



<b>Title:</b>	<b>Learning From Serious Adverse Incidents (SAIs) Policy and Procedure</b>		
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March 2024	3	SAI Manager	Policy Review
February 2022	2.2	Risk Manager	Addition of New Staff Checklists
February 2021	2.1	Risk Manager	Addition of Never Events
May 2019	1.0	Risk Manager	New Procedure (Regional Guidance)

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## 1.0 INTRODUCTION:

A high standard of incident management will ensure that lessons are learned and continual improvement is achieved. Serious Adverse Incidents (SAIs) should be seen as significant learning opportunities.

### 1.1 Background:

Within the Northern Ireland Ambulance Service (NIAS), how we respond when things go wrong is an important part of the care we deliver. It is fundamental that we as a Trust ensure service users / families / carers etc. are engaged, receive the information they need and are reassured that everything possible will be done to ensure that a similar type of incident does not occur again. It is also vital that, where necessary, we support and educate staff involved in such incidents and ensure that they are treated justly and appropriately.

This procedure has been developed to ensure that robust systems are in place to appropriately manage Serious Adverse Incidents (SAIs). This includes reporting, gathering / analysing information, identifying risk control measures and implementing an action plan.

**The Northern Ireland Ambulance Service Health and Social Care Trust (NIAS) is committed to the reduction of harm to staff, patients and any other persons affected by its activities.**

### 1.2 Purpose:

The purpose of this document is to improve the management of Serious Adverse Incidents (SAIs) by clarifying roles and responsibilities and establishing a framework for the effective and efficient management of SAIs.

### 1.3 Objectives:

The key objectives are to ensure:

- Compliance with statutory obligations and regional guidance; i.e. HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) and HSC revised Never Events List.
- The relevant staff are suitably trained to manage Serious Adverse Incidents (SAIs).
- All staff are aware of their particular responsibilities with regards to SAIs.
- SAIs are correctly identified, escalated and reported within HSCB timescales.
- The relevant staff, service users, family members, carers etc. are informed, and suitable arrangements are put in place for effective ongoing communication.
- The principles of 'Being Open' are adhered to.
- The principles of "Supporting Staff Involved in Incidents, Complaints, Claims and Coroner's Inquests" are adhered to.

- Where appropriate staff provide an explanation of what happened, make any necessary apologies and take the appropriate remedial action.
- Suitable arrangements are made for Coroner involvement.
- The necessary tools and templates are available to assist all staff in the process (screenshots are available in the appendices however always check SharePoint for the most up to date templates).
- That root causes and contributory factors are identified where appropriate, and the relevant staff are involved in the identification of these factors.
- That effective remedial action is taken, lessons are learned and improvements are made at an individual and organisational level.
- Reoccurrence is prevented and where necessary, learning is embedded into existing policy, standard operating procedures (SOPs), processes, training, templates etc.
- The appropriate SAIs are reviewed at the Learning Outcomes Review Group.
- That adequate records are kept, i.e. fully embed DATIXWeb incidents.
- Those affected (including Investigating Officers) are aware of the support available, from colleagues, management, Training, Medical Directorate (and other Directorates / agencies as appropriate) and as necessary in the form of independent support.
- That the Medical Directorate is provided with appropriate information / documentation for governance / reporting / compliance purposes.

## 2.0 SCOPE:

This document covers Serious Adverse Incidents (defined below) and Never Events (Appendix 15) and applies to:

- All staff at all levels, i.e. employees, bank, agency, voluntary ambulance services, private ambulance services, volunteer drivers, students, work experience etc. and any other persons working for or on behalf of NIAS.
- NIAS service users, patients, patient's family / representatives, carers, members of the public in any setting where the Trust is involved / has duties.

### 2.1 What is a Serious Adverse Incident (SAI)?

An SAI is an adverse incident that must be reported to the Health & Social Care Board (HSCB) because it meets at least one of the following criteria:

- Serious injury to, or the unexpected / unexplained death of:
  - a service user, (including a looked after child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit).
  - a staff member in the course of their work.
  - a member of the public whilst visiting a HSC facility.
- Unexpected serious risk to a service user and/or staff member and / or member of the public.

- Unexpected or significant threat to provide service and / or maintain business continuity.
- Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service.
- serious self-harm or serious assault (including homicide and sexual assaults):
  - on other service users,
  - on staff, or
  - on members of the public

by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and / or known to / referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and / or learning disability services, in the 12 months prior to the incident.

- Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and / or known to / referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and / or learning disability services, in the 12 months prior to the incident.
- Serious incidents of public interest or concern relating to:
  - Any of the criteria above.
  - Theft, fraud, information breaches or data losses.
  - A member of HSC staff or independent practitioner.

## 2.2 What is a Never Event?

Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Strong systemic protective barriers are defined as barriers that must be successful, reliable and comprehensive safeguards or remedies – for example, a uniquely designed connector that stops a medicine being given by the wrong route.

- **‘Never Events’ are also to be investigated as SAIs.**
- Each ‘Never Event’ type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- All categories included in the current HSCB Never Events Guidance should be identified to the HSCB when notifying a SAI.

- A separate question within the SAI notification form is to be completed to specify if the SAI is listed on the Never Events list. The SAI will continue to be reviewed in line with the current SAI procedure.
- NIAS has reviewed the HSC (SQSD) 36/18 Revised Never Event List issued by Department of Health on the 10 Dec 2018 and Never events applicable to NIAS can be found in Appendix 15. The full circulate is available on SharePoint.

### **3.0 ROLES & RESPONSIBILITIES:**

#### **3.1 All Staff:**

All staff are required to:

- Take any immediate preventative action to ensure individuals involved (staff, service users, visitors, family members, carers etc.) and the environment / equipment are made safe as far as possible.
- With regards to SAIs that involve service users, family members or carers, as appropriate, provide an acknowledgment, explanation and apologise if and when appropriate.
- Remove and immediately quarantine any faulty items / equipment.
- Report any hazards with the potential to cause harm.
- Report incidents / SAIs in compliance with Trust incident reporting procedures
- Ensure immediate escalation of incidents meeting SAI criteria to the relevant line manager and the Risk Manager / Medical Director.
- Follow all incident management policies and procedures; adhere to the relevant investigation timescales.
- Attend any training required.
- Lead / participate in / co-operate with SAI reviews, providing witness statements and any other information that will assist with the review as directed by the procedures.
- Support line management with the monitoring and implementation of SAI action plans, recommendations and learning. For example helping to draft learning letters etc.
- Implement any actions within your control.
- Escalate any actions which are not within your control.
- Encourage others to avail of the necessary support.
- Escalate to line management any concerns with regards to any of the above.

The Trust supports a 'just culture', i.e. a culture of openness and accountability where individuals are encouraged to report incidents and are not automatically 'blamed' for 'honest errors'. The organisation is committed to an open, honest and just culture so that it can learn from incidents and take action including changes in practice to reduce the risk of recurrence. It also will ensure that staff feel able to talk to their colleagues and line management about any incident, are treated fairly, supported in making changes to their practice and held to account where necessary.

#### **3.3 All Line Managers:**

It is the responsibility of line managers at all levels to support a just culture, and implement this procedure to ensure:

- Staff are aware of the importance of ensuring SAIs are escalated.
- Staff have access to a suitable means of reporting incidents (paper / fax or online).
- Equipment involved in an SAI / faulty items / equipment are quarantined and retained for the appropriate person to inspect.
- Contact is made with staff who have reported the SAI in order to provide them with an opportunity to be involved in and discuss the incident, to offer support and referrals to occupational health, counselling etc. as necessary. Appendix 6 and Appendix 16 should be used.
- SAIs for which they are responsible are appropriately managed; this includes those raised by other healthcare professionals / other organisations for review within NIAS.
- Service Users / Family Members / Carers are appropriately engaged with in accordance with procedures.
- Mechanisms are in place for engagement with and feedback to staff, including sharing of the final report.
- Guidance is provided to staff to ensure measures are taken to prevent the recurrence of incidents.
- Any necessary local / divisional remedial action is taken and lessons learned.
- Trust governance procedures and arrangements for wider / regional / national learning are followed.
- Resources are available for a proper review; this includes ensuring suitable operational resources are available so that time can be set aside for reviews.
- That root causes and / or contributory factors are identified.
- Processes are in place to refer staff for reflection / coaching / retraining etc. as appropriate.
- Trust procedures are followed in the event of an incident which may attract media attention.
- Medical Director / Risk Manager / DATIXWeb is kept up to date.

