Adverse Incident Policy

Version 4

Approved October 2014

Reviewed August 2018

Contents

1. Aims and Objectives

1.1 The aim of this policy is to set out NIGALA's commitment to ensuring an effective approach to the reporting, investigating, learning lessons, implementing and sustaining change as a result of investigation findings and analysis of incidents in order to provide safe, high quality care to our clients and a safe environment for our staff and members of the public. NIGALA recognises that identifying risks and ensuring these are managed effectively, provides opportunities to improve patient care and safety.

1.2 NIGALA aims to create an active awareness of risk throughout the organisation, and place the management of risk at the core of all activities. In order to achieve its commitment to providing high quality care, NIGALA strives to improve all internal systems and procedures which identify and minimise risks to all staff, visitors and users of our services.

1.3 NIGALA will actively promote a culture in which errors can be reported and analysed openly, and in which the reporting of 'near miss' is actively encouraged.

1.4 NIGALA is committed to learning from events external to the local environment and will ensure that essential findings and recommendations are considered and implemented. Where necessary NIGALA will collaborate with other HSC bodies during investigations of adverse incidents and learn lessons to prevent occurrence.

1.5 There are Statutory Regulations that require NIGALA to report certain categories and types of incidents within specified timescales. These incidents and the specific reporting and notification arrangement are outlined in Appendix 1.

1.6 Risks are to be graded using the HSC Regional Risk Matrix as outlined in Appendix 2.

1.7 This policy links directly with the corporate Risk Register and associated documents which in turn, provides greater detail as to NIGALA's control over the risks identified.

2. Principles

There are four key principles in creating an effective and open reporting culture. These are:

- **Openness and accessibility:** Staff will be encouraged to report all incidents and have access to the relevant forms and mechanisms for reporting.
- **Fairness and independence:** All incident reports will be dealt with in a fair and independent manner.
- **Responsiveness:** All incidents will be dealt with in a punctual and positive non punitive manner with all staff being kept informed of progress.
- **Learning and Development:** The organisation will ensure that all incidents are reviewed regularly to incorporate actions that ensure the risk of similar incidents are reduced or minimised.

3. Responsibilities

Chief Executive

3.1 The overall responsibility for ensuring compliance with the incident reporting policy and systems lies with the Chief Executive of NIGALA and the Senior Management Team.

3.2 They will ensure that lessons are learned and care is improved through the effective reporting, analysis, investigation of incidents, action planning, implementing and sustained change and dissemination of lessons learned.

Managers

3.3 Line Managers will ensure all staff within their sphere of responsibility are aware of the need to complete the incident report form.

3.4 A manager will undertake initial investigation requirements as follows:

- Establish the facts.
- Analyse the findings. An incident review may be required dependent on the severity of the incident.
- Establish the immediate causes and any contributory factors.

- Take short term actions to prevent reoccurrence as appropriate.
- Make recommendations to prevent reoccurrence in the medium to long term.
- Develop and implement an action plan.
- Make formal records of findings and remedial actions.
- Record changes as a result of the action plan on the adverse incident record.
- Distribute lessons learned within their teams and to the Senior Management Team.

All Staff

3.5 Staff should advise their line manager of all incidents, including near misses. An adverse incident form should be completed and emailed to: incidents@nigala.hscni.net.

3.6 Staff are to provide, where relevant, further information of any incident.

3.7 Staff should cooperate with their line managers on the management of adverse incidents.

3.8 Staff should not interfere with anything provided to safeguard their health, safety and wellbeing.

Senior Management Team

3.9 The Senior Management Team examines all incidents on a quarterly basis in order to identify trends or themes that require attention or change in practice. The incidents and near miss events identified within Social Care are also reported quarterly to the Social Care Governance Committee. Incident trends are reported back to the NIGALA Board every six months through the Audit Committee and Social Care Governance chair's report.

