Belfast Health and Social Care Trust
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Reference No: TP 80/11

Title:	***Being Open* Policy – saying sorry when things go wrong**			
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Ownership:	Mr Chris Hagan, Medical Director			
Approval by:	Policy Committee Executive Team Meeting		**Approval date:**	04 June 2020 10 June 2020
Operational Date:	June 2020		**Next Review:**	June 2025
Version No.	V4	**Supercedes**	V3 July 2018	
Key words:	Being Open, Duty of Candour, Adverse Incident, Complaint			
Links to other policies	BHSCT Adverse Incident Reporting and Management Policy (2018) TP 08/08 BHSCT Procedure for grading an adverse incident (2018) TP 95/14 BHSCT Serious Adverse Incident (SAI) Procedure (2016) TP 97/14 BHSCT Risk Management Strategy 2017 – 2020 (2019) TP 58/08 BHSCT Memorandum of Understanding – Investigating Service User Safety Incidents			

Date	Version	Author	Comments
17/04/2014	1.1	Julian R Johnston	S+G put into new template
09/10/2014	1.2	Julian R Johnston	Hyperlinks fixed; Francis report
22/01/2015	1.3	CM	Change to scope and Appendix 2b to reflect application of principles to minor incidents
24/02/2015	1.4	Julian R Johnston	Editing, Duty of candour section 1.1.2
14/04/2015	1.5	Julian R Johnston	Check Hyperlinks, Contents, appendices, 1.1.2
24/05/2018	1-4	[redacted]	Linked Policies hyperlinks removed. Contents table updated and repaired. Broken hyperlinks corrected. Seven steps graphic revised. Benefits for Patients & Staff combined. Being Open Process Stages

			table (appendix 5) changed to table as used in BHSCT e learning. Appendix 8 – NI ombudsman guidance reproduced in appendix rather than link. Appendix 9 – inquiry reports relating to duty of candour, including Francis report section from main body of policy. Being open changed to Being Open for consistency. Appendices bookmarked. Formatting corrected for consistency.
13/05/2020	3.1	[redacted]	Comparison review to Being Open Policy v3 and regional policy template for being Open issued by HSCB. Amendments made as follows: • Ownership changed from Dr Cathy Jack to Mr Chris Hagan, Medical Director • 1.1.6 Definition of Service User added as per HSCB Policy • Wording 'Patient' or 'Patients' changed to 'Service User' or Service Users' throughout in line with HSCB policy terminology. • Automatic Table of Contents (TOC) has been added and Headings and Sub-Headings formatted.

Table of Contents

1.0 INTRODUCTION / PURPOSE OF POLICY

Harming a patient can have devastating emotional and physical consequences on the individuals, their families and carers, and can be distressing for the professionals involved.

'Being Open' is a set of principles that healthcare staff should use when offering an explanation and apologising to patients and/or their carers when harm has resulted from an incident.

"saying sorry is not an admission of liability"

Being Open' involves:

- acknowledging, apologising and explaining when things go wrong
- keeping patients and carers fully informed when an incident has occurred.
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring.
- providing support for those involved to cope with the physical and psychological consequences of what happened.
- recognising that direct and/or indirect involvement in incidents can be distressing for healthcare staff, permission will be given to seek emotional support.

The BHSCT is committed to improving the safety and quality of the care we deliver to the public. This BHSCT '*Being Open'* policy expresses this commitment to provide open and honest communication between healthcare staff and a patient (and/or their family and carers) when they have suffered harm as a result of their treatment. It is based on published guidance by the National Patient Safety Agency (NPSA) and also complies with step 5 of '*Seven steps to Patient Safety'* (appendix 1).

1.1 Background

1.1.1 Openness, Transparency and Candour

Openness and honesty towards patients are supported and actively encouraged by many professional bodies including the General Medical Council, the Royal College of Nursing, the Medical Defence Union and the Medical Protection Society.

The duty of candour has received support through the Joint statement from the Chief Executives of statutory regulators of healthcare professionals.

This is supported by *Openness and honesty when things go wrong: the professional duty of candour*, issued by the GMC and NMC in 2015 summarising their position on this and provides guidance on how to follow the principles set out in *Good Medical Practice* (GMC) and *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC)

In September 2005, the National Patient Safety Agency (NPSA) called on all NHS organisations to develop local '*Being Open'* policies. Their guidance was

replaced in November 2009 by *Being Open: communicating patient safety incidents with patients, their families and carers* in response to changes in the healthcare environment and in order to strengthen '*Being Open'* throughout the NHS.

They also produced a *Being Open Framework* to act as a best practice guide on how to create an open and honest environment through:

- aligning with the *Seven steps to patient safety* (appendix 1) which outlines for leaders of healthcare organisations on how to create an open and fair culture.
- ensuring a '*Being Open'* policy is developed that clearly describes the process to be followed when harm occurs. This relates directly to, and expands upon, step 5.
- committing publicly to '*Being Open'* at board and senior management level.
- identifying senior clinical counsellors to mentor and support fellow healthcare professionals involved in incidents.

This BHSCT policy is based upon adopting openness, transparency and candour throughout the organisation and is modelled on the NPSA *Being Open* policy and the '*Being Open'* Framework document.

1.1.2 Recommendations from Inquiry Reports

In recent years there have been a number of reports arising from diverse inquiries into healthcare both in England and Northern Ireland and all of these have included recommendations in regard to Being Open and Duty of candour. The summary of the relevant recommendations are in **appendix 9** and include the Francis Report (2013), the Donaldson Report (2014) and the Hyponatraemia Inquiry (O'Hara 2018)

Although there is currently no statutory duty of candour in Northern Ireland, as recommended by the Donaldson and O'Hara reports, the suggestion has been endorsed by previous Northern Ireland health minsters

1.1.3 Culture, Policy and Support

BHSCT will have the following foundations to implement '*Being Open'* successfully:

To implement '*Being Open'* successfully, the BHSCT will have the following foundations:

A. a culture that is open and fair.
B. a '*Being Open'* policy and mechanisms to raise awareness about it.
C. staff and patient support for '*Being Open'.*

A. Open and fair culture

Promoting a culture of openness is vital to improving patient safety and the quality of healthcare systems. A culture of openness is one where healthcare:

- staff are open about incidents they have been involved in.
- staff and organisations are accountable for their actions.
- staff feel able to talk to their colleagues and superiors about any incident
- organisations are open with patients, the public and staff when things have gone wrong and explain what lessons will be learned.
- staff are treated fairly and are supported when an incident happens.

To achieve this goal of openness with the public, the BHSCT has adopted the nationally recognized seven steps to patient safety in their risk management strategy and will continuously strive to achieve these objectives contained within the steps (appendix 1).

B. 'Being Open' policy & associated training

A *'Being Open'* policy that sets out the process of communication with patients, and raising awareness about this, will provide staff with the confidence to communicate effectively following an incident.

An elearning programme that provides information on the fundamentals of applying the Being Open Process and includes a case study

C. Staff and patient support

To ensure both staff and patients support the implementation of *'Being Open'* it is vital that:

- Patients, their families and carers feel confident in the openness of the communication following a patient safety incident, including the provision of timely and accurate information;
- healthcare professionals understand the importance of openness and feel supported by their healthcare organisation in delivering it, and were appropriate they undertake the Being Open e-learning programme.

1.1.4 Prevented and 'no harm' incidents

The Trust encourages staff to report all patient safety incidents; even those that were prevented (i.e.' near misses'), insignificant and minor incidents. These are often the type of incidents, which if addressed promptly and taken seriously will lead to minimizing or preventing more serious incidents. This monitoring of all incidents will lead to the achievement of a high quality safety culture.

It is not a requirement of these guidelines that no harm patient safety incidents are discussed with patients as this would cause undue and

unnecessary anxiety. This does not absolve staff of their responsibility to report such incidents to ensure that they are recorded, monitored and reported through the Trust incident reporting system.

1.1.5 Being Open

The main thrust of this 'Being Open' policy is concerned with patient safety incidents which cause moderate, major or catastrophic harm (appendix 2). It describes the process of 'Being Open' and gives advice on the 'do's and don'ts' of communicating with patients and/or their carers following harm.

The focus is on rapid and open disclosure and emotional support to patients and families who experience serious incidents. They also address ways to support and educate clinicians involved in such incidents.

The Trust will approach these issues from the patient's point of view, asking, "What would I want if I were harmed by my treatment?"

While Trust employees and caregivers may have competing interests, including legitimate concerns about legal liability, our frame of reference is the simple question, "What is the right thing to do?"

1.1.6 Definitions

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances, it can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death. It can be rated as insignificant, minor, moderate, major or catastrophic (appendix 2).

Service User[1] refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

1.2 Purpose

This document is relevant to all board, executive, managerial and healthcare staff and by explaining the principles behind '*Being Open'* it ensures that patients and families who experience incidents which have caused moderate, major or catastrophic harm receive rapid and open disclosure along with emotional support. It also addresses ways to support and educate staff involved in such incidents.

1.3 Objectives

This policy defines the BHSCT's commitment to '*Being Open'* by establishing a culture where:

[1] As per the draft statement of what you should expect in relation to a Serious Adverse Incident (SAI) Review, January 2019.

- patients and carers receive rapid and open disclosure and emotional support when they experience serious incidents which cause moderate, major or catastrophic harm.
- they receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not occur again.
- ways to support and educate healthcare staff involved in such incidents are addressed.
- staff involved are treated justly and appropriately.
- healthcare professionals, managers, patients & carers are appropriately supported when things go wrong.
- Patients and carers receive timely information about the outcome of any investigation.

2.0 SCOPE OF THE POLICY

The BHSCT Adverse Incident Reporting and Management Policy encourages staff to report all patient and service user safety incidents, including those where there was no harm or it was a 'near miss' event.

The *'Being Open'* **principles** apply to any incident where any harm has occurred to a patient. The *'Being Open'* **process** outlined in the policy must be followed where incidents are of moderate, major or catastrophic severity as defined in appendix 2 a+b and within steps 1+2 of the BHSCT Procedure for grading an adverse incident; incidents that are regarded as insignificant or minor do not require implementation of the Being Open process , although the principles should be applied (section 1.1.4).

This policy applies to all Trust employees.

This policy establishes a culture of openness as a basic principle of how we interact with patients which then underpins other policies. It sets the scene of openness as a founding principle behind:-

- Capability Policy and Procedure
- Complaints Policy
- Disciplinary Policy and Procedure
- Adverse Incident Reporting and Management policy and procedures
- Information Governance Policy
- Procedure for investigating Adverse Incidents
- Risk Management Strategy
- Consent Policy.

It also complements standards as set out by professional bodies e.g. GMC and NMC.

3.0 ROLES/RESPONSIBILITIES

This policy is aimed at all levels of healthcare staff working for or in the BHSCT. The following responsibilities and accountabilities reinforce the

concept of this *'Being Open'* culture of openness applying throughout the organization.

3.1 Trust Board

The Trust Board are responsible

- for actively championing the *'Being Open'* process.
- for promoting an **open and fair** culture that fosters peer support and discourages the attribution of blame. This should result in staff being empowered to improve patient care by learning from mistakes rather than denying them.

3.2 Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to support openness between healthcare professionals and patients and/or their carers following an incident that led to moderate, major or catastrophic harm.

3.3 Executive Directors

Medical Director/Director of Nursing/ Director of Adult Social & Primary Care

Overall professional responsibility for managing the '*Being Open'* process.

Service Directors

Responsibility within their own service directorate for managing the '*Being Open'* process.

3.4 Managers

- Ensure all staff are aware of the "Being Open" policy.
- Support staff, particularly those who will have a key role in managing the Being Open process, in completing Being Open e-learning training available on the HUB http://elearning.belfasttrust.local/
- Support staff involved in patient and service user safety incidents, including advising on sources of appropriate support such as StaffCare.
- Notify the
  - Associate Medical / Nursing / Co- Directors when an incident has caused moderate harm or more.
  - Medical Director } that the '*Being Open'* process has
    Nursing Director } been initiated for an incident
    Primary and Social Care Director } causing
    Service Director } major or catastrophic harm.

3.5 All Healthcare Staff

All staff working within the organisation will be expected to adhere to this policy and are responsible and accountable for:

- ensuring that patient incidents are acknowledged and taken seriously.
- treating concerns with compassion and understanding.
- reporting as soon as they are identified.
- informing their line manager.
- participating in the investigation process.
- communicating in a timely, truthful & clear fashion.

- recording and documenting discussions with patients and families
- complying with the *Being Open* policy
- undertaking the Being Open e-learning programme where appropriate.

4.0 KEY POLICY PRINCIPLES

4.1 Key Policy Statement(s)

Patient safety incidents will be managed using the principles outlined in this BHSCT '*Being Open'* policy. Each incident will trigger a 5 stage process as set out in appendix 5; with modifications in certain circumstances detailed in appendix 6.

4.2 The principles of 'Being Open' should also apply to the full spectrum of unexpected or unplanned clinical events. Especially where there is a risk of moderate, major or catastrophic harm, a rapid and open disclosure of these changes in a service user's medical condition e.g. C. Diff. infection, should be communicated and discussed with the patient and, where appropriate, their family.

10 principles of 'Being Open'

1. Acknowledge incident
2. Communicate – truthful, timely, clear
3. Apology
4. Patient, family & carer support
5. Support for Professions
6. Risk management
7. Multidisciplinary responsibility
8. Clinical Governance
9. Confidentiality
10. Continuity of care

Also, in keeping with the 'Being Open' philosophy, if a death certificate is needed it is the responsibility of the Consultant to ensure that it is completed accurately and that the details of the service user's illness, its treatment and the factors causing and/or contributing to the service user's death are discussed with the relatives and recorded in the clinical record.

4.3 All patient safety incidents will be **acknowledged** and reported as soon as possible in line with the BHSCT adverse incident reporting and management policy; denial of a concern makes further open and honest communication more difficult.

4.4 The most appropriate person must **communicate** with the service user about an incident in a truthful open and timely manner. Information must be based solely on the facts. Service users will not receive conflicting information from different members of staff.

4.5 Service users and/or their families [unless there are confidentiality issues] will receive a sincere **apology** and expression of sorrow or regret for the harm caused by a service user safety incident.

Both verbal and written apologies will be given. Verbal apologies are essential because this allows face-to-face contact and they should be given as soon as staff are aware of the incident. Delay is likely to increase anxiety, anger or frustration.

The NI Ombudsman has issued a 'Guidance on Issuing an Apology' leaflet which provides helpful guidelines regarding issuing an apology (appendix 9).

4.6 Support for the Service Users

A key part of 'Being Open*'* is considering the service user's needs, or the needs of their carers or family in circumstances where the service user has been involved in a serious service user safety incident or died. The Trust will ensure early identification of and provision for the service user's practical and emotional needs.

Service users and/or their carers can reasonably expect to be kept fully informed of the issues surrounding a service user safety incident in a face-to-face meeting. They will be treated sympathetically with respect and consideration. They will be provided with **support** in a manner appropriate to their needs.

This includes providing the names of people who can give assistance and support, and to whom the service user has agreed that information about their health care can be given. This person (or people) may be different to both the service user's next of kin and from people whom the patient had previously agreed should receive information about their care prior to the service user safety incident.

The Trust will provide information on services offered by all the possible support agencies (including their contact details) that can give emotional support, help the service user identify the issues of concern, support them at meetings with staff and provide information about appropriate community services.

Contact details will be provided of a staff member who will maintain an ongoing relationship with the service user, using the most appropriate method of communication from the perspective of the service user and/or their carer(s). Their role is to provide both practical and emotional support in a timely manner.

It is important to identify at the outset if there are any special restrictions on openness that the service user would like the healthcare team to respect. It is also important to identify whether the service user does not wish to know every aspect of what went wrong, to respect their wishes and reassure them this information will be made available if they change their mind later on.

Public information statement
'*Being Open*' if things go wrong:
We will

- tell you if we know something has gone wrong.
- listen to you if you see something is wrong.
- say sorry.
- find out what happened and why.
- keep you informed.
- answer your questions.
- work to stop it happening again.

4.7 Support for Families, Carers

Service users and/or their carers may need considerable practical and emotional help and support after experiencing a service user safety incident. Support may be provided by service users' families, social workers, religious representatives, directorate and corporate governance leads. Details of the Patient Client Council should also be available among others. Where the service user needs more detailed long-term emotional support, advice should

be provided on how to gain access to appropriate counselling services, e.g. Cruse (the UK's largest bereavement charity).

A service user and/or their family may, at any time through this process wish to avail of advocacy or representation if they feel this would help them to understand and address issues.

4.8 Information for Service Users, Families and Carers

Information on the 'Being Open*'* process in the form of a short leaflet explaining what to expect should also be provided along with information on how to make a formal complaint and/or any other available means of giving positive or negative feedback to healthcare staff involved in their care.

When a Serious Adverse Incident (SAI) has occurred service users, families and/or carers will be made aware of the incident and have opportunity to engage in the review process in line with the Regional HSCB Procedure for Reporting & Follow-Up of SAIs.

An SAI Information leaflet will be provided explaining what an SAI is, how it will be investigated and how they can contribute to the process including opportunity for expressing their concerns and sharing their experiences. On completion of the SAI Review, a copy of the final report will be shared detailing the outcomes and learning identified.

4.9 Support for staff

These guidelines apply to all staff that have a role in providing service user care. The Trust acknowledges that most incidents usually result from system failures and it is unusual that incidents arise solely from the actions of an individual. Senior managers and senior clinicians must participate in incident investigation and clinical risk management.

When a service user safety incident occurs, healthcare professionals involved in the clinical care may also require emotional support and advice. Both the clinical staff who have been involved directly in the incident and those with the responsibility for '*Being Open'* discussions should be given access to assistance, support and any information they need to fulfil this role.

To **support staff** involved the Trust will:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. The Trust will work towards a culture where blame is the enemy of learning and where human error is understood to be a consequence of flaws in the healthcare systems, not necessarily the individual.
- Create an environment in which staff are encouraged to report service user safety incidents. Staff should feel supported throughout any incident investigation process.
- Provide facilities for formal and informal debriefing of the clinical team involved in an incident separate from the requirement to provide statements for the investigation. Individual feedback about the final outcome of the service user safety incident will be available.

- Provide advice and training on the management of service user safety incidents.
- Provide counselling by professional bodies for staff distressed by service user safety incidents. Stress management courses for staff that have responsibilities for leading “Being Open” discussion.
- Avail of the support services provided by staff representative organisations and ensure staff have access to the information they can provide.
- Recognise that there is a need for healthcare staff to develop the skills necessary to be effective when communicating with service users and/or their carers in these rare but very distressing circumstances. The Trust will provide training to assist communicating in these difficult situations.

4.10 Service user safety incidents will be investigated to uncover the underlying cause(s). Investigations should focus on improving systems of care. The ‘*Being Open*’ policy is part of an integrated approach to addressing service user safety incidents. They are embedded in an approach to **risk management** that includes incident reporting, analysis of incidents and decision about staff accountability.

4.11 This policy applies to all members of the **multidisciplinary teams** that have key roles in providing the service user’s care. This should be reflected in the way that service users, their families and carers are communicated with when things go wrong. This will ensure that the ‘*Being Open’* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual.

To ensure multidisciplinary involvement in the ‘*Being Open’* process, it is important to identify clinicians, nurses and managers who will support it. Both senior managers and senior clinicians who are local leaders must participate in incident investigation and clinical risk management.

4.12 The guidelines will require support of patient safety and quality improvement processes through the assurance and **governance** framework in which service user safety incidents are investigated and analysed and to find out what can be done to prevent a recurrence.

The findings of any investigation should be disseminated to all relevant persons and monitored so they can learn from events. This will also facilitate the move towards increased awareness of service user safety issues and the value of ‘*Being Open’*.

4.13 Full **confidentiality** of and respect for service users, carers and staff will be maintained. Consent will be sought from individuals prior to disclosing information beyond the clinicians involved in treating service users. Communication with parties outside of the clinical team should also be on a strictly need-to-know basis.

4.14 Service users are entitled to expect, and the Trust will ensure, that they will receive **continuity of care** with all the usual treatment and continue to be treated with dignity, respect and compassion.

If a service user expresses a preference for their healthcare needs to be taken over by another team, the Trust will make every effort to make the

appropriate arrangements unless it is clearly obvious not to be in the service user's best interests.

5.0 IMPLEMENTATION OF POLICY

On-line training "Being Open – Saying sorry when things go wrong" is suitable for all staff and is available on the HUB e-learning page at:

http://elearning.belfasttrust.local/

6.0 MONITORING

This policy will be audited through the Risk & Governance Departments.

