Family Nursing & Home Care
Serious or Untoward Incidents
Policy and Procedure

August 2009
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<td><strong>Name</strong></td>
<td>Serious or Untoward Policy &amp; Procedure</td>
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Chief Executive Officer, P Massey |
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### Policy Amendments

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<th><strong>Version No.</strong></th>
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Copy of this form to be given to Information Governance Officer
1.0 Statement of Intent:

Family Nursing and Home Care is committed to improving services for patients, staff, members and the general public. Part of this commitment is to make sure that when things go wrong, events are reported and reviewed so learning and action can take place, to prevent similar occurrences in the future.

It is recognised that incidents of this nature are distressing for everyone involved be they staff, patients / clients, relatives, contractors or members of the public. The Association does not seek to apportion blame but to learn from these incidents and change practice accordingly / appropriately.

For this reason disciplinary action will not be instigated against those staff who may be involved in or reporting any type of incident EXCEPT where it is evident there has been:
- Deliberate, malicious or Criminal intent
- Serious professional misconduct
- Failure to improve performance after counselling or training.

2.0 Introduction

A robust system for identifying and managing serious and untoward incidents will allow Family Nursing and Home Care to investigate incidents quickly, review practice and identify trends and patterns.

This document lays out the process to be followed in the event an incident should occur. It is one of the documents that underpins the risk management and Governance agendas of the Association.

2.1 Definition of a Serious or Untoward Incident (SUI)

A SUI may be defined as an incident where a patient, member of staff, or member of the public has suffered serious injury, major permanent harm, or unexpected death or where there is a cluster / pattern of incidents or actions by Family Nursing and Home Care staff which have caused or are likely to cause significant public concern, legal, media or other interest which may lead to loss of reputation or financial assets.

Near misses may also constitute SUI’s where the contributory causes are serious and in different circumstances could have led to serious injury, major permanent harm, or unexpected death, but no actual harm resulted on this occasion.

Examples of Serious untoward incidents are shown in Appendix 1

2.2. When should the policy be implemented

This policy should be applied only to SUI’s requiring investigation and review.

Any major incidents which may cause difficulties with the continuity of the business of Family Nursing and Home Care are covered in the Business Continuity Plan.
2.3. Purpose

To ensure that:

- SUI’s are responded to correctly
- Staff are aware of and understand their responsibilities
- Appropriate reporting takes place
- The needs of the person / persons adversely affected are met
- Investigations are thorough and timely
- Every effort is made to learn from the experience and mitigate future risks
- Clinical / non Clinical policies and procedures are improved as necessary
- Raise staff performance

3.0 Scope:

All staff including temporary and bank staff employed by Family Nursing and Home Care are responsible for adhering to this policy and procedure, should SUI occur anywhere staff are working or delivering services.

4.0 Responsibilities

4.1 Committee will:

- Be advised by the Chief Executive Officer of any SUI as and when they occur. They will monitor the progress of the process and subsequent outcome of the investigation and risk factors as part of their overall risk management responsibilities.
- Ensure as far as is reasonably practicable adequate resources are provided to meet risk Management requirements including investigation costs.

4.2 The Chief Executive Officer (deputy in the CEO’s absence) will:

- Ensure there is an effective policy / procedure for managing SUI’s, which is reviewed within the time frames of Family Nursing and Home Care's policy and procedure guidelines.
- Have overall responsibility for the management of a serious or untoward Incident.
- Be accountable for the Risk Management Systems within Family Nursing and Home Care.
- Advise the Committee of any SUI that has occurred and if there is a likelihood that an external review and or the involvement of the States of Jersey Police may be required or media interest incurred.

4.3 Divisional Manager for Governance will:

- Provide the Terms of Reference for all SUI’s convened by the SUI panel. Including advice as to the appropriate membership of the investigating team.
- Provide the Governance Sub Group and Senior Management Team with quarterly reports to include key themes and recommendations arising from serious or untoward incidents.
• Ensure that systems are in place to provide appropriate training and Organisational learning to take place.

• Support Managers through the process.

4.4 Divisional Managers will:

• Be familiar with the SUI policy and procedure, as well as other related policies

• Undertake appropriate risk management training including Root Cause Analysis training and ensure their operational leads also undertake this training

• Ensure that Key Staff involved are notified a SUI investigation is taking place.