#### 3.4 Directors:

Directors are responsible for ensuring:

- Performance management with regards to compliance with NIAS procedures and regional guidance.
- Resources are available for effective SAI reviews.
- Family engagement takes place for SAIs in their Directorate (and DATIX kept up to date).
- A just culture is embedded.
- Action plans are developed and implemented, and that learning takes place within their area of control.

#### 3.5 All Staff – Information Governance / Data Protection:

An SAI review will include the sourcing of records such as the call incident log, Patient Report Form and 999 calls as required. All staff must ensure the following:

- Ensure all templates etc. and paperwork are marked “Private and Confidential”
- Comment should be placed in necessary area that states:
  - “All information collated as part of the SAI fall under the remit of the General Data Protection Regulations/Data Protection Act and Access to Health Records (NI) Order 1993. All records created as part of an SAI require to be managed confidentiality and kept secure at all times.”

For further assistance in this area please contact Information and Clinical Audit.

### 3.6 Rapid Review Group (RRG)

The Rapid Review group is responsible for monitoring and assessing all incidents or Query SAIs which have been identified as potentially meeting the SAI criteria.

In regard to Query SAIs and SAIs the Rapid Review Group will ensure:

- Timely review of all high risk/incidents with the potential to meet SAI criteria, i.e. Query Serious Adverse Incidents (QSAIs).
- Identification of complaints/incidents to be notified as Serious Adverse Incidents
- Timely notification of Serious Adverse Incidents (SAIs) to the SPPG (formally HSCB)
- Urgent learning is shared immediately.
- Relevant KPIs are monitored.
- That any areas of learning are escalated to the Learning Outcomes Review Group (LORG) and / or Safety, Quality, Patient Experience & Performance Committee.

## **4.0 PERFORMANCE MANAGEMENT:**

The responsible Director is accountable for ensuring that reviews are monitored and timescales are met. A monthly performance report will be tabled at Senior Management Team (SMT) identifying any SAIs where progress issues have been identified. The relevant Director will be required to provide explanations for any delays.

## **5.0 HOW TO REPORT A SERIOUS ADVERSE INCIDENT (SAI) / NEVER EVENT:**

All incidents, whether in hours or out of hours, should be reported using the organisation’s adverse incident reporting system (DatixWeb). Incidents reported through the Datix system will be monitored and reviewed by the Datix Team and SAI Team. If any are deemed to meet or possibly meet the criteria outlined in section 2.1 this will be reviewed in detail at the weekly Rapid Review Group (RRG) meeting who will be responsible for making the final decision in regard to notifying an incident as an SAI.

If an incident occurs which is deemed to pose an immediate or ongoing risk it must be reported immediately to line management. The line manager should then escalate this to the SAI Team as a Query SAI. The final decision on notifying SAIs will be the responsibility of the RRG.

## **6.0 MANAGING ENQUIRIES FROM THE MEDIA OR THE PUBLIC:**

Some incidents may attract media attention, enquiries from Elected Members etc. All communications about an incident must be handled sensitively to avoid breaches of confidentiality, to avoid misunderstandings and to ensure those involved are properly informed or consulted before information is made public (think for a moment how you would react if you were to read intimate details about yourself or a close relative online).

Any enquiries from anyone or any organisation not involved in the incident should be referred to line management to alert the Communications Team. If there is any difficulty in contacting line management, Emergency Ambulance Control (EAC) should be contacted. If there is any doubt it is better to make line management / EAC aware. If the incident is outside of normal working hours, EAC should be notified so that the On Call Manager and Communications Team can be contacted; the Senior On Call Manager can be notified where necessary to act as the co-ordinating manager.

## **7.0 REPORTING TEMPLATE & TIMESCALES:**

Within 72 hours of an incident being identified as a SAI via the RRG, the SAI Manager must complete the Serious Adverse Incident Notification Form (See Appendix 2 for a screenshot / SharePoint for the template). The form will then be forwarded to the SPPG and if applicable to the Regulation and Quality Improvement Authority (RQIA).

All staff are required to follow the existing incident reporting procedures at all times, i.e. ensure an incident report form has been completed as per Trust procedures. All incident management policies and procedures can be found in the Medical Directorate, Incident Reporting section of SharePoint.

### **7.1 Notepad:**

As you take any actions associated with an SAI, you must update the notepad (section 3. In DATIXWeb) in the following format:

08/04/2020 – PRF requested from Corporate Manager. KK  
09/04/2020 – Contact made with family via telephone. Spoke to Mrs XXX to advise SAI would take place. KK.

This is very important as the notepad is used to update the SAI Review Group and SMT on a weekly basis.

### **7.1 General Guidance on Completing the SAI Notification Form:**

The following section has been developed to assist in the completion of the SAI Notification Form on behalf of the Northern Ireland Ambulance Service. Detailed regional guidance on completing the Serious Adverse Incident Notification Form can be found on SharePoint. Please note that the SAI Manager will review and complete

some sections.

Section	Guidance
1	Northern Ireland Ambulance Service (NIAS)
2	C3 Call Number / Incident Number and DATIX Reference
3	Ambulance Service
4	Insert date in the following format: DD / MM / YYYY
5	Exact location e.g. 123 Royal Avenue, Belfast City Hospital Car Park, Patients home etc.
6	Name – SAI Manager /DCM / Area Manager / Assistant Director or above
7	Pre hospital care
8	<p>Provide a brief factual description. All reports must be anonymised, staff should be referred to by job title and ‘patient / service user’ should be used rather than the name. For example:</p> <p><i>On Monday 8<sup>th</sup> April 2019 at 20:20 NIAS received a call for an elderly lady in her own home in Whitehead who had been found lying on her bathroom floor. She was reported as being awake, alert and breathing normally. The call was triaged and allocated a ‘green’ priority i.e. not immediately life threatening. A second call was received at 21:20 enquiring about the ETA of an ambulance. At 01:19 on the 9<sup>th</sup> April, a further call was received advising that the patient was deceased.</i></p> <p>Any Coroner involvement should be noted in this section.</p> <p>Include date of birth, gender and age where relevant.</p>
9	This section will be completed by the SAI Manager
10	<p>Briefly outline a summary of actions to date, for example:</p> <p><i>Early QA review of triage of call to determine consistency with AMPDS protocols. Review of ambulance activity at the time also being undertaken.</i></p>
11	If relevant and known, please provide the details on the current condition of the service user.
12	Consider any actions taken / required and select the correct answer (delete those which are not applicable).
13	<p>Consider the particulars of the incident and determine what actions will be relevant to the investigation, for example:</p> <p><i>All call recordings and NIAS Emergency Ambulance Control computer records (C3).</i></p>
14	Select the criteria under which you consider this to be an SAI and tick
15	Consider if there are implications for others either regionally or nationally; is there learning that needs to be shared immediately to prevent further harm?
16	If the Service User / Family / Carer has been notified of the incident before

	completing the SAI notification form, the appropriate date of notification must be included in section 15 of the form. If notification is planned and not yet complete at the time of reporting, or not planned, the reason(s) should be explained in the “Others” free text field in section 15 of the form, or where relevant in any updated form the SPPG subsequently issues. Once engagement has taken place, record in DATIX and notify the Risk Manager so that this information can be passed to HSCB.
17	Record any action taken with any regulators, Coroner etc.
18	Record the date(s) that any other organisations were informed
19 – 21	The remaining sections will be completed by the Risk Manager and the Risk Manager will inform SMT.

### 7.1.1 Recording Coroner Involvement on the SAI Notification Form:

Details of involvement with the Coroner (where applicable) must be included in the description section of the SAI Notification Form (section 8). It is also important to include the date of notification of the Coroner if applicable in section 17. When it is known that a death is to be investigated as an SAI, the Coroner must be notified of this, even if previously notified of the death. Any queries in this area should be referred to the SAI Manager.

## 8.0 INTERFACE INCIDENTS (POTENTIAL SAIs):

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another. In such instances, it is possible that the organisation where the incident occurred may not be aware of the incident; however the reporting and follow up investigation may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form. The SPPG Governance Team will upon receipt, contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI (for example BHSCCT will submit the form to SPPG who will then forward it to the NIAS SAI Manager).

In the case of suspected interface incidents (i.e. an incident occurring which should be investigated by another Trust and not NIAS), please follow Trust incident reporting procedures AND complete the SPPG Interface Incident Notification Form and forward to the SAI Manager for approval. **Remember: do not submit any forms directly to SPPG / RQIA etc. without SAI Manager approval.**

## 9.0 QUERY SERIOUS ADVERSE INCIDENTS (QSAIs):

The responsibility for identifying and escalating an SAI lies with the directorate in which the incident occurred. To support the directorate incident review processes and to act as a further control to delayed reporting, the SAI Manager may query any incident

report where SAI criteria appears to have been met. This is known as a Query SAI (QSAI).

