SI LEAD INVESTIGATORS AND CO-REVIEWERS RESPONSIBILITIES

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Abstract

How to Support and Lead a Serious Incident Review from a Patients Safety Systems Perspective.

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SI Reviews: Lead and Co-Reviewers Responsibilities	
Aim;	This guide aims to outline the procedure for Co reviewers investigating level 1b, level 2 and level 3 incidents. This guide should be used in conjunction with the Incident Management Policy that provides comprehensive information related to the definitions, reporting, rating and management of serious incidents by East London Foundation Trust. The Incident Management Policy also provides detailed guidance on the safeguarding of vulnerable adults and children. Independent investigations and comprehensive panelled investigations lie outside the scope of this guide.
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Staff to Liaise with For Further Support and Advice:	▪ Chief Medical Officer ▪ Borough Director ▪ Chief Nurse ▪ Directors of Nursing ▪ Medical Directors ▪ Incidents and Complaints Manager ▪ Associate Director Governance and Risk
Administrative team;	***Incident Coordinators: Ashraf Zaman- 020 7655 4133 Claire Marriott- 020 7655 4099 When sending documents/copies of reports etc. please copy the incident team via elft.incidentsreporting1@nhs.net **Incidents & Complaints Manager; Duncan Hall. 020 7655 4084; Duncan.hall3@nhs.net
Timeline;	Refer to Appendix A
Methods;	The investigation is conducted primarily by the SI lead and the Co reviewer. They are expected to work in collaboration through the stages of the investigation and make joint decisions where necessary. At the beginning of the investigation the SI lead will contact the Co reviewer to introduce themselves and outline the nature of the incident. The SI Lead and Co reviewer should review and agree the TOR in relation to the incident in question, making changes where necessary. . Both the SI lead and Co reviewer will read the relevant clinical notes. Together they will decide who to invite for interview and determine what further information is needed.

	The investigation findings are concluded in a final report. Both the SI Lead and Co reviewer are responsible for contributing to the final report, which will be distributed to the SI committee meeting for sign of.
Conflicts of Interest	Please note the definition below regarding conflicts of interest in Healthcare. Where any of these issues apply to you, you must notify whoever nominated you as co-reviewer or lead investigator and recuse yourself from the investigation. Definition: "A conflict of interest in health care exists when an individuals ability to apply judgement or act, in the context of delivering or assuring taxpayer funded healthcare / services, is or could be impaired or influenced by another interest they hold. A conflict of interest may be actual where there is a material conflict between one or more interests or potential where there is the possibility of a material conflict between one or more interests in the future" [NHSE: Managing Conflict of Interest in the NHS}. " Please see the link for more detailed information on Conflict of Interest. https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf
Roles and Responsibility;	**SI Lead Reviewer** ▪ SI Lead reviewers work within the Risk and Governance (Patient Safety) Team and are employed to investigate serious incidents for the trust. ▪ The SI Lead is responsible for the administrative duties in relation to the investigation. ▪ The SI Lead will be responsible for contacting any affected carer or family member and invite them to participate in the review if felt appropriate. ▪ The SI Lead will liaise with the directorate leads regarding interviews and have primary responsibility for organising interviews. ▪ The SI Lead will complete the tabular timeline in most cases and circulate to the review team prior to the first review meeting. ▪ The SI Lead will write the draft SI report at the end of the review and will meet with the rest of the panel to amend and agree the final draft. **Co Reviewer** ▪ The Co Reviewer is a clinical / subject matter expert, independent from the treating team, nominated by the Chief Medical Officer, Medical