• Be responsible for ensuring the recommendations following a SUI investigation are implemented.

• Support staff through the process

4.5 Operational Leads will:

• Be familiar with the SUI Policy and Procedure as well as other related policies.

• Undertake Root cause Analysis training.

• Implement any changes / recommendations within their sphere of responsibility.

• Support staff through the process

4.6 All Employees will:

• Be familiar with the SUI policy and procedure as well as other related policies

• Co – operate with those charged with undertaking a SUI investigation whether internal or external.

4.7 The SUI Panel will:

• Convene SUI investigations and nominate a head investigator and chair of the panel.

• Inform the relevant managers and employees of the SUI investigation.

• The Chair will report to the Committee Chairman, advising if an external investigation is required and on progress of the investigation.

4.8 Serious / Untoward Incident Panel

The SUI Panel membership will consist of 3 senior Managers and the Medical Advisor:

The remit of the panel will be to hear all SUI investigation Reports.

4.9 The Investigation Team

• This team will change according to nature of the incident.
It will consist of two or more dependent on the incident. One member will be appointed by the SUI Panel, as the lead investigator who will be responsible for coordinating the investigation and subsequent report. This person will have received training in Root Cause Analysis.

4.10 Incident Occurs out of Hours

Should an incident occur out of normal working hours the Operational Lead on call must be contacted and they will assume the lead role in the initial management of the incident. The Operational Lead on Call will:

- Notify the Chief Executive Officer or their Deputy and depending on the severity of the incident inform other parties as directed by the CEO.
- Notify the CEO of any media interest or potential police / viscount department involvement.
- The panel will agree subsequent recommendations and provide the CEO with a written summary.
- Ensure an incident form is completed
- Isolate any equipment that may be involved
- Ensure that the Staff involved are available to make statements as soon as possible but within 24 hours.
- Secure Patient / Client health records
- Keep a time line of events

4.11 Involvement of/with Other Agencies/Organisations

If during a SUI investigation it becomes evident that a staff member(s) involvement has been:

- Deliberate, malicious or criminal intent
- Serious professional misconduct
- Failure to improve performance after counselling or training;

And they are known to be employed by another relevant agency(s), Family Nursing and Home Care will inform that said agency, having first informed the staff member of their intention to do so.

If another agency is carrying out a SUI, and wish FNHC to provide them with information pertinent to that SUI, staff will be expected to comply with their request having first informed their Divisional Manager of that request.

4.0 Procedure for Managing Serious/Untoward Incidents

**Within 24 hours**

To enable the successful and efficient management of SUI’s it is necessary for a number of actions to take place within specific time frames.

Once an incident has occurred this must be reported directly to the Operational Lead or Divisional Manager of the area in which the incident occurred – depending on who is available. If neither is available, report the incident to another Divisional Manager.

5.1 The Divisional Manager will:
• Inform the Chief Executive, (This will usually be within 1-2 hours during working hours but MUST occur within 24 hours of the incident), and the Divisional Manager of the area where the incident occurred.

5.2 The CEO will:

• Ensure that the Chairman is informed as appropriate
• Decide whether the incident is serious enough to inform the Minister for Health and Social Services.
• Convene the SUI panel and if an internal inquiry is required appoint an investigating Officer and team.
• Decide which stakeholders/partners to brief i.e. H&SS, GP’s parish etc.
• Contact the Association’s Public Relations Agency if there is a possibility of adverse media interest for handling the interest and strategy required.

5.3 The Divisional Manager and Operational Lead of the area concerned will make decisions following consultation with the CEO re:

• Informing patient(s) and family/care/relatives
• Informing Police/other agencies as directed
• Providing Support for staff and patient(s) and others as deemed appropriate
• Isolating any equipment that may be involved
• Securing case notes and records
• Identifying all the individuals involved
• Undertaking a risk assessment as per the risk management Policy/Procedure
• Keeping the CEO updated
• Obtaining the completed accident/incident form
• Obtaining initial statements from all staff who may have been involved. These must be factual, legible, signed, dated and timed. Staff should be encouraged to seek help, if required this can be from their Union Representative.
• Maintaining a time line and log of all documents related to the incident ensuring they have been completed and are well secured.

