Serious Incident Management Toolkit

1st Edition

Serious Incident Investigation Team

Serious Incident Management Toolkit

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V.1 March 2019

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Serious Incident Investigation and Learning Process

(Quick Reference Guide)

Serious Incident Investigation and Learning Process

(Quick Reference Guide)

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Phase 2 – The Review
• Tabular timeline development • General enquiries to be made • Case note review • Serious Incident Investigation Accounts to be requested from individuals involved • Prepare for learning event i.e. presentation, venue, specific requirements
Phase 3 – Learning Event
• Learning event (up to half day and ideally held within 1 month from the date of the incident)
Phase 4 - Report
• Follow up enquires • Final draft report • Scrutiny and sign off process • Welsh Government closure process (up to 60 working days from the date the incident is reported to WG)
Phase 5 - Learning
• Serious Incident Learning Brief • Post Investigation Reflection Meeting

Section 2

Serious Incident Investigation and Learning Process

Serious Incident Investigation and Learning Process

This process aims to ensure the effective and consistent management of all Serious Incidents.

Serious Incident Investigation Threshold

Clinical or process issues that have resulted in avoidable:

- Loss of life or unnecessary shortening of life expectancy;
- Irrecoverable injury or impairment of health, having a lifelong adverse effect on lifestyle, quality of life, physical and mental well-being

All Serious Incident investigations undertaken in keeping with the NHS Concerns, Complaints and Redress Arrangements (Wales) Regulations 2011. Further guidance on the management of concerns can be found **here** and feed directly into the wider concerns agenda (complaints & legal claims as well as incidents and inquests).

Actions Phase 1 – Immediate

Immediate Actions	Responsibility	Guidance	Timeframe
Incident reported on Datix	Managed Unit	**Datix**	Day 1
Confirmation of whether incident is a reportable SI as defined by Welsh Government	Managed Unit in consultation with Serious Incident Team where necessary	WG Reportable Serious Incidents **Reportable SI's**	Within 5 days of reporting on Datix
Welsh Government (WG) Incident Notification to be completed by Managed Unit and forwarded to SI Team	Managed Unit	abm.seriousincidentsteam@wales.nhs.uk **SI Notification Form** **NSR Notification Form**	WG deadline – Notification to be received within 24 hours of incident occurrence
Serious Incident Notification to WG and notify all Executives via e-mail	Serious Incident Team	Welsh Government Serious Incident/No Surprise Report Reporting Protocol	
Intelligence checks of all Datix modules seeking to identify linked/previous/duplicate records i.e. Claims, Complaints, Inquests (searches to be undertaken using no less than three parameters to	Managed Unit		

include date of birth and NHS number)			
Use of NHS Incident Decision Tree (where applicable) to ensure consistent and fair decisions regarding staff management and support	Managed Unit	NHS Incident Decision Tree – Appendix 1	
Strategy meeting to be held Required at attendees: - Assistant Head of Concerns Assurance - Nominated SI Investigator - Unit Nurse Director and Medical Director or nominated deputies - Unit Quality and Safety Governance Manager or nominated deputy - Any other person immediately involved in the management of the incident	Managed Unit to organise time and venue. Meeting to be chaired by Unit Nurse/Medical Director or Nominated Deputy In the event of a Never Event Incident, meeting to be chaired by nominated Executive Lead	Serious Incident Strategy Meeting Agenda - Section 3 Strategy Meeting Invite.msg	Within 3-5 Working Days of reporting to WG

	All meetings to be fully minuted by Nominated SI Investigator		
Identification of those involved and key stake holders	Managed Unit		
Identify appropriate date for learning event	Managed Unit		
Immediate patient/family contact	Managed Unit		
Securing Evidence – Witness contact details	Managed Unit		
Managing any immediate patient safety concerns with issuing of local patient safety alert where applicable	Managed Unit		
External reporting requirements i.e. Police, Health and Safety Executive, Health Inspectorate Wales, Local Authority/Social Services	Managed Unit		