7.0 EVIDENCE BASE / REFERENCES

- BSHCT Adverse Incident Reporting and Management Policy
- BHSCT Risk Management Strategy 2017-20.
- National Patient Safety Agency documents.
- Australian Open Disclosure Framework
- *Seven steps to patient safety: full reference guide – (NPSA July 2004).*
- *Being open: communicating patient safety incidents with patients, their families and carers (NPSA, 2009)*
- *'Being Open' Framework* – (NPSA, November 2009).
- Openness & Honesty when things go wrong: the professional duty of candour (NMC/GMC 2015) **https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf**
- The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013),
- Right time, right Place (Donaldson Report) (2014)
- Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018)
- Guidance on issuing an apology, NIPSO June 2016, https://nipso.org.uk/site/wp-content/uploads/2018/05/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-June-2016-1.pdf

8.0 CONSULTATION PROCESS

- Trust Service Directors & Staff Side
- Standards and Guidelines Committee.
- BHSCT Clinical Ethics Committee

9.0 APPENDICES / ATTACHMENTS

Appendix 1: Seven steps to Patient Safety
Appendix 2a: NPSA grade and definition of patient safety incident

Appendix 2b: Grades and consequent actions following Service User Safety Incidents.
Appendix 3: Benefits for Service Users & Staff
Appendix 4: The '*Being Open'* process
Appendix 5: Being open in particular circumstances
Appendix 6: NPSA '*Being Open'* safety alert November 2009
Appendix 7: Comparison of BHSCT vs NPSA incident grading matrix.
Appendix 8: Guidance on issuing an apology – NI Ombudsman
Appendix 9: Inquiry reports relating to duty of candour

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018, the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☒

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

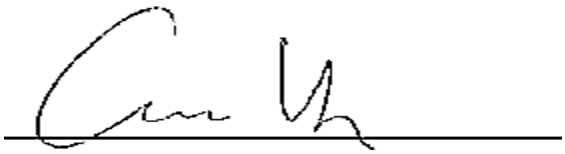
12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services. It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES



17/08/2020

_____ **Date:** _____

Chris Hagan
Medical Director

18/08/2020

_____ **Date:** _____

Cathy Jack
Chief Executive

Appendix 1: NPSA - Seven Steps to Patient Safety

National Patient Safety Agency. *Seven steps to patient safety. The full reference guide*. 2004.

Appendix 2a: BHSCT – definitions for grading of Service User Safety Incidents

Insignificant

Incident prevented / Near Miss

Any service user safety incident that had the potential to cause harm but was prevented and no harm was caused to service users receiving NHS-funded care. Incidents that did not lead to harm but could have, are referred to as **near misses**. (*Doing Less Harm. NHS. National Patient Safety Agency 2001*).

Incident not prevented

Any service user safety incident that occurred but insignificant harm was caused to service users receiving NHS-funded care.

Minor harm

Any service user safety incident that required:

- *Minor injury or illness requiring first aid/intervention.*
- *Requiring increased patient monitoring.*
- *Increase in hospital stay by 1-3 days.*

Moderate harm

Any service user safety incident that resulted in a moderate increase in treatment* and that caused significant but not permanent harm to one or more service users receiving NHS funded care.

**Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Major harm

Any service user safety incident that appears to have resulted in permanent harm* to one or more service users receiving NHS-funded care.

**Permanent harm directly related to the incident and not related to the natural course of the service user's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*

Catastrophic

Any service user safety incident that directly resulted in the death* of one or more service users receiving NHS-funded care.

**The death must be related to the incident rather than to the natural course of the service user's illness or underlying condition.*

Appendix 2b: Grades and consequent actions following Service User Safety Incidents

BHSCT	Insignificant	Minor	Moderate	Major	Catastrophic
BHSCT definition	Not requiring first aid or any intervention.	Requires extra observation or minor treatment.	**Significant but not permanent harm - moderate increase in treatment.**	Permanent harm arising directly from incident.	Resulted in the death.
Example		Intervention required. Requires first aid Increased service user monitoring. Additional medication Increased hospital stay (1-3 days) No return to surgery No readmission	Semi-permanent physical / emotional injury / trauma / harm. Treatment given. Recovery expected within 1 year. Return to surgery, Unplanned readmission, Prolonged episode of care, Extra time in hospital (4-14 days) or as an outpatient, Cancellation of treatment, Transfer to another area e.g. ICU	Permanent physical / emotional injuries/trauma/harm Increased hospital stay >14 days.	The death must be related to the incident rather than to the natural course of the service user's illness or underlying condition.
Action	↓	↓	↓	↓	↓
	Apply the principles of 'Being Open'.		**Apply the 'Being Open' process Stages I →VI.**		
	1. Report the incident in line with the adverse incident reporting and management policy. 2. Review the incident to determine its cause and take local action to prevent it happening again. **3.** The principles of the 'Being Open' policy apply but no documented actions are required.		A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the '*Being Open*' process if required.		

Appendix 3 – Benefits for Service Users and Staff

BENEFITS FOR PATIENTS

Being open when things go wrong has not always been part of the Health and Social Care culture. However evidence shows that being open and honest is fully supported by service users and they are more likely to forgive and understand healthcare errors when they have been discussed fully in a timely and thoughtful manner. Research and the feedback from those involved in a serious service user safety incident indicate that the service users would like:

- To know when a safety incident affects them;
- An acknowledgement of the distress that the incident caused;
- A sincere and compassionate statement of regret for the distress being experienced;
- A factual explanation of what happened;
- A clear statement of what is going to happen from then onwards;
- A plan about what can be done to repair or redress the harm done.

BENEFITS FOR STAFF

Being open has several benefits for healthcare staff including:

- Satisfaction that communication with services users and /or their carers following a service user safety incident has been handled in the most appropriate way;
- improving the understanding of incidents from the perspective of the service user and /or their carers;
- the knowledge that lessons learned from incidents will help prevent them happening again;
- having a good professional reputation for handling a difficult situation well and earning respect among peers and colleagues.

Appendix 4 – Being Open Process

'Being Open' is a process rather than a one-off event and can be considered in 6 stages with documentation being a constant feature throughout the process.

Stage I	Stage II		Stage III	Stage IV	Stage V
Service User incident detection and recognition	Preliminary Team discussion		Initial Being Open meeting/ contact	Follow-up meetings/ contacts	Being Open process completed
	Inform service user/carer	Plan further Being Open process			
Service user safety incident recognised Prompt care and actions to prevent any further harm Incident reporting Identify staff and service user support & communication needs	Minor Initial assessment to determine level of response - grading Provide open honest factual information Offer initial verbal apology / expression of regret/sympathy Offer initial support Discuss further contacts	Moderate, Major, Catastrophic Establish the facts Decide the process Identify lead person & clarify if this is lead contact Agree with SU/Family who will meet with who when and where Identify support needed	Explain the process Offer apology /regret/sympathy & support Provide factual details Explain learning process Invite questions / comments/take notes Agree any further contact	Confirm meeting in writing and provide written apology Keep in touch as agreed at meeting Trust investigation process Feedback method agreed with SU/family	Feedback from the investigation process, learning and actions - to service users / family and carers - to other Trust staff and partners Monitoring
No Being Open process required for near miss or no harm incidents	End of the Being Open process for low harm incidents		May be end of Being Open process or may agree further contact		End of Being Open process

Documentation

Keep written records of all ***Being Open*** contacts/discussions:

- **When** (date/time)
- **Who** was involved
- **What** information was given by who

Record incident review process & learning outcomes

Adapted From: National Patient Safety Agency. 'Being Open' Framework. November 2009.

Details of Key Stages of Being Open Process

STAGE I: INCIDENT DETECTION AND MANAGEMENT

The '*Being Open*' process begins with the recognition that a patient has suffered moderate harm, major harm, or has died, as a result of a service user safety incident.

Detection of the incident

A service user safety incident may be identified by:

- a member of staff at the time of the incident.
- a member of staff retrospectively when an unexpected outcome is detected.
- a service user and/or their carers who expresses concern or dissatisfaction with the service user's healthcare either at the time of the incident or retrospectively.
- incident detection systems such as incident reporting or medical records review.
- other sources such as detection by other service users, visitors or non-clinical staff.

Priority

As soon as a service user safety incident is identified, the top priority is prompt and appropriate clinical care and prevention of further harm. Where additional treatment is required this should occur whenever reasonably practicable after a discussion with the service user and with appropriate consent. An incident report form should be completed which will trigger the Trust processes for reporting and then investigating and analysing incidents. If the incident is considered to meet Serious Adverse Incident (SAI) criteria, the incident should also be escalated to the appropriate directorate senior manager and governance and quality manager to ensure timely appropriate management which may result in a serious adverse incident report to HSCB.

Service user safety incidents occurring elsewhere

A service user safety incident may have occurred outside the Trust. The individual who first identifies the possibility of an earlier service user safety incident should notify Corporate Governance. The same individual, or a colleague, should make contact with their equivalent at the organisation where the incident occurred and establish whether:

- the service user safety incident has already been recognized.
- the process of '*Being Open*' has commenced.
- incident investigation and analysis is underway.

The '*Being Open*' process and the investigation and analysis of a service user safety incident should occur where the incident took place.

Criminal or intentional unsafe act

Service user safety incidents are almost always unintentional. However, if at any stage following an incident it is determined that harm may have been the result of a criminal or intentional unsafe act, Corporate Governance Department and the relevant Executive Director should be notified immediately.

The BSHCT Adverse Incident Reporting and Management Policy should be referred to.

STAGE II: INFORM SERVICE USER/CARER

Provide open honest factual information

Offer initial verbal apology / expression of regret /sympathy

An expression of genuine sympathy, regret and an apology for the harm that has occurred.

Appropriate language and terminology are used when speaking to service users, their families and carers.

Offer initial support

Staff should ensure the service user, their family and/or their carers

- are informed that an incident investigation is being carried out if appropriate.
- show understanding of what happened is taken into consideration, as well as any questions they may have.
- are provided with information on the complaints procedure if they wish to have it;

Consideration and formal noting of the views and concerns of the service user, their family and carer(s), and demonstration that these are being heard and taken seriously.

Discuss further contacts

An offer of practical and emotional support for the service user, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.

Discussions with service users and/or their carers are documented and that information is shared with them;

This is the end of the Being Open process for low harm incidents

STAGE III: PRELIMINARY TEAM DISCUSSION/ Plan further Being Open Process

The multidisciplinary team, including the most senior health professional involved in the service user safety incident, should meet as soon as possible after the event to:

- establish the basic clinical and other facts.
- assess the incident to determine the level of immediate response.
- identify who will be responsible for discussion with the service user and/or their carers = '*Being Open'* coordinator.
- consider the appropriateness of engaging service user support at this early stage. This includes the use of a facilitator, a patient advocate or a healthcare professional that will be responsible for identifying the service user's needs and communicating them back to the healthcare team.
- identify immediate support needs for the healthcare staff involved.
- ensure there is a consistent approach by all team members around discussions with the service user and/or their carers.

Assessment to determine level of response

All incidents should be assessed initially by the healthcare team to determine the level of response required. The nature and subsequent grading of the incident will determine the level of response.

Incident	Level of Response
Insignificant harm **(including prevented patient safety incident)**	It is not a requirement of this policy to communicate prevented service user safety incidents and insignificant incidents to service users and/or carers.
Minor harm	Unless there are specific indications or the service user requests it, the communication, investigation and analysis, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the incident. Communication should take the form of an open discussion between the staff providing the service user's care and the service user and/or their carers. Reporting to the corporate governance department will occur through standard incident reporting mechanisms and monthly data will provided to Directorate teams for analysis to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed. **↳Apply the principles of 'Being Open' – locally.**
Moderate harm, **Major harm** **Death**	A higher level of response is required in these circumstances. Report the incident in line with adverse incident reporting and management policy. The Governance Manager in your Directorate should be notified immediately and will be available to provide support and advice during the 'Being Open' process if required. **↳Apply the 'Being Open' process – Stages I → VI.**

Timing of discussion with patient and/or carers

Preliminary discussions with the service user and/or their carers should occur as soon as possible after recognition of the service user safety incident. Factors to consider when timing this and any future '*Being Open*' discussions include:

- clinical condition of the service user.
- service user preference (i.e. meeting place and timing, who leads the discussion(s).
- availability of key staff involved in the incident and in the '*Being Open'* process.
- availability of the service user's family and/or carers.
- availability of support staff e.g. interpreter, independent advocate.

The *'Being Open'* coordinator role

It is essential to carefully consider the choice of the individual to communicate with service users and who informs the service user and/or their carers about a service user safety incident. Getting it right at the start of the process will reassure the service user and may lead to a favourable outcome.
This should be the most senior person responsible for the service user's care and/or someone with experience and expertise in the type of incident that has occurred. They should:

- be known to, and trusted by, the service user and/or their carers.
- have a good grasp of the facts relevant to the incident.
- be senior enough or have sufficient experience and expertise in relation to the type of service user safety incident to be credible to patients, carers and colleagues.
- have excellent interpersonal skills, including being able to communicate with service users and/or their carers in a way they can understand and avoiding excessive use of medical jargon.
- be willing and able to offer an apology, reassurance and feedback to service users and/ or their carers.
- be able to maintain a medium to long term relationship with the service user and/or their carers, where possible, and to provide continued support and information.
- be culturally aware and informed about the specific needs of the service user and/or their carers.

If for any reason it becomes clear during the initial discussion that the service user would prefer to speak to a different healthcare professional, the service user's wishes should be respected. A substitute with whom the service user is satisfied should be provided.

Use of a substitute healthcare professional for the 'Being Open' discussion

In exceptional circumstances, if the '*Being Open'* coordinator, who usually leads the discussion cannot attend, they may delegate to an appropriately trained substitute. The qualifications, training and scope of responsibility of this person should be clearly delineated.

Assistance with the initial 'Being Open' discussion

The healthcare professional communicating information about a service user safety incident should be able to nominate a colleague to assist them with the meeting. Ideally this should be someone with experience or training in communication and '*Being Open'* procedures.

Responsibilities of junior healthcare professionals

Junior staff or those in training should not lead the '*Being Open'* process except when all of the following criteria have been considered:

- the incident resulted in insignificant or minor harm.
- they have expressed a wish to be involved in the discussions.
- the senior healthcare professional responsible for the care is present for support.
- the service user and/or their carers agree to their involvement.

Where a junior healthcare professional who has been involved in a service user safety incident asks to be involved in the '*Being Open'* discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate patient safety information alone or to be delegated the responsibility to lead a '*Being Open'* discussion unless they volunteer and their involvement takes place in appropriate circumstances (i.e. they have received appropriate training and mentorship for this role).

Service user safety incidents related to the environment of care

In such cases a senior manager of the relevant service will be responsible for communicating with the service user and/or their carers. A senior member of the multidisciplinary team should be present to assist at the initial '*Being Open'* discussion. The healthcare professional responsible for treating the injury should also be present to assist in providing information on what will happen next and the likely effects of the injury.

Involvement of healthcare staff who made the mistake

Some service user safety incidents result from errors made by the healthcare staff caring for the service user. In these circumstances the member(s) of staff involved may or may not wish to participate in the '*Being Open'* discussion with the service user and/or their carers. Every case where an error has occurred needs to be considered individually, balancing the needs of the service user and/or their carers with those of the healthcare professional concerned.

In cases where the healthcare professional that has made an error wishes to attend the discussion to apologise personally, they should feel supported by their colleagues throughout the meeting and should be made aware of staff representation organization support.

In cases where the service user and/or their carers express a preference for the healthcare professional not to be present, it is advised that a personal written apology is handed to the service user and/or their carers during the first '*Being Open'* discussion.

STAGE IV: INITIAL 'BEING OPEN' DISCUSSION

Content of the initial 'Being Open' discussion

The service user and/or their carers should be advised of the identity and role of all people attending the *'Being Open'* discussion before it takes place. This allows them the opportunity to state their own preferences about which healthcare staff should be present.

The content of the initial *'Being Open'* discussion with the service user, their family and carers should cover the following:

- An expression of genuine sympathy, regret and an apology for the harm that has occurred.
- The facts that are known are agreed by the multidisciplinary team. Where there is disagreement, communication about these events should be deferred until after the investigation has been completed.
- The service user, their family and/or their carers
    - should be informed that an incident investigation is being carried out.
    - understanding of what happened is taken into consideration, as well as any questions they may have.
    - provided with information on the complaints procedure if they wish to have it;
- Consideration and formal noting of the views and concerns of the service user, their family and carers, and demonstration that these are being heard and taken seriously.
- Patient's account of the events leading up to the service user safety incident are fed into the incident investigation for example, through Root Cause Analysis (RCA) whenever applicable.
- Provide carers and those very close to the service user with access to information to assist in making decisions if the service user is unable to participate in decision-making or if the service user has died as a result of an incident. This should be done with due regard to confidentiality and in accordance with the service user's instructions.
- Ensure carers are provided with known information, care and support if a service user has died as a result of a service user safety incident. The carers should also be referred to the coroner for more detailed information.
- Discussions with service users and/or their carers are documented and that information is shared with them;
- Appropriate language and terminology are used when speaking to service users, their families and carers.
- Assurance that an ongoing care plan will be developed in consultation with the service user and will be followed through followed by an explanation about what will happen next in terms of the short through to long-term treatment plan and incident analysis findings.
- Assurance that the service user will continue to be treated according to their clinical needs and that the prospect of, or an actual dispute between, the service user and/or their carers and the healthcare team will not affect their access to treatment.
- Information on likely short and long-term effects of the incident (if known). The long-term effects may have to be presented at a subsequent meeting when more is known.
- An offer of practical and emotional support for the service user, their family and carers. This may involve getting help from third parties such as charities and voluntary organisations, as well as offering more direct assistance. Information about the service user and the incident should not normally be disclosed to third parties without consent.

STAGE V: FOLLOW UP DISCUSSIONS

Follow-up discussions with the service user, their family and carers are an important step in the
'Being Open' process - there may be more than one.

- The discussion(s) should occur at the earliest practical opportunity.
- Consideration should be given to the location and timing of meeting, based on both the service user's health and personal circumstances.
- Feedback should be given on progress to date and information provided on the investigation process.
- Repeated opportunities should be offered to the service user and/or their carers to obtain information about the service user safety incident.
- There should be no speculation or attribution of blame. Similarly, the healthcare professional communicating the incident must not criticise or comment on matters outside their own experience. Tell the service user and family what happened. Tell *what* happened now; leave details of *how* and *why* to later i.e. Stage V.
- The service user and/or their carers should be offered an opportunity to discuss the situation with another relevant professional where appropriate.
- A written record of the discussion should be kept and shared with the service user and/or their carers.
- All queries should be responded to appropriately.
- If completing the process at this point, the service user and/or their carers should be asked if they are satisfied with the investigation and a note of this made in the service user's records.
- The service user should be provided with contact details so that if further issues arise later there is a conduit back to the relevant healthcare professionals.

STAGE VI: PROCESS COMPLETION

Communication with the service user, their family and carers

After completion of the incident investigation, feedback should take the form most acceptable to the service user. Whatever method is used, the communication should include:

- the chronology of clinical and other relevant facts including an explanation of details of *how* and *why*.
- details of the concerns and complaints of the service user'], their family and carer(s).
- a repeated apology for the harm suffered and any shortcomings in the delivery of care that led to the service user safety incident.
- a summary of the factors that contributed to the incident.
- information on what has been and will be done to avoid recurrence of the incident and how these improvements will be monitored.
- an ongoing clinical management plan. This may be encompassed in discharge planning policies addressed to designated individuals e.g. GP.
- reassurance that they will continue to be treated according to their clinical needs, even in circumstances where there is a dispute between them and the healthcare team. They should also be informed that they have the right to continue their treatment elsewhere if they prefer.

It is expected that in most cases there will be a complete discussion of the findings of the investigation and analysis. In some cases information may be withheld or restricted, for example, where communicating information will adversely affect the health of the service user; where investigations are pending coronial processes; or where specific legal requirements preclude disclosure for specific purposes. In these cases the patient will be informed of the reasons for the restrictions.

Communication with the GP and other community care service providers

In certain circumstances, it may be prudent to communicate with the service user's GP, before discharge, describing what happened. When the service user leaves the Trust, the discharge letter should also be forwarded to the GP or appropriate community care service. It should contain summary details of:

- the nature of the service user safety incident and the continuing care and treatment;
- the current condition of the service user;
- key investigations that have been carried out to establish the service user's clinical condition;
- recent results;
- prognosis.

