SERIOUS UNTOWARD INCIDENT (SUI) POLICY

(Version 1.1)

Please also see the company RIDDOR Policy (**R**eporting **I**njuries, **D**isease and **D**angerous **O**ccurrences in health & Social care **R**egulations)

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1. AIM:

To ensure this policy and procedure is in place to outline the process of preparing for, dealing with and learning from a serious untoward incident.

2. INTRODUCTION:

A serious untoward incident (SUI) is an occurrence that results in either a 'near-miss' of harm to a patient or results in 'actual harm' to a patient. For the purpose of this policy a SUI would be a clinical/clerical incident relating to a patient/s healthcare.

Although we are not an urgent service and referrals for suspected pathology are very low, there is a potential for finding an unexpected pathology and the risk that a pathology may be missed.

The potential for a missed pathology or a miss-diagnosed pathology is always a factor to be considered in diagnostic practice. We try to mitigate the risks by high standards of clinical practice, continued clinical audit and continual professional development for all clinicians employed by the company.

The other potential risk is a clerical error, a clerical error also has the potential to cause a serious clinical incident, examples of significant clerical error are:

- A normal report put on the wrong patient's profile and sent back to the referrer.
- A report escalated in error for the wrong patient due to being put on the wrong patient's profile.
- A patient not being booked within the contracted timeframe
- Report not going back to GP within the contracted timeframe
- Patient being incorrectly booked – wrong scan/sonographer

The potential errors listed above are not an exhaustive list and have the potential to impact on multiple patients for example; the patient whose report was placed on the wrong patient's profile and the patients whose profile was wrongly used.

All serious clinical or clerical errors must be investigated and reported to the Care Quality Commission (CQC) and our contracted CCG (West Kent CCG), and the two CCG's who we have an agreement with to provide our service to their GP's they are Medway CCG and Swale CCG via their SUI officer. All near misses have also to be investigated and in both cases the company must carry out a full route cause analysis (RCA) into the cause of the incident and the outcome of the RCA must offer a strategy for improvement and monitoring of improvements implemented so the risk is reduced in future.

3. ROLES AND RESPONSIBILTIES

- The company Director is ultimately accountable for any incidents that occur, it is their responsibility to report and investigate any clinical incidents or put in place procedure to do so. Further they are ultimately responsible for the staff employed by the company and their practice and must ensure proper training and guidance have been given to all staff to minimise the risk of error
- All staff employed by the company also have a responsibility to ensure all risks are minimised, and best practice guidelines are adhered to.

4. PROCEDURE / SYSTEMS

Duty of Candour
Due to the nature of our business it is essential we have a clear ethical approach when it comes to the service we provide. Duty of candour is integral to our service and to providing safe care in line with the regulations of the CQC registration.
Duty of candour is our responsibility to ensure we are open and honest if things go wrong, and how it affects service users and commissioners of HEM Clinical Ultrasound Service Limited. In this section we look at minimising the risk of errors, and how, by following clear procedures, we ensure our responsibilities under duty of candour are met and patients, staff and commissioners have faith in how we manage the services we provide.

MINIMISE RISK OF ERRORS

The risk of clinical errors is minimised by:

- High standards of clinical practice
- Continued clinical audit
- Continual Professional Development (CPD)
- Only working within the individual clinician's scope of practice
- Always check that the patient's details both on the scanner and on e-clinic reporting system match the patient you are scanning and reporting on

In addition, prior to employment at HEM the following must be established for all Sonographers:

- A minimum of 5 years' clinical practice experience (Ave 900 patient scans per year)
- Be state registered
- Be DBS checked
- Have proven CPD
- References obtained from 2 previous employers

At the start of work on behalf of the company it is our policy to have the sonographer peer audited at random, for clinical competency and reporting content quality. This will be set out in an agenda by the managing director. The potential risks with an unknown locum sonographer are that the clinical auditing standards of a previous employer are not easy to gauge, and as a result they may have developed unchecked methodology that is not cohesive to HEM's Clinical reporting standards.

Once the clinical lead is satisfied with competency after the initial start the following would be established ongoing for all clinical staff:

1. Continued clinical Audit; 5% of all scans and reports performed are audited each month by specialist Radiologists to assess image quality and accuracy of reports.
2. CPD continued professional development must be shown for all clinicians, this includes self-development via reading medical articles and attending relevant courses
3. All clinicians must know their professional limitations and only practice within their individual scope of practice, i.e. never attempt scans that they are not competent to perform
4. Prior to each scan the clinician performing the scan must check that the patient demographics

on the scanner match the patient being scanned, further when reporting on e-clinic always check that the patient profile matches the patient you are reporting

The risk of a missed diagnosis or a miss diagnosis is substantially reduced if all the above is followed.

