Fareham and Gosport NHS
Primary Care Trust

Corporate Policy OP32

INCIDENT REPORTING POLICY

1. Purpose

Fareham & Gosport PCT encourages a safety culture, where staff have a constant and active awareness of the risks associated with their work. The PCT strives to achieve a culture that is open and fair and which encourages staff to report incidents within the organisation in order to learn from them and minimise future risk. This Policy details how all staff should report and respond to adverse events (including prevented incidents and incidents which do not result in harm), e.g. accidents, incidents, and untoward events or situations (recording, reporting and review).

The purpose of this policy is to:

a) Provide standard definitions for common terms to ensure all staff understand the different types/severity of incidents;
b) Promote action aimed at minimising the actual or potential consequences of the incident;
c) Promote action aimed at preventing further incidents from occurring;
d) Promote the identification of system/process weaknesses and learn from actual incidents and prevented incidents;
e) Promote the utilisation of data which will alert the organisation as a whole to conditions of risk;
f) Ensure other NHS organisations and external agencies who need to know, are made aware of the incident (e.g. Primary Care Trusts, Strategic Health Authority, Police, Social Services)
g) Comply with a range of legislation and guidance requiring the NHS organisations to have in place a system for recording, reporting and responding to incidents (HASAW Act 1974[1]; RIDDOR 1995[1]; NPSA[1]; MHRA[1]; CFSMS[1]).

The reporting and reviewing of adverse events is central to the agendas of Risk Management, Health & Safety and Clinical Governance. The purpose of recording, reporting and investigating incidents is to identify the underlying cause/s and to learn from them, to prevent their re-occurrence and not to apportion blame. The PCT Board fully supports and is committed to the promotion of a fair-blame, non-punitive culture (as stated in the Risk Management Strategy), where staff feel able to raise serious concerns with their line manager, other managers and if necessary through the procedure contained in the PCT's 'Whistle-blowing Policy'.

Disciplinary action will not usually be taken except in extreme circumstances such as an act of malice, criminal or gross/repeated professional mis-conduct. This is in line with the PCT's 'Disciplinary Policy' and the NPSA's Incident Decision Tree.

2. Scope

This Policy covers:

- all staff who work within the Primary Care Trust (PCT 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) be they within clinical or non-clinical services & activities.
- it also includes risks to PCT premises, property and products.

It is important to clarify the difference between an adverse event and risk assessment; an **adverse event** is an actual incident which either has occurred or almost occurred but was prevented from actually occurring. A **risk assessment** is the pro-active method for identifying potential future risk.
Risk assessment and management is *preventative*. Complaints, litigation and/or compensation claims are potential or actual *consequences* of adverse events. There are separate PCT Policies for handling complaints

[1] **HASAW** – Health & Safety at Work Act
NPSA – National Patient Safety Agency
CFSMS – Counter Fraud & Security Management Service
MHRA – Medicines and Healthcare Products Regulatory Agency
RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences

and claims. All types of risk reported to PCT Risk Management Department are recorded on the relevant module of the Risk Management Database (Incidents, Risk Assessments, Complaints, Claims) and investigated in line with the appropriate procedure. 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 reoccurrence.

The safest principle in adverse event / risk reporting is that if in doubt, the incident (or prevented incident) should be reported.

3. Definitions

The clarification of risk management terminology and the promotion of a common language are critical to the success of the incident reporting system. It also ensures consistency across other NHS organisations, enabling both local and national trend analysis.

Terms used to describe accidents and incidents are common across clinical and non-clinical events and it is really the severity of the incident which dictates the term used to describe it:

i. **Adverse Event** or **Untoward Incident** are global terms covering any clinical or non-clinical happening which is a deviation from the pattern of ordinary or expected circumstances, and which has adversely affected either the well-being of a person(s) or the smooth running of PCT services.
ii. **Adverse Event (no harm)** refers to an incident which actually occurred, but which caused no harm.
iii. **Adverse event (prevented)** replaces the term 'near-miss' and describes an incident which had the potential to cause harm but was prevented.
iv. **Patient Safety Incident** is an umbrella term introduced by the National Patient Safety Agency to describe 'any unintended or unexpected incident(s) that could have or did lead to harm for one or more persons receiving NHS-funded healthcare'.
v. **Critical Incident** is a serious, untoward event i.e. accident or incident which is believed could severely harm a person(s), service, PCT premises or property, or organisation as a whole.
vi. **Serious Untoward Incident** is a critical incident or series of incidents, which have the potential to have a significant impact on local health services or to attract public and media interest.
vii. **Major Incident** describes 'any incident that presents a serious threat to the health of the general public, disruption to health services, or causes such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance services, other health care providers, or health authorities.' (See the PCT's Emergency Planning & Major Incident Response Policy).
viii. **Harm** is defined as 'injury (physical or psychological), disease, suffering, disability or death'. In most instances, harm can be considered to be unexpected if it is not related to the natural cause of the patient's illness or underlying condition.

For consistency the term '**Adverse Event**' refers to an event which could cause, or actually results in, harm, injury, distress, loss or damage. 'Adverse Events' occur in a wide range of circumstances, examples of such events are detailed below:

- A Learning Disability Service user may react badly to a situation and may attempt to assault other clients/staff;
- Staff on an intermediate care ward may find that a patient has been admitted from the Acute Trust without their medicines records;
- A District Nurse may find that the patient they are visiting still has not had been given details of how to care for an installed medical device;
- Confidential information may be compromised by the revealing of a password, or loss of paper records;

A member of staff may be verbally abused (for any such incident of harassment please see the PCT Policy on 'The Management of Harassment, Aggression and violence from service users and visitors' – all serious incidents of harassment or bullying should be reported to the police / immediately)

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 PCT as a whole.

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

4. Procedure for Reporting, Responding to and Reviewing Adverse Events

The PCT has a single Adverse Event form for the purpose of reporting all adverse events, regardless of who was involved or the type of incident being reported - clinical/non-clinical/patient/staff/visitor/ property. There is an Adverse Event Report book in every area/ward/department across the organisation, and the process for reporting is the same for every type of incident.

The Adverse Event Form 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 to provide an update on the situation and perhaps, a revised severity grading and sent on to the Service Manager, who then forwards it to the Risk Manager for inclusion on the Risk Management database.

Once the Adverse Event Report Form is completed, it is dealt with according to the severity of the incident, please see 4.2 below and Appendix 2 for details.