Head of Corporate Services

3.10 The Head of Corporate Services provides information on incidents and adverse events it to the committees. Reports on specific incidents are then

initiated along with any investigation identified. Incidents will be reported to the Senior Management Team. This will facilitate the development and implementation of safety improvement activity.

3.11 The Head of Corporate Services will oversee and periodically review the effectiveness of an incidents procedure for the NIGALA that is based on:

- Awareness of a procedure for incident reporting throughout NIGALA.
- The provision of an incidents reporting form for local recording of adverse events.
- The collation of local incident reports for analysis and review.
- The collation of the violent incidents again staff – six monthly return for the DoH.

4. Definitions

4.1 **Accident**: an unplanned event that causes injury to persons, damage to property or a combination of both and may be minor/major/fatal. An injury or harm to staff or other person, caused by an event.

4.2 **Adverse Incident:** Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation, which includes an event that has or many have impacted upon the delivery of service or health improvement. Incidents include hazards (i.e. anything which as the potential under certain circumstances to cause injury, illness or harm), accidents (direct results of unsafe activities or conditions), dangerous occurrences and significant events. Examples of incidents include:

- Adverse events that have the potential to cause avoidable harm to a user/client.
- Events that have caused avoidable death to a user/client are serious incident and should be managed as such.
- Any event that resulted in an adverse effect (however minor) on a service user/member of the public or member of staff.
- Failure of equipment, whether or not injury occurs.
- Serious damage to property which NIGALA are tenants.
- Serious damage/loss/theft of NIGALA property.

- Accidents.
- Accidental injuries to staff and members of the public.
- Verbal, physical or psychological abuse or harassment.
- Unusual or dangerous occurrences.
- Damage to property, plant or equipment whilst on NIGALA related business.
- Loss/theft of personal property whilst on NIGALA related business.
- Fire or flood.
- Security, theft or loss.
- Near misses are defined as any event where under different circumstances significant injury or loss may have occurred.
- Illegal acts.
- Lost records/data breaches. (Refer to Information Governance Policy)
- Breach of information governance arrangements. (Refer to Information Governance Policy)[1]

It is essential that all incidents are reported and staff must seek guidance from their line manager.

4.3 **Near Miss:** An incident includes near misses. This is where any of the above may have happened had intervention or evasive action not been taken.

4.4 **Serious Adverse Incidents (SAI) Criteria:** As defined in the HSCB document Procedure for the Reporting and Follow up of Serious Adverse Incidents[2].

- Serious injury to, or the unexpected/unexplained death of:
  - A service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
  - A staff member in the course of their work
  - A member of the public whilst visiting a HSC facility.

- Unexpected serious risk to a service user and/or staff member and/or member of the public.

[1] https://nigala.sharepoint.hscni.net/PublishingImages/SitePages/Home/Information_Governance_Policy.pdf
[2] HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, page 11, point 4.2

- Unexpected or significant threat to provide service and/or maintain business continuity.

- Serious self-harm or serious assault (including attempted suicide, homicide and sexual assaults) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service.

- Serious self-harm or serious assault (including homicide and sexual assaults) on:
  - Other service users;
  - Staff;
  - Members of the public;

  by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.

- Suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986 and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident.

- Serious incidents of public interest or concern relating to:
  - Any of the criteria above
  - Theft, fraud, information breaches or data losses
  - A member of HSC staff or independent practitioner.

Any adverse incident which meets one or more of the above criteria should be reported as a SAI.

5. Reporting Incidents

Why Report an Incident?

5.1 The nature of NIGALA's business involves risks and things can go wrong. By analysing and tackling the root causes of incidents, these risks can be reduced and result in action being taken to reduce the risk of the same or similar incidents occurring.

