PROVIDING A CULTURE OF LEARNING FOLLOWING SERIOUS INCIDENTS

The following competences are primarily for managers, leaders and senior members of staff working in inpatient settings. These organisational competences aim to ensure a safe and productive ward culture and environment for inpatient staff patients and their family and carers. A serious incident is an adverse event where the consequences for patients, their family and carers, staff or organisations are so significant (and the potential for learning so important) that a heightened level of response is justified. Examples would include unexpected or avoidable death, or injury resulting in serious harm.

Ability to provide a culture of learning and support

An ability to ensure appropriate support structures are in place to enable staff to continuously learn and modify their practice
An ability for the leadership team to promote a culture of continuous learning, rather than a culture of blame, to ensure staff feel able to speak up and discuss issues or concerns
An ability for the leadership team to promote a culture of support relating to serious incidents and provide enhanced support during times of difficulty

Responding to serious incidents

An ability to draw on knowledge of what constitutes a serious incident and how one is reported (in line with local policy and procedure)
An ability to draw on the knowledge that because inpatients have complex needs and high levels of risk, serious incidents can occur
An ability to provide guidance and support for all employees affected by a serious incident
When a serious incident occurs, an ability to maintain services and to provide stability and appropriate information to staff, other patients and their families and carers
An ability to offer support to individuals and teams to which the serious incident relates, aimed at helping them to review the incident, discuss their reactions and feelings and receive further help if necessary
An ability to communicate with other patients involved and affected by the serious incident (for example, providing clinical follow-up and support)

Family and carers engagement and communication

An ability to ensure that the terms of reference of any investigation explicitly include arrangements for engaging and communicating with the patient's family and carers that the serious incident relates to
An ability to ensure that the person(s) making contact regarding the serious incident are suitable to take up this role (for example, have the appropriate communication skills and an appropriate level of authority)
An ability to ensure that information is provided to the patient's family and carers who the serious incident relates to in a timely and compassionate manner (in line with the duty of candour)
An ability for the organisation to acknowledge when they have made mistakes and apologise to relevant parties
If appropriate, an ability to put in place appropriate support for the patient's family and carers (for example, offering or signposting for emotional support)
Where the patient's family includes children or young people, if appropriate, an ability to put developmentally appropriate support in place for them, and to support the patient's family and carers to care for them

Establishing an internal review

An ability to identify appropriate staff members from the affected clinical team to review the incident

An ability for the identified staff member(s) to review the incident and:
confirm the type of investigation required
outline immediate action taken
capture immediate learning

Establishing an external independent review

An ability to identify an independent team with relevant experience, expertise, and authority, including lay membership where appropriate, which is empowered to:
investigate the circumstances relating to the serious incident
compile a record of the patient's care and treatment
write a clear report
An ability to ensure that reviews are set-up, completed and disseminated in as timely a manner as is practicable

Competences for the investigating team

An ability for the investigating team to:
review relevant documentation
identify the agencies and services with which the patient was in contact
interview members of the clinical and professional teams with whom the patient was in contact
review and evaluate the course and quality of treatment
review legal and ethical matters, particularly those concerning sharing of information within and between services
seek the views of the patient, and their family and carers

An ability to review the degree to which the service is operating in line with national and local guidance designed to reduce serious incident, such as:
actively monitoring the physical environment for risks (such as ligature points) and taking steps to modify dangers when these are identified
ensuring that there is an appropriate response when patients leave inpatient wards without staff agreement (for example, use of the Mental Health Act)
having agreed protocols in place for managing patients with comorbid substance misuse
maintaining safe staffing levels
maintaining a consistent staff group who are familiar with the patients in their care (by minimising staff turnover)
putting in place appropriate training for staff carrying out critical tasks (such as direct observations, search, and restraint)

Clinical policies relating to the management of serious incidents

An ability to review policies relevant to the safe management of patients who may be at high risk of a serious incident, such as (where applicable):
care planning
risk assessment
routine searches
use of restraint
use of seclusion
use of observation
use of medication
An ability to determine how these policies are implemented in practice (including arrangements for regular staff training)

Use of information and reporting systems

- An ability to draw on knowledge of the information systems used by NHS Trusts and the reporting arrangements used locally and nationally to record and flag serious incidents
- An ability to examine information and reporting systems to ascertain the degree to which:
  - staff in the organisation routinely and systematically record information, particularly information potentially relevant to the management of risk behaviours (for example, in care plans, risk assessments, clinical summaries and communications with other parts of the service or with other services)
  - the organisation follows up and acts on reports of adverse events and potential areas of concern (for example, use of seclusion and physical restraint)
  - reporting of serious incidents to national external bodies is appropriate (for example, CQC, NHS Improvement)

Effectiveness of leadership

- An ability to identify how information about serious incidents or areas of concern are considered by senior leaders in the organisation for example:
  - whether how and at what level the trust and/or its delegated authority (for example, a subcommittee of the trust board, clinical governance lead, patient safety services, quality oversight group) receive, take account of, and respond appropriately to, information about incidents, serious incidents, unexpected deaths, and previous incident reports

- An ability to consider the quality of reports of previous investigations (such as serious incidents requiring investigation reports), for example, to consider:
  - the standard of investigation
  - the quality of the report
  - the appropriateness of the actions it recommends
- An ability to determine whether and how recommendations from previous investigations have been implemented

Dissemination

- An ability to draw on knowledge of how reports can be disseminated to be helpful to front-line staff and those close to the patient whom the serious incident relates to (by giving them access to the report, by presenting its findings or otherwise providing a full account of the circumstances leading up to the incident)
- An ability to report both in writing and to present information verbally to relevant parties
- An ability to write reports in the appropriate tone, which is about promoting learning rather than blame
- An ability to recommend that reports are disseminated promptly to:
  - all professionals who can potentially learn from them, for example:
    - managers
    - staff (including front-line clinical staff, particularly those with whom the patient who has died had been in contact)
    - clinical and professional partners (such as local services or local agencies)
    - the patient’s family and carers