INCIDENT AND SERIOUS INCIDENT - POLICY ON A PAGE

Sussex Partnership NHS Foundation Trust

1. WHAT IS AN INCIDENT OR SERIOUS INCIDENT?

Incident ***'Any event whether planned or unplanned that has given or may give rise to actual or possible personal injury, to patient dissatisfaction, or to property loss or damage'***

A Serious Incident is defined as ***'an incident that occurred in relation to NHS Funded services and care resulting in an unexpected or avoidable death or serious harm to one or more patients, staff or members of the public'***

2. WHY WE NEED THIS POLICY

- It is important that as a Trust we have a system to report all incidents involving patients, staff, visitors, equipment, security and other factors regardless of severity or outcome.
- Requirement for the Trust to appropriately investigate incidents and serious incidents.
- High incident reporting is seen as positive as it indicates that the Trust is open and transparent, willing to learn which in turn will improve patient safety.
- The level of investigation must be proportionate to the incident.
- The NHS England Serious Incident Framework (2015) states the incidents which cause serious harm or result in death require investigation using the root cause analysis methodology.
- When investigating an incident, the focus must be on learning.

3. TYPES AND LEVELS OF INVESTIGATION

- **Incident –** completed by the team member following an incident. Reviewed by the Ward Manager/Team Leader and learning shared with the team.
- **Higher Learning Review–** An internal review of incidents which do not meet the SI threshold but require greater investigation.
- **Serious Incident Concise Investigation** – suited to less complex incidents.
- **Serious Incident Comprehensive Investigation –** appropriate for incidents which require investigation external to the team.
- **Serious Incident Independent Investigation –** this level of investigation is appropriate for a serious incident which will require investigation external to the Trust, such as a homicide.

4. PROCESS

- Incident is reported by a staff member
- Incident form indicates a 'Serious Incident' and the incident is reviewed and graded by Clinical Governance Team.
- If it meets SI criteria the service area are asked to complete an 'Initial Management Review'.
- A STEIS Notification is sent out to senior Trust staff, the CCG and the CQC within 2 working days of the serious incident being identified.
- The Initial Management Review is completed by Matron/ Service Manager within 2 working days and is intended to;
  - Enable an immediate review of the serious incident and establish any immediate actions required.
  - The Initial Management Review is also used to inform the CCG and CQC.
- Completion times for different types of investigation.
  - No further investigation required –managed through the Ulysses systems with learning shared with the team.
  - Higher Learning Review – required when the incident does not meet the SI criteria but requires more than incident review. To be completed within 28 working days.
  - Level 1 Concise Investigation – to be completed within 60 working days
  - Level 2 Comprehensive Investigation – to be completed within 60 days
  - Level 3 Independent Investigation – to be completed within 6 months

5. INVOLVING PATIENTS, FAMILIES/CARERS IN THE INVESTIGATION

- Involving family/carers is central to completing a thorough and open investigation.
- Number of publications such as the CQC Duty of Candour 2014 and the CQC, Learning, Accountability and Candour (Dec 2016) requires the Trust to involve wherever possible family and carers in any unexpected death investigation.
- The family need to have the opportunity to be:
  - able to ask specific questions they would like the investigation to answer;
  - have the opportunity to meet with the SI investigator to set the Terms of Reference for the review;
  - to read the draft report,
  - to have their concerns reflected within the report, and
  - to have a copy of the final report and know the actions we will take to reduce the likelihood of the incident occurring again.

6. SHARED LEARNING

The focus must be on how we learn from incidents and serious incidents with the aim being how we improve patient safety. There are many ways to share learning such as;

- Sharing learning from incidents within the ward/team
- Using the Ulysses dashboard to review the types of incidents occurring within the team.
- Reflecting on care within your team through supervision and reflective practice.
- Reading 'Patient Safety Matters'
- Reading Serious Incident Reports which occur within the area you work in.
- Attending 'Patient safety events'.

7. YOUR ROLE

- Report incidents which occur within your work area.
- Be accurate in the information you provide when reporting an incident.
- Report incidents in a timely way and within your span of duty
- Reflect upon and learn from incidents which are occurring within your team and within the Trust.

With acknowledgement to University of Morecambe Bay NHS Foundation Trust who devised this template as part of a LIA initiative and shared via twitter.