States of Jersey

The States of Jersey Department for
Health & Social Services

Policy and Procedure for the Management of Serious Incidents within Health and Social Services

November 2017

DOCUMENT PROFILE	
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Description	Serious Incident Policy and Procedure
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1. INTRODUCTION

1.1. Rationale

Serious incidents (SI) in health and social care are rare, but it is acknowledged that systems and processes have weaknesses and human error can occur that will inevitably happen. It is essential that as an organisation we can recognise harm and the potential for harm and undertake swift, thoughtful and practical actions in response, without inappropriately blaming individuals. This policy has been adapted from the NHS England 'Serious Incident Framework, Supporting learning to prevent recurrence' (2015) to fit the local island context.

Investigations are conducted to enable the organisation to learn from them and prevent recurrence in the future. They are not aimed at holding individuals to account, as there are other processes for that purpose including; criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Nursing and Midwifery Council (NMC), the Health and Care Professions Council, and the General Medical Council (GMC).

1.2. Purpose

This document has been split into two distinct parts, the policy and the procedure. Its purpose is to ensure that:

- Health and Social Service (HSSD) properly respond to serious incidents when they occur
- All staff understand their responsibilities
- Staff are supported at an appropriate level
- The needs of the person/persons adversely affected are met
- Proper reporting occurs
- Investigations are thorough and timely
- Lessons are learned that will reduce future risk

1.3. Scope

The reporting of an SI is the responsibility of all staff employed within HSSD. This includes temporary staff. This policy covers all SI's involving HSSD Services and staff including locations such as the hospital sites, day care, nursing units and group homes and private residences where services are delivered in client's own homes

1.4. Key Responsibilities

1.4.1. Head of Clinical Governance and Risk Management

1. Coordinate an SI huddle group within 24-72 hours of a potential SI in order to determine the incident meets the threshold of an SI. The same group will then consider if the Duty of Candour is triggered
2. Be a single point of reference for all HSSD Serious Incidents
3. Coordinate Serious Incident Investigations and meet the relevant investigators to explain process/ documentation etc.
4. Set the agenda of the Serious Incident Review Panel (SIRP)
5. Write to families explaining the SIRP process

6. Meet with the patient/ service users or families where appropriate with a member of the relevant speciality team
7. Feedback completed recommendations and action plans to panel
8. Engage and support the staff involved in the incident and investigation process.
9. Coordinate training in root cause analysis for investigators
10. Maintain a register of staff trained in root cause analysis
11. Audit the recommendations and complete a 3 yearly thematic review to be presented at the Integrated Governance Committee
12. Submit draft SI reports to insurers prior to any internal or external release
13. If an SI involves more than one organisation, the Head of Clinical Governance and Risk Management will liaise with the other organisations to identify which organisation will lead on the SI investigation and ensure that full cooperation occurs in order to deliver one overarching investigation (as far as possible). Contact will be made by phone, followed up in writing
14. Liaise with the Legal Administration Manager to notify insurers of SIs relevant to the insurance policy notification requirements for specific types of incidents

1.4.2. Serious Incident Huddle Group

The Serious Incident Huddle group should come together within 72 hours of a potential SI being reported. It should include-

- The Head of Clinical Governance and Risk Management or Clinical Governance and Risk Manager
- A Senior Manager/ Director or equivalent
- Most senior available person from the area involved in the incident/ professional group who is equipped with the known facts of the incident

The group have delegated responsibility from the Serious Incident Review Panel to-

1. Determine if the incident meets the threshold of a Serious incident investigation
2. Ensure any immediate steps to prevent further harm or similar incident from occurring have been actioned, including assessing as soon as possible whether any information needs to be shared with the police/ Deputy Viscount
3. Establish whether a Duty of Candour is triggered
4. Establish what level of investigation is required (level 1, 2 or 3)
5. Approve the terms of reference and initial scope for the Investigation
6. Identify an appropriate lead investigator, ensuring it is someone from outside the area where the incident occurred (levels 2 and 3, for independence)
7. Complete the notification form for SIRP
8. Identify any immediate learning to enable proactive measures to reduce the likelihood of recurrence

1.4.3. Serious Incident Review Panel (SIRP)

1. Review notifications of a Serious Incidents, levels of investigation to ensure an appropriate depth and or independence of investigation has taken place; the terms of references agreed by the SI huddle; the scope of investigations to ensure sufficient look back, breadth of investigation (e.g. other known cases considered, previous incidents involving the same staff or equipment, etc.), and range of time is covered

2. Prioritise serious incidents that require full (level 2 and 3) investigation and develop alternative methods for managing and learning from other types of incidents (Care Quality Committee [CQC] 2016)
3. Approve the SI investigation reports, recommendations and action plans
4. Monitor the completion of the action plans
5. Determine which reports are internally published and available to staff
6. Ensure that the organisation has staff with the expertise and resources to complete a root cause analysis investigation within the designated timeframe

1.4.4. Managing Directors of Hospital or Community and Social Services

1. Identify relevant people to undertake the investigation in liaison with the Head of Clinical Governance and Risk Management (the SIRP panel may make recommendations for this)
2. Ensure that Recommendations agreed by panel are allocated to relevant service lead and made into workable action plans with set timelines (the SIRP panel may make recommendations for this)
3. Report to the SIRP on action plan completion and any slippage
4. Follow up on action plans and ensure learning is embedded in practice
5. Make necessary resources available to staff
6. Ensure relevant entries are made onto the Risk Register

1.4.5. Senior Managers

1. Ensure that they are familiar with the Serious Incident Policy
2. Participate in SI huddle groups
3. Undertake risk management training including Root Cause Analysis (RCA)
4. Participate in formulating action plans from the recommendations and ensure those under their responsibility are implemented

In the event of a Serious Incident occurring out of hours the most senior member of staff in the area where the incident has occurred should ensure that it has been escalated to the duty manager who is made aware as a matter of urgency. The responsibilities of the person first informed are outlined in section B of the procedure

1.4.6. Investigating Team

The investigating team will be made up of a lead investigator trained in RCA methodology and usually one other investigator where necessary with expertise from someone skilled and experienced in the specialty involved in the incident.

1. Complete the investigation with an impartial non-biased approach
2. Using skilled analysis move the focus of the investigation from the acts or omissions of staff, to identifying the underlying causes of the incident
3. Ensure that root cause analysis methodology is used and that root causes are sought (often not a single root cause)
4. Use the provided documentation template for completion of the investigation report
5. Involve patient/ service users/ family/ carers as much as possible and meet with them before starting/ during the investigation process where appropriate to ensure that their questions are answered and that they have had the opportunity to participate in the process

6. Ensure that witness statements/ first-hand accounts and staff interviews are transcribed and sent to the Governance Support Administrative Assistant for scanning and saving in the relevant SI folder (statements may be requested for inquest purposes)
7. Make recommendations relevant and linked to the analysis of the case
8. Be prepared to present the report to the Serious Incident Review Panel
9. Ensure that National and International up to date and relevant guidance/ best practice is used as a benchmark. In addition or/in the absence of HSSD policies

Please note-

- the SI report will be shared with the patient/ service user or their family and they may raise additional questions – prior to this it will be sent to HSSD's insurers
- In the case of an SI following the death of a patient it is likely that investigators will be asked to attend the inquest as a witness and read the report out/ answer questions
- The primary responsibility in relation to serious incidents is from the provider of the care to the people who are affected and/or their families/carers

1.4.7. All HSSD Employees

- All Staff who suspect a serious incident has occurred should take immediate action to minimise and prevent further harm and appropriately escalate their concern
- Ensure that they are familiar with the Policy on the Management of Serious Incidents and the Duty of Candour Policy
- Cooperate with managers or other staff within HSSD or external to the organisation who are completing a Serious Incident investigation
- If external agencies are involved in the aftermath of an SI, Senior Managers must be present

1.5. Underpinning Principles

The NHS Framework endorses the application of 7 key principles in the management of all serious incidents (figure 1) which are adopted by HSSD in its approach to Serious Incidents.

Figure 1

Key Principle	Supporting Information
Open and Transparent	The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. The principles of openness and honesty as outlined in the Duty of Candour policy must be applied within the local guidance framework in discussions with those involved. This includes staff and patients, victims and perpetrators, and their families and carers. Openness and transparency means: • Acknowledging, sincerely apologising and explaining when things have gone wrong; • Conducting a thorough investigation into the incident, ensuring patients/service users, their families and carers are reassured that lessons learned will help prevent the incident recurring; • Providing support for those involved to cope with the physical and psychological consequences of what happened Saying sorry is not an admission of liability and is the right thing to do. Healthcare organisations should decide on the most appropriate members of staff to give both verbal and written apologies and information to those involved. This must be done as early as possible and then on an ongoing basis as appropriate.
Preventative	Investigations of serious incidents are undertaken to ensure that weaknesses in a system and/or process are identified and analysed to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again Investigations carried out under this Framework are conducted for the purposes of learning to prevent recurrence. They are not inquiries into how a person died (where applicable) as this is a matter for the Deputy Viscount/ Coroner. Neither are they conducted to hold any individual or organisation to account. Organisations must advocate justifiable accountability and a zero tolerance for inappropriate blame.
Objective	Those involved in level 2 and 3 investigation process should not be involved in the direct care of those patients affected, nor should they be working within the same team as they may have a shared perception of appropriate/safe care that is influenced by the culture and environment in which they work. As a result, they may fail to challenge the ‘status quo’ which is critical for identifying system

	weaknesses and opportunities for learning. Demonstrating that an investigation will be undertaken objectively will also help to provide those affected (including families/carers) with confidence that the findings of the investigation will be robust, meaningful and fairly presented. To fulfil the requirements for an independent investigation, the investigation must be both commissioned and undertaken independently of the care that the investigation is considering
Timely and responsive	Serious incidents must be reported without delay and no longer than 2 working days after the incident is identified Every case is unique, including: the people/organisations that need to be involved, how they should be informed, the requirements/needs to support/facilitate their involvement and the actions that are required in the immediate, intermediate and long term management of the case. Those managing serious incidents must be able to recognise and respond appropriately to the needs of each individual case.
Systems based	The investigation must be conducted using a Root Cause Analysis (RCA) investigation, a recognised systems-based investigation methodology that identifies. ○ The problems (the what?) ○ The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and ○ The fundamental issues/root cause (the why?) that need to be addressed. the investigation must be undertaken by those with appropriate skills, training and capacity
Proportionate	The scale and scope of the investigation should be proportionate to the incident to ensure resources are effectively used. Incidents which indicate the most significant need for learning to prevent serious harm should be prioritised. Typically, serious incidents require a comprehensive investigation, but the scale and scope (and required resources) should be considered on a case by-case-basis.
Collaborative	Serious incidents often involve several areas or organisations. Areas and organisations must work in partnership to ensure incidents are effectively managed and investigated. There must be clear arrangements in place relating to the roles and responsibilities of those involved. Wherever possible partners

	should work collaboratively to avoid duplication and confusion. There should be a shared understanding of how the incident will be managed and investigated and this should be described in jointly agreed policies/procedures for multi-agency working and coordinated by the Head of Clinical Governance and Risk Management.

NHS (2015)

2. POLICY

2.1. Serious Incidents

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a health system.

There is no definitive list of events/incidents that constitute a serious incident, and every incident must be considered on a case-by-case basis, however the NHS definitions below, which HSSD have adopted, sets out circumstances in which a serious incident ***must*** be declared.

1.	Unexpected or avoidable death of one or more people caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission) This includes • suicide/self-inflicted death; and • homicide by a person in receipt of mental health care within 6 months. Each case should be considered individually as it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously. (6 months and less are always SI's) (see Appendix 1)
2.	Unexpected or avoidable injury to one or more people that has resulted in serious harm
3.	Unexpected or avoidable injury to one or more people that requires further

	treatment by a healthcare professional in order to prevent the death of the service user; or serious harm
4.	Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where: • healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision by HSSD This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation
5.	A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.
6.	An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following: • Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues for further information see, *'Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (2015)* • Property damage; • Security breach/concern; This will include absence without authorised leave for patients who present a significant risk to themselves or the public • Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population; (for additional guidance see '*Managing Safety Incidents in NHS Screening Programmes' (2017)* • Inappropriate enforcement/care under the Mental Health Jersey Law (1969) and the Multi-Agency Capacity Policy and Procedures (2015) • Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services). It is recognised that in some cases ward closure may be the safest/ most responsible action to take but in order to identify problems in service/care delivery , contributing factors and fundamental issues which need to be resolved an investigation must be undertaken • Activation of Major Incident Plan (by provider or relevant agency)
7.	Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

2.1.1. Near Misses

Near Misses may be classified as Serious Incidents in certain circumstances, the outcome of an incident does not always reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. An assessment of risk based on the likelihood of the incident occurring again if current systems/process remain unchanged; and the potential for harm to staff, patients/ service users, and the organisation should the incident occur again should be carried out.