5.2 There are obligations under legislation and Departmental Guidance to ensure effective management of incidents and accidents. These include:

- Circular HSC (SQSD) 08/2010[3] covers medical devices, serious equipment failings, fire, counter fraud and security management as well as serious incidents involving staff, service users or members of the public.
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) Health and Safety legislation.
- The Health and Safety at Work Act 1974 and NI Order 1978.
- Management of Health and Safety at Work Regulations 1992.
- Management of Health and Safety at Work Regulations (Northern Ireland) 2000.
- Workplace (Health, Safety and Welfare) Regulations 1992.
- Workplace (Health, Safety and Welfare) Regulations (Northern Ireland) 1993.
- Manual Handling Operations Regulations 1992 (Amended 2004).
- Provision and Use of Work Equipment Regulations 1998 (PUWER 1998).
- General Data Protection Act 2018.
- Provision and Use of Work Equipment Regulations (Northern Ireland) 1999.
- Lifting Operations and Lifting Equipment Regulations 1998 (LOLER 1998).
- Lifting Operations and Lifting Equipment Regulations (Northern Ireland) 1999.
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).
- Human Rights Act 1998.
- Disability Discrimination Act 1995.

[3] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

- HSCB guidance on Serious Adverse Incidents as amended from time to time.

5.3 The process of reporting a Serious Adverse Incident aims to:

- Focus on service improvement for service users.
- Recognise the responsibilities of individual organisations and support them in ensuring compliance.
- Clarify the processes relating to the reporting, investigation, dissemination and implementation of learning arising from SAIs which occur during the course of the business of an HSC organisation/Special Agency or commissioned service.
- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication.
- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence.
- Provide a mechanism to effectively share learning in a meaningful way across the HSC.
- Maintain a high quality of information and documentation within a time bound process.

Adverse Incident Reporting

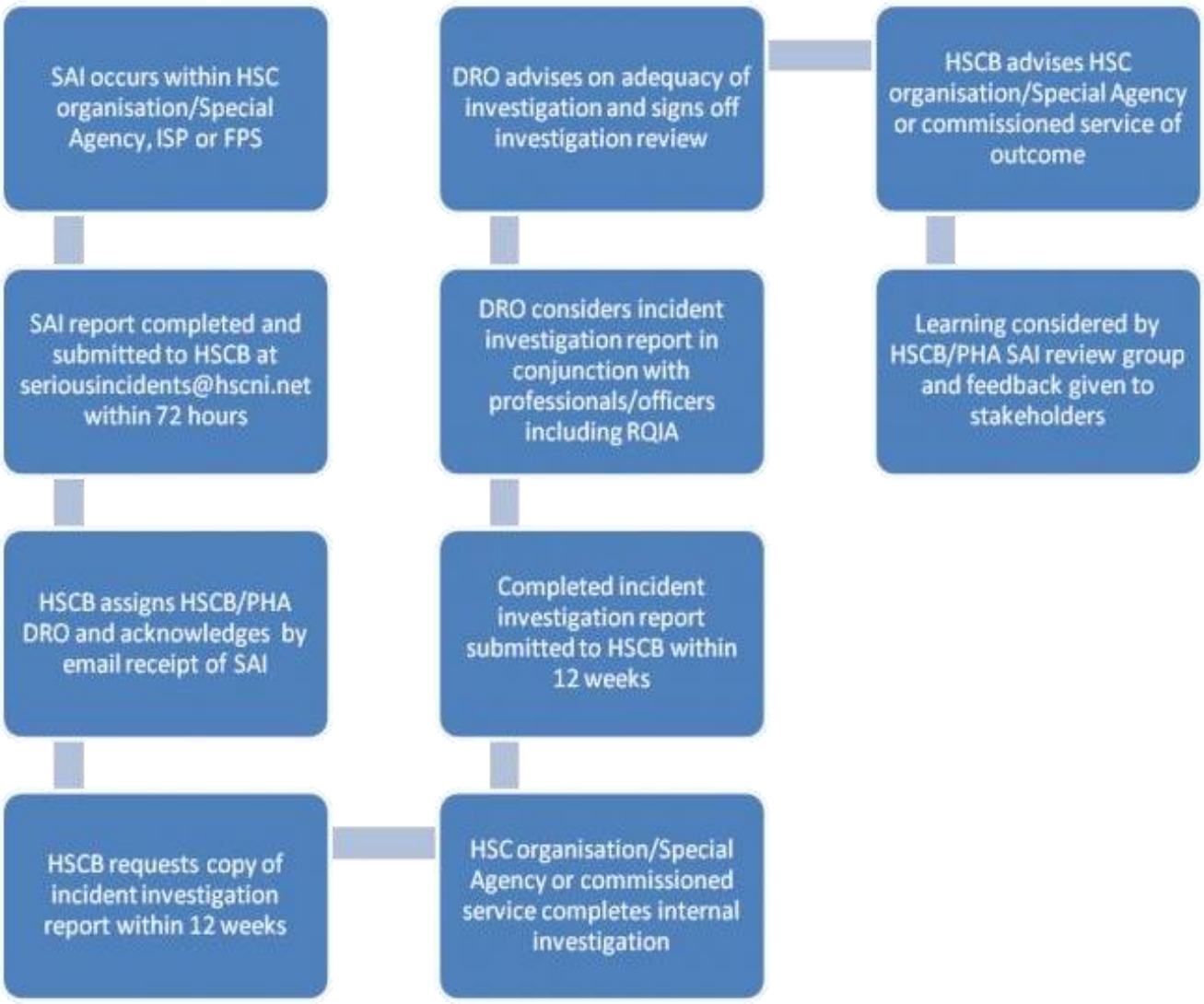
5.4 All staff should report adverse incidents, accidents and near misses to their line manager and complete the NIGALA's incident reporting form[4] (Appendix 3). The form should be saved then emailed to incidents@nigala.hscni.net. A manager will undertake an investigation and ensure that any follow up reports, learning outcomes or preventative measures are communicated to the Senior Management Team.