Phase 2 – The Review			
Immediate Actions	**Responsibility**	**Guidance**	**Timeframe**
Tabular Timeline Development	Nominated SI Investigator	Tabular Timeline - Section 7	
General enquiries to be made	Nominated SI Investigator		
Case note Review	Nominated SI Investigator		
Examination of clinical portals	Nominated SI Investigator		
Serious Incident Investigation Accounts to be requested from individuals involved	Nominated SI Investigator	Serious Incident Investigation Account Guidance – Section 4 Serious Incident Investigation Account – Section 5	Within 10 working days of notification to WG (Serious Incident Investigation Accounts to be received)
Learning Event Preparation - Presentation - Venue - Specific Requirements	Nominated SI Investigator		
Thematic Review	Nominated SI Investigator		

Phase 3 – Learning Event			
Immediate Actions	**Responsibility**	**Guidance**	**Timeframe**
Learning event (up to half day and ideally held within 1 month)	Nominated SI Investigator	 Reflection Event Invite.msg  Interview Learning Event Presentation.p	Within 20 working days of notification to WG

Phase 4 - Report			
Immediate Actions	**Responsibility**	**Guidance**	**Timeframe**
Follow up enquires	Nominated SI Investigator		
Final draft report	Nominated SI Investigator		Within 50 working days of Notification to WG
Scrutiny and sign off process, completion of WG Assurance Checklist	Nominated SI Investigator		
Welsh Government closure process (up to 60 working days).	Nominated SI Investigator		Within 55 working days of WG notification

Completion and submission of WG Closure Form to SI Team **ABM.SeriousIncidentsTeam@wales.nhs.uk**			

Phase 5 - Learning			
Immediate Actions	**Responsibility**	**Guidance**	**Timeframe**
Development of SMART Action Plan	Managed Unit		
Dissemination of Serious Incident Learning Brief across all sites	Managed Unit	Add hyperlink once learning brief completed.	
Presentation at relevant Quality and Safety Forums and High Risk Meeting	Managed Unit SI Team to add to High Risk Agenda		
Post investigation reflection meeting	Unit Nurse Director		6 weeks following completion of investigation (to allow clinical staff to attend)

Support and Escalation		
Issue	**Action**	**Timescale**
Identification of immediate patient safety concerns	- Discuss immediately with Unit Directors - SBAR to be completed immediately and sent to the relevant Unit Nurse and Medical Directors copying in Head and Deputy Head of Patient Experience, Risk and Legal Services and Deputy Director of Nursing and Patient Experience	
Non-engagement of Clinical Staff/Key Witness	- Discuss immediately with Unit Directors or nominated deputy	
Differing Clinical Opinions	- Discuss with Unit Directors	
Non-Agreement of Final Draft Report	- Report to be shared with Executive High Risk	
Identification of Professional Issues	- Refer to Incident Decision Tree	
Former employees/Agency Staff	- Locate using GMC number and NMC Registration details - Liaise with Medical HR	
Staff Sickness/Prolonged Periods of Absence	- Discuss with Unit Directors	

Patient/Family Communications	- Family point of contact to be nominated by Unit Directors	
External Requests for Information	- Discuss with Head of Patient Experience, Risk and Legal Services/Deputy Head	
Cross-Border Investigations	- Discuss with Head of Patient Experience, Risk and Legal Services/Deputy Head	

Section 3

Serious Incident Strategy Meeting Agenda

Serious Incident Strategy Meeting Agenda

Datix Incident Ref:

Date & Time:

Venue:

Invited Attendees

MEETING AGENDA

Item	Lead
Introductions:	
Apologies:	
Background to Incident/Information established to date:	
Immediate Actions Required/Undertaken	
Proposed Scope and Terms of Reference of the Investigation	
Lead Investigator/Clinical Advisor/Nurse Advisor/Other Investigation Support	
Being Open - Patient/Family Support and Communication/Nominated Single Point of Contact	
Staff Management and Support (Reference to Incident Decision Tree where applicable).	
Identification of any other internal stakeholders	
Consider any matters relating Safeguarding Adults/Children	
Consider matters requiring referral to claims team i.e. likely inquest, redress, litigation	
Liaise with Communication Department where applicable	
Communication with External Stakeholders	
Thematic Review - Meeting to consider learning and actions identified from past events with a view to incorporating within investigation scope	
Welsh Government Serious Incident Notification and Investigation Timeframes	
Summary of Actions:	
Any Other Business	

Section 4

Serious Incident Investigation Account (Guidance)

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Serious Incident Investigation Account Guidance

Abertawe Bro Morgannwg University Health Board

Serious Incident Investigation Account Guidance

Dear Colleague

You are invited to complete a Serious Incident Investigation Account in relation to the Serious Incident you have been involved in. The Health Board aims to undertake the Serious Incidents investigative process by mirroring the idea that reflection allows for critical analysis and identification of learning. The Health Board will therefore use your completed Serious Incident Investigation Account to help inform the investigation, but more importantly, to help identify lessons to be learned and improve future practice across the Health Board.

