Standard Operating Procedure (SOP)

# PATIENT SAFETY INCIDENT INVESTIGATION (PSII) RAPID INCIDENT REVIEW MEEETINGS (RIRM)

| | |
|---|---|
| **SETTING** | All Divisions within UHBW |
| **FOR STAFF** | Patient Safety Teams within all Divisions and Trust Headquarters. Patient Safety Group members, Divisional Governance Group members and Divisional Board Members. All staff reporting/ investigating an incident with harm and/ or a near miss or low harm incident that has been identified as a cause for concern |
| **PATIENTS** | Not applicable |

## PURPOSE

This SOP describes the Rapid Incident Review Meeting (RIRM) of the new Patient Safety Incident Investigation (PSII) process for incidents that have been identified of a potential harm level of moderate and above, are a near miss or low harm incident that has demonstrated significant further potential for learning that may have a wider patient safety impact. The objective of the meeting will be to identify and agree with a member of the Trust Executive team whether further investigation is indicated and the type of investigation required.

A Rapid Incident Review Meeting (RIRM) is called following an initial divisional fact finding Patient Safety Review (Rapid Incident Triage Meeting RiTM process in Children's Division) undertaken ideally within 48 hours: The Patient's care is reviewed by the clinical team, supported by the Divisional Patient Safety Team in reference to a reported incident of significant concern.

**Purpose/ outcome of the Rapid Incident Review Meeting:**

1. **Reporting:** To identify whether the incident meets the criteria to trigger a Patient Safety Investigation and/or is declared a Never Event, accounting for the potential for learning.

2. **Investigation:** To agree the type of investigation that will be undertaken (options outlined below):
   - **a.** ***No further investigation - action plan required*** to capture and disseminate any immediate learning identified at the RIRM (incident shared and action plan agreed by relevant governance group)
   - **b.** ***A Patient Safety Incident Investigation (PSII),*** using either a PSII template or the Falls /Tissue Viability PSII investigation templates.
   - **c.** ***A case note review Divisional level investigation*** using a case note review template.
   - **d.** ***A Mortality & Morbidity review*** undertaken by the clinical team which records M& M identified learning points and improvement actions.
   - **e.** ***Post infection Review (PIR)***
   - **f.** ***Structured Judgement Review (SJR)***
   - **g.** **Externally Commissioned Investigation**
   - **h.** **Safeguarding investigation.**
   - **i.** Or for other types, please see Appendix 1.

3. **Terms of reference:** To agree the Scope / Terms of Reference (TOR) for the investigation that will be undertaken and seniority of investigation lead.
4. **Executive lead:** To identify an Executive Lead for incidents identified as requiring a Patient Safety Incident investigation (PSII).

**Rapid Incident Meeting Attendees:**
Required:

- An Executive Director or Deputy.
- Patient Safety Manager (THQ Patient Safety Team).
- Divisional Patient Safety Team member.
- Member of Divisional Triumvirate or Deputy

Optional (if specialist input required):

- Senior Health Care Professional(s)/specialists who can provide objective analysis (e.g. Clinical Director, Head of Service, Matron, specialists).
- Members of the clinical team(s) who are aware of the facts of the case.

## PROCEDURE

1. A Divisional Patient Safety review of the patient's care is undertaken to establish the key facts (ideally within 48 hours).

2. The incident is identified by the Divisional Patient Safety Team as potentially meeting the criteria to trigger a further Patient Safety Incident investigation and/or significant learning potential from this incident has been identified (regardless of the harm identified). The Divisional Patient Safety Team then inform THQ Patient Safety Team PA/ Facilitator of the requirement to initiate the Rapid Incident Review process.