Serious Adverse Incident Reporting

5.5 Serious Adverse Incidents must be reported to the NIGALA Board, Sponsor Branch, DoH and HSCB as soon as possible via the NIGALA Head of

[4] NIGALA Adverse Incident Report Form
https://nigala.sharepoint.hscni.net/_layouts/15/WopiFrame.aspx?sourcedoc=/Documentation/Forms%20and%20Templates/Incident%20Reporting/NIGALA%20Incident%20Report%20Form.docx&action=default

Corporate Services. NIGALA, as an arms-length body, will report SAIs by completing the HSCB SAI Incident Notification Form[5] (Appendix 4) utilising the procedure detailed in the HSCB document Procedure for the Reporting and Follow up of Serious Adverse Incidents[6], and as displayed in the chart below.



[5] HSCB SAI Notification Form and Guidance
[6] http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf

RIDDOR Reporting

5.6 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) require NIGALA to notify the Health and Safety Executive NI (HSENI) of accidents at work. These reports enable the enforcing authorities to identify where and how risks arise and to investigate serious accidents.

5.7 Line managers have a duty to inform the Head of Corporate Services if an incident or accident has occurred to a member of staff and it has resulted in greater than 3 days sickness absence i.e. it is RIDDOR reportable.

5.8 It is the responsibility of the Head of Corporate Services to inform the HSENI, in some instances without delay (e.g. by telephone), dependent upon the type of incident, the detail of the incident. This must be followed up within ten days with a completed RIDDOR report form (NI2508). Further information can be found on the HSENI website[7].

5.9 The incident will be graded in relation to the severity, casual factors will be identified and the outcomes/management actions will be recorded along with any preventative measures.

5.10 NIGALA recognises that incidents may occur which impact on other external organisations. Where incidents occur that involve or impact on other external organisations/stakeholders, NIGALA will liaise directly to ensure a coordinated approach is taken to manage any risk to staff and service delivery.

