Northern Ireland Ambulance Service
Health and Social Care Trust

Title:	**Learning From Serious Adverse Incidents (SAIs) Procedure**		
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1.0 INTRODUCTION:

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

1.1 Background:

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

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

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

1.2 Purpose:

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

1.3 Objectives:

The key objectives are to ensure:

- Compliance with statutory obligations and regional guidance; i.e. HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs).
- The relevant staff are suitably trained to manage Serious Adverse Incidents (SAIs).
- All staff are aware of their particular responsibilities with regards to SAIs.
- SAIs are correctly identified, escalated and reported within HSCB timescales.
- The relevant staff, service users, family members, carers etc. are informed, and suitable arrangements are put in place for effective ongoing communication.
- Where appropriate staff provide an explanation of what happened, make any necessary apologies and take the appropriate remedial action.
- Suitable arrangements are made for Coroner involvement.
- The necessary tools and templates are available to assist all staff in the process (screenshots are available in the appendices however always check SharePoint for the most up to date templates).
- That root causes and contributory factors are identified where appropriate, and the relevant staff are involved in the identification of these factors.

- That effective remedial action is taken, lessons are learned and improvements are made at an individual and organisational level.
- Reoccurrence is prevented and where necessary, learning is embedded into existing policy, standard operating procedures (SOPs), processes, training, templates etc.
- The appropriate SAIs are reviewed at the Learning Outcomes Review Group.
- That adequate records are kept, i.e. fully embed DATIXWeb incidents.
- Those affected (including Investigating Officers) are aware of the support available, from colleagues, management, Training, Medical Directorate (and other Directorates / agencies as appropriate) and as necessary in the form of independent support.
- That the Medical Directorate is provided with appropriate information / documentation for governance / reporting / compliance purposes.

2.0 SCOPE:

This document covers Serious Adverse Incidents (defined below) and applies to:

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

2.1 What is a Serious Adverse Incident (SAI)?

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

- Serious injury to, or the unexpected / unexplained death of:
    - a service user, (including a looked after child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit).
    - a staff member in the course of their work.
    - a member of the public whilst visiting a HSC facility.
- Unexpected serious risk to a service user and/or staff member and / or member of the public.
- Unexpected or significant threat to provide service and / or maintain business continuity.
- Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service.

- serious self-harm or serious assault (including homicide and sexual assaults):

    - on other service users,
    - on staff, or
    - on members of the public

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

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

- Serious incidents of public interest or concern relating to:

    - Any of the criteria above.
    - Theft, fraud, information breaches or data losses.
    - A member of HSC staff or independent practitioner.

3.0 ROLES & RESPONSIBILITIES:

3.1 Responsibility, Accountability & Support:

This procedure incorporates a Responsibility, Accountability and Support (RAS) matrix at Appendix 1 to clearly define the roles and responsibilities for Serious Adverse Incident (SAI) management across NIAS, based on the following descriptors:

R	Responsible	This identifies the person or persons who have been assigned to do the work.
A	Accountable	This identifies those who are ultimately accountable (buck stops here!).
S	Support	This identifies those who can provide technical / expert support to the responsible and / or accountable persons as appropriate.

The corporate level RAS matrix at Appendix 1 can be supported by the development and implementation of directorate / service level RAS matrices as required.

3.2 All Staff:

In addition to such RAS matrices it must be emphasised that all staff are required to:

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

The Trust supports a 'just culture', i.e. a culture of openness and accountability where individuals are encouraged to report incidents and are not automatically 'blamed' for 'honest errors'. NIAS employees will however be held accountable for wilful violations, gross negligence and gross / repeated misconduct (normal / separate processes will apply).

3.3 <u>All Line Managers:</u>

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

- Staff are aware of the importance of ensuring SAIs are escalated.
- Staff have access to a suitable means of reporting incidents (paper / fax or online).
- Equipment involved in an SAI / faulty items / equipment are quarantined and retained for the appropriate person to inspect.
- Contact is made with staff who have reported the SAI in order to provide them with an opportunity to discuss the incident, to offer support and referrals to occupational health, counselling etc. as necessary.
- SAIs for which they are responsible are appropriately managed; this includes those raised by other healthcare professionals / other organisations for investigation within NIAS.
- Mechanisms are in place for engagement with and feedback to staff, including sharing of the final report.

- Guidance is provided to staff to ensure measures are taken to prevent the recurrence of incidents.
- Any necessary local / divisional remedial action is taken and lessons learned.
- Trust governance procedures and arrangements for wider / regional / national learning are followed.
- Resources are available for a proper investigation; this includes ensuring suitable operational resources are available so that time can be set aside for investigations.
- That root causes and / or contributory factors are identified.
- Processes are in place to refer staff for reflection / coaching / retraining etc. as appropriate.
- Trust procedures are followed in the event of an incident which may attract media attention.
- Medical Director / Risk Manager / DATIXWeb is kept up to date.