Once an incident is identified as being a query SAI (QSAI) it is forwarded to the SAI Manager for consideration for reporting as an SAI. The incident is presented at the RRG for consideration as a SAI and a group decision is reached.

## 10.0 PROCEDURE FOR INVESTIGATING SERIOUS ADVERSE INCIDENTS (SAIs):

The following procedure for the review of Serious Adverse Incidents (SAIs) is based on, and should be read in conjunction with the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents available on SharePoint.

### 10.1 Level of SAI Review:

When reporting an SAI, the SAI Manager (in conjunction with the RRG) must decide on the level of review required and this will be indicated on section 19 of the SAI Notification form. There are three recommended levels of review for SAIs.

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the event, not necessarily the significance. SAIs will be reviewed using one or more of the following:

	<b>Level 1</b>	<b>Level 2</b>	<b>Level 3</b>
<b>Type of review</b>	Not complex.	More complex review required.	Particularly complex. Multiple organisations involved. Requires independence.
<b>Timescale</b>	8 weeks.	12 weeks.	To be agreed with SPPG.
<b>Lead</b>	Designated review Officer	Medical Director or Director outside of the service area.	Independent.
<b>Team</b>	Local multidisciplinary team.	Multidisciplinary team outside of the service area.	Highly independent multi organisational.
<b>Responsible Officer</b>	Area Manager / Assistant Director	Director	Director / Chief Executive
<b>Action Plan / Learning</b>	Designated Review Officer / Area Manager / Assistant Director & Learning Outcomes Review Group	Medical Director or Director outside of the service area & Learning Outcomes Review Group	Medical Director or Director outside of the service area & Learning Outcomes Review Group

See Appendix 4 – Setting up a SAI Team / Panel and / or contact the / SAI Manager for guidance on a case by case basis.

### 10.2 Level 1 Review:

SAI notifications which indicate a level 1 review will enter the process at this level and a review will immediately be undertaken to:

- Assess what has happened and why.
- Agree follow up actions.
- Identify learning.

The possible outcomes may include:

- No action required.
- Identification of learning needs and actions.
- Sharing the learning.
- Requires level 2 or 3 review.

The template must be completed, approved by the relevant Director and sent to the SAI Manager for review and onward reporting to the SPPG within 8 weeks of the SAI being reported. Please provide at least five working days to allow for redacting and final checks / comments / feedback by the SAI Manager and ensure DATIX is up to date, PRFs, ECGs etc.

If during or on completion of the template, the review team determines that the SAI is more complex and requires a more detailed review, the review will move to either a level 2 or 3 review. If a level 2 review is required, the initial review report must still be forwarded to the SAI Manager as the SPPG report is still required within 8 weeks of the SAI being reported, along with completed sections 2 and 3 of the Level 2 template to include Team Membership and Terms of Reference (see Appendix 5 for examples of terms of reference). The level 2 review process will then need to be initiated. It may be possible to retain the same team but the level of independence needs to be considered and the SAI Manager may wish to contact the Medical Director / QSI Director for assistance in identifying suitable team members from other Directorates or external to the Trust if required.

### 10.3 Level 2 Review:

Level 2 reviews will usually be conducted for incidents of actual or potential serious harm or death and / or where the circumstances involved are relatively complex and may involve multiple processes / teams / disciplines.

The review should identify root causes and will normally be conducted by a multidisciplinary team with a degree of independence determined by the complexity of the incident. The review should be chaired by the Medical Director or a Director outside the service area (NIAS have engaged officers from other ambulance services in the past in this regard). The Chair should set up the team and ensure that team members have received the necessary training (see HRPTS for a record of staff having received SAI Training). The review report should be completed using the SPPG RCA report template (see Appendix 6 & 7 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents available on SharePoint).

Level 2 SAI reviews may involve two or more organisations. In these circumstances, it is important that a lead organisation is identified but also that all organisations contribute to the final review report. If required, the SAI Manager will liaise with the other organisation(s) to propose team member(s) and agree who leads the SAI. Refer to Appendix 12 of the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents available on SharePoint for further guidance.

Sections 2 and 3 of the Level 2 review template must be completed and forwarded to the SAI Manager by, or on behalf of the Director within 4 weeks of the level 2 SAI being notified, detailing the membership and terms of reference for the level 2 review.

#### 10.4 Level 3 Independent Review:

Level 3 reviews will be considered for highly complex SAIs where a high degree of external / independent representation on the review team is required. In some instances all team members may be independent to NIAS. The timescales for reporting, Chair and membership of the review team will be agreed with the SPPG / PHA Designated Review Officer (DRO) at the outset. The Director / Medical Director will liaise with the DRO through the SAI Manager to agree timescales, team membership and terms of reference. Level 3 review reports will take the same format as level 2 and use the same template structure for the final report. Any SAI which involves an alleged homicide perpetrated by a service user known to / referred to mental health and / or learning disability services will be reviewed as a level 3 incident. In these instances, the Protocol for Responding to an SAI in the Event of a Homicide, issued in 2010 and revised in 2013 should be followed (see appendix 13 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents).

### **11.0 COMPLETION OF TEMPLATES:**

Guidance on completing the level 1 and level 2 & 3 report templates for can be found at Appendix 5 & 6 respectively of the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents (SharePoint). The following points should be read in addition to those procedures:

- The report should be a complete picture taking evidence from all sources (what happened, what should have happened, what directly caused this, what contributed and what will be done to improve the situation).
- **Always have the reader in mind, i.e. service user / family members / carers.** Jargon or unexplained abbreviations must not be used within the report. Although clinical shorthand would be understandable to other clinicians, an SAI report is a formal report and not a clinical record. As such it should be understandable to non-clinicians including the service user / family members / carers and the Coroner. Also you may not be present make any explanations. See Appendix 7 for a list of acronyms which can be appended to the report if necessary.
- All reference to services, organisations, facilities etc. should be explained fully if not otherwise obvious to the reader e.g. it is not sufficient to include the name of a facility without explaining the purpose / function of the building.

- The SPPG RCA template is in tabular form. This may cause formatting difficulties. It is acceptable to use a blank word document instead but the SPPG section headings from the RCA template must be included.

#### 11.1 Service User Details (Section 11 SEA):

Please state Date of Birth, gender and age. Do not add patient names to this section.

### **12.0 REPORT EXTENSIONS:**

Review Officers must make every effort to ensure that the relevant timescales are met. Should an extension be required, the SAI Manager must be contacted in order to liaise with the SPPG / PHA. Advice from SPPG / PHA is as follows:

- Level 1 reviews – SPPG will not accept extension requests for this level of review. When reporting, an additional 2 weeks can be sought by exception only, giving the reason for the delay.
- Level 2 reviews – In most circumstances, timescales for submission of RCA review reports must be adhered to. However, it is acknowledged there may be some occasions where a review is particularly complex, perhaps involving two or more organisations. In these instances the reporting organisation may request an extension to the normal timescale i.e. 12 weeks from timescale for submission of interim update report. However, this request must be approved by the DRO and should be requested when submitting sections 2 & 3 of the report at 4 weeks.
- Level 3 reviews – Independent as per above, all timescales (including possible extensions) must be agreed with the DRO at the outset of the review.

### **13.0 DESIGNATED REVIEW OFFICER (DRO) / SPPG QUERIES:**

- Level 1 Reviews – DRO queries must be responded to within 2 weeks of the query being received.
- Level 2 Reviews – DRO queries must be responded to within 6 weeks of the query being received.
- Level 3 Reviews – Independent DRO queries must be responded to within 6 weeks of the query being received.

### **14.0 ENGAGEMENT WITH THE SERVICE USER / FAMILY MEMBER / CARER:**

**Serious Adverse Incidents (SAIs) must be raised with the family at the earliest opportunity.**

Addendum 1 of the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents sets out requirements for engagement / communication with the

service users / family / carer, following a Serious Adverse Incident (SAI). In particular, the following paragraph should be adhered to:

- “It is important that teams involved in reviews in any of the above three levels ensure sensitivity to the needs of the service user / relatives / carers involved in the incident and agree appropriate communication arrangements, where appropriate.
- The Review Team should provide an opportunity for the service user / relatives / carers to contribute to the review, as is felt necessary. The level of involvement clearly depends on the nature of the incident and the service users / relatives / carers wishes to be involved”.