2.1.2. Patient Never Events

Never Events are a particular type of serious incident that meet all the following criteria (NHS 2015b, 2018):

- They are wholly preventable
- 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.
- There is evidence that the category of Never Event has occurred in the past, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.
- Occurrence of the Never Event is easily recognised and clearly defined – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety. (NHS 2015b)

Never Events are key indicators that there have been failures to put in place the required systemic barriers to error. Their occurrence gives fundamental information to organisations on the quality, care and safety processes in place (NHS 2015b). Never Events will require root cause analysis which will not only examine issues such as compliance with, and the robustness of, local processes and procedures; but also the role of human factors. The following is a list of Never Events (2018), further information can be found in appendix 2

Surgical

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-procedure (surgical/ invasive procedure)

All Settings

4. Mis-selection of a strong potassium containing solution
5. Wrong route administration of medication, the patient receives one of the following:
    - Intravenous chemotherapy administered via the intrathecal route
    - Oral/enteral medication or feed/flush administered by any parenteral route
    - Intravenous administration of a medicine intended to be administered via the epidural route
6. Overdose of Insulin due to abbreviations or incorrect device

7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation

Mental Health

9. Failure to install functional collapsible shower or curtain rails when an inpatient suicide is attempted/ successful

General

10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso or orogastric tubes in the pleura or respiratory tract where the misplacement of the tube is not detected prior to commencement of feeding, flush or medication administration.
14. Scalding of patients
15. Unintentional connection of a patient requiring oxygen to an air flowmeter
16. Undetected oesophageal intubation -This Never Event has been temporarily suspended pending further clarification- please check for updates

2.1.3. Serious Case Reviews and Safeguarding

A memorandum of understanding is in place between HSSD and the Safeguarding Partnership Boards (SPB) to support information sharing and partnership working. Whenever a Serious Incident or Serious Case Review (SCR) are convened the investigator should check whether a SI or SCR has already been commissioned, in order to prevent duplication and promote learning across partners.

2.1.4. Multi-incident Investigations

It is essential to identify incidents that indicate the most significant opportunities for learning and prevention of future harm. If there are clusters of incidents, such as falls, pressure sores etc. Investigating each individually using a full root cause analysis framework could lead to a debilitating process which does not support effective learning. In these instances the SIRP may commission a multi-incident investigation in order to identify common problems, contributing factors and root causes. One comprehensive action plan should then be developed and monitored which could be expected to reduce the likelihood of the incidents happening again. Where an organisation has identified widespread risk and has undertaken (or is undertaking) a multi-incident investigation, consideration should be given to whether resources could be better used on the delivery of improvement work rather than initiating another investigation.

Grade 3 and 4 pressure sores developed under in the care of HSSD should be seen by the Tissue Viability nurse and a concise root cause analysis investigation completed (see appendix 3) these should be presented to the SIRP panel quarterly in order to inform their decision making in regards to commissioning a multi-incident investigation and for a general oversight of the number of grade 3 and 4 pressure sores occurring across HSSD.

2.1.5. Notification of Interested bodies

In different circumstances it is essential that additional people and relevant parties are notified of a Serious Incident. This will generally be coordinated by the Head of Clinical Governance and Risk management or the appropriate Corporate/Managing Director in liaison with the SIRP where appropriate. Relevant parties should be informed at the earliest opportunity and within 2 working days of a serious incident being identified. This includes-

Issue	**Who to notify**
Safeguarding issues- If there are any safeguarding concerns the Safeguarding nurse should be informed as soon as possible and the Safeguarding adult and child policies and procedures followed	Safeguarding Nurse Children or adults. (via switchboard). SPOR- Adults, MASH- Children
Incidents involving controlled drugs	Please ensure a datix is completed that will go to the Chief Pharmacist
Sudden deaths An unexpected death (where natural causes are not suspected) and all deaths of detained patients must be reported to the Deputy Viscount/Coroner by the treating clinician. This should be done immediately. It is recognised that, following an unexpected death, a serious incident may not be identified until notification by the coroner	In the case of sudden deaths the police should be notified on behalf of the Viscounts Department
Defects and equipment failure	Health and Safety Manager (45819) and Head of Clinical Governance / Risk Management (42744) as these will need to be notified to the MHRA
Information Governance and Data Protection Issues.	Information Governance Manager (44006) who will escalate to the States of Jersey Information Commissioner if appropriate.
Professional Bodies	This would go through the Senior Manager or Professional Lead
Police Investigations	Via Duty Senior Manager
Health and Safety incidents	Health and Safety Manager
Maternal Deaths- A maternal death is defined as any death of a woman, which occurs during or within one year of pregnancy, childbirth, miscarriage or termination, from any cause related to or aggravated by the pregnancy or its management. The death may occur in any setting, including acute or primary care. A maternal death must be notified by the clinician aware of the death in accordance with the regional maternal death guidelines as well as the	ALL maternal deaths are to be reported to the Head of Midwifery. NB - Although not all maternal deaths are classified as serious untoward incidents all cases should be reported.

local serious incident reporting process	
Healthcare associated infections (HCAIs). The categories for reporting include: • Outbreaks of healthcare associated infections (this includes the presumed transmission within a hospital and causes significant morbidity/mortality and/or impacts significantly on hospital activity) including ward or facility closure. • Infected healthcare workers (incidents which necessitate consideration of a 'look back' exercise) • Breakdown of infection control procedures/ serious decontamination failures with actual or potential for cross infection • RCAs are undertaken on all toxin positive Clostridium difficile patients and Hospital acquired MSSA MRSA and multi-drug resistant gram negative bacteria	Senior Nurse- Infection Prevention and Control (43085) Director of Infection Prevention and Control
Unexpected Child Deaths - all cases of child deaths in Jersey must be notified to the Safeguarding Board Manager, who is the Designated person in the SPB responsible for collating child death information.	The Consultant Paediatrician is responsible for co-ordination of the multi-agency response Refer to the Multi-Agency Procedures in the case of Child Deaths in Jersey (2016)
Grade 3 and 4 pressure sores developed in hospital	Tissue Viability Specialist Nurse (42055)

2.1.6. Police Investigations

The States of Jersey Police Service may undertake work in HSSD as part of a police investigation of suspicious death. The States of Jersey Police may also undertake investigative work on behalf of the Deputy Viscount in the absence of the Police Viscount Liaison Officer. Police involvement in safeguarding cases is automatic, however on other occasions they may become involved by:

- Attendance by members of the deceased person's family at a police station to report suspicions
- Referral from the Deputy Viscount
- Referral by enforcement agencies
- Referral by hospital where staff maybe implicated

Please also refer to the Memorandum of Understanding between HSSD, States of Jersey Police and the Health and Safety Inspectorate. HSSD must clearly co-operate with a police enquiry and should take steps to facilitate the enquiry and ensure timely reporting of any incident. The senior manager on call will liaise with the police in order to avoid situations where staff are interviewed without support or prior notice.

Staff approached by police officers undertaking an investigation in their working areas should:

- Record the number of their warrant card and make a record of their number
- Ensure that the site manager, Lead Nurse or the on call Senior Manager is immediately informed of their presence before any staff speak to the police, Health and Safety Inspectorate (HSI) or any other external agency. This is to ensure appropriate support can be given to staff if necessary.
- The writing of repos and investigation should continue so that lessons can be learnt but this may need to be done in consultation with the police
- The responsible Corporate Director or Head of Clinical Governance and Risk Management will ensure that the Legal and Administrative Manager is informed of the ensuing investigation.
- Staff should be advised that when giving a statement under caution they may want to contact their professional body and have legal representation.

2.2. Patient/ Service User/ Family Involvement

It is essential that the needs of those affected remain the primary concern of those involved in the response to and the investigation of serious incidents. Patients/ service users and their families/carers and victims' families must be routinely involved and supported throughout the investigation process (CQC 2016).

The patient/service user/ family/carer must be informed as soon as possible when a Serious Incident or Never Event occurs. Details of the conversation must be documented in the patient records; disclosure must not be delayed while the status of the SI or never event is being determined. Disclosure should be in line with the HSSD Duty of Candour (Being open) policy.

A meeting should be held with family early in the process to explain the actions that are being taken, how they can contribute, and the support services in place and who they can contact. Involvement should begin with a genuine apology. They should be given the leaflet on Serious Incidents (appendix 4). Staff involved in liaising with and supporting bereaved and distressed people must have the necessary skills, expertise, and knowledge of the incident in order to explain what went wrong promptly, fully and compassionately. The appropriate person must be identified for each case. This can include clinicians involved in the incident but this is not always appropriate and should be considered on a case-by-case basis. Families must also have access to the necessary information and should:

- Be made aware, in person and in writing, as soon as possible of the process of the investigation to be held, the rationale for the investigation and the purpose of the investigation;
- Have the opportunity to express any concerns and questions. Often the family offer invaluable insight into service and care delivery and can frequently ask the key questions;
- Have an opportunity to inform the terms of reference for investigations;
- Be provided with the terms of reference to ensure their questions are reflected;

- Know how they will be able to contribute to the process of investigation, for example their involvement in the investigation
- Be given access to the findings of any investigation
- Have an opportunity to respond/comment on the findings and recommendations outlined in the final report and be assured that this will be considered as part of the quality assurance and closure process
- Be informed, with reasons, if there is a delay in starting the investigation, completing the investigation or in the publication of the final report; and be offered media advice, should the media make enquiries.

NHS (2015)

2.3. Staff Support

Serious incidents can have a significant impact on staff who were involved or who may have witnessed the incident, all staff involved in a Serious Incident should be provided with the SI information leaflet that explains the process of an SI (see appendix 5). While it is clearly a priority to manage the immediate needs of the patient and their family, it is also important to support members of staff who may be affected by the incident (CQC 2016). Staff should receive written confirmation of what is expected of them and how they will be expected to contribute to the process with clear time lines. Staff will want to know what happened and why and what can be done to prevent the incident happening again.

The aims of investigating an incident using RCA should be made clear to staff so as not to confuse the investigation with any other legal and/or disciplinary process. Staff involved in the investigation process should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also have a point of contact in the same way that patients and families do so that they can address their questions to the appropriate person.

In order to ensure that staff feel confident to report Serious Incidents the organisation needs to promote a positive culture of accountability and learning and not defensiveness and blame. Research shows that systems failures are the root cause of the majority of safety incidents.

2.4. Shared Learning

All organisations have a responsibility for the dissemination of learning from Serious Incidents. Learning can be demonstrated at organisational level by sustainable changes and improvements in processes, policy, systems and procedures relating to patient safety at organisational level. Internal publication of serious incident investigation reports and action plans is considered best practice. The SIRP panel should give careful consideration when making decisions on internal publication, and can decide not to share the report for any reason. To support openness and transparency however reports and their recommendations and action plans should be made available to staff on. Prior to this occurring there must be processes in place for proof reading and steps must be taken to protect the anonymity of persons involved.

Reports should not contain confidential personal information unless consent has been obtained or there is an overriding public interest. The content must be considered by the Head of Clinical Governance and Risk Management with support from the organisations Caldicott Guardian, Information Governance Manager and legal advisor/ team as required. It is important to share information safely for the purposes of learning whilst maintaining the principle of openness and transparency.