3.4 Directors:

Directors are responsible for ensuring:

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

3.5 All Staff – Information Governance / Data Protection:

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

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

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

4.0 PERFORMANCE MANAGEMENT:

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

5.0 HOW TO REPORT A SERIOUS ADVERSE INCIDENT (SAI):

If an incident occurs which meets or seems to meet any of the criteria set out in section 2.1, it must be reported immediately to line management. The line manager must make sure that the SAI is notified to the relevant Area Manager, Duty Control Manager, or in the case of non-operational staff, the Assistant Director. In all cases, either the Medical Director or Risk Manager must also be informed either verbally or via email (see below for arrangements outside of normal working hours).

5.1 Out Of Hours Arrangements:

On discovery of a potential Serious Adverse Incident (SAI) outside of normal working hours, Emergency Ambulance Control (EAC) should be notified. EAC will then contact the On Call Manager. The On Call Manager should notify the Senior On Call Manager if necessary, who will act as the co-ordinating manager. NOTE: early but sketchy information is preferable to detailed information being provided late. Depending on the area involved, the Area Manager, Duty Control Manager, or in the case of non-operational staff, the Assistant Director must be then notified via email at the earliest opportunity. In all cases, either the Medical Director or Risk Manager must also be informed via email. See Appendix 3 for a Serious Incident Checklist – On Scene / Immediate.

6.0 MANAGING ENQUIRIES FROM THE MEDIA OR THE PUBLIC:

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

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

7.0 REPORTING TEMPLATE & TIMESCALES:

Within 72 hours the relevant Area Manager / Investigating Officer, Duty Control Manager, or in the case of non-operational staff, the Assistant Director must complete the Serious Adverse Incident Notification Form (See Appendix 2 for a screenshot / SharePoint for the template) and forward it to the Medical Director and Risk Manager for approval (contact the Risk Manager for assistance as necessary). As far as possible the form should be accompanied by the C3 incident number / call number, the PRF and the DATIX reference. The form will then be forwarded to the HSCB by the Risk Manager or Medical Director and if applicable to the Regulation and Quality Improvement Authority (RQIA). **Do not submit any forms directly to HSCB / RQIA**

etc. without Medical Directorate approval.

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

7.1 General Guidance on Completing the SAI Notification Form:

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

Section	Guidance
1	Northern Ireland Ambulance Service (NIAS)
2	C3 Call Number / Incident Number and DATIX Reference
3	Ambulance Service
4	Insert date in the following format: DD / MM / YYYY
5	Exact location e.g. 123 Royal Avenue, Belfast City Hospital Car Park, Patients home etc.
6	Name - DCM / Area Manager / Assistant Director or above
7	Pre hospital care
8	Provide a brief factual description. All reports must be anonymised, staff should be referred to by job title and 'patient / service user' should be used rather than the name. For example: *On Monday 8th April 2019 at 20:20 NIAS received a call for an elderly lady in her own home in Whitehead who had been found lying on her bathroom floor. She was reported as being awake, alert and breathing normally. The call was triaged and allocated a 'green' priority i.e. not immediately life threatening. A second call was received at 21:20 enquiring about the ETA of an ambulance. At 01:19 on the 9th April, a further call was received advising that the patient was deceased.* Any Coroner involvement should be noted in this section. Include date of birth, gender and age where relevant.
9	This section will be completed by the Risk Manager
10	Briefly outline a summary of actions to date, for example: *Early QA review of triage of call to determine consistency with AMPDS protocols. Review of ambulance activity at the time also being undertaken.*
11	If relevant and known, please provide the details on the current condition of the service user.
12	Consider any actions taken / required and select the correct answer (delete those which are not applicable).

13	Consider the particulars of the incident and determine what actions will be relevant to the investigation, for example: *All call recordings and NIAS Emergency Ambulance Control computer records (C3).*
14	Select the criteria under which you consider this to be an SAI and tick
15	Consider if there are implications for others either regionally or nationally; is there learning that needs to be shared immediately to prevent further harm?
16	If the Service User / Family / Carer has been notified of the incident before completing the SAI notification form, the appropriate date of notification must be included in section 15 of the form. If notification is planned and not yet complete at the time of reporting, or not planned, the reason(s) should be explained in the "Others" free text field in section 15 of the form, or where relevant in any updated form the HSCB subsequently issues. Once engagement has taken place, record in DATIX and notify the Risk Manager so that this information can be passed to HSCB.
17	Record any action taken with any regulators, Coroner etc.
18	Record the date(s) that any other organisations were informed
19 – 21	The remaining sections will be completed by the Risk Manager and the Risk Manager will inform SEMT.

Remember: do not submit any forms directly to HSCB / RQIA etc. without Medical Directorate approval.

7.1.1 Recording Coroner Involvement on the SAI Notification Form:

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

8.0 INTERFACE INCIDENTS (POTENTIAL SAIs):

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

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

Risk Manager).