**The SAI Manager should ensure the appropriate level of involvement of service user / family / carer throughout the review and ensure communication methods are tailored to meet individual communication needs.**

#### 14.1 Principles of Being Open with the Service User / Family:

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;
- Ensuring the service user / family have details for a single point of contact within the organisation.

**It is important to remember that saying sorry is not an admission of liability and is the right thing to do.**

#### 14.2 Process for Engagement:

It is vital that the incident is acknowledged by a Manager from the Trust and that there is openness and transparency throughout the process. **Individual circumstances should be considered when determining the appropriate timeframe for engagement.** The service user / family member / carer should be contacted via telephone at the appropriate time to advise them that the Trust considers that a serious incident has occurred and that a thorough review will be carried out to determine what happened, how and why. (ROs should take into account any matters which may require engagement to be delayed, for example a funeral, and make contact as soon as possible without causing unnecessary distress). At this point an offer should be made to meet the family to explain the SAI process and how they can be involved.

The SAI review process should be explained to the service user / family member / carer and they should be informed that there will be a final written report which will include recommendations, and that this will be discussed / shared with them. Full contact details should be taken and agreement reached as to the best person / family member to liaise with, and the best means / time to contact them (see Appendix 8 for guidance on engaging with family members / service users / carers via telephone). **This phone call must be followed up with a letter (see Appendix 9) and accompanied by the 'What I need to know about a Serious Adverse Incident' Leaflet for Service Users, Family Members and Carers (see Appendix 10 and SharePoint).**

The review officer responsible for the SAI is also responsible for ensuring the service user / family / carer is communicated with appropriately **on an ongoing basis** regarding the SAI and subsequent review. They must ensure that the service user / family / carer knows who to contact within NIAS throughout the SAI process. For further information please refer to Addendum 1 of the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents.

#### 14.3 Unable to engage with service user / family member / carer:

Approved SAI final reports must be shared with or talked through with the service user / family / carer as appropriate and where this is not done, an explanation must be submitted within the SAI checklist. If the checklist is pending, this should be included as an action in the subsequent action plan for that SAI. In all cases the principles of consent and patient confidentiality must be upheld.

There may be occasions where the service user / family member / carer does not wish to be involved in the review. If this is the case, this must be recorded in DATIX, for example:

*Telephone call made by KK (Risk Manager) on behalf of NIAS on the 8<sup>th</sup> April 2019 at 2pm. Mrs XXXX (sister of the deceased) advised that she did not wish to be involved or contacted again on the matter.*

There may also be occasions where as a Trust we have been unable to source contact details and / or there are no next of kin to contact; again this should be recorded to avoid any duplication of effort and for reporting to SPPG.

#### 14.4 Service User / Family / Carer Involvement Section Of The Report:

The SAI Manager should ensure the completion of the SAI Review Report checklist when submitting review reports to SPPG. This checklist will explicitly describe the involvement (and if not, the circumstances where it has not happened) of service user / family / carer in the review and whether they received a final report.

#### 14.5 Recording Coroner Engagement in the Report:

Reports should also routinely include in their chronology details of all engagements with the Coroner where a death has occurred and if the Coroner has not been involved

this should be stated and the decision explained. The SAI Manager should also ensure the completion of an SAI Review Report checklist when submitting review reports to SPPG. This checklist will seek information regarding notification to the Coroner and current status of the case.

## **15.0 ACTION PLANS:**

Action plans **must** be completed for all levels of SAIs. The level 2 & 3 report template (Appendix 6 & 7 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents) indicates that an action plan must be included within the final report for submission to SPPG. A final draft action plan must be forwarded to the SAI Manager as soon as approved (note actions do not need to be complete when submitting the action plan to the SPPG).

### **15.1 Action Plan Responsibilities / Requirements:**

This part of the procedure outlines the responsibilities and requirements to ensure appropriate actions are taken to prevent / minimise re-occurrence and share learning. The Director responsible for the SAI review has responsibility for ensuring any recommendations and lessons learned are incorporated into a plan of **appropriate, realistic and achievable actions** (action plan).

An action plan is an important tool to improve systems and implement recommendations from reviews into adverse incidents:

Action plans for SAIs should be approved by the Director / Assistant Director / Area Manager responsible for the review. When all actions are completed they should be signed off by the Director / Assistant Director / Area Manager and reviewed by the Learning Outcomes Review Group.

Action plans must incorporate SMART principles:

- S** Specific – clearly defined actions to be completed, with clearly defined owners (both name and designation).
- M** Measurable – how will implementation and effectiveness be measured.
- A** Aligned / achievable? – actions and action plans must be aligned with relevant policies and procedures and agreed by relevant action owners.
- R** Realistic / results based? – actions must be achievable, with sufficient resources, within agreed timescales.
- T** Time bound – both target and actual completion dates should be captured.

Avoid actions such as 'remind staff or promote awareness', but if they have to be used, explain how this will be done e.g. a poor action would be – share updated policy with staff. Be more specific – send staff the specific section which has changed, highlighting the change and drawing their attention to it. **SAI Action Plans should include actions for sharing lessons learned from SAI reviews as appropriate.**

### **15.2 Generating actions from the final report:**

Whilst recommendations drawn up in a final report are the responsibility of the review team, the corresponding actions are the responsibility of the relevant Director or Assistant Director. Action Plans must address all recommendations within the final report as deemed appropriate. Where actions are at variance with what has been recommended within the review report, the reason should be given to justify the differing course of action or no action.

If recommendations include actions external to the Trust, the action plan should identify who will take these forward and have sought agreement for this with the named person(s).

### 15.3 Plan To Share Action:

It may be appropriate to include an action in the action plan in relation to sharing the action plan with the service user / family / carer as appropriate and the progress of this should be monitored until complete.

### 15.4 Developing an Action Plan:

Overall responsibility for the SAI Action Plan must be with the Director / Assistant Director / Area Manager / Review Officer responsible for the SAI review.

- The Director / Assistant Director / Area Manager / Review Officer responsible for the review must determine who draws up the actions.
- Where the action identified is within the area of responsibility of the Director / Assistant Director / Area Manager / Review Officer responsible for the review, the person identified to take the action forward must be instructed to do so and have the capacity required.
- Where a recommendation is outside the area of responsibility of the Director / Assistant Director / Area Manager / Review Officer, discussion and agreement must be reached with the relevant manager for drawing up and taking any action(s) forward as appropriate. The Director / Assistant Director / Area Manager / must ensure agreement is reached.
- Timescales for each action must be agreed with the person / area responsible for implementing the action.
- With regards to Level 2 & 3 SAIs, a draft action plan must be submitted with the final report to the SPPG with a final draft submitted when approved. Actions do not need to be completed when submitting the action plan to the SPPG.

### 15.5 Documentation:

Every Action Plan must be documented using the SAI Monitoring / Tracking Report template (see Appendix 12) which complies with the minimum standard for Action Plans (HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013).

### 15.6 Monitoring:

The Director / Assistant Director who commissioned the review is responsible for monitoring and review processes to ensure actions are progressed as planned.

Where actions cannot be completed, the Director / Assistant Director who commissioned the review is responsible for ensuring that any associated risks are identified and managed in line with the Corporate Risk Management Strategy and brought to the Learning Outcomes Review Group for consideration, along with any other unresolved issues.

The relevant Assistant Director responsible for the SAI should notify the Learning Outcomes Review Group of the closure of any Action Plans which are complete and have no outstanding issues.

The Learning Outcomes Review Group will:

- Provide independent review to agree learning points for sharing.
- Note closure of all SAI action plans.
- Provide assurance of appropriate debriefing and sharing of learning.
- Agree appropriate escalation of risks and / or learning to the Assurance Committee.
- Review status reports from external bodies, such as HSCB / RQIA / HSCNI, as and when required.
- Make recommendations to corporate and operational risk registers as appropriate.
- Be supported by the Medical Directorate who will monitor processes centrally.

Directors / Assistant Directors / Area Manager / Review Officers are responsible for ensuring DATIX is kept up to date with the latest version of action plans.

## **16.0 LEARNING:**

**Any learning from SAI reviews must be shared as appropriate.** Where learning has been identified, the method for the dissemination of learning should be considered and will be at the discretion of the responsible Directorate. An example of this is the Learning Outcomes Review Group (LORG). Other examples include learning letters, training updates and clinical newsletters.

The NIAS committee, SMT & Trust Board groups will be provided with regular reports of progress against SAI recommendations.