In the event of a fire or fire alarm activation, in addition to the PCT Adverse Event Report Form, the 'Report of Fire or False Alarm' form should also be completed and sent directly to the Fire Safety Adviser.

ALL adverse events involving patients should be fully recorded in their clinical records/notes BUT Adverse Event Forms must not be filed in patient's notes.

4.1 Reporting and Responding to Adverse Events

Each 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 that robust reporting/feedback channels are in place.

Responsibility for ensuring that incidents are reported lies with each member of the organisation as part of their own accountability for governance. All individuals should be aware of what constitutes an adverse event or prevented incident. Should any member of staff wish to report in confidence they may do so through the normal reporting route. Staff should remain vigilant whilst undertaking their duties, in order to identify hazards, take action to eradicate/minimise potential risk and reduce possible 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.

Responsibilities of Person Reporting
An Adverse Event form must be completed as soon as possible after the event has occurred. **This should be immediately after the event, and certainly during the same shift /time period within which the incident occurred.** All information requested on the form should be entered using black ink and in clear, legible writing. A factual summary of the event must be recorded and immediate action taken to minimise the likelihood of the event re-occurring. This might include, for example, the application of first aid or removal of an item of equipment from use.

NOTE - In the case of staff or visitors, these forms replace local accident books.

As soon as is practicable the top copy of the form must be forwarded to the reporter's immediate line manager, **in usual circumstances this should be immediately after the event and no more than 24 hours after the event.** The bottom copy should be removed from the pad and stored separately in an 'Adverse Event Reports folder' in a secure cabinet (in line with data protection requirements – see the PCT's Data Protection Strategy for further guidance).

Cross-boundary Reporting
The reporting of cross-boundary incidents are as follows:

- **Clinical incidents** are to be reported to the organisation 'hosting' the patient, e.g. acute OTs on QA wards report clinical incidents to PHT Risk Department using PHT system.
- **Staff incidents** are reported to the employing organisation, e.g. acute OTs on QA wards report staff

incidents to employing organisation (F&G PCT), using PCT system.

- **Information Management & Technology** related incidents identified by IM&T staff will be reported using the Adverse Event Form belonging to the organisation which employs the person about whom the risk is being reported (for example Internet abuse or Data Protection breach). That form will be sent (by IM&T) to the employing organisation and copied to Portsmouth Hospitals NHS Trust, who manage the IM&T Service.

These reporting arrangements were agreed by the local Risk Network Group (represented by all of the South East NHS PCTs and Trusts) and any incidents reported to each of those organisations will a) enter the incident on their Risk Management Database, and b) copy the form to any other related organisation for action/information as appropriate.

Responsibilities of Ward / Area / Department Manager
The ward/department/area Manager is responsible for assessing the main (and contributory) causes and impact of the event, as soon as possible after the event and where appropriate ensure other individuals or departments are notified to minimise harm and, wherever possible, prevent re-occurrence.

The Manager must ensure that an *immediate* assessment of the circumstances of the event has been undertaken and grade the level of severity according to the impact on patient care, potential future risk to patients and to the organisation as a whole. The Manager is responsible for ensuring appropriate action, (such as staff referral to Occupational Health, review of patient's care plan, removal of equipment from service), has been taken to either minimise the likelihood of the event re-occurring or to minimise the adverse effects of the event. This should all be recorded on the form.

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. **In usual circumstances this should *be almost immediate and certainly no more than 24 hours after receipt.***

Responsibilities of Service / Senior Manager
Senior / Service Managers receive the top copy of the Adverse Event Report form, and ensures follow up action has been taken. These Managers are responsible for ensuring that external reports (see 4.3) 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.*

As the Service Manager will be notified of all incidents that occur in their area, they are responsible for monitoring trends and following-up on serious incidents or those which have service-wide implications, ensuring that learning is shared more widely as appropriate.

Informing patients, relatives, staff, media
Staff, patients/clients/service-users and/or their relatives must be made aware of any adverse incident which involves them. They should be informed as soon as is reasonably possible after the incident in a manner appropriate to their level of knowledge, understanding and personal circumstances. Wherever possible patients/clients/service-users 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.

In the event of a Serious Untoward Incident informing key individuals directly or indirectly involved should always occur before any information is released to the media and all media enquiries should be managed by the Communications team in consultation with the appropriate Manager and/or Executive Director.

A record of all information given to staff, the patient, relatives, the public and/or media should be clearly documented and kept as evidence.

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, or which, external agencies should be notified (e.g. GP, purchasers, etc).

Responsibilities of Executive Directors are responsible for fostering a risk management culture within their areas and ensuring that services comply with this policy. They have direct responsibility for ensuring implementation of actions resulting from Critical Incident Reviews and reporting progress to the Management Team. All Directors will receive notification of Critical Incidents and may be requested to liase with the media. They will also take the Lead in managing Serious Untoward Incidents in line with Appendix 3 of this Policy. The Director designated with the lead for the Serious Untoward Incident will oversee the process to ensure all relevant action has been taken.

Responsibilities of Risk Manager ensures there are systems and processes in place to enable the reporting and reviewing of all types of risk, and that those systems are communicated throughout the PCT. The Risk Manager is responsible for ensuring that all red/orange risks are included in the Risk Register, which is monitored and reviewed in order to record residual risk post-action. Communication of incidents throughout all Services and levels of the PCT includes summary of incident trends included in quarterly Service Review Reports, and to Health & Safety Committee, Risk Management Committee, Clinical Governance Committee and to the Board. The Risk Manager is also responsible for monitoring action completion, and shares learning with other organisations and network groups.

The Risk Manager ensures there are systems to report incidents to external agencies as appropriate, for example, all Patient Safety incidents to be reported to the NPSA.

Responsibilities of Quality Information Officer receives all Adverse Event Report forms and ensures they are fully completed and enters them into the Safeguard Risk Management system. The QIO also raises any concerns with the Risk Manager/Director of Nursing & Clinical Governance. The QIO prepares incident trend reports for all of the groups stated above, as well as ad hoc reports as requested by PCT Managers.

Responsibilities of Specialist/PCT 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.

4.2 Reporting Critical/Serious Untoward Incidents (Fast track System)

This system should be used for any event or situation where a person(s), PCT 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 Fast Track Reporting System for Critical Incidents is used.