6. Immediate Management of the Incident

6.1 The immediate responsibility for managing an incident falls to the most senior person on duty at the time the incident occurs. If the event is regarded as a Serious Adverse Incident, the Chief Executive, and the Head of Corporate Services must be informed immediately and they will decide whether to initiate Business Continuity plans if required.

6.2 It is the responsibility of the most senior person on duty to:

[7] https://www.hseni.gov.uk/report-incident

- Make the situation safe;
- Provide or arrange any first aid or medical care as needed;
- Decide in conjunction with either the Chief Executive or Head of Corporate Services what other parties require to be informed (taking into account issues of confidentiality), PSNI, NIAS, NIFRS, HSENI, ICO, DoH etc;
- If unable to inform people who need to know, ensure appropriate person(s) are delegated to inform people who need to know, reflective on the nature of the incident;
- Ensure that an Incident Report Form has been correctly and fully completed at the earliest opportunity and no later than two working days after the incident;
- If the incident relates to a Data Breach, every reasonable effort must be made to locate and retrieve documents lost, altered and disclosed. The Corporate Services Manager will inform the Information Commissioners Office or other relevant body if required in conjunction with the SIRO (Please refer to Information Governance Policy);
- All communications in regard to a possible Data Breach must be cleared by at least the Head of Corporate Services and the relevant Information Asset officer.

7. Investigating an Adverse Incident

7.1 Investigations will be led by someone with the status and knowledge (to make authoritative recommendations and approved by the Senior Management Team. Who investigates an incident will be determined by the nature of the incident, who was involved and where it occurred. A risk adviser, health and safety adviser, managerial or technical staff, or equipment suppliers may need to be involved if events have serious or potentially serious consequences.

7.2 Incident investigations should, if appropriate to the circumstances:

- Identify what happened by obtaining statements/interviewing relevant staff;
- Identify how it happened;
- Identify why it happened;
- Learn from incidents and make recommendations;

- Implement improvement strategies to help prevent, or minimise recurrences, thus reducing future risk of harm;
- Satisfy mandatory and reporting requirements;
- A detailed report of the investigation should be compiled;
- Serious Adverse Incident investigations must be concluded in accordance with the requirements of the HSCB procedure for the reporting and follow up of Serious Adverse Incidents.

8. Alternative Methods for Raising Concerns

8.1 This policy outlines the procedure for the reporting of all incidents; however NIGALA recognises that staff members have a right and a duty to raise with their employer any matters concerned with the delivery of care or services to a user or adverse events affecting staff within NIGALA without fear of any repercussions.

8.2 For that reason, NIGALA promotes that the purpose of reporting an incident is not to apportion blame to any individual or group of people, but to identify problems and to remedy them. Furthermore NIGALA acknowledges that without an open culture, the reporting of inappropriate care or the reporting of incidents will not take place and it will be difficult to learn lessons thus preventing similar situations. NIGALA, however, does recognise that there should be alternative methods for concerns to be raised.

Raising Concerns/Whistleblowing

8.3 Individuals may wish to raise concerns in relation to an incident, but may feel unable to do so for fear of victimisation. Line managers have a duty to ensure that staff are easily able to express their concerns within the organisation. Managers must ensure that any staff concerns are dealt with thoroughly and fairly, and that a full investigation will take place with the individual receiving feedback as to the outcome. The NIGALA Whistleblowing Policy[8] may also be consulted and is available on the intranet.

8 https://nigala.sharepoint.hscni.net/Documentation/Policies/HR/Whistleblowing%20Model%20Policy%20issued%20March%202018.pdf

9. Training

9.1 Training will be made available to staff as required.

10. Media Involvement

10.1 Any media involvement will be handled by the Chief Executive and Head of Corporate Services in association with other relevant senior staff depending on the issue.