## **17.0 WHERE AN SAI IS ALSO A COMPLAINT / LITIGATION / SPECIAL CASE REVIEW:**

Where a Serious Adverse Incident (SAI) is also a Complaint / Litigation / Special Case Review etc., the review under the SAI process will take precedence and the Litigation / Special Case Review will be put on hold until the SAI review is complete. The complaint will be closed in line with the Complaints Policy

In terms of Complaints, the Complaints Manager should notify the Complainant of this as soon as possible. The leaflet 'What do I need to know about SAI's should be given to the Complainant along with an explanation of the change in process (see Appendix 10). The SAI review process as per above will have a link person identified to communicate with the service user / family / carer and will communicate through this

process as appropriate. When complete the SAI final report will be shared with the Complainant.

## **18.0 SAFEGUARDING CHILDREN & ADULTS:**

These types of cases are unlikely to be led by NIAS, however it is useful to have an understanding of processes as NIAS will often have involvement.

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to child and adult protection (Adult Protection NI & SBNI Child Protection Procedures). If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the SPPG as an SAI. It should be noted that, where possible, safeguarding investigations will run in parallel as separate investigations to the SAI process with the relevant findings from these investigations informing the SAI review and vice versa. However, when the threshold is agreed with PSNI and Social Services an investigation may be conducted in accordance with the processes set out in the Protocols for Joint Investigation of Cases of Alleged or Suspected Abuse of Children or Adults. In these circumstances, the Trust should liaise closely with the DRO on the progress of the investigation and the likely timescales for completion of the SAI Report. On occasion the incident under review may be considered to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review. In these circumstances, the incident will be notified to the SPPG as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the DATIX system, and the SAI will be closed. If a CMR is being considered the SAI process may be suspended and the SPPG notified of this whilst a notification and decision regarding CMR is made. If it is approved as a CMR then the SAI process will close. In cases where a CMR/ DHR is being considered, the Head of Safeguarding will be informed as this will involve a separate process for agency review.

## **19. SAI's INVOLVING PSNI / HSENI:**

Incidents involving unexpected death or serious harm and requiring review by the police and / or Health and Safety Executive (HSENI) need to be handled correctly for public safety reasons as well as maintaining confidence in HSC, PSNI, Coroner and the HSENI. The Department's MoU between these four organisations seeks to ensure effective arrangements are in place to facilitate these complex interactions. The MoU compliments existing joint procedures in relation to the protection of children and vulnerable adults.

## **20.0 CLOSURE OF THE SERIOUS ADVERSE INCIDENT (SAI):**

The SAI can be closed (on DATIX) once it has been agreed by the Learning Outcomes Review Group that the action plan is complete and no outstanding issues remain. This process will usually include ensuring that the SPPG has also closed the SAI (which they do via email to the SAI Manager). Notification of this will be added to the DATIX

record by the Medical Directorate. The SAI Manager is responsible for ensuring that final versions of the report and action plan are added to DATIX. Up until this stage, the version used will be a “final approved draft” and subject to change due to further material changes for example after comments received from family members. Any change will be under strict version control through the SAI Manager and presented as an addendum to the report and forwarded to SPPG and any other relevant stakeholders.

## **21.0 SERIOUS ADVERSE INCIDENT (SAI) TRAINING:**

All staff will attend training appropriate to their level of responsibility with regards to SAIs; training will take place as follows:

- At induction.
- As part of NIAS certified / non certificated training programs.
- Upon promotion, where the level of incident management responsibility is to increase.
- On appointment at Board Level / Committee level.
- As part of the Trusts continuing professional development / statutory / mandatory training program for all staff.

Training will be delivered using a variety of methods, for example face to face, learning packs, workshops etc. (see HRPTS for a current list of staff who have been trained).

Frequency of training is outlined in the Trusts Statutory Mandatory Training Policy.

## **22.0 MONITORING:**

The process for monitoring the effectiveness of all of the above will be managed via the following arrangements:

- Governance Framework (under review).
- Assurance Framework.
- Controls Assurance Standards (under review).
- Learning Outcomes Review Group.
- Health and Safety Committee.
- Assurance Committee.
- Accountability / Performance Management Processes.
- Incident Management Training records.

This Procedure will be reviewed every three years by the SAI manager in consultation with key stakeholders. Feedback from stakeholders will be taken into consideration, along with a review of systems / processes along with ongoing analysis of the actual management of SAIs via the assurance structure. Processes will be benchmarked nationally and against any new legislation, best practice or guidance. Audit findings will be taken into consideration.

### **23.0 EVIDENCE BASE / REFERENCES:**

NIAS is required to comply with current legislation, guidance and best practice (both national and regional), for example policy, procedures, learning letters, safety / quality information etc. issued by DoH, SPPG, HSENI and PHA. The primary evidence base is the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents (available on SharePoint) and associated circulars (available on the DoH Website).

### **24.0 CONSULTATION PROCESS:**

This Procedure was developed by the Risk Manager with the support of a short life working group consisting of an Ambulance Service Area Manager, Trade Union Representative / Emergency Medical Technician, two Station Officers, two Station Supervisors, the Fleet Manager and the Clinical Training Manager; draft documentation was circulated (July 2018). Further consultation was carried out through the Learning Outcomes Review Group (28<sup>th</sup> January 2019), Medical Director and the Senior Management Team (30<sup>th</sup> April 2019). The Learning From Incidents Policy under which this procedure has been developed was approved by Trust Board in 6<sup>th</sup> December 2018.

### **25.0 EQUALITY STATEMENT:**

In line with duties under Section 75 of the Northern Ireland Act 1998; Targeting Social Need Initiative; Disability Discrimination Act 1995 and the Human Rights Act 1998, an initial screening exercise, to ascertain if this policy should be subject to a full impact assessment, has been carried out.

The outcome of the equality screening for this procedure undertaken on 8<sup>th</sup> April 2019 is:

<b>Major impact</b>	<input type="checkbox"/>
<b>Minor impact</b>	<input type="checkbox"/>
<b>No impact.</b>	<input checked="" type="checkbox"/>

### **26.0 SIGNATORIES:**

**Lead Author** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Lead Director**

**Date:**

## APPENDIX 2 SERIOUS ADVERSE INCIDENT NOTIFICATION FORM (See SharePoint for the most up to date template):

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM			
1. ORGANISATION: Northern Ireland Ambulance Service (NIAS)		2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE	
3. HOSPITAL / FACILITY / COMMUNITY LOCATION Ambulance Service		4. DATE OF INCIDENT: DD / MM / YYYY	
5. DEPARTMENT / WARD / LOCATION EXACT			
6. CONTACT PERSON:		7. PROGRAMME OF CARE: Pre hospital	
8. DESCRIPTION OF INCIDENT:  <i>Provide a brief factual description of what has happened and a summary of the events leading up to the incident. PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ BHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE. Where relevant include D.O.B, Gender and Age. All reports should be anonymised – the names of any practitioners or staff involved must not be included. Staff should only be referred to by job title.</i>			
DOB: DD / MM / YYYY      GENDER: M / F      AGE: <u>22</u> years (complete where relevant)			
9. IS THIS INCIDENT A NEVER EVENT?		If "YES" provide further detail on which never event - refer to DoH link below <a href="https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars">https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars</a>	
YES	NO	✓	
DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING			
STAGE OF CARE:		DETAIL:	ADVERSE EVENT:
10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE: <i>Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.</i>			
11. CURRENT CONDITION OF SERVICE USER: (complete where relevant) <i>Where relevant please provide details on the current condition of the service user the incident relates to.</i>			
12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? (please select)		YES	NO / N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? (please specify where relevant)		YES	NO / N/A
14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: (please select relevant criteria below)			
serious injury to, or the unexpected/unexplained death of:		✓	
- a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)			
- a staff member in the course of their work			
- a member of the public whilst visiting a HSC facility.			
unexpected serious risk to a service user and/or staff member and/or member of the public			
unexpected or significant threat to provide service and/or maintain business continuity			
serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service			
serious self-harm or serious assault (including homicide and sexual assaults)			
- on other service users,			
- on staff or			
- on members of the public			
by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the			