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

9.0 QUERY SERIOUS ADVERSE INCIDENTS (QSAIS):

The responsibility for identifying and escalating an SAI lies with the directorate in which the incident occurred. To support the directorate incident review processes and to act as a further control to delayed reporting, the Medical Directorate may query any incident report where SAI criteria appears to have been met but where the date for reporting the incident as an SAI is overdue and with no indication that it is being reported or considered. This is known as a Query SAI (QSAI) and "QSAI" is added to the incident reference.

Once an incident is identified as being a query SAI (QSAI) it is forwarded to the relevant Area Manager, Duty Control Manager or Assistant Director for consideration for reporting as an SAI. The incident will remain open as a QSAI until the Medical Directorate receives either:

- A completed approved SAI Notification form relating to the incident.

  OR

- An investigation report or if not applicable, a clear explanation of why the incident does not meet the criteria for reporting as an SAI. The investigation report should include any learning and actions taken to prevent re-occurrence where applicable. Please note that the decision not to report as an SAI may be subject to challenge by the Medical Director / SEMT as appropriate.

The response to the QSAI should be sent to the Risk Manager and any report should also be included within the DATIXWeb incident record and referenced in the investigation section.

10.0 PROCEDURE FOR INVESTIGATING SERIOUS ADVERSE INCIDENTS (SAIs):

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

10.1 Level of SAI Investigation:

When reporting an SAI, the responsible Investigating Officer (in conjunction with the Medical Director / Risk Manager) must decide on the level of investigation required and this will be indicated on section 19 of the SAI Notification form. There are three recommended levels of investigation for SAIs.

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

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

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

10.2 Level 1 Investigation:

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

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

The possible outcomes may include:

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

The template must be completed, approved by the relevant Assistant Director and sent to the Medical Director / Risk Manager for review and onward reporting to the HSCB

within 8 weeks of the SAI being reported. Please provide at least five working days to allow for redacting and final checks / comments / feedback by the Medical Directorate and ensure DATIX is up to date, PRFs, ECGs etc.

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

10.3 Level 2 Investigation:

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

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

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

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

10.4 Level 3 Independent Investigation:

Level 3 investigations will be considered for highly complex SAIs where a high degree of external / independent representation on the investigation team is required. In some instances all team members may be independent to NIAS. The timescales for

reporting, Chair and membership of the review team will be agreed with the HSCB / PHA Designated Review Officer (DRO) at the outset. The Director / Medical Director will liaise with the DRO through the Risk Manger to agree timescales, team membership and terms of reference. Level 3 investigation reports will take the same format as level 2 and use the same template structure for the final report. Any SAI which involves an alleged homicide perpetrated by a service user known to / referred to mental health and / or learning disability services will be investigated as a level 3 incident. In these instances, the Protocol for Responding to an SAI in the Event of a Homicide, issued in 2010 and revised in 2013 should be followed (see appendix 13 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents).

11.0 COMPLETION OF TEMPLATES:

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

- The report should be a complete picture taking evidence from all sources (what happened, what should have happened, what directly caused this, what contributed and what will be done to improve the situation).

- **Always have the reader in mind, i.e. service user / family members / carers.** Jargon or unexplained abbreviations must not be used within the report. Although clinical shorthand would be understandable to other clinicians, an SAI report is a formal report and not a clinical record. As such it should be understandable to non-clinicians including the service user / family members / carers and the Coroner. Also you may not be present make any explanations. See Appendix 7 for a list of acronyms which can be appended to the report if necessary.

- All reference to services, organisations, facilities etc. should be explained fully if not otherwise obvious to the reader e.g. it is not sufficient to include the name of a facility without explaining the purpose / function of the building.

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

12.0 INVESTIGATION REPORT EXTENSIONS:

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

- Level 1 Investigations – HSCB will not accept extension requests for this level of investigation. When reporting, an additional 2 weeks can be sought by exception only, giving the reason for the delay.

- Level 2 Investigations – In most circumstances, timescales for submission of RCA investigation reports must be adhered to. However, it is acknowledged there may be some occasions where an investigation is particularly complex, perhaps involving two or more organisations. In these instances the reporting organisation may request an extension to the normal timescale i.e. 12 weeks from timescale for submission of interim update report. However, this request must be approved by the DRO and should be requested when submitting sections 2 & 3 of the report at 4 weeks.

- Level 3 Investigations – Independent as per above, all timescales (including possible extensions) must be agreed with the DRO at the outset of the investigation.

13.0 DESIGNATED REVIEW OFFICER (DRO) / HSCB QUERIES:

- Level 1 Investigations – DRO queries must be responded to within 1 week of the query being received.

- Level 2 Investigations – DRO queries must be responded to within 4 weeks of the query being received.

- Level 3 Investigations – Independent DRO queries must be responded to within 4 weeks of the query being received.

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

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

Addendum 1 of the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents sets out requirements for engagement / communication with the service users / family / carer, following a Serious Adverse Incident (SAI). In particular, the following paragraph should be adhered to:

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

The Director responsible for the SAI should ensure the appropriate level of involvement of service user / family / carer throughout the investigation.