It is difficult to define a Critical Incident in terms of specific types of incidents as often it is a culmination of factors that determine the severity of an incident. However, the following incidents will <u>always</u> 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 <u>any</u> patient in the care of the PCT – 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 any patient who is under the care of the PCT
6. Any significant damage, theft or loss of and to PCT property or premises (>£1,000)
7. Any incident that may attract local or national media attention

The Senior Manager (or Duty Manager if out of hours) should be contacted *immediately* for advice, action and support. At this stage the Manager will determine the severity of the incident and next actions according to Appendix 1.

It is the responsibility of the Service Manager to ensure that staff, patients and/or relatives directly involved in the incident, whenever possible, be informed *before* the media become involved, and it is essential that all communications are documented. If there are concerns regarding confidentiality or repercussions of speaking with those involved, then a discussion with the appropriate Director is advised.

The Service Manager should establish a log detailing the times, dates and sequence of events leading up to,

during and immediately following the incident. If the Director-on-call has received sufficient information to designate the reported incident as a Serious Untoward Incident, the **Serious Untoward Incident (SUI) Reporting Procedure (Appendix 3 of this policy) should be followed**. The log should include details of actions taken after the incident and up to the Critical Incident Review (See Appendix 4).

The Adverse 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 available on request on the day of the incident to the Service Manager, Director-on-call and Risk Manager. Out of office hours, the person in charge of the ward, area or department must contact their Duty Manager with details of the incident. The Critical Incident fast-track process is detailed in Appendix 1.

Reviewing Critical/Serious Untoward Incidents
A Critical Incident Review should be convened in line with the PCT document ***"Guidelines for carrying out an Incident Review" (Appendix 4 of this Policy)*** and written up in the format of the template contained in the guidance.

Once all relevant information has become available/following action/investigation the Service Manager is required to re-grade the severity of the incident in order to assess the impact of risk treatment. This reviewed grading must be communicated to the Risk Manager for updating the central database.

Responsibility for implementing actions from the review remains with the service and the Operational Director. A summary of the CIR actions will then be discussed by the Management Team at the earliest opportunity following the review to enable any interface issues or actions involving other directorates or agencies, or problems in implementing actions to be highlighted and discussed.

A summary of actions following the review must be submitted to the Risk Management Committee and Clinical Governance Committee (as appropriate) and to the Board by the Chair of the review. The summary should also be sent to the Risk Manager for the PCT's central file.
The Risk Manager is responsible for reminding Managers of deadlines, and as far as possible, ensuring actions and timescales have been met.

The annual Risk Management Committee Report Executive Committee (PEC) and Clinical Governance report, provide a summary of the CIRs/SUIs which have taken place within the last year.

The Risk Management Committee monitors the number of Critical Incidents taking place within the PCT and has responsibility for ensuring that Critical Incident Reviews have been undertaken. It also highlights trend identification and promotes opportunities for inter-organisational learning.

Root Cause Analysis
Root Cause Analysis is an umbrella term used to describe a number of techniques available to review an adverse event to find out what happened, how and why. They pinpoint areas for change, and prompt recommendations for sustainable solutions that reduce the chances of the incident happening again.

A Root Cause Analysis of the incident should be undertaken by a senior member of staff who has received the appropriate training (course offered by the joint Training & Development Shared Service, based on NPSA guidance) according to the Root Cause Analysis Guidance.

4.3 External Reports

From December 2004 **all** patient safety incidents will be reported to the NPSA (National Patient Safety Agency) using the National Reporting and Learning System. This will be achieved through the local incident reporting system linking electronically with the national database. The Risk Manager is responsible for ensuring batches of files are regularly sent to the NPSA.

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

- Other PCTs and Trusts

- Strategic Health Authority
- RIDDOR to the HSE by Service/Senior Managers
- Coroner reports to HM Coroners Office by Responsible Medical Officer
- Accidents/Incidents involving medical devices by Service Manager or Clinical Manager to MHRA
- Adverse reaction to medicines by Service Manager or Clinical Manager to MHRA
- 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 and building fabrics to NHSE by Estates Department
- Damage/Special payments exceeding £1000 (refer to the PCT's Standing Financial Instructions) to NHSE by Risk Manager
- Suspected fraud to the Local Counter Fraud Specialist (LCFS) by Service Manager
- Insurance reports e.g. claims/litigation issues to NHS Litigation Authority by Risk Manager
- Reports to the Royal College of Psychiatrists' Confidential Enquiry into Suicides, and the local Suicide Prevention Group by Consultant Psychiatrist
- Reporting of Acts of Violence against PCT staff needs to be brought to the attention of the Counter Fraud and Security Management Service (CFSMS) or the PCT's Local Security Management Specialist (LSMS) by the Local Security Officer

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 immediately reported to the Service Manager and Director-on-call:

- Loss, theft or damage to PCT 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 suffering the loss but should be encouraged)
- Serious threats of violence towards members of staff including harassment, stalking, etc
- Violent attacks on members of staff or patients
- 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
- Drug offences on PCT premises

Incidents that are reported to the Police must be investigated by the PCT following the Incident Review procedure (Appendix 4), unless directed by the Police *not* to commence investigations. The PCT investigation is independent to the Police investigation and how the PCT 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 PCT may wish to pursue internal action such as following the disciplinary procedure for staff-related incidents and in the case of professional misconduct. Care should be taken to ensure that PCT investigations do not adversely affect Police investigations/evidence gathering.

5. Reviewing Adverse Events

All Adverse 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 Safeguard Risk Management database.

Quarterly incident trend reports are provided to the Board, Risk Management Committee, Clinical Governance Committee, Health & Safety Committee, Service Review, Clinical Incident Review Group and other specialist groups. Service specific reports are provided as requested by Service Managers/Service Clinical Governance Groups. Requests for ad-hoc reports may be made at any time via the Risk Manager or Quality Information Officer.

7. Supporting Policies/Guidelines/Training

This policy should be considered in conjunction with the following PCT policies and guidelines:

- National Patient Safety Agency 'Seven Steps to Patient Safety'
- National Patient Safety Agency Incident Decision Tree

- Fareham & Gosport PCT Risk Management Strategy
- Emergency Planning and Major Incident Policy (setting up of helplines)
- Fareham & Gosport PCT Complaints Policy
- Fareham & Gosport PCT Handling of Clinical Negligence and Personal Injury Claims Policy
- Risky Business Leaflet (Induction hand-out)

The following training is available to support these polices:

- Induction to Risk Management (Training & Development Shared Service)
- Root Cause Analysis Training (Training & Development Shared Service)
- Risk Assessment Training
- National Patient Safety Agency Root Cause Analysis e-learning package
- Complaints Training (Training & Development Shared Service)

8. Analysing and Auditing Risk Events

In line with the PCT Risk Management Strategy, the analysis of all adverse events - including critical incidents - is carried out at a number of levels; within each Service for local patient and staff accidents and incidents; by Occupational Health for staff accidents; by the Clinical Incident Review Group. The root cause/s of adverse events usually lies in the management and organisational systems that support the delivery of care and blame cannot, and should not, be attributed to individuals in the first instance. Identifying and addressing dysfunctional systems is, therefore, the key to reducing future risk or harm.