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM			
incident			
suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident			
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner			
15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: (please select)			YES / NO
if "YES" (full details should be submitted):			
16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?		YES / NO	DATE INFORMED: DD / MM / YYYY
		specify reason:	
17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? (refer to guidance notes e.g. GMC, GDC, ESNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant			YES / NO
if "YES" (full details should be submitted including the date notified):			
18. OTHER ORGANISATION/PERSONS INFORMED: (please select)		DATE INFORMED:	OTHERS: (please specify where relevant, including date notified)
DoH EARLY ALERT			Coroner had already been notified by ESNI.
HM CORONER			
INFORMATION COMMISSIONER OFFICE (ICO)			
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)			
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)			
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)			
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)			
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)			
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASE)			
19. LEVEL OF REVIEW REQUIRED: (please select)		LEVEL 1	LEVEL 2* / LEVEL 3*
* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6			
20. I confirm that the designated Senior Manager and Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (delete as appropriate)			
Report submitted by: Katrina Keating		Designation: Risk Manager	
Email: katrina.keating@nias.hscni.net		Telephone: 028 9040 0999      Date: DD / MM / YYYY	
21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: (refer to Guidance Notes)			
Additional information submitted by:		Designation:	
Email:		Telephone:      Date: DD / MM / YYYY	

Completed proforma should be sent to: [seriousincidents@hscni.net](mailto:seriousincidents@hscni.net)  
and (where relevant) [seriousincidents@rgia.org.uk](mailto:seriousincidents@rgia.org.uk)

**NOW RETURN TO THE MEDICAL DIRECTOR / RISK MANAGER**

### **APPENDIX 3 – SERIOUS INCIDENT CHECKLIST – ON SCENE / IMMEDIATE:**

At this point it is very important to care for and communicate with the patient.

Use empathetic and compassionate language, for example; I am so sorry that this has happened to you.

- Take any immediate action to minimise the risk to other patients, staff or anyone else affected. Staff must act within their own capabilities and training, expert help should be sought if necessary, e.g. Officers, NIFRS, HART etc.
- Report! Contact the SAI Manager / Report on Datix
- Record ALL persons involved (other services, Trusts etc.).
- Consider who else needs to be informed, e.g. Communications Team, HSENI, PSNI, Coroner etc.
- Ensure an incident form is completed, submitted and line manager informed. Ensure that the PRF is completed correctly (remember never to destroy any records, all records must be kept).
- Obtain brief recollection of events or if this is not possible, ensure that individuals involved provide recollections within 48 hours
- Record and secure any equipment involved.
- Record and secure any documentation involved.
- Identify and make arrangements for the provision of support for staff, service user / family member / carer etc. Face to face meetings are preferable. Appendix 16 should be used.
- Assist the Communications Team / Medical Director / SAI Manager with the preparation of any recollections / Early Alerts.
- Advise the SAI Manager via email / Datix if not already notified.

## **APPENDIX 4 – SETTING UP A SERIOUS ADVERSE INCIDENT (SAI) TEAM:**

The decision to convene a Serious Adverse Incident (SAI) review team will depend on the nature and severity of the incident and will be taken by the Director / Assistant Director / SAI Manager as appropriate. A team must be established as soon as possible and should aim to report within the timescales set out in section 10.

### Typical Team:

- Chair / Lead – Director / Assistant Director / Designated Review Officer (for cases which are not complex) to oversee proceedings, agree the final report and submit it.
- Line Manager to produce a synopsis of the facts, obtain staff recollection of events, prepare a list of staff involved in the incident.
- Medical Director / SAI Manager or his / her designated officer.
- Clinical Training Manager or his / her designated officer.

Optional / as appropriate:

- External Advisor.
- Note taker.

See section 10.1 for recommendations with regards to SAI level 1-3.

### Individuals Required To Attend:

Individuals required to attend should be given at least five working days' notice of the date. Individuals should be contacted verbally to explain the process and then asked to attend date / time confirmed in writing.

### Team / Panel Checklist For Interviews / Reports / Action Plans:

- Chair must outline the purpose of the panel at the beginning of each interview.
- Chair may suspend proceedings if the person being interviewed is under undue pressure or a significant disclosure is made.
- Chair may require further persons to be interviewed once the initial interviews have taken place. This will be arranged as soon as possible by the panel secretary.
- Chair may wish to meet with patient / carers / family etc. to understand their expectations / determine if they have any questions they would like answered. This decision needs to be carefully considered and the invite made both verbally and in writing on the appropriate template.
- The formal report should be produced in line with timescales set out in section 10. Once agreed by the panel members the report should be formally sent to the SAI Manager for consideration.
- The relevant Director is responsible for ensuring an action plan is produced to address any recommendations in the report.
- The action plan must be produced in line with timescales set out in section 10. The plan must be in compliance with SPPG Guidance and list each

recommendation, action agreed, person responsible, action start date, action end date, status, evidence of completion etc. (See Appendix 9 for template).

- The report must be shared with the service user / family member / carer. Directorate Management are responsible for staff and family liaison and addressing any concerns / queries / comments from the family. The report should be updated as necessary.
- The report must be shared with the staff involved and any relevant external agencies. If a number of staff are involved, a briefing meeting should be arranged to ensure that everyone hears the same message at the same time. Any necessary support should also be arranged. Appendix 16 should be used.
- Oversight will be provided by the Learning Outcomes Review Group.

## APPENDIX 5 – SAMPLE TERMS OF REFERENCE (LEVEL 2 / 3 SAIs):

Introduction:

This Terms of Reference relates to the review of the incident which occurred on <date> in <location/site>, which has been commissioned by the Director of <Operations / Medical Director>

Purpose of review (select the most appropriate / delete as appropriate):

1. To examine relating to <the incident>, identifying the causal and contributory factors which led to this incident and to make recommendations which when implemented would reduce the risk of reoccurrence.
  2. To thoroughly review the quality of service/care/treatment provided to <the service user> on the 8<sup>th</sup> April 2019 whilst in the care of the Northern Ireland Ambulance Service.
  3. To provide an opportunity for the service user / relatives / carers to contribute to the review and agree appropriate communication arrangements (for Level 2 & 3 Reviews, ToRs must reflect how the family will be engaged with / level of engagement).
  4. To ensure sensitivity to the needs of the service user / relatives / carers involved in the incident.
  5. To consider the evidence presented in order to determine the timeline of events.
  6. To gather all relevant information and analyse the information.
  7. To identify any care delivery problems.
  8. To identify root causes.
  9. To review the available evidence in order to determine appropriateness or otherwise of actions by those involved and consider if any additional recommendations are required in relation to staff performance in relation to this incident.
  10. To consider whether all Trust policies, procedures and training were followed and / or review any necessary current policies, procedures and guidelines pertinent to the case.
  11. To consider how information was shared between teams.
  12. Examine whether or not there were opportunities for Trust intervention that were missed.
  13. To identify and commend examples of good practice.
  14. To ensure relevant support was provided to those involved.
  15. To identify risk control measures / recommendations.
  16. To develop and implement an action plan.
  17. To document the incident clearly and completely in order to be able to provide copies of the report to the service user / family / carer involved, to staff involved and to other agencies as required.
  18. To adhere to the principle of confidentiality by providing an anonymised report copy of the report detailing these findings, recommendations, actions and lessons learnt.
  19. To learn from the incident, i.e. determine whether any organisational, regional or national learning is raised in line with evidence based practice.
  20. To drive change in the organisation to ensure in so far as is possible, that any systems failures associated with the incident are not repeated.
- The review will focus on <time/date> to <time/date>.
  - The review includes <name/title>.
  - A report will be provided detailing the findings and recommendations of the review.
  - It is expected that the review will commence on <date> and be completed by <date>.

## APPENDIX 6 – STAFF INVOLVEMENT CHECKLIST:

updates made RE email 01/03/2022

<b>Name:</b>	
<b>Designation:</b>	
<b>Directorate:</b>	
<b>Location:</b>	
<b>Date of incident:</b>	
<b>DATIX Ref:</b>	

<b>Section 1 – to be completed by line manager</b>		
<i>Please answer Yes, No or N/A</i>		
1	Has the Serious Adverse Incident (SAI) process been fully explained?	
2	Has a copy of the SAI Procedure been shared?	
3	Has a copy of the Being Open Policy been shared?	
4	Have any necessary tools / templates been shared?	
5	Have all of the necessary clinical records been shared (access to PRF, SOE, ECG etc.).	
6	Have staff been able to provide their own recollection of events?	
7	Have staff been supported with regards to data protection / information governance requirements?	
8	Has a single point of contact been provided to the staff member?	
9	Has a contact been provided for the staff member if they have any concerns regarding the process?	
10	Has the need for signposting to support services (including peer support/care call/professional/clinical) been discussed?	
11	Has a Clinical Support Officer been involved where necessary?	
12	Have staff been able to comment on the initial DRAFT report including root causes, contributory factors etc.?	
13	Is each staff member broadly content with the report?	
14	Have any concerns regarding the content of the report raised by staff been considered?	
15	With regards to any learning, has guidance been provided to staff to ensure measures are taken to prevent the recurrence of such an incident?	
16	Has the final report been shared with ALL staff involved?	
17	Do staff have a clear understanding of the need for effective family engagement ?	