Following the submission of your Serious Incident Investigation Account you will be invited by the Managed Unit to participate in a Serious Incident Learning Event. This event, facilitated by Managed Unit, will involve group working and discussion to help develop recommendations which can improve care delivery and patient experience. The model used for the purposes of this Serious Incident Investigation Account is Rolfe et al's Reflective Framework (2001), which asks you to consider three questions and apply them to the incident; **What? So What? Now What?.**

Reflection on action is more than a thoughtful practice; it requires a critical analysis of yours and others involvement in the event to identify potential learning situations. Reflection enables healthcare professionals such as yourself to develop and attain knowledge, skill and behaviours that ensure the continuous updating of your practice in order to meet the complex needs and demands of patients in the healthcare setting. However, we understand that completing this reflection might be an uncomfortable experience, but in order to ensure its effectiveness, an open and honest assessment of your role within the incident is required. Reflection on action can often focus on the negative aspects of what has occurred, but please ensure you also identify what went well.

Things to be Aware of

- The eventual Investigation Report produced by the Managed Unit will be shared with the Hospital's Senior Management Team and Executive Colleagues for adoption of the report's recommendations and embedment of future learning
- The report will be disclosed to the patient and/or family involved in the incident as part of the Health Board's commitment to being open and honest

- The report could be disclosed to other third parties i.e. Welsh Government and in the case of a patient death (certain circumstances), Her Majesty's Coroner for the purposes of an inquest

- As your Serious Incident Investigation Account will relate to a specific patient and is therefore not anonymised, it may not fulfil the requirements of any reflection required as part of your professional registration. However, you may wish to use this account as the basis of any such reflections you are required to undertake.

Your Serious Incident Investigation Account should therefore avoid the use of emotive language or negative statements about the patient, yourself and or your colleagues.

Further Guidance and Support

In order to focus on completing your Serious Incident Investigation Account, you will be supported with protected time away from your work environment. It is anticipated that at least one hour will be necessary.

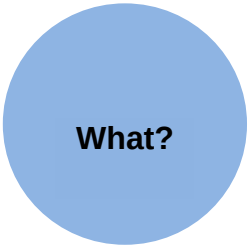
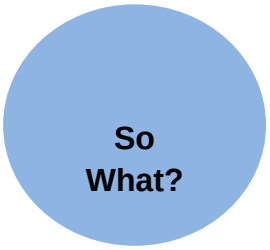
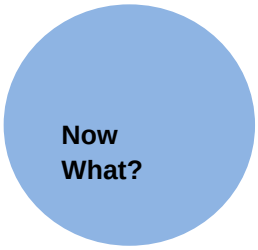
Further guidance surrounding the completion of this Serious Incident Investigation Account, can be sought from the Nominated Investigator.

Thank you for your support in improving patient safety and care within the Health Board.

Kind regards

Rolfe et al's

Reflective Framework (2001)

Descriptive Level of Reflection	Theory and Knowledge Building	Action Orientated (Reflexive) Reflection
		
What is the problem? What was my role in the situation? What was I trying to achieve? What actions did I take? What was the response of others? What were the consequences? • For the patient/family? • For myself? • For others? What feelings did it evoke? • in the patient/family? • For myself? • For others? What was good/bad about the experience?	So what does this tell me/teach me/imply/mean about me/the patient/others/our relationship/my patient's care/the model of care I am using/my attitudes/my patient's attitudes etc...? So what was going through my mind as I acted? So what did I base my actions on? So what other knowledge can I bring to the situation? • Social policy • Legislation • SW Theory • Personal So what could/should I have done to make it better? So what is my new understanding of the situation? So what broader issues arise from the situation?	Now what do I need to do in order to make things better/stop being stuck/improve my teaching/resolve the situation/feel better/get on better/etc...? Now what broader issues need to be considered if this action is to be successful? Now what might be the consequences of this action? Now what planning is required to activate the new direction?