11. Learning Lessons

11.1 Incident reporting and investigation is a method of identifying problems and addressing these to reduce risk, to improve both safety and the quality of care. One method of achieving this is to use the lessons learned from incidents to review the systems and processes in place to assess whether modifications are required to prevent the same incident occurring in the future. Dissemination of these lessons learned within NIGALA is essential to maximise the benefits of investigating incidents.

11.2 Incidents will be reported to the senior management team on a bi-annual basis.

11.3 The range of adverse incidents are extensive and the NIGALA's position on each and every area could not be effectively articulated in one policy document. The NIGALA's general position is that it wishes to promote a health and safety culture and reduce the risk of adverse activities emanating from NIGALA activities.

11.4 Within these general policy principles NIGALA will produce guidance, which will be, imperative to staff safety in areas such as personal protection, lone working, manual handling, violence to staff, alcohol and substance policy and stress in the workplace (this list is not exhaustive). Staff will be informed of any such specific guidance.

12. Monitoring and Review

12.1 This policy will be reviewed every 2 years or sooner in the event of legislation or regulatory changes, structural or role changes, operational or technological changes, organisational learning, audits and review of the effectiveness of the policy.

Monitoring and Review

Monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/Gaps Recommendations and Actions	Implementation of any required change
Policy	Every 2 years	Head of Corporate Services	Chief Executive	The policy will be reviewed in conjunction with any legislation changes and NIGALA objectives.	A revised policy will be published via the NIGALA intranet
Reporting of adverse incidents	Through quarterly analysis of incident records.	Head of Corporate Services	Senior Management Team (SMT)	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these.	Agreement from SMT
Reporting of Social Care adverse incidents	Through quarterly reporting of social care incidents.	Head of Corporate Services	Social Care Governance Committee	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these.	Agreement from SMT
Reporting of Health and Safety and staff incidents	Through quarterly reporting of incidents from the incidents record.	Head of Corporate Services	Health, Safety & Wellbeing Committee Meetings	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these.	Agreement from SMT
Reporting of Information Governance incidents	Through quarterly reporting of incidents from the incidents record.	Head of Corporate Services	Information Governance Forum	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these.	Agreement from SMT

Appendix 1: Internal and External Reporting of Incidents

Incident Type	Internal Contact/Responsible staff for regulatory reporting (unless otherwise stated)	Internal Reporting/Review	External Reporting Requirements
NIGALA Reputational Damage (actual or potential)	Chief Executive	Senior Management Team NIGALA Board	Serious Advise Incident System (SAI) DoH
Civil Action/Legal (either actual or potential)	Chief Executive	Senior Management Team NIGALA Board	DoH
Service user safety	Line Manager	Senior Management Team NIGALA Board	SAI DoH
Moving and Handling	Head of Corporate Services	Health, Safety & Wellbeing Committee Senior Management Team BSO Health & Safety	Health and Safety Executive NI (HSENI)
Health and safety over 3 days injuries (includes RIDDOR reportable)	Head of Corporate Services	Health, Safety and Wellbeing Committee Senior Management Team BSO Health & Safety	HSENI
Aggression/verbal and physical assault	Line Manager	Health, Safety & Wellbeing Committee	DoH PSNI

Incident Type	Internal Contact/Responsible staff for regulatory reporting (unless otherwise stated)	Internal Reporting/Review	External Reporting Requirements
Fire	Head of Corporate Services	Health, Safety & Wellbeing Committee Senior Management Team	DoH Estates
Buildings	Head of Corporate Services	Health, Safety & Wellbeing Committee Senior Management Team	DoH Estates
Information Device Defects and Failures	Head of Corporate Services	Information Governance Forum	Information Commissioner (if personal information is lost)

Appendix 2: HSC Regional Risk Matrix

Likelihood Scoring Descriptors	Impact (Consequence Levels)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)	Medium	Medium	High	Extreme	Extreme
Likely (4)	Low	Medium	Medium	High	Extreme
Possible (3)	Low	Low	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	High	High
Rare (1)	Low	Low	Medium	High	High

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency How often might it/does it happen?**	**Time Framed Description of Frequency**
Almost Certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

Appendix 3: Incident Reporting Form

Incident Reporting Form

Incidents should be reported within 24 hours of occurrence.