	Directors, Clinical Directors, Chief Nurse or Directors of Nursing to carry out the investigation of a serious incident in conjunction with the SI Lead reviewer. ▪ The Co reviewer is responsible for assisting the lead reviewer by providing clinical expertise and oversight during the investigation. ▪ The Co reviewer should highlight immediate actions required to ensure patient safety where necessary. ▪ The Co reviewer should co- produce a service map by; considering the usual processes in place relevant to the incident in question (or lack thereof), and examine the weaknesses in the current system. ▪ The Co reviewer should outline the details of the incident, be specific about what happened and compare it to usual practice, consider how information was communicated between the people involved, and the quality of the information shared, consider the impact of time of day/shift pattern/staffing levels and other contributing external pressures . ▪ In the absence of an identifiable process the Co reviewer should consider if there is scope for a standardised procedure that would reduce work load and benefit staff or, if the process is sound when followed, consider external factors that need to be addressed. ▪ The Co reviewer should obtain all relevant documentary evidence from the notes, and make sure it is secure and preserved so that it can be shared with the SI Lead. ▪ The Co reviewer should consider the direct or indirect contribution of medication prescribing/dispensing in relation to this incident and seek pharmacy input when necessary. Please see Appendix B for further information regarding pharmacy input. ▪ The Co reviewer should identify the need for further specialist input outside the scope of their own expertise such as, differing medical specialities, allied health professional, general practitioner, other (IT/security/admin). **The SI Lead and Co reviewer will work collaboratively to;** ▪ Identify witnesses, including staff, and other service users necessary for interview.

	▪ Consider the gaps in knowledge and what further information is needed. ▪ Participate in staff feedback sessions. Staff members are entitled to receive feedback regarding the findings and outcomes of the investigation. ▪ Feedback sessions could also be an opportunity to offer praise when members of staff have demonstrated excellent care in challenging cases. ▪ All findings should be discussed with the SI Lead for inclusion in the final report ▪ Jointly take notes from all meetings.
Interviews;	The SI Lead and Co reviewers are expected to conduct interviews with staff and service users pertinent to the investigation. The interview process is an opportunity to engage the treating team and involve them in the investigation process. The interview should aim to establish the facts of the case but also explore opportunities for service improvement and gather staff/service user feedback. Notes will be taken, at interview by whoever is NOT asking the questions at interview. This is a shared role. (The Risk and Governance team will provide notes storing advice and support as required). ➢ *Please read RCA^2 Improving root cause analysis and actions to prevent harm, Appendix 2&3, Triggering Questions for Root Cause Analysis and Interviewing tips for the RCA^2 reviews*[i]. Group interviews are an effective tool when exploring service delivery issues and should be readily utilised. The group interview can act as a foundation for the development of SMART action plans later in the investigation.
Analysing information;	At this stage the investigating team should meet in order to collate the information and agree the priority problems identified (so far). Now the team start to analyse their findings to identify the underlying problems known as contributory factors. Consideration is then given to the root causes contributing to the SI and any additional learning that needs to be addressed.[ii]
Generating a solution;	Recommendations; ▪ At this stage recommendations are developed by the investigating team that will help to prevent another safety incident (of same kind or similar).

	▪ Recommendations should be developed at the feedback meeting in agreement with the clinical directors and those with budgetary responsibilities and an understanding of the wider issues/competing priorities. Action Plans; ▪ Where there are recommendations made from an SI investigation, the directorate responsible for the care will develop action plans against the recommendations. Action plans for Trust wide recommendation will be agreed by the Medical Director and confirmed at the SI Committee.[iii] ▪ Once action plans have been agreed the SI Lead will update the report for recirculation and final agreement.
Coroner's court;	All serious incidents that include the death or homicide of a service user detained under the metal health act or considered an inpatient at the time of death will automatically be referred to the coroner for a jury inquest. The co reviewer will be expected to attend coroner's court when the SI lead is unable to attend or at the coroner's request. Staff members requested to attend coroner's court will have specialist support and supervision from the trust legal department.

[i] RCA[2] Improving Root Cause Analysis and Actions to Prevent Harm. National Patient Safety Foundation. Version 2. January 2016. http://www.ihi.org/resources/Pages/Tools/RCA2-Improving-Root-Cause-Analyses-and-Actions-to-Prevent-Harm.aspx

[ii] Serious Incident Framework; Supporting learning to prevent recurrence. NHS England. Published 2010, updated March 2015.
https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

[iii] Incident Management Policy. East London Foundation Trust.
http://elftintranet/Sites/Common/Private/search_quick21.aspx?q=Incident Policy&url=ObjectInContext.Show(new%20ObjectInContextUrl(2%2C28669%2C1%2Cnull%2C970%2Cundefined%2Cundefined%2Cundefined%2Cundefined%2Cundefined))%3B

