Kent and Medway
NHS and Social Care Partnership Trust

Management and Investigation of Serious Incidents Policy

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DOCUMENT TRACKING SHEET

Management and Investigation of Serious Incidents
(previously titled Investigation of Serious Incidents, Incidents, Complaints and Claims Policy)

Version	Status	Date	Issued to/approved by	Comments
V0.1	Draft	11th October 2007	Risk Management Group	
V1.0	Approved	11th October 2007	Risk Management Group	
V2.0	Approved	October 2009	Health & Safety and Risk Committee	
V3.0	Approved	October 2011	Health & Safety and Risk Committee	
V3.1	Draft	March 2016	Patient Safety Group	Absorbed into Management of SI policy but felt to be too large, so separated out again
V4.0	Approved	January 2017	Trust Wide Health Safety and Risk Group	Updated flow charts on p10 and 11. Ratified
V4.1	Approved	February 2018	Policy Manager	Separated Equality Impact Assessment from document. Amended 'service line' to 'care group' throughout the document.
V4.2	Draft	April 2019		Updated Management and Investigation of Serious Incidents, Incidents, Accidents and Near Misses Policy
V5.0	Final	September 2019	Trust-wide Patient Safety and Mortality Review Group	Ratified Appendix 3 added.
V6.0	Final	January 2020	Trust-wide Patient Safety and Mortality Review Group	Ratified

REFERENCES

Serious Incident Framework 2015 (NHS England)
Never Events policy and framework – revised January 2018 and Never Events List 2018 (NHS Improvement)
Kent Police & Kent Health Sector Bodies Joint Working Agreement. Tackling violence, crime and anti-social behaviour in the NHS (Kent Police and NHS). Service level agreement between Kent Police Mental Health Liaison Team and Kent and Medway Partnership Trust.
National Guidance on Learning from Deaths - A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (National Quality Board, March 2017)
Regulation 20: Duty of candour. Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare (Care Quality Commission 2014)
A just culture guide (NHS Improvement, 2018)

RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

	Reference
Complaints Handling Policy and Procedure	KMPT.CorG.019

Whistleblowing Policy	KMPT.HR.002
Claims Management Policy and Process	KMPT.CorG.014
Health and Safety Policy	KMPT.CorG.005
Duty of Candour – Being Open Policy	KMPT.CorG.018.05
Risk Management Strategy	KMPT.CorG.012
Disciplinary Procedure	KMPT.HR.007
Learning from Experience Policy	KMPT.CorG.011

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
18/06/2019	Head of Patient Safety		The policy was updated to include national policy, framework and regulations. There was also the addition of: • Use of RCA meetings • Just Culture Guide • Retention of records • Appendices added • Definitions updated and added • Evidence table updated and additional information included
September 2019	Head of Patient Safety	 3, 4, 5, 5, 6, 8,9,10 11, 18, 25	Change of title from 'Investigation of Serious Incidents, Incidents, Complaints, and Claims Policy' to 'Management and Investigation of Serious Incidents'. The previous policy has been separated into separate policies for serious incidents, incidents and claims. Updated duties. Amended section 5.2, 5.3 and 5.4 Updated external reporting of incidents table. Updated section 6 and 8. Added appendix 3
January 2020	Head of Patient Safety		Changes made as a result of MAZARS review. Updated section 4.12 Addition of section 4.13 Updated section 6.2 and 6.9.5

CONTENTS

1 INTRODUCTION

1.1 When a Serious Incident occurs, there must be systematic measures in place to respond to them. These measures must protect patients, staff and visitors and ensure that robust investigations are carried out, which result in organisations learning from serious incidents and putting actions in place to minimise the risk of the incident happening again.

1.2 Adherence with the policy supports KMPT in its objective to pursue continuous improvement in the delivery of its services, whilst being person-centred, acting openly, fairly and proportionately within just culture.

2 PURPOSE

2.1 The purpose of this policy is to ensure that risks associated with serious incidents are identified and managed in accordance with best practice and in line with the expectations of the NHS Resolution, the Health and Safety Executive, the Care Quality Commission, NHS England and NHS Improvement, Clinical Commissioning Groups and the public.

2.2 This policy formally endorses the NHS England Serious Incident Framework; be clear of roles and responsibilities; timescales for completing serious incident investigations and to define the additional requirements for serious incident reporting to all relevant external bodies as identified above.

3 DEFINITIONS

3.1 Serious Incident

3.1.1 The Serious Incident Framework of 2015 (NHSE) advises that, in broad terms, 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 which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

3.2 Serious Incidents in the NHS include:

3.2.1 Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

3.2.2 Unexpected or avoidable death of one or more people. This includes

- suicide/self-inflicted death; and
- homicide by a person in receipt of mental health care within the recent past;

3.2.3 Unexpected or avoidable injury to one or more people that has resulted in serious harm;

3.2.4 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;

3.2.5 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 of NHS-funded care.
- 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, where delivery of NHS funded care caused/contributed towards the incident;

3.2.6 A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death (see appendix 2);

3.2.7 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:

3.2.8 Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;

- Property damage;
- Security breach/concern;

3.2.9 Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;

3.2.10 Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);

3.2.11 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); or

3.2.12 Activation of Major Incident Plan (by provider, commissioner or relevant agency). Please refer to the KMPT Major Incident Plan. All major incidents are reported as SI.

3.2.13 Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

3.3 Never Event

3.3.1 Never events are defined by the Department of Health. The list of never-events is reviewed annually. Please refer to:

https://improvement.nhs.uk/resources/never-events-data/

3.4 Root cause analysis (RCA)

3.4.1 RCA is a structured investigation that aims to identify the true causes of a problem and the actions necessary to eliminate it by reviewing the whole system within which a problem, error or incident has occurred, including human factors.

3.4.2 The investigation must be conducted using 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.

3.4.3 The investigation must be undertaken by those with appropriate skills, training and capacity.

4 DUTIES

4.1 KMPT Board

4.1.1 The KMPT Board is responsible for ensuring systems and processes are in place to undertake suitable and sufficient investigations so learning and implementation can be demonstrated. They will receive assurance from the Quality Committee through Summary and Exception reporting. They will demonstrate leadership in underpinning a learning culture by supporting staff in taking forward the Duty of Candour Policy, and by ensuring KMPT continues to demonstrate improvements in service delivery and safety.

4.1.2 It is KMPT Board's responsibility to ensure staff feel safe to report issues and the information they share will be treated with respect and acted upon appropriately for the improvement of the safety and quality of KMPT services.

4.2 The Quality Committee

4.2.1 The Quality Committee, on behalf of the KMPT Board, will review the Quality Digest They will receive assurance that underpins that change has been/is being embedded throughout KMPT where it is appropriate to the learning. They will provide leadership and support to Care Group Heads of Service in undertaking their programme in continuous learning, review, implementing and sustaining change and then evaluating the outcomes.

