KH-HRP-009 SERIOUS UNTOWARD INCIDENT POLICY

Document Information	HR Policy		
Title	Serious Untoward Incident Policy		
Document Ref	KH-HRP-009		
Version	V1.6		
Version History	Version Number	Date of Update	Description
	1.0	01/02/2014	Author – Prof R Madhok
	1.1	Feb 2015	S Briggs
	1.2	Feb 2016	S Briggs
	1.3	Feb 2017	S Briggs
	1.4	Feb 2018	S Briggs
	1.5	Feb 2019	J Markendale
	1.6	12/05/2021	L Brearley
	1.6	May 2024	
Document Owner/Contact	Amanda Collins		
Email	Amanda.Collins@nhs.net		
Author(s)	Prof R Madhok - Operational Medical Director		
Contributors			
Review	This document will be reviewed every year, or earlier if there are changes in legislation		
Date Approved	February 2014		
Approved By	Dr Raj Kumar Managing Director		
Modifications			
Review Date	May 2025		

KH-HRP-009 SERIOUS UNTOWARD INCIDENT POLICY

Contents:

KH-HRP-009 SERIOUS UNTOWARD INCIDENT POLICY

INTRODUCTION

This document outlines the arrangements for the reporting and investigation of Serious Untoward Incidents (SUIs) within Kleyn Healthcare.

It follows the latest guidance from the various authoritative bodies , references Appendix 5. Including the recently dis-established National Patient Safety Agency. The investigations of SUIs will follow the National Patient Safety Agency's Incident Decision Tree (IDT) and Root Cause Analysis (RCA) technique. We also aim to use the Institute for Healthcare Improvement's (IHI Boston) SBAR technique and overall we will focus on establishing the root cause of the incident to understand what happened and how and why it happened.

This policy also makes clear how Kleyn Healthcare will ensure lessons are learned from all adverse events to actively reduce the risk of harm to patients, improve clinical quality and minimise the risk of similar incidents occurring in the future.

DEFINITION OF A SERIOUS UNTOWARD INCIDENT

The principle definition of a serious untoward incident (SUI) is any incident on an NHS site, or elsewhere, whilst in NHS-funded or NHS regulated care involving:

- Patients, relatives/carers
- Staff
- Members of the public

A serious incident requiring investigation is defined as an incident resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff or members of the public.
- Serious harm to one or more patients, staff or members of the public.
- allegations of abuse and especially the Never Events
- a scenario that prevents or threatens to prevent the organisations ability to continue to deliver health service, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment or IT failure.
- adverse media coverage
- fraud or suspected fraud

IMMEDIATE ACTION AND REPORTING PROCEDURE

The first action after any incident is to ensure the safety and well being of patients and staff.

Any equipment suspected of being the cause of, or implicated in the incident must, as far as possible, be withdrawn from use.

Incidents that occur during 'office hours' will initially be managed by the relevant clinical and management team. It is the responsibility therefore of all members of

staff, involved in, discovering or observing a SUI to immediately report the incident to the Clinical Director and/or the most senior manager available. In doing so the staff should use the proforma in Appendix 1.

Incidents that occur out of hours should be reported to the Director of Operations – Julie McCann
Staff must comply with the Caldicott principles of confidentiality when reporting an SUI and must not refer to patients by name or by any other identifiable information.

Statements should be obtained from witnesses as soon as possible as a written record of their recollections of events. Use proforma in Appendix 2.

MANAGING THE SUI

A flowchart outlining the reporting arrangements can be found at Appendix 3.

An initial investigation will commence no later than with 24 hours of the SUI being reported. The initial investigation will include the grading of the incident and will confirm the incident as an SUI (or not) and take appropriate action following the incident decision tree. Appendix 5

The Clinical Director for the service in which the incident has occurred will be designated as Lead Director for that incident. They will be responsible for ensuring arrangements for a full investigation are in place and will establish what communication is required and who will manage it.

All SUI investigations will be led by a senior manager appointed by the Lead Director. The senior manager appointed should have a degree of independence from the incident.

Full investigations using Root Cause Analysis will be completed within 30 days of the incident and a final report available within 45 days which should in so far as possible adopt the SBAR model, Appendix 5.

The Lead Director will be responsible for the final report and for informing the Board of the number and results of SUI investigations quarterly.

Following a review of the incident, the Medical Director will ensure that procedures are adopted or altered to reflect the lessons learnt from such incidents.