Following the identification of a trend in incidents, it may be that an audit is required in order to focus more closely on a specific issue, and identify resource implications.

The Risk Management and Clinical Governance Committees receive quarterly risk statistics identifying trends by type and by service. The Board also receive quarterly trend information and a summary of any Critical or Serious Incident Reviews within the previous quarter. Special interest groups such as the Health & Safety Committee, COSHH Group and Moving & Handling Group examine specific incidents to identify emerging trends and areas for urgent attention within their remit. It is the responsibility of individual services to identify and ensure completion of clinical audits relating to trends and areas for urgent attention.

9. Policy Distribution

This Policy will be distributed to the following:

- All PCT Policy Holders
- All members of the PCT Health & Safety Committee
- All members of the PCT Risk Management Committee
- All staff via notice on Health and Safety notice boards
- Estates Department, Portsmouth City PCT
- Information Management & Technology, Portsmouth Hospitals NHS Trust
- Occupational Health Department, Portsmouth Hospitals NHS Trust

10. References

NHS Litigation Authority, May 2004. Risk Management Standard for PCTs
National Patient Safety Agency, February 2004. Seven Steps to Patient Safety
Department of Health, April 2002. Building a Safer NHS
Department of Health, August 2001. Doing Less Harm
Department of Health, June 2000. An Organisation with a Memory

11. Policy Approval & Review

Policy produced by: Risk & Litigation Manager
Policy approved by: Operational Management Team; PCT Board – September 2004
Date of review: September 2005

Appendix 1 - Fast–Tracking Critical Incidents / Serious Untoward Incidents

Could it be a Critical Incident? **NO**

1 Form completed by any member of staff
2 Send/give top copy immediately to Ward/Dept/Team Manager

Ward/Dept/Team Manager will then:
1 State action taken immediately following the incident
2 Retain bottom copy in Adverse Event Report Forms Folder
3 Send/give top copy immediately to

Nominated line manager for action who will:
1 State action taken to prevent reoccurrence
2 If a **STAFF INCIDENT** photocopies form and sends copy to Personnel & Occupational Health
3 Inform external agencies as required (i.e. completes RIDDOR form)
4 Send original to

Senior/Service Manager for action who will:
1 Quality check form (all action taken, all boxes completed, etc.)
2 Decide **SEVERITY** (low, med, high, critical incident, etc.)
3 Ensure that Personnel, Occupational Health & external agencies have been informed (where applicable) and that copy notification is attached
4 Post original copy of form to reach the
Risk Management Team within 24 hours of receipt.

Risk Management Team must receive form within 5 days of the incident and will:
1 Ensure details are entered onto Safeguard Risk Management system
2 Share incident information with other NHS organisations where applicable
3 Request Critical Incident Review Report (if applicable) from Senior Manager

Forms should reach PCT headquarters within 5 days of reporting an incident

YES

1. The Adverse Event form must be completed as described in the section opposite and be provided on request to the Service Manager, Duty Manager, Director-on-call or Risk Manager

2. **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 Inform the PCT Headquaters who will initiate the critical incident process.

3. **Out of Hours (evenings/nights, 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 decide whether it is appropriate to notify the Director On-Call of a potential Serious Untoward Incident (SUI).
   The Director-on-call will follow the SUI procedure.

4. **For all Critical Incidents**, Services will take follow-up action as necessary including a Critical Incident Review.
   The CIR report must be copied to the appropriate individuals within and external to the PCT.

Details should reach PCT Headquarters on the day of the incident

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Appendix 2 - Incident Severity and Review Levels

Description	Impact Severity	Code	Action
Adverse Event (no harm) refers to an incident which actually occurred, but which caused no harm. **Adverse event (prevented)** replaces the term 'near-miss' and describes an incident which had the potential to cause harm but was prevented.	Prevented Incident/No Harm	**NM**	Follow Near Miss Guidance It is important near misses are recorded on adverse event Forms in order that lessons can be learned and actual incidents avoided.
Adverse Event - No permanent harm or injury (egg. Cut/bruise) some distress, financial loss up to £100	**Minor**	**MIN**	Local Review of Incident All minor and moderate incidents must have an immediate local review of the incident and its consequences by the manager of the area where it happened. Action take to prevent re-occurrence must be noted in Sections H and I of the Adverse Event form and passed to the Senior/Service manager.
Adverse Event - Semi permanent harm or injury lasting up to 1 year or requiring hospital treatment, moderate distress, or financial loss up to $1,000	**Moderate**	**MOD**	
Adverse Event - Permanent harm or injury lasting 1 year+, negligence, major distress, or financial loss up to £5,000	**Major**	**MAJ**	Follow Critical Incident Review Guidance 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.
Adverse Event - Unexpected death, severe emotional distress, media interest, or financial loss over £5,000	**Catastrophic**	**CAT**	Follow Serious Untoward Incident Guidance Any incident likely to have a significant impact on local health services or to attract public and media interest. This may be because it involves a large number of patients, there is a risk to public health, there is a question of poor clinical or managerial judgement, a service has failed or a patient has died in unusual circumstances.

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Appendix 3 - SERIOUS UNTOWARD INCIDENT (SUI) REPORTING PROCEDURE

This procedure uses the guidance produced the Hampshire and Isle of Wight Health Authority (1 April 2002). It sets out the criteria for identifying serious adverse incidents that may occur within Fareham & Gosport PCT, the reporting procedure, and ongoing communication, reporting and support arrangements.

1. Definition

How do I report a serious untoward incident?

The Strategic Health Authority Serious Untoward Incident Hotline can be contacted 24 hours a day, 7 days a week, 365 days a year on 07977 517637
During office hours this number will put you in touch with a strategic Health Authority Untoward Incident Duty Officer. Outside office hours this number is automatically diverted to the strategic Health Authority on-call manager.