4.1 Minimise risk of Clerical error

The minimising of clinical/clerical risk starts with the referral being sent to the company by a referring clinician:

Stage one triage of the request by a clinician; does the clinical indication match the type of scan being requested? if it does then the correct patient preparation must always be documented

Stage two the clerical team must upload the patient's referral onto the correct patient profile or create a new patient profile with the correct patient demographics if a new patient

Stage three the patient is contacted either via letter or a phone call, identity must be checked if a phone call or correct demographics used if a letter is sent

Stage four When the patient arrives for the scan the receptionist must check patients name and ask them to complete a consent form

Stage five the patient is called into the scan room by the clinic assistant who checks the patients name, date of birth and first line of address with the patient

Stage 6 The clinician performing the scan must always double check the patient's details are correct on both the scanner and the e-clinic profile prior to doing the scan and writing the report.

Stage 7 clerical team sending the completed report back to the referrer must double check the content of the report to ensure the following:

- The report is saved on the correct patient profile.
- The referral criteria i.e. renal report matches renal referral, prior to sending the report back to the referrer.
- The date and time of the appointment are correct
- The clinical indication has been added and matches the referral
- The date of the referral has been added
- The report and impression are on the report
- The correct sonographer and Chaperone have been documented on the report
- If a female pelvis and a TV scan undertaken – has there been details added regarding the TV scan.

If all these stages are completed routinely then the risk of a report being placed on the wrong patient's profile and or the wrong report being sent back to referrer is minimised.

PROCEDURE IN THE EVENT OF A SERIOUS UNTOWARD

INCIDENT

In the unwanted event that a SUI is suspected it can sometimes be difficult to establish what is considered a SUI. The following guidance from West Kent CCG is based on CQC guidance and is contained the body of the SUI Reporting Form:

Reasons for Reporting

- **Actual / alleged abuse**
- **Incident demonstrating existing risk that is likely to result in significant future harm**
- **Incident threatening organisations ability to continue to deliver an acceptable quality of healthcare services**
- **Never event (if never event please do not select any other option)**
- **Unexpected / potentially avoidable death**
- **Unexpected / potentially avoidable injury causing serious harm**
- **Unexpected / potentially avoidable injury requiring treatment to prevent death or serious harm Categories**

Categories

- **Abuse/alleged abuse of adult patient by staff**
- **Abuse/alleged abuse of adult patient by third party**
- **Abuse/alleged abuse of child patient by staff**
- **Abuse/alleged abuse of child patient by third party**
- **Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria**
- **Adverse media coverage or public concern about the organisation or the wider NHS**
- **Apparent/actual/suspected homicide meeting SI criteria**
- **Apparent/actual/suspected self-inflicted harm meeting SI criteria**
- **Blood product/ transfusion incident meeting SI criteria**
- **Commissioning incident meeting SI criteria**
- **Confidential information leak/information governance breach meeting SI criteria**
- **Diagnostic incident including delay meeting SI criteria (including failure to act on test results)**
- **Disruptive/ aggressive/ violent behaviour meeting SI criteria**
- **Environmental incident meeting SI criteria**
- **Failure to obtain appropriate bed for child who needed it**
- **HCAI/Infection control incident meeting SI criteria**
- **Incident affecting patient's body after death meeting SI criteria**
- **Major incident/ emergency preparedness, resilience and response/ suspension of services**
- **Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)**
- **Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)**
- **Maternity/Obstetric incident meeting SI criteria: mother only**
- **Medical equipment/ devices/disposables incident meeting SI criteria**
- **Medication incident meeting SI criteria**

- **Operation/treatment given without valid consent**
- **Pending review (a category must be selected before incident is closed)**
- **Pressure ulcer meeting SI criteria**
- **Radiation incident (including exposure when scanning) meeting SI criteria**
- **Screening issues meeting SI criteria**
- **Slips/trips/falls meeting SI criteria**
- **Sub-optimal care of the deteriorating patient meeting SI criteria**
- **Substance misuse whilst inpatient meeting SI criteria**
- **Surgical/invasive procedure incident meeting SI criteria**
- **Treatment delay meeting SI criteria**
- **Unauthorised absence meeting SI criteria**
- **VTE meeting SI criteria**

Never Events

- **Chest or neck entrapment in bedrails**
- **Failure to install functional collapsible shower or curtain rails**
- **Falls from poorly restricted window**
- **Mis-selection of high strength midazolam during conscious sedation**
- **Mis-selection of strong potassium containing solution**
- **Misplaced naso or oro-gastric tubes**
- **Overdose of insulin due to abbreviation or incorrect device**
- **Overdose of methotrexate for non-cancer treatment**
- **Retained foreign object post-procedure**
- **Scalding of patients**
- **Transfusion or transplantation of ABO incompatible blood components or organs**
- **Wrong implant/prosthesis**
- **Wrong route administration of medication**
- **Wrong site surgery**

Patient Outcome

- **Deceased**
- **Receiving acute hospital inpatient treatment**
- **Receiving on-going care but not acute hospital inpatient treatment**
- **Not relevant (not patient SI)**
- **Discharged - not receiving on-going care**
- **Unable to say - multiple patients**

Sometimes the event does not sit neatly within one category. In this case the best option is to choose the closest incident type.