Once the report has been ratified by the SIRP the staff involved in the incident should have the report shared with them within 2 weeks. This may be on an individual or team basis depending on the nature of the incident. It is essential that outcomes and lessons that are learnt in one area are shared more widely within the organisation in a timely manner. Morbidity and Mortality Meetings, Departmental and Divisional meetings and internal publication can all be utilised for the sharing of information. If immediate actions are identified during the investigation that may have implications across the organisation the investigating team should inform the HORM who will disseminate the relevant information immediately.

Organisational leaders are accountable and responsible for ensuring that all relevant learning is captured and implemented effectively, this is the most crucial aspect of this policy and framework. Learning outcomes should be monitored through robust monitoring structures and processes.

2.5. Who Should Carry out a Serious Incident Investigation?

Health and Social Services should have a central team of experts in all types of risk. The organisation is responsible for ensuring that staff who lead an investigation or take part in the investigation team should have an in-depth understanding of the investigation methodology, can apply the tools and techniques in various settings and have the capacity and support they need to carry out a good investigation. Access to external experts should be available when needed and opportunities to contribute to wider improvement initiatives when incidents may not warrant a formal investigation but where learning and solutions are needed to reduce the risk of them happening again should be available. A register of staff trained in root cause analysis (RCA) will be kept by the Head of Clinical Governance and Risk Management.

2.6. Training

It is the intention of HSSD that all staff leading a Root Cause Analysis, Patient Safety Investigation should have completed a 2-day training course which offers a practical element to the training, in particular the analysis section of the course will:

- cover effective solution generation and implementation
- follow and promote the NHS (2015) Serious Incident framework

Individuals should undertake or shadow an RCA investigation within 12 months of completing the training in order to consolidate learning. Individuals that continue to conduct investigations should complete advanced training within 2- 3 years of their initial 2-day course, aiming to advance analytical and improvement skills; and the subsequent quality of investigations and reports. The individuals should have updates to the training every three years. The NPS: A guidance on human error, just

culture, human factors, cognitive interviewing, being open and effective solution generation and implementation will all be part of the courses for all of the above (NHS 2016).

Research and human factors principles tell us that safety solutions that reduce the risk of the same incidents happening again are designed around a number of factors. These include:

- Designing tasks and processes to minimise dependency on short-term memory and attention span.
- Standardising processes and equipment, where relevant.
- Resisting reliance on policies and protocols as task aids; and that
- Retraining staff is not always the right solution.

The organisation should train clinical staff in human factors principles to develop solutions that reduce the risk of the same incidents happening again (CQC 2016).

2.7. Audit

A quarterly update of the monitoring of action plans and how they have impacted on the quality of care will be presented to the SIRP. There will be a yearly report to the Integrated Governance Committee on Learning from SI's and compliance with action plans which will be undertaken by the Clinical Governance and Risk Manager or their delegate. This will then be fed back to SIRP panel and Integrated Governance Committee.

Three yearly thematic reviews should be completed to ensure that lessons are being learnt from SI's and any themes are identified.

2.8. Involvement of Multiple Providers

If it is found that more than one organisation is involved in the care and service delivery in which a serious incident has occurred, the organisation that identifies the serious incident is responsible for recognising the need to alert other providers and partner organisations. Discussions about subsequent action can then be initiated. All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate. If there is multi-agency involvement in a case involving safeguarding consideration should be made as to whether this should be referred to the Safeguarding board for a Serious Case Review Investigation.

Any notifications to HSSD from external agencies or hospitals regarding the care that we have provided will be given the same priority as internally identified SI's and feedback provided to the relevant referring authority. The report will remain the property of HSSD and only be shared externally with the SIRP panel's permission.

2.8.1. HSSD Commissioned Services

Any organisation commissioned by HSSD to provide services are expected to adopt the same standards outlined in this policy or have a similar policy in place. SI reports from commissioned services related to HSSD patients will be presented to the SIRP.

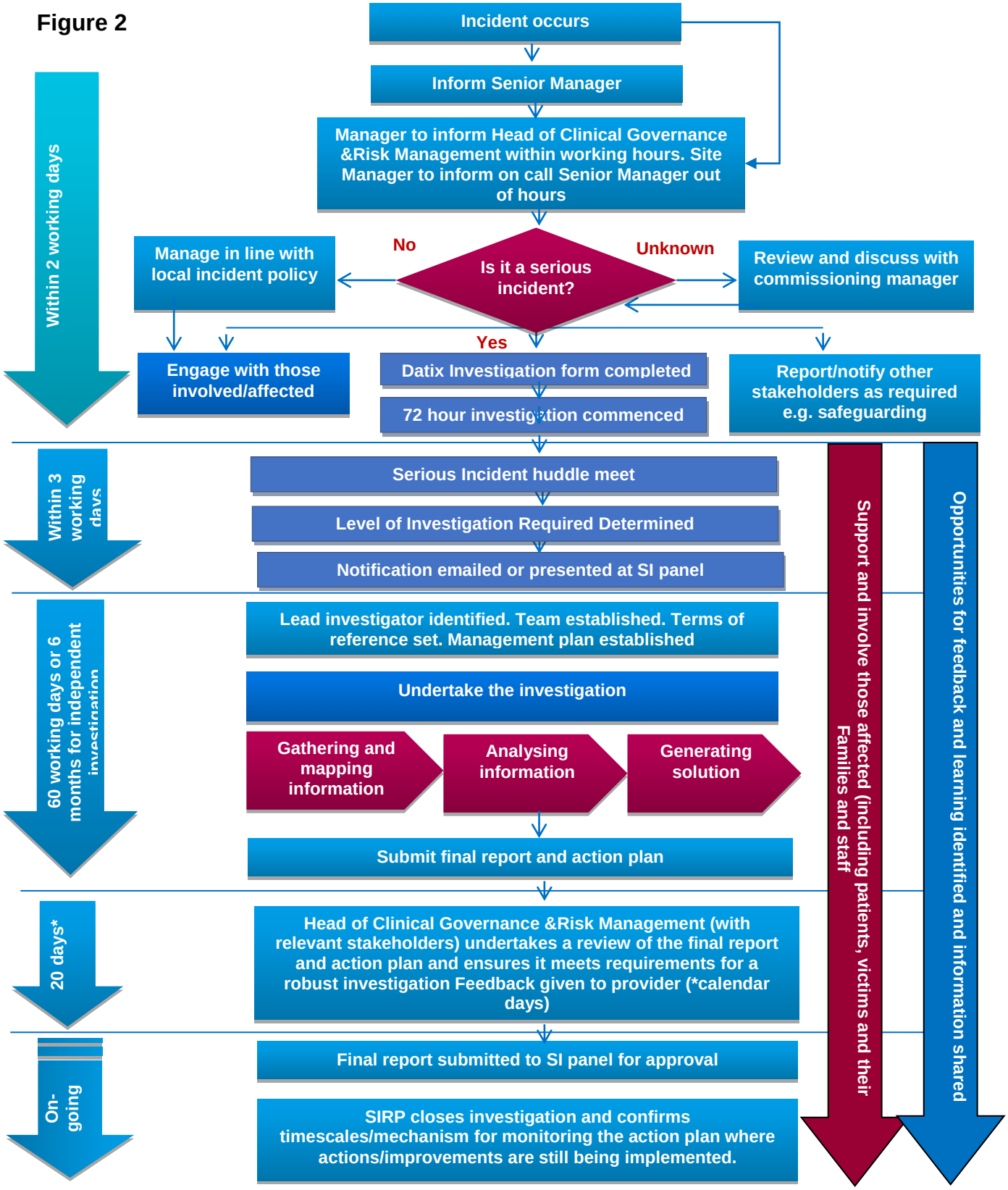
2.9. Media Enquiries

Any enquiries from the media must go through the communications officers in the hospital during working hours in order to ensure that there is a clear communication strategy. Media/ press relations are the responsibility of the Chief Executive Officer. Out of hours all requests for information should go via the Senior Manager on call.

3. PROCEDURE

3.1. Serious Incident Management Process

Figure 2



3.2. Identification of Serious Incidents

In many cases it will be immediately clear that a serious incident has occurred and further investigation will be required, however in circumstances where it is not clear whether or not an incident fulfils the definition of a serious incident, open and honest discussions need to be held to agree the appropriate and proportionate response. Serious incidents may be identified through various routes-

- Incidents identified during the provision of healthcare by a provider e.g. patient safety incidents or serious/distressing/catastrophic outcomes for those involved;
- Complaints
- Datix reports
- Allegations from a third party
- Initiation of other investigations, such as a Serious Case Review
- Whistleblowing

3.3. Immediate actions to be made when a Serious Incident is suspected

Serious Incidents or potential SI's should be notified as soon as possible to the Head of Clinical Governance and Risk Management, or in her absence the Patient Safety Officer who is responsible for pulling together an SI huddle and ensuring that the relevant information is cascaded to the SIR panel. Out of hours the duty senior manager on call should be informed in the first instance. The responsibility of the person first informed is to-

1. Arrange for any immediate actions required to ensure the safety of the patient(s)/ service user(s), other services users and staff.
2. Obtain all relevant physical, scientific and documentary evidence, and make sure it is secure and preserved. Initial actions of local managers in the collection and retention of information are important for the overall integrity of the investigation process
3. Identify witnesses, including staff, and other service users, to ensure they receive effective support.
4. Ensure the incident has been appropriately logged on the Datix system
5. Escalate the incident appropriately to the relevant people (see appendix 6)

If this occurred out of hours, and it may be more than 48 hours until 'normal working hours' the senior manager on call should consider the urgency of needing to start work on steps 6, 7 and 8. The Head of Clinical Governance and Risk Management (or their delegate) in collaboration with the relevant out of hour's manager will-

6. Identify an appropriate specialist/clinician to conduct an initial 72 hour incident review
7. Pull together a huddle in order to review the findings either immediately or with the 72 hour review, decide on whether it meets the threshold for an SI and determine the level of investigation required
8. Agree who will make the initial contact with those involved, or their family/carer(s). Where an individual(s) has been harmed by the actions of a patient, particular thought should be given to who is best placed to contact the victim and/or their family. Where necessary the provider must contact the police and agree with them who will make the initial contact with the victim(s),

their family/carer(s) and/or the perpetrator's family. Those involved should have a single point of contact within the organisation.

9. Complete a notification of a Serious Incident (see appendix 7) for submission to the SI panel

If there is some suspicion that a member of staff requires some management to work safely the Just Culture Guide (NHS 2018b) can be used to support a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely (see appendix 8)

If it is unclear as to whether a serious incident has occurred or not, it is better to err on the side of caution as an incident can be downgraded at any point in the investigation.

3.4. Levels of Serious Incidents

An SI huddle may be called straight away as it may be instantly clear from the immediate evidence available that an SI has occurred. If this is not clear the huddle may wait for the initial 72 hour investigation and information available from this before convening. The 72 hour review should take place regardless of when the huddle convene and should be recorded (see appendix 9). They should then determine whether a route cause analysis SI investigation is commissioned and at what level this will be. The nature, severity and complexity of serious incidents vary on a case-by-case basis. The level of response should therefore be dependent on the circumstances of each specific incident. Most SI's should be at level 2 and above, it is only in exceptional cases that level 1 SI's should be considered.

- **Level 1** investigations are concise internal investigations suited to less complex incidents.
- **Level 2** investigations are for more complex issues, which require multidisciplinary team involvement and some experts and/or specialist investigators.
- **Level 3**- An external review may be recommended by the panel when the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations

Once the huddle has made its decision the notification of an SI should be completed to update and inform the SIRP who ultimately have the decision to downgrade or deescalate a Serious Incident based on evidence gathered during the course of an investigation. The Lead Investigator, through the Head of Clinical Governance and Risk Management may request a downgrade of an incident and supple the evidence on which the decision should be made. A record of all such decisions should be kept. The Head of Clinical Governance and Risk Management will be responsible for liaising with external investigators and being the point of contact for all internal investigations. Further detail on the levels of investigation are outlined in appendix 1. For level 3 external reviews please see appendix 10 for additional guidance.

It is possible that the level of investigation may need to be reviewed and changed as new information or evidence emerges as part of the investigation process. The investigators should ensure that they update the SIRP panel via the Head of Clinical Governance and Risk Management of any significant changes or risks identified during their investigation.