**Please also ensure that that the Staff Support Checklist has been completed.**

## APPENDIX 7 – LIST OF ACRONYMS:

<b>A&amp;E</b>	Accident & Emergency	<b>JRCALC</b>	Joint Royal Colleges Ambulance Liaison Committee
<b>AD</b>	Assistant Director	<b>KPI</b>	Key Performance Indicator
<b>AED</b>	Automatic External Defibrillator	<b>KSF</b>	Key Skills Framework
<b>AMPDS</b>	Advanced Medical Priority Dispatch System	<b>MEG</b>	Medical Equipment Group
<b>ASAM</b>	Ambulance Service Area Manager	<b>MoU</b>	Memorandum of Understanding
<b>BIA</b>	Business Impact Analysis	<b>NARSF</b>	National Risk & Safety Forum
<b>BSO</b>	Business Services Organisation	<b>NEAC</b>	Non-Emergency Ambulance Control
<b>CFR</b>	Community First Responder	<b>NIAO</b>	Northern Ireland Audit Office
<b>CRDO</b>	Community Resuscitation Development Officer	<b>PaLS</b>	Procurement and Logistics Service
<b>CSD</b>	Clinical Support Desk	<b>PAM Plan</b>	Property Asset Management Plan
<b>CSO</b>	Clinical Support Officer	<b>PCS</b>	Patient Care Service
<b>DoH</b>	Department of Health	<b>PPI</b>	Patient and Public Involvement
<b>DTO</b>	Divisional Training Officer	<b>QI</b>	Quality Improvement
<b>EAC</b>	Emergency Ambulance Control	<b>REAP</b>	Resource Escalation Action Plan
<b>EPO / AEPO</b>	Emergency Planning Officer / Assistant Emergency Planning Officer	<b>RIDDOR</b>	Reporting of Injuries, Disease and Dangerous Occurrences
<b>FM</b>	Facilities Management	<b>RMC</b>	Resource Management Centre
<b>HALO</b>	Hospital Ambulance Liaison Officer	<b>RQIA</b>	Regulation and Quality Improvement Authority
<b>HART</b>	Hazardous Area Response Team	<b>RRV</b>	Rapid Response Vehicle
<b>HCPC</b>	Health and Care Professions Council	<b>SAI</b>	Serious Adverse Incident
<b>HEMS</b>	Helicopter Emergency Medical Service	<b>SMT</b>	Senior Management Team
<b>HSCB</b>	Health and Social Care Board	<b>TMPB</b>	Transformation and Modernisation Programme Board
<b>HSENI</b>	Health and Safety Executive for Northern Ireland	<b>ToR</b>	Terms of Reference
<b>ICV</b>	Intermediate Care Vehicles	<b>TU</b>	Trade Union
<b>IPC</b>	Infection Prevention and Control	<b>TYC</b>	Transforming Your Care
<b>JCNC</b>	Joint Consultative and Negotiating Committee	<b>VAS</b>	Voluntary Ambulance Service
<b>JESIP</b>	Joint Emergency Services Interoperability Programme	<b>VCS</b>	Voluntary Car Service

## **APPENDIX 8 – ENGAGING WITH FAMILY MEMBERS / SERVICE USERS / CARERS VIA TELEPHONE:**

Following an SAI the Review Officer must engage with the service user / family member / carer. **Individual circumstances should be considered when determining the appropriate timeframe for engagement.** The service user / family member / carer should be contacted via telephone at the appropriate time to advise them that the Trust considers that a serious incident has occurred and that a thorough review will be carried out to determine what happened, how and why. (ROs should take into account any matters which may require engagement to be delayed, for example a funeral and make contact as soon as possible without causing unnecessary distress).

The following information may assist:

- Gather the contact details and ensure that they are correct, e.g. patient's name, date of incident, time of incident, location, what happened etc.
- Before making the call, think through what you are going to say. Perhaps put yourself in the position of the service user / family member / carer to help you think of some questions that may come up.
- Make the call from a place where you will not be interrupted / place a sign on the door etc.
- Greet (hello / good afternoon etc.) and ask for the correct person.
- Identify yourself clearly, provide your name, job title and explain that you are contacting them on behalf of the Northern Ireland Ambulance Service.
- Speak respectfully and clearly and check that the person understands what you are referring to. Allow the person time to process what you are saying. Do not rush, use acronyms etc.
- Remain focused on the call, do not allow interruptions, do not check emails etc.
- Explain the SAI process, i.e. the Trust is required to notify the Strategic Planning & Performance Group (SPPG) within 72 hours, carry out a full review and submit a written report with recommendations to SPPG. Explain that part of the SPPG regional process is to engage with them as the service user / family member / carer and the report will be shared with them.
- Be empathetic but try not to enter into any discussions at this stage about what happened as the review has not yet taken place. The purpose of the call is to advise that a review will take place to establish what happened, how and why.
- Ask the family if they would like to be involved in the process and if they would like to meet at this stage regarding the process itself.
- Full contact details should be taken and agreement reached as to the best person to liaise with.
- Advise them that you will be sending them a letter and a leaflet to explain more about the SAI process. They can also find information on the SPPG website on the Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016).

This phone call must be followed up with a letter (Appendix 10) and the Information For Service Users, Family Members and Carers Leaflet (Appendix 11).

**Record significant dates / times and actions taken in DATIX.**

**Remember there is a professional obligation to be open, transparent and honest (Duty of Candour pending for Northern Ireland).  
APPENDIX 9 STANDARD LETTER (See SharePoint for the most up to date template):**



**REF Call Number:** 1234567

8<sup>th</sup> April 2019

**Private & Confidential**

ADDRESS

Dear NAME,

**SUBJECT HEADING**

Following our telephone conversation, we are writing to confirm that the Northern Ireland Ambulance Service Health and Social Care Trust will thoroughly investigate the events on 5<sup>th</sup> April 2019 involving the following:

**Patients Name:** Mrs XXXX

**Address:** 123 Rainbow Road, Anytown

**Date of Birth:** 08/04/2000

The Northern Ireland Ambulance Service Health and Social Care Trust will be following a regional procedure set out by the Health and Social Care Board, known as the Serious Adverse Incident (SAI) Procedure. For further information on this process please read the enclosed leaflet 'What I need to know about a Serious Adverse Incident (SAI)'. More detailed guidance can be found at the following link:

<http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAls-2016.pdf>

Your link person is:

**Name:** Mr Bob Baxter

**Job Title:** Station Officer

**Telephone Number:** 028 9040 0999

**Hours of Work:** Works Monday – Friday 8am to 4pm.

Bob is currently on leave and will return on 15<sup>th</sup> April. He will be happy to update you on his return.

Yours sincerely,

\_\_\_\_\_

**NAME**

**(Job Title)**

Enc

## APPENDIX 10 – EXPLANATORY LEAFLET FOR SERVICE USERS / FAMILY MEMBERS / CARERS (See SharePoint for the most up to date version):

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

### Who else gets a copy of the report?

The report is shared with the Strategic Planning & Performance Group (SPPG) - which is an integral part of the Department of Health. Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the SPPG/ PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.
- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the Northern Ireland Ambulance Service to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the Northern Ireland Ambulance Service.

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

### Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or

supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

### Contact details:

**Free phone number 0800 917 0222**

### Further information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is

Your link person's job title is

Contact number

Hours of work

Prior to any meetings or telephone call you may wish to consider the following:

- Think about what questions and fears/concerns you have in relation to:
  - (a) What has happened?
  - (b) Your condition / family member condition
  - (c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

HSC Northern Ireland Ambulance Service  
Health and Social Care Trust



## What I need to know about a Serious Adverse Incident (SAI)



**Information for Service Users,  
Family Members and Carers**

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

*\*The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

### Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

### What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Strategic Planning & Performance Group (SPPG) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the SPPG. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

### Can a complaint become a SAI?

Yes, if during the follow up of a complaint the Northern Ireland Ambulance Service identifies that a SAI has occurred it will be reported to the SPPG. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

### How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The Northern Ireland Ambulance Service will discuss with you how the SAI will be reviewed and who will be involved. The Northern Ireland Ambulance Service will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

### How is the service user or their family/ carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any

delays so that you are always aware of the status of the review;

- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;
- Are offered advice in the event that the media make contact.