5.4 Documents and Police requests

If documents are required as part of a police investigation then these must be provided as requested. For Criminal investigations consent is NOT required to release records but records being released must be copied first and a record made of what documents have been handed over, where they are going, who took them and when. They should also be signed for by the receiving officer.

5.5 Within 5 working days

The lead and co investigator must gather information and data relating to the incident and provide the SUI panel with an interim report which will establish if any further action is required. This report will also assist the SUI panel in gaining insight into the incident. This report should also include the risk assessment.

If another investigation is required this will be conducted over an extended period no longer than eight weeks.

5.6 Investigation:
The investigation team will use the gathered information to determine what further information is required and will, where necessary interview staff in order to obtain comprehensive understanding of what occurred. Staff who are interviewed may be accompanied by a friend, colleague or trade union representative who will support and assist them through the process.

The aim of the investigation is to be able to provide information on:
- What occurred
- How the incident was managed
- What implications for the association may be e.g. Legal, financial reputational
- Baselines / Bench marks from which acceptable practice can be compared
- What and how lessons can be learnt for the future.
- How required changes will be applied and monitored in practice
- What on going support will be required by patients / client and staff.

The investigation team will:
- Gather written data
- Interview the people involved in the incident and take statements (these will be typed and returned to the individual for checking details before signing as correct) – it may be necessary to re-interview individuals if further points come to light that require further clarification.
- Provide reports to the SUI panel as previously stated

The structure of the Reports (Interim and final) will include:
- Terms of reference
- Members of the investigation Team
- Summary – brief outline of key findings
- Outline of relevant medical history (if required)
- Background information
- Chronology of events (before and after event as appropriate
- Key findings and conclusions
- Recommendations
- Good practice

5.7 Within Eight weeks

The investigation team will compile a report which will include all the above information including good areas of practice, recommendations and a clear action plan which states who will be responsible for ensuring the actions are undertaken, time scales for implementation and monitoring progress.

5.8 SUI Panel

The SUI Panel will convene in order to hear the findings of the Investigating team who will present to the SUI Panel and any relevant managers, clinicians or practitioners. At this time there will be opportunity to correct any factual inaccuracies and discuss recommendations.

Following the panel hearing the final report will be completed with the names of staff involved removed. The report when signed off by the panel will be securely stored, along with a separate key index of the staff involved in the incident and the review, by the Divisional Manager for Governance.

5.9 Disseminating Outcome.
The Divisional Manager of the area concerned will ensure that copies of the reports recommendations are given to the staff who were interviewed / provided evidence and the lessons to be learnt and action plan is shared throughout the division in order to improve practice. Where good practice was identified this also should be shared.

The Divisional Manager for Governance will be responsible for ensuring progress towards the action plan is reported to the Operational Governance and Committee Sub group.

### 6.00 Special Circumstances

Some SUI’s require further attention in respect of the process applied due to the nature of their severity or sensitivity:

#### 6.1 Information Security Incidents

When associated with cases of breaches in data protection relating to person identifiable information the Family Nursing and Home Care Information Security Reporting Policy should be followed and if required, reported to the Jersey Data Protection Commissioner via the Information Governance Officer (IGO).

#### 6.2 Safeguarding Children:

Investigation process of Child Deaths and serious Cases relating to the protection of Children fall into the remit of the Jersey Child Protection Committee (JCPC) Serious Case Review Policy. Where the death or serious harm of a child occurs as a result of suspected or actual abuse, a Serious Care Review (SCR) will be initiated by the JCPC.

The process adheres to the same principles as the Serious or Untoward Incident Policy but is focused upon multi–agency child protection processes and arrangements. As part of the investigation the SCR will consider the work of a number of services including FNHC. The Named Nurse for Child Protection (Currently the Island Designated Nurse) will raise with FNHC’s internal SUI Panel any information arising from an SCR which might give rise to further investigation under the SUI Policy.

#### 6.3 Adult Protection

Family Nursing & Home Care recognises the need to have a framework for action should a vulnerable adult be identified as being abused or being at risk of abuse.

Should staff raise concern/be aware of the potential for and identification of abuse they should follow the FNHC Adult Protection Policy, which includes referral to Social Services.

Following the process of the internal Adult Protection Policy, if any area of clinical practice gives rise to serious concern, this may be further investigated under this SUI Policy.

#### 6.4 Health Associated Infections

Some incidents involving infections should be reported to the Public Health Department i.e.