14.1 Process For Engagement:

It is vital that the incident is acknowledged by a Manager from the Trust and that there is openness and transparency throughout the process. The service user / family member / carer should be contacted via telephone within **5 working days** to advise them that the Trust considers that a serious incident has occurred and that a thorough investigation will be carried out to determine what happened, how and why. At this point an offer should be made to meet the family to explain the SAI process and how they can be involved. The SAI investigation process should be explained to the service user / family member / carer and they should be informed that there will be a final written report which will include recommendations, and that this will be discussed / shared with them. Full contact details should be taken and agreement reached as to the best person / family member to liaise with, and the best means / time to contact them (see Appendix 8 for guidance on engaging with family members / service users / carers via telephone). **This phone call must be followed up with a letter (see Appendix 9) and accompanied by the 'What I need to know about a Serious Adverse Incident' Leaflet For Service Users, Family Members and Carers Leaflet (see Appendix 10 and SharePoint).**

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

14.2 Unable to engage with service user / family member / carer:

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

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

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

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

14.3 Service User / Family / Carer Involvement Section Of The Report:

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

14.4 Recording Coroner Engagement in the Report:

Reports should also routinely include in their chronology details of all engagements with the Coroner where a death has occurred and if the Coroner has not been involved this should be stated and the decision explained. The Director responsible for the SAI should also ensure the completion of an SAI Investigation Report checklist when submitting Investigation reports to HSCB. This checklist will seek information regarding notification to the Coroner and current status of the case.

15.0 ACTION PLANS:

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

15.1 Action Plan Responsibilities / Requirements:

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

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

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

Action plans must incorporate SMART principles:

S Specific – clearly defined actions to be completed, with clearly defined owners (both name and designation).
M Measurable – how will implementation and effectiveness be measured.
A Aligned – actions and action plans must be aligned with relevant policies and procedures and agreed by relevant action owners.

R Realistic – actions must be achievable, with sufficient resources, within agreed timescales.
T Time bound – both target and actual completion dates should be captured.

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

15.2 Generating actions from the final report:

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

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

15.3 Plan To Share Action:

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

15.4 Developing an Action Plan:

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

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

15.5 Documentation:

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

15.6 Monitoring:

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

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

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

The Learning Outcomes Review Group will:

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

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

16.0 LEARNING:

Any learning from SAI investigations must be shared as appropriate. Each SAI must be summarised and presented to the Learning Outcomes Review Group by the Lead Officer on the NIAS Learning Letter Template (see Appendix 13). Agreement will be reached as to the most appropriate means of sharing learning on a case by case basis.

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

Where a Serious Adverse Incident (SAI) is also a Complaint / Litigation / Special Case Review etc., the investigation under the SAI process will take precedence and the

Complaint / Litigation / Special Case Review will be put on hold until the SAI investigation is complete. In the event of

In terms of Complaints, the Complaints Manager should notify the Complainant of this as soon as possible. The leaflet 'What do I need to know about SAIs' should be given to the Complainant along with an explanation of the change in process (see Appendix 10). Note that communication through the complaints process with the Complainant should continue regarding timescales and any associated delays. The SAI investigation process as per above will also have a link person identified to communicate with the service user / family / carer and will communicate through this process as appropriate. When complete the SAI final report will be shared with the Complainant and the complaints process remains open until the complaint is formally closed with all complaints issued addressed.

18.0 SAFEGUARDING CHILDREN & ADULTS:

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

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

19.0 SAIs INVOLVING PSNI / HSENI:

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

The MoU compliments existing joint procedures in relation to the protection of children and vulnerable adults.

20.0 CLOSURE OF THE SERIOUS ADVERSE INCIDENT (SAI):

The SAI can be closed (on DATIX) once it has been agreed by the Learning Outcomes Review Group that the action plan is complete and no outstanding issues remain. This process will usually include ensuring that the HSCB has also closed the SAI (which they do via email to the Risk Manager). Notification of this will be added to the DATIX record by the Medical Directorate. The Director / Assistant Director / Area Manager / Investigating Officer is responsible for ensuring that final versions of the report and action plan are added to DATIX. Up until this stage, the version used will be a "final approved draft" and subject to change due to further material changes for example after comments received from family members. Any change will be under strict version control through the Medical Director / Risk Manager approved by the Director / Assistant Director / Area Manager / Investigating Officer and presented as an addendum to the report and forwarded to HSCB and any other relevant stakeholders.

21.0 SERIOUS ADVERSE INCIDENT (SAI) TRAINING:

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

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

Training will be delivered using a variety of methods, for example face to face, learning packs, workshops etc. (see Appendix 6 for current list of staff who have been trained at time of publication).

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

22.0 MONITORING:

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

- Governance Framework (under review).
- Assurance Framework.
- Controls Assurance Standards (under review).
- Learning Outcomes Review Group.
- Health and Safety Committee.
- Assurance Committee.

- Accountability / Performance Management Processes.
- Incident Management Training records.

