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| **NHS Definition** | **Tideway Care Interpretation & Guidance** |
| **Serious Incident Requiring Investigation**  A SIRI is an incident that occurred during NHS funded healthcare (including in the community) which resulted in one or more of the following:   * unexpected or avoidable death or severe harm of one or more patients, staff or members of the public * a ‘never event’ – all never events are defined as a SIRI although not all necessarily result in severe harm or death. * a scenario that prevents, or threatens to prevent, an organisation’s ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunization where harm potentially may extend to a large population * allegations or incidents of physical abuse and sexual assault or abuse * loss of confidence in the service, adverse media coverage or public concern about healthcare or an organization * All grade 3 and 4 pressure ulcers, death attributable to either C Diff or MRSA (part 1 of death certificate), death attributable to VTE , falls resulting in death and ‘Never Events’ – as defined by the Department of Health (Appendix A) – must be reported as SIRIs | Tideway Care determines whether an incident is serious by:   1. The level of harm is graded as medium to high  |  |  |  | | --- | --- | --- | | **Grading** | **Description** | **Examples** | | Medium | Any incident that resulted in significant injury requiring medical intervention | Bleeding profusely as a result of an assault - Ambulance called  Fell off the wall in the garden and in great pain in left leg | | High | Any incident that appears to have resulted in any permanent harm | Person saws off their finger making cabinets for the office - Loss of limb  Person jumps from a height leaving them with broken legs and possibly going to not retain mobility. | | Death | Unexpected death of person | Person found dead in bedroom thought to have been in good health |  1. The Tideway Care Policies are breached 2. Our legal duty to protect is breached and therefore prosecution could occur 3. There is an emerging theme that suggests several near misses / low level incidents of the same pattern may be indicating a hidden issue that constitutes an investigation. 4. Leads to a person requiring medical treatment in hospital 5. Emergency services are required to respond and deal with incident 6. Leads to a safeguarding report where actual harm has occurred   We will determine whether the incident is defined as an NHS SIRI at our initial panel meeting. |
| **Never Event**  ‘Never Events’ are defined as ‘largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.’  CCGs are required to monitor the occurrence of Never Events within the services they commission and publicly report them on an annual basis. | The list of potential Never Events we may have to report is:   * Maladministration of insulin leading to death or severe harm * Fall from unrestricted windows leading to death or severe harm * Entrapment in bedrails leading to death or severe harm * Severe scalding of patients as a result of water used for washing/bathing and leading to death or severe harm |
| **Initial Management Report (IMR)**  The IMR gives a brief outline of the incident and immediate actions taken and is completed and forwarded to the Risk Management Team within 24 hours of the SIRI occurring. | The Tideway Care 24hour serious incident report includes most of the details required for the NHS IMR. |
| **Root Cause Analysis**  A formal, well recognised way of investigating incidents, claims and complaints, which offers a framework identifying what, how and why an event happened. Analysis can then be used to identify areas of change, develop recommendations and look for new solutions. | Tideway Care will anticipate that the Root Cause Analysis approach will be utilised by the NHS if they should lead on the investigation into a serious incident. |
| **Strategic Executive Information System (STEIS)**  The electronic database ‘hosted’ by the Department of Health and onto which all SIRIs are reported by a member of the NHS Risk Management Team | The CCGs will be required to inform NHS England of all SIRIs. Their risk management team will report and monitor progress in investigations, lessons learnt and improvement plans. They will also input onto the STEIS. |

‘**Other SIRIs’**: the following examples are guidelines to assist staff and are not intended to serve as an exhaustive or all-inclusive list. If in doubt, it is better to report an incident as a potential SIRI, as this can then be confirmed by the Senior Management Team or at the Initial Investigation panel meeting.

**Person we support**

* Unexpected death, serious or life-threatening injury
* Falls related death
* Major clinical incidents such as a failure to diagnose a serious illness e.g. meningitis
* Medication errors which result in serious/prolonged harm or death
* Absconding or escape of a patient which may pose a significant risk to the patient, the public or generate media interest

**Staff**

* Suspension of clinical staff due to competence or conduct issues related to patient care. Note: it is essential in these circumstances to involve the Human Resources Department
* An assault on a member of staff which results in death or serious actual bodily harm

**Organisational**

* Significant damage to Tideway Care assets or reputation. For example: an incident that may create adverse regional or national media publicity
* Failure to follow procedures resulting in harm or death. For example: equipment not serviced as per protocol

**Major Health Risks**

* Significant health care associated infections. For example: an outbreak of infection, failure in decontamination or an infected health worker
* Significant toxic contamination or radiation hazard

**Breach of Confidentiality**

* Loss of health records or documentation containing person identifiable data (PID).