COMMUNICATION

The investigating manager will be responsible for keeping informed patients, relatives, staff, and members of the public affected by an incident. The Clinical Director will in discussion with the Medical Director agree how to involve the patient/relatives in the investigation as part of Being Open.

Once the investigation begins, staff other than the investigating manger should refrain from direct discussion with the patient or family concerned on any matters relating to the incident. Any such queries should be redirected accordingly.

Staff involved in providing information should limit any accounts of adverse incidents to their own involvement, rather than speculation or criticism of the roles of others. Their statements should be factual and should be written as quickly as possible following the incident.

Any media enquiries must be referred to the investigating manager.

The Medical Director will be responsible for informing Commissioners or any other external bodies.

CONFIDENTIALITY

Incidents related to SUIs are of a confidential nature. Staff involved in the handling of information or investigations concerning untoward incidents must not divulge information which could breach confidentiality.

Any breach of confidentiality will be treated as a serious matter and may lead to disciplinary action

SHARING OF LESSONS LEARNT

The sharing of lessons learnt post investigation is a critical part of incident management.

Following a review of the incident, the Medical Director will ensure that procedures are adopted or altered to reflect the lessons learnt from such incidents.

The Operational Manager will ensure that such procedures are disseminated to all staff.

OUR COMMITMENT TO A FAIR AND OPEN CULTURE

A clinical or non-clinical error, accident or incident, however serious, is rarely caused wilfully. It is not, in itself evidence of carelessness, neglect or a failure to carry out a duty of care. Errors are often caused by a number of factors including, process problems, human error, individual behaviours and lack of knowledge or skills. Learning from such incidents can only take place when they are reported and investigated in a positive, open and structured way.

To promote a fair and open culture and encourage the reporting of incidents Kleyn Healthcare will take a non-punitive approach to incidents.

Staff remain accountable to patients, Kleyn Healthcare and their professional bodies for their actions, but a non-punitive approach means that disciplinary action will not

be taken against a member of staff for reporting an incident, except in the rare circumstances where there is evidence of:

- Gross professional or gross personal misconduct
- Repeated breaches of acceptable behaviour or protocol
- An incident that results in a police investigation

SUPPORT FOR STAFF

Kleyn Healthcare recognises that an SUI is potentially stressful for all staff, both for those who are directly involved and those who are not.

Kleyn Healthcare will ensure that appropriate support is available to all staff.

The expectation is that line managers will offer staff involved appropriate support including the opportunity to talk through what happened with managers and colleagues.

Additional support such as individual counselling will be provided to those staff who requests it.

DISSEMINATION & IMPLEMENTATION OF THIS POLICY

Senior Managers will be responsible for ensuring their staff are fully aware of the procedure for reporting all incidents.

Formal training for all staff will be via the mandatory induction training for new staff and refresher training for existing staff.

This policy will be disseminated via email and hardcopies will be available at each site for reference.

Appendix 1

KLEYN HEALTHCARE SERIOUS UNTOWARD INCIDENT REPORTING FORM **To be completed within 24 hours of the incident occurring**	
TIME & DATE OF MAKING THE REPORT	**TIME:** **DATE:**
INCIDENT REFERENCE NUMBER (to be assigned by Operational Manager)	
LEAD DIRECTOR	
INVESTGATING MANAGER	
WHEN DID THE INCIDENT OCCUR?	**TIME:** **DATE:**
WHERE DID THE INCIDENT OCCUR?	
INFORMATION ABOUT PATIENT/s INVOLVED (patient description, initials only NOT name(s); include gender and age)	
INFORMATION ABOUT STAFF INVOLVED	

(Designations NOT names)	
WHAT HAPPENED (give a factual account of the incident including a description of any medical equipment involved)	
DESCRIBE ANY IMMEDIATE ACTION TAKEN TO PROTECT AND/OR IMPROVE PATIENT/STAFF SAFETY	
ANY OTHER RELEVANT INFORMATION	

Form completed by:

Name:.....