This Procedure will be reviewed every three years by the Risk Manager in consultation with a short life working group and the Learning Outcomes Review Group. Feedback from stakeholders will be taken into consideration, along with a review of systems / processes along with ongoing analysis of the actual management of SAIs via the assurance structure. Processes will be benchmarked nationally and against any new legislation, best practice or guidance. Audit findings will be taken into consideration.

23.0 EVIDENCE BASE / REFERENCES:

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

24.0 CONSULTATION PROCESS:

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

25.0 EQUALITY STATEMENT:

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

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

Major impact ☐
Minor impact ☐
No impact. ✓

26.0 SIGNATORIES:

Katrina Keating **Date: 21st May 2019**
Lead Author

Dr Nigel Ruddell **Date: 21st May 2019**
Lead Director

APPENDIX 1 – RESPONSIBILITY, ACCOUNTABILITY & SUPPORT MATRIX (SERIOUS ADVERSE INCIDENTS - SAIs):

	SAI MANAGEMENT FUNCTION	NIAS ROLE / POST									
		CEX	SEMT	Med Dir	Dir HR	Dir FIN	Dir OPS	AD / IO	Line	All	Comments
1	Ensuring compliance with both legislation and national / regional incident guidance (i.e. ensuring that partner agencies and other stakeholders are informed of SAIs as necessary). Ensuring that SAIs are effectively managed across NIAS through the implementation of suitable policies, procedures and accountabilities, and that internal governance procedures provide adequate assurance that processes are suitable and sufficient.	A	R	R	R	R	R	S	S	S	
2	Ensuring Trust Board is kept suitably informed of how effectively SAIs are being managed across NIAS.	A	R	R	R	R	R	S	S	S	
3	Ensuring Assurance Committee is kept suitably informed of SAIs, any particular concerns, trends / themes / peaks and of any action plans to address.	A	R	R	R	R	R	S	S	S	
4	Ensuring SAIs are effectively monitored, and formally reviewed on a monthly basis by SEMT.	A	R	R	R	R	R	S	S	S	
5	Embedding a 'just culture', i.e. a culture of openness and accountability where individuals are not blamed for 'honest errors' but are held accountable for wilful violations and gross negligence. Embedding a culture where everyone learns from incidents and makes any necessary improvements.	A	R	R	R	R	R	R	R	R	
6	Ensuring all relevant actions / recommendations from Serious Adverse Incidents (SAI's) are monitored, implemented and reported on as required.	A	R	R	R	R	R	R	S	S	

	SAI MANAGEMENT FUNCTION	NIAS ROLE / POST									
		CEX	SEMT	Med Dir	Dir HR	Dir FIN	Dir OPS	AD / IO	Line	All	Comments
7	Ensuring the relevant SAIs are discussed at the Learning Outcomes Review Group for oversight of the implementation of recommendations and learning.	S	S	A	R	R	R	R	S	S	
8	Identifying common trends and / or incidents, common contributory factors and common actions / recommendations, with the aim of identifying actions that maximise effectiveness, make the most efficient use of NIAS resources, and ensure all relevant lessons and opportunities for improvement are shared via the Learning Outcomes Review Group.	R	R	A	R	R	R	S	S	S	Key staff may attend to report on specific incidents
9	Lead on the effective implementation of the SAI Procedure across each directorate, including: • Ensure the timely reporting of the correct incidents. • Ensure that those incidents which require immediate attention are escalated promptly to the correct person to initiate a suitable response. • To ensure the proportionate investigation of incidents. • To provide the necessary resources, tools/templates to assist in the process. • Support a 'just culture'. • Ensure that root causes are identified where appropriate. • Effective communication on SAIs to all relevant staff. • Ensure that cover arrangements are in place so that the SAI process continues in the event of sickness, absence, annual leave etc. • Ensuring adequate support is available for staff all involved. • Engaging with patients and families. • Ensure that effective remedial action is taken and lessons are learned • Encouraging staff to provide an explanation of what happened, an apology and take appropriate remedial action. • The provision and maintenance of appropriate training and resources to support required competencies and effective incident management. • Analysis of themes and trends and the implementation of relevant learning in the Area / Directorate.	A	R	R	R	R	R	S	S	S	