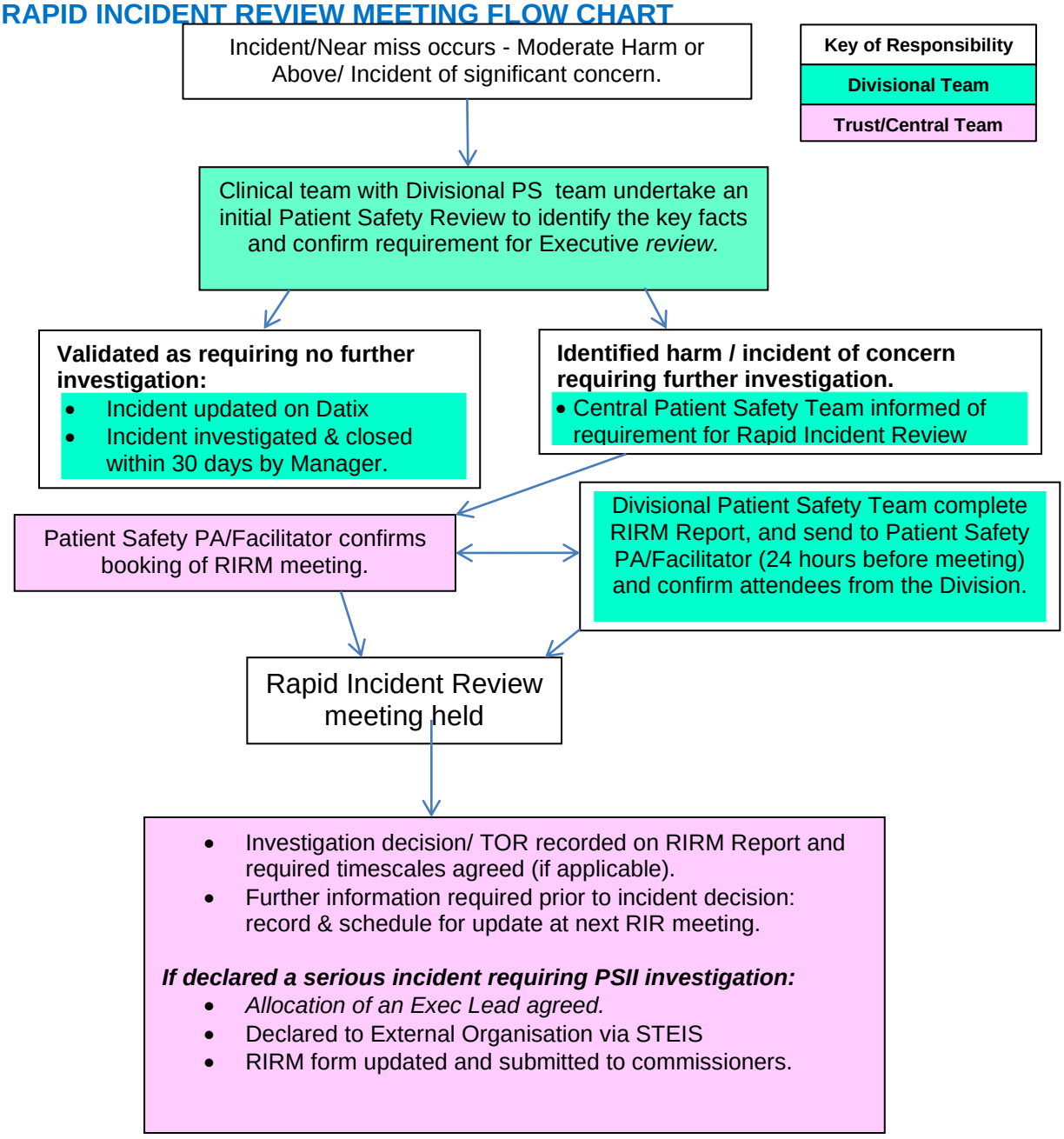
3. A Rapid Incident Review Report (Appendix 1: Template) is completed in full by the Divisional Patient Safety Team and sent to Patient Safety PA/ Facilitator in advance of the meeting for wider circulation, for discussion at the RIRM.

4. Confirmation of attendance and relevant documents for the convened meeting must be confirmed [through acceptance of electronic invite] to the Patient Safety PA/Facilitator 24 hours in advance of the proposed meeting.

## FORMAT OF RAPID INCIDENT REVIEW MEETING

- Confirmation of the initial facts of the incident which are known at the time
- Confirmation of immediate initial learning and agreement of actions required immediately to ensure patient and staff safety.
- Confirmation of support being in place for the staff involved or affected
- Determine and agree the decision (with the attending Trust Executive team member) the requirement and level of further investigation (if required).
- If further information is required prior to an investigation decision: record action and schedule for further review at next RIR meeting.
- Agree the Executive lead for incidents requiring Patient Safety Investigation (PSII).
- Agree the key questions to be answered/ scope/terms of reference for any ongoing investigation.
- Assurance that duty of candour requirements are being complied with.
- Recording the outcome and reporting to relevant external bodies if required e.g. STEIS (CCG database of Patient Safety Investigations).