Appendices

Appendix A

SI Review Milestone Actions Timeline

SI Investigation/Review Milestone Actions	Timeline (60 working days)	Owner/Responsible
Incident logged on StEIS	Days 1-5	Incident Team
Lead Reviewer appointed		Incident & Complaints Manager**
Directorate notified of SI details and request for co-reviewer		Incident team
Co- reviewer appointed		Borough Directors/Governance team Clinical Directors
Undertake initial review clinical records and produce chronology timeline in advance of initial review meeting with co-reviewer	Days 6-10	Lead Reviewer
Initial SI review panel meeting Review timeline, identify any potential gaps in care/service delivery Identify any other information required Contact patient/next of kin/family/carers - arrange meeting in line with their preferences Identify staff for interviews Set dates for staff interviews and feedback meetings*	By day 10-15	Lead and **Co-reviewer** *(Incident Co-ordinators to support booking meetings with staff for interviews and feedback meeting)
Undertake interviews/ Meet patient/next of kin/family/carers	Days 15-33	Lead and **Co-reviewer**
Draft initial report- circulate to key staff ahead of feedback meeting	Days 34-43	Lead Reviewer (share with **co-reviewer** prior to sending to wider staff)
Undertake feedback meeting with all staff involved in SI review plus key managers and borough/clinical directors	By day 43-45	Lead and **Co-reviewer**
Finalise report and action plan post feedback meeting	Day 45-46	Lead Reviewer
Send report to Incidents & Complaints Manager for quality assurance & review.	Day 46	Lead Reviewer/ Incidents & Complaints Manager**
Submit report for Executive approval in accordance with each Trust's assurance processes (lead	Days 46-59	Lead Reviewer/Incident team

reviewer to present report at Trust Executive SI Grading meeting.		
Prepare final report and submit to CSU/CCG Up load required data to StEIS	Day 60	Incident team
Share findings of review with patient/next of kin/family/carers	Within 10 days post sign off	Lead reviewer

Appendix B

Pharmacy

Pharmacists are a valuable resource when investigating SUI's and consideration of their involvement should be given to each case. Their oversight in relation to the prescribing and dispensing of medication can be vital for the completion of a report but also ensure their systems and process are routinely reviewed and updated.

- The pharmacy department is particularly interested in;

1. Clinical Governance and Professional Practice

· All events or near misses involving prescribing, administration, supply or dispensing of CDs
· Any concern(s) about professional practice or behaviour of staff in relation to CDs e.g. unusual prescribing patterns.
· Complaints from patients/carers/service users relating to CDs.

2. Record Keeping and Stock Discrepancies

· Unexplained losses/discrepancies of any CD, regardless of schedule.
· Any discrepancy in CD stock which, although resolved, raises concerns.
· Events or near misses involving CD destruction.
· Loss of CD Register/Order Book or other relevant controlled stationery.

3. Fraud and Possible Criminal Issues

· Any suspected illegal activity relating to CDs e.g. theft, patients attempting to obtain CDs by deception.
· Lost or stolen prescription forms.
· Attempts to fraudulently produce prescriptions.

- Some specific examples of when to involve Pharmacy have been outlined below;

- Controlled drugs – all SIs in which the CD could have contributed to the death
- Any type SI where medicines error occurred e.g. prescribing, dispensing and administration
- Medicines reconciliation – error or discrepancy in medicines reconciliation process
- Discharge notification – error or discrepancy in discharge notification
- Any intentional or unintentional prescription medication over dose

- Suicide where medicines involved, e.g. recent change in prescribed medication; intentional and unintentional overdoses
- High dose antipsychotics – antipsychotic(s) that exceed the BNF max
- Any high risk drugs that could have contributed to an SI– e.g. clozapine, lithium, valproate (in a woman of child-bearing potential), strong opioids, insulin
- Any SI involving delay in a patient receiving a critical medicines (time-dependent) e.g. antiparkinsonian, analgesia, antibiotics
- Any SI involving medications used in during rapid tranquilisation
- Any SI relating to an adverse drug reaction
- Any SI involving EPMA in relation to prescribing, dispensing and administration of medication

Pharmacy Referrals

If you would like pharmacy assistance during your investigation please send the relevant information to the Medicines Safety Officer inbox – elft.mso@nhs.net for the attention of Jenny Melville or Annabel Ikwuakolam.