Fiona Cameron - Director of Nursing _Clinical Governance

From: Caroline Harrington - Risk & Litigation Manager
Sent: 15 January 2004 13:04
To: Janice Combs - Business Manager
Cc: Fiona Cameron - Director of Nursing & Clinical Governance
Subject: Addendum to the Recording & Reviewing Risk Event Policy

Hi Janice

Glines for CIR-SUI.doc

Pleas could you send the attached guidelines out to Policy Holders with a request that they add them to the Recording & Reviewing Risk Event Policy as Appendix 4. Having discussed with Fiona, as these are guidelines rather than Policy, they do NOT need to go to the Board.

Also, please could you copy Fiona into the e-mail/memo which is sent to Policy Holders requesting the above.

Thanks,
Caroline

Glines for CIR.doc

Fareham and Gosport NHS
Primary Care Trust

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 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.

INCIDENT REVIEW TIMELINE

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

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):

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3. The death of any member of staff whilst on duty – including volunteers, agency, contractors, etc
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5. Absconding by patients detained under the Mental Health Act or the confused elderly who may present a risk to themselves or others
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7. 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 IRcumstances.'*

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.
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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.

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 an external independent review may be necessary.

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. PCT staff requested to attend a 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.

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.

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 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 root 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. 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 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.

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.

JANUARY 2004

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: Code A
Fax: 01329 234984
email: Code A

Fareham and Gosport NHS
Primary Care Trust

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 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.

Fareham and Gosport NHS
Primary Care Trust

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.

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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

APPENDIX 4

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.

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F. WHO SHOULD CHAIR THE REVIEW ?

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A combination of any of the following:-

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ROLES AND RESPONSIBILITIES

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- 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 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.

Fareham and Gosport NHS
Primary Care Trust

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

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)