3.5. Setting up a team

The SIRP panel may make recommendations on additions to, or the makeup of the investigation team, nominations should be provided by the relevant Managing Director of either Community and Social Services or the Hospital and the ultimate decision rests with the panel. The Head of Clinical Governance and Risk Management should provide an independent view to the panel in order to address any issues of conflict.

Investigation Team members must have-

- Knowledge of what constitutes an effective systems investigation process, and the skills/ competencies to lead and deliver this;
- Skills/ competencies in effective report writing and document formulation;
- Expertise in facilitating patient/family involvement;
- Understanding of the specialty involved – this often requires representation from more than one professional group to ensure investigation balance and credible;
- Responsibility for administration and documentation (or for there to be adequate administrative and IT support);
- Access to appropriate legal and/or information governance support where appropriate;
- Access to competent proof-reading services where required; and

The investigation team is also responsible for identifying valuable/ safety-critical learning to be shared at any stage of the investigation process. The team should not wait until completion of the investigation to highlight system weaknesses/ share valuable learning which may prevent future harm or imminent potential failings.

3.6. Terms of Reference

The Terms of Reference (TOR) for the investigation will be reviewed by the Serious Incident Huddle when they meet who will decide whether the standard TOR are adequate or whether additions need to be made to them. These will be shown to the SIR panel for oversight, they may also request additional TOR. The TOR will include;

1. Establish the factual circumstances surrounding [patient name]care in the [name of department/area] between [date] and [date]
2. Provide a chronology of the events
3. Identify care or service delivery issues, along with the factors that might have contributed to them. Establish if standard policy and procedure were followed.
4. Make clear, implementable recommendations related to key findings.
5. To look for improvements rather than to apportion blame

6. To establish how recurrence may be reduced or eliminated
7. To provide a means of *sharing learning* from the incident
8. To identify routes of *sharing learning* from the incident

The Terms of Reference should also make the expectations of the SIRP clear and that the investigation will be-

- Completed within 60 working days
- Conducted in a fair, comprehensive and impartial manner.
- Identify improvements and learning.
- The findings will be communicated in a report to the Serious Incident Review Panel.
- Once the report has been ratified by the SIRP, the patient and his/her family will have opportunity to meet to discuss the findings of the investigation, if they wish.

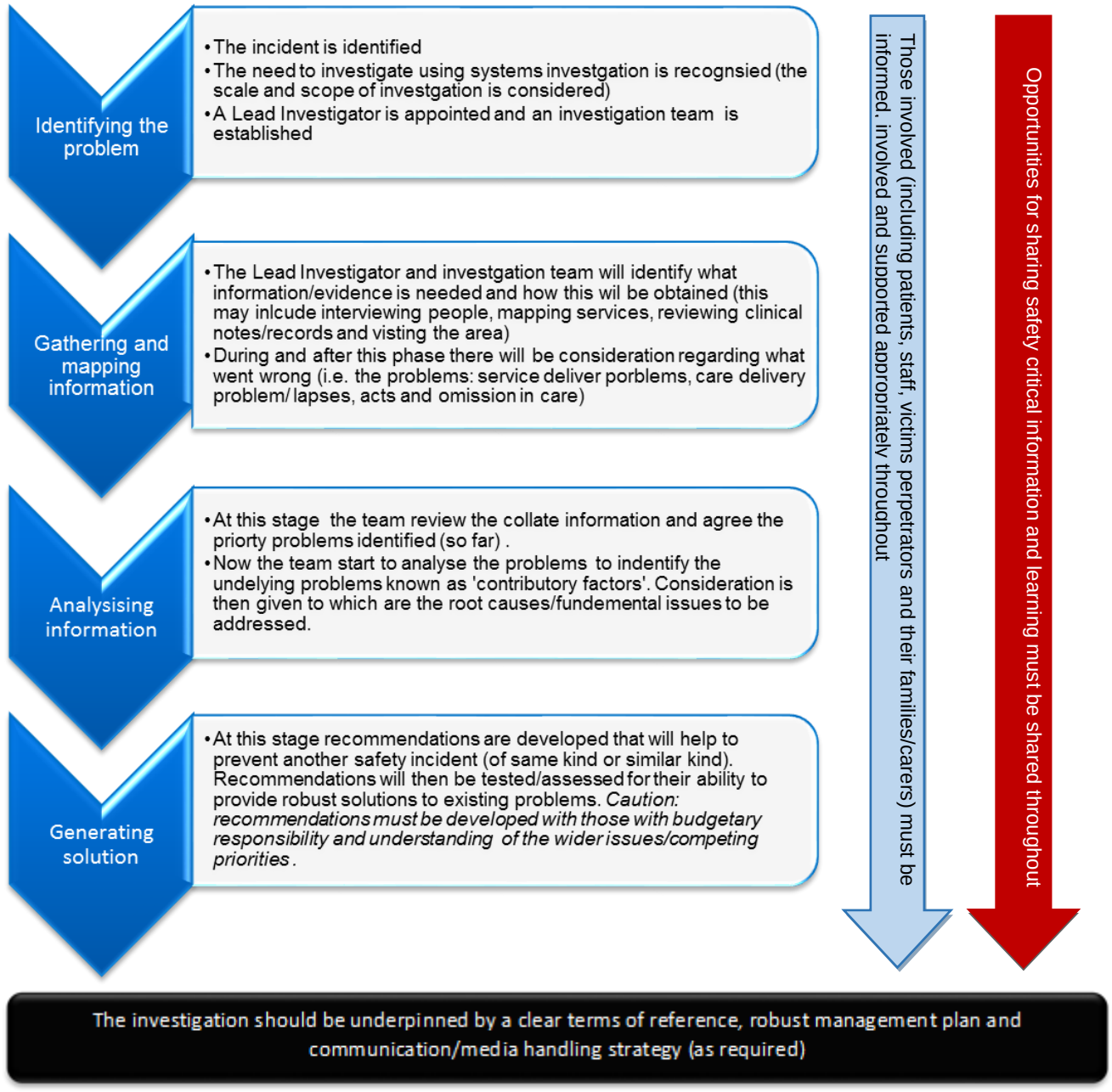
3.7. The Investigative Process

It is essential that the investigating team have a 'questioning attitude that never accepts the first response', and that they use the tools and techniques taught in RCA training in order to identify:

- The problems (the what?) including lapses in care/acts/omissions; and
- The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and
- The fundamental issues/root cause (the why?) that need to be addressed. See figure 3

Reports should not conclude that the actions of staff were the 'key causes' of the incident, or "the causal factors in the incident arise from failure to follow trust policy and procedures." without having very clear evidence to show that the reasons behind the failure to comply had been fully explored and that all unanswered questions or unexplained issues have been explored before leaving the focus on staff acts or omissions (CQC 2016).

Figure 3



NHS (2015)

3.8. Final Report and Recommendations

All reports should be completed using the appropriate hospital templates (see appendix 12 and 13). The report should:

- Be simple and easy to read;
- include the title of the document and state whether it is a draft or the final version;
- Include the version date, reference initials, document name, computer file path and page number in the footer;
- Disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest. This should however be considered by the Caldicott Guardian and where required confirmed by legal advice
- Include evidence and details of the methodology used for an investigation (for example timelines/cause and effect charts, brainstorming/brain writing, nominal group technique, use of a contributory factor Framework and fishbone diagrams, five whys and barrier analysis);
- Identify root causes and recommendations;
- Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable
- Include a description of how patients/victims and families have been engaged in the process;
- Include a description of the support provided to patients/victims/families and staff following the incident.

It should be clear from the report how the recommendations were considered and how they will reduce the risk of incidents happening again. They should not focus on reminding staff to follow the policy or single out individual staff members for supervisions/ retraining (CQC 2016).

Recommendations from each SI will be agreed by the SIRP panel, responsibility will then be allocated by the SIRP panel to the relevant Managing Director, Corporate Director or Chief Nurse. They will then be responsible for delegating to the relevant Divisional Lead or equivalent/ Head of Nursing or Clinical Director who will formulate the action plan within seven working days and present it back to them for approval. This will then be presented to the SIRP at the next meeting for monitoring of completion.

Action plans should be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions (not the investigator who has nothing to do with the service although clearly their recommendations must inform the action plan);

- Every recommendation must have a clearly articulated action that follows logically from the findings of the investigation;
- Actions should be designed and targeted to significantly reduce the risk of recurrence of the incident. It must target the weaknesses in the system (i.e. the ‘root causes’ /most significant influencing factors) which resulted in the

lapses/acts/omissions in care and treatment identified as causing or contributing towards the incident;

- A responsible person (job title only) must be identified for implementation of each action point;
- There are clear deadlines for completion of actions;
- There must be a description of the form of evidence that will be available to confirm completion and also to demonstrate the impact implementation has had on reducing the risk of recurrence;

The Integrated Governance Committee will seek assurance that recommendations are implemented through the Care Quality Groups, paying particular attention to those requiring additional support, significant investment or organisational change. This will be monitored by the SIRP and a quarterly report given to the Integrated Governance Committee.

3.9. Sign off and closure

Serious incident reports and recommendations must be submitted within 60 working days of the incident being reported to the Head of Clinical Governance and Risk Management, unless an independent investigation is required, in which case the deadline is 6 months from the date the investigation commenced. In specific circumstances, such as if the investigation is specifically complex or restraints are being set by outside agencies such as police/ safeguarding the viscount etc.. the SIRP can agree an alternative timeframe, which will be documented in the minutes of the SIRP and noted in the investigation report.

The report should be submitted to the Head of Clinical Governance and Risk Management who will provide quality assurance. The final report will then be presented, either by the head of of Clinical Governance and Risk Management or the Investigators to the SIRP, who will seek assurance that the report fulfils the required standard for a robust investigation and action plan. Any concerns or areas requiring further action should be highlighted at this time to the investigators in order tallow them the opportunity to facilitate timely action and resolution of issues raised.

Closure of an incident marks only the completion of the investigation process. The delivery and implementation of action and improvement may only just be beginning at this stage. Implementing change and improvement can take time, particularly where this relates to behavioural and cultural change. It is not unreasonable for improvements to take many months or even years in some cases.

4. DEVELOPMENT AND CONSULTATION PROCESS

4.10. Consultation Schedule

Name	Title of Individual	Date Consulted
Tarina Le Duc	Head of Clinical Governance and Risk Management	June 2017
Michelle West	Director of Operations Hospital	June 2017
Jason Turner	Director of Finance & Information Deputy CEO	June 2017
Gary Kynman	Deputy Director of Operations Hospital	June 2017
Judith Gindall	Divisional Lead Theatres & Anaesthetics and Women & Children	June 2017
Jackie Tardivel	Divisional Lead Medicine and Emergency Care	June 2017
Chris Sanderson	Deputy Director Operations & Divisional Lead Clinical Support Services	June 2017
Piers Andrews	Divisional Lead Operational Support Services	June 2017
Jo Poynter	Director of Operations Community and Social Services	June 2017
Gordon Muvuti	Interim Director Mental Health	June 2017
Rachel McBride	Acting Service Manager Older Adult Mental Health	June 2017
Marie Leeming	Head of Service, Mental Health	June 2017
Robert Gardner	Head of Learning Disability	June 2017
Chris Dunne	Director of Services for	June 2017
Ian Dyer	Director of Services for Older People	June 2017
Steve McVay	Head of Service- Adult Community Support Services	June 2017
Helen Jackson	Head of Service- Children's Safeguarding	June 2017
Chris Golbourn	Head of Service-Looked After Children	June 2017
Mandeep Gill	Head of Service- Children's Service	June 2017
Val Howard	Head of Governance C&SS	June 2017
Julie Mycock	Head of Midwifery	June 2017
Wendy Baugh	Lead Nurse- Hospital	June 2017
Ann Morgan	Lead Nurse- Hospital	June 2017
Jessie Marshall	Acting Lead Nurse- Hospital	June 2017
Paul McCabe	Chief Pharmacist	June 2017
Jan Warren	Health and Safety Manager	June 2017
Nick Cunningham	Director of Facilities	June 2017
Pete Gavey	Chief Ambulance Officer	June 2017
Jane Finlay	Drug and Alcohol Services	June 2017
Julie Le Masurier	Lead Nurse- Infection Prevention and Control	June 2017
Ivan Muscat	Director of Infection Prevention and Control	June 2017
Susan Walter	Safeguarding Designated Nurse	June 2017
Carol Brett	Tissue Viability Specialist Nurse	June 2017
Anna Adkin	Legal Administration Manager	June 2017
Tracey Fullerton	Information Governance and Legislation	June 2017