	SAI MANAGEMENT FUNCTION	NIAS ROLE / POST									
		CEX	SEMT	Med Dir	Dir HR	Dir FIN	Dir OPS	AD / IO	Line	All	Comments
	• Escalation of any themes / risks in compliance with the Corporate Risk Management Strategy. • Ensure the Medical Directorate is kept up to date. • Contribute to the Learning Outcomes Review Group. • Support the implementation of DATIXWeb.										
10	• Oversight of all Serious Adverse Incidents (SAIs), Never Events etc. (NIAS guidance pending). • Providing advice to senior management on issues of competence in incident management and / or arranging incident management training. • Ensuring relevant issues are escalated in line with the Corporate Risk Management Policy and Procedures. • Notifying other relevant agencies where appropriate for example Local Negligence Network (LIN), Northern Ireland Adverse Incident Centre (NIAIC), Regulation, Quality and Improvement Authority (RQIA), Department of Health (DoH), Health and Social Care Board, (HSCB), HM Coroner, Health and Safety Executive for Northern Ireland (HSENI), Police Service of Northern Ireland (PSNI), Northern Ireland Fire and Rescue Service (NIFRS), Public Health Agency (PHA). • Responding to requests for SAI investigations and by other Trusts (including Pharmacy providers) and other organisations for example DoH, HSCB. • Dealing with investigations by statutory / regulatory bodies e.g. HM Coroner, PSNI, HSENI, RQIA etc. • Reporting and highlighting of themes / trends quarterly to Trust Board, Assurance Committee and all other Groups and Committees as per assurance framework. • Populating SharePoint with quarterly reports. • Monthly report to Senior Executive Management Team (SEMT). • Ad hoc reports as necessary. • Participating in regional and national benchmarking exercises. • Responding to media enquiries, Freedom of Information Requests (FOIs) etc. relating to information held by the Medical Directorate. • Advising the Trusts Communication Team of any incidents which are likely to attract media attention (every effort must be made to ensure that the service	S	S	A	S	S	S	R	S	S	

	SAI MANAGEMENT FUNCTION	NIAS ROLE / POST									
		CEX	SEMT	Med Dir	Dir HR	Dir FIN	Dir OPS	AD / IO	Line	All	Comments
	user/relatives/carers etc. area informed of relevant information prior to the media). • Any other incidents involving staff in the Directorate. **NOTE: It is the role of the Medical Directorate ONLY to report to external agencies.**										
11	• Ensure individuals involved (staff, patients, service users, visitors etc.) and the environment / equipment are made safe as far as possible. • With regards to SAIs that involve service users, family members or carers, as appropriate, provide an acknowledgment, explanation and apologise if and when appropriate. • Remove and immediately quarantine any piece of faulty equipment. • Report incidents / SAIs in compliance with Trust incident reporting procedures. • Ensure escalation of incidents meeting SAI criteria ASAP to the relevant line manager. • Follow all incident management policies and procedures; adhere to the relevant investigation timescales. • Attend any training required. • Lead / participate in / co-operate with the investigations of SAIs, providing witness statements and any other information that will assist with the investigation of the SAI as directed by the procedures. • Support line management with the monitoring and implementation of SAI action plans, recommendations and learning. For example helping to draft learning letters etc. • Implement any actions within your sphere of control. • Escalate any actions which are not within your sphere of control. • Encourage others to avail of the necessary support. • Report any hazards with the potential to cause harm. • Escalate to line management any concerns with regards to the above.	R	R	R	R	R	R	R	R	R	
R	**Responsible – This identifies the person or persons who have been assigned to do the work.**										

	SAI MANAGEMENT FUNCTION	NIAS ROLE / POST									
		CEX	SEMT	Med Dir	Dir HR	Dir FIN	Dir OPS	AD / IO	Line	All	Comments
A	**Accountable – This identifies those who are ultimately accountable (buck stops here).**										
S	**Support – This identifies those who can provide technical/expert support to the responsible and/or accountable persons as appropriate.**										

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

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION: Northern Ireland Ambulance Service (NIAS)	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILITY / COMMUNITY LOCATION Ambulance Service	4. DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT	
6. CONTACT PERSON:	7. PROGRAMME OF CARE: Pre hospital

8. DESCRIPTION OF INCIDENT:

Provide a brief factual description of what has happened and a summary of the events leading up to the incident. PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE. Where relevant include D.O.B, Gender and Age. All reports should be anonymised – the names of any practitioners or staff involved must not be included. Staff should only be referred to by job title.

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: 22 years

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO	✓	

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE:	DETAIL:	ADVERSE EVENT:

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:
Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

11. CURRENT CONDITION OF SERVICE USER: ***(complete where relevant)***
***Where relevant** please provide details on the current condition of the service user the incident relates to.*

	YES	NO	N/A
12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*			
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*			

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	✓
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault ***(including attempted suicide, homicide and sexual assaults)*** **by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service**	
serious self-harm or serious assault ***(including homicide and sexual assaults)*** - **on other service users,** - **on staff or** - **on members of the public** **by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services)* and/or learning disability services, in the 12 months prior to the**	

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

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

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' *(full details should be submitted)*:		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?		
	YES	DATE INFORMED: DD / MM / YYY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' *(full details should be submitted including the date notified)*:		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		*Coroner had already been notified by PSNI.*
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: Katrina Keating Designation: Risk Manager

Email: katrina.keating@nias.hscni.net Telephone: 028 9040 0999 Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

~~Completed proforma should be sent to: seriousincidents@hscni.net~~
~~and (*where relevant*) seriousincidents@rqia.org.uk~~

NOW RETURN TO THE MEDICAL DIRECTOR / RISK MANAGER

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

- Record ALL persons involved (other services, Trusts etc.).
- Take any immediate action to minimise the risk to other patients, staff or anyone else affected. Staff must act within their own capabilities and training, expert help should be sought if necessary, e.g. Officers, NIFRS, HART etc.
- Contact the Medical Director / Risk Manger or the On Call Director if out of hours.
- Consider who else needs to be informed, e.g. Communications Team, HSENI, PSNI, Coroner etc.
- Ensure an incident form is completed, submitted and line manager informed.
- Take brief statements or if this is not possible, ensure that individuals involved make statements within 48 hours (see NIAS Guidelines for Statements, Interviews and Hearings).
- Record and secure any equipment involved.
- Record and secure any documentation involved.
- Identify and make arrangements for the provision of support for staff, service user / family member / carer etc. Face to face meetings are preferable.
- Assist the Communications Team / Medical Director / Risk Manager with the preparation of any statements / Early Alerts.
- Advise the Risk Manager or Medical Director via email / voicemail if not already notified.