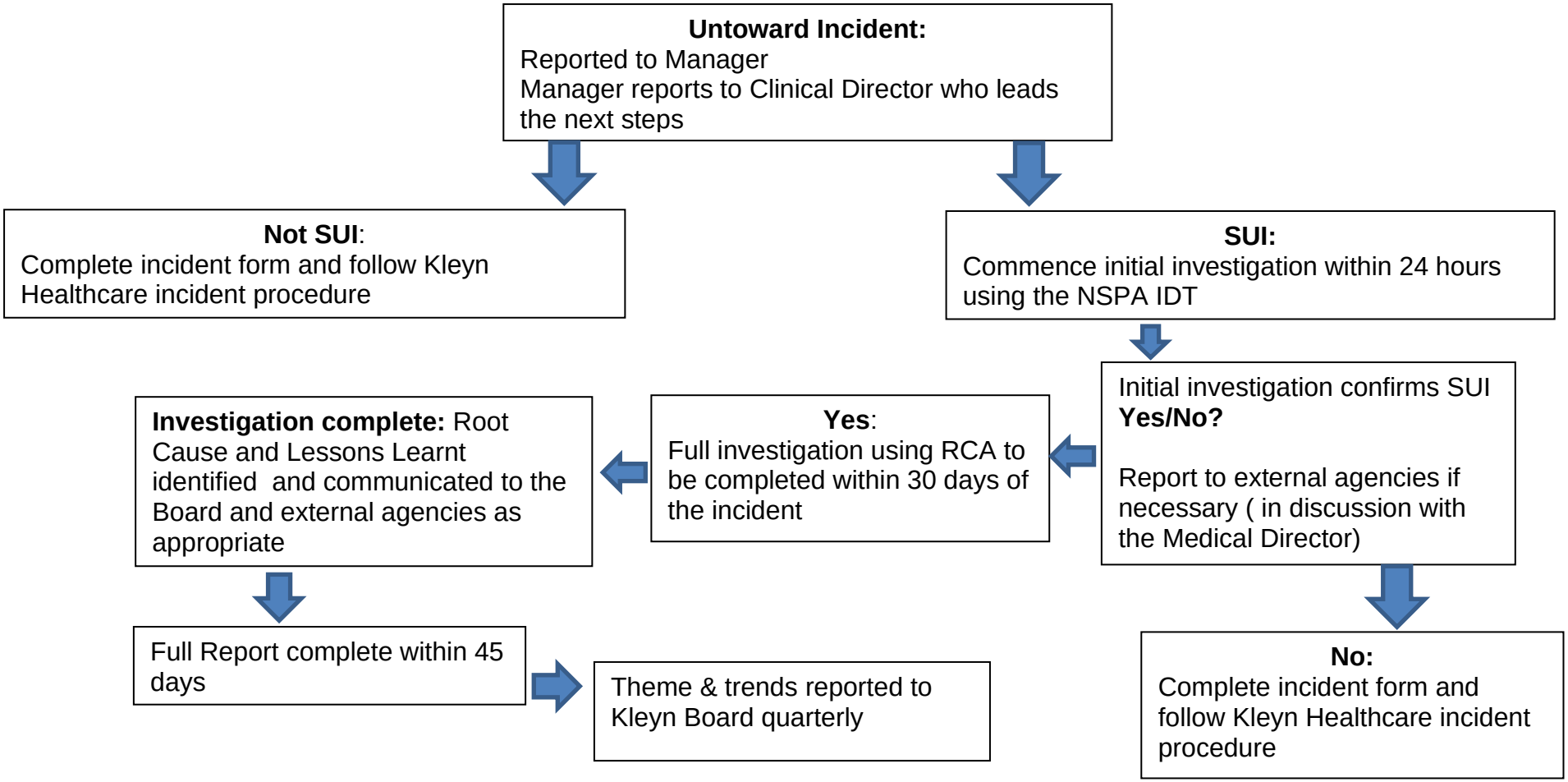
Designation:.....

Appendix 2

WITNESS STATEMENT
A copy of one of these forms is to be completed by all witnesses to the incident. They must complete the form in their own words and they should sign the statement immediately after the last line. Diagrams can be added is necessary.
Name:
Date:
Signature: **Page No.....**

Appendix 3

Serious Untoward Incident Process Flowchart



Appendix 4

KLEYN HEALTHCARE **SUI Final Report**
Incident No: **Date of incident:** **Site where incident took place:** **Reported by:**
Situation:
Background:
Assessment :
Recommendation/s:
Clinical Director (signed): **Date:**

