Health and Social Care Board

Public Health Agency

*What I need to know about a Serious Adverse Incident*

# Information for Service Users, Family Members And Carers

## Introduction

This leaflet is written for people who use Health and Social Care 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.*

In some circumstances events are reported as Serious Adverse Incidents (SAIs) to help identify learning even when it is not clear something went wrong with treatment or care. For example, we report the death of any child receiving health or social care services (up to the age of 18 years) regardless of the cause of death.

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 are also highlighted and shared where appropriate.

## What is a Serious Adverse Incident?

An SAI is an incident or event that must be reported to the Health & Social Care Board by the organisation where the SAI has occurred, and investigated. 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;
- When a child has died this includes any death of a child in receipt of HSC services (up to eighteenth birthday);
- The incident or event may affect services users, members of the public or staff.

## Can a complaint become an SAI?

Yes, if during the follow up of a complaint (**insert name of practice)** identifies a serious adverse incident has occurred it will be reported as a**n** SAI. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

## How is the SAI investigated?

Depending on the circumstance of the SAI an investigation will be undertaken. This will take between 4 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of practice**) will discuss with you how the SAI will be investigated and who will be involved. The Trust 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 investigation?

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

- Are made aware of the incident, the investigation process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the investigation, 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 investigation;
- Are offered the opportunity to meet and discuss the investigation findings;
- Are offered a copy of the investigation report;
- Are offered advice in the event that the media make contact.

## What happens once the investigation is complete?

The findings of the investigation will be shared with you. This will be done

in a way that meets your needs and can include a meeting facilitated by **(insert name of practice)** staff that is acceptable to you.

## How will learning be used to improve safety?

By investigating 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 investigation:

- 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.

## Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a Health and Social Care 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 investigations.

**Contact details:**
**Free phone number: 0800 917 0222**
**e-mail address: complaints.pcc@hscni.net**

## Do families get a copy of the report?

Yes;

- with the service users' consent;
- If the service user has died, families will get a copy of the report and an invite 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) has a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and investigation, RQIA works 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 (**insert name of practice)** 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 (**insert name of practice**).

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

## 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 meeting or telephone call you may wish to consider the following questions:

- 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
- 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.