### What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by Northern Ireland Ambulance Service staff that is acceptable to you.

### How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

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

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

### Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

## **APPENDIX 11 – ENGAGING WITH FAMILY MEMBERS / SERVICE USERS / CARERS FACE TO FACE:**

Communication following an adverse event is the ultimate test of professionalism. This is about your relationship with your patient and this is the point perhaps where they need you most. It is very important to note that delays / conflict etc. will compound grief and distress of the service user / family member / carer.

Ensure initial contact has been made by telephone and followed up with a letter and Information for Service Users, Family Members and Carers Leaflet (Appendix 8).

- Make contact via telephone using the information provided during the initial contact.
- Briefly outline the fact that the report has been drafted and NIAS would be keen to share it / discuss it with them. If necessary remind them of the SAI process.
- Agree a time suitable to all parties and advise them who should / will attend. Every situation will be different but here are some people who might participate:
  - Manager familiar with the department / someone with enough experience to answer as many questions as possible.
  - Second clinician can be helpful to clarify anything that the service user / family member / carer finds confusing.
  - Person to support the service user – discuss this with the service user / family member / carer over the phone and suggest that it may be helpful for them to have someone there to listen and ask any questions.
- Gather the relevant information and make sure that it is correct, e.g. patient's name, date of incident, time of incident, location, what happened etc.
- Think through what you are going to say. Perhaps put yourself in the position of the service user / family member / carer to help you think of some questions that may come up.
- On arrival identify everyone clearly, providing names, job titles etc.
- Speak respectfully and clearly and check that the person understands what you are referring to. Allow the person time process what you are saying. Do not rush, use acronyms etc.
- Be empathetic at all times.
- It is possible to identify a shortcoming without there being any blame, for example a capacity / demand issue.

### Summary:

- Acknowledgement.
- Explanation.
- Apologise where appropriate.
- Changes made / lessons learned.
- The SAI Manager must be kept informed of any family engagement.
- **Record significant dates / times and actions taken in DATIX.**
- **Remember there is a professional obligation to be open, transparent and honest (Duty of Candour pending for Northern Ireland).**

*Communication following an adverse event is not always easy but you just have to do the best you can.*

**APPENDIX 12 – SAI ACTION PLAN / TRACKING TEMPLATE (See SharePoint for the most up to date template):**



Northern Ireland Ambulance Service  
Health and Social Care Trust



**SERIOUS ADVERSE INCIDENT (SAI) ACTION PLAN / TRACKING TEMPLATE**

<b>Action Plan Agreed / Monitored by:</b>		<b>SAI Ref / Datix Ref / Call Number:</b>	
<b>Team Members:</b>			
<b>Name:</b>		<b>Designation:</b>	
<b>Name:</b>		<b>Designation:</b>	
<b>Name:</b>		<b>Designation:</b>	

Recommendation	Action Agreed	Person Responsible*	Action Start Date	Action End Date	Status	Evidence of Completion	Signature	Date
					Red			
					Amber			
					Green			

**This section to be completed once all actions are concluded:**

<b>Accountable Officer (Print Name):</b>		<b>Designation:</b>	
<b>Signature:</b>		<b>Date:</b>	

On Target Green  
 Partially On Track Amber  
 Not Achieved Red

\*Name and designation

**NOTE: action plans must be reviewed monthly**

**APPENDIX 13 – LEARNING TEMPLATE (See SharePoint for the most up to date template):**



Northern Ireland Ambulance Service  
Health and Social Care Trust



**NIAS LEARNING LETTER**

<b>SAFETY MESSAGE:</b>			
<b>REF:</b>		<b>DATE ISSUED:</b>	

LEARNING SOURCE			
INCIDENT / SAI	✓	COMPLAINT / COMPLIMENT	
AUDIT / OTHER REVIEW		CORONER'S INQUEST	
EXTERNAL LETTER / CIRCULAR		LITIGATION	

SUMMARY OF EVENT (WHAT HAPPENED AND WHY)

LEARNING POINTS
<b>For Staff:</b>
<b>For Line Management:</b>
<b>For Policy Leads / Heads of Departments / Senior Management:</b>

Learning Applicable to:			
Local Area	✓	Division / Directorate	
Regional	✓	Acute Trusts / National	

<b>Approved By (Print Name):</b>		<b>Designation:</b>	
<b>Signature:</b>		<b>Date:</b>	

## APPENDIX 14 – SAI FLOWCHART:



## APPENDIX 15 – NEVER EVENTS:

NIAS has reviewed the HSC Revised Never Events List issued 10<sup>th</sup> December 2018 HSC (SQSD) 36/18, and can confirm that the follow 'Never Events' are applicable to NIAS:

Never Event	Application to NIAS
<b>3. Retained foreign object post-procedure</b>	
<p>Retention of a foreign object in a patient after a surgical/invasive procedure.            'Surgical/invasive procedure' includes interventional radiology, cardiology, interventions related to vaginal birth and interventions performed outside of the surgical environment e.g. central line placement in ward areas            'Foreign object' includes any items that should be subject to a formal counting /checking process at the commencement of the procedure and a counting /checking process before the procedure is completed (such as swabs, needles, instruments and guide wires) <b>except where:</b></p> <ul style="list-style-type: none"> <li>• Items are inserted any time before the procedure that are not subject to the formal counting/checking process, with the intention of removing them during the procedure</li> <li>• Items are inserted during the procedure that are subject to the counting/ checking process, but are intentionally retained after completion of the procedure, with removal planned for a later time or date and clearly recorded in the patients notes</li> <li>• Items are known to be missing prior to the completion of the procedure and may be within the patient (e.g. screw fragments, drill bits) but where further action to locate and/or retrieve would be impossible or be more damaging than retention</li> </ul>	<p>This could potentially apply to intravenous cannulas or wound dressings which are either damaged and leave fragments within the body or are perhaps concealed within wounds.</p> <p>There is the potential for a cannula to be used and for the patient subsequently not to travel, but the vast majority of patients who undergo cannulation are transferred for hospital assessment. Similarly wounds requiring packing will all require ED referral for exploration and treatment.</p>
<b>12. Transfusion or transplantation of ABO-incompatible blood components or organs</b>	
<p>Unintentional transfusion of ABO-incompatible blood components.</p> <ul style="list-style-type: none"> <li>• Excludes where ABO-incompatible blood components are deliberately transfused with appropriate management.</li> </ul>	<p>At present only undertaken by HEMS.</p>

Unintentional ABO mismatched solid organ transplantation.

- Excluded are scenarios in which clinically appropriate ABO incompatible solid organs are transplanted deliberately.
- In this context, 'incompatible' antibodies must be clinically significant. If the recipient has donor specific anti-ABO antibodies and is therefore, likely to have an immune reaction to a specific ABO compatible organ then it would be a never event to transplant that organ inadvertently and without appropriate management.

## APPENDIX 16 – STAFF SUPPORT CHECKLIST:

<b>Name:</b>	
<b>Designation:</b>	
<b>Directorate:</b>	
<b>Location:</b>	
<b>Date of incident:</b>	
<b>Reason for support:</b>	

<b>Section 1 – to be completed by line manager</b>		
<i>Please answer Yes, No or N/A</i>		
1	Was immediate support/debriefing offered?	
2	Was a copy of relevant internal and external support agencies highlighted to the employee(s)?	
3	Was referral to the Occupational Health and Safety Service discussed with the employee(s)?	
4	Was counselling support discussed and offered to the employee(s)?	
5	Have temporary role adjustments, redeployment or reassignment of duties been considered?	
6	Has a second debriefing (24 – 48 hours) been offered and held with the employee(s)?	
7	Has further support been offered to the employee(s) (e.g. supervisor of midwives, chaplaincy, Trade Union)?	
8	Has the need for ongoing or long term support been discussed?	
9	Has (have) a referral(s) to Occupational Health been made for assessment about fitness to return to work?	

**Section 2 – Witness appearances only. To be completed by line manager**

***Please answer Yes, No or N/A***

*Has (have) the employee(s):*

10	Been briefed about the process?	
11	Been offered support in statement writing?	
12	Been offered support in preparation for appearing as a witness?	
13	Have arrangements been made to ensure that the employee will be supported on the day of the hearing?	
14	On conclusion of the case, was the employee debriefed (if the information was in the public domain)?	

**Any other comments:**

**Completed by:**

**Name:** \_\_\_\_\_

**Designation:** \_\_\_\_\_

**Date:** \_\_\_\_\_