	Programme Manager	
Rachel Williams	Director - System Redesign and Delivery	June 2017
Rebecca Sherrington	System Redesign & Delivery manager	June 2017
Clare Fitton	Primary Care Manager	June 2017
Bronwen Whittaker	Deputy Director of System Redesign & Delivery	June 2017

External

Stewart Gull	States of Jersey Police	February 2018
Caroline White	CNA/Hardy (Insurers)	June 2017

Name of Committee/Group	**Date of Committee/Group meeting**
Serious Incident Review Panel	June 2017
Policy and Procedures	September 2017

5. REFERENCE DOCUMENTS

Care Quality Committee (2016) BRIEFING- Learning from serious incidents in NHS acute hospitals, A review of the quality of investigation reports available at https://www.cqc.org.uk/sites/default/files/20160608_learning_from_harm_briefing_paper.pdf accessed May 2017

National Health Service England (2015a) Serious Incident Framework- Supporting learning to prevent recurrence, available at https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf accessed May 2017

National Health Service England (2015b) Revised Never Events Policy and Framework, available at https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/never-evnts-pol-framwrk-apr2.pdf accessed May 2017

National Health Service (2016) Serious Incident Framework 2015/16- frequently asked questions, available at https://www.england.nhs.uk/wp-content/uploads/2015/03/serious-incident-framwrk-15-16-faqs-fin.pdf accessed May 2017

National Health Service Improvements (2018) Never Events list 2018, available at https://improvement.nhs.uk/resources/never-events-policy-and-framework/ accessed March 2018

National Health Service Improvements (2018b) A Just Culture Guide, available at https://improvement.nhs.uk/resources/just-culture-guide/ accessed March 2018

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National Health Service England (2015a) Serious Incident Framework- Supporting learning to prevent recurrence, available at https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf accessed August 2017

National Health Service (2017) Managing Safety Incidents in NHS Screening Programmes, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/639504/Managing_Safety_Incidents_in_NHS_screening_programmes.pdf accessed August 2017

Health and Social Care Information Centre (2015) Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation, available at https://www.igt.hscic.gov.uk/resources/HSCIC%20SIRI%20Reporting%20and%20Checklist%20Guidance.pdf accessed August 2017

14. IMPLEMENTATION PLAN

Action	Responsible Officer	Timeframe
Present to SIR panel	Pam Le Sueur	September 2017
Arrange training in Root Cause Analysis for Relevant Managers and Clinicians	Pam Le Sueur	September 2017
Launch at Morbidity and Mortality Meeting	Pam Le Sueur	March 2018
Present at Sisters Meetings in the Hospital and Community	Pam Le Sueur	March 2018
Present at Operational Management Group	Pam Le Sueur	April 2018
Upload to Intranet and send HSSD Email	Pam Le Sueur	March 2018
Ensure staff and patient information Leaflets are available in relevant clinical areas and with Hospital and Community Governance Teams	Pam Le Sueur	April 2018

7. APPENDICES

Appendix 1: Suicides in contact with Mental Health Services

All suicides of people who have had contact with Mental Health within the last 6 months should have a Serious Incident investigation completed. This guidance from the NHS is to comply with Article 2 of the European Convention on Human Rights as detailed below.

Department of Health

Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services

November 2015

Introduction

1. This advice provides detail for NHS organisations on the factors to be taken into account when deciding whether an independent investigation needs to be carried out to satisfy (in whole or part) the State's obligations under Article 2 of the European Convention on Human Rights. NHS England and NHS bodies are public authorities who must comply with the Human Rights Act 1998 and the European Convention on Human Rights. NHS bodies implicated in serious incidents may be considered to be 'State agents' for the purposes of Article 2.

Context

2. In the NHS, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents that affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. The procedures to be followed when managing a serious incident are set out in the NHS England Serious Incident Framework – Supporting learning to prevent recurrence (the Framework) published in March 2015.

3. This advice, when read in conjunction with the Framework, replaces the DH guidance issued in 2005 (Independent Investigations of adverse events in mental health services).

Article 2 of the European Convention on Human Rights

4. Article 2 imposes a procedural obligation on the State to conduct an investigation in circumstances including:

- where the person has died while detained (for example under the Mental Health Act 1983); or has attempted suicide while so detained and has sustained serious injury (or potentially serious injury);
- where the State owed a duty to take reasonable steps to protect the person's life because the person was under the State's control or care and the State knew (or ought to have known) there was a real and immediate risk to the person's life. This could include voluntary psychiatric patients (eg Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2); and
- where the person was killed by an agent of the State.

5. An investigation conducted for the purposes of Article 2 is intended to open up the circumstances, correct mistakes, identify good practice and learn lessons for the future so as to prevent recurrence of similar incidents.

6. To satisfy this procedural obligation, the State must initiate an investigation that is reasonably prompt, effective, carried out by a person who is independent of those implicated, provides a sufficient element of public scrutiny and involves the next of kin to an appropriate extent.

7. A coroner's inquest is the means by which the state ordinarily discharges the procedural obligation – indeed inquests often go beyond the strict requirements of Article 2. The inquest will often be assisted by earlier investigations (independent or otherwise).

8. However, where a person detained under the Mental Health Act 1983, or a person in state control or care (in the sense set out at paragraph 4, the second bullet point, above), has attempted suicide and has sustained serious injury (or potentially serious injury), there will be no inquest because an inquest may be held only in the event of a death. In those circumstances, an investigation must be carried out to satisfy the State's obligations under Article 2.

9. Article 2 imposes a general positive duty on the State to have a system to protect life. An investigation should be considered where it may be necessary to examine the causation of a serious incident or multiple serious incidents (e.g. a cluster of suicides) that could indicate systemic failures to protect life. Such an investigation could look at the role of the wider commissioning system or configuration of services (involving multi-agencies/organisations).

10. NHS bodies should consider taking their own legal advice on whether, in a particular case, it would be appropriate for those carrying out the investigation to be employed by or be accountable to an entirely separate organisation than that which was responsible for providing the care in which the incident occurred (a Level 3 investigation under the Framework). Where this is required, it is the

responsibility of the commissioners of the care in which the incident occurred to commission that investigation. Alternatively, it might be appropriate for the investigation to be carried out by someone employed by the NHS body responsible for the care in question, provided that person is independent of those implicated (a Level 1 or 2 investigation under the Framework).

Appendix 2: Never Events List 2018 (NHS 2018)

The following never events list has been taken from the NHS (2015b) Never Event Policy. It is applicable for all incidents that occur on or after 1 April 2015.

SURGICAL
1. Wrong site surgery A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, wrong tooth or wrong organ); the incident is detected at any time after the start of the procedure. • Includes wrong level spinal surgery and interventions that are considered surgical but may be done outside of a surgical environment e.g. wrong site block (unless being undertaken as a pain control procedure), biopsy, interventional radiology procedures, cardiology procedures, drain insertion and line insertion e.g. PICC/ Hickman lines. This also includes teeth that are extracted in error and immediately reinplanted • Excludes interventions where the wrong site is selected because of unknown/unexpected abnormalities in the patient's anatomy. This should be documented in the patient's notes. • Excludes incidents where the wrong site surgery is due to incorrect laboratory reports/ results or incorrect referral letters • Excludes removal of wrong primary teeth (unless done under general anaesthetic) • Excludes contraceptive hormone injection into the wrong arm **Setting:** All patients receiving HSSD care.
2. Wrong implant/prosthesis Placement of an implant/prosthesis different from that specified in the procedural plan, either before or during the procedure. The incident is detected any time after the implant/prosthesis is placed in the patient. **Excludes:** • placed implant/prosthesis is intentionally different from that specified in the surgical plan, based on clinical judgement at the time of the procedure • specified implant/prosthesis is placed as planned but later found to be suboptimal • implant/ prosthesis is different from the one specified due to incorrect preprocedural measurements or incorrect interpretation of the preprocedural data – for example, wrong intraocular lens placed due to wrong biometry or using wrong dataset from correct biometry. **Includes:** • implantation of an intrauterine contraceptive device different from the one in the procedural plan.

Setting: All patients receiving HSSD care.

3. Retained foreign object post-procedure

'Foreign object' includes any items subject to a formal counting/checking process at the start of the procedure and before its completion (such as for swabs, needles, instruments and guidewires) **except** where items:

- not subject to the formal counting/checking process are inserted any time before the procedure, with the intention of removing them during the procedure but they are not removed
- subject to the counting/checking process are inserted during the procedure and then intentionally retained after its completion, with removal planned for a later time or date as clearly recorded in the patient's notes
- are known to be missing before completion of the procedure and may be inside the patient (eg screw fragments, drill bits) but action to locate and/or retrieve them is impossible or more damaging than retention.

Settings: All patients receiving HSSD care

MEDICATION

4. Mis–selection of a strong potassium containing solution

Mis-selection refers to:

- When a patient intravenously receives a strong potassium solution rather than an intended different medication

Setting: All patients receiving HSSD care.

5. Wrong route administration of medication

The patient receives one of the following:

- Intravenous chemotherapy administered via the intrathecal route
- Oral/enteral medication or feed/flush administered by any parenteral route
- Intravenous administration of a medicine intended to be administered via the epidural route *

* During the transition period for the introduction of NRFit™ devices, the 'intravenous administration of a medicine intended to be administered by the epidural route' cannot be considered a Never Event. Please check for updates

Setting: All patients receiving HSSD care.

6. Overdose of Insulin due to abbreviations or incorrect device

Overdose refers to when:

- a patient is given a 10-fold or greater overdose of insulin because the words 'unit' or 'international units' are abbreviated; such an overdose was given in a care setting with an electronic prescribing system
- a healthcare professional fails to use a specific insulin administration device

– that is, an insulin syringe or pen is not used to measure the insulin
- a healthcare professional withdraws insulin from an insulin pen or pen refill and then administers this using a syringe and needle.

Setting: All patients receiving HSSD care.

7. Overdose of methotrexate for non-cancer treatment

Overdose refers to when:
- a patient is given a dose of methotrexate, by any route, for non-cancer treatment that is more than the intended weekly dose; such an overdose was given in a care setting with an electronic prescribing system.

Setting: All patients receiving HSSD care.

8. Mis – selection of high strength midazolam during conscious sedation

- a patient is given an overdose of midazolam due to the selection of a high strength preparation (5 mg/mL or 2 mg/mL) instead of the 1 mg/mL preparation, in a clinical area performing conscious sedation
- excludes clinical areas where the use of high strength midazolam is appropriate; these are generally only those performing general anaesthesia, intensive care, palliative care, or areas where its use has been formally risk-assessed in the organisation.

Setting: All healthcare premises.

MENTAL HEALTH

9. Failure to install functional collapsible shower or curtain rails

Involves either:
- failure of collapsible curtain or shower rails to collapse when an inpatient attempts or completes a suicide
- failure to install collapsible rails and an inpatient attempts or completes a suicide using non-collapsible rails.

Setting: All mental health inpatient premises.

GENERAL

10. Falls from poorly restricted windows

A patient falling from poorly restricted window.
- Applies to windows “within reach” of patients. This means windows (including the window sill) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to assist in climbing out of the window.
- Includes windows located in facilities/areas where healthcare is provided

and where patients can and do access.
- Includes where patients deliberately or accidentally fall from a window where a restrictor has been fitted but previously damaged or disabled, but does not include events where a patient deliberately disables a restrictor or breaks the window immediately before the fall.
- Includes where patients are able to deliberately overcome a window restrictor by hand or using commonly available flat bladed instruments as well as the 'key' provided.

Setting: All patients receiving HSSD funded care

11. Chest or neck entrapment in bedrails

Entrapment of a patient's chest or neck within bedrails, or between bedrails, bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance

Setting: All patients receiving HSSD funded care

12. Transfusion or transplantation of ABO-incompatible blood components or organs

Unintentional transfusion of ABO-incompatible blood components.