What is serious untoward incident reporting?

All NHS Trusts and Primary Care Trusts are required to inform their strategic Health Authority of any serious untoward incident. This enables the strategic Health Authority to offer advice and support and to ensure that information about the incident is shared appropriately with other affected organisations. It also allows the strategic Health Authority to brief ministers and other people who need to be told. This is an essential part of the accountability of the NHS as a public service.

What is a serious untoward incident?

There is no set definition of a serious untoward incident but, in general terms, it is something that is likely to have a significant impact on local health services or to attract public and media interest. This may be because it involves a large number of patients, there is a risk to public health, there is a question of poor clinical or managerial judgement, a service has failed or a patient has died in unusual circumstances.
Such incidents might include:

A number of unexpected of unexplained deaths, including apparent clusters of patients receiving psychiatric care. Impending major litigation, suspicion of large-scale theft or fraud. Any incident likely to lead to serious criminal charges including violent attacks on either staff or patients, hostage situations or abductions. Repeated serious complaints about a member of staff or contractor. Suspicion of a serious error by a member of staff or contractor that could lead to public concern, or a serious breach of confidentiality. The suicide of any person on NHS premises or under the care of a specialist team in the community. Accidental or suspicious death of, or serious injury to, any individual on NHS premises. Serious damage that occurs on NHS premises, particularly resulting in injury or disruption to services. Absence without leave by patients who may present a risk to themselves or others. A serious outbreak of an infectious disease, food poisoning or transmission of an infectious disease from a staff member to a patient, or any incident involving a healthcare worker infected with HIV or Hepatitis B or C. Serious chemical or microbiological contamination or radiation incidents. Suspension of a doctor. Critical care out-of-network transfers

If you are not sure whether or not you are dealing with a serious untoward incident, it is likely that you should report the incident.

What information should I provide?

Your report is likely to include:

The date of the report - The name of the reporting organisation - The name and contact details for someone who can be contacted for further information - The apparent impact and likely future impact of the incident in terms of harm (e.g. none, moderate, catastrophic) - When the incident occurred - Where the incident occurred (specialty, location) - Who was involved - What has happened (the sequence of events) - What action has been taken as a consequence of the incident., and what else the organisations is planning to do - The likely implications of the incident for other organisations (e.g. NHS, social services) - An indication of likely media interest and the lines taken / to be taken - Any other relevant information

The role of the strategic Health Authority

The strategic Health Authority will be able to provide information and advice about the handling of major incidents. For example, they may be able to put you in touch with other organisations where similar incidents have occurred. They are also responsible for ensuring that Ministers are briefed on major incidents in the NHS, an important part of the accountability of the NHS as a public service. The strategic Health Authority additionally has some operational responsibilities in the event of certain major incidents (e.g. commissioning independent inquiries following homicide committed by people in contact with specialist mental health services). These responsibilities are set out in the strategic Health Authority's *Interim Serious Untoward Incident Guidance.*

Further Information:

A full version of this reporting guidance has been published by the Hampshire and Isle of Wight Health

Authority as *Interim Serious Untoward Incident Guidance.* Further information is also available form the local Safer NHS website at **www.hiow.nhs.uk/safernhs.html**.

2. Reporting procedure

2.1 Incidents of this nature must be reported as Critical Incidents using the Adverse Event reporting procedure and notified to the appropriate Executive Director and the PCT headquarters immediately.

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 the PCT headquarters, the appropriate Executive Director will determine whether the incident is to be designated as a Serious Untoward Incident and if so, invoke this procedure.

2.4 The nominated Executive Director will take the lead in managing the incident, with support from other Executive Directors, Service Managers and Risk/Governance 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

(b) Ensure details are communicated immediately to the Strategic Health Authority, PCT Communications team and where appropriate, Primary Care PCTs and Portsmouth Hospitals.

(c) Ensure details of the incident are communicated to the Chairman and Non-Executive Directors of the PCT 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, etc.

W ITHIN 48 HOURS

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

(f) As appropriate and in liaison with the Strategic Health Authority, Communications team 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

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

(h) In liaison with (as appropriate) Operational Directors and the Strategic Health Authority, convene a Review Team and appoint a suitably senior and experienced person to lead/chair the Review process

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

UNTIL INCIDENT CONCLUDED

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

(k) Ensure the outcome of the CIR/Investigation is communicated to relevant parties including the PCT Board, Strategic Health Authority

(l) 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 PCT documents ***"Guidelines for carrying out an Incident Review"*** and "***Root Cause Analysis Guidelines***" when convening review meetings, arranging for witness statements to be taken, producing the review report, etc.

4. Concluding the Serious Untoward Incident

4.1 A single report on the incident presented to the PCT Board and Strategic Health Authority will conclude the Serious Untoward 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 Quarterly Review) until that happens.

5. Role of the Strategic Health Authority

5.1 The role of the Strategic Health Authority is to:

(a) to offer support and guidance to the PCT in carrying out their local investigation of the incident
(b) to liaise with the nominated PCT 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

Further information can be found in the Hampshire & Isle of Wight Strategic Health Authority's document entitled '*Interim Serious Untoward Incident Guidance*'.

Fareham and Gosport NHS
Primary Care Trust

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Appendix 4 - GUIDELINES FOR CARRYING OUT AN INCIDENT REVIEW (CRITICAL INCIDENT (CI) / SERIOUS UNTOWARD INCIDENT (SUI))

These guidelines provide Managers with a PCT-wide template for dealing with Critical and Serious Untoward Incidents. Critical and Serious Untoward Incidents are discussed below in detail; the main difference between a Critical and Serious Untoward Incident is the likelihood of the incident attracting media attention.

Persons involved in reviewing a critical incident may also wish to refer to the PCT Investigating Officer Guidelines for carrying out an investigation.

