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**Code A - PA (Nursing Clinical Governance)**

**From:** Caroline Harrington - Risk & Litigation Manager  
**Sent:** 20 January 2004 11:59  
**To:** Fiona Cameron - Director of Nursing & Clinical Governance  
**Subject:** PRINTED AND PUT IN POST CORRESPONDENCE FILE - FW: CIR/SUI Report Writing

**Follow Up Flag:** Follow up  
**Due By:** 27 January 2004 10:00  
**Flag Status:** Flagged

For the 'evidence' file.

Caroline

-----Original Message-----

**From:** Caroline Harrington - Risk & Litigation Manager  
**Sent:** 20 January 2004 11:05  
**To:** Janet Peach - Service Manager; Toni Scammell - Senior Nurse Coordinator; Sue Hutchings - Senior Nurse Co-ordinator; Martin Cowdry - Physiotherapy Service Manager; Rachel Wylie - CES OT; Jessie Bell - Senior Personnel Manager; Rosemary Salmond - OT District Advisor; Ged Kearney - Assessment Treatment + Specialist Healthcare; Babs Gray - DN Service Manager  
**Subject:** CIR/SUI Report Writing

Hi all

Thank you for attending the meeting yesterday, to discuss the CIR/SUI Guidance.

Attached is the updated guidance document, reflecting yesterday's discussions.

Main changes:

Page 1 - Timeline clearer, and Section A. incidents reported to Police no longer automatically constitute 'Critical Incident'

Page 3 - Paragraph re. disciplinary investigation/external investigation either delaying/cancelling this process; Section E. includes sentence on 'sensitivity to shift patterns'; Section G. includes sentence on admin support

Page 4 - Section K. Action Plan includes requirement for debrief.

Page 5 - Section P. New section sign-posting further guidance available to support these guidelines.

Pages 10 - 14 - Forms for reporting/alerting CIR/SUI



Glines for  
CIR-SUI.doc

I'd be grateful if would let me have any comments by **27 January**.

Many thanks,  
Caroline

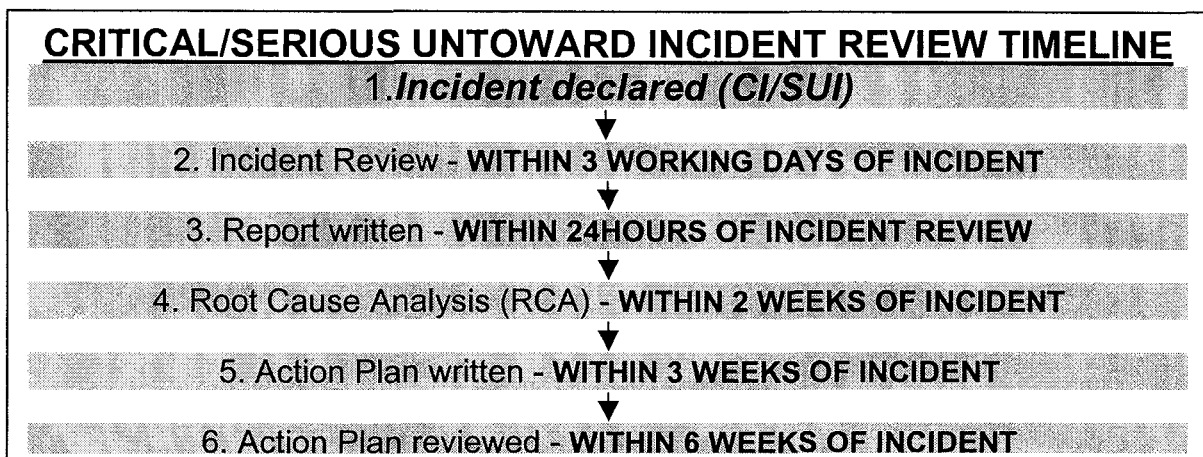
## GUIDELINES FOR CARRYING OUT AN INCIDENT REVIEW

### (CRITICAL INCIDENT (IR) / 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.

These Guidelines supplement the PCT Policy on Recording and Reviewing Risk Events.

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



#### 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 care of the PCT – 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. Absconding by patients detained under the Mental Health Act or the confused elderly who may present a risk to themselves or others
5. Any significant damage, theft or loss of and to PCT property or premises (>£1,000)
6. 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!