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

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

Typical Team:

- Chair / Lead – Director / Assistant Director / Designated Investigating Officer (for cases which are not complex) to oversee proceedings, agree the final report and submit it.
- Line Manager to produce a synopsis of the facts, obtain statements, prepare a list of witnesses.
- Medical Director / Risk Manager or his / her designated officer.
- Clinical Training Manager or his / her designated officer.

Optional / as appropriate:

- External Advisor.
- Note taker.

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

Individuals Required To Attend:

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

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

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

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

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

APPENDIX 5 – SAMPLE TERMS OF REFERENCE (LEVEL 2 / 3 SAIs). See SharePoint for the most up to date template:

Introduction:

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

Purpose of investigation (delete as appropriate):

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

- The investigation will focus on <time/date> to <time/date>.
- The investigations includes <name/title>.
- A report will be provided detailing the findings and recommendations of the investigation.
- It is expected that the investigation will commence on <date> and be completed by <date>.

APPENDIX 6 – STAFF WHO HAVE ATTENDED SAI TRAINING:

SERIOUS INCIDENT INVESTIGATION & REPORTING	
16-04-2018	
NAME	**JOB TITLE**
Norman Cunningham	Duty Control Manager
Eddie Richmond	Duty Control Manager
Kieran Devine	Duty Control Manager
Gary Richardson	Area Manager
Seamus McAllister	Clinical Training Manager
John Wright	AD Operations
Sean Graham	Emergency Planning Support Officer
Katrina Keating	Risk Manager
Keith Stewart	Station Officer
Fiona McGarey	Station Officer
Ken Reid	Regional Training Officer
Mark Cochrane	Area Manager
Ruth McNamara	Area Manager
Laura Hill	Datix Administrator
Michael McConville	Station Officer
Evelyn Hughes	Station Officer
Tommy Blee	Station Officer
Jeremy Cowen	Emergency Planning Officer
Alan McAuley	Duty Control Manager
Nigel Ruddell	Medical Director

SERIOUS INCIDENT INVESTIGATION & REPORTING	
15-05-2018	
NAME	**JOB TITLE**
Heather Sharpe	Emergency Planning Support Officer
Bryan Snoddy	AD Operations (Performance)
Malcolm Stewart	NEAC Manager
John McClintock	Station Officer
Neil Duncan	Station Officer
John Amos	Regional Training Officer
Frank Orr	Assistant Director of HR, ELD
Joe McCaughern	Station Officer
Glyn Mercer	Station Officer
Sammy Nicholl	Station Officer
Ciaran McKenna	Clinical Service Improvement Lead
Rob McConnell	Station Officer
David Marshall	Clinical Hub Manager
Frank Armstrong	Divisional Training Officer
Sean Maguire	Divisional Training Officer
Gareth Tumelty	Area Manager

Laura Coulter	Area Manager
David McCrory	Station Officer
Gary Alexander	Health & Safety Advisor

SERIOUS INCIDENT INVESTIGATION & REPORTING	
08-06-2018	
NAME	**JOB TITLE**
Jonny McMullan	Control Quality Assurance Auditor
Heather Lyons	Control Training & Quality Assurance Officer
Glenn O'Rorke	HEMS Operational Lead
Andrew Chambers	Regional Training Officer
Andrew Moore	Station Officer
Jonathan Noble	Clinical Training Manager
Michael Heasley	Fleet Manager
Shirley Jones	Duty Control Manager
Norman Wotherspoon	Duty Control Manager
Tommy Sinnerton	Regional Training Officer
Joanne Murphy	Clinical Support Officer
Brian McNeill	Director of Operations
Phil Lockhart	Station Officer
Joanna Smylie	Station Officer
Simon Fell	Station Officer
Sarah Williamson	Transformation and Organisational Change Manager
Karen McVeigh	HALO
Sean Mullan	Station Officer
Lorraine Gardner	Assistant Director of HR (Employee Relations)

SERIOUS INCIDENT INVESTIGATION TRAINING – BUILDING COMPETENCY	
20-03-2019	
NAME	**JOB TITLE**
Gary Alexander	Health and Safety Advisor
Nick Alexander	Hospital Ambulance Liaison Officer
Frank Rafferty	EAC Continuous Development Manager
22-03-2019	
Stephanie Leckey	Community Resuscitation Lead
Andrew Watterson	Complaints & Administration Manager
David Marshall	Clinical Hub Manager
25-03-2019	
Laura Hill	DATIX Administrator.
Ciaran McKenna	Ciaran McKenna – Clinical Service Improvement Lead.
SERIOUS INCIDENT INVESTIGATION TRAINING – MASTERCLASS	
26-03-2019 & 27-03-2019	
Neil Duncan	Station Officer
Katrina Keating	Risk Manager
Malcolm Stewart	Non-Emergency Ambulance Service (date pending)

APPENDIX 7 – LIST OF ACRONYMS:

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

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

Following an SAI the Investigating Officer must engage with the service user / family member / carer within **5 working days**.