Excludes:
- where ABO-incompatible blood components are deliberately transfused with appropriate management.

Unintentional ABO-mismatched solid organ transplantation.

Excludes:
- situations in which clinically appropriate ABO-incompatible solid organs are deliberately transplanted.

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, the inadvertent transplantation of that organ without appropriate management is a Never Event.
Setting: All patients receiving HSSD care.

14. Scalding of patients

Patient scalded by water used for washing/bathing.

Excludes:

- scalds from water being used for purposes other than washing/bathing (eg from kettles).

Settings: All patients receiving HSSD funded care.

15. Unintentional connection of a patient requiring oxygen to an air flowmeter

This applies when a patient who requires oxygen is connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter.

Excludes:

- unintentional connection to an air cylinder instead of an oxygen cylinder as robust barriers to prevent this have not yet been identified.

Setting: All settings providing HSSD funded care.

16. Undetected oesophageal intubation

This Never Event has been temporarily suspended pending further clarification.

Appendix 3: Mini Root Cause Analysis- Pressure Ulcers

States of Jersey

The States of Jersey Department for Health & Social Services

Concise Root Cause Analysis – Pressure ulcers

Organisation:	States of Jersey Health & Social Services Department
Incident Investigation Title:	
Incident Number:	
Investigating Team and job titles:	
Report Date:	
Date presented to Panel & Teams:	
Approval Date:	
Date to Patient or Client Family	

Patient Details			
Patient's name		Age	
Datix no			
URN		DOB	
Ward			

Assessment and findings					
1.	Date pressure ulcer detected/date deterioration of ulcer detected				
2.	Where was the person resident when the pressure ulcer was acquired				
3.	Current Waterlow score	Score		Date	
4.	Previous Waterlow score	Score		Date	
5.	Location and size of pressure ulcer(s)				
6.	Grade / stage of pressure ulcer(s)				
7.	Reason for admission / transfer?				
8.	Outline any **relevant** past medical history				
9.	Has a movement and handling assessment been carried out? (delete as appropriate)			Yes	No
10.	Were there delays in:				
	• using appropriate preventative equipment			Yes	No
	• providing nursing care			Yes	No
	If yes – please state reason				
11.	Comments / additional information:				

12.	Has there been a rapid onset / deterioration of skin integrity? (delete as appropriate)	Yes	No
13.	Has there been a change in medical condition? (delete as appropriate)	Yes	No
	If yes, explain briefly:		
14.	Were reasonable steps taken to prevent skin damage?	Yes	No
	Appropriate pressure relieving mattress (delete as appropriate)	Yes	No
	Regular turning (delete as appropriate)	Yes	No
	Heel protectors (delete as appropriate)	Yes	No
	Pressure relieving cushion (delete as appropriate)	Yes	No
	Regular skin checks (delete as appropriate)	Yes	No
	Other (please specify)		
15.	Were the pressure areas and any skin breaks monitored regularly	Yes	No
16.	Were treatments and care plans altered as necessary and recorded	Yes	No
17.	Was there concordance with the care plan?	Yes	No
18.	If no – please explain what the issues were:		
19.	Did the patient have capacity to make informed decisions?	Yes	No
	Was the capacity assessment recorded	Yes	No
	Are / were there concerns regarding family / carers?	Yes	No
	Is a safeguarding referral needed?	Yes	No
20.	Were agreed protocols followed? (delete as appropriate)	Yes	No
21.	**Summary of findings**		
22.	**Root causes –** what caused the pressure ulcer to develop / deteriorate?		
23.	Is there any concern about nursing care? (delete as appropriate)	Yes	No
	If yes please provide detail		
24.	What are the **lessons learned** (if any)?		

25.	**Actions** to be taken to address any lessons learned	By when	action plan	To be added (Y/N)
	•			
	•			
	•			
26.	If any actions are **not** being added to the action plan please specify monitoring arrangements			
27.	Being open (duty of candour) for **PUs grade 3 / 4** please detail discussion/s with the patient (family / carers if the patient consents / does not have capacity) about the pressure ulcers			

		Date:

Appendix 4: Patient Information Leaflet

What happens if I am involved in a serious incident

You and /or your relatives / carers will be informed if you are involved in a serious incident and that an investigation will take place. Sometimes you will be asked some questions to help with gathering the facts or you may have questions that you would like the investigation team to answer as part of the investigation.

You can choose to have a face-to-face meeting with the Head of Clinical Governance and Risk Management or the relevant clinicians to discuss the investigation process. If you have any questions that you would like answering please let us know at that meeting or you can provide the questions by phone, post or e-mail.

You may also want to meet with the investigators, or they may ask to meet with you to help as part of their investigation into the root cause of the incident. Once the investigation report has been completed we will share a copy of this with you. You can choose to have a copy of the report either by post / e-mail or a meeting can be arranged with the relevant clinicians or managers to discuss the investigation and then you can receive a copy in person. If you choose to have a copy of the report sent to you but then decide that you would like to attend a meeting this can be arranged.

Who can I contact regarding the investigation

You will be advised who is the best member of staff to contact if you have any specific questions you wish to ask; this may be the Head of Clinical Governance and Risk Management or a Senior Clinician. You will be given a contact phone number for this member of staff. This member of staff will be able to let you know how the RCA is progressing.

Your contact:

Name:

Role:

Telephone no:

States of Jersey

The States of Jersey Department for Health & Social Services

Patient/ Relative Information

Serious Incidents

This leaflet gives you information about Serious Incidents (SIs). It explains what an SI is and what happens if one occurs. It also tells you about the process for investigating a serious incident

What is a Patient Safety Incident

An incident is defined as any unintended or unexpected event which could have resulted in or did result in harm to a patient, staff, visitor or member of the public

Serious Incidents requiring investigation is defined as an incident that occurred in relation to HSSD funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical / medical intervention
- Permanent harm or shortening of life expectancy
- Prolonged pain or psychological harm
- Allegations of abuse

If a serious incident happens we need to understand how it happened and learn from this so that we can try to stop it happening again in the future. To do this we investigate the incident by undertaking a Root Cause Analysis (RCA).

How is a serious patient safety incident managed

A group of Senior HSSD Managers and Clinicians will decide if the incident meets the criteria for a serious incident. If it meets the threshold they will then start the review and organise an investigation of the incident.

What is involved in a Root Cause Analysis (RCA)

The lead investigator will arrange a meeting for an appropriate group of staff, who have not been directly involved in the incident, to review the incident information which is gathered prior to the meeting. This usually includes:

- A timeline of events leading up to the incident
- Staff statements or interview notes
- Copies of relevant documents such as policies / clinical guidelines
- Nursing / midwifery notes and medical case notes

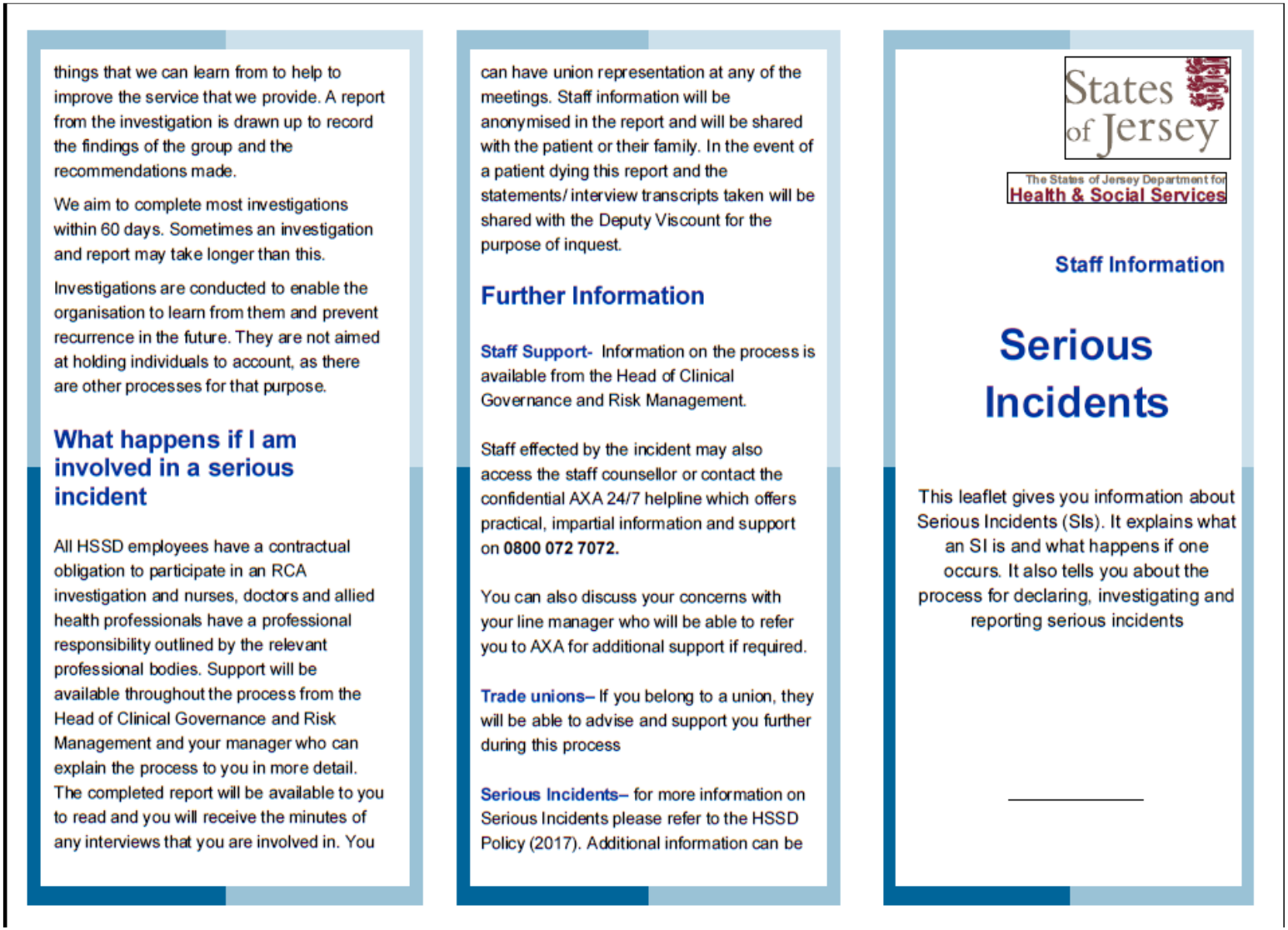
Other information may be required such as staff rotas, training records and equipment records etc. This other information depends upon the nature of the incident.

The investigators review the information and discuss any problems with the care or the service provided that may have caused the incident or made it more likely to happen. They then look at the factors linked to the problems to decide which factor/s was the most significant, the "root cause" of the incident. If a root cause has been identified then the group make recommendations for actions to either prevent the incident happening again or to reduce the chances of it happening again.

Sometimes there is no root cause of an incident but an investigation will usually find things that we can learn from to help to improve the service that we provide. A report from the investigation is drawn up to record the findings of the group and the recommendations made. We aim to complete most investigations within 60 days. Sometimes an investigation and report may take longer than this.

Investigations are conducted to enable the organisation to learn from them and prevent

Appendix 5: Staff Information Leaflet



things that we can learn from to help to improve the service that we provide. A report from the investigation is drawn up to record the findings of the group and the recommendations made.

We aim to complete most investigations within 60 days. Sometimes an investigation and report may take longer than this.

Investigations are conducted to enable the organisation to learn from them and prevent recurrence in the future. They are not aimed at holding individuals to account, as there are other processes for that purpose.

What happens if I am involved in a serious incident

All HSSD employees have a contractual obligation to participate in an RCA investigation and nurses, doctors and allied health professionals have a professional responsibility outlined by the relevant professional bodies. Support will be available throughout the process from the Head of Clinical Governance and Risk Management and your manager who can explain the process to you in more detail. The completed report will be available to you to read and you will receive the minutes of any interviews that you are involved in. You can have union representation at any of the meetings. Staff information will be anonymised in the report and will be shared with the patient or their family. In the event of a patient dying this report and the statements/ interview transcripts taken will be shared with the Deputy Viscount for the purpose of inquest.