CRITICAL/SERIOUS UNTOWARD INCIDENT REVIEW TIMELINE

1. ***Incident declared (CI/SUI)***
2. Incident Review - **WITHIN 3 WORKING DAYS OF INCIDENT**
3. Report written - **WITHIN 24HOURS OF INCIDENT REVIEW**
4. Root Cause Analysis (RCA) - **WITHIN 2 WEEKS OF INCIDENT**
5. Action Plan written - **WITHIN 3 WEEKS OF INCIDENT**
6. Action Plan reviewed - **WITHIN 6 WEEKS OF INCIDENT**

A. WHAT IS A CRITICAL INCIDENT ?

A **Critical Incident** is a serious, untoward event i.e. accident or incident which is believed could severely harm a person(s), service, PCT premises or property, or the organisation as a whole. Types of Critical Incidents will vary from Service to Service, however, the following will always be classed as a Critical Incident (this list is not exhaustive and is intended for guidance):

1. The unexpected death of any patient in the PCT'S – residential, community, in-patient, out-patient, etc
2. The death of any member of staff whilst on duty – including volunteers, agency, contractors, etc
3. Any incident that might lead to criminal charges including violent attacks on patients, staff or hostage situations
4. Any significant damage, theft or loss of and to PCT property or premises (>£1,000)
5. Any incident that may attract local or national media attention

* It is recommended that lead managers, lead clinical and medical staff from each Service discuss and agree what types of incidents would be classed as critical within their Service and convey this to front line staff.

B. WHAT IS A SERIOUS UNTOWARD INCIDENT ?

Guidance issued by Hampshire & Isle of Wight Strategic Health Authority in April 2002 defines a Serious Untoward Incident (SUI) as *'something that is likely to have a significant impact on local health services or to attract public and media interest. This may be because it involves a large number of patients, there is a risk to public health, there is a question of poor clinical or managerial judgement, a service has failed or a patient has died in unusual circumstances.'*

Examples of SUIs include:

1. A number of unexpected or unexplained deaths, including apparent clusters of patients receiving psychiatric care.
2. Impending major litigation, suspicion of large-scale theft or fraud.
3. Any incident likely to lead to serious criminal charges including violent attacks on either staff or patients, hostage situations or abductions.
4. Repeated serious complaints about a member of staff or contractor.
5. Suspicion of a serious error by a member of staff or contractor that could lead to public concern, or a serious breach of confidentiality.
6. The suicide of any person on NHS premises or under the care of a specialist team in the community.
7. Accidental or suspicious death of, or serious injury to, any individual on NHS premises.
8. Serious damage that occurs on NHS premises, particularly resulting in injury or disruption to services.
9. Absence without leave by patients who may present a risk to themselves or others.

10. A serious outbreak of an infectious disease, food poisoning or transmission of an infectious disease from a staff member to a patient, or any incident involving a healthcare worker infected with HIV or Hepatitis B or C.

If you are not sure whether or not you are dealing with a serious untoward incident, you should report the incident to PCT Headquarters. A PCT Director will be nominated to take the lead on the incident and it will be decided at Director level whether the incident is a CI or SUI. If the decision is unclear, the StHA will advise.

All SUIs will be reported to the StHA by the Lead Director.

C. WHAT IS THE PURPOSE OF AN INCIDENT REVIEW (IR)?

An Incident Review provides an opportunity to reflect on the incident and to:

- Explore and understand what happened
- Improve clinical and other working practices
- Identify helpful outcomes for service users and staff after an incident
- Identify issues of significance and make sure they are appropriately followed-up
- Enhance staff and service user's safety
- Minimise the occurrence of a similar incident
- Identify staff who may require additional support
- Provide a learning experience for staff
- Support the PCT's Recording and Reviewing Risk Events Policy
- Recognise what went well!
- Ensure those who need to know about the incident and learn from it are kept informed

D. WHO DECIDES AN INCIDENT REVIEW IS NEEDED ?

All Critical/SU Incidents should be notified immediately (same day) to the appropriate area Manager and PCT Headquarters by the Manager of the area where the incident happened (see attached paperwork).

The Lead Director will decide whether a CI/SUI Review is to be convened - this will often follow discussion and agreement with staff at ward or department level and the Service Manager.

In some circumstances the process and timescales set out in this guidance may be delayed or cancelled altogether, for example if an external independent review is necessary, or if a member of staff has been suspended and the PCT is carrying out a disciplinary investigation.

E. HOW SOON AFTER THE INCIDENT SHOULD THE REVIEW TAKE PLACE?

The IR should take place ***as soon as possible*** but no later than **3 working days** after the incident. Whilst the IR organiser will be sensitive to shift patterns, PCT staff requested to attend an IR *must* give it priority and re-arrange diaries to accommodate the IR meeting/s.

F. WHO SHOULD CHAIR THE REVIEW ?

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 IR process.

As IRs 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.

G. WHO ELSE SHOULD BE INVOLVED ?

All PCT staff involved or a witness to the incident AND staff from other agencies as appropriate - Police, Social Services, Contractors, etc.

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

All staff invited to attend an IR are welcome to invite their Union representative to accompany them.

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

A standard IR invitation letter is attached.

In order to enable the IR Report to be typed up as quickly as possible, the Chair-person should invite administrative

support from the pool of trained staff. The administrative staff will take minutes and then as a priority, type up the report in the format set out on page 8.

H. WHO ELSE (NOT DIRECTLY INVOLVED IN THE IR) NEEDS TO KNOW IT'S HAPPENING ?

- Service Manager (for inclusion in Quarterly Review)
- PCT Headquarters (Executive Directors and Risk Advisers)
- Occupational Health (for staff accidents only)
- Consultant/Responsible Medical Officer - to be notified by Service Manager if a patient under their care has been involved in an incident leading to a Review

I. HOW SHOULD AN INCIDENT REVIEW BE CONDUCTED ?

A combination of any of the following:-

- Individuals may be asked to provide a statement which sets out their recollection of events before any meetings
- All people involved in the incident are invited to attend the same meeting at the same time in the first instance
- The one-off meeting may suffice in completing the Review however, it could be followed by a series of meetings to clarify ambiguities that may subsequently arise
- All staff involved in an incident should make it their priority to attend the IR 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

J. WHAT SHOULD HAPPEN DURING AN INCIDENT REVIEW ?

- Chair person makes an introduction stating the purpose of the review
- All individuals are asked to provide a detailed account of what happened
- Factual chronological sequence of events is established
- Causal factors (breakdown in procedures, communications, equipment, systems, etc.) identified
- The practicality and effectiveness of relevant policies and procedures is assessed

K. OUTCOME OF AN INCIDENT REVIEW?

An IR report must be produced **within 24 hours** of the Review meeting.

