility for ensuring Action Plans are implemented within agreed timescales.

b) Divisional Managers will ensure Action Plans are followed-up and 'signed-off' at Divisional Reviews. Key points from Action Plans will remain roll forward from Review to Review until they are 'signed-off' i.e. all action has been completed.

c) Completion of the action will be confirmed to and checked by the relevant Trust Board Panel/Group i.e. Clinical Governance Panel, Risk Management Group, etc.

15. Ensuring lessons learned from Critical Incidents are shared

a) It is important to ensure that action is taken to prevent reoccurrence of similar incidents within a Service. However, the organisation as a whole should also learn from serious incidents and key lessons or actions will be cascaded by Trust Central Office through the appropriate channels as soon as an incident occurs which has Trust-wide implications.

16. Auditing to ensure system changes resulting from CIRs are still in place

a) In the aftermath of a serious incident, action to address shortcomings in working practice, policies and procedures is often welcomed by staff. Over time however, new practices may lapse and staff may revert to the systems they are familiar with.

b) To ensure changes arising from CIRs are embedded, periodically TCO will ask Divisional Managers to audit action plans to establish whether remedies are still in place and working effectively.

These Guidelines have been distributed to:

Divisional General Managers
Corporate Services Managers
Lead Consultants
Personnel Managers
Service Managers
Trust Advisers (Occupational Health, Risk, Handling, Fire, Catering, Housekeeping)

For information:
Portsmouth Hospitals Trust
East Hampshire Primary Care Trust
Portsmouth City Primary Care Trust
Fareham & Gosport Primary Care Groups

If you have any questions about this procedure, please contact:

Julie Jones
Corporate Risk Adviser
Trust Central Office, St James Hospital
Tel: (023) 9289 4353
Fax: (023) 9229 4347
email: j Code A

APRIL 2001

ROLES AND RESPONSIBILITIES

The CIR Chairperson

a) to convene the CIR within 10 days of the incident
b) to open/introduce the CIR meeting and clarify it's purpose
c) to facilitate an open discussion which will elicit the facts of what actually happened (and what didn't)
d) to give everyone present the opportunity to share their views and decide whether briefing/counselling support is required for staff (this is separate to the CIR process)
e) to identify what could have been done differently
f) to facilitate the development of an action plan which will minimise the risk of a similar incident happening again
g) to thank all CIR participants for their co-operation before closing the CIR meeting
h) to write up the CIR Report in the required format
i) to submit the CIR Report within 7 working days of the Review to the relevant people

Staff involved in an incident and requested to attend a CIR meeting

a) to give an honest and factual account of what happened (and what didn't)
b) to openly explore alternative actions where appropriate

Service Managers

a) to appoint a person to Chair the CIR
b) to ensure the Review takes place within 10 days of the incident
c) to present the CIR Report to appropriate Managers as required by the Service
d) to ensure the Action Plan has been implemented within specified time limits and provide quarterly progress reports to the Divisional Manager

Divisional General Managers

a) to be aware of all CIRs being planned or underway in their Division at any given time
b) to provide a summary report at Divisional Review which identifies CIRs carried out during the previous quarter, key areas for action with timescales and highlights learning points which may be applicable to other Services/Divisions
c) to report at subsequent Divisional Reviews when action arising from a CIR has been fully implemented

Trust Central Office

a) upon notification of a critical incident, to check with the Service Manager that a CIR is underway
b) to circulate details of the incident to Executive Directors and other senior managers in Trust Central Office
c) to ensure the incident is recorded on the Risk Event database
d) in consultation with Service and Divisional Manager/s, to liaise with the media and other external agencies (i.e. Health Authority) in providing information about the incident
e) to prompt Service Managers for a copy of the final CIR report as necessary
f) to share learning points that are identified at Divisional Review with other Services/Divisions as appropriate
g) to advise the relevant Trust Board Panel/Groups of emerging issues, action planned and completed.

STAFF TRAINING

CIR Awareness

The Critical Incident Review process forms part of the Trust's Risk Event Reporting Policy. As such it will be introduced in the Trust's Risk Awareness Training Programme.

The role of the CIR Chair

A short course will be available to Service Managers, Team Leaders, Clinical Managers, Duty Managers and other people who may be required to Chair a Critical Incident Review.

Template : Invitation to attend a Critical Incident Review

[*Date*]

Dear

CRITICAL INCIDENT REVIEW:
[*Brief description of incident, date & time*]

I have been asked to lead a review following the above incident. The purpose of the review is to understand exactly what happened, why it happened and to identify what action is needed to reduce the chance of something similar happening again.

I understand you [*were involved in/witnessed*] the incident and everyone who was involved is being asked to attend a meeting on:

[Date]
[Time]
[Venue]

At the meeting each person will be asked in turn to recall events leading up to, during and after the incident to help establish a complete picture of what happened. You may also be asked to give your opinion about why things happened the way they did and the effectiveness of any policies and procedures you may have followed.

[Upon receipt of this letter, junior medical staff should discuss the incident and their attendance at the review meeting with their Consultant].

Please make every effort to attend this meeting. If you are unable to attend please let me know as you may be asked to send in a written statement which can be presented at the meeting in your absence.

Following the meeting a written Report will be produced which sets out what action will be taken to prevent the incident happening again and will also identify any wider lessons for sharing with other services.

If you have any questions or would like to speak to me before the meeting, I can be contacted at *[address and telephone number].*

Thank you in advance for your co-operation.

Portsmouth HealthCare NHS
NHS Trust

CONFIDENTIAL

CRITICAL INCIDENT REVIEW REPORT

Date of the Incident

Location of the Incident

Time of the Incident

Staff on duty at the time of the Incident *(Name, job title and location of each person)*

Date of the Critical Incident Review meeting/s

CIR Chairperson *(Name, job title and location)*

Persons present at the CIR *(Name, job title and location of each person)*

Review Date / Review Meeting Date

1. INTRODUCTION

(Background information about events leading up the incident may be helpful; as may be a brief summary of relevant clients medical history as appropriate)

2. WHAT WAS HAPPENING BEFORE THE INCIDENT?

(This section is optional as relevant)

3. CHRONOLOGICAL SEQUENCE OF EVENTS

(List events in date and time order as they happened - state facts not opinions - where there are differing accounts of what happened, all accounts should be included)

4. WHAT ACTION WAS TAKEN IMMEDIATELY AFTER THE INCIDENT?

(List events in date and time order - this may include whether first aid was given, the Police were called, etc.)

5. WHAT WAS THE OUTCOME OF THE INCIDENT?

(This may not be known until hours or even days after the incident has happened but may include details of injuries to people involved, etc.)

6. WHAT COULD HAVE BEEN DONE DIFFERENTLY?

(An exploration of alternative approaches to the same situation and their possible outcomes or impact on the situation).

7. WHAT ARE THE ROOT CAUSES OF THE INCIDENT?

a) Organisational factors

b) Conditions of work

c) Failures, mistakes or omissions

d) Controls or defences

8. WHAT ARE THE LEARNING POINTS AND ACTION REQUIRED (OR ALREADY TAKEN) TO PREVENT THIS INCIDENT HAPPENING AGAIN?

(This section of the Report should also identify those learning points which have a wider application that the immediate area where the incident happened (e.g. those which may be relevant to an entire, site, service or the Trust as a whole)).

	Learning Point	Action Required	Lead Person	By When
1.				
2.				
3.				
4.				