Further Information

Staff Support- Information on the process is available from the Head of Clinical Governance and Risk Management.

Staff effected by the incident may also access the staff counsellor or contact the confidential AXA 24/7 helpline which offers practical, impartial information and support on **0800 072 7072.**

You can also discuss your concerns with your line manager who will be able to refer you to AXA for additional support if required.

Trade unions– If you belong to a union, they will be able to advise and support you further during this process

Serious Incidents– for more information on Serious Incidents please refer to the HSSD Policy (2017). Additional information can be

States of Jersey

The States of Jersey Department for Health & Social Services

Staff Information

Serious Incidents

This leaflet gives you information about Serious Incidents (SIs). It explains what an SI is and what happens if one occurs. It also tells you about the process for declaring, investigating and reporting serious incidents

What is a Patient Safety Incident

An incident is defined as any unintended or unexpected event which could have resulted in or did result in harm to a patient, staff, visitor or member of the public

Serious Incidents requiring investigation are defined as an incident that occurred in relation to HSSD funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical / medical intervention
- Permanent harm or shortening of life expectancy
- Prolonged pain or psychological harm
- Allegations of abuse

If a serious incident happens we need to understand how it happened and learn from this so that we can try to stop it happening again in the future. To do this we investigate the incident by undertaking a Root Cause Analysis (RCA).

How is a serious patient safety incident managed

A small group of Senior HSSD Managers and Clinicians will meet and decide if the incident meets the criteria for a serious incident, they will then ask for a 72 hour review if this has not already been started. The information will then be put into a notification to the Serious Incident Review Panel chaired by the Chief Executive of HSSD as they are ultimately responsible for all SI investigations. If an SI investigation reaches the required threshold they will then decide on a level for the investigation. Level 1 investigations and short concise investigations suited to less complex cases. Most investigations will be level 2 investigations, which have 2 investigators and are more comprehensive investigation suited to more complex cases. On occasion an external/ level 3 investigation will be commissioned in order to provide us with an independent opinion.

What is involved in a Root Cause Analysis (RCA)

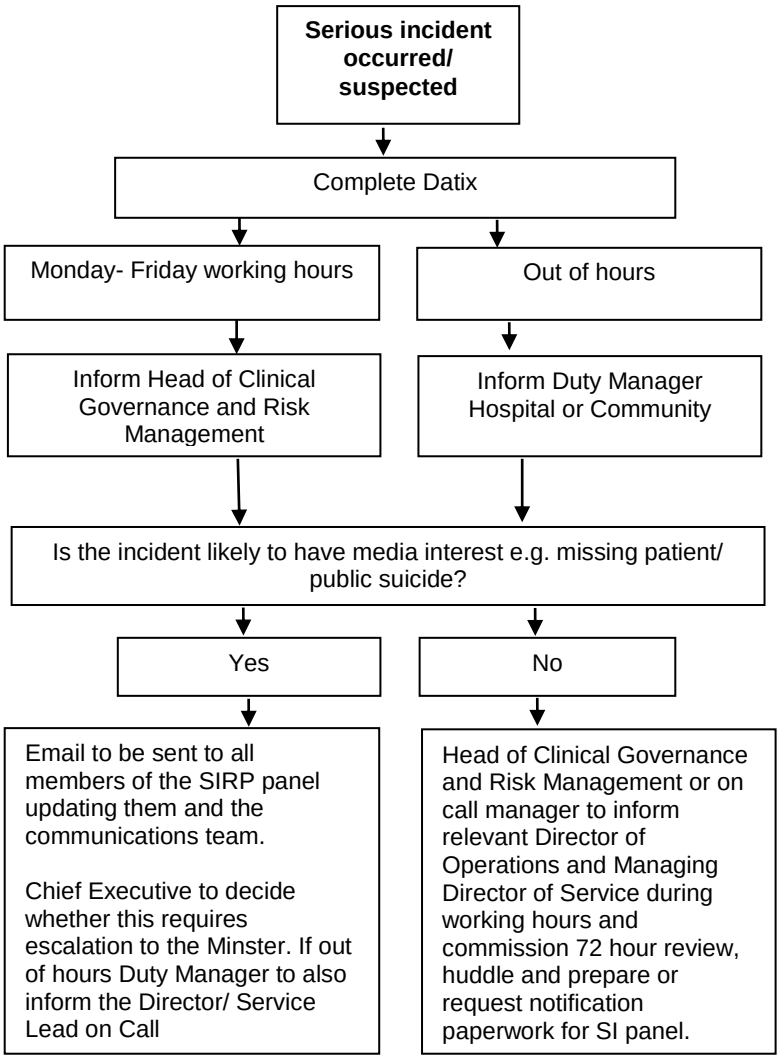
Two investigators will generally be appointed one of whom will have completed RCA training. The lead investigator will arrange a meeting to review the incident information gathered. This usually includes:

- A timeline of events leading up to the incident
- Staff statements or interview notes (if available at the time)
- The 72 hour review
- Copies of relevant documents such as policies / clinical guidelines
- Nursing / midwifery notes and medical case notes

Other information may be required such as staff rotas, training records and equipment records etc. The additional information depends upon the nature of the incident. They will then interview relevant staff and these meetings will be minuted. Reports from staff may also be requested. In the case of the death of a patient it is likely that an inquest will be opened and staff statements will be requested by the Deputy Viscount, these will go via the Head of Clinical Governance and Risk Management to be checked by our legal advisors. These are also made available to the investigators to avoid duplication of work.

The investigators review all of the information and discuss any problems with the care or the service provided that may have caused the incident or made it more likely to happen. They then look at the factors linked to the problems to decide which factor/s was the most significant, the “root cause” of the incident. If a root cause has been identified

Appendix 6: Escalation Pathway for Serious Incidents



List of SIRP
Chief Executive
Chief Nurse
Manging Director Hospital
Managing Director Community
Medical Director- Hospital
Medical Director- Community and Social Services
Medical Director- Primary Care
Assistant Medical Director
Head of Clinical Governance and Risk Management
Medical Officer of Health
Head of Nursing and Governance – Hospital
Head of Nursing and Governance – Community and Social Services

Appendix 7: Notification of a Serious Incident

The States of Jersey Department for Health & Social Services

States of Jersey

Serious Incident Notification Form/Decision Record

Name of Person Reporting	
Post Held	
Date of Reporting	
Date of Incident	
Time of Incident	
Site of Incident	
SI huddle date	
Datix Incident Report Number	
Ward/Department/Service	
Name of Affected Person(s)	
URN	
Date of Birth	

Nature of Incident (e.g. Surgical, Medication Incident, Fire)
Full Details of Incident

Affected Person and/or Relatives Informed of Incident? If No, please explain why person/relatives have not been informed

Action Taken Immediately Following Incident
SI Huddle Decision
Internal/External Stakeholders which have been/need to be informed
Details of any anticipated media and/or political interest

Investigation Commissioned:		Yes		No
RCA Level:				
SIRP Members Making Decision:				
Date:				
Name of Responsible Director:				
Date:				
Lead Investigator:				
Date Agreed:				
Other Investigator(s):				
Date Agreed:				
Date Final Report Due:				

Appendix 8: A Just Culture Guide

NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. **Was there any intention to cause harm?**

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. END HERE

No go to next question - **Q2. health test**

2a. **Are there indications of substance abuse?**

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. END HERE

2b. **Are there indications of physical ill health?**

2c. **Are there indications of mental ill health?**

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. **Are there agreed protocols/accepted practice in place that apply to the action/omission in question?**

3b. **Were the protocols/accepted practice workable and in routine use?**

3c. **Did the individual knowingly depart from these protocols?**

If **No** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. **Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?**

4b. **Was the individual missed out when relevant training was provided to their peer group?**

4c. **Did more senior members of the team fail to provide supervision that normally should be provided?**

If **Yes** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. **Were there any significant mitigating circumstances?**

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by: Academy of Medical Royal Colleges; avma action against medical accidents; Care Quality Commission; General Medical Council; National Guardian Freedom to Speak Up; NMC Nursing & Midwifery Council; NHS England; Royal College of Nursing

collaboration trust respect innovation courage compassion

Additional information can be found at https://improvement.nhs.uk/resources/just-culture-guide/

Appendix 9: Levels of Serious Incidents

States of Jersey

The States of Jersey Department for
Health & Social Services

72 hour Update Report

Organisation:	States of Jersey Health & Social Services Department
Date of Incident:	
Datix no:	
Investigating Team and job titles:	
Date of 3 day update report:	

Patient Details			
Patient's name		Age	
URN		DOB	
Ward			

Initial Incident Details	
Incident Description:	

Additional Incident Details

1. **Provide any further details regarding the incident**

2. Immediate actions taken to ensure the safety of patients, staff and the public
3. Duty of Candour progress (action taken and planned action)
4. Any impact on service delivery
5. Detail any external agencies involved i.e. Coroner, Police, Media
6. Any safeguarding concerns
7. Additional Information or findings
8. Recommendations of the Investigators (optional)

Appendix 10: Levels of Serious Incident

Information in this table provides an outline of the levels of systems-based investigations recognised in the NHS (currently referred to as RCA investigation). Within the NHS, most serious incidents are investigated internally using a comprehensive investigation approach.				
Level	**Application**	**Product/ outcome**	**Owner**	**Timescale for completion**
Level 1 **Concise internal investigation**	Suited to less complex incidents which can be managed by individuals or a small group at a local level	Concise/ compact investigation report which includes the essentials of a credible investigation	Provider organisation in which the incident occurred, providing principles for objectivity are upheld	Internal investigations, whether concise or comprehensive must be completed within 60 working days of the incident being reported All internal investigation should be supported by a clear investigation management plan
Level 2 **Comprehensive internal investigation** (this includes those with an independent element or full independent investigations commissioned by the provider)	Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable	Comprehensive investigation report including all elements of a credible investigation	Provider organisation in which the incident occurred, providing principles for objectivity are upheld. Providers may wish to commission an independent investigation or involve independent members as part of the investigation team to add a level of external scrutiny/objectivity	
Level 3 **Independent investigation**	Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved (see Appendix 1 and 3 for further details)	Comprehensive investigation report including all elements of a credible investigation	The investigator and **all** members of the investigation team must be independent of the provider. To fulfil independency the investigation must be commissioned and undertaken entirely independently of the organisation whose actions and processes are being investigated.	6 months from the date the investigation is commissioned
HSSD standard reporting templates should be used				

Appendix 11: External Investigations

The decision to commission an independent investigation can be made at any stage of the incident management process, depending on the nature and circumstances of the incident. In order to ensure independence and avoid any conflict of interest, no member of the independent investigation team can be in the employment of HSSD, nor should they have had any clinical involvement with the individual(s) to whom the investigation relates. Investigators must declare any connectivity that might, or might appear to, compromise the integrity of the investigation and adhere to the following principles-

Investigators must:

- Carry out their work with professionalism, integrity, sensitivity and courtesy;
- Evaluate the standard of care delivered by the provider objectively;
- Report fairly and without favour;
- Communicate clearly and objectively using accessible language;
- Act in the best interests of patients;
- Respect the confidentiality of information received and judgements made before, during and after the investigation;
- At all times adhere to the requirements outlined in the Terms of Reference; and
- Pay close regard to legal requirements for safeguarding the welfare of patients

Investigators must ensure that their recommendations are;

- Comprehensive, in that they cover all the requirements of the investigations Terms of Reference;
- Consistent, in that the evaluations of the evidence do not contradict one another;
- Reliable, in that they are based on consistent application of the evaluative criteria i.e. extent to which that care corresponded with statutory obligations, relevant national guidance, Trust policies, including any team or service operational policies and professional standards; and
- Objective, in that the actions of the provider are fully and fairly evaluated and recommendation are made in the best interests of patients.

Members of investigation teams need to be properly appointed with formal appointment letters and a Lead Investigator must be identified from the outset. The skills and expertise of the independent investigation team appointed must include the following:

- Relevant clinical, social care and managerial expertise.
- Expert investigation skills such as Root Cause Analysis.
- Interviewing and communication skills.
- Understanding of the independent investigation process.
- Excellent report writing skills.