## RAPID INCIDENT REVIEW MEETING FLOW CHART

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|---|---|
| **RELATED DOCUMENTS** | Serious Incident Policy |
| **AUTHORISING BODY** | Clinical Quality Group |
| **SAFETY** | This document relates to ensuing actions arising from patient safety serious incidents are implemented in a timely manner and action plans are signed off as complete. |
| **QUERIES** | [redacted] Head of Quality (Patient Safety), [redacted] Deputy Head of Patient Safety. |

## Appendix 1:

## Other review types:

| Technique | Method | Objective |
|---|---|---|
| **Immediate safety actions** | Incident recovery | To take urgent measures to address serious and imminent:<br>a. discomfort, injury, or threat to life<br>b. damage to equipment or the environment. |
| **'Being open' conversations** | Open disclosure | To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns. |
| Case record/note review | Clinical documentation review | To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.) |
| **Hot debrief** | Debriefing | To conduct a post-incident review as a team by discussing and answering a series of questions. |
| Safety huddle | Briefing | A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to:<br>• improve situational awareness of safety concerns<br>• focus on the patients most at risk<br>• share understanding of the day's focus and priorities<br>• agree actions<br>• enhance teamwork through communication and collaborative problem-solving<br>• celebrate success in reducing harm. |
| **Incident timeline** | Incident review | To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'. |
| After-action review | Team review | A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely. |
| **LeDeR (Learning Disabilities Mortality Review)** | Specialist Review | To review the care of a person with a learning disability (recommended alongside a case note review). |
| Perinatal mortality review tool | Specialist review | Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care. |
| **Mortality review** | Specialist Review | Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care. |
| **Transaction audit** | Audit | To check a trail of activity through a department, etc, from input to output. |
| **Process audit** | Audit | To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended |
| **Outcome audit** | Audit | To systematically determine the outcome of an intervention and whether this was as expected/intended |
| Clinical audit | Outcome audit | A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes. |
| Risk assessment | Proactive hazard identification and risk analysis | To determine the likelihood of an identified risk and its potential severity (eg clinical, safety, business). |

**Appendix 2: Rapid Incident Review Report**

# Rapid Incident Review (RIR) Report

A Divisional Incident Review of the patient's care (Rapid Incident Triage Meeting RiTM process in Children's Division)takes place when it is agreed that an incident has caused harm (moderate harm or above) or is a no harm/ near miss incident of concern. This should be as soon as possible after an incident occurs or is identified, ideally within 48 hours. Following this initial review and completion of this form a Rapid Incident Review meeting (RIRM) is held.
The purpose/outcome of the Rapid Incident Review is:

1. To agree whether the incident requires a further comprehensive investigation taking into consideration the potential for further learning regardless of the harm identified.
2. To agree next steps/ type of investigation that will be undertaken *(options below*):
   - No further investigation, share and agree action plan in response to immediate learning identified at the RIRM (managed by the relevant governance group).
   - A patient safety incident investigation (PSII) using the new PSII template
   - A case note review reporting to the relevant governance groups.
   - An M&M discussion.
   - Post infection Review (PIR)
   - Externally Commissioned Investigation
   - Safeguarding Investigation
   - Structured Judgement Review (SJR)
3. To agree key questions/terms of reference for further investigation if deemed appropriate
4. Agree an Executive Lead for incidents identified as requiring a Patient Safety Incident investigation (PSII).

**Part 1: To be completed by the division prior to the executive review meeting**

<table>
<tr><td>Date of Rapid Incident Review</td><td colspan="3"></td></tr>
<tr><td rowspan="5">Professionals involved in the Rapid Incident Review.</td><td>Name</td><td colspan="2">Profession</td></tr>
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<tr><td></td><td colspan="2"></td></tr>
<tr><td>Datix Incident Number:</td><td colspan="2"></td><td>Date:</td></tr>
<tr><td>Date/Time of Incident</td><td colspan="3"></td></tr>
<tr><td>Location of patient safety incident – Ward/Department & Hospital</td><td colspan="3"></td></tr>
<tr><td rowspan="6">Summary of clinical event / patient safety incident (including key timeline of events (only) , Post falls checklist/ Datix details (attach)).</td><td colspan="3"></td></tr>
<tr><td>Date:</td><td>Event:</td><td>Source:</td></tr>
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<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="2">Were any immediate actions necessary to ensure patient safety? (circle)</td><td>Yes</td><td>No</td></tr>
</table>

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|---|---|---|---|
| **If yes, provide details of the actions taken/planned** | | | |
| **Who is responsible for implementing the above actions** (individual name and by when?) | | | |
| **Is support in place for the staff involved?** *(circle)* | **Yes** | **No** | **N/a** |
| **If yes: provide details/ lead.**<br>**If no: indicate proposed actions/lead.** | | | |
| **Have Duty of Candour obligations been complied with?** *(circle)* | | **Yes** | **No** |
| **If yes, describe here.**<br>(Face to face discussions; offered with a meaningful, empathetic apology; offered written confirmation of the initial discussion regarding this incident; confirmation of all recorded in the notes?)<br>**If No, outline reason and/ or plans to complete.** | | | |
| **Name of lead professional liaising with the family about this incident?** | | | |
| **Are there any known patient/family concerns/ questions regarding patient management?** *(circle)* | | **Yes** | **No** |
| **If yes, please describe:** | | | |
| **Report author** | | | |

**Part 2: To be completed during/immediately following the Rapid Incident Review meeting.**

| **Outcome of the Rapid Incident Review:** | | | | |
|---|---|---|---|---|
| **Date of Rapid Incident Review Meeting** | | | | |
| **Professionals involved in the Exec Rapid Incident Review** | **Name** | **Profession** | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **1. Outline the outcome and initial learning identified from the Rapid Incident Review** | | | | |
| **2. Is further investigation required?** | **Yes/ No** | **Awaiting further validation/ investigation.**<br>**Detail:**<br><br>**Schedule for next RIR meeting: Y/N** | | |
| **3. If yes, detail level of investigation agreed** | **PSII:** | **Case note review:** | **M&M:** | **Other:** (PIR, SJR, External, Safeguarding) |
| **And next steps:**<br>(Including review at relevant governance group). | | | | |

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| **4. Executive Team Lead** (if PSII). | |
| **5. Scope/Terms of Reference/ Key questions to be answered by the Investigation.** | |
| **6. Details of other key personnel and relevant external bodies that need to be notified of the RIRM outcome.** | *CCG, Key stakeholders, Governance leads, Exec team etc.* |
| **Date / time report completed** | |

## Complete relevant investigation questions/ delete if N/A
## Falls Specific Questionnaire:

| PATIENT RISK FACTORS | | | |
|---|---|---|---|
| **Does the patient have the following risk factors?** | **Yes** | **No** | **Details** |
| Reduced mobility or immobility | | | |
| Sensory impairment | | | |
| Sudden deterioration in medical condition | | | |
| Reduced level of consciousness | | | |
| Aged over 65yo [ ] 75yo [ ] | | | |
| Cardiovascular disease | | | |
| Peripheral vascular Disease | | | |
| Diabetes | | | |
| Incontinence | | | |
| Dementia/Delirium /Confusion or Anxiety | | | |
| Osteoporosis or previous fragility fracture | | | |
| Prescribed sedative medication | | | |
| Hypnotics, antipsychotics or anxiolytics prescribed during their current admission | | | |
| If yes to the above, was the rationale for the prescription, documented in the patient's medical notes? | | | |
| **Falls History** | **Yes** | **No** | **Details** |
| Have they been admitted because of a fall? | | | |
| How often have they fallen in past six months? | | | |
| Have they fallen as an in-patient previously during this admission? | | | |
| Were the incidents reported on Datix? | | | |
| Was any in-patient fall handed over? | | | |
| Have they expressed anxiety about falling? | | | |
| Have the carers / family raised concerns about falls? | | | |

| Post Fall Assessment And Management | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Were the following implemented for the patient?** | **Yes** | **No** | **N/A** | **Details** | | | |
| Was both lying and standing blood pressure taken during this admission? | | | | | | | |
| Was a falls risk assessment conducted within 6 hours of admission? ( If **yes** give details of the outcome of the risk assessment) | | | | | | | |
| Was the patient wearing non slip footwear? | | | | | | | |
| Was the call bell in reach? | | | | | | | |
| Were any slips or trips hazards a factor in the fall? | | | | | | | |
| Were there any factors relating to the Toilet/Bathroom environment? | | | | | | | |
| Was an individual care plan implemented immediately following the risk assessment that included: | | | | | | | |
| • *Multidisciplinary Falls Prevention & Management Care Plan including Bed Rails assessment* | | | | | | | |
| • *Patient Mobility (MH1) Care plan* | | | | | | | |
| • *Toileting & Bathroom Care plan* | | | | | | | |
| • Care Log | | | | | | | |
| Provision of appropriate mattress and seating | | | | | | | |
| Provision of a Hi-Lo bed | | | | | | | |
| Evidence of re-assessment, evaluation and adjustment of care plans | | | | | | | |
| Is there evidence that the patient/carer(s) were involved in the care plan and agreed with it? | | | | | | | |
| Tagged bay [ ] 1:1 [ ] | | | | | | | |
| Had a walking aid been issued? By who? | | | | | | | |
| Was the Post Falls Guideline followed in full? | | | | | | | |
| What manual handling methods were employed? | | | | | | | |
| Were the visual identification falling stars in place? (If **Yes** please tick to indicate which colour was evident) | | | | Amber | | Red | |
| Were referrals made to MDT staff involved in care plan? (If **Yes** please tick to indicate which MDT was evident) | | | | **Physio** | | **OT** | |
| Was Enhanced Supervision triggered? (If **Yes** please tick to indicate the level of enhanced supervision) | | | | **Tagged Bay** | | **1:1** | |

| Organisational Factors | | | |
|---|---|---|---|
| | Yes | No | Details |
| Was the environment staffed to its full potential? | | | |
| What was the ratio of permanent/temporary staff? | | | |
| Was the patient referred to the Falls team if further assessment was required or the care plan was not achieving the desired outcomes? | | | |
| Are nursing staff regularly receiving training in falls prevention and management either by attending in-service training or ward based training? | | | |
| Do nursing staff know how to use all manual handling equipment appropriately and have received training in the selection and operational arrangements for this equipment? | | | |
| Does the ward have a Falls link nurse / Champion attending at least one study day each year? | | | |
| Are Falls incident forms being completed? | | | |
| How many Falls has the ward had in the last 6 months? | | | |

## Tissue Viability Specific Questionnaire:

| Pressure Injury Review date: | |
|---|---|
| Incident Reference No. | |
| Date of Incident | |
| Location of incident | |
| **Tissue Viability Review – validation of pressure injury – date and outcome** | |
| | |

| NICE Quality Standard (QS89) | Yes/No | Comment |
|---|---|---|
| Patient Identified as Pressure Injury Risk | | |
| Was a comprehensive skin assessment / body map completed within 6 hours of admission | | |
| Was a pressure injury risk assessment completed within 6 hours of internal transfer | | |
| Was the patient risk category reassessed as per Trust policy and NICE Guidance (2015) i.e. change of condition/ward move etc. | | |
| Was the patient's skin condition documented daily or as clinically relevant? | | |

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|---|---|---|
| Was a moving and handling assessment completed? | | |
| Was a nutritional assessment completed? | | |
| Was a continence assessment completed? | | |
| Was pressure ulcer preventative care plan in place? | | |
| Were correct referrals made and MDT staff involved in care plan? | | |
| Was preventative care delivered?<br>e.g. care plans, SSKIN, equipment, repositioning | | |
| Is there evidence of evaluation and modification of care including failure to escalate? | | |
| Was appropriate equipment used?<br>e.g. redistribution or off-loading devices | | |
| Was repositioning of patient evident? | | |
| Was the repositioning appropriate to the patient's needs? | | |
| Was there any medical device involved in the development of the pressure injury? | | |
| Was medical photography/ Careflow record completed? | | |
| Was a wound care plan implemented? | | |
| Was wound management plan appropriate? | | |

**Provide brief details on the following**

Past Medical History:

Pressure Injury History:

Tissue Viability reviews:

Safeguarding Comments:

| Organisational Factors | | | |
|---|---|---|---|
| | Yes | No | Details |
| Was the environment fully staffed? | | | |
| Did the ratio of permanent/temporary staff impact on the patient's care? | | | |
| Are nursing staff regularly receiving pressure ulcer prevention and management training either by attending in-service training or ward based training? | | | |
| Do nursing staff know how to use all pressure ulcer equipment appropriately and have received training in the selection and operational arrangements for this equipment? | | | |
| Does the ward have a tissue viability link nurse attending at least 1 link nurse day each year? | | | |
| Are pressure ulcer incident forms being completed? | | | |
| How many grade 3 and 4 pressure ulcers has the ward had in the last twelve months? | | | |
| Have the identified action(s) from the previous grade 3 and 4 Pressure Ulcer incident investigations been fully implemented? | | | |