The report is produced in a standard PCT-wide format (sample attached) which includes:

1) Introduction including relevant background information which may help to set the scene (i.e. summary of patient medical history for patient related incidents)

2) Name, job title and location of the person chairing the Review

3) Names, job titles, locations of all persons involved in the incident and IR (this information can be anonymised if the Report is to be shared outside the Service for learning purposes)

4) Chronological sequence of events

5) The outcome of the incident

6) The main cause/s of the incident identifying organisational, environmental, individual and procedural factors which may have contributed to occurrence of the incident (Section L)

7) Key learning points - learning points which may have relevance beyond the immediate ward or service should be highlighted in the Report

Action plan - the action plan 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. Action planning should always include a debrief for staff involved in the incident. For each action point a lead person and timescale for completion will be identified.

L. ROOT CAUSE ANALYSIS

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:

Organisation & processes – management decisions, organisational structure, culture, etc

Conditions of work – workload, supervision, staffing levels, communication, equipment, knowledge, training, ability, etc

Unsafe acts – Care Delivery Problem (CDP) – care deviates beyond safe limits; Service Delivery Problem (SDP) – acts or omissions indirectly linked to patient care e.g. environmental risks
Multiple Defences – were policies, guidelines or procedures in place? were they followed? were they ineffective?

The RCA team should consist of 3 or 4 multi-disciplinary people who were *not* directly involved in the incident investigation. Ideally a Non-Executive Director would be involved in the RCA team which would be led by someone who has been trained in carrying out RCA.

The Root Cause Analysis must be completed **within 2 weeks** of the incident date.

M. FOLLOW-UP TO ENSURE IR ACTION PLAN IS IMPLEMENTED

Service Managers have direct responsibility for ensuring Action Plans are implemented within agreed timescales, action plans should always include a debrief for staff involved in the incident.

Operational Director/s will ensure Action Plans are followed-up and 'signed-off' at Quarterly Reviews. Key points from Action Plans will roll forward from Review to Review until they are signed-off i.e. all action has been completed.

Completion of the action will be confirmed to and checked by the relevant PCT Board Committee i.e. Clinical Governance/Risk Management, Audit & Assurance etc. Through this process the Board will be assured that the appropriate action has been taken to minimise risk of re-occurrence.

The final Action Plan should be reviewed **within 6 weeks** of the incident date.

N. ENSURING LESSONS LEARNED FROM INCIDENT REVIEWS ARE SHARED

It is important to ensure action is taken to prevent reoccurrence of similar incidents within a Service. However, the organisation as a whole should also learn from serious incidents.

Key lessons will be cascaded by the PCT Risk Adviser through appropriate channels as soon as an incident occurs and updates will be circulated to all wards and departments which highlight wider learning points.

O. AUDITING TO ENSURE SYSTEM CHANGES RESULTING FROM INCIDENT REVIEWS ARE STILL IN PLACE

In the aftermath of any 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.

To ensure changes arising from IRs are embedded Service Managers to audit action plans to establish whether remedies are still in place and working effectively.

P. FURTHER GUIDANCE
Further information can be found in the PCT's Personnel Policies Folder; Disciplinary Procedure Policy and Guidance for Conducting Investigations, as well as the Investigating Officers Training provided by the Training & Development Shared Service (TDSS).

ROLES AND RESPONSIBILITIES

The IR Chairperson

- ❑ To convene the IR **within 3 working days** of the incident
- ❑ To open/introduce the IR meeting and clarify it's purpose
- ❑ To facilitate an open discussion which will elicit the facts of what actually happened (and what didn't)
- ❑ 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 IR process)
- ❑ To identify what could have been done differently
- ❑ To thank all IR participants for their co-operation before closing the IR meeting
- ❑ To write up the IR Report in the required format
- ❑ To produce the initial IR Report **within 24 hours** of the Review to the relevant people
- ❑ To facilitate the development of an action plan which will minimise the risk of a similar incident happening again
- ❑ To produce the final report, including Action Plan **within 3 weeks** of the incident

Staff involved in an incident and requested to attend an Incident Review

- ❑ To make themselves available to attend an IR meeting

- ❑ To give an honest and factual account of what happened (and what didn't)
- ❑ To openly explore alternative actions where appropriate

Service Managers

- ❑ To appoint a person to Chair the IR
- ❑ To ensure the Review takes place **within 3 working days** of the incident
- ❑ To ensure the report is written up **within 24 hours** of the review
- ❑ To ensure Root Cause Analysis is completed **within 2 weeks** of the incident
- ❑ To ensure the final report, including Action Plan is produced **within 3 weeks** of the incident
- ❑ To present the IR Report to appropriate Managers as required by the Service
- ❑ To ensure the Action Plan has been implemented within specified time limits
- ❑ To provide a summary report at Quarterly Review which identifies IRs carried out during the previous quarter, key areas for action with timescales and highlights learning points which may be applicable to other Services
- ❑ To report at subsequent Quarterly Reviews when action arising from a IR has been fully implemented

PCT Headquarters (Nominated Lead Director)

- ❑ Upon notification of a critical incident, to check with the Service Manager that the Incident Review process is underway
- ❑ To circulate details of the incident to Executive Directors and other Senior Managers within the PCT
- ❑ In consultation with Strategic Health Authority, to liaise with the media and other external agencies (i.e. Police) to provide information about the incident
- ❑ To ensure the incident timeline is followed by those responsible for implementing the IR procedure
- ❑ To share learning points that are identified at Quarterly Review with other Services as appropriate
- ❑ To advise the relevant PCT Board Committees of emerging issues, action planned and completed
- ❑ To ensure the incident is recorded on the Risk Management database
- ❑ To ensure the PCT Board is briefed on the incident and receives assurance that the Incident Review Report and Action Plan have been carried out and actions fully implemented.

STAFF TRAINING

- ❑ The Incident Review process forms part of the PCT's Risk Event Reporting Policy. As such it will form part of the PCT's Risk Awareness Training Programme.
- ❑ The role of the IR Chair will form part of the Investigating Officer Training.
- ❑ Root Cause Analysis Training will be available from the National Patient Safety Agency, then within the PCT through trained staff.

These Guidelines have been distributed to:
Executive Directors
Services Managers
Lead Consultants
Personnel Managers
PCT Advisers (Occupational Health, Moving & Handling, Fire Safety, Hotel Services)

For information:
Head of Quality, East Hampshire PCT & Portsmouth City PCT

Fareham and Gosport NHS
Primary Care Trust

Corporate Policy OP32

Template : Invitation to attend an Incident Review

[*Date*]

Dear

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.

Fareham and Gosport NHS
Primary Care Trust

Corporate Policy OP32

CONFIDENTIAL

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 Incident Review meeting/s

IR Chairperson — *(Name, job title and location)*

Persons present at the IR — *(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?