- An understanding of the treatment of witnesses.
- Other specific skills and expertise may be required as is specific to each case, and should be determined by the person commissioning the investigation and/or SIRP
- Verbal communication skills including, if required, giving evidence in Court.

The draft report should be sent to the organisations that commissioned, where it will be shared at the SIRP and sent to the relevant stakeholders including the patient/family involved. The commissioner of the investigation will send a copy of the draft report to the relevant bodies to check for factual accuracy only. There should not be any amendments to any outcomes or recommendations detailed within the report. The SIRP or delegated person should review the report and provide an updated action plan based on recommendations/ findings.

Appendix 12: Level 1- Concise RCA report template

States of Jersey

The States of Jersey Department for Health & Social Services

Concise Root Case Analysis Investigation Report
Level 1 investigations

Organisation:	States of Jersey Health & Social Services Department
Incident Investigation Title:	
Incident Number:	
Investigating Team and job titles:	
Report Date:	
Page Numbers:	
Date presented to Panel & Teams:	
Approval Date:	
Date to Patient or Client Family	

1. Incident Description and Consequences

1.1 Incident description:

1.2 Incident date:

1.3 Incident type:

1.4 Speciality

1.5 Actual effects on patient:

1.6 Actual Severity of the incident:

1.6.a Example

2. Involvement and Support of patients and relatives

E.g. Meetings to discuss questions the patient anticipates the investigation will address and to hear their recollection of events (anonymised in line with the patient / relatives wishes).

E.g. Point of contact for family appointed, information given on sources of independent support.

2.1 Example

2.2 Example

2.3 Example

Findings

3. Detection of Incident

3.1 Example

3.2 Example

3.3 Example

4. Care and service delivery problems

4.1 Example

4.2 Example

5. Contributory factors

5.1 Example

5.2 Example

6. Root cause

6.1 Example

6.2 Example

7. Lessons Learnt

7.1 Example

Conclusion

8. Recommendations

1. **Example**
2. **Example**
3. **Example**

9. Arrangements for shared learning

9.1 Example

9.2 Example

10. Chronology of events

Chronology (timeline of events)	
Date & Time	**Event**

11. Action Plan

Action Plan	Action 1	Action 2	Action 3
Root CAUSE			
EFFECT on Patient			
Recommendation			
Action to Address Root Cause			
Level for Action (Org, Direct, Team)			
Implementation by:			
Target Date for Implementation			
Additional Resources Required (Time, money, other)			
Evidence of Progress and Completion			
Monitoring & Evaluation Arrangements			
Sign off - action completed date:			
Sign off by:			

Appendix 13: Level 2- Concise RCA report template

States of Jersey

The States of Jersey Department for
Health & Social Services

Comprehensive and Independent Investigation Report Template

Organisation:	States of Jersey Health & Social Services Department
Incident Investigation Title:	
Incident Number:	
Investigating Team and job titles:	
Report Date:	
Page Numbers:	
Date presented to Panel & Teams:	
Approval Date:	
Date to Patient or Client Family	

Summary Guidance

The following format and headings are designed to improve the recording and standardisation of information in investigation reports (including multi-incident investigations), and to facilitate collection and learning from findings. These headings will continue to be evaluated and developed over time.

1. Write your investigation report in the blank comprehensive investigation template which accompanies this guidance
   a. Refer to quick ref. guidance here in green as you go.
   b. For detailed guidance refer to the NHS England guidelines, formerly known as the NPSA's 'RCA investigation report writing guidance'.
2. On completion of the investigation and to complete your final report
   a. Ensure all guidance (in green) is deleted
   b. Update table of contents.
   c. Save the document with the chosen file name. Always include a version number in the filename.

Contents

Executive Summary
(complete this summary AFTER the main report has been written). This forms an important • Brief Incident description • Incident date • Incident type • Speciality • Actual effect on patient and/or service • Actual Severity of incident
Level of Investigation conducted
Involvement and support of the patient and/or relatives
Detection of incident
Care and Service Delivery problems
Contributory Factors
Root cause
Lessons Learnt
Recommendations

Arrangements for shared learning

Main Report

3. Incident Description and Consequences

Concise description of the incident.

Example only
A lady with asthma sustained brain damage following IV administration of a drug to which she was known to be allergic.

3.1 Incident description:

3.2 Incident type:

3.3 Speciality

3.4 Actual effects on patient

3.5 Actual Severity of the incident

3.5.a Example

4. Pre investigation risk assessment

Assess the realistic severity and likelihood of recurrence, using your organisation's Risk Matrix

A Potential Severity (1-5)	B Likelihood of recurrence at that severity (1-5)	C Risk Rating (C=A x B)

5. Background and context

A brief description of the service type, service size, clinical team, care type, treatment provided etc.

5.1 Example

5.2 Example

5.3 Example

6. Terms of Reference

Guide provided below. Amend this to build your own. Add only a summary to the body of the report.

Purpose To identify the root causes and key learning from an incident and use this information to significantly reduce the likelihood of future harm to patients
Objectives To establish the facts i.e. **what** happened (*effect*), to **whom**, **when, where**, **how** and **why** (*root causes*) To establish whether failings occurred in care or treatment To look for improvements rather than to apportion blame To establish how recurrence may be reduced or eliminated To formulate *recommendations and an action plan* To provide a *report and* record of the investigation process & outcome To provide a means of *sharing learning* from the incident To identify routes of *sharing learning* from the incident
Key questions/issues to be addressed ...specific to this incident or incident type
Key Deliverables Investigation Report, Action Plan, Implementation of Actions
Scope (investigation start & end points)
Investigation type, process and methods used • Single or Multi-incident investigation • Gathering information e.g. *Interviews* • Incident Mapping e.g. *Tabular timeline* • Identifying Care and service delivery problems e.g. *Change analysis* • Identifying contributory factors & root causes e.g. *Fishbone diagrams* • Generating solutions e.g. *Barrier analysis*
Arrangements for communication, monitoring, evaluation and action
Investigation Commissioner
Investigation team Names, Roles, Qualifications, Departments
Resources
Involvement of other organization's
Stakeholders/audience
Investigation timescales/schedule

7. Level of Investigation

Choose from: Level 2 (Comprehensive); Level 3 (Independent Investigation)

5.2 Example

8. Involvement and Support of patients and relatives

E.g. Meetings to discuss questions the patient anticipates the investigation will address and to hear their recollection of events (anonymised in line with the patient / relatives wishes).

E.g. Family point of contact appointed, information given on sources of independent support.

Example

8.1 Example

8.2 Example

8.2.a Example

9. Involvement and support provided for staff involved

Refer (anonymously) to involvement of staff in the investigation, and to formal & informal support provided to those involved and not involved in the incident.

9.1 Example

10. Information and evidence gathered

A summary of relevant local and national policy / guidance in place at the time of the incident, and any other data sources used:-
(Include:-Title and date of Guidance, Policies, Medical records, interview records, training schedules, staff rotas, equipment, etc.)
Example only (please delete and use your own findings)
Interviews with the four staff on duty - 01.02.08
Interviews with patient relatives - 05.02.08
A visit to the location of the incident -14.02.08
The patient's clinical records

10.1 Example

10.2 Example

10.3 Example

Findings

9. Chronology of events

Chronology (timeline of events)	
Date & Time	**Event**

10. Detection of incident

10.1 Example

10.2 Example

10.3 Example

11. Notable practice

11.1 Example

11.2 Example

11.3 Example

12. Care and service delivery problems

12.1 Example

12.2 Example

13. Contributory factors

13.1 Example

13.2 Example

14. Root cause

14.1 Example

14.2 Example

15. Lessons Learnt

15.1 Example

15.2 Example

16. Post investigation risk assessment

A Potential Severity (1-5)	B Likelihood of recurrence at that severity (1-5)	C Risk Rating (C=A x B)

Conclusion

17. Recommendations

4. Example
5. Example
6. Example

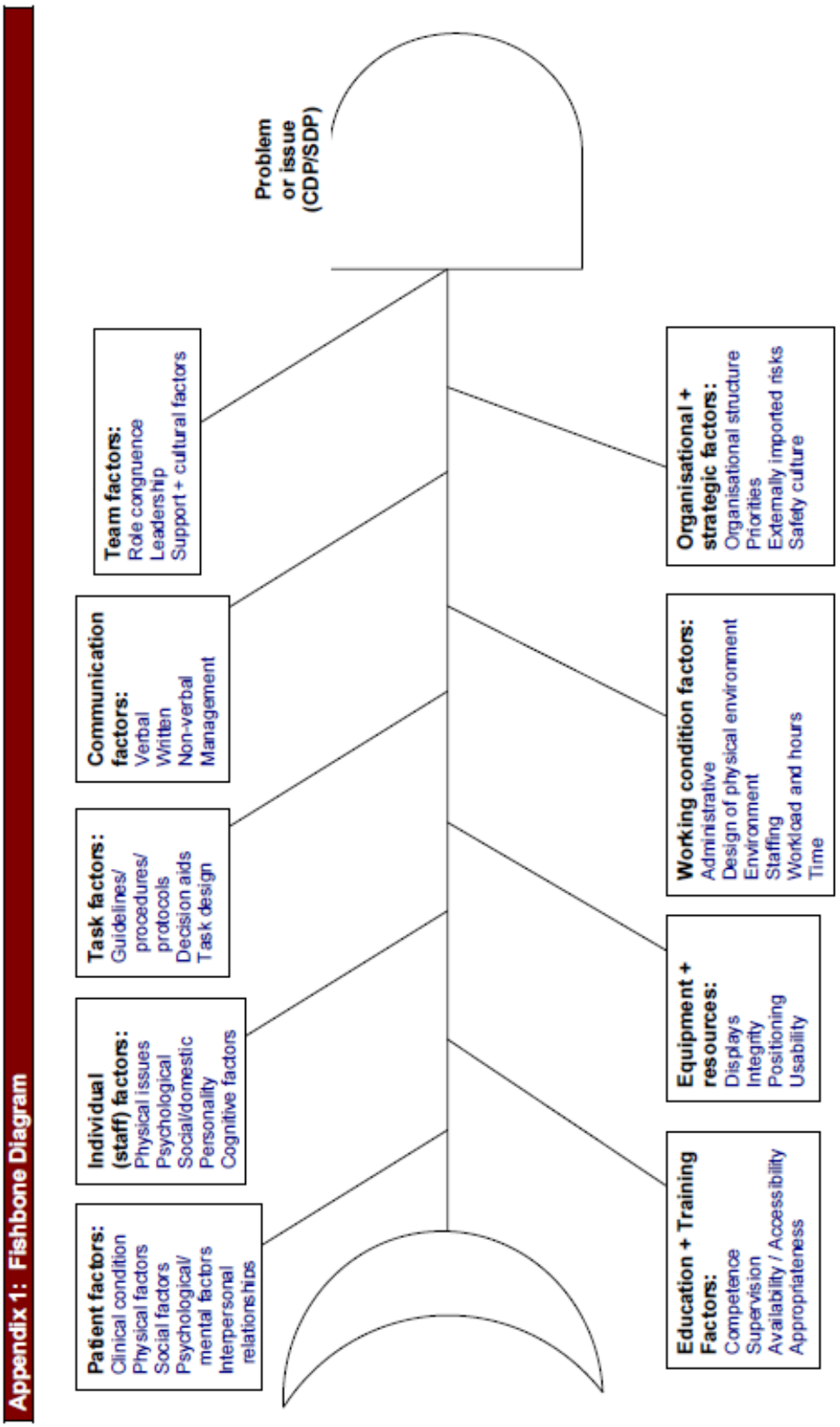
18. Arrangements for shared learning

18.1 Example

18.2 Example

19. Appendices

Appendix 1: Fishbone Diagram



Appendix 2: Action Plan

	Action 1	Action 2	Action 3	Action 4	Action 5
Root CAUSE					
EFFECT on Patient					
Recommendation					
Action to Address Root Cause					
Level for Action (Org, Direct, Team)					
Implementation by:					
Target Date for Implementation					
Additional Resources Required (Time, money, other)					
Evidence of Progress and Completion					
Monitoring & Evaluation Arrangements					
Sign off - action completed date:					
Sign off by:					