- Outbreak of food poisoning
- Clostridium Difficile
- Other high profile infections
For other guidance please refer to the Infection Control Policy.

### 6.5 External Reviews

In exceptional circumstances it may be necessary to hold an independent external inquiry. The decision to do this will be taken by the SUI Panel and the Chairman of FN&HC.

Consultation may also be required with the Minister and Chief Executive Officer for Health and Social Services.

*For example.*  
Part 8 Reviews Child Protection Cases  
Homicide by a service user  
Clusters of serious incidents demonstrating a very serious problem within FN and HC.

### 6.6 Police Investigations:

In certain cases the States of Jersey Police Service may undertake enquiries within FN & HC or as part of work they are undertaking within H & SS, on behalf of the Deputy Viscount or as part of a police investigation into a suspicious death.

Other reasons for Police involvement may be:

- The reporting of suspicions by family members of a deceased person
- Referral from the Deputy Viscount
- Referral by enforcement agencies
- Referral by FN & HC where staff maybe implicated.

Once such referrals have been made an investigation must ensue. FN & HC must cooperate with a police inquiry and facilitate that enquiry. Senior managers will liaise with officers to ensure that where staff interviews are required support is available.

Staff approached by police officers carrying out the investigation in their working areas should:

- Ask to see their warrant card and record their police Number
- Inform their Divisional Manager of their presence before speaking to the police, in order that appropriate support can be given
- No staff should give a statement under caution without proper legal representation
- The Divisional Manager for Governance will ensure that FNHC’s legal representatives are informed of the investigation
- The writing of reports should not take place until after the police enquiry has been completed.

### 7.00 Media Enquiries

Media/Press enquiries are the responsibility of the CEO and Chairman of FN&HC.

Staff must adhere to the Media Policy.

### 8.00 Informing Patient(s),Client(s) or Relatives.
8.1 When the incident involves a Patient / Client, :

The Operational Lead and Divisional Manager for Clinical Services, will within 24 hours communicate the details of what has occurred and the actions to be taken to the Patient / Client and family. (The facts are to be recorded in the Patient / client record.) It is important that the staff / managers do not try to suggest any causation, blame or identify any person(s) involved to the patient unless otherwise directed to do so. This is to ensure that only the facts are communicated and patients, clients, relatives and other staff are not misinformed.

8.2 When there has been a delay:

Should exposure to harm come to light at a later date the Divisional Manager for Clinical Services will inform that Patient / client. The CEO will also be notified of the delay and the reasons for this.

8.3 Patients / clients and the Media.

FN & HC will make every effort to inform the patient / clients prior to media involvement this is particularly relevant in cases where the incident was not immediately apparent.

9. Linked Policies & Procedures

Business Continuity Plan
Jersey Child Protection Committee Serious Case Review Policy
Child Protection Policy
Adult Protection Policy
Health & Safety Policy
Complaints Policy
Data Protection Policy
Incident Reporting Policy
Risk Management Policy
Information Security Policy
Infection Control Policy
EXAMPLES OF SERIOUS OR UNTOWARD INCIDENTS:

The Principal definition of an SUI is any incident that occurs on an FN & HC site or elsewhere in the course of providing care in the community setting, which involves:

- FN HC Patients/clients/service users or relatives
- Staff, including students undertaking clinical or work experience
- Contractors, equipment, building or property.

Which meets one or more of the following criteria:

- Causes death or serious injury or was life threatening
- Contributes to a pattern of sustained reduction and standards of care that the Association or our commissioning body identifies as below agreed standards
- Involves a hazard to Public Health
- Causes significant damage to the reputation of FN & HC and its staff
- Relates to fraud or suspected fraud
- May or does give rise to a significant claim for damages or legal proceedings
- Serious outbreak of infection/disease, the transmission of an infectious disease from a member of FN & HC staff to a patient (s), client(s)
- Repeated serious complaints about a member of staff’s clinical or professional practice or a specific service
- Allegations of patient / client abuse and neglect against a staff member (including alleged or actual physical or sexual abuse)
- A serious breach of patient confidentiality / theft of equipment files containing patient information
- Incidents leading to Police enquiries or investigations by the Deputy Viscount
- Serious damage of FN & HC premises which results in major disruption of service provision.

This list is not exhaustive and is intended as a guide.