DOCUMENTATION

Throughout the *Being Open* process it is important to record discussions with the service user, their family and carers as well as the incident investigation. Written records of the '*Being Open'* discussions should consist of:

- the time, place and date, as well as the name and relationships of all attendees.
- the plan for providing further information to the service user, their family and carers.
- offers of assistance and the response of the service users, their family and carers.
- questions raised by the service user, their family and carers, and the answers given.
- plans for follow-up meetings.
- progress notes relating to the clinical situation and an accurate summary of all the points explained to the service user, their family and carers.
- copies of letters sent to the service user, their family and carers, and the GP.
- copies of any statements taken in relation to the service user safety incident.
- a copy of the incident report.

Appendix 5: BEING OPEN IN PARTICULAR CIRCUMSTANCES

The approach to being open may need to be modified according to the service user's personal circumstances. The following gives guidance on how to manage different categories of service user circumstance.

When a service user dies

When a service user safety incident has resulted in a service user's death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The service user's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

> "it may be appropriate to wait for the coroner's inquest before holding the '*Being Open'* discussion"

Usually, the 'Being Open' discussion and any investigation occur before the coroner's inquest. In certain circumstances the Trust may consider it appropriate to wait for the coroner's inquest before holding the 'Being Open' discussion with the service user's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the service user's death. In any event, an apology should be issued as soon as possible after the service user's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

When a child reaches 16 years they acquire the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision-making.

Children younger than 16 years who understand fully what is involved in the proposed procedure can also give consent (Frazer competent). Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the 'Being Open' process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Service users with mental health issues

'Being Open' for service users with mental health issues should follow standard procedures, unless the service user also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold service user safety incident information from a mentally ill service user is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the service user. Except where exceptional circumstances prevail, it is inappropriate to discuss patient safety incident information with a carer or relative without the express permission of the service user; to do so may constitute an infringement of the service user's Human Rights and/or a breach of Data Protection legislative provisions.

Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorized a person to act on their behalf by an enduring power of attorney. In these cases, steps must be taken to ensure this extends to decision-making and to the medical care and treatment of the patient. The '*Being Open'* discussion would be held with the holder of the power of attorney.

Where there is no such person the clinicians may act in the service user's best interests in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the service user as a whole and not simply their medical interests. However, the service user with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the service user to assist in the communication process.

Service users with learning disabilities

Where a service user has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the service user is not cognitively impaired they should be supported in the '*Being Open'* process by alternative communication methods (e.g. given the opportunity to write questions down). An advocate, agreed on in consultation with the service user, should be appointed. Appropriate advocates may include carers, family or friends of the service user. The advocate should assist the patient during the '*Being Open'* process, focusing on ensuring that the service user's views are considered and discussed.

Service users with different language or cultural considerations

Reference must be made to the interpreting protocol when booking interpreters.

Service users with different communication needs

A number of service users will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Service users who do not agree with the information provided

Sometimes, despite the best efforts of healthcare staff or others, the relationship between the service user and/or their carers and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the '*Being Open'* process.

In this case the following strategies may assist to deal with the issue as soon as it emerges:

- Where the service user agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the service user has access to support services.
- Where the senior health professional is aware of the relationship difficulties, provide mechanisms for communicating information, such as the service user expressing their concerns to other members of the clinical team.
- Offer the service user and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for clinical risk management.
- Use a mutually acceptable mediator to help identify the issues between the healthcare organisation and the service user, and to look for a mutually agreeable solution.
- Ensure the service user and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the service user and/or their carer disagree with and reassure them you will follow up these issues.

Appendix 6: National Patient Safety Agency - Being Open

Alert

Patient Safety Alert

NPSA/2009/PSA003
19 November 2009

NHS
National Patient Safety Agency

National Reporting and Learning Service

Being Open

Communicating with patients, their families and carers following a patient safety incident

Being open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which the patient was harmed.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened.

In 2005, the National Patient Safety Agency (NPSA) issued a Safer Practice Notice advising the NHS to develop a local *Being open* policy and to raise awareness of this policy with all healthcare staff.

The guidance has now been revised in response to changes in the healthcare environment and in order to strengthen *Being open* throughout the NHS.

The revised *Being open* framework (available at **www.nrls.npsa.nhs.uk/beingopen**) should be used in conjunction with this Alert to help develop and embed *Being open* in each NHS organisation.

The *Being open* principles are fully supported by a wide range of royal colleges and professional organisations, including the Medical Defence Union, Medical Protection Society, NHS Litigation Authority and Welsh Risk Pool.

Tools to support organisations in the implementation of this Alert are available at: **www.nrls.npsa.nhs.uk/beingopen**

Endorsed by:

Action Against Medical Accidents
Department of Health
Healthcare Inspectorate Wales
NHS Confederation (England)
NHS Confederation (Wales)
NHS Litigation Authority
Medical Defence Union
Medical Protection Society
Royal College of General Practitioners
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal College of Psychiatrists
Welsh Assembly Government
Welsh Risk Pool

Action for the NHS

For action by Chief Executives of organisations commissioning and providing healthcare.

Deadlines:

- Actions underway: **22 February 2010**
- Actions completed: **23 November 2010**

Actions:

1) **Local policy:** Review and strengthen local policies to ensure they are aligned with the *Being open* framework and embedded with your risk management and clinical governance processes.
2) **Leadership:** Make a board-level public commitment to implementing the principles of *Being open*.
3) **Responsibilities:** Nominate executive and non-executive leads responsible for leading your local policy. These can be leads with existing responsibilities for clinical governance.
4) **Training and support:** Identify senior clinical counsellors who will mentor and support fellow clinicians. Develop and implement a strategy for training these staff and provide ongoing support.
5) **Visibility:** Raise awareness and understanding of the *Being open* principles and your local policy among staff, patients and the public, making information visible to all.
6) **Supporting patients:** Ensure Patient Advice and Liaison Services (PALS), and other staff have the information, skills and processes in place to support patients through the *Being open* process.

worth repeating...

This Alert replaces the *Being Open Safer Practice Notice* (2005)

NPSA Reference Number: NPSA/2009/PSA003
Gateway Reference: 13015
1097 November 2009

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Appendix 7: Comparison of BHSCT vs NPSA Incident Grading Matrix

BHSCT Grading	NPSA grading
Insignificant	None
Minor	Low
Moderate	Moderate
Major	Severe
Catastrophic	Death

Appendix 8: NI Public Services Ombudsman – Guidance on Issuing an Apology.

GUIDANCE ON ISSUING AN APOLOGY

When the Ombudsman investigates a complaint and finds maladministration, she may recommend that the public service provider offers an apology. In these circumstances the complainant may have been waiting a considerable period of time for the organisation to provide a full explanation as to what went wrong and to acknowledge any failings.

What is an apology?

An apology can be defined as a 'regretful acknowledgement of an offence or failure'. Mistakes can be made by one member of staff, a whole team or there may be systemic failures within an organisation. When things do go wrong, most people who have had a bad experience may simply seek an acknowledgement and, if appropriate, to be given an explanation and an apology.

Why apologise?

In many cases an apology and explanation may be a sufficient and appropriate response to a complaint. The value of this approach should not be underestimated. A prompt acknowledgement and apology, where appropriate, can often prevent the complaint escalating. It can help restore dignity and trust in the public service provider and can be the first step in putting things right.

What are the implications of an apology?

Although there is no legislation in this area of law which applies specifically to Northern Ireland, the Compensation Act 2006 governing England and Wales states that 'an apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or statutory duty.' The timely provision of a full apology may in fact reduce the chances of litigation.

What is a meaningful apology?

Each complaint is unique so your apology will need to be based on the individual circumstances. It is important when you are making an apology, you understand how and why the person making the complaint believes they were failed and what they want in order to put things right. Failing to acknowledge the complainant's whole experience is only a partial apology and therefore less effective.
To make an apology meaningful you should:

- Accept you have done wrong. You should include identifying the failure along with a description of the relevant action or omission to which the apology applies. This should include any failings that the Ombudsman identified in her investigation that warrant an apology. Your description must be specific to show that you understand the effect your act or omission has had on the complainant. It must also acknowledge if appropriate, that the affected person has suffered disappointment, hurt, anxiety, upset or loss.
- Clearly explain why the failure happened and include that the failure was not intentional or personal. If there is no explanation, however, one should not be offered. Care should be taken to provide full explanations rather than excuses.
- Demonstrate that you are sincerely sorry. An apology should be an expression of sorrow or at the very least an expression of regret. The nature of the harm done will determine whether the expression of regret should be made in person as well as being reinforced in writing; or simply in writing.
- Reassure the complainant that you will not repeat the failure. This may include a statement of the steps that have been taken, or will be taken, to address the failure, and, if possible, to prevent a reoccurrence.
- Provide the complainant with a statement of specific steps proposed to address the grievance or problem, by mitigating the harm or offering a remedy.

How should I make an apology?

There is no ‘one size fits all’ apology but the following points reflect some general good practice:

1. The timing of an apology is very important. Once you establish that you have done wrong, apologise. If you delay, you may lose your opportunity to apologise.
2. The language you use should be clear, plain and direct.
3. Your apology should not be conditional by qualifying the apology by saying for example: ‘I apologise if you feel that the service provided to you was not acceptable’ or ‘if mistakes have been made, I apologise’.
4. To make an apology meaningful, do not distance yourself from the apology.

   Generalised apologies such as ‘I am sorry for what occurred’ or ‘mistakes were made’ do not sound natural or sincere. It is much better to accept responsibility by stating ‘It was my fault’.
5. Avoid enforced apologies such as ‘I have received the Investigation report from the Ombudsman and am therefore carrying out her recommendations by apologising to you for the shortcomings identified in her report.’
6. It is also very important to apologise to the right person or the right people.

Who should apologise?

If, in her Investigation report, the Ombudsman has made a recommendation that an apology should be provided to the complainant, then we would expect to see the

Chief Executive, Director or Head of Department of the public service provider involved making the apology.

Who should receive the apology?

The apology should be sent directly to the complainant who is named in the Ombudsman's Investigation report. We will not, as a matter of course, review apologies prior to them being issued. However, in order to monitor compliance with the Ombudsman's recommendations, we would expect to receive a copy of the apology letter within the time required by the Ombudsman.

The benefits to organisations of apologising

It is important to remember that an apology is not a sign of weakness or an encouragement to take legal action. An apology can be a sign of confidence and competence and demonstrates a willingness to learn from mistakes and a commitment to put things right. To apologise in a fulsome and timely manner is good administrative practice and is an important part of effectively managing complaints.

Contact Details

You can contact us in the following ways:

Freepost: Freepost NIPSO

or The Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
BELFAST
BT1 6HN

Telephone: 028 9023 3821 **or Freephone:** 0800 34 34 24

Text Phone: 028 9089 7789

Email: nipso@nipso.org.uk

or By calling, 9.00am & 5.00pm, Monday to Friday,
at the above address.

June 2016

Appendix 9: Inquiry Reports relating to Duty of Candour

Miscellaneous Inquiry Recommendations Relating to Being Open and A Duty of Candour

The Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report) (Feb, 2013)

In 2013, Robert Francis QC published the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Of the 290 recommendations detailed in the report, 12 were related to a requirement for 'openness, transparency and candour'

These were defined as,

- Openness: enabling concerns to be raised and disclosed freely without fear, and for questions to be answered;
- Transparency: allowing true information about performance and outcomes to be shared with staff, service users and the public;
- Candour: ensuring that service users harmed by a healthcare service are informed of the fact and that an appropriate remedy is offered, whether or not a complaint has been made or a question asked about it.

Recommendation 180 of the report reads 'Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.'

Right time, right Place (Donaldson Report) (2014)

On 8 April 2014 former Health Minister Edwin Poots announced his intention to commission former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the improvement of governance arrangements across the HSC. This was subsequently published in January 2015 by his successor, Jim Wells

Amongst the recommendation within this was that there should the introduction of a Duty of Candour, in Northern Ireland in line with the *Making Amends* that examined the handling of complaints, incidents and medical negligence claims in a whole systems manner for England

The Review Team considered that priority in Northern Ireland should be given to the areas covered by its recommendations and this included:

"a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom"

Furthermore he suggested that:

> *".In Northern Ireland, it is already a requirement to disclose to patients if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an*

organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators."

p36, § **4.5.3 Duty of candour**

Inquiry into Hyponatraemia-related Deaths (O'Hara) (2018):

The Inquiry into Hyponatraemia-related deaths in Northern Ireland was established in 2004 and chaired by Lord Justice O'Hara. His report, published in 2018, found that there had been significant failings both in the care of five children in Northern Ireland's hospitals, leading to their deaths, and in the subsequent dealings with their families
Amongst the many recommendations in the report were those relating to the issue of candour and openness

Candour

1. A statutory duty of candour should now be enacted in Northern Ireland so that:
    i. Every healthcare organisation **and** everyone working for them must be open and honest in all their dealings with service users and the public.
    ii. Where death or serious harm has been or may have been caused to a service user by an act or omission of the organisation or its staff, the service user (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances.
    iii. Full and honest answers must be given to any question reasonably asked about treatment by a patient (or duly authorised representative).
    iv. Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission.
    v. Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.
    vi. Healthcare organisations who believe or suspect that treatment or care provided by it, has caused death or serious injury to a service user must inform that service user (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances.
    vii. Registered clinicians and other registered healthcare professionals, who believe or suspect that treatment or care provided to a service user by or on behalf of any healthcare organisation by which they are employed has caused death or serious injury to the service user, must report their belief or suspicion to their employer as soon as is reasonably practicable.
2. Criminal liability should attach to breach of this duty and criminal liability should attach to obstruction of another in the performance of this duty
3. Unequivocal guidance should be issued by the Department to all Trusts and their legal advisors detailing what is expected of Trusts in order to meet the statutory duty.

4. Trusts should ensure that all healthcare professionals are made fully aware of the importance, meaning and implications of the duty of candour and its critical role in the provision of healthcare.
5. Trusts should review their contracts of employment, policies and guidance to ensure that, where relevant, they include and are consistent with the duty of candour.
6. Support and protection should be given to those who properly fulfil their duty of candour.
7. Trusts should monitor compliance and take disciplinary action against breach.
8. Regulation and Quality Improvement Authority ('RQIA') should review overall compliance and consideration should be given to granting it the power to prosecute in cases of serial non-compliance or serious and wilful deception.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 097/14

Title:	**Serious Adverse Incident (SAI) Procedure**			
Author(s)	Claire Cairns, Senior Manager, Corporate Governance [redacted] Governance Manager, Corporate Governance Colin McMullan, Senior Manager Corporate Governance			
Ownership:	Dr Cathy Jack, Medical Directorate			
Approval by:	Trust Policy Committee Executive Team		**Approval date:**	03 August 2016 10 August 2016
Operational Date:	August 2016		**Next Review:**	August 2017
Version No.	V4	**Supersedes**	V3 – June 2014-March 2015	
Key words:	Serious Adverse Incident, SAI, Learning, Investigation, Action Plan			
Links to other policies	- Adverse Incident Reporting & Management Policy - HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents October 2013 http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-followup-of-Serious-Adverse-Incidents.pdf - Being Open Policy - Policy for Sharing Learning - Complaints Policy			

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1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 This procedure covers the reporting, investigating and management of Serious Adverse Incidents for Belfast HSC Trust staff and is based on the HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents October 2013. It should be read in conjunction with the BHSCT Adverse Incident Reporting & Management Policy and other associated procedures.

1.2 Purpose and scope of this procedure

The purpose of this procedure is to enable a robust and systematic approach to the management of Serious Adverse Incidents that will be consistently applied across the Trust. This will contribute to ensuring that the Trust meets the SAI reporting and management requirements as defined by the HSCB within "Procedure for the Reporting and Follow-up of Serious Adverse Incidents (SAI's), October 2013" (and amended criteria effective from 1st February 2016) through guiding staff on their duties and responsibilities regarding:-

- Reporting a Serious Adverse Incident
- Informing the Service User / family / carer
- Coroner Involvement
- Investigating a Serious Adverse Incident to identify any learning and recommendations
- Completing an action plan on any actions identified

2.0 SCOPE OF THE POLICY

This procedure applies to all staff in the Belfast Health and Social Care Trust. This includes BHSCT employees, students, agency, contractors and volunteers.

Adverse Incident:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."
(*How to Classify Adverse Incidents and Risk, HPSS 2006*)

Harm is defined as 'injury (physical or psychological), disease, suffering, disability or death'. In most instances can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition.
(*Doing Less Harm. NHS. National Patient Safety Agency 2001*)

Serious Adverse Incident (SAI) is an adverse incident that must be reported to the Health and Social Care Board (HSCB) because it meets at least one of the criteria as defined by the HSCB within "Procedure for the Reporting and Follow-up of

Serious Adverse Incidents (SAI's), Oct 2013" (see section 3.0). The criteria were then amended with effect from 1st February 2016. The Trust will be responsible for the onward reporting of SAIs relevant internally, and to their Independent Service Providers (ISPs) and contractors, and will ensure the appropriate investigation, learning and sharing of lessons regarding same.

3.0 Reporting a Serious Adverse Incident (SAI)

3.1 What is an SAI?

An SAI is an adverse incident that must be reported to the Health & Social Care Board (HSCB) because it meets at least one of the following criteria:

- Serious injury to, or the unexpected/unexplained death of:
  - a service user (including 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)
  - o - on other service users,
  - o - on staff or
  - o - 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;
- 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 an SAI.

3.2 How to Report an SAI

If an adverse incident occurs which meets or seems to meet any of the above criteria it should be reported immediately through the reporters management line and ultimately to Director or Co-Director for consideration for reporting as an SAI (the directorate Governance & Quality Manager or equivalent, should also be included in any communication). This should be done urgently and in the form of verbal as well as email communication.

When Director/Co-Director agrees to report the incident as an SAI, the relevant Manager or Governance & Quality Manager (or equivalent) should then complete the SAI Notification Form, send it to the Director / Co-Director for approval and forward the approved copy (including details of who approved it) to the Corporate Governance Department SAI mailbox (address below) for onward reporting to the Health & Social Care Board (HSCB).

The form can also be obtained by emailing your request to Serious Adverse Incident mailbox SeriousAdverseIncident@belfasttrust.hscni.net (also in Outlook address book) or by contacting Corporate Governance Services on Tel: 028 950 48098.

(The Serious Adverse Incident mailbox should also be used for all SAI correspondence with Corporate Governance and external bodies.)

Corporate Governance will then check and redact the SAI Notification form of personal identifying information and give it a BHSCT SAI reference number. The form will then be forwarded to the HSCB and if applicable to the Regulation and Quality Improvement Authority (RQIA).

A Trust Incident Report Form should also be completed as soon as possible (if not already done so) as per Trust procedures.

(All Adverse Incident policies and procedures can be found in the Policies & Guidelines page of Trust Intranet under the Medical Directorate/Risk & Governance sub folders.)

3.3 Timescale

All SAIs are required to be reported to HSCB within 72 hours of the incident being discovered.

3.4 General guidance on completing the SAI Notification form

Guidance on completing the SAI Notification Form can be found at Appendix 1. The following points should be read in conjunction with those procedures:-

Sections to complete

Complete all of the following sections (Corporate Governance will complete the remainder)

Sections 3, 4, 5, 6, 8 (excluding CCS coding), 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18.

Section 8: Incident Description:

- Provide a brief factual description of what has happened and a summary of the events leading up to the incident. Please ensure sufficient information is provided so that the HSCB/PHA is able to come to an opinion on the immediate actions, if any, that they must take.
- Where relevant include D.O.B, Gender and Age.
- All reports should be anonymised – the names of any practitioners or staff involved must not be included. Staff should only be referred to by job title.

3.5 Informing the service user / family / carer

The principles of the Being Open Policy must be adhered to when communicating to service users, their families or carers regarding the reporting of a Serious Adverse Incident. Where it is clear or suspected that an SAI has resulted in unexpected serious harm or death to a service user, rapid and open disclosure and emotional support must be given.

The Co-Director responsible for the SAI is also responsible for ensuring the service user / family / carer is communicated with appropriately regarding the SAI and subsequent investigation. They will nominate the appropriate person to speak with the service user / family / carer initially and also ensure the service user / family / carer has a link person to contact throughout the SAI process as required. An information leaflet[1] covering "What do I need to know about Serious Adverse Incidents" should be given to the service user / family / carer to include contact details for the link person. **NB -This leaflet should only be used when it is confirmed that an SAI has been reported.**

If the Service User/Family/Carer has been notified of the incident before completing the SAI notification form, the appropriate date of notification must be included in section 15 of the form (see appendix 1). If notification is planned and not yet complete at the time of reporting, or not planned, the reason(s) should be explained in the "Others" free text field in section 15 of the form, or where relevant in any updated form the HSCB subsequently issues.

3.6 Coroner Involvement

Details of involvement with the Coroner must where applicable, be included in the description section 8 of the SAI Notification form. It is also important to include date of notification of the Coroner if applicable in section 17. When it is known that a death is to be investigated as an SAI the Coroner must be notified of this even if previously notified of the death.

Ensure the form is forwarded by email to the Trust SAI email address seriousadverseincident@belfasttrust.hscni.net along with confirmation of approval by the relevant Director or Co-Director (name of whom must be provided).

3.7 Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up investigation may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

[1] There are two Trust leaflets informing service users / family / carers about SAIs. One is specifically for Adult Social and Primary Care and the other is general and should be used in all other areas.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

3.8 "Query Serious Adverse Incidents" (QSAIs)

The responsibility for identifying and the decision to report an SAI is primarily with the directorate responsible for that incident. To support directorate incident review processes and to act as a further control to delayed reporting, the Corporate Governance department may query any incident report where an SAI criteria seems to have been met but where the date for reporting the incident as an SAI is overdue and with no indication that it is being reported or considered. This is known as a Query SAI (QSAI) and "QSAI" is added to the incident reference until closed.

Once an incident is identified as being a query SAI (QSAI) it is forwarded to the relevant Governance & Quality manager or alternative for consideration for reporting as an SAI. The incident will remain open as a QSAI until Corporate Governance receives either:-

- A completed approved SAI Notification form relating to the incident, or
- An investigation report or if not applicable, a clear explanation of why the incident does not meet the criteria for reporting as an SAI. The investigation report should include any learning and actions taken to prevent re-occurrence where applicable. Please note that the decision not to report as an SAI may be subject to challenge from the Medical Directorate's office.

  The response to the QSAI should be sent to the Trust SAI mailbox and any report should also be included within the Datixweb incident record and referenced in the investigation section.

4.0 Procedure for investigating Serious Adverse Incidents (SAI)

The following procedures for the investigation of Serious Adverse Incidents (SAI) are based on, and should be read in conjunction with, the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013.

When reporting an SAI, the responsible Director / Co-Director (in conjunction with the Medical Director if considering a level 3) must decide on the level of investigation required and this must be indicated on section 18 of the SAI Notification form. There are 3 levels of investigation available for SAIs and these are explained below with a summary table for quick reference (table 1).

4.1 Level of SAI Investigation

SAI investigations should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning of all SAIs reported, it is important the level of investigation focuses on the complexity of the incident and not necessarily on the significance of the event.

SAIs will be investigated using one or more of the following:

4.1.1 Level 1 Investigation – Significant Event Audit (SEA)

A level 1 investigation requires the use of Significant Event Audit (SAE) investigation methodology to investigate the incident. For guidance on using SEA methodology please see NPSA Significant Event Audit.

SAI notifications which indicate a level 1 investigation will enter the investigation process at this level and a SEA will immediately be undertaken to:

- assess why and what has happened
- agree follow up actions
- identify learning

The possible outcomes may include:

- no action required
- identification of a learning need and actions
- sharing the learning
- Requires Level 2 or 3 investigation.

The SEA report must be completed, approved by the relevant Director or Co-Director and sent to the Trust SAI mailbox for onward reporting to the HSCB within 4 weeks of the SAI being reported.

If during or on completion of the SEA the investigating team determines the SAI is more complex and requires a more detailed investigation, the investigation will move to either a level 2 or 3 investigation.

If a Level 2 investigation is required, the SEA report must still be forwarded to the HSCB within 4 weeks of the SAI being reported along with completed sections 2 and 3 of the Level 2 template to include Team Membership and Terms of Reference. The level 2 investigation process will then need to be initiated (see section 4.1.2). It may be possible to retain the same team but the level of independence needs to be considered and the Director / Co-Director may wish to contact Corporate Governance for assistance in identifying suitable members from other Directorates or external to the Trust if required.

In most circumstances, completed SEA investigations at this level will be adequate for incidents where the circumstances are of a less complex nature. In these instances it is more proportionate to use a concise SEA to ensure there are no unique factors and then focus resources on implementing improvement rather than conducting a comprehensive investigation that will not produce new learning. NB Family Involvement, see section 4.4.

Learning

Any learning from these investigations should be shared as appropriate within the Directorate governance structures and in accordance with the Trust Policy for Sharing Learning. If there is significant learning at any stage of the SEA process which requires urgent sharing outside the directorate, this should be brought to the next SAI Group meeting by the relevant Co-Director on a Shared Learning Template (see Policy for Sharing Learning).

4.1.2 Level 2 – Root Cause Analysis (RCA)

Level 2 Investigations will usually be conducted for incidents of actual or potential serious harm or death and/or where the circumstances involved are relatively complex and may involve multiple processes/teams/disciplines.

The investigation should include use of appropriate RCA analytical tools (see section 4.3 below and NPSA Root Cause Analysis (RCA) guidance). They will normally be conducted by a multidisciplinary team (not directly involved in the incident) with a degree of independence determined by the complexity of the incident. The investigation should be chaired by someone independent to the service area involved as a minimum. The investigation report should be completed using the HSCB RCA report template (see appendix 6 & 7 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013).

Team membership for level 2 investigations is the responsibility of the Director / Co-Director who commissioned the SAI. The Director / Co-Director should select the Chair from an established Trust wide pool of RCA Chairs maintained by Corporate Governance, and should consider team membership to include members independent of the directorate concerned where appropriate. Where the

Commissioning Director / Co-Director requires team member(s) external to the Trust, and is having difficulty obtaining these, they should liaise with Corporate Governance who may contact the HSCB/PHA for further advice if required.

Level 2 SAI investigations may involve two or more organisations. In these circumstances, it is important a lead organisation is identified but also that all organisations contribute to the final investigation report. If required Corporate Governance will liaise with the other organisation(s) to propose a team member(s) and agree who leads the SAI. Refer to Appendix 12 of (HSCB) Procedures for reporting and managing SAIs, October 2013 for further guidance.

Sections 2 and 3 of the Level 2 investigation template must be completed and forwarded to the HSCB via the SAI Mailbox by, or on behalf of the Director / Co-Director within 4 weeks of the level 2 SAI being notified, detailing the membership and terms of reference for the level 2 investigation. NB Family Involvement, see section 4.4.

Learning

Any learning from these investigations should be shared as appropriate within the Directorate governance structures and in accordance with the Trust Policy for Sharing Learning. If there is significant learning at any stage of the SEA process which requires urgent sharing outside the directorate, this should be brought to the next SAI Group meeting by the relevant Co-Director on a Shared Learning Template (see Policy for Sharing Learning).

4.1.3 Level 3 – Independent Investigation (RCA)

Level 3 investigations will be considered for highly complex SAIs where a high degree of external/independent representation on the investigation team is required. In some instances all team members may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting, Chair and membership of the review team will be agreed with the HSCB/PHA Designated Review Officer (DRO) at the outset. The Commissioning Director / Co-Director and Medical Director should liaise with the DRO through Corporate Governance to agree timescales, team membership and terms of reference.

Level 3 investigation reports will take the same format as level 2 and use the same template structure for the final report.

Any SAI which involves an alleged homicide perpetrated by a service user known to/referred to mental health and/or learning disability services will be investigated as a level three incident. In these instances, the Protocol for Responding to an SAI in the Event of a Homicide, issued in 2010 and revised in 2013 should be followed (see appendix 13 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013).

4.2 Timescales

4.2.1 Notification

Any adverse incident that meets the criteria of an SAI must be reported within 72 hours of the incident being discovered using the SAI Notification Form.

4.2.2 Investigation Reports

- Level 1 – SEA

SEA reports must be completed using the SEA template and submitted to the HSCB within 4 weeks (6 weeks by exception) of the SAI being notified.

Note: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to HSCB to allow for redacting and final checks.

- Level 2 – RCA

Sections 2 and 3 of the Level 2 & 3 report template must be forwarded to the SAI Mailbox for onward forwarding to HSCB no later than 4 weeks after notification to HSCB of a level 2 investigation.

RCA investigation reports must be completed using the level 2 & 3 report template and submitted to the HSCB no later than 12 weeks from the initial notification of the SAI to HSCB, or if previously a level one investigation, 12 weeks from submission of the level one SEA report.

Note: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to HSCB to allow for redacting and final checks.

- Level 3 – Independent Investigations

Timescales for completion of level 3 investigations will be set by the HSCB/PHA lead officer and/or DRO in agreement with the Trust.

Note: Corporate Governance will ask for the final report to be submitted to their office 2 days prior to submission date to HSCB to allow for redacting and final checks.

4.2.3 Investigation Report Extensions

- Level 1 Investigations – SEA

HSCB and PHA will not accept extension requests for this level of investigation. When reporting the SEA, an additional 2 weeks can be sought by exception only, giving the reason for the delay.

- Level 2 Investigations - RCA

In most circumstances, all timescales for submission of RCA investigation reports must be adhered to. However, it is acknowledged there may be some occasions where an investigation is particularly complex, perhaps involving two or more organisations. In these instances the reporting organisation may request an extension to the normal timescale i.e. 12 weeks from timescale for submission of interim update report. However, this request must be approved by the DRO and should be requested when submitting sections 2 & 3 of the report at 4 weeks.

- Level 3 Investigations – Independent

As per above, all timescales (including possible extensions) must be agreed with the DRO at the outset of the investigation.

4.2.4 Queries the Designated Review Officer (DRO) at HSCB may have regarding the submitted report

- Level 1 Investigations – SEA

DRO queries must be responded to within 1 week of the query being received

- Level 2 Investigations - RCA

DRO queries must be responded to within 4 weeks of the query being received

- Level 3 Investigations – Independent

DRO queries must be responded to within 4 weeks of the query being received

4.2.5 Monitoring

The commissioning Director / Co-Director is responsible for ensuring that investigation progress is monitored and timetables are met. A performance report will be tabled at each SAI Group identifying any SAIs where progress issues have been identified. The relevant Co-Director will be required to provide explanations for any delays.

When the draft final report is complete, the Investigation team chair is advised to share the report with a Trust colleague independent to the directorate for review. The reviewer may have comments/feedback which should then be considered by the Investigation team before finalisation of the report for approval by relevant Director/Co-director.

4.2.6 Actions

The level 2 & 3 report template (appendix 6 & 7 of HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013) indicates that an action plan should be included within the Final report for submission to HSCB.

This should be done as far as possible. A final draft Action Plan must be forwarded as soon as approved. Actions do not need to be complete when submitting the action plan to the HSCB. Further details on the Action Plan can be found in section 5.0 below.

4.3 Completion of Level 1 (SEA) & level 2&3 report (RCA) templates

Guidance on completing the level 1 and level 2 & 3 report templates for can be found at Appendix 5 & 6 respectively of the HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013. The following points should be read in addition to those procedures:-

- Jargon or unexplained abbreviations must not be used within the report. Although clinical shorthand would be understandable to other clinicians, a SEA or RCA report is a formal report and not a clinical record. As such it should be understandable to non-clinicians including the service user / family members / carers and the Coroner.
- All reference to services, organisations, facilities etc should be explained fully if not otherwise obvious to the reader e.g. it is not sufficient to include the name of a client accommodation building without explaining the purpose/function of the building.
- The HSCB RCA template is in tabular form. This may cause formatting difficulties. It is acceptable to use a blank word document instead but the HSCB section headings from the RCA template must be included.

4.4 Service User/Family/Carer involvement

HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013 Paragraph 5.4 should be adhered to and states the requirement for service user / family / carer involvement in SAI investigations is as follows:-

"It is important that teams involved in investigations in any of the above three levels ensure sensitivity to the needs of the service user/relatives/carers involved in the incident and agree appropriate communication arrangements, where appropriate. The Investigation Team should provide an opportunity for the service user / relatives / carers to contribute to the investigation, as is felt necessary. The level of involvement clearly depends on the nature of the incident and the service users/relatives/carers wishes to be involved."

The Co-Director responsible for the SAI should ensure the appropriate level of involvement of service user / family / carer throughout the investigation including discussion / sharing of the final report with the service user / family / carer and this should be agreed with the investigation team from the outset.

The Director / Co-Director responsible for the SAI should ensure the completion of an SAI Investigation Report checklist (appendix 2) when submitting Investigation reports to HSCB via the BHSCT SAI mailbox. This checklist will explicitly describe the involvement (and if not, the circumstances where it has not happened) of Service Users/Relatives/Carers in the Investigation and whether they received a final report.

Approved SAI final reports should be shared or talked through with the service user/relatives/Carer as appropriate and where this is not done, an explanation must be submitted within the SAI checklist and if pending, this should be included as an action in the subsequent Action Plan for that SAI (see below).

In all cases the principles of consent and patient confidentiality must be upheld.

For guidance on how to involve families in the SAI investigations please refer to the RCA Chairs Guidance on the hub.

Involvement specific to level 1 (SEA) reports

Under the HSCB timeframe for completing level 1 investigations it may not be possible to involve the service user / family / carer in the investigation process before the final report is submitted to the HSCB. In such cases, where family involvement is deemed appropriate, the approved report should be discussed / shared with the family at a date as soon as possible after submission of the report and any issues addressed and those requiring material changes to the level 1 report should be added as an addendum and forwarded to Corporate Governance for sending to HSCB in a revised report.

Where an SAI is also a Complaint

Where a Serious Adverse Incident is also a Complaint, the investigation under the SAI process will take precedence and the Complaints investigation will be put on hold until the SAI investigation is complete. The Complaints department should notify the Complainant of this as soon as possible. The leaflet '*What do I need to know about SAIs'* should be given to the Complainant along with an explanation of the change in process.

Note that communication through the complaints process with the Complainant should continue regarding timescales and any associated delays. The SAI investigation process as per above will also have a link person identified to communicate with the service user / family / carer and will communicate through this process as appropriate. When complete the SAI final report will be shared with the

Complainant and the complaints process remains open until the complaint is formally closed with all complaints issued addressed.

4.5 Coroner engagement

Reports should also routinely include in their chronology details of all engagements with the Coroner where a death has occurred and if the Coroner has not been involved this should be stated and the decision explained.

The Director / Co-Director responsible for the SAI should also ensure the completion of an SAI Investigation Report checklist (appendix 2) when submitting Investigation reports to HSCB. This checklist will seek information regarding notification to the Coroner and current status of the case.

4.6 Safeguarding Children and Adults

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the investigation of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.

It should be noted that, where possible, safeguarding investigations will run in parallel as separate investigations to the SAI process with the relevant findings from these investigations informing the SAI investigation and vice versa. However, all such investigations should be conducted in accordance with the processes set out in the Protocols for Joint Investigation of Cases of Alleged or Suspected Abuse of Children or Adults.

In these circumstances, the Trust should liaise closely with the DRO on the progress of the investigation and the likely timescales for completion of the SAI Report.

On occasion the incident under investigation may be considered to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

If a CMR is being considered the SAI process may be suspended and the HSCB notified of this whilst a notification and decision regarding CMR is made. If it is approved as a CMR then the SAI process will close.

4.7 Memorandum of Understanding (MoU) March 2013.

Incidents involving unexpected death or serious harm and requiring investigation by the police and/or Health and Safety Executive (HSENI) need to be handled correctly for public safety reasons as well as maintaining confidence in the HPSS, Police, Coroner and the HSENI. The Department's MoU between these four organisations seeks to ensure effective arrangements are in place to facilitate these complex interactions. The MoU compliments existing joint procedures in relation to the protection of children and vulnerable adults.

Table 1: SAI Investigation process – Teams, tools and timescales

For further details please see HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013

							Responsible officer			
SAI type *(guide only)*	**Inv. level**	**Inv. tool/ Template**	**Timescale**	**Chair**	**Team**	**Extension**	**Approval**	**Action Plan**	**Learning**	**DRO Queries timescale**
Not complex	Level 1	SEA	4 weeks	Outside Service Area. SEA trained	Local multi-disciplinary.	No (2 additional weeks when reporting SAI, by exception)	Director/Co-Director	Director/Co-Director	To SAI group if sharing beyond Directorate	1 week
SEA not sufficient, more complex issues	Level 2	RCA	12 weeks from SAI level 2 Notification. ToR & Team membership by 4 weeks	Outside Service Area/Dir. or Trust. RCA trained	Multi-disciplinary / Trust independent input possible.	1 extension by exception, sought at 4-6 weeks.	Director	Director/Co-Director & SAI Group	To SAI group if sharing beyond Directorate	4 weeks
Particularly complex/ multiple orgs involved; requires significant degree of independence; high profile.	Level 3	RCA	To be agreed with HSCB	Outside Dir or Trust. RCA trained	Highly independent multi organisational	To be agreed with HSCB	Director/ Chief Executive	Director & SAI Group	To SAI group if sharing beyond Directorate	4 weeks

5.0 Action Plans

5.1 Introduction

These procedures outline the responsibilities and requirements to ensure appropriate actions are taken to prevent/minimise re-occurrence and share learning.

The Director / Co-Director responsible for the SAI investigation has responsibility for ensuring any recommendations and lessons learned are incorporated into a plan of appropriate and realistic actions (SAI Action Plan).

An action plan is an important tool to improve systems and implement recommendations from investigations into adverse incidents:

Action plans for SAIs should be approved by the Director / Co-Director responsible for the Investigation. When all actions are completed they should be signed off by the Director/ Co-Director and in the case of Level 2 & 3 SAIs noted as closed at SAI Group.

A robust Action Plan should be:-

- explicit
- time bound
- deliverable
- assign responsibility for the action
- measurable

Avoid actions such as *remind staff* or *promote awareness,* but it they have to be used, explain how this will be done e.g. a poor action would be – *share updated policy with staff*.

Be more specific – *send staff the specific section which has changed highlighting the change and drawing their attention to it*.

SAI Action Plans should include actions for sharing lessons learned from SAI investigations as appropriate.

5.2 Generating actions from the Final Report

Whilst recommendations in a final report are drawn up and are the responsibility of the Investigation team, the corresponding actions are the responsibility of the relevant Director or Co-Director. Action Plans must address all recommendations within the Final Report as deemed appropriate. Where actions are at variance with what has been recommended within the Investigation report the reason should be given to justify the differing course of action or no action.

If recommendations include actions external to the Trust, the Action Plan should identify who will take these forward and have sought agreement for this with the named person(s).

Additional actions

- It may be appropriate to include an action in the action plan in relation to sharing the action plan with the service user / family / carer as appropriate and the progress of this should be monitored until complete.
- Actions should be included as appropriate on how the learning from the SAI is being shared.

5.3 Developing an Action Plan

- Overall responsibility for the SAI Action Plan must be with the Director / Co-Director responsible for the SAI Investigation.
- The Director / Co- Director responsible for the investigation must determine who draws up the actions.
- Where the action identified is within the area of responsibility of the Director / Co-Director responsible for the investigation, the person identified to take the action forward must be instructed to do so and have the capacity required.
- Where a recommendation is outside the area of responsibility of the Director / Co-Director, discussion and agreement must be reached with the relevant manager for drawing up and taking any action(s) forward as appropriate. The Director / Co-Director must ensure agreement is reached.
- Timescales for each action must be agreed with the person/area responsible for implementing the action.
- A draft action plan should be submitted if possible with the Final Report to the HSCB with a final draft submitted when approved. Actions do not need to be completed when submitting the action plan to the HSCB.

5.4 Documentation

- Every Action Plan must be documented using the SAI Monitoring / Tracking Report template which complies with the minimum standard for Action Plans (appendix 8 HSCB SAI Procedure for Reporting and Follow up of Serious Adverse Incidents October 2013).

- The SAI Monitoring / Tracking Report template for recording Action Plans includes the following:-
    - The reference number of the SAI
    - Date of the SAI Investigation report
    - Date of the latest version of the Action Plan
    - Version number and how often the Action Plan is to be reviewed
    - Who will monitor the implementation of the Action Plan.
    - Who will sign off the Action Plan when all actions are complete
- Each action on the "SAI Monitoring / Tracking Report template" must include:-
    - An associated recommendation, Contributory factor or lesson learned from the Investigation report.
    - A reference or sub-reference number.
    - The current position – this should provide the latest position in relation to progressing the action to date.
    - A description of the action to be taken.
    - Name of the responsible lead for that action (not only their job title).
    - A timescale for completion (if unknown an estimate should be made).
    - Evidence of progress/completion (including any intended Action Plan reviews or audits).
    - Indication of current status which must be one of the following:-
        - RED – Action agreed but not yet commenced
        - AMBER – Action in progress
        - GREEN – Action complete

5.5 Monitoring

- The Director / Co-Director who commissioned the investigation is responsible for setting up directorate level monitoring and review processes to ensure actions are progressed as planned.

- Where actions cannot be completed, the Director / Co-Director who commissioned the investigation is responsible for ensuring that any associated risks are identified and managed in line with the Trust Risk management strategy and brought to the SAI Group for consideration, along with any other unresolved issues.

- The relevant Co-Director responsible for the SAI should notify the SAI Group of the closure of any Action Plans which are complete and have no outstanding issues. Action Plans will not normally be required to be tabled at SAI Group.

- The SAI Group will in respect of its provision:-

    - Provide independent review to agree learning points for sharing;
    - Note closure of action plans through exception reporting;
    - Directorate membership will provide assurance of appropriate debriefing and sharing of learning at Directorate level;
    - Agree appropriate escalation of learning to the Learning from Experience Steering Group;
    - Review status reports from external bodies, such as HSCB/RQIA/HSCNI, as and when required;
    - Members will report on identified risks/issues associated with SAIs and agree appropriate escalation to the Learning from Experience Steering Group;
    - Make recommendations to corporate and operational risk registers as appropriate.

- The Corporate Governance department of the Medical Director's Office will have responsibility for administering a central monitoring process to facilitate SAI Group monitoring.

- Directorate senior managers responsible for governance are responsible for ensuring Corporate Governance has the latest version of action plans held centrally.

- The Corporate Governance department will have responsibility within the central monitoring process for providing a final check on Action Plan progress and will provide liaison with external organisations as required.

6.0 Closure of the SAI

The SAI is closed when signed off by the SAI Group. This will be done when the Action Plan is complete and no outstanding issues remain and will usually include ensuring that the HSCB has also closed the SAI (which they do via email to Corporate Governance and notification of this will be forwarded to the commissioning Director / Co-Director). When closed, a confirmation email is sent to the Director / Co-Director to include a final version of the Final report and Action Plan. Up until this stage, the version used will be a “final approved draft” and subject to change due to further material changes for example after comments received from family members. Any change will be under strict version control through Corporate Governance, approved by the commissioning Director / Co-Director and presented as an addendum to the report and forwarded to HSCB and any other relevant stakeholders.

7.0 Monitoring

The process for monitoring the effectiveness of all of the above will be managed via the following arrangements:

- Accountability/Performance Management Reviews
- Adverse Incident Training records
- Assurance Framework
- Belfast Risk Audit & Assessment Tool (BRAAT)
- Controls Assurance Standards
- Directorate Assurance meetings
- Serious Adverse Incident Group

8.0 Consultation process

Serious Adverse Incident Group

9.0 Evidence base

- Adverse Incident Reporting & Management Policy
- HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents October 2013
- Being Open Policy
- Policy for Sharing Learning

10.0 Equality Statement

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this procedure should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this procedure is:

Major Impact	
Minor Impact	
No impact	X

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

10 August 2016

Date: _____

Name Dr Cathy Jack
Title Medical Director

10 August 2016

Date: _____

Name Dr Michael McBride
Title Chief Executive

APPENDIX 1

Guidance Notes
HSC SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

All Health and Social Care Organisations, Family Practitioner Services and Independent Service Providers are required to report serious adverse incidents to the HSCB within 72 hours of the incident being discovered It is acknowledged that not all the relevant information may be available within that timescale, however, there is a balance to be struck between minimal completion of the proforma and providing sufficient information to make an informed decision upon receipt by the HSCB/PHA.

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB/PHA to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *(to be completed by Corporate Governance department)*	**2. UNIQUE INCIDENT IDENTIFICATION NO. / REF NO.** *(to be completed by Corporate Governance department)*
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* **5. DEPARTMENT / WARD / LOCATION EXACT** *(where incident occurred)*	**3. DATE OF INCIDENT: DD / MMM / YYYY** *Insert the date incident occurred*
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7. PROGRAMME OF CARE:** *(to be completed by Corporate Governance department)*

8. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Child Protection Committee have been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into t he community arrangements;*

whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(to be completed by Corporate Governance department)*	**DETAIL:** *(to be completed by Corporate Governance department)*	**ADVERSE EVENT:** *(to be completed by Corporate Governance department)*

9. IMMEDIATE ACTION TAKEN TO PREVENT RECURRANCE:

Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.
10. CURRENT CONDITION OF SERVICE USER: ***Where relevant*** *please provide details on the current condition of the service user the incident relates to.*

11. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	**YES**	**NO**	**N/A**
12. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please select and specify **where relevant**)*	**YES**	**NO**	**N/A**

13. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*	
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	
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	
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	

14. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED? *(please select)*	**YES**	**NO**
if 'YES' *(full details should be submitted):*		

15. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING INVESTIGATED AS AN SAI	**YES - Date informed**	**No – Specific reason?** *If the service user suffered harm but was not informed of the SAI, or if the SAI involves the death of a Service User and their family / carer were not informed, please*

		include here the reason for this.

16. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? ***where there appears to be a breach of professional code of conduct***	**YES**	**NO**

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH PROFESSIONALS COUNCIL **(HPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
OTHER – PLEASE SPECIFY BELOW

if 'YES' ***(full details should be submitted including date notified):***

17. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	**DATE INFORMED:**	**OTHER:** *(please specify where relevant).*
DHSS&PS EARLY ALERT		**Date informed:**
HM CORONER		
INFORMATION COMMISSIONER OFFICE **(ICO)**		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE **(NIAIC)**		
NORTHERN IRELAND HEALTH AND SAFETY EXECUTIVE **(NIHSE)**		
POLICE SERVICE FOR NORTHERN IRELAND **(PSNI)**		
REGULATION QUALITY IMPROVEMENT AUTHORITY **(RQIA)**		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

18. LEVEL OF INVESTIGATION REQUIRED *(please select)*	Level 1 *SEA*	Level 2 *RCA – Can be Trust and/or independent*	Level3 *RCA Complex / Multi organisational*

19. 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 / MMM / YYYY**

20. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION *(refer to Guidance Notes)*

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further investigation may not meet the criteria of an SAI. Use this section to request that an SAI be de-escalated. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further investigation under the SAI process.

The HSCB/PHA will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full investigation report is required.

Use this section also to provide updates on progress with investigations – e.g. where the reporting organisation knows that the investigation report will not be submitted within the 12 week timeframe, this will be communicated to HSCB via Corporate Governance Dept with the unique incident identification number/reference in the subject line and provide the rationale for the delay and revised timescale for completion .

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED INVESTIGATION REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO THE 12 WEEK TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED

Additional information submitted by: _____ **Designation:** _____

Email: **Telephone:** **Date: DD / MMM / YYYY**

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

APPENDIX 2

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

(This checklist should be completed in full and submitted to the HSCB along with the completed SAI Review Report <u>for all levels of SAI reviews)</u>

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

INFORMING THE SERVICE USER[1] / FAMILY / CARER						
1) Please indicate if the SAI relates to a single service user, a number of service users or if the SAI relates **only** to a HSC Child Death notification *(SAI criterion 4.2.2)* **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		**HSC Child Death Notification only**	
	Comment: ***If multiple service users involved please indicate the number involved***					
2) Was the Service User[2] / Family / Carer informed the incident was being investigated as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**			
	If **YES**, insert **date informed**:					
	If **NO**, please select **<u>only one</u>** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being investigated as a SAI					
	a) No contact or Next of Kin details or Unable to contact					
	b) Not applicable as this SAI is not 'patient/service user' related					
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user					
	d) Case involved suspected or actual abuse by family					
	e) Case identified as a result of review exercise					
	f) Case is environmental or infrastructure related with no harm to patient/service user					
	g) Other rationale					
	If you selected c), d), e), f) or g) above please provide further details:					
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**						
Content with rationale?	**YES**		**NO**			

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER ***(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)***				
3) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)** *Continued overleaf*	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **<u>only one</u>** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further			

[1] *Service User or their nominated representative*

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being investigated as a SAI)*		
	engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)				
Content with rationale?	**YES**		**NO**	

SECTION 2

INFORMING THE CORONER'S OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner at the time of death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) Following or during the review of the SAI was there a Statutory Duty to notify the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
3) If you have selected 'YES' to any of the above **'1' or '2'** has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

APPENDIX 3

HSC INTERFACE INCIDENTS NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT:**
3. CONTACT PERSON AND TEL NO: SeriousAdverseIncident@belfasttrust.hscni.net	**4. UNIQUE REFERENCE NUMBER:**
5. DESCRIPTION OF INCIDENT: **DOB:** **GENDER:** **AGE:** *(complete where relevant)*	
6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**if 'YES' (*full details should be submitted in section 7 below*)**
7. PROVIDE SUFFICIENT DETAILS TO ALLOW FOLLW UP:	
8. IMMEDIATE ACTION TAKEN BY REPORTING ORGANISATION:	
9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE INVESTIGATION AND FOLLOW UP OF THIS INCIDENT?	
10. OTHER COMMENTS: **REPORT SUBMITTED BY:** **DESIGNATION:** **Email:** **Telephone:** **Date:**	

Completed proforma should be sent to: seriousadverseincident@belfasttrust.hscni.net

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: TP 111/20

Title:	**Memorandum of Understanding policy - Investigating Service User Safety Incidents**		
Author(s)	Claire Cairns, Co-Director, Risk & Governance [redacted] Robert Henry, Senior Manager, Corporate Governance [redacted] [redacted] Governance Manager, Corporate Governance [redacted]		
Ownership:	Dr Chris Hagan, Medical Director		
Approval by:	Trust Policy Committee Executive Team Meeting	**Approval date:**	04 June 2020 10 June 2020
Operational Date:	June 2020	**Next Review:**	June 2025
Version No.	1	**Supercedes**	New policy
Key Words:	Memorandum of Understanding (MOU)		
Links to other policies	BHSCT Adverse Incident Reporting and Management Policy (2018) TP 08/08 BHSCT Serious Adverse Incident Procedure (2016) TP 97/14 BHSCT Being Open Policy – saying sorry when things go wrong (2020) TP 80/11 BHSCT Supporting Staff at Court Policy		

Date	Version	Author	Comments
14 May 2020	0.1	[redacted]	Initial draft from Regional HSCB Policy for review by Trust Policy Committee

Table of Contents

1.0 INTRODUCTION/PURPOSE OF POLICY

1.1 Background

On 15 March 2013, the Department of Health (DoH) issued a revised Memorandum of Understanding (MOU) for Investigating Service User Safety Incidents involving unexpected death and serious untoward harm.

1.2 Purpose

The purpose of this policy is to promote effective relationships with the Police Service of Northern Ireland (PSNI), Coroner's Office and the Health & Safety Executive (HSENI), and improve appropriate information sharing and co-ordination to save time and other resources when joint or simultaneous investigations are required into a serious incident that caused unexpected death or serious untoward harm. **This is likely to be the case when an incident has occurred from, or involved, criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.**

1.3 Definitions

Harm is defined as injury (physical or psychological), disease, suffering, disability or death. In most instances, it can be considered to be unexpected if it is not related to the natural cause of the patient illness or underlying condition. The injury or damage can be described as physical, psychological (or both), suffering, disability or death.

Service User[1] refers to a patient, service user, family (of a service user and/or family of a victim), carer or nominated representative.

2.0 SCOPE OF POLICY

2.1 The Trust has a responsibility to ensure the safety and well-being of service users and staff and to investigate when things go wrong, occasionally involving other agencies.

2.2 Some accidents to service users have a requirement to be reported to HSENI by the Trust, under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) Northern Ireland 1997. HSENI will normally investigate all reportable incidents 'arising out of or in connection with work' but not accidents that arise from medical treatment or diagnosis.

2.3 In situations where the same incident is subject to investigation by a number of separate organisations, it is essential there is clarity of roles and responsibilities by effective liaison and communication between all parties involved.

[1] As per the draft statement of what you should expect in relation to a Serious Adverse Incident (SAI) Review, January 2019.

3.0 ROLES AND RESPONSIBILITIES: TRUST STAFF AND OTHER RELEVANT BODIES

3.1 It is the responsibility of all line managers to ensure this policy is brought to the attention of relevant staff. Staff must familiarise themselves with, and adhere to, the contents of this policy. This policy should be read in conjunction with the Trust's Adverse Incident and SAI Reporting & Management Policies.

3.2 In cases where more than one organisation may have an involvement in investigating any particular incident it is the responsibility of the Director (or nominee) to liaise with each of the organisations.

3.3 The PSNI may investigate all criminal offences. The types of incident the Trust will report to the PSNI are those that display any one or more of the following characteristics: -

- Evidence or suspicion that the actions leading to harm were intended;
- Evidence or suspicion that adverse consequences were intended;
- Evidence or suspicion of gross negligence and/or recklessness including as a result of failure to follow safe practice or procedure or protocols.

3.4 The HSENI is responsible for the enforcement of the Health and Safety at Work (Northern Ireland) Order 1978 (HSWO). Generally, the HSENI does not seek to apply the HSWO to clinical judgment or to the level of provision of care. However, HSENI is responsible for enforcing work related health and safety legislation in a large variety of settings including nursing homes and hospitals. District councils have this responsibility for residential facilities within the Trust area.

3.5 Coroners have a responsibility under the Coroners Act (Northern Ireland) 1959 to investigate the cause and circumstances of deaths reported to them. Appendix 1 sets out guidelines on reporting deaths to the Coroner.

3.6 Other organisations may also investigate service user or safety incidents locally and/or nationally. These include the Health and Social Care Board (HSCB), the Regulation and Quality Improvement Authority (RQIA), Northern Ireland Adverse Incident Centre (NIAIC) and professional regulatory bodies.

3.7 In line with the Regional Procedure for Reporting and Follow Up of Serious Adverse Incidents (November 2016) – section 3.5.1, the Trust will consider invoking the Memorandum of Understanding when reviewing a serious adverse incident that involves any of those organisations noted above.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

4.1.1 Preliminary Meeting: An initial meeting between the Trust and relevant parties to collate initial information about the incident.

4.1.2 Incident Co-ordination Group (ICG): This group is set up to provide strategic oversight of a service user safety incident or direct safety incident involving multiple investigations.

4.2 Preliminary Meeting and Commissioning an Incident Coordination Group (ICG) Coordination of investigatory activities, responsibility and investigation and documenting the ICG

4.2.1 Where more than one organisation is involved, the Director (or nominee) will make arrangements with the relevant organisations to attend a preliminary meeting.

4.2.2 The purpose of this meeting will be for a Trust representative to brief the various parties on the circumstances so that they can decide where responsibility for investigation lies.

4.2.3 The Director (in conjunction with the Assistant Director /Co-Director) will be the named Trust contact to facilitate ongoing communication and liaison.

4.2.4 The preliminary meeting is to be followed by an Incident Coordination Group (ICG) meeting. The purpose of this is to provide strategic oversight of a service user safety incident involving multiple investigations. It allows each organisation involved to identify actions to be taken that do not prejudice the work of other organisations e.g. legal proceedings. The information that may be shared will be constrained by the requirements of any criminal investigation and disclosure restrictions.

4.2.5 The Trust should continue to ensure service user safety but not undertake any activity that might compromise subsequent statutory investigations. If in doubt the Trust's Assistant Director/Co-Director will seek legal advice and consult with the PSNI, Coroner, HSENI or other investigating bodies.

4.2.6 Those attending the ICG should be sufficiently senior to take decisions concerning the management of the incident. Police representation would be at the level of Detective Chief Inspector. The Trust's representation will be the Director (or nominee) supported by the Assistant Director /Co-Director of the Directorate where the incident occurred.

4.2.7 The statutory investigating bodies will come to an early decision about the nature of the incident and where responsibility for investigation should lie e.g. the PSNI and HSENI may conclude they have no further role in the matter. On some occasions the Trust may have to investigate further and if more information or evidence is found, another ICG meeting may have to be convened.

4.2.8 On some occasions the incident may cause concern about wider service user safety. In such circumstances the ICG needs to discuss if the necessary further investigation can be conducted to avoid the danger of prejudicing the police, coroner and/or HSENI investigation e.g. by interviewing members of staff who may subsequently give evidence at court. The PSNI have the authority to prevent the Trust from undertaking an investigation until its investigation is completed in the event that it might prejudice their investigation. However, this should not prevent the Trust from ensuring that immediate learning is undertaken.

4.2.9 The Trust is responsible for minuting the ICG meeting(s) and circulating them to other members. If the Trust has been excluded the ICG must agree who will minute the meeting.

4.3 Securing and Preserving Evidence

4.3.1 The safeguarding of physical, scientific and documentary evidence (including CCTV where applicable) may be critical to understanding what happened in a serious incident and promote a satisfactory investigation. Destruction of evidence may prevent or delay adequate safety measures being put in place and may lead to a more complex investigation. Documentation (including any CCTV footage) should be secured in line with the Trust's policy on securing records and any Trust Policy on the handling of forensic items.

4.3.2 Where a criminal offence is suspected, failure to retain evidence may mean that legal proceedings are undermined. Even in incidents where concerns arise after a long time period every effort to secure and preserve all available evidence should be made.

4.3.3 When Trust documents, records or other items are required to be passed to other agencies then the Director (or nominee) should liaise with the Information Governance Department to ensure that procedures are followed in line with relevant Trust policies and legislative requirements such as GDPR.

4.4 Sharing Information

4.4.1 There will be a need for organisations in the ICG to share information for the purposes of coordinating multiple investigations.

4.4.2 There are a number of factors to take account of when making judgments about information sharing including: -

- The nature and degree of risk;
- The purpose;
- Consent;
- Justification for breach of patient/client confidentiality;
- Current law and guidance; and
- Confidentiality agreements.

4.4.3 Advice on sharing of information can be sought from the Trust's Information Governance Department and/or the Trust's Legal team.

4.5 Supporting Those Affected

4.5.1 The Trust should agree and follow a liaison strategy for each incident, agreed at the first meeting and reviewed at subsequent meetings. This should include keeping the relevant affected parties informed.

4.5.2 When an incident involves litigation then reference should be made to the Trust Policy Supporting Staff a Court.

4.5.3 Staff involved in incidents should be made aware of the support available from a Trade Union Representative and/or Trade Union appointed legal representative.

4.6 Communications

4.6.1 A strategy will be agreed by all relevant parties for dealing with the media, service users and relatives. The organisations should take a common approach to communication although in the event of legal proceedings this may not be practicable. Legal advice will be sought by the Trust, as required.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This policy will be disseminated to all relevant Operational and Corporate Directorates and will be available on the Trust's intranet site.

5.2 Resources

The Audit and Risk & Governance Departments will be responsible for organising awareness and/or training sessions for all relevant managers and staff in relation to this policy, as appropriate.

5.3 Exceptions

This policy is applicable to all service areas within the Trust.

6.0 MONITORING

This policy will be audited through the Audit and Risk & Governance Departments.

7.0 EVIDENCE BASE / REFERENCES

- Memorandum of Understanding: Investigating Patient Safety Incidents Involving Unexpected Death and Serious Untoward Harm: Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health & Safety Executive for Northern Ireland [HSS(MD) 8/2013 – 15 March 2013
- https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf
- https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mou-patient-client-safety-incidents.pdf
- HSENI Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) NI 1997
- Guidelines for Notifying the Coroner of a Death - https://www.health-ni.gov.uk/sites/default/files/publications/health/Guidelines%20for%20Notifying%20the%20Coroner%20of%20a%20Death.pdf

8.0 CONSULTATION PROCESS

- Standards & Guidelines Committee

9.0 APPENDICES / ATTACHMENTS

- Appendix 1 – Reporting Deaths to the Coroner

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required ☐

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

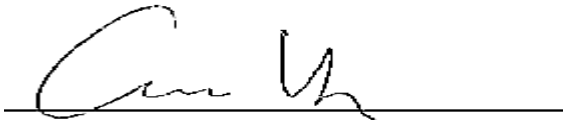
From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly references "reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).



Date: 17/08/2020

Chris Hagan
Medical Director

Date: 18/08/2020

Cathy Jack
Chief Executive

Appendix One: Deaths that must be reported to the Coroner

The duty to report arises if a medical practitioner has reason to believe that the deceased person (to include a fetal demise in utero, beyond the legal limit for viability (24 weeks) and considered to be 'then capable of being born alive') died directly *or* indirectly,

- as a result of violence, misadventure or by unfair means;
- as a result of negligence, misconduct or malpractice (e.g. where a medical mishap is alleged);
- from any cause other than natural illness or disease, for example:

    i. homicidal deaths or deaths following assault;
    ii. road traffic accidents or work-related accidents;
    iii. injury, direct or indirect (including birth injury);
    iv. deaths associated with the misuse of drugs (whether accidental or deliberate);
    v. any apparently suicidal death; or
    vi. all deaths from industrial or occupational disease e.g. asbestosis.

- from natural illness or disease if the deceased had not been seen and treated for it by a registered medical practitioner within 28 days prior to death; or
- in other circumstances that may require investigation; for example:

    i. the death, although apparently natural, was unexpected;
    ii. Sudden Unexpected Death in Infancy (SUDI);
    iii. as the result of an operation, following a procedure or where a person has had an accident or adverse incident in the hospital environment;
    iv. as the result of the administration of an anaesthetic, e.g. hypoxia, circulatory failure, drug reaction, (there is no statutory requirement to report a death occurring within 24hours of an operation – though it may be prudent to do so).

Doctors should also consider the extra-statutory list of causes of death that are referable to the Coroner. If in doubt, seek advice from the Coroner's Office.

1. Industrial diseases or poisoning and other poisonings

    a. Industrial lung diseases e.g. asbestosis, pneumoconiosis, extrinsic allergic alveolitis.
    b. Other industrial diseases e.g. mesothelioma, leptospirosis.
    c. Industrial poisoning e.g. heavy metal, chemicals.
    d. Other poisonings e.g. Food poisoning, Tetanus.

2. Death resulting from an injury

    a. Injury e.g. Asphyxia, Drowning, Intracranial Haemorrhage.
    b. Indirect injury e.g. pneumonia following a fractured femur.
    c. Birth injury.
    d. Operation / Anaesthetic.

NB: There is no requirement to report Clostridium deaths to the Coroner's Office. Deaths which are considered to be due to the Coronavirus are considered "natural" and do not need to be reported to the Coroner, however, where there is any concern surrounding a death, as per section 7 of the Coroners Act (NI) 1959, the death must be reported. A Coroner has discretion to investigate any death about which a concern has been raised. Therefore, should concerns be raised in relation to a death from Covid-19, the Coroner could investigate on a case by case basis, based on the individual merits of each case.

Belfast Health and Social Care Trust
caring supporting improving together

Reference No: SG 04/09

Title:	**Guidance on Actions to be Taken after a Patient's Death in Hospital**			
Author(s)	Irene Thompson, Interim Director of Nursing Heather Russell, Bereavement Coordinator Dr Ann Harper, RJMH			
Ownership:	Dr Cathy Jack, Medical Director			
Approval by:	Standards and Guidelines Committee Policy Committee Executive Team Meeting		**Approval date:**	03/10/2018 04/10/2018 10/10/2018
Operational Date:	October 2018		**Next Review:**	October 2023
Version No.	5	**Supercedes**	V4 December 2013-2016	
Key words	Death, Coroner, Death certificate, MCCD, Last Offices, Organ Donation			
Links to other policies	Post-Mortem Examination Regional policy Patient Property Policy Infection Control Manual Organ Donation from heart beating donors Organ Donation from Donors following circulatory death Release of a baby or child from the place of their death Management of Maternal Death Being Open Policy Adverse Incident Reporting and Management policy Multi-Cultural and Beliefs Handbook Bereavement Policy Memorandum of Understanding and Evidential procedures policy			

Date	Version	Author	Comments
28/08/2013	3.1	JRJ	Appendix 2 changes
28/11/2013	3.2	JRJ	Review by D Robinson
28/05/2014	4.1	Heather Russell JRJ	Bereavement additions
09/06/2016	4.2	Heather Russell JRJ	Review-Addition of Appendix 11 - Check List of Nursing Actions required following Death of a Patient
01/12/2017	5	Irene Thompson Heather Russell	RM&MR and resource additions and procedural changes
09/07/2018	5.1	Heather Russell	Revised to incorporate table of Infectious Diseases

1.0 INTRODUCTION

This policy provides the underlying principles, guidance and information required on the actions, care and support to be provided by BHSCT staff, following the death of a patient in hospital.

1.1 Purpose

The purpose is to:

- provide guidance to medical and nursing staff when a patient dies to ensure the appropriate legal and procedural processes are followed
- promote effective interagency working by outlining the roles and responsibilities of relevant professionals and organisations who have a role with deceased patients and their relatives
- ensure that deceased patients, and those important to them, are treated with dignity and respect in a caring, compassionate and professional manner, and that their cultural/spiritual needs are acknowledged and, if possible, addressed
- comply with DoH circulars HSS(MD) 3/2008, 8/2008, 10/2008, 44/2013.

1.2 Objectives

To ensure a consistent approach to all aspects of care of dying, deceased and bereaved people across all BHSCT in-patient areas; and to meet the statutory requirements regarding:

- confirmation and verification of death and stillbirth
- completion of Medical Certificate of Cause of Death
- when and how to report deaths to the Coroner's Service .
- completion of cremation certification
- organ donation and hospital post-mortem examination
- care of the body including religious and cultural considerations, infection control issues, local arrangements for removal from place of death
- reporting of maternal deaths and still births
- supportive bereavement care

2.0 DEFINITIONS/SCOPE OF THE POLICY

This policy applies to all staff with responsibility for procedures after death in hospital, e.g. verifying and recording life extinct, completing medical certificate of cause of death, reporting deaths to the Coroner's office, managing or delivering care to deceased patients and providing information to bereaved people and supporting them.

It applies to all inpatient settings: wards, ICU/CCU, theatres, emergency and outpatients departments.

The current position in law is that there is no statutory definition of death in the United Kingdom. The definition of death should be regarded as the irreversible loss of the capacity for consciousness, combined with irreversible loss of the capacity to breathe[2].

3.0 ROLES/RESPONSIBILITIES

3.1 All Staff

All staff employed by BHSCT whose duties involve coming into contact with and/or caring for dying people, and those important to them, should perform their duties with professionalism, sensitivity, compassion and respect. They have a responsibility to consider any training or learning required in order to provide the best care and identify this in Personal Development Plans. A range of training is provided across the organisation. Specific responsibilities include those listed below:

3.2 Medical Staff

Medical staff responsibilities include:

- timely verification of life extinct
- verbal communication of fact and cause of death to family, next of kin or carers and explaining coroner's processes if applicable
- timely and accurate electronic completion of medical certificate of cause of death (MCCD) or discussion with coroner using the RM&MRs platform on BHSCT Hub,
- liaising with the coroner's service/PSNI when death is due to unnatural causes or is sudden/unexpected and sharing coroner's/PSNI decisions with nursing colleagues
- completing Form B on cremation documentation when requested
- liaising with Specialist Nurse Organ Donation to identify patients eligible for organ donation
- completing training in post mortem consent, discussing value of hospital post-mortem examination and obtaining consent if applicable
- writing to the patient's GP to inform of the death

Medical Consultants

Consultants responsibilities include:

- reviewing their patients' completed MCCDs and presenting their deaths at the monthly M&M meeting for discussion
- overseeing timely completion of the MCCD to allow release of patient from mortuary, especially at weekends
- being available for a follow up meeting when requested by complaints or service managers or bereavement coordinator on behalf of family

NB The doctor completing the MCCD must have been involved in the care of the patient, but need not have verified death or have seen the body of the deceased.

3.3 Nursing Staff

Nursing staff responsibilities include:

- encouraging a quiet and respectful environment when a patients through the use of the waterlily symbol
- reporting the death of a patient to medical colleagues and requesting their timely attendance for verification of life extinct
- liaising with medical colleagues regarding family communication and support
- contacting next of kin if not present at time of death and supporting those in attendance

- providing compassionate support that is responsive to the needs of bereaved people
- providing verbal and written information to bereaved people, in a format/language they understand, that explains legal and procedural requirements after death, and includes help with management of grief reactions
- returning personal possessions to the family respectfully or informing mortuary if the deceased patient has no NoK
- appropriately caring for the patient's body after death
- arranging the safe and timely removal of deceased patients from their place of death
- informing and involving other members of the multi-disciplinary team as requested by the family, e.g. chaplains/social worker
- recording all aspects of care provided in patients' health records
- facilitating follow-up for every family i.e. sending sympathy card;
- accessing learning opportunities that promote competence/confidence when caring for deceased and bereaved people

Ward/Department Sister/Charge Nurse

The responsibilities of the Ward/Department Sister/Charge Nurse include:

- providing training opportunities for staff that support and equip them to manage dying patients, bereaved people and themselves
- ensuring that there is an ethos of sensitivity and respect for dying and deceased patients and those important to them
- ensuring that the GP and other relevant Community HSC Services are informed of the patient's death within one working day, this task may be delegated to a member of the ward team, e.g. Nurse in charge of the shift or Ward Clerk:

All nurses must adhere to "The code:Professional Standards of practice and behavior for nurses and midwives" (NMC 2015).

3.4 **Managers**

Healthcare Managers responsibilities include:

- recognising the importance of care before, at the time of and after death; and the impact that care has on bereaved people and staff
- commissioning training for staff who deliver care and support at the time of and after death
- addressing support needs of staff who are affected by bereavement (personal or professional).

4.0 KEY POLICY PRINCIPLES

Awareness and compliance with the policy and procedures detailed below will ensure that:

- statutory and procedural requirements are met
- deceased patients and those important to them are dealt with in a professional, safe, sensitive and supportive way.

5.0 IMPLEMENTATION OF POLICY

The policy will be hosted on the policy and guidelines and bereavement sections of the Trust intranet. Awareness of the procedures contained within it will be raised at staff induction and training opportunities.

6.0 MONITORING

Implementation of the policy will be monitored by:

- Review of MCCD completion on RM&MR database at M&M meetings
- Regular audit of documentation e.g. Completion of Body Transfer and PM examination consent forms, provision of bereavement booklets
- Presentation of organ donation statistics
- Regional audit against the bereavement standards
- The activity of BHSCT bereavement fora

7.0 EVIDENCE BASE / REFERENCES

1. Guidance on Death, Stillbirth & Cremation Certification. Part A DHSSPSNI, 2008.
2. Guidance on Death, Stillbirth & Cremation Certification. Part B DHSSPSNI, 2008.
3. A code of practice for the diagnosis and confirmation of death. Academy of Medical Royal Colleges, 2008.
4. HSS(MD) 3/2008. Guidance for doctors certifying cause of death involving health care associated infections.
5. HSS(MD) 8/2008. Verifying and recording life extinct by appropriate professionals.
6. Guidelines for Verifying Life Extinct (PDF 62 KB)
7. HSS(MD) 10/2008. Enhanced monitoring arrangements for deaths where C.DIFFICILE or MRSA infection is mentioned on the death certificate.
8. Coroner's Service for Northern Ireland - June 2011.
9. Working with the Coroner's Service for Northern Ireland
10. HSC Multicultural and Beliefs Handbook 2012f
11. HSS (MD) 44/2013 Appeal Court Decision on Referral of Stillbirth to Coroner
12. Care of the deceased patient and their family Guideline for Nursing Practice in Northern Ireland - March 2017
13. Care of the deceased patient and their family A Guideline for Nursing Practice in Northern Ireland May 2017

8.0 CONSULTATION PROCESS

Endorsement of regionally and nationally consulted documents
Coroner Office

9.0 APPENDICES / ATTACHMENTS

Topic	Appendix
Verifying life extinct.	1
Protocol for actions to be taken after a death in hospital	2
Certifying the medical cause of death or stillbirth	3
Referral to the Coroner.	4
Hospital post mortem examination	5
Managing maternal death and stillbirth	6
Obtaining a burial or cremation order.	7
Care of the body after death	8
Faith/cultural considerations	9
Body Transfer Forms 1a and 1b	10
Check List of Nursing Actions required following Death of a Patient	11

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out. The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact. ☒

SIGNATORIES

18/09/2018

Author **Date:**

18/09/2018

Director **Date:**

This first step has no formal legal term and is referred to in a number of ways including recognition of life extinct, verification of death, pronouncing death, confirming death.

Verifying life extinct can be undertaken by all doctors and, where service groups deem necessary, this role can also be undertaken by nurses who are appropriately trained.

Further requirements regarding these roles are provided in the circular - HSS(MD) 8/2008 - *Verifying and recording life extinct by appropriate professionals* and its guideline.

Procedure for verification of death

Life extinct must always be verified by examining all of the following systems:

1. Cessation of circulatory system e.g.
   - No pulses on palpation.
   - No heart sounds (verified by listening for heart sounds or asystole on an ECG tracing).

2. Cessation of respiratory system e.g.
   - No respiratory effort observed.
   - No breath sounds (verified by listening for one full minute).

3. Cessation of cerebral function e.g.
   - Pupils dilated and not reacting to light.
   - No reaction to painful stimuli.

Documentation

An explanation of the examination undertaken and verification of life extinct should be completed in the patient's health record. The date and time of verification should be recorded. (**N.B** This applies whether a doctor or nurse verifies death).

It is important that verification of life extinct is timely as this will influence the actual date and time of death inserted on the MCCD. This is crucially important if the death occurs close to midnight, or if the Coroner will be issuing a Death Certificate to the family after the funeral has taken place.

Certain situations can make the clinical confirmation of life extinct more difficult, in particular, **drowning, hypothermia, drug overdose and pregnancy.** In these situations active resuscitation should continue until an experienced doctor has confirmed death.

There are some special circumstances, including brain-stem death in ventilated patients, where medical consultants will be involved in verifying life extinct under more detailed protocols. (See appendix 3)

Next steps

Following the verifying of life extinct, the practitioner needs to determine the next steps, which will depend on the circumstances of the death. (Appendices 3 & 4)

Although most deaths, even sudden deaths, are not suspicious, it is important that the professional who has verified life extinct considers the general circumstances of the death. Where there are major concerns about the cause of death, the body and the area around it should be secured and not disturbed, the Police should be contacted and they will direct next steps. See *Memorandum of Understanding. Investigating patient or client safety incidents (Unexpected death or serious untoward harm)*

There are some special circumstances concerning the diagnosis and confirmation of death e.g. brain-stem death in ventilated patients, where these artificial interventions are sustaining cardiorespiratory function in the absence of a patient's ability to breathe independently. A code of practice designed to address these issues - A code of practice for the diagnosis and confirmation of death. (Academy of Medical Royal Colleges, 2008) outlines current practice.

Whilst dying is a process rather than an event, a definition of when the process reaches the point (death) at which a living human being ceases to exist is necessary to allow the confirmation of death without an unnecessary and potentially distressing delay. This is especially so within a primary or secondary care environment, where clear signs that are pathognomonic of death (hypostasis, rigor mortis) are present. However, in the absence of such signs, we recommend that the point after cardiorespiratory arrest at which death of a living human being occurs is identified by the following conditions:

- The simultaneous and irreversible onset of apnoea and unconsciousness in the absence of the circulation.
- Full and extensive attempts at reversal of any contributing cause to the cardiorespiratory arrest have been made. Such factors, which include body temperature, endocrine, metabolic and biochemical abnormalities, are considered under section.
- One of the following is fulfilled:
    - the individual meets the criteria for not attempting cardiopulmonary resuscitation
    - attempts at cardiopulmonary resuscitation have failed
    - treatment aimed at sustaining life has been withdrawn because it has been decided to be of no further benefit to the patient and not in his/her best interest to continue and/or is in respect of the patient's wishes via an advance decision to refuse treatment
- The individual should be observed by the person responsible for confirming death for a minimum of five minutes to establish that irreversible cardiorespiratory arrest has occurred. The absence of mechanical cardiac function is normally confirmed using a combination of the following:
    - absence of a central pulse on palpation
    - absence of heart sounds on auscultation

These criteria will normally suffice in the primary care setting. However, their use can be supplemented in the hospital setting by one or more of the following:

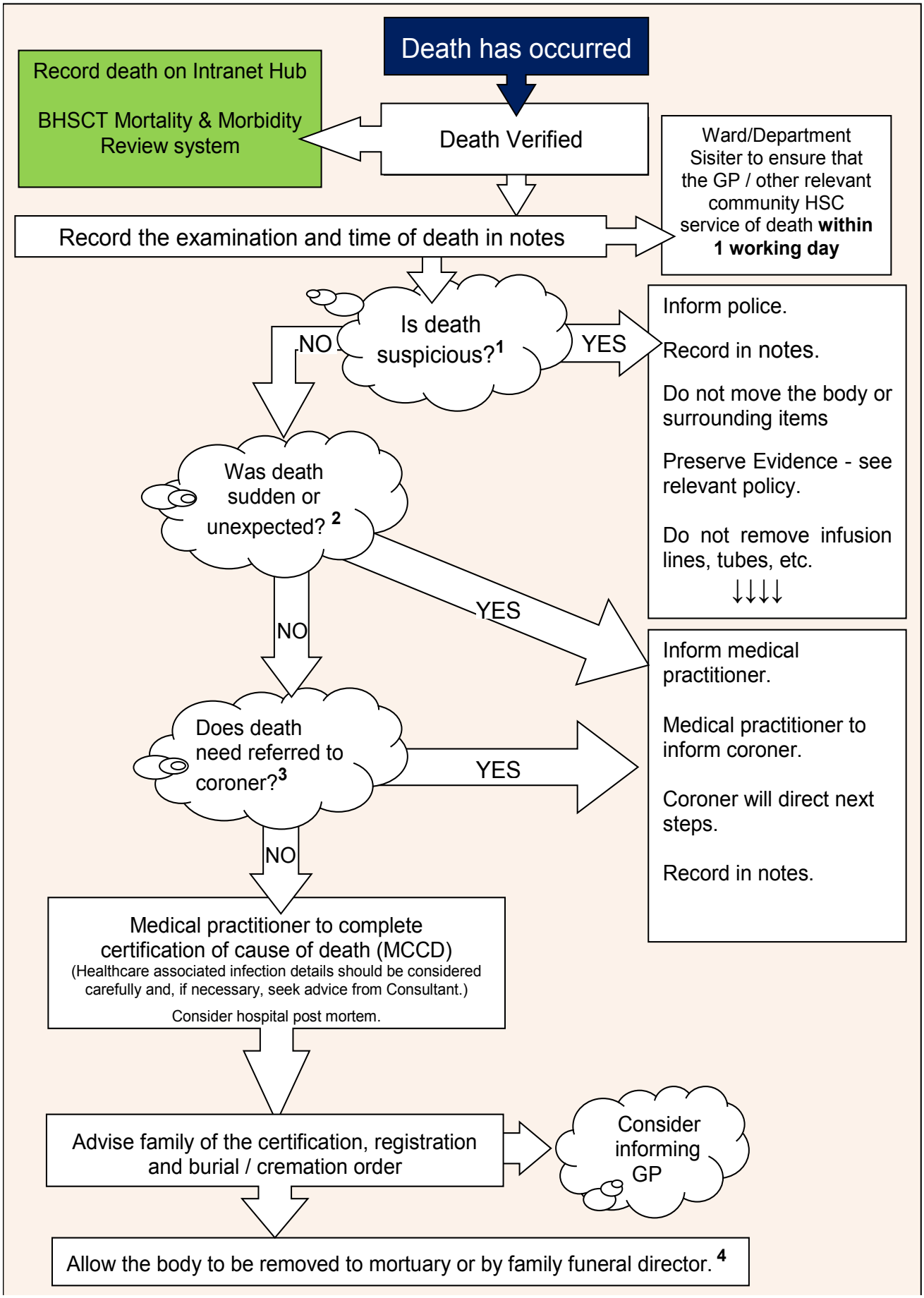
- asystole on a continuous ECG display
- absence of pulsatile flow using direct intra-arterial pressure monitoring
- absence of contractile activity using echocardiography

- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest
- After five minutes of continued cardiorespiratory arrest the absence of the pupillary responses to light, of the corneal reflexes, and of any motor response to supra-orbital pressure should be confirmed
- The time of death is recorded as the time at which these criteria are fulfilled.

A CODE OF PRACTICE FOR THE DIAGNOSIS AND CONFIRMATION OF DEATH

Protocol for actions to be taken after a death in hospital

appendix 2



Notes for Appendix 2

Death involving suspicious circumstances e.g. injuries, apparent suicide, and scene of death raises concerns about break-in, fire, struggle.

- *The body must not be moved. Do not disturb the scene*
- There must be immediate contact with the Police and the appropriate medical practitioner
- The police or medical practitioner must contact the Coroner
- The body will require a forensic post mortem examination by a State Pathologist
- The police will arrange transfer to a mortuary

Sudden/unexpected death without suspicious circumstances e.g. person found dead or initial resuscitation is unsuccessful but circumstances do not raise concerns.

- The appropriate medical practitioner must contact the coroner
- The coroner may direct a coroner's post mortem examination
- If the coroner is content that a post mortem examination is not required the doctor should complete a pro-forma letter (unsigned MCCD) and clinical summary for the coroner on the RM&MRS
- If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the person's GP is available to discuss the case) the body should be taken to the hospital mortuary
- The trust contracted funeral director will transfer the deceased patient to BHSCT mortuary on behalf of the coroner, they will then be moved to State Pathologist's Department if a post mortem examination is to take place

Death related to specific conditions that need to be referred to the Coroners Service. In addition to suspicious and unexpected deaths there is a statutory requirement to refer to the Coroner any death as outlined in appendix 4. e.g. Industrial disease such as asbestosis or mesothelioma, during or shortly after an anaesthetic, any injury, including fractures, neglect.

- The appropriate medical practitioner must contact the coroner
- The coroner may direct a coroners post mortem examination
- If the coroner is content that post mortem examination is not required the doctor should complete a pro-forma letter and clinical summary for the coroner on RM&MRS, print off and fax them to the coroners office
- If the medical practitioner and coroner cannot immediately deal with the death (e.g. if the coroner needs to wait until the person's GP is available to discuss the case) the body should be taken to the designated hospital mortuary
- The trust contracted funeral director will transfer the deceased patient to BHSCT mortuary on behalf of the coroner, they will then be moved to State Pathologist's Department if a post mortem examination is to take place

Paediatric deaths

Parents may wish to take their child directly home following death and where appropriate this choice should be supported. In this event BHSCT mortuary, the child's GP and a family funeral director must be informed prior to the family leaving the ward. See BHSCT policy Removal of a baby or child from the place of their death.

1. Death certification provides a permanent legal record of the cause and facts of death, allows registration, enables a family to arrange a funeral and settle their estate.
2. A doctor who has treated the patient in the last 28 days for a natural illness that caused their death may issue a Medical Certificate of Cause of Death (MCCD).
3. All doctors completing MCCDs or cremation forms, and doctors and midwifes completing stillbirth certificates, should be aware of when and how to complete them and which deaths should be referred to the coroner.
4. All staff should refer to the DHSSPSNI Guidance on Death, Stillbirth and Cremation Certification, when completing death certification / liaising with the coroner.

Expected Deaths

5. An expected death can be defined as: "a death where the patient's demise is anticipated in the near future". In such cases the treating doctor will be able to issue a medical certificate as to the cause of death.
6. Registered Medical Practitioners have a legal duty to provide, without delay, a MCCD if, to the best of their knowledge, the person died of natural causes for which they had treated that person in the last 28 days.
7. **Whenever a patient dies, a doctor who is familiar with their medical history and who is able to give an explanation of why death occurred should speak to family members. This will provide an opportunity for the family to express any concerns before a Medical Certificate of Cause of Death (MCCD) is completed. If the family is unhappy with the care and treatment the deceased received it is advisable to report the death to the coroner with particulars of the family's concerns**. A written record of these concerns should always be made and retained with the patient's health record. The MCCD should be completed electronically on RM &MRS. This will enable the patient's consultant to review/revise the cause of death and provide information for discussion at Mortality and Morbidity Review meeting.
8. Registrars need to be assured that the doctor completing a MCCD is fully registered and because they sometimes need to contact the doctor to clarify issues before registering the death, the MCCD should contain a:
    - legible printed name
    - signature
    - GMC number
    - doctor's contact details.

    Difficulty contacting the doctor can lead to delay in funeral arrangements and distress for families.

9. If a MCCD cannot be completed because no doctor involved in the patient's care is on duty (as may happen at weekends) the duty doctor should contact the patient's consultant to avoid delay of release. It is also permissible to discuss the death with the coroner's office and, after agreement, complete a pro-forma which will allow the death to be registered under the "Form 14 – **Pro-forma system**" (page 29 of *Working with the Coroner's Service for Northern Ireland*).
10. If the coroner agrees this approach, the doctor will be asked to complete a MCCD giving the cause of death as agreed, leave it unsigned and fax it to the coroner's office along with a signed clinical summary letter explaining the circumstances of the death (including any relevant investigations and results). Printed originals should then be sent to coroner's office by post.

11. It is ultimately the responsibility of the consultant in charge of the patient's care to ensure that the death is properly certified. Foundation level doctors should not complete medical certificates of cause of death unless they have received training.

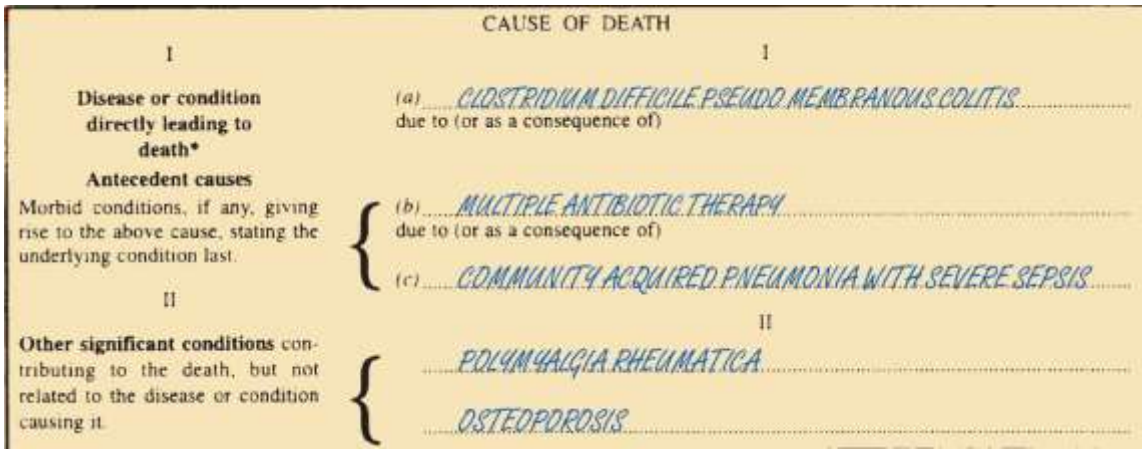
Recording Healthcare Associated Infections (HCAI)

12. The level of healthcare associated infections (HCAI) remains a matter of concern to clinicians and the public.
13. The Health Service depends on accurate information gained from death certificates to record changes in mortality associated with infections. Trends which are identified can highlight new areas of concern, or monitor changes in deaths associated with certain infections.
14. Families may be surprised if an infection the patient was being treated for, such as MRSA or Clostridium Difficile, is not mentioned on a death certificate.

It is a matter of clinical judgement if a HCAI was the disease:

i. directly leading to the death [record at part I (a)],
ii. was an antecedent cause [record at part I (b) or I (c)] or
iii. was a significant condition not directly related to the cause of death [record at part II].

A. If a health care associated infection was part of the sequence leading to death, it must be recorded on part I of the MCCD and all the conditions in the sequence of events back to the original disease being treated should be included.


CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CLOSTRIDIUM DIFFICILE PSEUDO MEMBRANOUS COLITIS
due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.

(b) MULTIPLE ANTIBIOTIC THERAPY
due to (or as a consequence of)

(c) COMMUNITY ACQUIRED PNEUMONIA WITH SEVERE SEPSIS

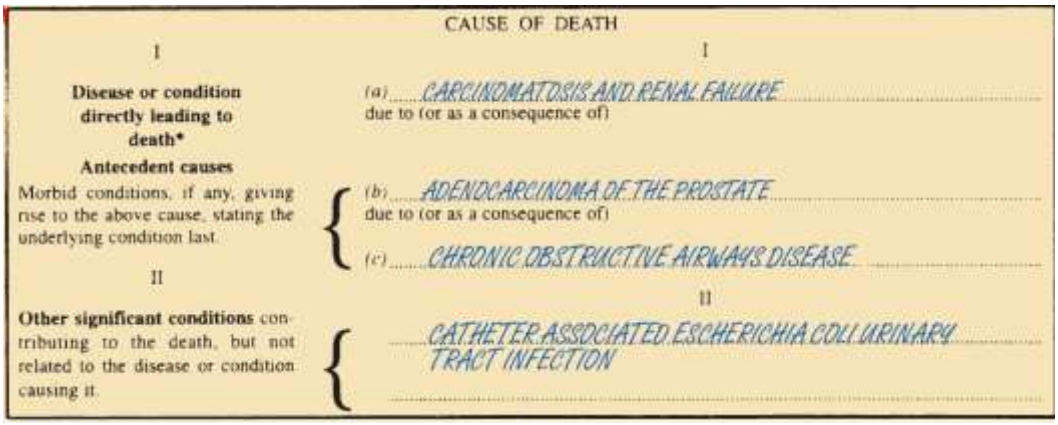
II

Other significant conditions contributing to the death, but not related to the disease or condition causing it.

POLYMYALGIA RHEUMATICA

OSTEOPOROSIS

B. If a patient had a HCAI which was not part of the direct sequence but which was thought to contribute to their death it must be mentioned in part II.


CAUSE OF DEATH

I

Disease or condition directly leading to death*

(a) CARCINOMATOSIS AND RENAL FAILURE
due to (or as a consequence of)

Antecedent causes

Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.

(b) ADENOCARCINOMA OF THE PROSTATE
due to (or as a consequence of)

(c) CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

II

Other significant conditions contributing to the death, but not related to the disease or condition causing it.

CATHETER ASSOCIATED ESCHERICHIA COLI URINARY TRACT INFECTION

C. If the HCAI is thought not to have contributed to a patient's death it is important **not** to record it on the MCCD.

The recommended sequence should be:

1. **Discuss** if it is appropriate to include HCAI on MCCD with a consultant before completion.
2. **Inform** family where HCAI appears on certificate. (also explain, in cases where it is non-contributory and therefore not on the MCCD, why it does not.)
3. **Inform** Ward sister/ Charge nurse that MCCD with contributory HCAI has been issued.
4. **Assist** Ward sister/ Charge nurse in completion of incident report form and ensure that causes of death as they appear on the death certificate are recorded on the incident form.

For further guidance on this topic refer to:

- Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.
- Consultant advice

Doctors should be aware of the criteria for referring death to the coroner and also the Registrar General's Extra-statutory list of Causes of Death that should be referred to the Coroner. Before proceeding to MCCD completion doctors should ask themselves:
Does this death have to be reported to the Coroner?

Causes of death that must be reported to the Coroner

The duty to report arises if a medical practitioner has reason to believe that the deceased died directly or indirectly:

1. As a result of violence, misadventure or by unfair means;

2. As a result of negligence, misconduct or malpractice (e.g. deaths from the effects of hypothermia or where a medical mishap is alleged);

3. From any cause other than natural illness or disease e.g.:

   • homicidal deaths or deaths following assault;
   • road traffic accidents or accidents at work;
   • deaths associated with the misuse of drugs (whether accidental or deliberate);
   • any apparently suicidal death;
   • all deaths from industrial diseases e.g. asbestosis.

4. From natural illness or disease where the deceased had not been seen and treated by a registered medical practitioner within 28 days of death;

5. Stillbirth:
   - Since the Appeal Court Decision on Reporting Stillbirths to the Coroner (November 2013) all babies stillborn, deemed by obstetricians to be capable of being born alive, are to be reported to the coroner for a decision on post mortem examination. If the coroner doesn't direct a post mortem examination the parents should be approached about a hospital post mortem examination.
   - Stillbirth forms can be completed for a baby delivered at or beyond 24-week gestation, by a medical practitioner who was present at the birth or who examined the baby's body.
   - Foundation level doctors should not complete stillbirth forms without discussion with a more senior colleague.
   - A registered midwife who was present at the birth or examined the body can also complete the stillbirth certificate.

6. Death as the result of the administration of an anaesthetic (there is no statutory requirement to report a death occurring within 24 hours of an operation – though it may be prudent to do);

7. In any circumstances that require investigation;
   - the death, although apparently natural, was unexpected;
   - Sudden Unexpected Death in Infancy (SUDI).

8. Doctors should refer to the Registrar General's extra-statutory list of causes of death that are referable to the coroner.

    - Industrial diseases or poisoning and other poisonings
        A. Industrial lung diseases
        B. Other industrial diseases
        C. Industrial poisoning
        D. Other poisonings

    - Death resulting from an injury
        - Injury
        - Indirect injury
        - Birth injury
        - Operation / anaesthetic

    - Family Concerns
      In the event of a family expressing concern about treatment and care received by the deceased patient it is advisable to report the death to the coroner outlining the family's concerns. A written record of the concerns should always be made and retained in the medical records.

For further detail go to:
Guidance on Death, Stillbirth & Cremation Certification. DHSSPSNI, 2008.

When reporting a patient's death to the Coroner:

- A child's death should be reported to the coroner by a consultant.

- Notification to the coroner and any discussions with the coroner should be recorded in the child's health record.

- A foundation level doctor must consult a more senior colleague before reporting a death to the coroner

- A coroner is always on call and can be reached if necessary out-of-hours to discuss a need to obtain consent for the transplantation of organs, the death of a child or a complicating factor that requires the death to be reported as soon after death as possible. In cases where death may have resulted from a crime or foul play the doctor should immediately inform the police and allow them to take the matter forward with the coroner.

- Most deaths occurring in hospital during the night do not need to be immediately reported to the coroner. The body should be moved to the mortuary for overnight storage and the coroner's office contacted promptly the following morning. If parents do not want their child to be taken to the mortuary the coroner can be contacted out of hours.

- The office of the Coroners Service for Northern Ireland:
  Address: Laganside House,
  23-27 Oxford Street
  BT1 3LA

  Tel: 0300 200 7811

Website: www.coronersni.gov.uk
E-mail: coronersoffice@courtsni.gov.uk
Office Hours: Weekdays 9.00am – 5.00pm,
Weekends and public holidays 9.30am – 12.30pm
Christmas Day the office is closed

- When a doctor needs to contact the coroner's office outside office hours for immediate direction they will hear a recorded message. ***It is important that they listen to the full range of options presented before selecting one as the most appropriate option may not be clear until the message is completed. The on-call coroner's mobile telephone number is only given at the very end of the recording.***

For information regarding the Coroner's office refer to the Coroners Service for Northern Ireland – June 2011.

Coroner's direction to doctors
Following report of a death the coroner will direct one of three courses:

1. Advise doctor to complete a MCCD

2. Direct that a death be processed under the 'pro-forma' system
    - When the Coroner directs that the death can be processed using the 'pro-forma' system, a clinical summary, along with an unsigned MCCD, should be printed and faxed/ e-mailed to the Coroner's Service as soon as possible and the hard copy of both documents posted to them (see contact details in section 8)
    - The new Regional Mortality and Morbidity Review System will generate a 'Coroners Clinical Summary' when the 'Coroner notified – Coroner Requested Proforma' option is selected along with a MCCD for this purpose.
    - NB. In this situation the MCCD **is not** given to the family. They should be given an explanation about this process and that the coroner, on receipt of the clinical summary and unsigned MCCD, will notify the Registrar about the death who will then issue a death certificate to them at the Registrar's Office.

3. Direct a post mortem examination to establish cause of death
    - When the coroner directs that a coroner's post mortem examination is required it is particularly distressing for families.
    - Doctors must give information to families that will help them understand the coroner's process and what will happen next i.e. that police will attend as coroner's agents and complete staff and family statements regarding the deceased's last few minutes/hours.
    - Requests for formal statements or medical records are usually requested through the Trust Coroner Liaison Officer

Families should be informed of any contact with the coroner's office as part of the Trust's obligation of duty of candour.

Care of the patient's body:

- In a case of suspicious death or homicide all medical devices including ET tube should remain in position.

- When there are no suspicious circumstances and where the endotracheal tube has been clinically confirmed to have been in the appropriate position and there are no questions regarding intubation or anaesthesia having played a role in the death, the ET tube can be removed.

- Any medical device which is removed should be documented in the medical notes and in the clinical summary provided to the pathologist, along with any supporting evidence with regard to its correct positioning and function prior to removal. If there are any doubts, the device should be left in-situ, again any supporting evidence regarding correct position and function should be documented in the medical records and clinical summary, as it is possible that the device could become dislodged in transfer.

Post-mortem (PM) examination is important for informing relatives, healthcare professionals and other interested parties about the cause of death. Following a death due to natural causes the treating clinician may wish to request a hospital PM examination to investigate further the cause of death, to improve knowledge of the disease or effectiveness of the treatment given. Occasionally relatives may request that a hospital PM examination is performed.

Who may seek consent?
It is usually the responsibility of the deceased person's clinician to raise the possibility of a PM examination however others in the team may be involved in the consent process.

The need for a hospital PM examination of a child must be discussed and agreed with the child's consultant, and consent must be obtained by an experienced clinician.

The Human Tissue Authority (HTA) requires that anyone approaching relatives to seek consent for hospital post-mortem examination:

> *"should have relevant experience and a good understanding of the consent procedure. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations. Ideally, they should also have witnessed a post-mortem examination." HTA Code B, Para 82*

The DoH has developed a 2-part training programme for those obtaining consent or supporting families who have consented to a post mortem examination.

Part 1, an e-learning module can be accessed at
http://www.hsclearning.com/belfasttrust/

Part 2, a face to face session on "grief, bereavement and communicating with grieving families" can be booked by contacting Heather Russell, Trust Bereavement Coordinator. heather.russell@belfasttrust.hscni.net

For detailed guidance please refer to the policy:
HSC Consent for Hospital Post-Mortem Examination Regional Policy

A **maternal death** is defined as a death of woman while pregnant or within 42 days of the end of the pregnancy (includes delivery, ectopic pregnancy, miscarriage or termination of pregnancy) from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

However, a maternal death can effectively be any death which occurs during or within one year of pregnancy, ectopic pregnancy or abortion as it can be directly, indirectly, coincidentally related to the pregnancy or late.

A **Direct** death is defined as a death resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above.

An **Indirect** maternal death is defined as a death that resulted from previously existing disease, or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiological effects of pregnancy. These include cases of self-harm as consequence of postnatal depression.

A **Coincidental (fortuitous**) death is defined as a death that occurs from unrelated causes which happen to occur in pregnancy or puerperium, i.e. some malignancies, domestic violence, road traffic accidents, etc.

A **Late** death is defined as a death that occurs between 42 days and one year after miscarriage or delivery that is due to **direct or indirect** maternal causes.

For detailed guidance please refer to the BHSCT policy on "Management of a Maternal Death"

When the death is directly related to the pregnancy the attending doctor cannot issue a death certificate without first referring to the Coroner.

Northern Ireland Maternal and Child Health (NIMACH)
It is a statutory requirement that all health professionals provide information and participate in confidential inquires and that maternal deaths are reported to:

ALL maternal deaths (direct, indirect or coincidental) which occur during pregnancy or within 42 days of delivery should be reported to the NIMACH Regional Manager.

In addition, the following deaths should be notified if they occur from 42 days to 6 months following delivery, termination or abortion:

- Direct Deaths
- Deaths due to peripartum cardiomyopathy
- Deaths due to suicide.

NIMACH is commissioned by the DoH through the Public Health Agency for Northern Ireland and can be contacted through:

Regional Manager: Dr Heather Reid

Address:
NIMACH Regional Office
Public Health Agency (PHA) (Floor 2)
12 - 22 Linenhall Street
Belfast BT2 8BS
Northern Ireland

Phone:
028 9536 3481

Fax:
028 9536 3947

Obtaining a burial or cremation order. Appendix 7

The registrar or coroner can issue a burial or cremation order.

Cremation
When a body is to be cremated there are a series of special medical forms to be completed by 2 independent doctors, to provide assurance that the death does not require further investigation. If the death has not been referred to the coroner, and a MCCD – medical certificate of cause of death has been completed, the medical forms are Forms B, C and F.

Cremation forms are not required for coroner's cases where a pro-forma has been agreed (they will issue burial or cremation orders in this instance) or where there is to be a coroner's post-mortem.

Form B
This should be completed by a registered medical practitioner who has attended the deceased during his last illness. It is often the same doctor who completed the MCCD.

Foundation level doctors should NOT complete cremation Form B unless they have been trained to do so.

Form C
The doctor completing cremation Form C should:

- be a registered medical practitioner of not less than 5 years standing
- be independent of the doctor who completed Form B. The legal requirement is that the doctor completing Form C should not be a relative, partner or assistant of the doctor who completed Form B. It would be good practice that the doctor completing Form C should not have been directly involved in the patient's care;
- not be related to the deceased.

Form F
This is completed by the Medical Referee for the Cremation Authority.

Care and removal of the body after death (Last Offices) Appendix 8

Preparing the body of deceased patients for removal is the final, important clinical role of staff who cared for them during their last hospital admission. Many patients, due to the nature of their illness, will die in hospital after a lengthy stay; others are admitted and die soon after. It is important that safe and effective care continues for patients after death and that their bodies are treated with dignity, their wishes are respected and any cultural or religious requirements are met.
The Trust has adopted the Royal Marsden clinical nursing procedure guidelines Chapter 22 and "Care of the deceased patient and their family" HSC Bereavement Network
The procedure should not commence until after death has been verified and the patient's immediate family has had an opportunity to attend the ward/department and spend some time with them following death, should they so wish. However, Last Offices should usually be carried out and the body removed within two to four hours of death. In exceptional circumstances e.g. after arriving from overseas, additional relatives may view the deceased patient in the Trust Mortuary Viewing Room on the Royal Hospitals site. This can be arranged by contacting mortuary staff.
Before relatives see their loved one, items of medical/nursing equipment should be removed from the room/bed space.
The procedure describes steps to be taken following most deaths in hospital however:

- In the event of the death falling under the jurisdiction of the coroner the body should not be unduly handled, to preserve evidence especially if the death occurs after assault
- In the event of the death of a child or baby their parents may wish to be involved in the care after death and removal arrangements (see BHSCT policy "Release of a baby or child from the place of their death")

Two members of staff, at least one qualified, should conduct the last offices procedure at the bedside. The senior member of staff is responsible for overseeing the procedure and completing the documentation.
Before commencing, it is important to assess the patient for any risks:

- If there is an infection risk the infection prevention precautions, taken when the patient was alive, should be continued after death
- If there is a manual handling risk the number of staff required to undertake Last Offices procedure may need to be increased from 2 to a number that ensures safe manual handling

Last Offices Equipment

- Disposable plastic gloves and aprons (additional PPE if patient has an infection)
- Towels, bowl of warm water, soap, disposable wash cloths, comb, items for mouth care/teeth cleaning
- Gauze, waterproof tape, dressings and bandages to cover wounds or intravenous/arterial lines or cannulae

- Receptacle for collecting urine/uribag if appropriate, plastic bags for clinical waste
- Laundry skip and appropriate bag for soiled linen
- Clean sheet or purple woven body sheet (MIH), shroud (or patient's personal clothing if requested by family)
- Two identity bands: one on each wrist or other limb if applying to second wrist is not possible
- Body bag if:
    - Patient's medical history is unknown
    - Actual or potential leakage of body fluids
    - Infection (with labels to indicate nature of infection)
- Purple woven bag for return of patient's personal possessions
- Record book for property and valuables
- Body Transfer Form book

Last Offices Procedure and notification of GP

Two members of staff (unless more are required) will conduct the procedure. Senior staff member is responsible for completing required documentation. All equipment should be gathered before entering the room/bedspace.

- If family is present ask if patient had any wishes or cultural/religious requirements for care after death; a member of the family may want to assist
- Explain that after completion of Last Offices they will not be able to view their loved one until the family funeral director has taken them to his premises.
- If family is waiting for the patient's property find them somewhere to sit and ask if they would like a cup of tea
- Wash hands and put on disposable gloves and apron.
- If the patient is on a pressure relieving mattress follow manufacturer's instructions
- Lay the patient on their back. Remove all but one pillow. Support the jaw by placing a pillow or rolled up towel on the chest underneath the jaw.
- Remove any subcutaneous infusions and apply gauze to the site firmly with tape, remove ET tubes and infusions. Securely close all devices e.g. venflons, drains, catheters and leave in situ.

  NB. If a death is referred to the coroner leave all devices, tubes and dressings in situ, unless advised otherwise by medical colleagues (see Page 17)
- Straighten limbs and close eyes with pressure or moistened cotton wool, not tape.
- Pad any leaking areas e.g. vagina or bowel. If leaking continues the patient should be placed in a body bag before removal.
- Cover exuding wounds or unhealed surgical scars with clean, absorbent dressing and secure with an occlusive dressing. Cover stomas with a clean bag.
- Wash patient, do not shave male patients.

- Clean mouth, removing debris and secretions. Clean dentures and replace in mouth if possible. If not replaced they should be returned to the family or recorded on the Body Transfer Form and sent to the Mortuary with the patient.
- Remove all jewellery unless requested by the family not to do so. Jewellery remaining on the patient should be recorded on the Body Transfer Form, rings should be taped. Record removed jewellery and other valuables in the Patient Property Book and store according to Trust policy.
- Dress the patient in a shroud (or personal clothing documented on Body Transfer Form).
- Ensure there are 2 identical armbands which detail patient name, H&C number, DOB and ward/dept.
- Senior staff member completes **every part** of Section 1 of Body Transfer Form, adding their name and the time of completion.
- Wrap the patient in white or purple sheet, ensuring that limbs and face are covered but leaving armband near opening and accessible so that the name can be checked at time of removal.
- Place the wrapped body in a body bag if any of the criteria apply i.e. infection, actual or potential leakage, history unknown.
- Remove gloves and apron, dispose of equipment and wash hands.
- Return patient's property in purple property bag and give family a bereavement booklet, telling them it contains helpful information on what they need to do next.
- If there is patient property in the Trust Cash Office, tell the family how to access it.
- Record all details and actions in the patient's nursing record. Complete Checklist following the Death of a Patient (appendix 11) and clip to outside of notes until complete.

It is the responsibility of the Ward/Department Sister to ensure that the General Practitioner or other relevant Community HSC Services are informed of the patient's death within one working day. This task may be delegated to other members of the ward team, e.g. Nurse in charge of the shift or Ward Clerk.

Removal Procedure

Across the Trust there are various removal arrangements in place, these are outlined below.

- Allow families time with their loved one before completing Last Offices.
- Before the removal takes place check that all of Section A of the Body Transfer Form has been completed in full (**all parts are important**!) and add any missing information. Record your name, designation and time of removal.
- Ask family if they are considering cremation and tell them additional documentation is required. Inform the patient's clinician if cremation is the family's choice as a doctor has to see the patient and complete cremation

documentation before removal. If this doesn't happen in the ward is the doctor will have to attend the Mortuary.

In **BCH, MIH, RVH** all deceased patients are transported to the Trust Mortuary on the Royal site by the Trust Contracted Funeral Director.

- Last Offices must be completed **before** requesting the Trust Contracted Funeral Director via switchboard as he may be on site and arrive before you are ready
- When contacting switchboard (0) to request attendance of the Trust Contracted Funeral Director provide: Name of ward, Name of patient, Any infection or manual handling risk.

In **MPH** the arrangement is that a Family Funeral Director is requested to attend the ward and remove the deceased patient. Any MPH patients, whose deaths cannot immediately be certified, should be transferred to the Trust Mortuary on the Royal site by the Trust Contracted Funeral Director. This can be arranged by contacting switchboard (0) and following the procedure outlined above.

In **Muckamore Abbey and Knockbracken Healthcare Park** the arrangement is that a Family Funeral Director is requested to attend the ward and remove the deceased patient. If the patient has no family or next of kin a local funeral director can be used.

NB. In the event of an unexplained or suspicious death all removals will be arranged by the PSNI and carried out by the Coroner's Contracted Funeral Director.

When the Funeral Director arrives to remove the deceased patient the name of the patient must be checked by ward staff and Funeral Director together. The ward will provide the equipment required for manual handling of the body.

- Check patient name and important information recorded in Section A, Body Transfer Form.
- Complete Section B of Body Transfer Form in full, i.e. removal time and name of Funeral Director.
- Give top 2 copies of Body Transfer Form to Trust Contracted Funeral Director or top copy only to Family Funeral Director.
- Prepare the ward and other patients for removal of the deceased patient, where possible pulling curtains

Multi faith/cultural considerations Appendix 9

This section contains information that will enable the provision of appropriate religious/spiritual care of the body after death. Hospital chaplains, the family or relevant faith community representatives may also provide specific support and information. The acute sites have 24/7 chaplaincy cover. Contact details for the on-call chaplains are available from Switchboard.

Even if a patient has not previously declared any particular religious affiliation it should not be assumed they/their family will have no spiritual or pastoral needs. The services of chaplains should also be offered in these situations, where appropriate.

For fuller information see:

- BHSCT Multi Cultural & Beliefs Handbook for all health and social care staff (2012)

Agnostic or atheistic

Last Offices – Normal procedures are appropriate

Bahá'í

Last Offices – Normal procedures are appropriate. Bahá'ís believe that after death the body should be treated with respect. Embalming is not allowed. It is customary for Bahá'ís to place a ring on the finger after death. In such circumstances it should not be removed.

Brahma Kumaris

Last Offices - Normal procedures are appropriate. Dedicated Brahma Kumaris would prefer the body to be in special white clothes although there is some flexibility in this.

Buddhist

A priest from the patient's tradition should be contacted as soon as possible and the body should not be moved too much before the priest arrives. Depending on the tradition, prayers could take an hour. It is possible that the priest will decide to recite prayers where he is or in a temple rather than come to the ward. In this case, last offices can continue as normal.

Last Offices - Normal procedures are usually acceptable, but check with family.

Christian

Last Offices - Routine Last Offices are appropriate.

Christian Science.

Last Offices -. Normal procedures are appropriate. Female staff should handle females after death (so far as possible).

Hindu

Some families may call a Hindu priest, a pandit, to perform holy rites. He may tie a thread around the shoulder down to the waist or round the neck or wrist of the dying person. Do not remove this thread or any other religious items before or after death without the family's agreement. When a Hindu dies, a priest is called to invoke blessings on the body.

Last Offices - After death the patient's body should be left uncovered. Consult the family about what they wish to be done and whether they wish to wash the body themselves

before taking it from the hospital. Often, elders in the family wash and prepare the body for the funeral. Non-Hindus handling the body can cause distress. Disposable gloves should be worn for necessary procedures not performed by the family. Religious items such as sacred threads and perhaps jewellery should not be removed except with the family's permission and, if possible, in their presence.

Humanist

Last Offices - Normal procedures are appropriate

Jain

Last Offices - The family may provide a white gown or shroud for the dead patient. They may also wish to be present and assist; this should be checked with the family.

Jehovah's Witness

Last Offices – Routine last offices are appropriate

Jewish

Last Offices - In some cases the son or nearest relative (if present) may wish to close the eyes and mouth. The arms should be extended by the side. The body is cleaned and wrapped in a plain linen shroud in preparation for burial.

Some Orthodox Jews will wish the deceased's body to remain where it is until their funeral director can come to take it away, but most will be happy for the body to be taken to the hospital mortuary until it can be collected. If the patient dies on the Sabbath, this, in any case, will be necessary, as they cannot be collected on that day.

Orthodox Jewish families will probably want watchers to stay with the deceased until collection. In this situation, necessary arrangements will need to be made with the Mortuary.

Mormon

Last Offices - Normal procedures are appropriate. A sacred garment must be placed on the body, following last offices.

Muslim

Last Offices - DO NOT wash the body or cut nails and hair

Wrap in a plain white sheet and do only the practical essential tasks following death and wear disposable gloves. The family and Muslim undertakers will carry out all Islamic requirements and you could distress the family by carrying out normal last offices. Muslims believe that the deceased retains some awareness until he/she is buried. Talk to the family and be guided by them on what is acceptable or helpful to them in carrying out the last offices.

It is normal practice for relatives of the deceased to wash the body. The body is dressed in a Kaffon (white shroud) and the foot of the bed is turned to face Mecca or the patient's head will be turned to the right shoulder in order that the deceased's face looks towards Mecca..

Pagan

Last Offices – Normal procedures are appropriate

Quaker

Last Offices - Normal procedures are appropriate.

Rastafarian

Last Offices – Normal procedures are appropriate.

Scientologist

Last Offices – Normal procedures are appropriate.

Seventh Day Adventist

Last Offices – Normal procedures are appropriate.

Sikh

Last Offices - Normal procedures are appropriate but DO NOT remove 5 K'S.

KESH - do not cut hair, beard or remove turban

KANGHA - comb

KARA - Sikh bracelet

KACHHA - special shorts/underwear

KIRPAN - sword.

NB. If, for any reason, the patient's KACHHA has to be removed, they should be replaced by another pair.

Spiritualist

Last Offices - Normal procedures are appropriate.

Zoroastrian

Last Offices - Normal procedures are appropriate The body should be placed in white clothing. The family may provide a special shirt to be worn under the clothing with the girdle. They may also wish for the head to be covered by a cap or scarf.

Health and Social Care in Northern Ireland

BODY TRANSFER FORM (1A) ID number

USE TO TRANSFER ALL DECEASED CHILDREN AND ADULTS

Section A - To be completed before body is moved from place of death

Hospital/Facility: Ward/Dept: Consultant:

Name DOB:	Address:
Male ☐ Female ☐ H&C no.	Date of Death: Time of Death:

Death Certificate issued: Yes ☐ **IF NOT**, specify reason:

Has death been reported to the Coroner? No ☐ Yes ☐

If Yes, has Coroner ordered PM examination? No ☐ Yes ☐ Unsure ☐

Is a hospital PM examination to take place? No ☐ Yes ☐

Organ retrieval has occurred/is to take place. No ☐ Yes ☐ Specify:

Additional Information - if yes please specify. Detail:

Infection Risk (if pathogen 3 apply sticker) No ☐ Yes ☐_____

Property left on body No ☐ Yes ☐_____

Drains, tubes left in situ No ☐ Yes ☐_____

Cardiac pacemaker/implantable defibrillator in situ No ☐ Yes ☐_____

Spiritual/religious/cultural requirements No ☐ Yes ☐_____

Section A completed by:_____ (**PRINT NAME AND DESIGNATION**)

Section B - To be completed at time of transfer from place of death to:

Hospital mortuary ☐ State Pathology ☐ Family funeral director ☐ Own home ☐ Other ☐

Patient's Name checked by person releasing:_____ and person removing the body:_____

(**PRINT NAMES AND DESIGNATIONS**)

Any significant information in Section A has been shared Yes ☐ No ☐ **Time:**

Section C - To be completed ONLY if body is transferred to hospital mortuary

C1 Patient named above admitted into mortuary **Date:** **Time:**

By: _____(**PRINT NAME AND DESIGNATION**)

C2 Patient released from mortuary **Date:** **Time:**

Patient's Name checked by person releasing:_____ and person removing the body:_____

(**PRINT NAMES AND DESIGNATIONS**)

Any significant information in Section A has been shared Yes ☐ No ☐ **Time:**

Release authorisation: Death Certificate issued ☐ Coroner authorised ☐ Transferring for PM ☐

Health and Social Care in Northern Ireland

BODY TRANSFER FORM (1B) ID number USE TO TRANSFER ALL BABIES OVER 12 WEEKS GESTATION

Section A - To be completed before baby is moved from place of birth/death

Hospital/Facility: Ward/Dept: Consultant:
Name of mother: Address:
H&C no.

Complete Section A1) if baby miscarried/stillborn OR A2) if baby died after birth

A1) Baby miscarried/stillborn at ___weeks gestation Baby name (if given):
Date of delivery: Time: If required has Stillbirth Certificate been issued? Yes ☐ No ☐

A2) Baby born live at ___ weeks gestation Baby name (if given):
Date of birth: Date of death: Time: H&C no.
Death Certificate issued: Yes ☐ **IF NOT** specify reason:_____

Additional Information - if yes please specify. Detail:
Infection Risk (if pathogen 3 apply sticker) No ☐ Yes ☐_____
Drains, tubes left in situ No ☐ Yes ☐_____
Is hospital PM examination to take place? No ☐ Yes ☐
Has death been reported to the Coroner? No ☐ Yes ☐
If Yes, has Coroner ordered PM examination? No ☐ Yes ☐ Unsure ☐
Spiritual/religious/cultural requirements. No ☐ Yes ☐_____

Section A completed by:_____(**PRINT NAME AND DESIGNATION**)

Section B - To be completed at time of transfer from place of death to:

Baby transferring to: Hospital mortuary ☐ Family funeral director ☐ Own home ☐ Other ☐

Baby's/Mother's Name checked by person releasing:_____ and person

removing the baby:_____

(**PRINT NAMES AND DESIGNATIONS**)

Any significant information in Section A has been shared Yes ☐ No ☐ **Time:**

Section C - To be completed ONLY if body is transferred to hospital mortuary

C1 Baby named above admitted into mortuary **Date:** **Time:**
by: _____(**PRINT NAME AND DESIGNATION**)

C2 Baby released from mortuary **Date:** **Time:**

Baby's/Mother's Name checked by person releasing:_____ and person

removing the baby:_____

(**PRINT NAMES AND DESIGNATIONS**)

Any significant information in Section A has been shared Yes ☐ No ☐ **Time:**

Release authorisation: Dr/Midwife authorised release ☐ Death or Stillbirth Certificate issued ☐
Coroner authorised ☐ Transferring for PM ☐ Baby returning to ward ☐

2017 Check List of Nursing Actions required following Death of a Patient

- To be commenced by nursing staff conducting Last Offices Procedure
- Attach to front of Patient's Health Record until all sections completed
- File in Patient's Health Record on completion

Name and H&C No. of patient:		
GP Name and Telephone Number:		
	Time	Sign
Date and time of death is recorded in patient's health record		
Water Lily symbol displayed		
Next of Kin/ recorded carer has been informed		
Next of Kin/recorded carer attended after death		
General Practitioner has been informed		
Last Offices Procedure carried out by: Name (Printed): Designation: Name (Printed): Designation:		
Body Transfer Form Sections A & B completed		
Contracted Funeral Director (RVH BCH MIH via switchboard) or Family Funeral Director contacted		
Trust Bereavement Booklet/s given to family		
Patient Property placed in purple bag and returned to family		
Mortuary notified that MCCD is issued if appropriate (Tel. no. 90633679)		
Water Lily symbol removed		
Sympathy card signed and sending date recorded		
Other staff and services involved with patient informed		

Guidelines for cadavers with infections: www.infectioncontrolmanual.co.ni Issue

Advisable Degree of risk	Infection	Bagging	Viewing	Embalming	Hygienic Preparation
Low	Acute encephalitis	No	Yes	Yes	Yes
	Chickenpox/shingles	No	Yes	Yes	Yes
	Cryptosporidiosis	No	Yes	Yes	Yes
	Dermatophytosis	No	Yes	Yes	Yes
	Legionellosis	No	Yes	Yes	Yes
	Lyme disease	No	Yes	Yes	Yes
	Measles	No	Yes	Yes	Yes
	Meningitis (except meningococcal)	No	Yes	Yes	Yes
	Mumps	No	Yes	Yes	Yes
	Meticillin-resistant Staphylococcus aureus (MRSA)	No	Yes	Yes	Yes
	Ophthalmia neonatorum	No	Yes	Yes	Yes
	Orf	No	Yes	Yes	Yes
	Psittacosis	No	Yes	Yes	Yes
	Rubella	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Whooping cough	No	Yes	Yes	Yes
Medium	Acute poliomyelitis	No	Yes	Yes	Yes
	Cholera	No	Yes	Yes	Yes
	Diphtheria	Adv*	Yes	Yes	Yes
	Dysentery	Adv*	Yes	Yes	Yes
	Food poisoning	No	Yes	Yes	Yes
	Hepatitis A	No	Yes	Yes	Yes
	HIV/AIDS	No	Yes	No	No
	Leptospirosis (Weil's disease)	No	Yes	Yes	Yes
	Malaria	No	Yes	Yes	Yes
	Paratyphoid fever	Adv*	Yes	Yes	Yes
	Q fever	No	Yes	Yes	Yes
	Relapsing fever	Adv*	Yes	Yes	Yes
	Meningococcal septicaemia	Adv*	Yes	Yes	Yes
	Scarlet fever	Adv*	Yes	Yes	Yes
	Tuberculosis	Adv*	Yes	Yes	Yes
	Typhoid fever	Adv*	No	No	No
	Typhus				
High	Anthrax	Adv*	No	No	No
	CJD and TSE	No	Yes	No	Yes
	Group A streptococcal infection (invasive)	No	Yes	Yes	Yes
	Hepatitis B and C	Yes	Yes	No	Yes
	Plague	Yes	No	No	No
	Rabies	Yes	No	No	No
	Smallpox	Yes	No	No	No
	Viral haemorrhagic fever	Yes	No	No	No
	Yellow Fever	Yes	No	No	No

References:

1. Healing TD, Hoffmann PN, Young SEJ. The infection hazards of Human Cadavers. CDR review 1995; (5); 61-68. (Available at: **www.hpa.org.uk/cdr/archives/CDRreview/1995/cdrr0595.pdf**)

2. Health and safety executive: Controlling the risks of infection at work from human remains. (Available at: **www.hse.gov.uk/pubns/web01.pdf**)