Organisational factors

Conditions of work

Human errors or omissions

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 PCT as a whole)).

Learning Point	Action Required	Lead Person	By When

8. FINAL REPORT DISTRIBUTION LIST

(Include all staff involved in the Review/RCA, Board sub-Committees, PCT Board, Strategic Health Authority, Neighbouring PCTs/ Trusts)

Fareham and Gosport NHS
Primary Care Trust

FORM A

Corporate Policy OP32

CRITICAL INCIDENT & SERIOUS UNTOWARD INCIDENT GUIDANCE FOR ALL STAFF – IN & OUT OF HOURS

The table below sets out the procedure for managing the communication aspect of any Critical Incident. Copies of this guidance is kept by the safe haven fax machine at Unit 120, Fareham Reach.

Column C MUST be completed by the person receiving the fax – decisions may be scrutinised post-incident and this form will provide your evidence.

RESPONSIBLE PERSON (Column A)	ACTION – DURING OFFICE HOURS (Column B)	ACTION TAKEN (Column C) Note who you spoke to/what action was agreed and by whom etc.
STEP 1 **Member of staff reporting the incident**	1. As soon as SERIOUS/CRITICAL incident discovered inform the local manager. 2. Complete an Adverse Event Form *as soon as* possible.	**Name of Manager informed:** _____ **Time informed:** _____
STEP 2 **Appropriate Local Manager**	1. Telephone PCT Headquarters main switchboard (01329 233447) to: a) Alert staff to incoming fax, and b) notify appropriate Director 2. Fax Adverse Event Form directly to PCT Headquarters – to safe haven fax (Unit 120). Ensure fax cover clearly states the **NAME** of the receiving Director. **Fax No: 01329 229446**	**Name of Director informed:** _____ **Time informed:** _____

RESPONSIBLE PERSON (Column A)	ACTION – OUT OF HOURS (Column B)	ACTION TAKEN (Column C) Note who you spoke to/what action was agreed and by whom etc.
Member of staff reporting the incident	1. Adverse Event Form completed *as soon as* incident occurs. 2. Report incident to Person in Charge **(COMPLETE COLUMN C)**	**Name of Manager informed:** _____ **Time informed:** _____
Person in Charge of Ward/Home/ Premise	1. Report incident to Service Manager on-call **(COMPLETE COLUMN C)**	**Name of Manager informed:** _____ **Time informed:** _____

Fareham and Gosport NHS
Primary Care Trust

Corporate Policy OP32

FORM B

CRITICAL INCIDENT & SERIOUS UNTOWARD INCIDENT GUIDANCE FOR SECRETARIAT/RECEIVING STAFF

The table below sets out the procedure for managing the communication aspect of any Critical Incident. Copies of this guidance is kept by the safe haven fax machine at Unit 120, Fareham Reach.

Column C MUST be completed by the person receiving the fax – decisions may be scrutinised post-incident and this form will provide your evidence.

1. Adverse Event Form completed by staff at point of incident, as soon as incident occurs.

2. Member of staff reporting the incident will telephone the PCT Headquarters main switchboard (01329 233447) to:
   c) Alert staff to incoming fax and
   d) notify appropriate Director

3. Completed Adverse Event Form will be faxed directly to PCT Headquarters – to safe haven fax (Unit 120). The fax cover should clearly state the **NAME** of the receiving Director.

RESPONSIBLE PERSON	ACTION	ACTION TAKEN Note who you spoke to/what action was agreed and by whom etc.
Any person receiving an Adverse Event Form marked 'CI'	**1. As soon as the completed Adverse Event Form is faxed through to the Safe Haven fax (Fax No: 01329 229446), *hand it* to the named Director (as stated on the fax cover sheet).** Confirm hand-over by completing column C.	**Fax receiver's initials:** _____ **Named Director's initials:** _____ **Time of handover:** _____

FORM C

Corporate Policy OP32

Fareham and Gosport NHS
Primary Care Trust

CRITICAL INCIDENT & SERIOUS UNTOWARD INCIDENT GUIDANCE FOR DIRECTORS
(IN & OUT OF OFFICE HOURS)

The table below sets out the procedure for managing the communication aspect of any Critical Incident. Copies of this guidance is kept in a) all Director's on-call packs and b) by the safe haven fax machine at Unit 120, Fareham Reach.

Column C MUST be completed by the Named Director – decisions may be scrutinised post-incident and this form will provide your evidence.

COLUMN A	COLUMN B	COLUMN C
STEP 1 **In hours** - Named Director **Out of hours** – Director on-call is 'Named director')	**2. From the information you have been given via conversation with member of staff reporting the incident and the Adverse Event Form, decide whether this incident is a Critical Incident (CI) or a Serious Untoward Incident (SUI). The main difference is that a Critical Incident would be contained within the PCT, whereas a SUI is likely to attract media interest (see SUI Guidance issued by HIOW StHA, April 2002, a copy of summary guidance is in every Director's on-call pack).** **Note: During office hours you should have a faxed copy of the completed adverse Event Form. The form should have been faxed as soon as possible to the Safe Haven fax located in Unit 120.** **Out of hours information will be via on-call mobile phone, and a copy of the faxed Adverse Event Form should be available the next working day via the Safe Haven fax located in Unit 120.**	**Time informed of incident: _____** **Route to be followed for this incident will be CI or SUI was made based on the following elements:**
FOR SERIOUS UNTOWARD INCIDENTS **GO TO** STEP 3 – **SEE OVERLEAF** **FOR** CRITICAL INCIDENTS **GO TO RECORDING & REVIEWING RISK EVENT POLICY**		

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STEP 2 – **Named Director**	**1.** Immediately **VERBALLY inform the Chief Executive, Chair, and on-call Director. Note time of conversation and action agreed with each person.** **2. Inform the Strategic Health Authority by telephoning the SUI Hotline:** 07977 517637 **3. E-mail all Directors and Chair giving brief details of incident and action taken so far. Remember to note the date and time of the e-mail.** COMPLETE THE TABLE BELOW TO CONFIRM ACTION TAKEN.

INCIDENT CHECKLIST	**Yes/No**	**Details**
Family informed		
Police involvement		
Media involvement		
Staff involvement		
Patient involvement		

ALERTING ARRANGEMENTS	Time	Action agreed
1. Chief Executive informed		
2. Chair informed		
3. On-call Director informed		
4. Communications team informed		
5. Strategic Health Authority informed		