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Section 5

Serious Incident Investigation Account

Serious Incident Investigation Account

"The ability to critically reflect on our practice is fundamental to developing and maintaining expertise" *(Mamede et al 2006).*

This document is not the same as a professional learning reflection. It will be disclosable and used to inform the timeline. However, we recommend that you use this for your professional reflection.

Name:
Role:
Registering Body No (If applicable):

Please write your reflection as a narrative

What? A description of the event looking at the Clinical Situation, Feelings, Communication, Decision making, Team working as you witnessed it.

So What? **An analysis of the event looking at the Clinical Situation, Feelings, Communication, Decision making, Team working which discovers what learning arises from the process of reflection.**

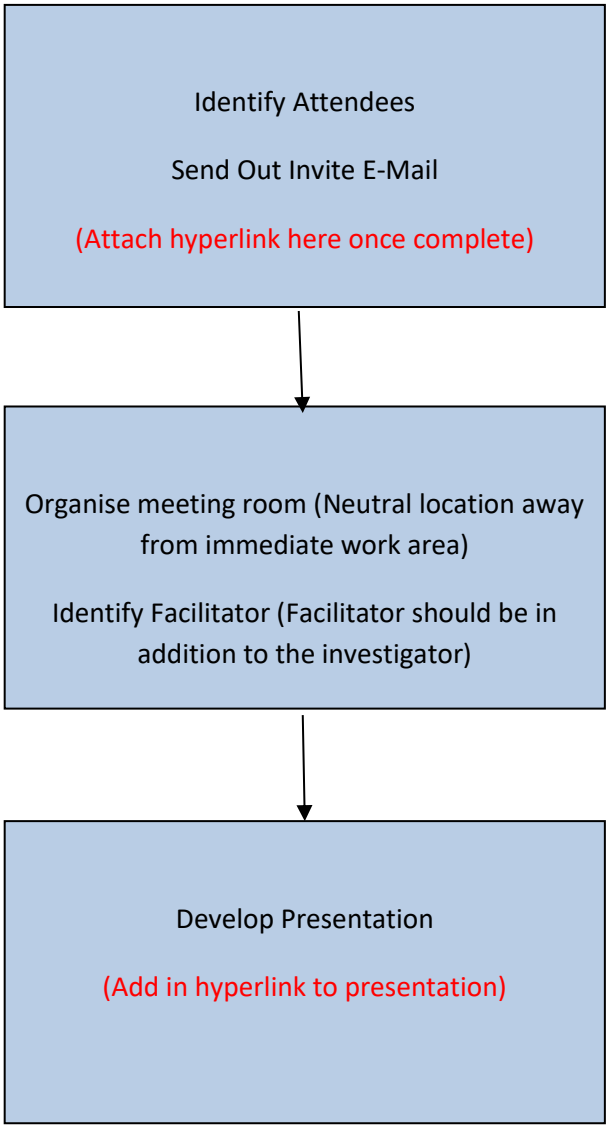
Now What? **The synthesis of the event looking at Clinical Situation, Feelings, Decision making, Team working which leads to discovering the proposed actions following the event.**

Section 6

Planning the Learning Event

(Flowchart)

Planning the Learning Event



Section 7

Serious Incident Review Report

(Template)

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CONFIDENTIAL

Serious Incident Investigation

INC:12345

WG Ref:November12345

Serious Incident Review

Abertawe Bro Morgannwg University Health Board

Author: Rebecca Sowter

Serious Incident Investigator

Incident Details	
Date of Incident	
WG Closure Date	
Incident Type	
Incident Location	
Commissioned By	

Assurance Sign Off	
Name/Title	**Signature**
Unit Nurse Director **(Insert Name)**	
Unit Medical Director **(Insert Name)**	
Corporate Lead **(Insert Name)**	

CONTENTS

1. PERSONS INVOLVED IN INVESTIGATION

Contributors	
Investigator	
Clinical Advisors	

2. BACKGROUND

3. INVESTIGATION SCOPE AND TERMS OF REFERENCE

The Managed Unit were commissioned to review the circumstances ……..