## 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
- 8) 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 *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.

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).

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

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

Risk & Litigation Adviser  
Fareham & Gosport PCT  
Tel: 01329 229412  
Fax: 01329 234984  
email: [caroline.harrington@ports.nhs.uk](mailto:caroline.harrington@ports.nhs.uk)

JANUARY 2004

## 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 its 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 complete
- To ensure the incident is recorded on the Risk Management database
- To ensure the PCT Board is briefed on the incident and receives a copy of the Incident Review Report and Action Plan.

### 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.



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.

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 to 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)*

FORM A

Fareham and Gosport   
Primary Care Trust**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.
<b>STEP 1</b> Member of staff reporting the incident	<ol style="list-style-type: none"> <li>As soon as SERIOUS/CRITICAL incident discovered inform the local manager.</li> <li>Complete an Adverse Event Form <u>as soon as possible</u>.</li> </ol>	Name of Manager informed: <hr/> Time informed: <hr/>
<b>STEP 2</b> Appropriate Local Manager	<ol style="list-style-type: none"> <li>Telephone PCT Headquarters main switchboard (01329 233447) to:               <ol style="list-style-type: none"> <li>Alert staff to incoming fax, and</li> <li>notify appropriate Director</li> </ol> </li> <li>Fax Adverse Event Form directly to PCT Headquarters – to safe haven fax (Unit 120). Ensure fax cover clearly states the <u>NAME</u> of the receiving Director. <b>Fax No: 01329 229446</b></li> </ol>	Name of Director informed: <hr/> Time informed: <hr/>

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	<ol style="list-style-type: none"> <li>Adverse Event Form completed <u>as soon as</u> incident occurs.</li> <li>Report incident to Person in Charge <b>(COMPLETE COLUMN C)</b></li> </ol>	Name of Manager informed: <hr/> Time informed: <hr/>
Person in Charge of Ward/Home/ Premise	<ol style="list-style-type: none"> <li>Report incident to Service Manager on-call <b>(COMPLETE COLUMN C)</b></li> </ol>	Name of Manager informed: <hr/> Time informed: <hr/>
Service Manager on-call	<ol style="list-style-type: none"> <li>Report incident to PCT Director on-call (Mob: 07880 737245; back-up pager 07699 716954):  Be prepared to provide as much information as possible about the situation, who has been informed, and what action has already been taken.</li> <li>Fax Adverse Event Form directly to PCT Headquarters – to safe haven fax (Unit 120). Ensure fax cover clearly states the <u>NAME</u> of the receiving Director. <b>Fax No: 01329 229446</b> <b>(COMPLETE COLUMN C)</b></li> </ol>	Name of Director informed: <hr/> Time informed: <hr/>

FORM B

Fareham and Gosport **NHS**  
Primary Care Trust

**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.

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

FORM C

## 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
<p><b>STEP 1</b></p> <p>In hours - <b>Named Director</b></p> <p>Out of hours – <b>Director on-call is 'Named director'</b></p>	<p>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 <b><u>Critical Incident (CI)</u></b> or a <b><u>Serious Untoward Incident (SUI)</u></b>. 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).</p> <p>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.</p> <p>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.</p>	<p>Time informed of incident: _____</p> <p>Route to be followed for this incident will be <u>CI</u> or <u>SUI</u> was made based on the following elements:</p>
<p><b>FOR SERIOUS UNTOWARD INCIDENTS GO TO STEP 3 – SEE OVERLEAF</b></p> <p><b>FOR CRITICAL INCIDENTS GO TO RECORDING &amp; REVIEWING RISK EVENT POLICY</b></p>		

<b>STEP 2 – Named Director</b>	<p>1. <b>Immediately</b> <u>VERBALLY</u> inform the Chief Executive, Chair, and on-call Director. Note time of conversation and action agreed with each person.</p> <p>2. Inform the Strategic Health Authority by telephoning the SUI Hotline: <b>07977 517637</b></p> <p>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.</p> <p style="text-align: center;"><b>COMPLETE THE TABLE BELOW TO CONFIRM ACTION TAKEN.</b></p>
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<b>INCIDENT CHECKLIST</b>	<b>Yes/No</b>	<b>Details</b>
Family informed		
Police involvement		
Media involvement		
Staff involvement		
Patient involvement		

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