To complete the form electronically, first save the form to your desktop. Once completed attached to email and forward to incidents@nigala.hscni.net

Name	
Incident Date and Time	
Date Reported	
Line Manager	

Description of Incident:

Immediate Action Taken:

Was any person injured or affected in the incident?	Yes/No
If yes, please provide details	

Were there any witnesses to the event?	Yes/No
If yes, please provide details	

Was any other person involved in the incident?	Yes/No
If yes, please provide details	

Was there any equipment involved in the incident?	Yes/No
If yes, please provide details	

For Manager Use Only:

Name	
Date	

Type of Incident:

Abuse	☐
First Aid	☐
Health & Safety	☐
IT	☐
Information Governance	☐
Serious Adverse Incident	☐

If the incident is a Serious Adverse Incident, SAI Notification Form to be completed. Please refer to the HSCB Procedure for Reporting and Follow up of Serious Adverse Incidents (SAI).

Risk Grading

(Refer to Appendix 2 of Adverse Incident Policy – HSC Regional Risk Matrix):

Likelihood	Consequence	Risk Grading

Action Taken:

Date Closed:	

Outcome:

Learning:

Additional Information:

Appendix 4: Serious Adverse Incident Report Form

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM			
1. ORGANISATION		2. UNIQUE INCIDENT IDENTIFICATION NO./REFERENCE	
3. HOSPITALFACILTY/COMMUNITY LOCATION *(where incident occurred)*		4. DATE OF INCIDENT: DD/MM/YYYY	
5. DEPARTMENT/WARD/LOCATION EXACT *(where incident occurred)*			
6. CONTACT PERSON:		7. PROGRAMME OF CARE: *(refer to guidance notes)*	
8. DESCRIPTION OF INCIDENT: DOB: DD/MM/YYYY GENDER: M/F AGE: years *(complete where relevant)*			
9. IS THIS INCIDENT A NEVER EVENT? YES ☐ NO ☐	If 'YES' *provide further detail on which never event – refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars		
COMMON CLASSIFICATION SYSTEM (CCS) CODING			
STAGE OF CARE: *(refer to guidance notes)*	DETAIL: *(refer to guidance notes)*	ADVERSE EVENT: *(refer to guidance notes)*	
10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:			
11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*			
12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS/MEDICAL DEVICES/EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A
14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*			
serious injury to, or the unexpected/unexplained death of: - A serious user (including a Looked After Child or a child whose name is on the child Protection Register and those events which should be reviewed through a significant event audit			
- A staff member in the course of their work			
- A member of the public whilst visiting a HSC facility			
unexpected serious risk to a service user and/or staff member and/or member of the public			
unexpected or significant threat to provide service and/or maintain business continuity			
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service			
serious self-harm or serious assault *(including homicide and sexual assaults)* - On other service users - On staff or - On members of the public By a service user in the community who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services)* and/or learning disability services, in the 12 months prior to the incident			

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM		
Suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services)* and/or learning disability services, in the 12 months prior to the incident		
Serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of the HSC staff or independent practitioner		
15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMEDED: *(please select)*	YES	NO
If 'YES' *(full details should be submitted)*		

16. HAS THE SERVICE USER/FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, HCPC etc) please specify where relevant*	YES	NO
If 'YES' *(full details should be submitted)*		

18. OTHER ORGANISATION/PERSONS INFORMED *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULARLY QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2	LEVEL 3

*FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICAITON REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board/Public Health Agency and Regulation and Quality Improvement Authority (*delete as appropriate)*

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD/MM/YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to guidance notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD/MM/YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and *(where relevant)* seriousincidents@rqia.org.uk