In the first instance once establishing there has been a SUI there needs to be a meeting of the senior team to enact the SUI Procedure as follows:

1) Establish if there is an immediate risk to life. If so:
    a. The Patients GP/Consultant needs to be contacted and Informed of the incident
    b. The Patient/s in question need to be contacted and advised on immediate action – if

not by their GP/Consultant – they by a HEM Clinician

c. the SUI form needs to be completed and submitted to West Kent CCG for upload to the Strategic Executive Information System (STEIS)
d. The CQC needs to be informed and forwarded a copy of the SUI form.

If an accident the HSE needs to be informed and forwarded a copy of the form. If appropriate, complete form F2508 for the Health and Safety Executive, copy to file, and send the original to the local HSE office.

e. This process needs to be actioned as soon as possible within 24 hours

2) If the risk to life is not yet known, but not immediate.
   a. Collection of evidence and setting out of facts regarding the incident needs to be created by the senior team.
   b. The SUI Form (Please see appendices) needs to be completed and submitted to the SUI lead at West Kent CCG **WKCCG.SUI@nhs.net** – followed by a phone call to confirm receipt.
   c. The form needs to be forwarded the CQC via their online tool – and call to confirm receipt 03000 616161.
   d. CCG's with affected patients need to be contacted and informed.
   e. If possible, and known at this stage, GP's and Patients need to contacted regarding the incident.

3) Due to the nature of SUI's it is very difficult know the form they will take as they are often unexpected. This is a basic overview of the mitigation procedure necessary to assess the incident.
   Once the incident has been reported the following procedure needs to be implemented:
   a. Quantify all patients and staff concerned and ensure all details are reviewed and documented.
   b. Identify patients who have already been audited
   c. Identify patients in need of Medica/Peer Audit
   d. Based on clinical opinion from review of the incident – quantify the potential impact to service user/s and staff members.
   e. Submit anonymised data to CCG's regarding service user impact.
   f. Complete route cause analysis. How, when and why did it happen?
   g. Submit the findings to the CQC, SUI lead at West Kent CCG (For upload the STIES) and the the CCG's involved.
   h. Action any steps for changes in patient care and ensure Patients and GP's are informed of necessary actions.
   i. Create action and improvement plan. This is to ensure that the incident does not reoccur. The Action and improvement plan would generally be comprised of:
      - Review of current policies and procedures
      - Review of staff awareness – is additional training needed?
      - Actions to prevent reoccurrence.

After 6 months the action and improvement plan need to be reviewed to ensure that the improvements implemented have been valid and implemented across the board.

   j. SUI panel with West Kent CCG to review handling and outcome of SUI.
   k. CQC confirmation of incident closed.

In some instances, the procedure may be protracted if further review of the service and actions for improvement are requested by the Care Quality Commission.

5. QUALITY CONTROL and AUDIT

All aspects of the company's service are audited and quality controlled internally and externally.

If an error is found that has the potential to be a serious clinical incident than a full RCA must be carried out and the CQC informed.

All serious incidents must be reported to the CQC within 2 days, currently there is no guidance on how SI's should be reported or what qualifies as a SI for our service

6. REFERENCES

HSE Website guidance, CQC essential standards, NHS England Serious Incident Framework. CQC- brief guide to incident reporting, SUI Reporting form – West Kent CCG,

7. APPENDICES / RELATED DOCUMENTS

West Kent CCG – SUI REPORTING FORM (List of reportable category incidents in procedure and systems)

SERIOUS INCIDENT REPORTING FORM

REPORTER DETAILS	
Provider	
Full Name	
Job Title	
Telephone	
Email	

PATIENT DETAILS	
Date of Birth	
NHS Number	
Registered GP CCG	

INCIDENT DETAILS	
Date of Incident	
Time of Incident	
Location	*I.e. Hospital and ward, Patient's Home, Ambulance etc.*
Reason for Reporting	*See attached list*
Category	*See attached list*
Is this a Never Event?	*YES / NO*
Never Event Type	*See attached list*
Patient Outcome	*See attached list*
Description	
Immediate Action Taken	
Media Interest	*YES / POSSIBLE / NO* *Details…*

Please return the completed form by e-mail to WKCCG.SUI@nhs.net