In particular the aims of the review were:

- To establish the facts across all relevant disciplines and specialties i.e. what happened, to whom, when, where, how and why
- To establish whether issues care and/or service delivery have occurred
- To establish key findings and learning opportunities rather than to apportion blame
- To produce recommendations so that an improvement plan can be developed by Maternity Services
- To identify any immediate system or safety issues that require action to prevent future incidents to other patients.

4. METHODOLOGY

This review was undertaken using a structured review process but not limited to the following:

- Development of tabular timeline detailing episodes of care and identifying issues in care and treatment and/or incidental learning opportunities.
- Use of the National Patient Safety Agency (NPSA's) Contributory Factors Framework to support the identification of root cause/causes.
- Reflective meeting held on 12 April 2018

5. SOURCES OF REFERENCE

- Reflective accounts from staff involved
- Reflection Event held on the 13th September 2018
- Datix Records (INC-?????)
- Ms. ?? Medical Records
- Ms. ?? GP Records
- Theatre Operating Management System Record (TOMS)

6. INVOLVEMENT, SUPPORT AND IMPACT ASSESSMENT OF PATIENT AND/OR RELATIVES

Ms ??, Complaints Investigator at Morriston Hospital has been identified as the point of contact for Ms. ??? family. Ms ?? notified Ms. ??'s family of the investigation on the 25th June 2018 and advised that a copy of the final report would be shared with them on completion. In accordance with the NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011, Ms. ??'s family will also be offered a meeting with senior members of staff to discuss the findings of the investigation.

7. SUMMARY OF CARE SERVICE DELIVERY ISSUES IDENTIFIED

Issue 1	Initial Triage and Placement within the Emergency Department
Issue 2	Initial Investigations
Issue 3	Timing of Diagnosis

8. THE INVESTIGATION

ISSUE 1
FINDING
CONTRIBUTORY FACTORS IDENTIFIED (Identified with the use of the NPSA Contributory Factors Classification Framework 2009) NPSA Contributory Factors Classificatio
•
LESSONS LEARNED
•
RECOMMENDATIONS
•

9. CONCLUSION AND ROOT CAUSE

10. ARRANGEMENTS FOR SHARING AND LEARNING

- The final report and its outcomes will be shared with the Ms ??? (Patient/or family) and managed via the NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011.

- All staff involved in the incident will undertake a personal reflection, which will form part of their Personal Development Review (PDR) process.

- The outcome of the investigation will be shared with all staff involved.

- The outcome of the investigation and lessons learned will be shared with the wider clinical Maternity Service's network

- Lessons learned will be shared with all other Unit Medical Directors.

- The outcome of the serious incident investigation and action plan will be shared/approved at the Maternity Quality & Safety Board.

- Maternity Quality and Safety Board will report the outcome of the serious incident investigation and action plan to the Health Board's Learning Group.

- Summary of the investigation and learning will be presented to the Quality and Safety Committee of the Health Board.

11. Tabular Timeline

Event Date & Time	Event	Supporting Information	Source	Care/Service Delivery Issues

Section 8

Serious Incident Review and Checklist Assurance Document

ABMU Serious Incident Clinical Review Checklist & Assurance Document

ABMU Health Board	
INC Reference:	
Service Area:	
Description:	
Clinical Advisors:	
Date of incident:	
Date SI sent to WG:	
WG Closure Date (60 Working Days)	
WG Reference:	

Event	Start date	Completed Date	Comments
Strategy meeting (s):			
Under Investigation:			
Local Patient Safety Alert disseminated (if applicable):			
Reflective statements received:			
Reflective Learning Event:			

Event	Start date	Completed Date	Comments
Draft report submitted to Assistant Head of Concerns Assurance:			
Draft report sent to contributors for comment:			
Reviewed by Head of Legal & Risk Services/Patient Experience & Deputy Director of Nursing & Patient Experience:			
Managed Unit Senior Team sign-off:			
Sent to High Risk Meeting for Corporate sign-off:			
Action Plan:			
Closure form sent to WG:			
Completion of Executive Learning Brief			
WG closure confirmation:			

Section 1: Impact of incident on patient/service
1. What immediate action(s) have been taken to make the patient, staff and situation safe following the incident? Include both immediate and intermediate make safe actions

2. What impact did this have on the patient and/or service? What harm could have resulted from this incident?

Was any treatment, clinical intervention or ongoing care required? What is the patient's condition subsequently? If this cannot be stated with certainty due to patient's co-morbidities, complexities etc. This should be noted.