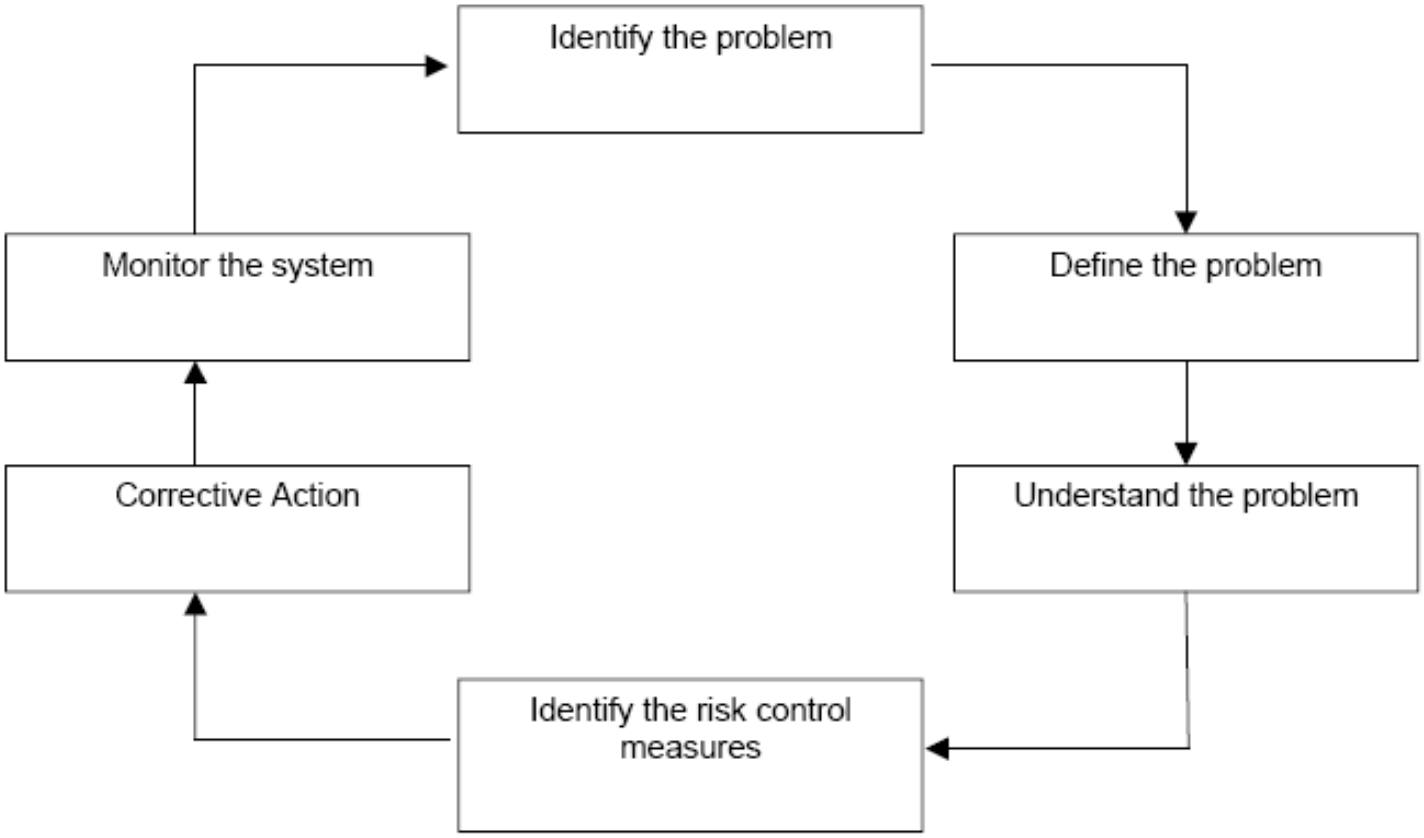
- ***Based on SBAR***

Unless the fundamental, or root causes of adverse patient incidents are properly understood, lessons will not be learned and suitable improvements will not be made to secure a reduction in the risk of harm to future patients.

Root cause analysis is a structured investigation that aims to identify the true cause of a problem, and the actions necessary to eliminate it."

Appendix 5

ROOT CAUSE ANALYSIS



Appendix 6

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

			RIDDOR/agency reportable incident An event which impacts on a small number of patients	Mismanagement of patient care with long-term effects	
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review)	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry

		Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Repeated failure to meet internal Major patient safety implications if findings are not acted on	Critical report	Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating

		rating if unresolved		Low performance rating Critical report	Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

INSTRUCTIONS FOR USE

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include on the risk

Appendix 7

Serious Untoward Incidents - links to tools, guidance and documents

National Patient Safety Agency's Incident Decision Tree (IDT) http://www.ncbi.nim.nih.gov/books/NBK20586/

Institute for Healthcare Improvement's (IHI Boston) SBAR technique
http://www.ihi.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx

National Patient Safety Agency's Root Cause Analysis (RCA)

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/