72-hour reports

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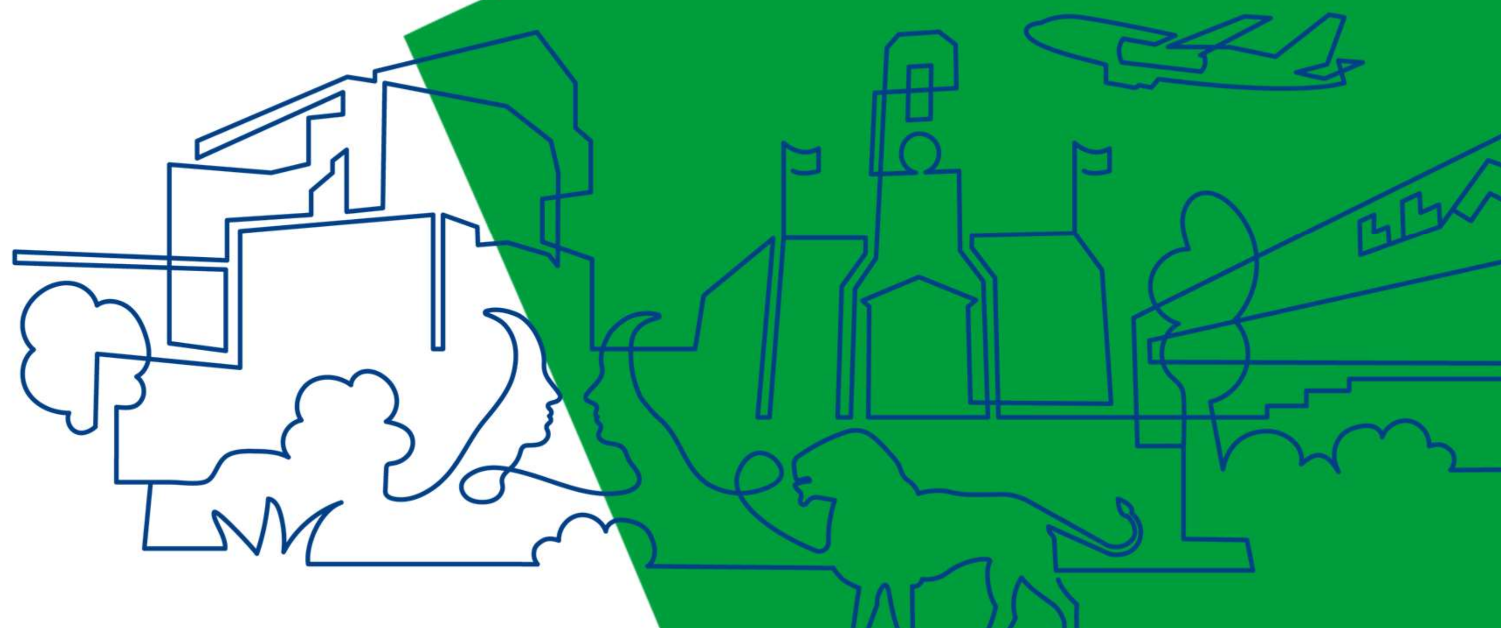
How the report used by the Trust &

What you should be focussing on when writing the report



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Definitions

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Definition of an Incident

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare"

Definition of a near miss.

"Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care."

We also report incidents for staff.

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The journey of the 72 hr report

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Starts with gathering of information from the service

Quality check by Risk & Governance team

Decision Making Panel to decide outcome

Either closed or may progress to other forms of learning response

Final report sent to Trust Legal Team, which discloses it to the Coroner's Court.

Trust's Decision Making Panel (DMP)

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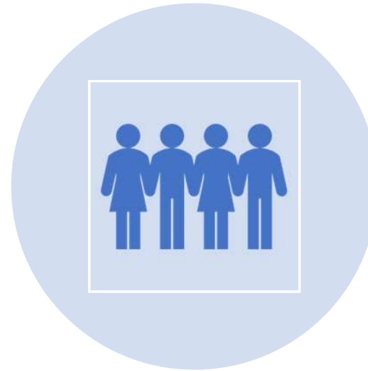

Panel is made of senior clinicians from across the trust

Panel must have at least one medical and one nursing representative

The panel aims to make a decision as to whether they are assured and satisfied about the management of the incident.

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Decision Making Process (DMP

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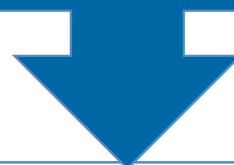
Sign off – when the report has provided assurance that everything that could have been done was done; including any learning and/or actions taken to prevent similar incident from happening again.



Progresses to other form of learning responses– AAR or PSII:

This happens when the panel feels that there's more that can be learnt from the incident.	If the incident meets the national criteria for a PSII e.g. inpatient death, unexpected but avoidable death etc…

After sign-off from DMP

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The 72-hour report is now increasingly being used by the Trust's solicitors to provide information to the Coroner's Court.

Therefore:

- This may generate additional questions
- If not clear, the Coroner may summon the author and/or additional staff

Example of a Good Chronology

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Date/Time	Source of information (Rio, EMIS etc.)	Action/Event	Comments/Concerns/gaps in care/analysis.
20.11.23 **TC by CCO**	Rio	CCO made telephone contact. Pt was in a psychology session agreed to call him back.	Appears there has been no contact since 20.10.23 at the last medical review with Dr despite plan indicating weekly review of mental state and risks. No contact with family. No physical health check booked. No focused work around meaningful occupation No progression of family work /carer's assessment.
30.11.23 **TC by CCO to Pt's Father**	Rio	Dad appeared very worried about Pt having increased in weight and also is anxiety levels. Dad was informed that he will be booked in for both physical health checks and medical review.	Physical health check required. Particularly given Olanzapine and associated risks around weight gain /cardio metabolic issues. Not clear when this was booked for. No further follow up with Pt by CCO since telephone call on 20.11.23.

SMART Action Plan

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Issue Identified (clearly link to identified lesson/gap/care or service delivery problem)	**Recommendation**	**Themes** (for listing - click here)	**Actions to be taken** (Please refer to guidance below on producing SMART actions which explain **how** the action will best prevent the issue arising again)	**By Who** (Name and designation)	**Completion Date**	**Current status of action ('not started', 'in progress', or 'completed'?)**	**Outcome**	**Completion Sign-off**
Requirements of 8-week assessment were not followed: Weekly contact Completion of Care Plan using Dialog+ Completion of up to date risk assessment and, where relevant, Safety Plan Discussion of EIP package, including Family Intervention and Carer Support, with the patient and their support network.	8-week every Senior team member supervising those with CCO responsibilities provides clear guidance on expectations during the 8-week assessment as part of induction of new staff, and checks that these are being followed in supervision	Care and welfare	To reiterate expectations of 8-week assessment in business meeting and by recirculating the 8 week assessment checklist to CCOs. Supervisors to conduct caseload audit in supervision as per Trust expectations (one per month).	Operational Lead & Senior Practitioners Operational Lead & Senior Practitioners Operational Lead to review with Seniors in monthly Senior's meeting.	28/3/24 31/5/24 Ongoing	Not started	Improved	

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Final thoughts

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- Standard of writing must be representative of a report that the trust would be happy to disclose outside of the trust.
- Issues [gaps in care] must be identified clearly with actions that are SMART & realistic in preventing similar incident in future.
- When writing the report think that if anything you are writing might generate a question in the mind of a reader [who is not familiar with your service] then just make sure that you have answered that question before being asked to do so.
- Be open and honest with your report.