Section 2: Support and inclusion of individuals involved in the incident

3. What communication and involvement has taken place with the patient, and/or their family/carers? What support has been offered?

Including:

- An apology
- Explanation of what has happened and clarification that this incident will be the subject of an investigation
- Actions taken to address any problems incurred
- On-going mechanism for support e.g. allocated point of contact person
- Involvement in the investigation e.g. provision of recollection of events

4. What communication has taken place with staff? For staff directly involved, how have they been involved in the investigation and what support has been offered to them?

Including:

- How staff were notified
- Counselling and de-briefing where considered appropriate

- Involvement in the investigation, including opportunities to raise concerns for investigation
- Staff updates relating to the progress of the investigation
- Communication of the outcome of the investigation

Section 3: Clinical Review

5. Does the investigation scope include all the relevant issues?

How was the scope agreed?
Is there evidence of patient/family/staff involvement in agreeing the scope?

6. What evidence of broader information gathering has been provided to inform the background and context to the investigation?

- Did the organisation review other information sources such as no/low harm incidents, other SI's, complaints, Reg 28 reports, risk registers etc to understand whether the incident or potential for the incident to occur has been identified?
- Has the organisation had similar incident(s) of this nature in the past?
- Are there patient safety solutions relevant to this incident and if so, has the organisation reviewed their compliance status?

7. Has an investigation team been assembled which provides (1) independence and (2) expertise?

8. Have the relevant care and service delivery issues been identified?

9. Have the issues identified been explored or analysed to understand the underlying reasons why they occurred?

10. Do the root causes identified demonstrate an understanding of the underlying reasons why the incident occurred?

11. Does the report identify what happened and why?

- Is there a logical flow of information throughout the report?
- Are there any outstanding questions which have not been answered by the report?

Section 4: Identifying and Planning Change

12. Is there a clear link between analysis and lessons learned?

13. Recommendations

- Are recommendations linked to analysis?
- Do the recommendations address the problem, contributory factors, and/or root causes identified?
- Is there evidence that recommendations have been developed collaboratively with those who will implement and/or be affected by them?

14. Action Plan

- Does the action plan address the problems identified and the recommendations made?
- Are actions SMART (Specific, Measurable, Achievable, Relevant and Timely) proportionate (strong, medium, weak), with clear deadlines and responsible individuals assigned?

15. How will learning from this incident be shared?

- Across relevant areas/departments
- With other organisations where relevant
- National learning/across professional networks

16. What is the national learning (if any)?

Section 5: Joint Investigations only

17. Were arrangements made from the outset for joint investigation to include all relevant organisations?

18. Is there evidence on completion of a collaborative approach to investigation and action planning?

Section 6: Governance

19. Is there evidence of robust quality and assurance and independent scrutiny of this report?

- Is there sufficient background and context to support the explanation of what happened and why?

- Is the report jargon free or with clinical terms explained? - Is the report formatted, with correct spelling, completed sentences, with person identifiable information removed?


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Section 9

Serious Incident Review Learning Brief

Once learning brief design agreed, can be added here

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Section 10

Investigating pressure ulcers

(Guidance)

Investigation of Pressure Damage

- Every DATIX report requires a level of investigation. However, as a minimum requirement all category/grade 2, 3, 4, Unstageable and Suspected Deep Tissue Injury pressure ulcers, should be investigated using the All Wales Review Tool for Pressure Damage Investigation (Appendix 3)
- Each Health Board/Trust may choose to use the All Wales Device Related Pressure Ulcer Investigation Tool (Appendix 4) in conjunction with the All Wales Review Tool for Pressure Damage Investigation to aid investigation in relation to device related pressure damage.
- The tool(s) must be completed within the specified timescale as per local arrangements to ensure that there is no delay in the organisation meeting its statutory duty to report an “adult or child at risk” as required under the Social Services and Wellbeing (Wales) Act (2014).
- Use of the tool(s) will facilitate detailed examination of whether the appropriate pressure ulcer prevention strategy was employed prior to the pressure damage occurring and highlight what learning needs to take place in order for similar incidents to be prevented.
- If there is uncertainty about when the pressure damage occurred, it may be deemed appropriate for the identifying nursing team and the nursing team or caring team that had previously been responsible for the patient’s care to carry out the investigation collaboratively.
- If the patient from community has had no health or social care involvement and has developed pressure damage, then discussion with the Health Board / Trust safeguarding team should be considered, highlighting the patient’s potential vulnerability.
- Communication following patient transfer between Welsh Health Boards/Trusts about specific incidents of pressure damage can be facilitated through use of the All Wales Pressure/Moisture Damage Passport (Appendix. 5).
- Health Boards/Trust need to ensure that systems are in place to share learning outcomes throughout the organisation so that similar causal and contributory factors are not repeated in different clinical areas.
- If previously reported and investigated pressure damage deteriorates a further investigation must be completed, to determine cause of deterioration.