The service user / family member / carer must be advised that that the Trust considers that a serious incident has occurred and that a thorough investigation will be carried out to determine what happened, how and why. The following information may assist:

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

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

Record significant dates / times and actions taken in DATIX.

Remember there is a professional obligation to be open, transparent and honest (Duty of Candour pending for Northern Ireland).

APPENDIX 9 STANDARD LETTER (See SharePoint for the most up to date template):

Northern Ireland Ambulance Service
Health and Social Care Trust

REF Call Number: 1234567

8th April 2019

Private & Confidential

ADDRESS

Dear NAME,

SUBJECT HEADING

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

Patients Name: Mrs XXXX

Address: 123 Rainbow Road, Anytown

Date of Birth: 08/04/2000

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

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

Your link person is:

Name: Mr Bob Baxter

Job Title: Station Officer

Telephone Number: 028 9040 0999

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

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

Yours sincerely,

_____

NAME

(Job Title)

Enc

Northern Ireland Ambulance Service Health and Social Care Trust, Ambulance Headquarters, Site 30 Knockbracken Healthcare Park, Saintfield Road, Belfast BT8 8SG • Tel: 02890 400999 • Fax: 02890 400900 • Textphone: 02890 400871 • www.niamb.co.uk

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

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

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

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

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

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

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

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number 0800 917 0222

Further Information

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

Your link person is

Your link person's job title is

Contact number

Hours of work

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

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

You could also:

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

Northern Ireland Ambulance Service Health and Social Care Trust

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

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

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

Introduction

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

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

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

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

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

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

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

Can a complaint become a SAI?

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

How is a SAI reviewed?

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

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

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

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

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

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;
- Are offered advice in the event that the media make contact.

What happens once the review is complete?

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

How will learning be used to improve safety?

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

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

For each completed review:

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

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

Do families get a copy of the report?

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

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

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

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

- Make contact via telephone using the information provided during the initial contact.
- Briefly outline the fact that the report has been drafted and NIAS would be keen to share it / discuss it with them. If necessary remind them of the SAI process.
- Agree a time suitable to all parties and advise them who should / will attend. Every situation will be different but here are some people who might participate:
    - Manager familiar with the department / someone with enough experience to answer as many questions as possible.
    - Second clinician can be helpful to clarify anything that the service user / family member / carer finds confusing.
    - Person to support the service user – discuss this with the service user / family member / carer over the phone and suggest that it may be helpful for them to have someone there to listen and ask any questions.

- Gather the relevant information and make sure that it is are correct, e.g. patient's name, date of incident, time of incident, location, what happened etc.
- Think through what you are going to say. Perhaps put yourself in the position of the service user / family member / carer to help you think of some questions that may come up.

- On arrival identify everyone clearly, providing names, job titles etc.
- Speak respectfully and clearly and check that the person understands what you are referring to. Allow the person time process what you are saying. Do not rush, use acronyms etc.
- Be empathetic at all times.
- It is possible to identify a shortcoming without there being any blame, for example a capacity / demand issue.

Summary:

- Acknowledgement.
- Explanation.
- Apologise where appropriate.
- Changes made / lessons learned.

- The Medical Director / Risk Manager must be kept informed of any family engagement.

- **Record significant dates / times and actions taken in DATIX.**
- **Remember there is a professional obligation to be open, transparent and honest (Duty of Candour pending for Northern Ireland).**

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

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

Northern Ireland Ambulance Service
Health and Social Care Trust

SERIOUS ADVERSE INCIDENT (SAI) ACTION PLAN / TRACKING TEMPLATE			
Action Plan Agreed / Monitored by:		SAI Ref / Datix Ref / Call Number:	
Team Members:			
Name:		Designation:	
Name:		Designation:	
Name:		Designation:	

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

This section to be completed once all actions are concluded:

Accountable Officer (Print Name):		Designation:	
Signature:		Date:	

On Target	Green
Partially On Track	Amber
Not Achieved	Red

*Name and designation

NOTE: action plans must be reviewed monthly

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

NIAS LEARNING LETTER

SAFETY MESSAGE:			
REF:		DATE ISSUED:	

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

SUMMARY OF EVENT (WHAT HAPPENED AND WHY)

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

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

Approved By (Print Name):		Designation:	
Signature:		Date:	

APPENDIX 14 – SAI FLOWCHART: