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POLICY FOR HANDLING SERIOUS UNTOWARD INCIDENTS (SUI)

Introduction

Definition of a Serious Untoward Incident in General Practice

Broadly speaking, serious incidents are events where the potential for learning lessons is so great, or the consequences to patients, families and carers, staff, organisations or property are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can include incidents that may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

There is no definitive list of events or incidents that can be classified as a serious incident, and every incident will need to be judged on a case-by-case basis to determine its significance. The following list contains examples of incidents that would be classed as serious:

- The event resulted in one or more unexpected/avoidable deaths (this includes deaths from suspected suicide/suicide or homicide).
- The event resulted in one or more people suffering an unexpected/avoidable serious or life-threatening injury.
- Examples of actual or alleged abuse.
- A Never Event.
- The event prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services.
- The event led to a major loss of confidence in the service.

Action to Take

The Operational Manager and/or the Clinical Director are usually the people to escalate a Significant Event to a SUI.

Serious incidents must be declared internally as soon as possible and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation. Serious incidents should be disclosed as soon as possible to any affected patient, their family (including victims' families where applicable) or carers.

The relevant commissioning organisation must be informed (via Strategic Executive Information System (STEIS) and/or verbally if required) of a serious incident within 2 working days of it being discovered. Other regulatory, statutory and advisory bodies, such as CQC, Monitor, NHS Trust Development Authority or NHS Improvement, must also be informed as appropriate without delay.

The CCG should respond with a written acknowledgement within 48 hours. The Thanet Health Community Interest Company (TH CIC) should co-operate at all times with any investigation, as well as keeping anyone involved with the incident up to date with developments.

This course of action should be taken as well as, and not instead of, any potential police investigation.

National Reporting and Learning System (NRLS)

The NRLS was established in 2003. The system enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care. This information is used to develop tools and guidance to help improve patient safety at a local level. Most incidents are submitted to the NRLS electronically from local risk management systems.

This policy should be read in conjunction with the significant event protocol to clarify in to which area an incident falls. **All Clinical Commissioning Groups will have their own policy and should be able to provide a reference copy**, and will have in place a Local Reporting and Learning System (LRLS).

The National Reporting and Learning System (NRLS) is a central database that collects patient safety incident reports for the NHS in England and Wales. All information submitted is analysed to identify hazards, risks and opportunities, with the aim of continuously improving the safety of patient care.

From 1 April 2010 it became mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process.

To avoid duplication of reporting, all incidents resulting in death or severe harm **that relate to a serious untoward incident rather than the natural course of the patient's illness or underlying condition** will be reported to the NRLS, which will in turn report them to the Care Quality Commission (CQC).

Examples of patient safety incidents resulting in deaths that should be reported to the NRLS are as follows:

- A patient suffering from chest pain is asked to wait for a free slot in the GP surgery. As he feels difficulty in getting his breath, he goes for a walk, collapses and dies in the GP surgery's car park.

- A practice receives a telephone call from a mother with a small child who seems unwell. The details are taken and a non-urgent note is left for the GP to give the mother a call at the end of surgery. When the GP rings, the child is now quite ill with suggested meningitis symptoms. The GP immediately visits the child and gives antibiotics and arranges an emergency admission. However, the child collapses on route and is pronounced dead on arrival to hospital.

It is important to point out however that the CQC should be contacted **directly** in the event of any death that **would not have happened if the person had been receiving appropriate care and treatment** and either:

- Occurred while a person was actually receiving a regulated activity from or at the GP practice (including in a person's own home, for example during a home visit).
- Occurred, or may have occurred, as a result of regulated activity having been provided by your GP practice in the two weeks before the person died.

An example of an incident resulting in death that should be reported to the CQC follows:

- A patient in a dispensing practice is on a repeat prescription for morphine sulphate 10mg twice a day for chronic pain. The patient requests a prescription and, in error, a prescription is issued for morphine sulphate 100mg twice a day. The medication is dispensed by the practice dispensary and the patient's wife, who looks after his medicines, gives her husband 100mg tablets of morphine sulphate. He takes 2 doses over the next day and then his wife is unable to rouse him in the morning. He is admitted to hospital where he has a cardiac arrest and dies.

The death should be reported to CQC as the person died within a few days of receiving care from the practice when a prescribing error has been made.

Additional Information

In January 2014 NHS England Patient Safety Domain launched the National Patient Safety Alerting System in collaboration with the National Reporting and Learning System. The full guide can be accessed by following the link below.

www.england.nhs.uk/wp-content/uploads/2014/01/npsas-guide.pdf

www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents/

www.cqc.org.uk/content/regulation-16-notification-death-service-user

www.cqc.org.uk/content/gp-mythbuster-24-reporting-patient-safety-incidents-national-reporting-and-learning-system

www.england.nhs.uk/wp-content/uploads/2015/02/gp-nrls-rep-guide.pdf

www.cqc.org.uk/sites/default/files/documents/statutory_notifications_for_nhs_bodies_-_provider_guidance_v6.pdf