Scrutiny and Governance of Reporting and Investigation Process

- Each Health Board/Trust will undertake a degree of scrutiny of each pressure damage incidence to determine causal factors and lessons to be learnt.
- The outcome of this scrutiny will determine whether the pressure damage is avoidable or unavoidable.

- Avoidable Category/Grade 3, 4 and/or unstageable pressure damage that developed when patients was in receipt of Welsh NHS funded care will require a serious incident report to be submitted (see section 9.)

- Each Health Board/Trust will have their own Terms of Reference for the scrutiny and governance process, however it would be anticipated that gold standard would be an interdisciplinary approach.

Serious Incident (SI) Reporting

- A Serious Incident (SI) should be submitted to Welsh Government (WG) for all individuals with **avoidable** Category/Grade 3, 4 and/or Unstageable pressure damage who are in receipt of Welsh NHS funded health care.

- Notification to Welsh Government of a SI is no longer required.

- The SI closure form should be submitted once the investigation is complete, within 60 working days from date of incident reporting on DATIX.

- The SI closure form must include evidence of the outcome and learning from the investigation.

- An SI submission will consist of an investigation of the damage using the All Wales Pressure Damage Review tool and closure form submitted to WG.

- Information regarding why the damage was determined as avoidable must be reported via the closure form as per agreed individual Health Board/NHS Trust policy.

- A Regulation 60 notification must be completed and submitted to Care Inspectorate Wales (CIW) for all individuals with Category/Grade 3, 4 and/or Unstageable pressure damage living in the Care Home Sector. Residents in receipt of Residential Care will be governed by the NHS process.

- In complex situation across Health Board's and NHS Trusts joint investigations are encouraged to ensure that lessons are learnt across Wales.

Section 11

Investigating inpatient falls

(Guidance)

Incident Investigating

The Health Board can learn and improve practices through the regular review of local falls incidents. Through the review of this data, as part of integrated governance, it can identify local or Health Board wide action for environmental and clinical factors which may require the input from multi-professional teams, patients and their carers. Consider the following as an aid to completing incident investigation:

- Time and place of incident;
- Circumstances surrounding the fall;
- Strategies in place prior to fall;
- Non compliance with strategies already in place;
- Staffing levels.

Root Cause Analysis

This must and will be triggered by Datix for multiple falls, abnormalities on post-fall CT head, fracture and death.

The NPSA's Patient Safety Observatory report on falls found that falls can be a symptom of underlying illness and that unless a first fall leads to a review, the patient is likely to fall again. Patients are most likely to fall during weekdays, when there are more patients in hospital and mid-morning, when patients are most likely to be active. Fewer falls occur whilst patients are walking and that they are particularly likely to fall whilst using the toilet or commode. Falls from trolleys may be more likely to lead to serious injury and litigation.

As a result of a patient fall, interventions may include:

- Detecting and managing cognitive impairment;
- Reviewing medication associated with a risk of falls;
- Detecting and treating causes of delirium;
- Detecting and treating cardiovascular instability, particularly orthostatic hypotension;
- Detecting and treating or managing incontinence or urgency;
- Detecting and treating eyesight problems and having correct glasses;
- Encouraging safer footwear;
- Physiotherapy, exercise and access to walking aids;
- Addressing psychological morbidity associated with falls [fear of falling].

Section 12

Infection Control

(Guidance)

Guidance to be added once I have spoken to Delyth Davies w/c 04.03.19