SERIOUS INCIDENT PROCEDURES

Introduction

This policy details the process for the management of incidents. This includes incidents ranging from 'No Harm' to 'Serious Incidents'. The aim of this policy is to ensure that all incidents, whether clinical or non-clinical are reported to the Senior Management Team, investigated appropriately and action[s] taken to minimise the risk of reoccurrence.

PSIRF (patient safety incident reporting Framework) is a whole system change to how we respond to patient safety incidents and is fundamental to the wider improvement work Vranch House is already undertaking. A key component of this will be the greater involvement and interactions of staff and patients with patient safety incidents leading to improved
teamwork and a safe culture.

Vranch House has identified the following key patient safety leads:
• PSIRF Executive Lead – Chief Executive
• PSIRF Learning Response Leads – Head of Education, Head of Therapies
• PSIRF oversight – Head of Therapies, Head Of Education, Business Manager, Chief Executive, Chair of Trustees

All staff receive training in accordance with national requirements.

Definitions of terms commonly used in incident management

'Near miss' or 'Prevented Incident' – Any incident that had the potential to cause harm but was prevented (by chance or appropriate intervention) and resulted in no harm.

'Incident' – an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.

'Serious Incident' (SI) - An accident or incident when a patient, member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on Vranch House premises or where Vranch House is providing services. Serious incidents requiring investigation, in the NHS, are rare (none reported at Vranch House to date). These measures are written to protect patients and ensure that robust investigations are carried out if required. When a serious incident occurs, it must be reported to all relevant bodies, trustees and governors by the Chief Executive.

After Action Review (AAR): is a method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid failure and promote success for the future.

Multidisciplinary Team (MDT) review supports health and education teams to identify learning from multiple patient safety incidents; agree the key contributory factors and system gaps in patient safety incidents; explore a safety theme, pathway, or process.

Patient Safety Incident Investigation (PSII): offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how. A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning.

Swarm Huddle: used to quickly identify learning from patient safety incidents. Immediately after an incident, management staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

Thematic Review: can identify patterns in data to help answer questions, show links or identify issues. Thematic reviews can use qualitative (e.g. open text survey responses, field sketches, incident reports and information sourced through conversations and interviews) as well as quantitative data to identify safety themes and issues

Roles and responsibility

The Chief Executive of Vranch House has responsibility for supervising the way regulated activity is managed and reporting via the PSRIF to the LFPSE, (the Learn from Patients Safety Events service. The Head of Therapies will notify the ICB about events that indicate or may indicate risks to ongoing compliance to our clinical service. The Head of Education has responsibility to notify Ofsted about events that indicate risks to practice in the school.

All Employees/Staff have a duty to Report Incidents.

Reporting Process

Those involved in or witnessing an incident should, to the best of their ability take all necessary action to ensure that the needs of the person(s) or facilities affected by the event are attended to, minimising the risk of further harm to the person affected and others.

Ensure that any medicines or equipment that has been involved in the incident are quarantined, labelled and under the jurisdiction of the Head of Service.

Report the incident verbally to your line manager or member of the Senior Management team. Immediately following any action in relation to the

person/facility affected and complete the appropriate department incident file as soon is reasonably possible.

A member of the Senior Management Team will review the incident within 3 working days and will follow up with the appropriate review or investigation and reporting process. If the incident is linked to the clinic side of the service, the PSIRF will be completed.

If it is suspected that the cause of the incident was the unacceptable performance or conduct of a member of staff the Chief Executive may be required to consider suspension of the member of staff to ensure the safety of patients, children or the service.