4.3 The Trust Wide Patient Safety and Mortality Review Group

4.3.1 The Trust Wide Patient Safety and Mortality Review Group Chaired by the Executive Director of Nursing and Governance is responsible for ensuring evidence is available to demonstrate that learning is taken forward across the Trust. Additionally the Group will monitor exception reporting of delayed actions from SIs. .

4.3.2 They will ensure learning is disseminated across KMPT and actively support the continuous publication of best practice and examples of learning from Serious Incidents via the learning from experience group to ensure all staff have access to information and that there is a continuous re-evaluation of risk reduction measures undertaken in a systematic and sustained process.

4.4 Trust Wide Serious Incident and Mortality Panel

4.4.1 The Trust Wide Serious Incident and Mortality panel is chaired by the Head of Patient Safety or the deputy and sits twice a week on Mondays and Wednesdays.

4.4.2 The purpose of the panel is to review all incidents reported on Datix where the level of harm is moderate to death and make decisions about the level of investigation required and external reporting, based on the 72 hour management report and further review where required.

4.4.3 Decisions will, be made in line with national guidance and KMPT decision making flow charts (appendix 4 and 5). This may include further review before a decision is made or that a structured judgement review is required.

4.4.4 To identify panel member to escalate to executive staff and to the communications team when cases are identified which are likely to attract publicity or have been/may be in social media.

4.4.5 To agree responsibility (in conjunction with executive lead) for informing the patient, family and/or carers if the case is likely to attract publicity through media forms.

4.5 Trust Wide Health Safety and Risk Group (TWHSRG)

4.5.1 The TWHSRG will routinely monitor the number and types of incidents arising from health and safety issues, in particular those that are reportable under the RIDDOR regulations.

4.5.2 The TWHSRG may also review the numbers of clinical and non-clinical incidents to establish themes and trends and assist with obtaining assurances for the management of risk.

4.6 Care Group Governance/Risk Management Groups

4.6.1 The Care Groups will retain responsibility for implementing local action plans and ensuring there is a system of evaluation. They will provide evidence on service changes and improvements and evidence of the implementation of best practice. They will review and monitor their Serious Incidents and will organise any additional investigations.

4.6.2 Care Group Groups will utilise the information gained from the analysis of reports and ensure risk management and risk reduction strategies are put in place. Escalation and dissemination of urgent issues should take place through care group processes.

4.7 Chief Executive

4.7.1 The Chief Executive has overall responsibility for ensuring investigations are appropriate and effective and learning is identified and disseminated across the organisation. The Chief Executive is committed to KMPT demonstrating sustainable effective change based on learning from Serious Incidents.

4.8 Executive Director of Nursing and Quality (Designated Board Member Lead for Patient Safety)

4.8.1 Takes responsibility for ensuring all serious incidents are managed and investigated appropriately according to KMPT Policy and meet all external requirements. The Executive Director of Nursing and Quality takes responsibility for sharing lessons learnt, ensures that the Chief Executive and Trust Board are appraised of incidents that are reportable to the Clinical Commissioning Groups and other external Stakeholders.

4.8.2 Ensures learning is demonstrable and evidenced and good practice is shared across the organisation.

4.8.3 Takes responsibility for alerting the Chief Executive.

4.9 Lead Investigating Manager/Team

4.9.1 The lead investigator will have received training in RCA investigating either through specific training or through experience. The lead investigator should be 2 day RCA trained. Reviews will be conducted using RCA methodologies.

4.9.2 Other members of the investigating team may be trained in RCA but may also be part of the investigating team. This could include, for example, pharmacy, expert nurses, doctors, corporate staff, health and safety or security staff due to their expertise.

4.10 Role of Clinicians/Specialist Advisors

4.10.1 There will be access to staff that are able to provide consultation and support to the process.

4.10.2 This will be determined at the onset of the investigation process. Specific support will be allocated to each team. However it is sometimes only recognised that expert involvement will be required as the investigation proceeds and experts may be included later in the investigation on occasions.

4.10.3 Where there is insufficient expertise within the organisation KMPT will consider identifying an external Consultant experienced in RCA who will support the Team

4.11 Communication Team

4.11.1 Communications are a vital element of supporting and delivering effective management of serious incidents. The Trust ensures that robust communication and media management arrangements are in place for both internal and external communication. In some cases serious incidents may lead to media attention which can be prolonged. The Trust will make every effort to ensure that staff are informed and supported prior to any media involvement (see corporate communication strategy).

4.12 All Staff

4.12.1 All staff have a responsibility to highlight and report any incidents or risk issues on Datix that would warrant further review or investigation.

4.12.2 KMPT will expect them to contribute fully to the investigation process openly and honestly.

4.13 Chief Operating Officer and Medical Director

4.12.3 The Chief Operating Officer and Medical Director will sign off high profile cases as well as the Director of Nursing and Quality, Heads of Service, Patient Safety Lead and Head of Patient Safety.

5 KEY ISSUES

5.1 In most cases a serious incident does not result from one single event, but is more likely to have involved cumulative triggers which, in isolation may have no effect, but when they occur in an event chain can be serious or even catastrophic.

5.2 When investigating a serious incident, it is important to concentrate on the facts, with a retrospective review of events to establish the underlying causes. Analysis will then identify areas for change, looking at long-term solutions, improving standards and improving patient safety and to minimise reoccurrence in the future or to reduce the level of harm.

5.3 The key features of a good investigation are:

5.3.1 Clear terms of reference and parameters (scope);

5.3.2 Involvement of staff involved, and patients and carers where possible;

5.3.3 A thorough identification and analysis of events with clear rationale;

5.3.4 A clear and concise report;

5.3.5 SMART actions put in place to prevent repeat incidents.

5.4 Why investigations are necessary

5.4.1 Serious Incidents can occur across KMPT and it is the responsibility of staff to ensure we learn from these, avoid repeating the same mistakes and introduce safer ways of working, better services to patients and ensure high standards of care are delivered across the organisation. In order to do this we need to be able to investigate the underlying root cause(s). The investigations do not look to apportion blame but instead looks reasons at why Serious Incidents occur.

5.4.2 We achieve this by creating an environment of open and honest review of incidents. This enables staff at all levels to review practice and service delivery, learning lessons and enabling the development of safer systems of working, ensuring and supporting improving standards of care.

5.4.3 It is important to also note that learning occurs equally from good practice as well as practice that requires improvement.

5.5 The Process for Effective Internal and External Communication

5.5.1 KMPT executive team fully supports the expectation that staff participate in the investigation process as our opportunity to learn and develop improving standards and improving safety. Effective communication is necessary to ensure all those who have been involved in the serious incident fully understands:

a) The time scale;

b) Their involvement and what they can expect when being involved in the investigation if required;

c) Any other role they are being asked to contribute such as a review of the process, a consultation group, or as lead clinicians to comment on an aspect of practice. Staff, patients or any other group may be approached by the Investigating team to take part in the investigating process, and their roles will be clearly stated. Communication back to those involved will be made explicit so all are aware when they can expect feedback and the final report.

5.5.2 Following a decision made by the Trust Wide Patient Safety and Mortality Panel to investigate a Serious Incident, the Care Group Patient Safety Leads will identify an investigation team who will ensure all communication is undertaken, recorded and completed:

a) Contacting, communicating and meeting with patients, families/carers;

b) Ensuring staff are communicated with prior to any meeting to discuss their involvement. Support is given to staff who may be asked to contribute to the learning process;

c) That the investigation is completed within the national timescale and

d) And ensure feedback at the completion of the final report.

5.5.3 On completion, the Lead Investigator / or Care Group Patient Safety Lead will ensure the report is shared with all relevant parties, for example:

a) Patient/families or carers,

b) Service Manager and

c) Staff.

5.5.4 Summaries of learning to share safety lessons and best practice will continue to be publicised in Trust Wide and local learning bulletins.

5.5.5 If the need to communicate to all staff is urgent this will be done through the Communications Team.

5.5.6 This will also be subject to the Duty of Candour Policy.

5.5.7 The Serious Incident and Mortality Panel will identify when there is a need to involve external agencies following a Serious Incident. This is based on NHS England's Serious Incident Framework 2015:

a) All homicides
b) All inpatient suicides
c) SIs that cross into other provider services
d) Death or serious injury through negligence
e) Death or serious injury of a member of staff
f) Equipment has significant failure causing serious injury or death
g) Serious Criminal act
h) Death in suspicious circumstances (unexplained/unexpected)
i) Involvement of other agencies requiring other expertise

5.5.8 And will be reported, where necessary and appropriate, to

a) Clinical Commissioning Groups
b) NHS England/NHS Improvement
c) Health & Safety Executive
d) Local Authority Social Services
e) Acute Hospitals Trusts
f) Care Quality Commission
g) Medical Devices Agency
h) Medicines Regulatory Authority
i) Healthcare Products Regulatory Agency (MHRA)
j) Police
k) Environmental Health Agency (EHA)
l) Counter Fraud and Security Management Service

5.5.9 External reporting of incidents

	Incident Type	**Contact (who and how)**
NHS England Clinical Commissioners Groups Local Authorities e.g. Social Services, police	Suicide of any person on NHS premises or under the care of a specialist team in the community Homicide committed by a patient with mental health problems Serious injury or unexpected death involving a member of staff, visitor, contractor or another person to whom the organisation owes a duty of care Serious damage to NHS property, particularly resulting in injury or disruption of services e.g. through fire, flood or criminal activity. Incidents associated with infection that produce, or have the potential to produce, unwanted effects involving the safety of patients, staff or others Any other Serious Incidents that may be identified as a cluster of events that lead to something more significant including those that may attract media attention.	The Serious Incident and Mortality Panel review the management review and Rio where necessary to identify if a Serious Incident has occurred. Where it is decided that this is the case, the Serious Incident Administrator will enter the incident on to the STEIS System within two working days. Other organisations should be notified as soon as possible to ensure appropriate engagement. Communication leads will be determined through the above panel. National Reporting & Learning System by the Datix Team within two working days.
Her Majesty's Coroner	Deaths to be reported to HM Coroner: • Death where no doctor saw the deceased during his or her last illness; • A death where, although a doctor attended the deceased during the last illness, the doctor is not able or available, for any reason, to certify the death; • Death from industrial diseases or poisoning • Death at work • Cot death and postnatal deaths • the death was sudden and unexplained; • Death occurred during an operation or before full recovery from anaesthetic • Cause of death unknown or within 24 hours of admission • Any violent, suspicious or unnatural death or a death due to neglect • Drug related deaths • Death of anyone currently or recently detained in Police/Prison Custody or another type of state custody	Registrars of births and deaths, doctors or police must report these types of deaths to HM Coroner. The ward doctor would contact the police to advise of a death and the police would normally inform the Coroner's Office.
Health & Safety Executive (HSE)	Death, major injury or dangerous occurrence. Over seven day injuries Specified injuries (such as fractures, scalp injuries and some burns)	Managers have the responsibility to ensure that the HSE are informed. They should inform the Health and Safety team, who will contact, on behalf of managers, the Health & Safety Executive see Health &

	Incident Type	Contact (who and how)
		Safety files or Health & Safety home page (Trust Intranet) Managers have the responsibility to ensure that the HSE are informed within seven days. They should inform the Health and Safety team, who will contact the HSE, on behalf of managers, using a RIDDOR form (see Health & Safety file or go to link on the Health & Safety home page – Trust Intranet)
National Health Service Resolution	Incidents where the Trust becomes aware that litigation will result	All staff through the Legal Services Team as soon as they are aware. 01622 724100
Professional Regulatory bodies	Incidents where there appears to have been a breach of the professional code of conduct.	All staff members to escalate to managers as soon as a breach of the professional code of conduct becomes apparent in line with the disciplinary policy. Managers should escalate to Human Resources Team and the Deputy Director of Nursing.
Medicines and Healthcare Products Regulatory Agency (MHRA)	Incidents involving injury or risk of serious injury involving healthcare products and equipment	All staff, in line with the Medical Devices Policy, must report incidents /near misses relating to medical devices via Datix. The Datix Team will then report these to the Medicines and Healthcare products Regulatory Agency (MHRA) on-line reporting system. A copy of the on-line report will then be forwarded to the Medical Devices Coordinator for information and any necessary action.
Safeguarding Vulnerable Children	Any incident involving serious harm to a child	All staff immediately via Safeguarding processes on the intranet
Safeguarding Vulnerable Adults	Any serious incident involving a vulnerable adult	All staff immediately via Safeguarding processes on the intranet.
Care Quality Commissioner	All unexpected mental health related deaths including suicides and homicides or those where individuals have died in hospital of a physical illness where mental health services may have contributed. For statutory requirements, any death of any patient that is detained or liable to be detained whilst in KMPT care. as well as sending the 72 hr report, I also	Reported by the Quality and Compliance Manager as informed by the SI and Mortality Panel.

	Incident Type	Contact (who and how)
Environmental Health/Food Standards Agency/Public Health England	Incident involving contaminated food products resulting in illness	All staff to escalate incidents immediately to the Infection Control team and Estates as soon as identified. The former would escalate to Public Health England.
Local Community	Any incident that is likely to impact on the local community	The SI and Mortality Panel will determine other organisations e.g. KCC, other Trusts, charitable organisations, police to be contacted and who would lead the communication. This may need to be in consultation with executive staff.

5.6 Involving and supporting patients/carers/relatives and staff

5.6.1 The Trust believes that patients and their families/carers are a critical part of learning from serious incidents. The level of patient/family/carer involvement depends on the nature of the incident, the patient and the patient's consent for their family to be involved. Access to language and sign interpreters will be provided, as required.

5.6.2 Usually the lead clinician will have commenced the Duty of Candour process as soon as is reasonably practicable (Regulation 20.2).

5.6.3 Additionally, the identified lead investigator will

a) Make contact with all those involved and explain the process for the RCA learning review.

b) Arrangements should be made with the patient and/or their families/carers to meet with the investigation team to discuss potential areas for investigation and to be an integral part of the investigation process if they so wish. Unless there are specific indications to the contrary or the patient/their family requests other arrangements, a series of ongoing open discussions scoping the form of the investigation will take place between the staff providing the patient's care and the patient and/or their relatives or carers.

c) Explain and agree how they can expect to be communicated with during the review.

d) Give an explanation of any timescales involved in the process.

e) Advise how to contact the investigating team.

f) Offer any other support the patient/family/carer would find beneficial that is reasonable.

g) Agree arrangements for sharing the final report.

5.6.4 For further information on the Duty of Candour and the Trust process for ensuring full compliance please refer to the Duty of Candour – Being Open Policy.

6 INVESTIGATION AND ROOT CAUSE ANALYSIS

Serious Incident reporting severe harm and above

IMMEDIATELY inform manager/ shift lead/service manager/on call manager

→ Assesses medical needs of people involved

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BEFORE END OF DAY Qualified staff member completes **INCIDENT FORM (online Datix)**

- Inform the service user / relatives – Tell them that the incident will be reviewed and actions taken as appropriate.
- Review risk assessment/care plan/observation levels/leave etc
- Consider adult/child protection alert and/or police involvement
- Urgent learning shared
- Consider Duty of Candour for incidents where moderate, severe, death or prolonged psychological harm has occurred or where the degree of harm is not yet clear but may fall into the above categories in future, in line with the requirements of Regulation 20, and follow the process.

→ Takes URGENT action as relevant

→ * Where staff member injured or traumatised, manager considers referral to Occupational Health
* Informs Ministry of Justice (Forensic services)
* Head of Patient Safety or Patient Safety and Risk Manager communicates with other external agencies/media (e.g. police)

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WITHIN 48 HOURS Manager completes **MANAGEMENT REPORT (on Datix) and DRAFTS ACTION PLAN**

This must include:

- To share and reflect upon current practice (actions before, during and after the incident)
- To highlight ways of improving practice (learning)
- To support staff and service users and encourage the therapeutic relationship between staff, service users and their carers
- To ensure best practice is followed
- To provide an opportunity to highlight issues with trust systems and trust/local policies, procedures and protocols.
- This report will be reviewed by the care group, Head of Patient Safety or deputy and provided to the Director of Nursing and Quality and to be sent to the CQC as required.
- Assurance that Duty of Candour has been commenced if the incident meets this criteria.

Where disturbed/violent behaviour – Clinical team carry out a Clinical Review meeting using NICE format (within 72 hours)

→ * Considers **RIDDOR**
* Where patient/staff is potentially traumatised, Clinical Team OFFER initial support. Manager/psychology to monitor wellbeing of staff/service user and offer access to further support / counselling if signs of trauma still evident in long term
*Consider the use of the Just Culture Guide if there is consideration of a managerial investigation (see section 7).

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Trust Wide Serious Incident and Mortality panel reviews the 48 hour Management Report at the next meeting, using the SI and Mortality Decision making flow chart to determine if a reportable incident has occurred. In the event that a Serious Incident is declared the Serious Incident Administrator will report this by entering on the STEIS system.

WITHIN TWO WORKING DAYS OF THE SI AND MORTALITY DECISION

- 48 hour report to be updated, amended appropriately and sent to the Compliance and Assurance Manager.

Those requiring notification to the CQC are:

- Unexpected deaths including suicide and homicide (for statutory requirements any death of any patient detained or liable to be detained whilst in our care).

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WITHIN 45 WORKING DAYS the investigation team completes a LEARNING REVIEW INVESTIGATION (RCA) to highlight root cause(s), contributory factors, learning and recommendations. This should involve all staff involved in the incident.

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Learning Review is approved by Care Group Head of Service, Head of Patient Safety and Executive Director of Nursing and Quality and submitted to the CCG within 60 working days of reporting on STEIS.

When the action plan completed SI closed by Care Group Patient Safety meeting/Chair.

6.1 **Investigation Process**

6.1.1 Appointment of an investigating lead/team

6.1.2 The RCA investigation must be undertaken by more than one person to enable greater objectivity.

6.1.3 One of the investigators must be 2 day RCA trained.

6.1.4 The investigating team will consist of a lead investigator trained in root cause analysis, supported by other staff. The appointment of the investigating lead will be made by the Care Group Patient Safety Lead

6.1.5 Where the SI is a homicide, inpatient suicide or likely to attract a lot of public interest, it may be necessary to appoint an external investigator to support the internal investigating team. This will be approved by the Executive Director of Nursing and Governance and the Chief Executive. The communications team should be informed.

6.1.6 The team will receive the full support and authorisation of the KMPT Board.

6.1.7 Where the Serious Incident is a homicide or child death, board level panel reviews will be conducted and will be chaired by a non- executive director.

6.2 The first step in conducting an RCA is to commence a tabular timeline of events based on the scope and Terms of Reference provided by the Serious Incident and Mortality Panel. Investigators are asked to identify any good practice, problems in care, acts or omissions within the timeline. It is important that timelines are not made up of just healthcare records. Evidence should be gleaned from multiple sources. This process will help to identify who may need to be invited to meet with investigators as part of the investigation.

6.3 Identification of people to be included in the RCA meeting or to have a meeting with the investigator

6.3.1 Information must be collected from all available sources, both in terms of the specific events (which should be added to the timeline) and those underlying contributing factors. During this scoping exercise, consideration will be given to those staff, visitors, patients that the team may wish to meet with during the investigation. This will vary on a case by case basis.

Evidence to be considered when undertaking a root cause analysis investigation	
Identified areas of evidence to consider (5 Ps)	**Involvement**
People	Those staff, patients, visitors or anyone else who was involved in the Serious Incident. Anyone who witnessed the event but was not directly involved. The wider team(s). Organisation leads. It can be helpful to ask people to make notes of the event to refresh themselves when the RCA meeting or meeting with people occurs as part of the investigation.
Place(s)	Review of the area where the incident occurred. It can be helpful to visit the area at the same time on the same day of the week that an incident occurred. This can identify areas of concern. Health and Safety Leads Staff involved NHS Accredited Security Management Specialist (ASMS)
Parts (equipment)	Any equipment that has been involved and has been considered to have participated in the Serious Incident should be retained and be checked. Medical Devices Manager – Medical devices Hoists – Moving and Handling Trainer Resuscitation Officer Health and Safety Leads
Paper	Medical records will often be a starting point to commencing a timeline in a clinical investigation, however there will be other areas that need to be reviewed: EME records and other maintenance records Duty rotas Diaries Handover records Policies Mental Health Act External guidance such as NICE guidance Staff involved or other experts

	Records Manager Information Rights Manager Caldicott Guardian
Paradigm of working.	The widely held beliefs about the normal working processes, team relationships, and adequacy of leadership in the work place (how the team works). Staff within the team Consultation group Experts Executive Director of Nursing and Quality Deputy Director of Nursing Executive Medical Director Clinical Leads Senior Practitioners Heads of Service Another similar team External Experts/other Trusts
	This list is not exhaustive and each investigation has to be reviewed on a case to case basis

6.3.2 It may be useful to advise staff/patients/families/carers or visitors to keep their own record of the incident and events leading up to it. This is for their own personal use. Very occasionally staff will be asked to write a statement if there will be a court case, however this would normally not be required or investigations. For assistance with writing statements please contact the Trust Legal Services Department, Human Resources Managers or Trade Union Officer.

6.3.3 It is recognised that the Trust may have to involve other organisations in the investigation or that other organisations may take the lead on the investigation process such as a Police investigation. However since the introduction of the Memorandum of Understanding this enables Trusts, Police, NHS organisations and the Health & Safety Executive to meet post incidence and identify roles, processes and information sharing.

6.4 RCA meetings

6.4.1 Ideally the investigation team and staff involved will meet to review the timeline and analyse what has occurred. This will lead to the team involved to determine SMART actions to prevent further incidents occurring.

6.5 Conducting meetings with staff involved

6.5.1 At all stages sensitivity and tact will be practised with appropriate support available for anyone providing information into the investigation process

6.5.2 All those identified for to meet with the investigators will be contacted by the investigation team who will explain the process and purpose of the investigation, to include

a) To find out what happened?

b) To identify areas of good practice

c) Areas where systems did not work

d) Implement safety improvements

6.5.3 Following the meeting, the investigator will share notes with the interviewee via email for an agreement of accuracy. This ensures there is a record.

6.5.4 All staff involved must have access to confidential support and counselling during a potentially stressful period and that they can bring a staff side representative or workplace colleague with them at any interview.

6.5.5 Patients/families/carers may wish to have a friend or relative with them or wish to bring an advocate. Patients/families/carers and visitors to sites will be offered further support and signposted to counselling.

6.5.6 All investigations to be conducted in a manner:

a) That is demonstrably supportive and with listening;

b) In a blame free atmosphere;

c) For learning and improving

d) And those involved will be given information on progress as appropriate.

6.6 On occasions, at end stage during an investigation, it may be deemed that a managerial investigation may also be required. When this occurs the Just Culture Guide must be used. See section 7.

6.7 **Support for the investigating team**

6.7.1 Patient Safety Lead and the Head of Patient Safety are to be available to anyone undertaking an investigation who requires support or the opportunity to discuss process and progress or who just wants the opportunity to reflect on the investigation so far.

6.8 **Timescales for feedback to interested parties**

6.8.1 Time scales: it is important investigations are carried out expeditiously as delay can lead to a reduction in reliability of the memories of those concerned, anxiety on the part of those involved in the investigation, including patients, families and staff, and dissatisfaction for those who have raised the matter for investigation. The timescale for completion of the investigation is 60 working days, although this may be extended where there are exceptional circumstances and investigators should discuss this in good time with the Patient Safety Lead to allow for an extension request to be made to the CCG. Feedback will be the responsibility of the Lead Investigator. Patients and families should be advised of extensions.

6.9 **Involvement of any external agencies**

6.9.1 Other agencies or organisations may become involved depending on the nature of the SI e.g.

a) Police Force,

b) Coroners Officer,
c) Local Authority,
d) Clinical Commissioning Groups,
e) Primary Care Trusts,
f) Health & Safety Executive,
g) NHS England,
h) Care Quality Commission,
i) Social Services and
j) Other health care trusts
k) (This list is not exhaustive).

6.10 **Completing the RCA report**

6.10.1 The report of the investigation should be prepared using the template that will be provided by the Patient Safety Lead and will include the development of a SMART action plan:

SPECIFIC	Specific: say exactly what you mean.
MEASURABLE	Measurable: it can be evidenced that the action is completed.
ACHIEVABLE	Achievable: they can be completed in a reasonable timeframe
REALISTIC	Realistic: Actions that can be achieved
TIME-RELATED	Time-related: they have realistic deadlines.

6.10.2 All actions will be inputted on to the actions module on Datix by the care group Patient Safety Team

6.10.3 Each action has an individual "owner" who is responsible for the monitoring and completion (including evidence) of the action.

6.10.4 The care group patient safety team meeting will review the evidence to ensure it is robust before closing the action

6.10.5 The report will be quality checked and returned to investigators if necessary for amendments. Once complete the report will be scrutinised by the Head of Service, Head of Patient Safety and the Executive Director of Nursing and Quality. For high profile cases or those of significant concern, the sign off will also include the Chief Operating Officer and Medical Director. High profile cases or those of significant concern would include, for example, homicide cases or media cases. The final report must be submitted to the relevant Clinical Commissioning Group within 60 working days. There are some circumstances in which the deadline can be extended, for example to allow for Police investigations. The report must be submitted to the Head of Patient Safety and Risk Manager within 45 working days from the date the incident was declared.

6.10.6 A copy of the report is shared with the patient, family and/or carers, the team and others as relevant in a manner agreed with them.

7 JUST CULTURE GUIDE

7.1 The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. The Just Culture Guide was developed as a tool in promoting cultural change.

7.2 The guide was developed by NHS Improvement in March 2018 and is 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.

7.3 It asks a series of questions that help clarify whether there truly is something specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counter-productive. It also helps reduce the role of unconscious bias when making decisions and will help ensure all individuals are consistently treated equally and fairly.

7.4 The guide should not be used routinely. It should only be used when there is already suspicion that a member of staff requires some support or management to work safely, or as part of an individual practitioner performance/case investigation. The guide does not replace the need for patient safety investigations as the aim of RCA investigations is system learning and improvement.

7.5 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. It 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.

8 RETENTION OF RECORDS

8.1 The Records Management Code of Practice for Health and Social Care 2016 produced by the Information Governance Alliance advices on how incident records should be maintained:

Record type	Retention start	Retention period	Action at end of retention period
Serious Incidents	Date of Incident	20 Years	Review and consider transfer to a place of deposit
Incidents (not serious)	Date of Incident	10 Years	Review and if no longer needed destroy

8.2 All information relating to Serious Incidents will be retained on Datix. This includes the RCA report and any draft reports, any statements if required, analysis records, notes from the investigation and any further information used in the investigation. During the course of the investigation, each version of the report must be uploaded to Datix. This should be uploaded by individuals responsible for the version or can be sent to the Patient Safety team for uploading. The remainder of the information can be uploaded following the

completion of the investigation. This should clearly state the version control number and whether it is draft or final.

9 LINKS WITH OTHER PROCEDURES

9.1 This procedure does not stand alone. It must, where appropriate be read with the following:

9.1.1 Learning from Experience Policy

9.1.2 Duty of Candour Policy

9.1.3 Safeguarding Policy

9.1.4 Complaints Policy

9.1.5 Stakeholder, Carer and User Involvement

9.1.6 The Disciplinary Procedure

10 TRAINING

10.1 Set out below is the training needs analysis for all staff groups identifying which members of staff require training and the level they require.

10.2 The aim of the training is to:

10.2.1 Ensure all staff are aware of their duties/roles and responsibilities to enable them to implement the policy.

11 TRAINING NEEDS ANALYSIS

Staff Group	Policy Awareness/Roles & Responsibilities Team Briefings, Local Induction	Root Cause Analysis Training
Medical Staff/Inpatient Adult Community/Consultants	✓	For those staff who undertake investigations as part of the SI process
Junior Doctor	✓	
Locums	✓	
Clinical Staff Based in Adult Wards/Learning Disability Units/Specialist Units Registered Nurses/ HCA's/ OT's/Psychologists	✓	
Clinical Staff Based Older Adult Units Registered Nurses/HCA's/OT's	✓	
Clinical Staff Based in Rehab. Services Registered Nurses/HCA's/ OT's, Psychologists	✓	
Clinical Staff Based in Forensic Services Registered Nurses/HCA's/ OT's/Psychologists	✓	

Community Team Staff Adult/Older Adults/ Registered Nurses/OT's/ Psychologists/Art/Drama Therapists/Speech & Language Therapists/.STR Workers/Technical Instructors	✓	
Social Workers	✓	
Administration/Reception Staff	✓	
Porters	✓	
Domestics	✓	
Catering Staff	✓	
Non Clinical, not Admin. Including Managers/Directors	✓	

12 EQUALITY IMPACT ASSESSMENT

12.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

13 HUMAN RIGHTS

13.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds.

14 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring	Action to be taken in the event of non-compliance
Completeness of information on 72 hour management reports as reported via the Datix system	Patient Safety and Risk Manager will review the 72 hour reports to ensure completeness.	Trust Wide Serious Incident and Mortality Panel.	All forms on receipt	Trends will be raised with The Head of patient Safety.	The managers of Datix 72 hour report will be contacted by the patient safety and risk manager in the first instance and thereafter using the escalation process to Head of Service.
Reporting to The Quality Committee	Via reporting schedule for key committee/ groups Directorate meetings	Heads of service Medical Director Director of Nursing and Quality	Monthly	Reports Minutes of meetings	Director of Nursing and Quality
Demonstration of learning from incidents and evidence of change	Through Clinical Audit and Effectiveness Team Learning from experience group.	Director of Nursing and Quality Care Group Patient Safety and Risk manager.	Care Group Governance meetings QPR Learning from experience group	Minutes of meetings Reports re-audit/re-evaluation reports	Follow up with Care group Heads of service risks highlighted
Reporting within the timescales for Serious Incidents	Trust Wide Patient Safety and Mortality review group	Deputy director of Quality and Safety.	Monthly Board reports	Minutes of meetings and reports	Care Group Leads on the panel will take action through the Care Groups to ensure compliance
Staff are aware of how to raise concerns	Concerns recorded in Datix incident forms.	Locality managers	Ongoing/Monthly supervision	NA	NA

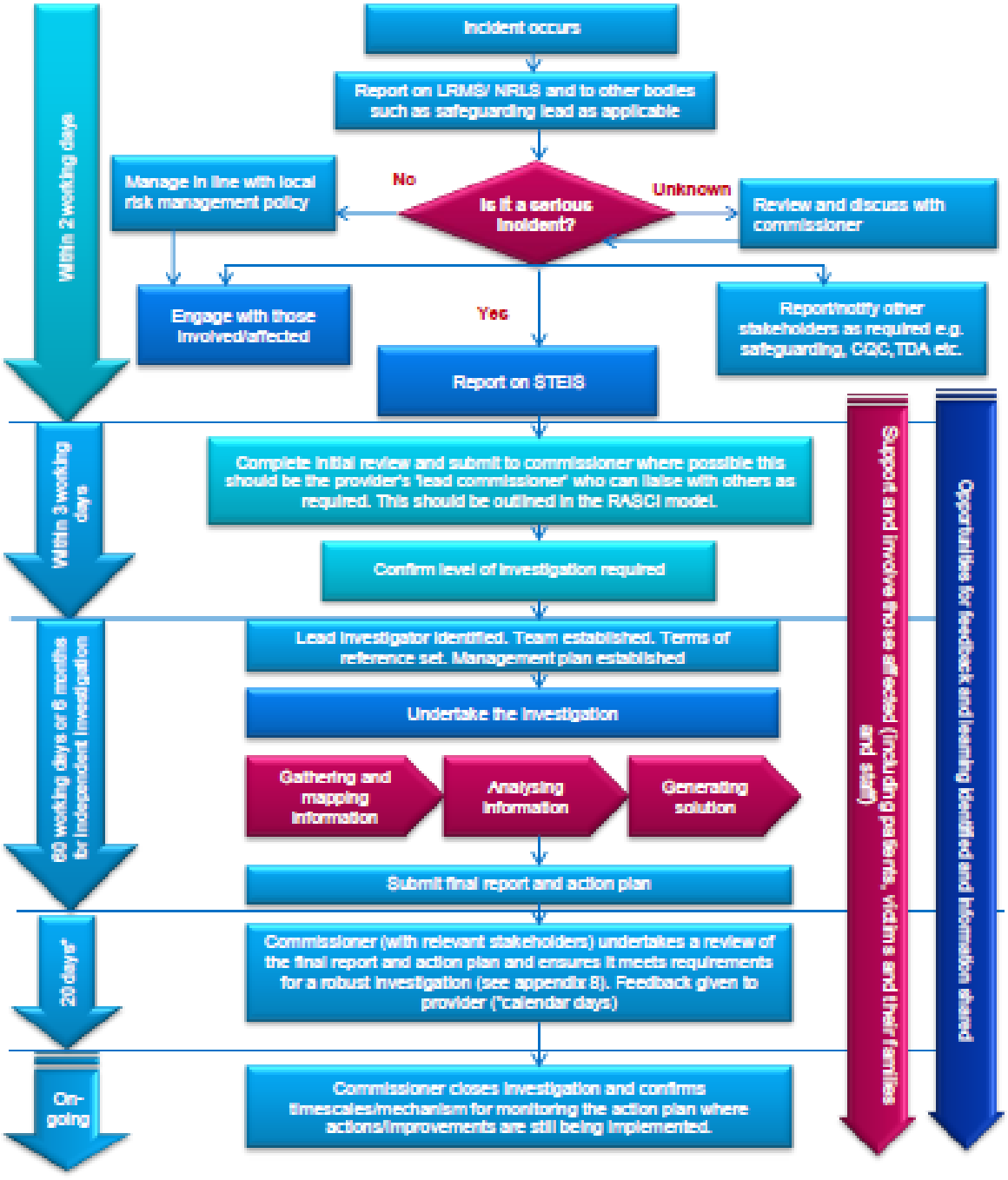
14.1 There are no exceptions to this Policy.

APPENDIX 1 OVERVIEW OF THE INVESTIGATION PROCESS

This schematic provides a brief overview of a systems investigation for investigating serious incidents in the NHS. It requires a 'questioning attitude that never accepts the first response', and uses recognised tools and techniques 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.

1. Overview of the Serious Incident Management Process



APPENDIX 2 NEVER EVENTS LIST 2018

Full details can be found at: https://improvement.nhs.uk/documents/2899/Never_Events_list_2018_FINAL_v7.pdf

Those in bold particularly could relate to mental health services

Surgical

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post procedure

Medication

4. Mis-selection of a strong potassium solution
5. Administration of medication by the wrong 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
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.**

General

10. Falls from poorly restricted windows
A patient falling from a poorly restricted window. This applies to:

- **windows 'within reach' of patients; this means windows (including the window sills) 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 climb out of the window**
- **windows located in facilities/areas where healthcare is provided and that patients can and do access**
- **where patients deliberately or accidentally fall from a window where a fitted restrictor is damaged or disabled, but not where a patient deliberately disables a restrictor or breaks the window immediately before they fall**
- **where patients can deliberately overcome a window restrictor using their hands or commonly available flat-bladed instruments as well as the 'key' provided.**

11. Chest or neck entrapment in bed rails
Entrapment of a patient's chest or neck between bedrails or in the 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 settings providing NHS-funded care including care homes, and patients' own homes where equipment for their use has been provided by the NHS.

12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes

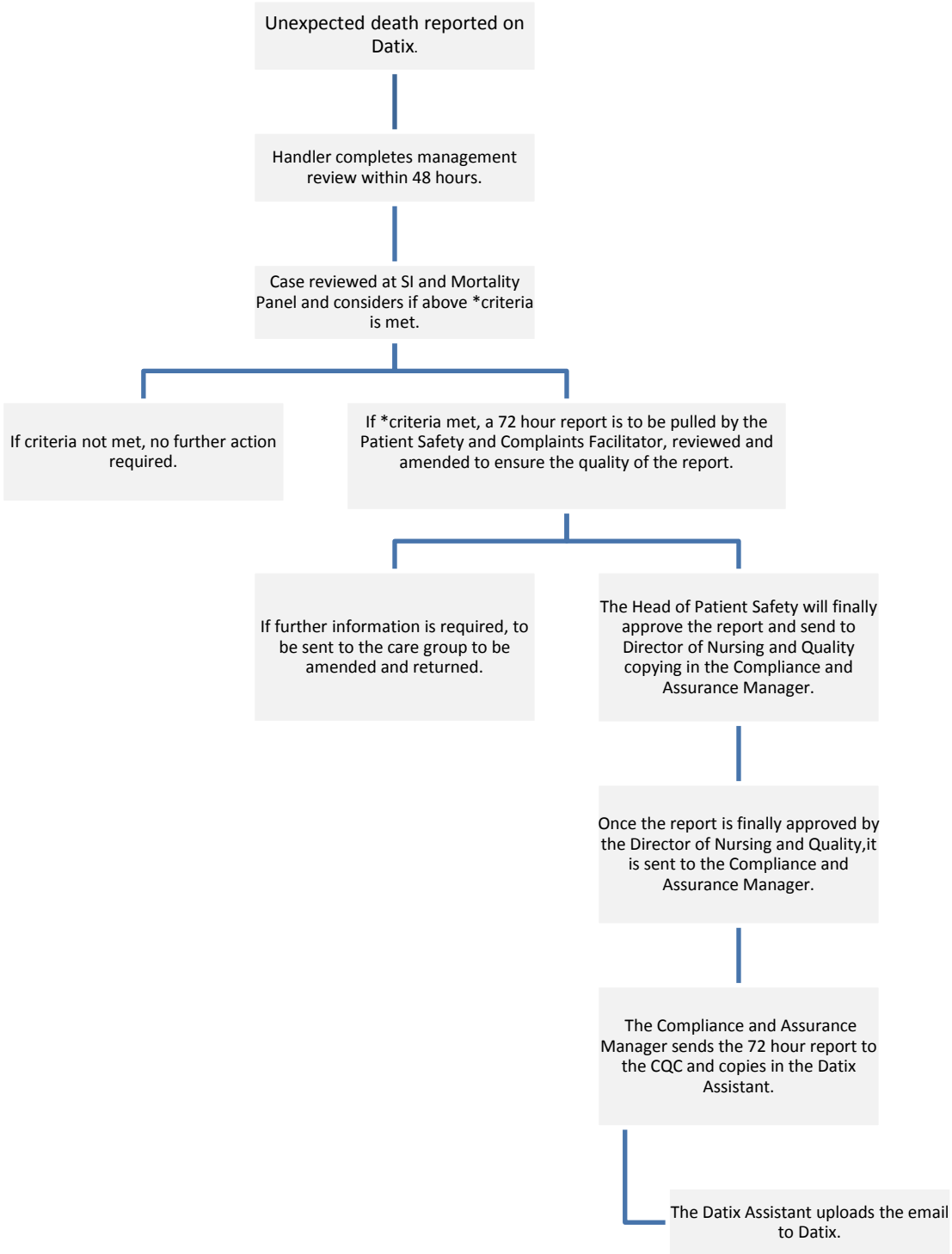
14. Scalding of patients
Patient scalded by water used for washing/bathing.
Excludes:
• scalds from water being used for purposes other than washing/bathing (e.g. from kettles)

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

APPENDIX 3 72 HOUR REPORT FLOW CHART

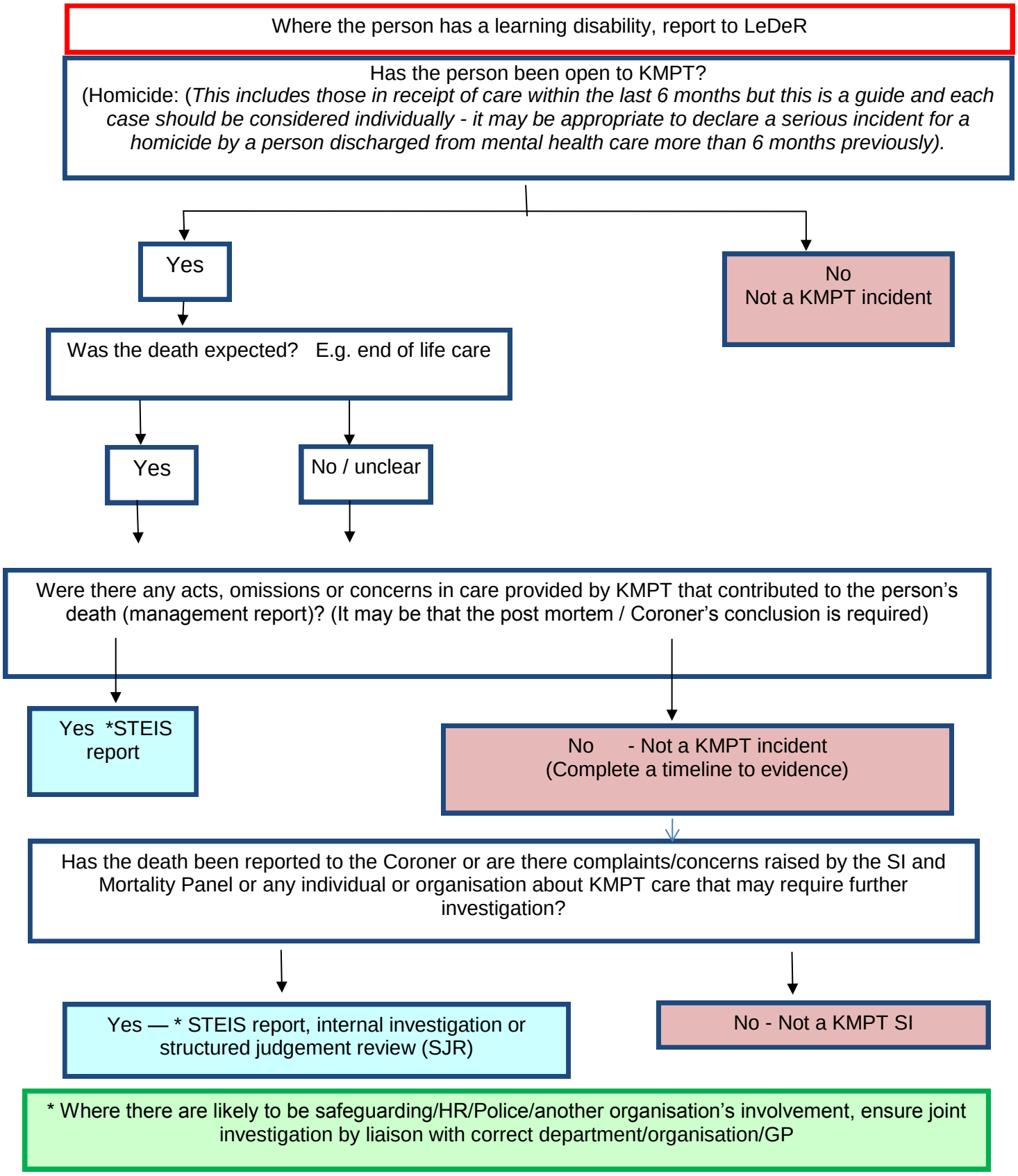
The purpose of this flow chart is to clarify the process for reporting unexpected deaths to the CQC. The CQC require informing of the cases that meet the following criteria:

* Unexpected deaths of patients that do not appear to be natural deaths
* Cases where individuals have died in acute Trusts but mental health services contributed to the death



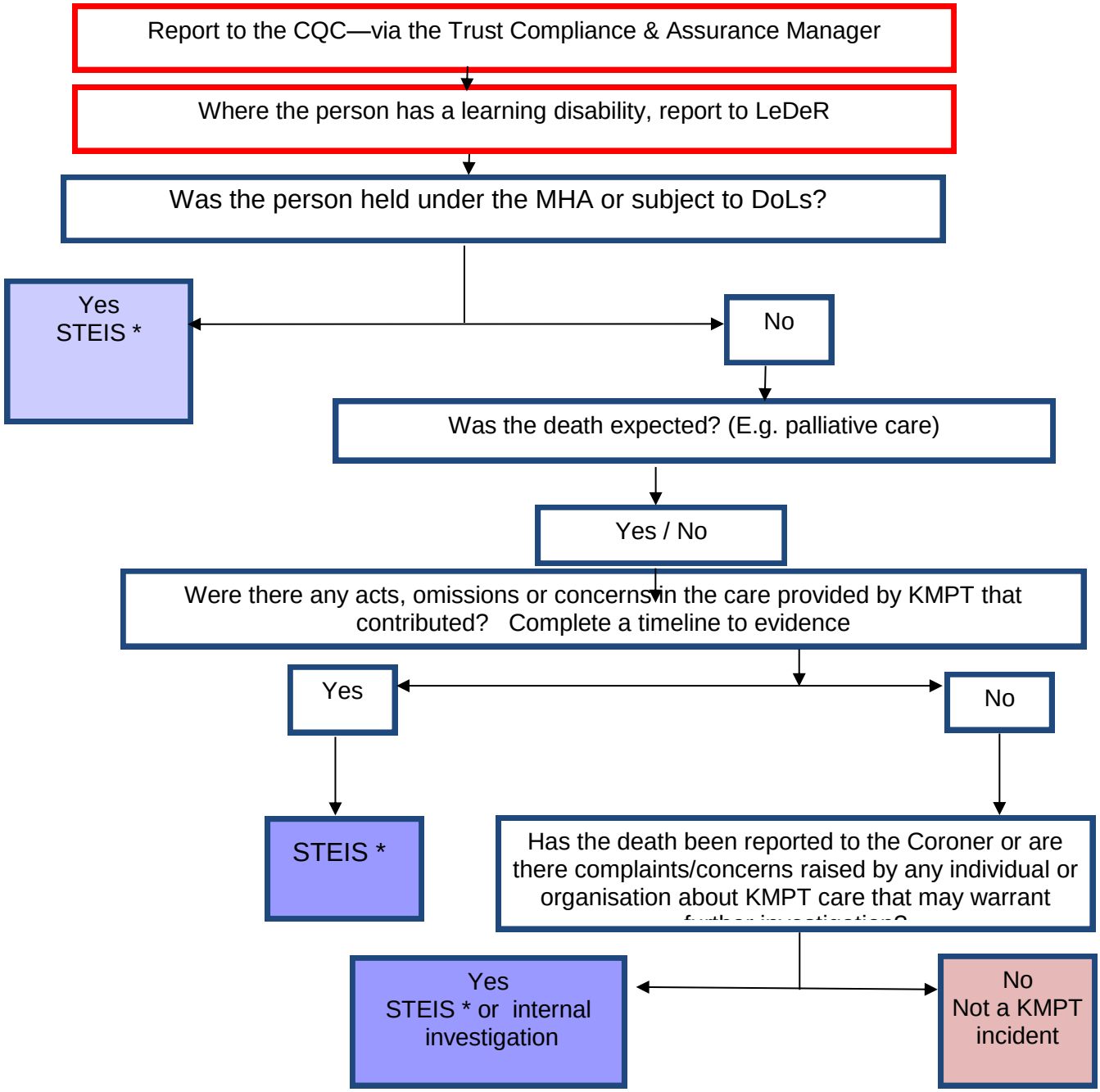
APPENDIX 4

Death in the Community
SI and Mortality Panel Decision Making (13.06.18)
following completion of the Datix management report



APPENDIX 5

IN-PATIENT DEATH
SI and Mortality Panel Decision Making (13/06/18)
following completion of the Datix management report



* Where there are likely to be safeguarding/HR/Police/another organisation's involvement, ensure joint investigation by liaison with correct department/organisation / GP